

Nursing by Another Name: Nursing Science Impact on Special Forces Clinicians in Prolonged Evacuation Situations

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Faculty Disclosure

Faculty Name:	Kate Rocklein Kemplin, DNP, RN, MSN, BNSc, CCEMTP
Conflicts of Interest:	Served as research & development advisor for remote critical care monitoring device acquisitioned by the United States Special Operations Command (US SOCOM)
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Goals and Objectives

- Session Goal:
 - Stimulate discourse on nursing science influences on Special Forces (SF) medics' care delivery for critical care in prolonged care contexts
- Session Objectives:
 - Contextualize geopolitical factors contributing to prolonged field care, SF medics' practice, & outcomes conundrums
 - Present the development of prolonged field care (PFC) as based in nursing science translation & application

Caveats

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The Archetypes

- “Special Operations”
 - United States (US) Army Special Forces (SF) [‘The Green Berets’]
 - Special Forces Operational Detachment – Delta (‘Delta Force’)
 - Naval Special Warfare (Sea, Air, Land ‘SEALS’)
 - US Army Rangers
 - US Air Force Pararescue Jumpers (‘PJs’)
 - Marine Special Operations (‘MARSOC’)
- All teams have an assigned medic



The Reality

- Practice at level of advanced critical care RN (Rocklein, 2014) or 1st-year surgical resident (Graham, 1994)
- Medics' school: lower acceptance & higher attrition than Harvard
- 8+ years military medical experience
- Fluent in host-nation language (Pashto, Arabic, Tagalog, French, Spanish, Russian, etc)



SF medic students in advanced airway & ventilation



SF medic applies junctional tourniquet to abdominal trauma



SEAL medic provides veterinary care



SF medic practices diagnostic ultrasound



SF medic preps to perform surgery w/nerve block



Special Operations Rescue Team (SORT) medics



SF medics provide pediatric care (and reassurance) in village stability operations

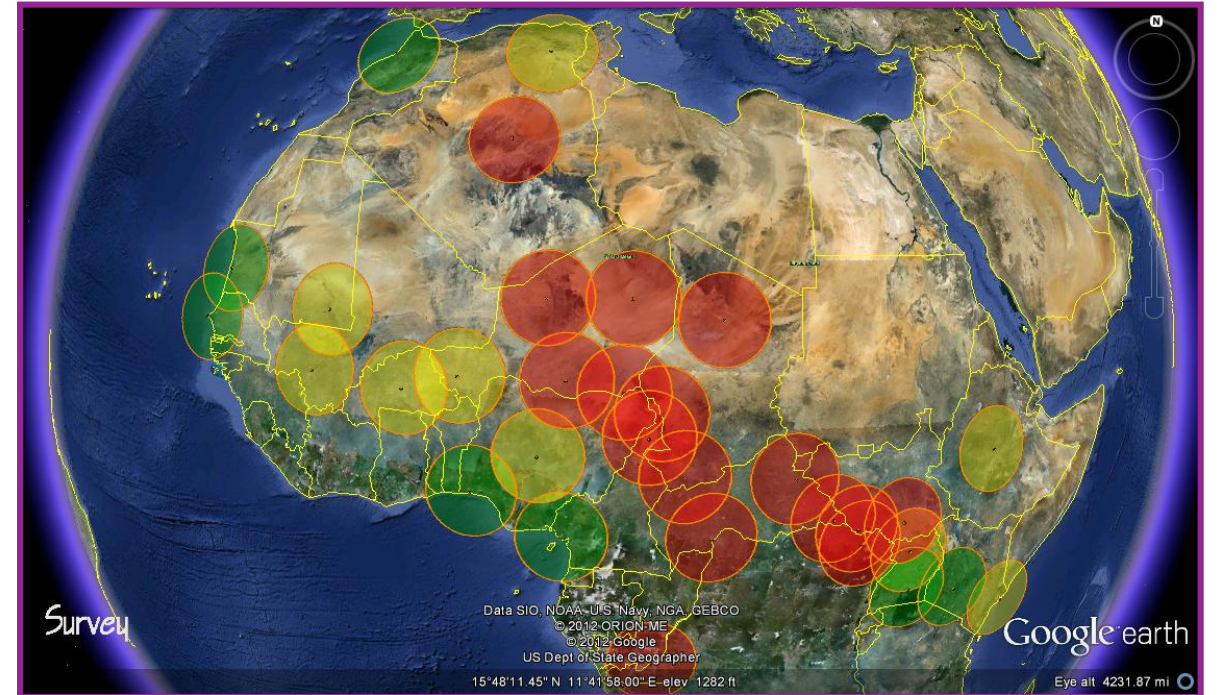
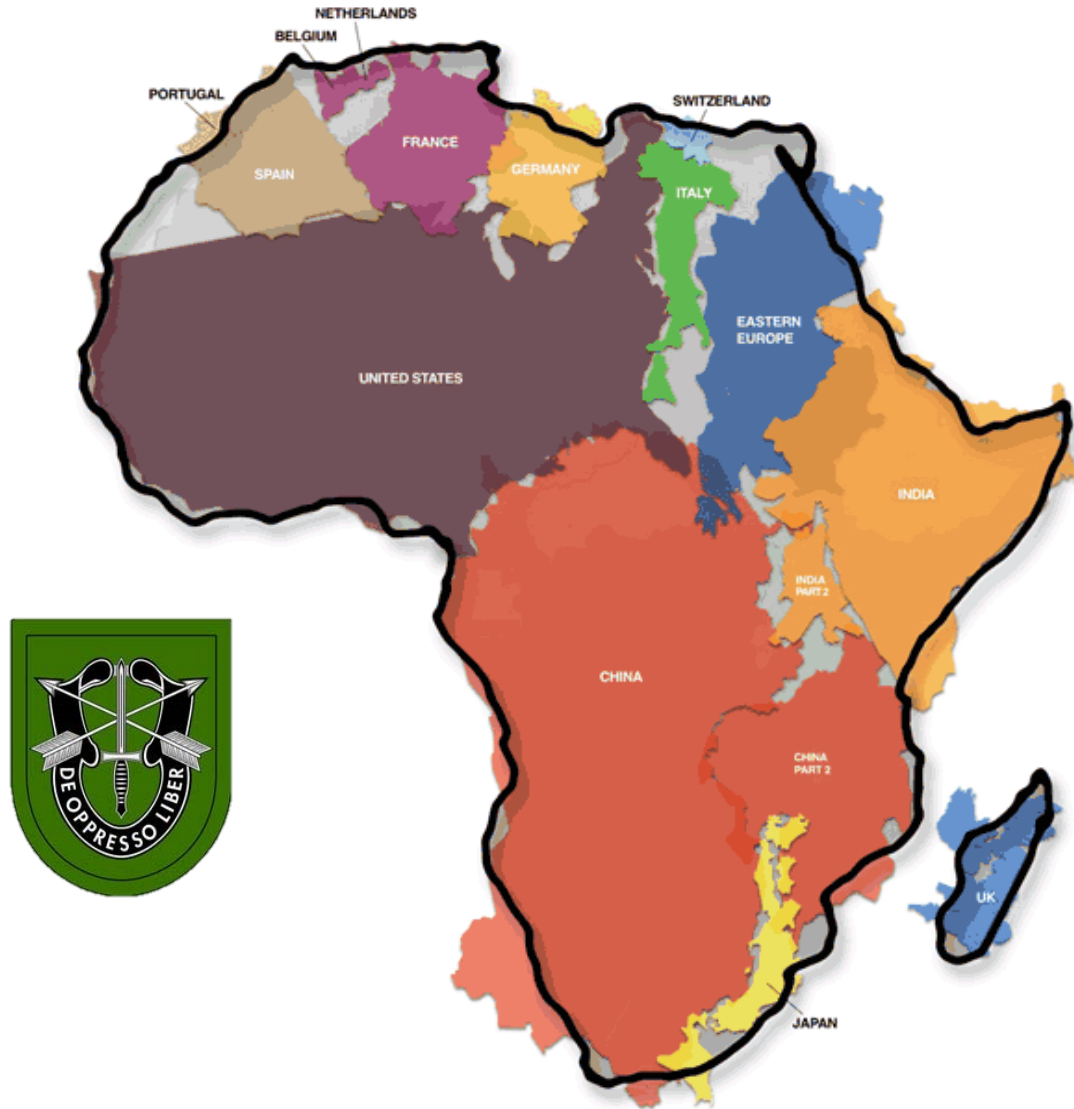


PJ medics prepare for rotary-wing evacuation



SF medic who really wanted to be included in this presentation

Geopolitical Context



Photos provided by COL M Givens, MD, US Army Special Forces Command

The Problem

- Evacuation platforms assume the “Golden Hour” exists
(Blackbourne et al., 2012; Hetzler & Risk, 2009; Risk & Hetzler, 2009)
- “Survivability” poorly operationalized
- Without evacuation, medics *de facto* nurses
 - Nursing care without nursing science
- SF operate in “special” areas & are excellent resuscitators
 - Liberators of the oppressed, not purveyors of aggression (Bank, 1986; Prados, 2015)



Medical supplies for a team, village, and contingencies



All-in-one treatment area, OR, ICU, resuscitation bay



Wound care & respiratory assessment from the back of a truck



The Solution

- Canadians & North Atlantic Treaty Organization (NATO)
 - Field medical care, applied beyond 'doctrinal planning time-lines' by an NSOCM (NATO Special Operations Combat Medic), in order to decrease patient mortality and morbidity.
 - Utilizes limited resources, and is sustained until the patient arrives at the next appropriate level of care
- Nursing: 90.4% female (Budden et al., 2013)
- Reexamine extant knowledge, assumptions, and concepts
- Discard all environmental “knowns” about critical care resources
- Give profound thanks for nursing science

The Obstacles

- Command structure: all physicians
- Special Forces: all male & alpha male – and enlisted soldiers
 - Sexism?
- Cure vs care dichotomy: physicians cure, nurses care (Weaver, 2013)
 - Fix vs maintain
- Exited entrenchment from under physicians & sought academic nursing

The Approach

- Philosophical: Critical pedagogy - Constructivist epistemology
 - Medics' knowledge acquisition not empirical: is contextual & practice is complex (Rocklein, 2011)
 - Kuhn (1962): scientific [clinical] problems instigate revolutions in scientific practice & paradigm shifts
- Foucault: '*pouvoir-savoir*' (Springer & Clinton, 2015)– medics powerless to maintain life due to lack of knowledge
 - Foucauldian discourse methods to translate nursing knowledge to affect survivability
 - Nursing has patterns of knowing foreign to other professions (Carper, 1978 as cited by Springer & Clinton, 2015)
- Theoretical
 - Approach includes Vygotskian theory: zone of proximal development & scaffolded curriculum (Pea, 2004), **subtracts** technology
 - Disruptions in health via **catastrophic events** (Newman, 1997)
 - Care of systems **constantly changing from baseline** (Neuman, 2011b as cited in Fawcett & DeSanto-Medeya, 2013)
 - Care emphasizing nutrition, hygiene, comfort, and sanitation (Davies, 2012; **Nightingale, 1858; Nightingale, 1860**)
- Clinical Evidence Translation
 - Systematic & Integrative review methodology (Whittemore & Knafl, 2005) – fresh whole blood transfusions, fluid resuscitation, hemodynamic stabilization, critical care transport (Galvagno et al., 2014), monitoring
 - Collaborative model to promote knowledge translation (Baumbusch et al., 2008) & care along a continuum: ruck – truck – house – plane → hospital

The Product: Prolonged Field Care (PFC)

And Now, to Teach It: A Model for Prolonged Field Care (PFC) Curriculum Design & Training Pathways

Background

- In contrast to the last decade(s) of war, the next generation of conflicts will have prolonged austere settings.
- To improve survivability, medics can incorporate critical care nursing science (NSC) evidence with their practice expertise to provide care in austere, prolonged circumstances.
- Clinicians – medics – must initiate and maintain solid patient management principles before all critical information or diagnostic studies are available and be able to do so in austere and resource-devoid circumstances.
- To address this need, Special Operations Forces (SOF) clinicians partnered with academic nursing to map out best practices in clinical care, teaching, and education.

Unconventional Clinicians

- SOMAs / 180s are a blend of clinical disciplines, not mini-physicians!
- Mostly physician-driven curricula / development? Thus far, but PFC requires strong NSC & care delivery expertise!
- SOF medics can't be wholly reduced to skill sets or task lists (though important!)
- PFC requires conceptually-based more than competency/protocol-based education & instruction!
- SOMAs / 180s prefer scenario / experiential / reflection-based education?
- CANUSOF has proven success with interdisciplinary program design!

Curriculum Core Concepts

- Teach for retention, not regurgitation
- Enhanced Crawl, Walk, Run
 - Scaffold in 3 stages!
- Focus on shock, austere & preventing deterioration!
- "Truth 5" – use non-SOF subject-matter experts (SMEs)!
- End user / outcomes-driven
- "Truth 1" – Humans vs hardware (brains vs tools)!
- Keep it simple!

The Method: Scaffolding

- Arguably the most potent educational method for fostering critical reasoning!
- Scaffolding is inextricably linked to preventing clinical errors & ensuring safe medication administration!
- Scaffolding transforms lower- to higher-order learning & extracts knowledge in waiting toward knowledge in-use!
- SMEs give few answers, only questions!
- Instructor is not the opposing force!
- Scaffolding is key to connecting associations, concepts, rule relationships, and to develop meta-cognition!
- Bloom: "higher-order learning requires insight, reflection, and critical reasoning!"

CRAWL Stage 1: Critical Tasks

- Resuscitation/Perfusion/Post-resuscitation care
- NG/OG insertion
- Chest Tube care and maintenance
- Hygiene
- Foley catheter insertion, monitoring strict input & output
- IV resuscitation/ maintenance/ fluid balance
- Nutrition/ hydration
- Monitoring & trending vital signs/ Documentation
- Ventilation (when & why) circuits w/ vents, BVM, ET/OT, trending, etc.)
- Tourniquet assessment, comfort, and removal
- Casualty comfort/ Pain control/ Positioning
- Wound care
- Palliative care
- Administration of blood products/volume expanders
- Telemedicine/consults with Higher Medical Authority
- Thorough clinical & nursing assessments

WALK Stage 2: Solidify & Apply

- ~ 6 hours rotating through recognizable scenarios (shock, trauma, sepsis, infectious disease, lethal triad)
- Walk throughs with newly acquired/refreshed skills
- SMEs pull triggers & give prompts!
- Hi/Lo/4 SIM² and/or medic
- Switches out and acts as patient
- SME guides through scenario
- Documentation, charting, SBAR/report to blinded provider

RUN Stage 3: Optimal Conditions

- Critical tasks applied in operational but controlled environment (FOB/civilian/CSM)
- Scenario recognizable but unpredictable
- Deterioration of medical and tactical conditions
- 1 medic/1 patient (SIM or moulaged actor)-starts as stable case and progresses to unstable
- Supplies available are contents of the aid bag they packed
- Must communicate patient status to SME & remote provider
- Stabilize & maintain patient while waiting for extraction/evacuation
- Monitor v/s, treat injuries appropriately, medication administration (antibiotics, pain meds), attempt to reach pre-surgical treatment standards

RUN AGAIN: Culmination of Critical Skills Acquisition-Austere PFC

- Resource-devoid: no comms, no electricity, no tech
- Scenario – 22-36h, scaffold withdraws support!
- Familiar in initial presentation to unfamiliar along stages 1-3
- Clinical SME as PFC evaluator, Operational SME evaluates as well

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MSG Christopher Mohr, 18D
COL Sean Keenan, MD

MAJ Chris Harris, PA-C
SFC Paul Loos, 18D
LTC Jamie Riesberg, MD

Goals

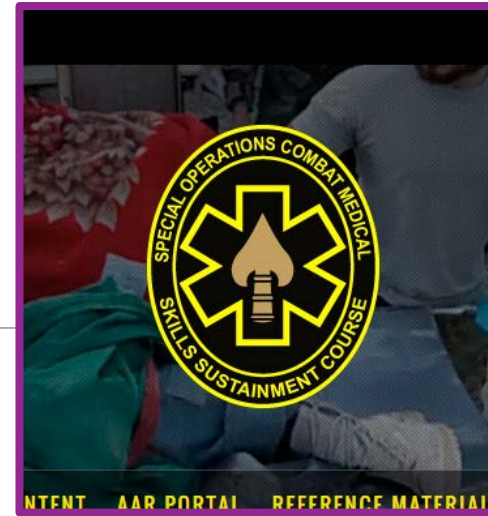
- Develop valid & vetted evidence-based academic scaffold for PFC curricula
- Use educational methods (NSC & GME that will work for PFC)
- Consistently incorporate the nature of care delivery (Hygiene)
- Remember remember remember the end user of the instruction
- SURVIVABILITY

Moving Forward

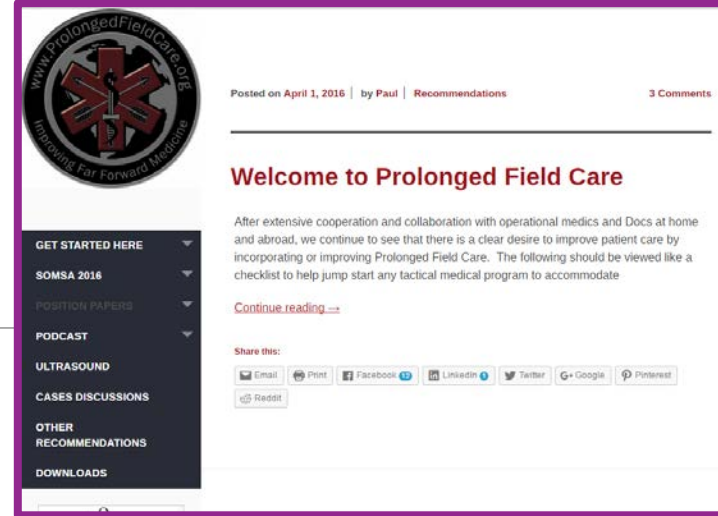
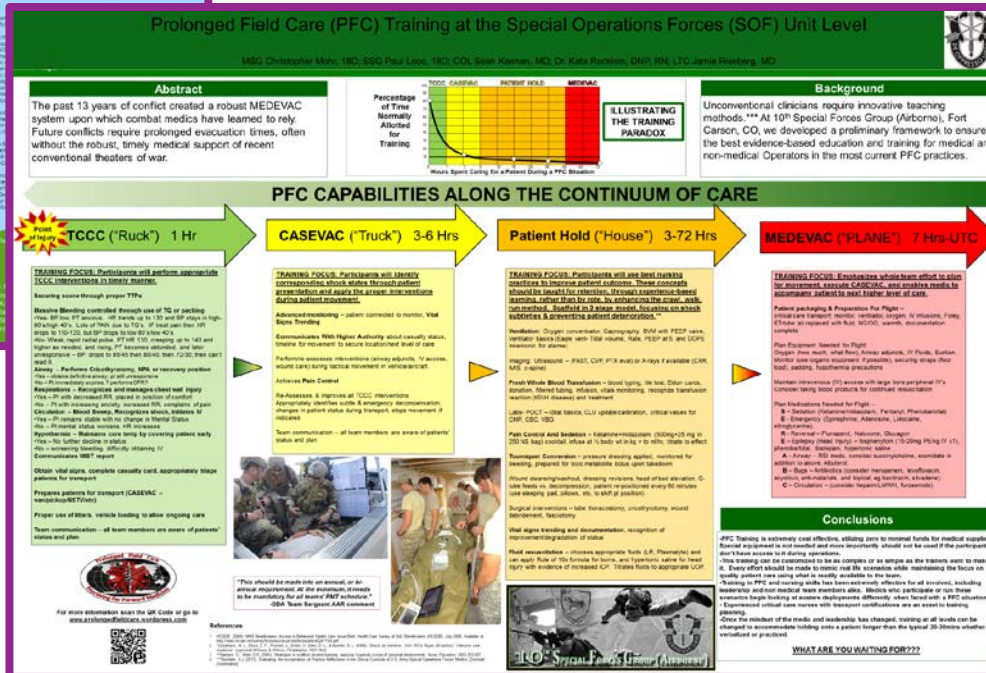
- "Gather the Tools"
- Define critical concepts/skills with associated task listing
- Identify required shock trauma pathophysiology didactic training
- Produce refereed white papers on skills, skill sustainment and shock trauma training for 48-72h of patient care – medic needs to understand what to do next, when to stop doing, and when/what to ask
- Skills App/Electronic platforms
- Skills criteria/ syllabus to guide MPT training & for rotations in MTF & civilian facilities

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SF Medic Curricular Changes



Prolonged Field Care Website & Podcasts

PROLONGED FIELD CARE

Prolonged Field Care Working Group Position Paper Prolonged Field Care Capabilities

Justin A. Ball, 18Z; Sean Keenan, MD

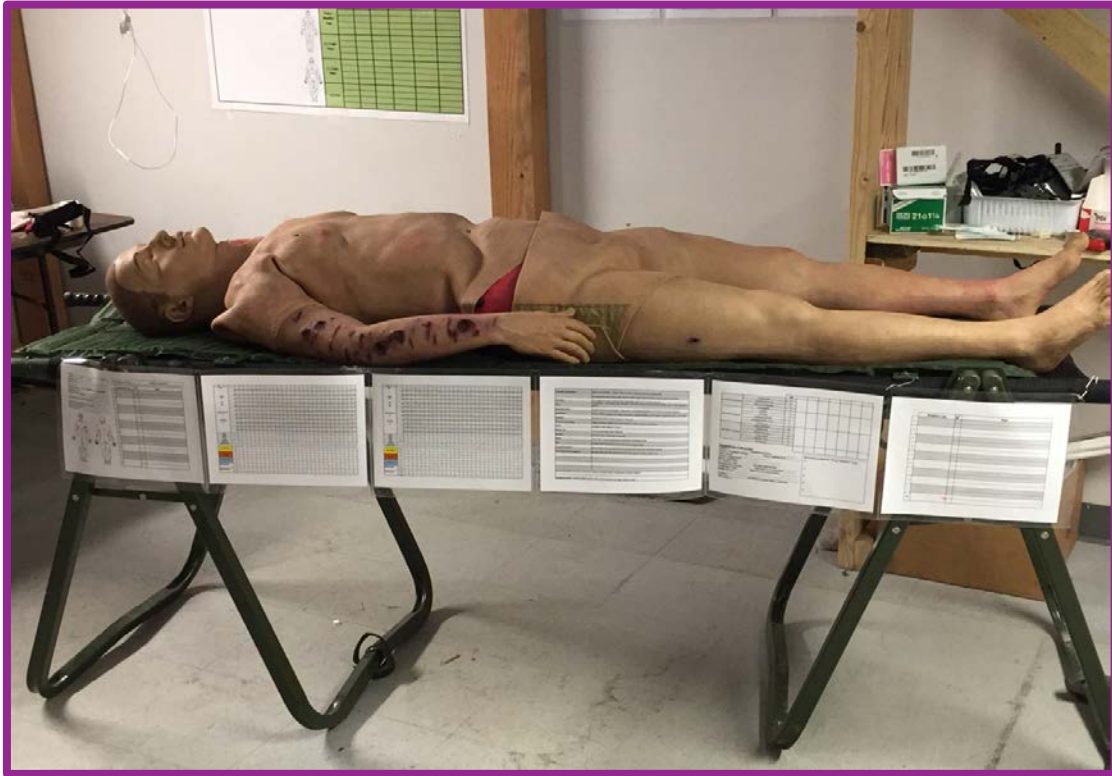
- The Special Operations Command Prolonged Field Care Working Group (SOCOM PFC WG), composed of medical-specialty subject matter experts, has been tasked to evaluate the current training and preparedness of Special Operations Forces (SOF) medics. The first formal position paper from the working group suggests that medical providers consider the following list of capabilities when preparing their medical personnel to provide prolonged field care (PFC) in austere settings. It is presented in a "minimum, better, best" format. The intent is to demonstrate those basic skills, with suggested adjunctive skills and equipment that may be used when considering PFC training.
- At first glance, the list may seem somewhat simple, but it emphasizes basic medical skills that, when put together, allow for a more comprehensive approach to critical patient care in an austere setting. Of note, equipment is relatively de-emphasized, since medical skills and training should be the focus of preparing the SOF provider to give this care.
1. Best: vital signs monitor to provide hands-free vital signs data at regular intervals
 2. Resuscitate the patient beyond crystalloid/collloid infusion
 - a. Minimum: field fresh whole blood (FWB) transfusion kits
 - b. Better: maintenance crystalloids also prepared for a major burn and/or closed head injury resuscitation (two to three cases of lactated Ringer's solution or Plasmalyte A; hypertonic saline); consider adding lyophilized plasma as available; fluid warmer
 - c. Best: maintain a stock of packed red blood cells, fresh frozen plasma, and have type-specific donors identified for immediate FWB draw.
 3. Ventilate/oxygenate the patient
 - a. Minimum: provide positive end-expiratory pressure (PEEP) via bag-valve mask (you cannot ventilate a patient in the PFC setting [prolonged ventilation] without PEEP or they will be at risk of developing acute respiratory distress syndrome)

Prolonged Field Care White Papers (Ball & Keenan, 2015)



PFC Posters – International Military Medical Conference (Rocklein, Harris, Mohr, Loos, Keenan, & Riesberg, 2014; Mohr, Loos, Keenan, Rocklein, & Riesberg, 2014).

Images courtesy Kate Rocklein Kemplin & SF Medic Paul Loos, Joint Special Operations Medical Training Center

“This concept has completely changed and revolutionized the way I think about medicine and treating casualties” (Loos, 2016, para 1).



Images & Photos provided by Sergeant First Class Paul Loos, US Army SF Medic
Prolongedfieldcare.org, "Create a Prioritized Care Plan"

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The Future



- Joint Special Operations Medical Training Center [Medics' school] (faculty previously physicians, physician assistants, medics) has new billet for military nurse corps officer



- \$48 million (USD) 2017 funding announcement from Congress to research PFC; \$3 million (USD) in funding to research medics' performance in delivering combat casualty care
- In 2016, PhD RN (LTC Elizabeth Mann-Salinas, US Army) presented at Special Operations Medical Association Scientific Assembly
- Refugee & Non-governmental organizations (NGOs): resource-devoid care delivery, caring for & transporting critically ill in oppressed areas
- Translating innovations from Special Operations medics to civilian trauma/critical care nursing & medicine is unprecedented
 - Nasal core temp, capnography, freeze-dried plasma (accelerated IND), RFID monitoring to handhelds

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Questions?

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Thank you
very much!