MED-TAC INTERNATIONAL

FIRE / RESCUE & EMS · AGENCY READINESS SERIES

# FIRE/EMS OPERATIONAL MEDICAL READINESS AUDIT

## For Fire & Rescue and EMS Services

A structured tool for fire chiefs, EMS officers, medical directors, and training coordinators to evaluate and strengthen readiness for everyday trauma, mass-casualty incidents, and high-threat events — across doctrine, gear, training, and partnerships.

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SCAN · FIRE/EMS GEAR GUIDE

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INTRODUCTION

# Why this document exists.

Fire and EMS occupy the space between chaos and the trauma bay. You own the everyday trauma call, the complex medical case, and — increasingly — the mass-casualty and active-violence event. In the average jurisdiction, the patient who is exsanguinating from a junctional wound has minutes, and EMS response alone takes seven to fourteen, before any transport to a trauma surgeon. What your crews do in those minutes is the difference between a survivable injury and a fatality.

Most services have strong clinical protocols and good people doing their best against limited time and budget. The gaps appear where clinical excellence meets operational reality: equipment laid out for the warehouse rather than for how crews actually work a scene; no shared doctrine for operating in a warm zone alongside law enforcement; training that checks a box without changing behavior on the rig. Most services have never been audited against a standard. Most discover their real gaps during the after-action review of an event that has already gone badly.

This audit is built to surface those gaps before they surface on their own. It is structured around the same doctrinal framework that governs modern prehospital trauma response — the Committee for Tactical Emergency Casualty Care (C-TECC), the Committee on Tactical Combat Casualty Care (CoTCCC), the Hartford Consensus, and NFPA 3000 (the Standard for an Active Shooter / Hostile Event Response) — translated into the operational language of a fire and EMS service.

HOW TO USE THIS DOCUMENT

# How to use this audit.

This document is written for fire chiefs and deputy chiefs, EMS chiefs and supervisors, company officers and captains, training officers and QA/QI coordinators, and medical directors who want an operational view of how their protocols actually live in the field. Use it as a self-assessment, as a discussion tool with crews and leadership, and as a baseline for planning over the next training and budget cycle.

For each item, mark one of four states. Be honest. The point is not to score well; it is to find the gaps before the gaps find you.

| SCORING LEGEND | |
|---|---|
| YES | In place and functioning as intended. You could point a reviewer to written protocol, current gear, recent training records, or after-action documentation and demonstrate the item without scrambling. |
| PARTIAL | Present but inconsistent, informal, outdated, or unevenly applied across stations and shifts. The thing exists, but it would not survive scrutiny in its current form. |
| NO | Not currently in place. Either you have never built this, or what you had has lapsed and has not been reconstituted. |
| N/A | Genuinely not applicable to your service or mission. Use this honestly — it is not a synonym for “we don’t want to deal with this.” |

At the end of each section there is space to capture action items and assign responsibility. Use it. A score with no follow-through is administrative theater. Section 7 provides a summary scoring grid and a 30/60/90-day action plan template. Work through the six operational sections, return to Section 7, capture your scores, identify your top three to five gaps, and assign each one an owner and a date. That worksheet is the deliverable. The rest of the document is the rigorous way to populate it.

SECTION 1

# Organizational Doctrine & Medical Direction

*Before the rig rolls, the program is already decided.*

Clinical protocols tell crews what to do. Operational doctrine governs how and when in complex, evolving, and dangerous environments. Medical direction is the clinical authority that makes both defensible. This section asks whether your service has actually decided what it stands for on prehospital trauma and high-threat care — and written it down.

SCAN Doctrinal foundation: The Trauma Brief

1.1
# Medical Oversight

*Operational readiness rests on a clinical foundation. If your medical direction is a name on a protocol cover and nothing more, the rest of the program is improvisation in a uniform.*

An effective program has an identified medical director who does three things, not one. First, they provide current, evidence-informed protocols and scope-of-practice guidance — protocols that reflect the present standard of trauma care, including hemorrhage control, airway positioning and ventilation management, respiratory emergencies and opioid response, vented chest seal use, and mass-casualty triage. Second, they are genuinely accessible for real-time questions and case review, not a signature obtained annually and never seen again. Third, they participate at some level in training and QA/QI, so that what is taught, what is carried, and what is reviewed all trace back to the same clinical authority.

Protocols only count if crews actually use them. A protocol that lives in a binder or a PDF nobody opens is not medical direction; it is documentation of an intention. The test is alignment: does written protocol match observed field practice, and does both match what the regional trauma system expects when your patient arrives at their door. Where those three diverge, you have a defensibility problem that will surface in the worst possible forum — litigation discovery, or a child who did not survive a survivable injury.

If your service does not have an engaged medical-director relationship for this purpose, establishing one is itself the first gap to close. Everything downstream — gear selection, training standards, the authority to carry and use advanced interventions — depends on it.

| AUDIT · 1.1 — MEDICAL OVERSIGHT | | Y | P | N | NA |
|---|---|---|---|---|---|
| 1. | An identified medical director with clear clinical authority over the trauma program. | ☐ | ☐ | ☐ | ☐ |
| 2. | Current, evidence-informed protocols covering hemorrhage control, chest injury, airway, and MCI triage. | ☐ | ☐ | ☐ | ☐ |
| 3. | Medical director is accessible for real-time questions and case review. | ☐ | ☐ | ☐ | ☐ |
| 4. | Medical director participates in training and QA/QI, not only protocol sign-off. | ☐ | ☐ | ☐ | ☐ |
| 5. | Protocols align with regional trauma-system expectations and destination criteria. | ☐ | ☐ | ☐ | ☐ |
| 6. | Written protocol matches observed field practice — verified, not assumed. | ☐ | ☐ | ☐ | ☐ |

1.2
# Operational Doctrine

*Clinical protocols answer “what care.” Operational doctrine answers “under what conditions, at what risk, and who decides.” In high-threat and MCI environments, the second question is the one that gets people killed when it is unanswered.*

Your written doctrine should cover at least three operating contexts, because each produces a different threat profile, timeline, and acceptable-risk posture. Routine EMS operations: scene safety, staging, and movement, and explicit authority for go / no-go decisions as conditions evolve. Mass-casualty incidents: when and how the service shifts from

one-patient-at-a-time care to triage-based operations, and how finite resources are allocated across many patients. High-threat / warm-zone operations: the conditions under which providers may work alongside law enforcement inside a warm zone, and what protective posture and risk are considered acceptable.

Adopt the zone framework explicitly. C-TECC divides care into Direct Threat (hot zone), Indirect Threat (warm zone), and Evacuation Care (cold zone), and defines what interventions are appropriate in each. In a warm zone, care is deliberately abbreviated to life-threats — hemorrhage control, airway positioning, rapid movement — because time under threat is the dominant risk. A service that applies a single cold-zone standard of care across all three contexts will either over-treat under threat or freeze when the doctrine does not fit the scene.

Doctrine must name who sets and re-sets zones, who holds medical command, and how and when command transfers as an incident scales. It should be known to chiefs and company officers, reflected in preplans and training scenarios, reviewed at least annually, and updated after real events and exercises. Doctrine that is older than the current edition of the TECC or CoTCCC guidelines is out of date.

| AUDIT · 1.2 — OPERATIONAL DOCTRINE | | Y | P | N | NA |
|---|---|---|---|---|---|
| 1. | Written operational doctrine exists for routine, MCI, and high-threat / warm-zone operations. | ☐ | ☐ | ☐ | ☐ |
| 2. | Doctrine explicitly adopts the hot / warm / cold zone framework (C-TECC Direct / Indirect / Evacuation). | ☐ | ☐ | ☐ | ☐ |
| 3. | Risk thresholds for warm-zone entry and care under threat are explicitly stated, not implied. | ☐ | ☐ | ☐ | ☐ |
| 4. | Doctrine names who sets zones, who holds medical command, and how command transfers. | ☐ | ☐ | ☐ | ☐ |
| 5. | Doctrine is reflected in preplans and training scenarios, not filed and forgotten. | ☐ | ☐ | ☐ | ☐ |
| 6. | Doctrine has a named owner and has been reviewed within the last 12 months. | ☐ | ☐ | ☐ | ☐ |

1.3

## Policies and SOPs

*Doctrine without policy is opinion. SOPs translate the doctrinal position into rules crews are held accountable to and reviewers can audit against.*

Your SOP framework should, at minimum, codify the triage system and tags in use (START, SALT, or a documented local variant) and the operational roles that run an MCI: triage, treatment, and transport officers, the medical branch director, and the staging and resource functions that feed them. Roles should be defined by position and trained, so that the role exists whether or not the usual person is on shift.

Integration with law enforcement at active-violence events needs its own explicit SOP, built on the Rescue Task Force (RTF) model: how an RTF is composed and triggered, the protective posture for providers operating under armed escort, how casualty collection points are established and operated, and the handoff procedures from point of injury to CCP to transport. Use-of-intervention policy — authorization and conditions for tourniquets, hemostatic gauze, vented chest seals, and airway adjuncts within scope — should be reviewed by your medical director and aligned with the regional EMS system.

Policies should reference doctrine, not duplicate it. When a policy and a piece of doctrine conflict, crews follow neither. Align them, review them together, and update them together.

| AUDIT · 1.3 — POLICIES AND SOPS | | Y | P | N | NA |
|---|---|---|---|---|---|
| 1. | Triage system and tags (START, SALT, or documented local variant) are defined and stocked. | ☐ | ☐ | ☐ | ☐ |
| 2. | MCI operational roles are defined by position and exercised in training. | ☐ | ☐ | ☐ | ☐ |
| 3. | SOP for active-threat integration with law enforcement (Rescue Task Force model or equivalent). | ☐ | ☐ | ☐ | ☐ |
| 4. | SOP for establishing and operating a casualty collection point (CCP). | ☐ | ☐ | ☐ | ☐ |
| 5. | Use-of-intervention policy for tourniquets, hemostatics, chest seals, and airway adjuncts within scope. | ☐ | ☐ | ☐ | ☐ |
| 6. | Policies reference doctrine and are reviewed together, not in isolation. | ☐ | ☐ | ☐ | ☐ |

## SECTION 1 — ACTION ITEMS

Which gaps surfaced? Who owns each? Target date? Resources?

| GAP TO CLOSE | OWNER | TARGET DATE | RESOURCES |
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SECTION 2

# Equipment & Layout

*What's on the rig — and whether crews can find it under stress.*

Good equipment in a bad layout fails under pressure. This section assesses whether your units carry what the mission demands, standardized across the fleet, staged for rapid access, and maintained so that what is on the rig is actually ready when the rig arrives.

SCAN Fire/EMS kit & cache catalog

2.1

# Unit-Level Equipment

*On most scenes the first medical capability available is whatever is on the rig that arrived. What every frontline unit carries must be clinically appropriate, standardized, and reachable.*

Every frontline unit — ambulance, engine, or rescue — should carry hemorrhage control sized for more than one patient: multiple CoTCCC-recommended limb tourniquets (the CAT Gen 7, SOF-T Wide, SAM XT, and TMT are among the recommended devices), hemostatic gauze (Combat Gauze and equivalents), pressure dressings, and vented chest seals in twin-pack configuration. “Several, not one” is the standard for tourniquets; a single tourniquet on a unit does not meet the demand of even a two-patient MVC. Tourniquets and hemostatics must be sourced from authorized distributors — the gray market is full of counterfeits that fail at terminal pressure, and a counterfeit on the rig is worse than an empty pouch because it produces false confidence.

Airway and ventilation tools should match your level of care, BLS through ALS, with backup options such as supraglottic devices where within scope. Circulation, access, and monitoring — IV/IO supplies, fluids, medications, and functioning monitors — must be present and in date. None of this matters if the crew cannot find it: items belong in predictable, standardized locations across similar units, clearly labeled, and accessible in low light and confined space. When the same drawer in every ambulance holds the same kit in the same order, any provider can work any rig. Where the apparatus supports it, consider vehicle-mounted staged caches — bracketed or hard-case hemorrhage-control kits mounted in the cab or crew compartment — so the first provider through the door has tourniquets and hemostatics before the rear compartments are even opened. When layout is unit-specific, reliability collapses to whoever stocked that particular truck.

| AUDIT · 2.1 — UNIT-LEVEL EQUIPMENT | | Y | P | N | NA |
|---|---|---|---|---|---|
| 1. | Each frontline unit carries multiple CoTCCC-recommended tourniquets, hemostatic gauze, pressure dressings, and vented chest seals. | ☐ | ☐ | ☐ | ☐ |
| 2. | Hemorrhage-control supplies are sourced from authorized distributors with anti-counterfeit verification. | ☐ | ☐ | ☐ | ☐ |
| 3. | Airway and ventilation equipment matches level of care and is functioning, with backup options in scope. | ☐ | ☐ | ☐ | ☐ |
| 4. | Circulation, access, and monitoring equipment is present, in date, and operational. | ☐ | ☐ | ☐ | ☐ |
| 5. | Kit layout is standardized across similar units and clearly labeled. | ☐ | ☐ | ☐ | ☐ |
| 6. | Critical items are accessible in low light and confined space. | ☐ | ☐ | ☐ | ☐ |
| 7. | Pediatric-capable supplies are carried: appropriately sized tourniquets, weight-based dosing references, and pediatric triage criteria (JumpSTART or equivalent). | ☐ | ☐ | ☐ | ☐ |

2.2
## High-Threat & MCI Gear

*High-threat environments and mass-casualty incidents place demands no day-to-day jump bag is built to meet. They require purpose-built, pre-staged, dedicated capability.*

Build dedicated RTF / high-threat kits that are physically separate from routine day-to-day supply, so they are complete and deployable the moment they are needed rather than cannibalized over a slow month of restocking. These kits concentrate what warm-zone work demands: massed hemorrhage control, vented chest seals, and casualty-movement tools for rapid deployment under escort. They must be compatible with your law-enforcement partners' gear — the same tourniquet families, interchangeable dressings — so a shared casualty event does not become a scavenger hunt across two agencies' incompatible kits.

MCI caches scale you past what any single unit can carry: prepackaged triage kits and tags, bulk hemorrhage-control supplies, and extra litters and movement devices for confined-space and large-area incidents. The standard planning factor for a contained active-threat event is two to three serious casualties per attacker plus walking wounded; your aggregate capability should let first-arriving units control hemorrhage on multiple casualties simultaneously while additional resources stage. Caches must be staged where they can be reached within minutes, clearly labeled, and known to every supervisor — not behind a door only the logistics officer can open at 0300 on a Saturday.

| AUDIT · 2.2 — HIGH-THREAT & MCI GEAR | | Y | P | N | NA |
|---|---|---|---|---|---|
| 1. | Dedicated RTF / high-threat kits exist, physically separate from routine day-to-day supply. | ☐ | ☐ | ☐ | ☐ |
| 2. | High-threat kits are compatible with law-enforcement partners' tourniquet and dressing types. | ☐ | ☐ | ☐ | ☐ |
| 3. | MCI cache exists with prepackaged triage kits, bulk hemorrhage control, and movement devices. | ☐ | ☐ | ☐ | ☐ |
| 4. | Aggregate capability matches a multi-casualty planning factor, not a single-patient call. | ☐ | ☐ | ☐ | ☐ |
| 5. | Caches and kits are staged for rapid deployment and known to all supervisors and crews. | ☐ | ☐ | ☐ | ☐ |
| 6. | Inventory and expiration checks for caches and high-threat kits are documented. | ☐ | ☐ | ☐ | ☐ |

2.3
## Maintenance & Checks

*No matter how good the equipment is on paper, if it is not ready on the rig, it is not real. Sustained accountability is what separates a program from a one-time procurement.*

Build a layered check system with named owners. Daily or per-shift checks of critical equipment verify presence, function, and that nothing was consumed on the last call and never replaced. Formal monthly or quarterly audits go deeper: expiration dates across the unit, function of monitors, pumps, and specialty devices, and the state of the high-threat kits and MCI caches that rarely get opened and therefore rarely get checked.

Component dating matters and varies. Tourniquets have no calendar expiration but degrade with UV, heat cycling, and training use — and apparatus compartments in summer heat are an environment they were not designed for. Hemostatic gauze and chest seals carry printed shelf lives; track them in a centralized log, not on sticky notes, and rotate proactively rather than discovering the lapse during a call. Any item used in the field or in training is replaced

before the unit returns to service, from a predictable cached location.

Accountability must be explicit: who signs off per unit, and who reviews compliance at the supervisor or chief level. A check that no one audits decays into a signature ritual. Discrepancies and failures should be documented and corrected with traceable accountability, and usage data — every tourniquet and hemostatic applied — fed back into training and budget.

| AUDIT · 2.3 — MAINTENANCE & CHECKS | Y | P | N | NA |
|---|---|---|---|---|
| 1. Written daily / per-shift checks of critical equipment, with sign-off. | ☐ | ☐ | ☐ | ☐ |
| 2. Formal monthly or quarterly audits of expirations and device function. | ☐ | ☐ | ☐ | ☐ |
| 3. Component expirations tracked in a centralized log and rotated proactively. | ☐ | ☐ | ☐ | ☐ |
| 4. Used items replaced from a cached location before the unit returns to service. | ☐ | ☐ | ☐ | ☐ |
| 5. Clear accountability: who signs off per unit and who reviews compliance. | ☐ | ☐ | ☐ | ☐ |
| 6. Discrepancies documented and corrected with traceable accountability. | ☐ | ☐ | ☐ | ☐ |

## SECTION 2 — ACTION ITEMS

Which gaps surfaced? Who owns each? Target date? Resources?

| GAP TO CLOSE | OWNER | TARGET DATE | RESOURCES |
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SECTION 3

# Crew Training & Competency

*Skill is perishable. Train like it.*

Gear without training is a liability. Training without sustainment is a one-time event with diminishing returns. Bleeding-control skill decay is well documented: correct tourniquet application drops measurably within six months without practice and significantly within twelve. This section assesses whether your training infrastructure can produce — and keep producing — competent crews.

SCAN Foundational doctrine reference: The Trauma Brief

3.1
# Core Clinical Skills

*Core trauma and critical-care skills must be habit, not memory. The depth threshold is whether a provider can perform each critical intervention under stress, not whether they have seen it.*

Recurrent, hands-on practice is non-negotiable for the interventions that decide survival: hemorrhage control (tourniquet application, wound packing, pressure dressings, vented chest seals), airway and ventilation management with the specific devices your service carries, and recognition and initial management of shock. Lecture and video are familiarization; they do not build the motor skill or the decision speed that a bleeding patient demands. Every provider should be comfortable with every hemorrhage-control tool actually carried on their rig.

Train in realistic conditions, because the call will not be a calm manikin under fluorescent lights at 1 p.m. Build scenarios with multi-system trauma, low light, confined or difficult access, pediatric patients, and the emotional load of multiple casualties. A provider who has only packed a wound on a clean task trainer in a quiet classroom has not been trained for the call they will actually run. Use time pressure and competing priorities deliberately; the cognitive load is the point.

Document every session — date, content, instructor qualifications, and the individual's evaluation result — in the personnel record. That documentation is what protects the service when a deposition asks about the foundation of the trauma program, and it is what lets QA/QI see who is due for a refresher before the skill has decayed.

| AUDIT · 3.1 — CORE CLINICAL SKILLS | | Y | P | N | NA |
|---|---|---|---|---|---|
| 1. | Hands-on hemorrhage-control refreshers occur at least annually (every six months is the gold standard). | ☐ | ☐ | ☐ | ☐ |
| 2. | Airway and ventilation skills are practiced with the actual devices carried in service. | ☐ | ☐ | ☐ | ☐ |
| 3. | Scenario-based training incorporates real constraints: low light, confined access, multiple casualties. | ☐ | ☐ | ☐ | ☐ |
| 4. | Providers are comfortable with every hemorrhage-control tool carried on their unit. | ☐ | ☐ | ☐ | ☐ |
| 5. | Shock recognition and initial resuscitation are trained, not assumed. | ☐ | ☐ | ☐ | ☐ |
| 6. | Training is documented in personnel records with date, content, instructor, and evaluation result. | ☐ | ☐ | ☐ | ☐ |

3.2
# High-Threat / RTF Training

*If your crews are expected to operate in or near warm zones with law enforcement, that capability must be trained deliberately and jointly — not assumed because a class was attended once.*

Providers operating in the warm zone must understand the doctrine before they enter it: warm-zone operating concepts, their protective posture and PPE, and the deliberate limits on clinical intervention under threat. Care in the warm zone is abbreviated by design — life-threat hemorrhage control, airway positioning, and rapid movement — because every additional minute under threat is risk to provider and patient alike. A crew that tries to deliver cold-zone care in a warm zone endangers everyone on the scene.

The capability only becomes real through joint training with law enforcement. Crews must have practiced moving and

working under armed escort, performing rapid triage and hemorrhage control while moving patients, and establishing and operating casualty collection points. The Rescue Task Force model — integrated LE-Fire-EMS elements moving into a secured warm zone — is the framework most regions are converging on under NFPA 3000; if your plans and training do not align with it, you are likely out of step with how your partners have been trained to operate.

Expectations about what care is delivered in which zone must be explicit and shared across agencies. When a police officer and a paramedic mean different things by “secure” or “clear,” the casualty pays for the ambiguity.

| AUDIT · 3.2 — HIGH-THREAT / RTF TRAINING | | Y | P | N | NA |
|---|---|---|---|---|---|
| 1. | Providers are trained on warm-zone doctrine, protective posture, and the limits of care under threat. | ☐ | ☐ | ☐ | ☐ |
| 2. | Crews have trained moving and working under armed escort. | ☐ | ☐ | ☐ | ☐ |
| 3. | Joint high-threat exercises with law enforcement have been conducted (Rescue Task Force or equivalent). | ☐ | ☐ | ☐ | ☐ |
| 4. | Crews have practiced establishing and operating a casualty collection point. | ☐ | ☐ | ☐ | ☐ |
| 5. | Expectations about which care is delivered in which zone are explicit and shared with LE partners. | ☐ | ☐ | ☐ | ☐ |
| 6. | Training aligns with NFPA 3000 / regional active-threat response doctrine. | ☐ | ☐ | ☐ | ☐ |

3.3
## Simulation, Competency Tracking & Remediation

*High-consequence skills need more than an annual check-off. Attendance is not competency; a defensible program evaluates against a standard, tracks it, and remediates when it is not met.*

Define performance benchmarks in writing and evaluate against them — correct one-handed tourniquet application on a simulated self-injury in under sixty seconds, two-handed application on a casualty in under thirty, correct wound packing with adequate pressure duration, vented chest seal placement verified on both wounds. Evaluations should be conducted by qualified instructors against a written skills checklist, not by group judgment or a comfortable peer sign-off. A clean pass/fail decision leaves less room for “good enough” than a vibe.

Maintain a central competency-tracking record: who has completed what, when each provider is due for a refresher, and any remediation history. The record is what lets you act before a skill decays rather than after a bad call reveals it. A defined remediation process — additional supervised practice, targeted simulation, and follow-up assessment — must exist for providers who do not meet standard, and a provider who cannot meet the minimum after remediation should not be carrying the intervention into the field. That is a difficult conversation; a defensible program is prepared to have it.

Training and QA/QI must talk to each other regularly, so that what the data shows failing in the field becomes what the next training block drills. What is evaluated is what gets trained; what is not evaluated atrophies regardless of how often it is named in policy.

| AUDIT · 3.3 — SIMULATION, COMPETENCY TRACKING & REMEDIATION | | Y | P | N | NA |
|---|---|---|---|---|---|
| 1. | Written skills benchmarks with specific time and correctness standards (referenced to TECC / CoTCCC). | ☐ | ☐ | ☐ | ☐ |

| AUDIT · 3.3 — SIMULATION, COMPETENCY TRACKING & REMEDIATION (CONTINUED) | | Y | P | N | NA |
|---|---|---|---|---|---|
| 2. | Evaluations conducted by qualified instructors against a written checklist, documented like a skills test. | ☐ | ☐ | ☐ | ☐ |
| 3. | Central record of individual competencies and refresher due-dates is maintained. | ☐ | ☐ | ☐ | ☐ |
| 4. | Defined remediation process exists for providers who do not meet standard. | ☐ | ☐ | ☐ | ☐ |
| 5. | Providers who cannot meet the minimum after remediation are not carrying advanced interventions. | ☐ | ☐ | ☐ | ☐ |
| 6. | Training and QA/QI teams communicate regularly so data drives the next training block. | ☐ | ☐ | ☐ | ☐ |

## SECTION 3 — ACTION ITEMS

Which gaps surfaced? Who owns each? Target date? Resources?

| GAP TO CLOSE | OWNER | TARGET DATE | RESOURCES |
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SECTION 4

# Response Plans: MCI & High-Threat

*The plan you never exercised is a wish.*

No fire or EMS service responds to a mass-casualty or active-threat event alone. These incidents demand police, fire, EMS, hospitals, and emergency management operating inside one incident under one command. The plans that make that work are built before the event — and exercised, because a plan that has never been run is an aspiration.

SCAN MED-TAC — tactical-medicine.com

4.1
# Mass Casualty Incidents (MCI)

*A written, distributed, exercised MCI plan is the difference between an organized response and a scene where everyone treats the first patient they reach while others bleed out unseen.*

A real MCI plan defines when an incident is declared an MCI and who has that authority, the triage system and tags in use (START, SALT, or a documented local variant), including pediatric triage criteria (JumpSTART or equivalent) where children may be present, and the operational roles that structure the response: triage, treatment, transport, and medical command, with the treatment and transport area layouts that make those roles function. It describes how additional resources and mutual aid are requested and integrated, and how hospitals and trauma centers are notified, updated, and load-balanced so the nearest facility is not buried while others sit empty.

The plan must be written, accessible on every unit, and — critically — trained, so that the roles are muscle memory rather than a document someone opens for the first time on the worst day of their career. Triage is where MCIs are won or lost: a service that has drilled rapid triage moves the salvageable to transport while a service that has not stalls on the first critical patient it finds. Tags must be in stock and in the cache, not theoretically specified in a binder.

| AUDIT · 4.1 — MASS CASUALTY INCIDENTS (MCI) | | Y | P | N | NA |
|---|---|---|---|---|---|
| 1. | Written MCI plan is accessible on every unit and known to supervisors. | ☐ | ☐ | ☐ | ☐ |
| 2. | Triage system and tags are defined, trained, and physically in stock. | ☐ | ☐ | ☐ | ☐ |
| 3. | Operational roles (triage, treatment, transport, medical command) are defined and exercised. | ☐ | ☐ | ☐ | ☐ |
| 4. | Resource request and mutual-aid integration procedures are specified. | ☐ | ☐ | ☐ | ☐ |
| 5. | Hospital and trauma-center notification and load-balancing procedures are defined. | ☐ | ☐ | ☐ | ☐ |
| 6. | MCI roles and triage are included in recurring training, not only in the plan. | ☐ | ☐ | ☐ | ☐ |

4.2
# Active Threat / High-Risk Incidents

*Your active-threat plan is only as good as the agreement behind it. It must be built jointly with law enforcement and emergency management, and exercised with live movement of casualties.*

A defensible active-threat plan is developed jointly with law enforcement, emergency management, and receiving hospitals, and it is explicit about the questions that paralyze an uncoordinated scene: who defines and re-defines hot, warm, and cold zones; under what conditions EMS enters a warm zone, if at all; how victims move from point of injury to casualty collection point to transport; and how and when command is held and transferred under a unified command structure. NFPA 3000 and the Hartford Consensus provide the doctrinal backbone, and the THREAT construct — Threat suppression, Hemorrhage control, Rapid Extrication, Assessment by medical providers, and Transport — is the integrated framework most regions are aligning to.

The plan must be exercised in live drills, not validated on a tabletop and shelved. Tabletops are useful for command and control, but the friction that kills people lives in field execution: how the RTF physically moves into the warm zone, who calls the CCP, how casualties move from an interior space to an ambulance, what radio channel the lead medic

and the tactical commander actually share. Run it live, at least annually, with the communications challenges and time pressure built in — and capture what breaks.

| AUDIT · 4.2 — ACTIVE THREAT / HIGH-RISK INCIDENTS | | Y | P | N | NA |
|---|---|---|---|---|---|
| 1. | Active-threat plan is jointly developed with law enforcement, emergency management, and hospitals. | ☐ | ☐ | ☐ | ☐ |
| 2. | Plan defines who sets zones, conditions for EMS warm-zone entry, and casualty movement to transport. | ☐ | ☐ | ☐ | ☐ |
| 3. | Unified command structure and command-transfer triggers are specified. | ☐ | ☐ | ☐ | ☐ |
| 4. | Plan aligns with NFPA 3000, the Hartford Consensus, and the THREAT / RTF construct. | ☐ | ☐ | ☐ | ☐ |
| 5. | Plan is exercised in live drills at least annually, not only on tabletop. | ☐ | ☐ | ☐ | ☐ |
| 6. | Casualty collection point establishment and operation is included in the drill. | ☐ | ☐ | ☐ | ☐ |

4.3

## Communications & Interoperability

*Cross-agency communications fail precisely when they are needed most. The fixes are not exotic — agreed channels, shared plain language, and radio discipline exercised under load.*

Establish and publish a communications plan for the predictable incident types — routine EMS-LE interface, MCI, and active threat — specifying which channels or talkgroups are used by whom, when and by whose authority channels shift, and how the regional emergency operations center is brought in. Reference your jurisdiction's P25 interoperability architecture or equivalent. If your fire/EMS units and law enforcement still cannot talk directly on a shared channel, that is a finding to close, not a quirk to work around.

Standardize language. Plain language has been the national standard for multi-agency incidents since 2006 under NIMS/ICS, yet agency-specific codes still infect the air during real responses. Adopt plain language for any incident involving more than one agency or that could become one, and standardize the vocabulary that crosses agency lines: casualty categories, zone designations (hot / warm / cold), staging and rally points, and RTF and command roles. When two responders from two agencies use the same word to mean different things, the casualty pays for it.

Test communications under load. A system that works on a quiet Tuesday can collapse during a multi-unit response with everyone keying up at once. Exercise interoperability in conditions that approximate real incident loading, between your own units and with partner agencies, at least annually — and capture and fix the failures.

| AUDIT · 4.3 — COMMUNICATIONS & INTEROPERABILITY | | Y | P | N | NA |
|---|---|---|---|---|---|
| 1. | Documented, published comms plan for routine EMS-LE, MCI, and active-threat incidents. | ☐ | ☐ | ☐ | ☐ |
| 2. | Fire/EMS and law enforcement can talk directly on shared channels or documented patches. | ☐ | ☐ | ☐ | ☐ |
| 3. | Plain language is the standard for any multi-agency incident. | ☐ | ☐ | ☐ | ☐ |
| 4. | Casualty categories, zone designations, and role vocabulary are standardized across agencies. | ☐ | ☐ | ☐ | ☐ |

| AUDIT · 4.3 — COMMUNICATIONS & INTEROPERABILITY (CONTINUED) | Y | P | N | NA |
|---|---|---|---|---|
| 5. Interoperability is exercised under load, with partner agencies, at least annually. | ☐ | ☐ | ☐ | ☐ |
| 6. Communications failures from real incidents are captured and inform plan revisions. | ☐ | ☐ | ☐ | ☐ |

## SECTION 4 — ACTION ITEMS

Which gaps surfaced? Who owns each? Target date? Resources?

| GAP TO CLOSE | OWNER | TARGET DATE | RESOURCES |
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SECTION 5

# Data, QA/QI & Debrief

*What you measure is what improves.*

A readiness program is a continuous process, not a project. Every significant call is data. Every near-miss is feedback. And every provider's resilience after a hard incident is part of what determines whether the program survives the people who built it. This section asks whether your service learns from its own operations.

SCAN Talking TACMED — continuing education

5.1
# Event Review & After-Action Reviews

*Significant incidents — wins and near-misses alike — must be reviewed. An AAR is not a critique session and not a vindication exercise; it is a structured examination of what changed and why.*

Conduct a structured debrief for any major trauma call, any MCI or near-MCI, and any high-threat operation. Run it on a defined cadence — an operational debrief within roughly seventy-two hours, with a structured AAR following within two weeks, because beyond two weeks recollections diverge and the learning value compresses. Use a written framework; the four-question military model — what was supposed to happen, what actually happened, why the difference, and what we do about it — is common, but the discipline matters more than the format.

The review must include medical, operational, and communications perspectives, and a representative from partner agencies where the incident touched their domain. Separate the operational AAR from any disciplinary process: if the debrief is perceived as a disciplinary tool, you will not get truthful input, and untruthful input produces no learning. Capture both sustains and improves honestly.

Translate findings into action. Every AAR should generate a small number of specific changes — a protocol update, a training adjustment, an equipment change, a comms-plan revision — each with an owner and a date, tracked to closure and fed back to crews. An AAR that produces findings but no changes is the most expensive kind of administrative theater.

| AUDIT · 5.1 — EVENT REVIEW & AFTER-ACTION REVIEWS | | Y | P | N | NA |
|---|---|---|---|---|---|
| 1. | Formal debrief process exists for major trauma, MCI / near-MCI, and high-threat incidents. | ☐ | ☐ | ☐ | ☐ |
| 2. | Operational debrief within ~72 hours; structured AAR within two weeks. | ☐ | ☐ | ☐ | ☐ |
| 3. | AAR uses a written framework and includes medical, operational, and comms perspectives. | ☐ | ☐ | ☐ | ☐ |
| 4. | AAR is separated from disciplinary review to preserve truthful input. | ☐ | ☐ | ☐ | ☐ |
| 5. | Findings translate into specific changes with owners and dates, tracked to closure. | ☐ | ☐ | ☐ | ☐ |
| 6. | Findings are shared appropriately with crews and leadership. | ☐ | ☐ | ☐ | ☐ |

5.2
# Data & Quality Improvement

*Anecdotes do not justify budgets, refine training, or survive a city council. Data does. A service that captures and uses operational data defends itself and improves itself.*

Track, at minimum: use of tourniquets and hemostatic agents (field and training), time from arrival to first meaningful hemorrhage control, scene times in major trauma relative to severity, airway interventions and outcomes where traceable, and deviations from protocol with their reasons. Capture enough context — patient category, mechanism — that the numbers can teach you something rather than merely accumulate.

The infrastructure can be simple: a spreadsheet owned by the training or QA/QI coordinator, populated from run sheets and AARs, is sufficient for most services. What matters is the discipline of populating it and the habit of

reviewing it — quarterly, at command level, looking for patterns. The patterns tell you where to invest training hours and equipment dollars, and they replace vendor influence and anecdote with evidence.

Use the data publicly when appropriate. “In the last year our crews applied tourniquets eleven times and ten of those patients survived to discharge” is a sentence that moves a budget meeting, a grant application, and a community briefing in a way national statistics never will. Close the loop back to the frontline providers who generated the data.

| AUDIT · 5.2 — DATA & QUALITY IMPROVEMENT | | Y | P | N | NA |
|---|---|---|---|---|---|
| 1. | Basic trauma performance metrics are monitored (tourniquet use, time to hemorrhage control, scene times). | ☐ | ☐ | ☐ | ☐ |
| 2. | Protocol deviations and their reasons are captured. | ☐ | ☐ | ☐ | ☐ |
| 3. | Data capture is owned by a named position (training or QA/QI coordinator). | ☐ | ☐ | ☐ | ☐ |
| 4. | Command reviews program data at least quarterly and looks for patterns. | ☐ | ☐ | ☐ | ☐ |
| 5. | Data drives training focus, equipment choices, and budget advocacy — not anecdote or vendor influence. | ☐ | ☐ | ☐ | ☐ |
| 6. | A feedback loop returns findings to frontline providers. | ☐ | ☐ | ☐ | ☐ |

5.3

## Provider Support & Resilience

*High-acuity trauma and critical events leave a mark. An honest readiness program accounts for the people who run the calls, not only the gear they carry.*

Providers who work a pediatric arrest, a multiple-fatality MCI, or a colleague’s line-of-duty injury carry a psychological load that accumulates over a career. The service must provide real access to confidential peer support and mental-health resources, an EAP relationship that actually responds rather than a number that rings unanswered, and Critical Incident Stress Management integrated into the AAR process so that the operational debrief and the human one are not strangers to each other.

Culture decides whether any of that gets used. Leadership messaging must make clear that seeking support is professional, not weakness or career damage, and leaders should model healthy approaches to cumulative stress themselves. A peer-support program that exists on paper but is culturally radioactive to use is not a program. Post-incident check-ins should be routine after significant events, not exceptional and not stigmatizing.

This is operational, not soft. Burnout, attrition, and unaddressed cumulative stress degrade the same crews you spent years training. Protecting provider resilience protects the readiness investment. Behavioral health is one of the eight core areas of MED-TAC International’s clinical teaching doctrine — it is treated as an operational capability, not a peripheral one.

| AUDIT · 5.3 — PROVIDER SUPPORT & RESILIENCE | | Y | P | N | NA |
|---|---|---|---|---|---|
| 1. | Access to confidential peer support and mental-health resources is available and responsive. | ☐ | ☐ | ☐ | ☐ |
| 2. | EAP relationship is active and responds to provider requests promptly. | ☐ | ☐ | ☐ | ☐ |

| AUDIT · 5.3 — PROVIDER SUPPORT & RESILIENCE (CONTINUED) | Y | P | N | NA |
|---|---|---|---|---|
| 3. Critical Incident Stress Management is integrated into the AAR / debrief process. | ☐ | ☐ | ☐ | ☐ |
| 4. Leadership messaging supports utilization of these resources without stigma. | ☐ | ☐ | ☐ | ☐ |
| 5. Post-incident wellness check-ins are routine after significant events. | ☐ | ☐ | ☐ | ☐ |
| 6. Cumulative stress and burnout are monitored as an operational, not a peripheral, concern. | ☐ | ☐ | ☐ | ☐ |

## SECTION 5 — ACTION ITEMS

Which gaps surfaced? Who owns each? Target date? Resources?

| GAP TO CLOSE | OWNER | TARGET DATE | RESOURCES |
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SECTION 6

# Community & Interagency Integration

*You are one node in a regional system. Act like it.*

Survival in large-scale trauma is a regional product. Bystanders are the true first responders in the minutes before your units arrive; neighboring agencies, hospitals, and emergency management are your partners in everything that exceeds a single service. This section assesses how well your service operates inside that larger system.

SCAN MED-TAC — tactical-medicine.com

6.1

# Public Education & Bystander Involvement

*The person standing over the wound when it happens is almost never wearing your uniform. Community Bleeding Control capability extends survival into the minutes before you arrive.*

Offer or support public access bleeding control training (the national Stop the Bleed program) that teaches laypeople to recognize life-threatening hemorrhage, pack a wound, and apply a tourniquet correctly. The same minutes that matter to your crews matter more to the bystander who is already there, and a community trained to control bleeding buys time your response cannot manufacture. Pair the skills with clear public guidance on what to do while awaiting responders and how to interact safely with police and EMS at a scene.

Alignment is the discipline that keeps public education honest. Your public messaging must match what your crews can actually support on arrival — promising a capability you cannot deliver erodes trust and confuses scenes. Coordinate the message across the agencies the public will encounter, so a bystander who took your class hears the same instructions from the dispatcher, the responding medic, and the law-enforcement officer who arrives first.

| AUDIT · 6.1 — PUBLIC EDUCATION & BYSTANDER INVOLVEMENT | | Y | P | N | NA |
|---|---|---|---|---|---|
| 1. | Public access bleeding control training is offered or supported (the national Stop the Bleed program). | ☐ | ☐ | ☐ | ☐ |
| 2. | Public guidance covers what to do while awaiting responders and how to interact safely at scenes. | ☐ | ☐ | ☐ | ☐ |
| 3. | Public messaging matches the capability crews can actually support on arrival. | ☐ | ☐ | ☐ | ☐ |
| 4. | Messaging is coordinated across the agencies the public will encounter. | ☐ | ☐ | ☐ | ☐ |

6.2

# Regional Cooperation

*No agency stands alone in a large-scale incident. The relationships that make a regional response work are built in low-stakes planning, not invented on scene at the worst moment.*

Participate actively in regional preparedness groups and joint planning with neighboring fire/EMS services, law enforcement, hospitals and trauma centers, and emergency management. These standing relationships are what produce workable joint plans for the high-consequence scenarios — active threat, MCI, large public events — and they are what let agencies that have planned together actually coordinate on scene rather than meeting for the first time inside a crisis.

Host and attend joint drills, and treat the joint debrief as the point of the exercise — not the photo of agencies standing together at the end. Share lessons learned, protocol updates that affect cross-agency work, and an honest accounting of your capabilities and limitations so partners can plan against reality. Managing expectations is itself a safety function: a partner who knows what you cannot do plans around it, while a partner who assumes a capability you lack builds a gap into the regional response.

| AUDIT · 6.2 — REGIONAL COOPERATION | Y | P | N | NA |
|---|---|---|---|---|
| 1. Active participation in regional preparedness groups and joint planning. | ☐ | ☐ | ☐ | ☐ |
| 2. Joint drills are conducted with neighboring fire/EMS, law enforcement, and hospitals. | ☐ | ☐ | ☐ | ☐ |
| 3. Lessons learned and protocol updates affecting cross-agency work are shared. | ☐ | ☐ | ☐ | ☐ |
| 4. Capabilities and limitations are communicated honestly to manage partner expectations. | ☐ | ☐ | ☐ | ☐ |

## SECTION 6 — ACTION ITEMS

Which gaps surfaced? Who owns each? Target date? Resources?

| GAP TO CLOSE | OWNER | TARGET DATE | RESOURCES |
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SECTION 7

# Scoring & Action Plan

You have now worked through six sections covering doctrine and medical direction, equipment and layout, training and competency, response plans, data and improvement, and community integration. The final step is to translate your scores into action. The matrix below summarizes your standing; the 30/60/90-day action plan that follows is the worksheet your command staff will actually use to assign and track the work.

## Maturity scale (0–2 per section):

| | |
|---|---|
| **0 — ABSENT** | Not present. Either never built, or lapsed beyond recovery without a dedicated rebuild effort. |
| **1 — INFORMAL** | Some elements exist but are inconsistent, informal, outdated, or unevenly applied across stations and shifts. Would not survive scrutiny in current form. |
| **2 — DEFINED** | Formally established, documented, and consistently applied. Would survive scrutiny. Forms the operational baseline of the program. |

## Section-by-section scores:

| PROGRAM AREA | 0 | 1 | 2 | NOTES |
|---|---|---|---|---|
| **1. Organizational Doctrine & Medical Direction** | ◯ | ◯ | ◯ | |
| **2. Equipment & Layout** | ◯ | ◯ | ◯ | |
| **3. Crew Training & Competency** | ◯ | ◯ | ◯ | |
| **4. Response Plans: MCI & High-Threat** | ◯ | ◯ | ◯ | |
| **5. Data, QA/QI & Debrief** | ◯ | ◯ | ◯ | |
| **6. Community & Interagency Integration** | ◯ | ◯ | ◯ | |

**TOTAL POSSIBLE: 12** 10–12 = mature program · 6–9 = formalize & sustain · ≤5 = build from doctrine up

**Service total score: _____ / 12**

SECTION 7 — CONTINUED

# 30 / 60 / 90-Day Action Plan

Pick the three to five gaps that, if closed, would produce the largest readiness improvement or risk reduction. Resist the temptation to list everything — a focused plan that closes three gaps is worth more than an aspirational plan that names twelve. Assign each item to a named individual, not a unit. Set a specific target date. Identify the resources required. Review progress at 30, 60, and 90 days.

**30 DAYS** *Quick wins. Doctrine and protocol items, rig-check cadences, AAR templates.*

| GAP TO CLOSE | OWNER | TARGET DATE | RESOURCES |
|---|---|---|---|
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**60 DAYS** *Procurement cycle. Unit-kit standardization, RTF / MCI caches, training contracts.*

| GAP TO CLOSE | OWNER | TARGET DATE | RESOURCES |
|---|---|---|---|
| | | | |
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**90 DAYS** *Sustaining infrastructure. First sustainment cycle, joint exercise, re-score.*

| GAP TO CLOSE | OWNER | TARGET DATE | RESOURCES |
|---|---|---|---|
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**SCAN** Request a procurement quote — typically returned within 1 business day for govt agencies.

MED-TAC INTERNATIONAL

NEXT STEP

# Build the program.
# We'll source the kit.

MED-TAC International Corp. is a clinician-founded, veteran-led, SDVOSB-certified tactical medicine company headquartered in Pembroke Pines, Florida. We supply fire and EMS services, law enforcement agencies, federal partners, and international government customers with CoTCCC-recommended kit sourced exclusively from authorized manufacturers. We are SAM.gov registered and SDVOSB-certified, and support federal, state, local, tribal, and territorial procurement vehicles.

**If you found gaps in this audit:**

If you have worked through this audit and identified gaps in your unit kits, RTF and MCI caches, or training, we can help you cost, configure, and source what you need to close them. Quotes for bonafide government agencies are typically returned within one business day at Net 30 terms.


AGENCY PROCUREMENT CONTACT

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tactical-medicine.com/pages/government-procurement-solutions


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