
The Medical Detachment, Forward Resuscitative and Surgical

DECEMBER 2020

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The Medical Detachment, Forward Resuscitative and Surgical

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Remove Old Pages	Insert New Pages
pages i through v	pages i through v
page 2-1	page 2-1
page 3-2	page 3-2
page 4-7	page 4-7
page references-1	page references-1
page index-1	page index-1

2. New or changed material is indicated by a star (★).
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The Medical Detachment, Forward Resuscitative and Surgical

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Preface

Army Techniques Publication (ATP) 4-02.25, *The Medical Detachment, Forward Resuscitative and Surgical*, provides guidance for training, establishing, employing, and sustaining the detachment.

The principal audience for ATP 4-02.25 is medical commanders and their staff, medical planners, forward resuscitative and surgical detachment staff, and supported medical company commanders.

This publication does not include tactics, techniques, procedures, and the employment of medical capabilities specifically addressing medical support during large-scale combat operations and the associated Army strategic roles as discussed in Field Manual (FM) 3-0. This publication is technical in nature and the aspects of the Army Health System contained in it will be employed similarly regardless of the operational environment or type of operation being supported. For a discussion of the Army Health System support provided during large-scale combat operations, see FM 4-02.

This publication uses joint terms where applicable. Selected joint and Army terms and definitions appear in both the text and the glossary. This publication is not the proponent for any Army terms.

ATP 4-02.25 applies to the Active Army, Army National Guard/Army National Guard of the United States, and the United States Army Reserve unless otherwise stated.

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Introduction

The Section One (1) of Table of Organization and Equipment 08528KA00, approved on 19 January 2017 designates this organization as a medical detachment and assigns it the title of “***medical detachment, forward resuscitative and surgical.***” This is the result of a force design update conducted to address the shortcomings and limitations of the forward surgical team. The product of that force design update is a modular, agile forward resuscitative and surgical detachment that when necessary, can be evenly divided to support split-based operations, a mission that the forward surgical team was never designed for or capable of accomplishing.

For purposes of brevity and user familiarity, this publication will from this point forward, refer to this organization as the “***forward resuscitative and surgical detachment.***”

★Change 1 to ATP 4-02.25 includes changes to the preface, introduction, chapters two (2), three (3), references, and index. The purpose of these changes is to correct errors and add clarity to information that was deemed vague and/or confusing regarding the capabilities, deployment, and training of the FRSD. These changes do not change or alter the manning, equipping, or primary functions of the FRSD.

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Chapter 1

The Forward Resuscitative and Surgical Detachment

MISSION

1-1. The primary mission of the forward resuscitative and surgical detachment (FRSD) is to provide far forward damage control resuscitation and damage control surgery to stabilize patients for further medical evacuation to the next higher role of medical care. The FRSD is designed to support short and extended duration operations that may exceed 72 hours when detachment personnel observe established rest/work cycles and associated dependency support requirements are met.

1-2. Due to staffing, equipment, and logistical constraints the FRSD must focus on eight (8) clearly defined surgical interventions in order to effectively treat the maximum number of patients. These are discussed in paragraph 1-5.

DAMAGE CONTROL RESUSCITATION AND SURGERY

1-3. Damage control resuscitation and damage control surgery are not new concepts. The following discussion describes some (but not all) of the most common resuscitative and surgical procedures performed to reduce morbidity and mortality of injured Soldiers and maximize patient outcomes.

DAMAGE CONTROL RESUSCITATION

1-4. Damage control resuscitation refers to those rapidly implemented medical interventions that prevent or mitigate a casualty's irreversible physiologic deterioration. These interventions include but are not limited to:

- Rapid hemorrhage control.
- Hypotensive resuscitation (permissive hypotension).
- Rapid replacement of circulating volume.
- Prevention or treatment of hypothermia and correction of acidosis through use of blood products and medications.
- Ongoing resuscitation in the post-op recovery area.

DAMAGE CONTROL SURGERY

1-5. Damage control surgery refers to a series of rapidly implemented surgical interventions that include but are not limited to:

- Laparotomy for control of trauma induced internal bleeding and enteric spillage.
- Abbreviated thoracotomy for penetrating chest injury to control trauma-induced internal bleeding.
- Placement of external fixators.
- Temporary restoration of blood flow to an injured limb using vascular shunts.
- Rapid amputation of mangled limbs.
- Fasciotomy.
- Decompression of cardiac tamponade.
- Emergency decompressive craniotomy.

ASSIGNMENT

1-6. Assignment of the FRSD and FRSD (Airborne) are too either a medical command (deployment support) or a medical brigade (support). They are typically placed under the operational control of a combat support hospital or hospital center. When operationally employed the FRSD is attached to a medical company, area support or medical company, brigade support battalion.

1-7. When attached to a Role 2 medical treatment facility (medical company, area support or medical company, brigade support battalion), the FRSD has access to—

- Additional imaging modalities (X-ray).
- Additional laboratory testing capabilities.
- Additional blood capacity.
- Patient holding.
- Medical evacuation support (via air or ground ambulance).

Note. The FRSD is most effective and efficient when attached to a medical company for support.

LIMITATIONS

1-8. The FRSD does not possess the personnel, equipment, medications, supplies, or administrative capabilities necessary to perform a primary care mission. However, if requested, FRSD personnel can augment the sick call capabilities of a supporting or supported medical treatment facility, at the discretion of the FRSD Chief.

1-9. Soldiers assigned to the FRSD can assist in the limited coordinated defense of the unit's area or installation when not actively engaged in patient care. The detachment's defense requirements are normally met under dependency support requirements.

Note. The FRSD staff members are not trained to perform maintenance that exceeds the operator level on assigned equipment.

MOBILITY

1-10. Detachments with well-trained and rehearsed personnel can transport 100 percent of their personnel and equipment in a single lift using organic vehicle assets after the equipment has been consolidated, cross-leveled, and loaded onto vehicles using proven load plans.

DEPENDENCIES

1-11. The FRSD is dependent upon the following organizations:

- When operationally attached to a medical company of the brigade support battalion, the brigade medical supply office provides or coordinates for—
 - Medical equipment maintenance and repair.
 - Resupply of Class VIIIA (medical materiel).
 - Resupply of Class VIIIB (blood and blood products).
- Aeromedical evacuation from the supporting air ambulance elements.
- When operationally employed at echelons above brigade, the medical battalion (multifunctional) through the medical logistics company or the medical detachment, blood support for—
 - Class VIIIA (medical materiel) resupply.
 - Medical equipment maintenance and repair.
 - Class VIIIB (blood and blood products) resupply.

- Medical company (ground ambulance) for ground medical evacuation support.
- Appropriate elements within the area of responsibility for—
 - Personnel services support.
 - Financial management support.
 - Administrative services.
 - Food service support.
 - Communications support.
 - Information management support.
 - Logistical support.
 - Generator support.
 - Unit maintenance support.
- Appropriate elements of the sustainment brigade, quartermaster company (aerial delivery support) or the brigade support battalion (airborne), infantry brigade combat detachment (airborne), when rigging for aerial delivery operations are required (airborne only).
- Appropriate elements of the sustainment brigade quartermaster company (aerial delivery support) or the brigade support battalion (airborne), infantry brigade combat detachment (airborne) for sling load operations when required.
- When deployed as part of a multinational joint task force, or supporting special operations forces, medical planners and FRSD staff must consider personnel and equipment augmentation in the following areas:
 - Command and control.
 - Communications.
 - Medical operations planning.
 - Additional power generation.
 - Vehicle maintenance.
 - Force protection.
 - Force health protection.
 - Primary care and patient administration.
 - Pharmacy.
 - Patient holding.
 - Class VIIIA and Class VIIIB resupply.
 - Medical equipment maintenance and repair.
 - X-ray services.
 - Medical laboratory services.

BASIS OF ALLOCATION

1-12. The basis of allocation for the FRSD is one (1) per Armored Brigade Combat Team (ABCT), one (1) per Committed Infantry Brigade Combat Team (IBCT) (not including IBCT Airborne), and one (1) per BCT assigned to a theater conducting stability and reconstruction operations.

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Chapter 2

Organization and Capabilities

ORGANIZATION

2-1. ★The FRSD's modular design and organization enables its staff to provide a tailored forward resuscitative and surgical support package based on the type and number of operations being conducted. The detachment's design provides a flexibility that allows it to be employed as a complete detachment, forward resuscitative and surgical sections, or as individual surgical teams. This modular design, however, limits what the detachment and its subsets can accomplish without being attached to a medical company area support or medical company brigade support battalion when operationally employed.

DETACHMENT

2-2. ★The organizational construct of a complete FRSD includes an Administration/Supply Section, a forward resuscitative section, and a forward surgical section. Figure 2-1 on page 2-2 depicts a complete FRSD using approved Army Health System (AHS) symbols.

2-3. ★In this configuration, the detachment is designed and equipped to receive, triage, provide emergency treatment, and prepare up to 30 incoming patients for damage control resuscitation and/or damage control surgery over a 72-hour period using its organic medical equipment set. The detachment can provide post-operative care for no more than eight (8) patients at one time. The FRSD is capable of monitoring a post-operative patient for up to six (6) hours after which the patient is generally determined to be sufficiently stable to survive evacuation to the next role of care.

SECTION

2-4. There are situations when it may be necessary for the FRSD to provide forward resuscitative and surgical support for multiple units conducting concurrent operations. To meet this requirement, the detachment is staffed and equipped to divide the Administration/Supply Section, the forward resuscitative section and the forward surgical section evenly in order to form two (2) composite forward resuscitative and surgical sections thus establishing a split FRSD. Figure 2-2 on page 2-3 depicts a split FRSD.

2-5. ★In this configuration, the detachment is designed and equipped to receive, triage, provide emergency treatment, and prepare up to 12 incoming patients for damage control resuscitation and/or damage control surgery over a 72-hour period using its organic medical equipment set. The section can provide post-operative care for no more than four (4) patients at one time. The section is capable of monitoring a post-operative patient for up to six (6) hours after which the patient is generally determined to be sufficiently stable to survive evacuation to the next role of care.

TEAM

2-6. The team is the smallest element within the detachment and constitutes the fundamental building block on which the FRSD is built. Based on this design, the detachment chief can, under certain circumstances send a single surgical team forward to provide limited forward surgical support.

2-7. ★In this configuration, the team is designed and equipped to receive, triage, provide emergency treatment, and prepare up to four (4) incoming patients for damage control resuscitation and/or damage control surgery. The team can provide limited post-operative care no more than four (4) patients for up to 24 hours using its organic medical equipment set.

Note. As written in Section One (1) of the FRSD's table of organization and equipment (TOE), the terms, elements, teams, and sections are used interchangeably. To avoid confusion, this publication specifically points out the type of element discussed, for example, detachment, section, or team.

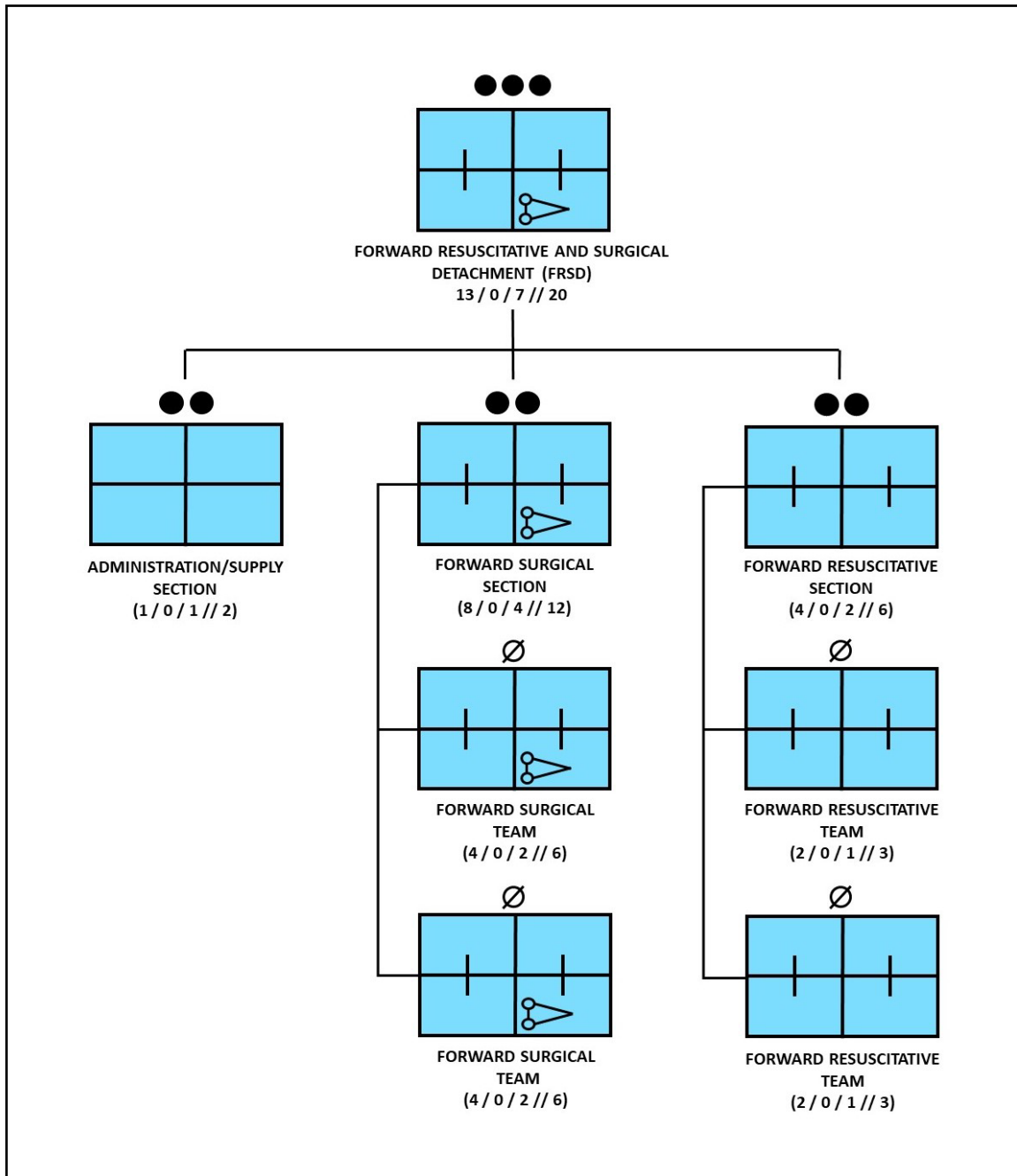


Figure 2-1. Organization of a complete Forward Resuscitative and Surgical Detachment

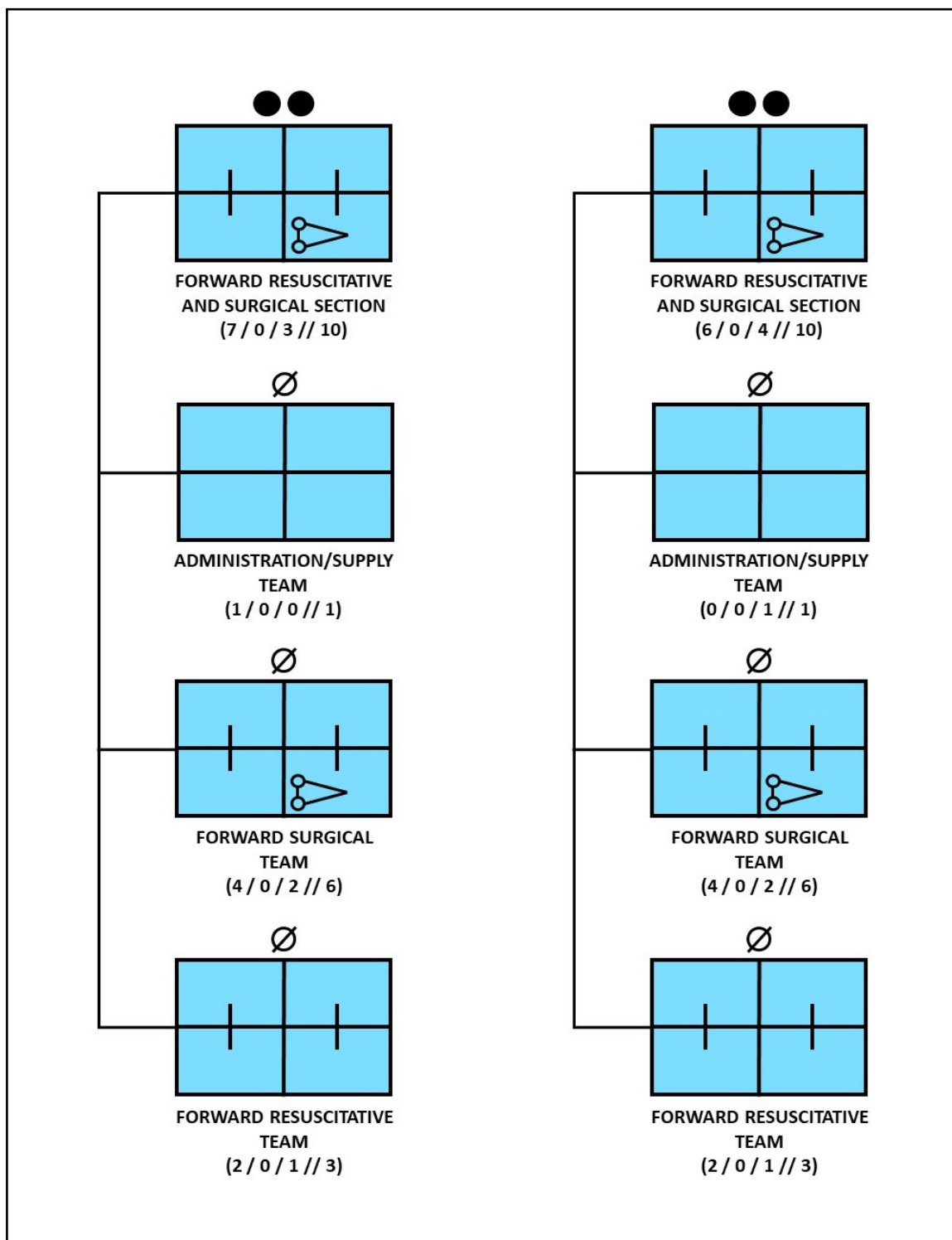


Figure 2-2. Organization of a split Forward Resuscitative and Surgical Detachment

PERSONNEL AND CAPABILITIES

2-8. The personnel breakdown and capabilities of the personnel assigned to each section within the FRSD are discussed in paragraph 2-9 through paragraph 2-32.

ADMINISTRATION/SUPPLY SECTION

2-9. The personnel breakdown of the Administration/Supply Section is reflected in Table 2-1 listed below.

Table 2-1. Composition of the Administration/Supply Section

<i>Position</i>	<i>Grade</i>	<i>AOC/MOS</i>	<i>Required</i>
FRSD Chief	O5	61J00	0
Field Medical Assistant	O2	70B67	1
Detachment Sergeant	E7	68W40	1
Notes: The TOE identifies the senior (O5) general surgeon as the chief of the FRSD. Soldiers assigned to airborne FRSDs must be parachute qualified.			
Legend: AOC Area of Concentration FRSD forward resuscitative and surgical detachment MOS military occupational specialty TOE table of organization and equipment			

2-10. Paragraph 2-11 through paragraph 2-14 provide an overview of the duties and responsibilities of the Soldiers assigned to the Administration/Supply Section.

DUTIES AND RESPONSIBILITIES

2-11. Specific duties and responsibilities of the Field Medical Assistant and Detachment Sergeant include management of the routine operating issues of the detachment and keeping the chief apprised of—

- Ongoing tactical operations.
- Requirements to displace.
- Movement considerations.
- Reestablishment of the surgical facility.
- Status of organization and medical supply or resupply.
- Plan for FRSD current and future operations.
- Status of individual and unit training.
- Status of communications connectivity.

2-12. As the detachment is dependent upon its supporting Role 2 medical treatment facility for a significant share of its administrative and logistical requirements, continuous coordination between the FRSD and the medical company is required to ensure that shortfalls in support do not adversely impact patient care.

2-13. When operationally employed, the Administration/Supply Section enables the detachment to concentrate on its core mission of providing damage control resuscitation and damage control surgery.

2-14. When the FRSD is required to split, the Field Medical Assistant will fall in on one (1) of the forward surgical section and the Detachment Sergeant on the other, so that each section has an administration and supply point of contact.

FORWARD RESUSCITATIVE SECTION

2-15. The personnel breakdown of the forward resuscitative section is reflected in Table 2-2 on page 2-5 below.

Table 2-2. Composition of the forward resuscitative section

<i>Position</i>	<i>Rank</i>	<i>AOC/MOS</i>	<i>Required</i>
Emergency Physician	O3	62A00	2
Emergency Nurse	O3	66T00	2
Emergency Care Sergeant	E5	68W20	2
Note: Soldiers assigned to airborne FRSDs must be parachute qualified.			
Legend: AOC Area of Concentration FRSD forward resuscitative and surgical detachment MOS military occupational specialty TOE table of organization and equipment			

2-16. Personnel assigned to the forward resuscitative section provide—

- Trauma resuscitation (for example, blood and blood products, parenteral fluids).
- Point of care laboratory assay measurements.
- Imaging modalities (ultrasound).
- Assistance with initial assessment and ongoing patient management and treatment.
- Infection control.
- Pre-and post-operative care that includes:
 - Initial burn management.
 - Advanced airway management.
 - Intravenous, intraosseous, and central line placement.
- Continuation of trauma resuscitation through the use of—
 - Blood and blood products.
 - Parenteral fluids and medications.
- Critical care services that include:
 - Mechanical ventilation.
 - Advanced airway management.
- Post-operative recovery care, which includes:
 - Pain management.
 - Pulmonary therapy.
 - Fluid resuscitation.

DUTIES AND RESPONSIBILITIES

2-17. Paragraph 2-18 through paragraph 2-23 provide an overview of the primary functions of personnel assigned to the forward resuscitative section.

EMERGENCY PHYSICIANS

2-18. The forward resuscitative section includes two (2) O3, 62A00 Emergency Physicians. Their immediate decisions and actions are intended to stabilize the patient until surgical intervention is available.

2-19. Specific duties and responsibilities of Emergency Physicians include:

- Providing—
 - Initial examinations.
 - Evaluations.
 - Diagnostic measures.
 - Treatment.
 - Stabilization.
 - Resuscitation.

- Providing clinical management of—
 - Trauma.
 - Burns.
 - Altered levels of consciousness.
 - Acute illnesses.
 - Toxic exposures.
- Obtaining intravascular access.
- Draining blood or air from the chest cavity.
- Reducing and splinting fractures.
- Operating life-support equipment.
- Performing limited ultrasound examinations for diagnostic purposes.
- Providing ongoing sedation and analgesia of patients, as required.

EMERGENCY NURSES

2-20. The forward resuscitation section includes two (2) 66T00 Emergency Nurses.

2-21. Specific duties and responsibilities of Emergency Nurses include:

- Caring for patients across the age spectrum during the initial phase of hospitalization and treatment.
- Providing trauma and emergency care to all categories of patients.
- Practicing in settings in which patients require extremely complex and rapid assessment, high-intensity therapies and interventions, and continuous nursing vigilance.
- Conducting thorough assessments and performing life-saving interventions as required.
- Performing point-of-care testing.
- Performing operator-level maintenance of medical equipment in accordance with appropriate technical manuals and manufacturer's instructions.

EMERGENCY CARE SERGEANTS

2-22. The forward resuscitation section includes two (2) E5, 68W20 Emergency Care Sergeants.

2-23. Specific duties and responsibilities of Emergency Care Sergeants include:

- Administering emergency and routing medical treatment.
- Assisting with outpatient care and treatment.
- Performing point-of-care testing.
- Performing operator-level maintenance on medical equipment in accordance with appropriate technical manuals and manufacturer's instructions.

FORWARD SURGICAL SECTION

2-24. The personnel breakdown of the forward surgical section is reflected in Table 2-3 below.

Table 2-3. Composition of the forward surgical section

<i>Position</i>	<i>Grade</i>	<i>AOC/MOS</i>	<i>Required</i>
General Surgeon	O5	61J00	1
General Surgeon	O4	61J00	1
Orthopedic Surgeon	O4	61M00	2
Critical Care Nurse	O4	66S00	1
Critical Care Nurse	O3	66S00	1
Nurse Anesthetist	O3	66F00	2
Operating Room NCO	E6	68D30	1
Practical Nurse NCO	E5	68C20	1
Operating Room Sergeant	E5	68D20	1
Practical Nursing Specialist	E4	68C10	1
Notes: The TOE identifies the senior (O5) general surgeon as the chief of the FRSD. Soldiers assigned to airborne FRSDs must be parachute qualified.			
Legend: AOC Area of Concentration FRSD forward resuscitative and surgical detachment MOS military occupational specialty NCO non-commissioned officer TOE table of organization and equipment			

2-25. Personnel assigned to the forward surgical section provide—

- Anesthesia services.
- Damage control surgery.
- Infection control.
- Post-operative care that includes:
 - Initial burn management.
 - Advanced airway management.
 - Intravenous and intraosseous infusions and central line placement.
- Continuing trauma resuscitation through the use of—
 - Blood and blood products.
 - Parenteral fluids and medications.
 - Advanced airway management.
 - Intravenous, intraosseous, and central line placement.
- Critical care services that include:
 - Mechanical ventilation.
 - Advanced airway management.
- Post-operative recovery care, which includes:
 - Pain management.
 - Pulmonary therapy.
 - Fluid resuscitation.

DUTIES AND RESPONSIBILITIES

2-26. Paragraphs 2-27 through 2-38, provide an overview of the primary functions of personnel assigned to the forward surgical section.

GENERAL SURGEONS

- 2-27. The forward surgical section includes two (2) 61J00 General Surgeons, one (1) O5 and one (1) O4.
- 2-28. Specific duties and responsibilities of General Surgeons include:
- Examining, Diagnosing, and treating or prescribing courses of treatment.
 - Performing surgery for patients with injuries or disorders that require surgical intervention.

ORTHOPEDIC SURGEONS

- 2-29. The forward surgical section includes two (2) O4, 61M00 Orthopedic Surgeons.
- 2-30. Specific duties and responsibilities of Orthopedic Surgeons include:
- Examining, Diagnosing, and treating or prescribing courses of treatment.
 - Performing surgery for patients having disorders, malformations, diseases, and injuries of the musculoskeletal system.

CRITICAL CARE NURSES

- 2-31. The forward surgical section includes two (2) 66S00 Critical Care Nurses, one (1) O4 and one (1) O3. Critical Care Nurses.
- 2-32. Specific duties and responsibilities of Critical Care Nurses include:
- Provide intensive nursing care to all categories of operational casualties.
 - Conduct thorough assessments and taking immediate lifesaving action as required.
 - Performing—
 - Point-of-care testing.
 - Operator-level maintenance of medical equipment in accordance with appropriate technical manuals and manufacturer's instructions.

NURSE, ANESTHETIST

- 2-33. The forward surgical section includes two (2) O3, 66F00 Nurse Anesthetists.
- 2-34. Specific duties and responsibilities of Nurse Anesthetists include administering general or regional anesthesia for:
- Surgical procedures.
 - Diagnostic procedures.
 - Therapeutic procedures.
 - Respiratory care.
 - Cardiopulmonary resuscitation.
 - Fluid therapy.

OPERATING ROOM NON-COMMISSIONED OFFICERS

- 2-35. The forward surgical section includes one (1) E6, 68D30 Operating Room Non-Commissioned Officer (NCO) and one (1) E5, 68D20 Operating Room Sergeant.
- 2-36. Specific duties and responsibilities of Operating Room NCOs include:
- Assisting the nursing staff in preparing patients and the operating rooms for surgery.
 - Supervising maintenance programs in the operating room and the central materiel service.
 - Monitoring the quality of sterilization techniques to ensure adherence to established standards.
 - Establishing stock levels for requisitioning supplies and equipment and supervise their storage and issue.
 - Preparing and maintaining various reports and files.
 - Supervising and advising subordinate personnel.

- Creating and maintaining sterile fields.
- Draping patients.
- Preparing, manipulating, and delivering surgical instruments and equipment.
- Accounting for all instruments, needles, sponges, and medications placed within the sterile field.
- Cleaning and sterilizing surgical instruments.

PRACTICAL NURSE NON-COMMISSIONED OFFICER AND PRACTICAL NURSING SPECIALIST

2-37. The forward surgical section includes one (1) E5, 68C20 Practical Nurse NCO and one (1) E4, 68C10 Practical Nursing Specialist.

2-38. Specific duties of the Practical Nurse NCO and Practical Nursing Specialist include:

- Providing preventive, therapeutic, and emergency nursing care procedures under the supervision of a physician or nurse.
- Administering point-of-care testing.
- Performing operator-level maintenance on medical equipment in accordance with appropriate technical manuals and manufacturer's instructions.

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Chapter 3

Training

TRAINING THE DETACHMENT

3-1. To ensure that the members of the FRSD are able to function at their best, all personnel assigned must be trained to proficiency in individual and collective tasks that support the unit's mission essential tasks. The chief, in concert with detachment leaders, must refine the detachment's mission essential tasks to determine what training is required. For guidance in developing the mission essential task list and determining what the detachment's training priorities must be, refer to Army Doctrine Publication (ADP) 7-0.

LEADER DEVELOPMENT TRAINING

3-2. Leader development training and education for officers assigned to the FRSD is available through a number of courses available at the U.S. Army Medical Center of Excellence, Joint Base San Antonio, and Fort Sam Houston, Texas. For example, the 7M-F11 Forward Surgical Team Commander Course delineates the knowledge and skills needed by individuals assuming the role of the FRSD Chief. Major areas covered include the duties and responsibilities of the FRSD Chief. Major areas covered include the duties and responsibilities of the FRSD Chief, the organization of a brigade, doctrinal employment of brigade assets, and AHS support in brigades and at echelons above brigade. The course is designed to build upon previous experience and training received in the Basic Officer Leadership Course, the Brigade Health Care Provider Course, and the Captains Career Course.

3-3. The Army Medical Center of Excellence Noncommissioned Officer Academy provides leader development training and education. The academy provides sergeants, staff sergeants and sergeants first class with the technical, tactical, and leadership skills necessary to be successful in Army operations as squad leaders, platoon sergeants, and first sergeants.

TRAUMA TRAINING

3-4. Providing ongoing care for trauma patients in high volume and high acuity trauma centers is the basis of trauma competency for unit personnel.

3-5. Table 3-1 on page 3-2 provides examples of trauma related training courses designed to enhance trauma management skill sets of FRSD clinicians.

★Table 3-1. Examples of trauma related, professional development training

TRAUMA TRAINING			
AOC/MOS	Course title	Duration	Frequency
All	ATTC	14 days	Predeployment.
All	ATLS	2 days	Predeployment, every four (4) years before expiration.
66E, 66F, 66S, 66T	TNCC and ATNCC	2 days	Predeployment, every four (4) years before expiration.
61J, 61M, 62A, 68D	EWSC, ASSET, COTS, and other AOC specific courses in development under the EWSC banner	2 days	Predeployment, every 2 years.
All	TCMC and TCCC	7 days	Predeployment.
All	ATTC	14 days	Predeployment.
Legend: AOC area of concentration ASSET Advanced Surgical Skills for Exposure in Trauma ATNCC Advanced Trauma Nursing Care Course ATLS Advanced Trauma Life Support ATTC Advanced Trauma Training Course COTS Central Ohio Trauma System EWSC Emergency War Surgery Course MOS military occupational specialty TCCC tactical combat casualty care TCMC Tactical Combat Medical Care Course TNCC Trauma Nursing Care Course			

DISEASE AND NONBATTLE INJURY TRAINING

3-6. Table 3-2 below lists examples of disease and nonbattle injury related training courses designed to enhance clinical management skill sets of FRSD clinicians.

★Table 3-2. Examples disease and nonbattle injury related, professional development training

DISEASE AND NONBATTLE INJURY TRAINING			
AOC/MOS	Course title	Duration	Frequency
All	ACLS and PALS	2 days	Every 2 years before expiration.
61J, 62A, 66E, 66F, 66S, 66T, 68C, 68W	Global Medicine, Military Tropical Medicine, or Tropical Medicine and Traveler's Health	14 days, 3 days, 12 weeks	Either course, once during military career.
62A, 66E, 66F, 66S, 66T, 68C, 68W	Medical Management of Chemical and Biological Casualties	5 days	Once during military career, predeployment based upon threat assessment.
62A, 66F, 66S, 66T, 68C, 68W	JECC	14 days	Once during military career, predeployment based upon threat assessment.
Legend: ACLS Advance Cardiac Life Support AOC area of concentration JECC Joint Enroute Care Course MOS military occupational specialty PALS Pediatric Advanced Life Support			

REHEARSALS

3-7. After completing training, FRSD personnel must refine their newly acquired skills through the use of frequent and realistic rehearsals. Rehearsals reinforce newly acquired skills and help detachment personnel become more confident and efficient in establishing, disestablishing and rapidly relocating the facility. This is especially helpful when frequent displacement, movement, and setup are likely.

STANDARD OPERATING PROCEDURES

3-8. Written standard operating procedure (SOP) outline the duties and responsibilities of individual positions within an organization. Standard operating procedures provide step-by-step instructions compiled by a unit to help personnel carry out complex routine operations. The aim of an SOP is to achieve efficiency, quality output and uniform performance, while reducing miscommunication and failure to comply with regulations and standards. Each SOP must clearly articulate those critical tasks that personnel must accomplish in each position for the organization to be successful. This is especially important in the event that a primary team member is absent and another member or members of the unit must fill the position. Development and maintenance of unit and clinical SOPs is the responsibility of the FRSD Chief. The detachments will base their SOPs on medical command (deployment support) and medical brigade (support) SOPs and refine the SOPs based on the operational experience of the individuals drafting them. Standard operating procedures must be clear and concise. They must reflect procedural guidance that supports the mission and doctrinal requirements.

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Chapter 4

Deployment

DEPLOYING THE DETACHMENT

4-1. When deployed, the FRSD generally attaches to a combat support hospital or hospital center when not otherwise operationally employed. When supporting a maneuver brigade, the FRSD is most effective when attached to a Role 2 medical treatment facility such as the medical company (brigade support battalion) or medical company (area support). Role 2 medical treatment facilities provide support functions that the FRSD is not designed or equipped to provide for itself.

4-2. If necessary, the detachment can be split into two (2) forward surgical sections of 10 Soldiers each. Each forward surgical section is capable of supporting operations in two (2) geographically dispersed locations. This may be a single brigade operating in two (2) different areas or two (2) separate brigades in contact.

4-3. Under certain circumstances, each forward surgical section can collocate its six (6) Soldier forward surgical team with a maneuver battalion aid station for very short period. An example would be to complete one (1) urgent surgical case.

PLANNING

4-4. Requests for FRSD support and the tasking authority that directs the support resides in the operations staff channel. For example, if a brigade combat team surgeon determines surgical support is required, the brigade combat team's S-3 requests that support from the division G-3, who may then request it from the Corps G-3, who then tasks the medical brigade (support) for an FRSD to be temporarily attached to the brigade combat team. The surgeon's staff sections should be simultaneously coordinating at these echelons to synchronize the FRSD's support to the brigade combat team.

4-5. Prior to (when possible) or upon arrival in the area of operations, the chief of the FRSD either directly or through the detachment's Administration/Supply Section makes contact with the supporting or supported unit to communicate the detachments support requirements. The detachment's Administration/Supply Section should also obtain situational updates and coordinate for X-ray, medical laboratory, medical records, patient administration support, replacement of patient movement items, as well as force protection requirements.

4-6. Operational planning for employment of the FRSD is the responsibility of the medical command (deployment support) or the medical brigade (support) with input from the FRSD's chief, field medical assistant, and detachment sergeant. Operational and support estimates developed by the medical staff, along with input from the brigade medical staff is used in the planning process to develop the AHS support estimates for medical support at echelons above brigade and forward deployed forces at brigade and below. All factors must be considered during the initial development of the operations plan. The plan is updated, as required, to meet health service support operational requirements. The brigade surgeon's cell is responsible for planning the employment of the airborne or air assault FRSD.

4-7. Forward resuscitative and surgical detachment operations involve all of the factors that are considered in the initial developmental stages of the medical plan. The medical plan is updated to meet mission, enemy, terrain and weather, troops, time available, civilian considerations, and operational requirements.

CRITICAL INFORMATION REQUIREMENTS

4-8. Clear and concise communication is a key component for the success of any operation. To ensure the success of the detachment, the chief, either directly or through the administrative/supply team, must identify or report those items of equipment, supply, and personnel that will enable the detachment to successfully support Soldiers in the field. The chief accomplishes this by identifying the critical information requirements. Examples of the chief's critical information requirements may include, but are not limited to the following:

- Blood (on-hand and required).
- Medications.
- Surgical supplies.
- Central materiel services support.
- Medical evacuation support (availability and times).
- Medical equipment maintenance.
- Vehicle maintenance.
- Fuel.
- Rations.
- Water.

4-9. Table 4-1 below provides a short list of FRSD-specific planning considerations that may be used in determining the full potential and or limitations of forward resuscitative and surgical support.

Table 4-1. Planning considerations

- | |
|--|
| <ul style="list-style-type: none"> ● Detachment requires a minimum of two (2) hours to set up and become functional. ● Two (2) operating tables per detachment. ● Average time per patient is 135 minutes (not including post-operative recovery). ● Maximum caseload per 24 hours equals 10 cases (medical equipment set can only support a combination of 30 resuscitation and surgical cases without rest and resupply). ● Must not begin surgery unless sufficient time to safely begin and complete necessary procedures and permit adequate post-operative recovery time for patient to survive evacuation (approximately six (6) hours). ● Post-operative care for up to six (6) hours with eight (8) patients. ● The detachment must be relieved or rested and resupplied after 72 hours. |
|--|

MEDICAL EQUIPMENT MAINTENANCE AND REPAIR

4-10. When forward deployed with a medical company, a medical maintenance and repair contact team from the medical logistics company should accompany the detachment. The contact team assists the biomedical equipment maintenance specialist from the brigade medical supply office in providing medical equipment maintenance, and repair support. The contact repair team may (if the situation permits) remain in place as long as the FRSD is engaged.

BLOOD AND BLOOD SUPPORT

4-11. The FRSD is authorized 4 blood storage units which can be set for frozen or refrigerated storage. Each storage device can maintain 40-50 units regardless of setting. Frozen plasma or cryogenic units are stored using the freezer setting. Red blood cells, liquid plasma, and low titer group O whole blood are stored using the refrigerator setting. Detachment personnel must be trained and equipped to collect fresh whole blood during emergency situations when the need for blood and blood products exceeds the available supply.

Requests for resupply of blood and blood products are submitted by the Administration/Supply Section to the supporting medical detachment, blood support, or other blood supply unit as designated by the combatant command joint blood program officer.

4-12. The medical detachment, blood support provides collection, manufacturing, storage, and distribution of blood and blood products to medical units operating at brigade, echelons above brigade, and to other services as required. The medical detachment, blood support can deploy a collection storage and distribution detachment or a collection manufacturing and distribution detachment to collect, process, and test whole blood from the available donor pool when needed for emergent medical conditions. See ATP 4-02.1 for additional information on blood support and medical equipment maintenance and repair.

ESTABLISHING THE SURGICAL FACILITY

4-13. Forward resuscitative and surgical detachments deploy using several different shelter systems. The type of shelter system used is based on the detachment's modified TOE. The configuration or layout of the FRSD is influenced by factors such as the type and location of the unit on which the FRSD falls in (hospital or medical company), terrain, anticipated patient load, and the frequency with which they may be required to displace as designed and equipped, the FRSD, requires less than 1,000 square feet of space to operate. For convenience and additional space, the chief of the FRSD may choose to set up using multiples of a given shelter system or, if possible occupy a building opportunity. Figures 4-1 below through 4-5 depicted on pages 4-3 through 4-7, show examples of how an FRSD may be configured.

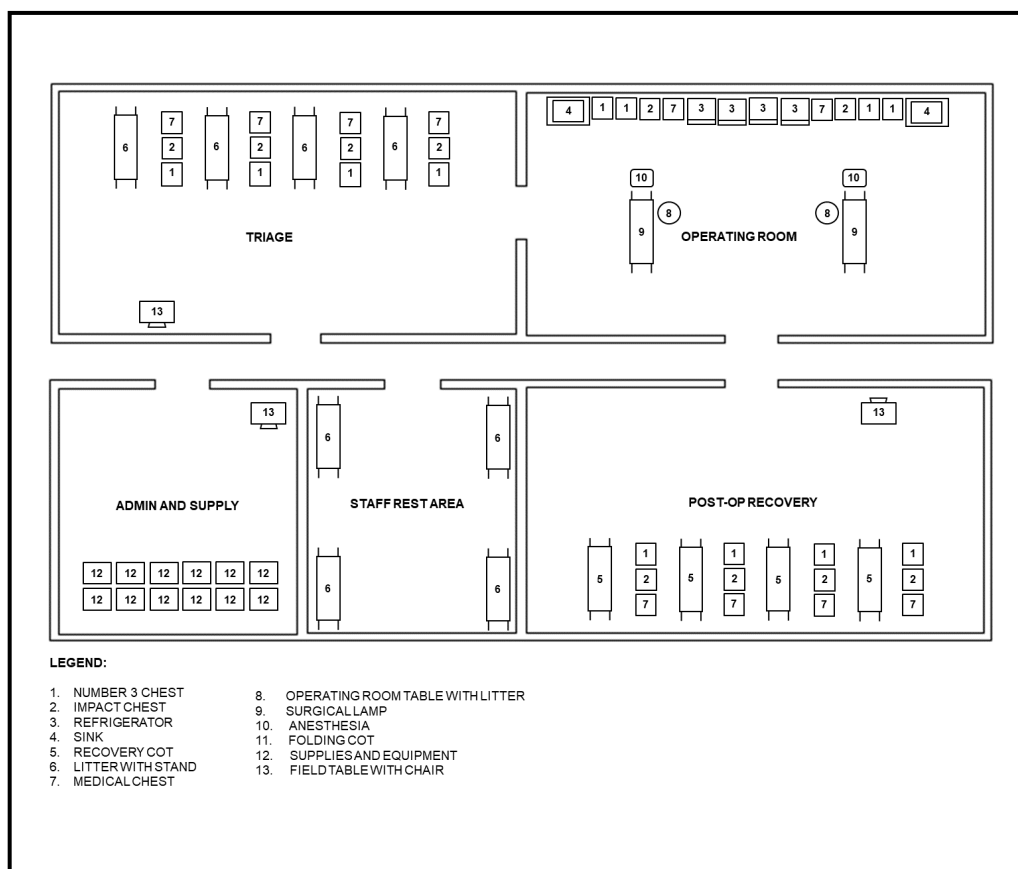


Figure 4-1. Sample layout of a Forward Resuscitative and Surgical Detachment set up in a building of opportunity

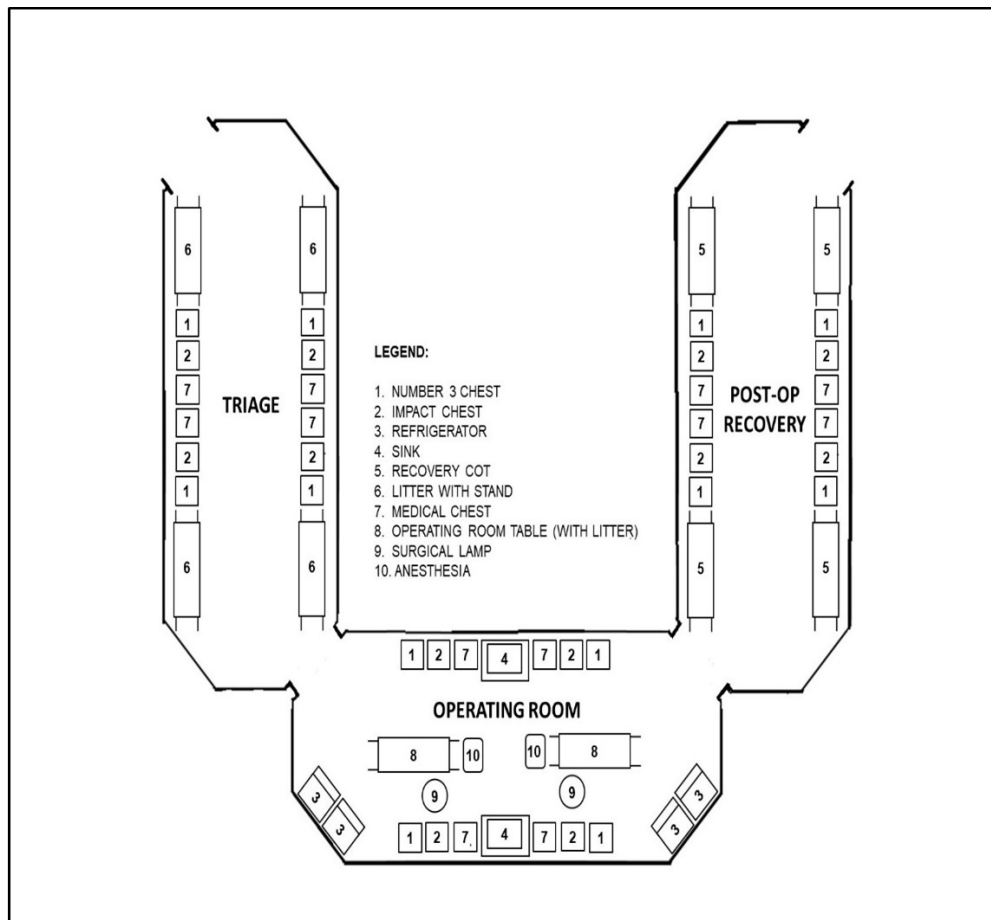


Figure 4-2. Sample layout of a Forward Resuscitative and Surgical Detachment in a U configuration

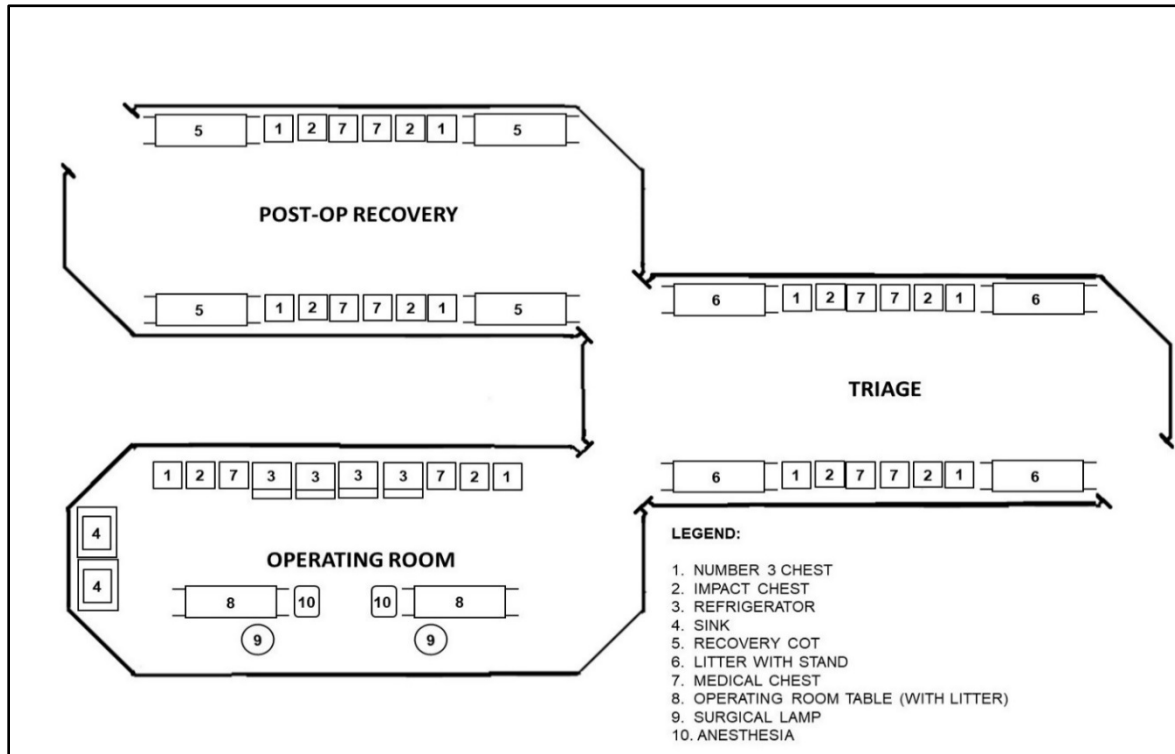


Figure 4-3. Sample layout of a Forward Resuscitative and Surgical Detachment in a Y configuration

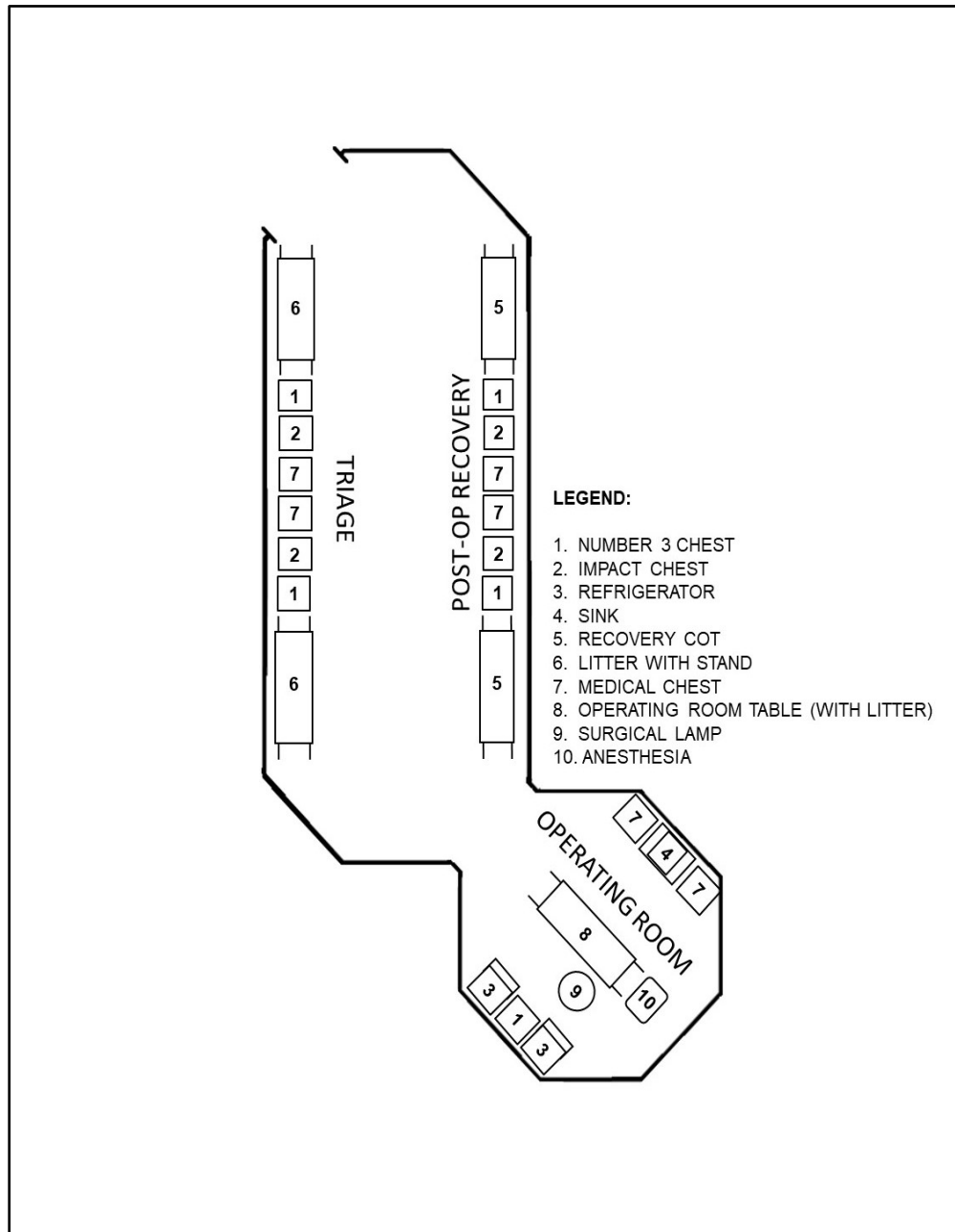


Figure 4-4. Sample layout of a Forward Resuscitative and Surgical Detachment in a Split configuration

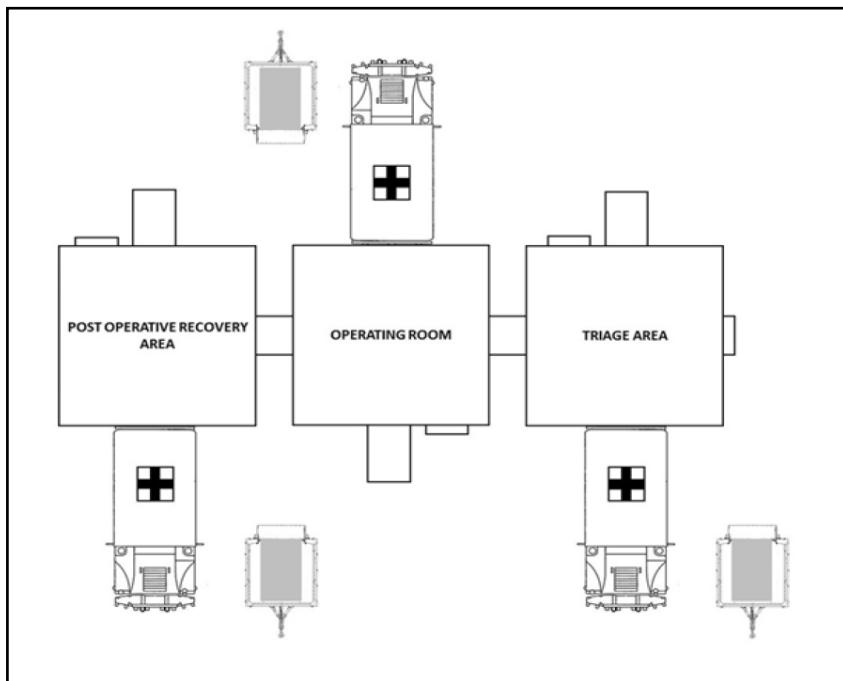


Figure 4-5. Sample layout of a Forward Resuscitative and Surgical Detachment using chemical and biological protective shelter systems

DISPLACEMENT AND REDEPLOYMENT

4-14. When deploying the detachment, the medical command (deployment support) or medical brigade (support) commander issues orders, either verbally or in writing, to the FRSD Chief. When attached to medical company (brigade support) movement orders are issued by the brigade combat team (BCT) commander. Frequently, the time to respond to orders is short; therefore, the FRSD must be constantly prepared to move. For this reason, a flexible entry and exit strategy during movement into and withdrawal from the area of operations is essential. After receiving the commander's order, the Chief, Field Medical Assistant, and Detachment Sergeant, conduct a mission analysis, incorporating changes based on mission, enemy, terrain and weather, troops, time available, civilian considerations, and operational requirements.

Note. When a FRSD is attached to a medical company, it can be subjected to frequent movement based upon the BCT's operations.

4-15. The FRSD is generally attached for a period of up to 72 hours, after which it redeploys to its unit of assignment for rest and resupply. In situations where the detachment is required to remain on station for longer than 72 hours, the detachment must be resupplied through established support channels. In some cases, it may be augmented by another FRSD to manage patient loads during a given situation.

DISPOSITION OF REMAINS

4-16. ★If a patient dies while being treated at the FRSD, a Department of Defense (DD) Form 1380 (*Tactical Combat Casualty Care [TCCC] Card*) must be completed then signed by a physician. Coordination is then made with the Role 2 medical treatment facility (medical company [brigade support battalion] or medical company [area support]) and the deceased is immediately removed from the FRSD facility to the supported medical treatment facility's temporary morgue for further processing. The supported medical treatment facility is responsible for notifying the deceased's unit and the mortuary affairs coordinator for the coordination, movement, and transport of human remains to the designated mortuary affairs collection point.

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Glossary

SECTION I – ACRONYMS AND ABBREVIATIONS

ABCT	armored brigade combat team
ADP	Army doctrine publication
AHS	Army Health System
ATP	Army techniques publication
BCT	brigade combat team
DA	Department of the Army
FM	field manual
FRSD	forward resuscitative and surgical detachment
IBCT	infantry brigade combat team
MOS	military occupational specialty
OCID	operational clinical infectious disease
SOP	standard operating procedure
TOE	table of organization and equipment
U.S.	United States

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★All websites verified on 7 December 2022.

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★These documents must be available to the intended users of this publication.

★*DOD Dictionary Military and Associated Terms*. October 2022.

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★FM 1-02.1. *Operational Terms*. 9 March 2021.

★FM 1-02.2. *Military Symbols*. 18 May 2022.

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Most Army doctrinal publications are available online at <https://armypubs.army.mil>.

ATP 4-02.1. *Army Medical Logistics*. 29 October 2015.

★FM 3-0. *Operations*. 1 October 2022.

★FM 4-02. *Army Health System*. 17 November 2020.

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This section contains no entries.

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★Unless otherwise indicated, DA forms are available on the Army Publishing Directorate website at <https://armypubs.army.mil>; DD forms are available on the Executive Services Directorate website at <https://www.esd.whs.mil/Directives/forms/>.

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ATP 4-02.25

07 December 2020

By Order of the Secretary of the Army:

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