

JOINT TRAUMA SYSTEM CLINICAL PRACTICE GUIDELINE (JTS CPG)



Documentation Requirements for Combat Casualty Care (CPG ID: 11)

This CPG stresses the need for complete and accurate trauma documentation of an event, including evacuation on all trauma patients from point of injury to Role 2/3.

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BACKGROUND

Trauma documentation within the military trauma system supports optimal patient care and performance improvement (PI). Documentation has continuously increased since the Joint Theater Trauma Registry (JTTR), now known as the DoD Trauma Registry (DoDTR), was initiated in 2004. DoDTR data acquisition and processing has improved greatly, due in part to standardization of the Resuscitation Record, Tactical Combat Casualty Card (TCCC), and Tactical Evacuation (TACEVAC) Patient Care Record (PCR) as well as standardized prehospital and en route care after action reports (AARs) and PI reviews. The dedicated efforts by Service, Combatant Command, and JTS personnel to capture these documents following patient care promotes inclusion within the medical record and transfer to the DoDTR. During massive casualty events, documentation reduces chaos and improves patient tracking.

Accurate documentation improves:

- Trauma readiness
- Treatments
- Outcomes
- Standard of care development
- The evaluation of rescue systems
- Casualty response processes
- Adherence to approved treatment guidelines

It is critical that all levels of the trauma system, including point of injury, en route, austere and facility-based roles of care, ensure that their casualty documentation, after action reports, and PI forms reach the JTS for incorporation into the DoDTR.

Combat casualty care documentation incorporates information from numerous sources such as nursing flow sheets, monitors, Medical Evacuation (MEDEVAC) patient care records, point of care laboratory devices, and anesthesia records. Documentation of history, physical examination, interventions and decision-making not only optimizes ongoing care of the casualty, but also contributes to improved care of future casualties when incorporated into the DoDTR. For prehospital providers and small teams who operate in a kinetic and austere setting, it may not be possible to document and provide care simultaneously, and providing optimal care always takes priority. In such cases, completion of the documentation and AAR as soon as possible after the event with transmission to JTS, preferably within 72 hours of injury, is necessary and meets the intent of this CPG.

Documentation of trauma care provided to all patients treated within the military system is relevant, and all categories of patients treated are incorporated into the DoDTR. It is critical that all roles of care utilize the same name for an individual casualty according to the theater standard pseudo name policy to ensure quality data. This requires communication and follow up, particularly for reports submitted after evacuation from that role of care. While technology is being implemented to facilitate electronic documentation by the initial roles of care, much of the initial trauma documentation is still hand-written and must be scanned in to the Theater Medical Data Store (TMDS) order to incorporate into the records. As there is no global solution to this challenge, each treating location must identify a means to transfer hand-written records to a location where they can be scanned.

PATIENT CARE DOCUMENTATION GUIDELINES

PREHOSPITAL DOCUMENTATION

The DD 1380, TCCC Card, is initiated by point of injury non-medical or medical personnel once all major life threats have been addressed in accordance with TCCC guidelines. Each Service member should carry a DD 1380 with their personal identifiers pre-positioned and stored within their first aid kit.

The purpose of the DD 1380 is to provide prehospital providers a standardized document to record all TCCC interventions administered at the point of injury and facilitate handoff to the next role of care. It should accompany the casualty during initial evacuation and be accounted for upon arrival at the first surgery capability. The TCCC card will be scanned and uploaded into TMDS utilizing the casualty name established by the first surgical team.

TCCC AAR documents should be submitted for each casualty to the JTS via the [AAR submission email link](#) on the [JTS Forms and After Action Report Submission](#) web page within 72 hours post injury or as soon as possible after mission completion. AARs must be submitted using the actual name or pseudo name for all patients subsequently treated by surgical teams; this requires communication and follow up between the prehospital and surgical teams. A secure email option is provided for convenience, however AARs submitted to the DoDTR should include only content up to the “For Official Use Only” level. The prehospital PI form should be used to review care and documentation and should be completed by the Unit Medical Officer or the Senior Enlisted Medical Advisor and submitted along with the AAR using the previous JTS web link. Units requesting a unit-specific PI report can contact JTS at dha.jbsa.j-3.list.jts-prehospital@mail.mil (unit must be identified on the AARs or a patient log provided).

When prehospital care transitions to PFC, documentation should transition from the TCCC card to the [Prolonged Field Care \(PFC\) Worksheet](#). As a follow-on to the TCCC card, the PFC Worksheet is used to document trends over time and is the most useful tool to recognize important clinical changes in complex casualties such as decompensation, response to resuscitation, development of complications, effectiveness of medications, etc.

TRANSPORT DOCUMENTATION

The TACEVAC Evacuation Patient Care Record (DA 4700) and AAR should be initiated on all patients transported via ground or rotary-wing platform. This form may be initiated during transport, but is ideally suited to be completed electronically after mission completion. Forms should be reviewed by local medical directors to aid in unit level quality assurance efforts. These forms should be completed within 72 hours of a patient care event, and may be completed digitally or by hand. (This form is not intended to supersede the AF 3899 during patient transport by Air Force air evacuation assets).

ROLE 2 & ROLE 3 DOCUMENTATION

A Resuscitation Record (DD 3019) and any required supplemental documentation (JTS Burn Flow Sheet, C-Spine Clearance Form, etc.) should be initiated on ALL patients anticipated to be admitted in a Role 2 setting or higher role of care (including those patients who are transferred for admission to a host nation facility). This includes patients with battle/non-battle injury who are coalition forces, local nationals, contractors, and civilians. *It is the intent of this guideline that the broadest definition of **trauma** be used.* This should include the majority of patients with single or multi-system injury seen in the emergency department who may require admission or who are admitted directly to the hospital, and is to be used as the primary method of initial documentation.

In situations when there are not enough team members to allocate one individual to documentation, such as during mass casualty events or austere surgical team treatments, the MASCAL/Austere Team Record may be utilized (DD Form # pending).

The Resuscitation Record (DD 3019) should be completed on all patients evaluated and admitted within the first 72 hours following injury, including but not limited to the following injury causes:

- Building Collapse
- Bullet/Gunshot Wound/Firearm
- Burn
- Explosively Formed Projectile/Penetrator
- Fall
- Fire/Flame
- Improvised Explosive Device
- Inhalation Injury
- Mine
- Mortar/Rocket/Artillery Shell
- Multi-Frag
- Motor Vehicle Crash
- Sports
- Unexploded Ordnance
- All trauma admissions to any/all Role 2 or 3 facilities in the continuum

All care delivered by each resuscitation and surgical capability will be documented for that role of care on the appropriate record and signed by the physician (preferably), nurse, or team member documenting before transport to next role of care. In situations where evacuation occurs before documentation can be completed, the record should be completed as soon as possible and transmitted electronically to the next role of care as well as to JTS. It is important that all documents are annotated with provider names with both a time and date of injury as well as arrival to surgical capability in order to ensure timeline accuracy within the registry. If time of injury is an estimate, note that in the documentation.

THEATER MEDICAL DATA STORE & TRAUMA LOGS

The TMDS provides web-based access to Service member medical information entered at deployed medical treatment facilities using AHLTA-Theater (Armed Forces Health Longitudinal Technology Application), Shipboard Automated Medical System (SAMS), Global Expeditionary Medical System (GEMS), Caché TC2, and TRANSCOM Regulating and Command & Control Evacuation System (TRAC2ES). Additionally, all documentation saved as PDF files, including scanned documents, can be uploaded to TMDS as PDF files.

Authorized individuals may request a TMDS user account by accessing the website <https://tmds.tmip.osd.mil>, connecting to “need access” and completing the registration form; account requests must be reviewed and validated before user accounts are created. User accounts are usually validated and activated within 48 hours of the request. TMDS is accessible from a government computer with .mil account.

Records entered in the deployed electronic health records must utilize an appropriate ICD-10 diagnosis code to ensure the records are identified as trauma records (do not utilize the generic 9999 code). In order to ensure all TMDS trauma records are identified by JTS, each team must record a log of trauma patients treated and submit the log to JTS weekly. The log should include the following for each patient:

- Name/pseudo name; SSN/PSSN
- Patient Category; Injury Date; Transferred From (prior to arrival)
- Arrival Date; Discharge Date
- Discharge Status

- Discharge/Transfer To
- Record uploaded in TMDS/Sent to JTS? (YES/NO)

In the event that no trauma patients were treated the previous week, a 0-patient report should be submitted. Submit to: <mailto:dha.jbsa.j-3.list.jts-trauma-log@mail.mil>

Services should develop and implement doctrine, tactics, training, security procedures, and logistical support that ensures combat casualty care documentation is uploaded into TMDS and transmitted to the JTS.

DOD & JTS FORMS

Fillable PDF forms are available on the *JTS Forms and After Action Report Submission* website. Forms can be downloaded individually or together in the forms ZIP file at https://jts.amedd.army.mil/index.cfm/documents/forms_after_action

PRIMARY REQUIRED FORMS

- [Tactical Combat Casualty Care Card \(DD 1380\)](#)
- [Point of Injury Tactical Combat Casualty Care After Action Report](#)
- [Tactical Evacuation After Action Report & Patient Care Record](#) and [Instructions](#)
- [Resuscitation Record \(DD 3019\)](#) and [Instructions](#)
- [Mass Casualty \(MASCAL\)/Austere Trauma Team Resuscitation Record](#) and [Instructions](#)

PROLONGED FIELD CARE

- [Prolonged Field Care Casualty Card - Worksheet](#)
- [Excel version of Prolonged Field Care Card - Worksheet](#)

BLOOD TRANSFUSION FORMS

- [Vampire Program CCOP-01: Urgent Resuscitation Using Blood Products During Tactical Evacuation From Point Of Injury](#)
- [Urgent Resuscitation Using Blood Products During Tactical Evac - Appendix A](#)
- [Infectious Disease Testing for Blood Donation \(ASBP 145\)](#)
- [Eldon Card ABO/Rh Typing Record \(ASBP 147\)](#)
- [Pre-screen Whole Blood Sample Shipping Manifest \(ASBP 148\)](#)
- [Emergency Release Letter of Understanding \(tested\) \(ASBP 150A\)](#)
- [Emergency Release Letter of Understanding \(untested\) \(ASBP 150B\)](#)
- [Whole Blood Transfusion Checklist \(ASBP 151\)](#)
- [Blood or Blood Component Transfusion Record ASBP \(SF 518\)](#)
- [Emergency Whole Blood Donation Record \(ASBP 572\)](#)

- [AABB Medications Deferral List](#)
- [DHQ Medication Deferral List](#)

BURN CPG FORMS

- [JTS Burn Resuscitation Worksheet](#)
- [JTS Burn Resuscitation Flow Chart](#)
- [Lund Browder Burn Estimate Diagram \(Adult & Pediatric\)](#)
- [JTS Burn CPG Physician's Order Form](#)

REBOA FORM

- [Aortic Occlusion \(AO\) Procedure Notes: REBOA or Resuscitative Thoracotomy](#)

SPINAL INJURY – CERVICAL & THORACOLUMBAR FORMS

- [Cervical Spine Clearance Status Note](#)
- [ASIA Worksheet for Spinal Cord Injury](#)
- [Combat Neuro Exam Worksheet](#)

BRAIN INJURY FORM

- [Military Acute Concussion Evaluation 2 \(MACE 2\) Form, 2018](#)

MILITARY WORKING DOG FORMS

- [Canine Tactical Combat Casualty Card \(DD 3073\)](#) and [Instructions](#)
- [Canine Treatment and Resuscitation Record \(DD 3074\)](#) and [Instructions](#)

All forms can be downloaded from the JTS website:

JTS Forms and AARs: https://jts.amedd.army.mil/index.cfm/documents/forms_after_action

EXPECTATIONS : FORM COMPLETION

- All individuals providing prehospital trauma care will complete a DD 1380 TCCC Card and ensure it is passed to providers at the next role of care for all casualties treated. The TCCC AAR form will be completed by the point of injury provider and submitted within 72 hours after mission completion via the JTS AAR Report Submission site at: https://jts.amedd.army.mil/index.cfm/documents/forms_after_action. The Prehospital PI Form will be completed by the unit senior medic or Command Surgeon and submitted to the JTS [TCCC/POI AAR email submission link](#).
- All individuals providing en route care during MEDEVAC or Casualty evacuation (CASEVAC) by air or ground will complete a TACEVAC AAR & PCR or Service equivalent form and submit within 72 hours after mission completion to the JTS AAR Report Submission site at: https://jts.amedd.army.mil/index.cfm/documents/forms_after_action. The TACEVAC Form will be

completed by the unit senior medic or Command Surgeon and submitted via the [JTS TACEVAC AAR & PCR submission email](#).

- Air Evacuation and Critical Care Air Transport teams will use appropriate Air Force documentation forms (e.g., AF 3899 series) and submit forms to JTS within 7 days after mission completion. DHA.JBSA.j-3.List.JTS-Trauma-Registry@mail.mil.
- All Role 2 and Role 3 surgical teams and all austere resuscitative and surgical teams will complete the DD 3019 Resuscitation Record or MASCAL/Austere Trauma Team Record (whichever is most appropriate) for all trauma patients anticipated to be admitted and ensure the document is uploaded into TMDS within 72 hours of injury.
 - The DD 3019 Resuscitation Record is considered the primary form and should be used preferentially for trauma evaluations.
 - The MASCAL form should be used in austere trauma scenarios and during mass casualty events when an individual cannot be dedicated to documentation. The MASCAL form is not a substitution for the DD 3019 Resuscitation Record.

NOTE: Any documentation related to patient care should be uploaded to TMDS. **Documentation of trauma care does NOT require a DD/DA/AF form number to be uploaded to the medical record and should never be discarded.** Examples may include: photos of the injury and surgical procedures; photos of medical documentation written directly on the skin or dressings. All documents detailed in this CPG should be included, as well as any other medical form used that is not listed within the CPG (i.e. medication administration record, anesthesia record, SF 600).

PI MONITORING

POPULATION OF INTEREST

All trauma patients evaluated within 72 hours of injury and admitted to Role 2 or Role 3.

INTENT (EXPECTED OUTCOMES)

1. All trauma patients who receive prehospital care have a DD 1380 TCCC card completed in patient's record and uploaded in TMDS.
2. All patients evacuated by MEDEVAC or CASEVAC air or ground have a DA 4700 form completed in patient's record and uploaded in TMDS.
3. Trauma log is received at least monthly from all Role 2 and Role 3 locations.
4. Resuscitation Record is completed at each surgical role of care on all trauma patients who present within the first 72 hours following injury and are admitted.
5. Resuscitation Record Part 1 has time of injury and time of arrival documented.
6. Resuscitation Record has complete and accurate documentation of patient identification utilizing theater trauma naming convention policy.
7. Resuscitation Record Part 2 has complete history and physical documented.

PERFORMANCE/ADHERENCE METRICS

1. Number and percentage of patients who have a DD 1380 TCCC card and/or TCCC AAR uploaded in TMDS or submitted to JTS.
2. Number and percentage of patients evacuated by MEDEVAC or CASEVAC air or ground who have a DA 4700 form uploaded in TMDS or submitted to JTS.
3. Number and percentage of Role 2s that submit a trauma log to JTS each month.
4. Number and percentage of patients of in the population of interest with Resuscitation Record uploaded into TMDS or received by JTS within 72 hours of injury.
5. Number and percentage of patients in population of interest with time of injury and time of arrival documented in Resuscitation Record Part 1.
6. Number and percentage of patients in population of interest with complete and accurate patient identification documented according to theater trauma naming convention policy.
7. Number and percentage of patients in population of interest with complete history and physical documented.

DATA SOURCE

- Patient Record
- Department of Defense Trauma Registry (DoDTR)

SYSTEM REPORTING & FREQUENCY

The above constitutes the minimum criteria for PI monitoring of this CPG. System reporting will be performed biannually; additional PI monitoring and system reporting may be performed as needed.

The system review and data analysis will be performed by the JTS Chief and the JTS PI Branch.

RESPONSIBILITIES

1. It is the trauma team leader's responsibility to ensure the Resuscitation Record Part 2, Physician H&P is complete at Role 2 and Role 3.
2. It is the responsibility of the nurse assigned to the trauma bay/patient to ensure the Resuscitation Record Part 1, Nursing Flow Sheet is completed at Role 3.
3. A member of the trauma team who is receiving report (Critical Care Air Transport, MEDEVAC, ground ambulance) should request a copy of the transport run-sheet and ensure it is included in the patient's record. All times on the Resuscitation Record should be local 24-hour military format (hhmm).