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PROLONGED FIELD CARE why, who, what, where & when?

by **Simon Greenfield**

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INTRODUCTION

Pre-hospital, first responder, austere, tactical, care under fire, high risk, remote, prolonged care, medic, clinician, practitioner, expert; the list goes on for the amount of names and phrases used to describe people, roles and courses working in a non-hospital environment. Some of them (in my opinion and I do have a few!) are used to make someone or a course sound more than it is. Some though, do exactly as it says on the tin.

I've been involved in pre-hospital care for the best part of three decades, predominately in the NHS but also have what I would deem a "reasonable background" of working in challenging environments around the world, including in an overseas medical response capacity. I have met a lot of people, done a lot of courses, got my hands dirty and treated who knows how many people in my time. I'd like to say I'm experienced but by no means an expert and I'm a firm believer in "every day is a school day".

I like to do courses that can challenge my thinking, push my comfort zone and are "a bit different". For a while I've been thinking about a Prolonged Field Care/Prolonged Casualty Care or remote area medical course. So, for the past twelve months or so I've been looking at various companies and reading reviews on the multitude of courses out there… there are a lot! However, after having previously experienced the quality of teaching with a company in North Wales on a Prehospital Trauma Life Support course with emphasis on remote areas and then on a a specialist remote area operations risk management course, it was a no brainer to go and try out their "Prolonged Field Care" two-day course. As the name implies, the course centres on what to do if help isn't arriving any time soon.

SATURDAY

So, it was in the early hours of a damp Saturday morning in September that I set off to the training centre of Remote Area Risk International (R2Ri) in Snowdonia. Their training facility is at the National Outdoor Centre and they are the pre hospital care and risk management partner to Plas y Brenin. Sitting down in the welcoming environment with a brew and biscuit, the other attendees consisted of doctors, paramedics, members of a disaster response team who deploy both in the UK and overseas, Mountain Rescue, expedition medic and remote area safety specialist; a whole wealth of experience, knowledge and ideas all there for the same reason; to learn what to do beyond the scope of 'traditional' remote area medical courses, given the context of where they work.

One of the things I look for when deciding on a course is who will be teaching and their credibility and experience. R2Ri do not disappoint in this area. The course lead being a doctor, expedition leader, published author and contributor to the new 3rd edition Oxford Expedition and Wilderness Medical Handbook, having worked in some of the most remote areas on earth; Mount Everest, Arctic Circle and Antarctica (as a British Antarctic Survey Doctor), to name but a few. The other two Faculty members being experienced paramedics within the military (including background as a medical element of one of the most elite units in the UK), NHS and civilian expedition sectors. Importantly, the Faculty had real world experience of Prolonged Field Care, including in both civilian context and hostile settings overseas in a military context.

R2Ri have been running the course for years, to military, expedition, disaster response and outdoor sector teams.

R2Ri also had an academic researcher from one of their partner Universities attending the course as a delegate, in advance of a series of research studies related to Prolonged Field Care (we weren't told what). During the course, a second researcher attended, from a globally renowned University. This second academic undertook the world first PhD study into Prolonged Field Care and R2Ri was apparently one of the key parties supporting that PhD, data wise. All excellent credentials for what would be an excellent course.

Day one was predominantly classroom-based discussions and lectures until the evening. The one thing that became apparently clear is that PFC considerations go well beyond actual immediate medical care. The rest is made up of

equipment considerations, nursing protocols and techniques, check cards covering key mnemonics and algorithms, non-technical roles and skills, communications, team logistic considerations, evacuation plans; the list goes on. All relevant, all thought provoking, all important cogs in an ever-turning wheel of which most probably go unconsidered in an untrained or inexperienced eye.

On most pre-hospital courses you will run through a patient scenario, assess, treat and package all within probably no more than half an hour and the exercise ends when the big yellow van or notional rescue helicopter turns up and whisks the patient away, at which time we all high five each other and go home for tea and medals. However, PFC doesn't stop there. In PFC this is only the beginning. Discussions, lectures and equipment reviews revolving around nursing and general healthcare of the patient took place; toileting, feeding, dental hygiene, environmental protection, to name a few of the subject areas. It's all very well treating that patient who has fallen and sustained a head injury and ankle fracture; the treating bit is relatively easy. But what about when the patient is six hours or more away from definitive care or further help? What do we do when they need to pee? What do we need to do if they are thirsty or hungry or have soiled themselves? What if the tourniquet is causing more pain than we can deal with? Lots of important things that we don't necessarily think about on a day-to-day basis when dealing with a patient. And this patient doesn't have to be up a mountain in the Cairngorms, in the middle of a jungle or an African desert. With the way things are in the UK with ambulance response times, this could be a teenager with a broken leg on a rugby pitch or an elderly patient who has been on the floor all night with a broken hip.

Equipment was a key discussion part; the minimum kit, the should have, must have, nice to have. The "ooooh nice and shiny" and the "wow that's clever". The specifics and the improvised. Medications. The stretchers. The big and small. What the book says and reality... but you do need duct tape. Always duct tape. And scissors! Importantly, the training and kit choices also had to work across a range of skill levels and qualifications.

When you have this type and level of experience under one roof from both sides of the desk, I always find it useful to hear of the "what went wrong"; equipment freezing up and failing to work because of sudden temperature changes. Using certain types of fluid giving sets as some become "sticky" in warmer climates. Different duct tape in different climates as the glue can be less effective. If taking chocolate to a cold environment then you are best to take ones with "air bubbles" in them rather than solid chocolate as these warm up quicker and are less likely to cause dental problems when biting into a piece that's frozen. You learn something new every day!

After a casual lunch and more tea, the early afternoon carried on with discussions about casualty evacuations, team welfare and communication before being split up into two teams, ready for the night-time exercise. One of the factors for me in deciding on a course provider is looking at the course title, the content, course structure and if these parts all tie in together. One of the main selling points for me was the fact that a real time PFC exercise would take place throughout the night; this wasn't a course that just discussed PFC, it did it as well. A very long night (more than 12 hours) was ahead of us.

The teams were split equally with doctors, paramedics and non-HCP's. The course is designed to benefit all skill levels and so the make - up of the delegates reflected a broad church, with everyone operating to their skills level. Time was allocated to decide on what casualty care equipment would be taken and splitting the carrying of this kit between the team; all our own personal equipment, tents, cookers, sleeping kit, food and water had to be carried in expedition backpacks for the duration of the exercise. Once the logistics were covered; there was a couple of hours spare in which to eat, rest and relax before being let out into the wild.

THE EXERCISE

The two teams "Broadsword" and "Danny Boy" (you had to be there or over a certain age!) were given a simple map to follow from the base, up into the mountains. The exercise simulated a civilian expedition in a remote area, overseas. The instructions were simple; "here's a map of your expedition route, follow it!"

From the nature of the course, whilst we weren't told, we were expecting a casualty or casualties somewhere along the way and as we set off it was starting to get dark, the weather was clear, but the forecast was "light showers".

After approximately half an hour, the "light showers" started. For anyone who has been to Wales and experienced light showers you'll know what I mean when I say that this is a slight understatement. After about another thirty minutes, each team came across a casualty with multiple injuries and started to work independently. The great thing about this course and the environment we were in, was that everything was fluid and had to take into account the environment and conditions, including looking after ongoing personal admin needs. By this time, it was raining heavily and dark. Two people were tasked with casualty assessment and treatment, one took the role of team leader while the others carried out communications and discussed evacuation plans. It soon became apparent that no help was coming and that after a team chat it was decided to make camp until help arrived….. or would it?

Fast forward to early Sunday morning (I don't want to give it all away) and a camp had been set up for all team members including a casualty care area. A rota had been set up providing fulltime care for the patient with two casualty carers at any one time. With injects from a faculty member, real time care and treatment was carried out for several hours at a time, including reassessment, feeding and hydration, toileting and personal care of the casualty while also taking into account the welfare and safety of all the team members and plans for evacuation.

Communication came through that we were to move the patient to a new position, for a realistic reason within the scenario, following which would then allow the patient to be evacuated safely. By now it was dawn, light enough to see but still raining. Working together as a team the camp was taken down while casualty care was being continued. A route out was decided and reconnoitred.

The casualty was safely evacuated under the watchful eyes of the faculty to a point of "end ex", a Helicopter Landing Zone. Tired, cold and wet but feeling accomplished, the exercise took just over 12 hours to complete.

SUNDAY MORNING

After some downtime to allow for getting showered, fed and watered a constructive and interactive debrief took place. For me, this was one of the most worthwhile parts of the course with valid and worthwhile learning and take-home points. New things to consider, next time think about this, what if?; all useful thoughts and take-home points.

I went away on the Sunday afternoon with a quiet warmth in me; I don't know what I was expecting from the course if I am honest, but I felt as though I had learnt new things, refreshed on some areas, and have been encouraged to spend time researching some of the areas that were new or rusty to me.

CONCLUSION

Prolonged Field Care (PFC) is as it says. It's about the prolonged care of a patient in a non-hospital environment (and not just in a field!). However there seems to be a lot of emphasis these days on everything being "tactical" or "hostile". The R2Ri course is civilian context (although the training has successfully been used in hostile environments by Faculty members). While there is no doubt a need and place for these phrases and courses, PFC is not just about the medical care, it's all the other stuff that goes into it as well.

In the near on three decades I've been a paramedic, I have undertaken countless courses and exercises but I have never spent a solid 12 hours dealing with the care and evacuation of a casualty. When I think about it, it seems madness that PFC is not seen as a standard part of training for UK pre-hospital clinicians, specialist rescue teams, HART and similar. You can checkout Remote Area International at

www.r2rinternational.com