San Mateo County Tactical Medic Team

APPROVED: _____ _____
EMS Medical Director EMS Administrator

1. The Tactical Medic team for San Mateo County is comprised of members from both JPA Fire Agencies and American Medical Response. The team is designed to provide embedded, tactical medical support for San Mateo County SWAT teams and other allied Law Enforcement agencies.

2. The Tactical Medic Team can be requested by a Law Enforcement Commander from a Tactical Team and will only respond upon request from Law Enforcement or other allied law agencies (i.e. FBI, DHS, Secret Service). Approval for allied agency operations will rest with Fire, Chiefs, Police Chiefs and American Medical Response management as needed.

3. The Tactical Medic Team is comprised of San Mateo County accredited paramedics and EMTs who operate under San Mateo County EMS protocols and policies at all times.

4. Tactical Medics will follow the San Mateo County Tactical Casualty Care Assessment and Treatment Model (see attached).

5. In the event that the operation takes place out of county the Tactical Medics will operate exclusively under San Mateo County EMS protocols and polices and complete patient care reports for all patients treated. If an incident occurs a Patient Care Report shall be completed and sent to the hospital as well as the LEMSA having jurisdiction and San Mateo County EMS.

6. The San Mateo County Tactical Medic Team shall make every attempt to adhere to guidelines under the California EMSA/POST document "POST/EMSA Tactical Medicine Operational Programs and Standardized Training Recommendations".

7. In the event of an injury to a SWAT/Law Enforcement operator, the tactical medic will begin treatment and request transport if not already available. The Tactical Medic will maintain care of the operator along with transport medic to the hospital.

8. In the event of an injury to a civilian the tactical medic may initiate care and activate the 911 system medical response. When first responders arrive, care will be transferred from the tactical medic to the 911 system first responder for treatment and transport.

TACTICAL CASUALTY CARE ASSESSMENT AND TREATMENT MODEL

BASIC MANAGEMENT PLAN FOR CARE UNDER FIRE/SITUATIONAL AWARENESS

1. Take hard cover.
2. Determined if patient is Alive or Dead.
3. Direct patient to move to cover and apply self-aid if able and try to keep the Patient from sustaining additional wounds.
4. Airway management is generally best deferred until the Tactical Field Care phase.
5. STOP *LIFE-THREATENING* EXTERNAL HEMORRHAGE, using appropriate PPE, if Tactically feasible:
   - Use Emergency Trauma Dressing
   - Use a tourniquet for hemorrhage that is anatomically amenable to tourniquet Application
6. Communicate with the patient, if possible in order to encourage and reassure.
7. Extract patient from unsafe area, to include using a soft litter as needed.
   - Call for Tactical Evacuation (Ground or Air Ambulance)

BASIC MANAGEMENT PLAN FOR TACTICAL FIELD CARE

1. DETERMINE LEVEL OF RESPONSIVENESS
   - Use AVPU (Alert-Voice-Pain-Unresponsive)
   - Patients with an altered mental status should be disarmed immediately
2. AIRWAY MANAGEMENT
   a. Unconscious patient without airway obstruction:
      - Chin lift or jaw thrust maneuver
      - Nasopharyngeal airway
      - Place patient in Recovery position
   b. Patient with airway obstruction or impending airway obstruction:
      - Chin lift or jaw thrust maneuver
      - Nasopharyngeal Airway
      - Allow patient to assume position that best protects the airway, including sitting
      - Place unconscious patient in Recovery position
      - If previous measures unsuccessful:
        - King Tube
        - Endotracheal Intubation or Blind Nasotracheal Intubation
3. BREATHING
   a. Consider tension pneumothorax and decompress with needle thoracostomy if patient has torso trauma and respiratory distress.
   b. Sucking chest wounds should be treated by applying a Chest Seal or three-sided occlusive dressing during expiration, then monitoring for development of a tension pneumothorax.
4. BLEEDING
   a. Assess for unrecognized hemorrhage and control all sources of bleeding.
   b. Assess for discontinuation of tourniquets once hemorrhage is definitively controlled by other means. Before releasing any tourniquet on a patient who has been resuscitated for hemorrhagic shock, ensure a positive response to resuscitation efforts (i.e., a peripheral pulse normal in character and normal mentation if there is no traumatic brain injury (TBI).
5. INTRAVENOUS (IV) ACCESS
   - Start an 18-gauge or larger IV (or saline lock) if indicated
   - If resuscitation is required and IV access is not obtainable, use the intraosseous (IO) route
6. FLUID RESUSCITATION
   Assess for hypoperfusion; altered mental status in the absence of head injury and Weak or absent peripheral pulses are the best field indicators of hypoperfusion.
   a. If no hypoperfusion:
      - No IV fluids necessary
      - PO fluids permissible if conscious and can swallow
   b. If hypoperfusion present:
      - Normal Saline, 500-mL IV bolus
      - Repeat once after 15 minutes if still in shock
      - Titrate to Systolic BP of 90-100
   c. Elevate Lower Extremities
   d. If a patient with traumatic brain injury (TBI) is unconscious and has no peripheral pulse, resuscitate to restore the radial pulse
7. PREVENTION OF HYPOTHERMIA
   a. Minimize patient's exposure to the elements. Keep protective gear on if feasible.
   b. Replace wet clothing with dry if possible.
   c. Apply self-heating Blanket to torso.
   d. Wrap in Rescue Blanket or reflective shell.
   e. Put hypothermia prevention cap on the patient's head, under the helmet.
   f. If mentioned gear is not available, use dry blankets, poncho liners, sleeping bags, or anything that will retain heat and keep the patient dry.
8. MONITORING
   Consider Pulse oximetry if available as an adjunct to clinical monitoring.
9. SECONDARY EXAM
   - Check for additional wounds or conditions
   - Inspect and dress known wounds
10. TREAT OTHER CONDITIONS AS NECESSARY
    - Spinal Immobilization
    - Use of antidote Kit for Nerve Agent Exposure
    - Use of EpiPen or Allergic Reaction protocol for Anaphylactic Reaction
    - Treat for Burns
11. PENETRATING EYE TRAUMA
    If a penetrating eye injury is noted or suspected: 1) perform a rapid field test of visual acuity; 2) cover the eye with a rigid eye shield (NOT a pressure patch).
12. SPLINT FRACTURES AND RECHECK PULSE
13. PROVIDE ANALGESIA AS NECESSARY
    a. Able to fight:
       - Recommend OTC analgesic to operator
    b. Unable to fight:
       - IV or IO access obtained:
       - Morphine sulfate, 5-10 mg IV/IO
       - Repeat dose every 10 minutes as necessary to control severe pain
       - Monitor for respiratory depression. Have Naloxone available.
14. CARDIOPULMONARY RESUSCITATION (CPR) AND AED
    Resuscitation in the tactical environment for victims of blast or penetrating trauma who have no pulse or respirations should only be treated when resources and conditions allow.
15. COMMUNICATE WITH THE PATIENT IF POSSIBLE
    - Encourage; Reassure and explain care.
16. DOCUMENTATION
    Document clinical assessments, treatments rendered, and changes in the patient's status. Forward this information with the patient to the next level of care.
17. PREPARE PATIENT FOR TACTICAL EVACUATION
    - Move packaged patient to site where evacuation is anticipated
    - Monitor airway, breathing, bleeding, and reevaluate the patient for shock.

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