# Soldier's Manual and Trainer's Guide

## MOS 68W

## Combat Medic Specialist

**Skill Levels 1/2/3**

**with**

**Readiness Requirements**

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## Preface

This publication is for skill level 1, 2, and 3 including readiness requirements, for Soldiers holding military occupational specialty 68W, and for trainers and first-line supervisors. It contains standardized training objectives, in the form of task summaries, to train and evaluate Soldiers on critical tasks that support unit missions during wartime. Trainers and first-line supervisors should ensure Soldiers have access to this publication. This Soldier training publication is available for download from the Central Army Registry.

According to AR 25-30, the use of trade or brand names of products should be avoided. Instead, the use of a standard Army nomenclature, specifications, or generic category when referring to a product is recommended. The task conditions and standards found in the Training Development Capability website for Soldier training publications have not changed in this publication; however, standard Army nomenclature, specifications, or generic category are used in lieu of brand names of products used in the individual critical task lists.

This publication applies to the Active Army, the Army National Guard, and the United States Army Reserve unless otherwise stated.

The proponent of this publication is the United States Army Training and Doctrine Command. The preparing agency of STP 8-68W13-SM-TG is the United States Army Medical Center of Excellence, Directorate of Training and Doctrine, Doctrine Literature Division. Send comments and recommendations on DA Form 2028 (*Recommended Changes to Publications and Blank Forms*) directly to usarmy.jbsa.medical-coe.mbx.dotd-tngpubs@army.mil or to Commander, United States Army Medical Center of Excellence, ATTN: ATMC-DTC-M, 2377 Greeley Road, Suite B, Joint Base San Antonio Fort Sam Houston, Texas 78234-7731.

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# Chapter 1

# Introduction

## 1-1. General.

This Soldier training publication (STP) identifies the individual military occupational specialty (MOS) training requirements for Soldiers in MOS 68W. Another source of STP task data is the Central Army Registry (CAR) at the Army Training (and Education) Network. The individual critical tasks found in the CAR are the primary use for training, can be supplemented by this STP. Commanders, trainers, and Soldiers should use the STP to plan, conduct, and evaluate individual training in units. In conjunction with Army Doctrine Publication (ADP) 7-0, Training, Soldier's Manual of Common Tasks publication STP 21-1-SMCT, and collective training products, the STP establishes effective training plans and programs that integrate leaders, Soldiers, and collective tasks. This chapter explains how to use the STP in establishing an effective individual training program and describes doctrinal principles and their implications outlined in ADP 7-0. Based on these guidelines, commanders and unit trainers must tailor the information to meet the requirements for their specific unit.

## 1-2. Training Requirement.

Every Soldier, noncommissioned officer (NCO), and officer has one primary mission-to be trained and ready to fight and win our nation's wars. Success in battle does not happen by accident; it is a direct result of tough, realistic, and challenging training.

a. Operational Environment.

(1) An operational environment is a composite of the conditions, circumstances, and influences that affect the employment of capabilities and bear on the decisions of the commander. An operational environment encompasses physical areas of the air, land, maritime, space, and cyberspace domains, as well as the information environment (which includes cyberspace), the electromagnetic spectrum, and other factors.

(2) The current operational environment faced by our forces presents enormous challenges to operate across the competition continuum. Factors that affect operations extend beyond the boundaries of a commander's assigned area of operations. Commanders and their staffs must develop and maintain a thorough understanding of their particular operational environment. Real world planning considerations for conducting large-scale combat operations are focused against adversaries. Peer threats can employ resources across multiple domains to create lethal operational environments. Large-scale combat operations are sustained combat operations involving multiple corps and divisions. They present the greatest challenge for Army forces.

(3) Army forces must be organized, trained, and equipped to meet worldwide challenges against a full range of threats. The Army accomplishes its mission by supporting the joint force in its strategic roles. Within each phase of a joint operation, the Army's operational concept of unified land operations guides how Army forces conduct operations. In large-scale combat operations, Army forces combine offensive, defensive, and stability tasks to seize, retain, and exploit the initiative in order to shape operational environments, prevent conflict, prevail in large-scale ground combat operations, and consolidate gains in support of the joint force and unified action partners. The Army's primary mission is to conduct prompt and sustained land combat to defeat enemy ground forces and seize, occupy, and defend land areas. The ability to deploy the right combination of Army forces to the right place at the right time requires unit leadership focused on the training and readiness essential to a successful deployment.

(4) Training is the most important thing the Army does to prepare for operations. It is the cornerstone of combat readiness and the foundation for successful operations. Effective training must be commander driven, rigorous, and realistic and conducted to the standard and under the conditions that units expect to operate in during combat. Units execute effective individual and collective training based on the Army's principles of training. Through training and leader development, units achieve the tactical and technical competence that builds confidence and allows them to conduct successful operations across the competition continuum.

(5) A chemical, biological, radiological, and nuclear (CBRN) event could potentially occur during both military combat and peacetime operations. To assist commanders and leaders in unit training, CBRN-related information should be included in United States Army Medical Center of Excellence collective training. Even though most collective tasks within an MOS training plan may support a CBRN event, those tasks that will most directly be impacted must be clearly identified with a statement in the CONDITION that reads: "THIS TASK MAY BE USED TO SUPPORT A CBRN EVENT." These collective tasks and any supporting individual tasks in this Soldier's manual should be considered for special training emphasis.

(6) Leaders at all echelons should actively seek training opportunities that directly involve the Regular Army, United States Army Reserve, the Army National Guard, combat training centers, joint Services, and unified action partners. Training individual tasks occurs in the institutional, operational, and self-development training domains. Individual skill proficiency is the basis for collective task proficiency.

b. How the Army Trains.

(1) Training is a team effort and the entire Army-Department of the Army and major commands, the institutional training bases, organizational units, the combat training centers, each individual Soldier, and the Civilian workforce-has a role that contributes to force readiness. Department of the Army and major commands are responsible for resourcing the Army to train. The Institutional Army, including schools, training centers, and NCO academies, for example, train Soldiers and leaders to take their place in units in the Army by teaching doctrine tactics, techniques, and procedures. Units, leaders, and individuals train to standard on their assigned critical individual tasks. The unit trains first as an organic unit and then as an integrated component of a team. Before the unit can be trained to function as a team, Soldiers must be trained to perform their individual supporting tasks to standard. Operational deployments and major training opportunities, such as major training exercises, combat training centers, and combined arms training strategy evaluations, provide rigorous, realistic, and stressful training and operational experience under actual or simulated combat and operational conditions to enhance unit readiness and produce bold, innovative leaders. The result of this Army-wide team effort is a training and leader development system that is unrivaled in the world. Effective training produces Soldiers and leaders who can successfully execute any assigned mission.

(2) The Army Training and Leader Development Model centers on developing trained and ready units led by competent and confident leaders. The model depicts an important dynamic that creates a lifelong learning process. The three core domains that shape the critical learning experiences throughout a Soldier's and a leader's time span are the institutional, operational, and self-development domains. Together, these domains interact using feedback and assessment from various sources and methods to maximize warfighting readiness. Each domain has specific, measurable actions that must occur to develop our leaders (see figure 1-1 on page 1-3).

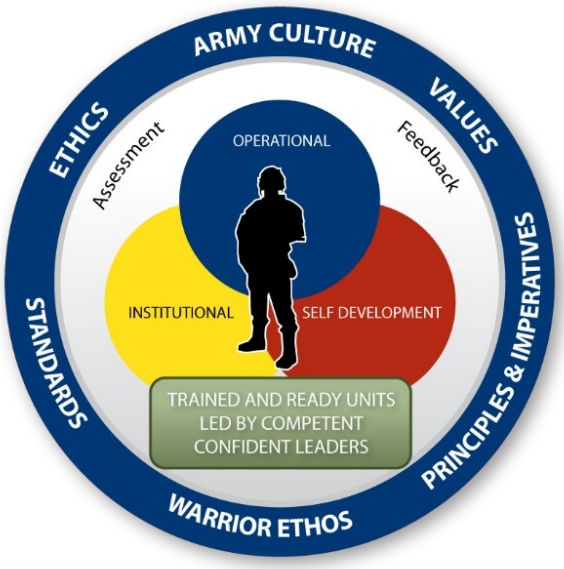


**Figure 1-1. Army Training and Leader Development Model**

- The institutional domain focuses on educating and training Soldiers and leaders on the key knowledge, skills, and attributes required to operate in any environment. It includes individual, unit, and joint schools and advanced education.
- The operational domain includes home station training, combat training center rotations, and joint training exercises and deployments that satisfy national objectives. Each of these actions provides foundational experiences for Soldier, leader, and unit development.
- The self-development domain, both structured and informal, focuses on taking those actions necessary to reduce or eliminate the gap between operational and institutional experiences.

(3) Throughout this lifelong learning and experience process, there is formal and informal assessment and feedback of performance to prepare leaders and Soldiers for their next level of responsibility. Assessment is the method used to determine the proficiency and potential of leaders against a known standard. Feedback must be clear, formative guidance directly related to the outcome of training events measured against standards.

c. Leader Training and Leader Development.

(1) Competent and confident leaders are a prerequisite to the successful training of units. It is important to understand that leader training and leader development are integral parts of unit readiness. Leaders are inherently Soldiers first and should be technically and tactically proficient in basic Soldier skills. They are also adaptive and capable of sensing their environment, adjusting the plan when appropriate, and properly applying the proficiency acquired through training.

(2) Leader training is an expansion of these skills that qualifies them to lead other Soldiers. As such, doctrine and principles of training require the same level of attention from senior commanders. Leader training occurs in the Institutional Army, the unit, the combat training centers, and through self-development. Leader training is just one portion of leader development.

(3) Leader development is the deliberate, continuous, sequential, and progressive process grounded in Army values that grows Soldiers and Department of the Army Civilians into competent and confident leaders capable of decisive action. Leader development is achieved through the lifelong synthesis of the knowledge, skills, and experiences gained through institutional training and education, organizational training, operational experience, and self-development. Commanders play a key role in leader development that ideally produces technically and tactically competent, confident, and adaptive leaders. These leaders act with boldness and initiative in dynamic, complex situations to execute mission-type orders achieving the commander's intent.

(4) The life cycle management diagram combined with the 68W MOS training plan forms the Soldier's career development model. This information, combined with the MOS training plan in chapter 2, forms the career development model for the MOS.

d. Training.

(1) Soldier and leader training and development continue in the unit. Using the institutional foundation, training in organizations and units focuses and hones individual and team skills and knowledge.

(2) Commander Responsibility.

(a) The unit commander is responsible for the wartime readiness of all elements in the formation. The commander is, therefore, the primary trainer in the organization and is responsible for ensuring all training conducted is in accordance with the STP and to the Army standard.

(b) Commanders ensure STP standards are met during all training. If a Soldier fails to meet established standards for identified MOS tasks, the Soldier must retrain until the tasks are performed to standard. Training to standard on MOS tasks is more important than completion of a unit training event such as combined arms training strategy evaluation. The objective is to focus on sustaining MOS proficiency-this is the critical factor commanders must adhere to when training individual Soldiers in units.

(3) NCO Responsibility.

(a) A great strength of the Army is its professional NCO Corps who take pride in being responsible for the individual training of Soldiers, crews, and small teams. The NCO support channel parallels and complements the chain of command. It is a channel of communication and supervision from the command sergeant major to the first sergeants and then to other NCOs and enlisted personnel within an organization. The NCOs train Soldiers to the non-negotiable standards published in STPs. Commanders delegate authority to NCOs in the support channel as the primary trainers of individual, crew, and small team training. Commanders hold NCOs responsible for conducting standards-based, performance-oriented, battle-focused training and for providing feedback on individual, crew, and team proficiency. Commanders define the responsibilities and authority of NCOs to their staffs and subordinates.

(b) Professional development programs enhance the individual's career through developmental assignments, experiential learning, continuing education, attendance in workshops and seminars and by working with experienced professionals. Professional programs strengthen and augment the individual's skills while building their expertise. A career map of these professional programs is available for every Soldier by accessing the Army Career Tracker, selecting My Planner, and clicking on the button labeled Printable Career Map.

(c) The NCOs continue the Soldierization process of newly assigned enlisted Soldiers and begin their professional development. The NCOs are responsible for conducting standards-based, performance-oriented, battle-focused training. They identify specific individual, crew, and small team tasks that support the unit's collective mission-essential tasks. The NCOs plan, prepare, rehearse, and execute training. They evaluate training and conduct after action reviews (AARs) to provide feedback to the commander on individual, crew, and small team proficiency. Senior NCOs coach junior NCOs to master a wide range of individual tasks.

(4) Soldier Responsibility.

(a) Each Soldier is responsible for performing individual tasks identified by the first-line supervisor based on the unit's mission-essential task list. Soldiers must perform tasks to the standards included in the task summary. If Soldiers have questions about tasks or about which tasks in this manual they must perform, they are responsible for asking their first-line supervisor for clarification, assistance, and guidance.

(b) First-line supervisors know how to perform each task or can direct Soldiers to appropriate training materials, including current field manuals, technical manuals, and Army regulations. Soldiers are responsible for using these materials to maintain proficiency. They are also responsible for maintaining standard performance levels of all Soldier's manuals of common tasks at their current skill level and below. Periodically, Soldiers should ask their supervisor or another Soldier to check their performance to ensure they can perform the tasks.

**1-3. Battle-Focused Training.**

Battle focus is a concept used to derive peacetime training requirements from assigned and anticipated missions. Battle focus is applied to all missions across the competition continuum. The priority of training in units is to train to standard on the wartime mission. Battle focus guides the planning, preparation, execution, and assessment of each organization's training program to ensure its members train as they are going to fight. Battle focus is critical throughout the entire training process and is used by commanders to allocate resources for training based on wartime and operational mission requirements. Battle focus enables commanders and staffs at all echelons to structure a training program that copes with non-mission-related requirements while focusing on mission-essential training activities. It is recognized that a unit cannot attain proficiency to standard on every task whether due to time or other resource constraints. However, unit commanders can achieve a successful training program by consciously focusing on a reduced number of mission-essential task list tasks that are essential to mission accomplishment.

a. Linkage between mission-essential task list and STP. A critical aspect of the battle-focus concept is to understand the responsibility for and the linkage between the collective mission-essential tasks and the individual tasks that support them. For example, the commander and the command sergeant major or first sergeant must jointly coordinate the collective mission-essential tasks and supporting individual tasks on which the unit will concentrate its efforts during a given period. This task hierarchy is provided in the task database in the Central Army Registry. The command sergeant major or first sergeant must select the specific individual tasks that support each collective task to be trained. Although NCOs have the primary role in training and sustaining individual Soldier skills, officers at every echelon remain responsible for training to established standards during both individual and collective training.

b. Relationship of STPs to battle-focused training. The two key components of any STP are the Soldier's manual and trainer's guide. Each component gives leaders important information to help implement the battle-focused training process. The trainer's guide relates Soldier and leader tasks in the MOS and skill level to duty positions and equipment. It states where the task

is trained, how often training should occur to sustain proficiency, and which unit should be trained. As leaders assess and plan training, they should rely on the trainer's guide to help identify training needs.

(1) Leaders conduct and evaluate training based on Army-wide training objectives and on the task standards published in the Soldier's manual task summaries or in the Central Army Registry. The task summaries ensure trainers—

- Define task standards the same way.
- Evaluate all Soldiers to the same standards.

(2) Table 1-1 demonstrates how battle-focused training relates to the Soldier's manual and trainer's guide:

- The left column shows the steps involved in training Soldiers.
- The right column shows how the STP supports each of these steps.

**Table 1-1. Relationship of battle-focused training and Soldier training publication**

| Battle-Focused Process | STP Support Process |
|---|---|
| Select supporting Soldier tasks | Use TG to relate tasks to METL |
| Conduct training assessment | Use TG to define what Soldier tasks to assess |
| Determine training objectives | Use TG to set objectives |
| Determine strategy; plan for training | Use TG to relate Soldier tasks to strategy |
| Conduct precombat checks | Use SM task summary as source for task performance |
| Execute training; conduct after action review | Use SM task summary as source for task performance |
| Evaluate training against established standards | Use SM task summary as standard for evaluation |
| **Legend:** | |
| METL = mission-essential task list | STP = Soldier training publication |
| SM = Soldier's manual | TG = trainer's guide |

**1-4. Task Summary Format.**
Task summaries outline the wartime performance requirements of each critical task in the Soldier's manual. They provide the Soldiers and the trainer with the information necessary to prepare, conduct, and evaluate critical task training. At a minimum, task summaries include information the Soldiers must know and the skills they must perform to standards for each task. The task summaries included in this Soldier's manual follow a specific format.

a. Task Title. The task title identifies the action to be performed.

b. Task Number. A 10-digit number identifies each task or skill. This task number, along with the task title, must be included in any correspondence pertaining to the task.

c. Conditions. The task conditions identify all the equipment, tools, references, job aids, and supporting personnel the Soldier needs to use to perform the task in wartime. This section identifies any environmental conditions that can alter task performance, such as visibility, temperature, or wind. This section also identifies any specific cues or events that trigger task performance, such as a chemical attack or identification of a threat vehicle.

d. Standards. The task standards describe how well and to what level the task must be performed under wartime conditions. Standards are typically described in terms of accuracy, completeness, and speed.

e. Performance Steps. This section includes a detailed outline of information on how to perform the task. Additionally, some task summaries include safety statements and notes. Safety statements (danger, warning, and caution) alert users to the possibility of immediate death, personal injury, or damage to equipment.

f. Evaluation Preparation (when used). This subsection indicates necessary modifications to task performance in order to train and evaluate a task that cannot be trained to the wartime standard under wartime conditions. It may also include special training and evaluation preparation instructions to accommodate these modifications and any instructions that should be given to the Soldier before evaluation.

g. Performance Measures. This evaluation guide identifies the specific actions the Soldier must do to successfully complete the task. These actions are listed in a GO/NO GO format for easy evaluation. Each evaluation guide contains an evaluation guidance statement that indicates the requirements for receiving a GO on the evaluation.

h. References. This section identifies references that provide more detailed and thorough explanations of task performance requirements than those given in the task summary description.

**1-5. Training Execution.**
All good training, regardless of the specific collective, leader, and individual tasks being executed, must comply with certain common requirements. These include adequate preparation, effective presentation and practice, and thorough evaluation. The execution of training includes preparation for training, conduct of training, and recovery from training.

a. Preparation for Training. Formal near-term planning for training culminates with the publication of the unit training schedule. Informal planning, detailed coordination, and preparation for executing the training continue until the training is performed. Commanders and other trainers use training meetings to assign responsibility for preparation of all scheduled training. Preparation for training includes selecting tasks to be trained, planning the conduct of the training, training the trainers, conducting reconnaissance of the site, issuing the training execution plan, and conducting rehearsals and precombat checks. Precombat checks are preliminary actions commanders and trainers use to identify responsibility for these and other training support tasks. They are used to monitor preparation activities and follow up to ensure planned training is conducted to standard. Precombat checks are a critical portion of any training meeting. During preparation for training, battalion and company commanders identify and eliminate potential training distracters that develop within their own organizations. They also stress personnel accountability to ensure maximum attendance at training.

(1) Subordinate leaders, as a result of the bottom-up feed from internal training meetings, identify and select the individual tasks necessary to support the identified training objectives. Commanders develop the tentative plan to include requirements for preparatory training, concurrent training, and training resources. At a minimum, the training plan should include

confirmation of training areas and locations, training ammunition allocations, training simulations and simulators availability, transportation requirements, Soldier support items, a risk management analysis, assignment of responsibility for the training, designation of trainers responsible for approved training, and final coordination. The time and other necessary resources for retraining must also be an integral part of the original training plan.

(2) Leaders, trainers, and evaluators are identified, trained to standard, and rehearsed prior to the conduct of the training. Leaders and trainers are coached on how to train, given time to prepare, and rehearsed, so training will be challenging and doctrinally correct. Commanders ensure trainers and evaluators are not only tactically and technically competent on their training tasks but also understand how the training relates to the organization's mission-essential task list. Properly prepared trainers, evaluators, and leaders project confidence and enthusiasm to those being trained. Trainer and leader training is a critical event in the preparation phase of training. These individuals must demonstrate proficiency on the selected tasks prior to the conduct of training.

(3) Commanders, with their subordinate leaders and trainers, conduct site reconnaissance, identify additional training support requirements, and refine and issue the training execution plan. The training plan should identify all those elements necessary to ensure the training is conducted to standard. Rehearsals are essential to the execution of good training. Realistic, standards-based, performance-oriented training requires rehearsals for trainers, support personnel, and evaluators. Preparing for training in United States Army Reserve organizations can require complex precombat checks. United States Army Reserve trainers must often conduct detailed coordination to obtain equipment, training support system products, and ammunition from distant locations. In addition, United States Army Reserve precombat checks may be required to coordinate Regular Army assistance from the numbered continental United States training support divisions and directed training affiliations.

b. Conduct of Training. Ideally, training is executed using the crawl-walk-run approach. This allows and promotes an objective, standards-based approach to training. Training starts at the basic level. Crawl events are relatively simple to conduct and require minimum support from the unit. After the crawl stage, training becomes incrementally more difficult requiring more resources from the unit and home station and increasing the level of realism. At the run stage, the level of difficulty for the training event intensifies. Run stage training requires optimum resources and ideally approaches the level of realism expected in combat. Progression from the walk to the run stage for a particular task may occur during a one-day training exercise or may require a succession of training periods over time. Achievement of the Army standard determines progression between stages.

(1) In crawl-walk-run training, the tasks and the standards remain the same; however, the conditions under which they are trained change. Commanders may change the conditions, for example, by increasing the difficulty of the conditions under which the task is being performed, by increasing the tempo of the task training, by increasing the number of tasks being trained, or by increasing the number of personnel involved in the training. Whichever approach is used, it is important that all leaders and Soldiers involved understand in which stage they are currently training and understand the Army standard.

(2) An AARs are immediately conducted and may result in the need for additional training. Any task not conducted to standard should be retrained. Retraining should be conducted at the earliest opportunity. Commanders should program time and other resources for retraining as an integral part of their training plan. Training is incomplete until the task is trained to standard. Soldiers will remember the standard enforced not the one discussed.

c. The training recovery process is an extension of training, and once completed, it signifies the end of the event. At a minimum, recovery includes conducting of maintenance training, turning in of training support items, and conducting of AARs of the overall effectiveness of the training just completed.

(1) Maintenance training is the conduct of post-operations preventive maintenance checks and services, accountability of organizational and individual equipment, and final inspections. Class IV, Class V, training aids, devices, simulators, simulations, and other support items are maintained, accounted for, and turned in. Once all these have been accomplished, training sites and facilities are closed out.

(2) AARs conducted during recovery focus on collective, leader, and individual task performance as well as the planning, preparing, and conducting of the training just completed. Unit AARs focus on individual and collective task performance, and they identify shortcomings, and the training required to correct deficiencies. AARs with leaders focus on tactical judgment. These AARs contribute to leader learning and provide opportunities for leader development. AARs with trainers and evaluators provide additional opportunities for leader development.

**1-6. Training Assessment.**

Assessment is the commander's responsibility. It is the commander's judgment of the organization's ability to accomplish its wartime operational mission. Assessment is a continuous process that includes evaluating individual training, conducting an organizational assessment, and preparing a training assessment. Commanders use their experience, feedback from training evaluations, and other evaluations and reports to arrive at their assessment. Assessment is both the end and the beginning of the training management process. Training assessment is more than just training evaluation, and it encompasses a wide variety of inputs. Assessments include such diverse systems as training, force integration, logistics, and personnel and provide the link between the unit's performance and the Army standard. Evaluation of training is, however, a major component of assessment. Training evaluations provide the commander with feedback on the demonstrated training proficiency of Soldiers, leaders, staffs, and units. Commanders cannot personally observe all training in their organization; therefore, they gather feedback from their senior staff officers and NCOs.

a. Evaluation of Training. Training evaluations are a critical component of any training assessment. Evaluation measures the demonstrated ability of Soldiers, commanders, leaders, staffs, and units against the Army standard. Evaluation of training is integral to standards-based training and is the cornerstone of leader training and leader development. The STPs describe standards that must be met for each Soldier task.

(1) All training must be evaluated to measure performance levels against the established Army standard. The evaluation can be as fundamental as an informal, internal evaluation performed by the leader conducting the training. Evaluation is conducted specifically to enable the individual undergoing the training to know whether the training standard has been achieved. Commanders must establish a climate that encourages candid and accurate feedback for the purpose of developing leaders and trained Soldiers.

(2) Evaluation of training is not a test; it is not used to find reasons to punish leaders and Soldiers. Evaluation tells Soldiers whether they achieved the Army standard and, therefore, assists them in determining the overall effectiveness of their training plans. Evaluation produces disciplined Soldiers, leaders, staffs, and units. Training without evaluation is a waste of time and resources.

(3) Evaluations are used by leaders as an opportunity to coach and mentor Soldiers. A key element in developing leaders is immediate, positive feedback that coaches and leads

subordinate leaders to achieve the Army standard. This is a tested and proven path to develop competent and confident adaptive leaders.

b. Evaluators. Commanders must plan for formal evaluation and must ensure the evaluators are trained. These evaluators must also be trained as facilitators to conduct AARs that elicit maximum participation from those being trained. External evaluators will be certified in the tasks they are evaluating and normally will not be dual-hatted as a participant in the training being executed.

c. Role of Commanders and Leaders. Commanders ensure evaluations take place at each echelon in the organization. Commanders use this feedback to teach, coach, and mentor their subordinates. They ensure every training event is evaluated as part of training execution and every trainer conducts evaluations. Commanders use evaluations to focus command attention by requiring evaluation of specific mission-essential and battle tasks. They also use evaluation information to develop appropriate lessons learned for distribution throughout their commands.

d. AARs. The AARs, whether formal or informal, provides feedback for all training. It is a structured review process that allows participating Soldiers, leaders, staffs, and units to discover what happened during the training, why it happened, and how it can be done better. The AARs are a professional discussion that requires the active participation of those being trained.

**1-7. Training Support.**
This manual includes the following information that provides additional training support information:

a. Glossary. The glossary, which follows the last appendix, is a single comprehensive list of acronyms, abbreviations, definitions, and letter symbols.

b. References. This section contains two lists of references, required and related, that support training of all tasks in this Soldier’s manual. Required references are listed in the conditions statement and are required for the Soldier to do the task. Related references are materials that provide detailed information and a more thorough explanation of task performance.

## Chapter 2

## Trainer's Guide

### 2-1. Readiness Requirements.

The readiness requirements are tasks that have been identified by the MOS-specific proponent at the Medical Center of Excellence as essential for preparing Soldiers for deployment. The readiness requirements tasks are a part of the complete MOS critical performance list, but special emphasis must be put on these tasks to ensure the Soldiers are obtaining the skills crucial to missions that contribute to lethality. The readiness requirements tasks are identified in each MOS. The task title, appropriate skill level, frequency of training, and training location are also provided. The tasks can be tracked for individual or unit accountability. The readiness requirements tasks can be used as an individual or collective training assessment tool for preparing and sustaining a Soldier's skills.

### 2-2. General.

The MOS training plan identifies the essential components of a unit training plan for individual training. Units have different training needs and requirements based on differences in environment, location, equipment, dispersion, and similar factors. Therefore, the MOS training plan should be used as a guide-not a rigid standard-for conducting unit training. The MOS training plan consists of two parts. Each part is designed to assist the commander in preparing a unit training plan that satisfies integration, cross-training, training-up, and sustainment training requirements for Soldiers in the MOS. The MOS training plan shows the relationship of an MOS skill level between duty position and critical tasks. These critical tasks are grouped by task commonality into subject areas:

- **Subject Area.** This column lists the subject area number and title.
- **Task Number.** This column lists the task numbers for all tasks included in the subject area.
- **Title.** This column lists the task title for each task in the subject area.
- **Training Location.** This column identifies the training location and how the training is distributed to the Soldier (institutional, operational, or self-development). This STP uses codes to define the environments where training takes place. For example, if the task is first trained to standard in the unit, the abbreviation for operational (also known as OP) will be in this column. Table 2-1 contains a list of training locations and their brevity codes.

**Table 2-1. Training locations**

| | |
|---|---|
| INST | Institutional |
| OP | Operational |
| S-D | Self-Development |

- **Sustainment Training Frequency.** This column indicates the recommended frequency at which the tasks should be trained to ensure Soldiers maintain task proficiency. Table 2-2, on page 2-2, identifies the frequency codes used in this column.

**Table 2-2. Sustainment training frequency codes**

| | |
|---|---|
| AN | Annually |
| SA | Semi-Annually |
| MO | Monthly |

- **Sustainment Training Skill Level.** This column lists the skill level of the MOS for which Soldiers must receive sustainment training to ensure they maintain proficiency to Soldier's manual standards.

**2-3. Duty Position Training Requirements.**
Table 2-3 identifies the total training requirement for each duty position within an MOS and provides a recommendation for cross-training and train-up/merger training.

- **Duty Position.** This column lists the duty positions of the MOS, by skill level, which have different training requirements.
- **Subject Area.** This column lists, by numerical key, the subject areas a Soldier must be proficient in to perform in that duty position.
- **Cross-Train.** This column lists the recommended duty position for which Soldiers should be cross-trained.
- **Train-up/Merger.** This column lists the corresponding duty position for the next higher skill level or MOS code the Soldier will merge into on promotion.

**Table 2-3. Duty position training requirements**

| Skill Level | Duty Position | Subject Areas | Cross-train | Train-up/Merger |
|---|---|---|---|---|
| 1 | Combat Medic Specialist | 1-12 | X | Combat Medic Sergeant |
| 2 | Combat Medic Sergeant | 12-19 | X | Combat Medic Section NCO |
| 3 | Combat Medic Section NCO | 19-23 | X | Senior Combat Medic NCO |
| **Legend:**<br>NCO = noncommissioned officer | | | | |

**2-4. Critical Tasks List.**

**MOS TRAINING PLAN**

**CRITICAL TASKS**

Table 2-4 cross-references each task in all skill levels for a specific MOS with training location, sustainment training frequency, and sustainment training skill level.

**Table 2-4. MOS training plan**

| Task Number | Title | Location | Frequency | Skill Level |
|---|---|---|---|---|
| **Readiness Requirements** | | | | |
| **Subject Area 1. Airway Management** | | | | |
| 081-000-0061 | Perform Patient Suctioning | INST | AN | 1-4 |
| 081-000-0122 | Perform a Surgical Cricothyroidotomy | INST | AN | 1-4 |
| 081-68W-0230 | Place an Intermediate Airway Device | INST | AN | 1-4 |
| 081-68W-0236 | Perform End Tidal Carbon Dioxide Monitoring | INST | AN | 1-4 |
| 081-68W-2001 | Operate a Simplified Automated Ventilator | INST | AN | 1-4 |
| **Subject Area 2. Fluid Management** | | | | |
| 081-000-0128 | Administer Whole Blood | INST | SA | 1-4 |
| 081-68W-0237 | Place an Intraosseous Device | INST | AN | 1-4 |
| 081-68W-0238 | Manage an Intraosseous Infusion | INST | AN | 1-4 |
| 081-68W-0314 | Administer Fluids Through an Infusion | INST | AN | 1-4 |

**Table 2-4. MOS training plan (cont'd)**

| Task Number | Title | Location | Frequency | Skill Level |
|---|---|---|---|---|
| 081-68W-2000 | Operate a Fluid Warmer | INST | AN | 1-4 |
| **Subject Area 3. Force Health Protection** | | | | |
| 081-000-0016 | Treat a Casualty for a Heat Injury | INST | AN | 1-4 |
| 081-000-0017 | Treat a Casualty for a Cold Injury | INST | AN | 1-4 |
| 081-000-0059 | Decontaminate a Casualty | INST | AN | 1-4 |
| 081-68W-0005 | Enforce Field Sanitation Measures | OP | AN | 1-4 |
| 081-68W-0167 | Employ Telemedicine | INST | AN | 1-4 |
| 081-68W-3016 | Brief Mission Commander on Casualty Response Plan | INST | AN | 1-4 |
| **Subject Area 4. Medical Management** | | | | |
| 081-000-0018 | Perform Basic Life Support | INST | AN | 1-4 |
| 081-000-0072 | Perform a Medical Patient Assessment | INST | AN | 1-4 |
| 081-000-0114 | Treat a Blood Agent (Hydrogen Cyanide) Casualty | INST | AN | 1-4 |
| 081-000-0115 | Treat a Choking Agent Casualty | INST | AN | 1-4 |
| 081-000-0116 | Treat a Blister Agent Casualty (Mustard, Lewisite, Phosgene Oxime) | INST | AN | 1-4 |

**Table 2-4. MOS training plan (cont'd)**

| Task Number | Title | Location | Frequency | Skill Level |
|---|---|---|---|---|
| 081-000-0118 | Treat a Radiation Casualty | INST | AN | 1-4 |
| 081-68W-0275 | Treat a Nerve Agent Casualty | INST | AN | 1-4 |
| 081-68W-0279 | Treat a Biological Casualty | INST | AN | 1-4 |
| **Subject Area 5. Medication Management** | | | | |
| 081-000-0025 | Treat a Poisoned Casualty | INST | AN | 1-4 |
| 081-000-0032 | Treat an Allergic Reaction | INST | AN | 1-4 |
| 081-000-0038 | Manage Intravenous Access | INST | AN | 1-4 |
| 081-000-0056 | Prepare an Injection for Administration | INST | SA | 1-4 |
| 081-000-1006 | Administer Medication | INST | SA | 1-4 |
| 081-68W-0311 | Administer Tranexamic Acid | INST | SA | 1-4 |
| **Subject Area 6. Trauma Management** | | | | |
| 081-000-0023 | Manage a Mild Traumatic Brain Injury | INST | AN | 1-4 |
| 081-000-0037 | Treat a Thoracic Injury | INST | AN | 1-4 |
| 081-000-0040 | Treat a Head Injury | INST | AN | 1-4 |
| 081-000-0049 | Perform a Combat Casualty Assessment | INST | AN | 1-4 |

**Table 2-4. MOS training plan (cont'd)**

| Task Number | Title | Location | Frequency | Skill Level |
|---|---|---|---|---|
| 081-000-1001 | Assess Patient Vital Signs | INST | AN | 1-4 |
| 081-68W-0075 | Perform Needle Decompression of the Chest | INST | AN | 1-4 |
| 081-68W-0079 | Treat a Casualty with an Axillary Wound | INST | AN | 1-4 |
| 081-68W-0081 | Treat a Casualty with an Inguinal Wound | INST | AN | 1-4 |
| 081-68W-0091 | Treat a Casualty with a Neck Wound | INST | AN | 1-4 |
| 081-68W-0092 | Apply a Junctional Tourniquet | INST | AN | 1-4 |
| 081-68W-0231 | Manage Shock | INST | AN | 1-4 |
| **Subject Area 7. Triage and Evacuation** | | | | |
| 081-000-0055 | Perform Casualty Triage | INST | AN | 1-4 |
| 081-000-0070 | Establish a Casualty Collection Point | INST | AN | 1-4 |
| 081-68W-0282 | Perform Casualty Movement | INST | AN | 1-4 |
| 081-68W-0298 | Transport a Casualty Using a Litter | INST | AN | 1-4 |
| **Skill Level 1** | | | | |
| **Subject Area 8. Airway Management** | | | | |
| 081-000-0034 | Place an Oropharyngeal Airway | INST | AN | 1-4 |

**Table 2-4. MOS training plan (cont'd)**

| Task Number | Title | Location | Frequency | Skill Level |
|---|---|---|---|---|
| 081-000-0061 | Perform Patient Suctioning | INST | AN | 1-4 |
| 081-000-0073 | Administer Oxygen | INST | AN | 1-4 |
| 081-000-0122 | Perform a Surgical Cricothyroidotomy | INST | AN | 1-4 |
| 081-000-0125 | Maintain a Nasogastric Tube | OP | AN | 1-4 |
| 081-68W-0230 | Place an Intermediate Airway Device | INST | AN | 1-4 |
| 081-68W-0236 | Perform End Tidal Carbon Dioxide Monitoring | INST | AN | 1-4 |
| 081-68W-0313 | Apply an Impedance Threshold Device | INST | AN | 1-4 |
| 081-68W-2001 | Operate a Simplified Automated Ventilator | INST | AN | 1-4 |
| **Subject Area 9. Fluid Management** | | | | |
| 081-000-0027 | Measure a Patient's Fluid Balance | INST | AN | 1-4 |
| 081-000-0124 | Maintain Urinary Catheter | INST | AN | 1-4 |
| 081-000-0128 | Administer Whole Blood | INST | SA | 1-4 |
| 081-000-3054 | Administer Blood Products | INST | SA | 1-4 |
| 081-68W-0237 | Place an Intraosseous Device | INST | AN | 1-4 |
| 081-68W-0238 | Manage an Intraosseous Infusion | INST | AN | 1-4 |

**Table 2-4. MOS training plan (cont'd)**

| Task Number | Title | Location | Frequency | Skill Level |
|---|---|---|---|---|
| 081-68W-0314 | Administer Fluids Through an Infusion | INST | AN | 1-4 |
| 081-68W-2000 | Operate a Fluid Warmer | INST | AN | 1-4 |
| 081-68W-3054 | Operate an Intravenous Infusion Pump | OP | AN | 1-4 |
| **Subject Area 10. Force Health Protection** | | | | |
| 081-000-0016 | Treat a Casualty for a Heat Injury | INST | AN | 1-4 |
| 081-000-0017 | Treat a Casualty for a Cold Injury | INST | AN | 1-4 |
| 081-000-0052 | Treat a Casualty for Insect Injury | INST | AN | 1-4 |
| 081-000-0053 | Treat a Snake Bite Casualty | INST | AN | 1-4 |
| 081-000-0054 | Manage a Patient Restraint | INST | AN | 1-4 |
| 081-000-0059 | Decontaminate a Casualty | INST | AN | 1-4 |
| 081-000-0075 | Perform Patient Hygiene | OP | AN | 1-4 |
| 081-000-0130 | Perform a Gastric Lavage | OP | AN | 1-4 |
| 081-000-0131 | Obtain an Electrocardiogram | INST | AN | 1-4 |
| 081-68W-0005 | Enforce Field Sanitation Measures | OP | AN | 1-4 |
| 081-68W-0167 | Employ Telemedicine | INST | AN | 1-4 |

**Table 2-4. MOS training plan (cont'd)**

| Task Number | Title | Location | Frequency | Skill Level |
|---|---|---|---|---|
| 081-68W-0168 | Treat Dental Emergencies | OP | AN | 1-4 |
| 081-68W-0169 | Perform Field Disinfection of Instruments | OP | AN | 1-4 |
| 081-68W-0246 | Treat a Behavioral Emergency | INST | AN | 1-4 |
| **Subject Area 11. Medical Management** | | | | |
| 081-000-0018 | Perform Basic Life Support | INST | AN | 1-4 |
| 081-000-0026 | Treat a Diabetic Emergency | INST | AN | 1-4 |
| 081-000-0068 | Record Patient Care Using the Subjective, Objective, Assessment, Plan (SOAP) Note Format | INST | AN | 1-4 |
| 081-000-0072 | Perform a Medical Patient Assessment | INST | AN | 1-4 |
| 081-000-0076 | Place a Patient on a Cardiac Monitor | INST | AN | 1-4 |
| 081-000-0092 | Perform Visual Acuity Testing | INST | AN | 1-4 |
| 081-000-0094 | Remove a Patient's Ring | INST | AN | 1-4 |
| 081-000-0103 | Treat Common Musculoskeletal Disorders | INST | AN | 1-4 |
| 081-000-0114 | Treat a Blood Agent (Hydrogen Cyanide) Casualty | INST | AN | 1-4 |
| 081-000-0115 | Treat a Choking Agent Casualty | INST | AN | 1-4 |

**Table 2-4. MOS training plan (cont'd)**

| Task Number | Title | Location | Frequency | Skill Level |
|---|---|---|---|---|
| 081-000-0116 | Treat a Blister Agent Casualty (Mustard, Lewisite, Phosgene Oxime) | INST | AN | 1-4 |
| 081-000-0118 | Treat a Radiation Casualty | INST | AN | 1-4 |
| 081-000-0163 | Establish a Sterile Field | INST | AN | 1-4 |
| 081-000-1008 | Obtain Specimen Collection | INST | AN | 1-4 |
| 081-000-1031 | Perform a Wound Irrigation | INST | AN | 1-4 |
| 081-68W-0060 | Manage Vaginal Delivery | INST | AN | 1-4 |
| 081-68W-0063 | Treat a Soft Tissue Injury | INST | AN | 1-4 |
| 081-68W-0125 | Treat Skin Disorders | INST | AN | 1-4 |
| 081-68W-0166 | Prevent Deep Veinous Thrombosis | INST | AN | 1-4 |
| 081-68W-0170 | Perform Point of Care Testing | OP | AN | 1-4 |
| 081-68W-0239 | Treat Abdominal Disorders | INST | AN | 1-4 |
| 081-68W-0240 | Treat Common Eye Infections | INST | AN | 1-4 |
| 081-68W-0241 | Treat Common Ear Disorders | INST | AN | 1-4 |
| 081-68W-0242 | Treat Sinus Disorder | INST | AN | 1-4 |

**Table 2-4. MOS training plan (cont'd)**

| Task Number | Title | Location | Frequency | Skill Level |
|---|---|---|---|---|
| 081-68W-0243 | Treat Common Throat Disorders | INST | AN | 1-4 |
| 081-68W-0245 | Treat Common Respiratory Disorders | INST | AN | 1-4 |
| 081-68W-0254 | Perform an Otolaryngology Exam | INST | AN | 1-4 |
| 081-68W-0258 | Apply Flouri-Strip to an Eye | OP | AN | 1-4 |
| 081-68W-0260 | Treat Dislocations | INST | AN | 1-4 |
| 081-68W-0263 | Apply a Rigid Splint | INST | AN | 1-4 |
| 081-68W-0268 | Perform a Knee Examination | INST | AN | 1-4 |
| 081-68W-0269 | Perform a Shoulder Examination | INST | AN | 1-4 |
| 081-68W-0270 | Perform an Elbow Examination | INST | AN | 1-4 |
| 081-68W-0271 | Perform a Back Examination | INST | AN | 1-4 |
| 081-68W-0272 | Perform an Ankle Examination | INST | AN | 1-4 |
| 081-68W-0273 | Perform a Wrist Examination | INST | AN | 1-4 |
| 081-68W-0274 | Perform a Hip Examination | INST | AN | 1-4 |
| 081-68W-0275 | Treat a Nerve Agent Casualty | INST | AN | 1-4 |

**Table 2-4. MOS training plan (cont'd)**

| Task Number | Title | Location | Frequency | Skill Level |
|---|---|---|---|---|
| 081-68W-0279 | Treat a Biological Casualty | INST | AN | 1-4 |
| **Subject Area 12. Medication Management** | | | | |
| 081-000-0025 | Treat a Poisoned Casualty | INST | AN | 1-4 |
| 081-000-0032 | Treat an Allergic Reaction | INST | AN | 1-4 |
| 081-000-0038 | Manage Intravenous Access | INST | AN | 1-4 |
| 081-000-0056 | Prepare an Injection for Administration | INST | SA | 1-4 |
| 081-000-1006 | Administer Medication | INST | SA | 1-4 |
| 081-68W-0024 | Treat Paronychia | OP | AN | 1-4 |
| 081-68W-0035 | Treat a Patient for High Altitude Illness | OP | AN | 1-4 |
| 081-68W-0311 | Administer Tranexamic Acid | INST | SA | 1-4 |
| 081-68W-3036 | Perform a Digital Block Anesthesia | OP | AN | 1-4 |
| 081-68W-3090 | Administer Local Anesthesia | INST | AN | 1-4 |
| **Subject Area 13. Trauma Management** | | | | |
| 081-000-0005 | Treat a Seizing Patient | INST | AN | 1-4 |
| 081-000-0023 | Manage a Mild Traumatic Brain Injury | INST | AN | 1-4 |

**Table 2-4. MOS training plan (cont'd)**

| Task Number | Title | Location | Frequency | Skill Level |
|---|---|---|---|---|
| 081-000-0037 | Treat a Thoracic Injury | INST | AN | 1-4 |
| 081-000-0040 | Treat a Head Injury | INST | AN | 1-4 |
| 081-000-0044 | Treat a Casualty with Burns | INST | AN | 1-4 |
| 081-000-0048 | Replace an Extremity Tourniquet | INST | AN | 1-4 |
| 081-000-0049 | Perform a Combat Casualty Assessment | INST | AN | 1-4 |
| 081-000-0051 | Manage a Minor Laceration | INST | AN | 1-4 |
| 081-000-0083 | Apply a Cervical Collar | INST | AN | 1-4 |
| 081-000-0107 | Treat Subungual Hematoma | OP | AN | 1-4 |
| 081-000-0110 | Apply an Elastic Bandage | INST | AN | 1-4 |
| 081-000-0111 | Treat a Pelvic Injury | INST | AN | 1-4 |
| 081-000-0112 | Manage a Suspected Spinal Injury | INST | AN | 1-4 |
| 081-000-0127 | Treat an Open Abdominal Wound | INST | AN | 1-4 |
| 081-000-1001 | Assess Patient Vital Signs | INST | AN | 1-4 |
| 081-000-3006 | Manage a Chest Tube | OP | AN | 1-4 |
| 081-68W-0020 | Treat Compartment Syndrome | INST | AN | 1-4 |

**Table 2-4. MOS training plan (cont'd)**

| Task Number | Title | Location | Frequency | Skill Level |
|---|---|---|---|---|
| 081-68W-0021 | Treat Crush Injury | INST | AN | 1-4 |
| 081-68W-0036 | Treat a Casualty with an Impaled Object | INST | AN | 1-4 |
| 081-68W-0040 | Treat Eye Injuries | INST | AN | 1-4 |
| 081-68W-0053 | Perform an Emergency Medical Technician Trauma Patient Assessment | INST | AN | 1-4 |
| 081-68W-0075 | Perform Needle Decompression of the Chest | INST | AN | 1-4 |
| 081-68W-0079 | Treat a Casualty with an Axillary Wound | INST | AN | 1-4 |
| 081-68W-0081 | Treat a Casualty with an Inguinal Wound | INST | AN | 1-4 |
| 081-68W-0091 | Treat a Casualty with a Neck Wound | INST | AN | 1-4 |
| 081-68W-0092 | Apply a Junctional Tourniquet | INST | AN | 1-4 |
| 081-68W-0141 | Apply a Traction Splint | INST | AN | 1-4 |
| 081-68W-0231 | Manage Shock | INST | AN | 1-4 |
| 081-68W-0265 | Apply a Sling and Swath | INST | AN | 1-4 |
| **Subject Area 14. Triage and Evacuation** | | | | |
| 071-334-4662 | Establish a Helicopter Landing Point | INST | AN | 1-4 |

**Table 2-4. MOS training plan (cont'd)**

| Task Number | Title | Location | Frequency | Skill Level |
|---|---|---|---|---|
| 081-000-0055 | Perform Casualty Triage | INST | AN | 1-4 |
| 081-000-0070 | Establish a Casualty Collection Point | INST | AN | 1-4 |
| 081-000-0088 | Establish an Ambulance Exchange Point | INST | AN | 1-4 |
| 081-000-0093 | Prepare an Aid Bag | INST | AN | 1-4 |
| 081-000-0151 | Load Casualties onto Nonstandard Vehicles | INST | AN | 1-4 |
| 081-000-0152 | Unload Casualties from Nonstandard Vehicles | INST | AN | 1-4 |
| 081-000-1015 | Load Casualties onto Ground Ambulances | INST | AN | 1-4 |
| 081-000-1016 | Unload Casualties from Ground Ambulances | INST | AN | 1-4 |
| 081-68W-0282 | Perform Casualty Movement | INST | AN | 1-4 |
| 081-68W-0293 | Load Patients on an Air Ambulance | INST | AN | 1-4 |
| 081-68W-0294 | Unload Casualties from an Air Ambulance | INST | AN | 1-4 |
| 081-68W-0298 | Transport a Casualty Using a Litter | INST | AN | 1-4 |
| 081-68W-0299 | Transport a Casualty Using a Modular Sled Based Rescue System or SKED ® Basic Rescue System | INST | AN | 1-4 |

**Table 2-4. MOS training plan (cont'd)**

| Task Number | Title | Location | Frequency | Skill Level |
|---|---|---|---|---|
| **Skill Level 2** | | | | |
| **Subject Area 15. Force Health Protection** | | | | |
| 081-000-0095 | Remove a Toenail | OP | AN | 2-4 |
| 081-000-1030 | Change a Sterile Dressing | OP | AN | 2-4 |
| 081-68W-2004 | Process an Infectious Sample | OP | AN | 2-4 |
| **Subject Area 16. Medical Management** | | | | |
| 081-68W-2005 | Place an Orogastric Tube | OP | AN | 2-4 |
| 081-68W-2006 | Remove an Orogastric Tube | OP | AN | 2-4 |
| **Subject Area 17. Medication Management** | | | | |
| 081-68W-0192 | Treat an Abscess | OP | AN | 2-4 |
| **Subject Area 18. Trauma Management** | | | | |
| 081-68W-0171 | Perform a Focused Assessment with Sonography for Trauma Exam | OP | AN | 2-4 |
| **Subject Area 19. Triage and Evacuation** | | | | |
| 081-68W-2003 | Manage a Combat Lifesaver Program | OP | AN | 2-4 |
| **Skill Level 3** | | | | |
| **Subject Area 20. Airway Management** | | | | |

**Table 2-4. MOS training plan (cont'd)**

| Task Number | Title | Location | Frequency | Skill Level |
|---|---|---|---|---|
| 081-68W-0100 | Place an Endotracheal Tube | OP | SA | 3-4 |
| **Subject Area 21. Force Health Protection** | | | | |
| 081-68W-3008 | Manage a Team During Prolonged Care | INST | AN | 3-4 |
| 081-68W-3009 | Interpret Running Estimates Tracking | INST | AN | 3-4 |
| 081-68W-3011 | Develop Annex F to Appendix 3 Medical Plan | INST | AN | 3-4 |
| 081-68W-3016 | Brief Mission Commander on Casualty Response plan | INST | AN | 3-4 |
| **Subject Area 22. Medical Management** | | | | |
| 081-000-3011 | Treat Life Threatening Cardiac Arrhythmias | INST | AN | 3-4 |
| **Subject Area 23. Trauma Management** | | | | |
| 081-68W-1653 | Manage Canine Emergencies | INST | AN | 3-4 |
| **Subject Area 24. Triage and Evacuation** | | | | |
| 081-000-3058 | Establish a Casualty Decontamination Station | INST | AN | 3-4 |
| 081-68W-3010 | Coordinate Evacuation Plans | INST | AN | 3-4 |
| **Legend:**<br>AN = annually<br>OP=operational | | INST= institutional<br>SM = Soldier's manual | | |

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# Chapter 3

## Skill Level Tasks

## Readiness Requirements

## Subject Area 1: Airway Management

Perform Patient Suctioning

081-000-0061

**WARNING:** Eye protection is required when performing suctioning procedures.

**CAUTION:** All body fluids should be considered potentially infectious. Always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have a patient that requires suctioning. You may have a portable suction apparatus, suction tubing, a rigid or flexible suction catheter, saline solution or sterile water, basin, gloves, goggles, collection bottle, oxygen delivery system, and an SF 600 (*Chronological Record of Medical Care*), or the patient's electronic medical record (EMR). You have performed a patient care handwash, gathered equipment, and performed a patient baseline vital signs assessment.

**Standards:** Perform suctioning in accordance with the *Clinical Patient Guidelines,* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Prepare equipment.
   a. Turn on the suction in order to check proper functioning.
   b. Open the basin package.
   c. Pour the saline solution into the basin.
   d. Open the suction catheter package.
   e. Attach catheter to the suction tubing.
2. Explain the procedure to the patient, if conscious.
3. Don personal protective equipment.
4. Position the patient.
   a. Position a conscious patient in a semi-Fowler's (semi-sitting) position.
   b. Position a severe trauma patient, onto their side allowing gravity to assist in clearing the airway.
5. Hyper-oxygenate the patient with 100% oxygen.
   a. Increase the oxygen to 100% for up to 2 minutes if the patient is already receiving oxygen therapy in order to hyper-oxygenate.
   b. Instruct the patient to take a minimum of five deep breaths or administer the breaths with a bag-valve-mask system, if the patient is not receiving oxygen therapy.

**NOTE:** After each suctioning attempt or suctioning period, reoxygenate the patient.

**CAUTION:** Suctioning activities should pause if the patient has a pulse oximeter reading less than 92%.

c. Monitor the patient's pulse oximeter reading during the entire procedure.

6. Test the patency of the catheter.
   a. Turn the suction unit on with your nondominant hand.
      (1) Adults: negative pressures of 120 to 150 millimeters of mercury (mmHg).
      (2) Children: negative pressures of 100 to 120 mmHg.
      (3) Infants: negative pressures of 80 to 100 mmHg.
   b. Pick up attached suction tubing using your nondominant hand.

**NOTE:** The suction tubing is considered contaminated. After this is touched, then that hand is considered contaminated.

c. Insert the catheter tip into the saline solution using your dominant hand.

**NOTE:** Moistening the catheter lubricates the catheter and helps to minimize trauma to the mucous membranes and increases the patient's comfort.

d. Occlude the suction control port with your nondominant thumb while observing the saline entering the drainage bottle.

7. Suction the patient.
   a. Rigid catheter.
      (1) Instruct a conscious patient to cough to help bring secretions up to the back of their throat.
      (2) Use the cross-finger method of opening the airway with your nondominate hand, if the patient is unconscious.
      (3) Place the convex (outward curving) side of the rigid tip against the roof of the mouth and insert to the base of the tongue.

**NOTE:** A rigid tip does not need to be measured. Only insert the tip as far as you can see it. Be aware that advancing the catheter too far may stimulate the patient's gag reflex and cause them to vomit.

**WARNING:** Never suction for more than 15 seconds at one time for adults, 10 seconds for children, and 5 seconds for infants. Longer periods of continuous suctioning may cause oxygen deprivation.

(4) Apply suction by placing the thumb of your dominant hand over the suction control port.
(5) Clear the secretions from the catheter between each suctioning interval by inserting the tip into the saline solution and suction the solution through the catheter until the catheter is clear of secretions.
(6) Repeat steps 7a (1) through 7a (5) until all secretions have been removed or until the patient's breathing becomes easier.

**NOTE:** If no suction is required go to step 10.

b. Flexible catheter.

(1) Measure the catheter from the patient's earlobe to the corner of the mouth or the center of the mouth to the angle of the jaw.

**WARNING:** Insert the catheter no further down than the base of the tongue.

(2) Insert the catheter into the patient's mouth to the correct depth no lower than the back of throat, without the suction applied.

**NOTE:** If an oropharyngeal airway is in place, insert the catheter alongside the airway and then back into the pharynx.

(3) Place the thumb of your nondominant hand over the suction control port on the catheter, applying intermittent suction by moving your thumb to cover and uncover the suction control port.

(4) Apply suction in a circular motion as you withdraw the catheter.

**WARNING:** Advancing the catheter too far into the back of the patient's throat may stimulate the gag reflex. This could cause vomiting and the aspiration of stomach contents.

(5) Suction for no longer than 10 to 15 seconds removing secretions from the back of the throat, along outer gums, cheeks, and base of tongue.

(6) Clear the secretions from the catheter between suctioning by inserting the tip into the saline solution and suction the solution through the catheter until the catheter is clear of secretions.

**NOTE:** If step 7b (6) is not required move to step 11.

(7) Repeat steps 7b (2) through 7b (6) until all secretions have been removed or until the patient's breathing becomes easier. Noisy, rattling, or gurgling sounds should no longer be heard.

c. Endotracheal (ET) suctioning.

(1) If an in-line suction catheter is not in place, attach one to the ventilator circuit after estimating the proper size by multiplying the ET tube's inner diameter by two, then selecting the next smallest size catheter. For example, an 8-millimeter ET tube: 2 x 8 = 16 catheters are measured in French (Fr) the next size down from 16 Fr would be 14 Fr.

**NOTE:** In-line suction catheters are recommended for patients receiving ventilatory support because they allow suctioning without disconnecting the patient from the ventilator and, therefore, preventing lung derecruitment, loss of oxygen, and cross-contamination.

(2) Attach a sterile saline ampoule to the irrigation port of the in-line suction catheter.

(3) Check the suction level by closing the catheter thumb port and suctioning sterile saline from the irrigation port.

(4) Hyper-oxygenate patient, this can either be done by the ventilator if applicable or by increasing the fraction of inspired oxygen to 100% for 2 minutes.

(5) Insert the catheter into the ET tube by advancing the catheter until the numbers on the suction catheter match the numbers on the ET tube that indicate the depth of insertion, resulting in the tip of the catheter only reaching the tip of the ET tube.

**NOTE:** This is called the shallow method and prevents tracheal mucosa damage.

**CAUTION:** Nerves in the trachea and carina can cause transient brady cardia and asystole. If major changes in heart rate or rhythm stop and immediately administer oxygen.

(6) Apply suction while withdrawing the catheter for no longer than 15 seconds.

(7) Clear the catheter by suctioning sterile saline from the irrigation port.

(8) Repeat steps 7c (1) to 7c (6) as needed.

d. Nasotracheal suctioning.

(1) Select an appropriate size suction catheter kit according to manufacturer's recommendation.

(2) Open the kit, using the sterile technique, and pour water-soluble lubricant into the kit.

(3) Don the sterile gloves supplied in the suction kit.

(4) Connect the thumb-control valve of the suction catheter to the vacuum tubing using your nondominant hand.

**NOTE:** The nondominant hand is now considered contaminated and should not be used to touch any sterile part of the suction catheter.

(5) Open the sterile water container included in the kit.

(6) Check suction pressure by suctioning sterile water through the catheter.

(7) Lubricate the catheter with water-soluble lubricant.

(8) Remove the non-rebreathing mask from the patient's face with your nondominant hand.

(9) Insert the catheter gently through the nostril, directing it toward the septum and the floor of the nasal cavity, without applying suction.

**NOTE:** If resistance is felt, gently twist the catheter; however, if resistance is still felt, withdraw the catheter, and attempt to insert it in the other nostril. Utilizing a nasopharyngeal airway will reduce mucosa damage and assists when multiple passes are necessary.

(10) Ask the patient to assume a "sniffing" position once the catheter reaches the lower pharynx.

(11) Continue to advance the catheter until the patient coughs or resistance is met.

**NOTE:** If resistance is met, withdraw the catheter approximately 1 centimeter.

(12) Apply suction for no longer than 15 seconds while simultaneously withdrawing the catheter.

(13) Reapply the non-rebreathing mask on the patient with your nondominant hand and hyper-oxygenate for at least one minute before attempting to suction again.

(14) Clear the catheter by suctioning sterile water.

(15) Repeat steps 7d (1) to 7d (14) as needed.

(16) Remove the non-rebreathing mask and return the patient to the original oxygen device, if any.

8. Reoxygenate the patient or ventilate for at least five assisted ventilations, as appropriate.
9. Observe the patient for signs of hypoxemia.
   a. Signs of cyanosis.

**WARNING:** Discontinue suctioning immediately if severe changes in color or pulse rate occur.

   b. Increased or decreased pulse rate.

10. Place the patient in a position of comfort.
11. Record the procedure on the SF 600 or EMR.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Prepared equipment. | _____ | _____ |
| 2 | Explained the procedure to the patient, if conscious. | _____ | _____ |
| 3 | Donned personal protective equipment. | _____ | _____ |
| 4 | Positioned the patient. | _____ | _____ |
| 5 | Hyperoxygenated the patient with 100% oxygen. | _____ | _____ |
| 6 | Tested the patency of the catheter. | _____ | _____ |
| 7 | Suctioned the patient. | _____ | _____ |
| 8 | Reoxygenated the patient or ventilated for at least five assisted ventilations, as appropriate. | _____ | _____ |
| 9 | Observed the patient for signs of hypoxemia. | _____ | _____ |
| 10 | Placed the patient in a position of comfort. | _____ | _____ |
| 11 | Recorded the procedure on the SF 600 or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
*Clinical Patient Guidelines.*
Joint Trauma System *website.*
*SF 600.* Chronological Record of Medical Care.

**Related**
None

Place an Intermediate Airway Device

081-68W-0230

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You have an unconscious patient in need of a definitive airway. You will have access to *Committee on Tactical Combat Casualty Care (CoTCCC)*, recommended intermediate airway device, gloves, syringe, stethoscope, bag valve mask (BVM), pulse oximeter, pen, clipboard, combat lifesaver qualified Soldiers, DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)) Instructions*)), and the patient's SF 600, (*Chronological Record of Medical Care*), or electronic medical record (EMR).

**Standards:** Place an intermediate airway device in accordance with *PHTLS Prehospital Trauma Life Support* and *Tactical Combat Casualty Care (TCCC) Guidelines* while adhering to all warnings and cautions without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Take BSI precautions.

2. Inspect the upper airway for visible obstruction.

3. Direct assistant to hyperventilate the patient for a minimum of 30 seconds.

**NOTE:** If using a supraglottic airway device continue with steps 3 through 16. If using a subglottic airway continue with steps 17 through 22.

4. Test cuff and inflation system for leaks by injecting the maximum recommended volume of air into the cuffs (size 3: 60 milliliter [ml], size 4: 80 ml, size 5: 90 ml).

5. Remove all air from both cuffs prior to insertion.

6. Apply lubricant to beveled distal tip and posterior aspect of the tube.

7. Position the head in the "sniffing" position. Verbalize alternate position is the "neutral" position.

8. Hold the supraglottic airway device at the connector with dominant hand. With nondominant hand perform a tongue and chin lift.

9. Introduce tip into mouth and advance behind base of tongue.

**NOTE:** With the supraglottic airway device on the corner of the mouth, rotate it laterally 45-90 degrees, such that the blue orientation line is touching the corner of mouth.

10. Pass the supraglottic airway device towards the back of tongue, rotate tube back to midline (blue orientation line faces chin).

11. Advance tube until base of connector is aligned with teeth or gums.

**NOTE:** Without exerting excessive force.

12. Using the syringe provided, inflate the cuffs of the supraglottic airway device with the appropriate volume of air (size 3: 45-60 ml, size 4: 60-80 ml, size 5: 70-90 ml).

13. Attach the BVM to the supraglottic airway device. While gently bagging the patient to assess ventilation, simultaneously withdraw the supraglottic airway device until ventilation is easy and free flowing (large tidal volume with minimal airway pressure).

14. Direct the combat lifesaver to ventilate casualty with the BVM, auscultate lung fields and watch for rise and fall of the chest to confirm tube placement. Attach a pulse oximeter.

15. Secure device to the casualty.

16. Document information onto DD Form 1380, SF 600, or EMR.

17. Remove subglottic airway device from the protective cradle.

**NOTE:** a. Apply lubricate on the tray of the protective cradle and lubricate the subglottic airway on all sides. b. Remove any excess lubricant.

**WARNING:** Casualties with facial trauma or facial burns with suspected inhalation injury, an extraglottic airway (EGA) device might not be adequate. Surgical cricothyroidotomy may be a better option.

**CAUTION:** An EGA device will only be accepted if the patient is unconscious.

18. Open the patient's airway with the head tilt chin lift.

**NOTE:** a. Use scissor technique to open the mouth. b. If patient has suspected C-spine injury use a jaw thrust.

19. Insert the subglottic airway device by grasping the device by the bite block and introducing the leading soft tip into the mouth of the patient towards the hard palate.

**NOTE:** a. Tip of subglottic airway should be in upper esophageal opening with cuff located against laryngeal framework. b. Glide the device downwards and backwards along the hard palate with a continuous but gentle push until a definitive resistance is felt.

20. Secure the device with tape or securing strap.

21. Monitor end tidal carbon dioxide ($CO_2$) and attach pulse oximeter to patient.

22. Document information onto DD Form 1380, SF 600, or EMR.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Took BSI precautions. | _____ | _____ |

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 2 | Inspected the upper airway for visible obstruction. | _____ | _____ |
| 3 | Directed assistant to hyperventilate the patient for a minimum of 30 seconds. | _____ | _____ |
| 4 | Tested cuff and inflation system for leaks by injecting the maximum recommended volume of air into the cuffs (size 3: 60 milliliter [ml], size 4: 80 ml, size 5: 90 ml). | _____ | _____ |
| 5 | Removed all air from both cuffs prior to insertion. | _____ | _____ |
| 6 | Applied lubricant to beveled distal tip and posterior aspect of the tube. | _____ | _____ |
| 7 | Positioned the head in the “sniffing” position. Verbalized alternate position was the “neutral” position. | _____ | _____ |
| 8 | Held the supraglottic airway device at the connector with dominant hand. With nondominant hand performed a tongue and chin lift. | _____ | _____ |
| 9 | Introduced tip into mouth and advanced behind base of tongue. | _____ | _____ |
| 10 | Passed the supraglottic airway device towards the back of tongue, rotated tube back to midline (blue orientation line faces chin). | _____ | _____ |
| 11 | Advanced tube until base of connector was aligned with teeth or gums. | _____ | _____ |
| 12 | Used the syringe provided, inflated the cuffs of the supraglottic airway device with the appropriate volume of air (size 3: 45-60 ml, size 4: 60-80 ml, size 5: 70-90 ml). | _____ | _____ |
| 13 | Attached the BVM to the supraglottic airway device. While gently bagging the patient to assess ventilation, simultaneously withdrew the supraglottic airway device until ventilation was easy and free flowing (large tidal volume with minimal airway pressure). | _____ | _____ |
| 14 | Directed the combat lifesaver to ventilate casualty with the BVM, auscultated lung fields and watched for rise and fall of the chest to confirm tube placement. Attached a pulse oximeter. | _____ | _____ |
| 15 | Secured device to the casualty. | _____ | _____ |
| 16 | Documented information onto DD Form 1380, SF 600, or EMR. | _____ | _____ |
| 17 | Removed subglottic airway device from the protective cradle. | _____ | _____ |
| 18 | Opened the patient’s airway with the head tilt chin lift. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 19 | Inserted the subglottic airway device by grasping the device by the bite block and introducing the leading soft tip into the mouth of the patient towards the hard palate. | _____ | _____ |
| 20 | Secured the device with tape or securing strap. | _____ | _____ |
| 21 | Monitored end tidal carbon dioxide ($CO_2$) and attached pulse oximeter to patient. | _____ | _____ |
| 22 | Documented information onto DD Form 1380, SF 600, or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
Committee on Tactical Combat Casualty Care (CoTCCC).
Joint Trauma System *website.*
PHTLS Prehospital Trauma Life Support*.*
SF 600. *Chronological Record of Medical Care.*
Tactical Combat Casualty Care (TCCC) Guidelines.

**Related**
None

Operate a Simplified Automated Ventilator

081-68W-2001

**WARNING:** Do not use a mask with a filter and make sure any ports on the mask are sealed with caps.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment and have a patient requiring lifesaving ventilator support to manage acute respiratory failure. You are provided with a Simplified Automated Ventilator (SAVe) device, *Rosdahl's Textbook of Basic Nursing,* pen, clipboard, notepad, DD 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*), the patient's SF 600 (*Chronological Record of Medical Care*), or electronic medical record.

**Standards:** Operate the SAVe maintaining adequate ventilation, in accordance with *Rosdahl's Textbook of Basic Nursing,* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Look, listen and feel for breathing and pulse.
2. Verify the airway is not blocked.
3. Open cover labeled Patient Breathing Circuit and connect patient circuit in the well.
4. Insert airway device.

**NOTE:** a. Connect the other end of the patient circuit to the airway device. b. Connect the other end of the patient circuit to the airway mask.

5. Engage the SAVe and rotate the knob one position from off to the on.
6. Open airway with head tilt chin lift or jaw thrust maneuver.
7. Use two hands to maintain the seal of the mask.

**NOTE:** a. Verify adequate chest rise, feel for leaks, and listen for exhale at the valve.

8. Verify battery life and that there are no alarms.
9. Select six liters per minute.

**NOTE:** a. Supplemental oxygen: connect oxygen tube to port under the cover labeled "$O_2$". b. Medical-grade air.

10. Monitor the patient and alarms.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Looked, listened and felt for breathing and pulse. | _____ | _____ |
| 2 | Verified the airway was not blocked. | _____ | _____ |
| 3 | Opened cover labeled Patient Breathing Circuit and connected patient circuit in the well. | _____ | _____ |
| 4 | Inserted airway device. | _____ | _____ |
| 5 | Engaged the SAVe and rotated the knob one position from off to the on. | _____ | _____ |
| 6 | Opened airway with head tilt chin lift or jaw thrust maneuver. | _____ | _____ |
| 7 | Used two hands to maintain the seal of the mask. | _____ | _____ |
| 8 | Verified battery life and that there were no alarms. | _____ | _____ |
| 9 | Selected six liters per minute. | _____ | _____ |
| 10 | Monitored the patient and alarms. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
SF 600. *Chronological Record of Medical Care*.
Rosdahl's Textbook of Basic Nursing.

**Related**
None

## Perform a Surgical Cricothyroidotomy

081-000-0122

**DANGER:** Casualties with a total upper airway obstruction, inhalation burns, or massive maxillofacial trauma who cannot be ventilated by other means are candidates for a surgical cricothyroidotomy.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have a casualty requiring a surgical cricothyroidotomy. You have a scalpel, tracheal hook, tracheotomy tube or any non-collapsible tube, alcohol swabs, bag valve mask (BVM), stethoscope, gloves, 2x2 gauze, and tape.

**Standards:** Perform a surgical cricothyroidotomy in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines* and *Committee on Tactical Combat Casualty Care (CoTCC)*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Don gloves.

**NOTE:** In a true emergency, there may not be time for sterile preparation of the skin.

**WARNING:** Do not hyperextend the casualty's neck if a cervical injury is suspected.

2. Hyperextend the casualty's neck.
   a. Place the casualty in the supine position.
   b. Place a blanket or poncho rolled up under the casualty's neck or between the shoulder blades to hyperextend the neck.

3. Locate the cricothyroid membrane.
   a. Place a finger of the nondominant hand on the thyroid cartilage (Adam's apple) and slide the finger down to the cricoid cartilage.
   b. Palpate for the soft cricothyroid membrane below the thyroid cartilage and just above the cricoid cartilage.
   c. Slide the index finger down into the depression between the thyroid and cricoid cartilage.
   d. Prepare the skin over the membrane with an alcohol swab.

4. Stabilize the larynx with the nondominant hand.

5. Perform a 1 1/2-inch vertical incision through the skin over the cricothyroid membrane with the cutting instrument in the dominant hand.

**NOTE:** A vertical incision will allow visualization of the cricothyroid membrane but keep the scalpel blade away from the lateral aspect of the neck. This is important because of the large blood vessels located in the lateral areas of the neck.

**CAUTION:** Do not cut the cricothyroid membrane with this incision.

6. Maintain the opening of the skin incision by pulling the skin taut with the fingers of the nondominant hand.

7. Stabilize the larynx with one hand while cutting horizontally through the cricothyroid membrane.

8. Insert a commercially designed cricothyroidotomy hook or improvise with the tip of an 18-gauge needle.

**NOTE:** Formed into a hook through the opening, when hooking the cricoid cartilage and lifting to stabilize the opening.

9. Insert the end of the tracheotomy tube or endotracheal tube through the opening and towards the lungs.

**NOTE:** The tube should be in the trachea and directed toward the lungs. Inflate the cuff with 10 cubic centimeters (cc) of air.

10. Auscultate lung fields and watch for rise and fall of the chest to confirm tube placement.

11. Assess the casualty for spontaneous respirations (10 seconds).

12. Attach a pulse oximeter to the casualty, if available.

13. Assist with ventilations when respirations are less than 8 or greater than 30 or a pulse oximeter reading in less than 90%.

**NOTE:** Direct an assistant to ventilate the casualty with a BVM, if necessary.

14. Secure the tube, using tape, cloth ties, or other measures, while applying a dressing to further protect the tube and incision.

15. Monitor the casualty's respirations on a regular basis.
    a. Reassess air exchange and placement every time the casualty is moved.
    b. Assist with respirations if the respiratory rate falls below 8 or rises above 30 per minute.

16. Document treatment on a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*) or the electronic medical record.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Donned gloves. | _____ | _____ |
| 2 | Hyperextended the casualty's neck. | _____ | _____ |
| 3 | Located the cricothyroid membrane. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 4 | Stabilized the larynx with the nondominant hand. | _____ | _____ |
| 5 | Performed a 1 1/2-inch vertical incision through the skin over the cricothyroid membrane with the cutting instrument in the dominant hand. | _____ | _____ |
| 6 | Maintained the opening of the skin incision by pulling the skin taut with the fingers of the nondominant hand. | _____ | _____ |
| 7 | Stabilized the larynx with one hand when cutting horizontally through the cricothyroid membrane. | _____ | _____ |
| 8 | Inserted a commercially designed cricothyroidotomy hook or improvised with the tip of an 18-gauge needle. | _____ | _____ |
| 9 | Inserted the end of the tracheotomy tube or endotracheal tube through the opening and towards the lungs. | _____ | _____ |
| 10 | Auscultated lung fields and watched for rise and fall of the chest to confirm tube placement. | _____ | _____ |
| 11 | Assessed the casualty for spontaneous respirations (10 seconds). | _____ | _____ |
| 12 | Attached a pulse oximeter to the casualty, if available. | _____ | _____ |
| 13 | Assisted with ventilations when respirations were less than 8 or greater than 30 or a pulse oximeter reading was less than 90%. | _____ | _____ |
| 14 | Secured the tube, using tape, cloth ties, or other measures, while applying a dressing to further protect the tube and incision. | _____ | _____ |
| 15 | Monitored the casualty's respirations on a regular basis. | _____ | _____ |
| 16 | Documented treatment on a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions))* or the electronic medical record. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**

*Committee on Tactical Combat Care (Co TCCC).*
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
Joint Trauma System website.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**

None

Perform End Tidal Carbon Dioxide Monitoring

081-68W-0236

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you encounter a casualty who requires end-tidal carbon dioxide ($EtCO_2$) monitoring. You have a vital signs monitor or manual defibrillator with capnography capability, an $EtCO_2$ sampling with a 15 millimeter (mm) connector, or an $EtCO_2$ nasal cannula, pen, clipboard, notepad, DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*), the patient's SF 600 (*Chronological Record of Medical Care*), or electronic medical record (EMR).

**Standards:** Perform $EtCO_2$ monitoring in accordance with *Nancy Caroline's Emergency Care in the Streets*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Don personal protective equipment.

2. Turn on vital signs monitor or monitor defibrillator with $EtCO_2$ capnography capability.

3. Attach sampling line of the $EtCO_2$ device to the vital signs monitor or monitor defibrillator.

4. Attach the $EtCO_2$ device to the patient.
   a. If using the $EtCO_2$ nasal canula, place the two prongs of the nasal canula at the opening of the nares with the concave side of the sampling device facing the mouth.
   b. If using the $EtCO_2$ sampling line that attaches to the standard 15 mm tube connector for intubation tubes, and tube style supraglottic airways, in conjunction with an impedance threshold device (ITD), connect the $EtCO_2$ sampling line connector directly to the tube style airway connector and then attach the ITD above the sampling line connector.

5. Observe the monitor interface of the vital signs monitor or monitor defibrillator for an $EtCO_2$ numerical reading.

**NOTE:** Normal $EtCO_2$ numerical values range between 35-45 millimeters of mercury (mmHg).

6. Interpret the $EtCO_2$ capnography wave form.
   a. Observe phase 1 (A and B baseline wave) of the wave form.
   b. Observe phase 2 (B and C expiratory upslope) of the wave form.
   c. Observe phase 3 (C and D expiratory or alveolar plateau) of the wave form.
   d. Observe phase 4 (D and E inspiratory downstroke) of the wave form.

7. Document the procedure.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Donned personal protective equipment. | _____ | _____ |
| 2 | Turned on vital signs monitor or monitor defibrillator with $EtCO_2$ capnography capability. | _____ | _____ |
| 3 | Attached sampling line of the $EtCO_2$ device to the vital signs monitor or monitor defibrillator. | _____ | _____ |
| 4 | Attached the $EtCO_2$ device to the patient. | _____ | _____ |
| 5 | Observed the monitor interface of the vital signs monitor or monitor defibrillator for an $EtCO_2$ numerical reading. | _____ | _____ |
| 6 | Interpreted the $EtCO_2$ capnography wave form. | _____ | _____ |
| 7 | Documented the procedure. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
*Nancy Caroline's Emergency Care in the Streets.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

**Subject Area 2: Fluid Management**

Administer Whole Blood

081-000-0128

**WARNING:** Whole blood (WB) collected can be stored for 21 days at 1-6 degrees (°) Celsius (C) in citrate-phosphate-dextrose or 35 days at 1-6 °C in citrate-phosphate-dextrose-adenine and is designated stored whole blood in *Joint Trauma System Clinical Practice Guideline (JTS CPG).*

**WARNING:** Fresh whole blood (FWB) refers to WB collected on an emergency basis from a "walking blood bank".

**WARNING:** FWB can either be stored at room temperature and used within 24 hours of collection (and then destroyed if not used) or it can be refrigerated within 8 hours of collection.

**CAUTION:** Because FWB presents a higher risk of disease transmission, it is reserved for situations in which tested blood products are unavailable or ineffective (further discussion below).

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have a trauma patient presenting with hemorrhagic shock and must administer WB. You are provided a constricting band, antiseptic wipes, 450-500 milliliter (ml) blood collection bag, blood donation bag label, permanent marking pen, 4x4 gauze, 3-inch tape, hemostats, personal protective equipment, donor bag measuring device (digital scale or appropriate length of parachute 550 cord), and a sharp's container.

**Standards:** Administer WB in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines*, and *Whole Blood Transfusion CPG ID: 21 by Joint Trauma System (JTS)*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Confirm the patient's blood type.
2. Prepare to collect blood from the donor.

**NOTE:** The best practice for donor collection is to pre-draw and cold-store WB during pre-mission preparations. Use donors that will not be engaged in the mission.

a. Apply a constricting band at least two inches above the venipuncture site.

**NOTE:** Infusion of a blood pack should be initiated within 30 minutes of being issued.

b. Identify the vein that will be used.

**NOTE:** Return the blood pack to the blood bank if any abnormality is present or suspected.

c. Disinfect the venipuncture site using an antiseptic wipe.

d. Remove the donor bag from the packaging.
e. Clamp the tubing using hemostats 12-18 inches from the needle.
f. Apply one of the following measuring devices to the collection bag.
(1) Zip tie marked at 6.5 inches around the center of the bag.
(2) Clamping the bottom of the bag with a folded overlap of 1-1.5 inches.
(3) Parachute 550 cord cut at 10 inches wrapped around the bag with the ends slightly overlapping.
(4) Utilizing a digital scale and discontinue collection at 500 grams (g).

3. Collect blood from the donor.

**NOTE:** Keep the donor bag insulated from the ground and below the level of the donor's heart.

a. Twist off the cap of the 16-gauge needle.
b. Insert the needle bevel up at 15- to 30-degree angle through the skin.

**NOTE:** The donor should not bend the arm during the process.

c. Remove the clamp from the collection line when blood is observed in the line.
d. Secure the tubing and needle with 3-inch tape.
e. Sway the collection bag back and forth every 60 seconds to mix the anticoagulants with the blood.
f. Monitor the donor throughout the process for following.
(1) Sign and symptoms of blood loss.
(2) Hematomas at the venipuncture site.
(3) Blood flow into the collection bag.

**NOTE:** You may need to reposition the needle if the flow stops.

4. Determine when the bag is full using the methods in step 2f.

5. Discontinue the collection process.
a. Clamp the line using hemostats.
b. Place a 4x4 gauze over the venipuncture site.
c. Remove the needle from the donor site.
d. Apply pressure to the donor venipuncture site.
e. Release the clamp to allow the blood in the line to enter the collection bag.
f. Tie two overhand knots in the line as close to the bag as possible.
g. Cut the remaining line and needle away from the collection bag.

6. Label the blood collection bag.
a. Annotate the donor's information on the collection bag.
b. Annotate the patient's blood type on the collection bag.
c. Annotate the collection time and date on the collection bag.
d. Annotate the name of the person who collected the blood.

7. Monitor the donor after the donation is complete.

**NOTE:** The donor should remain seated or lying down after complete.

8. Document the collection on the appropriate forms for the environment.

9. Identify the casualty meets criteria for blood transfusion.
    a. Heart rate > 100 beats per minute.
    b. Systolic blood pressure < 100 millimeters of mercury (mmHg).
    c. Altered mental status with signs and symptoms of hemorrhagic shock.
    d. Penetrating trauma to chest or abdomen, junctional injuries.
    e. Pelvic fracture.
    f. Any above the knee amputation or multiple amputations (regardless of vital signs).

10. Obtain intravenous (IV) or intraosseous (IO) access.

**NOTE:** If there are no adverse reactions and the vital signs are stable after 15 minutes, set the main roller clamp to administer the prescribed flow rate.

11. Assemble the blood administration set.
    a. Clamp all tubing above and below the filter.
    b. Expose the port to the collection bag.
    c. Remove the cap from the spike and insert it into the collection bag.
    d. Turn the bag upright, release the clamp to the normal saline (NS) and charge the line.
    e. Clamp the line to the NS and release the clamp to the blood. Squeeze the filter chamber until it is halfway full.
    f. Attach the line to the IV or IO, release the clamp on the distal line and check for patency.

12. Administer FWB rapidly.
    a. Best – Prescreened cold-stored low-titer O whole blood (LTOWB) for all when readily available.
    b. Better – Prescreened group specific FWB.
        (1) Group A to group A.
        (2) LTOWB for group B to group AB.
        (3) Group O to group O.
    c. Minimum – When prescreened blood is not available, use point-of-care blood typing system to identify donors.

**NOTE:** Use approved infusion warming devices when administering cold-stored FWB.

**DANGER:** Monitor for transfusion reaction. If transfusion reaction is noted you should: stop the transfusion, keep the IV line open with saline, identify and treat the cause of reaction, reinstitute the transfusion only if it is deemed to be clinically essential.

13. Monitor the casualty for transfusion reactions.

a. Anaphylaxis.
b. Acute hemolytic reaction.
   (1) Acetaminophen 500 milligram (mg) by mouth every four hours.
   (2) Diphenhydramine 25 mg IV or intramuscular.
   (3) Consider osmotic diuresis with 20 g mannitol or 250 ml 3% sodium chloride.

14. Administer 1 g calcium chloride IV, during or after the transfusion, if massive transfusion is expected.

15. Administer tranexamic acid within three hours of injury.

16. Document on the DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*), SF 600 (*Chronological Record of Medical Care*), or electronic medical record.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Confirmed the patient's blood type. | _____ | _____ |
| 2 | Prepared to collect blood from the donor. | _____ | _____ |
| 3 | Collected blood from the donor. | _____ | _____ |
| 4 | Determined when the bag was full using the methods in step 2f. | _____ | _____ |
| 5 | Discontinued the collection process. | _____ | _____ |
| 6 | Labeled the blood collection bag. | _____ | _____ |
| 7 | Monitored the donor after the donation was complete. | _____ | _____ |
| 8 | Documented the collection on the appropriate forms for the environment. | _____ | _____ |
| 9 | Identified the casualty met criteria for blood transfusion. | _____ | _____ |
| 10 | Obtained intravenous (IV) or intraosseous (IO) access. | _____ | _____ |
| 11 | Assembled the blood administration set. | _____ | _____ |
| 12 | Administered FWB rapidly. | _____ | _____ |
| 13 | Monitored the casualty for transfusion reactions. | _____ | _____ |
| 14 | Administered 1 g calcium chloride IV, during or after the transfusion, if massive transfusion was expected. | _____ | _____ |
| 15 | Administered tranexamic acid within three hours of injury. | _____ | _____ |
| 16 | Documented on the DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*), SF 600 (*Chronological Record of Medical Care*), or electronic medical record. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
*Joint Trauma System Clinical Practice Guideline (JTS CPG) Whole Blood Transfusion (CPG ID: 21).*
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

## Place an Intraosseous Device

081-68W-0237

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment and have a casualty requiring an IO infusion. You are provided with an IO driver, IO cartridge, alcohol prep pads, betadine or iodine prep pads, protective cover pad, 10-cubic centimeters (cc) sterile syringe, sterile normal saline (NS) flush, intravenous (IV) pole, IO fluid (NS or Lactated Ringer's), IV tubing administration set, leak-free connector extension set, gauze pads (2x2), biohazard bag, pressure infuser, pen, and SF 600 (*Chronological Record of Medical Care*) or electronic medical record (EMR).

**Standards:** Place an IO device in accordance with (IAW) *PHTLS Prehospital Trauma Life Support* and *Tactical Combat Casualty Care (TCCC) Guidelines* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Don BSI equipment.
    a. Eye protection.
    b. Gown.
    c. Gloves.
    d. Shoe covers if needed.

2. Select the appropriate IO device.
    a. EZ IO (humeral placement).
    b. Focused assessment with sonography for trauma (FAST) 1 (sternal placement).

3. Locate proper site for EZ IO insertion.
    a. Anterior tibia.
    b. Distal tibia.
    c. Proximal humerus (used in adult patients only).

4. Assemble IV infusion fluid and tubing using aseptic technique (see task 081-000-0038, Manage Intravenous Access).

5. Clean the insertion site using aseptic technique.

6. Prepare the EZ IO driver and needle set.

**NOTE:** Ensure that the driver and needle set are securely seated.

    a. Remove the driver and one EZ IO cartridge from the case.
    b. Open the EZ IO cartridge and attach the needle set to the driver (you should feel a "snap" as the small magnet connects).
    c. Remove the needle set from the cartridge.

d. Remove and discard the safety cap from the needle set.

e. Remove the cap by momentarily powering the driver while holding the cap.

7. Insert EZ IO needle set.

**NOTE:** Control the patient's movement prior to and during needle insertion.

a. Secure the driver in your dominant hand, stabilize the leg near the insertion site with your nondominant hand.

b. Position the driver at the insertion site with the needle at a 90-degree angle to the surface of the bone.

c. Insert the needle set until the needle set tip touches bone.

d. Insert into bone cortex by squeezing the driver's trigger and applying gentle, steady, downward pressure.

**CAUTION:** If the driver stalls and will not penetrate the bone, you may be applying too much downward pressure. In the unlikely event of a driver failure, remove the power driver, grasp the needle set by your dominant hand and advance the needle set into the medullary space while twisting the needle set.

e. Release driver's trigger and stop insertion process when a sudden "give" or "pop" will be felt upon entry into the medullary space or when the desired depth is obtained.

8. Stop when the needle flange touches the skin or a sudden decrease in resistance is felt.

9. Remove the power driver and stylet.

a. Secure the hub gently with nondominant hand, unscrew the stylet with dominant hand, counterclockwise from the catheter and place it in a sharp's container.

b. Do not replace or attempt to "recap" the stylet.

10. Confirm catheter stability.

**WARNING:** Do not attach a syringe directly to the EZ IO catheter hub when drawing blood for laboratory analysis, with the needle set stabilized.

11. Attach the extension set to the EZ IO hub.

12. Attach the syringe with the saline to the extension set.

a. Open the clamp on the extension set.

b. Draw back with the syringe plunger slightly, looking for fluid from the marrow cavity to mix with the saline.

c. Inject 5 to 10 milliliters (ml) of the saline, observing for signs of infiltration.

d. Secure extension tubing and remove the syringe.

e. Attach the IV tubing, open clamps on extension tubing and set the flow rate per physician's orders.

f. Secure the needle and IV tubing.

13. Apply dressing and EZ IO wristband.

14. Discard all contaminate waste IAW local standard operating procedure (SOP) and infection control guidelines.

15. Clean and disinfect power driver according to manufacturer's guidelines.

16. Remove and discard gloves and BSI IAW local SOP.

17. Perform a patient care handwash.

18. Document procedure on SF 600, DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*), or in the casualties EMR.

19. Prepare the site for the IO infusion system insertion.
    a. Remove outer clothing to expose the sternum.
    b. Identify the suprasternal notch.
    c. Apply aseptic technique to prepare the site.

20. Place the target patch.
    a. Remove the top half of the backing (labeled remove 1) from the patch.
    b. Identify the sternal notch using your index finger.
    c. Align the locating notch in the target patch with the sternal notch.
    d. Verify that the target zone (circular hole) on the patch is directly over the casualty's midline.
    e. Secure the top half of the patch to the body by pressing firmly downward on the patch, engaging the adhesive.
    f. Remove the remaining backing (labeled remove 2) and secure patch to the casualty.
    g. Verify correct patch placement by checking the alignment of the locating notch with the casualty's sternal notch and making sure the target zone is over the midline of the casualty's body.

21. Insert the introducer.
    a. Remove sharps cap from the introducer.
    b. Place the bone probe cluster needles in the target zone of the target patch and ensure that all the bone probe needles are within the target zone.
    c. Secure the introducer perpendicular to the sternum of the casualty to ensure proper functioning of the depth-control mechanism.
    d. Press straight along the introducer axis, with hand and elbow in line, push with firm constant force until a distinct release is heard and felt.
    e. After the release, expose the infusion tube by gently withdrawing the introducer along the same path used to insert it (perpendicular to the skin). The stylet supports will fall away.
    f. Locate the orange sharps plug and place it on a flat surface with the foam facing up. Keep both hands behind the needles and push the bone probe cluster straight into the foam. After the sharps plug has been engaged and the sharps are safely covered, reattach the clear sharps cap to the introducer.
    g. Dispose of the introducer using contaminated sharps protocols.

22. Connect the infusion tube to the right-angle female connector on the target patch.
    a. Connect syringe and flush infusion tube with 5 ml of sterile solution.
    b. Connect IV infusion tubing and open IV line to introduce fluids.

23. Secure the protector dome.

**NOTE:** Place the protector dome directly over the target patch and press down firmly to engage the hook-and-loop fastener. Ensure that the infusion tubing and the right-angle female connector are contained under the dome.

**NOTE:** The dome can be removed by holding the patch against the skin and peeling back the dome hook-and-loop fastener.

24. Check the infusion system for leaks.

25. Assess the IO site by visual inspection of the insertion site and surrounding tissue.

26. Check the insertion site and document the IO intake every 8 hours (if possible).

27. Attach the remover package with casualty for transport.

28. Record procedure on DD Form 1380, SF 600, or EMR.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Donned BSI equipment. | _____ | _____ |
| 2 | Selected the appropriate IO device. | _____ | _____ |
| 3 | Located proper site for EZ IO insertion. | _____ | _____ |
| 4 | Assembled IV infusion fluid and tubing using aseptic technique (see task 081-000-0038, Initiate an Intravenous Infusion). | _____ | _____ |
| 5 | Cleaned the insertion site using aseptic technique. | _____ | _____ |
| 6 | Prepared the EZ IO driver and needle set. | _____ | _____ |
| 7 | Inserted EZ IO needle set. | _____ | _____ |
| 8 | Stopped when the needle flange touched the skin or a sudden decrease in resistance was felt. | _____ | _____ |
| 9 | Removed the power driver and stylet. | _____ | _____ |
| 10 | Confirmed catheter stability. | _____ | _____ |
| 11 | Attached the extension set to the EZ IO hub. | _____ | _____ |
| 12 | Attached the syringe with the saline to the extension set. | _____ | _____ |
| 13 | Applied dressing and EZ IO wristband. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 14 | Discarded all contaminate waste IAW local standard operating procedure (SOP) and infection control guidelines. | _____ | _____ |
| 15 | Cleaned and disinfected power driver according to manufacturer's guidelines. | _____ | _____ |
| 16 | Removed and discarded gloves and BSI IAW local SOP. | _____ | _____ |
| 17 | Performed a patient care handwash. | _____ | _____ |
| 18 | Documented procedure on SF 600, DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*), or in the casualties EMR. | _____ | _____ |
| 19 | Prepared the site for the IO infusion system insertion. | _____ | _____ |
| 20 | Placed the target patch. | _____ | _____ |
| 21 | Inserted the introducer. | _____ | _____ |
| 22 | Connected the infusion tube to the right-angle female connector on the target patch. | _____ | _____ |
| 23 | Secured the protector dome. | _____ | _____ |
| 24 | Checked the infusion system for leaks. | _____ | _____ |
| 25 | Assessed the IO site by visual inspection of the insertion site and surrounding tissue. | _____ | _____ |
| 26 | Checked the insertion site and documented the IO intake every 8 hours (if possible). | _____ | _____ |
| 27 | Attached the remover package with casualty for transport. | _____ | _____ |
| 28 | Recorded procedure on DD Form 1380, SF 600, or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
Joint Trauma System website.
*PHTLS Prehospital Trauma Life Support.*
SF 600. Chronological Record of Medical Care.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

## Manage an Intraosseous Infusion

081-68W-0238

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you must manage a patient receiving an intraosseous (IO) infusion. You will be provided clean gloves, tape, gauze, medications, a pen, DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*), the patient's SF 600 (*Chronological Record of Medical Care*), or electronic medical record.

**Standards:** Manage an IO infusion in accordance with the *Lippincott Manual of Nursing Practice*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Check the SF 600 against the medical officer's order.
    a. Type of solution to be infused.
    b. Flow rate.
    c. Volume to be infused.
2. Review the patient record.
    a. History of complications with previous infusions.
    b. Identify patient allergies.
3. Communicate the procedure to the patient.
4. Perform handwashing and follow standard precautions.
5. Ensure the correct solution is infused.

**NOTE:** Read the label on the container and compare it to the privileged provider's order.

a. If the solution running is incorrect slow the infusion to a minimum rate to keep the vein open and immediately notify the provider.
b. Change the solution to that prescribed.
c. If the solution is correct but the rate is too fast, adjust the rate.
d. If the infusion is running at less than the prescribed rate.

(1) Ensure the drip chamber is at least half full. Squeeze the drip chamber to add fluid if needed.

(2) Ensure the fluid container is at least 3 feet above the insertion site.

(3) Check the tubing for kinks, pinching, or resting under the patient's arm.

(4) Open the roller clamp on a gravity system and observe the speed of flow into the drip chamber.

(5) If there is limited or no IO flow with the clamp wide open, hold the entire fluid container below the level of the infusion site and assess for blood return.

(6) Raise or lower the hub of the needle. If the flow improves, secure it in place with tape and gauze as needed.

6. Check the infusion system for leaks.

7. Confirm the container volume.
   a. Read at eye level.
   b. For bag containers, grasp the top edges and pull laterally, and then read at the meniscus.

8. Assess the IO site by visual inspection of the insertion site and surrounding tissue.
   a. Infiltration.
   b. Signs of infection.
   c. Bleeding.

9. Provide the patient education on maintaining the catheter site.
   a. Avoid sudden twisting or jerking motions.
   b. Avoid stretching the tubing.
   c. Keep tubing above the insertion site.
   d. Keep pressure off the tubing.

10. Inform the patient to report.
   a. Container is almost empty.
   b. Solution stops dripping.
   c. Pain, tenderness, or swelling at the insertion site.
   d. Blood in the tubing.

11. Inspect the insertion site and document the IO intake every 8 hours.
   a. Check infusion every hour.
   b. Check infusion every 30 minutes if the infusion rate is 150 cubic centimeters (cc) per hour or greater.

12. Report unexpected outcomes to the charge nurse and document the catheter assessment in automated medical record or SF 600 (if automated medical record is unavailable).
   a. Condition of insertion site.
   b. Volume infused.
   c. Unexpected outcomes and actions taken.
   d. Patient's tolerance.
   e. Patient education provided.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Checked the SF 600 against the medical officer's order. | _____ | _____ |

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 2 | Reviewed the patient record. | _____ | _____ |
| 3 | Communicated the procedure to the patient. | _____ | _____ |
| 4 | Performed handwashing and followed standard precautions. | _____ | _____ |
| 5 | Ensured the correct solution was infused. | _____ | _____ |
| 6 | Checked the infusion system for leaks. | _____ | _____ |
| 7 | Confirmed the container volume. | _____ | _____ |
| 8 | Assessed the IO site by visual inspection of the insertion site and surrounding tissue. | _____ | _____ |
| 9 | Provided the patient education on maintaining the catheter site. | _____ | _____ |
| 10 | Informed the patient to report. | _____ | _____ |
| 11 | Inspected the insertion site and documented the IO intake every 8 hours. | _____ | _____ |
| 12 | Reported unexpected outcomes to the charge nurse and documented the catheter assessment in automated medical record or SF 600 (if automated medical record was unavailable). | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
*Lippincott Manual of Nursing Practice.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

## Administer Fluids Through an Infusion

081-68W-0314

**WARNING:** Liquids should not be mixed with tranexamic acid (TXA) or through an intravenous (IV) line with TXA in it.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment, and you encounter a casualty who requires fluid administration. You have obtained IV or intraosseous (IO) access. You are provided Lactated Ringer's, 0.9% sodium chloride or other fluid for administration, an IV drip set, DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*), or access to an electronic medical record.

**Standards:** Administer fluids through an infusion in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines* while adhering to all warnings, and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Reassure the casualty to reduce anxiety.

**NOTE:** Anxiety increases the heart rate, which worsens the casualty's condition. Anyone who has just been shot or who has experienced detonation of explosives nearby will have tachycardia.

2. Assess for and control bleeding (see task 081-000-0064, Control Bleeding).
    a. Perform a blood sweep of the casualty from head to toe.
    b. Apply tourniquets, dressings, or pressure dressings if any bleeding is found.

**NOTE:** All tourniquets applied during care under fire must be reassessed for effectiveness.

3. Assess and maintain the airway.
    a. Insert a nasopharyngeal airway (NPA), if indicated (see task 081-000-0067, Insert a Nasopharyngeal Airway).
    b. Administer oxygen, if available (see task 081-000-0073, Administer Oxygen).

4. Assess the casualty's breathing.
    a. Assess front and back for penetrating trauma.
    b. Apply an occlusive dressing, if indicated

5. Assess casualty's bilateral radial pulses and gain vascular access.

**NOTE:** Presence or absence of a distal radial pulse and mental status should be assessed as an estimation of systolic blood pressure in combat. Systolic pressure in adults is generally assumed to be at least 80 millimeters of mercury (mmHg) in the radial artery, 70 mmHg in the

femoral artery, and 60 mmHg in the carotid artery. An absent radial pulse implies a systolic blood pressure less than 80 mmHg.

a. Significant injuries, present radial pulses, normal mental status = saline lock (see task 081-000-0133, Initiate a Saline Lock).

b. Significant injuries, absent radial pulses and altered mental status = direct IV cannulation and fluid resuscitation (see task 081-000-0038, Manage Intravenous Access).

**NOTE:** If unable to initiate a peripheral IV or after two attempts, initiate a sternal IO line to provide fluids.

6. Administer one of the following fluids: Lactated Ringer's, or 0.9% sodium chloride.

**NOTE:** If a saline lock is already in place, the combat medic can provide fluids through the saline lock. If the casualty does not have a saline lock the combat medic provides fluids by starting a direct IV line without a saline lock.

a. Initiate 500 milliliters (ml) bolus of fluids.

b. Reassess the casualty after each 500 ml IV bolus for a palpable radial pulse, improved mental status, or systolic blood pressure (BP) of 80-90 mmHg.

c. Continue resuscitation until one or more of the above end points have been achieved (palpable radial pulse, improved mental status, or systolic BP of 80-90 mmHg).

d. Once the casualty has an improved mental status, palpable radial pulse, or a systolic BP of 80-90 mmHg then:

(1) Disconnect IV tubing from the saline lock if one was already placed.

(2) If a direct IV line was started then disconnect the IV tubing, leaving the IV catheter in place, and secure a saline lock over the catheter hub.

e. Reassess the casualty frequently to check for recurrence of shock. If shock reoccurs, recheck all external hemorrhage control measures to ensure that they are still effective and repeat the fluid resuscitation as outlined above.

7. Maintain normal body temperature. Aggressively treat for hypothermia in a trauma casualty.

**NOTE:** Hypothermia is a common finding in battlefield casualties, regardless of the ambient temperature. The combination of trauma and hypothermia has a significant impact on casualty survival.

a. Wrap the casualty with a casualty blanket.

b. Apply a ready-heat blanket from a hypothermia prevention and management kit and cover the casualty with the heat-reflective shell.

8. Monitor the casualty.

a. Check vital signs every 5 minutes until they return to normal, and then check every 15 minutes.

b. Check the casualty's level of consciousness.

9. Record all interventions on DD Form 1380 (see task 081-000-0013, Initiate a Tactical Combat Casualty Care Card).

10. Request medical evacuation.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Reassured the casualty to reduce anxiety. | _____ | _____ |
| 2 | Assessed for and controlled bleeding (see task 081-000-0064, Control Bleeding). | _____ | _____ |
| 3 | Assessed and maintained the airway. | _____ | _____ |
| 4 | Assessed the casualty's breathing. | _____ | _____ |
| 5 | Assessed casualty's bilateral radial pulses and gained vascular access. | _____ | _____ |
| 6 | Administered one of the following fluids: Lactated Ringer's, or 0.9% sodium chloride. | _____ | _____ |
| 7 | Maintained normal body temperature. Aggressively treated for hypothermia in a trauma casualty. | _____ | _____ |
| 8 | Monitored the casualty. | _____ | _____ |
| 9 | Recorded all interventions on DD Form 1380 (see task 081-000-0013, Initiate a Tactical Combat Casualty Care Card). | _____ | _____ |
| 10 | Requested medical evacuation. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
*PHTLS Prehospital Trauma Life Support.*
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Operate a Fluid Warmer

081-68W-2000

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In a clinical or operational environment, you have received medical orders to provide heated intravenous (IV) solution, blood, or blood products via an IV infusion. All other immediate life threats have been treated and managed. You have performed a patient care handwash and taken body substance isolation. You are provided with the patient's clinical records, a blood fluid warmer system, IV solution, blood or blood products, alcohol pads, adhesive tape, pen, and a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*), SF 510 (*Medical Record - Nursing Notes*), SF 600 (*Chronological Record of Medical Care*), or electronic medical record.

**Standards:** Operate a fluid warmer in accordance with manufacture operating procedures, *Tactical Combat Casualty Care (TCCC) Guidelines* and *Committee on Tactical Combat Casualty Care (CoTCCC)*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Gather all necessary supplies.
    a. Make sure that the battery is fully charged, 5-segment shown on the battery liquid-crystal display.
    b. Recharge battery if necessary.
    c. Inspect the heater unit to ensure that the heater plates are clean and dry.
    d. Wipe off any particles or debris on the plate with a soft cloth.

2. Install the disposable set.

**NOTE:** The heater unit will not close if the disposable is not installed properly.

    a. Remove the disposable from its pouch.
    b. Install it into the heater unit, being careful to line up the red orientation hub on the disposable with the notch marked with a red arrow on the heater unit.
    c. Take care not to damage the disposable.

3. Connect to the fluid bag and administration set.

**NOTE:** Ensure all air is purged from the IV line, IV fluid warmer device, and extension set.

    a. Hang a fluid bag and administration set.
    b. Connect the fluid administration set to the disposable luer-lock fitting with the blue slide clamp.

4. Prime the disposable set.
    a. Open the roller clamps of the administration set.

b. Prime the unit making sure there is no air visible in the IV line or patient extension.

c. Tap the heater unit while priming to expel any air bubbles that may collect in the disposable.

5. Establish power to the heater unit.

**NOTE:** If the alternating current and direct current (AC/DC) power is needed, plug the AC/DC input to the wall outlet and the output to the AC adapter on the battery housing. If not, return for service.

a. Depress the ON/OFF switch, on the battery housing, to supply power to the heater unit.

b. Blue light-emitting diode (LED) turns ON and Red LED flashes once if the heater unit is functioning normally.

6. Initiate infusion.

**NOTE:** If a longer administration set is desired, it should be no longer than 6 inches for optimal thermal transfer.

a. Select an appropriate catheter size for the intended flow rate.

b. Use an aseptic technique, make patient connection without entrapping air.

c. Adjust the roller clamp to the desired flow rate.

d. Secure the system in a horizontal position, on a flat surface near the patient using bed sheet clamp ensuring that there is no strain on the patient line.

e. Use of longer set will result in some line cooling from heater to patient.

f. The preferred position, of the heater unit, is at or below the level of the insertion site.

7. Maintain infusion.

a. Observe the LED, on the battery housing.

b. The LED is BLUE when the power is ON.

c. The GREEN LED, on the heater unit, flashes with each heating cycle.

d. If there is an alarm, the BLUE and RED LEDs flash alternately, respond to and correct system alarms as needed.

8. End of procedure.

a. Clamp roller clamp on the administration set off.

b. Clamp the input end of disposable set off using the blue slide clamp.

c. Turn heater unit off by pressing the ON/OFF switch on the battery housing.

d. Disconnect the AC/DC supply, if used.

e. Open the heater unit and remove disposable set.

f. Dispose of disposable set using hospital practices for biohazardous materials.

g. Remove the battery by pushing the tab holding the battery, in the housing, up and pull battery tab.

h. Recharge the battery.

9. Document treatment on appropriate form.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 1 | Gathered all necessary supplies. | _____ | _____ |
| 2 | Installed the disposable set. | _____ | _____ |
| 3 | Connected to the fluid bag and administration set. | _____ | _____ |
| 4 | Primed the disposable set. | _____ | _____ |
| 5 | Established power to the heater unit. | _____ | _____ |
| 6 | Initiated infusion. | _____ | _____ |
| 7 | Maintained infusion. | _____ | _____ |
| 8 | Ended of procedure. | _____ | _____ |
| 9 | Documented treatment on appropriate form. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
*Committee on Tactical Combat Casualty Care (CoTCCC).*
Joint Trauma System *website.*
SF 510. *Medical Record - Nursing Notes*.
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

**Subject Area 3: Force Health Protection**

Decontaminate a Casualty

081-000-0059

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment as a member of an established decontamination station. Medical personnel and nonmedical augmentees are in mission-oriented protective posture level 4. Contaminated patients have been triaged by the senior medic and have been routed to your area for decontamination. You may be provided with an M258A1 decontamination wipes, 5% chlorine solution, 0.5 % chlorine solution, reactive skin decontamination lotion (RSDL), butyl rubber aprons, butyl rubber gloves, stainless steel buckets, cellulose sponges, water source, plastic bags, litters, litter stands, bandage scissors, M8 or M9 chemical detection paper, unit chemical agent detector, unit radiological detector, contaminated disposal containers, bandages, gauze, tourniquets, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*).

**Standards:** Decontaminate a patient using the proper sequence in accordance with ATP 4-02.7, without further contamination or error, while adhering to all warnings and cautions, using the task GO/NO GO checklist.

**NOTE:** The supported unit must provide a minimum of eight nonmedical personnel to augment the decontamination station as the decontamination team. Although casualty decontamination is routinely performed by these nonmedical personnel, the supervision of and final determination as to the completeness of the decontamination rests with medical personnel.

**Performance Steps:**

1. Decontaminate the mask and exposed skin.

**NOTE:** Decontaminate patient with soap and water, RSDL, or 0.5% chlorine solution for skin and skin contact, 5% chlorine solution for non-skin contact surfaces (least preferred and not used for radiological decontamination). If the patient is in full protective ensemble, the best method is to decontaminate only those skin areas where there was a break in the ensemble (for example, around wounds, areas where the underlying uniform is wet with agent, or where there is a tear in the overgarment). If the patient is not wearing protective ensemble or had significant uniform tears, or underlying uniform is damaged, an alternate method is to decontaminate the entire skin surface by wiping the skin with a sponge copious amount of soapy water with a water rinse.

   a. Cut the hood above the forehead, cutting toward the back of the hood.
   b. Cover the patient’s mask air inlets with clean gauze or sponges.
   c. Decontaminate the patient’s mask and exposed skin.
      (1) Use the RSDL, soapy water, or 0.5% chlorine solution.

**CAUTION:** Use only the 0.5% chlorine solution to decontaminate the skin and the parts of the mask that touch the face. The 5% chlorine solution is corrosive and will burn the skin.

(2) Use 0.5% chlorine solution for the mask and skin.

(3) Decontaminate the exterior of the mask.

(4) Wipe down all the exposed skin areas.

(5) Remove the patient's TCCC card, DD Form 1380.

**NOTE:** The TCCC card will remain with the patient until transcribed on to a clean TCCC card.

(a) Cut the patient's TCCC card tie wire, allowing the TCCC card to fall into a self-sealing plastic bag.

(b) Seal the plastic bag and decontaminate the outside of the bag with a decontamination solution.

(c) Place the plastic bag with the TCCC card under the back of the protective mask head harness straps.

d. Uncover the mask air inlets.

2. Remove and secure the patient's personal effects.

a. Remove the patient's personal articles from pockets.

(1) Place all articles in a plastic bag.

(2) Label the bags with the patient's name and social security number.

(3) A card with the patient's name and identification number must be placed inside the bag.

b. Secure the patient's personal effects from overgarment.

(1) Remove all items from the protective overgarment pockets and place them in a self-sealing plastic bag.

(2) Label the bag with the patient's identification and seal the bag.

(3) Survey the items.

(4) If the articles are not contaminated, place them in a separate bag from suspected contaminated items.

(5) Wipe down the outside of the bag with M258A1 or dip it in a bucket of 5% chlorine solution.

(6) Dip in soap and water if the contamination is radiological. The bags are sent on the litter with the patient and checked for contamination at the contamination check area.

**CAUTION:** Bandages may have been applied to control severe bleeding and are treated like tourniquets. Only medical personnel remove bandages, tourniquets, and splints.

3. Cut the patient's overgarment.

**NOTE:** The overgarment jacket and trousers may be cut simultaneously. Two persons may be cutting clothing at the same time.

**NOTE:** Cutting is performed using sharp bandage scissors or long-handled seat belt cutters (for example, medical strap cutter). Three or more cutting tools are needed for each team member who is cutting off patient clothing, as the tools typically become dull after cutting off the garments of 5 patients.

**NOTE:** Cut around bandages, tourniquets, and splints, leaving them in place. Only medical personnel remove bandages, tourniquets, and splints.

**NOTE:** Put the cutting device in a bucket of 5% chlorine solution after each complete line of cut and get another cutting tool, which has been sitting in the chlorine solution bucket, for the next cut. Example: Cutting the sleeve from the cuff to the jacket collar is one cut. If a bucket of 5% chlorine solution is not available, then the cutting tools must be scrubbed using RSDL between each cut or rinsed thoroughly in running soapy water.

4. Remove patient's overgarment jacket.

**NOTE:** It is essential that cutting tools be replaced as soon as they become dull. Dull tools make cutting difficult and can aerosolize dried agent particles as material is tugged by the cutting tool. A new cutting tool blade will be needed about every 5 patients.

a. Unfasten or cut the hook and pile closures at the wrists.

b. Make a cut, one up each sleeve from the wrist to the shoulder and then to the collar.

c. Keep the cuts close to the insides of the arms so that most of the sleeve material is folded outward.

d. An alternative is to start at the collar and cut down the sleeve to the wrist.

e. Cut the jacket drawstring at the bottom of the jacket and unfasten the hook and pile closures, moving from the waist to the neck and then unzip the jacket.

f. If the jacket will not unzip then make a cut parallel to the zipper.

g. Carefully fold the sleeves of the overgarment away from the patient's arms, exposing only the black liner.

h. Avoid aerosolizing any dust particles on the garment or allowing the outside of the garment to touch the patient.

**NOTE:** To reduce aerosolization of dry agent on the protective overgarment, the overgarment can be lightly misted with water from an insect sprayer bottle before the patient's mask hood is removed or cutting begins. This will dampen the dry agent which can reduce its aerosolization. The spray from the mister must be very light so that it does not blow the dry agent into the air.

i. Instruct the patient to keep their hands to the sides, away from the pieces of overgarment that are lying on their chest.

j. If the patient is unable to lift their arms, then one decontamination team member will hold the patient's gloved hand and perform this action.

k. Another team member then carefully folds the chest sections over the outside of the litter.

l. The patient's arms are then lowered to the sides, keeping the arms away from the area where the overgarment has been removed.

5. Remove the patient's overgarment trousers.
   a. Cut the trouser suspenders.

**NOTE:** While you and another team member hold the patient's raised feet, have a third member wipe down the end of the litter with the 5% solution before lowering the feet to the litter.

b. Cut the leg closure cord and hook and pile fasteners at the ankle cuff.

c. Using the cutting tool, cut from the ankle along the inseam of the left trouser leg until the crotch area is reached, and then cut across the zipper.

d. An alternative is to start at the waist and cut from the waist, along the inseam of the trousers, to the ankle cuff.

e. Allow the trouser halves to drape over the sides of the litter.

f. Carefully roll and tuck the remaining cloth (at the crotch and on the inside of the legs) in on itself ensuring that only the black liner of the cloth is showing.

6. Remove the patient's outer gloves.

**NOTE:** Always remove the patient's gloves over the sides of the litter.

a. The decontamination team members will decontaminate their gloves with the M258A1 or dipping them in a 5% chlorine solution or soap and water.

b. Next, decontaminate the patient's gloves with the M258A1, or a 5% chlorine solution or soap and water.

c. Instruct the patient to hold their arms away from the litter and upper body or, if they are not able to do this then hold the patient's gloves at the fingers.

d. Grasp the cuff of the outer rubber glove, turning the outer glove inside out, and remove it. The inner glove insert, if present, remains on the patient.

e. Carefully lower the patient's arms across their chest as each glove is removed. Avoid touching the patient's cloth glove insert or arm with your rubber glove.

f. Dispose of the contaminated rubber gloves by placing them in the designated contaminated trash bag.

g. Decontamination team members then decontaminate their own gloves with the M258A1, or dipping them in a 5% chlorine solution, or use soap and water.

7. Remove the patient's overboots.
   a. Unfasten the boot closures.
   b. If the overboot will not come off, cut the boot from top to bottom along the centerline of the boot or along the inside of the boot.
   c. Fold the overboot down and gently pull on the heel until the boot is removed.
   d. Remove the two overboots simultaneously.
   e. This reduces the likelihood of contaminating one of the combat boots.
   f. Soap and water can be used for radiological contamination.

8. Lower the patient's heels onto the decontaminated litter.
   a. Place the overboots in the contaminated trash.
   b. Decontamination personnel dip their gloves in the 5% chlorine solution.

9. Remove the patient's personal effects.

**NOTE:** For litter patient decontamination in a personnel decontamination system (PDS), removal of inner clothing immediately follows removal of overgarment, and both take place before the first patient lift.

a. Place personal effects in a self-sealing plastic bag.

b. This can be the same bag used for items taken from the overgarment pockets, otherwise place these items in a separate bag.

c. Seal the bag.

d. A card with the patient's name and identification number must be placed inside the bag.

e. Decontaminate the outside of the bag.

f. Keep the bag with the patient or send it to a contaminated item holding area where the items in it can be decontaminated or properly inventoried and disposed of.

g. Remove combat boots by cutting the bootlaces along the tongue.

h. While holding the heels off the litter, have decontamination team member wipe the end of the litter with the M258A1 or 5% chlorine solution to neutralize any liquid chemical contamination that was transferred to the litter from the overboots.

i. Remove the boots by pulling them towards you.

j. Place the boots in the designated contaminated waste bag.

k. Do not touch the patient's skin with contaminated gloves when removing their boots.

l. Remove inner clothing as follows:

(1) Decontamination team members decontaminate their gloves and cutting tools.

(2) Cut or unbuckle the uniform belt.

(3) Cut the uniform jacket and trousers (such as work uniform) worn under the protective overgarment in the same manner as described above for the protective overgarment.

(4) Roll the jacket and trousers as described for the protective overgarment.

**CAUTION:** The cutting tools must be decontaminated frequently with 5% chlorine solution (after each cut) to keep any contamination from contacting the patient's bare skin.

10. Remove undergarments.

a. Remove the patient's T-shirt by dipping the cutting device in the 5% chlorine solution between each cut.

b. Cut both sleeves from the inside, starting at the elbow, up to the armpit.

c. Continue cutting across the shoulder to the collar.

d. Cut around bandages or splints, leaving them in place.

e. Peel the T-shirt away from the body to avoid spreading contamination.

f. If the patient is wearing a brassiere, cut it between the cups.

g. Cut both shoulder straps where they attach to the cups and lay them back off the shoulders.

h. Remove the patient's undershorts or panties by cutting from the lower side of the hip to the waist on both sides.

i. Fold the front flap of the shorts or panties down between the patient's legs onto the litter.

j. Do not allow the outside of the garment to touch the patient's skin.

k. Remove the patient's socks.

l. Remove the patient's glove insert.

m. Keep the patient's arms crossed over the chest if possible.

n. Do not remove the patient's identification tags.

**NOTE:** These stay with the patient at all times.

o. If not yet decontaminated then decontaminate the tags with M258A1, 0.5% chlorite solution, soap, and water.

**WARNING:** At this point, the patient has nothing on their body except their protective mask and medical items (dressings, splints, and tourniquets).

**CAUTION:** Use proper body mechanics to avoid injury to your back. Use your legs instead of your back to lift the patient.

11. Transfer the patient.

a. Transfer the patient to clean litter. This is either a non-contaminated litter or a canvas litter with a plastic sheeting cover.

b. Decontaminate butyl apron with 0.5% chlorine solution and gloves with 5.0% chlorine solution and rinse gloves with water.

c. Lift the patient.

(1) Lift the patient out of the cutaway garment.

(2) Use a three-person arms carry.

(a) First team member places their forearms to support the patient's shoulders and the waist.

(b) Second team member places their forearms to support the patient's hip and thighs.

(c) Third team member places their forearms to support the patient's knees and ankles.

(d) The first team member gives the command to lift the patient. (Prepare To Lift: LIFT.)

(e) Stand upright.

(f) Once the patient has been lifted off the litter, all three lifters stand upright and turn the patient in against their chests.

(3) At this point, the patient has nothing on their body except their protective mask (minus the hood) and medical items (dressings, splints, and tourniquets).

**NOTE:** A decontaminable mesh litter should be positioned, if available.

d. Replace contaminated litter.

(1) The lone team member, who is not involved in lifting the patient, takes the dirty litter and the contaminated clothing on it from the litter stands and puts it to the side.

(2) Take a clean decontaminable litter and place it on the litter stands. If decontaminable litters are not available use plastic sheeting on a clean canvas litter.

e. Lower the patient to a clean litter in a supine position on the command given by first team member.

f. Transport patient to skin decontamination area.

g. Dispose of contaminated materials.

(1) Transfer all contaminated material to the clothing removal area for disposal.

(2) Double bag the patient's contaminated clothing and put it in a contaminated disposal container.

**NOTE:** Contaminated material from two litter patients can be placed into one 35-gallon trash bag. The remaining 5 percent chlorine solution and soapy water (if used) can be poured into the bags. The bag must be tightly secured and transported to the dirty dump.

**CAUTION:** Before obtaining another patient, the clothing removal team should rinse their gloves and aprons in a 5% decontamination solution and drink enough water to compensate for the heat and workload.

(3) The dirty litter is sent to the litter decontamination area and decontaminated with 5 percent chlorine solution, allowed to sit for 10 minutes, and then rinsed with clean water. The litter remains on the warm (dirty) side of the hot line and does not cross the hot line, but instead is rotated between the drop-off point and the hot line.

**CAUTION:** Review guidance for cold and hot weather operations.

12. Complete skin decontamination.

a. Begin washing the patient from the midline outward, constantly washing, making sure not to place a dirty sponge back on a clean area without first rinsing the sponge.

**NOTE:** When using 0.5% chlorine solution (least preferred), do not do a full body wash. Only decontaminate contaminated areas.

b. The complete topside of the patient is washed in this manner, paying particular attention to hairy areas of the body (groin and auxiliary regions) and sweaty areas (beltline, just above the boots, the crease of the buttocks, and wrists).

c. Then log roll the patient to their side.

d. With the patient lying on their side, wash the backside of the patient working from the higher areas of the backside and washing down toward the litter.

e. Ensure not to miss any areas.

**CAUTION:** Log rolling and washing the back of some patients may be difficult and dangerous for the patients depending on their injuries. Procedures will need to be modified in these cases. The supervising medical personnel should be consulted in these cases and should guide the decontamination of these patients closely.

f. The side of the litter that the patient was rolled away from is then decontaminated prior to rolling the patient onto their back on the litter.

g. The patient is then moved to their back and now log rolled to their opposite side.

h. Wash the opposite side of the patient in exactly the same manner as above.

i. Decontaminate the litter as above before rolling the patient onto their back on the litter.

j. After the patient is decontaminated, the medical personnel remove the dressings and replace them if dressings are suspected or found to be contaminated with agent.

**NOTE:** Medical personnel decontaminate superficial wounds by flushing with soapy water.

13. Remove field dressings and bandages.
    a. Dressings.
        (1) Carefully cut off dressings and bandages.

**NOTE:** Be alert to the fact that removing dressings may disturb the clotting mechanism and result in the reoccurrence of bleeding. This is particularly important when multiple dressings are removed.

        (2) Cut off any remaining clothing that was covered by the dressings and bandages.
    b. Decontaminate skin.
        (1) Decontaminate the exposed areas of skin with 0.5% chlorine solution.
        (2) Irrigate the wound with clean or sterile water (such as an IV bag of saline) is the most appropriate material for the irrigation of the eyes and contaminated open wounds. Soft tissue closed wounds can be irrigated with clean water, IV saline, or soap and water.
        (3) Remove pieces of contaminated clothing or debris that may be lodged in the wound.

**NOTE:** Bandages are not replaced unless there is a critical medical need, such as to control bleeding. Bandages are replaced when the patient's skin has been decontaminated.

        (4) Place all removed dressings and clothing in a contaminated disposal container.

14. Replace any tourniquets.
    a. Remove the old tourniquet.
    b. Remove any remaining clothing or dressing covered by the old tourniquet.
    c. Place the new tourniquet 1 inch above the old tourniquet.
    d. Decontaminate a large area around the existing tourniquet.
    e. Decontaminate and irrigate.
        (1) Decontaminate the newly exposed areas of skin with 0.5% chlorine solution.
        (2) Irrigate the wound with water, saline solution, or, if the wound is suspected to be contaminated, use 0.5% chlorine solution.
        (3) Place the removed tourniquet, dressings, and clothing in a contaminated disposal container.

15. Recheck the patient for contamination.
    a. Use the Chemical or Radiological Agent Detector to check the patient a second time.
    b. Decontaminate any areas of contamination, as necessary.
    c. Team decontaminates gloves and aprons with 0.5% chlorine solution.

16. Transfer patient to the shuffle pit and place on litter stands.
    a. Augmentee shows the TCCC card to clean side medic so they can transcribe a new TCCC card.
    b. Team lifts patient off litter, removes their litter from stands, and clean side personnel place clean litter on stands, lower patent on clean litter and move away.

17. Decontaminate yourself by rinsing butyl rubber gloves and apron with a 5% chlorine solution.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Decontaminated the mask and exposed skin. | _____ | _____ |
| 2 | Removed and secured the patient's personal effects. | _____ | _____ |
| 3 | Cut the patient's overgarment. | _____ | _____ |
| 4 | Removed patient's overgarment jacket. | _____ | _____ |
| 5 | Removed the patient's overgarment trousers. | _____ | _____ |
| 6 | Removed the patient's outer gloves. | _____ | _____ |
| 7 | Removed the patient's overboots. | _____ | _____ |
| 8 | Lowered the patient's heels onto the decontaminated litter. | _____ | _____ |
| 9 | Removed the patient's personal effects. | _____ | _____ |
| 10 | Removed undergarments. | _____ | _____ |
| 11 | Transferred the patient. | _____ | _____ |
| 12 | Completed skin decontamination. | _____ | _____ |
| 13 | Removed field dressings and bandages. | _____ | _____ |
| 14 | Replaced any tourniquets. | _____ | _____ |
| 15 | Rechecked the patient for contamination. | _____ | _____ |
| 16 | Transferred patient to the shuffle pit and placed on litter stands. | _____ | _____ |
| 17 | Decontaminated yourself by rinsing butyl rubber gloves and apron with a 5% chlorine solution. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
ATP 4-02.7. *Multi-Service Tactics, Techniques, and Procedures for Health Service Support in a Chemical, Biological, Radiological, and Nuclear Environment*.
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.

**Related**
None

Brief Mission Commander on Casualty Response Plan

081-68W-3016

**Conditions:** In an operational environment you are required to brief the mission commander on the casualty response plan. You are provided with access to the tactical operation center and computer monitor with wide screen display.

**Standards:** Brief mission commander on casualty response plan in accordance with (IAW) unit's tactical standard operating procedures (SOPs), while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Define the principals of casualty response.
    a. Casualty care.

        (1) When combat begins and casualties occur, the platoon must first provide aid to those wounded in action (WIA). Combat medics, who are assisted by nonmedical personnel in alleviating potentially life-threatening situations to ensure maximum survivability on the battlefield, provide casualty care. This support is most commonly provided by enlisted personnel and includes first aid (self-aid and buddy aid), enhanced first aid by combat lifesaver (CLS), and emergency medical technician (EMT) (platoon medic). First aid (self-aid and buddy aid) is the immediate medical care provided by a nonmedical Servicemember to themselves (first aid) or by other persons (buddy aid). Casualties are cared for at the point of injury or under nearby cover and concealment. Enhanced first aid is the measure which requires an additional level of training above self-aid and buddy aid administered by a CLS.

        (2) The tactical situation will determine how quickly fellow Soldiers can provide aid for wounded Soldiers. Understandably, fewer casualties occur if Soldiers focus on destroying or neutralizing the enemy that is responsible for the casualties. This is a critical situation discussed and rehearsed by the squads and platoons prior to executing a mission.

        (3) During the fight, casualties should remain under cover. As soon as the situation allows, squad leaders arrange for casualty evacuation (CASEVAC) to the platoon casualty collection point (CCP). The platoon normally sets up the CCP in a covered and concealed location to the rear of the platoon position. At the CCP, the platoon medic conducts triage on all casualties, takes steps to stabilize their conditions, and starts the process of moving them to the rear for advanced treatment.

        (4) Before the platoon evacuates casualties to the CCP or beyond, leaders should remove all essential operational items and equipment from each person. Removal should include an automated network control device, maps, position-locating devices, and laser pointers. Every unit should establish an SOP for handling of the weapons and ammunition of its WIA.

    b. Movement.

        (1) Timely movement of casualties from the battlefield is important not only for safety and for care for the wounded, but also for troop morale. Squad leaders are responsible for CASEVAC from the battlefield to the platoon CCP. At the CCP, the senior medic assists the platoon sergeant (PSG) and first sergeant in arranging evacuation by ground, air ambulance, or by nonstandard means. Leaders must minimize the number of Soldiers required to evacuate casualties.

(2) Casualties with minor wounds can walk or even assist with carrying the more seriously wounded. Soldiers can make field-expedient litters by cutting small trees and putting the poles through the sleeves of zippered Army combat uniform blouses or ponchos. A travois or skid may be used for CASEVAC. This is a type of litter on which the wounded can be strapped and pulled by one person. It can be fabricated locally from durable, plastic rolls on which tie-down straps are fastened. In rough terrain (or on patrols), casualties may be evacuated all the way to the battalion aid station (BAS) by litter teams. From there, they can be carried with the unit until transportation can reach them or remain at a position to be picked up later.

(3) From the platoon area, casualties normally are evacuated to the company CCP and back to the BAS. The company first sergeant, with the assistance of the PSG, normally is responsible for movement of the casualties from the platoon CCP to the company CCP. The unit SOP should address this activity, including the marking of casualties during limited visibility operations. Small, standard, or infrared chemical lights work well for this purpose. Once the casualties are collected, evaluated, and treated, they are sent to the company CCP. When they arrive, the above process is repeated while awaiting their evacuation back to the BAS.

(4) When the company is widely dispersed, the casualties may be evacuated directly from the platoon CCP by vehicle or helicopter. Helicopter evacuation may be restricted due to enemy air-defense artillery or small arms or rocket-propelled grenade threat. In some cases, casualties must be moved to the company CCP or battalion combat trains before helicopter evacuation. When there are not enough battalion organic ambulances to move the wounded, unit leaders may direct supply vehicles to “backhaul” casualties to the BAS once supplies are delivered. Normally, urgent casualties will move by ambulance. Less seriously, hurt Soldiers are moved by other means. If no ambulance is available, the most critical casualties must get to the BAS as quickly as possible. In some cases, the PSG may direct platoon litter teams to carry casualties to the rear.

(5) The senior military person present determines whether to request medical evacuations (MEDEVACs) or CASEVACs, then assigns precedence. These decisions are based on the advice of the senior medical person at the scene, the patient’s condition, and tactical situation. Casualties will be picked up as soon as possible, consistent with available resources and pending missions. For priority categories of evacuation precedence and criteria see table 3-1 on page 3-49.

**Table 3-1. Categories of evacuation precedence**

| | |
|---|---|
| ***Priority I—URGENT*** | Is assigned to emergency cases that should be evacuated as soon as possible and within a maximum of one hour in order to save life, limb, or eyesight and to prevent complications of serious illness and to avoid permanent disability. |
| ***Priority IA—URGENT-SURG*** | Is assigned to patients that should be evacuated as soon as possible and within a maximum of one hour who must receive far forward surgical intervention to save life, limb, or eyesight and stabilize for further evacuation. |
| ***Priority II—PRIORITY*** | Is assigned to sick and wounded personnel requiring prompt medical care. This precedence is used when the individual should be evacuated within four hours or if his medical condition could deteriorate to such a degree that he will become an URGENT precedence, or whose requirements for special treatment are not available locally, or who will suffer unnecessary pain or disability. |
| ***Priority III—ROUTINE*** | Is assigned to sick and wounded personnel requiring evacuation but whose condition is not expected to deteriorate significantly. The sick and wounded in this category should be evacuated within 24 hours. |
| ***Priority IV—CONVENIENCE*** | Is assigned to patients for whom evacuation by medical vehicle is a matter of medical convenience rather than necessity. |
| The NATO STANAG 3204 has deleted the category of Priority IV—CONVENIENCE, however, this category is still included in the United States Army evacuation priorities as there is a requirement for it in an operational environment. | |

b. MEDEVAC.

(1) MEDEVAC is the timely and effective movement of the wounded, injured, or ill to and between medical treatment facilities on dedicated and properly marked medical platforms with en route care provided by medical personnel. The term is used to refer to movement of casualties by air or ground utilizing medical vehicles or aircraft. MEDEVAC operations normally involve the initial movement of wounded or injured Soldiers to the nearest medical treatment facility. MEDEVAC includes the provision of en route medical care, whereas CASEVACs might not provide medical care during movement. (Refer ATP 4-02.2 for more information.)

(2) When possible, medical platoon ambulances provide evacuation and en route care from the Soldier's POI or the platoon or company's CCP to the BAS. The ambulance team supporting the company works in coordination with the senior combat medic supporting the platoons. In mass casualty situations, nonmedical vehicles may be used to assist in CASEVAC as directed by the company commander or leader. However, plans for use of nonmedical vehicles to perform CASEVACs should be included in the unit SOP.

(3) Aerial evacuation, if it is available, is preferred because of speed. The platoon coordinates with their higher headquarters and then switch to the designated frequency to coordinate directly with the MEDEVAC aircraft. They must pick a relatively flat, open, and covered and concealed position for the aircraft's landing zone (LZ). The location should be given to the aircraft by FM radio and then marked with colored smoke as the aircraft approaches the area. The platoon provides local security of the LZ until the evacuation is complete.

c. CASEVAC.

(1) CASEVAC is the unregulated movement of casualties that can include movement both to and between medical treatment facilities. If a dedicated

MEDEVAC platforms (ground and air) are available, casualties should be evacuated on these conveyances to ensure they receive proper en route medical care.

(2) Since CASEVAC operations can reduce combat power and degrade the efficiency of the Army health system (AHS), units should only use CASEVAC to move Soldiers with less severe injuries when MEDEVAC assets are overwhelmed. Planners should ensure CASEVACs operations are addressed in the operation plan and operation order as a separate operation, as these operations require preplanning, coordination, synchronization, and rehearsals. The CASEVAC plan should ensure casualties with severe or life-threatening injuries are prioritized for evacuation and are evacuated on dedicated MEDEVAC platforms.

(3) When possible, nonmedical vehicles or aircraft transporting casualties should be augmented with a combat medic or CLS. On nonmedical aircraft, sufficient space may not be available to permit a caregiver to accompany the casualties. (Refer to ATP 4-02.13 for more information.) The type of en route monitoring and medical care and first aid provided is limited by the following factors:

(a) Skill level of the individual providing care. (The combat medic is military occupational specialty [MOS]-qualified [MOS 68W] to provide EMT; the CLS is trained to provide enhanced first aid.) The combat medic can provide emergency medical intervention, whereas the CLS only can monitor the casualty and ensure the basic lifesaving first-aid tasks are accomplished.

(b) Medical equipment available.

(c) Number of casualties being transported.

(d) Accessibility of casualties–if nonstandard evacuation vehicle is loaded with the maximum number of casualties, the combat medic or CLS may not be able to attend to the casualties while the vehicle is moving. If the condition of a casualty deteriorates and emergency measures are required, the vehicle will have to be stopped to permit care to be given.

d. Unit reporting.

(1) Killed in action (KIA)

(a) The platoon leader designates a location of the collection of KIAs. All personal effects remain with the body. However, squad leaders remove and safeguard equipment and issue items. They keep these until they can turn the equipment and issue items over to the PSG. The PSG turns over the KIA to the first sergeant. As a rule, the platoon should not transport KIA remains on the same vehicle as wounded Soldiers. KIAs normally are transported to the rear on empty resupply trucks, but this depends on unit SOP.

(b) Commanders and first sergeants must establish procedures to ensure the Soldier’s next of kin are notified properly and according to procedure. The potential for unofficial communications exists with KIA and casualty operations. The use of cell phones and computers in proximity to the area of operation enables many Soldiers to contact their home station regarding the casualty. Such communication is unofficial and unacceptable. The next of kin for Soldiers WIA or KIA should not receive notification through unofficial means. There usually is a communication blackout until the next of kin is notified. No internet or phone calls home are permitted.

(2) A casualty report is filled out when a casualty occurs, or as soon as the tactical situation permits. A casualty report is usually done by the Soldier’s squad leader and turned into the PSG, who forwards it to the first sergeant. A brief description of how

the casualty occurred (including the place, time, and activity being performed) and who or what inflicted the wound is included. If the squad leader does not have personal knowledge of how the casualty occurred, the squad leader gets this information from Soldiers who have the knowledge.

(3) As casualties occur, the nearest observer informs the PSG who then informs the first sergeant via the most expedient method available; for example, free text within mission command systems, radio voice. The first sergeant submits a personnel status report to the battalion S-1 section. This report documents duty status changes on all casualties. Casualties are taken to CCP for classification of injury type (routine, urgent, return to duty), evacuation, and integration into the medical treatment system.

(4) Department of the Army (DA) Form 1156 (*Casualty Feeder Card*), is used to report those Soldiers who have been killed and recovered, and those who have been wounded. This form also is used to report KIA Soldiers who are missing, captured, or not recovered. The Soldier with the most knowledge of the incident should complete the witness statement. This information is used to inform the Soldier's next of kin and to provide a statistical base for analysis of friendly or enemy tactics. Once the casualty's medical condition has stabilized, the company commander may write a letter to the Soldier's next of kin. During lulls in the battle, the platoon forwards casualty information to the company headquarters. The first sergeant ensures a completed DA Form 1156 is forwarded to the battalion S-1, who then enters the data into the defense casualty information processing system.

e. Medical role in accountability of casualties.

**NOTE:** When a Soldier becomes a casualty, the platoon combat medic or senior combat medic records the medical treatment the Soldier receives on the Soldier's DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*). The BAS and brigade support medical company read the Soldier's DD Form 1380 when they treat the Soldier. The battalion S-1 should electronically receive a notification message to update the Soldier's patient tracking status. In turn, this message should be forwarded to the company. In this manner, a casualty's location can be determined, and Soldiers properly accounted for by the company.

f. Personnel reports.

**NOTE:** Its use personnel reports to notify the command group of casualties and to request replacement personnel. A request for replacements must immediately follow a casualty report.

2. Define duties and responsibilities.

**NOTE:** Casualty response is a portion of the company's sustainment plan that the platoon and squad must plan, prepare, and execute. Concurrent with other operational planning, the platoon develops its sustainment plan during mission analysis and refines it in the war gaming portion of the troop leading procedures. The duties and responsibilities of leadership and platoon members must be executed even in the absence of a particular leader to ensure mission accomplishment IAW the commander's intent.

a. Medical planners.

(1) During the planning phase, the battalion medical personnel and medical planners.

(a) Provide recommendations and advise to leadership on AHS support.

(b) Recommend to the unit leadership and coordinate the following as required:

_1_ CCP locations of subordinate units by phase.

_2_ Medical task organization and distribution.

_3_ Ground (on the target) evacuation plan and platforms.

_4_ Air or ground (off the target) evacuation plan and platforms.

_5_ CCP, helicopter landing zone (HLZ), and evacuation platform security.

_6_ Augmentation requirements of subordinate units.

(c) Link in with tactical operations.

(2) During the execution phase, the battalion medical personnel and medical planners.

(a) Triage, treatment, monitoring, and packaging.

(b) Conduct delegation of treatment.

(c) Request assistance from other medical or platoon assets.

(d) Provide guidance and recommendations to leadership on casualty management.

b. Platoon Leader.

(1) The platoon leader is responsible for their platoon's execution of the sustainment plan at platoon level. They plan and relay support requirements for mission accomplishment to the company headquarters where it is consolidated and passed on.

(2) The platoon leader develops their sustainment plan by determining exactly what they have on hand to accurately estimate their support requirements. It is critical for the company to know what the platoon has on hand for designated critical supplies. This process is important not only in confirming the validity of the sustainment plan but also in ensuring the platoon's support requests are submitted as early as possible. The platoon leader can formulate their sustainment execution plan and submit support requests based on the results of their maneuver plan.

(3) The sustainment plan should provide answers to operational questions such as the following:

(a) Types of support. Based on the nature of the operation and specific tactical factors, what types of medical support will the platoon need?

(b) Quantities. In what quantities will this support be required?

_1_ Will emergency resupply of class VIII be required during the battle?

_2_ Does this operation require prestocked supplies?

(c) Threat. What is the composition, disposition, and capabilities of the expected enemy threat? How will these affect sustainment plan during execution?

_1_ Where and when will the expected contact occur?

_2_ What are the platoon's expected casualties and vehicle losses based on the nature and location of expected contact?

_3_ What impact will the enemy's special weapons capabilities (such as chemical, biological, radiological, and nuclear) have on the battle and on expected sustainment requirements?

_4_ How many enemy prisoners of war are expected, and where?

(d) Terrain and weather. How will terrain and weather affect sustainment plan during the battle?

_1_ What ground will provide the best security for maintenance and CCPs?

_2_ What are the platoon's vehicle and CASEVAC routes?

_3_ What are the company's dirty routes for evacuating contaminated personnel, vehicles, and equipment?

(e) Time and location. When and where will the platoon need sustainment?

_1_ Based on the nature and location of expected contact, what are the best sites for the CCP?

_2_ Where will the EPWs collection points be located?

(f) Requirements. What are the support requirements, by element and type of support?

_1_ Which section has priority for medical support?

_2_ Which section or squad has priority for emergency resupply?

(g) Risk. Will lulls in the battle permit support elements to conduct resupply operations in relative safety?

(h) Resupply techniques. Based on information developed during the sustainment planning process, which resupply technique should the platoon use?

(4) During the planning phase, unit leadership establish

(a) The CASEVAC by phase of the operation.

(b) CCP locations, HLZ locations, and ambulance exchange point (AXP) locations.

(c) Security of CCP, security of HLZ, and AXP.

(d) Allocation of aid and litter (A and L) teams and planning for caring evacuation equipment.

(e) Accountability and reporting plan.

(f) Distribution and task organization of medical personnel.

(g) Pre-combat inspection (PCI) of junior medics, platoon casualty response kits, and CLS tasks.

(h) Casualty response rehearsals.

(i) Assistance to medics with EMT augmentation and directing A and L teams.

(j) When to gather and distribute casualty equipment and sensitive items.

(k) Accountability and reports to higher.

(l) Proper evacuation request and establish CASEVAC link-up point.

(m) Proper management of KIA remains.

c. Platoon Sergeant (PSG).

(1) The PSG is the platoon's most experienced NCO and second-in-charge, accountable to the platoon leader for leadership, discipline, training, and welfare of the platoon's Soldiers. The PSG is the platoon's primary sustainment planner, coordinator, and operator, reporting directly to the platoon leader. They execute the platoon's logistical plan, relying heavily on platoon and company SOPs. The PSG directly supervises and controls the platoon's assets. During preparations of the mission, they work closely with the platoon leader and squad leaders to determine specific support requirements of the tactical plan. They then ensure proper arrangements are made to provide those support requirements. The PSG also performs these logistical functions:

(a) Coordinates and synchronizes human resources support with the company first sergeant. This includes personnel accountability reports, casualty reports, replacement operations, personnel readiness management, mail operations, essential personnel services, and other administrative or personnel requirements.

(b) Directs and supervises evacuation of casualties, detainees, and damaged equipment.

(c) Directs and supervises the collection, initial identification, and evacuation of human remains to the mortuary affairs collection point.

(2) As the second-in charge, the PSG assumes no formal duties except those prescribed by the platoon leader. However, the PSG traditionally establishes and operates the unit's CCP, this includes:

(a) Directing the platoon medic with A and L teams in moving casualties.

(b) Directing the platoon's CASEVAC process during operations.

(c) Maintaining platoon strength level information by:

_1_ Consolidating and forwarding the platoon's casualty reports.

_2_ Receiving and orienting replacements.

(d) If wounded Soldiers require evacuation, the platoon leader or PSG can take one of the following actions:

_1_ Coordinate with the closest troop or company for ground evacuation.

_2_ Request the company, troop, battalion, squadron or to task organize a dedicated ambulance to the platoon for operations forward of the larger element.

_3_ Conduct self-evacuation with organic platoon assets.

_4_ Coordinate for aerial evacuation through the company, troop battalion, or squadron.

d. Squad Leader.

**NOTE:** It is the squad leaders' responsibility to ensure casualties receive immediate first aid and immediate tactical combat casualty care in conjunction with self-aid, buddy aid, and CLS care performed by nonmedical personnel, and then immediately notify the platoon leader or PSG of all casualties. The use of CLS care is critical. As a minimum, one member of each squad must train as a CLS.

e. CLS.

(1) Immediate, far-forward medical care is essential on a widely dispersed and fluid battlefield to prevent Soldiers from dying of wounds. Medical personnel may not be able to reach and apply lifesaving measures to all wounded Soldiers in a timely manner. The CLS is a nonmedical Department of Defense person who has received additional trauma training and equipment, providing enhanced medical treatment beyond self-aid or buddy aid (JP 4-02). A properly trained CLS is capable of stabilizing many types of casualties and can slow the deterioration of a wounded Soldier's condition until medical personnel arrive. Functioning as a CSL is a secondary mission undertaken when the tactical situation permits. When a casualty occurs, the CLS renders first aid, or first aid is provided through self-aid or buddy aid.

(2) Each squad, crew, or equivalent-sized deployable unit will have at least one member certified as a CLS. CLSs must be recertified every 12 months at unit level IAW AR 350-1.

f. Combat Medic.

(1) Emergency medical treatment procedures performed by the combat medic may include opening an airway, starting intravenous (IV) fluids, controlling hemorrhage, preventing or treating for shock, splinting fractures or suspected fractures, and providing relief for pain.

(2) The combat medic is trained under the supervision of the battalion surgeon or physician's assistant and medical platoon leader. The platoon combat medic is responsible for:

(a) Triaging injured, wounded, or ill friendly and enemy personnel for priority of treatment.

(b) Conducting sick call screening.

(c) Assisting in the evacuation of sick, injured, or wounded personnel under the direction of the PSG.

(d) Assisting in the training of the platoon's CLSs in enhanced first-aid procedures.

(e) Requisitioning class VIII supplies from the BAS for the platoon according to the tactical SOPs.

(f) Recommending locations for CCPs.

(g) Providing guidance to the platoon's CLSs as required.

(3) Combat medics are assigned to the medical platoon and tasked to support the battalion. Combat medics are normally allocated to the maneuver companies based on one combat medic per platoon, and one senior combat medic per company. The location of the combat medic is of extreme importance for rapid medical treatment of casualties.

(4) The company senior combat medic collocates with the company trains. The company trains usually operate 500 to 1000 meters or one terrain feature to the rear of the company to provide immediate recovery and medical support. The company trains conduct evacuation (of those WIA, weapons, and equipment) and resupply as required. The company trains are located in covered and concealed positions close enough to the company to provide responsive support, but out of enemy direct fire. The company first sergeant or executive officer positions the trains and supervises sustainment operations with the platoon. It is the company commander's responsibility to ensure all subordinate units know the locations of battalion combat and field trains as well as the company CCP, BAS, and medical and CASEVAC procedures.

**NOTE:** Mission, enemy, terrain and weather, troop and supports available, time, and civilians ultimately dictates the actual distance at which the company trains operate.

(5) The platoon combat medic usually locates with, or near, the PSG. When the platoon moves on foot in the platoon column formation, the combat medic positions themselves near the PSGs. If the platoon is mounted, the combat medic usually rides in the same vehicle as the PSG.

(6) The platoon combat medic or the company senior combat medic goes to the casualty's location, or the casualty is brought to the combat medic at the CCP. The

CCP combat medic makes their assessment, administers initial medical care, initiates a DD Form 1380 then requests evacuation or returns the individual to duty. Refer to AR 40-66 for details and instructions on completing the form.

(7) During the planning phase, the senior medic or combat medic

(a) Provides recommendations and advise to leadership on medical support.

(b) Plans AHS support by phase of the operation.

(c) Plans casualty response and evacuation by phase of the operation.

(d) Recommends to the unit leadership and coordinates the following as required:

_1_ CCP locations by phase.

_2_ Medical task organization and distribution.

_3_ Ground (on the target) evacuation plan and platforms.

_4_ Air or ground (off the target) evacuation plan and platforms.

_5_ CCP, HLZ, and evacuation platform security.

(e) Conducts PCI of junior medics, platoon casualty response kits, and CSL tasks.

(8) During the execution phase, the senior medic or combat medic

(a) Implements triage, treatment, monitoring, and packaging.

(b) Conducts delegation of treatment.

(c) Requests assistance from other medical or unit assets.

(d) Provides guidance and recommendations to leadership on casualty management and evacuation.

3. Establish CCP operations.

a. The CCP is a location that may or may not be staffed, where casualties are assembled for evacuation to a medical treatment facility (ATP 4-02.2). CCPs are normally predesignated along the axis of advance or evacuation routes. Forward of the BAS, the combat medic, CLS, and combat troops take casualties to the CCPs. These points facilitate acquisition of casualties by supporting ambulance teams and reduce evacuation time. When used by the BAS, CCPs help preserve BAS mobility, preclude carrying casualties forward, and reduce evacuation time to the sustainment area.

b. When designating a CCP, the designating authority makes a decision whether or not to provide medical staff at the location. This decision is based upon the assessment of risk versus the availability of personnel. Normally, the role of care designating the point is responsible for staffing. Medical personnel may not be available to staff these points, and CLSs and ambulatory patients may be required to perform self-aid, buddy aid, or enhanced first aid. The CCPs should be identified on operational overlays and planned by phase for operations. The CCP planning considerations include site security, proximity to the LZ, cover and concealment, and access to evacuation routes. Leaders should provide guidance on A and L teams, distribution of casualty equipment, and proper avoidance of choke points.

c. When no longer receiving effective enemy fire, the tactical field care phase is entered, allowing more medical intervention. When conducting CCP operations medical personnel are responsible for activity inside the CCP, and the supported unit leadership is responsible for activity outside the CCP.

d. If possible, casualty flow should be planned from the POI all the way back to a fixed medical facility in the continental United States. Combat medics should understand the casualty flow up two levels above themselves at a minimum, including patient regulating, casualty accountability, and hospitalization requirements. For example, a platoon medic should have a good understanding of where a casualty goes after leaving the tactical CCP or BAS.

e. There are several questions that need to be answered in order to establish the tactical casualty flow.

(1) Where are the casualties being evacuated to?

(2) Will ground, air, or water assets conduct evacuation to the CCP?

(3) How will evacuation be conducted to casualty transload points?

(4) What are the distances and times of travel?

(5) Will expected casualties be able to make it that far? If not, what parts of the plan need to be corrected?

(6) Who will evacuate the casualties (CASEVAC or MEDEVAC)?

(7) Are medical assets positioned to ensure continuity of care?

f. Establish a CCP (see task 081-000-0070, Establish a Casualty Collection Point).

4. Plan for contaminated casualty care.

**NOTE:** Refer to ATP 4-02.7, for detailed information on patient decontamination.

a. To perform self-aid, immediate lifesaving interventions and decontamination is required. The correct antidotes (for nerve agent exposure) must be administered, and the appropriate mission-oriented protective posture (MOPP) level must be assumed. See ATP 4-02.7 for information that is more detailed.

b. Buddy aid. The individual may be incapable of providing self-aid. Buddy aid actions include:

(1) Treat immediate life-threating injuries per tactical combat casualty care guidelines: massive hemorrhaging, airway, respiration, circulation, and hypothermia.

(2) Determine type of contamination (chemical, biological, and radiological).

(3) Administer appropriate antidotes (use the casualty’s own antidotes).

(4) Decontaminate exposed skin and contaminated MOPP gear using:

(a) Reactive skin decontamination lotion or M291 Skin Decontamination Kit (chemical).

(b) Soap and water (chemical, biological, and radiological).

(c) Brushing or vacuum (radiological).

(d) Put the remaining protective clothing on the casualty.

(e) Move to decontamination point as soon as possible for more definitive care.

5. Brief commander.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 1 | Defined the principals of casualty response. | _____ | _____ |
| 2 | Defined duties and responsibilities. | _____ | _____ |
| 3 | Established CCP operations. | _____ | _____ |
| 4 | Planned for contaminated casualty care. | _____ | _____ |
| 5 | Briefed commander. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
JP 4-02. *Joint Health Services*.
AR 350-1. *Army Training and Leader Development*.
AR 40-66. *Medical Record Administration and Healthcare Documentation*.
ATP 4-02.13. *Casualty Evacuation*.
ATP 4-02.2. *Medical Evacuation*.
ATP 4-02.7. *Multi-Service Tactics, Techniques, and Procedures for Health Service Support in a Chemical, Biological, Radiological, and Nuclear Environment*.
DA Form 1156. *Casualty Feeder Card*.
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.

**Related**
None

Employ Telemedicine

081-68W-0167

**Conditions:** In the operational environment, you have a patient whose chief complaint requires a higher level of medical knowledge and skill to diagnose. You are required to employ telemedicine (TM) based on the patient's category to determine what modality is needed to communicate with the senior medical professional. You have Joint Trauma System Clinical Practice Guidelines list of approved equipment.

**Standards:** Employ TM in accordance with (IAW) *Joint Trauma System Clinical Practice Guidelines (CPG)*. Use TM for the deployed environment, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Identify injured or illness patient that require communication between prehospital provider and TM consultant.

2. Deploy the primary, alternate, contingency, and emergency (PACE) plan. The PACE plan should have a patient care plan and what TM technology available that the unit can use.

**NOTE:** The PACE plan is uniquely developed by the unit prior to arriving in an area of operations.

3. Identify which modality to use for current situation. Factors that determine modality are equipment available and precedence of the injury.

    a. Use photographs and asynchronous technologies (for example, email and text) for routine problems or simple updates to a remote expert for their situational awareness. Slow internet connections will delay transmission of images especially ones of sufficient quality to be used. Dermatologic problems, for example, are well suited for using asynchronous technology to make diagnoses and care plans.

    b. Use synchronous technologies, like phone calls, to discuss complex problems like diagnostic dilemmas, care plans with complex risk-benefit trade-offs, problem solving for management of scarce resources, or timing of patient transport.

4. Conduct TM.

**NOTE:** For asynchronous encounters send patient screening to the medical provider.

    a. Nonurgent and routine will conduct an asynchronous encounter. This is unidirectional information flow (that is, text or email), sometimes known as store and forward, refers to TM that is delivered at a later time from when the patient or another healthcare provider requests it. This could be text-based interactions, a specialist reviewing labs or records at a later time, or a patient conducting an online assessment for medications.

    b. Urgent non-critical care specialty consultations are those in with remote consultants need to speak with a specialist in order to best manage a patient within hours. This could be a patient-related need (in other words, the patient may worsen in the next several hours) or mission-specific need (that is, there is a short communications window or there is a mission-essential decision to make like "Does this casualty need to get on the

evacuation platform that is leaving in the next hour?" or "Can the casualty continue the mission until the next available evacuation time?").

c. Immediate or urgent will conduct a synchronous encounter which is bidirectional information flow (that is, voice, video, or both). Synchronous TM refers to TM that is performed in real time via video or phone consult. In practice, this looks like an urgent care provider assessing symptoms of a sore throat and fever, a psychiatrist managing a patient's medication, or a primary care provider conducting a follow-up visit with a patient.

d. If video is not available, then immediate or urgent and emergent encounter will contact the ADVISOR system. It provides a full spectrum of on-demand urgent or emergent medical and dental consultation services to caregivers in operational settings 24 hours, 7 days a week, 365 days a year.

5. Document the encounter with a SF 600 (*Chronological Record of Medical Care*), DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*), or electronic medical record.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Identified injured or illness patient that require communication between prehospital provider and TM consultant. The PACE plan should have a patient care plan and what TM technology available that the unit can use. | _____ | _____ |
| 2 | Deployed the primary, alternate, contingency, and emergency (PACE) plan. | _____ | _____ |
| 3 | Identified which modality to use for current situation. Factors that determined modality were equipment available and precedence of the injury. | _____ | _____ |
| 4 | Conducted TM. | _____ | _____ |
| 5 | Documented the encounter with a SF 600 (*Chronological Record of Medical Care*), DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*), or electronic medical record. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
*Clinical Practice Guidelines (CPG).*
Joint Trauma System website.

SF 600. *Chronological Record of Medical Care*.

**Related**
None

## Treat a Casualty for a Heat Injury

081-000-0016

**WARNING:** Heatstroke is identified by elevated body temperature and altered mental status. Any casualty warm to the touch with an altered mental status should be suspected of having heatstroke and treated aggressively.

**CAUTION:** All body fluids should be considered potentially infectious. Always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you have a casualty suffering from a heat injury. You are provided with water, thermometer, intravenous (IV) administration set, Lactated Ringer's or sodium chloride, ice sheets, stethoscope, sphygmomanometer, and an electronic medical record (EMR) or DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*). Available are ATP 4-02.13 and TC 4-02.1.

**Standards:** Treat a casualty for a heat injury in accordance with *PHTLS Prehospital Trauma Life Support,* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**NOTE:** Training of this task should be conducted at various levels of mission-oriented protective posture for increased rigor and practice.

**Performance Steps:**

1. Perform a medical patient assessment (see task 081-000-0072, Perform a Medical Patient Assessment).

**NOTE**: Identify the type of heat injury.

a. Heat cramps–muscle cramps of the arms, legs, or abdomen.
b. Heat exhaustion.
   (1) Often–
      (a) Profuse sweating and pale (or gray), moist, cool skin.
      (b) Headache.
      (c) Weakness.
      (d) Dizziness.
      (e) Loss of appetite or nausea.
      (f) Clumsy or unsteady walk.
      (g) Normal or slightly elevated body temperature; or (rarely) as high as 104 degrees (°) Fahrenheit (F).
   (2) Sometimes–
      (a) Heat cramps.
      (b) Nausea (with or without vomiting).
      (c) Urge to defecate.
      (d) Chills.

(e) Rapid breathing.
(f) Tingling sensation of the hands and feet.
(g) Confusion.

c. Heatstroke.
(1) Core body temperature above 104 °F.
(2) Hot, dry skin.

**NOTE:** Early in the progression of heatstroke, the skin may be moist or wet.

(3) Headache.
(4) Dizziness.
(5) Nausea.
(6) Confusion.
(7) Weakness.
(8) Loss of consciousness.
(9) Seizures.
(10) Pulse and respirations are weak and rapid.

d. Hyponatremia (“water intoxication”).
(1) Mental status changes.
(2) Vomiting.
(3) Excessive water consumption.
(4) Poor diet.
(5) Abdomen bloated.
(6) Large amounts of clear urine.

e. Exertional collapse associated with sickle cell trait (SCT).
(1) SCT is an inherited blood disorder.
(2) Associated exertion risk with people who have SCT.
(3) Severe or prolonged muscle pain and tenderness during and after exertion.
(4) Loss of coordination, evolving in awkward running, posture, and gait.
(5) Rapid breathing; shortness of breath.
(6) Slightly elevated body temperature (usually less than 103 °F).
(7) Progression to mental confusion and unconsciousness.
(8) Conscious collapse (slumping to the ground).

**CAUTION:** Do not give salt tablets.

2. Provide the proper treatment for the heat injury.
a. Heat cramps.
(1) Move the casualty to a cool shaded area, if possible.
(2) Loosen the casualty’s clothing unless is in a chemical environment.
(3) Rest the cramping muscles.
(4) Oral rehydration with water or electrolyte solution.
(5) Evacuate the casualty if the cramps are not relieved after treatment.

b. Heat exhaustion.

(1) Conscious casualty.

(a) Move the casualty to a shaded area, if possible.

(b) Loosen or remove the casualty's clothing and boots unless is in a chemical environment.

(c) Pour water on the casualty and fan, if possible.

(d) Ensure excess water has not been consumed, have casualty drink 2 quarts of water over 1 hour. If nauseated, initiate IV hydration.

(2) A casualty who is unconscious or if symptoms have not improved after 30 minutes.

(a) Cool the casualty with ice sheets.

(b) Initiate an IV infusion of Lactated Ringer's or sodium chloride.

(c) Provide oxygen to the casualty, if not already done as part of the initial assessment.

(d) Evacuate the casualty.

(e) Transport the casualty on their side if nauseated.

**CAUTION:** Heatstroke is a medical emergency. If the casualty is not cooled rapidly, the body cells, especially the brain cells, will be damaged; irreversible damage is also done to the central nervous system. The casualty must be evacuated to the nearest medical treatment facility immediately.

c. Heatstroke.

(1) Remove the casualty's outer garments or protective clothing, unless in a chemical environment.

(2) Cool the casualty with ice sheets. If ice sheets are not available, cool the casualty with any means available.

(3) Place ice packs in groin, axillae and around the neck, if available.

(4) Provide supplemental oxygen, if available.

(5) Initiate an IV infusion of Lactated Ringer's or sodium chloride.

(6) Evacuate the casualty.

d. Hyponatremia ("water intoxication").

**CAUTION:** Do not give water.

(1) If conscious, allow casualty to consume salty food or snacks.

(2) Evacuate immediately.

(3) Medical personnel can perform testing for hyponatremia using point-of-care blood analyzer.

(4) All heat casualties require constant monitoring.

**CAUTION:** This is a medical emergency evacuate immediately!

e. Exertional collapse associated with sickle cell trait (ECAST).

(1) Identify if the casualty has SCT (looking for red identification tag or unit specific marking).

(2) Check the casualty's pulse, breathing, and mental status.

(3) Remove the casualty from the environment.

(4) Cool the casualty (as indicated by weather conditions).

(5) Notify nearest medical personnel to assess the casualty for a suspected ECAST event.

(6) Call for urgent medical evacuation or immediately transport the casualty to the nearest medical treatment facility (MTF).

(7) Notify the receiving MTF that the Servicemember is suspected of experiencing an ECAST.

3. Record the treatment given on the EMR or DD Form 1380 (see task 081-000-0013, Initiate a Tactical Combat Casualty Care Card).

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Performed a medical patient assessment (see task 081-000-0072, Perform a Medical Patient Assessment). | _____ | _____ |
| 2 | Provided the proper treatment for the heat injury. | _____ | _____ |
| 3 | Recorded the treatment given on the EMR or DD Form 1380 (see task 081-000-0013, Initiate a Tactical Combat Casualty Care Card ). | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
ATP 4-02.13. *Casualty Evacuation.*
*PHTLS Prehospital Trauma Life Support.*
TC 4-02.1. *First Aid*.
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.

**Related**
None

## Treat a Casualty for a Cold Injury

081-000-0017

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment and must treat a casualty with a cold injury. Casualty has been removed from the environment. You are provided with, emergency blanket, trauma dressing, thermometer, surgical sponge, 2x2 gauze, ATP 4-02.13, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*).

**Standards:** Treat a casualty for a cold injury in accordance with (IAW) *PHTLS Prehospital Trauma Life Support,* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Recognize the signs and symptoms of cold injuries.
    a. Chilblains are caused by repeated prolonged exposure of bare skin to low temperatures from 60 degrees (°) Fahrenheit (F) down to 32 °F.
        (1) Acutely red, swollen, hot, tender, or itching skin.
        (2) Surface lesions with shedding of dead tissue or bleeding lesions.
    b. Frostbite is caused by exposure of the skin to cold temperatures that are usually below 32 °F depending on the windchill factor, length of exposure, and adequacy of protection.

**NOTE:** The onset is signaled by a sudden blanching of the skin of the nose, ears, cheeks, fingers, or toes followed by a momentary tingling sensation.

        (1) First degree.
            (a) Epidermal injury: limited to skin that has brief contact with cold air or metal.
            (b) No blister or tissue loss; healing occurs in 7-10 days.
        (2) Second degree.
            (a) Involves epidermis and superficial dermis.
            (b) Redness of the skin in light-skinned individuals and grayish coloring of the skin in dark-skinned individuals, followed by a flaky sloughing of the skin.
            (c) Blister formation 24 to 36 hours after exposure followed by sheet-like sloughing of the superficial skin.
            (d) No permanent loss of tissue; healing occurs in 3-4 weeks.
        (3) Third degree.
            (a) Involves the epidermis and dermis layers.
            (b) Frozen skin stiff with restricted mobility.
            (c) After tissue thaws, skin swells along with blood-filled blister.
            (d) Skin loss occurs slowly; healing is delayed.
        (4) Fourth degree.

(a) Frozen tissue involves full thickness skin with muscle and bone involvement.

(b) Necrotic tissue develops along with sloughing of tissue and auto amputation of nonviable tissue.

**CAUTION:** With generalized hypothermia, the entire body has cooled with the core temperature below 95 °F.

c. Generalized hypothermia is caused by prolonged exposure to low temperatures, especially with wind and wet conditions, and it may be caused by immersion in cold water.

(1) Moderate hypothermia.

**NOTE:** This condition should be suspected in any chronically ill person who is found in an environment of less than 50 °F.

(a) Conscious, but usually apathetic or lethargic.

(b) Shivering, with pale, cold skin, slurred speech, poor muscle coordination, faint pulse.

(2) Severe hypothermia.

(a) Unconscious or stuporous.

(b) Ice cold skin.

(c) Inaudible heartbeat or irregular heart rhythm.

(d) Unobtainable blood pressure.

(e) Unreactive pupils.

(f) Very slow respirations.

d. Immersion syndrome (immersion foot, trench foot and hand) is caused by fairly long (hours to days) exposure of the feet or hands to wet conditions at temperatures from about 50 °F down to 32 °F.

(1) Minimal.

(a) Increased blood flow to feet.

(b) Slight sensory change for 2-3 days.

(c) Self-limiting injury with no signs of injury after 7 days.

(2) Mild.

(a) Edema, hyperemia, and sensory changes remain for 2-3 days.

(b) Loss of sensation found on bottom of feet and toes for 4-9 weeks after injury.

(c) Blisters and skin loss does not occur.

(d) Casualty can walk when walking does not cause pain.

(3) Moderate.

(a) Edema, hyperemia, blisters, and mottled skin appear 2-3 days after injury.

(b) Loss of sensation and edema for 2-3 weeks.

(c) Blister sloughing occurs, no loss of deep tissue.

(4) Severe.

(a) Severe edema and gangrene present 2-3 days after injury.

(b) Loss of sensation, edema for 2-3 weeks.

(c) Significant tissue loss with auto-amputation.
(d) Casualties will have permanent disability.

e. Snow blindness.
(1) Scratchy feeling in the eyes as if from sand or dirt.
(2) Watery eyes.
(3) Pain, possibly as late as 3 to 5 hours later.
(4) Reluctant or unable to open eyes.

2. Treat the cold injury.
a. Chilblains.
(1) Apply local rewarming within minutes.

**CAUTION:** Do not treat with ointments.

(2) Protect lesions (if present) with dry sterile dressings.

b. Frostbite.

**CAUTION:** Avoid thawing the affected area if it is possible that the injury may refreeze before reaching the treatment center.

(1) Apply local rewarming using body heat.
(2) Loosen or remove constricting clothing and remove jewelry.

**CAUTION:** Do not massage the skin or rub anything on the frozen parts.

(3) Increase insulation and exercise the entire body as well as the affected body part(s).
(4) Move the casualty to a sheltered area, if possible.
(5) Fingers and toes should be separated and protected with dry sterile gauze.
(6) Protect the affected area from further cold or trauma.
(7) Evacuate the casualty.

**NOTE:** For frostbite of a lower extremity, evacuate the casualty by litter, if possible.

**CAUTION:** Do not allow the casualty to use tobacco or alcohol.

c. Generalized hypothermia.
(1) Moderate.
(a) Remove the casualty from the cold environment.
(b) Replace wet clothing with dry clothing.
(c) Cover the casualty with insulating material or blankets.
(d) Avoid unnecessary movement from the casualty.

**NOTE:** If far from a medical treatment facility and the situation and facilities permit, immerse the casualty in a tub of 104-108 °F water. Avoid rewarming with intense sources of heat (campfire).

**CAUTION:** Do not give the casualty alcohol or caffeine drinks.

(e) If casualty is conscious, slowly give high caloric sweet warm fluids.

(f) Wrap the casualty from head to toe.

(g) Evacuate the casualty lying down.

**CAUTION:** Handle the casualty very gently.

(2) Severe.

(a) Cut away wet clothing and replace it with dry clothing.

(b) Maintain the airway (see task 081-COM-1004, Perform Airway Management).

**NOTE:** Do not use artificial airways or suctioning devices.

**CAUTION:** Do not hyperventilate the casualty. Keep the rate of artificial ventilation at approximately 8 to 10 breaths per minute.

_1_ Administer oxygen.

**CAUTION:** Do not hyperventilate the casualty. Keep the rate of artificial ventilation at approximately 8 to 10 per breaths minute.

_2_ Assist with ventilation if the casualty's respiration rate is less than five per minute.

(c) Initiate an intravenous (IV) infusion of any crystalloid fluid, warmed up to 109 degrees (°) Fahrenheit (F). Do not infuse cold IV fluids.

(d) Evacuate the casualty.

**NOTE:** The treatment of moderate hypothermia is aimed at preventing further heat loss and rewarming the casualty as rapidly as possible. Rewarming a casualty with severe hypothermia is critical to saving their life, but the kind of care rewarming requires is nearly impossible to carry out in the field. Evacuate the casualty promptly to a medical treatment facility. Use stabilizing measures en route.

d. Immersion syndrome.

**CAUTION:** Never massage the skin. After rewarming the affected part, it may become swollen, red, and hot. Blisters usually form due to circulation return.

(1) Dry the affected part immediately and gradually rewarm it in warm air.

(2) Protect the affected part from trauma and secondary infection.

(3) Fingers and toes should be separated and protected with a dry sterile gauze.

(4) Elevate the affected part.

(5) Evacuate the casualty as soon as possible.

e. Snow blindness. Cover the eyes with a dark cloth and evacuate the casualty to a medical treatment facility.

3. Record treatment.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Recognized the signs and symptoms of cold injuries. | _____ | _____ |
| 2 | Treated the cold injury. | _____ | _____ |
| 3 | Recorded treatment. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
ATP 4-02.13, *Casualty Evacuation.*
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
*PHTLS Prehospital Trauma Life Support.*

**Related**
None

Enforce Field Sanitation Measures

081-68W-0005

**Conditions:** You are in an operational environment. You are required to enforce field sanitation measures. You will be provided a field sanitation kit which will include a wet bulb globe temperature device (WBGT), water purification chemicals, windchill chart, list of unit hazards, and hazardous noise mitigation equipment.

**Standards:** Enforce field sanitation measures ensuring effective preventive measures are in place to mitigate threats from waterborne, foodborne, and waste-borne illnesses to include environmental threats in accordance with (IAW) TC 4-02.3, while adhering to all warnings and cautions, without error, using the GO/NO GO checklist.

**Performance Steps:**

1. Facilitate planning for potable water use or disinfection.
   a. Ensure Soldiers wash or disinfect hands and conduct proper personal hygiene.
   b. Check potable water source prior to consumption.
2. Enforce foodborne illness prevention measures.
   a. Ensure Soldiers wash or disinfect hands and conduct proper personal hygiene.
   b. Check food sources and preparation areas prior to consumption.
3. Enforce waste-borne illness prevention measures.
   a. Facilitate collection, handling, and disposal of liquid and solid human waste.
   b. Check cleanliness of individual living and workspaces.
4. Enforce measures to protect against environmental hazards.
   a. Prepare Soldiers for cold weather operations.
   b. Prepare Soldiers for hot weather operations.
5. Enforce measures to protect against vector-borne hazards.
   a. Ensure Soldiers use DOD approved insect repellent to exposed skin.
   b. Enforce proper wear of the uniform.
   c. Remove standing water from area.
6. Enforce measures to protect against noise hazard exposure.
   a. Enforce proper wear of ear protection.
   b. Monitor the time Soldiers spend in hazardous noise environments only to the time required to perform critical tasks.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|
| 1 Facilitated planning for potable water use or disinfection. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 2 | Enforced foodborne illness prevention measures. | _____ | _____ |
| 3 | Enforced waste-borne illness prevention measures. | _____ | _____ |
| 4 | Enforced measures to protect against environmental hazards. | _____ | _____ |
| 5 | Enforced measures to protect against vector-borne hazards. | _____ | _____ |
| 6 | Enforced measures to protect against noise hazard exposure. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
TC 4-02.3. *Field Hygiene and Sanitation*.

**Related**
None

**Subject Area 4: Medical Management**

Perform a Medical Patient Assessment

081-000-0072

**Conditions:** In an operational environment, you have a patient requiring a medical assessment. You have a stethoscope, sphygmomanometer, airway adjuncts, and monitoring equipment. You have performed a patient care handwash.

**Standards:** Perform a medical patient assessment without causing further injury in accordance with (IAW) *Nancy Caroline's Emergency Care in the Streets* and *Tactical Combat Casualty Care (TCCC) Guideline*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Take body substance isolation precautions.

2. Perform scene size up.
   a. Determine if the scene or situation is safe.
   b. Determine the mechanism of injury or nature of illness.
   c. Determine the number of patients.
   d. Request additional help if necessary.
   e. Consider stabilization of the spine.

3. Perform a primary survey.
   a. Form a general impression of the patient and the patient's environment.
   b. Assess the patient's mental status using the Alert, Verbal, Pain, Unresponsive (AVPU) scale.
      (1) A – Alert and oriented.
      (2) V – Responsive to verbal stimuli.
      (3) P – Responsive to painful stimuli.
      (4) U – Unresponsive.
   c. Determine the chief complaint and apparent life-threatening condition.
   d. Assess the airway.
      (1) Perform an appropriate maneuver to open and maintain the airway, if necessary.
      (2) Insert an appropriate airway adjunct, if necessary.
   e. Assess breathing.
      (1) Determine the rate, depth, and ease of breathing, by observing the chest for rise and fall and assess for signs of difficulty breathing, such as increased rate and use of accessory muscles.
      (2) Administer oxygen, if necessary, using the appropriate delivery device.
   f. Assess circulation.
      (1) Check for major bleeding. Control major bleeding, if necessary.
      (2) Check skin color, temperature, and moisture.

(3) Assess the pulse for rhythm and force.
(a) Check the radial pulse in adults.
(b) Check the radial pulse and capillary refill for children under 6 years old.
(c) Check the brachial pulse and capillary refill for infants.
(4) Treat for shock, if necessary.
g. Identify priority patients and make a transport decision.

**NOTE:** High priority conditions that require immediate transport include poor general impression, unresponsive, responsive but not following commands, difficulty breathing, shock, complicated childbirth, chest pain with systolic blood pressure less than 100, uncontrolled bleeding, and severe pain.

4. Conduct a secondary assessment.
a. Obtain history of present illness using OPQRST.
(1) Onset.
(2) Provocation.
(3) Quality.
(4) Radiation.
(5) Severity.
(6) Time.
b. Obtain past medical history.
(1) Signs and symptoms.
(2) Allergies.
(3) Medications.
(4) Past pertinent history.
(5) Last oral intake.
(6) Events leading to present illness.
c. Perform a focused physical exam (assess affected body part or system or, if indicated, completes rapid assessment).
d. Assess vital signs.
e. Provide medication, interventions, and treatment as needed.
f. Reevaluate the transport decision.

5. Perform ongoing assessment.
a. Repeat the initial assessment.
b. Repeat vital signs.
c. Repeat the focused assessment regarding the patient's complaint or injuries.
d. Check effectiveness of interventions.
e. Confirm priority.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | | GO | NO GO |
|---|---|---|---|
| **Performance Measures:** | | | |
| 1 | Took body substance isolation precautions. | _____ | _____ |
| 2 | Performed scene size up. | _____ | _____ |
| 3 | Performed a primary survey. | _____ | _____ |
| 4 | Conducted a secondary assessment. | _____ | _____ |
| 5 | Performed ongoing assessment. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**

Deployed Medicine website**.**
*Nancy Caroline's Emergency Care in the Streets.*
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Treat a Blood Agent (Hydrogen Cyanide) Casualty

081-000-0114

**DANGER:** Blood agents (hydrogen cyanide) cause symptoms ranging from seizures to coma. After inhaling a high concentration of blood agent, a person may become unconscious and die within minutes. Blood agents in high concentration act quickly and death may result in 15 seconds. These agents release an odor of bitter almonds or peach kernels; however, approximately 50% of the population is genetically unable to detect the odor of cyanide. Anyone smelling the odors should mask immediately.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment, treat a casualty suffering from blood agent (hydrogen cyanide) poisoning. You have ventilation equipment (if available) and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*).

**Standards:** Treat a blood agent (hydrogen cyanide) casualty in accordance with (IAW) ATP 4-02.85, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Check for signs and symptoms of blood agent poisoning.

**NOTE:** Cyanide causes very few signs and symptoms.

a. Check or ask the patient with exposure from low concentration (Moderate) if they are suffering from:
   (1) Vertigo.
   (2) Nausea and vomiting.
   (3) Transient increase in rate and depth of breathing.
   (4) Headache.
   (5) Eye irritation.

**NOTE:** Above symptoms may progress to severe effects if exposure continues. The time of onset of these effects depends on the concentration but is often within minutes after exposure.

b. Check or ask the patient with exposure to high concentration (Severe) if they are suffering from:
   (1) Intense irritation of the eyes, nose, and airways.
   (2) Transient increase in rate and depth of breathing, after 15 seconds of exposure.
   (3) Violent convulsions after 30 seconds of exposure.
   (4) Respiratory arrest after 2 to 4 minutes of exposure.
   (5) Coma.
   (6) Cardiac arrest after 4 to 8 minutes of exposure.

2. Manage a casualty exposed to blood agents.

**NOTE:** Management of cyanide poisoning begins with self-protection.

a. Immediately mask and remove the casualty from the contaminated site.
b. If exposed to liquid agents, wet clothing should be removed.
c. If exposed to liquid agents, skin should be washed with soap and water.

**NOTE:** A casualty that has ingested cyanide does not require decontamination.

**CAUTION:** No device currently exists that can provide medical assistance in a contaminated environment. If available, hydroxocobalamin should be used as soon as mission dictates. Dosing for hydroxocobalamin is 5 grams (g) intravenous over 5 minutes in 200 milliliters (ml) normal saline. May repeat dose if first has no effect.

**CAUTION:** If hydroxocobalamin is unavailable use amyl nitrite 0.3 ml and sodium thiosulfate 12.5 g. This medicine is suboptimal due to possible development of methemoglobinemia.

3. Administer positive pressure ventilation, if available.
   a. Assemble the bag valve mask (BVM) (connect the mask to port on the bag).
   b. Position yourself at the top of the patient's head.
   c. Insert a nasopharyngeal airway.
   d. Affix a BVM to the patient.
   e. Perform an E-C technique to hold the mask in place over the patient's mouth.

**NOTE:** The E-C hand position technique is performed using one hand.

(1) Form the "C" by placing your thumb over the part of the mask covering the bridge of the nose and your index finger over the part covering the cleft of the chin.

(2) Sealing the mask firmly on the face by pushing down with the thumb and index finger while pulling up on the mandible form the "E" with the other three fingers, opening the airway by performing the head tilt, chin-lift maneuver.

(3) Maintain a leakproof mask seal with one hand by using firm pressure to hold the mask in position and seal over the patient's mouth.

(4) Squeeze the bag with your other hand for 1-2 seconds while observing the chest rise to make certain lungs are inflating effectively.

(5) Alternatively, the bag may be compressed against your body or forearm to deliver a greater tidal volume to the patient or help with hand fatigue.

(6) Continue squeezing the bag once every 5-6 seconds (10-12 breaths per minute).

**NOTE:** For pediatric patients, the rate would be 20-30 breaths per minute.

4. Record the treatment given on a DD Form 1380.

5. Position the casualty.
   a. Conscious – in a comfortable position, preferably sitting.
   b. Unconscious – on the injured side.

6. Evacuate the casualty.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Checked for signs and symptoms of blood agent poisoning. | _____ | _____ |
| 2 | Managed a casualty exposed to blood agents. | _____ | _____ |
| 3 | Administered positive pressure ventilation, if available. | _____ | _____ |
| 4 | Recorded the treatment given on a DD Form 1380. | _____ | _____ |
| 5 | Positioned the casualty. | _____ | _____ |
| 6 | Evacuated the casualty. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
ATP 4-02.85. *Multi-Service Tactics, Techniques, and Procedures for Treatment of Chemical Warfare Agent Casualties and Conventional Military Chemical Injuries*.
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.

**Related**
None

Treat a Choking Agent Casualty

081-000-0015

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in a chemical environment and have a casualty who is lying on the ground wearing protective overgarments, overboots, and mask carrier. You are wearing mission-oriented protective posture level 4. Treat a casualty displaying signs and symptoms of a choking agent poisoning. You have ventilation equipment and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*).

**Standards:** Treat a choking agent casualty in accordance with ATP 4-02.85, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Check for the signs and symptoms of choking agent poisoning.
    a. Immediate signs and symptoms.

**NOTE:** Although heavy concentrations of poison bring on these symptoms very quickly, small doses may take up to 2 to 6 hours before there is any sign of poisoning.

        (1) Watery eyes.
        (2) Coughing.
        (3) Choking.
        (4) Tightness in the chest.
        (5) Nausea.
        (6) Vomiting.
        (7) Headache.
        (8) Transient blindness.
        (9) Increased salivation.
        (10) Tingling burning sensation on the skin.
    b. Delayed signs and symptoms.
        (1) Rapid shallow breathing.
        (2) Cyanosis.
        (3) Apprehension.
        (4) Severe coughing, producing frothy fluid.
        (5) Weak and rapid pulse.
        (6) Chest wall retractions.
        (7) Pulmonary edema.
    c. Asymptomatic (the casualty has been exposed but shows no signs or symptoms).

2. Prepare the casualty for treatment.
    a. Mask the casualty, but do not fasten the hood.

**NOTE:** The hood is the protective covering for the area of the head not covered by the mask.

b. Position the casualty.

**NOTE:** Patients should be placed in either the supine or seated positions.

3. Treat the casualty.
   a. Asymptomatic.
      (1) Restrict the casualty's activities to light duties to avoid stress to the respiratory system.
      (2) Monitor the casualty for the onset of symptoms.
   b. Symptomatic.
      (1) Keep the casualty at rest seated.
      (2) Provide intermittent positive pressure ventilation if equipment is available.
      (3) Keep the casualty warm.

**NOTE:** Consider prompt treatment with intravenous and inhalation corticosteroids. Rest, oxygen, antibiotics.

   c. Additional treatment items.
      (1) Sedation should be used sparingly. Codeine in doses of 30 to 60 milligrams (mg) may be effective for cough.

**NOTE:** Barbiturates, atropine, analeptics, and antihistamines are all contraindicated.

      (2) Early administration of positive airway pressure (intermittent positive pressure breathing, continuous positive airway pressure mask, positive end expiratory pressure mask, or, if necessary, intubation with or without a ventilator), may delay or minimize the pulmonary edema and reduce the degree of hypoxemia.
      (3) Antimicrobial therapy should be reserved for cases complicated by suspected bacterial bronchitis or pneumonitis modified by culture results if available.
      (4) Treatment should commence as soon as possible with the inhalation of the steroid from an inhaler.

4. Record the treatment given on the DD Form 1380.
   a. Date and time.
   b. Injury characteristics.
   c. Equipment used.
   d. Treatment employed.
   e. Patient tolerance of procedure.
   f. Difficulties and complications during procedure.
   g. Plan for future care.

5. Evacuate the casualty.

**CAUTION:** A casualty with potentially significant unprotected exposure to a choking (lung-damaging) agent should be kept at rest until the danger of pulmonary edema is past if the operational situation permits.

a. Position the casualty.
   (1) Conscious – In a comfortable position, preferably sitting.
   (2) Unconscious – On the injured side.
b. Evacuate the casualty.

**NOTE:** Continue to assess the casualty until evacuated. The casualty should be evacuated by the most expedient means available.

c. The casualty should be evacuated in a semi-seated position if dyspnea or orthopnea make a supine posture impractical.
d. Evacuation by litter is strongly advised in cases of significant respiratory involvement.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Checked for the signs and symptoms of choking agent poisoning. | _____ | _____ |
| 2 | Prepared the casualty for treatment. | _____ | _____ |
| 3 | Treated the casualty. | _____ | _____ |
| 4 | Recorded the treatment given on the DD Form 1380. | _____ | _____ |
| 5 | Evacuated the casualty. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
ATP 4-02.85. *Multi-Service Tactics, Techniques, and Procedures for Treatment of Chemical Warfare Agent Casualties and Conventional Military Chemical Injuries*.
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.

**Related**
None

## Treat a Biological Casualty

081-68W-0279

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you encounter a casualty with symptoms consistent with biological agent exposure. All other life-threatening injuries have been treated. You will need a fully stocked aid bag, intravenous (IV) administration equipment, IV fluids, oxygen, suction and ventilation equipment (if available), selected medications, documentation forms, and chemical personal protective equipment. You are in a chemical, biological, radiological, and nuclear environment.

**Standards:** Perform appropriate identification and treatment for a casualty exposed to a biological agent, causing no additional harm to the casualty with 100% accuracy utilizing GO/NO GO criteria.

**Performance Steps:**

1. Determine the biological warfare agent.

**NOTE:** Ensure personal protective equipment is available for yourself and the casualty.

**NOTE:** All scene size up, initial assessment, focused history, examination, detailed physical examination, on-going assessment, and transport assessment steps must be taken to ensure that injuries or illnesses are not overlooked resulting in further injury to the casualty.

   a. Pneumonia-like agents.
      (1) Anthrax.
      (2) Tularemia.
      (3) Plague.
      (4) Q fever.
   b. Encephalitis-like agents.
      (1) Smallpox.
      (2) Venezuelan equine encephalitis.
   c. Biological toxins.
      (1) Botulinum.
      (2) Staphylococcal enterotoxin B.
      (3) Ricin.
      (4) Mycotoxins.
   d. Other agents.
      (1) Cholera.
      (2) Viral hemorrhagic fevers (VHFs).
      (3) Brucellosis.

2. Recognize findings.

a. Pneumonia-like agents.
   (1) Inhalational anthrax (bacillus anthracis).
      (a) Symptoms: malaise, fatigue, myalgia, headache, dyspnea, shortness of breath and chest pain.
      (b) Signs: fever, cough, tachypnea, hypotension, meningitis, stridor, diaphoresis, cyanosis, shock, and lesions if skin is exposed.
   (2) Plague (yersinia pestis).
      (a) Symptoms: fever, chills, malaise, chest pain, swollen and painful lymph nodes called buboes, headache, and meningitis.
      (b) Signs: high fever, buboes, severe pneumonia, cough with hemoptysis, cyanosis, convulsions, shock, hemorrhagic skin changes and blackening of skin at extremities, disseminated intravascular coagulation, and septic shock.
   (3) Tularemia (francisella tularensis).
      (a) Symptoms: fever, chills, malaise, fatigue, and substernal chest discomfort.
      (b) Signs: fever, tachycardia, tachypnea, non-productive cough, mucous membrane lesions, hypotension, prostration, sepsis, and respiratory distress.
   (4) Q fever (coxiella burnetti).
      (a) Symptoms: severe headache, chills, myalgia, and fatigue. Less common symptoms are nausea, vomiting, diarrhea, abdominal and chest pain.
      (b) Signs: high fever, dry cough, and sweats. Physical exam of chest is usually normal, but inspiratory rales may be present, and consolidation may be seen on chest x-ray.
b. Encephalitis-like agents.
   (1) Smallpox (variola major).
      (a) Symptoms: malaise, rigors, headache, and backache.
      (b) Signs: fever, vomiting, macular-papular rash that progresses to characteristic vesicular pustules, which become scabs and scars, prostration, and delirium.
   (2) Venezuelan equine encephalitis.
      (a) Symptoms: fever, severe headache, photophobia, myalgia, and nausea.
      (b) Signs: chills, vomiting and sore throat.
c. Biological toxins.
   (1) Botulinum.
      (a) Symptoms: generalized skeletal-muscle weakness, diplopia, blurred vision, and difficulty breathing.
      (b) Signs: generalized paralysis, ptosis, difficulty breathing, and respiratory failure.
   (2) Staphylococcal enterotoxin B.
      (a) Symptoms: headache, myalgia, and abrupt-onset abdominal pain.
      (b) Signs: fever, chills, non-productive cough, shock, vomiting, and diarrhea.
   (3) Ricin.
      (a) Symptoms: weakness.
      (b) Signs: fever, cough, and hypotension.
   (4) T-2 mycotoxins.

(a) Symptoms: nose and throat pain, itching, dizziness, and chest pain.

(b) Signs: redness, lesions on exposed skin, runny nose, sneezing, bloody vomiting, diarrhea, and shock.

d. Other agents.

(1) Cholera.

(a) Symptoms: abdominal cramping, malaise.

(b) Signs: diarrhea, vomiting.

(2) Brucellosis.

(a) Symptoms: fever, malaise, myalgia, arthralgias and back pain.

(b) Signs: profuse sweating, cough, malaise, chills, and weight loss.

(3) VHFs.

(a) Symptoms: fever, myalgia, malaise, fatigue, prostration, headache, and easy bleeding.

(b) Signs: fever, conjunctival infection, petechiae, hypotension, flushing of face and chest, edema, vomiting, and diarrhea.

(4) Glanders.

(a) Symptoms: fever, myalgia, headache, and pleuritic chest pain.

(b) Signs: rigors, sweats, cervical lymphadenopathy, hepatosplenomegaly, and generalized popular or pustular eruptions.

3. Terminate exposure.

**NOTE:** Physically remove the casualty from the contaminated environment.

4. Provide generalized emergency care.

a. Recognition and identification.

(1) Differentiate between chemical and biological weapons.

**NOTE:** Chemical agents present symptoms within minutes to hours. Biological agents can present as delayed symptoms up to two weeks after initial exposure.

(2) Call for additional resources.

(a) Medical officers will be needed to prescribe proper antibiotic coverage and antitoxin treatment.

(b) Laboratory support will be needed for positive identification of the agent.

b. Isolation of selected cases.

(1) Smallpox, plague, and Ebola are highly transmissible.

(2) Isolate biological casualties from unaffected individuals.

(3) Enforce protective measures.

c. Supportive care.

(1) Secure and maintain the airway (see task 81-000-0073, Administer Oxygen).

(2) Initiate IV fluid or saline locks.

d. Arrange for antibiotic or antitoxin therapy.

(1) Ciprofloxacin.

(2) Doxycycline.
(3) Gentamycin.
(4) Oral tetracycline.
(5) Erythromycin.

5. Treat for specific exposure.
   a. Treat pneumonia-like agents.
      (1) Anthrax.
         (a) Aggressive respiratory and cardiovascular support.
         (b) Administer intravenous fluids.
         (c) High dose intravenous antibiotics combined with oral ciprofloxacin or oral doxycycline.
         (d) Contact isolation is required.
      (2) Plague.

**NOTE:** Early admission of antibiotics is critical, as pneumonic plague is invariably fatal if antibiotic therapy is delayed more than 1 day after the onset of symptoms.

         (a) Aggressive fluid resuscitation.
         (b) Parenteral streptomycin or gentamicin, with doxycycline or ciprofloxacin representing alternatives for 10-14 days.
         (c) Contact isolation is required.
      (3) Tularemia.
         (a) Respiratory and fluid support as needed.
         (b) Administration of antibiotics (streptomycin or gentamycin) with early treatment is very effective for naturally acquired disease.
         (c) Contact isolation is required.
      (4) Q fever-oral tetracycline or doxycycline for 14 to 21 days.

**NOTE:** Q fever may be a self-limited illness, however, the potential for severe complications and relapse warrant that all cases be treated.

   b. Treat encephalitis-like agents.

**NOTE:** At present, there is no effective chemotherapy, and treatment of a clinical case remains supportive.

      (1) Smallpox.
         (a) Respiratory and contact isolation.
         (b) Consider immediate vaccination.
      (2) Venezuelan equine encephalitis.
         (a) Provide supportive treatment.
         (b) Blood and body fluid precautions required.
         (c) Investigational live, attenuated vaccine available.
   c. Treat biological toxins.

(1) Botulinum.

(a) Early intravenous administration of trivalent licensed antitoxin or heptavalent antitoxin may prevent or decrease progression to respiratory failure.

(b) Intubation and ventilator assistance is needed for respiratory failure.

(2) Staphylococcal enterotoxin B.

(a) Provide respiratory support.

(b) Initiate saline lock for vascular access.

(c) Hypochlorite solution effectively inactivates toxin when applied to most nonporous surfaces.

(3) Ricin.

(a) Management is supportive and should include treatment for pulmonary edema.

(b) Gastric lavage and cathartics are indicated for ingestion.

(c) Consider initiation of intravenous fluids.

(4) Mycotoxins.

(a) Thorough decontamination with hypochlorite solution.

(b) Provide respiratory support.

(c) Consider intravenous fluid.

(d) Super activated charcoal should be given orally if the toxin is swallowed.

d. Treat other agents.

(1) Cholera.

(a) Aggressive rehydration with oral rehydration solution or IV Lactated Ringer's.

(b) Intravenous normal saline.

(c) Antibiotic treatment with tetracycline or doxycycline 100 milligram (mg) by mouth (PO), twice a day (BID) for 3 days.

(d) Consider ciprofloxacin or erythromycin for resistant strains of cholera.

(e) Treat children with tetracycline, erythromycin, or trimethoprim-sulfamethoxazole.

(2) Brucellosis.

(a) Intravenous fluid initiation.

(b) Oral doxycycline combined with rifampin or streptomycin for 6 weeks.

(c) Endocarditis or other serious complication (hepatitis, splenitis, meningoencephalitis or osteomyelitis) may require triple antibiotic coverage.

(3) VHFs.

(a) Judicious use of intravenous fluids.

(b) Consider antiviral therapy with intravenous ribavirin.

(c) Consider immediate vaccination.

6. Triage casualties based upon level of exposure.

**NOTE:** Most biological warfare casualties will be triaged as "delayed" or "minimal."

a. Minimal: all ambulatory casualties.

b. Delayed: moderate to severe symptoms.

c. Immediate.
   (1) Respiratory failure.
   (2) Decompensated shock.
d. Expectant.
   (1) Pulseless.
   (2) Persistent decompensated shock despite adequate IV fluids.

7. Provide protection for biological agents.
   a. Recognition and identification of agent.
   b. Personal protective equipment.
      (1) Protective masks.
         (a) M50 gas mask.
         (b) Self-contained breathing apparatus.
      (2) Protective overgarment.
         (a) Hood.
         (b) Gloves.
         (c) Boots.
         (d) Joint Service Lightweight Integrated Suit Technology (JSLIST) jacket.
         (e) JSLIST pants.
   c. Immunization and prophylaxis.
      (1) Immunizations.
         (a) Anthrax.
         (b) Plague.
         (c) Q fever (experimental).
         (d) Tularemia.
         (e) Smallpox.
         (f) Venezuelan equine encephalitis (experimental).
         (g) VHFs (experimental).
         (h) Botulinum.
      (2) Prophylaxis.
         (a) Anthrax: oral ciprofloxacin or doxycycline.
         (b) Plague: doxycycline 100 mg is given orally BID for 7 days (alternative antibiotics: ciprofloxacin, tetracycline, or chloramphenicol).
         (c) Q fever: tetracycline or doxycycline should be started 8-12 days post-exposure and continued for at least 5-7 days.
         (d) Brucellosis: doxycycline and rifampin prophylaxis.
         (e) Tularemia: 2-week course of doxycycline or ciprofloxacin.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 1 | Determined the biological warfare agent. | _____ | _____ |
| 2 | Recognized findings. | _____ | _____ |
| 3 | Terminated exposure. | _____ | _____ |
| 4 | Provided generalized emergency care. | _____ | _____ |
| 5 | Treated for specific exposure. | _____ | _____ |
| 6 | Triaged casualties based upon level of exposure. | _____ | _____ |
| 7 | Provided protection for biological agents. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
ATP 4-02.84. *Multi-Service Tactics, Techniques, and Procedures for Treatment of Biological Warfare Agent Casualties*.
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions).*

**Related**
None

Perform Basic Life Support

081-000-0018

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you are required to perform basic life support on a casualty with signs of apneic and pulseless. You have a pocket mask with one-way-valve, oxygen, bag valve mask (BVM), pen, exam gloves, eye protection, an automated external defibrillator (AED), SF 600 (*Chronological Record of Medical Care*), electronic medical record (EMR), and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*).

**Standards:** Perform basic life support until return of spontaneous circulation, relieved by another competent personnel, too exhausted to continue, or instructed to cease efforts by a licensed medical provider in accordance with (IAW) *Basic Life Support for Healthcare Providers, Instructor's Manual*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Conducts visual survey.
    a. Check surrounding area for safety.
    b. Obtain an initial impression of the patient (including whether there is life-threatening bleeding).
    c. Detect the need for additional resources.
2. Check for responsiveness.
    a. Obtain a verbal response from the patient (shout "Are you OK?").
    b. Obtain a pain response from the patient (tap patient shoulder to elicit painful stimuli).
3. Check for breathing, pulse, and life-threatening bleeding.
    a. Open airway using head-tilt or chin-lift technique to a past-neutral position (place in neutral position for infants).
    b. Checks for breathing and carotid pulse simultaneously for no more than 10 seconds (check brachial pulse for infants).
    c. Inspect the body looking for life-threatening bleeding or other signs and symptoms (at the same time as the breathing and pulse check).
4. Perform chest compressions.
    a. Remove clothing from torso area.
    b. Position hands on the center of the lower half of the sternum (use two-finger technique for infants).
    c. Maintain a depth of at least 2 inches, no more than 2.4 inches per compression (about 1 1/2 inches for infant).
    d. Perform 30 compressions (100 to 120 per minute for adult, child, and infant patients).
    e. Maintain equal compression and recoil time of the sternum.

**WARNING:** Gastric inflation frequently develops during mouth-to-mask or BVM ventilation. It can result in serious complications. Rescuer(s) can reduce the risk of gastric inflation by avoiding giving breaths too rapidly, too forcefully, or with too much volume.

5. Ventilate the casualty.

**NOTE:** Mouth-to-mouth is only recommended for family and friends according to American Red Cross.

a. Mouth-to-mask.

(1) Insert an appropriate airway adjunct.

**NOTE:** See tasks 081-000-0034, Place an Oropharyngeal Airway, and 081-COM-1023, Perform First Aid to Open the Airway.

(2) Position yourself at the casualty's side.

(3) Place the mask over the casualty's face, beginning at the bridge of the nose and walking the mask down so that it rests just below the lower lip.

(4) Form a tight seal between the mask and the casualty's face while maintaining a head tilt or jaw thrust.

(5) Administer one breath every 5 to 6 seconds for an adult and every 3 to 5 seconds for a child and infant. Deliver each breath over 1 second, just enough to produce visible chest rise.

(6) Connect the mask to an appropriate oxygen source, if available, at a flow rate of 15 liters per minute (lpm).

**NOTE:** See task 081-000-0073, Administer Oxygen.

b. BVM system one-rescuer method.

**NOTE:** Position yourself directly above the casualty's head.

(1) Insert an appropriate airway adjunct.

**NOTE:** See tasks 081-000-0034, Place an Oropharyngeal Airway, and 081-COM-1023, Perform First Aid to Open the Airway.

(2) Maintain a leak proof mask seal with one hand. Use firm pressure to hold the mask in position and to maintain a seal on the patient's face.

**NOTE:** Perform a head tilt chin lift for one rescuer using the BVM, unless casualty has a suspected spinal injury. Ensure that no pressure is applied to the eyes of the casualty.

(3) Use the E-C technique. Form a C around the ventilation port. Hold your index finger over the lower part of the mask and your thumb over the upper part of the mask. Form the E using the third, fourth, and fifth fingers under the casualty's jaw to hold the mask in place.

**NOTE:** The most difficult part of performing rescue breathing using the BVM system is maintaining an adequate seal. The American Heart Association recommends two rescuer BVM

ventilation; in this method, one rescuer maintains a two-hand seal while the other rescuer squeezes the bag.

(4) Administer one breath every 5 to 6 seconds for an adult and every 3 to 5 seconds for a child and infant. Deliver each breath over 1 second, just enough to produce visible chest rise.

(5) Release pressure from the bag and allow the casualty to exhale passively.

(6) Connect BVM to oxygen at 15 lpm, if available.

**NOTE:** See task 081-000-0073, Administer Oxygen.

c. Ventilate the patient using the two-rescuer method.

**NOTE:** Position yourself directly above the casualty's head.

(1) Insert an appropriate airway adjunct.

**NOTE:** See tasks 081-000-0034, Place an Oropharyngeal Airway, and 081-COM-1023, Perform First Aid to Open the Airway.

(2) Hold the mask in place with two hands.

(a) Place your little, ring, and middle fingers along the mandible.

(b) Place your thumb on the upper portion of the mask above the valve connection.

(c) Place your index finger on the lower portion of the mask under the valve connection.

(3) Have your assistant continue squeezing the bag with two hands every 5 to 6 for an adult and every 3 to 5 seconds for a child and infant.

(4) Connect the mask to an appropriate oxygen source, if available, at a flow rate of 15 lpm.

**NOTE:** See task 081-000-0073, Administer Oxygen.

6. Maintain effective cardiopulmonary resuscitation (CPR).

a. Maintain 30 chest compressions using correct hand placement at the proper rate and depth, allowing for full chest recoil.

**NOTE:** Chest recoil allows blood to flow into the heart. Incomplete chest recoil reduces the filling of the heart between compressions and reduces the blood flow created by chest compressions.

b. Maintain open airway.

c. Maintain two ventilations using a pocket mask (per each compression cycle).

7. Direct additional providers.

a. Maintain uninterrupted CPR.

b. Position additional provider (1) to the opposite side of patient.

c. Position additional provider (2) behind patient's head for mechanical ventilation with BVM.

d. Inform providers for possible role switch upon AED analysis.

8. Apply AED.
   a. Turn on AED (within 15 seconds of arrival of AED).
   b. Apply AED pads to patient IAW manufacturer guidelines.

9. Perform AED analysis.
   a. Ensures all providers are clear while AED analyzes and prepares for shock.
   b. Communicate the word "Clear" aloud to all providers.
   c. Change position with other providers to prevent fatigue (if needed).

10. Administer shock to patient (when prompted by device).
    a. Communicate the word "Clear" aloud to all providers.
    b. Ensures no one is touching the patient.
    c. Deliver shock to patient within 10 seconds (press flashing shock button).
    d. Immediately resume effective CPR.

11. Perform ventilations with BVM.
    a. Apply BVM to patient using E-C hand technique.
    b. Maintain mask seal and open airway in a past-neutral position (neutral position for infants).
    c. Compress BVM giving two ventilations, 1 second per compression, while simultaneously checking for chest rise.
    d. Check for chest rise during each ventilation.
    e. Ensure any interruptions of chest compressions are less than 10 seconds.

12. Communicate plan to switch roles.

13. Perform second AED analysis.
    a. Ensures all providers are clear while AED analyzes and prepares for shock.
    b. Communicate the word "Clear" aloud to all providers.
    c. Change position with other providers to prevent fatigue (if needed).

14. Maintain effective CPR.
    a. Maintain 30 chest compressions using correct hand placement at the proper rate and depth, allowing for full chest recoil.

**NOTE:** Chest recoil allows blood to flow into the heart. Incomplete chest recoil reduces the filling of the heart between compressions and reduces the blood flow created by chest compressions.

    b. Maintain open airway.
    c. Maintain two ventilations using a BVM (per each compression cycle).

15. Communicate plan to switch roles.

16. Perform third AED analysis.
    a. Ensures all providers are clear while AED analyzes and prepares for shock.
    b. Communicate the word “Clear” aloud to all providers.
    c. Change position with other providers to prevent fatigue (if needed).

**WARNING:** Discontinue AED use if pulse is present.

17. Check pulse.
    a. Open the airway.
    b. Check breathing.
    c. Check carotid pulse or femoral pulse for no more than 10 seconds (check brachial pulse for infants).

18. Continue rescue breathing.
    a. Ventilate the casualty at the appropriate rate.
        (1) Adult: 10-12 breaths per minute.
        (2) Children (one year of age to the onset of puberty): 12-20 breaths per minute.
        (3) Infants (less than one year of age): 12-20 breaths per minute.
    b. Watch for rise and fall of the chest with each breath.
    c. Observe for vomiting or secretions in or around the mouth or mask.

**NOTE:** If vomiting or secretions are present suction patient’s upper airway (see task 081-000-0061, Perform Patient Suctioning).

    d. Continue rescue breathing until patient begins to breathe on their own, you have been relieved by another provider, or instructed to stop by licensed medical provider.

19. Perform a secondary assessment.
    a. Listen to the anterior and posterior lung fields with the stethoscope.
    b. Look at the chest and abdomen and note the presence of any retractions.
    c. Check the skin for the presence of cyanosis.
    d. Check the lower extremities for the presence of edema.

20. Obtain a patient history using either signs and symptoms, allergies, medications, past illnesses, last oral intake, events leading up to present illness or injury (SAMPLE) or onset of the event, provocation, quality of the pain, region and radiation, severity, and time (OPQRST).
    a. Ask the patient if there is an existing condition such as asthma.
    b. Ask the patient if they are taking any medications.
    c. Question the patient about allergies to medications.
    d. Ask the patient if difficulty breathing was of sudden or gradual onset.

21. Document treatment performed on SF 600, DD 1380, or EMR.

**Evaluation Preparation:** None

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 1 | Conducted visual survey. | _____ | _____ |
| 2 | Checked for responsiveness. | _____ | _____ |
| 3 | Checked for breathing, pulse, and life-threatening bleeding. | _____ | _____ |
| 4 | Performed chest compressions. | _____ | _____ |
| 5 | Ventilated the casualty. | _____ | _____ |
| 6 | Maintained effective cardiopulmonary resuscitation (CPR). | _____ | _____ |
| 7 | Directed additional providers. | _____ | _____ |
| 8 | Applied AED. | _____ | _____ |
| 9 | Performed AED analysis. | _____ | _____ |
| 10 | Administered shock to patient (when prompted by device). | _____ | _____ |
| 11 | Performed ventilations with BVM. | _____ | _____ |
| 12 | Communicated plan to switch roles. | _____ | _____ |
| 13 | Performed second AED analysis. | _____ | _____ |
| 14 | Maintained effective CPR. | _____ | _____ |
| 15 | Communicated plan to switch roles. | _____ | _____ |
| 16 | Performed third AED analysis. | _____ | _____ |
| 17 | Checked pulse. | _____ | _____ |
| 18 | Continued rescue breathing. | _____ | _____ |
| 19 | Performed a secondary assessment. | _____ | _____ |
| 20 | Obtained the patient history using either signs and symptoms, allergies, medications, past illnesses, last oral intake, events leading up to present illness or injury (SAMPLE) or onset of the event, provocation, quality of the pain, region and radiation, severity, and time (OPQRST). | _____ | _____ |
| 21 | Documented treatment performed on SF 600, DD 1380, or EMR. | _____ | _____ |

**Evaluation Guidance:** None

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
SF 600. *Chronological Record of Medical Care*.

**Related**
None

Treat a Blister Agent Casualty (Mustard, Lewisite, Phosgene Oxime)

081-000-0116

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you observe a casualty under Chemical, Biological, Radiological, Nuclear (CBRN) conditions and recognize sign and symptoms of blister agent poisoning you must treat. You and the casualty are wearing mission-oriented protective posture (MOPP) level 4 gear, you have the casualty's canteen, personal decontamination kit, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*).

**Standards:** Treat a blister agent casualty, without kneeling, in accordance with (IAW) ATP 4-02.7, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Check for the signs and symptoms of blister agent poisoning (mustard [HD], lewisite [L] and phosgene oxime).

**NOTE:** Moist areas of the body are highly susceptible to blister agents. Therefore, during hot weather, blister agents can cause a greater number of casualties. L and phosgene oxime, in contrast to HD, cause immediate pain or irritation to the eyes, skin, or respiratory tract.

a. Skin issues:

**NOTE:** Onset can be delayed from 2-24 hours if contaminated by HD.

(1) Ask about Itching.
(2) Erythema (redness).
(3) Blisters.
(4) Pain.

b. Eyes issues:

**NOTE:** Symptoms can be delayed for up to 1 hour with HD. Symptoms are typically immediate for L.

(1) Mild exposure

**NOTE:** Onset of Signs and symptoms can be delayed from 4-12 hours.

(a) Tearing.
(b) Gritty feeling.
(c) Itchy.
(d) Burning.

(2) Moderate exposure.

**NOTE:** Onset of signs and symptoms can be delayed from 3-6 hours.

(a) Swelling and blistering of eyelids.
(b) Erythema (redness).
(c) Moderate pain.

(3) Severe exposure.

**NOTE:** Onset of signs and symptoms can be delayed from 1-2 hours.

(a) Marked swelling of lids.
(b) Possible cornea damage.
(c) Severe pain.
(d) Permanent blindness (direct contact).

c. Respiratory tract.

**NOTE:** Signs and symptoms can be immediate with L and delayed by 4-6 hours with HD.

(1) Mild.

**NOTE:** Onset of signs and symptoms can be delayed from 12-24 hours.

(a) Runny nose.
(b) Sneezing.
(c) Nosebleed.
(d) Hoarseness.
(e) Hacking cough.

(2) Severe.

**NOTE:** Onset of signs and symptoms can be delayed for up to 2-4 hours.

(a) Severe productive cough.
(b) Shortness of breath.

d. Systemic.
(1) Malaise.
(2) Headache.
(3) Nausea and vomiting.
(4) Severe skin burns.
(5) Bloody diarrhea.

2. Provide treatment.

**CAUTION:** Casualties contaminated with vesicants (blister agents) endanger unprotected attendants. Individuals in contact with these casualties must be at MOPP level 4, plus wear a butyl rubber apron.

a. General treatment.

**NOTE:** If the patient is not displaying symptoms in the eyes (also known as was masked but received skin injury) there is no need to perform eye decontamination.

(1) Inform the casualty to take a deep breath, hold it, and close the eyes.

(2) Lift the casualty's mask.

**CAUTION:** While the eyes are being irrigated, the breath should be held, and the mouth kept closed to prevent contamination and absorption through mucous membranes.

(3) Irrigate the casualty's eyes (if contamination has occurred).

(a) Use water from the casualty's canteen.

**NOTE:** If the casualty's water has been contaminated, use sterile water or sterile normal saline from the aid bag.

(b) Tilt the casualty's head to one side.

(c) Tell the casualty to open the eyes as much as possible.

(d) Pour water slowly into one eye.

(e) To avoid spreading contamination, let the water run off the side of the face.

(f) Repeat steps 3a through 3e for the other eye.

**NOTE:** It may be necessary for the casualty to re-mask and take additional breaths if unable to hold the breath until both eyes are irrigated.

(4) Use the casualty's personal decontamination kit on both the face and the portion of the mask in contact with the face and exposed skin.

(5) Irrigate other contacted surfaces of the skin.

(6) For exposure in the throat, monitor the patient for the closing of the airway. Introduce artificial airway if necessary.

b. Treatment for HD or L.

**NOTE:** Include treatment for blisters, see ATP 4-02.7.

(1) Skin.

(a) Local dressings.

(b) Antibiotics for infection.

(2) Respiratory infection.

(c) Check airway patency. (Mask)

(d) Intravenous antibiotic fluids.

c. Treatment for phosgene oxime.

(1) Skin.

(a) Apply dressings of sodium bicarbonate systemic analgesics.

(b) Treat as any other necrotic skin lesion.

(2) Central nervous system.

(a) Anxiety.

(b) Depression.

3. Complete post-decontamination procedures.

**WARNING:** Patient should be re-masked as soon as eye and face decontamination is complete; and NOT wait until after skin decontamination is performed.

   a. Replace the casualty's mask.
   b. Inform the casualty to clear and check the mask.
   c. Inform the casualty to breathe normally.

4. Document treatment on DD Form 1380.
   a. Date and time.
   b. Injury characteristics.
   c. Equipment used.
   d. Treatment employed.
   e. Patient tolerance of procedure.
   f. Difficulties and complications during procedure.
   g. Plan for future care.

5. Evacuate the casualty, if necessary.
   a. Position the casualty.
      (1) Conscious – in a comfortable position, preferably sitting.
      (2) Unconscious – on the injured side.
   b. Evacuate the casualty.
      (1) Continue to assess the casualty until evacuated.
      (2) The casualty should be evacuated by the most expedient means available.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Checked for the signs and symptoms of blister agent poisoning (mustard [HD], lewisite [L] and phosgene oxime). | _____ | _____ |
| 2 | Provided treatment. | _____ | _____ |
| 3 | Completed post-decontamination procedures. | _____ | _____ |
| 4 | Documented treatment on DD Form 1380. | _____ | _____ |
| 5 | Evacuated the casualty, if necessary. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
ATP 4-02.7. *Multi-Service Tactics, Techniques, and Procedures for Health Service Support in a Chemical, Biological, Radiological, and Nuclear Environment*.
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.

**Related**
None

Treat a Radiation Casualty

081-000-0118

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment and are required to treat a casualty with symptoms consistent with radiological exposure. You have a fully stocked aid bag, intravenous (IV) administration equipment and fluids, oxygen, suction and ventilation equipment, selected medications, DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*), or electronic medical record (EMR), and personal chemical protective equipment.

**Standards:** Treat a radiation casualty in accordance with, ATP 4-02.83, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Perform an assessment of the casualty to identify any conventional injuries.

**NOTE:** When assessing casualties during nuclear detonation and radiation injuries, it is important to realize that this is a multiple-casualty incident and should be approached from a triage perspective.

2. Recognize the course of radiation sickness on various systems in the body.
   a. Hematopoietic (bone marrow and blood cells).
      (1) Initial stage (occurs 1 hour to 2 days after exposure) – symptoms are anorexia, nausea, vomiting, fatigue, malaise, clotting disorders, and possible uncontrolled hemorrhage.

**NOTE:** Occurs 1 hour to 2 days after exposure.

      (2) Latent stage (lasts 1 to 6 weeks) – casualty may appear and feel well, although stem cells are dying.
   b. Gastrointestinal (GI) (bowel).
      (1) Initial stage (lasts about 2 days) – nausea and vomiting, loss of appetite, diarrhea, fluid loss, malaise, and dehydration.
      (2) Latent stage (lasts less than 1 week) – casualty may appear and feel well, although cells lining the GI are dying.
   c. Cardiovascular (CV) and central nervous system.
      (1) Initial stage (occurs within minutes of exposure and lasts for minutes to hours) – rapid onset of incapacitation, CV collapse, confusion, burning or “on fire” sensation with high doses.
      (2) Latent stage (may last for hours) – casualty may return to partial functionality.
   d. Skin-symptoms reddening of skin (erythema).

**NOTE:** Duration of symptoms vary with the level of exposure; at low doses incapacitation should not be severe enough to warrant evacuation.

e. Effect on overall body during clinical phase.

**NOTE:** Symptoms frequently occur in the whole-body irradiated casualties within the first few hours of post exposure.

(1) Nausea and vomiting occur with increasing frequency as the radiation exceeds 100-200 centigrays (cGy).

(a) Onset may be as long as 6 to 12 hours post exposure.

(b) Vomiting within the first hours is associated with fatal doses.

(2) Hyperthermia.

(a) Significant rise in body temperature within the first few hours of potentially lethal radiation injury.

(b) Fever and chills are associated with severe and life-threatening radiation dose.

(3) Erythema.

**NOTE:** Developed within the first day of post exposure if casualty received a whole-body dose of more than 1000-2000 cGy. Erythema is restricted to the affected area.

(4) Hypotension.

(a) A noticeable decline in systemic blood pressure if received a lethal dose of whole-body radiation.

(b) Severe hypotension after irradiation is associated with a poor prognosis.

(5) Neurologic dysfunction.

(a) Almost all persons who demonstrate obvious signs of damage to the central nervous system within the first hour's post exposure have received a lethal dose.

(b) Symptoms include mental confusion, seizures, and coma.

3. Treat conventional injuries first.

4. Remove the casualty's clothing (if radiation is present).

5. Wash exposed body surfaces with soap and water.

6. Start an IV.

7. Administer antibiotics as appropriate.

8. Provide supportive care for the casualty depending on the situation.

**NOTE:** The number of supplies required by radiation casualties can exceed the capabilities of small clinics. Consider the chance of survival of the casualty and the number of supplies on hand when providing supportive care for the casualties.

9. Record treatment on a DD Form 1380 or EMR.

10. Transport the casualty.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Performed an assessment of the casualty to identify any conventional injuries. | _____ | _____ |
| 2 | Recognized the course of radiation sickness on various systems in the body. | _____ | _____ |
| 3 | Treated conventional injuries first. | _____ | _____ |
| 4 | Removed the casualty's clothing (if radiation was present). | _____ | _____ |
| 5 | Washed exposed body surfaces with soap and water. | _____ | _____ |
| 6 | Started an IV. | _____ | _____ |
| 7 | Administered antibiotics as appropriate. | _____ | _____ |
| 8 | Provided supportive care for the casualty depending on the situation. | _____ | _____ |
| 9 | Recorded treatment on a DD Form 1380 or EMR. | _____ | _____ |
| 10 | Transported the casualty. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
ATP 4-02.83. *Multiservice Tactics, Techniques, and Procedures for Treatment of Nuclear and Radiological Casualties*.
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.

**Related**
None

Treat a Nerve Agent Casualty

081-68W-0275

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have a casualty displaying signs and symptoms of nerve agent poisoning. You are in mission-oriented protective posture level 4. You have a medical aid bag, MARK I nerve agent antidote kits (NAAK) or antidote treatment nerve agent (ATNNA) auto-injectors, convulsant antidote for nerve agents (CANA) auto-injectors, DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*), and decontamination litter.

**Standards:** Treat a nerve agent casualty in accordance with ATP 4-02.85, *Tactical Combat Casualty Care (TCCC) Guidelines* and *Committee on Tactical Combat Casualty Care (CoTCCC)*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Assess the casualty for the signs and symptoms of nerve agent poisoning.

**NOTE:** If the casualty has been exposed to vapor or aerosol, the pupils will become pinpointed immediately. However, if the nerve agent is absorbed through the skin only or by ingesting contaminated food or water, the pinpointing of the pupils may be delayed or absent.

a. Vapor exposure.

**NOTE:** Effects from vapor exposure will occur within seconds to minutes after being exposed. Some of the respiratory distress from a mild exposure will spontaneously decrease within 15 to 30 minutes after termination of exposure.

(1) Mild (small exposure).

**NOTE:** Exposure to small amount of vapor for a brief period usually causes effects in the eyes, nose, and lungs.

(a) Unexplained runny nose.
(b) Unexplained sudden headache.
(c) Sudden and excessive salivation (drooling).
(d) Difficulty in seeing (dimness of vision and miosis [constricted pupils]).
(e) Tightness in the chest or difficulty in breathing.
(f) Stomach cramps.
(g) Nausea with or without vomiting.
(h) Tachycardia or bradycardia.

(2) Severe (large exposure).

**NOTE:** Severe exposure includes all the mild or moderate symptoms.

**NOTE:** Effects may occur after one breath but normally take place within several seconds of a large vapor exposure.

(a) Fatigue and weakness.
(b) Red eyes with tearing.
(c) Convulsions (severe muscular twitching).
(d) Copious secretions from nose, mouth, and lungs.
(e) Strange or confused behavior.
(f) Wheezing, dyspnea, and coughing.
(g) Severely pinpointed pupils.
(h) Vomiting.
(i) Involuntary urination and defecation.
(j) Sudden loss of consciousness.
(k) Respiratory failure.
(l) Bradycardia.
(m) Flaccid paralysis.

b. Skin (percutaneous) exposure.

**NOTE:** It is difficult to separate this type of exposure into categories due to the continued absorption of nerve agent into skin layers. Due to continued absorption, the effects from the nerve agent may be progressive in nature. They may occur from minutes up to 18 hours after exposure and continue even after the skin has been decontaminated. The greater the amount of exposure to nerve agent, the shorter the onset time of symptoms with increased severity.

(1) Mild exposure.
(a) Localized sweating at the exposure site.
(b) Muscular twitching at the exposure site.
(c) Stomach cramps, nausea, and vomiting.
(d) Fatigue.
(e) Weakness.

(2) Severe exposure.
(a) All or most of the mild symptoms.
(b) Sudden loss of consciousness.
(c) Vomiting.
(d) Convulsions and severe muscle twitching.
(e) Flaccid paralysis.
(f) Loss of bladder and bowel control.
(g) Severe breathing difficulty or cessation of respiration.

**NOTE:** Death would be the result of complete respiratory system failure.

2. Apply mask on the casualty.
a. Instruct the casualty to mask self if they are able.

**CAUTION:** Do not kneel or come into unnecessary contact with the chemically contaminated ground or any visible liquids.

b. Position the casualty face up and mask the casualty if the casualty is unable to mask themself. Do not fasten the hood at this time.

3. Check the casualty's pocket flaps and the area around the casualty for expended auto-injectors.

4. Administer the antidote and place the used canister in the left pocket of the sleeve or chest.

**NOTE:** Atropine is the drug of choice for treating nerve agent poisoning.

a. Mild symptoms. Instruct the casualty to administer one to two MARK I NAAK or one ATNAA depending on the severity of symptoms, followed by observation for several long hours.

**NOTE:** ATNAA contain dual chambers, which administer 2.1 milligram (mg) atropine and 600 mg 2-Pam Cl (pralidoxime chloride) sequentially through one needle.

b. Severe symptoms. Administer three MARK I NAAK or ATNAA and one CANA (diazepam) auto-injector to the casualty.

**NOTE:** Removal of any liquid nerve agent on the skin, on clothing, or in the eyes should be accomplished as soon as possible after administration of the antidote. Decontamination should be performed by the casualty, if able, or by a buddy.

5. Check the casualty for signs of effectiveness of treatment.

**NOTE:** The casualty should be observed for at least several hours and not returned to duty. Liquid exposures can cause symptoms with onset delayed by many hours.

a. Atropinization.
   (1) Heart rate above 90 beats per minute.
   (2) Reduced bronchial secretions and bronchial constriction (patient breathes easily without excess secretions complicating breathing).
   (3) Reduced salivation.
   (4) Decreased gastrointestinal motility.

b. Cessation of seizure.

6. Administer additional atropine or CANA, if needed and place the used canister in the left pocket of the sleeve or chest.

a. After the administration of the three MARK I NAAK, additional auto-injectors are not administered until an hour later.

b. Administer additional atropine (2 mg) at approximately 5-minute intervals until atropinization is achieved.

c. A total of 15 to 20 mg of atropine may be required in the first 3 hours after the onset of symptoms to maintain atropinization or until the casualty is evacuated to a medical treatment facility (MTF).

**CAUTION:** Do not give more than two additional CANA injections for a total of three.

d. Administer a second and, if needed, a third CANA at 5- to 10-minute intervals to casualties suffering convulsions.

**NOTE:** Additional atropine and the two additional CANA injections can be administered by a combat lifesaver, the Soldier medic, or other medical personnel (diazepam is not for self-use).

e. Ensure all expended auto-injectors are secured to the casualty's left upper pocket of the Army combat uniform or the left pocket on the sleeve of the joint service lightweight integrated suit technology over garment (which has no pockets on the upper torso portion of the garment).

7. Provide assisted ventilation for severely poisoned casualties if equipment is available.

**NOTE:** The resuscitation device, individual chemical is a hand-powered ventilator equipped with a chemical, biological, radiological, nuclear, and explosives filter. When the casualty reaches an MTF where oxygen and a positive pressure ventilator are available, these should be employed continuously until adequate spontaneous respiration is resumed.

8. Record the number of injections given and all other treatment provided on the DD Form 1380.

9. Evacuate the casualty.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Assessed the casualty for the signs and symptoms of nerve agent poisoning. | _____ | _____ |
| 2 | Applied mask on the casualty. | _____ | _____ |
| 3 | Checked the casualty's pocket flaps and the area around the casualty for expended auto-injectors. | _____ | _____ |
| 4 | Administered the antidote and placed the used canister in the left pocket of the sleeve or chest. | _____ | _____ |
| 5 | Checked the casualty for signs of effectiveness of treatment. | _____ | _____ |
| 6 | Administered additional atropine or CANA, if needed and placed the used canister in the left pocket of the sleeve or chest. | _____ | _____ |
| 7 | Provided assisted ventilation for severely poisoned casualties if equipment was available. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 8 | Recorded the number of injections given and all other treatment given on the DD Form 1380. | _____ | _____ |
| 9 | Evacuated the casualty. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
ATP 4-02.85. *Multi-Service Tactics, Techniques, and Procedures for Treatment of Chemical Warfare Agent Casualties and Conventional Military Chemical Injuries*. *Clinical Patient Guidelines*.
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
Joint Trauma System website.
*Tactical Combat Casualty Care (TCCC) Guidelines*.

**Related**
None

## Subject Area 5: Medication Management

Treat an Allergic Reaction

081-000-0032

**WARNING:** Allergic reactions occur within minutes or even seconds after contact with the substance to which the casualty is allergic. Reactions occur in the skin, respiratory system, and circulatory system.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you are required to treat an allergic reaction. All other immediate life threats have been assessed and treated. You have been provided with the casualty's epinephrine auto-injector (pediatric or adult), stethoscope, sphygmomanometer, alcohol pads, bag-valve-mask system, oxygen equipment, ink pen, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*) or electronic medical record.

**Standards:** Treat an allergic reaction in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Assess the casualty's mental status using the alert, verbal, pain, unresponsive scale.
2. Assess the airway.
    a. Perform an appropriate maneuver to open and maintain the airway, if necessary.
    b. Check for sputum (may be blood tinged).
    c. Check for edema (swelling) in mouth, tongue, and throat.
    d. Insert an appropriate airway adjunct, if necessary.
3. Assess breathing.
    a. Tightness or pain in the chest.
    b. Sneezing and coughing.
    c. Wheezing, stridor, or difficulty in breathing (dyspnea).
    d. Respiratory failure.
4. Administer oxygen, if necessary, using appropriate delivery device or ventilation (see task 081-000-0073, Administer Oxygen).
5. Assess circulation.
    a. Check skin color, temperature, and moisture.
        (1) Flushed or ashen.
        (2) Burning or itching.
        (3) Edema.
        (4) Urticaria (hives) spreading over the body.

(5) Marked swelling of the lips and cyanosis about the lips.

b. Assess the pulse for rhythm and force.

c. Check for major bleeding.

d. Control major bleeding.

e. Assess blood pressure.

f. Treat for shock.

6. Conduct a rapid physical exam if the patient is unconscious. Inspect for each of the following areas for deformities, contusions, abrasions, punctures or penetration, burns, tenderness, lacerations, and swelling.

a. Assess the head.

b. Assess the neck.

c. Assess the chest.

d. Assess the abdomen.

e. Assess the pelvis.

f. Assess the extremities.

g. Assess the posterior.

7. Conduct a focused history exam.

**NOTE:** For example, if patient is conscious look for signs and symptoms of anaphylactic shock.

a. Gather history of the signs and symptoms, allergies, medications, pertinent past medical history, last oral intake, and event(s) leading up to illness or injury.

b. Gather history of the present illness onset, provocation, quality, radiation, severity, and time and intervention(s), from the casualty.

8. Administer epinephrine auto-injector, if necessary.

9. Provide supportive measures for the treatment of shock, respiratory failure, circulatory collapse, or cardiac arrest.

a. Position the casualty in the supine position with legs elevated if injuries permit.

b. Cover the casualty in a blanket.

c. Perform rescue breathing, if necessary.

d. Administer external chest compressions, if necessary.

10. Assess vital signs every 5 minutes.

11. Document care given, vital signs, interventions, and response to intervention(s).

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|
| 1 Assessed the casualty's mental status using the alert, verbal, pain, unresponsive scale. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 2 | Assessed the airway. | _____ | _____ |
| 3 | Assessed breathing. | _____ | _____ |
| 4 | Administered oxygen, if necessary, using appropriate delivery device or ventilation (see task 081-000-0073, Administer Oxygen). | _____ | _____ |
| 5 | Assessed circulation. | _____ | _____ |
| 6 | Conducted a rapid physical exam if the patient was unconscious. Inspected for each of the following areas for deformities, contusions, abrasions, punctures or penetration, burns, tenderness, lacerations, and swelling. | _____ | _____ |
| 7 | Conducted a focused history exam. | _____ | _____ |
| 8 | Administered epinephrine auto-injector, if necessary. | _____ | _____ |
| 9 | Provided supportive measures for the treatment of shock, respiratory failure, circulatory collapse, or cardiac arrest. | _____ | _____ |
| 10 | Assessed vital signs every 5 minutes. | _____ | _____ |
| 11 | Documented care given, vital signs, interventions, and response to intervention(s). | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
*Tactical Combat Casualty Care (TCCC) Guidelines*.

**Related**
None

Manage Intravenous Access

081-000-0038

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have a patient who requires an intravenous (IV) infusion. You will need appropriate dressing material, sterile gauze, saline lock kit, IV administration set, IV solution, tape, exam gloves, SF 600 (*Chronological Record of Medical Care*), electronic medical record (EMR), and DD Form 792 (*Nursing Service - Twenty-Four Hour Patient Intake and Output Worksheet)*.

**Standards:** Manage IV access in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines* while adhering to all warnings and cautions, without causing further harm to the patient, using the task GO/NO GO checklist.

**Performance Steps:**

1. Take BSI.
2. Prepare equipment.
3. Select the infusion site.
   a. Choose the most distal and accessible vein of an uninjured arm or hand.
   b. Select a vein large enough to accommodate the size of needle and catheter to be used.
4. Apply constricting band.
5. Cleanse site with alcohol wipe.
6. Hold skin taut distal to the site of venipuncture with nondominant hand.
7. Hold needle at a 20-30-degree angle, bevel up, over top of the venipuncture site.
8. Insert needle and catheter into vein.
   a. Pierce skin with needle and catheter until blood is visualized in the flash chamber.
   b. Decrease angle of needle and catheter to 10-15 degrees and advance 1/8 of an inch.
   c. Advance the catheter until the hub touches the skin or until significant resistance is felt.
9. Release the constricting band with the nondominant hand.
10. Place pressure on the vein with the nondominant hand.
11. Remove the needle and place it in a sharps container.
12. Apply saline lock.

**NOTE:** Apply a saline lock if the casualty is not in immediate need of fluid resuscitation or IV medications.

a. Place a transparent dressing over both hub and saline lock.
b. Clean saline lock with alcohol wipe.
c. Aspirate and flush site with five milliliters (ml) of sterile IV solution.

13. Prepare equipment for IV fluid resuscitation.

**NOTE:** An IV bag container may be placed under the patient's body if there is no way to hang it. You must completely fill the drip chamber if you place it under the patient's body to prevent air from entering the tubing.

a. Move the flow regulator six to eight inches below the drip chamber and tighten and close it.
b. Remove the protective covers from the spike and from the outlet of the IV container.
c. Push the spike firmly into the container's outlet tube.
d. Hang the container at least two feet above the level of the patient's heart, if possible.
e. Squeeze the drip chamber until it is half full of the IV fluid.
f. Ensure all air is expelled from the tubing by opening flow regulator and allowing fluid to flow to the end of the tubing.
g. Tighten and close the flow regulator once all air in line has been expelled.

14. Place IV catheter (repeat steps 1-11).

**NOTE:** If saline lock was previously applied, place needle and catheter in saline lock to gain IV access.

15. Remove the protective cover from the needle adapter on the tubing.

16. Connect the adapter to the catheter or needle hub.

17. Adjust the flow rate to keep the vein open or to keep open.

18. Secure IV tubing to casualty.

19. Check for signs and symptoms of IV therapy complications.
a. Infiltration – accumulation of fluids in the tissue surrounding an IV needle site.
b. Phlebitis – inflammation of the wall of the vein (usually caused by long term IV therapy).
c. Air embolism – obstruction of a blood vessel by air carried via the bloodstream (usually occurring in the lungs or heart).

20. Record the procedure on the SF 600, DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)* or EMR.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 1 | Took BSI. | _____ | _____ |
| 2 | Prepared equipment. | _____ | _____ |
| 3 | Selected the infusion site. | _____ | _____ |
| 4 | Applied constricting band. | _____ | _____ |
| 5 | Cleansed site with alcohol wipe. | _____ | _____ |
| 6 | Held skin taut distal to the site of venipuncture with nondominant hand. | _____ | _____ |
| 7 | Held needle at a 20-30-degree angle, bevel up, over top of the venipuncture site. | _____ | _____ |
| 8 | Inserted needle and catheter into vein. | _____ | _____ |
| 9 | Released the constricting band with the nondominant hand. | _____ | _____ |
| 10 | Placed pressure on the vein with the nondominant hand. | _____ | _____ |
| 11 | Removed the needle and placed it in a sharps container. | _____ | _____ |
| 12 | Applied saline lock. | _____ | _____ |
| 13 | Prepared equipment for IV fluid resuscitation. | _____ | _____ |
| 14 | Placed IV catheter (repeated steps 1-11). | _____ | _____ |
| 15 | Removed the protective cover from the needle adapter on the tubing. | _____ | _____ |
| 16 | Connected the adapter to the catheter or needle hub. | _____ | _____ |
| 17 | Adjusted the flow rate to keep the vein open or to keep open. | _____ | _____ |
| 18 | Secured IV tubing to casualty. | _____ | _____ |
| 19 | Checked for signs and symptoms of IV therapy complications. | _____ | _____ |
| 20 | Recorded the procedure on the SF 600, DD Form 1380, or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**

DD Form 792. *Nursing Service - Twenty-Four Hour Patient Intake and Output Worksheet*.
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Treat a Poisoned Casualty

081-000-0025

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, treat a poisoned casualty. You have a patient that has been poisoned and all other more serious injuries have been assessed and treated. You have taken standard precautions and have performed an initial assessment. You will be provided with activated charcoal, airway adjuncts, oxygen, water source, suction equipment, and a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*) or electronic medical record (EMR).

**Standards:** Treat a poisoned casualty in accordance with *Joint Trauma System Clinical Practice Guidelines* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

**CAUTION:** If determination cannot be made to the type of poisoning, the casualty should be treated by the symptoms presented.

1. Determine the type of poisoning.
    a. Ingested poisons.
        (1) Altered mental status.
        (2) Nausea or vomiting.
        (3) Abdominal pain.
        (4) Diarrhea.
        (5) Chemical burns around the mouth.
        (6) Unusual breath odors.
    b. Inhaled poisons.
        (1) Carbon monoxide.
            (a) Headache.
            (b) Dizziness.
            (c) Dyspnea.
            (d) Nausea or vomiting.
            (e) Cyanosis.
            (f) Coughing.
        (2) Smoke Inhalation.
            (a) Dyspnea.
            (b) Coughing.
            (c) Breath that has a smoky smell or the odor of chemicals involved at the scene.
            (d) Black residue in any sputum coughed up by the casualty.
            (e) Nose hairs singed from super-heated air.

c. Injected poisons.
   (1) Sympathomimetics (uppers – for example, cocaine).
      (a) Excitement.
      (b) Tachycardia.
      (c) Tachypnea.
      (d) Dilated pupils.
      (e) Sweating.
   (2) Sedative-Hypnotics (downers – for example, diazepam and alprazolam).
      (a) Sluggish.
      (b) Sleepy typical coordination of body and speech.
      (c) Pulse and breathing rates are low, often to the point of a true emergency.
   (3) Hallucinogens.
      (a) Tachycardia.
      (b) Dilated pupils.
      (c) Flushed face.
      (d) Often sees or hears things, has very little concept of time.
   (4) Narcotics.
      (a) Reduced rate of breathing.
      (b) Dyspnea.
      (c) Low skin temperature.
      (d) Muscles relaxed.
      (e) Pinpoint pupils.
      (f) Very sleepy.
d. Absorbed poisons.
   (1) Liquid or powder on the casualty's skin.
   (2) Burns.
   (3) Itching.
   (4) Irritation.
   (5) Redness.

2. Initiate treatment for the poisoned casualty.
   a. Ingested poisons.
      (1) Maintain the airway.
      (2) Gather all information about the type of ingested poisoning.

**CAUTION:** Activated charcoal is contraindicated for casualties that have an altered mental status, that you suspect have swallowed acids or alkalis, or that are unable to swallow.

      (3) Administer activated charcoal.

**NOTE:** Be prepared to provide oral suctioning if the casualty starts to vomit. All vomitus must be saved.

(a) Adults and children: 1 gram (g) of activated charcoal per kilogram (kg) of body weight.

(b) Usual adult dose: 25-50 g.

(c) Usual pediatric dose: 12.5-25 g.

(4) Give supplemental oxygen.

(5) Record the name, dose, and time of administration of medication.

(6) Transport to the nearest medical treatment facility.

b. Inhaled poisons.

(1) Remove the casualty from the unsafe environment.

(a) Maintain the airway.

(b) Administer high concentrations of oxygen.

**NOTE:** This is the most important treatment for inhalation poisoning.

(2) Transport to the nearest medical treatment facility.

(3) Document interventions.

c. Injected poisons.

(1) Maintain the airway and be prepared to provide assisted ventilations.

(2) Give supplemental oxygen.

(3) Look for gross soft tissue damage (“tracks”).

(4) Protect the casualty from harming self and others.

**NOTE:** Be prepared to use restraints.

(5) Transport to the nearest medical treatment facility.

d. Absorbed poisons.

(1) Remove the casualty from the source.

(2) Remove contaminated clothing.

(3) Brush off any powders from the casualty’s skin.

(4) Flush the skin with large amounts of water for at least 20 minutes.

3. Document procedures using DD Form 1380 or EMR.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Determined the type of poisoning. | _____ | _____ |
| 2 | Initiated treatment for the poisoned casualty. | _____ | _____ |
| 3 | Documented procedures using DD Form 1380 or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or

parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Joint Trauma System Clinical Practice Guidelines website.

**Related**
None

Administer Medication

081-000-1006

**WARNING:** Do not leave a medication tray, package, or cup within the reach of patient. If you must leave the room, take the medication with you.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you are given the medical provider's orders to administer medication to a patient and the patient's medical records. You will need the prescribed medication, you may have available: calibrated disposable medicine cups, tray, non-sterile gloves, sterile gauze, sterile normal saline, tongue depressor, sterile medication chamber T-piece, corrugated tubing, non-rebreather mask, airflow tubing, a source of compressed air or oxygen with flowmeter, nebulizer kit, metered dose inhaler mouthpiece, DA Form 4678, (*Therapeutic Documentation Care Plan (Medication)),* DA Form 3949, (*Controlled Substances Record*), DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions*), electronic medical record (EMR), and a pen. A patient care handwash has been performed.

**Standards:** Administer medications in proper sequence, without error or causing any further harm to the patient, while adhering to all warnings and cautions in accordance with (IAW) the medical provider's orders *Tactical Combat Casualty Care (TCCC) Guidelines* and *Clinical Practice Guidelines*, and utilizing the GO/NO GO criteria.

**Performance Steps:**

1. Confirm the medical provider's orders.

**NOTE:** Always use BSI precautions when administering common medications, at a minimum gloves and eye protection.

   a. Right medication.
   b. Right dose of medication.
   c. Right patient.
   d. Right route of administration.
   e. Right time to be administered.

2. Select the right medication.

**NOTE:** Take the DA Form 4678 with you when giving medications. This provides a means for a final check before giving the medication(s). This also allows you to document the administration before leaving the patient and prevents forgetting to document or documenting on the wrong patient's DA Form 4678.

   a. Check the medication label three times to ensure that the correct medication is being prepared for administration.
      (1) First time–when removing the container from the storage shelf.

(2) Second time–when preparing the medication dose.
(3) Third time–when returning the container to the storage shelf.

b. Check the expiration date of the medication.
c. Handle only one medication at a time.

**NOTE:** Repeat step 2 if the patient requires multiple medications.

3. Validate the right dose of medication.

**WARNING:** If unfamiliar with a medication, use reference to determine contraindications, precautions, and side effects before preparing it for administration.

a. Calculate the amount of medication required to equal the prescribed dose.
b. Prepare the prescribed dose of medication.
c. Keep all unit-dose medications in their individual packages until you are with the patient.

4. Confirm the right patient.
   a. Ask patient for their full name.
   b. Check patient's identification band, Department of Defense identification number.
   c. Have patient state their date of birth.
   d. Ask patient about any allergies.

**NOTE:** Checking for allergies is essential to prevent patient injury. Allergies include foods and latex.

(1) Check patient's clinical records for allergies.
(2) Check patient's wrist for allergy bands or bracelet(s).

5. Explain the procedure to the patient.

6. Select the right route of administration.
   a. Oral medication.
      (1) Capsule or tablet.
      (2) Powder or liquid.
   b. Buccal or sublingual medication.
      (1) Capsule or tablet.
      (2) Dissolvable film or gel.
   c. Nasal medication.
      (1) Aerosolized or powdered inhalation medication.
      (2) Nose drop or spray.
      (3) Ointment.
   d. Ocular medication.
      (1) Drops.
      (2) Ophthalmic ointment.

e. Otic medication.
f. Dermal medication.
   (1) Topical cream or lotion or ointment.
   (2) Transdermal patch.
g. Injectable medication.
   (1) Intradermal (ID).
   (2) Intramuscular (IM).
   (3) Subcutaneous (SQ).
h. Intravenous (IV) medication.
   (1) IV push (IVP).
   (2) IV piggyback (IVPB).
   (3) Intraosseous (IO).
i. Rectal or vaginal medication.
   (1) Suppository.
   (2) Enema.
   (3) Cream or ointment.
   (4) Vaginal irrigation or douche.

7. Confirm the right time.

8. Wash your hands, follow standard precautions, and obtain vital signs (as applicable based on medication to be administered).

9. Administer medications.
   a. Administer oral medication.
      (1) Prepare the prescribed dose of medication.
         (a) Tablets or capsules. Transfer the prescribed dose of tablets or capsules to the medicine cup.
         (b) Liquids. Pour the prescribed dose of liquid medication into the medicine cup.

**NOTE:** Small amount of liquid medication should be drawn up in a syringe.

         (c) Powders.
            _1_ Pour the correct dose of powdered or granulated medication into the medicine cup.
            _2_ Dissolve prescribed dose of powdered or granulated medication into appropriate liquid.
      (2) Position patient sitting or lying with head elevated.
   b. Administer buccal or sublingual.

**WARNING:** If the patient smokes, tell them not to do so before the drug has dissolved because nicotine's vasoconstrictive effects slow absorption.

**CAUTION:** Do not give liquids to a patient receiving buccal medications because some buccal tablets can take up to 1 hour to be absorbed.

(1) Prepare the prescribed dose of medication.

(a) Place the tablet, film, or gel in the buccal pouch (between the cheek and gum).

**NOTE:** Alternate sides of the mouth for repeat doses to prevent continuous irritation of the same site.

(b) Sublingual administration (place the tablet, film, or gel under the patient's tongue).

**NOTE:** Instruct patient to keep medication in place until it is fully dissolved. Caution patient against chewing medication or touching with their tongue to prevent accidental swallowing.

(2) Position patient sitting or lying with head elevated.

**NOTE:** Alternate sides of the mouth for repeat doses to prevent continuous irritation of the same site.

c. Administer nasal medication.

(1) Prepare the prescribed dose of medication.

(2) Administer the prescribed medication to the patient.

**WARNING:** Remind the patient using a translingual aerosol form that they should not inhale the spray but should release it under tongue. Also tell them to wait 10 seconds or so before swallowing.

(a) Administer aerosolized and powdered respiratory medications.

**NOTE:** Avoid treatments immediately before and after meals. This helps decrease the chance of vomiting or appetite suppression, especially with medications that cause the patient to cough or expectorate or those that are taken in conjunction with percussion and bronchial drainage.

_1_ Small volume nebulizer.

_a_ Assemble equipment according to manufacturer's instructions.

_b_ Add the prescribed medication and diluent to the nebulizer.

_c_ Have the patient hold the mouthpiece between the lips using gentle pressure.

_d_ Turn the nebulizer on and set the driving air or oxygen to manufacturer's recommended setting.

_e_ Ask the patient to take a slow deep breath, pause, and exhale passively.

_f_ Observe to determine if a mist forms. If a mist does not form, the nebulizer is not operating correctly.

_g_ Monitor for tachycardia during medication administration.

_h_ Tap the nebulizer cup periodically to prevent obstruction.

_i_ Turn off the compressor or oxygen when administration is complete.

_j_ Encourage the patient to rinse their mouth after treatment is complete, especially if steroids were used.

_k_ Reset oxygen to the prescribed rate if ordered.

_2_ Inhaler with a spacing device.

_a_ Shake the inhaler.

_b_ Remove the mouthpiece cover.

_c_ Insert the metered dose inhaler into the spacer device.

_d_ Have the patient place in mouth and close lips.

_e_ Instruct the patient to breathe normally through the spacer device mouthpiece.

_f_ Have the patient depress the canister one time.

_g_ Ask the patient to breathe in slowly for 5 seconds.

_h_ Have the patient hold their breath for 5 to 10 seconds and then slowly exhale.

_i_ Wait the appropriate interval and repeat the procedure for the prescribed number of puffs.

_3_ Dry powder inhaler.

_a_ Have the patient hyperextend the neck.

_b_ Ask the patient to place their lips around the mouth of the dispenser, creating an airtight seal.

_c_ Have the patient depress the canister while taking a quick deep breath.

_d_ Instruct the patient to hold their breath for 10 seconds.

_e_ Have the patient exhale slowly through pursed lips.

_f_ Instruct the patient to wait instructed amount of time between puffs, if more than one puff is ordered.

_4_ Liquid metered dose inhaler.

_a_ Ensure the patient is in an upright position.

_b_ Insert the medication canister stem down into the longer part of the metered dose dispenser.

_c_ Hold the canister upright and shake to mix the medication and propellant before each use.

_d_ Remove the mouthpiece cover and have the patient hold the mouthpiece 2 inches from their mouth.

_e_ Have the patient take a deep breath through pursed lips and then exhale to promote greater inspiratory volume.

_f_ Instruct the patient to place inhaler mouthpiece between lips, and inhale slowly through the mouth as the canister is depressed. Have the patient inhale fully.

_g_ Instruct the patient to hold their breath for 10 seconds and then exhale slowly through pursed lips.

_5_ Evaluate the patient’s response to treatment and report unexpected outcomes to the medical provider.

(b) Administer nasal drop or spray medication.

_1_ Nose drops.

_a_ Instruct patient to gently blow their nose.

_b_ Position the patient sitting or lying with the head tilted back.

_c_ Have the patient hold a paper tissue for expectoration of secretions.

_d_ Instruct the patient to breathe through the mouth.

**NOTE:** Do not allow the dropper to touch the nares because it may cause the patient to sneeze.

_e_ Hold the dropper with medication just above the nostril and instill the medication. Repeat the procedure for the other nostril, if needed.

_f_ Instruct the patient to remain in position with the head titled back to prevent escape of the solution.

_2_ Nasal spray.

_a_ Instruct patient to gently blow their nose.

_b_ Position the patient sitting or lying with the head tilted back.

_c_ Block one nostril.

_d_ Hold the bottle upright, shake it well, and insert it into the nostril.

_e_ Ask the patient to breathe in as the bottle is squeezed.

_f_ Instill the prescribed number of sprays.

_g_ Repeat the procedure for the other nostril, if indicated.

(c) Administer nasal ointment medication.

_1_ Instruct patient to gently blow their nose.

_2_ Position the patient sitting or lying with the head tilted back.

_3_ Insert prescribed dose into the nostril. (Repeat with second nostril if indicated).

_4_ Instruct the patient to press the sides of the nose together and gentle massage after application to spread the ointment throughout nostril.

d. Administer eye medication.

(1) Ocular drops.

(a) Provide the patient with a tissue or cotton ball to remove the solution or tears which may spill from the eye.

(b) Clean the eye lids and lashes of any drainage with saline moistened cotton ball or gauze.

**NOTE:** Use a separate cotton ball or gauze for each eye to prevent cross contamination.

(c) Position the patient with the head tilted slightly back.

(d) Uncap the bottle and place the cap on its side to prevent contamination.

(e) Use your dominant hand to hold the bottle slightly above the eyeball.

(f) Pull down on the cheek just below the eye with the index finger and thumb of the nondominant hand to expose the conjunctival sac.

(g) Ask patient to look up and place the prescribed number of drops into the conjunctival sac.

(h) Place gentle pressure on the inner canthus to prevent the solution from draining into the lacrimal duct.

(i) Instruct the patient to keep the eye closed.

(j) Wipe away excess solution and tears.

(k) Repeat the procedure for the other eye, if needed.

(2) Ophthalmic ointments.

(a) Maintain sterile technique and open the tube.

(b) Squeeze a small amount of ointment onto a cotton ball or gauze and discard it.

**NOTE:** Do not allow the tip to touch the eye, eye lid, lashes, or skin.

(c) Place the tube slightly above the eyeball.

(d) Expose the conjunctival sac.

(e) Squeeze a ribbon of ointment in the middle third of the lower lid.

(f) Instruct the patient not to rub the eye. Have the patient close the eyes and move them around.

(g) Ask the patient to blink a few times.

(h) Wipe away excess ointment.

**CAUTION:** The administration of drops and ointment can impair patient vision. Always consider the increased potential for falls or injury.

e. Administer otic medication.

(1) Fill the medication dropper with the prescribed amount of medication.

(2) Straighten the ear canal.

(a) Draw the earlobe gently downward and back for administration to a child under the age of three.

(b) Lift the earlobe up and back for administration to a patient over age three.

(3) Clear the outer ear canal of earwax using a cotton tipped applicator.

(4) Hold the dropper slightly above the ear and instill the prescribed number of drops.

(5) Instruct patient to remain on their side for the prescribed timeframe.

(6) Place a portion of a cotton ball against the external opening of the ear to prevent escape of medication, if indicated.

**NOTE:** If a cotton ball is placed against the ear, it must be removed after 15 minutes.

f. Administer dermal medication.

(1) Topical cream or lotion or ointment.

(a) Administer using measuring paper.

_1_ Remove any previously placed paper.

_2_ Select an alternate site for the application of the new dose.

_3_ Clean the area with soap and water, unless contraindicated. Allow the area to dry thoroughly.

_4_ Clip hair if needed but do not shave to prevent micro abrasions.

_5_ Place the prescribed medication directly on the measuring paper, for the appropriate dose.

_6_ Spread the medication over a 2-inch area and use tape to secure the paper over the administration site.

(b) Write the date, time, and your initials on the securing tape.

(2) Transdermal patch.

(a) Clean the area with soap and water, unless contraindicated. Allow the area to dry thoroughly.

(b) Remove the protective cover from the patch.

(c) Apply it to the selected area immediately.

(d) Write the date, time, and your initials on the patch.

g. Administer medication by injection.

**NOTE:** For infants and small or debilitated children, use the vastus lateralis or ventrogluteal muscles; the dorsogluteal muscle is sufficiently developed to be a safe site for infants and small children.

**WARNING:** 1. If there is a known allergy, do not administer the injection. Consult your supervisor.

**WARNING:** 2. Determine if a female is pregnant because of possible side effects of certain immunizing agents on the unborn child. If there is a question, do not administer the injection without written authorization.

(1) Administer medication by ID injection.

(a) Gather appropriate supplies.

**NOTE:** ID injections are typically to deliver small volumes under the skin to form a small bubble-like wheal. Use a tuberculin 1 milliliter (ml) syringe with a 25 gauge, 3/8- to 5/8-inch needle.

(b) Draw appropriate amount of medication into syringe according to medical provider's order.

(c) Select and expose the injection site.

**NOTE:** Avoid injection sites too close to the wrist or elbow joints.

_1_ Inner forearm.

_2_ Back of the upper arm.

_3_ On the back below the shoulder blades.

(d) Position the patient.

_1_ Inner forearm–standing, sitting, or lying. Palm up, with the arm supported and relaxed.

_2_ Upper arm–standing or sitting with the area completely exposed, muscles relaxed, and the arm at the side.

_3_ Back–seated, leaning forward and supported on a stable object, or lying face down.

(e) Clean the injection site.

_1_ Open the antiseptic pad package.

_2_ Begin at the injection site and move the pad outward in a circular motion to a circumference of about 2 inches or 5 centimeters (cm).

_3_ Allow the skin to dry completely before administering injection.

**NOTE:** This will avoid a stinging sensation from introducing alcohol into SQ tissue.

**WARNING:** Do not violate aseptic technique.

(f) Pull the needle cover straight off without bending or touching the needle.

(g) Prepare the skin for the injection.

**CAUTION:** Do not retract or move the skin laterally.

_1_ Using the thumb of the nondominant hand, apply downward pressure directly below and outside the prepared injection site.

_2_ Hold the skin taut until the needle has been inserted.

(h) Insert the needle.

_1_ With the dominant hand, position the needle, bevel up, at a 15- to 20-degree angle to the skin surface.

_2_ Insert it just under the skin until the bevel is covered. Do not move the skin.

(i) Release the hold on the skin.

**NOTE:** To help avoid injecting the drug into compressed tissue and irritating the nerve fibers.

(j) Administer the medication.

**NOTE:** Do not aspirate before injecting medication.

_1_ Push the plunger slowly forward until all medication has been injected and a wheal appears at the site of the injection.

_a_ If a wheal does not appear–begin the procedure again. Use a new needle, syringe, and medication and select a different injection site.

_b_ If a wheal appears, continue the procedure.

_2_ Quickly withdraw the needle at the same angle at which it was inserted.

_3_ Without applying pressure, cover the injection site with dry sterile gauze.

_4_ Instruct the patient not to scratch, rub, or wash the injection site.

_5_ If appropriate, instruct the patient when and where to have the test read IAW local standard operating procedure (SOP).

_6_ Remove the dry sterile gauze from the injection site and check for bleeding.

(k) Monitor the patient for any adverse reactions.

_1_ Observe the patient for anaphylactic shock symptoms IAW local SOP.

_2_ Notify the medical officer of any adverse reactions immediately.

(l) Discard all equipment IAW standard precautions, SOP, and infection control guidelines.

(m) Document procedure in appropriate medical record.

(2) Administer medication by IM injection.

(a) Gather appropriate supplies.

**NOTE:** IM injections are to administer medication into muscle tissue. Syringe size may vary depending on medication (3 to 10 ml). Needle size can also vary depending on viscosity of medication (can range from 16-22 gauge, 1- to 1 1/2-inches long depending on amount of muscle patient has at administration site).

(b) Draw appropriate amount of medication into syringe according to medical provider's order.

(c) Select and expose the injection site.

**NOTE:** Rotate sites with multiple injections.

_1_ Deltoid muscle.

**NOTE:** Used only for small volumes (0.5 to 1 ml). Avoid use of the deltoid muscle in infants or in children and adults with underdeveloped muscles.

_a_ Muscle is located in the outer 1/3 of the arm between the shoulder bone (acromion process) and axilla.

_b_ Injection site is approximately 3 finger widths below the acromion process, in the middle of the deltoid muscle mass.

_2_ Ventrogluteal muscle.

**NOTE:** Used for larger medication volumes. Preferred injection site for infants, children, and adults.

_a_ Muscle is located by dividing one buttock into four imaginary quadrants.

_b_ Injection site is in the upper outer quadrant.

**CAUTION:** An injection given in an area outside this site could cause damage to the sciatic nerve or puncture the superior gluteal artery, causing either paralysis or severe bleeding. Use extreme caution when identifying site.

_3_ Vastus lateralis muscle.

**NOTE:** Used for medication volumes up to 3 ml. Preferred injection site for children younger than 3 years of age due to absence of major nerves and blood vessels.

_a_ Muscle is located on anterior lateral thigh.

_b_ Injection site extends from the middle of the anterior thigh to the middle of the lateral thigh, and from one hand width below the hip joint to one hand width above the knee.

(d) Position the patient.

**WARNING:** It is permissible to use a standing position for injections. However, some patients may experience a vasovagal response to an injection and become dizzy or lose consciousness. The seated or lying positions are therefore preferable.

_1_ Deltoid – standing, sitting, or lying with the area completely exposed, muscles relaxed, and the arm at the side.

_2_ Ventrogluteal – lying face down or leaning forward and supported by a stable object with the weight shifted to the leg that will not be injected. The area is completely exposed.

**NOTE:** If the patient is lying face down, place the toes together with the heels apart. This will relax the muscles of the buttocks.

_3_ Vastus lateralis – lying face up or sitting with site exposed.

**NOTE:** If the patient is lying face up have them flex knee on the side where medication will be given.

(e) Clean the injection site.

**WARNING:** Do not violate aseptic technique.

(f) Pull the needle cover off quickly without bending or touching the needle.

(g) Prepare the skin for the injection.

_1_ Form a fold of skin at the injection site by pinching the skin gently between the thumb and the index finger of the nondominant hand.

_2_ Do not touch the inject site.

(h) Insert the needle.

**NOTE:** For Infants and small or debilitated children, use the vastus lateralis or ventrogluteal muscles; the dorsogluteal muscle is sufficiently developed to be a safe site for infants and small children.

_1_ With the dominant hand, position the needle, bevel up, at a 90-degree angle to, and about 1/2 inch from the skin surface.

_2_ Plunge the needle firmly and quickly, in one motion straight into the muscle.

(i) Release the hold on the skin.

(j) Administer the medication.

**WARNING:** Do not aspirate for blood when giving insulin or heparin. It is not necessary with insulin and may cause a hematoma with heparin.

_1_ Aspirate by pulling back slightly on the plunger of the syringe.

**CAUTION:** If blood appears in the syringe, the needle is in a blood vessel. If this occurs, stop the injection, withdraw the needle, prepare another injection with new equipment, and inject another site.

_2_ Using a slow continuous movement, completely depress the plunger, injecting the medication.

_3_ After injection, withdraw the needle gently by quickly, at the same angle at which it was inserted.

_4_ Discard the syringe with the needle attached in sharps container IAW local facilities' SOP.

_5_ Place an antiseptic pad (or 2x2 gauze pad) over the injection site and gently massage the site (unless contraindicated, as with heparin and insulin), to distribute the medication and facilitate absorption.

_6_ Place bandage over site.

(k) Monitor patient for any adverse reactions.

_1_ Observe the patient for anaphylactic shock symptoms IAW local SOP.

_2_ Notify medical officer of any adverse reactions immediately.

(l) Discard all equipment IAW standard precautions, SOP, and infection control guidelines.

(m) Document the procedure in medical record.

(3) Administer medication by SQ injection.

(a) Gather appropriate supplies.

**NOTE:** SQ injections are to administer medication into the loose connective tissue between the dermis and the muscle layer. Injections should not exceed more than 1 ml. Needle size usually 25 gauge and is 1/2 to 5/8 inch in length.

(b) Draw appropriate amount of medication into syringe according to medical provider's order.

(c) Select and expose the injection site.

**NOTE:** The preferred injection sites for insulin are the arms, abdomen, thighs, and buttocks. The preferred injection site for heparin is the lower abdominal fat pad, just below the umbilicus.

_1_ Lateral upper arm.

**NOTE:** Medication volume should not exceed 1 ml.

_2_ Vastus lateralis.

**NOTE:** Medication volume should not exceed 1 ml.

_3_ Abdomen.

**NOTE:** Medication volume will vary according to the needs of the patient.

(d) Position the patient.

_1_ Upper arm – standing, sitting, or lying with the area completely exposed, muscles relaxed, and the arm at the side.

_2_ Vastus lateralis – lying face up or sitting with site exposed.

_3_ Abdomen – lying face up, with the area completely exposed.

(e) Clean the injection site.

_1_ Open the antiseptic pad package.

_2_ Begin at the injection site and move the pad outward in a circular motion to a circumference of about 2 inches (5 cm).

_3_ Allow the skin to dry completely before administering injection.

**NOTE:** This will avoid a stinging sensation from introducing alcohol into SQ tissue.

**WARNING:** Do not violate aseptic technique.

(f) Pull the needle cover straight off without bending or touching the needle.

(g) Prepare the skin for the injection.

_1_ Form a fold of skin at the injection site by pinching the skin gently between the thumb and the index finger of the nondominant hand.

_2_ Do not touch the injection site.

(h) Insert the needle.

_1_ With the dominant hand, position the needle, bevel up, at a 45-degree angle or 90-degree angle to the skin surface.

_2_ Insert the needle firmly and quickly in one motion into the fatty tissue below the skin.

(i) Release the hold on the skin.

**NOTE:** To help avoid injecting the drug into compressed tissue and irritating the nerve fibers.

(j) Administer the medication.

_1_ Using a slow continuous movement, completely depress the plunger, injecting the medication.

**NOTE:** Rapid pressure may cause a burning pain.

_2_ After injection, withdraw the needle, gently but quickly at the same angle at which it was inserted.

_3_ Discard syringe with needle attached in sharps container IAW local facilities' standing SOP and infection control guidelines.

_4_ Place an antiseptic pad or 2x2 gauze pad over the injection site and gently massage the site unless contraindicated, as with heparin and insulin, to distribute the medication and facilitate absorption.

_5_ Place bandage over site.

(k) Monitor patient for any adverse reactions.

_1_ Observe the patient for anaphylactic shock symptoms IAW local SOP.

_2_ Notify medical officer of any adverse reactions immediately.

(l) Discard all equipment IAW standard precautions, SOP, and infection control guidelines.

(m) Document the procedure in the medical record.

h. Administer medication into a vessel.

(1) Administer medication by IVP.

(a) Gather appropriate supplies.

**NOTE:** Administration may be through an injection port using needle or by connecting syringe to leak-free connector connection site.

(b) Draw appropriate amount of medication into syringe according to medical provider's order.

(c) Locate vessel access.

_1_ IV.

_2_ IO.

_a_ Intraosseous power driver-placement will be in the proximal humerus, proximal tibia, or distal tibia.

**NOTE:** May be placed in distal femur in pediatric patients.

_b_ Intraosseous infusion system-placement will be in the sternum.

(d) Clean catheter hub.

**WARNING:** Do not violate aseptic technique.

**CAUTION:** Do not inject air into catheter due to risk of air embolism.

(e) Connect the syringe to the catheter hub by either piercing the injection port with a sterile needle attached to the syringe containing medication or connect the leak-free connector syringe onto the leak-free connector connection site.

(f) Slowly push the syringe plunger to administer medication.

(g) Document procedure on medical record.

(2) Administer medication by IVPB.

(a) Gather appropriate supplies.

**NOTE:** Administration may be through an injection port using needle or by connecting syringe to leak-free connector connection site.

(b) Prepare the piggyback unit referring to drug manufacturer's instructions.

(c) Prime the piggyback infusion tubing.

(d) Connect the piggyback unit to the primary tubing.

(e) Hang the piggyback unit on the IV pole, ensuring that the piggyback unit is at least 6 inches higher than the primary container.

(f) Locate vessel access.

_1_ IV.

_2_ IO.

_a_ Intaosseous power driver-placement will be in the proximal humerus, proximal tibia, or distal tibia.

_b_ Intraosseous infusion system-placement will be in the sternum.

(g) Clean catheter hub.

**WARNING:** Do not violate aseptic technique.

**CAUTION:** Do not inject air into catheter due to risk of air embolism.

(h) Connect the syringe to the catheter hub by either piercing the injection port with a sterile needle attached to the syringe containing medication or connect the leak-free connector syringe onto the leak-free connector connection site.

(i) Begin the IVPB by opening the roller.

(j) Document procedure on medical record.

i. Administer rectal or vaginal medication.

(1) Administer rectal suppository.

(a) Ensure patient privacy by closing the door or drawing the curtain.

(b) Ensure there is adequate light to see the anal opening.

(c) Squeeze water-soluble lubricant on a paper towel.

(d) Remove the wrapper from the suppository.

(e) Apply lubricant to the tip of the suppository.

(f) Place the patient in the Sim's position.

(g) Ensure the patient is draped for warmth and privacy.

(h) Instruct the patient to bear down in order to identify the anal opening.

(i) Instruct patient to mouth breath. This action helps the patient relax and eases insertion.

(j) Insert the suppository gently into rectal canal and past the anal sphincter.

(k) Avoid embedding the suppository into a fecal mass.

(l) Use a tissue to wipe away excess lubricant.

(m) Instruct the patient to lie quietly for 15 minutes.

(2) Enema.

**NOTE:** Provide a bedpan if the patient is unable to ambulate to the latrine to expel the solution.

(a) Lubricate the rectal tip with water-soluble jelly.

(b) Insert the rectal tip into the rectum about 3 to 4 inches.

(c) Release the clamp on the tubing and allow the solution to flow slowly. (If using a disposable enema, squeeze the container to dispense the solution.)

(d) Slow the flow of solution if the patient complains of cramping.

(e) Administer all the solution and withdraw the enema tip.

(f) Tell the patient how long the solution must be retained.

**CAUTION:** Do not leave any medication at the patient's bedside without a specific physician's order.

(3) Suppository.

(a) Explain the procedure to the patient.

(b) Ask the patient if they are pregnant. Hold the medication and notify the charge nurse or privileged provider if pregnancy is suspected.

(c) Have the patient void.

(d) Wash your hands and follow standard precautions.

(e) Remove the wrapper from the suppository. Insert the suppository into the applicator (if applicable).

(f) Provide the patient privacy by closing the door or drawing the curtain.

(g) Ensure there is adequate light to see the vaginal opening.

(h) Place the patient in the dorsal recumbent or Sim's position.

(i) Drape the patient for warmth and privacy.

(j) Spread the labia with the fingers and cleanse the area of the vaginal orifice with cotton balls and warm water.

(k) Insert medication, tapered end first into vaginal opening.

_1_ If using your finger, insert suppository 1 to 1 1/2 inches into vaginal opening.

_2_ If using applicator, insert applicator plunger as far as it will comfortably go into vaginal opening.

_3_ Remove applicator once suppository has been inserted.

(l) Instruct patient to sit or lie still for 5 to 10 minutes to allow the medication to dissolve.

(m) Offer a perineal pad to collect excess discharge.

(n) Wash the applicator after use and store it in a protective wrap at the patient's bedside.

(4) Cream or ointment.

(a) Explain the procedure to the patient.

(b) Ask the patient if they are pregnant. Hold the medication and notify the charge nurse or privileged provider if pregnancy is suspected.

(c) Have the patient void.

(d) Wash your hands and follow standard precautions.

(e) Fill applicator with prescribed amount of cream or ointment.

(f) Provide the patient privacy by closing the door or drawing the curtain.

(g) Ensure there is adequate light to see the vaginal opening.

(h) Place the patient in the dorsal recumbent or Sim's position.

(i) Drape the patient for warmth and privacy.

(j) Spread the labia with the fingers and cleanse the area of the vaginal orifice with cotton balls and warm water.

(k) Insert applicator plunger as far as it will comfortably go into vaginal opening.

(l) Push the applicatory plunger to instill the medication.

(m) Withdraw applicator once cream or ointment has been inserted.

(n) Instruct patient to sit or lie still for 5 to 10 minutes to allow the medication to dissolve.

(o) Offer a perineal pad to collect excess discharge.

(p) Wash the applicator after use and store it in a protective wrap at the patient's bedside.

(5) Vaginal irrigation or douche.

**NOTE:** Place a catch basin or bedpan under the patient to collect return solution.

(a) Lubricate the douche tip with water-soluble jelly.

(b) Gently insert the douche tip into the vagina.

(c) Release the clamp on the tubing and allow solution to flow slowly. (If using a disposable douche, gently squeeze the container to dispense the solution.)

(d) Rotate the douche tip to direct fluid over all parts of the vagina.

(e) Administer all the solution and gently withdraw the douche tip.

(f) Remove the bedpan or catch basin and place a sanitary pad over the vulva.

10. Monitor patient for any adverse reactions.
    a. Assess for changes in the patient.
    b. Report any adverse reactions to the medication or possible drug interactions to the register nurse.
    c. Report outcomes objectively in the appropriate medical forms or EMR.

11. Clean and store all equipment.

12. Record the administration of all medications on the appropriate medical forms or EMR.
    a. Annotate the notes when administering controlled drugs, nonscheduled (as necessary) medications, and other medications as required by local policy.
        (1) Patient.
        (2) Name of the medication.
        (3) Dose.
        (4) Route.
        (5) Time the medication was administered.
        (6) Reason for the medication.
        (7) Patient's tolerance to procedure.
        (8) Any adverse reactions to procedure or medication.
    b. Record the omission of a medication on the appropriate medical forms whenever a scheduled medication is not administered.

**NOTE:** If a patient refuses the instillation of a medication, offer it again in five minutes. If refused a second time, document the refusal.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Confirmed the medical provider's orders. | _____ | _____ |
| 2 | Selected the right medication. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 3 | Validated the right dose of medication. | _____ | _____ |
| 4 | Confirmed the right patient. | _____ | _____ |
| 5 | Explained the procedure to the patient. | _____ | _____ |
| 6 | Selected the right route of administration. | _____ | _____ |
| 7 | Confirmed the right time. | _____ | _____ |
| 8 | Washed your hands, followed standard precautions, and obtained vital signs (as applicable based on medication to be administered). | _____ | _____ |
| 9 | Administered medications. | _____ | _____ |
| 10 | Monitored patient for any adverse reactions. | _____ | _____ |
| 11 | Cleaned and stored all equipment. | _____ | _____ |
| 12 | Recorded the administration of all medications on the appropriate medical forms or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
*Clinical Practice Guidelines.*
DA Form 3949. *Controlled Substances Record*.
DA Form 4678. *Therapeutic Documentation Care Plan (Medication).*
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine *website.*
Joint Trauma System *website.*
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Prepare an Injection for Administration

081-000-0056

**Conditions:** You must prepare an injection for administration. You will need needles, syringes, medication, alcohol sponges, dry sterile gauze, and a medical officer's orders. You have performed a patient care handwash. You are not in a chemical, biological, radiological, and nuclear environment.

**Standards:** Prepare an injection for administration. Select, inspect, and assemble the appropriate needle and syringe. Draw the correct medication. Follow aseptic technique throughout the procedure.

**Performance Steps:**

1. Select an appropriate needle.
    a. Select a needle with the proper length based upon the following factors:
        (1) The type of injection to be given (subcutaneous, intramuscular, or intradermal).
        (2) The size of the patient (thin, obese).
        (3) The injection site (1 inch for deltoid, 1 1/2 inches for gluteus maximus).
    b. Select a needle with the proper gauge based upon the thickness of the medication to be injected.

**NOTE:** The gauge of the needle is indicated by the numbers 10 through 27. The higher the number, the smaller the diameter (bore) of the needle. A small-bore needle is indicated for thin medications. A large-bore needle is indicated for thick medications.

2. Select an appropriate syringe.
    a. Check the drug manufacturer's specifications to determine whether a glass or plastic syringe should be used for the medication.

**NOTE:** Some medications deteriorate in a plastic syringe. Drug manufacturer's specifications provide guidance.

    b. Ensure that the total capacity of the syringe, usually measured in cubic centimeters (cc), is appropriate for the amount of medication to be administered.
    c. Check the intervals of the calibration marks on the syringe.

3. Inspect the needle and syringe packaging for defects such as open packages, holes, and water spotting.

**NOTE:** Discard the equipment if any defect is found.

4. Unpack the syringe.
    a. If the syringe is in a flexible wrapper, peel the sides of the wrapper apart to expose the rear end of the syringe barrel.

**CAUTION:** The needle adapter and the shaft of the plunger are sterile. Contamination could cause infection in the patient. The outside of the syringe barrel does not have to be kept sterile.

b. Grasp the syringe by the barrel with the free hand.

c. Pull the syringe from the packaging.

d. If the syringe is packaged in a hard plastic tube container, press down, and twist the cap until a distinct “pop” is heard. If the “pop” is not heard, the seal has been previously broken, and the equipment must be discarded.

5. Inspect the syringe.

a. Grasp the flared end of the syringe and pull the plunger back and forth to test for smooth, easy movement.

b. Visually check the rubber stopper (inside the syringe) to ensure that it is attached securely to the top end of the plunger, forming a seal.

c. If the plunger is stuck or does not move smoothly, discard the syringe.

d. Push the plunger fully into the barrel until ready to fill the syringe with medication.

**CAUTION:** All parts of the needle are sterile. Be careful not to touch the hub. This would contaminate the needle and possibly pass an infection to the patient. Only the outside of the needle cover may be touched.

6. Unpack the needle.

a. If the needle is packaged in a flexible wrapper, peel the sides of the wrapper apart to expose the needle hub.

b. If the needle is packaged in a hard plastic tube, twist the cap of the tube until a “pop” is heard. Remove the cap to expose the needle hub. If a “pop” is not heard, the seal has been previously broken, and the equipment must be discarded.

7. Attach needle to the syringe.

a. Insert the needle adapter of the syringe into the hub of the needle.

b. Tighten the needle by turning 1/4 of a turn to ensure that it is securely attached.

8. Inspect the needle.

a. Hold the needle and syringe upright and remove the protective cover from the needle by pulling it straight off.

**NOTE:** A twisting motion may pull the needle off the hub.

b. Visually inspect the needle for burrs, barbs, damage, and contamination. If the needle has any defects or damage, replace it with another sterile needle.

c. Place the protective cover back on the needle utilizing the “scoop” method.

9. Place the assembled needle and syringe on the work surface.

a. Leave the protective cover on the needle.

b. Leave the plunger pushed fully into the barrel.

c. Keep the assembled needle and syringe continually within range of vision.

**NOTE:** When you assemble a needle and syringe, you are responsible for maintaining sterility and security of the equipment.

10. Verify the drug label and check the container for defects.

a. Compare the medication with the medical officer's orders. The medication label must be verified three times.

(1) When obtained from the place of storage.

(2) When withdrawing the medication.

(3) When returning the container to storage.

b. Examine the container.

(1) Examine the rubber stopper for defects, such as small cores or plugs torn from the stopper.

(2) Hold the vial to the light to check for foreign particles and changes in color and consistency. If the solution is in a dark vial, withdraw some solution to perform the checks.

(3) Check the date a multidose vial was opened and check the expiration date of the medication.

(4) Determine whether the medication was stored properly, such as under refrigeration.

**NOTE:** If there is any evidence of contamination, discard the container and obtain another.

11. Prepare medication for injection.

a. Draw medication from a stoppered vial which contains a prepared solution.

(1) Remove the protective cap.

(2) Clean the stopper and neck of the vial with an alcohol sponge.

(3) Pick up the assembled needle and syringe and remove the protective needle cover.

(4) Slowly draw the plunger to the prescribed cc mark of medication.

(5) Pick up the vial and insert the needle into the rubber stopper, exerting slight downward and forward pressure. Ensure that the needle tip passes completely through the cap.

**NOTE:** To avoid contamination, the hub of the needle should not touch the rubber cap.

(6) Push the plunger fully into the barrel to inject the air.

(7) With the vial inverted (and keeping the needle tip in the solution), pull the plunger back to the desired cc mark, withdrawing the medication.

(8) Withdraw the needle from the container.

(9) Verify the correct dosage against the medical officer's orders by raising the syringe to eye level and ensuring that the forward edge of the plunger is exactly on the prescribed cc mark.

b. Draw medication from a stoppered vial which contains a powdered medication which must be prepared.

(1) Remove the protective caps from the vial containing the powdered medication and the vial containing the sterile diluent.

(2) Clean the stoppers of both vials with alcohol sponges.

(3) Withdraw the required diluent, using the same procedure as for a stoppered vial, see steps 11a (3) through 11a (8).

(4) Hold the vial with the powdered medication horizontally, insert the needle through the stopper, and inject the diluent.

**NOTE:** If the vial with powdered medication contains air, the diluent may be difficult to inject. Air may have to be withdrawn to allow the diluent to be injected.

(5) Withdraw the needle.

(6) Gently invert the vial several times until all the powder is dissolved. Visually inspect the solution to ensure that it is well-mixed.

(7) Change the needle (or needle and syringe) and insert it into the vial of reconstituted solution.

(8) Withdraw the prescribed amount of medication, see step 11a (7).

(9) Withdraw the needle from the container.

(10) Verify the correct dosage, see step 11a (9).

c. Draw medication from an ampule.

(1) Lightly tap the upright ampule to force any trapped medication from the ampule neck and top.

(2) Clean the neck of the ampule with an alcohol sponge and wrap it with the same sponge.

(3) Grasp the ampule with both hands and snap the neck by bending it away from the break line, directing it away from yourself and others.

(4) Inspect the ampule for minute glass particles. If any are found, discard the ampule.

(5) Remove the protective cover from the assembled needle and syringe.

(6) Insert the needle and withdraw the medication by holding the ampule vertically or by placing the ampule upright on a flat surface.

(7) Withdraw the prescribed medication, being careful not to touch the outside edge or bottom of the ampule with the needle.

(8) Withdraw the needle.

(9) Verify the correct dosage, see step 11a (9).

12. Check the syringe for air bubbles.

a. Hold the syringe with the needle pointing up.

b. Pull back on the plunger slightly to clear all the medication from the needle shaft.

c. Tap the barrel lightly to force bubbles to the top of the barrel.

d. Pull the plunger back slightly and push it forward until the solution is in the needle hub, clearing it of bubbles.

13. Reverify the correct dosage, see step 11a (9).

14. Cover the needle with the protective needle cover utilizing the “scoop” (one-handed technique) method.

a. Place the needle cover on flat surface.

b. Hold syringe in the dominant hand, scoop the needle cap onto the needle.

c. Tip syringe vertically to slide cover over needle.

d. Do NOT hold onto the needle cap with nondominant hand while scooping. Keep nondominant hand well away from needle cap.

e. Secure the needle cap by grasping it near the hub.

15. Do not violate aseptic technique.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in a field condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Selected an appropriate needle. | _____ | _____ |
| 2 | Selected an appropriate syringe. | _____ | _____ |
| 3 | Inspected the needle and syringe packaging for defects such as opened packages, holes, and water spotting. | _____ | _____ |
| 4 | Unpacked the syringe. | _____ | _____ |
| 5 | Inspected the syringe. | _____ | _____ |
| 6 | Unpacked the needle. | _____ | _____ |
| 7 | Attached needle to the syringe. | _____ | _____ |
| 8 | Inspected the needle. | _____ | _____ |
| 9 | Placed the assembled needle and syringe on the work surface. | _____ | _____ |
| 10 | Verified the drug label and checked the container for defects. | _____ | _____ |
| 11 | Prepared medication for injection. | _____ | _____ |
| 12 | Checked the syringe for air bubbles. | _____ | _____ |
| 13 | Reverified the correct dosage, see step 11a (9). | _____ | _____ |
| 14 | Covered the needle with the protective needle cover utilizing the “scoop” (one handed technique method). | _____ | _____ |
| 15 | Did not violate aseptic technique. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
None

**Related**
None

Administer Tranexamic Acid

081-68W-0311

**DANGER:** Give tranexamic acid (TXA) only if able to administer within 3 hours of severe hemorrhagic injury. It can cause worsening hemorrhage if given after 3 hours.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You encounter a casualty with severe internal bleeding and is anticipated to need a significant blood transfusion or has symptoms of significant traumatic brain injury (TBI) or has altered mental status associated with blast injury or blunt trauma. You will be provided a fully stocked aid bag with a 100 cubic centimeter (cc) bag of normal saline (NS) or Lactated Ringer's and 2 grams (g) of TXA.

**Standards:** Employ TXA to manage internal bleeding without causing further injury to the casualty in accordance with the *Committee on Tactical Combat Casualty Care (CoTCCC) Guidelines* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Apply BSI precautions.

2. Obtain vascular access.
   a. Check distal pulse on extremity.
   b. Perform an intravenous (IV) infusion.
   c. Perform an intraosseous (IO) infusion if unable to gain vascular access by other means (see task 081-68W-0237, Place an Intraosseous Device).

**WARNING:** Administering undiluted TXA by slow IV push (over 10 minutes) is acceptable ONLY if supplies or tactical situation prevents providing a diluted infusion with 100 milliliter (ml) NS. If TXA is given too rapidly, it can cause hypotension.

3. Administer 2 g of TXA in a 100 cc bag of NS or Lactated Ringer's via slow IV or IO push.

**NOTE:** TXA is supplied in 1 g (1000 milligram [mg]) ampules.

4. Observe casualty for any adverse side effects.

5. Record TXA given on a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*).

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|
| 1 Applied BSI precautions. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 2 | Obtained vascular access. | _____ | _____ |
| 3 | Administered 2 g of TXA in a 100 cc bag of NS or Lactated Ringer's or via slow IV or IO push. | _____ | _____ |
| 4 | Observed casualty for any adverse side effects. | _____ | _____ |
| 5 | Recorded TXA given on a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References**

**Required**
*Committee on Tactical Combat Casualty Care (CoTCCC).*
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Joint Trauma System *website.*

**Related**
None

**Subject Area 6: Trauma Management**

Treat a Thoracic Injury

081-000-0037

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You must treat a thoracic injury. You have a DD Form 1380 *(Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions))* or electronic medical record (EMR).

**Standards:** Treat a thoracic injury in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Perform a combat casualty assessment (see task 081-000-0049, Perform a Combat Casualty Assessment).

2. Check the casualty for signs and symptoms of chest injuries.
   a. Deformities, contusions, abrasions, punctures or penetrations (DCAP), bleeding, tenderness, lacerations, and swelling (BTLS).
   b. Pleuritic pain that is increased by or occurs with respirations and is localized around the injury site.
   c. Labored or difficult breathing.
   d. Diminished or absent breath sounds.
   e. Cyanotic lips, fingertips, or fingernails.
   f. Coughing up blood or bloody sputum.
   g. Failure of one or both sides of the chest to expand normally upon inhalation.
   h. Paradoxical breathing-the motion of the injured segment of a flail chest, opposite to the normal motion of the chest wall.
   i. Enlarged neck veins.
   j. Tracheal deviation-shift of the trachea from the midline toward the unaffected side due to pressure buildup on the injured side.

3. Check for an exit wound if a penetrating thoracic wound is initially found.

4. Identify the type of injury.
   a. Open pneumothorax-air entering the pleural space through a defect in the pleural wall. Signs and symptoms:
      (1) Respiratory distress.
      (2) Anxiousness.
      (3) Tachypnea.

b. Tension pneumothorax-air enters the chest cavity (pleural space) through a hole in the lung, expanding the space with every breath the casualty takes. The air becomes trapped and cannot escape. Signs and symptoms:

(1) Chest pain.

(2) Increased pressure in the chest causes lung(s) to collapse.

5. Initiate treatment for the open chest injury.

a. Open pneumothorax.

(1) Apply an occlusive dressing.

**NOTE:** Should no commercial chest seal be available to use, any airtight material can be used. It must be large enough, so it is not sucked up into the chest injury and extend past the wound 2 inches on all sides.

(2) Check the casualty for an exit wound. If present, apply a second occlusive dressing.

(3) Apply supplemental oxygen if available.

b. Tension pneumothorax.

(1) Apply an occlusive dressing.

(2) Perform a needle chest decompression if indicated (see task 081-68W-0075, Perform Needle Decompression of the Chest).

(3) Administer oxygen.

(4) Assist the casualty's respirations as necessary.

(5) Monitor the casualty for progression of symptoms.

6. Record the care provided on the DD Form 1380 or EMR.

7. Prepare the casualty for evacuation.

a. Position the casualty.

(1) Conscious–in a comfortable position, preferably sitting.

(2) Unconscious–on the injured side.

b. Evacuate the casualty–continue to assess the casualty until evacuated. The casualty should be evacuated by the most expedient means available.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Performed a combat casualty assessment (see task 081-000-0049, Perform a Combat Casualty Assessment ). | _____ | _____ |
| 2 | Checked the casualty for signs and symptoms of chest injuries. | _____ | _____ |
| 3 | Checked for an exit wound if a penetrating thoracic wound was initially found. | _____ | _____ |
| 4 | Identified the type of injury. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 5 | Initiated treatment for the open chest injury. | _____ | _____ |
| 6 | Recorded the care provided on the DD Form 1380 or EMR. | _____ | _____ |
| 7 | Prepared the casualty for evacuation. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Assess Patient Vital Signs

081-000-1001

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you are to obtain vital signs and determine if a patient's vital signs are within normal limits. You are provided with a watch with a second hand (analog or digital), thermometer (electronic, glass, or tympanic), alcohol pads, cover probes, water soluble lubricant, stethoscope, sphygmomanometer, pulse oximetry device, sensing probe, pen, and SF 600 (*Chronological Record of Medical Care*) or electronic medical record (EMR). The use of an automated vital signs monitor is allowed if available.

**Standards:** Assess the patient's vital signs, in accordance with the *PHTLS Prehospital Trauma Life Support*, while adhering to all warnings and cautions with 100% accuracy utilizing GO/NO GO criteria.

**Performance Steps:**

**CAUTION:** All body fluids should be considered potentially infectious. Always observe BSI precautions.

1. Identify the patient.
    a. Verify full name.
    b. Verify date of birth.

2. Explain the procedure to the patient and family.

3. Assess pulse rate.
    a. Position the patient so the pulse site is accessible.

**NOTE:** Pulse sites will vary based on the age and level of alertness of the patient. Palpating for the brachial pulse is best practice with an infant patient. In responsive patients you should palpate the radial pulse at the wrist. In unresponsive patients you should palpate the carotid pulse at the neck.

    b. Palpate (feel) the pulse site.
        (1) Place the tips of your index and middle fingers on the pulse site.

**NOTE:** Do not use your thumb to palpate a pulse as your thumb has its own pulse.

        (2) Apply moderate pressure with your fingers to palpate the pulse.
    c. Count the number of pulses felt in a 30 second period and multiply by two.

**NOTE:** A pulse that is weak, difficult to palpate, or irregular should be palpated and counted for a full minute.

    d. Determine if the pulse is within normal limits.
        (1) Adults: 60-100 beats per minute.

(2) Children (1-6 years): 70-120 beats per minute.

(3) Infants (6-12 months): 80-140 beats per minute.

(4) Infants (0-5 months): 90-140 beats per minute.

(5) Pulse rates in an adult patient that exceed 100 beats per minute are described as tachycardia.

(6) Pulse rates less than 60 beats per minute are described as bradycardia.

**NOTE:** Pulse rates can vary from patient to patient. In well-conditioned athletes or patients taking certain heart medications, the pulse rate may be considerably lower. In these adult patients, bradycardia may be considered normal.

e. Evaluate the pulse rhythm (regularity).

(1) Regular rhythms.

(a) Are easy to palpate.

(b) Present with a regular rate and rhythm.

(2) Irregular rhythms.

**NOTE:** If the pulse is irregular, you should assess a second site. Report all irregular pulse rhythms to a medical officer.

(a) Maybe difficult to palpate.

(b) Present with an irregular beat pattern.

f. Evaluate the pulse strength.

(1) Strong (full) pulse.

(a) Usually easy to find.

(b) Beats evenly and forcefully.

(2) Bounding (stronger than normal) pulse.

(a) Easy to find.

(b) Exceptionally strong heartbeats that make the arteries difficult to compress.

(3) Weak (thready) pulse.

(a) Usually difficult to find.

(b) Weak and thin.

g. Record the rate, rhythm, strength, and any significant deviations from normal on the appropriate medical forms.

h. Report any significant pulse abnormalities to your supervisor immediately.

4. Assess respiratory rate.

a. Count the number of times the chest rises (inspiration) and returns to its normal position (expiration) for 30 seconds and multiply by two.

**NOTE:** Each respiratory cycle (inspiration and expiration) counts as one respiration. The patient should not be aware that their respirations are being counted. The conscious patient that is aware their respirations are being counted will often alter their respiratory rate by breathing slower and deeper. If a patient is speaking, this too may result in an inaccurate assessment of respirations.

b. Normal respirations for each age group are as follows:
   (1) Adults: 12-20 breaths per minute.
   (2) Children (1-10 years): 15-30 breaths per minute.
   (3) Infants (6-12 months): 25-50 breaths per minute.
   (4) Infants (0-5 months): 25-40 breaths per minute
c. Evaluate Depth.
   (1) Normal: deep, even movement of the chest.
   (2) Shallow: minimal rise and fall of the chest and abdomen.
   (3) Labored: increased effort to breathe, with possible gasping.
d. Evaluate quality.
   (1) Normal: effortless, automatic, regular rate, even depth, noiseless, and free of discomfort.
   (2) Dyspnea: difficult or labored breathing.
   (3) Tachypnea: rapid respiratory rate; usually is a rate exceeding 24 breaths per minute (adult).
   (4) Noisy: snoring, rattling, wheezing (whistling), or grunting.
   (5) Apnea: temporary absence of breathing.
e. Observe for physical characteristics of abnormal respirations.
   (1) Appearance: the patient may appear restless, anxious, pale, ashen, or cyanotic (blue skin color).
   (2) Position: the patient may alter their position by leaning forward with their hands on their legs (tripod position) or may be unable to breathe while lying down.
f. Record the rate of respirations and any observations noted (depth and quality) on the appropriate medical forms.
g. Report any abnormal respirations to your supervisor immediately.

5. Assess blood pressure.

**NOTE:** The following procedures describe the procedure for obtaining a blood pressure reading using the upper arm (brachial artery).

a. Position the patient so the extremity used is accessible.

**NOTE:** Measuring the blood pressure of a standing patient will result in a slightly higher reading.

b. Select the proper size of sphygmomanometer cuff.

**NOTE:** The cuff width should wrap around the arm 1-1.5 times and take up two-thirds of the upper arm length, if using the brachial artery, and two-thirds of the upper leg length if using the popliteal artery. A cuff that is too small may result in false high readings; a cuff that is too large may result in falsely low readings.

c. Check the equipment.
   (1) Ensure the cuff is completely deflated and fully retighten the one-way valve thumbscrew.

(2) Ensure the sphygmomanometer pressure gauge is at 0 millimeter of mercury (mmHg).

d. Place the blood pressure cuff on the patient's arm.

(1) Locate the brachial pulse.

(2) Palpate the brachial pulse.

(3) Wrap the blood pressure cuff snugly around the arm.

(4) Support the arm so it is in a relaxed state.

e. Position the stethoscope.

(1) Palpate the arm with the blood pressure cuff, just above the crease of the arm to locate the strongest pulse.

(2) Place the diaphragm of the stethoscope over the brachial pulse site.

(3) Hold the diaphragm in place with your nondominant hand.

f. Inflate the blood pressure cuff.

**NOTE:** When the blood pressure (BP) cuff has inflated enough to stop blood flow you should hear no sounds through the stethoscope. The gauge should read 30 to 40 mmHg above the person's normal BP reading. If this value is unknown, you can inflate the cuff to 160-180 mmHg. (If pulse sounds are heard right away, inflate to a higher pressure.)

(1) Close the valve on the sphygmomanometer.

(2) Begin inflating the cuff using the ball pump as you listen to the pulse sounds.

**CAUTION:** The cuff should not remain inflated for more than 2 minutes

(3) Stop inflating at 30 mmHg above the last pulse sound.

g. Deflate the blood pressure cuff slowly.

**NOTE:** The American Heart Association recommends that the pressure should fall at 2-3 mmHg per second, anything faster may likely result in an inaccurate measurement.

(1) Open the valve slowly to begin deflating the cuff.

(2) Listen for the systolic reading.

(a) Watch the gauge and note when the first occurrence of rhythmic sounds is heard as blood begins to flow through the artery.

(b) This will be the systolic reading.

**NOTE:** This may resemble a tapping noise at first.

(3) Listen for the diastolic reading, watch the gauge while listening as the BP cuff pressure drops.

(a) This will be the diastolic reading.

(b) The sounds fade.

h. Determine the blood pressure reading in a noisy environment or if a stethoscope is unavailable.

(1) Repeat step 5a through 5d.

(2) With your nondominant hand, palpate the radial pulse (at the wrist) on the same arm as the cuff.

(3) While palpating the radial pulse, rapidly inflate the cuff until you can no longer feel the pulse under your fingertips, and then inflate an additional

30 mmHg above where you last felt the radial pulse.

(4) Rotate the thumbscrew allowing the cuff to deflate slowly at about 3 mmHg per second.

(5) Watch the gauge, when you again feel the radial pulse return, note the reading on the gauge (systolic blood pressure).

**NOTE:** The diastolic pressure cannot be determined using this method.

(6) As soon as you note the systolic reading, open the valve by rotating the thumbscrew and release the remaining air rapidly.

i. Record the blood pressure on the appropriate medical forms.

(1) Record the systolic reading over the diastolic reading.

**NOTE:** If obtaining the blood pressure without a stethoscope (by palpation), record the systolic reading alone alongside the letter P, for example 120/P.

(2) Record all readings in even numbers.

**NOTE:** Record the blood pressure readings with the time it was taken. For example, 120/80.

j. Evaluate the blood pressure readings by noting the normal ranges for the blood pressure.

**NOTE:** The standard normal is 120/80.

(1) Adults and Children 14+ years old: 90-140 mmHg (systolic); 60-90 mmHg (diastolic).

(2) Children (1-13 years): 98-120 mmHg (systolic), 52-80 mmHg (diastolic).

(3) Infants (0-12 months): 70 mmHg (systolic).

**NOTE:** Blood pressure readings vary with age and sex. A patient has hypotension when the blood pressure is lower than the normal range; the patient has hypertension when the blood pressure is higher than the normal range.

k. Report any abnormal blood pressure findings to the supervisor immediately.

6. Assess temperature.

a. Determine which site to use.

**CAUTION:** Do not take an oral temperature if the patient has had recent facial or oral surgery, presents with altered mental status, is being administered oxygen by mouth or nose, is likely to bite down on the thermometer, or has smoked, chewed gum, or has eaten or drank anything hot or cold within the last 15 to 30 minutes.

(1) Take an oral temperature if the patient is a conscious adult or child who can follow directions and can breathe normally through their nose.

**CAUTION:** Do not attempt to take a tympanic temperature if the patient has had recent facial or ear surgery or has cerumen (earwax) impaction.

(2) Obtain the patient's temperature using the tympanic method if the patient has recently had something to eat or drink.

**CAUTION:** Do not attempt to take a rectal temperature if the patient has had recent rectal surgery, unless directed to by a medical officer. Do not attempt to take a rectal temperature on an infant unless directed by a medical officer.

(3) Obtain the patient's temperature by the rectal method if the oral or tympanic methods are ruled out by the patient's condition.

(4) Obtain the patient's temperature by the axillary (least preferred) method if the patient's condition rules out using the other methods.

b. Select the appropriate thermometer.
   (1) Oral thermometer: has a blue tip and may be labeled "Oral."
   (2) Tympanic thermometer.
   (3) Rectal thermometer: has a red tip and may be labeled "Rectal."
   (4) Axillary temperatures may be obtained using an oral thermometer.
c. Explain the procedure to the patient.
d. Position the patient appropriately.
   (1) Oral method. Position the patient seated or lying down.
   (2) Tympanic method. Position the patient with their head turned to make the ear canal easily accessible.
   (3) Rectal method. Position the patient lying on either side with the top knee flexed.
   (4) Axillary method. Position the patient either seated or lying face up with the armpit exposed.
e. Place the thermometer at the proper site.
   (1) Oral method.
      (a) Ensure cover probe is firmly attached to the appropriate probe attachment.
      (b) Digital disinfect the thermometer with an alcohol pad.
      (c) Insert it into the disposable sheath opening; then twist to tear the seal at the dotted line.
      (d) Instruct the patient to close their lips around the instrument firmly but not to bite down.
   (2) Pull it apart. Place the thermometer underneath the patient's tongue.
f. Leave the thermometer in place for the required time.

**NOTE:** The time will vary when using a digital and glass oral thermometer. Leave the digital oral thermometer in place until testing is complete. The digital unit will normally have an audible tone (beep) when complete.

(1) Oral method: must remain in place for 1 to 3 minutes.

**NOTE:** The time will vary when using a digital and glass oral thermometer. Leave the digital oral thermometer in place until testing is complete. The digital unit will normally have an audible tone (beep) when complete.

(2) Tympanic method: must remain in place until an audible tone (beep) occurs, and the patient's temperature appears on the digital display.

(3) Rectal method: must be held in place for 1 to 3 minutes.

**NOTE:** The time will vary when using a digital and glass rectal thermometer. Leave the digital rectal thermometer in place until testing is complete. The digital unit will normally have an audible tone (beep) when complete.

(4) Axillary method: must remain in place for 1 to 10 minutes.

g. Remove the thermometer and eject the cover probe or discharge the protective plastic sheath as appropriate.

h. Read the temperature scale or digital display.

i. Evaluate the temperature reading. The normal temperature ranges are as follows:

(1) Oral method: 97.0 degrees (°) Fahrenheit (F) to 99.0 °F.

(2) Tympanic method: 97.0 °F to 99.0 °F.

(3) Rectal method: 98.0 °F to 100.0 °F.

(4) Axillary method: 96.0 °F to 98.0 °F.

j. Clean and store thermometer as appropriate.

k. Record the patient's temperature to the nearest 0.2 °F on the appropriate medical forms.

(1) Record a rectal temperature with an "R" on the patient's record.

(2) Record an axillary reading, use an "A" on the patient's record.

l. Report any significant temperature abnormalities to the supervisor immediately.

**CAUTION:** The pulse oximeter is a tool, do not solely rely on it. Treat the patient, not the machine.

7. Measure a patient's oxygen saturation.

**NOTE:** Normal pulse oximetry values are greater than 95% in room air.

**NOTE:** Continuous monitoring devices come with preset limits. These limits can be changed per medical officer's order.

a. Select the appropriate sensing probe location for the patient.

(1) For adults, sensing probes can be placed on the index, middle, or ring finger.

(2) Sensing probes can also be placed on the toe unless the patient has decreased circulation to the lower extremities.

(3) Earlobe clips and neonate sensing probes for the foot are available for infants and newborns.

b. Wipe the selected site with alcohol to ensure it is clean and dry.

c. Apply the sensor so that the emitting light is directly opposite to the detector.

d. Attach the sensor cable to the machine and turn the power on.

e. Notify the medical officer if the digital readout is below the prescribed parameters.

f. Document the oximeter reading, the location of the device, the time taken, and the amount of oxygen being delivered, if applicable.

g. Take appropriate measures for continuous monitoring, if applicable.

(1) Move the sensing probe location every 2 hours.

(2) Move adhesive sensors every 4 hours.

8. Document all values on the appropriate form and report abnormal values to the supervisor.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Identified the patient. | _____ | _____ |
| 2 | Explained the procedure to the patient and family. | _____ | _____ |
| 3 | Assessed pulse rate. | _____ | _____ |
| 4 | Assessed respiratory rate. | _____ | _____ |
| 5 | Assessed blood pressure | _____ | _____ |
| 6 | Assessed temperature. | _____ | _____ |
| 7 | Measured a patient's oxygen saturation. | _____ | _____ |
| 8 | Documented all values on the appropriate form and reported abnormal values to the supervisor. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
*PHTLS Prehospital Trauma Life Support.*
*SF 600.* Chronological Record of Medical Care.

**Related**
None

Perform Needle Decompression of the Chest

081-68W-0075

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you are required to perform needle decompression of the chest (NDC) on a casualty you encounter who has penetrating torso trauma and has been treated with an occlusive dressing. All other immediate life threats have been treated and managed. You are provided with treatment gloves, eye protection, an improved first aid kit, alcohol prep pads, 2-3-inch silk medical tape, a pulse oximeter, and a 3.15-inch 10-14-gauge angiocatheter and needle.

**Standards:** Perform an NDC and relieve a tension pneumothorax in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines*, while adhering to all warnings and cautions, without error, using the GO/NO GO checklist.

**Performance Steps:**

1. Assess the casualty for signs of suspected tension pneumothorax.
2. Burp or replace the chest seal (if improperly applied).
3. Identify the site for needle insertion.

**NOTE:** Use either of two sites (whichever one was most accessible): (a) The fifth intercostal space in the anterior axillary line on the side of the injury or decreased breath sounds. (b) The second intercostal space at the midclavicular line on the side of the injury or decreased breath sounds.

4. Use appropriate needle catheter (either 10 or 14 gauge, 3 1/4 inches).
5. Clean the site using antiseptic solution when available.
6. Remove the leek-free connector cap from the needle catheter (if applicable).
7. Insert the needle just over the top of the lower rib at the insertion site, at a 90-degree angle (perpendicular) to the chest wall, advancing it to the hub.
8. Leave the needle in place for 5-10 seconds to allow decompression to occur; then remove the needle, leaving the catheter in place.
9. Assess for successful needle decompression.

**NOTE:** You should hear air escaping the chest. Respiratory distress improves.

10. Perform another NDC using a new needle on the second site, same side.
11. Place the casualty in a position of comfort or recovery position with injured side down.

12. Document all findings and treatments on the DD Form 1380 *(Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions))*.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Assessed the casualty for signs of suspected tension pneumothorax. | _____ | _____ |
| 2 | Burped or replaced the chest seal (if improperly applied). | _____ | _____ |
| 3 | Identified the site for needle insertion. | _____ | _____ |
| 4 | Used appropriate needle catheter (either 10 or14 gauge, 3 1/4 inches). | _____ | _____ |
| 5 | Cleaned the site using antiseptic solution when available. | _____ | _____ |
| 6 | Removed the leek-free connector cap from the needle catheter (if applicable). | _____ | _____ |
| 7 | Inserted the needle just over the top of the lower rib at the insertion site, at a 90-degree angle (perpendicular) to the chest wall, advancing it to the hub. | _____ | _____ |
| 8 | Left the needle in place for 5-10 seconds to allow decompression to occur; then removed the needle, leaving the catheter in place. | _____ | _____ |
| 9 | Assessed for successful needle decompression. | _____ | _____ |
| 10 | Performed another NDC using a new needle on the second site, same side. | _____ | _____ |
| 11 | Placed the casualty in a position of comfort or recovery position with injured side down. | _____ | _____ |
| 12 | Documented all findings and treatments on the DD Form 1380 *(Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions))*. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions).*
Deployed Medicine website.
Tactical Combat Casualty Care (TCCC) Guidelines.

**Related**
None

Treat a Casualty with an Inguinal Wound

081-68W-0081

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you must treat a casualty who is bleeding externally from a penetrating inguinal wound. You have the casualty's improved first aid kit, scissors, 2 tourniquets, a 1-quart canteen, gauze style hemostatic dressing, 2-3-inch surgical silk tape, rolled or compressed gauze, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*).

**Standards:** Treat a casualty with an inguinal wound by packing the wound within 90 seconds, in accordance with *Tactical Combat Casualty Care Guidelines*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Don personal protective equipment.

2. Expose the injury and assess the bleeding source.

**NOTE:** Clothing may need to be cut away to properly expose the injury.

3. Apply direct pressure to the source of the most active bleeding by placing a hand, fist, or elbow squarely in the inguinal gutter on the injured while opening the sterile hemostatic gauze package.

**NOTE:** The inguinal gutter is the crevice between the top of the thigh and the lower abdomen where heavy blood flow structures are located. The location is halfway between the bone above the genitals and top of the thigh.

**CAUTION:** If a penetrating object is lodged in the casualty's body, bandage it in place. Do not remove the object.

4. Remove the hand, fist, or elbow and immediately apply direct pressure while tightly packing the inguinal wound with hemostatic gauze until the wound cavity is filled.

**NOTE:** Using the four Ps of packing (peel, push, pile, and pressure) pack the gauze directly into the wound. More than one roll of gauze may be required to stop the blood flow. Ensure that the gauze extends 1-2 inches above the skin. If the gauze does not extend 1-2 inches above the skin, place additional gauze on top of the packed gauze. (All packing should be completed within 90 seconds).

5. Hold pressure for a minimum of 3 minutes.

6. Reassess that the bleeding is controlled while maintaining pressure.
    a. If packed with hemostatic dressing, and bleeding is not controlled, remove the prior packing material, and repack starting at step 3.

b. If packed with regular roller gauze, and bleeding is not controlled, apply additional gauze and pressure (for 3 minutes) until bleeding has stopped.

7. Select a cylindrical or spherical pressure deliver device (PDD) and position into the inguinal gutter while continuously maintaining pressure to the dressing.

**NOTE:** PDD examples: shoe or boot, full water bottle, or canteen.

8. Select a tourniquet that can wrap around the casualty's waist or hip area or connect two tourniquets.

9. Place the windlass or ratchet tourniquet directly over the middle of the PDD; ensure that the routing buckle is located toward the medial (middle) aspect of the body.

10. Remove all slack from the self-adhering band or strap using a pushing motion across the casualty's body before tightening the tourniquet.

11. Tighten the tourniquet until bleeding has stopped and the distal pulse has been checked and is absent.

**NOTE:** If bleeding is not controlled or distal pulse (a pulse below the tourniquet) is present, remove any remaining slack in the strapping (if possible) and twist or ratchet the tourniquet device until bleeding is controlled and a distal pulse is absent.

12. Inspect placement of equipment, ensuring the PDD is in place and the windlass or ratchet is properly positioned over the device.

13. Document all findings and treatments on a DD Form 1380 and attach it to the casualty.

14. Tape PDD and tourniquet in place prior to transport.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Donned personal protective equipment. | _____ | _____ |
| 2 | Exposed the injury and assessed the bleeding source. | _____ | _____ |
| 3 | Applied direct pressure to the source of the most active bleeding by placing a hand, fist, or elbow squarely in the inguinal gutter on the injured while opening the sterile hemostatic gauze package. | _____ | _____ |
| 4 | Removed the hand, fist, or elbow and immediately applied direct pressure while tightly packing the inguinal wound with hemostatic gauze until the wound cavity was filled. | _____ | _____ |
| 5 | Held pressure for a minimum of 3 minutes. | _____ | _____ |
| 6 | Reassessed that the bleeding was controlled while maintaining pressure. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 7 | Selected a cylindrical or spherical pressure deliver device (PDD) and positioned into the inguinal gutter while continuously maintaining pressure to the dressing. | _____ | _____ |
| 8 | Selected a tourniquet that could wrap around the casualty's waist or hip area or connected two tourniquets. | _____ | _____ |
| 9 | Placed the windlass or ratchet tourniquet directly over the middle of the PDD; ensured that the routing buckle was located toward the medial (middle) aspect of the body. | _____ | _____ |
| 10 | Removed all slack from the self-adhering band or strap using a pushing motion across the casualty's body before tightening the tourniquet. | _____ | _____ |
| 11 | Tightened the tourniquet until bleeding had stopped and the distal pulse had been checked and was absent. | _____ | _____ |
| 12 | Inspected placement of equipment, ensuring the PDD was in place and the windlass or ratchet was properly positioned over the device. | _____ | _____ |
| 13 | Documented all findings and treatments on a DD Form 1380 and attached it to the casualty. | _____ | _____ |
| 14 | Taped PDD and tourniquet in place prior to transport. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine *website.*
*Tactical Combat Casualty Care Guidelines.*

**Related**
None

## Treat a Casualty with a Neck Wound

081-68W-0091

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment; you must treat a casualty who is bleeding from a penetrating neck wound. You are provided tape, gloves, elastic bandages, scissors, sling, gauze bandage, hemostatic device, and the patients improved first aid kit, pen and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*), SF 600 (*Chronological Record of Medical Care*), or an electronic medical record.

**Standards:** Treat a casualty with a neck wound in accordance *with Tactical Combat Casualty Care (TCCC) Guidelines* and the *Committee on Tactical Combat Casualty Care*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Don personal protective equipment.
2. Expose injury.
3. Assess the wound.

**NOTE:** If active bleeding is revealed apply immediate pressure and continue treatment.

4. Check for an exit wound.
5. Pack neck wound with dressing hemostatic or rolled gauze directly into the wound, using the four Ps of packing (peel, push, pile, and pressure).
6. Ensure the gauze extends 1-2 inches above the skin.

**NOTE:** If gauze does not extend 1-2 inches above the skin, place additional gauze.

7. Hold pressure for 3 minutes.
8. Reassess to ensure bleeding has been controlled while maintaining pressure.

**NOTE:** EVALUATOR: “hemorrhage has been controlled,” if packed properly. EVALUATOR: “hemorrhage has not been controlled,” if not packed properly (Soldier may repack at this time).

9. Place 6-inch elastic bandage over the dressing leaving a tail wrapping the elastic bandage, covering the packing material, in anterior direction under the opposite arm.
10. Continue to wrap around neck and under arm pulling elastic bandage tightly for pressure, covering the packing material.
11. Secure dressing by tying a nonslip knot with end of elastic bandage and tail.

12. Secure elastic bandage tails with tape, wrapping a minimum of 1 1/2 times around the knot.

13. Swath the upper arm (of the injured side) to the chest using a bandage.

14. Continue to assess the wound for further bleeding.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Donned personal protective equipment. | _____ | _____ |
| 2 | Exposed injury. | _____ | _____ |
| 3 | Assessed the wound. | _____ | _____ |
| 4 | Checked for an exit wound. | _____ | _____ |
| 5 | Packed neck wound with dressing hemostatic or rolled gauze directly into the wound, using the four Ps of packing (peel, push, pile, and pressure). | _____ | _____ |
| 6 | Ensured the gauze extended 1-2 inches above the skin. | _____ | _____ |
| 7 | Held pressure for 3 minutes. | _____ | _____ |
| 8 | Reassessed to ensure bleeding had been controlled while maintaining pressure. | _____ | _____ |
| 9 | Placed 6-inch elastic bandage over the dressing leaving a tail wrapping the elastic bandage, covering the packing material, in anterior direction under the opposite arm. | _____ | _____ |
| 10 | Continued to wrap around neck and under arm pulling elastic bandage tightly for pressure, covering the packing material. | _____ | _____ |
| 11 | Secured dressing by tying a nonslip knot with end of elastic bandage and tail. | _____ | _____ |
| 12 | Secured elastic bandage tails with tape, wrapping a minimum of 1 1/2 times around the knot. | _____ | _____ |
| 13 | Swathed the upper arm (of the injured side) to the chest using a bandage. | _____ | _____ |
| 14 | Continued to assess the wound for further bleeding. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Committee on Tactical Combat Casualty Care (CoTCCC).*
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
Joint Trauma System *website.*
*SF 600*. Chronological Record of Medical Care.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Apply a Junctional Tourniquet

081-68W-0092

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You have a casualty with external bleeding from an inguinal wound that is not amenable to pressure bandage(s), or hemostatic dressing. Apply a junctional tourniquet. You have a *Committee for Tactical Combat Casualty Care (CoTCCC)* e recommended junctional tourniquet, a sling (cravat), tape, gloves, and a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*).

**Standards:** Apply a junctional tourniquet with 100% accuracy and in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines* and *Committee on Tactical Combat Casualty Care (CoTCCC)*.

, without error, using the task GO/NO GO checklist.

**Special Condition:** You have an assistant with you to perform this task.

**Performance Steps:**

1. Take BSI precautions.

2. Expose the injury, assess, and check for an exit wound.

**NOTE:** Clothing may need to be cut away to properly expose the injury.

**CAUTION:** Remember, a high percentage of above the knee amputations and inguinal wounds have a higher percentage of a pelvic fractures as well. Therefore, log rolling casualties with these type injuries is not recommended.

3. If possible, apply direct pressure to the source of the most active bleeding.

4. Empty the casualty's pockets and remove items (for example, equipment and weapons) from around the hip area.

5. Place the casualty in the supine position.

6. Continue to apply direct pressure over the femoral pulse just below the inguinal ligament while gathering and preparing the junctional tourniquet.

7. Pass the belt of the junctional tourniquet behind the thighs and slide it upward positioning the target compression device (TCD) over the area to be compressed.
    a. Over the femoral pulse just below the inguinal ligament.

**NOTE:** If wound was not previously packed, use gauze or hemostatic dressing if targeting the TCD directly over an open wound.

b. Place just below the midpoint of the imaginary line between the anterior superior iliac spine and pubic tubercle if femoral pulse is not palpable.

8. Hold the TCD in place and connect the belt by snapping the buckle together.

9. Pull the brown handles away from each other firmly until the buckle is secured, ensuring that all slack is removed from the belt before TCD inflation.

**NOTE:** You will hear an audible click.

10. Fasten excess belt in place by pressing it down on the hook and loop fastener.

**NOTE:** You may hear a second click once the belt is secure.

11. Use the hand pump to inflate the TCDs until the hemorrhage stops and a distal pulse is no longer present.

**NOTE:** When treating bilateral junctional injuries, use a second TCD following the same procedure. Monitor casualty for hemorrhage control and adjust device as necessary.

12. Document time of tourniquet placement on the casualty's forehead.

13. Open and unroll the device and prepare for application.

**NOTE:** Ensure the "This Side Toward Casualty" label is facing up and toward the casualty.

14. Slide the belt under the small of the casualty's back or buttocks.

15. Locate the femoral pulse, just below the inguinal ligament running from the superior iliac crest to the pubic bone to guide the proper placement of the device.

16. Using a back-and-forth motion, slide the belt under the buttocks so that the buttocks pad is centered behind the casualty, allowing alignment of the pressure pads just below the inguinal ligament.

17. Adjust the two junctional pressure pads on the straps to position them in the area over the femoral pulse just below the inguinal ligament.

18. Angle the junctional pressure pads so that their long axis is lined up with (parallel to) the inguinal ligament or gutter (the distal part of the pad will be pointed somewhat medially at approximately a 30-degree angle), ensuring the casualty's genitals are clear of the area to be compressed.

19. Slide the female end into the male end of the buckle; you should hear an audible "click."

20. Pull the free-running end of the strap with the loop handle to tighten up the device and remove all slack.

**NOTE:** Stabilize the belt with your other hand while tightening.

21. Reassess pad placement to ensure the pressure pads are correctly positioned over the femoral pulse and below and parallel (~30-degree angle) to the inguinal ligament.

22. Tighten the threaded T handle on the injured side by turning it in a clockwise direction while using your other hand to stabilize the base plate until the bleeding has stopped.

**NOTE:** If the extremity is intact, check to confirm that the distal pulse has been occluded.

23. Insert the toggle into the opening on the threaded handle and cinch it tight at the base plate to secure the device.

**NOTE:** Repeat the same procedure on the other side if bilateral junctional injuries are present. Monitor the casualty often during movement and transport to ensure the device remains properly positioned, and adjust the device as needed to maintain hemorrhage control.

24. Document the time of application on the designated space on the loop handle.

25. Document all findings and treatments on a DD Form 1380 and attach it to the casualty.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Took BSI precautions. | _____ | _____ |
| 2 | Exposed the injury, assessed, and checked for an exit wound. | _____ | _____ |
| 3 | If possible, applied direct pressure to the source of the most active bleeding. | _____ | _____ |
| 4 | Emptied the casualty's pockets and removed items (for example, equipment and weapons) from around the hip area. | _____ | _____ |
| 5 | Placed the casualty in the supine position. | _____ | _____ |
| 6 | Continued to apply direct pressure over the femoral pulse just below the inguinal ligament while gathering and preparing the junctional tourniquet. | _____ | _____ |
| 7 | Passed the belt of the junctional tourniquet behind the thighs and slid it upward positioning the target compression device (TCD) over the area to be compressed. | _____ | _____ |
| 8 | Held the TCD in place and connected the belt by snapping the buckle together. | _____ | _____ |
| 9 | Pulled the brown handles away from each other firmly until the buckle was secured, ensuring that all slack was removed from the belt before TCD inflation. | _____ | _____ |
| 10 | Fastened excess belt in place by pressing it down on the hook and loop fastener. | _____ | _____ |
| 11 | Used the hand pump to inflate the TCDs until the hemorrhage stopped and a distal pulse was no longer present. | _____ | _____ |

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 12 | Documented time of tourniquet placement on the casualty's forehead. | _____ | _____ |
| 13 | Opened and unrolled the device and prepared for application. | _____ | _____ |
| 14 | Slid the belt under the small of the casualty's back or buttocks. | _____ | _____ |
| 15 | Located the femoral pulse, just below the inguinal ligament running from the superior iliac crest to the pubic bone to guide the proper placement of the device. | _____ | _____ |
| 16 | Used a back-and-forth motion, slid the belt under the buttocks so that the buttocks pad was centered behind the casualty, allowing alignment of the pressure pads just below the inguinal ligament. | _____ | _____ |
| 17 | Adjusted the two junctional pressure pads on the straps to positioned them in the area over the femoral pulse just below the inguinal ligament. | _____ | _____ |
| 18 | Angled the junctional pressure pads so that their long axis was lined up with (parallel to) the inguinal ligament or gutter (the distal part of the pad would be pointed somewhat medially at approximately a 30-degree angle), ensuring the casualty's genitals were clear of the area to be compressed. | _____ | _____ |
| 19 | Slid the female end into the male end of the buckle; you should hear an audible "click." | _____ | _____ |
| 20 | Pulled the free-running end of the strap with the loop handle to tightened up the device and removed all slack. | _____ | _____ |
| 21 | Reassessed pad placement to ensure the pressure pads were correctly positioned over the femoral pulse and below and parallel (~30-degree angle) to the inguinal ligament. | _____ | _____ |
| 22 | Tightened the threaded T handle on the injured side by turning it in a clockwise direction while using your other hand to stabilize the base plate until the bleeding had stopped. | _____ | _____ |
| 23 | Inserted the toggle into the opening on the threaded handle and cinched it tight at the base plate to secure the device. | _____ | _____ |
| 24 | Documented the time of application on the designated space on the loop handle. | _____ | _____ |
| 25 | Documented all findings and treatments on a DD Form 1380 and attached it to the casualty. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Committee on Tactical Combat Casualty Care (CoTCCC).*
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
Joint Trauma System *website.*
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

## Manage Shock

081-68W-0231

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, manage shock in a casualty who suffered significant blood loss from an injury. You are provided with goggles, gloves, intravenous (IV) supplies, ammonia inhalants, blanket, poncho, a hypothermia prevention and management kit (HPMK) and a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*).

**Standards:** Manage shock in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Assess for and control bleeding (see task 081-000-0064, Control Bleeding).
    a. Perform a blood sweep of the casualty from head to toe.
    b. Apply tourniquets, dressings, or pressure dressings if any bleeding is found.
2. Assess and maintain the airway.
    a. Insert a nasopharyngeal airway if indicated (see task 081-000-0067, Insert a Nasopharyngeal Airway).
    b. Administer oxygen, if available (see task 081-000-0073, Administer Oxygen).
3. Assess the casualty's breathing.
    a. Assess front and back for penetrating trauma.
    b. Apply an occlusive dressing, if indicated.
4. Assess casualty's bilateral radial pulses.

**NOTE:** Check for a radial pulse and if absent, check for a carotid pulse. The purpose of the pulse check is to see if a pulse is present and to assess the casualty's need for fluid resuscitation. It also helps determine an approximate systolic blood pressure.

    a. Significant injuries, present radial pulses, normal mental status = saline lock (see task 081-000-0133, Initiate a Saline Lock).
    b. Significant injuries, absent radial pulses and altered mental status = direct IV cannulation and fluid resuscitation (see task 081-000-0038, Manage Intravenous Access).

5. Administer fluid if indicated (see task 081-68W-0314, Administer Fluids Through an Infusion).
6. Maintain normal body temperature.

**NOTE:** Aggressively treat for hypothermia in a trauma casualty. Hypothermia is a common finding in battlefield casualties, regardless of the ambient temperature. The combination of trauma and hypothermia has a significant impact on casualty survival.

a. Wrap the casualty with a casualty blanket.

b. Apply a ready-heat blanket from (HPMK) and cover the casualty with the heat reflective shell.

7. Monitor the casualty.

a. Check vital signs every 5 minutes until they return to normal, and then check every 15 minutes.

b. Check the casualty's level of consciousness.

8. Record all interventions on a DD Form 1380 (see task 081-000-0013, Initiate a Tactical Combat Casualty Care Card).

9. Request medical evacuation (see task 081-000-0120, Initiate a 9-Line Medical Evacuation Request).

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in a field condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Assessed for and controlled bleeding (see task 081-000-0064, Control Bleeding). | _____ | _____ |
| 2 | Assessed and maintained the airway. | _____ | _____ |
| 3 | Assessed the casualty's breathing. | _____ | _____ |
| 4 | Assess casualty's bilateral radial pulses. | _____ | _____ |
| 5 | Administered fluid, indicated (see task 081-68W-0314, Administer Fluids Through an Infusion). | _____ | _____ |
| 6 | Maintained normal body temperature. | _____ | _____ |
| 7 | Monitored the casualty. | _____ | _____ |
| 8 | Recorded all interventions on a DD Form 1380 (see task 081-000-0013, Initiate a Tactical Combat Casualty Care Card). | _____ | _____ |
| 9 | Requested medical evacuation (see task 081-000-0120, Initiate a 9-Line Medical Evacuation Request). | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**

*DD Form 1380. Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Manage a Mild Traumatic Brain Injury

081-000-0023

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment and have a casualty with mild traumatic brain injury (mTBI) and are required to manage mTBI care. You will need a pen, a clipboard, a notepad, a military acute concussion evaluation 2 (MACE 2) card, and Department of Defense Instruction (DoDI) 6490.11.

**Standards:** Manage a patient with mild traumatic brain injury including concussive care in accordance with DoDI 6490.11 while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Special Condition:** Engage Soldier when emotional symptoms are present and validate those symptoms (depression, anxiety, flashbacks, and panic attacks). Discontinue any activity when Soldier reports and increase in symptoms.

**NOTE:** Regional standard operating procedure (SOP) governs mTBI. Refer to unit or clinic's SOP upon arrival to the unit.

**Performance Steps:**

**CAUTION:** Defer Medical Acute Concussion Evaluation (MACE 2) website if any red flags are present. Immediately consult higher level of care and consider urgent evacuation according to evacuation precedence per tactical combat casualty care.

1. Conduct evaluation of the patient using Glasgow coma scale.

**NOTE:** Document initial patient encounter (steps 1-4 MACE card) if negative concussion screen STOP MACE 2- every 24 hours rest.

2. Discuss the results with the primary care manager (PCM).
3. Administer balance error score system assessment.
4. Discuss post-concussive symptoms and prognosis with the patient.
5. Administer the vestibular/ocular-motor screening (VOMS).
    a. Baseline symptoms.
    b. Smooth pursuits.
    c. Saccades: horizontal and vertical.
    d. Visual motion sensitivity test.
    e. Convergence.
    f. Vestibular-ocular reflex test (VOR): horizontal and vertical.
6. Apply the mTBI algorithm using the MACE results.

7. Administer the gait assessment.

8. Administer the graded symptom checklist.

9. Administer the sleep measure assessment.

10. Administer the headache impact test.

11. Record exam summary: cognitive results, neurological results, symptom results, history results, and VOMS results.

12. Provide the baseline measurements to the PCM.

13. Instruct the patient in sleep hygiene, headache and neck pain management, nutrition, and relaxation techniques.

14. Instruct the patient on how to perform memory techniques.

15. Apply results to guide activity intervention while demonstrating functional performance improvement for recommendation to return to duty.

16. Direct the patient to begin light activity.

17. Record observable improvements.

18. Manage the patient's rest, observation, and education.

19. Manage the patient's participation in more strenuous cognitive activities.
    a. Balance.
    b. Board games.
    c. Video games.
    d. Light board (dynatron).

20. Manage the patient's participation in more strenuous physical activities.

**NOTE:** Avoid sit-ups and high-impact exercises.

    a. Warrior task training.
    b. Resistance training in an upright position.

21. Administer exertion test with consent from PCM to determine the Servicemember's (SM's) target heart rate (THR).
    a. Calculate the THR for the patient.
    b. Instruct the patient to ride a bicycle until 65-85% of THR is achieved.
    c. Have the patient cycle an additional 2 minutes after THR is reached.
    d. Have the patient dismount the bicycle and immediately perform 5 push-ups.

**NOTE:** If the SM is on a profile and is unable to perform push-ups, have SM do sit-ups followed by turning over to all fours, assume a standing position, and walk for 10 minutes. If the SM is

unable to do push-ups or sit-ups, continue cycling for 3 minutes total, dismount and stand or walk for 10 minutes.

e. Have the patient stand and walk for 10 minutes immediately following the push-ups.

f. Inform PCM of exertion testing results.

g. Have the patient rest with symptom-free exertion test for 1 hour in preparation for additional vigorous testing activity.

22. Administer the military performance assessment.

a. Determine the patient's THR.

b. Assess the patient's performance on the engagement skills trainer 2000 simulation activity or equivalent simulation center activity.

c. Assess the patient's performance on donning improved outer tactical vest (IOTV) and Army combat helmet (ACH).

d. Instruct the patient to perform a dual task challenge as a warm-up.

(1) Walking on a flat surface while reciting the phonetic alphabet.

(2) Walking on a flat surface while reciting the times table through number 5.

e. Assess if the patient has any difficulty with the dual task challenge while documenting the results.

f. Instruct the patient to take a knee and touch nose to knee.

g. Evaluate the patient on balance, loss, or presence of symptoms with alternating positions.

h. Instruct the patient to force road march for 5 minutes.

i. Ensure the patient's heart rate does not exceed THR.

j. Instruct the patient to force road march again with a pace that is not to exceed a "fast walk."

k. Introduce the patient to balance challenges.

l. Instruct the patient to perform a 5-minute cooldown walk and remove IOTV and ACH.

m. Check the patient's heart rate to ensure it is below the THR.

23. Record findings and results on the SF 600 (*Chronological Record of Medical Care*) (include the mTBI diagnostic code).

**NOTE:** *MACE 2 list of things to be aware of are the Etiology, Location, Severity and, Encounter. Deployment code must fall within the first four codes when applicable.

24. Provide the MPA results to the PCM.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Conducted evaluation of the patient using Glasgow coma scale. | _____ | _____ |
| 2 | Discussed the results with the primary care manager (PCM). | _____ | _____ |

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 3 | Administered balance error score system assessment. | _____ | _____ |
| 4 | Discussed post-concussive symptoms and prognosis with the patient. | _____ | _____ |
| 5 | Administered the vestibular ocular-motor screening (VOMS). | _____ | _____ |
| 6 | Applied the mTBI algorithm using the MACE results. | _____ | _____ |
| 7 | Administered the gait assessment. | _____ | _____ |
| 8 | Administered the graded symptom checklist. | _____ | _____ |
| 9 | Administered the sleep measure assessment. | _____ | _____ |
| 10 | Administered the headache impact test. | _____ | _____ |
| 11 | Recorded exam summary: cognitive results, neurological results, symptom results, history results, and VOMS results. | _____ | _____ |
| 12 | Provided the baseline measurements to the PCM. | _____ | _____ |
| 13 | Instructed the patient in sleep hygiene, headache and neck pain management, nutrition, and relaxation techniques. | _____ | _____ |
| 14 | Instructed the patient on how to perform memory techniques. | _____ | _____ |
| 15 | Applied results to guide activity intervention while demonstrating functional performance improvement for recommendation to return to duty. | _____ | _____ |
| 16 | Directed the patient to begin light activity. | _____ | _____ |
| 17 | Recorded observable improvements. | _____ | _____ |
| 18 | Managed the patient's rest, observation, and education. | _____ | _____ |
| 19 | Managed the patient's participation in more strenuous cognitive activities. | _____ | _____ |
| 20 | Managed the patient's participation in more strenuous physical activities. | _____ | _____ |
| 21 | Administered exertion test with consent from PCM to determine the Servicemember's (SM's) target heart rate (THR). | _____ | _____ |
| 22 | Administered the military performance assessment. | _____ | _____ |
| 23 | Recorded findings and results on the SF 600 (*Chronological Record of Medical Care*) (include the mTBI diagnostic code). | _____ | _____ |
| 24 | Provided the MPA results to the PCM. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DoDI 6490.11. *DoD Policy Guidance for Management of Mild Traumatic Brain Injury/Concussion in the Deployed Setting.*
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Medical Acute Concussion Evaluation website.
SF 600. *Chronological Record of Medical Care*.

**Related**
None

## Treat a Head Injury

081-000-0040

**WARNING:** Treat casualties with any type of traumatic head injury or loss of consciousness as if they have a spinal injury.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In any operational environment, a casualty is suffering from a head injury. All other more serious injuries have been assessed and treated. You will be provided head supports, bandage gauze, field dressing, emergency dressing, elastic bandage, bandage scissors, adhesive tape, rigid cervical collar device, pen, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*), SF 600 (*Chronological Record of Medical Care*), or an electronic medical record.

**Standards:** Treat a head injury in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

**WARNING:** Brain injury, leading to a loss of function or death, often occurs without evidence of a skull fracture or scalp injury. Because the skull cannot expand, swelling of the brain or a collection of fluid pressing on the brain can cause pressure. This can compress and destroy the brain tissue.

1. Conduct combat casualty assessment (see task 081-000-0049, Perform a Combat Casualty Assessment).

**NOTE:** Check for the signs and symptoms of head injuries.

a. Closed head injury–caused by a direct blow to the head.
   (1) Deformity of the head.
   (2) Clear fluid or blood escaping from the nose or ear(s).
   (3) Periorbital discoloration (raccoon eyes).
   (4) Bruising behind the ears, over the mastoid process (battles sign).
   (5) Lowered pulse rate if the casualty has not lost a significant amount of blood.
   (6) Signs of increased intracranial pressure.
      (a) Headache, nausea, or vomiting.
      (b) Possible unconsciousness.
      (c) Change in pupil size or symmetry.
      (d) Lateral loss of motor nerve function–one side of the body becomes paralyzed.

**NOTE:** Lateral loss may not happen immediately but may occur later.

(e) Change in the casualty's respiratory rate or pattern.

(f) A steady rise in the systolic blood pressure if the casualty has not lost significant amounts of blood.

(g) A rise in the pulse pressure (systolic pressure minus diastolic pressure).

(h) Elevated body temperature.

(i) Restlessness–indicates insufficient oxygenation of the brain.

b. Concussion–caused by a violent jar or shock.

**NOTE:** A direct blow to the skull may bruise the brain.

(1) Temporary unconsciousness followed by confusion.

(2) Temporary, usually short term, loss of some or all brain functions.

(3) The casualty has a headache or is seeing double.

(4) The casualty may or may not have a skull fracture.

c. Contusion–an internal bruise or injury. It is more serious than a concussion. The injured tissue may bleed or swell. Swelling may cause increased intracranial pressure that may result in a decreased level of consciousness and even death.

d. Open head injury.

(1) Penetrating wound–an entry wound with no exit wound.

(2) Perforating wound–the wound has both entry and exit wounds.

(3) Visibly deformed skull.

(4) Exposed brain tissue.

(5) Possible unconsciousness.

(6) Paralysis or disability on one side of the body.

(7) Change in pupil size.

(8) Lacerated scalp tissue–may have extensive bleeding.

2. Direct manual stabilization of the casualty's head.

3. Assess the casualty's level of consciousness.

a. Alert, voice, pain, unresponsive method.

b. Is the casualty unconscious?

c. Does the casualty respond to verbal stimuli or commands?

d. Does the casualty respond to painful stimulus?

e. Does the casualty know their name, date, or time; location and events leading up to the injury, (alert and oriented x four)?

4. Perform a military acute concussion evaluation screening for traumatic brain injury.

5. Monitor unstable casualties every 5 minutes and document findings.

a. Level of consciousness.

b. Pupillary responsiveness and equality.

c. Vital signs.

d. Motor functions.

(1) Evaluate the casualty's strength, mobility, coordination, and sensation.
(2) Document any complaints, weakness, or numbness.

6. Record the treatment on the DD Form 1380 or EMR.

7. Evacuate the casualty.

**NOTE:** Casualty should be facing you during transport. It is much easier to monitor and manage their airway if you can see it all times. Have suction readily available.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Conducted combat casualty assessment (see task 081-000-0049, Perform a Combat Casualty Assessment). | _____ | _____ |
| 2 | Directed manual stabilization of the casualty's head. | _____ | _____ |
| 3 | Assessed the casualty's level of consciousness. | _____ | _____ |
| 4 | Performed a military acute concussion evaluation screening for traumatic brain injury. | _____ | _____ |
| 5 | Monitored unstable casualties every 5 minutes and documented findings. | _____ | _____ |
| 6 | Recorded the treatment on the DD Form 1380 or EMR. | _____ | _____ |
| 7 | Evacuated the casualty. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care Guidelines.*

**Related**
None

Perform a Combat Casualty Assessment

081-000-0049

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You are required to perform a combat casualty assessment (CCA) on a casualty who is lying on the ground and appears to be wounded. You will need a fully stocked M9 or medical aid bag and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*).

**Standards:** Perform a CCA in accordance with (IAW) *Tactical Combat Casualty Care (TCCC) Guidelines* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Perform actions for care under fire or threat.
    a. Inform casualty to return fire and take cover.
    b. Inform casualty to move to cover and apply self-aid.

**NOTE:** Use a *Committee on Tactical Combat Casualty Care (CoTCCC)* for a recommended limb tourniquet for hemorrhage that is anatomically amenable to tourniquet use.

    c. Move to casualty (when tactically feasible).

**WARNING:** If the site of the life-threatening bleeding is not readily apparent, place the tourniquet “high and tight” (as proximal as possible) on the injured limb.

    d. Neutralize life-threatening external hemorrhage.

**NOTE:** Apply the limb tourniquet over the uniform clearly proximal to the bleeding site (if casualty was unable to perform self-aid).

    e. Move casualty from the site of injury to cover.

**NOTE:** Try to keep the casualty from sustaining additional wound during movement.

2. Check casualty for responsiveness.
    a. Communicate to casualty to elicit a verbal response.
    b. Check for presence of carotid pulse (see task 081-000-1001, Assess Patient Vital Signs).
    c. Check for presence of respirations (see task 081-000-1001, Assess Patient Vital Signs).
    d. React to findings IAW tactical environment.

**WARNING:** Casualties with an altered mental status should have weapons and communications equipment taken away immediately.

**CAUTION:** Establish a security perimeter IAW unit tactical standard operating procedures or battle drills. Triage casualties as required. Maintain tactical situational awareness. This is the tactical field care phase.

3. Manage massive hemorrhage (MARCH).
    a. Check the effectiveness of previously applied tourniquets.
    b. Perform blood sweep of neck, axillary, inguinal and extremity areas.
    c. Treat all sources of bleeding.
        (1) Apply CoTCCC-recommended limb tourniquet directly to the skin 2-3 inches above the bleeding site (if applicable).

**NOTE:** If bleeding is not controlled with the first tourniquet, apply a second tourniquet side-by-side with the first.

**CAUTION:** Hemostatic dressings should be applied with at least 3 minutes of direct pressure.

        (2) Apply dressing hemostatic as the CoTCCC hemostatic dressing of choice (if applicable) (see task 081-COM-0099, Apply a Hemostatic Dressing).
        (3) Apply a CoTCCC-recommended junctional tourniquet (if applicable) (see task 081-68W-0092, Apply a Junctional Tourniquet). If the bleeding site is amenable to use of a junctional tourniquet.
    d. Perform initial assessment for hemorrhagic shock.
        (1) Check for altered mental status in the absence of brain injury.
        (2) Check for weak or absent radial pulse (see task 081-000-1001, Assess Patient Vital Signs).

4. Manage airway (mArch).
    a. Check casualty for presence of open airway.

**NOTE:** Open (head tilt) the casualty's airway (look, listen, and feel). Allow a conscious casualty to assume any position that best protects the airway, to include sitting up or leaning forward.

    b. Place a nasopharyngeal airway (if indicated).
    c. Place an extra glottic airway device (if indicated) (see task: 081-68W-0230, Place an Intermediate Airway Device).

**NOTE:** The subglottic airway is the preferred extra glottic airway device.

**WARNING:** Surgical cricothyroidotomies should not be performed on unconscious casualties who have no direct airway trauma unless use of a nasopharyngeal airway or an extra glottic airway have been unsuccessful in opening the airway.

    d. Perform a surgical cricothyroidotomy (if indicated) (see task 081-000-0122, Perform a Surgical Cricothyroidotomy).

**CAUTION:** Always remember that the casualty's airway status may change over time and requires frequent reassessment.

    e. Monitor the casualty's hemoglobin oxygen saturation.

f. Place the casualty in the recovery position (if unconscious).

5. Manage respiration or breathing (maRch).
   a. Check casualty's breathing and respiration rate.
      (1) Remove casualty's equipment or individual body armor (if applicable).
      (2) Check casualty chest for equal rise and fall (spontaneous respiratory effort).
      (3) Check casualty's chest for penetrating injury (front and back).
   b. Treat all chest wounds.

**NOTE:** First wound found is the first one treated.

      (1) Apply vented chest seal to wound.

**NOTE:** If a vented chest seal is not available, use a non-vented chest seal.

      (2) Monitor the casualty for the potential development of a subsequent tension pneumothorax.

   c. Perform needle chest decompression for tension pneumothorax (if indicated) (see task 081-68W-0075, Perform Needle Decompression of the Chest).

**WARNING:** Readings may be misleading in the settings of shock or marked hypothermia.

   d. Administer pulse oximetry monitoring (if not previously applied).

**NOTE:** All individuals with moderate or severe traumatic brain injury (TBI) should be monitored with pulse oximetry.

**WARNING:** Casualties with moderate or severe TBI should be given supplemental oxygen when available to maintain an oxygen saturation > 90%.

   e. Administer oxygen if available (see task 081-000-0073, Administer Oxygen).

6. Manage circulation (marCh).
   a. Check all prior tourniquet applications.

**NOTE:** Expose the wound and determine if a tourniquet is needed. If it is needed, replace any limb tourniquet placed over the uniform with one applied directly to the skin 2-3 inches above the bleeding site.

**CAUTION:** If bleeding persists or a distal pulse is still present, consider additional tightening of the tourniquet or the use of a second tourniquet side-by-side with the first to eliminate both bleeding and the distal pulse.

   b. Check distal pulses (if no traumatic amputation is present).

**DANGER:** Do not remove a tourniquet that has been in place more than 6 hours unless close monitoring and lab capability are available. Every effort should be made to convert tourniquets in less than 2 hours if bleeding can be controlled with other means.

**WARNING:** Limb tourniquets and junctional tourniquets should be converted to hemostatic or pressure dressings as soon as possible if three criteria are met: the casualty is not in shock; it is possible to monitor the wound closely for bleeding; and the tourniquet is not being used to control bleeding from an amputated extremity.

c. Replace tourniquets with hemostatic or pressure dressings (if applicable).
d. Treat significant non-pulsatile hemorrhage.
e. Check for hemorrhagic shock.

**NOTE:** Indicators include, altered mental status in the absence of brain injury or weak or absent radial pulse.

f. Obtain vascular access.
   (1) Check radial pulse, if absent, check for carotid pulse.
   (2) Perform an intravenous (IV) or intraosseous (IO) infusion (if indicated) (see tasks 081-000-0038, Manage Intravenous Access, and 081-68W-0237, Place an Intraosseous Device).

**NOTE:** IV or IO access is indicated if the casualty is in hemorrhagic shock or at significant risk of shock (and may therefore need fluid resuscitation), or if the casualty needs medications, but cannot take them by mouth.

**WARNING:** DO NOT GIVE later than 3 hours after injury.

g. Administer tranexamic acid (if indicated) (see task 081-68W-0311, Administer Tranexamic Acid).

**WARNING:** If a casualty in shock is not responding to fluid resuscitation, consider untreated tension pneumothorax as a possible cause of refractory shock.

h. Perform fluid resuscitation as needed.

**CAUTION:** Minimize casualty's exposure to cold ground, wind, and air temperatures. Place insulation material between the casualty and any cold surface as soon as possible.

7. Manage hypothermia (marcH).

**NOTE:** Take early and aggressive steps to prevent further body heat loss and add external heat when possible, for both trauma and severely burned casualties.

a. Maintain casualty's protective equipment.
b. Replace wet clothing with dry clothing, if possible.
c. Place an active heating blanket on the casualty's anterior torso and under the arms in the axillae.
d. Apply a battery-powered warming device to deliver IV or IO resuscitation fluids.

8. Treat penetrating eye trauma.
   a. Perform a rapid field test of visual acuity.
   b. Place a cover over the eye with a rigid eye shield (if indicated).

c. Ensure that the 400 milligram (mg) moxifloxacin tablet in the combat wound medication pack is taken (if possible).

9. Perform monitoring.

**NOTE:** Administer advanced electronic monitoring if indicated (if available).

**WARNING:** Casualties need to be disarmed after being given oral transmucosal fentanyl citrate (OTFC), IV or IO fentanyl, ketamine, or midazolam.

10. Manage analgesia.
    a. Check for drug allergies.
    b. Administer appropriate pain management.
        (1) Administer acetaminophen – 500 mg tablet, 2 per orally (PO) every 8 hours and meloxicam – 15 mg PO once a day for mild to moderate pain.

**WARNING:** Give only if the casualty IS NOT in shock or respiratory distress AND casualty IS NOT at significant risk of developing either condition.

        (2) Administer OTFC 800 microgram (µg) for mild to moderate pain.

**NOTE:** May repeat once more after 15 minutes if pain uncontrolled by first dose.

**WARNING:** For all casualties given opioids, ketamine, or benzodiazepines – monitor airway, breathing, and circulation closely.

        (3) Administer ketamine 30 mg (or 0.3 mg or kilogram [kg]) slow IV or IO push or ketamine 50-100 mg (or 0.5-1 mg/kg) intramuscular (IM) or intranasal (IN) for moderate to severe pain.

**NOTE:** Repeat doses every 20 minutes as needed via IV or IO and repeat doses every 20-30 minutes as needed for IM or IN. End points: control of pain or development of nystagmus, (rhythmic back-and-forth movement of the eyes).

**CAUTION:** Antibiotics are recommended for all open combat wounds.

11. Administer antibiotics.
    a. Administer moxifloxacin, 400 mg PO once a day (if able to give by mouth).
    b. Administer ertapenem, 1 gram (g) IV or IO or IM once a day (if unconscious).

12. Perform secondary assessment.

**NOTE:** When completing the secondary assessment, adhere to the pneumonic DCAP (deformities, contusions, abrasions, punctures, or penetration), BLS (burns, lacerations, and swelling), and TIC (tenderness, instability, and crepitus) when checking the body for additional injuries.

    a. Check head.
        (1) Inspect the skull for DCAP-BLS and TIC.
        (2) Inspect for pupils equal, round, and reactive to light.

(3) Inspect mouth, nose, and ears.
(4) Treat all injuries appropriately.

b. Check neck.
(1) Inspect for DCAP-BLS and TIC.
(2) Check position of trachea.
(3) Check cervical spine for TIC.
(4) Check jugular veins for distention.
(5) Treat all injuries appropriately.

c. Check chest.
(1) Inspect and palpate for DCAP-BLS and TIC in chest (shoulder girdle, sternum, and rib cage) and axilla.
(2) Check both sides of chest for presence or absence of lung sounds.
(3) Treat any injuries appropriately.

d. Check abdomen and pelvis.
(1) Inspect and palpate abdomen for DCAP-BLS and TIC.
(2) Check pelvis for TIC.
(3) Inspect genitalia and perineum.
(4) Treat all injuries appropriately.

e. Check lower extremities and upper extremities.
(1) Inspect and palpate for DCAP-BLS and TIC.
(2) Check for motor, sensory, and circulatory function.
(3) Perform splinting (if needed).

f. Check posterior thorax, lumbar and buttocks.
(1) Inspect for DCAP-BLS and TIC.
(2) Check for TIC along the spine.
(3) Treat any injuries appropriately.

13. Prepare for evacuation.
a. Communicate with the evacuation system to arrange for tactical evacuation.
b. Complete and secure the DD Form 1380 to the casualty.
c. Secure all interventions.
d. Secure litter straps as required.
e. Position casualties for evacuation IAW unit standard operating procedures (SOPs).
f. Maintain security at the evacuation point IAW unit SOPs.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Performed actions for care under fire or threat. | _____ | _____ |
| 2 | Checked casualty for responsiveness. | _____ | _____ |
| 3 | Managed massive hemorrhage (MARCH). | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 4 | Managed airway (mArch). | _____ | _____ |
| 5 | Managed respiration or breathing (maRch). | _____ | _____ |
| 6 | Managed circulation (marCh). | _____ | _____ |
| 7 | Managed hypothermia (marcH). | _____ | _____ |
| 8 | Treated penetrating eye trauma. | _____ | _____ |
| 9 | Performed monitoring. | _____ | _____ |
| 10 | Managed analgesia. | _____ | _____ |
| 11 | Administered antibiotics. | _____ | _____ |
| 12 | Performed secondary assessment. | _____ | _____ |
| 13 | Prepared for evacuation. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
Committee on Tactical Combat Casualty Care (CoTCCC).
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
Joint Trauma System website.
Tactical Combat Casualty Care (TCCC) Guidelines.

**Related**
None

## Treat a Casualty with an Axillary Wound

081-68W-0079

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you must treat a casualty who is bleeding externally from a single penetrating axillary wound that requires packing and a pressure dressing. You will be provided with an improved first aid kit, scissors, dressing hemostatic, a cravat, and a 6-inch elastic bandage.

**Standards:** Treat a casualty with an axillary wound by packing the bleeding wound and applying a dressing within 90 seconds, in accordance with the *Tactical Combat Casualty (TCCC) Care Guidelines*, while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**Performance Steps:**

1. Don personal protective equipment.

2. Lift the arm to expose the injury and assess the bleeding source.

**NOTE:** Clothing may need to be cut away to properly expose the injury. The best position to treat the casualty is the seated position. If the casualty cannot be treated in the seated position, you will need to sit the casualty up as much as possible to apply the elastic bandage.

3. Apply direct pressure to the source of the most active bleeding and using the casualty's joint first aid kit and remove the hemostatic dressing from its sterile package.

4. Extend the casualty's arm at a 90-degree angle by placing it on your shoulder to maintain elevation of the arm, while proceeding through steps 5-12.

**CAUTION:** If a penetrating object is lodged into the casualty's body, bandage it in place. Do not remove the object.

5. Pack the axillary wound tightly with hemostatic gauze until the wound cavity is filled.

**NOTE:** More than one gauze may be required to stop the blood flow. All gauze should be finished packing within 90 seconds.

6. Ensure the gauze extends 1-2 inches above the skin.

**NOTE:** If the gauze does not extend 1-2 inches above the skin, place additional gauze.

7. Hold pressure for a minimum of 3 minutes.

8. Reassess to ensure bleeding has been controlled while maintaining pressure.
   a. If bleeding has not been controlled:
      (1) If packed with hemostatic dressing, remove prior packing material, and repack starting at step 4.

(2) If packed with gauze, apply additional gauze and pressure (for 3 minutes) until bleeding has stopped.

b. If bleeding is controlled moved to step 9.

9. While maintaining pressure on the dressing or gauze, wrap the pressure (or elastic) bandage around the injured shoulder twice, ensuring the gauze underneath is completely covered.

**NOTE:** If using an elastic bandage without a closure bar, leave a tail on the posterior side of the casualty.

10. Wrap the elastic bandage across, back, and under the opposite armpit, anchoring around the opposite shoulder in a figure-eight pattern.

11. Depending on the bandage used, secure with the closure bar or tie the tails of the elastic bandage together with a nonslip knot.

12. Secure pressure (elastic) bandage tails and knot using 3-inch tape, wrapping the tape a minimum of 1-1 1/2 times around the knot.

13. Swath the upper arm to the side of the chest using a cravat.

14. Continue to assess the wound for further bleeding.

15. Document all findings and treatments on a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*) and attach it to the casualty.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Donned personal protective equipment. | _____ | _____ |
| 2 | Lifted the arm to expose the injury and assessed the bleeding source. | _____ | _____ |
| 3 | Applied direct pressure to the source of the most active bleeding and using the casualty's joint first aid kit and removed the hemostatic dressing from its sterile package. | _____ | _____ |
| 4 | Extended the casualty's arm at a 90-degree angle by placing it on your shoulder to maintain elevation of the arm, while proceeding through steps 5-12. | _____ | _____ |
| 5 | Packed the axillary wound tightly with hemostatic gauze until the wound cavity was filled. | _____ | _____ |
| 6 | Ensured the gauze extended 1-2 inches above the skin. | _____ | _____ |
| 7 | Held pressure for a minimum of 3 minutes. | _____ | _____ |
| 8 | Reassessed to ensure bleeding had been controlled while maintaining pressure. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 9 | While maintaining pressure on the dressing or gauze, wrapped the pressure (or elastic) bandage around the injured shoulder twice, ensuring the gauze underneath was completely covered. | _____ | _____ |
| 10 | Wrapped the elastic bandage across, back, and under the opposite armpit, anchoring around the opposite shoulder in a figure-eight pattern. | _____ | _____ |
| 11 | Depending on the bandage used, secured with the closure bar or tied the tails of the elastic bandage together with a nonslip knot. | _____ | _____ |
| 12 | Secured pressure (elastic) bandage tails and knot using 3-inch tape, wrapping the tape a minimum of 1-1 1/2 times around the knot. | _____ | _____ |
| 13 | Swathed the upper arm to the side of the chest using a cravat. | _____ | _____ |
| 14 | Continued to assess the wound for further bleeding. | _____ | _____ |
| 15 | Documented all findings and treatments on a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*) and attach it to the casualty. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

**Subject Area 7: Triage and Evacuation**

Perform Casualty Movement

081-68W-0282

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment. You are required to perform casualty movement for a team member wounded by sniper fire. You must rapidly move your casualty by evacuating the Soldier from the point of injury to cover. You will be provided with and must utilize one of the following items: rescue sling, extraction device, tactical evacuation strap, or an extraction strap system and if none are present, use the manual carry.

**Standards:** Perform casualty movement in accordance with *PHTLS Prehospital Trauma Life Support,* while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**Performance Steps:**

1. Determine the appropriate extraction device or carry for the tactical situation.
2. Communicate the plan to the casualty.
3. Tactically approach the casualty.
4. Secure the casualty's weapon and other equipment as feasible.
5. Attach the appropriate extraction device or secure the casualty for manual carry.
   a. Rescue sling (single rescuer).

**NOTE:** The rescue sling is a five link, tubular nylon, extraction device that enables rescuers to either drag or carry a casualty. The rescue sling has five color coded tubular nylon loops (one green, two brown, and two black) and is rated at 4,500 pounds (lbs).

(1) Spread the rescue sling over the casualty's body with the green loop on the casualty's neck and the two brown loops at the casualty's arms.

(2) Place each arm through each of the two brown loops (one arm per loop).

**CAUTION:** Do not place the casualty's head through the green loop.

(3) Take the entire green loop, which is on the casualty's neck, and rotate it behind the casualty's head.

(4) Position yourself at the casualty's head and grab both black loops, as handles.

(5) Drag the casualty to cover.

b. Rescue sling (four-man rescue).

(1) Spread the rescue sling over the casualty's body with the green loop on the casualty's neck and the two brown loops at the casualty's arms.

(2) Slide one of the casualty's legs through one of the black loops and the other leg through the other black loop.

(3) Place each arm through each of the two brown loops (one arm per loop).

**CAUTION:** Do not place the casualty's head through the green loop.

(4) Take the entire green loop, that is on the casualty's neck and rotate it behind the casualty's head.

(5) Have all four rescuers position themselves two on each side of the casualty, facing the same direction.

(6) The rescuers at the casualty's shoulders grab the brown loops and the rescuers at the casualty's thighs grab the black loops.

(7) All four rescuers lift the casualty off the ground simultaneously and move out to cover.

c. Extraction device (headfirst extraction).

**NOTE:** The extraction device is a rapid extraction device that has two handles, a metal floating bull ring (which provides for adjustable attachment points), and a spring actuated non-locking carabiner. The extraction device has a tensile strength of 4,200 lbs and is made of 1-inch tech tape.

(1) Kneel down next to the closest shoulder of the casualty.

**WARNING:** Do not pass the carabiner under the strap that attaches the deltoid armor protection (DAP) to the shoulder strap of the body armor.

(2) Pass the carabiner (that is attached to the distal portion of the extraction device) under the shoulder strap of the casualty's body armor.

(3) Pass the extraction device through the keeper of the carabiner and pull up (taking out the slack).

**NOTE:** If the rescuer is short, hook the carabiner through the two loops located approximately 1/3 down from the handles.

(4) Grab both extraction device with the non-firing hand and stand up.

(5) Stand up and lean slightly back (which will slightly elevate the casualty's torso off the ground.

(6) Drag the casualty to cover.

d. Extraction device (feet first extraction).

(1) Kneel down next to the casualty's feet.

(2) Pass the carabiner (that is attached to the distal portion of the extraction device) under and around the casualty's ankles.

(3) Pass the extraction device straps through the keeper of the carabiner and pull up (taking out the slack).

(4) Grab both extraction device with the non-firing hand and stand up.

(5) Stand up and lean slightly back (which will slightly elevate the casualty's legs off the ground).

**NOTE:** This will lift both of the casualty's legs and reduce the friction that the casualty's body would create.

(6) Drag the casualty to cover.

e. Tactical evacuation strap.

**NOTE:** The tactical evacuation strap is a lightweight, built-in handle harness system that is constructed of two-inch nylon webbing and is rated at over 3,000 lbs tensile strength. The harness is worn like a vest under the body armor of the casualty. The drag handles are stowed slightly above the rear collar of the body armor and are held in place by a hook-and-loop fastener strap. The benefit of the tactical evacuation strap is that when the casualty is being extracted, the casualty's body armor does not move up toward the casualty's head exposing more of the casualty's torso to possible enemy fire.

(1) Kneel down next to the casualty's shoulders.

(2) Grab both extraction device with the non-firing hand and stand up.

(3) Stand up and lean slightly back (which will slightly elevate the casualty's torso off the ground).

(4) Drag the casualty to cover.

f. Extrication strap (feetfirst rescue).

**NOTE:** The extrication strap is a 1-inch tech tape casualty extraction system that has a quick release shackle on one end and a National Fire Protection Agency rated carabiner on the opposite end. The extrication strap is rated at 4,200 lbs tensile strength. Along over two thirds of the length of the strap (from the quick release shackle to approximately two thirds of the strap) there is reinforced stitching, triple bar tacked loops which enables the rescuer to shorten the length of the strap to elevate the casualty's body off the ground and reduce friction during the extraction.

**NOTE:** In order to use the extraction strap, a special belt with a carabiner attachment ring must be worn or a regular military belt must be fitted with a carabiner. The extraction strap should be attached to the carabiner attachment ring, or the carabiner (attached already to the rescuer's belt) by way of the quick release shackle and tucked into the rescuer's trouser pocket that is located on the rescuer's non-firing hand side, prior to tactically approaching the casualty.

**NOTE:** Estimate the amount of slack that would be needed to be taken out of the overall length of the extraction strap to ensure that the casualty's upper torso will lift off the ground. Hook the carabiner through the triple bar tack loop that will give you the proper length of the extraction strap.

(1) Kneel down next to the casualty's feet.

(2) Pass the carabiner (that is attached to the distal portion of the extrication strap) under and around the casualty's ankles.

(3) Loop the extrication strap through the keeper of the carabiner and pull up (taking out the slack).

(4) Stand up and lean slightly back (which will slightly elevate the casualty's legs off the ground).

(5) Drag the casualty to cover.

g. Extrication strap (headfirst rescue).

**WARNING:** Do not pass the carabiner under the strap that attaches the DAP to the shoulder strap of the body armor.

(1) Pass the carabiner (that is attached to the distal portion of the extrication strap) under the shoulder strap of the casualty's body armor.

(2) Pass the extrication strap through the keeper of the carabiner and pull up (taking out the slack).

(3) Stand up and lean slightly back (which will slightly elevate the casualty's legs off the ground).

(4) Drag the casualty to cover.

h. Hawes carry.

**NOTE:** The Hawes carry can only be performed on a conscious casualty that can hold onto the rescuers body.

(1) Assist the casualty in standing.

(2) Squat in front of the casualty, while maintaining an erect posture.

(3) Have the casualty lean forward, against the rescuer's back, and wrap an arm around the rescuer's neck and across the rescuer's chest.

**NOTE:** The casualty wraps the same arm as the rescuer's shooting hand around the rescuer's neck. This enables the rescuer to secure the casualty's arm with their non-firing hand.

(4) The rescuer then leans slightly forward and then stands up (lifting with the large muscles of the legs).

(5) The rescuer then moves out to cover with the casualty.

i. Sea, air, and land team three carry.

(1) Have a rescuer kneel on both sides of the casualty.

(2) Place the casualty in the sitting position.

(3) Place the casualty's arms around each of the two rescuer's neck.

(4) Have the rescuers grab the casualty's wrist with the hands located on the outside of the rescuers' bodies.

(5) Have the rescuers grab the casualty's belt with the hands located on the inside towards the casualty.

(6) Both rescuers simultaneously stand (lifting with the large muscles of the legs).

(7) The rescuers then move out to cover with the casualty.

6. Extract the casualty to cover.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|
| 1 Determined the appropriate extraction device or carry for the tactical situation. | _____ | _____ |
| 2 Communicated the plan to the casualty. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 3 | Tactically approached the casualty. | _____ | _____ |
| 4 | Secured the casualty's weapon and other equipment as feasible. | _____ | _____ |
| 5 | Attached the appropriate extraction device or secured the casualty for manual carry. | _____ | _____ |
| 6 | Extracted the casualty to cover. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*PHTLS Prehospital Trauma Life Support.*

**Related**
None

**Transport a Casualty Using a Litter**

**081-68W-0298**

**Conditions:** You have completed triaging and treating a casualty. You are in charge of placing the casualty onto a litter and transporting to an evacuation vehicle. You will need a litter, two patient securing straps, ATP 4-02.13, and assistance from three other Soldiers to act as litter bearers.

**Standards:** Transport a casualty using a litter without causing further injury to the casualty.

**Performance Steps:**

1. Prepare the litter for the casualty.
    a. Standard litter.
        (1) Unfasten both litter straps.
        (2) Stand the litter on one end, and pull open.
        (3) Using one foot, lock the bottom spreader bar open.
        (4) Rotate the litter into a standing position with the opposite end on the ground.
        (5) Using one foot, lock the second spreader bar open (see figure 3-1).

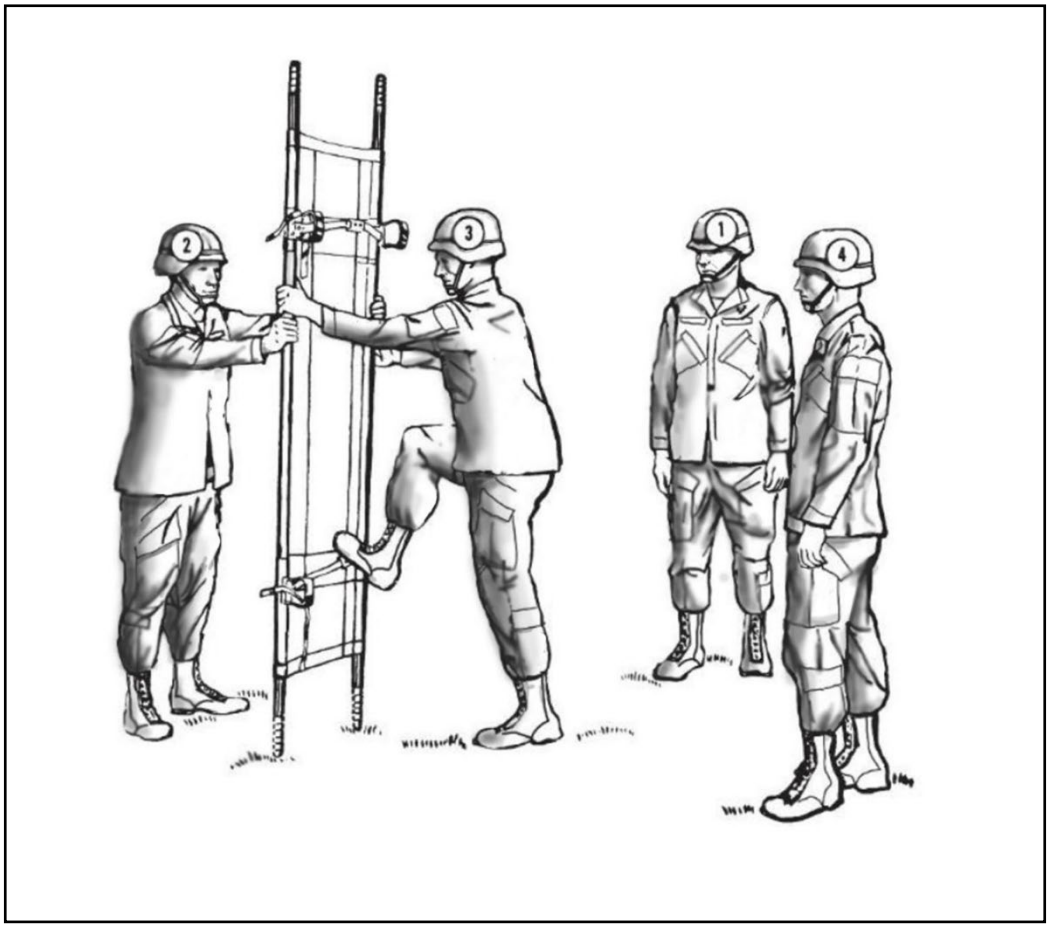


**Figure 3-1. Litter bearer opening the litter**

(6) Lower the litter to the ground with the canvas (mesh) side in the up position.

b. Collapsible handle litter.

(1) Stand the collapsed litter upright with handles pointing skyward. Extend all four collapsible handles (if using the collapsible handle version of the collapsible handle litter) until the button pops out on each handle.

(2) Release buckles from the litter.

(3) Place the litter on the ground, and completely extend it with the fabric side up.

(4) Keeping the litter as straight as possible, grab the handles, and rotate inward until all hinges rotate and lock.

**NOTE:** This action is best executed simultaneously using two individuals on each end of the litter.

**WARNING:** This step should be performed while the Soldier is sitting on the ground to prevent falling.

(5) While maintaining the hinges in the locked position, apply firm, steady pressure on the spreader bar with a foot. Increase the pressure with the foot until the spreader bar fully opens and locks into place.

(6) Rotate the litter, and place a foot on the opposite spreader bar applying firm and steady pressure. Increase the foot pressure on the spreader bar until the spreader bar fully opens and locks into place.

**WARNING:** When moving a casualty onto a litter, the casualty must be wearing an Army combat helmet unless the casualty's wounds prevent the use of an Army combat helmet.

2. Load a casualty onto a litter.
   a. Have three litter bearers kneel at the casualty's side (see figure 3-2 on page 3-196).

**NOTE:** Have a litter bearers face the casualty and kneel by the casualty's shoulders, hips, and ankles at the same side of the casualty.

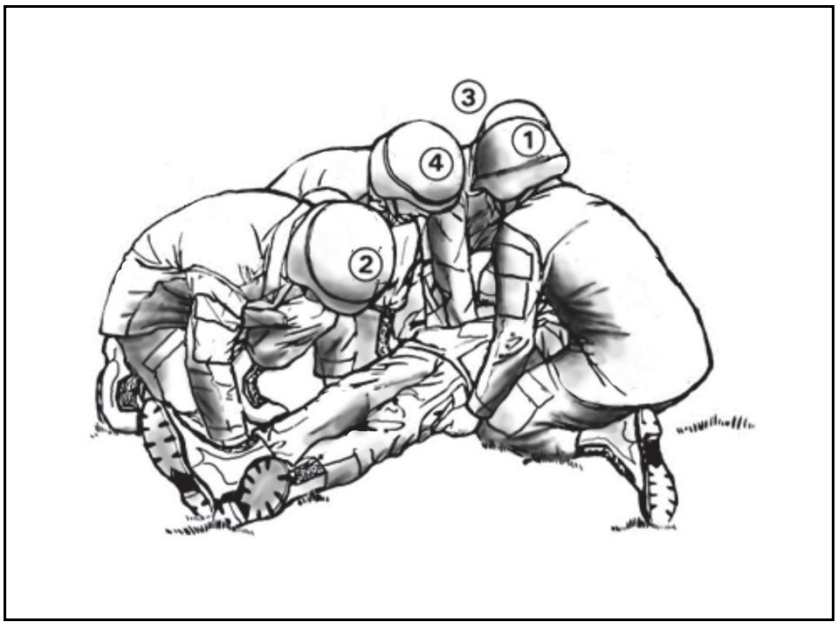


**Figure 3-2. Litter squad kneels by casualty's side**

b. Have the litter bearers place their arms under the casualty's shoulders, back, hips, and lower legs carefully supporting the casualty's neck and body.

c. All bearers lift the casualty to their chests while supporting the casualty on one knee (see figure 3-3).

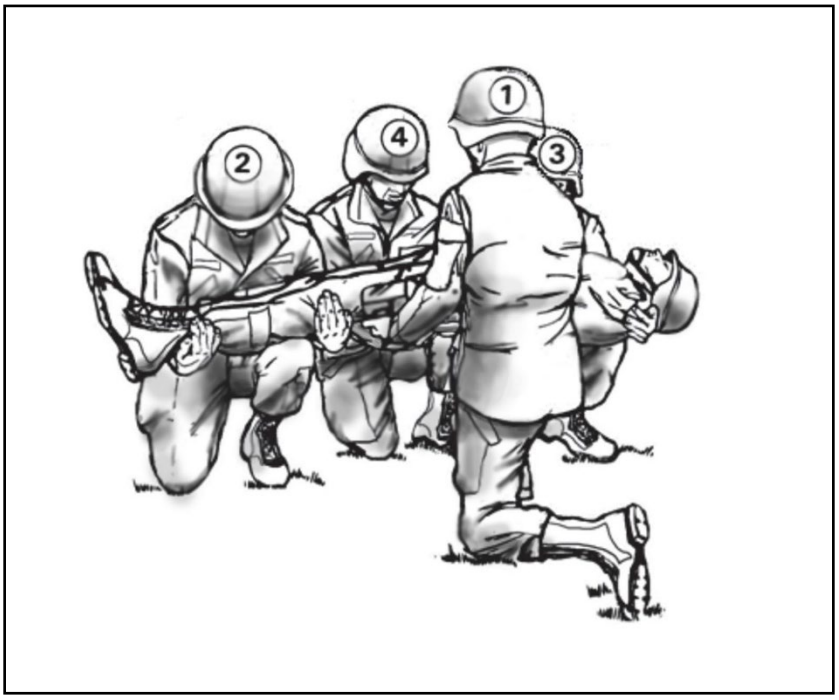


**Figure 3-3. Raising the casualty to be placed on litter**

d. Have the fourth litter bearer place the litter below the casualty on the ground (see figure 3-4 on page 3-197).

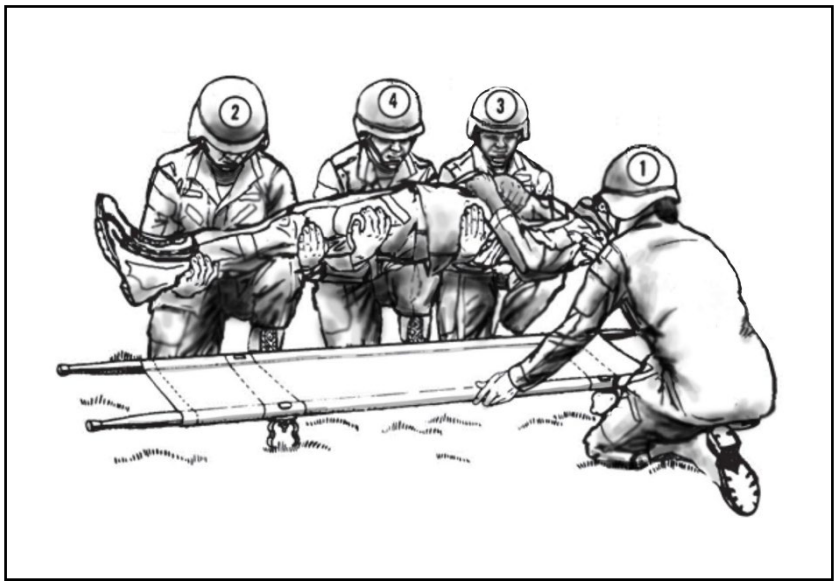


**Figure 3-4. Have fourth litter bearer place litter below the casualty**

e. The fourth litter bearer supports the opposite side of the casualty while the casualty is lowered slowly to the litter.

f. Slowly lower the casualty onto the litter.

g. Secure the casualty to the litter by applying a patient securing strap around the chest of the casualty and the litter as well as a patient securing strap around the knees of the casualty and the litter. (If securing casualty to a collapsible handle litter, secure the chest and leg patient securing straps that come attached to the litter.)

**NOTE:** Using three personnel to support the body of the casualty is the preferred method of placing the casualty on a litter when the casualty possibly has a spinal injury.

3. Transport a casualty using a litter.
   a. Four-man carry.
      (1) Have a litter bearer stand at each handle of the litter (four litter bearers total).
      (2) Each position is numbered from 1 to 4.
         (a) The position at the right side of the casualty's head is the number 1 position and is the squad leader. All commands come from the number 1 litter bearer.
         (b) The position at the casualty's right foot is the number 2 litter bearer.
         (c) The position at the left side of the casualty's head is the number 3 litter bearer.
         (d) The position at the casualty's left foot is the number 4 litter bearer.
      (3) Have all four litter bearers face toward the casualty's feet, kneel, and grab the litter handles (see figure 3-5 on page 3-198).

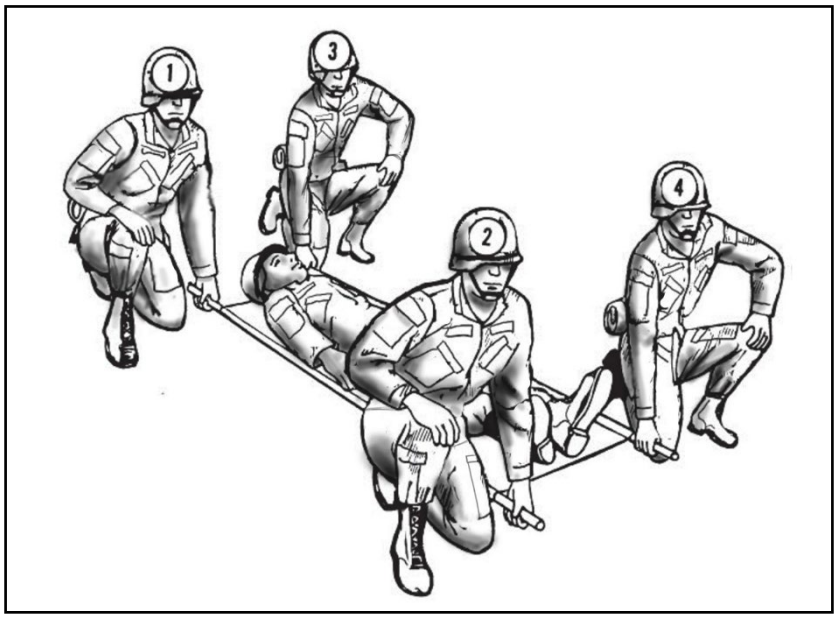


**Figure 3-5. Four-man litter squad preparing to lift the litter**

(4) The number 1 position gives the preparatory command “Prepare to lift” and the command of execution “Lift.”

(5) Upon the command of execution “Lift,” all four litter bearers will stand simultaneously (see figure 3-6).

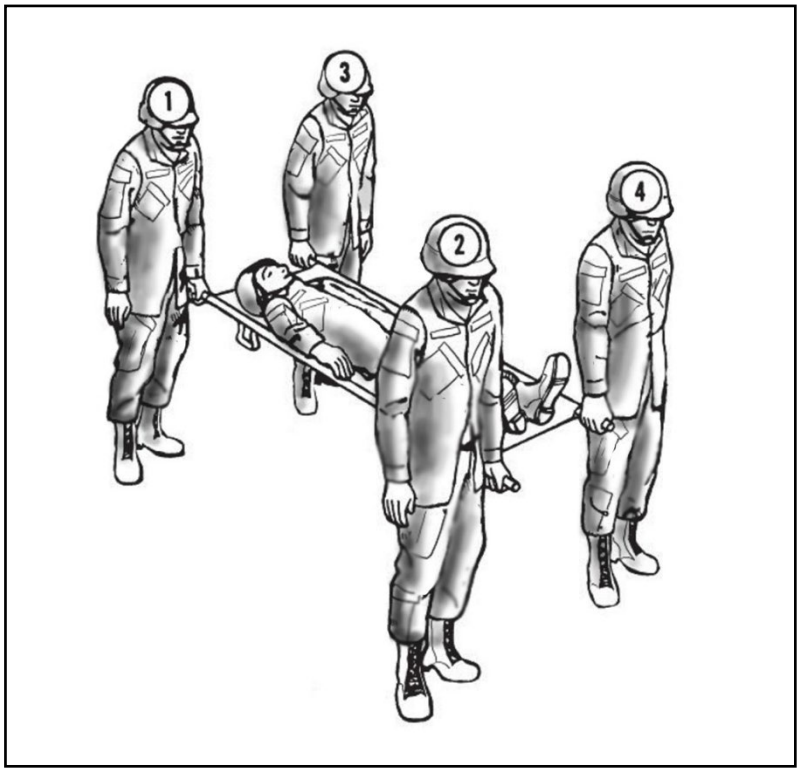


**Figure 3-6. Lift the casualty**

(6) The direction of travel for the patient is feetfirst on level terrain.

(7) Once the litter is lifted off the ground and all four litter bearers are standing, the command to proceed is “Four-man carry, Move.”

b. Two-man carry.

**NOTE:** The two-man carry is used when passing through or over narrow passages, such as trails, bridges, gangplanks, culverts, and catwalks.

(1) The preparatory command is “Two-man carry,” and the command of execution is “Move.”

(2) Upon the preparatory command “Two-man carry” and the command of execution “Move,” the number 3 litter bearer adjusts their hold and grabs both litter handles at the casualty’s head.

(3) At the same time, the number 2 litter bearer (while facing in the direction of travel) adjusts their hands and grabs both litter handles at the casualty’s feet.

(4) Simultaneously, the number 1 litter bearer releases their grasp of the litter handle (once the number 3 litter bearer has securely grasped both handles) and moves to one pace in front of the number 2 litter bearer (this position is in the lead).

(5) Simultaneously, the number 4 litter bearer releases their grasp of the litter handle (once the number 2 litter bearer has securely grasped both handles) and moves to one pace behind the number 3 litter bearer (located in the rear of the litter team) (see figure 3-7).

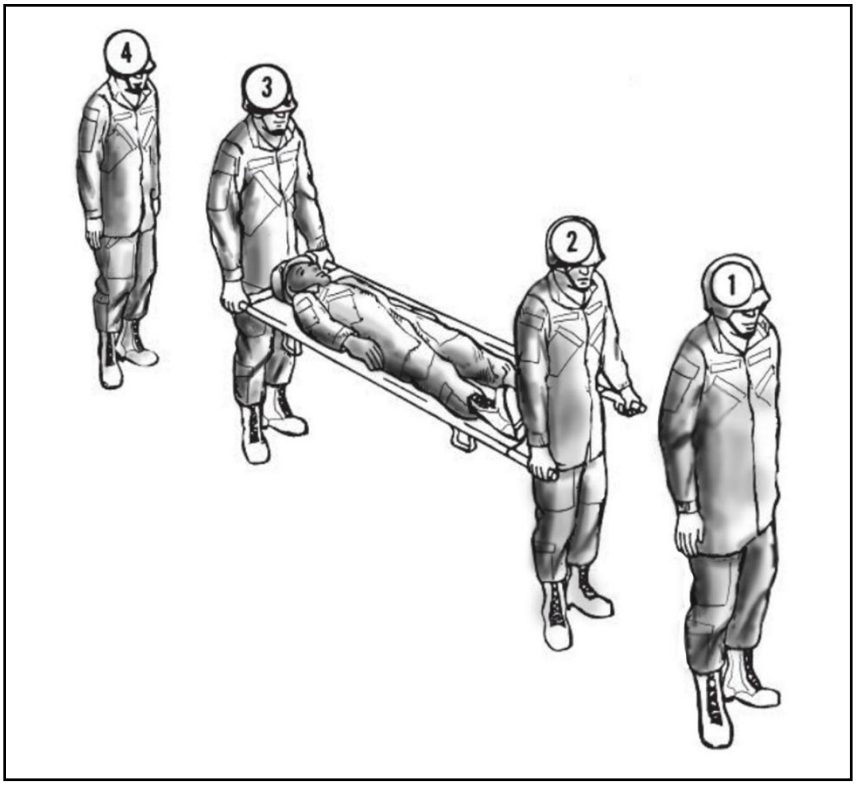


**Figure 3-7. Litter squad performing a two-man carry**

(6) Upon the command of execution “Move,” the litter team moves out.

c. Litter post carry.

(1) The command “Litter post carry, Move” is given to enable the litter squad to move over rough terrain.

(2) The preparatory command is “Litter post carry,” and the command of execution is “Move.”

(3) With the litter squad in position of the four-man carry, upon the preparatory command “Litter post carry” and the command of execution “Move” the number 3 litter bearer grasps the handles of the litter at the casualty’s head while the number 2 litter bearer grasps the handles of the litter at the casualty’s feet (facing the direction of travel).

(4) Simultaneously, litter bearers numbers 1 and 4 release their holds and move to the sides of the litter.

(5) Once litter bearers numbers 1 and 4 have positioned themselves on the sides of the litter, they grasp the sides of the litter and assist in supporting the weight of the casualty (see figure 3-8).


**Figure 3-8. Litter squad performing a litter post carry**

(6) Once all litter bearers are in position, the number 1 litter bearer gives the command of execution “Move,” and the litter team moves out.

d. Uphill carry.

(1) When carrying a casualty uphill or up stairs, the casualty should be transported headfirst. The litter must be turned to accomplish this.

**NOTE:** If the casualty has a leg splint, the casualty should be transported feetfirst.

(2) From the position of four-man carry, the preparatory command “Litter post carry” and the command of execution “Move” are given.

(3) Once the litter team is in the litter post carry positions, the next preparatory command is “Prepare to rotate.”

(4) The numbers 2 and 3 litter bearers let go of the litter handles and step back.

(5) Once the command of execution “Rotate” is given, the numbers 1 and 4 litter bearers will rotate the litter 180-degrees counterclockwise, which will place the casualty’s head toward the direction of travel.

(6) Once the rotation is complete the numbers 2 and 3 litter bearers will grasp the handles.

(7) The next command, from the squad leader, will be “Uphill carry,” and the command of execution will be “Move.” After this command is given, the number 4 litter bearer will move to the foot of the litter and take one of the handles released by the number 3 litter bearer.

(8) The number 1 litter bearer will move to the front of the litter team and lead the litter team forward (see figure 3-9).

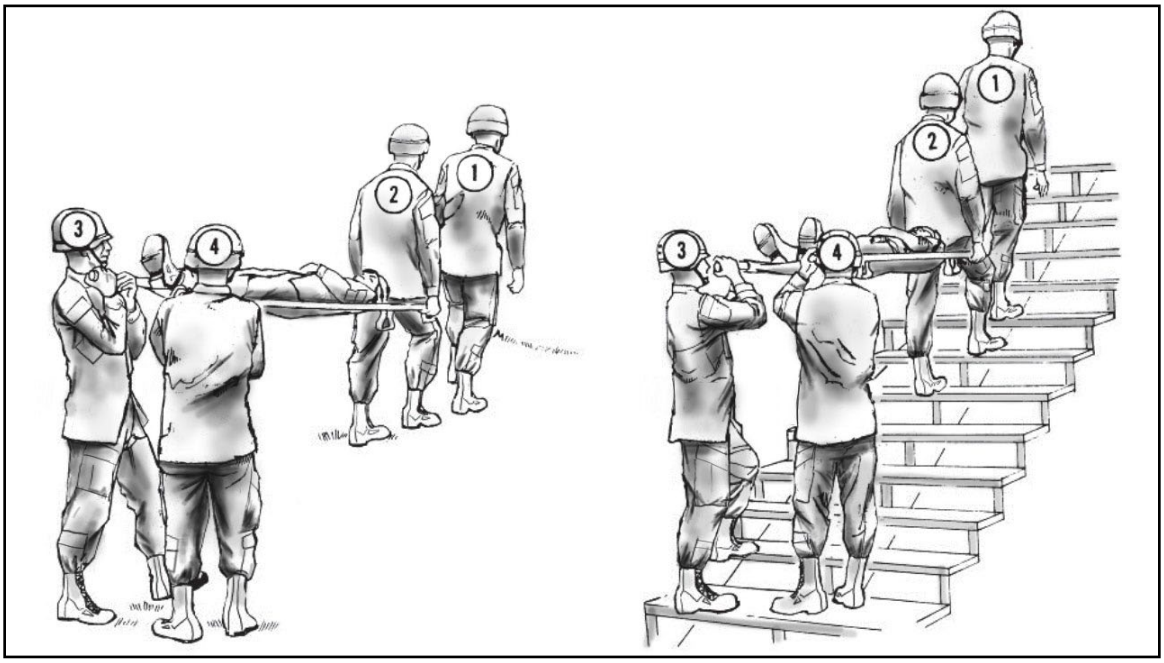


**Figure 3-9. Litter squad performing an uphill carry**

e. Downhill carry.

(1) When carrying a casualty downhill or down stairs, the casualty should be transported feetfirst.

(2) With the litter squad in the four-man carry, the preparatory command “Downhill carry” is given.

(3) The litter bearer number 3 will grasp both litter handles and support the litter at the patient’s head.

(4) Simultaneously, the number 1 litter bearer moves to the front, facing the squad.

(5) Litter bearer number 1 supports litter bearers numbers 2 and 4 and ensures the litter remains level (see figure 3-10).

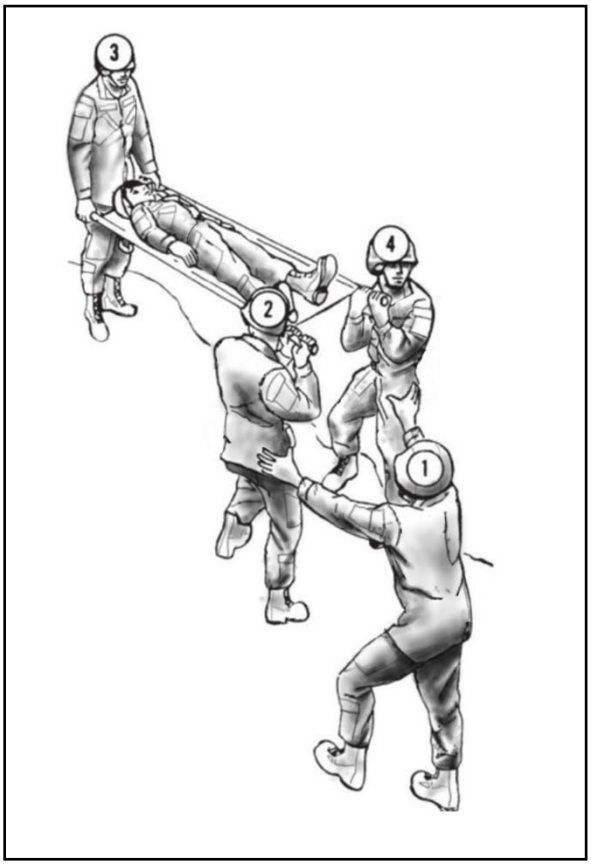


**Figure 3-10. Litter squad performing a downhill carry**

4. Do not cause further harm to the casualty.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in a field condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Prepared the litter for the casualty. | _____ | _____ |
| 2 | Loaded a casualty onto a litter. | _____ | _____ |
| 3 | Transported a casualty using a litter. | _____ | _____ |
| 4 | Did not cause further harm to the casualty. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
ATP 4-02.13. *Casualty Evacuation*.

**Related**
None

Perform Casualty Triage

081-000-0055

**CAUTION:** All body fluids should be considered potentially infectious. Always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. Perform casualty triage on multiple casualties with varying injuries.

**Standards:** Perform Casualty triage in accordance with *Tactical Combat Casualty (TCCC) Care Guidelines*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

**WARNING:** Casualties with an altered mental status should have weapons and communications equipment taken away immediately.

1. Assess the casualties while prioritizing for treatment in the tactical field care phase.
   a. Assess massive hemorrhage, airway management, respiration or breathing, circulation, hypothermia prevention (MARCH) of each casualty for triage purposes. This should take no more than one minute per casualty.

**NOTE:** Talk to the casualty while assessing them. If the casualty can talk easily, obeys commands and has a strong radial pulse, then the casualty has an excellent chance of survival, if there is no ongoing internal or external hemorrhage. This casualty is usually in the minimal or delayed category.

(1) Immediate–casualties whose conditions demand immediate treatment to save life, limb, or eyesight. This category has the highest priority.

(a) Massive external bleeding.

(b) Airway obstruction.

(c) Respiratory and cardiorespiratory distress from otherwise treatable injuries (for example, electrical shock, drowning, or chemical exposure).

**NOTE:** A casualty with cardiorespiratory distress may not be classified “Immediate” on the battlefield. This casualty may be classified “Expectant,” contingent upon such things as the situation, number of casualties, and available support.

(d) Shock.

(e) Burns on the face, neck, hands, feet, perineum, or genitalia.

**NOTE:** After all life- or limb-threatening conditions have been successfully treated; give no further treatment to the casualty until all other “Immediate” casualties have been treated. Salvage of life always takes priority over salvage of limb.

(2) Delayed–casualties who have less risk of loss of life or limb if treatment is delayed.

(a) Open wounds of the chest without respiratory distress.

(b) Open or penetrating abdominal injuries without shock.

(c) Severe eye injuries without hope of saving eyesight.

(d) Other open wounds.

(e) Fractures.

(f) Second- and third-degree burns (not involving the face, hands, feet, genitalia, and perineum) covering 20% or more of the total body surface area (TBSA).

(3) Minimal–"walking wounded," can be treated by self-aid or buddy aid.

(a) Minor lacerations and contusions.

(b) Sprains and strains.

(c) Minor combat stress problems.

(d) First- or second-degree burns (not involving the face, hands, feet, genitalia, and perineum) covering under 20% of the TBSA.

**NOTE:** Minimal casualties may assist the Soldier medic by providing buddy aid or by monitoring other casualties.

(4) Expectant–casualties who are so critically injured that only complicated and prolonged treatment can improve life expectancy. This category is to be used only if resources are limited. If in doubt as to the severity of the injury, place the casualty in one of the other categories.

**NOTE:** Provide ongoing supportive care if the time and condition permit; keeps separate from other triage categorized casualties.

(a) Massive head injuries with signs of impending death.

(b) Burns, mostly third degree, covering more than 85% of the TBSA.

b. Perform immediate lifesaving interventions (LSI) as indicated, such as applying a tourniquet for life-threatening extremity hemorrhage, using dressing hemostatic or junctional hemorrhage control devices for life-threatening external hemorrhage where a tourniquet cannot be applied, or performing needle decompression of a tension pneumothorax.

c. Complete a detailed physical exam once all LSI have been assessed and treated for all casualties. Manage any other injuries found.

2. Establish medical evacuation (MEDEVAC) priorities by precedence category.

a. Urgent. Evacuation is required as soon as possible, but within one hour, to save life, limb, or eyesight and to prevent complication of serious illness and to avoid permanent disability. Generally, casualties whose conditions cannot be controlled and have the greatest opportunity for survival are placed in this category.

(1) Cardio-respiratory distress.

(2) Shock not responding to intravenous (IV) fluid therapy.

(3) Prolonged unconsciousness.

(4) Head injuries with signs of increasing intracranial pressure.

(5) Burns covering 20 to 85% of the TBSA.

b. Urgent surgical. Evacuation is required as soon as possible, but within one hour, for casualties who must receive far forward surgical intervention to save life and stabilize for further evacuation.

(1) Decreased circulation in the extremities.

(2) Open chest or abdominal wounds with decreased blood pressure.

(3) Penetrating wounds.

(4) Uncontrollable hemorrhage or open fractures with severe hemorrhage.

(5) Severe facial injuries.

c. Priority. Evacuation is required within four hours or the casualty's condition could get worse and become an "urgent" or "urgent surgical" category condition. Generally, this category applies to any casualty whose condition is not stabilized or who is at risk of trauma-related complications.

(1) Closed-chest injuries, such as rib fractures without a flail segment or other injuries that interfere with respiration.

(2) Brief periods of unconsciousness.

(3) Soft tissue injuries and open or closed fractures.

(4) Abdominal injuries without hypotension.

(5) Eye injuries that do not threaten eyesight.

(6) Spinal injuries.

(7) Burns on the hands, face, feet, genitalia, or perineum, even if under 20% of the TBSA.

d. Routine. Evacuation is required within 24 hours for further care. Immediate evacuation is not critical. Generally, casualties who can be controlled without jeopardizing their condition or who can be managed by the evacuating facility for up to 24 hours.

(1) Burns covering 20 to 80% of the TBSA if the casualty is receiving and responding to IV fluid therapy.

(2) Simple fractures.

(3) Open wounds including chest injuries without respiratory distress.

(4) Behavioral emergencies and combat stress casualties.

(5) Terminal cases.

e. Convenience. Evacuation by medical vehicle is a matter of convenience rather than necessity.

(1) Minor open wounds.

(2) Sprains and strains.

(3) Minor burns under 20% of TBSA.

3. Record treatment given on a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*).

4. Prepare a MEDEVAC request (see task 081-COM-0101, Request Medical Evacuation).

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 1 | Assessed the casualties while prioritizing for treatment in the tactical field care phase. | _____ | _____ |
| 2 | Established medical evacuation (MEDEVAC) priorities by precedence category. | _____ | _____ |
| 3 | Recorded treatment given on a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*). | _____ | _____ |
| 4 | Prepared a MEDEVAC request (see task 081-COM-0101, Request Medical Evacuation). | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

## Establish a Casualty Collection Point

## 081-000-0070

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. Your unit is receiving casualties. You are directed to treat the casualties and prepare them for evacuation. You will be provided chemical lights, evacuation litters, standard and nonstandard vehicles for ground transportation, M9 aid bag, and the unit's tactical standard operating procedures (TSOPs).

**Standards:** Establish a casualty collection point (CCP) in accordance with ATP 4-02.2, while adhering to all warnings and cautions with 100% accuracy utilizing GO/NO GO criteria.

**Performance Steps:**

1. Select the site.

**NOTE:** Tactical battle plans will vary depending on the type and number of units incorporated into the plan. The plan for CCPs will vary also. The medical treatment provided on the battlefield is usually accomplished by the unit's combat medics and combat lifesavers (CLSs). Establishment of a CCP is essential for the rapid treatment, triage, and evacuation of the casualty.

   a. The location of the CCP will depend on the site security, proximity to the landing zone (LZ), cover and concealment, access to evacuation routes, and number of casualties.

   b. This location should be decided by a designating authority, such as a first sergeant, with guidance from the company or platoon medics.

   c. Battle drills and TSOPs should be established on how they will get the casualty from the fighting position or vehicle to the CCP.

   d. Medical personnel may be limited at this location, and CLSs and ambulatory patients may be required to perform self-aid, buddy aid, or enhanced first aid.

   e. The platoon CCP should be located at the platoon's rear.

   f. The company CCP should be located in a covered and concealed position with the company trains.

2. Establish the CCP with day and night marking systems.

3. Establish a triage point for entry into and exit from the CCP to track casualties and control access.

**NOTE:** The triage point is also the area where casualties are triaged and categorized in one of the triage categories (Immediate, Delayed, Minimal, and Expectant) prior to being taken to that triage area.

4. Establish a separate triage area with day and night marking systems.

**NOTE:** The triage point is also the area where casualties are triaged and categorized in one of the triage categories (Immediate, Delayed, Minimal, and Expectant) prior to being taken to that triage area.

5. Establish and properly mark evacuation categories for day and night (non-tactical or tactical operations).

**NOTE:** When marking the evacuation category areas for day and night operations, one should utilize the marking procedures outlined in the unit's TSOP. An example of marking evacuation category areas for daytime operations is utilizing red for Immediate (urgent or urgent surgical), green for Delayed or Priority, blue for Expectant or Routine and none for Minimal or Convenience. For night non-tactical CCP operations, the same color code used during daytime CCP operations can be used with colored chemical lights. For night tactical CCP operations, an example of marking would be 1 infrared (IR) chemical light for Immediate (urgent or urgent surgical), 2 IR chemical lights for Delayed or Priority, 3 IR chemical lights for Expectant or Routine, and 4 IR chemical lights for Minimal or Convenience.

6. Establish a killed in action (KIA) area away from the other casualties.

7. Establish a centralized medical resupply area where supplies can be easily accessed for use and resupply.

8. Establish a helicopter LZ.

**NOTE:** A helicopter LZ should be properly marked for air evacuation. For casualty collection point see ATP 4-02.2.

9. Establish and provide guidance to aid and litter (A and L) teams within the CCP.

10. Initially sort casualties by visual assessment.
    a. If they are still or have obvious life threats, assess first.
    b. If they can wave or have purposeful movement, assess second.
    c. If they are walking, assess third.

11. Assess: Utilize the Delayed, Immediate, Minimal, and Expectant triage categories to refine the sorting of patients:
    a. DELAYED (YELLOW): Patients in the delayed category can tolerate evacuation delay from 8-10 hours without unduly compromising the likelihood of a successful outcome. When medical resources are overwhelmed, Soldiers in this category are held until the IMMEDIATE cases are cared for.
    b. IMMEDIATE (RED): This category is for the patient whose condition demands immediate, resuscitative treatment and evacuation within 2-4 hours. Generally, the procedures used are short in duration and economical in terms of medical resources.
    c. MINIMAL (GREEN): This category consists of patients with superficial wounds who can be returned to duty or evacuation can be delayed up to 24 hours.
    d. EXPECTANT (BLACK): Patients in the expectant category have wounds that are so extensive their survival would be very unlikely and utilize an unjustifiable expenditure of limited resources. The EXPECTANT patients should be separated from the view of others; however, they should not be abandoned. Above all, attempts to make them

comfortable should be made by whatever means necessary and to provide attendance by a minimal but competent staff.

12. Maintain casualty treatment and flow within the CCP.
    a. Sort and organize casualties at choke point into appropriate treatment categories.
    b. Maintain organization of medical equipment and supplies.
    c. Ensure the DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*) is used to record the treatment and medications that all casualties receive.
    d. Ensure medical personnel, CLS, and A and L teams assist with treatment and packaging of casualties.
    e. Ensure minimal casualties and KIAs remain with their organic element.

**NOTE:** Minimal and Delayed casualties may be able to assist with CCP security, self-aid, or buddy aid.

13. Plan movement of casualties.
    a. Casualty movement from point of injury to the platoon CCP will be by field expedient means: individual manual carries, litter (rescue system complete, collapsible handle litter, poleless) carries, or casualty evacuation vehicle.
    b. Nonstandard casualty evacuation vehicles are positioned forward with a M113A3, M1133 Stryker, M1284, and M997 ambulance designated for litter casualties at the company CCP.
    c. The first sergeant coordinates casualty flow between the platoon CCPs and the company CCP while the senior medic conducts triage.

**NOTE:** Casualties coming from platoon CCPs may have been triaged already but they should be reevaluated to determine if their condition changed during evacuation.

    d. Communication of 9-line medical evacuation requests is conducted via the platoon or company elements to the battalion aid station (BAS) or medical company air ambulance.
    e. The procedure or drill from the CCP to the BAS focuses largely on distance, routes, security, staffing, and TSOP and standard operating procedure (SOP) at the BAS.

**NOTE:** SOP should refer to the set up and functionality of the BAS with regards to casualty flow, triage, treatment, and various other functions required for successful operation.

**Note:** Doctrinal distance is considered to be 1 to 4 kilometers or one to two terrain features behind the unit supported, emphasizing mission, enemy, terrain, troops, time available, and civilian considerations. Failure to maintain this is a common error.

    f. Casualty movement from point of injury to the platoon CCP will be by field expedient means: individual manual carries, litter (rescue system complete, collapsible handle litter, poleless) carries, or casualty evacuation vehicle.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 1 | Selected the site. | _____ | _____ |
| 2 | Established the CCP with day and night marking systems. | _____ | _____ |
| 3 | Established a triage point for entry into and exit from the CCP to track casualties and control access. | _____ | _____ |
| 4 | Established a separate triage area with day and night marking systems. | _____ | _____ |
| 5 | Established and properly marked evacuation categories for day and night (non-tactical or tactical operations). | _____ | _____ |
| 6 | Established a killed in action (KIA) area away from the other casualties. | _____ | _____ |
| 7 | Established a centralized medical resupply area where supplies could be easily accessed for use and resupply. | _____ | _____ |
| 8 | Established a helicopter LZ. | _____ | _____ |
| 9 | Established and provided guidance to aid and litter (A and L) teams within the CCP. | _____ | _____ |
| 10 | Initially sorted casualties by visual assessment. | _____ | _____ |
| 11 | Assessed: Utilize the Delayed, Immediate, Minimal, and Expectant triage categories to refine the sorting of patients: | _____ | _____ |
| 12 | Maintained casualty treatment and flow within the CCP. | _____ | _____ |
| 13 | Planned movement of casualties. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
ATP 4-02.2. *Medical Evacuation*.
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.

**Related**
None

**Skill Level 1**

**Subject Area 8: Airway Management**

Place an Oropharyngeal Airway

081-000-0034

**WARNING:** Use an oropharyngeal airway (OPA) for an unconscious casualty only. Do not use an OPA on a conscious or semiconscious casualty because the Soldier may still have an active gag reflex. In such cases, a nasopharyngeal airway would be more appropriate. An OPA should not be used in children who may have ingested a caustic or petroleum-based product, as it may induce vomiting.

**CAUTION:** All body fluids should be considered potentially infectious. Always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have an unconscious casualty requiring an OPA. You have the appropriately sized OPA, an ink pen, and a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*) or the patient's electronic medical record (EMR). You have performed a patient care handwash and donned appropriate personal protective equipment.

**Standards:** Place an OPA in accordance with *Clinical Practice Guidelines (CPGs)* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Place the OPA beside the outside of the casualty's jaw measure from the corner of the casualty's mouth to the casualty's earlobe.

2. Open the airway (see task 081-COM-1023, Perform First Aid to Open the Airway).

3. Open the casualty's mouth.
   a. Place the crossed thumb and index finger of one hand on the casualty's upper and lower teeth at the corner of the mouth.
   b. Use a scissors motion to pry the casualty's teeth apart.

**NOTE:** If the teeth are clenched, wedge the index finger behind the casualty's back molars to open the mouth.

4. Insert the OPA.
   a. Insert the OPA with the tip pointing to the roof of the casualty's mouth.
   b. Slide the OPA along the roof of the mouth while following the natural contour of the tongue past the soft palate.
   c. Rotate the airway 180 degrees as the tip reaches the back of the tongue.

**NOTE:** The OPA may be difficult to insert. If so, use a gauze pad to pull the tongue forward or a tongue blade to depress the tongue.

**WARNING:** If the casualty starts to regain consciousness and gags or vomits, remove the OPA immediately.

d. Advance the OPA gently so the flange rests against the casualty's lips or teeth.

**NOTE:** The tip of the OPA should rest just above the epiglottis. If the flange of the airway did not seat correctly on the lips, repeat the procedure using a different size of airway.

5. Record the procedure on the DD Form 1380 or EMR.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Placed the OPA beside the outside of the casualty's jaw measured from the corner of the casualty's mouth to the casualty's earlobe. | _____ | _____ |
| 2 | Opened the airway (see task 081-COM-1023, Perform First Aid to Open the Airway). | _____ | _____ |
| 3 | Opened the casualty's mouth. | _____ | _____ |
| 4 | Inserted the OPA. | _____ | _____ |
| 5 | Recorded the procedure on the DD Form 1380 or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
*Clinical Practice Guidelines (CPGs).*
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Joint Trauma System website.

**Related**
None

Perform Patient Suctioning

081-000-0061

This individual task was presented earlier in the STP on page 3-1 as a readiness requirements task. The content requirements are the same.

Administer Oxygen

081-000-0073

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you have a patient requiring oxygen administration. You will be provided with an oxygen tank with a pin index safety system, a pressure regulator with a pressure gauge and adjustable liter flow outlet, a key or wrench, sterile water, humidifier, non-rebreather mask (NRB) with extension tubing, bag valve mask (BVM), a nasal cannula, pen, SF 600 (*Chronological Record of Medical Care*), DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*), and electronic medical record.

**Standards:** Administer oxygen in accordance with (IAW) *Tactical Combat Casualty (TCCC) Care Guidelines* while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**Performance Steps:**

1. Brief procedure to patient.
2. Assemble the equipment.

**NOTE:** Ensure the cylinder (bottle or tank) is labeled for medical oxygen.

a. Remove protective seal on oxygen tank.

**NOTE:** Keep the plastic washer. Check the oxygen cylinder tag to determine whether the tank is “FULL,” “IN USE” (partially full), or “EMPTY.”

b. Crack the main cylinder for one second to remove dust and debris.

**NOTE:** Make sure cylinder is stabilized during entire process of assembly and once in use by patient.

c. Select the correct pressure regulator.

**NOTE:** Place the plastic washer on the regulator oxygen port.

d. Place yoke of the regulator over the cylinder valve and align the pins.

**NOTE:** Make sure the pressure regulator is turned to zero.

e. Hand-tighten the T-screw on the regulator.
f. Open the main cylinder valve.

**NOTE:** The safe residual level of the oxygen at which the cylinder should be replaced has been established to be 200 pounds per square inch (psi).

(1) Check the pressure.

**NOTE:** The safe residual level of the oxygen at which the cylinder should be replaced has been established to be 200 psi.

(2) Check for leaks.

g. Attach the oxygen delivery device to the regulator.

**NOTE:** Humidified oxygen is usually more comfortable to the patient and is particularly helpful for children and for chronic obstructive pulmonary disease (COPD) patients. They provide moisture to the dry oxygen.

h. Secure the oxygen cylinder.

3. Place patient in position of comfort.

4. Determine oxygen delivery device.
   a. BVM.
   b. NRB.
   c. A nasal cannula.

5. Administer oxygen with appropriate device.
   a. Apply a BVM.

**NOTE:** Used for nonbreathing patients or patients who own respirations are not enough to support life.

b. Apply an NRB.

(1) Select the correct sized mask.

**NOTE:** The apex of the mask should fit over the bridge of the patient's nose and extend to rest on the chin, covering the mouth and nose completely. NRB masks come in different sizes for adults, children, and infants.

(2) Connect tubing to regulator.

(3) Set the regulator to 15 liters per minute (lpm).

**NOTE:** The oxygen concentration delivered is usually around 90-100 percent.

(4) Pre-fill the reservoir bag completely.

**NOTE:** You may need to press down on the rubber valve gasket found covering the one-way valve between the mask and the reservoir.

(5) Place the device on the patient.

(a) Adjust the straps as necessary.

(b) Conform soft metal piece to the patient's nose.

(6) Instruct the patient to breathe normally.

(7) Continually monitor the reservoir bag to ensure that it remains filled during inhalation.

c. Apply a nasal cannula.

(1) Connect tubing to regulator.

(2) Insert the two prongs of the cannula into the patient's nostrils with the tab pointing down.

**WARNING:** Do not make tubing too tight. If an elastic strap is used, adjust it so it is secure and comfortable.

(3) Position tubing over and behind each ear. Gently secure it by sliding the adjuster underneath the chin.

(4) Set the regulator to 1-6 lpm.

**NOTE:** The delivered oxygen concentration ranges from 24 to 45 percent. A liter is approximately equal to 4 percent oxygen increase.

(5) Instruct patient to breathe normally.

(6) Check the cannula position periodically.

6. Check patient every 5 minutes.

**NOTE:** Monitor for a decline in vital signs, confusion, restlessness, and altered mental status.

7. Check the equipment.
   a. Ensure tubing connections and device are secure.
   b. Monitor oxygen flow.
   c. Change the delivery device and tubing every 24 hours or more often IAW local protocols.
   d. If humidifier is attached, water should be changed every shift or more often IAW with local protocols.

8. Calculate the duration of flow of the oxygen cylinder.
   a. Determine the remaining pressure in the tank by reading the regulator gauge.
   b. Determine the safe residual level of the oxygen cylinder.

**NOTE:** The safe residual level of the oxygen at which the cylinder should be replaced has been established to be 200 psi.

c. Determine the available cylinder pressure by subtracting the safe residual level from the remaining pressure.

**NOTE:** Example: 2,000 psi remaining pressure minus 200 psi safe residual level = 1,800 psi available pressure.

d. Select the conversion factor for the oxygen cylinder in use.

(1) D size oxygen cylinder–0.16.

(2) E size oxygen cylinder–0.28.

(3) M size oxygen cylinder–1.56.

(4) G size oxygen cylinder–2.41.

(5) H size oxygen cylinder–3.14.

(6) K size oxygen cylinder–3.14.

e. Determine available liters by multiplying the conversion factor by the amount of available pressure.

**NOTE:** Example: D size cylinder is being used. 0.16 conversion factor x 1,800 psi available pressure = 288 liters of oxygen available for use.

f. Determine the duration of the oxygen by dividing the available liters by the flow rate.

**NOTE:** Example: 288 available liters divided by the prescribed flow rate of 15 lpm = 19.2 minutes duration of oxygen flow.

9. Apply safety precautions.

a. Never allow combustible materials such as oil or grease to touch the cylinder, regulator, fittings, valves, or hoses.

b. Ensure “OXYGEN” and “NO SMOKING” signs are posted wherever oxygen is used or stored.

**WARNING:** The principal danger in using oxygen is fire. The presence of oxygen in increased concentrations makes all materials more combustible. Materials that burn slowly in ordinary air, burn violently and even explosively in the presence of increased oxygen.

c. Inform the patient and visitors about the restrictions.

d. Use only non-sparking wrenches on oxygen cylinders.

e. Position oxygen cylinders away from doors and high traffic areas.

f. Secure and store oxygen cylinders in an upright position.

**WARNING:** When you are working with an oxygen cylinder, never place any part of your body over the cylinder valve. A full cylinder is at 2,000 psi and if the tank is punctured or if a valve breaks off, any oxygen cylinder can accelerate with enough force to penetrate concrete walls. A loosely fitting regulator can be blown off the cylinder with sufficient force to decapitate a person, penetrate the body or demolish any object in its path.

g. Keep all valves closed when the oxygen cylinder is not in use, even if the tank is empty.

10. Document treatment given on either DD Form 1380, SF 600, or EMR.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Briefed procedure to patient. | _____ | _____ |
| 2 | Assembled the equipment. | _____ | _____ |
| 3 | Placed patient in position of comfort. | _____ | _____ |
| 4 | Determined oxygen delivery device. | _____ | _____ |
| 5 | Administered oxygen with appropriate device. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 6 | Checked patient every 5 minutes. | _____ | _____ |
| 7 | Checked the equipment. | _____ | _____ |
| 8 | Calculated the duration of flow of the oxygen cylinder. | _____ | _____ |
| 9 | Applied safety precautions. | _____ | _____ |
| 10 | Documented treatment given on either DD 1380, SF 600, or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Perform a Surgical Cricothyroidotomy

081-000-0122

This individual task was presented earlier in the STP on page 3-13 as a readiness requirements task. The content requirements are the same.

Perform End Tidal Carbon Dioxide Monitoring

081-68W-0236

This individual task was presented earlier in the STP on page 3-17 as a readiness requirements task. The content requirements are the same.

Operate a Simplified Automated Ventilator

081-68W-2001

This individual task was presented earlier in the STP on page 3-11 as a readiness requirements task. The content requirements are the same.

Maintain a Nasogastric Tube

081-000-0125

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you have a patient that will require placement and possibly removal of a nasogastric (NG) tube during treatment. You have an NG tube (single lumen nasogastric tube or dual-lumen nasogastric tube), water soluble lubricant, suction equipment if ordered, clamp for tubing, towel, tissues, emesis basin, glass of water and straw, tincture of benzoin, hypoallergenic tape 1 inch, bio-occlusive transparent dressing, irrigating set with 20-milliliter (ml) syringe or a 50-ml catheter tip syringe, stethoscope, tongue blade, penlight, disposable gloves, apron, a waste container, protective sheet, normal saline, lip pomade, mouth hygiene materials, pen, DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*), electronic medical record (EMR), or an SF 600 (*Chronological Record of Medical Care*).

**Standards:** Maintain an NG tube in accordance with (IAW) the *Tactical Combat Casualty (TCCC) Care Guidelines*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Assemble equipment for “PLACEMENT” of an NG tube.

**NOTE:** NG tubes may be contraindicated in patients with nasopharyngeal or esophageal obstruction, severe, uncontrolled coagulopathy, or severe maxillofacial trauma.

2. Verify patient’s identity with the medical records.

3. Explain procedure to the patient.

**NOTE:** Advise the patient that there is a wastebasket in case they feel the need to vomit.

   a. Ask patient if they have ever had nasal surgery, trauma, a deviated septum, or bleeding disorder.
   b. Explain that mouth breathing, panting, and swallowing will make it easier to insert the tube.
   c. Tell the patient that the tube will be inserted along the nasal passage.

**NOTE:** Determine the gesture patient might use, such as raising the index finger, to indicate “wait a few moments” because of gagging or discomfort.

   d. Explain that this procedure may cause them to gag and bring tears to their eyes.

4. Don protective equipment.

5. Place patient in a sitting or high-Fowler’s position to facilitate passage of the tube into the esophagus.

**NOTE:** Unconscious patients should be placed on their left side in the recovery position. Remove dentures, place emesis basin and tissues within patient's reach.

6. Inspect the tube for defects; look for partially closed holes or rough edges.

**NOTE:** Irrigation and suction may be affected by a defective tube.

7. Place rubber tubing in ice-chilled water for a few minutes to make the tube firmer.

**NOTE:** Plastic tubing may already be firm enough, if too stiff, dip in warm water.

8. Determine length of the tube needed to reach the stomach.

**NOTE:** Determining the correct length will prevent coiling of the tube in the stomach or having the tube end in the esophagus.

a. Measure from the patient's nose to earlobe.

**NOTE:** The distance from the nose to the earlobe is the first mark on the tube. This measurement represents the distance to the nasal pharynx.

b. Measure from the patient's earlobe to xiphoid (NEX) and mark the tube appropriately.

**NOTE:** The distance from the earlobe to the NEX is the second mark on the tube. This measurement represents the length required to reach the stomach.

9. Inspect the nostrils with a penlight, observing for any obstruction.
   a. Have the patient blow nose to clear nostrils.
   b. Occlude each nostril and have the patient breathe.

10. Insert NG tube.
    a. Coil the first 3-4 inches (7.5-10 centimeters [cm]) of the tube around your fingers.

**NOTE:** This curves tubing and facilitates tube passage.

b. Lubricate the coiled portion of the tube with water-soluble lubricant, avoiding occluding the tube's holes.

**NOTE:** Lubrication reduces friction between the mucous membranes and tube and prevents injury to the nasal passages. Using a water-soluble lubricant prevents oil aspiration pneumonia if the tube accidentally slips into the trachea.

c. Tilt the patient's head back before inserting tube into nostril and gently pass the tube into the posterior nasopharynx, directing downward and backward toward the ear.

**NOTE:** The passage of the tube is facilitated by following the natural contours of the body. The slower the advancement of the tube, the less likelihood of putting pressure on the turbinate, which could cause pain and bleeding.

d. When the tube reaches the pharynx, the patient may gag; allow patient to rest for a few moments if necessary.

e. Have the patient tilt the head slightly forward.

(1) Offer several sips of water through a straw or have patient suck on ice chips if not contraindicated.

(2) Advance the tube as patient swallows.

**NOTE:** Flexed head position partially occludes the airway, and the tube is less likely to enter the trachea. Swallowing closes the epiglottis over the trachea and facilitates passage of the tube into the esophagus.

**CAUTION:** If there are signs of distress, such as gasping, coughing or cyanosis, immediately remove the tube.

f. Gently rotate the tube 180 degrees to redirect the curve.

**NOTE:** This prevents the tube from entering the patient's mouth. If obstruction appears to prevent tube from passing, do not use force. Rotating the tube may help. If unsuccessful, remove tube and try another nostril.

g. Continue to advance tube gently each time the patient swallows.

h. Continue to advance tube until the second tape mark reaches the patient's nostril.

11. Check tube placement.

a. Visualize tube placement.

(1) Instruct conscious patient to open mouth, use penlight to exam mouth and assess proper placement of the NG tube through the posterior pharynx.

(2) For an unconscious patient, use the tongue blade and penlight to examine the patient's mouth to assess proper placement of the NG tube through the posterior pharynx.

**NOTE:** The presence of stomach contents in the tube or syringe indicates correct placement.

b. Auscultate for tube placement.

(1) Position the diaphragm of the stethoscope over the patient's stomach (about 2 inches below the sternum).

(2) Inject 10 cc of air into the tube.

(3) Listen for the sound of the air entering the stomach (gurgling or whooshing sound) which indicates correct tube placement. Proceed to step 12 if placement is correct.

(4) Check for tube placement in the trachea if air is not heard entering the stomach.

(a) Auscultate over the lung field.

(b) Reinject 10 cc of air into the tube.

(c) Remove the tube if air injection is heard over the lungs.

c. Repeat steps 1-10 to reinsert the tube if indicated.

12. Secure tube to the patient's nose.

13. Connect the tube to the suction apparatus, if ordered.

14. Dispose of soiled equipment in the container for contaminated waste IAW infection control policy.

15. Remove protective equipment.

16. Perform handwashing.

17. Document the procedure.

18. Flush every 4 hours with 20 to 30 milliliters (ml) of normal saline to maintain tube.

19. Assemble equipment for the “REMOVAL” of an NG tube.

20. Explain procedure to the patient.

21. Don protective equipment.

22. Instruct patient to sit up in bed at a 30-degree angle with a towel across the chest.

23. Clear NG tube with air, to clear any fluids, water, or nutritional supplements that may be at the distal end of the tube.

**WARNING:** Turn off the suction or continuous feeding (if applicable).

24. Remove NG tube.
    a. Turn patient’s head to the side.
    b. Put on gloves, then remove securement device used to secure the tube to the patient.

**NOTE:** Use adhesive remover, if necessary, to prevent irritating the skin.

    c. Clamp or pinch the end of the tube to prevent release of gastric contents, remove tube.

**NOTE:** Advise the patient that they may feel the need to vomit. If the patient vomits, stop the procedure immediately. Provide the patient an emesis basin and towel. Continue the procedure when the patient is ready.

(1) Instruct the patient to take a deep breath and hold it.

**NOTE:** This will decrease the possibility of aspiration when the tube is being withdrawn.

**WARNING:** If resistance is felt, do not attempt to remove the tube, and notify the medical officer immediately. Be sure to cover the tube with a towel when pulling it out.

(2) Pull the tube out of the patient’s nose using a swift and continuous motion.
(3) Cover tube with a towel as it emerges.
(4) Provide the patient with materials for oral care and lubricant for nasal dryness.

25. Dispose of soiled equipment in the container for contaminated waste IAW infection control policy.

26. Remove protective equipment.

27. Perform handwashing.

28. Annotate the procedure on the SF 600 or EMR.
    a. Annotate color of drainage in the tube.
    b. Annotate consistency of the drainage.
    c. Annotate remainder of feeding in bag or amount of drainage in the suction canister.
    d. Annotate patient's level of pain and tolerance of the procedure.
    e. Annotate time of removal.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Assembled equipment for "PLACEMENT" of an NG tube. | _____ | _____ |
| 2 | Verified patient's identity with the medical records. | _____ | _____ |
| 3 | Explained procedure to the patient. | _____ | _____ |
| 4 | Donned protective equipment. | _____ | _____ |
| 5 | Placed patient in a sitting or high-Fowler's position to facilitate passage of tube into the esophagus. | _____ | _____ |
| 6 | Inspected the tube for defects; looked for partially closed holes or rough edges. | _____ | _____ |
| 7 | Placed rubber tubing in ice-chilled water for a few minutes to make the tube firmer. | _____ | _____ |
| 8 | Determined length of the tube needed to reach the stomach. | _____ | _____ |
| 9 | Inspected the nostrils with a penlight, observing for any obstruction. | _____ | _____ |
| 10 | Inserted NG tube. | _____ | _____ |
| 11 | Checked tube placement. | _____ | _____ |
| 12 | Secured tube to the patient's nose. | _____ | _____ |
| 13 | Connected the tube to the suction apparatus, if ordered. | _____ | _____ |
| 14 | Disposed of soiled equipment in the container for contaminated waste IAW infection control policy. | _____ | _____ |
| 15 | Removed protective equipment. | _____ | _____ |
| 16 | Performed handwashing. | _____ | _____ |
| 17 | Documented the procedure. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 18 | Flushed every 4 hours with 20 to 30 milliliters (ml) of normal saline to maintain tube. | _____ | _____ |
| 19 | Assembled equipment for the “REMOVAL” of an NG tube. | _____ | _____ |
| 20 | Explained procedure to the patient. | _____ | _____ |
| 21 | Donned protective equipment. | _____ | _____ |
| 22 | Instructed patient to sit up in bed at a 30-degree angle with a towel across the chest. | _____ | _____ |
| 23 | Cleared NG tube with air, to clear any fluids, water, or nutritional supplements that might be at the distal end of the tube. | _____ | _____ |
| 24 | Removed NG tube. | _____ | _____ |
| 25 | Disposed of soiled equipment in the container for contaminated waste IAW infection control policy. | _____ | _____ |
| 26 | Removed protective equipment. | _____ | _____ |
| 27 | Performed handwashing. | _____ | _____ |
| 28 | Annotated the procedure on the SF 600 or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier’s military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Place an Intermediate Airway Device

081-68W-0230

This individual task was presented earlier in the STP on page 3-7 as a readiness requirements task. The content requirements are the same.

Apply an Impedance Threshold Device

081-68W-0313

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment when you encounter a casualty who is breathing on their own and have suffered a gunshot wound (GSW). The GSW has been treated and bleeding is controlled. You will be provided with an impedance threshold device (ITD) and additional first aid equipment.

**Standards:** Apply an ITD in accordance with manufacture instructions while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**Performance Steps:**

1. Apply the ITD with a face mask.
    a. Connect the ITD to the face mask.
    b. Explain to the casualty that they will feel some slight resistance when inhaling. This means that the device is working and helping to improve blood flow.

**NOTE:** This means that the device is working and helping to improve blood flow.

    c. Hold the mask over the nose and mouth maintaining a tight face mask seal.
    d. Have the casualty breathe at 10-16 breaths per minute.

**NOTE:** May use an optional noseclip that prevents breathing through the nose

    e. Inform the casualty to inhale slowly (over 2-3 seconds) and deeply, exhale normally.
    f. If available, administer oxygen. Connected the oxygen tubing to the port and delivered up to 15 liters per minute (lpm).

2. Apply the ITD with a mouthpiece.
    a. Connect the ITD to the mouthpiece.
    b. Explain to the casualty that they will feel some slight resistance when inhaling.

**NOTE:** This means that the device is working and helping to improve blood flow.

    c. Place the mouthpiece into the mouth and maintain a tight seal with the lips.
    d. Have the casualty breath through the mouth at 10-16 breaths per minute.
    e. Inform the casualty to inhale slowly (over 2-3 seconds) and deeply, exhale normally.
    f. If available, administer oxygen. Connect the oxygen tubing to the port and deliver up to 15 lpm.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 1 | Applied the ITD with a face mask. | _____ | _____ |
| 2 | Applied the ITD with a mouthpiece. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
None

**Related**
None

**Subject Area 9: Fluid Management**

Measure a Patient's Fluid Balance

081-000-0027

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you have a patient requiring measurement of their fluid balance (intake and output). You will need a calibrated graduated container, gloves, specimen collection container, urinal, bedpan, urinary drainage bag, pen, and DD Form 792 (*Nurse Service - Twenty-Four Hour Patient Intake and Output Worksheet)*, SF 600 (*Chronological Record of Medical Care*), or electronic medical record (EMR).

**Standards:** Measure a patient's fluid balance recording in accordance with (IAW) *Rosdahl's Textbook of Basic Nursing,* and on a DD Form 792, SF 600, or EMR while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Explain the procedure to the patient.
   a. Inform the patient of the length of time during which the intake and output will be measured and the purpose of taking the measurements.
   b. Inform the patient of any medical officer's orders on fluid intake, such as forcing fluids or restricting the amount of intake.

2. Tell the patient what types of items require intake and output measurement.
   a. Intake measurement.
      (1) Items that are naturally fluid at room temperature such as gelatin, ice cream, ice, and infant cereals.
      (2) Fluids consumed with and between meals, such as water, coffee, tea, broth, juice, milk, milkshakes, and carbonated beverages.
      (3) Intravenous (IV) infusion fluids, blood, and blood products.
      (4) Oral liquid medications.
      (5) Irrigating solutions that are not returned.
   b. Output measurement.
      (1) Urine.
      (2) Liquid stool.
      (3) Vomitus.
      (4) Drainage from wounds, chest tubes, and suction devices.

3. Tell the patient to use specified containers such as a bedpan, specimen collection container, or urinal to save all fluid output.

4. Measure the intake.
   a. Calculate the oral fluid intake.

**NOTE:** Check the water pitcher at the beginning and end of each shift. Check the meal tray for the amount of liquids consumed before removing it from the room.

(1) Note the type and size of the oral fluid containers.
(2) Check the container to find the fluid capacity.
(3) Check the “Intake Equivalents” table on DD Form 792.

**NOTE:** If an unmarked container is not listed on DD Form 792, fill it with water and pour its contents into a graduate to check its capacity.

b. Calculate the amount of IV solution or blood given.
c. Calculate the amount of any irrigating solutions that are not returned, if applicable.
(1) Subtract the amount of solution returned from the known amount used for the irrigating procedure.
(2) Record the difference as intake.

5. Record, in cubic centimeters (cc), the fluid intake under the appropriate heading on DD Form 792 or other form of documentation.

**NOTE:** To convert ounces (oz) to cc, multiply the number of fluid (fl) oz by 30. Example: 12 fl oz multiplied by 30 equals 360 cc. One millimeter is approximately equal to one cc.

6. Measure the output.
a. Put on gloves.
b. Record the level of output (urine, liquid, stool, or emesis) in a graduated container.

**NOTE:** If it is not possible to weigh or measure liquid stool, estimate the amount IAW local standard operating procedure (SOP). Estimate the amount of solid stool IAW local SOP.

c. Estimate the amount of wound drainage, if present, IAW local SOP.
d. Estimate any output not in a container, such as on the floor, skin, or sheets, IAW SOP.
e. Observe characteristics of the output.
(1) Color and odor of urine.
(2) Color, odor, and consistency of stool.
(3) Color and consistency of nasogastric drainage.

7. Remove gloves.

8. Conduct a patient care handwash.

9. Record accumulated intake and output totals on the EMR, SF 600, or DD Form 792 IAW SOP.

**NOTE:** Include characteristics of output.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in a field condition related to the actual task.

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 1 | Explained the procedure to the patient. | _____ | _____ |
| 2 | Told the patient what types of items required intake and output measurement. | _____ | _____ |
| 3 | Told the patient to use specified containers such as a bedpan, specimen collection container, or urinal to save all fluid output. | _____ | _____ |
| 4 | Measured the intake. | _____ | _____ |
| 5 | Recorded, in cubic centimeters (cc), the fluid intake under the appropriate heading on DD Form 792 or other form of documentation. | _____ | _____ |
| 6 | Measured the output. | _____ | _____ |
| 7 | Removed gloves. | _____ | _____ |
| 8 | Conducted a patient care handwash. | _____ | _____ |
| 9 | Record accumulated intake and output totals on the EMR, SF 600, or DD Form 792 IAW SOP. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 792. *Nursing Service - Twenty-Four Hour Patient Intake and Output Worksheet*.
SF 600. *Chronological Record of Medical Care*.
*Rosdahl's Textbook of Basic Nursing.*

**Related**
None

Manage an Intraosseous Infusion

081-68W-0238

This individual task was presented earlier in the STP on page 3-29 as a readiness requirements task. The content requirements are the same.

Administer Fluids Through an Infusion

081-68W-0314

This individual task was presented earlier in the STP on page 3-32 as a readiness requirements task. The content requirements are the same.

Maintain Urinary Catheter

081-000-0124

**WARNING:** Too large of a catheter may cause painful distention of the meatus and cause damage to the uroepithelium.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have been given a medical provider's orders to manage a urinary catheter on a patient. You will review the medical record, verify patient identification using 2-factor validation, explain the procedure, gather all equipment and supplies, perform patient handwash, observe standard precautions, and check patient for any known allergies. You will be provided with the appropriate size catheter, drainage bag, sterile gloves, betadine swabs, benzalkonium chloride antiseptic cleaning agent (in case patient has an allergy to betadine or iodine) located inside kit, compressed hydrogen gas applicator, a penlight, flashlight or standing lamp, protective cover pad, sheet for draping, pen, antibacterial ointment, protective pads, 4x4 gauze, clamps, a drainage set, sterile needle and syringe, sterile specimen container, thermometer, DD Form 792 (*Nursing Service - Twenty-Four Hour Patient Intake and Output Worksheet*), SF 600 (*Chronological Record of Medical Care*), DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*), or electronic medical record.

**Standards:** Manage a urinary catheter in accordance with (IAW) *Tactical Combat Casualty Care (TCCC) Guidelines and Clinical Practice Guidelines (CPGs),* without violating aseptic technique while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Prepare for urinary catheterization.
    a. Adjust bed to a comfortable working height.

**NOTE:** Make sure the side rails are up and the brakes are locked on bed for patient safety. Lower side rails closest to you in order to perform the task comfortably without causing injury to the patient. Once procedure is complete, side rails need to be returned to upright position and bed must be lowered to maintain patient safety. Brakes are to remain in locked position during the entire procedure.

    b. Position the patient.
        (1) Provide privacy for the patient.
        (2) Male patient – Place patient in supine position with thighs slightly abducted.
        (3) Female patient – Place patient in supine position with knees bent, hips flexed, and feet resting on the bed.
        (4) Position protective cover pad between the patient's legs and under the hips.
    c. Drape patient with bath blanket, covering upper body, and shaping over both knees and legs but leaving genital area exposed.
    d. Arrange supplies and equipment.
        (1) Male patient – Place tray next to the hip closest to you.

(2) Female patient – Place tray between patient's legs.

e. Don clean gloves and wash perineal area with mild soap and warm water.

f. Remove gloves and place them in proper receptacle.

g. Prepare catheterization kit.

(1) Open catheterization tray using aseptic technique.

(2) Don sterile gloves.

(3) If an indwelling catheter is used, test the balloon.

(a) Attach the prefilled syringe to the leak-free connector.

(b) Push the plunger and check for seepage as the balloon expands.

(c) Aspirate the water to deflate the balloon.

(4) Tear open the packet of antiseptic cleaning agent.

**NOTE:** Be careful not to spill the solution on the equipment.

(5) Saturate the sterile cotton balls or applicators with antiseptic cleaning agent.

(6) Open the packet of water-soluble lubricant and apply it to the catheter tip.

**NOTE:** Make sure all tubing ends remain sterile and that clamp at the emptying port of the drainage bag is closed to prevent urine leakage from the bag.

2. Insert urinary catheter.

**NOTE:** Bacteria that normally colonize the distal urethra may be introduced into the bladder during or immediately after the catheter insertion.

a. Insert urinary catheter into a female patient (if applicable).

(1) Separate labia majora and labia minora as widely as possible with the thumb, middle, and index fingers of your nondominant hand to expose the urinary meatus.

**NOTE:** The nondominant hand is no longer sterile and must not come in contact with sterile supplies.

(2) Keep the labia well separated throughout the procedure so they do not obscure the urinary meatus or contaminate the area when it is cleaned.

**NOTE:** This maneuver helps prevent labial contamination of the catheter.

(3) With your dominant hand pick up the sterile, cotton-tipped applicator (or pick up a sterile cotton ball with the plastic forceps).

(a) Wipe one side of the urinary meatus with a single downward motion.

(b) Dispose of the cotton-tipped applicator or cotton ball after use.

(c) Secure another sterile cotton-tipped applicator or cotton ball and wipe the other side of the urinary meatus with a single downward motion, disposing after use.

**WARNING:** Never force a catheter during insertion. Maneuver gently as the patient bears down or coughs. If you still meet resistance, stop, and notify the medical officer.

(d) Secure a third sterile cotton-tipped applicator or cotton ball and wipe directly over the meatus and dispose after use.

(e) With your dominant hand pick up the catheter near the tip and hold the remaining part of the catheter coiled in hand.

(f) Gently insert the well lubricated catheter 2-3 inches (5-8 centimeters [cm] into the urinary meatus using strict aseptic technique while continuing to hold the labia apart.

_1_ Avoid contaminating the surface of the catheter.

_2_ Make sure that the catheter is not too large or too tight at the urinary meatus.

_3_ Once urine flow is established, insert catheter another 1 1/2-2 inches (3.81-5 cm) farther move to step c.

**NOTE:** If no urine returns, observe whether catheter has been inadvertently inserted into the vagina. If so, leave it there as a landmark and repeat procedure with new sterile gloves and supplies.

b. Insert a urinary catheter into a male patient (if applicable).

**NOTE:** If the patient is uncircumcised, retract the foreskin with nondominant hand. Be certain to replace foreskin when the procedure has been completed.

(1) Grasp the penis at the shaft below glans with your nondominant hand.

**NOTE:** The nondominant hand is no longer sterile and must not come in contact with sterile supplies.

(2) Gently lift and stretch the penis to a 60- to 90-degree angle. Continue holding the penis this way throughout the procedure to straighten the urethra and maintain a sterile field.

(3) With your dominant hand pick up the sterile, cotton-tipped applicator (or pick up a sterile cotton ball with the plastic forceps).

(a) Cleanse meatus by beginning at the top of the penis and moving in a circular motion down and around the meatus one time.

(b) Dispose of the cotton-tipped applicator or cotton ball after use.

(c) Repeat cleansing two more times with sterile cotton-tipped applicator or cotton balls, disposing after each use.

(d) With your dominant hand pick up the catheter near the tip and hold the remaining part of the catheter coiled in hand.

(e) Gently insert the well lubricated catheter 6-7 inches (5-8 cm) into the urinary meatus using strict aseptic technique.

_1_ Avoid contaminating the surface of the catheter.

_2_ Make sure that the catheter is not too large or too tight at the urinary meatus.

_3_ Once urine flow is established, insert catheter another 1 1/2-2 inches (3.81-5 cm) farther and move to step c.

**WARNING:** Make sure the catheter is draining properly before inflating balloon. Once inflated, withdraw the catheter until slight resistance is met.

**CAUTION:** Never inflate the balloon without first establishing urine flow.

c. Inflate balloon (male or female patients).

**NOTE:** Inflation of balloon will keep the catheter in place in the bladder.

(1) Attach the prefilled syringe to catheter balloon port.

(2) Push plunger of prefilled syringe to inflate balloon with 5-10 milliliters (ml) of sterile water or IAW manufacturer's directions.

(3) Remove syringe after inflation of balloon from the leak-free connector.

(4) Pull gently until slight resistance is met.

(5) Hang the collection bag below bladder level to prevent urine reflux into the bladder and to facilitate gravity drainage of the bladder.

d. Apply external urinary device to a patient (male patient).

(1) Identify patient and provide privacy.

(2) Wash hands and follow standard precautions.

(3) Explain the procedure to the patient and family.

(4) Position the patient in the supine or sitting position.

(5) Drape the patient as needed to expose only the penis.

(6) Inspect the patient's penis for swelling or excoriation.

**NOTE:** This finding would contraindicate the use of a urinary sheath.

(7) Clean the patient's penis with soap and water and allow it to dry thoroughly.

(8) Apply and secure the condom (urinary sheath) at the base of the penis.

(a) Open the condom and roll the condom outward onto itself.

(b) Roll the condom smoothly over the penis leaving 1 inch (2.54 cm) between the condom and the base of the penis.

**CAUTION:** Ordinary tape is contraindicated for the securing of external catheters because it is not flexible and can stop blood flow. Some condoms have adhesive at the proximal end that adheres to the skin; other external catheters are packaged with special tape or hook-and-loop fastener.

(c) Secure the condom firmly but not too tightly to the penis.

(d) Attach the urine drainage system. Ensure the tip of the penis is not against the condom and the condom is not twisted.

(9) Inspect the catheter 30 minutes after application for pain, swelling, or discoloration of the penis.

(10) Change the condom and provide skin care daily.

(11) Report unexpected outcomes to the charge nurse or privileged provider and document the nursing activity in appropriate medical record.

e. Tape and secure the catheter.

(1) Tape catheter to thigh or attach to catheter stabilization device.

(2) Tape the catheter to the male patient's abdomen or secure to thigh using tape or catheter stabilization device to prevent pressure on the urethra at the penoscrotal junction.

**NOTE:** The penis may be positioned toward the patient's head or feet, depending on the patient's diagnosis, the medical officer's order, and the patient's comfort preference.

(3) Alternatively, the catheter can be secured to patient's thigh using a leg band with hook-and-loop fastener.

**NOTE:** Securing of catheter using leg band and hook-and-loop fastener decreases skin irritation, especially in patients with long term indwelling catheters.

f. Secure the drainage bag to the bed frame. For ambulatory patients attach drainage bag to leg.

**NOTE:** Ensure the urinary drainage bag is not damaged when manipulating bed position. Remind ambulatory patients that the urinary drainage bag must be brought with them during ambulation.

g. Place the patient in a comfortable position.

(1) Lower the patient's bed back down (if necessary) and ensure brake is in locked position.

(2) Lower the upper side rails as appropriate on patient's bed.

h. Dispose of all used supplies properly IAW local infection control standard operating procedure (SOP).

(1) Prefilled syringe should be disposed of in a sharps container and not a waste receptacle.

(2) Remove and dispose of gloves and wash hands.

i. Document procedure on appropriate medical record.

(1) Patient's tolerance of procedure.

(2) Any discharge or bleeding discovered during procedure.

(3) Amount of urine in drainage bag.

(4) Any color, odor (if detected), and sedimentation in foley bag.

3. Maintain urinary catheter.

**NOTE:** Patient will feel reassured if the procedure is explained.

a. Assess patient and provide privacy.

(1) Assess how long the catheter has been in place.

(2) Assess for any encrustation or discharge around urethral meatus.

(3) Assess for complains of pain.

(4) Assess patient temperature.

(5) Assess patient fluid intake.

b. Place patient in comfortable position for catheter care.

(1) If the patient is awake and alert, place patient in the semi-Fowler's position.

(2) If the patient is unconscious, place patient in the supine position.

**NOTE:** Catheter care should be performed as a part of the normal morning and evening patient care, and as necessary.

c. Inspect the catheter, drainage tubing, all connections, and the drainage bag for cracks, leaks, kinks, or obstruction of drainage.

d. Observe the urinary meatus and surrounding area for erythema and leakage of urine.

e. Clean the urinary meatus and surrounding area with soap and warm water (or a cleaning solution IAW local SOP), rinse thoroughly, and blot dry.

**NOTE:** Apply antibacterial ointment to the urinary meatus only if ordered by the medical officer or IAW local SOP.

f. Ensure that the catheter is secured.

(1) To the thigh using tape, catheter stabilization device, or leg band in female patients.

(2) To the lower abdomen using tape or to the thigh using tape, catheter stabilization device, or leg band in male patients.

**NOTE:** The penis may be positioned up or down (facing the patient's head or feet) depending upon the patient's diagnosis, the medical officer's order, and the patient's comfort preference.

g. Maintain patency of the drainage tubing.

(1) Keep the tubing free from kinks and twists.

(2) Keep the tubing free of pressure caused by bed rails, mattress, or the patient's body.

(3) Keep the tubing above the level of the drainage bag to ensure free gravity drainage.

h. Always maintain the correct position of the drainage bag at all times.

**CAUTION:** The drainage bag must be kept below the level of the patient's bladder to prevent urinary reflux. If the bag must be raised to or above the level of the bladder for any reason, it must be clamped first.

(1) Hang the drainage bag from the bed frame, not the bed rails (if applicable).

(2) Do not allow the drainage bag to rest on the floor.

i. Assess the patient for indication of urinary tract infections such as: chills, fever, back or flank pain, hematuria, and cloudy or foul-smelling urine.

**NOTE:** If a urinary tract infection is suspected, collect a urine specimen for culture.

j. Collect a sterile urine specimen without contaminating or disconnecting the closed system.

(1) Clamp off the drainage tubing just below the aspiration port.

(2) Wait until a sufficient quality of urine has pooled above the aspiration port (about 15 minutes).

**NOTE:** Post a sign at the patient's bed indicating the urinary drainage system has been temporarily clamped off.

(3) Swab the aspiration port with alcohol.

(4) Withdraw the desired amount of urine using a sterile needle and syringe.

(5) Remove the clamp from drainage tubing.

(6) Transfer the urine from syringe to a sterile specimen container.

k. Irrigate the catheter with the prescribed sterile solution IAW the medical officer's order.

l. Empty the drainage bag.

(1) Empty the drainage bag without disconnecting or contaminating the closed system.

(2) Measure and discard, or save, the urine as indicated by the medical officer's orders.

**NOTE:** The drainage bag must be emptied before it overfills to prevent reflux of urine into the drainage tubing.

m. Reposition the urinary bag and tubing IAW local SOP.

n. Replace the urinary catheter IAW local SOP.

o. Remove gloves.

p. Perform a patient care handwash.

q. Maintain an accurate intake and output record.

r. Document the procedure and all significant nursing observations in appropriate medical record.

s. Provide suprapubic catheter care (if applicable).

(1) Identify the patient and provide privacy.

(2) Wash hands and follow standard precautions.

(3) Explain procedure to the patient and family and teach how to care for catheter.

(4) Observe the catheter for patency and put on gloves.

(5) Maintain a closed drainage system.

**NOTE:** Do not open the system to irrigate or obtain a urine sample.

(6) Observe for signs and symptoms of a urinary tract or skin infection.

(7) Keep the dressing dry around the site of insertion and apply a new dressing using sterile technique as needed.

(8) Perform the clamping protocol IAW local SOP.

(9) Clamp the catheter throughout the night in preparation for removal when patient is voiding normally.

(10) Check for residual urine every time the patient voids and notify the charge nurse or privileged provider when the patients residual urine output is less than 100 ml on two successive checks.

**NOTE:** This is an indication that the patient is ready for catheter removal.

4. Remove urinary catheter.
    a. Adjust bed to a comfortable working height.

**NOTE:** Make sure that the side rails are up, and brakes are locked for patient safety.

    b. Explain the procedure to the patient.
        (1) Tell the patient that they may feel slight discomfort when removing indwelling catheter or urinary sheath (in male patients).
        (2) Tell the patient that you will check on them periodically during the first 24 hours after catheter removal to ensure the patient resumes voiding normally.
    c. Place protective cover pad underneath patient's buttocks.
    d. Clamp the catheter.
    e. Remove the tape, catheter securement device, or hook-and-loop fastener that secures the catheter to patient's abdomen (male patients) or thigh (male or female patients).
    f. Remove indwelling catheter.

**NOTE:** Instruct the patient that they will likely feel the sensation to void directly after removal of an indwelling catheter.

        (1) Attach an empty 10-ml leak-free connector syringe to the balloon port of the catheter.

**NOTE:** Do not cut the catheter. The balloon may not deflate completely when cut.

        (2) Pull back on the plunger of the syringe.
            (a) This deflates the balloon by aspirating the injected fluid.
            (b) Withdraw all the fluid from balloon (usually 5 to 10 ml of fluid is in the balloon).

**NOTE:** The amount of fluid injected is usually indicated on the tip of the catheter's balloon lumen and in the patient's chart.

            (c) Pull gently on the catheter to ensure the balloon is deflated before attempting to remove it.
        (3) Hold a towel under the catheter in your nondominant hand.
        (4) Grasp the catheter and pinch it with your thumb and index finger of your dominant hand.

**NOTE:** Have the patient inhale and exhale slowly and deeply as you gently and slowly pull out the catheter. This helps the patient to relax and makes removal more comfortable. Easing the catheter through the urethra minimizes the risk of trauma.

        (5) Gently pull the catheter from the urethra if there is no resistance.

**NOTE:** If you meet resistance, do not apply force; instead notify the medical officer immediately.

    g. Remove external urinary device.

(1) Clamp drainage tubing at end closest to urinary sheath.

(2) Disconnect drainage tubing from urinary sheath.

(3) Remove securement device from base of penis.

(4) Remove urinary sheath by rolling up from base of penis.

(5) Wash leftover adhesive (if any) from penis using soap and warm water; blot dry with towel.

h. Disconnect the catheter bag from bed frame.

i. Lower the bed for patient safety and comfort.

j. Measure the amount of urine in collection bag before discarding it.

k. Dispose of the catheter and used equipment IAW local SOP for infection waste.

**NOTE:** For indwelling catheter disconnect syringe from balloon port and discard it in sharps container.

l. Remove and discard gloves and wash your hands.

m. Document patient's tolerance of procedure and amount of urine collected in bag prior to removal in appropriate medical record.

n. Document time and amount of each void for the first twenty-four hours after catheter removal.

(1) Color of the urine.

(2) Amount.

(3) Odor if detected.

(4) Sediment formation in urine.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Prepared for urinary catheterization. | _____ | _____ |
| 2 | Inserted urinary catheter. | _____ | _____ |
| 3 | Maintained urinary catheter. | _____ | _____ |
| 4 | Removed urinary catheter. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
*Clinical Practice Guidelines (CPGs).*
DD Form 792. *Nursing Service - Twenty-Four Hour Patient Intake and Output Worksheet*.
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.

Deployed Medicine website.
Joint Trauma System *website.*
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC) Guidelines*

**Related**
None

Administer Whole Blood

081-000-0128

This individual task was presented earlier in the STP on page 3-19 as a readiness requirements task. The content requirements are the same.

Administer Blood Products

081-000-3054

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have a patient that requires the administration of a specific blood product. You have available the medical provider's orders, prescribed blood component, appropriate administration set, clean gloves, the patient's DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*) or electronic medical record (EMR), and an SF 518 (*Blood or Blood Component Transfusion*).

**Standards:** Administer blood products in accordance with (IAW) *Tactical Combat Casualty Care (TCCC) Guidelines*, *Clinical Practice Guidelines (CPG ID: 21);* by Joint Trauma System Committee on Tactical Combat Casualty Care (CoTCCC), while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Verify the medical provider's orders ensuring the patient has a current signed informed consent for transfusion.
2. Obtain the blood component from the blood bank.
3. Obtain the appropriate administration set.
4. Review the directions and facility protocol for administration of the blood product.
    a. Rate of administration.
    b. Route.
    c. Risk factors.
    d. Possible complications.
5. Obtain a positive identification of the patient while providing privacy.
6. Explain the procedure to the patient.
7. Administer the prescribed blood product.

**NOTE:** When using an infusion control device (pump), review the manufacturer's instructions for use to ensure you are using the correct pump, configured correctly, with the proper tubing and filter.

**NOTE:** 68C, Practical Nursing Specialist, is not legally able to initiate blood product administration. A registered nurse or privileged provider should initiate transfusion.

    a. Low titer group O whole blood.
    b. Packed red blood cells – using standard blood administrating set and filter.
    c. Fresh frozen plasma – rapid administration with straight line administration set.

d. Platelets – administer at a rate of 10 minutes per unit, using the platelet infusion set and filter.

e. Cryoprecipitate – coagulation factor VIII administer with standard syringe or component drip filter. 10-20 milliliters (ml) per kilogram per hour (hr) (30-60 minutes per five pool unit).

8. Monitor the patient for unexpected outcomes reporting abnormal findings to the medical provider.

a. Monitor vital signs every 15 minutes for the first hr, every 30 minutes for the second hr, or IAW medical provider's orders.

b. Compare the vital signs with previous and baseline vital signs.

c. Observe for changes that indicate an adverse reaction to the blood product.

**CAUTION:** When a transfusion reaction occurs or is suspected, stop the transfusion immediately. The unused blood and recipient tubing must be sent to the laboratory along with a 10 ml specimen of the patient's venous blood.

d. Stop the blood and notify the charge nurse and medical provider if a reaction is suspected. Disconnect the Y tubing and flush the intravenous site to insure patency.

9. Discontinue the infusion of blood.

a. When the blood has emptied, close the clamp to the blood, and open the clamp to the normal saline.

b. Flush the tubing and filter with approximately 50 cubic centimeters of normal saline to deliver the residual blood.

c. Take and record the vital signs at the completion of the transfusion and 1 hr after completion.

10. Conduct patient education based on specific patient needs.

11. Document the procedure on the patient's DD 1380, SF 518, SF 600 (*Chronological Record of Medical Care*), or EMR.

a. Type and amount of blood product administered.

b. Volume of saline or diluent used.

c. Patient's response to the procedure.

d. Unexpected outcomes and interventions.

e. Patient education provided.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Verified the medical provider's orders ensured the patient had a current signed informed consent for transfusion. | _____ | _____ |
| 2 | Obtained the blood component from the blood bank. | _____ | _____ |
| 3 | Obtained the appropriate administration set. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 4 | Reviewed the directions and facility protocol for administration of the blood product. | _____ | _____ |
| 5 | Obtained a positive identification of the patient while providing privacy. | _____ | _____ |
| 6 | Explained the procedure to the patient. | _____ | _____ |
| 7 | Administered the prescribed blood product. | _____ | _____ |
| 8 | Monitored the patient for unexpected outcomes reported abnormal findings to the medical provider. | _____ | _____ |
| 9 | Discontinued the infusion of blood. | _____ | _____ |
| 10 | Conducted patient education based on specific patient needs. | _____ | _____ |
| 11 | Documented the procedure on the patient's DD 1380, SF 518, SF 600 (*Chronological Record of Medical Care*), or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
*Clinical Practice Guidelines (CPG ID: 21).*
Deployed *Medicine* *website.*
Joint Trauma System *website*
SF 518. *Blood or Blood Component Transfusion*.
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Place an Intraosseous Device

081-68W-0237

This individual task was presented earlier in the STP on page 3-24 as a readiness requirements task. The content requirements are the same.

Operate a Fluid Warmer

081-68W-2000

This individual task was presented earlier in the STP on page 3-35 as a readiness requirements task. The content requirements are the same.

Operate an Intravenous Infusion Pump

081-68W-3054

**WARNING:** Pumps have various detectors and alarms that automatically signal or respond to the completion of an infusion, air in the line, low battery power, and occlusion or inability to deliver at the set rate. Depending on the problem, these devices may sound or flash an alarm, shut off or switch to keep-vein-open rate.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have received medical orders to provide fluids to a patient requiring an intravenous (IV) infusion using a pump. You have the patient's clinical records, a peristaltic pump, IV pole, IV solution, sterile peristaltic tubing, or cassette (if needed), alcohol pads, adhesive tape, 10-milliliter (ml) sterile saline flush, exam gloves, pen, and SF 510 (*Medical Record - Nursing Notes*), SF 600 (*Chronological Record of Medical Care*), or electronic medical record (EMR). You have the medical officer's orders, the medication (using the six rights) and the patient. You have performed a patient care handwash and taken proper BSI precautions.

**Standards:** Operate an IV infusion pump in accordance with *Lippincott's Visual Encyclopedia of Clinical Skills*, while adhering to all warnings and cautions, without error, using the GO/NO GO checklist.

**Note:** Various types of IV pumps electronically regulate the flow of IV solutions or drugs with great accuracy. Volumetric pumps used for high pressure infusion of drugs or for highly accurate delivery of fluids or drugs, have mechanisms to propel the solution at the desired rate under pressure. The peristaltic pump applies pressure to the IV tubing to force the solution through it.

**Performance Steps:**

1. Attach the pump according to the manufacturer's instructions.

2. Prepare the pump.
    a. Pull the port tab.

**NOTE:** Maintain aseptic technique.

    b. Insert the administration set spike and hang the medication on an IV pole (prevent air from reentering the tubing).
    c. Fill the drip chamber completely to prevent air bubbles.

**NOTE:** If your facility utilizes a bar code automated pump, scan your badge, the patient's identification (ID) bracelet, and the patient ID on the medication bag.

    d. Prime the tubing.
    e. Close the clamp.
    f. Follow the manufacturer's instruction for the placement of the tubing.

3. Position the pump on the same side of the patient as the IV or anticipated venipuncture site.

4. Plug in the machine.

5. Attach the tubing to the catheter hub.

6. Turn on the machine.

**NOTE:** Set the appropriate dials on the front panel to the desired infusion rate and volume according to manufacturer's instructions.

a. Press the START button.
b. Set the appropriate dials on the front panel to the desired infusion rate and volume.

**NOTE:** Always set the volume dial to 50 ml less than the prescribed volume or 50 ml less than the volume in the container so that you can hang a new container before the old one empties.

7. Confirm that the pump displays the correct information.

**NOTE:** This can be verified by having a second person check the pump with you and the medical officer's orders.

8. Push the RUN button.

**NOTE:** Keep in mind that infiltration can develop rapidly with infusion by volumetric pump because the increased subcutaneous pressure will not slow the infusion rate until significant edema occurs.

9. Check the patency of the IV line. (Clean IV hub with alcohol pad, pull back on IV, may or may not see a blood flash, flush IV with a 10-ml saline flush to ensure patency.)

**NOTE:** Infiltration can develop rapidly with infusion by volumetric pump because the increased subcutaneous pressure will not slow the infusion rate until significant edema occurs.

10. Watch the IV line for infiltration.

**NOTE:** Explain the alarm system to the patient. This will prevent anxiety when a change in infusion activates the alarm.

**WARNING:** Check the manufacturer's recommendations before administering opaque fluids, such as blood, because some pumps fail to detect such fluids and others may cause hemolysis of infused blood.

11. Connect the tubing to the patient.

**NOTE:** Monitoring frequently will ensure the device's correct operation, flow rate and rapid detection of infiltration and such complications such as infection and air embolism.

12. Tape all connections.

13. Turn on the alarm switches.

**WARNING:** Check the manufacturer's recommendations before administering opaque fluids, such as blood, because some pumps fail to detect such fluids and others may cause hemolysis of infused blood.

14. Explain the alarm system to the patient.

**NOTE:** This will prevent anxiety when a change in infusion activates the alarm.

15. Monitor the pump and the patient frequently.

**NOTE:** Monitoring frequently will ensure the device's correct operation, flow rate, rapid detection of infiltration, and complications such as infection and air embolism.

16. Record procedure on SF 510, SF 600, or EMR.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Attached the pump according to the manufacturer's instruction. | _____ | _____ |
| 2 | Prepared the pump. | _____ | _____ |
| 3 | Positioned the pump on the same side of the patient as the IV or anticipated venipuncture site. | _____ | _____ |
| 4 | Plugged in the machine. | _____ | _____ |
| 5 | Attached the tubing to the catheter hub. | _____ | _____ |
| 6 | Turned on the machine. | _____ | _____ |
| 7 | Confirmed that the pump displayed the correct information. | _____ | _____ |
| 8 | Pushed the RUN button. | _____ | _____ |
| 9 | Checked the patency of the IV line. (Cleaned IV hub with alcohol pad, pulled back on IV, may or may not seen a blood flash, flushed IV with a 10-ml saline flush to ensure patency.) | _____ | _____ |
| 10 | Watched the IV line for infiltration. | _____ | _____ |
| 11 | Connected the tubing to the patient. | _____ | _____ |
| 12 | Taped all connections. | _____ | _____ |
| 13 | Turned on the alarm switches. | _____ | _____ |
| 14 | Explained the alarm system to the patient. | _____ | _____ |
| 15 | Monitored the pump and the patient frequently. | _____ | _____ |
| 16 | Recorded procedure on SF 510, SF 600, or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
Lippincott's Visual Encyclopedia of Clinical Skills.
SF 600. *Chronological Record of Medical Care*.
SF 510. *Medical Record - Nursing Notes.*

**Related**
None

**Subject Area 10: Force Health Protection**

Treat Dental Emergencies

081-68W-0168

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you have a patient who requires treatment for a dental emergency. You are provided with irrigating syringe, examination gloves, catch basin, sterile gauze sponge, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*) or electronic medical record.

**Standards:** Treat a dental emergency casualty in accordance with local standard operating procedures, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

**DANGER:** Fractures and dislocation of the jaw occur frequently among members of the military population, particularly in combat.

**WARNING:** The primary risk associated with oral and dental injuries is airway compromise from oropharyngeal bleeding, occlusion by a displaced dental appliance such as a bridge or partial plate, or possibly occlusion by the aspiration of avulsed or fractured teeth.

**CAUTION:** Any patient with significant facial trauma should be carefully assessed for injuries to the mouth and teeth.

1. Verify patent airway.

**CAUTION:** All body fluids should be considered potentially infectious. Always observe BSI precautions by wearing gloves and eye protection as a minimal standard of protection.

2. Control hemorrhage.

3. Stabilize maxillofacial injuries.
   a. Fracture stabilization.
   b. Soft tissue injury or lacerations.

4. Prescribe pain medication.

5. Evacuate for definitive care.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|
| 1 Verified patent airway. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 2 | Controlled hemorrhage. | _____ | _____ |
| 3 | Stabilized maxillofacial injuries. | _____ | _____ |
| 4 | Prescribed pain medication. | _____ | _____ |
| 5 | Evacuated for definitive care. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
ATP 4-02.19. *Dental Services*.
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.

**Related**
None

Treat a Casualty for a Heat Injury

081-000-0016

This individual task was presented earlier in the STP on page 3-62 as a readiness requirements task. The content requirements are the same.

## Perform Patient Hygiene

081-000-0075

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, perform patient hygiene for a patient who requires assistance with activities of daily living. You have washcloths, towels, bath blanket or coversheet, toiletry items (deodorant, powder and other requested items), bedpan or urinal, clean hospital gown or pajamas, gloves, wash basin, clean bed linens, toothbrush or oral care mouth moisturizer, emesis basin, suction equipment, water-soluble lubricant, brush, comb, shampoo, lotion, razor, shaving cream, orange stick nail file, sheets, waterproof pads, protective cover pad, SF 600 (*Chronological Record of Medical Care*) or electronic medical record, a pen, and dirty linen receptacle. You have performed a patient care handwash and taken BSI precautions.

**Standards:** Perform patient hygiene in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines* while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**Performance Steps:**

1. Verify the activity with medical provider's order.

2. Explain the procedure to the patient.

**NOTE:** Some of the following steps may be omitted based upon the patient's condition. Patients should be encouraged to participate in self-care to the extent that they are able.

3. Provide a bed bath.
    a. Provide privacy.
        (1) Close the door and draw a curtain around the patient.
        (2) Expose only the areas being bathed.
    b. Raise the entire bed to comfortable working height.
    c. Place the bath blanket or sheet over the patient and remove top covers without exposing the patient.
    d. Remove the patient's gown.
        (1) If the patient has an intravenous (IV) catheter in, remove the gown from the arm without the IV first. Move the IV bag and the tubing through the sleeve and rehang the bag.

**NOTE:** If an IV pump is used, turn off the pump, clamp the tube, and then remove it as described above. Unclamp the tube, reinsert it into the pump, turn on the pump, and adjust the rate.

        (2) If the patient has an injured extremity, remove the sleeve from the unaffected side first.
    e. Place a towel under the patient's head.

f. Wash the face.

(1) Wash the patient's eyes from inner to outer canthus, using a clean part of the cloth for each eye.

**NOTE:** If the patient is unconscious, clean the eyes as above. Instill prescribed eye drops or ointment, if applicable. If the patient does not have a blink reflex, keep the eyelids closed and cover with a patch. Do not tape the eyelid.

(2) Wash, rinse, and dry the forehead, cheeks, ears, nose, and neck with plain warm water.

**NOTE:** Soap tends to dry the face. Men may want to be shaved (see step 5b).

g. Wash the upper body.

(1) Remove the bath blanket from over the arm. Place a towel under the arm.

(2) Bathe the arm using long firm strokes from distal to proximal end.

(3) Lift the arm above the head if possible and wash and dry the axilla completely.

(4) Repeat step 3g(1) on other arm.

(5) Apply powder or deodorant to the axilla if applicable.

(6) Bathe and dry the chest.

**NOTE:** Take special care to wash the skin under a female's breasts. Lift the breasts upward if necessary. Clean and dry thoroughly.

h. Wash the lower body.

(1) Place a bath towel over the chest and abdomen. Fold the blanket down to just above the patient's pubic region.

(2) Wash, rinse, and dry the abdomen paying attention to the umbilicus and the skin folds of the abdomen and groin.

(3) Wash and dry the leg nearest you.

(a) Place a towel under the leg.

(b) Support the leg at the knee and place the foot flat on the bed.

**NOTE:** The patient's foot may be placed in the basin to soak while the leg is being washed. However, soaking feet is NOT recommended for patients with diabetes mellitus or peripheral vascular disease.

**CAUTION:** Avoid massaging the legs when the patient is at risk for thrombosis or emboli.

(c) Wash and dry the leg using long firm strokes. Wash from ankle to knee and then from knee to thigh.

(d) Wash and dry the foot completely.

(e) Move to the opposite side and repeat steps 3h (3)(a) through 3h (3)(d) for the other leg.

**NOTE:** Always raise the side rail for safety.

i. Change bath water and gloves.

j. Wash the perineum.

(1) Place the patient in a side lying position and keep the patient covered with a bath blanket as much as possible.

(2) Wash the buttocks and anus from front to back.

**NOTE:** If feces are present, wrap it in an under-pad fold and remove as much as possible with disposable wipes first. Use as many washcloths as necessary to clean completely. Ensure to cleanse the gluteal folds.

(3) Dry the area and replace the under pad with a clean one.

k. Wash the genitals.

(1) Female.

(a) Position the patient supine with a waterproof pad beneath the buttocks. Drape the patient with a bath blanket to maintain privacy.

(b) Wash the labia majora and then gently pull back the labia majora to wash the groin from perineum to rectum.

(c) Clean the pubic area from front to back.

**NOTE:** Clean around an indwelling catheter if applicable without pulling tension on it. Ensure the catheter is secured to the upper thigh or positioned over the thigh (not under it).

(2) Male.

(a) Gently grasp the penis. Retract the foreskin if uncircumcised.

(b) Wash the tip of the penis and urinary meatus cleansing away from the meatus. Use a circular motion.

(c) Clean the penile shaft, scrotum, and underlying folds.

(d) Rinse and dry.

l. Change bath water and gloves.

m. Wash the back.

(1) Place the patient on their side.

(2) Clean and dry the back from neck to buttocks using long firm strokes.

n. Apply lotion to the skin if needed.

o. Replace the gown.

4. Provide oral care.

a. Place the casualty in a side-lying position with a towel under the chin. Have an emesis basin available.

b. Separate the upper and lower teeth.

**NOTE:** Oral suction must be available, especially if the patient has no gag reflex.

c. Clean the mouth using a toothbrush, moistened 4x4 gauze, or oral care mouth moisturizer with water. Ensure the tongue, roof of mouth, inside cheeks, and tooth surfaces have been cleaned.

**NOTE:** The toothbrush should be soft bristled. Angle the brush at 45 degrees to clean the teeth. Avoid using glycerin or lemon swabs.

d. Rinse with a clean oral care mouth moisturizer and water.

**NOTE:** Use as little water as possible to avoid aspiration.

e. Suction the oral cavity as secretions accumulate if the patient is unable to remove them.

f. Apply lip balm or water-soluble jelly to the lips.

5. Provide hair care.
   a. Shampoo the hair.
      (1) Place a towel and waterproof pad under the head.
      (2) Comb or brush the patient's hair to release any tangles.
      (3) Position the patient supine with a plastic trough under the head.
      (4) Pour warm water over the head until completely wet.

**NOTE:** Protect the patient's face and eyes by placing a towel or washcloth over them. If hair is matted with blood, apply hydrogen peroxide to dissolve it, and then rinse with saline or water.

      (5) Apply shampoo and lather.
      (6) Massage gently starting at the hairline and working toward the back of the scalp.
      (7) Rinse the hair.
      (8) Apply conditioner if needed.
      (9) Dry the hair.
      (10) Complete styling of the hair as necessary.

**NOTE:** Braids may be helpful to prevent tangling of long hair.

   b. Shave the beard.
      (1) Position the patient into a sitting position if possible. Place a towel over the chest.
      (2) Place a moist, warm washcloth over the patient's face.
      (3) Apply shaving cream.
      (4) While pulling the skin taut, angle the razor to 45 degrees. Shave in the direction of hair growth.

**NOTE:** Ask the patient to direct you on their usual technique.

      (5) Rinse and dry the face. Apply after shave if patient desires.

6. Perform foot and nail care.
   a. Using an orange stick, gently clean under the patient's nails.

**CAUTION:** Never cut the toenails. A patient with diabetes or hypertrophy should be referred to a podiatrist.

   b. Clip the nails straight and even with the digits. File the nails to shape and smooth rough edges.

c. Push the cuticle back gently with an orange stick.
d. Apply lotion.

7. Change the patient's linen (make an occupied bed).
   a. Raise the entire bed to a comfortable working height.
   b. Lower the head of the bed, if tolerated by the patient.
   c. Remove the bedspread or blanket. Leave a sheet covering the patient.
   d. Roll the patient to a side-lying position on the far side of the bed.
   e. Roll the bottom sheet, draw sheet, and under pad toward the patient as far as possible.
   f. Place a clean bottom sheet on the bed.
      (1) The sheet may be fitted.
      (2) Flat sheet. Center the sheet on the bed and pull the bottom hem toward the foot of the bed. Open the sheet toward the patient. Tuck and miter the top under the head of the bed.
   g. Place draw sheets or waterproof pads on the center of the bed. Fanfold toward the patient.
   h. Cover the unoccupied side of bed with the linen. Tuck the draw sheet under the mattress.
   i. Assist the patient to logroll over all the linen toward the other side of the bed.
   j. Raise the bed rail on the side facing the patient. Go to the other side and lower the bed rail.
   k. Remove soiled linens. Place them on the floor or in the hamper.
   l. Pull clean linen toward you. Straighten the linen out.
   m. Tuck and miter the corners.
   n. Tuck in the draw sheet.
   o. Straighten the waterproof pads.
   p. Assist the patient to a supine position.
   q. Place a clean top sheet and blanket over the patient.
   r. Remove the original cover sheet.
   s. Tuck the bottom of the covers under the mattress making a modified miter. Loosen the linen at the feet for comfort.
   t. Change the patient's pillowcase.

8. Assist the patient to a position of comfort and place needed items within reach.

9. Raise the side rails and lower the bed.

10. Remove soiled supplies.

11. Document what was performed and the patient's response on SF 600.

**NOTE:** Inability to tolerate a procedure should be documented.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 1 | Verified the activity with medical provider's order. | _____ | _____ |
| 2 | Explained the procedure to the patient. | _____ | _____ |
| 3 | Provided a bed bath. | _____ | _____ |
| 4 | Provided oral care. | _____ | _____ |
| 5 | Provided hair care. | _____ | _____ |
| 6 | Performed foot and nail care. | _____ | _____ |
| 7 | Changed the patient's linen (made an occupied bed). | _____ | _____ |
| 8 | Assisted the patient to a position of comfort and placed needed items within reach. | _____ | _____ |
| 9 | Raised the side rails and lowered the bed. | _____ | _____ |
| 10 | Removed soiled supplies. | _____ | _____ |
| 11 | Documented what was performed and the patient's response on SF 600. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
Deployed Medicine website.
SF 600. *Chronological Record of Medical Care*.

**Related**
None

Perform Field Disinfection of Instruments

081-68W-0169

**WARNING:** When working with high-level disinfectant (HLD), you must wear gloves and avoid placing unprotected hands in liquid, avoid splashing, wear protective eyewear such as goggles.

**CAUTION:** Examples of items for which disinfection is appropriate in the field (hemostatic forceps, tissue forceps, mastoid retractors, and surgical scissors).

**Conditions:** You are in an operational environment. You have been directed to disinfect instruments in the tactical combat medical care (TCMC) set for use on future patients. You are provided with the following equipment: soak pans with cover, instruments from TCMC set in need of disinfection, bottle of HLD, HLD solution test strips, clean table or surface, surgical brush or sponge, sterile towels, sterile distilled water, and personal protective equipment (PPE).

**Standards:** Perform field disinfection of instruments in accordance with TC 8-38 while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**Performance Steps:**

1. Identify instruments to be disinfected.

2. Check for defects or scratches on metal and improperly functioning instruments as applicable.

3. Clean all organic debris from instruments with surgical brush.

4. Remove excess moisture from instruments prior to immersion and disinfection.

5. Prepare HLD solution for use.
    a. Test HLD solution before use on instruments.

**NOTE:** HLD must be tested before each use with a solution test strip to verify that the appropriate concentration of chemical is present. Record the test result in logbook. Solution must be discarded after 14 days, even if the test strips indicated a good concentration.

    b. Check expiration date.

**NOTE:** The shelf life for an unopened bottle of HLD is 2 years. HLD requires no activation. Open bottle can be stored up to 75 days.

    c. Pour solution into the soak pan.
    d. Record the date the solution was poured and the date its reuse life ends, not to exceed 14 days. This should be recorded in a record or logbook.

6. Submerge clean instruments into solution for disinfection.
    a. Immerse clean, dry instruments completely in HLD solution.
    b. Ensure all instruments are completely submersed in solution and fill all lumens if applicable.
    c. Cover the pan with lid.

d. Soak instruments for 12 minutes to achieve HLD.

7. Rinse instruments using three sink and rinse method.

a. Rinse sink number one: thoroughly flush with sterile water for a minimum of 1 minute.

b. Rinse sink number two: thoroughly flush with sterile water for a minimum of 1 minute.

c. Rinse sink number three: thoroughly flush with sterile water for a minimum of 1 minute.

**NOTE:** A large volume of sterile water should be used for each rinse.

8. Dry the instrument(s) immediately with sterile towels and store in a manner to minimize recontamination.

9. Dispose of HLD.

**NOTE:** May be disposed of down sewer system with copious amounts of water.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Identified instruments to be disinfected. | _____ | _____ |
| 2 | Checked for defects or scratches on metal and improperly functioning instruments as applicable. | _____ | _____ |
| 3 | Cleaned all organic debris from instruments with surgical brush. | _____ | _____ |
| 4 | Removed excess moisture from instruments prior to immersion and disinfection. | _____ | _____ |
| 5 | Prepared HLD solution for use. | _____ | _____ |
| 6 | Submerged clean instruments into solution for disinfection. | _____ | _____ |
| 7 | Rinsed instruments using three sink and rinse method. | _____ | _____ |
| 8 | Dried the instrument(s) immediately with sterile towels and stored in a manner to minimize recontamination. | _____ | _____ |
| 9 | Disposed of HLD. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
TC 8-38. *Sterile Processing Department*.

**Related**
None

Treat a Casualty for a Cold Injury

081-000-0017

This individual task was presented earlier in the STP on page 3-66 as a readiness requirements task. The content requirements are the same.

Treat a Casualty for Insect Injury

081-000-0052

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment and are required to treat a casualty with insect bites or stings. You have taken BSI precautions and obtained normal saline, soap solution, pen, clean (aseptic) tweezers, blade or card (hard plastic for example, identification card), sterile 4x4 gauze pads, sphygmomanometer, stethoscope, and a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*) or electronic medical record (EMR).

**Standards:** Treat the casualty for insect bites or stings without causing further injury, in accordance with (IAW) *Tactical Combat Casualty Care (TCCC) Guidelines* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Expose the injury site.

**NOTE:** Remove clothing, rings, watches, and other constricting items that are in the area of the bite or sting to prevent circulatory impairment in the event swelling of the extremity occurs.

2. Identify the type of injury based on signs and symptoms of insect bites and stings.
    a. Gather information from the casualty, ask them if they saw what bit or stung them.

**NOTE:** If the casualty is unconscious, check for a medical alert bracelet or tag or (allergy band).

    b. Bee, wasp, hornet, and yellow jacket.

**NOTE:** A wasp or yellow jacket (slender body with elongated abdomen) retains its stinger and can sting repeatedly. A honeybee (round abdomen) usually leaves its stinger in the casualty.

        (1) Mild reaction
            (a) Pain at the sting site.
            (b) A wheal, redness, and swelling.
            (c) Itching.
            (d) Anxiety.
        (2) Severe reaction
            (a) Generalized itching and burning.
            (b) Urticaria (hives).
            (c) Chest tightness and cough.
            (d) Swelling around the lips and tongue.
            (e) Bronchospasm and wheezing.
            (f) Dyspnea.

(g) Abdominal cramps.
(h) Anxiety.
(i) Respiratory failure.
(j) Anaphylactic shock.

c. Black widow spider.

(1) A pinprick sensation at the bite site, becoming a dull ache within about 30 minutes.

(2) Severe painful muscle spasms, especially in the shoulders, back, chest and abdomen.

(a) Begin in 10 to 40 minutes.
(b) Peak in 1 to 3 hours.
(c) Persist for 12 to 48 hours.

(3) Rigid, board-like abdomen.

(4) Dizziness, nausea and vomiting and respiratory distress in severe cases.

d. Brown recluse spider.

**NOTE:** The brown recluse spider is medium sized, generally brown but can range in color from yellow to dark chocolate brown. It has a distinct groove between its chest and abdominal body parts. The characteristic marking is a brown, violin-shaped marking on the upper back.

(1) Casualty seldom recalls being bitten, since bite is painless at first.
(2) Several hours after the bite, it becomes bluish surrounded by a white periphery.
(3) A red halo or bull's-eye pattern appears sometime later.
(4) Within 7-10 days, the bite becomes a large ulcer.

e. Fire ant(s).

**NOTE:** Fire ants inject a very irritating toxin into the skin. They bite repeatedly and in a very short period. Fire ants are known for their aggressive nature and for their bites. A fire ant sting is itchy yet painful and very prone to infection.

(1) Intense, fiery, burning sensation at the site.
(2) Characteristic circular pattern of bites.

**NOTE:** Fire ants bite down into the skin, then sting downwardly as they pivot.

(3) Extremely painful vesicles that are filled with fluid within minutes.
(4) Cloudy, fluid-filled bubble within 2 to 4 hours.
(5) Bubble on red base within 8 to 10 hours.
(6) Ulceration (with scarring after healing).
(7) Fire ant bites can also cause a large local reaction characterized by swelling, pain and redness that affects the entire extremity.
(8) Anaphylactic shock.

f. Scorpion.

**NOTE:** There are two general types of scorpions. The Arizona (black) scorpion is the only deadly type in the United States.

(1) Harmless species.
(a) Severity of the sting depends on the amount of venom injected.
(b) Ninety percent of all scorpion stings occur on the hands.
(c) Scorpion stings cause a sharp pain at the injection site.
(d) The symptoms last for 24 to 72 hours.
(2) Deadly species.
(a) Sharp pain at the injection site, “pins and needles” sensation.
(b) Severe muscle contractions.
(c) Drooling.
(d) Poor circulation.
(e) Hypertension
(f) Cardiac failure.
(g) Incontinence.
(h) Seizures.

**WARNING:** Lyme disease, usually transmitted by the tiny deer tick but now thought to be transmitted by the larger dog tick, can cause long-term neurological and other complications if not identified and treated early.

g. Tick.

**NOTE:** Tick bites are serious because ticks can carry Rocky Mountain spotted fever, Lyme disease, and may even cause anemia if the infestation is severe enough.

(1) Itching and redness at the site.
(2) Headache.
(3) Moderate to high fever, which may last 2 to 3 weeks.
(4) Pain in the joints or legs.
(5) Swollen lymph nodes in the bitten area.

**CAUTION:** Generally, a tick must remain attached to the body for 4 to 6 hours in order to transmit infections. Early detection and proper removal may prevent transmission.

(6) Paralysis and other central nervous system disorders are possible after several days.

h. Unknown, nonspecific insects.
(1) Pain and swelling at the site.
(2) Breathing difficulty.
(3) Shock.

**WARNING:** If the casualty shows signs and symptoms of an allergic reaction, begin transport immediately.

3. Treat the bite or sting.
a. Black widow spider, brown recluse spider, fire ant, and scorpion bites or stings.
(1) Keep the casualty calm and reassured.

(a) Explain to casualty what will be done.

(b) Limit their physical activity.

**NOTE:** Keep the limb immobilized and the casualty still to prevent distribution of the poison to other parts of the body.

(2) Remove jewelry.

(3) Cleanse the bite site gently using normal saline and mild or strong soap cleansing solution.

**NOTE:** If necessary, irrigate the area with a large amount of sterile saline. Make sure contaminated saline flows away from the body. Never scrub the area.

(4) Place the site below the level of the casualty's heart.

(5) Treat the casualty for anaphylactic shock, if necessary.

(6) Monitor vital signs.

b. Bee, wasp, hornet, and yellow jacket.

(1) Keep the casualty calm and reassured.

(a) Explain to the casualty what will be done.

(b) Limit their physical activity and keep warm.

(2) Remove any jewelry or other constricting objects as soon as possible, ideally before any swelling begins.

(3) Remove the stinger or venom sac.

(4) Cleanse the site using normal saline and a mild or strong soap solution.

**NOTE:** If necessary, irrigate the area with a large amount of sterile saline. Make sure that the contaminated saline flows away from the body. Never scrub the area.

**CAUTION:** Application of a cold pack to an insect bite or sting to relieve pain and swelling should be followed IAW local standard operating procedure and medical officer's orders.

(5) Apply a cold pack to an insect bite or sting to relieve pain and swelling.

(6) Treat the casualty for anaphylactic shock, if necessary.

(7) Monitor vital signs.

c. Tick.

(1) Remove all parts of the tick. Leave nothing embedded in the skin.

(a) Using tweezers, grasp the tick as close to the skin as possible. Using steady pressure, pull the tick straight out.

(b) If tweezers are not available, use an absorbent material (gauze or toweling) to protect your skin. Grasp the tick as close to the skin as possible and pull straight out using steady pressure.

(2) Wash the area around the bite gently using normal saline and a mild or strong soap solution.

(3) Monitor vital signs.

d. Unknown, nonspecific insect.

(1) Cleanse the site using antiseptic.

(2) Treat the casualty for anaphylactic shock, if necessary.
(3) Monitor the vital signs.

4. Record the treatment on a DD Form 1380.

5. Evacuate the casualty, if necessary.

**NOTE:** It is necessary to evacuate any casualty who shows signs and symptoms of respiratory distress, shock, anaphylaxis, or who does not respond to initial treatment.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Exposed the injury site. | _____ | _____ |
| 2 | Identified the type of injury based on signs and symptoms of insect bites and stings. | _____ | _____ |
| 3 | Treated the bite or sting. | _____ | _____ |
| 4 | Recorded the treatment on a DD Form 1380. | _____ | _____ |
| 5 | Evacuated the casualty, if necessary. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.
PHTLS Prehospital Trauma Life Support.

**Related**
None

Treat a Snake Bite Casualty

081-000-0053

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment and are required to treat a snakebite casualty after conducting a scan of the area you determine the scene is safe. You have taken BSI and obtained normal saline, soap solution, pen, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*) or electronic medical record (EMR).

**Standards:** Treat a snakebite casualty in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Expose the injury site.

**NOTE:** The bite presentation may vary from noticeable puncture marks to discoloration. There may be only one fang mark.

2. Check the casualty for signs and symptoms of a poisonous snakebite.

**NOTE:** The signs and symptoms may include but are not limited to pain and swelling at the site, rapid pulse, labored breathing, progressive general weakness, blurred or dim vision, seizures, shock, dizziness or faintness, fever, chills, increased sweating, nausea, vomiting, drowsiness, unconsciousness, paralysis, and coma. The onset and progression of symptoms will vary from immediate to several hours.

3. Explain to the casualty what will be done.

**NOTE:** Limit the casualty's physical activity and keep them calm and reassured.

**CAUTION:** Do not apply a cold pack or administer sedatives, alcohol, food, or tobacco to the casualty.

4. Wash the areas around the bite gently using a soap solution and sterile normal saline.

**NOTE:** Do not scrub the area.

5. Contact higher echelon for medical direction.

6. Ask the receiving facility where antivenom will be most readily available to treat the casualty.

7. Ask the receiving facility for local protocols on the application of a constricting band in the treatment of a snakebite.

**NOTE:** If indicated for use the constricting band should be place proximal to the bite.

8. Remove any rings, bracelets, or other constricting items on the bitten extremity.

**NOTE:** Removing jewelry and other constricting objects from the casualty's affected limb will prevent further injury if the limb swell, making the removal more difficult.

9. Keep the bitten extremity immobilized, the application of a splint will help.

**NOTE:** The extremity should be positioned below the level of the heart.

10. Record the procedure on the DD Form 1308 or EMR.

11. Evacuate the casualty.

12. Provide en route care.
    a. Monitor airway, breathing, circulation, and vital signs.
    b. Assess the distal pulse of the bitten extremity.
    c. Observe for delayed onset symptoms.
    d. Treat for shock.
    e. Treat for hypothermia prevention.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Exposed the injury site. | _____ | _____ |
| 2 | Checked the casualty for signs and symptoms of a poisonous snakebite. | _____ | _____ |
| 3 | Explained to the casualty what would be done. | _____ | _____ |
| 4 | Washed the areas around the bite gently using a soap solution and sterile normal saline. | _____ | _____ |
| 5 | Contacted higher echelon for medical direction. | _____ | _____ |
| 6 | Asked the receiving facility where antivenom would be most readily available to treat the casualty. | _____ | _____ |
| 7 | Asked the receiving facility for local protocols on the application of a constricting band in the treatment of a snakebite. | _____ | _____ |
| 8 | Removed any rings, bracelets, or other constricting items on the bitten extremity. | _____ | _____ |
| 9 | Kept the bitten extremity immobilized, the application of a splint would help. | _____ | _____ |
| 10 | Recorded the procedure on the DD Form 1380 or EMR. | _____ | _____ |
| 11 | Evacuated the casualty. | ____ | _____ |
| 12 | Provided en route care. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*.
Deployed Medicine website.

**Related**
None

## Manage a Patient Restraint

081-000-0054

**WARNING:** Restraints can cause numerous problems, including limited mobility, skin breakdown, impaired circulation, incontinence, psychological distress, and strangulation. Do not restrain a patient in the prone position. This position limits their field of vision, intensifies feelings of helplessness, and impairs respiration, especially if the patient has been sedated.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You are attending to a casualty exhibiting signs of extreme combat stress and must manage the patient restraints to prevent injury. You may have a bed, restraints (for example limb, vest, or mitt, as needed), padding if needed, restraint flow sheet, DA Form 4700 (*Supplemental Medical Data*), rolled gauze, cravats, pen, SF 600 (*Chronological Record of Medical Care*), electronic medical record (EMR), bed alarm if bed has one, minimum of three coworkers, and sheets.

**Standards:** Manage a patient restraint in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**NOTE:** Restraint is a method of physically restricting a person's freedom of movement, physical activity, or normal access to their body. This includes not only traditional restraints, such as limb restraints, but also tightly tucked sheets or the use of side rails to prevent a patient from getting out of bed.

**Performance Steps:**

1. Assess and verify the need for restraint usage.
    a. Follow Joint Commission (JS) and Centers for Medicare & Medicaid Services (CMS) standards for applying restraints.
    b. Make sure that less-restrictive measures have been tried before applying restraints.
2. Obtain a written or verbal order from a medical officer for the restraints.
3. Tell the patient what you are about to do and describe the restraints to them.

**NOTE:** Assure them that they are being used to protect them from injury, not to punish them.

4. Obtain adequate assistance if necessary to restrain the patient before entering their room.
    a. Enlist the aid of at least three coworkers.
    b. Organize their effort.
    c. Give each person a specific task.

**WARNING:** Never secure restraints to the side rails because someone might inadvertently lower the rail before noticing the attached restraint. This may jerk the patient's limb or body, causing them discomfort and trauma.

**CAUTION:** Never secure all four restraints to one side of the bed because the patient may fall out of bed.

5. Apply appropriate restraining device to patient.

**NOTE:** Do not apply a limb restraint above an intravenous site because the constriction may occlude the infusion or cause infiltration into surrounding tissue.

a. Limb restraint.

(1) Wrap the patient's wrist or ankle with a padded restraint.

(2) Pass the strap on the narrow end of the restraint through the slot in the broad end and adjust for snug fit.

(3) Alternatively, fasten the buckle or hook-and-loop fastener cuffs to fit the restraint.

(4) You should be able to slip one or two fingers between the restraint and the patient's skin.

(5) Avoid applying the restraint too tightly because it may impair circulation distal to the restraint.

(6) Tie all restraints securely to the frame of the bed, chair, or wheelchair and out of the patient's reach.

**WARNING:** Never secure the restraint to a bedrail or other movable part of the equipment.

(7) Use a bow or knot that can be released quickly and easily in an emergency.

**NOTE:** Never tie a regular knot to secure the straps.

(8) Leave 1 to 2 inches (2.5 to 5 centimeters) of slack in the straps to allow room for movement.

(9) After application, be alert for signs of impaired circulation, movement, or sensation in the extremity distal to the restraint.

**NOTE:** Check skin color, condition, temperature, and check pulse. If the restraints are too tight or the patient is complaining of numbness and tingling, loosen the restraints.

(10) Release the restraints every 2 hours to assess the skin and perform range of motion (ROM) exercises to stimulate circulation and prevent contractures and loss of mobility.

b. Vest restraint.

(1) Assist the patient to a sitting position if their condition permits.

(2) Slip the vest over their gown.

(3) Crisscross the cloth flaps at the front, placing the V-shaped opening at the patient's throat.

**WARNING:** Never crisscross the flaps in the back because this may cause the patient to choke if they try to squirm out of the vest.

(4) Pass the tab on one flap through the slot on the opposite flap.

(5) Adjust the vest for the patient's comfort.

(6) You should be able to slip your fist between the vest and the patient.

**CAUTION:** Avoid wrapping the vest too tightly because it may restrict respiration.

(7) Tie the restraint.

(8) After applying the vest, check the patient's respiratory rate and breath sounds regularly.

(9) Be alert for signs of respiratory distress.

(10) Make sure the vest has not tightened with the patient's movement.

(11) Loosen the vest frequently, if possible, so the patient can stretch, turn, and breathe deeply.

c. Mitt restraint.

(1) Wash and dry the patient's hands.

(2) Roll up a washcloth or gauze pad and place it in the patient's palm.

(3) Have the patient form a loose fist, if possible; then pull the mitt over it and secure the closure.

(4) To restrict the patient's arm movement, attach the strap to the mitt and tie it securely, using a bow or a knot that can be released quickly and easily in an emergency.

**WARNING:** When using mitts made of transparent mesh, check hand movement and skin color frequently to assess circulation.

(5) Remove the mitts regularly to stimulate circulation and perform passive ROM exercises to prevent contractures.

6. Inform the medical officer within 12 hours of placing the patient in restraints.

**NOTE:** The patient must be examined by the medical officer within 24 hours of the initiation of restraints.

7. Evaluate and assist the restrained patient IAW JC and CMS.

a. If patient is at high risk of aspiration, ensure they are restrained on their side.

b. The restrained patient has limited mobility, therefore their nutrition, elimination and positioning become your responsibility.

c. Assess and monitor the condition of the restrained patient continually.

**NOTE:** Ensure skin color, condition, temperature, and pulse are monitored continually. Loosen restraints per local standard operating procedures and perform ROM exercises to keep patient's circulation intact and to avoid permanent injury.

8. Document the procedure on the DA 4700 or EMR.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 1 | Assessed and verified the need for restraint usage. | _____ | _____ |
| 2 | Obtained a written or verbal order from a medical officer for the restraints. | _____ | _____ |
| 3 | Told the patient what you were about to do and described the restraints to them. | _____ | _____ |
| 4 | Obtained adequate assistance if necessary to restrain the patient before entering their room. | _____ | _____ |
| 5 | Applied appropriate restraining device to patient. | _____ | _____ |
| 6 | Informed the medical officer within 12 hours of placing the patient in restraints. | _____ | _____ |
| 7 | Evaluated and assisted the restrained patient IAW JC and CMS. | _____ | _____ |
| 8 | Documented the procedure on the DA 4700 or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DA Form 4700. *Supplemental Medical Data*.
Deployed Medicine website.
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC) Guidelines*.

**Related**
None

Decontaminate a Casualty

081-000-0059

This individual task was presented earlier in the STP on page 3-38 as a readiness requirements task. The content requirements are the same.

Perform a Gastric Lavage

081-000-0130

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment and have been tasked to perform a gastric lavage. You are provided with irrigation water, surgical lubricant, a stethoscope, a stomach tube, a digital thermometer, a sphygmomanometer cuff, an irrigation syringe, a beaker, a towel, a wash basin, a waterproof barrier, gloves, a nasogastric (NG) tube, pen, clipboard, notepad, DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions) (Instructions)*), the patient's SF 600 (*Chronological Record of Medical Care*) or electronic medical record (EMR).

**Standards:** Perform a gastric lavage in accordance with (IAW) *Rosdahl's Textbook of Basic Nursing*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Greet the patient.
2. Verify the identity of the patient with the orders.
3. Brief the procedure to the patient.
4. Perform proper handwashing techniques.
5. Don sterile gloves.
6. Establish baseline vital signs.
7. Assemble the equipment at the patient's bedside.
8. Place the patient in the Fowler's or semi-Fowler's position.

**NOTE:** If the patient is not alert or too weak to sit, position them on the left side with the bed elevated 15 degrees. If the patient is wearing dentures, be sure to have them removed prior to the procedure.

9. Place a towel over the patient's chest.
10. Insert the lavage tube slowly through the nose.

**NOTE:** Insert the lavage tube nasally and advance it slowly and gently because forceful insertion may injure tissues and cause epistaxis.

    a. Insert the large NG tube or the Ewald stomach tube for a stomach wash (if applicable).

**NOTE:** The Ewald stomach tube is normally inserted through the mouth rather than the nose, because it is a large bore tube. When the lavage tube passes the posterior pharynx, help the patient into a Trendelenburg position and turn the patient on their left side in a three-quarter prone posture.

**CAUTION**: Gloves and eye protection should be worn for self-protection against transmission of contaminants, spills, and splatters.

b. Insert a large lumen NG tube for control of gastric bleeding (if applicable).

**NOTE:** The patient may vomit when the lavage tube reaches the posterior pharynx during insertion. Be prepared to suction the airway immediately if this occurs.

c. Insert the NG tube with gastric and esophageal balloons if the patient has severe bleeding or esophageal varices (if applicable).

**NOTE:** In any situation, a large lumen tube is indicated. Particles of food, mucous, or blood may occlude the lumen of a small tube.

11. Remove stomach contents using a large syringe.

**NOTE:** Clamp and secure the nasal or oral lavage tube. Connect the unattached end of the tube to the lavage tube and allow the stomach contents to empty into the drainage container before using any irrigation solutions. Repeat the steps until all stomach contents have been removed.

12. Annotate the total amount as output on the local intake and output (I and O) worksheet.

**NOTE:** Save the stomach contents for disposition as directed by the medical officer.

13. Clean the stomach with irrigating solution IAW local standard operating procedures (SOPs).

**CAUTION:** When using the funnel method, it is imperative that the patient be carefully assessed for abdominal distention. The size and tolerance of the patient will determine how much fluid can be instilled at one time.

a. Perform the syringe method (if applicable).

**NOTE:** This method is performed by injecting 250 cubic centimeters (cc) (or milliliters) with a 50-cc catheter-tip syringe. This is continuously performed until it is clear.

b. Perform the funnel method (if applicable).

**NOTE:** This method is performed by slowly pouring 500 cc into a funnel or barrel syringe.

14. Remove the irrigation solution from the stomach.
    a. Perform the syringe method (if applicable).
    b. Perform the funnel method (if applicable).

15. Annotate the amount of irrigation solution and character that is removed.

16. Repeat steps 7 and 8 of the lavage as necessary IAW with the guidance provided by the medical officer.

**NOTE:** That is, continue until the stomach contents are clear, the prescribed amount of solution has been administered, or as otherwise directed.

17. Clamp the tubing.

18. Measure the lavage return.
    a. Annotate the total amount of lavage that was removed.
    b. Calculate the amount of stomach contents.

**NOTE:** This is done by subtracting the known amount of irrigating solution used from the measured amount of total lavage return.

    c. Annotate the amount of stomach contents as output on the local I and O worksheet.

19. Dispose of the initial stomach aspirate and all lavage solutions IAW local SOPs and policies on regulated medical waste.

20. Annotate the procedure on the SF 600 or EMR.
    a. Annotate the type and amount of lavage solution used.
    b. Annotate the color, odor, character, and amount of initial stomach contents aspirated.
    c. Annotate the color, odor, character, and amount of lavage return.
    d. Annotate the patient's pain level and tolerance of the procedure.
    e. Annotate the disposition of any specimens.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Greeted the patient. | _____ | _____ |
| 2 | Verified the identity of the patient with the orders. | _____ | _____ |
| 3 | Briefed the procedure to the patient. | _____ | _____ |
| 4 | Performed proper handwashing techniques. | _____ | _____ |
| 5 | Donned sterile gloves. | _____ | _____ |
| 6 | Established baseline vital signs. | _____ | _____ |
| 7 | Assembled the equipment at the patient's bedside. | _____ | _____ |
| 8 | Placed the patient in the Fowler's or semi-Fowler's position. | _____ | _____ |
| 9 | Placed a towel over the patient's chest. | _____ | _____ |
| 10 | Inserted the lavage tube slowly through the nose. | _____ | _____ |
| 11 | Removed stomach contents using a large syringe. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 12 | Annotated the total amount as output on the local intake and output (I and O) worksheet. | _____ | _____ |
| 13 | Cleaned the stomach with irrigating solution IAW local standard operating procedures (SOPs). | _____ | _____ |
| 14 | Removed the irrigation solution from the stomach. | _____ | _____ |
| 15 | Annotated the amount of irrigation solution and character that was removed. | _____ | _____ |
| 16 | Repeated steps 7 and 8 of the lavage as necessary IAW with the guidance provided by the medical officer. | _____ | _____ |
| 17 | Clamped the tubing. | _____ | _____ |
| 18 | Measured the lavage return. | _____ | _____ |
| 19 | Disposed of the initial stomach aspirate and all lavage solutions IAW local SOPs and policies on regulated medical waste. | _____ | _____ |
| 20 | Annotated the procedure on the SF 600 or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
*Rosdahl's Textbook of Basic Nursing.*

**Related**
None

Obtain an Electrocardiogram

081-000-0131

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you have a patient who requires an electrocardiogram (EKG). You are provided with an EKG machine, shaving prep kit, EKG recording paper, disposable electrodes, alcohol prep pads, 4x4 gauze pads, towels, tape, OF 520 (*Electrocardiographic Record*), pen, manufacturer's instruction, local standard operating procedures (SOPs), electronic medical record (EMR), SF 600 (*Chronological Record of Medical Care*) or DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*), and optional equipment such as clippers.

**Standards:** Obtain an EKG with minimal artifact for interpretation by placing each lead in accordance with (IAW) *Joint Trauma Systems Clinical Practice Guidelines* and *Advanced Cardiovascular Life Support Provider Manual* and the manufacturer's instructions while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Prepare the equipment.
    a. Read the manufacturer's instructions for the proper use of the equipment on hand if you are not familiar with it.
    b. Plug the machine into a grounded wall outlet or use the machine's internal battery.
    c. Turn the power switch to ON and allow the machine to perform self-checks and warm up per manufacturer guidelines.

**NOTE:** If machine does not perform self-checks, turn it into clinical engineers and obtain another electrocardiograph.

    d. Ensure the machine's graph paper supply is sufficient to print EKG results.
    e. Ensure you have enough equipment to perform the EKG.

**NOTE:** Ensure that wires are not frayed or damaged, and electrodes are not expired.

    f. Ensure shaving prep kits are available if needed.

2. Prepare the treatment area.
    a. Make area comfortable and private for the patient.
    b. Arrange area convenient for the technologist performing the EKG.
    c. Ensure area is free from distractions (noise and traffic).
    d. Ensure area is free from electrical interference.

3. Greet the patient and introduce yourself.
    a. Explain the procedure and answer any questions.

**NOTE:** A patient may be apprehensive about being connected to an electrical instrument. Reassure the Soldier that there is no danger and nothing unusual will be felt.

b. Ask patient about allergies to adhesive paste and gels.

c. Ask or assist the patient in removing wristwatch, shoes, socks or hose, and all clothing from the waist up.

**NOTE:** Some metal objects, watches, or jewelry may interfere with the accurate recording of the electrical impulses.

4. Prepare the patient.
   a. Provide a chest drape for female patients.
   b. Male technologists should call for a female chaperone to be present during the EKG procedure for a female patient.
   c. Expose the upper torso.

**NOTE:** Be aware that patient may feel uncomfortable about being touched on their upper torso. You must make every effort to respect the sensitivity of the patient and minimize the patient's embarrassment. Adhere to the chaperone policy.

d. Position the patient in a supine position with arms at side and legs uncrossed.

e. Shaves hair from electrode sites if necessary.

f. Rub skin vigorously with a pad such as a 2x2 or 4x4 gauze to remove dead skin cells and oil, and to increase capillary blood flow.

g. Ensure that the patient's body is not in contact with the bed frame or any metal objects and all limbs are firmly supported.

5. Apply the chest leads.

**NOTE:** Attach the lead wire to each electrode before applying the electrode for patient comfort.

a. For a three (3) lead.
   (1) Right arm: Place near the right mid-clavicular line, directly below the clavicle.
   (2) Left arm: Place near the left mid-clavicular line, directly below the clavicle.
   (3) Left leg: Place between the eighth (8th) and ninth (9th) intercostal space on the left mid-clavicular line.

**NOTE:** Or just above and left of the umbilicus.

b. For five (5) lead.
   (1) Right arm: Place near the right mid-clavicular line, directly below the clavicle.
   (2) Left arm: Place near the left mid-clavicular line, directly below the clavicle.
   (3) Left leg: Place between the eighth (8th) and ninth (9th) intercostal space on the left mid-clavicular line.

**NOTE:** Or anywhere on the limbs, placed symmetrically.

(4) Right leg: Place between the eighth (8th) and ninth (9th) intercostal space on the right mid-clavicular line.

**NOTE:** Or anywhere on the limbs, placed symmetrically.

(5) "V" lead: Place to the right of the sternum at the fourth (4th) intercostal space.

c. For a twelve (12) lead.

(1) V1: Right 4th intercostal space, immediately adjacent to right border of sternum.

(2) V2: Left 4th intercostal space, immediately adjacent to left border of sternum.

(3) V3: Midway between placement of V2 and V4.

(4) V4: Fifth intercostal space at the mid-clavicle line.

(5) V5: Anterior axillary line on the same horizontal level as V4 line.

(6) V6: Mid-axillary line on the same horizontal level as V4 and V5.

6. Apply limb electrodes.

**NOTE:** Only for a twelve (12) lead.

a. Place electrodes on flat, fleshy parts of the arms and legs, avoiding bony areas and major muscles if possible, to minimize muscle and motion-related artifact and maximize the EKG signal strength.

b. Apply the electrode by pressing around the entire edge of the electrode.

**NOTE:** Avoid pressing directly on the electrode center since it spreads the gel out and may create air pockets that contribute to artifact.

c. Uniformly placed per manufacturer instructions.

7. Record a copy of the EKG.

a. Check leads and make sure the leads are in contact with the skin.

b. Tell the patient to breathe normal.

c. Push "RECORD" or "START" button.

8. Assess the EKG tracing as it is printed and take the appropriate action.

a. Observe for irregularities that are a result of artifact, interference, or equipment malfunction.

(1) Check the patient's position.

(2) Check the placement of the electrodes.

(3) Obtain new equipment if necessary.

(4) Repeat the EKG recording.

**DANGER:** Notify the physician IMMEDIATELY if you note the presence of any of the life-threatening ventricular arrhythmias such as ventricular fibrillation or ventricular tachycardia.

b. Observe for irregularities of the heart's rhythm.

**NOTE:** Take care not to alarm the patient if any irregularities are noted.

9. Prepare the report.
    a. Remove the EKG tracing from the machine.
    b. Mark the EKG tracing printout with the patient's identification.
    c. Attach the completed OF 520, if required, to the EKG tracing printout.

10. Document the procedure and significant observations IAW local standard operating procedure.

11. Report findings to the ordering provider.

12. Store the equipment.
    a. Dispose of used electrodes.
    b. Restock the machine with EKG paper, electrodes, alcohol prep pads, towels, and drapes, as necessary.
    c. Clean and store the machine.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Prepared the equipment. | _____ | _____ |
| 2 | Prepared the treatment area. | _____ | _____ |
| 3 | Greeted the patient and introduced yourself. | _____ | _____ |
| 4 | Prepared the patient. | _____ | _____ |
| 5 | Applied the chest leads. | _____ | _____ |
| 6 | Applied limb electrodes. | _____ | _____ |
| 7 | Recorded a copy of the EKG. | _____ | _____ |
| 8 | Assessed the EKG tracing as it was printed and took the appropriate action. | _____ | _____ |
| 9 | Prepared the report. | _____ | _____ |
| 10 | Documented the procedure and significant observations IAW local standard operating procedure. | _____ | _____ |
| 11 | Reported findings to the ordering provider. | _____ | _____ |
| 12 | Stored the equipment. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
*Advanced Cardiovascular Life Support Provider Manual.*

DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
Joint Trauma Systems website.
OF 520. *Electrocardiographic Record*.
SF 600. *Chronological Record of Medical Care*.

**Related**
None

Enforce Field Sanitation Measures

081-68W-0005

This individual task was presented earlier in the STP on page 3-71 as a readiness requirements task. The content requirements are the same.

Employ Telemedicine

081-68W-0167

This individual task was presented earlier in the STP on page 3-59 as a readiness requirements task. The content requirements are the same.

## Treat a Behavioral Emergency

081-68W-0246

**WARNING:** Be alert for personal safety or scene safety problems while providing treatment for a behavioral emergency. Do not isolate yourself from other sources of help.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you have to treat a patient with a suspected behavioral emergency. The scene is safe. You have treated all other immediate life threats. You have the patient's medical records, physician's orders for use of restraints, if applicable, restraint devices, *Lippincott Manual of Nursing Practice*, a pen, and SF 600 (*Chronological Record of Medical Care*).

**Standards:** Provide treatment for a behavioral emergency in accordance with (IAW*) Lippincott Manual of Nursing Practice* without causing injury to patient while adhering to all warnings and cations, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Recognize a behavioral emergency.
    a. Panic.
    b. Agitation.
    c. Bizarre thinking and behavior.
    d. Danger to self – self-destructive behavior, suicide.
    e. Danger to others – threatening behavior, violence.

2. Recognize general factors that may alter a patient's behavior.
    a. Situational stresses.
        (1) Fires.
        (2) Accidents.
        (3) Deaths.
    b. Medical illnesses.
        (1) Dehydration.
        (2) Low blood sugar, particularly in patients with diabetes.
        (3) Lack of oxygen.
        (4) Inadequate blood flow to brain.
        (5) Head trauma.
        (6) Mind-altering substances.
        (7) Excessive cold.
        (8) Excessive heat.
        (9) Neurologic disease, injury.
    c. Psychiatric disorders or problems.
        (1) Anxiety or panic attacks.

(2) Phobia.
(3) Depression.

**NOTE:** May be seen as the presenting condition at the health-care facility or may be masked by the presentation of anxiety and somatic complaints.

(4) Bipolar disorder.
(5) Hallucinations.

**CAUTION:** Never play along with hallucinations or delusions. Do not lie to the patient.

(6) Paranoia.
(7) Suicide ideation.
(8) Schizophrenia

d. Alcohol and drug intoxication or withdrawal.
e. Violent patient(s).

3. Recognize signs and symptoms of physiological causes of behavioral emergencies.
   a. Unusual odors on the patient's breath.
   b. Dilated, constricted, or unequally reactive pupils.
   c. Tachycardia and tachypnea.
   d. Numbness and tingling in fingers.
   e. Patient feels incapable of functioning.
   f. Mental and emotional signs.
      (1) Anxious, keyed up, worried, expects the worse.
      (2) Irritable, swearing, complaining, easily bothered.
      (3) Difficulty paying attention, remembering details.
      (4) Difficulty thinking, speaking, communicating.
      (5) Trouble sleeping, awakened by bad dreams.
      (6) Tearful and crying.
      (7) Feeling badly about mistakes or what had to be done.
      (8) Angry, often inappropriately directed.
      (9) Beginning to lose confidence in self.
   g. Rapid rather than gradual onset of symptoms.
   h. Excessive salivation.
   i. Loss of bladder control.
   j. Hallucinations.

4. Obtain a patient history.
   a. Appearance and behavior.
      (1) Grooming.
      (2) Emotional status.
      (3) Body language.
   b. Emotional stability.

(1) Mood and feelings.

(a) Depressed patient: observe for sadness, apathy, feeling of worthlessness, self-blame, suicidal thoughts, desire to escape, worsening of mood in morning, anorexia, weight loss, sleeplessness, lessening interest in sex, reduction of activity, or ceaseless activity.

(b) Violent patient:

_1_ Assess for over activity, aggression, or anger out of proportion to the circumstances.

_2_ Determine risk factors for violence, including intoxicated with drugs or alcohol withdrawal and acute paranoid schizophrenic states, acute organic brain syndrome, acute psychosis, paranoia, or borderline personality.

(2) Thought process.

c. Cognitive abilities.

(1) State of consciousness.

(a) Orientation to person.

(b) Orientation to place.

(c) Orientation to time.

(d) Orientation to events, if appropriate.

(2) Memory.

(3) Attention span.

(4) Judgment.

d. Speech and language.

e. Risk for suicide.

(1) Previous suicide attempt.

(2) Personality traits such as aggression, impulsivity, depression, and hopelessness.

(3) Individuals, who have experienced early loss, decreased social support, chronic illness, or divorce.

(4) Genetic familial factors such as family history of suicide and previous history of self-destructive behavior.

(5) Determine whether patient has communicated suicidal intent, such as preoccupation with death or talking about someone else's death.

(6) Determine whether there is a specific plan for suicide and a means to carry out the plan.

5. Manage the behavioral emergency.

a. Act in a calm manner.

b. Identify yourself and your role.

c. Acknowledge that the patient seems upset and restate that you are there to help.

d. Always try to talk the patient into cooperation.

e. Speak slowly and clearly.

f. Use positive body language.

g. Do not enter the patient's space, stay about 3 feet away.

h. Give patient time to gain control of emotions.

i. Quietly and carefully evaluate the situation.
j. Keep your own emotions under control. Do not be judgmental and show compassion.
k. Honestly explain things to the patient.
l. Let the patient know that you are listening to what they are saying.
m. Stay alert for sudden changes in behavior.

**NOTE:** Consider restraints if necessary to keep the patient from harming themselves or others.

n. Refer to medical officer as soon as possible.

6. Document all findings and care provided on SF 600.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Recognized a behavioral emergency. | _____ | _____ |
| 2 | Recognized general factors that may alter a patient's behavior. | _____ | _____ |
| 3 | Recognized signs and symptoms of physiological causes of behavioral emergencies. | _____ | _____ |
| 4 | Obtained a patient history. | _____ | _____ |
| 5 | Managed the behavioral emergency. | _____ | _____ |
| 6 | Documented all findings and care provided on SF 600. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Lippincott Manual of Nursing Practice.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

**Subject Area 11: Medical Management**

Perform a Medical Patient Assessment

081-000-0072

This individual task was presented earlier in the STP on page 3-73 as a readiness requirements task. The content requirements are the same.

Manage Vaginal Delivery

081-68W-0060

**CAUTION:** All body fluids should be considered potentially infectious. Always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you encounter a woman who is in labor and must assist in their delivery. You are provided with a sterile obstetric kit (if kit is not available, you will be provided with clean sheets and towels, heavy flat twine or new shoelaces, plastic bag, scissors, sterile pad, warm blanket, and clean, unused examination gloves) and pen and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*) or SF 600 (*Chronological Record of Medical Care*) or an electronic medical record (EMR).

**Standards:** Manage vaginal delivery in accordance with (IAW) *Emergency Care*, *PHTLS Prehospital Trauma Life Support,* and Tactical Combat Casualty Care (TCCC), while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Assist with the first stage of labor.

**NOTE:** 1. Scene size up, initial assessment, focused history, examination, detailed physical examination, ongoing assessment, and evacuate assessment steps must be taken to ensure that injury(ies) or illness is not overlooked resulting in further injury to the patient. 2. Evacuate an expecting mother unless delivery is expected within a few minutes.

2. Request health history.

**NOTE:** If the medic is in an isolated environment and is unable to evacuate the patient, the medic will deliver the infant.

   a. Pregnancy history: Is this your first pregnancy? When is your due date? Have there been complications during your pregnant?
   b. Medical history: Is there a history of diabetes, hypertension, or chronic diseases?
   c. Obstetric history: How many times have you been pregnant? How many times have you given birth? Were there any complications with previous deliveries?

3. Review the patient present condition.
   a. Assess general appearance and behavior.

**WARNING:** If hypotension occurs, place the patient on their left side, administer oxygen (if available), and notify the health-care provider immediately.

   b. Check vital signs between contractions.
   c. Assess the labor pattern status.
      (1) Contractions – initial onset, frequency, and duration.
      (2) Discomfort or pain.

d. Assess amniotic membranes status. Inquire if the patient has experienced constant leakage or rupture of vaginal fluid.

4. Assist with the second stage of labor.
   a. Assist with delivery of the infant as directed by health-care provider.
   b. Determine if the umbilical cord is around the infant's neck as the infant is being born.
      (1) Bring the cord forward, over the baby's upper shoulder and head.
      (2) If you cannot loosen or slip the cord over the baby's head, clamp the cord in two places and, with extreme care.
      (3) Cut the cord between the two clamps.
      (4) Unwrap the ends of the cord from around the baby's neck and proceed with the delivery.
   c. Support the infant's head after it is born.
   d. Suction the mouth two or three times and the nostrils. Avoid contact with the back of the mouth.
   e. Provide gentle downward pressure with hands on both sides of the infant's head to deliver the anterior shoulder.
   f. Once anterior shoulder delivered, provide gentle upward pressure with hands on infant's shoulder and supporting the head to deliver the posterior shoulder.
   g. Ensure good hold on infant's shoulders and torso as body is born.
   h. Wipe blood and mucus from the mouth and nose with sterile gauze. Suction the mouth and nose again.
   i. Clamp or tie approximately four finger widths from the infant with two clamps or ties and cut the umbilical cord between the clamps or ties as pulsations cease.
   j. Wrap the infant in a warm blanket and give the infant to the mother.

**WARNING:** Never pull or tug on the cord for quicker delivery of the placenta.

5. Assist with the third stage of labor.
   a. Observe for delivery of the placenta while preparing the mother and infant for evacuation.
   b. Place a sterile pad over the vaginal opening and lower the patient's legs.

6. Provide initial care for the newborn.
   a. Position, dry, wipe, and wrap the newborn in a blanket and cover the head.
   b. Perform appearance, pulse, grimace, activity, and respirations (APGAR) testing at 1 and 5 minutes after birth.
      (1) Appearance (color)–no central (trunk) cyanosis.
      (2) Pulse–greater than 100 beats per minute.
      (3) Grimace–vigorous and crying.
      (4) Activity–good motion in extremities.
      (5) Respirations, breathing effort–normal, crying.

7. Document the care given: The time of delivery and evacuate the mother, infant, and placenta to the hospital.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 1 | Assisted with the first stage of labor. | _____ | _____ |
| 2 | Requested health history. | _____ | _____ |
| 3 | Reviewed the patient present condition. | _____ | _____ |
| 4 | Assisted with the second stage of labor. | _____ | _____ |
| 5 | Assisted with the third stage of labor. | _____ | _____ |
| 6 | Provided initial care for the newborn. | _____ | _____ |
| 7 | Documented the care given: The time of delivery and evacuated the mother, infant, and placenta to the hospital. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
*Emergency Care.*
*PHTLS Prehospital Trauma Life Support.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

Perform Point of Care Testing

081-68W-0170

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You have been instructed to perform laboratory testing on a patient. You are provided with medical equipment set, tactical combat medical care (2), CG8 Plus test cartridge, and the *Joint Trauma Systems Clinical Practice Guidelines* as the reference.

**Standards:** Perform point of care testing in accordance with (IAW) the *Joint Trauma Systems Clinical Practice Guidelines* while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**NOTE:** This task is for deployment readiness purposes. This task allows commanders to track required training and skills and to select appropriate personnel for deployment. Medical professionals received their competency training during licensure and area of concentration producing training and education.

**Performance Steps:**

1. Verify patient's identity.
    a. Ask patient to state their full name and date of birth.
    b. Check patient's wristband against clinical records.

2. Explain the urine collection procedure to the patient and check their history for medications that may interfere with the test.
    a. If patient is ambulatory and has bathroom privileges give a clean specimen collection container to the patient to obtain specimen.
    b. If patient is unable to use toilet offer urinal in order to obtain specimen.

**NOTE:** Inform patient to not place toilet tissue in urinal. Tell patient to notify you when specimen is ready.

3. Gather equipment.

4. Don gloves.

5. Remove cap from reagent strip bottle and place on a clean dry surface upside down, using aseptic technique.

6. Remove one reagent strip from the bottle.

7. Replace the reagent strip bottle container cap immediately.

**NOTE:** This will minimize exposure of the remaining test strips to light and air.

8. Remove cap from container of urine specimen using aseptic technique.

9. Place cap from container of urine specimen upside down on a clean, dry surface using aseptic technique.

10. Immerse the reagent pads of the strip completely in the urine sample.

11. Remove immediately to avoid dissolving the reagent pads.

12. Remove excess urine by running the strip along the edge of the specimen cup.

13. Hold the strip in a horizontal position to prevent possible cross contamination of chemicals located in adjacent reagent pads.

14. Compare the color change of reagent pads to the corresponding color chart on the bottle label.

a. Read results according to the chart's time frame for each panel tested.

**NOTE:** As with all tests dealing with color intensity or color matching, it is often recommended to obtain another staff or coworker's interpretation of the result.

b. The closest color match indicates the test result.

**NOTE:** Further testing and consultation with a health-care professional is necessary to confirm the presence of specific disease or health conditions.

15. Discard materials IAW infection control guidelines.

a. Discard the reagent strip in the appropriate waste container.

b. Discard remainder of urine in the toilet or in designated waste container IAW local protocol.

c. Discard used specimen cup in appropriate waste container.

16. Remove gloves and wash hands.

17. Don gloves.

**NOTE:** A new set of gloves are used to prevent cross contamination.

18. Explain the stool specimen collection procedure to the patient and check their history for medications that may interfere with the test.

a. If patient is ambulatory and has bathroom privileges place a clean specimen collection container in toilet to obtain specimen.

b. Inform patient that specimen collection container is for stool specimen only not urine.

c. If patient is unable to use toilet or bedside commode, offer bedpan in order to obtain stool specimen.

**NOTE:** Inform patient to not place toilet tissue in bedpan with specimen and not to urinate in bedpan with specimen. Tell patient to notify you when specimen is ready.

**CAUTION:** Make sure stool specimens are not contaminated with urine, soap solution, or toilet tissue, and test them as soon as possible after collection.

19. Collect stool sample.

**NOTE:** Do not collect routine samples during or until 3 days after a female's menstrual period to avoid a false-positive test from contamination of the specimen.

20. Test stool sample.

**NOTE:** Check the expiration date on the hemoccult slides and developer, and protect the unused slides from heat, moisture, light, and chemicals.

a. Open the flap on the slide package.

(1) Use a wooden applicator to apply a thin smear of the stool specimen on the guaiac-impregnated filter paper exposed in box A.

(2) Apply a second smear from another part of the specimen to the filter paper exposed in box B.

(3) Allow the specimen to dry for 3 to 5 minutes.

b. Open the flap on the reverse side of the slide package.

(1) Place two drops of hemoccult developing solution on the paper over each smear.

(2) A blue reaction will appear in 30 to 60 seconds if the test is positive.

**NOTE:** Ingestion of 2 to 5 milliliters (ml) of blood, such as from bleeding gums or active bleeding from hemorrhoids, may produce a false positive.

21. Discard materials IAW infection control guidelines.

22. Remove gloves and wash hands.

23. Explain the glucometer testing procedure to the patient.

24. Conduct the glucometer testing.

25. Select the puncture site (usually the fingertip or earlobe for an adult or a child).

26. Don gloves.

27. Wipe the puncture site with an alcohol pad and allow the site to dry completely.

28. Turn on the glucometer.

**NOTE:** The meter will indicate its readiness for testing blood glucose by message or symbol. Some meters require that the glucose strip be inserted at this time.

29. Collect sample from the fingertip with disposable lancet.

a. Position the lancet on the lateral side of the patient's fingertip perpendicular to the lines of the fingerprints.

**NOTE:** This avoids the most sensitive area of the fingertip.

b. Pierce the skin sharply and quickly to minimize the patient's anxiety and pain and to increase blood flow.

c. Alternatively, you can use a mechanical blood-letting device, which uses a spring-loaded lancet.

d. Obtain a large, hanging drop of blood.

**NOTE:** After puncturing the fingertip, do not squeeze the puncture site, to avoid diluting the sample with tissue fluid. Some glucose meters require that the test area be covered completely for accurate results. Others use only a small drop of blood inserted at the side of the test strip.

e. Apply a drop of blood to the test area of the test strip carefully.

f. After collecting the blood sample, briefly apply pressure to the puncture site.

**NOTE:** Applying pressure will prevent painful extravasation of blood into the subcutaneous tissues. You may ask an adult to hold a gauze pad firmly over the puncture site until the bleeding stops. After the bleeding has stopped, you may apply a small adhesive bandage to the puncture site.

**WARNING:** If you get an extremely low or high blood glucose reading, immediately notify the medical officer and obtain a serum blood glucose level to confirm the result.

30. Insert the test strip into the blood glucose meter according to the manufacturer's instructions.

31. Read the digital display when the alarm sounds.

**NOTE:** Processing time varies between meters but will be programmed to display result at the appropriate time.

32. Discard the lancet and test strip in a sharps container IAW infection control guidelines.

33. Remove gloves and wash hands.

34. Document all results, treatments and procedures in the patient's electronic health record or simulation training record utilizing current International Classification of Diseases and Current Procedural Terminology.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Verified patient's identity. | _____ | _____ |
| 2 | Explained the urine collection procedure to the patient and checked their history for medications that may interfere with the test. | ____ | _____ |
| 3 | Gathered equipment. | _____ | _____ |
| 4 | Donned gloves. | _____ | _____ |

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 5 | Removed cap from reagent strip bottle and placed on a clean dry surface upside down, using aseptic technique. | _____ | _____ |
| 6 | Removed one reagent strip from the bottle. | _____ | _____ |
| 7 | Replaced the reagent strip bottle container cap immediately. | _____ | _____ |
| 8 | Removed cap from container of urine specimen using aseptic technique. | _____ | _____ |
| 9 | Placed cap from container of urine specimen upside down on a clean, dry surface using aseptic technique. | _____ | _____ |
| 10 | Immersed the reagent pads of the strip completely in the urine sample. | _____ | _____ |
| 11 | Removed immediately to avoid dissolving the reagent pads. | _____ | _____ |
| 12 | Removed excess urine by running the strip along the edge of the specimen cup. | _____ | _____ |
| 13 | Held the strip in a horizontal position to prevent possible cross contamination of chemicals located in adjacent reagent pads. | _____ | _____ |
| 14 | Compared the color change of reagent pads to the corresponding color chart on the bottle label. | _____ | _____ |
| 15 | Discarded materials IAW infection control guidelines. | _____ | _____ |
| 16 | Removed gloves and washed hands. | _____ | _____ |
| 17 | Donned gloves. | _____ | _____ |
| 18 | Explained the stool specimen collection procedure to the patient and checked their history for medications that may interfere with the test. | _____ | _____ |
| 19 | Collected stool sample. | _____ | _____ |
| 20 | Tested stool sample. | _____ | _____ |
| 21 | Discarded materials IAW infection control guidelines. | _____ | _____ |
| 22 | Removed gloves and washed hands. | _____ | _____ |
| 23 | Explained the glucometer testing procedure to the patient. | _____ | _____ |
| 24 | Conducted the glucometer testing. | _____ | _____ |
| 25 | Selected the puncture site (usually the fingertip or earlobe for an adult or a child). | _____ | _____ |
| 26 | Donned gloves. | _____ | _____ |
| 27 | Wiped the puncture site with an alcohol pad and allowed the site to dry completely. | _____ | _____ |
| 28 | Turned on the glucometer. | _____ | _____ |
| 29 | Collected sample from the fingertip with disposable lancet. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 30 | Inserted the test strip into the blood glucose meter according to the manufacturer's instructions. | _____ | _____ |
| 31 | Read the digital display when the alarm sounds. | _____ | _____ |
| 32 | Discarded the lancet and test strip in a sharps container IAW infection control guidelines. | _____ | _____ |
| 33 | Removed gloves and washed hands. | _____ | _____ |
| 34 | Documented all results, treatments and procedures in the patient's electronic health record or simulation training record utilizing current International Classification of Diseases and Current Procedural Terminology. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Clinical Practice Guidelines.*
Joint Trauma Systems *website.*

**Related**
None

Treat Abdominal Disorders

081-68W-0239

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you must treat a patient with an abdominal complaint. You have performed a patient care handwash and taken BSI precautions. You are provided with a stethoscope, a pen, SF 600 (*Chronological Record of Medical Care*), and the patient's medical record.

**Standards:** Treat abdominal disorders in accordance with (IAW) *Rosdahl's Textbook of Basic Nursing*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Solicit a patient history.
    a. History of present illness.
    b. Chief complaint (usually in patient's own words).
    c. Use onset, provocation or palliation, quality, region and radiation, severity, timing type questions.
    d. Past medical history.
    e. Family history.
    f. Social history.
    g. Menstrual history (women of childbearing age).
    h. Travel history.

2. Check for red flags of abdominal symptoms (must see a medical officer as soon as possible).
    a. Abdominal pain with guarding or rebound tenderness or progressive severe pain that persists without improvement for over 6 hours.
    b. Recent (< 6 months) abdominal surgery.
    c. Abdominal pain with fever.
    d. Abdominal pain with tachycardia.
    e. Abdominal pain with dehydration.
    f. Abdominal pain in a pregnant patient.

3. Perform an abdominal physical exam.
    a. Inspection.
        (1) Observe the abdominal contour.
        (2) Skin characteristics.
        (3) Symmetry.
        (4) Peristalsis.
        (5) Pulsations.

(6) Presence of the following:
(a) Masses.
(b) Hernia.
(c) Separation of muscles.
b. Auscultation.
c. Palpation.
(1) Palpate for the kidneys on each side of the abdomen.
(2) Palpate the liver at the right costal border.
(3) Palpate for the spleen at the left costal border.
(4) Palpate the femoral pulses in the groin.

4. Manage gastroesophageal reflux disease.
a. Signs and symptoms.
(1) Heartburn, burping, regurgitation (worse after eating large meal, when lying down, in the middle of night).
(2) Physical exam is usually normal.
(3) Red Flags: bloody vomitus, blood in stool, dark tarry stools, significant weight loss.
b. Treatment – refer all abdominal pain patients to the medical officer.
(1) Medications:
(a) Antacids.
(b) Histamine type 2 blockers.
(c) Proton pump inhibitors.
(2) Lifestyle changes:
(a) Weight loss.
(b) Avoid alcohol, tobacco, caffeine, and large meals.
(c) Elevate the head of your bed.

5. Manage gastroenteritis.
a. Signs and symptoms.
(1) Nausea, vomiting, diarrhea (may be mild or severe).
(2) Malaise, fever, abdominal cramps.
(3) May have history of eating or drinking from an unapproved source.
b. Physical exam.
(1) May be normal, but abdomen may be diffusely tender if prolonged vomiting.
(2) Normal to increased bowel sounds.
c. Red flags.
(1) Vomiting blood (hematemesis) or bloody diarrhea.
(2) Fever (febrile).
(3) Signs of dehydration.
(4) Protracted vomiting or diarrhea.
d. Treatment.

(1) Medications: check with medical officer for permission to give an antiemetic if vomiting is severe.

(2) Correct fluid loss if signs of dehydration.

(3) Clear liquid diet.

(4) Bed rest may be indicated (check with medical officer).

6. Manage constipation.
   a. Signs and symptoms.
      (1) History of delayed or difficult bowel movements (BMs) (may be hard and dry).
      (2) Crampy abdominal pain, painful BMs.
   b. Physical Examination.
      (1) Usually normal (may have tenderness to palpation if severe).
      (2) Bowel sounds are variable (may be increased, normal, or decreased).
   c. Treatment.
      (1) Increase fluid and fiber intake.
      (2) Laxatives and stool softeners.

7. Manage abdominal pain with peritoneal signs.
   a. Signs and symptoms.
      (1) Anorexia, with pain that is increasing in severity.
      (2) Nausea, vomiting, diarrhea.
   b. Physical exam.
      (1) Fever.
      (2) Guarding and rebound tenderness present.
   c. Treatment – severe abdominal pain is referred to the medical officer immediately.

8. Manage hemorrhoids.
   a. Signs and symptoms.
      (1) Rectal itching.
      (2) Pain with BM.
      (3) Rectal bleeding.
   b. Physical exam

      (1) Rectal bleeding, with obvious source (external hemorrhoid visible). If no obvious source refer to medical officer immediately.

      (2) Ensure vital signs do not indicate a severe hemorrhage problem.

   c. Red flag. If bleeding is excessive or vital signs indicate hypovolemia, notify the medical officer immediately.
   d. Treatment.
      (1) Increase fiber and fluids in diet.
      (2) Avoid straining.
      (3) Sitz bath (sitting in warm water) for 15 minutes three times a day.
      (4) Pain medications, topical (dibucaine) or oral (acetaminophen).

9. Manage cystitis (bladder infection).
    a. Signs and symptoms.
        (1) Urgency, frequency, dysuria (urinary triad).
        (2) Malodorous urine.
        (3) Hematuria (blood in urine).
    b. Physical exam.
        (1) Fever.
        (2) If present, this indicates a more severe infection. Refer to the medical officer immediately.
    c. Treatment.
        (1) Diagnosis confirmed by urinalysis.
        (2) Requires antibiotics (refer to medical officer).

10. Manage diarrheal conditions.
    a. Acute (symptoms are acute in onset and persist for less than 3 weeks).
        (1) Signs and symptoms.
            (a) Frequent loose or watery stools.
            (b) Abdominal pain and cramping.
            (c) History of travel outside the U.S. within the last month.
        (2) Physical exam.
            (a) Fever.
            (b) Vital signs, orthostatic hypotension – (tilts) a drop in blood pressure when the patient changes position from lying to sitting or from sitting to standing. A drop of 10 millimeters of mercury (mmHg) in systolic pressure or an elevation of the pulse rate by 20 beats per minute (bpm) can indicate a volume deficit.
            (c) Signs of a viral upper respiratory infection.
            (d) Tenderness on palpation of abdomen.
            (e) Bowel sounds may be (normal, increased, or decreased).
        (3) Red flags: dehydration, bloody diarrhea, blood in stool, dark tarry stools (melena), severe abdominal pain and significant weight loss.
        (4) Treatment.
            (a) Diet: clear liquids, progressing to bland diet. Avoid caffeine, dairy products and raw fruit and vegetables.
            (b) Fluid resuscitation: IV or oral fluid and electrolyte replacement.
            (c) Medications: bismuth subsalicylate or loperamide. Antibiotics may be required (check with medical officer).
            (d) Consume food and water only from approved sources.
    b. Chronic diarrhea – diarrhea persisting for more than 3 weeks.
        (1) Chronic diarrhea may be viral, bacterial, or parasitic in nature. Diarrhea not caused by infections could be attributed to a number of malabsorptive, secretory, inflammatory or motility disorders. Sometimes the cause of chronic diarrhea remains unknown.
        (2) Refer to the medical officer.

11. Document patient's response and tolerance to exam procedure(s) and treatments provided on SF 600.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Solicited a patient history. | _____ | _____ |
| 2 | Checked for red flags of abdominal symptoms (must see a medical officer as soon as possible). | _____ | _____ |
| 3 | Performed an abdominal physical exam. | _____ | _____ |
| 4 | Managed gastroesophageal reflux disease. | _____ | _____ |
| 5 | Managed gastroenteritis. | _____ | _____ |
| 6 | Managed constipation. | _____ | _____ |
| 7 | Managed abdominal pain with peritoneal signs. | _____ | _____ |
| 8 | Managed hemorrhoids. | _____ | _____ |
| 9 | Managed cystitis (bladder infection). | _____ | _____ |
| 10 | Managed diarrheal conditions. | _____ | _____ |
| 11 | Documented patient's response and tolerance to exam procedure(s) and treatments provided on SF 600. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
SF 600. *Chronological Record of Medical Care*.
*Rosdahl's Textbook of Basic Nursing.*

**Related**
None

Treat Common Eye Infections

081-68W-0240

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you must treat a patient with symptoms of an eye disorder. You have performed a patient care handwash and taken BSI precautions. You are provided with a penlight, a Snellen visual acuity chart, disposable cotton-tipped applicators, a pen, and SF 600 (*Chronological Record of Medical Care*) or electronic medical record.

**Standards:** Treat common eye infections in accordance with *Tintinalli's Emergency Medicine*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Gather equipment and supplies.
2. Identify patient and inquire about allergies.
3. Provide privacy and safety for the patient.
   a. Place patient in position of comfort.
   b. Explain procedure to patient.
4. Obtain patient history and perform a physical examination of the eyes.
5. Identify the common eye infection.
   a. Conjunctivitis – inflammation of the conjunctiva.
      (1) Common causes – a chemical irritation, infections, or allergies.
      (2) Signs and symptoms may start in one or both eyes and include:
         (a) Grittiness, redness, burning and discharge.
         (b) Sclera and conjunctivae are commonly reddened with a clear, watery (allergy) or purulent (bacterial) discharge.
         (c) Allergic conjunctivitis – patient may have associated sneezing and water nasal discharge.
   b. Red eye.
      (1) Common causes – red eye can be a sign or symptom of a variety of abnormalities of the eye. Infection, allergies, drugs, chemical exposure, trauma, or systemic disease may cause a red eye.
      (2) Signs and symptoms can begin in one or both eyes and include pain and redness.
6. Provide treatment for common eye infections.
   a. Conjunctivitis – inflammation of the conjunctiva.
      (1) Referral to a medical officer is required in all ocular complaints.

(2) Eye pain with decreased visual acuity should be considered an emergency and be evaluated on an urgent basis.

b. Red eye.

(1) Referral to a medical officer is required in all ocular complaints.

(2) Eye pain with decreased visual acuity should be considered an emergency and be evaluated on an urgent basis.

7. Document treatment on SF 600.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Gathered equipment and supplies. | _____ | _____ |
| 2 | Identified patient and inquired about allergies. | _____ | _____ |
| 3 | Provided privacy and safety for the patient. | _____ | _____ |
| 4 | Obtained patient history and performed a physical examination of the eyes. | _____ | _____ |
| 5 | Identified the common eye infection. | _____ | _____ |
| 6 | Provided treatment for common eye infections. | _____ | _____ |
| 7 | Documented treatment on SF 600. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
SF 600. *Chronological Record of Medical Care*.
*Tintinalli's Emergency Medicine.*

**Related**
None

Treat Common Ear Disorders

081-68W-0241

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you must treat a patient complaining of ear pain. All other immediate life threats have been treated and managed. You have performed a patient care handwash and taken BSI precautions. You are provided with on otoscope, disposable speculum attachments, penlight or other light source, pen, and SF 600 (*Chronological Record of Medical Care*) or electronic medical record (EMR).

**Standards:** Treat common ear disorders in accordance with *Tintinalli's Emergency Medicine*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Gather equipment and supplies.

2. Identify the patient.
   a. Ask the patient's name.
   b. Ask the patient's date of birth.

3. Explain the procedure to the patient.
   a. Provide privacy and safety for the patient.
   b. Ask about any known allergies.
   c. Place the patient in a position of comfort, as long as the procedure permits.

4. Perform an otolaryngology examination (see task 081-68W-0254, Perform an Otolaryngology Exam).

5. Identify common ear disorders.

**NOTE:** Over 50% of ear pain complaints are dental in nature.

   a. Cerumen impaction – wax in the ears.

      (1) Common causes – wax is a natural byproduct of the body. Occasionally, cerumen impaction is caused by the improper use of cotton-tipped swab.

      (2) Signs and symptoms can include hearing loss and dizziness. It rarely causes pain.

   b. Otitis externa (OE) (swimmer's ear) inflammation or infection of the external auditory canal.

      (1) Common causes – excessive moisture in the ear canal (swimming, use of ear plugs or hearing aids) or trauma are the most common causes of OE. Bacterial or viral causes are also common. It is rarely a fungal infection.

      (2) Signs and symptoms include ear pain, ear canal swelling, drainage, and increased pain on movement of the auricle. A low-grade fever may be present.

c. Otitis media (OM) – middle ear infection. OM is a condition that is typically unilateral (occurs in one ear).

(1) Common causes – viral and bacterial.

(2) Signs and symptoms include fever, ear pain, decreased hearing in the affected ear, and the tympanic membrane will be bulging and red.

**NOTE:** The cone of light that is commonly seen with an otoscopic examination will generally be absent.

6. Provide treatment for common ear disorders.

**NOTE:** Ear irrigation or uses of ear drops that will dissolve the earwax are effective.

a. Cerumen impaction.

(1) Perform an ear irrigation, if trained to do so.

(2) Refer to a medical officer (MO) after the irrigation.

b. OE (swimmer's ear).

(1) Referral to MO.

(2) Oral antibiotics and pain medication will be prescribed.

**NOTE:** Irrigation of the ear canal is not recommended. MO may prescribe antibiotic or steroid ear drops as the first line of treatment and a nonsteroidal anti-inflammatory drug (NSAID) such as ibuprofen for pain.

c. OM.

(1) Referral to MO.

(2) Oral antibiotics and pain medication will be prescribed.

7. Document treatment noting patient's response to treatment on appropriate form.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Gathered equipment and supplies. | _____ | _____ |
| 2 | Identified the patient. | _____ | _____ |
| 3 | Explained the procedure to the patient. | _____ | _____ |
| 4 | Performed an otolaryngology examination (see task 081-68W-0254, Performed an Otolaryngology Exam). | _____ | _____ |
| 5 | Identified common ear disorders. | _____ | _____ |
| 6 | Provided treatment for common ear disorders. | _____ | _____ |
| 7 | Documented treatment nothing patient's response to treatment on appropriate form. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
SF 600. *Chronological Record of Medical Care*.
*Tintinalli's Emergency Medicine.*

**Related**
None

Treat Skin Disorders

081-68W-0125

**Conditions:** In an operational environment you have a patient with a skin disorder. You have identified the patient and have their medical records. You are provided with a standard fully stocked aid bag, pen, and SF 600 (*Chronological Record of Medical Care*). You have performed a patient care handwash and donned appropriate personal protective equipment. This task should not be trained in mission-oriented protective posture 4.

**Standards:** Treat skin disorders in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines*; by Joint Trauma System (JTS) Committee on Tactical Combat Casualty Care (CoTCCC), while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**DANGER:** None.

**WARNING:** None.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Performance Steps:**

1. Obtain a patient history.

**NOTE:** Including: a. primary lesions. b. secondary lesions. c. shape and configuration. d. complaints related to the dermatologic condition. (1) When did the rash first occur? (2) Was the onset sudden or gradual? (3) What site was first affected? (4) Describe the spread and its severity. (5) Is there any associated pruritis (itching), burning, tingling, pain, numbness (constant or intermittent), or fever?

2. Manage viral disorders of the skin.
    a. Herpes simplex.
        (1) Assessment findings include grouped vesicles on a red base, most commonly noted at the corner of the mouth (cold sore), or on the cervix or labia on women and the penis of men.

**NOTE:** Vesicles appear, ulcerate, and encrust. When a vesicle ruptures a burning pain is felt.

        (2) Management.
            (a) Abstain from sexual activity until infection is resolved.
            (b) Antiviral medications are indicated – refer to a medical officer for treatment.
            (c) Counsel patient on safe sex practices – condom usage.
    b. Herpes zoster vesicle (shingles).
        (1) Lesions located along the nerve fibers of spinal ganglia where inflammation occurs.
        (2) Forms an erythematous rash of small vesicles along a spinal nerve pathway.
        (3) Assessment findings.

(a) Rash generally in thoracic region.
_1_ Many occur elsewhere.
_2_ Follow dermatomal pattern.
(b) Vesicles rupture and form crust.
(c) Serous fluid in vesicle may become purulent.
(d) Last 7 to 28 days.
(e) Patients report severe burning or knife-like pain.
(f) Does not cross midline unless the patient is immuno-compromised.
(4) Management – refer patient to a medical officer for treatment.

3. Manage bacterial disorders of the skin.
   a. General characteristics.
      (1) Commonly occur in warm, moist locations but may be secondary to local trauma.
      (2) All bacterial infections need to be aggressively treated in a field environment.
   b. Impetigo.
      (1) Assessment findings.
         (a) Appears on face, hands, arms, and legs.
         (b) Pustular lesions distributed over involved area.
         (c) Large amount of dried serous exudate (honey-colored crust).
         (d) Spread by touching personal articles, linens, and clothing.
      (2) Management.
         (a) Consider antiseptic soap.
         (b) Consider application of antibiotic cream, ointment, or lotion.
         (c) Refer to a medical officer for treatment.
   c. Folliculitis, furuncles, carbuncles, and felons.
      (1) Assessment findings.
         (a) Edematous, erythematous, and painful.
         (b) Pruritus commonly occurs.
         (c) Infected area becomes shiny, points up, and if furuncle or carbuncle, the center turns yellow.
         (d) Carbuncles can have four to five cores with spontaneous rupture of core.
         (e) Pain stops immediately upon rupture of core.
      (2) Management. (Felons may spread to fascial planes in the hand and may require surgical exploration and debridement. Refer to a medical officer for treatment.)

4. Manage fungal infections of the skin.
   a. General characteristics.
      (1) Are not part of the normal flora.
      (2) About 20 species produce skin diseases.
   b. Tinea capitis (ringworm of the scalp).
      (1) Spread by contact with infected articles.

(2) Trauma or irritation breaks in skin facilitates spread.

(a) Assessment findings.

_1_ Areas of brittle or broken off hairs with some crusting.

_2_ Occasionally pruritus.

_3_ Non-scarring alopecia occurs at the site.

(b) Management – refer to medical officer for treatment.

c. Tinea corporis (ringworm of the body). Occurs in parts of body with little or no hair.

(1) Assessment findings.

(a) Produces lesions with raised erythemic borders as lesions expand there is central clearing (annular lesion).

(b) May have scale.

(c) May or may not have pruritus.

(2) Management – consider use of topical or oral antifungal drugs. Refer to medical officer if topical agents are not effective.

d. Tinea cruris (jock itch). Found in groin area.

(1) Assessment findings.

(a) Produces lesions with raised erythemic borders as lesions expand there is central clearing (annular or arciform lesions).

(b) Pruritus and skin excoriation from scratching may be found.

(c) May spare scrotum.

(2) Management.

(a) Consider methods of drying out area such as loose clothing (use of boxers or no underwear) and powder.

(b) Consider use of topical or oral antifungal drugs.

(c) Refer to medical officer if topical agents are not effective.

e. Tinea pedis (athlete's foot). Normally starts between 4th and 5th toes and then may spread.

(1) Assessment findings.

(a) Itching and burning.

(b) Maceration between toes.

(c) Cracking and peeling of interdigital skin.

(d) If secondarily infected may have associated discoloration.

(2) Management.

(a) Powder.

(b) Frequent sock changes.

(c) Rotation of footwear.

(3) Consider use of topical or oral antifungal drugs.

(4) Refer to medical officer if topical agents are not effective.

5. Manage inflammatory disorders of the skin.

**NOTE:** This disorder is a local or generalized inflammation caused by a number of factors.

a. General characteristics.

(1) Can be caused by numerous agents such as drugs, plants, chemicals, metals, and food.

(2) Erythema and edema in acute disorders.

(3) Skin thickening and chronic pigmentation in chronic disorders.

(4) Pruritus is almost always present; if present it can cause excoriation due to scratching.

b. Contact dermatitis (irritant and allergic).

(1) Caused by direct contact with agents that cause irritation or allergic reaction.

(2) Epidermis becomes inflamed and damaged.

(3) Common causes are detergents, soaps, industrial chemicals, medications, hypersensitivity reactions, and plants such as poison ivy.

(a) Assessment findings.

_1_ Lesions appear at point of contact.

_2_ Patient feels burning, pain, pruritus, and edema.

_3_ Involved area becomes erythematous with papules.

_4_ Vesicles appear most often on dorsal surfaces.

(b) Management.

_1_ Identify cause of hypersensitive reaction.

_2_ Symptomatic treatment for inflammation, edema, and pruritus.

6. Document treatment provided on SF 600.

7. Provide information on the prevention of skin disorders.

**NOTE:** Tell the patient to maintain healthy skin by avoiding causative agents (poison ivy, excessive sunlight). Always inspect the skin after each mission and avoid self-treatment of anything out of the ordinary.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Obtained a patient history. | _____ | _____ |
| 2 | Managed viral disorders of the skin. | _____ | _____ |
| 3 | Managed bacterial disorders of the skin. | _____ | _____ |
| 4 | Managed fungal infections of the skin. | _____ | _____ |
| 5 | Managed inflammatory disorders of the skin. | _____ | _____ |
| 6 | Documented treatment provided on SF 600. | _____ | _____ |
| 7 | Provided information on the prevention of skin disorders. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all

performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
Joint Trauma System website.
SF 600. *Chronological Record of Medical Care*.

**Related**
None

Treat Common Respiratory Disorders

081-68W-0245

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you must treat a patient with a respiratory complaint. You have performed a patient care handwash and donned the proper personnel protective equipment. You are provided with the patient's medical records, a stethoscope, sphygmomanometer, otoscope and ophthalmoscope, tongue depressors, pen, and *Rosdahl's Textbook of Basic Nursing*.

**Standards:** Treat common respiratory disorder in accordance with *Rosdahl's Textbook of Basic Nursing*, without causing further harm or injury to the patient while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Identify the signs and symptoms of pneumonia.
    a. Solicit a patient history.
        (1) Cough frequently productive of purulent sputum (green, yellow, rusty brown colored).
        (2) Chest pain that is sharp and pleuritic (worse with cough or upon inhalation).
        (3) Shortness of breath at rest.
        (4) Malaise, lethargy.
        (5) Poor appetite.
    b. Perform a physical exam looking for:
        (1) Fever occasionally with shaking chills.
        (2) Tachycardia.
        (3) Tachypnea.
        (4) Respiratory distress (retractions).
        (5) Abnormal breath sounds: rhonchi, rales, wheezing or crackles.
        (6) Abnormal pulse oximetry < 95%.
    c. Consult with medical officer for treatment as applicable.

2. Provide supportive care for pneumonia.
    a. Ibuprofen or acetaminophen for fever.
    b. Decongestant: pseudoephedrine, guaifenesin with phenylephrine (do not give antihistamines).
    c. Cough suppressants if trouble sleeping at night.
    d. Increase fluid intake.
    e. Bronchodilators.
    f. Consider bed rest and profile, evacuate if in field environment.
    g. Record all treatment in the patient's medical record.

h. Seek the advice and assistance of a higher medical authority whenever possible.

3. Identify the signs and symptoms of asthma.
   a. Solicit a patient history (may vary widely from mild to life threatening).
      (1) Shortness of breath.
      (2) History of wheezing.
      (3) Chronic cough (usually nonproductive).
      (4) Nocturnal attacks.
      (5) Triggers.
         (a) Emotional upset.
         (b) Physical exertion.
         (c) Cold weather.
         (d) Upper respiratory infection.
         (e) Allergic components: Insect stings, air pollutants, infection, strenuous exercise, or emotional stress.
   b. Perform a physical exam looking for:
      (1) Dyspnea.
      (2) Wheezing.
      (3) Cough.
      (4) Tachycardia.
      (5) Abnormal pulse oximetry < 95%.

4. Provide immediate treatment and care for acute asthma attacks only.
   a. Inhaled bronchial dilators either metered dose inhaler or nebulizers.
   b. IV hydration.
   c. Oxygen.
   d. Evacuate immediately if in field environment.
   e. Record all treatment in the patient's medical record.
   f. Seek the advice and assistance of a higher medical authority whenever possible.

5. Identify the signs and symptoms of a viral respiratory infection.
   a. Solicit a patient history.
      (1) Nasal congestion or runny nose.
      (2) Sore or scratchy throat.
      (3) Cough (productive or nonproductive).
      (4) Hoarseness.
      (5) Malaise.
      (6) Fatigue.
      (7) Headache.
      (8) Sinus pressure.
   b. Perform a physical exam looking for:
      (1) Eyes: conjunctiva injected, increased lacrimation.

(2) Ears: tympanic membrane may be injected, moves poorly with Valsalva maneuver.

(3) Nose: mucoid or purulent nasal discharge, swollen mucus membranes, decreased air movement.

(4) Throat: oropharynx injected, tonsillar pillars may be swollen with or without exudate.

(5) Neck: supple, tender to palpation with shoddy, lymph nodes usually in the anterior chain.

(6) Chest: lungs may be clear or have scattered rhonchi or mild wheezing, usually no retractions or accessory muscle use.

(7) Vital signs: temperature, normal to low-grade fever (100.0 degrees (°) Fahrenheit (F) -101.0 °F.

6. Provide supportive care for the viral respiratory infection.

**NOTE:** Treatment and care for a viral upper respiratory infection is symptomatic.

a. Ibuprofen or acetaminophen for fever.

b. Decongestant: pseudoephedrine, guaifenesin with phenylephrine (do not give antihistamines).

c. Cough suppressants if trouble sleeping at night.

d. Increase fluid intake.

e. Bronchodilators.

f. Consider bed rest and profile, evacuate if in field environment.

g. Record all treatment in the patient's medical record.

h. Seek the advice and assistance of a higher medical authority whenever possible.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Identified the signs and symptoms of pneumonia. | _____ | _____ |
| 2 | Provided supportive care for pneumonia. | _____ | _____ |
| 3 | Identified the signs and symptoms of asthma. | _____ | _____ |
| 4 | Provided immediate treatment and care for acute asthma attacks only. | _____ | _____ |
| 5 | Identified the signs and symptoms of a viral respiratory infection. | _____ | _____ |
| 6 | Provided supportive care for the viral respiratory infection. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Rosdahl's Textbook of Basic Nursing.*

**Related**
None

Perform an Otolaryngology Exam

081-68W-0254

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You have a patient requiring an ears, eyes, nose, and throat examination. You will be provided with an otoscope, disposable speculum attachments, tongue blades, penlight, pen, Snellen chart, and SF 600 (*Chronological Record of Medical Care*) or electronic medical record.

**Standards:** Perform an otolaryngology exam in accordance with *Tintinalli's Emergency Medicine* without causing further injury to the patient while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**Performance Steps:**

1. Obtain equipment and supplies.
2. Identify patient while inquiring about allergies.
3. Provide privacy and safety for the patient.
   a. Place patient in a position of comfort as long as the procedure permits.
   b. Explain procedure to the patient.
4. Perform a physical exam of the eyes.
   a. Obtain patient history.

**NOTE:** An accurate history is needed in establishing a possible cause for the eye problem.

(1) Mechanism of injury (if there is a history of injury).
(a) Blunt trauma verses penetrating injury.
(b) Was there a projectile or missile injury? (Glass from a motor vehicle accident.)
(c) Thermal, chemical or laser burn?
(2) Does the patient wear glasses, contact lenses or safety goggles?
(3) History of eye disease or previous eye trauma or surgery?
(4) Is there eye pain or loss of vision? If there is vision loss, is it in one eye or both?

**NOTE:** Ocular injuries are classified as penetrating or nonpenetrating. Eye injuries are common in spite of protection by the bony orbit.

b. Perform a physical exam.

**WARNING:** In cases of ocular burns, the eyes must be flushed first. Once the mechanism of the burn has been eliminated, then a visual acuity screening is accomplished.

(1) Inspect and palpate.

**NOTE:** Avoid putting pressure on the globe while performing the exam.

(2) Obtain visual acuity using the following methods.
  (a) Read any available printed material.
  (b) Count fingers.

**NOTE:** If the patient is unable to count fingers, assess their ability to detect hand motion 1 to 2 inches in front of the eye.

  (c) Distinguish between light and dark.

**CAUTION:** When equipment, light, or space does not permit, a gross vision examination is recommended as opposed to no vision exam.

  (d) Read the Snellen chart (eye chart).

**NOTE:** If the patient has corrective lenses, test without glasses first, and then test with glasses on.

(3) Note any drainage or bleeding from the eye.
(4) Inspect eyelids for:
  (a) Ability to open wide and close completely.
  (b) Edema.
  (c) Discoloration.
  (d) Foreign bodies.
  (e) Position of the lids in relationship to the eyeballs.
(5) Inspect conjunctiva and sclera for:

**NOTE:** Ask patient to look upward as you pull the lower lid downward. Then tell the patient to look down as you pull the upper lid upward.

  (a) Color of conjunctiva (pink to dark color is normal).
  (b) Erythema or exudate.
  (c) Color of sclera (white is normal).

**NOTE:** Patients who have darker pigmented skin may have scattered areas of brown pigments, a normal finding, but this observation should be noted.

(6) Inspect cornea (should be clear and avascular).
(7) Inspect pupil – note any irregularity in the shape of the pupils.

**NOTE:** Unequal size of pupils (anisocoria) may be congenital (approximately 20% of healthy people have minor or noticeable differences in pupil size, but pupillary reaction is normal.)

  (a) Pupils should be equal, round, regular, and reactive to light.
  (b) Assess extra ocular movement.
(8) Test pupillary reaction to light both directly and consensually.
  (a) Dim the lights in the room so that the pupils dilate.

**NOTE:** Do not shine into both eyes simultaneously.

(b) Shine a penlight directly into one eye and observe the pupil constrict.

(c) Note consensual reaction response of the opposite pupil constricting simultaneously with the tested pupil.

5. Perform a physical exam of the ears.
   a. Obtain patient history.

      (1) Ask patient about symptoms associated with ear problems, pain, swelling, redness, drainage.

      (2) Ask patient about history of recent illness, upper respiratory infection, sore throat, or recent swimming.

      (3) Ask patient about any hearing loss.

      (4) Ask the patient about possible embedded foreign objects in ear.

   b. Perform physical exam.

**NOTE:** Physical examination consists of inspection, palpation and otoscopic examination of the ear.

(1) Examine external pinna for erythema, swelling, deformity, trauma, or drainage from canal.

(2) Inspect the ear size, shape, symmetry, landmarks, color, and position on the head; palpate the auricle for tenderness and swelling.

(3) Palpate the ear and mastoid process.

(4) Inspect the external auditory canal (EAC) for discharge or cerumen (earwax).

**CAUTION:** Consult with your medical officer before completing an otoscopic exam on a child.

(5) Inspect the EAC and middle ear using the otoscope.

**NOTE:** Use the largest speculum the ear canal will accommodate.

(a) Examine the normal ear first.

(b) Hold the otoscope handle between your thumb and fingers; brace your hand against the patient's face.

(c) Pull the auricle back and out on an adult patient.

(d) Visualize the canal as you insert the speculum.

(e) Slowly insert the speculum noting discharge, lesions, narrowing of the EAC, foreign bodies, or presence of cerumen (earwax).

**NOTE:** A healthy tympanic membrane or eardrum may be pearly gray to amber in color. Redness indicates infection.

6. Perform a physical exam of the nose and sinuses.
   a. Obtain patient history.

      (1) Ask about recent upper respiratory infection symptoms, drainage, bleeding, congestion, trauma, pressure, recent dental problems, and pain.

(2) Ask about any medications, prior history, or chronic illnesses.

(3) Ask about duration of symptoms.

(4) Ask about any allergies or family history of allergies.

b. Perform physical exam.

(1) Inspect for shape, size, symmetry, color, and presence of deformities or lesions.

(2) Palpate the external nose for tenderness, swelling or masses.

(3) Inspect paranasal sinuses.

(a) Inspect the frontal and maxillary sinus area for swelling.

(b) Palpate the frontal and maxillary sinuses for tenderness.

**NOTE:** Only the maxillary and frontal sinuses are accessible to physical examination.

7. Perform a physical examination of the throat.

a. Obtain patient history.

(1) Ask patient about recent symptoms, bad breath, sore throat, hoarseness, difficulty swallowing, and inability to open mouth.

(2) Ask patient about duration of symptoms, smoking habits, and drooling.

b. Perform physical exam.

(1) Inspect and palpate the patient's lips for symmetry, color, edema, and surface abnormalities.

(2) Inspect buccal mucosa, teeth, and gums.

**NOTE:** If patient wears dentures, have them remove their dentures and then open their mouth. Gums should have a slightly stippled, pink appearance with a clearly defined, tight margin at each tooth.

(a) Have the patient to open their mouth, stick out their tongue and say "ah."

(b) Use a disposable tongue blade and bright light to inspect mucous membrane of the entire mouth, teeth, posterior pharynx, and tonsils.

**NOTE:** Mucous membranes should look pinkish-red, smooth, and moist. Take note of any missing teeth, cavities, ulcerations, and lesions.

(3) Inspect the tongue.

**NOTE:** The tongue should appear dull red, moist, and glistening; should be smooth with increasing roughness.

(4) Inspect the oropharynx.

**NOTE:** The whitish hard palate should be dome shaped. The pinker soft palate should be continuous with the hard palate.

8. Document findings on the SF 600.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 1 | Obtained equipment and supplies. | _____ | _____ |
| 2 | Identified patient while inquiring about allergies. | _____ | _____ |
| 3 | Provided privacy and safety for the patient. | _____ | _____ |
| 4 | Performed a physical exam of the eyes. | _____ | _____ |
| 5 | Performed a physical exam of the ears. | _____ | _____ |
| 6 | Performed a physical exam of the nose and sinuses. | _____ | _____ |
| 7 | Performed a physical exam of the throat. | _____ | _____ |
| 8 | Documented findings on the SF 600. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Tintinalli's Emergency Medicine.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

## Apply Fluorescein to an Eye

081-68W-0258

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You have a medical officer's orders to apply a fluorescein stain to a patient's eye to facilitate examination. You have verified the orders and the patient. You have the patient's medical records; you have performed a patient care handwash and taken appropriate BSI precautions. You are provided with sterile fluorescein, an illumination source, cotton applicators, sterile normal saline, waste receptacle, pen, and SF 600 (*Chronological Record of Medical Care*).

**Standards:** Apply fluorescein to an eye in accordance with *Lippincott Manual of Nursing Practice* without causing injury while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**Performance Steps:**

1. Obtain supplies and equipment.

2. Brief procedure to patient.
   a. Place patient in a position of comfort.
   b. Provide privacy for the patient.

3. Apply fluorescein to eye(s).
   a. Gather one fluorescein strip to detect whether a foreign body or corneal abrasion are present.

**NOTE:** Green stain will indicate if abrasion is present.

   b. Apply a drop of saline to the strip; pull the lower eyelid down and gently touch the tip of the strip to the inner aspect of the eyelid.

**NOTE:** Moistening the strip will enhance the release of the dye.

   c. Ask the patient to blink several times to distribute the dye.

**NOTE:** Dye will be dispersed over the conjunctive and cornea.

   d. View cornea through a blue filter light to best illuminate area of abrasion and foreign body.

**NOTE:** Breaks in the epithelium will cause aqueous humor to color the fluorescein dye green under the blue light.

4. Inform the medical officer that the patient is ready to be examined.

5. Decontaminate work area.

6. Record procedure on appropriate medical form.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 1 | Obtained supplies and equipment. | _____ | _____ |
| 2 | Briefed procedure to patient. | _____ | _____ |
| 3 | Applied fluorescein to eye(s). | _____ | _____ |
| 4 | Informed the medical officer that the patient was ready to be examined. | _____ | _____ |
| 5 | Decontaminated work area. | _____ | _____ |
| 6 | Recorded procedure on appropriate medical form. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Lippincott Manual of Nursing Practice.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

Treat Dislocations

081-68W-0260

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you have a patient who requires treatment for dislocation, which may involve either shoulder, elbow, fingers, knee, ankle, or toes. You are provided with rigid splints, elastic bandages, slings and swathes, traction splints, and either an SF 600 (*Chronological Record of Medical Care*), a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*), or an electronic medical record.

**Standards:** Treat a dislocation in accordance with *Emergency Care*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Treat life-threatening issues first.
2. Identify the injury site.
   a. Remove clothing to expose injured area.
   b. Control any bleeding.
3. Check distal circulation, sensory, motor function (CSM) if applicable.
   a. Check for presence of distal circulation.
   b. Check distal sensation in extremities.
   c. Check for presence of motor function.

**CAUTION:** Do this under gentle traction if severe deformity exists or distal circulation is compromised.

4. Place long-bone injuries to the anatomic position, if applicable.
5. Perform splinting for injuries.
6. Apply padding to voids left by splinting to provide stability.
7. Recheck distal CSM.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Treated life-threatening issues first. | _____ | _____ |
| 2 | Identified the injury site. | _____ | _____ |
| 3 | Checked distal circulation, sensory, motor function (CSM), if applicable. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 4 | Placed long-bone injuries to the anatomic position, if applicable. | _____ | _____ |
| 5 | Performed splinting for injuries. | _____ | _____ |
| 6 | Applied padding to voids left by splinting to provide stability. | _____ | _____ |
| 7 | Rechecked distal CSM. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*. *Emergency Care.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

## Apply a Rigid Splint

081-68W-0263

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment and are required to apply a rigid splint to a casualty with a suspected fracture to an arm or leg. All other injuries have been assessed and treated. You are provided with a rigid or formable splint, four muslin bandages (cravats), three-inch tape and a six-inch elastic bandage, and SF 600 (*Chronological Record of Medical Care*), a pen, and personal protective equipment.

**Standards:** Apply a rigid splint to a suspected fracture so it does not move nor impair circulation in accordance with *PHTLS Prehospital Trauma Life Support,* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Take BSI precautions.

2. Prepare the casualty for the application of the splint.
    a. Upper extremity injury.
        (1) Have the casualty sit up.
        (2) Have someone support the fractured extremity.
        (3) Remove all jewelry from the fractured extremity.
        (4) Expose the fracture site.
    b. Lower extremity injury.
        (1) Have the casualty sit or lie down.
        (2) Have another person manually immobilize the fractured extremity.
        (3) Remove the foot gear and expose the fracture site.

**WARNING:** If a pulse cannot be palpated, apply gentle manual traction in line with the long axis of the limb. This maneuver may restore the pulse. If a pulse does not return after one attempt, splint the limb in the most comfortable position for the casualty and evacuate the casualty immediately.

3. Check distal pulse and capillary refill on the injured extremity.

4. Prepare the splint for application.

**NOTE:** If using a formable splint, measure and shape the splint on the uninjured extremity.

    a. Forearm or wrist fracture.
        (1) Fold the formable splint in half, upon itself creating a double layered splint, leaving one side approximately 1 inch longer than the other.

(2) Take the folded end of the formable splint and roll at least two times towards the side with the shortest end. This will provide a natural curvature for the hand when the splint is applied.

(3) Shape the formable splint into a C curve along the long axis from the rolled end to the opposite end.

(4) Shape the splint until the splint generally conforms to the curve and shape of the limb being splinted.

(5) Pad the splint and fill in the voids as needed.

b. Elbow injury.

(1) The injured extremity should be placed in a V (bent) position with the forearm across the anterior thorax.

(2) Take one splint and fold it in half, creating a double layered splint. After folding the splint in half make a C curve along the long axis of the splint.

(3) Take another formable splint and fold it in half.

(4) After folding the second formable splint in half, fold the splint in half again but along the long axis of the splint.

(5) Pad the formable splint if needed.

c. Fractured humerus.

(1) Fold one third of the 36-inch formable splint upon itself to create a 12-inch section of double-layered splint.

(2) Bend the double layered portion of the splint into a J and tape both layers together.

(3) Fold the rest of the splint into a slight C, along the long axis of the splint, to create rigidity.

d. Ankle injury.

(1) Apply padding to the bony prominence of the medial and lateral ankle bones (medial and lateral malleolus).

(2) Fold a 36-inch formable splint to create two equal halves.

**NOTE:** When folding the formable splint, make sure that the middle fold is large enough to accommodate the foot.

(3) Fold both sides of the splint in a slight C to create rigidity along the long axis of the splint.

e. Tibia or fibula fracture.

(1) Apply padding to the bony prominence of the medial and lateral ankle bones (medial and lateral malleolus).

(2) Completely extend the entire 36-inch formable splint.

(3) Curve approximately 6 inches of the splint into a J shape.

(4) Form a C curve along the long axis of the remaining 30 inches of the splint.

(5) Perform the same steps to another 36-inch formable splint.

5. Prepare cravats.

**NOTE:** If cravats are to be used in securing the splint to the injured extremity, position the cravats above and below the fracture site.

6. Secure the splint to the injured extremity with the limb in the position of function.
    a. Forearm or wrist fracture.
        (1) Place the fractured forearm in the splint with the hand in a natural curve on top of the rolled end of the splint.
        (2) Tie one cravat proximal to the fracture site and one cravat distal to the fracture site.
        (3) Tie the tails of the cravats in nonslip knot on the outside of the splint.
        (4) Recheck the casualty's pulse and capillary refill below the most distal cravat. Loosen the cravats and reapply the splint if needed.
        (5) Cut the tails of each cravat to prevent accidental entanglement when the casualty is moved.
        (6) Apply and sling and swathe to further immobile the fractured arm.
    b. Elbow injury.
        (1) While the arm is in the bent slight V position across the anterior thorax, place the formable splint that is folded in half along the long axis on the outside of the arm from the humerus to the forearm.
        (2) Place the formable splint that is bent into a C curve on the inside of the arm, also running from the humerus to the forearm.
        (3) The splint should extend approximately two inches past the forearm and two inches past the humerus.
        (4) Tie both splints together with one cravat in the middle area of the anterior elbow crease. The injured extremity should still be sandwiched between both formable splints.
        (5) Tie a cravat around both formable splints on the outside of the humerus.
        (6) Tie a cravat around both formable splints just past the forearm.
        (7) Apply a sling and swathe to further immobilize the fractured arm.
    c. Fractured humerus.
        (1) Support the casualty's arm in an L shape.
        (2) Hook the elbow with the J portion of the splint, running the rest of the splint along the upper arm towards the shoulder (on the outside of the arm).
        (3) Fold any excess splint that may be extending above the top of the shoulder, back upon itself (double layer).
        (4) Secure the splint with an elastic bandage distal to proximal and secure the elastic bandage with tape.
        (5) Apply a sling and swathe to further immobilize the fractured arm.
    d. Ankle injury.
        (1) Apply the splint to the ankle by placing the foot in the stirrup portion of the splint.
        (2) Form the splint to the length of the lower leg.
        (3) Secure the splint by wrapping the elastic bandage from the top of the foot, around the bottom of the foot and up the length of the splint.
        (4) Tape the wrap in place.
    e. Tibia or fibula fracture.
        (1) Apply the splint to the outside area of the fractured tibia or fibula.

(2) Place the foot in the J portion of the splint and run the long axis of the splint up the leg toward the knee.

(3) Apply the second splint to the inside area of the fractured tibia and fibula.

(4) Place the foot (with the previous splint) into the J and run the long axis of the splint up the leg toward the knee.

(5) Wrap both splints around the lower leg with an elastic bandage starting from the top of the foot, around the bottom of the foot and then up the length of the splints toward the knee.

(6) Tape the wrap in place.

7. Recheck distal pulse.

**NOTE:** Recheck the distal pulse periodically to ensure that the swelling has not compromised the extremity. If swelling occurs and the distal pulse is lost, evacuate the casualty immediately.

8. Record treatment given on the SF 600.

9. Evacuate the casualty.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Took BSI precautions. | _____ | _____ |
| 2 | Prepared casualty for the application of the splint. | _____ | _____ |
| 3 | Checked distal pulse and capillary refill on the injured extremity. | _____ | _____ |
| 4 | Prepared the splint for application. | _____ | _____ |
| 5 | Prepared cravats. | _____ | _____ |
| 6 | Secured the splint to the injured extremity with the limb in the position of function. | _____ | _____ |
| 7 | Rechecked the distal pulse. | _____ | _____ |
| 8 | Recorded treatment given on the SF 600. | _____ | _____ |
| 9 | Evacuated the casualty. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*PHTLS Prehospital Trauma Life Support.*
SF 600. *Chronological Record of Medical Care.*

**Related**
None

Perform a Back Examination

081-68W-0271

**Conditions:** In an operational environment you have a patient that requires a back examination. You will have a physical examination table or flat surface, a pen, and an SF 600 (*Chronological Record of Medical Care*) or electronic medical record.

**Standards:** Perform a back examination in accordance with *Bates' Guide to Physical Examination and History Taking* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Identify the patient.

2. Obtain the patient history.
   a. Record past medical injuries or conditions.
   b. Record past surgical procedures including date of procedure.
   c. Record current medications.
   d. Record drug allergies.
   e. Record social history including tobacco, alcohol, and illegal drug use.
   f. Record family medical history.

3. Obtain history of present illness.
   a. Record the mechanism of injury.
   b. Record onset of symptoms (specify date when possible).
   c. Record previous attempts to treat the condition (for example, nonsteroidal anti-inflammatory drugs [NSAIDs], physical therapy, and activity modification).
   d. Record provocating activities.
   e. Record referred or radiating symptoms.
      (1) Ability to walk after injury.
      (2) Any numbness, tingling or weakness in the lower extremities.
      (3) Any bladder or bowel changes.
   f. Record severity of symptoms on a 10-point pain scale.
   g. Record family medical history.
   h. Record military occupational specialty or duty description.

4. Screen for red flags (saddle paresthesia, urinary symptoms [retention, urgency, or incontinence], bilateral radiculopathies).

5. Record any systemic or rheumatological symptoms (fever, eye pain, history of uveitis, dysphagia or odynophagia, chest pain, irritable bowel or abdominal symptoms, polymyalgia, distal paresthesia).

6. Perform a physical examination.
   a. Observe gait and record abnormalities (Trendelenburg).

b. Inspection – have the patient place one finger on the spot that hurts the most. Look for the following:

(1) Swelling.

(2) Erythema.

(3) Ecchymosis.

(4) Obvious deformity.

c. Palpate key anatomy and record associated pain, tenderness, crepitus, masses (spinous processes, facets, paramuscular structures).

d. Range of motion (ROM) – ask the patient to complete the ROM movements, but you or the patient should never force a motion.

(1) Flexion.

(2) Extension.

(3) Lateral bending.

(4) Rotation.

e. Inspect area for edema, erythema, ecchymosis, effusion, or obvious deformity.

f. Perform neuromuscular examination.

(1) Test nerve roots L4-S1.

(a) The front of the thigh (L1-4).

(b) Inside of lower leg from the knee to the inner ankle and arch (L4).

(c) The top of foot and toes (L5).

(d) The outside of your ankle and foot (S1).

(2) Test dermatomes L1-S1.

(3) Perform deep tendon reflexes.

(a) The front of the thigh (L1-4).

(b) On each L4 and S1.

g. Perform special tests.

(1) Perform straight leg raise test.

(2) Perform hip flexion, abduction, external rotation, or Patrick's test.

(3) Perform Trendelenburg test.

(4) Evaluate patient for myoclonus.

7. Document patient medical history, history of present illness, and physical examination on SF 600 in subjective, objective, assessment, and plan note format.

8. Present patient to a medical provider with a differential diagnosis and proposed treatment plan. (Should consider medications, physical therapy, profiling, and further diagnostic tests as indicated.)

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|
| 1 Identified the patient. | _____ | _____ |

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 2 | Obtained the patient history. | _____ | _____ |
| 3 | Obtained history of present illness. | _____ | _____ |
| 4 | Screened for red flags (saddle paresthesia, urinary symptoms [retention, urgency, or incontinence], bilateral radiculopathies). | _____ | _____ |
| 5 | Recorded any systemic or rheumatological symptoms (fever, eye pain, history of uveitis, dysphagia or odynophagia, chest pain, irritable bowel or abdominal symptoms, polymyalgia, distal paresthesia). | _____ | _____ |
| 6 | Performed a physical examination. | _____ | _____ |
| 7 | Documented patient medical history, history of present illness, and physical examination on SF 600 in subjective, objective, assessment, and plan note format. | _____ | _____ |
| 8 | Presented patient to a medical provider with a differential diagnosis and proposed treatment plan. (Should have considered medications, physical therapy, profiling, and further diagnostic tests as indicated.) | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Bates' Guide to Physical Examination and History Taking.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

Perform an Ankle Examination

081-68W-0272

**Conditions:** In an operational environment you have a patient that requires an ankle examination. You will have a physical examination table or a flat surface, exam table paper, an SF 600 (*Chronological Record of Medical Care*) and a pen.

**Standards:** Perform an ankle examination in accordance with *Bates' Guide to Physical Examination and History Taking* without causing injury to the patient while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Identify the patient.

2. Obtain the patient history.
   a. Record past medical injuries or conditions.
   b. Record past surgical procedures including date of procedure.
   c. Record current medications.
   d. Record drug allergies.
   e. Record social history including tobacco, alcohol, and illegal drug use.
   f. Record family medical history.
   g. Record military occupational specialty and duty description.

3. Obtain history of present illness.
   a. Record a mechanism of injury.
   b. Record onset of symptoms (specify date when possible).
   c. Record provocating activities.
   d. Record referred or radiating symptoms.
   e. Record severity of symptoms on a 10-point pain scale.
   f. Record previous attempts to treat the condition (for example, nonsteroidal anti-inflammatory drugs [NSAIDs], physical therapy, and activity modification).

4. Screen for red flags (discoloration, pain, warmth, swelling, and tenderness of the affected extremity).

5. Perform a physical examination of the ankle.
   a. Gait – Watch the patient walk, if able. Note any abnormalities.
   b. Inspection – Have the patient place one finger on the spot that hurts the most. Look for the following:

**NOTE:** Compare the affected extremity to the unaffected one.

   (1) Swelling.
   (2) Erythema.
   (3) Ecchymosis.

(4) Obvious deformity.

c. Palpation – palpate the following:
   (1) Bony prominences.
   (2) Three primary ligaments. (medial, lateral and Achilles)
   (3) Pulses. (dorsalis pedis and posterior tibial)
   (4) Is there sensation distal to the injury?
d. Perform neuromuscular examination (S1).
e. Record any systemic or rheumatological symptoms. (fever, edema, or tenderness)

**WARNING:** You or the patient should never force a motion.

f. Range of motion (ROM). Ask the patient to complete the ROM movements.

**NOTE:** Compare ROM of the affected ankle with the unaffected one.

(1) Dorsiflexion.
(2) Plantarflexion.

6. Document patient medical history, history of present illness, and physical examination on SF 600 in subjective, objective, assessment, and plan note format.

7. Present patient to a medical provider with a differential diagnosis and proposed treatment plan. (Should consider medications, physical therapy, profiling, and further diagnostic tests as indicated.)

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Identified the patient. | _____ | _____ |
| 2 | Obtained the patient history. | _____ | _____ |
| 3 | Obtained history of present illness. | _____ | _____ |
| 4 | Screened for red flags (discoloration, pain, warmth, swelling, and tenderness of the affected extremity). | _____ | _____ |
| 5 | Performed a physical examination of the ankle. | _____ | _____ |
| 6 | Documented patient medical history, history of present illness, and physical examination on SF 600 in subjective, objective, assessment, and plan note format. | _____ | _____ |
| 7 | Presented patient to a medical provider with a differential diagnosis and proposed treatment plan. (Should have considered medications, physical therapy, profiling, and further diagnostic tests as indicated.) | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all

performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Bates' Guide to Physical Examination and History Taking.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

Perform a Wrist Examination

081-68W-0273

**Conditions:** In an operational environment you have a patient that requires a wrist examination. You will have a physical examination table or a flat surface, SF 600 (*Chronological Record of Medical Care*) and a pen.

**Standards:** Perform a wrist examination in accordance with *Bates' Guide to Physical Examination and History Taking* without causing injury to the patient while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Identify the patient.

2. Obtain the patient history.
   a. Record past medical injuries or conditions.
   b. Record past surgical procedures including date of procedure.
   c. Record current medications.
   d. Record drug allergies.
   e. Record social history including tobacco, alcohol, and illegal drug use.
   f. Record family medical history.
   g. Record military occupational specialty and duty description.

3. Obtain history of present illness.
   a. Record right- or left-hand dominance.
   b. Record a mechanism of injury.
   c. Record onset of symptoms. (specify date when possible)
   d. Record provocating activities.
   e. Record referred or radiating symptoms.
   f. Record severity of symptoms on a 10-point pain scale.
   g. Record previous attempts to treat the condition (for example, nonsteroidal anti-inflammatory drugs, physical therapy, and activity modification).

4. Screen for red flags. (discoloration, pain, warmth, swelling, and tenderness of the affected extremity)

5. Perform a physical examination of the wrist.

**WARNING:** You or the patient should never force a motion.

   a. Inspection – Have the patient place one finger on the spot that hurts the most. Look for the following:

**NOTE:** Compare the affected extremity to the unaffected one.

      (1) Swelling.

(2) Erythema.
(3) Ecchymosis.
(4) Obvious deformity.

b. Palpation – palpate the following:
(1) Bony prominences to include the anatomic snuffbox.
(2) Joint lines. (radiocarpal or wrist joint, the distal radioulnar joint, and the intercarpal joints)
(3) Pulses – radial.

c. Perform neuromuscular examination. (ulnar, radial, and median nerve)
(1) Is there sensation in the hand?
(2) Nerve root (C6).
(3) Dermatome (C6-C7).

**WARNING:** You or the patient should never force a motion.

d. Range of Motion (ROM) – Ask the patient to complete the ROM movements.

**NOTE:** Compare ROM of the affected wrist with the unaffected one.

(1) Flexion.
(2) Extension.
(3) Radial flexion.
(4) Ulnar flexion.

e. Perform specialty test.
(1) Tinel sign.
(2) Phalen sign.

6. Document patient medical history, history of present illness, and physical examination on SF 600 in subjective, objective, assessment, and plan note format.

7. Present patient to a medical provider with a differential diagnosis and proposed treatment plan. (Should consider medications, physical therapy, profiling, and further diagnostic tests as indicated.)

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Identified the patient. | _____ | _____ |
| 2 | Obtained the patient history. | _____ | _____ |
| 3 | Obtained history of present illness. | _____ | _____ |
| 4 | Screened for red flags. (discoloration, pain, warmth, swelling, and tenderness of the affected extremity) | _____ | _____ |
| 5 | Performed a physical examination of the wrist. | _____ | _____ |

| Performance Measures: | GO | NO GO |
|---|---|---|
| 6 Documented patient medical history, history of present illness, and physical examination on SF 600 in subjective, objective, assessment, and plan note format. | _____ | _____ |
| 7 Presented patient to a medical provider with a differential diagnosis and proposed treatment plan. (Should have considered medications, physical therapy, profiling, and further diagnostic tests as indicated.) | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Bates' Guide to Physical Examination and History Taking.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

Perform a Hip Examination

081-68W-0274

**Conditions:** In an operational environment you have a patient that requires a hip examination. You will be provided an examination table or flat surface, an SF 600 (*Chronological Record of Medical Care*) and a pen.

**Standards:** Perform an examination of the hips in accordance with *Bates' Guide to Physical Examination and History Taking*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Identify the patient.

2. Obtain the patient history.
   a. Record past medical injuries or conditions.
   b. Record past surgical procedures including date of procedure.
   c. Record current medications.
   d. Record drug allergies.
   e. Record social history including tobacco, alcohol, and illegal drug use.
   f. Record family medical history.
   g. Record military occupational specialty and duty description.

3. Obtain history of present illness.
   a. Record a mechanism of injury.
   b. Record onset of symptoms (specify date when possible).
   c. Record provocating activities.
   d. Record referred or radiating symptoms.
   e. Record severity of symptoms on a 10-point pain scale.
   f. Record previous attempts to treat the condition (for example, nonsteroidal anti-inflammatory drugs, physical therapy, and activity modification).

4. Screen for red flags. (discoloration, pain, warmth, swelling, and tenderness of the affected extremity)

5. Perform a physical examination of the hip.

**NOTE:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

   a. Gait – Watch the patient walk, if able. Note any abnormalities.
   b. Inspection – Have the patient place one finger on the spot that hurts the most. Look for the following:
      (1) Swelling.
      (2) Erythema.

(3) Ecchymosis.
(4) Obvious deformity.

c. Palpation – palpate for:

(1) Bony prominences. (acetabulum, the ilium, the ischium, and the sacroiliac bone)
(2) Tenderness.
(3) Crepitus.
(4) Abnormal masses.

d. Perform neuromuscular examination.

(1) Nerve roots (L4, L5, S1, S2, and S3).
(2) Dermatomes (L4, L5, S1, S2, and S3).

**WARNING:** You or the patient should never force a motion.

e. Range of motion (ROM) – Ask the patient to complete the ROM movements.

**NOTE:** Compare the affected hip with the unaffected hip.

(1) Flexion.
(2) Extension.
(3) Abduction.
(4) Adduction.

6. Document patient medical history, history of present illness, and physical examination on SF 600 in subjective, objective, assessment, and plan note format.

7. Present patient to a medical provider with a differential diagnosis and proposed treatment plan. (Should consider medications, physical therapy, profiling, and further diagnostic tests as indicated.)

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Identified the patient. | _____ | _____ |
| 2 | Obtained the patient history. | _____ | _____ |
| 3 | Obtained history of present illness. | _____ | _____ |
| 4 | Screened for red flags. (discoloration, pain, warmth, swelling, and tenderness of the affected extremity) | _____ | _____ |
| 5 | Performed a physical examination of the hip. | _____ | _____ |
| 6 | Documented patient medical history, history of present illness, and physical examination on SF 600 in subjective, objective, assessment, and plan note format. | _____ | _____ |

| Performance Measures: | GO | NO GO |
|---|---|---|
| 7 Presented patient to a medical provider with a differential diagnosis and proposed treatment plan. (Should have considered medications, physical therapy, profiling, and further diagnostic tests as indicated.) | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Bates' Guide to Physical Examination and History Taking.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

Treat a Nerve Agent Casualty

081-68W-0275

This individual task was presented earlier in the STP on page 3-103 as a readiness requirements task. The content requirements are the same.

Treat a Radiation Casualty

081-000-0118

This individual task was presented earlier in the STP on page 3-100 as a readiness requirements task. The content requirements are the same.

Treat Common Musculoskeletal Disorders

081-000-0103

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment, you required to treat a patient that identifies a musculoskeletal complaint. You may have available a shoulder sling, splint, elastic bandage, crutches, anti-inflammatory drugs, ice packs, and the patient's SF 600 (*Chronological Record of Medical Care*) or electronic medical record.

**Standards:** Treat common musculoskeletal disorders in accordance with *The Merck Manual of Diagnosis and Therapy,* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Review the patient's medical record, if available.

2. Obtain a history.
   a. O = onset. When did it start? What were you doing when it started? What was the position of the foot (inverted or supinated)?
   b. P = provocative and palliative factors. What makes it better? What makes it worse? Is there any pain without weight bearing?
   c. Q = quality. Is it sharp, dull, aching, pounding, constant, or intermittent? What is the character of the pain?
   d. R = region and radiation. Where exactly is the pain? Does it seem to spread anywhere, or does it stay right there? Is there any involvement of other joints?
   e. S = severity. How bad is the pain? Is it incapacitating? Does it cause you to change your activity?
   f. T = time, temporal characteristics (duration). When does it hurt? How long does it last? Have you had prior episodes? Any history of trauma or prior surgery?

3. Manage cervical pain.
   a. Cervical strain.
      (1) A strain happens when a muscle-tendon unit is overloaded or stretched.
      (2) Motion of the neck becomes painful.
      (3) Peaks after several hours or the next day.
      (4) Treat with nonsteroidal anti-inflammatory drugs (NSAIDs), heat, massage, and other therapeutic modalities.
   b. Cervical sprain.
      (1) Movement is limited.
      (2) Ligamentous disruption may be extensive enough to result in instability with associated neurologic involvement.
      (3) Routine cervical spine radiographs are indicated.

(4) Treatment of a cervical sprain consists of immobilization, rest, support, and NSAIDs.

(5) Return to participation is permitted when motion and muscle strength normalize.

c. Cervical fracture. Any patient suspected of cervical fracture or having any neurologic deficit as a result of a cervical injury requires x-rays and must be evaluated by a medical provider.

4. Manage low back pain (lumbosacral strain mild to moderate).

a. Signs and symptoms.

(1) Usually have reduced range of motion.

(2) Discomfort which is localized to the lumbar-sacral area.

(3) Palpable muscle tenderness or spasm.

(4) Negative straight leg raise.

b. Treatment. Decrease activity and ice massages. Medications, if required, usually consist of anti-inflammatory drugs and muscle relaxants. Often obesity is a factor in low back pain and patients should be encouraged to lose weight.

5. Manage shoulder pain.

a. Rotator cuff tear.

(1) Usually presents with shoulder pain or tenderness.

(2) History of trauma.

(3) Patient is unable to abduct the arm or hold it abducted against gravity.

(4) Treat initially with a shoulder sling and oral anti-inflammatory drugs (aspirin and ibuprofen). Any shoulder complaint with a history of trauma must be referred to a medical provider.

b. Impingement syndrome (shoulder pain).

(1) Most common cause of shoulder pain and refers to mechanical compression or wear of the rotator cuff tendons.

(2) Any process which compromises this normal gliding function may lead to mechanical impingement.

(3) Most commonly seen in tennis players, pitchers and swimmers.

(4) The first step in treating shoulder impingement is to eliminate any identifiable cause or contributing factor.

(5) Nonsteroidal anti-inflammatory medication may be used.

(6) The mainstay of treatment involves exercises to restore normal flexibility and strength to the shoulder girdle.

c. Acute bursitis.

(1) Usually produces pain with movement.

(2) Follows overuse in most instances.

(3) Most frequently tender to palpation over subdeltoid bursa.

(4) Treated with anti-inflammatory drugs and progressive shoulder exercises. There should be a reduction of certain physical activities including lifting, push-ups and pulling for 7 days.

d. Septic arthritis.

(1) Should be considered if the patient has a fever or other signs and symptoms of inflammation.

(2) Emergent referral to a medical provider is indicated.

e. Dislocation.

(1) Usually follows a history of trauma but may occur spontaneously in some people.

(2) Sudden onset of pain with gross deformity of shoulder joint.

(3) Severe limitation of motion.

(4) X-ray should be done to rule out (R/O) associated fracture if a history of trauma. Often deferred until after reduction in order not to delay.

(5) Splint and assess distal pulses.

(6) Prompt referral to a medical provider.

(7) Pain medication and muscle relaxant may be used to relieve anxiety, pain, and muscle spasm prior to reducing.

6. Manage knee pain.

a. Septic knee joint.

(1) Hot, tender knee with or without swelling.

(2) Orthopedic emergency requiring referral to a medical provider.

b. Sprain or strain.

(1) Tenderness over medial collateral ligament (MCL) or lateral collateral ligament (LCL) without laxity may indicate grade I sprain or strain.

(2) If mild laxity and tenderness of MCL or LCL is present, possible grade II sprain.

(3) If ecchymosis, effusion present with laxity, possible grade III sprain (torn ligament).

(4) Initial treatment consists of ice packs, elastic bandage, and elevation for the first 24 hours. Crutches may be indicated for comfort. Anti-inflammatory agents are used as required.

c. Patellar dislocation. Gross instability of the patella indicates that injury to the soft tissues of the medial aspect of the knee has been extensive.

(1) When dislocation of the patella occurs alone, it may be caused by a direct force or activity of the quadriceps, and the direction of dislocation of the patella is usually lateral.

(2) Spontaneous reduction may occur if the knee joint is extended.

(3) Initially treat with rest, ice, compression, elevation (RICE), NSAIDs, profile, and crutches if unstable. Will need orthopedic referral to evaluate for arthroscopic surgery.

d. Retropatellar (patellofemoral) pain syndrome.

(1) The symptoms probably represent the majority of knee pain complaints in athletes.

(2) Vague knee pain, which is usually after several hours of exercise.

(3) Walking downhill or downstairs, bending at the knees, and kneeling exacerbates pain.

(4) Initially treat with RICE, NSAID, stretches and exercises to strengthen quadriceps. Physical therapy consult for prolonged cases.

7. Manage foot pain.
    a. Perform a physical examination (PE).
        (1) Inspect the problem area.
        (2) Determine the range of motion.
        (3) Palpate the problem area.
        (4) Check muscle strength.
    b. Refer to a medical provider for x-rays of problem area, if appropriate and available.
    c. Formulate assessment based upon history, PE, or x-rays.

8. Manage ankle injuries.
    a. Grade I ankle sprain.
        (1) Antalgic gait.
        (2) Able to bear weight.
        (3) Minimal edema.
        (4) Mild tenderness of malleolar area.
        (5) Negative drawer sign.
        (6) Initially treated with ice, compression, and elevation for 24-48 hours. Crutches are indicated for up to 48 hours in Grade I sprains. Anti-inflammatory agents (ibuprofen) and elastic bandage protection are indicated for 5-7 days with gradually increased exercises.
    b. Grade II ankle sprain.
        (1) Unable to bear weight.
        (2) Edema.
        (3) Possible ecchymosis.
        (4) Acute tenderness.
        (5) Negative drawer sign.
        (6) Neurovascular status intact.
        (7) Range of motion reduced.
        (8) An x-ray should be done to R/O an associated fracture.
        (9) May require posterior or “U” splinting for 3-5 days with ice, elevation, crutches, and analgesics (ibuprofen). An elastic bandage is indicated with gradual increase of activity after 72 to 96 hours.
    c. Grade III ankle sprain.
        (1) Unable to bear weight.
        (2) Edema.
        (3) Ecchymosis present.
        (4) Acute tenderness.
        (5) Positive drawer sign.
        (6) Neurovascular status may be compromised.
        (7) Range of motion markedly reduced.
        (8) Should be referred to a medical officer for x-rays to be done to R/O an associated fracture.

(9) Immobilization using either a splint or non-weight bearing cast. Initially, ice, compression, and elevation are used to reduce edema and pain. Crutches, without weight bearing, and follow-up with podiatry or orthopedics is usually indicated. NSAIDs or a mild narcotic will often be needed for pain relief. In all sprains, physical activity must be reduced appropriately and will vary in length from 72 hours to several weeks.

9. Manage Achilles tendonitis.
   a. Pain, swelling, tenderness along tendon.
   b. Treat Achilles tendonitis with RICE, NSAIDs, ice for twenty minutes after activity, heel lift, and crutches if severe.

10. Manage metatarsalgia.
    a. Pain under the metatarsals that is exacerbated with functional activities and may present as burning.
    b. Commonly seen in women and in the second metatarsal.
    c. Important to R/O stress fracture, neuroma, and avascular necrosis of the metatarsal head.
    d. Conservative management is directed at relieving the pressure beneath the area of maximum pain.
    e. The patient should obtain a shoe of appropriate style and adequate size to allow an orthotic device to be inserted.

11. Manage bunion.
    a. Excessive bony growth (exostosis) on the head of the first metatarsal.
    b. Callous formation and bursal inflammation.
    c. The patient should be encouraged to wear shoes of adequate size and shape.
    d. Pads may be placed in the first web space or over the median eminence to help take pressure off a painful median eminence.
    e. Pads may also be placed underneath the metatarsal heads to take pressure off painful calluses or sesamoids.
    f. Podiatric surgical intervention may be considered.

12. Manage plantar fasciitis.
    a. Inflammation of plantar aponeurosis.
    b. Tenderness along plantar fascia.
    c. Treatment of pain 1-2 weeks in duration is with NSAIDs, rest, and stretches.
    d. The patient should perform ice massages with a cold bottle under the arch after activity.
    e. Over the counter insole arch support may help alleviate tension on the arch.
    f. Chronic pain may require a podiatry consult.

13. Record all treatment in the patient’s medical record.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 1 | Reviewed the patient's medical record, if available. | _____ | _____ |
| 2 | Obtained history. | _____ | _____ |
| 3 | Managed cervical pain. | _____ | _____ |
| 4 | Managed low back pain (lumbosacral strain mild to moderate). | _____ | _____ |
| 5 | Managed shoulder pain. | _____ | _____ |
| 6 | Managed knee pain. | _____ | _____ |
| 7 | Managed foot pain. | _____ | _____ |
| 8 | Managed ankle injuries. | _____ | _____ |
| 9 | Managed Achilles tendonitis. | _____ | _____ |
| 10 | Managed metatarsalgia. | _____ | _____ |
| 11 | Managed bunion. | _____ | _____ |
| 12 | Managed plantar fasciitis. | _____ | _____ |
| 13 | Recorded all treatment in the patient's medical record. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
*The Merck Manual of Diagnosis and Therapy.*

**Related**
None

Treat a Blister Agent Casualty (Mustard, Lewisite, Phosgene Oxime)

081-000-0116

This individual task was presented earlier in the STP on page 3-95 as a readiness requirements task. The content requirements are the same.

## Obtain Specimen Collection

081-000-1008

**WARNING:** Gloves should be worn for self-protection against transmission of contaminants whenever handling body fluids. Do not use the vacutainer to draw blood from small or fragile veins because this can cause the vein wall to collapse. Use a needle and syringe instead.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have a medical provider's orders to collect a specimen on a patient. You will review the medical record, verify patient identification using 2-factor validation, explain the procedure, gather all equipment and supplies, perform patient handwash, observe standard precautions, and check patient for any known allergies. You will document using SF 600 (*Chronological Record of Medical Care*), DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*), or electronic medical record if available.

**Standards:** Obtain a specimen, in the proper sequence with a 100% accuracy in accordance with (IAW) *Joint Trauma Care Clinical Practice Guideline* without violating aseptic technique while adhering to all warnings and cautions, using the task GO/NO GO checklist.

**Performance Steps:**

1. Adjust bed to a comfortable working height (if applicable).

**NOTE:** Make sure the side rails are up and the brakes are locked on bed for patient safety. Lower side rails closest to you to perform the task comfortably without causing injury to the patient. Once procedure is complete, side rails need to be returned to upright position and bed must be lowered to maintain patient safety. Brakes are to remain in locked position during the entire procedure.

2. Position the patient.

3. Identify specimen collection type.
    a. Blood.
        (1) Arterial.
        (2) Venous.
        (3) Central venous catheter.
        (4) Blood cultures.
        (5) Blood glucose sampling.
    b. Nasal culture.
    c. Throat culture.
    d. Sputum.
        (1) Expectoration.
        (2) Suctioning.
    e. Emesis.
    f. Gastric.

g. Urine.
   (1) Midstream.
   (2) Sterile via catheter port.
      (a) Straight or temporary catheter.
      (b) Indwelling.
h. Stool.
i. Wound.
   (1) Swab.
   (2) Aspiration.
      (a) Needle aspiration.
      (b) Aspiration from drainage system.
         _1_ Open drainage system.
         _2_ Closed drainage system.

4. Obtain blood specimen.
   a. Obtain arterial blood sample.

**NOTE:** Blood cultures should never be drawn from central lines, arterial lines, or arteriovenous shunt sites.

(1) Discard the leak-free connector cap of the 3-way stopcock closest to the catheter insertion site.

(2) Sanitize the leak-free connector of the 3-way stopcock with an alcohol pad IAW local standard operating procedure (SOP).

(3) Secure the syringe you intend to use for waste to the leak-free connector of the 3-way stopcock.

(4) Turn the valve stem on the 3-way stopcock toward the patient opening the flow of blood to the syringe.

(5) Pull the plunger on the waste syringe until whole blood begins to appear in the syringe.

(6) Turn the valve stem on the 3-way stopcock toward the leak-free connector port stopping the flow of blood to the syringe.

(7) Discard waste syringe IAW local SOP governing the disposal of biological waste.

(8) Attach the sample syringe on the 3-way stopcock.

(9) Turn the valve stem on the 3-way stopcock toward the patient opening the flow of blood to the syringe.

(10) Fill sample syringe with designated amount of blood.

(11) Turn the valve stem on the 3-way stopcock toward the leak-free connector port stopping the flow of blood to the syringe.

(12) Remove the sample syringe from the leak-free connector.

(13) Place new sterile leak-free connector cap on the 3-way stopcock.

(14) Transfer blood from the sample syringe to the appropriate tubes.

**NOTE:** You may need to roll syringe in your hand if you are using a syringe with heparin to collect an arterial blood gas (ABG) sample. If analysis of an ABG will take longer than 15 minutes place specimen on ice.

(15) Clear the arterial line of the remaining blood by pulling the rubber flush tab for 1-2 seconds.

b. Obtain a venous blood sample.

(1) Assemble the vacutainer adapter, the needle, and the blood specimen tube.

(a) Inspect the needle for nicks or barbs.

(b) Replace the needle if it is flawed or dull.

**WARNING:** Do not use large bore needles to draw blood from small or fragile veins because this can cause the vein wall to collapse. Use a gauge size that is appropriate for the selected vasculature.

**CAUTION:** Avoid veins that are infected, irritated, injured, or have an intravenous (IV) injection running distal to the proposed venipuncture site.

(2) Palpate one of the prominent veins.

**NOTE:** The first choice is the median cubital vein in the antecubital space (bend of the arm). It is well supported and least apt to roll. The second choice is the cephalic vein. The third choice is the basilic vein. Although the basilic vein is the most prominent, it tends to roll easily and can make venipuncture difficult. Hand and foot veins may be used, if necessary, but can also be difficult.

(3) Prepare the sponges for use by opening the betadine or alcohol and 2x2 gauze sponge packages then placing them within easy reach (still in the packages).

(4) Apply the constricting band with enough pressure to stop venous return without stopping the arterial flow (a radial pulse will be present).

(a) Wrap the constricting band around the limb approximately 2 inches above the selected venipuncture site.

(b) Instruct the patient to form a fist, clench and unclench several times, and then hold the fist in a clenched position.

(5) Palpate the selected vein lightly with the index finger, moving an inch or two in either direction so that the size and direction of the vein can be determined.

**WARNING:** Do not leave the constricting band on for more than 2 minutes.

(6) Cleanse the area around the puncture site with a disinfectant-soaked pad or an alcohol.

**CAUTION:** After cleansing the skin, do not re-palpate the area.

(7) Prepare to puncture the vein.

(a) Grasp the vacutainer hub and remove the protective needle cover.

(b) Position the needle directly in line with the vein. Using the free hand, grasp the patient’s arm below the expected point of entry.

(c) Place the thumb of the free hand approximately 1 inch below the expected point of entry and pull the skin taut toward the hand.

(8) Puncture the vein.

(a) Place the needle, bevel up, in line with the vein and pierce the skin at a 15- to 30-degree angle.

(b) Decrease the angle until the needle is almost parallel to the skin surface. Direct it toward the vein and pierce the vein wall.

**NOTE:** A faint “give” may be felt when the vein is entered, and blood will begin to enter the collection tube.

_1_ If the venipuncture is unsuccessful, pull the needle back slightly (not above the skin surface) and attempt to pierce the vein again.

_2_ If the venipuncture is still unsuccessful, release the constricting band, place a gauze sponge lightly over the site, quickly withdraw the needle, and immediately apply pressure to the site.

_3_ Notify your supervisor before attempting to enter another vein.

(c) Instruct the patient to unclench the fist.

(9) Collect the sample.

(a) Single specimen sample.

_1_ With the dominant hand, hold the vacutainer unit and the needle steady.

**WARNING:** If the vacutainer unit and needle are not held steady while pushing in the tube, the needle may either slip out of the vein or puncture the opposing vein wall.

_2_ Place the index and middle fingers of the free hand behind the flange of the vacutainer and ease the tube as far forward as possible. Blood will enter the tube.

_3_ After the tube is approximately two-thirds full of blood or the flow of blood stops, prepare to withdraw the needle.

(b) Multiple specimen samples (multiple tubes).

_1_ Follow steps 9(a) 1 and 9(a) 2 for collecting a single specimen.

_2_ Remove the first tube and insert another tube into the vacutainer.

_3_ Repeat this procedure until the desired number of tubes are filled or blood stops flowing.

_4_ After the last tube is approximately two-thirds full of blood or the flow stops, prepare to withdraw the needle.

**NOTE:** If the blood flow starts to slow down between samples, remove the restricting band.

(10) Withdraw the needle.

(a) Release the constricting band by pulling the long, looped end of the band or pulling the hook-and-loop fasteners open.

**WARNING:** Never withdraw the needle prior to removing the constricting band because this will cause blood to be forced out of the venipuncture site with resulting blood loss or hematoma formation.

(b) Place a 2x2 gauze pad loosely over the injection site.

(c) Remove the specimen tube form the vacutainer.

(d) Keeping the patients arm fully extended, withdraw the needle smoothly and quickly. Immediately apply firm manual pressure over the venipuncture site with the gauze pad.

(e) Instruct the patient to elevate the arm slightly and keep the arm fully extended. Continue to apply firm manual pressure to the site for 2 to 3 minutes.

(f) Apply an adhesive bandage strip to the venipuncture site to control and stop the bleeding.

c. Obtain specimen from a central venous catheter.

**CAUTION:** Use 10 milliliter (ml) or larger syringe on any long term central venous catheter (Hickman, Broviac, Groshong, peripherally inserted central catheter (PICC), implantable port) to avoid over-pressurization and rupture of the catheter.

(1) Prepare two syringes – one with 5 ml heparin (100 units [u]/ml), the other with 20 ml normal saline.

(2) Clamp the catheter if the injection cap is removed.

(3) Don sterile gloves.

(4) Prepare to draw the specimen.

(a) Hub-to-hub.

_1_ Remove the intermittent injection cap after vigorously scrubbing the connection with an iodine swab or an isopropyl alcohol pad for 30 seconds.

_2_ Discard the pad.

_3_ Turn off the continuous infusion and disconnect the tubing from the catheter and cover it with a capped sterile needle.

**NOTE:** If the calibration verification certification is a triple lumen device, use the proximal lumen to avoid contamination from the IV.

(b) Through the injection cap.

_1_ Clean the injection cap with an iodine swab or an isopropyl alcohol pad for 30 seconds.

_2_ Let it dry for 1 minute.

(c) Attach the syringe to the catheter hub or injection cap.

**NOTE:** Ask a registered nurse (RN) for assistance with flushing the catheter. Administration of the IV push medications is not a task that RNs can delegate to licensed vocational nurses.

_1_ If the injection cap is in place, insert the needle of the syringe containing 10 ml normal saline and flush.

_2_ If the injection cap is removed, connect the syringe tip to the catheter hub, release the clamp, flush with positive pressure, and reclamp.

**NOTE:** If the catheter is occluded and resistance is felt, do not force flushing. Vigorous flushing may cause the catheter to rupture or embolization of the catheter.

(d) Connect the syringe for blood sampling and release the clamp. Aspirate 5 ml fluid, reclamp, and discard the aspirate.

(e) Attach or insert a syringe of the size equal to the volume of blood sample to withdraw from the catheter. Release the clamp. Withdraw necessary blood for the samples and reclamp.

(f) Attach or insert the syringe filled with 10 ml normal saline to the catheter. Release the clamp, flush vigorously, and reclamp. Repeat using a syringe containing 5 ml heparin (100 u/ml).

(g) Replace a new cap to the end of the catheter and remove the clamp.

(h) Connect the IV tubing to the end of the catheter, if IV fluids are administered.

(i) Tape all connections and pin the pubbing to the patient's gown.

d. Obtain a blood specimen for culture.

(1) Prepare the culture bottles by cleaning the bottle tops with an alcohol swab.

(a) Adults and small children – 1 aerobic and 1 – anaerobic bottle.

(b) Infants – 1 pink pediatric bottle.

(2) Collect the blood specimen.

**NOTE:** Specimen collection can be completed using arterial blood, venipuncture, or central venous catheter access methods described in steps 6a-6c.

(a) Adult – draw 20 cubic centimeters (cc).

(b) Small children – draw 5-15 cc.

(c) Infants – draw 1-3 cc blood.

**NOTE:** Never use the same needle if the venipuncture must be redone.

(3) Fill the specimen bottles.

(a) Discard the needle used for the venipuncture and replace it with a new sterile large bore needle or safety transfer device.

(b) Inoculate the anaerobic specimen first.

(c) Discard the needle and replace the needle with a new sterile large bore needle.

(d) Inject equal amounts of blood into the two specimen bottles. If drawing infant cultures, inoculate the pink bottle with all the specimen.

(4) Mix the specimen gently after inoculation.

e. Obtain a blood glucose.

(1) Determine if the patient has a preexisting condition that limits the performance of a skin puncture.

(a) Low platelet count.

(b) Bleeding disorders.

(2) Choose vascular site.

(a) For an adult, select lateral side of the finger, be sure to avoid the central tip of the finger which has more dense nerve supply.

(b) For infants, select the outer aspect of the heel. The puncture must be no deeper than 2.4 ml.

(3) Prepare the site and obtain a peripheral blood specimen.

(a) Warm the patient's fingers or heel.

(b) Place the patient's fingers or heel in a dependent position or below the heart.

(c) Clean the site with an aseptic swab and allow it to dry completely.

(d) Remove the cover of the lancet or blood-letting device.

(e) Obtain a blood droplet.

_1_ Place the blood-letting device firmly against the side of the finger and push the release button causing the needle to pierce the skin.

_2_ Hold the lancet perpendicular to the puncture site and pierce the finger or heel quickly in one continuous motion.

(4) Perform the blood test evaluation.

(a) Wipe away the first droplet of blood with a cotton ball.

(b) Lightly squeeze the puncture site until a large droplet of blood has formed.

(c) Hold the reagent strip test pad close to the drop of blood and lightly smear blood.

(d) Insert the test strip into the glucose monitor per manufacturers recommendations. Observe the number displayed on the screen at the end of the test.

(e) Remove the test strip and compare the color change with the color code on the test strip container.

(5) Complete the blood specimen procedure.

(a) Apply pressure to the skin puncture site.

(b) Turn off the meter. Dispose of the test strip, cotton ball, and uncapped lancet or autolet appropriately.

5. Obtain a nasal culture.

a. Don disposable gloves.

b. Encourage patient to blow nose, check nostrils for patency with penlight.

c. Ask the patient to tilt head back.

**NOTE:** Patients in bed should have a pillow behind their shoulders.

d. Gently insert nasal speculum in one nostril. Carefully pass swab through nostril of speculum into nostril until it reaches that portion of mucosa that is inflamed or contains exudate.

e. Rotate swab quickly.

f. Remove swab without touching sides of speculum.

g. Carefully remove speculum and place in basin. Offer patient facial tissue.

h. Insert swab into culture tube. Crush ampule at bottom of tube, and then push tip of swab into liquid medium.

6. Obtain throat culture.

a. Don disposable gloves.

b. Explain that patient may have ticking sensation or gag during swabbing of throat. State that the procedure takes only a few seconds.

c. Ask patient to tilt head back, open the mouth, extend the tongue, and say “ah.”

d. Use the penlight to illuminate the posterior pharynx while depressing the tongue with a tongue blade. Depress the anterior third of tongue only.

e. Insert a swab into the mouth without touching any part of the mouth or tongue.

f. Gently but quickly swab tonsillar area making sure to contact any areas on the pharynx that are inflamed or contain exudate.

g. Remove swab.

h. Crush the ampule of culture medium at the bottom of the tube and push tip of swab into medium.

7. Collect a sputum specimen.
   a. Collect a sputum specimen by expectoration.

**NOTE:** You will need a sterile specimen container with cover, clean disposable gloves, and facial tissues.

(1) Don disposable gloves.

(2) Position patient on side of bed or in high semi-Fowler’s position.

(3) Provide sputum cup and instruct patient not to touch inside.

(4) Ask the patient to take several deep breaths then inhale deeply and cough forcefully, expectorating sputum directly into specimen container.

(5) Assist the patient to repeat coughing until 5 to 10 ml of sputum has been collected.

   b. Collect a sputum specimen by suctioning.

**NOTE:** You will need a suction device, sterile suction catheter, sterile glove, sterile saline in container, in-line specimen container sputum trap, and protective eyewear.

(1) Don disposable gloves.

(2) Prepare suction machine or device and determine that it is functioning correctly.

(3) Apply sterile glove to dominant hand.

(4) With gloved hand, connect sterile suction catheter to rubber tubing on sputum trap.

(5) Place ungloved thumb on trap to provide suction.

(6) Gently insert lubricated tip of suction catheter through nasopharynx, endotracheal tube, or tracheostomy without applying suction.

(7) Advance catheter into trachea.

(8) Ask patient to cough and apply suction for 5 to 10 seconds, collecting 2 to 10 ml of sputum.

(9) Remove catheter without applying suction, and then turn off suction.

(10) Detach catheter from specimen trap and dispose of catheter into appropriate receptacle.

(11) Secure top on specimen container tightly. Detach suction tubing and connect rubber tubing on sputum trap to plastic adapter.

8. Obtain an emesis specimen.

a. Don disposable gloves.
b. Collect emesis in a clean basin or directly into specimen collection cup.
(1) If collected in clean basin, use a clean 3 ml syringe or wooden applicator to transfer specimen to collection cup or onto Gastroocult card.
(2) Follow Gastroocult card instructions for processing.

9. Obtain a gastric specimen.
a. Don disposable gloves.
b. Collect gastric sample via nasal gastric or nasoenteral tube.
(1) Disconnect tube from suction or gravity drainage.
(2) Connect bulb syringe or catheter-tip syringe.
(3) Aspirate 5-10 ml.
(4) Transfer specimen into collection cup or onto Gastroocult card.
(5) Follow Gastroocult card instructions for processing.
(6) Reconnect NG tube to drainage system, suction, or clamp as ordered.

10. Obtain a urine specimen.
a. Obtain urine sample via midstream catch.

**NOTE:** You will need disposable gloves, 2 or 3 antiseptic towelettes, and a sterile specimen container.

(1) Don disposable gloves.
(2) Instruct female patient to clean perineal area from front to back and discard the towelette. Instruct patient to use all towelettes provided (usually two or three).
(3) Instruct the male patient to retract foreskin slightly if uncircumcised. Instruct patient to use a circular motion to clean the urinary meatus and the distal portion of the penis. Ask patient to use each towelette only once and clean several inches down the shaft of the penis.
(4) Instruct the patient to start voiding.
(5) Instruct patient to place the specimen container into the stream of urine and collect the specimen taking care not to touch the container to the perineum or penis.
(6) Ensure patient collects 30 to 60 ml of urine in the container.
(7) Cap the container tightly.
b. Collect urine specimen via catheter port.
(1) Collect urine from a straight or temporary catheter.
(a) Don disposable gloves.
(b) Place temporary catheter.
(c) Immediately after insertion of catheter collect urine from catheter in specimen collection cup or another device.
(d) Remove temporary catheter.
(2) Collect urine from an indwelling catheter.

**NOTE:** You will need disposable gloves, 3-ml syringe with 1-inch 21-gauge needle, 20-ml syringe, metal clamp or rubber band, alcohol, povidone iodine or another disinfectant swab, and a specimen container.

(a) Don disposable gloves.

(b) Emphasize although a syringe with a needle is used to remove the urine from the catheter, the patient will not experience any discomfort.

(c) Clamp the drainage tubing with a clamp or rubber band for about 30 minutes.

(d) Wipe the entry port of catheter with a disinfectant swab.

(e) Insert the needle at a 30- to 45-degree angle.

(f) Withdraw a minimum of 3 ml of urine.

(g) Unclamp the catheter.

(h) Transfer the urine to the specimen container.

11. Obtain a stool specimen.

a. Don disposable gloves.

b. Assist patient to the bathroom when necessary.

c. Ask the patient to defecate into commode, specimen device, or bedpan, preventing urine from entering the specimen.

d. Transfer stool to specimen cup with use of tongue blade and close the lid securely.

e. Assist patient back to bed if necessary.

12. Obtain a wound specimen.

**NOTE:** You will need a culture tube with swab and transport medium for aerobic culture, 20-ml syringe and 21-gauge needle, disposable gloves, sterile gloves, protective eyewear, antiseptic swab, sterile dressing, and a paper or plastic disposable bag.

a. Don disposable gloves.

b. Remove old dressing.

c. Observe drainage.

d. Discard dressings in a moisture-resistant bag.

e. Cleanse area around wound edges with antiseptic swab. Remove old exudate.

f. Remove gloves and dispose of them properly.

g. Open package containing sterile culture tube and dressing supplies.

h. Apply sterile gloves.

i. Open a specimen tube by twisting the cap to loosen the swab. Hold the tube in one hand and take out the swab in the other.

j. Explain to the patient they may feel a tickling or painful sensation during swabbing of the wound.

(1) Obtain wound specimen using wound swab.

(a) Insert the tip of the swab into wound near area of drainage and rotate gently.

(b) Avoid touching the swab to intact skin at the wound edges to prevent introduction of superficial skin organisms.

(c) Return swab to the culture tube, taking sure not to touch the top or outside of the tube.

(d) Crush ampule at the bottom of the tube and push tip of swab into liquid medium.

(e) Twist cap to secure.

(2) Obtain wound specimen via aspiration.

(a) Needle aspiration.

_1_ Insert the tip of a sterile syringe deep into wound cavity.

_2_ Aspirate drainage from inner wound.

_3_ Expel any air from the syringe and inject the syringe contents into vacuum container with culture medium.

(b) Aspiration from drainage system.

_1_ Open drainage system.

**NOTE:** Example – Penrose drain.

_a_ Don gloves.

_b_ Drainage system will be inserted directly into wound track with open end outside body.

_c_ Collect drainage from open end into sterile specimen cup.

_2_ Closed drainage.

**NOTE:** Example: wound vacuum.

_a_ Don gloves.

_b_ Remove plug or cover from sample port in drainage system.

_c_ Empty drainage into specimen cup or 10-ml syringe.

_d_ Transfer drainage into appropriate lab container if necessary.

13. Properly label all specimens and package for transport to lab.

14. Remove gloves and perform proper handwash.

15. Fill out lab slip with patient information to include the site, time, and date that specimen was collected.

16. Document procedure in appropriate medical record. Include site, time, date, and the patient's tolerance of procedure.

17. Report unexpected outcomes to the privileged provider.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in a field condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Adjusted bed to a comfortable working height (if applicable). | _____ | _____ |

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 2 | Positioned the patient. | _____ | _____ |
| 3 | Identified specimen collection type. | _____ | _____ |
| 4 | Obtained blood specimen | _____ | _____ |
| 5 | Obtained a nasal culture. | _____ | _____ |
| 6 | Obtained throat culture. | _____ | _____ |
| 7 | Collected a sputum specimen. | _____ | _____ |
| 8 | Obtained an emesis specimen. | _____ | _____ |
| 9 | Obtained a gastric specimen. | _____ | _____ |
| 10 | Obtained a urine specimen. | _____ | _____ |
| 11 | Obtained a stool specimen. | _____ | _____ |
| 12 | Obtained a wound specimen. | _____ | _____ |
| 13 | Properly labeled all specimens and package for transported to lab. | _____ | _____ |
| 14 | Removed gloves and performed proper handwash. | _____ | _____ |
| 15 | Filled out lab slip with patient information to include the site, time, and date that specimen was collected. | _____ | _____ |
| 16 | Documented procedure in appropriate medical record. Included site, time, date, and the patient's tolerance of procedure. | _____ | _____ |
| 17 | Reported unexpected outcomes to the privileged provider. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Solider must pass all performance measures to be scored GO. If the Solider fails any steps, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
Joint Trauma System website.
SF 600. *Chronological Record of Medical Care*.

**Related**
None

## Treat a Soft Tissue Injury

081-68W-0063

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have a casualty with a soft tissue injury. You are provided with gloves, bandage gauze, field dressing, emergency dressing, elastic bandage, bandage scissors, adhesive tape, pen and either a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*) or an SF 600 (*Chronological Record of Medical Care*) or an electronic medical record (EMR).

**Standards:** Treat a soft tissue injury in accordance with *PHTLS Prehospital Trauma Life Support* and Tactical Combat Casualty Care (TCCC), while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Expose the injury.

2. Assess the injury for underlying complications.
    a. Abrasions.
        (1) Depth of wound (relates to method of anesthesia and cleaning).
        (2) Amount of body surface (fluid loss can be significant in children).
        (3) Amount of contamination (precursor to infection).
    b. Contusions.
        (1) Underlying fracture. Forceful impact of objects creating injury can result in fractures.
        (2) Vascular involvement (extensive bleeding into tissue).
        (3) Check distal circulation.
        (4) Measure or mark the outline of the contusion.
        (5) Measure circumference of injured extremity and compare measurement to uninjured extremity.
        (6) Neurological involvement. Test the sensation and movement of the injured part.

**NOTE:** Any signs of neurologic deficit may indicate a serious complication.

3. Initiate treatment.

**NOTE:** Principles of management are prevention of infection, promotion of rapid healing, and prevention of “tattooing” from retained foreign bodies.

    a. Abrasion.
        (1) Wound must be gently but thoroughly scrubbed with normal saline.
        (2) Remove all foreign matter that cannot be scrubbed out by using a needle, number 11 blade, or tissue forceps.

(3) Apply antibiotic ointment.

(4) Give casualty instructions on wound care and signs and symptoms of infection.

(a) Topical antibiotic ointment applied three times or four times a day.

(b) Dressing changed every 2 to 3 days with gentle cleaning.

(c) Monitor abrasion for signs and symptoms of infection.

b. Contusion.

(1) Ensure that there is no underlying fracture or evidence of any neurological or vascular involvement.

(2) Pad and splint injury, if needed.

(3) Apply splint or cast to fractures (following medical officer's recommendation).

**NOTE:** Refer vascular or neurologic injury to a medical officer or if question of any underlying injury.

(4) Prescribe rest, ice, compression, and elevation.

(a) Wrap injured area with a roller bandage to compress the wound and slow bleeding into the tissue.

(b) Apply ice to area over the wound.

(c) If wound is significant, have casualty keep area elevated.

4. Administer antibiotics, if indicated.

5. Record all interventions.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Exposed the injury. | _____ | _____ |
| 2 | Assessed the injury for underlying complications. | _____ | _____ |
| 3 | Initiated treatment. | _____ | _____ |
| 4 | Administered antibiotics, if indicated. | _____ | _____ |
| 5 | Recorded all interventions. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
SF 600. *Chronological Record of Medical Care*.
*PHTLS Prehospital Trauma Life Support.*

**Related**

None

Prevent Deep Veinous Thrombosis

081-68W-0166

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have an immobile patient. Prevent deep vein thrombosis (DVT). You have compression stockings and elastic wraps.

**Standards:** Prevent a deep vein thrombosis in accordance with the *Joint Trauma System, Clinical Practice Guideline (JTS CPG)* prolonged casualty care for nursing intervention without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Identify patients at risk for DVT.

2. Instruct conscious patients on the cause of DVT.

3. Wrap patient's legs with compression stockings. If compression stockings are not available use elastic bandages. Wrap starting from the toes upward, ensuring toes remain exposed for capillary refill assessment.

4. Demonstrate exercises for conscious patients. Ten repetitions for each exercise for every hour they are awake.

**NOTE:** If patients are unconscious skip step 4 and do step 5.

a. Foot pumps.

**NOTE:** Have the patient stretch toes up and back, flexing feet, and hold for a few seconds. Then point toes and hold before repeating.

b. Ankle circles.

**NOTE:** Have patient raise both feet and trace a circle or each letter of the alphabet with their toes.

c. Leg raises.

**NOTE:** With left leg straight, have the patient raise foot off the bed or floor, then lower. Repeat with right leg. Alternatively, slowly have patient lift left knee up to chest, then bring foot back to the bed or floor; repeat with right leg.

d. Thigh stretches.

**NOTE:** While patient is lying on their back with straight legs, have them raise one leg to 90 degrees. Instruct patient to pull the leg gently toward the head and hold for up to 30 seconds. Slowly bring leg back down to a flat position and repeat with other leg.

e. Shoulder rolls.

**NOTE:** Although developing a clot in the upper body is not likely, blood still needs to keep flowing. Have the patient raise shoulders and circle them back and down five times. Then reverse direction for five more repetitions.

5. Perform DVT prevention for unconscious patients at least every 2 hours.
   a. Ankle plantarflexion-dorsiflexion.

**NOTE:** Hold the ankle and heel of one foot and alternately bend the foot forward into plantarflexion and then push the foot upward into dorsiflexion. Hold each position for 5-10 seconds.

   b. Lower extremity massage.

**NOTE:** Using both hands and starting at the ankle, apply consistent pressure, massaging the leg in an upward motion through the thigh. (Items such as a plastic bottle may be used to roll the skin toward the head.) Ensure deep pressure is avoided when massaging behind the knee or over bony prominences. Alternate legs (to simulate walking) for five times on each leg.

6. Document treatment on the SF 600 (*Chronological Record of Medical Care*).

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Identified patients at risk for DVT. | _____ | _____ |
| 2 | Instructed conscious patients on the cause of DVT. | _____ | _____ |
| 3 | Wrapped patient's legs with compression stockings. If compression stockings were not available use elastic bandages. Wrapped starting from the toes upward, ensuring toes remained exposed for capillary refill assessment. | _____ | _____ |
| 4 | Demonstrated exercises for conscious patients. Ten repetitions for each exercise for every hour they were awake. | _____ | _____ |
| 5 | Performed DVT prevention for unconscious patients at least every 2 hours. | _____ | _____ |
| 6 | Documented treatment on the SF 600 (*Chronological Record of Medical Care*). | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Clinical Practice Guidelines.*

Joint Trauma System website.
SF 600. *Chronological Record of Medical Care*.

**Related**
None

Treat Sinus Disorder

081-68W-0242

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you must treat a patient complaining of sinus pain and pressure. All other immediate life threats have been treated and managed. You have performed a patient care handwash and taken BSI precautions. You are provided with an otoscope, disposable speculum attachments, penlight, or other light source, pen, and SF 600 (*Chronological Record of Medical Care*).

**Standards:** Treat common sinus disorder in accordance with (IAW) *Tintinalli's Emergency Medicine*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Gather equipment and supplies.

2. Identify the patient.
    a. Ask the patient's name.
    b. Ask the patient's date of birth.

3. Explain the procedure to the patient.
    a. Provide privacy and safety for the patient.
    b. Explain procedure to patient.
    c. Ask about any known allergies.
    d. Place patient in position of comfort, as long as the procedure permits.

4. Perform an Otolaryngology examination (see task 081-68W-0254, Perform an Otolaryngology Exam).

5. Identify the sinus disorder.

**NOTE:** The sensitized immune system produces antibodies to these allergens, which cause chemicals called histamines to be released into the blood stream.

a. Seasonal allergies or allergic rhinitis (Hay fever) – rhinitis is an inflammation of the nasal membranes.

(1) Common causes – patients often have family history of multiple allergic disorders including hay fever, asthma, and eczema.

(2) Signs and symptoms include sneezing, swelling, and itching (pruritus) of the affected tissue, increased mucous production (rhinorrhea), nasal congestion, hives, and rashes.

**NOTE:** Signs and symptoms are predominately in the nose and eyes.

b. Sinus Infection (sinus pain or fullness) – general term.

(1) Common causes – sinus infection may be caused by anything interfering with airflow into the sinuses and the drainage of mucous out of the sinuses.

(2) Signs and symptoms can include those generally associated with colds and allergies.

c. Acute sinusitis – inflammation or infection of the paranasal sinuses.

(1) Common causes – infection by the pathogenic microorganism. These can be bacterial, viral or an allergen.

(2) Signs and symptoms include headache, facial tenderness or pain, fever, cloudy or discolored nasal drainage, nasal stuffiness, sore throat, and a cough.

6. Provide treatment for a sinus disorder.
   a. Increase fluids.
   b. Decongestant will be prescribed.
   c. Avoid antihistamines. Antihistamines dry and thicken the nasal mucosal areas.
   d. Refer to medical officer for antibiotics.

7. Document treatment on appropriate form.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Gathered equipment and supplies. | _____ | _____ |
| 2 | Identified the patient. | _____ | _____ |
| 3 | Explained the procedure to the patient. | _____ | _____ |
| 4 | Performed an Otolaryngology examination (see task 081-68W-0254, Perform an Otolaryngology Exam). | _____ | _____ |
| 5 | Identified the sinus disorder. | _____ | _____ |
| 6 | Provided treatment for a sinus disorder. | _____ | _____ |
| 7 | Documented treatment on appropriate form. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
SF 600. *Chronological Record of Medical Care*.
*Tintinalli's Emergency Medicine.*

**Related**
None

Treat a Biological Casualty

081-68W-0279

This individual task was presented earlier in the STP on page 3-82 as a readiness requirements task. The content requirements are the same.

Perform Visual Acuity Testing

081-000-0092

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have a patient who requires evaluation of visual acuity. You will be provided with an opaque eye card or eye occluder, a Snellen chart, pediatric vision chart, SF 600 (*Chronological Record of Medical Care*), electronic medical record (EMR), or DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*) and a pen.

**Standards:** Perform the visual acuity test in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines* while adhering to all warnings and cautions without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Identify the patient while providing privacy.
   a. Verify full name.
   b. Verify date of birth.
2. Perform a patient care handwash.
3. Explain the procedure to the patient and family.
4. Position the patient 20 feet (ft.) from the eye chart.

**NOTE:** If the patient cannot identify the material at set distance according to the chart, reposition them to half the distance from the chart double the acuity result, for example, reading the 20/400 line on a 20-ft chart at 10 feet would be recorded as 20/800.

5. Instruct the patient to leave corrective lenses on, if worn, ask if they are wearing contacts.

**NOTE:** Reading glasses are the only corrective lenses that should be removed.

6. Instruct patient to cover one eye with an opaque card or eye occluder and instruct the patient to read through the chart to the smallest line possible.

**NOTE:** The patient should read from top to bottom, left to right. The patient should be instructed to avoid squinting or leaning forward. Reading more than 50% of the letter on a given line is considered passing, proceed down the chart to the 20/20 line. Record the results as a fraction with the number 20 (= distance) as the numerator and the number of the last line read (= acuity) as the denominator. Also indicate the number of letters missed. Example: 20/30 -2.

7. Repeat the procedure for the other eye.
8. Repeat the exam with both eyes open.

**NOTE:** Certain situations, such as physical exams, may require this exam to be performed with and without corrective lenses. In these cases, conduct the visual acuity assessment without correction first before testing the patient with correction. Review the facility standing operating procedure for guidance. For pediatric patients who do not read, use symbols, and picture charts.

9. Perform gross visual acuity.
    a. Have the patient read any printed material available.
    b. If the patient is unable to read printed material.
        (1) Have patient determine the number of fingers held up, start at 10 feet away and move closer to the patient in one-foot increments.

**NOTE:** Record finger counting as: Finger count @ x (where x is the distance your hand was from the patient) for example, FC @ 5 feet.

        (2) Distinguish between light and dark record a light perception.

**NOTE:** Record the results as a fraction with the number 20 (= distance) as the numerator and the number of the last line read (= acuity) as the denominator. Also indicate the number of letters missed. Example: 20/30 -2.

10. Document the results of the test on SF 600 or in the EMR.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Identified the patient while providing privacy. | _____ | _____ |
| 2 | Performed a patient care handwash. | _____ | _____ |
| 3 | Explained the procedure to the patient and family. | _____ | _____ |
| 4 | Positioned the patient 20 feet (ft.) from the eye chart. | _____ | _____ |
| 5 | Instructed the patient to leave corrective lenses on, if worn, asked if they were wearing contacts. | _____ | _____ |
| 6 | Instructed patient to cover one eye with an opaque card or eye occluder and instructed the patient to read through the chart to the smallest line possible. | _____ | _____ |
| 7 | Repeated the procedure for the other eye. | _____ | _____ |
| 8 | Repeated the exam with both eyes opened. | _____ | _____ |
| 9 | Performed gross visual acuity. | _____ | _____ |
| 10 | Documented the results of the test on SF 600 or in the EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
Deployed Medicine website.
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Perform Basic Life Support

081-000-0018

This individual task was presented earlier in the STP on page 3-89 as a readiness requirements task. The content requirements are the same.

Treat a Diabetic Emergency

081-000-0026

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you are required to treat a patient with a diabetic emergency. You have taken BSI precautions and have performed a primary assessment and emergency medical technician secondary assessment (medical). You are provided with oral glucose, tongue depressors, oxygen, and the patient's medical record or a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*). You are not in a chemical, biological, radiological, and nuclear environment.

**Standards:** Treat a patient with a diabetic emergency in accordance with (IAW) *Tactical Combat Casualty Care (TCCC) Guidelines*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist without causing further injury to the patient.

**Performance Steps:**

1. Identify the signs and symptoms of a diabetic emergency.
    a. Hypoglycemia (low blood sugar).

**NOTE:** Hypoglycemia is the most common of all diabetic emergencies.

        (1) Rapid onset of altered mental status.

**NOTE:** This occurs after missing a meal, prolonged vomiting, or an unusual amount of physical exertion.

        (2) Intoxicated appearance, staggering, slurred speech, or unconsciousness.
        (3) Elevated heart rate.
        (4) Cold, clammy skin.
        (5) Hunger.
        (6) Seizures.
        (7) Uncharacteristic behavior.
        (8) Anxiety.
        (9) Combativeness.
    b. Hyperglycemia (high blood sugar).
        (1) Slow onset.
        (2) Warm, red, dry skin.
        (3) Sweet, fruity breath odor (acetone).
        (4) Deep, rapid breathing.
        (5) Dry mouth.
        (6) Intense thirst.
        (7) Abdominal pain.
        (8) Nausea and vomiting.

2. Administer the appropriate treatment.

**NOTE:** If you are unsure whether the patient has hyperglycemia or hypoglycemia, it is safer to treat the patient for hypoglycemia.

a. Hypoglycemia.
   (1) If conscious, administer oral glucose IAW local protocol.

**NOTE:** Give it only if the patient has a history of diabetes, the patient has an altered mental status, and the patient is awake enough to swallow.

   (a) Apply glucose to a tongue depressor and place it in the patient's mouth between the cheek and gum.
   (b) Or if the patient is able, let the patient squeeze the glucose from the tube directly into their mouth.
   (2) Monitor the patient for complications.
   (3) Assess vital signs.
   (4) If unconscious-
      (a) Secure the airway and administer oxygen.
      (b) Assess vital signs.
      (c) Place the patient in the recovery position.
      (d) Transport to the nearest medical treatment facility.

b. Hyperglycemia.
   (1) Maintain an open airway and administer oxygen.
   (2) Assess vital signs.
   (3) Place the patient on a cardiac monitor, if available.
   (4) Transport to the nearest medical treatment facility.

3. Document all treatment given.

**NOTE:** Document the patient's mental status using the alert, verbal, painful, unresponsive scale and vital signs every 5 minutes. A change in mental status may indicate an alteration in the patient's blood sugar level.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Identified the signs and symptoms of a diabetic emergency. | _____ | _____ |
| 2 | Administered the appropriate treatment. | _____ | _____ |
| 3 | Documented all treatment given. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*. Deployed Medicine website.

**Related**
None

Record Patient Care Using the Subjective, Objective, Assessment, Plan (SOAP) Note Format

081-000-0068

**CAUTION:** All body fluids should be considered potentially infectious. Always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment and have been tasked to record patient care using the subjective, objective, assessment, plan (SOAP) note format. You may have available a pen, clipboard, AR 40-66, DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*), SF 600 (*Chronological Record of Medical Care*), and electronic medical record (EMR).

**Standards:** Record patient care using the SOAP note format in accordance with AR 40-66, and the *Clinical Practice Guideline (CPG),* Tactical Combat Casualty Care (TCCC), while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Record the patient's information.
    a. Annotate the patient's full name.
    b. Annotate the rank of the patient (if applicable).
    c. Annotate the patient's date of birth (DOB).
    d. Annotate the current date and time.

2. Annotate the subjective data.
    a. Annotate the primary complaint of the patient.

**NOTE:** This is expressed in the own words of the patient whenever possible.

    b. Annotate the patient's illness or injury to include the history of the problem and the onset, provokes, quality, radiates, severity, time.

3. Annotate the objective data.
    a. Annotate the patient's vital signs and additional assessment data (if applicable).
    b. Annotate observations that support or relate to the subjective data (that is, sight, sound, touch, and smell).
    c. Annotate lab and radiology results (if applicable).

4. Record the assessment and analysis of the patient.
    a. Annotate the interpretation of the patient's problem or condition.
    b. Annotate the conclusions that were reached based upon the subjective and objective information.

5. Record the plan of treatment or therapy for the patient.
    a. Annotate the course of action to resolve the problem.

**NOTE:** This should include any treatment, patient education, profiles, and medications.

b. Annotate follow-up appointments or referrals (if applicable).
c. Ensure each item in the plan is numbered.

6. Confirm accuracy of information (make changes to information if applicable).
   a. Draw a single line through the error.
   b. Write the word error above it.
   c. Place initials next to the error.
   d. Write the correct note on the record.

7. Close the patient record entry.

**NOTE:** This is done by placing the printed name, title, rank, and signature of the authorized person completing the entry.

a. File the SF 600.
b. Finish the EMR.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Recorded the patient's information. | _____ | _____ |
| 2 | Annotated the subjective data. | _____ | _____ |
| 3 | Annotated the objective data. | _____ | _____ |
| 4 | Recorded the assessment and analysis of the patient. | _____ | _____ |
| 5 | Recorded the plan of treatment or therapy for the patient. | _____ | _____ |
| 6 | Confirmed accuracy of information (made changes to information if applicable). | _____ | _____ |
| 7 | Closed the patient record entry. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
AR 40-*66. Medical Record Administration and Healthcare Documentation.*
*Clinical Practice Guideline.*
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
*Joint Trauma System website.*
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC).*

**Related**
None

## Place a Patient on a Cardiac Monitor

081-000-0076

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You have a patient who requires cardiac monitoring. You have a cardiac monitor, lead wires, disposable pre-gelled electrodes (number of electrodes varies from 3-5, depending on the monitoring system), 4x4 gauze pads, washcloth, alcohol pads, and SF 600 (*Chronological Record of Medical Care*) or electronic medical record. You have performed a patient care handwash and have taken BSI precautions.

**Standards:** Place a patient on a cardiac monitor in accordance with (IAW) *Tactical Combat Casualty Care (TCCC) Guidelines* while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**Performance Steps:**

1. Identify the patient.
   a. Have the patient state their full name.
   b. Have the patient state their date of birth.
   c. Check the patient's wristband if one is available.
2. Explain procedure to the patient.
   a. Provide privacy.
   b. Ask the patient to expose their chest or expose patient if patient is unable to expose themself.
3. Prepare the equipment.

**NOTE:** Plug the cardiac monitor into an electrical outlet and turn it on to allow the unit to perform self-tests while you prepare the equipment and the patient, if not already done.

   a. Insert the cable into the appropriate socket in the monitor.
   b. Connect the lead wires to the cable, if necessary.
   c. Each lead wire should indicate the location for attachment to the patient.
      (1) Right arm (RA).
      (2) Left arm (LA).
      (3) Right leg (RL).
      (4) Left leg (LL).
      (5) Chest or ground (C or G).
   d. Check for the presence of recording paper and replace it as needed.
   e. Turn lead selection knob to the lead II position, if so equipped.

**NOTE:** Positions are based upon which system and lead you are using.

4. Determine electrode positions on the patient's chest.
    a. If necessary, clip the hair from an area of about 4 inches (10 centimeters) in diameter around each electrode site.
    b. Clean the area with soap and water then dry.
    c. An alcohol pad may be used to completely remove skin secretions that may interfere with electrode function.

**NOTE:** Gently abrade the dried areas by rubbing it briskly until it reddens to remove dead skin cells and to promote better electrical contact with living cells. Some electrodes have a small, rough patch for abrading the skin; otherwise, use a dry washcloth or a dry gauze pad.

5. Remove the backing from the pre-gelled electrode.

**NOTE:** Check the gel for moistness. If the gel is dry, discard electrode and replace with a fresh one.

6. Attach the lead wires to the electrodes.

7. Apply electrode to the site.

**NOTE:** Press firmly to ensure a tight seal.

    a. Place the first electrode RA on the right anterior chest just below the right clavicle.
    b. Place a second electrode LA on the left anterior chest just below the left clavicle.
    c. Place a third electrode C or G at the fourth intercostal space; right sternal border.
    d. Place the fourth electrode RL on the lower chest, just above and to the right of the umbilicus.
    e. Place the fifth electrode LL on the lower chest, just above and to the left of the umbilicus.
    f. When all electrodes are in place:
        (1) Check for tracing on the cardiac monitor.
        (2) Note the quality of the electrocardiogram.
        (3) Verify that each beat is being detected by the monitor.
            (a) Compare the digital heart rate display with your count of the patient's heart rate.
            (b) If necessary, use the gain control to adjust the size of the rhythm tracing.
            (c) Use the position control to adjust the waveform on the recording paper.

8. Set the upper and lower limits of the heart rate alarm.

**NOTE:** Turn the alarm on. The alarm should be set IAW unit policy or local standing operating procedure.

9. Document the procedure on an SF 600 or EMR.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 1 | Identified the patient. | _____ | _____ |
| 2 | Explained the procedure to the patient. | _____ | _____ |
| 3 | Prepared the equipment. | _____ | _____ |
| 4 | Determined electrode positions on the patient's chest. | _____ | _____ |
| 5 | Removed the backing from the pre-gelled electrode. | _____ | _____ |
| 6 | Attached the lead wires to the electrodes. | _____ | _____ |
| 7 | Applied electrode to the site. | _____ | _____ |
| 8 | Set the upper and lower limits of the heart rate alarm. | _____ | _____ |
| 9 | Documented the procedure on an SF 600 or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
Deployed Medicine *website.*
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

## Remove a Patient's Ring

081-000-0094

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment and have a patient who requires a ring to be removed. Provided with a Penrose drain, water-soluble lubricant, a 25-inch length of umbilical tape, string, or thick silk suture; if necessary, a ring cutter, pen, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*) or SF 600 (*Chronological Record of Medical Care*) or an electronic medical record.

**Standards:** Remove a patient's ring in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Lubricate the digit with a water-soluble lubricant and apply traction on the ring while turning in a circular motion.

**NOTE:** Frequently a ring must be removed to prevent laceration of tissue or vascular compromise.

2. Attempt to remove the ring using the string-wrap method.
   a. Wrap the Penrose drain circumferentially around the finger in a distal to proximal direction to reduce soft tissue swelling. For maximal effect, the wrap should stay in place for a few minutes.
   b. A 20- to 25-inch piece of string, umbilical tape or thick silk suture is first passed between the ring and the finger. If there is marked soft tissue swelling, the tip of a hemostat may be passed under the ring to grasp the string and pull it through the ring.
   c. The distal string is wrapped clockwise around the swollen finger (proximal to distal) to include the proximal interphalangeal (PIP) joint and the entire swollen finger.
      (1) The wrapping is begun next to the ring and should be snug enough to compress the swollen tissue.
      (2) The successive loops of the wrap are placed next to each other to keep any swollen tissue from bulging between the strands.
   d. When the wrapping has been completed, the proximal end of the string is carefully unwound in the same clockwise direction, forcing the ring over that portion of the finger that has been compressed by the wrap.

3. Use a ring cutter if there is excessive swelling.
   a. The ring cutter has a small hook that fits under the ring and serves as a guide for a saw-toothed wheel that cuts the metal.
   b. The cut ends of the ring are spread using large hemostats and the ring is removed.

4. Prevent further injury to the patient.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Lubricated the digit with a water-soluble lubricant and applied traction on the ring while turning in a circular motion. | _____ | _____ |
| 2 | Attempted to remove the ring using the string-wrap method. | _____ | _____ |
| 3 | Used a ring cutter if there was excessive swelling. | _____ | _____ |
| 4 | Prevented further injury to the patient. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
Deployed Medicine website.
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Treat a Blood Agent (Hydrogen Cyanide) Casualty

081-000-0114

This individual task was presented earlier in the STP on page 3-76 as a readiness requirements task. The content requirements are the same.

Treat a Choking Agent Casualty

081-000-0115

This individual task was presented earlier in the STP on page 3-77 as a readiness requirements task. The content requirements are the same.

Establish a Sterile Field

081-000-0163

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you are tasked with establishing a sterile field including performing a surgical hand scrub, gowning, and gloving procedures, and organizing and maintaining the sterile field. You have sterile packs, sterile drapes and towels, a small solution basin, sterile liquids, sterile needles and syringes, sterile gloves, and a flat, clean, dry surface.

**Standards:** Establish a sterile field in accordance with *Joint Trauma Systems Clinical Practice Guidelines*, while adhering to all warnings and cautions, without error, using the GO/NO GO checklist.

**Performance Steps:**

1. Obtain sterile equipment and supplies.
2. Select a flat, clean, dry surface.
3. Create a sterile field with a double-wrapped sterile package.
   a. Lift the top flap of the sterile pack away from the body without crossing your hand or arm over the sterile field.
   b. Lift the remaining flaps, one at a time, away from the center without crossing your hand or arm over the sterile field.
4. Introduce sterile items onto the sterile field.

**NOTE:** The outer two-inch border of the sterile field is considered contaminated. Items that fall into that area are considered contaminated and should not be used. If an item rolls from the two-inch border onto the sterile field, the sterile field is considered contaminated, and the procedure must be stopped immediately and the procedure must be repeated using a new sterile pack. If the wrapper of any item has been punctured, torn, or has watermarks, the item is no longer sterile.

   a. Commercially prepackaged items (syringes, sutures, needles).
      (1) Keeping your hands on the outside of the sterile wrapper, grasp the opening edge of the package.
      (2) Carefully fold (roll) each end of the wrapper back toward your wrists.
      (3) Without contaminating the contents, drop them onto the sterile field.
   b. Sterile processing department (SPD) items are wrapped in blue sterile wrappers.
      (1) Remove the outer wrapper.
      (2) Grasp the edge of the item being unwrapped, keeping your hand on the outside of the inner wrapper.
      (3) Fold each edge of the wrapper slowly back over your wrist of the hand holding the item.

(4) Drop the item onto the sterile field.

**CAUTION:** Discard the sterile solution if anyone touches the bottle rim, the lip of the bottle touches nonsterile items or an open sterile liquids.

**NOTE:** The bottle rim and inside of the cap are considered sterile. Liquids prepared in SPD are considered sterile if a vacuum release sound is heard when the bottle is opened. If there is no sound, the bottle is considered unsterile, and a new bottle must be obtained before continuing the procedure. Some commercially prepared bottles of sterile solution may not make a vacuum release sound.

a. Verify the six rights (patient, dose, medication, time, route, and expiration date).
b. Remove the outer protective bottle seal, if necessary, and remove the cap.
c. Hold the cap in one hand or place the cap so the top rests on the table.

**CAUTION:** If the sterile field is contaminated at any time, the procedure must be stopped immediately. Repeat all steps using new sterile equipment.

5. Pour sterile liquids.
   a. Hold the bottle with the label against your palm.
   b. Hold the bottle about 6 inches above the container into which the liquid is to be poured.
   c. Slowly pour a steady stream to avoid splashing, thus preventing contamination.
   d. The cap must not be replaced, if the cap is replaced the bottle will be contaminated.
6. Maintain sterility throughout the surgical procedure.

**NOTE:** Maintain organization of sterile field. Keep accountability of all items on sterile field. Ensure no break in aseptic technique has occurred. Surgical conscience is a must; any break in sterility must be identified and corrected at once.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Obtained sterile equipment and supplies. | _____ | _____ |
| 2 | Selected a flat, clean, dry surface. | _____ | _____ |
| 3 | Created a sterile field with a double-wrapped sterile package. | _____ | _____ |
| 4 | Introduced sterile items onto the sterile field. | _____ | _____ |
| 5 | Opened sterile liquids. | _____ | _____ |
| 6 | Poured sterile liquids. | _____ | _____ |
| 7 | Maintained sterility throughout the surgical procedure. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or

parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
*Clinical Practice Guidelines*.
Joint Trauma System website.

**Related**
None

## Perform a Wound Irrigation

081-000-1031

**CAUTION:** All body fluids should be considered as potentially infectious so always observe body substance isolation precautions by putting on clean gloves and an eye shield or face guard as a minimal standard of protection.

**Conditions:** In an operational environment, perform a wound irrigation on a patient. You have protective pads, irrigating syringe, examination gloves, sterile gloves, mask, prescribed irrigating solution, sterile dressing, catch basin, sterile gauze sponges, sterile solution basin, marked biohazard bag, and an SF 600 (*Chronological Record of Medical Care*).

**Standards:** Perform a wound irrigation in accordance with (IAW) *Joint Trauma Clinical Practice Guideline (JTS CPG) Burn Wound Management in Prolonged Field (CPG ID:57),* while adhering to all warnings and cautions, without error, using the GO/NO GO checklist.

**Performance Steps:**

1. Identify the patient.

2. Explain the procedure to the patient.

3. Provide privacy, if possible, and position the patient at an angle that allows the irrigating solution to run from the upper end of the wound downward.

4. Place the waterproof protective pad and clean basin or irrigating pouch directly under the area to be irrigated.

5. Drape the patient with a bath blanket to expose only the wound.

6. Remove the used outer dressing and discard in a marked biohazard bag. Discard gloves and wash hands.

7. Prepare the irrigation equipment.
   a. Open irrigation tray, using sterile technique (establish a sterile field using the wrapper of the sterile solution basin).
   b. Verify the prescribed irrigating solution.
   c. Open the irrigation solution; place the cover on the table, with the inside facing upward.
   d. Carefully pour the solution from the supply bottle into the irrigation bottle or syringe, pour solution with the bottle label facing your palm (if the bottle has been opened previously, pour off a small amount of the solution into a trash receptacle).
   e. Leave the cover off the irrigation supply bottle, with the inside of the cover pointing upward.

8. Put on a mask and eye protection.

9. Open the sterile dressing tray if one is to be used.

10. Put on sterile gloves.

11. Use sterile forceps to remove the inner dressings.

12. Carefully assess the amount and character of drainage, the size and condition of the wound and surrounding tissue.

13. Irrigate the wound.
    a. Hold the syringe just above the wound's top edge without touching it, and force fluid into the wound, slowly and continuously.
    b. Use enough force to flush out debris, but do not squirt or splash fluid.
    c. Irrigate all portions of the wound (do not force solution into the wound's pockets).
    d. Continue irrigating until the solution draining from the wound's bottom end is clear.
    e. Repeat steps 13a and 13c until the wound is clear of debris or drainage.
    f. Observe the drainage for blood or characteristics such as unusual color, odor, or consistency.

**NOTE:** If signs of infection are observed, notify the medical officer immediately.

**CAUTION:** Use extra care when irrigating a wound in which an abscess has formed. Check all internal surfaces of the wound to inspect for "sinus tract" (resembles tunnels in which purulence or "pus" may be collected). This may require using the gloved hand or a sterile object to gently pull back the flesh. Be careful not to tear healing tissue.

14. Dry the wound and apply a sterile dressing.
    a. Using sterile 4x4 pads, gently pat the wound's edges (unless the wound is to have a wet-to-dry dressing; then dry only the surrounding skin). Work from cleanest to most contaminated.

**NOTE:** Moving from clean to contaminated helps to prevent the spread of pathogens. If the wound is dry, the dressings will remain dry longer and contamination will not spread.

    b. Apply a sterile dressing to the wound.
    c. Remove the catch basin and protective pad if they are still in place.

15. Remove the mask, eye protection, and gloves.

16. Reposition the patient for comfort, if necessary.

17. Clean and store the equipment IAW local standard operating procedure.

18. Perform a patient care handwash.

19. Record the procedure on the appropriate medical form.

20. Do not violate aseptic technique or cause further injury to the patient.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 1 | Identified the patient. | _____ | _____ |
| 2 | Explained the procedure to the patient. | _____ | _____ |
| 3 | Provided privacy, if possible, and positioned the patient at an angle that allowed the irrigating solution to run from the upper end of the wound downward. | _____ | _____ |
| 4 | Placed a waterproof protective pad and clean basin or irrigating pouch directly under the area to be irrigated. | _____ | _____ |
| 5 | Draped the patient with a bath blanket to expose only the wound. | _____ | _____ |
| 6 | Removed the used outer dressing and discarded it in a marked biohazard bag. Discarded gloves and washed hands. | _____ | _____ |
| 7 | Prepared the irrigation equipment. | _____ | _____ |
| 8 | Put on a mask and eye protection. | _____ | _____ |
| 9 | Opened the sterile dressing tray if one was to be used. | _____ | _____ |
| 10 | Put on sterile gloves. | _____ | _____ |
| 11 | Used sterile forceps to remove the inner dressings. | _____ | _____ |
| 12 | Carefully assessed the amount and character of drainage, the size and condition of the wound and surrounding tissue. | _____ | _____ |
| 13 | Irrigated the wound. | _____ | _____ |
| 14 | Dried the wound and applied a sterile dressing. | _____ | _____ |
| 15 | Removed the mask, eye protection, and gloves. | _____ | _____ |
| 16 | Repositioned the patient for comfort, if necessary. | _____ | _____ |
| 17 | Cleaned and stored the equipment IAW local standard operating procedure. | _____ | _____ |
| 18 | Performed a patient care handwash. | _____ | _____ |
| 19 | Recorded the procedure on the appropriate medical form. | _____ | _____ |
| 20 | Did not violate aseptic technique or caused further injury to the patient. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
*Burn Wound Management in Prolonged Field Care Clinical Practice Guide*.
Joint Trauma System website.
SF 600. *Chronological Record of Medical Care*.

**Related**
None

Treat Common Throat Disorders

081-68W-0243

**Conditions:** In an operational environment you must treat a patient complaining of a sore throat. All other immediate life threats have been treated and managed. You have performed a patient care handwash and taken BSI precautions. You are provided with a tongue blades, penlight, or other light source, pen, and SF 600 (*Chronological Record of Medical Care*) or electronic medical record.

**Standards:** Treat common throat disorders in accordance with *Tintinalli's Emergency Medicine*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Obtain supplies and equipment.

2. Identify the patient.
   a. Ask patient's full name.
   b. Ask patient's date of birth.

3. Explain the procedure to the patient.
   a. Provide privacy and safety for the patient.
   b. Ask about known allergies.
   c. Place patient in position of comfort, as long as the procedure permits.

4. Perform an otolaryngology exam (see task 081-68W-0254, Perform an Otolaryngology Exam).

5. Identify throat disorders.
   a. Upper respiratory infection (URI) – acute infection of the upper airway.
      (1) Common causes – URIs are usually a result of different viruses but can be bacterial in nature.
      (2) Signs and symptoms.
         (a) Sore throat.
         (b) Cough which may be either productive or nonproductive.
         (c) Sputum may be clear or purulent.
         (d) Low-grade fever, possible.
         (e) Nasal congestion or discharge.
         (f) Sinus pressure.

**WARNING:** Streptococcal (strep) pharyngitis is spread by person-to-person contact with nasal secretions or saliva, often among family or household members.

         (g) Appearance of a slightly reddened pharynx with mucous streaking.

**WARNING:** Strep pharyngitis is spread by person-to-person contact with nasal secretions or saliva, often among family or household members.

b. Strep pharyngitis – infection of the posterior pharynx or tonsils.

**NOTE:** It is most common in the late fall, winter, and early spring.

(1) Common causes – most common is group A streptococcus bacteria.

(2) Signs and symptoms.

**NOTE:** In some individuals, strep throat is very mild with only a few of these symptoms. In others, strep throat is severe. The onset is usually sudden.

(a) Severe sore throat.

(b) Fever.

(c) Tender or swollen neck glands.

(d) Nausea.

(e) Malaise.

(f) Exudate (pus) is commonly seen on reddened tonsils and pharynx.

(g) Headache.

(h) Chills.

c. Peri-tonsillar abscess (PTA) – bacterial infection of the tonsils, which spreads into a cellulitis and abscess.

(1) Common causes – usually results as a complication of “strep” pharyngitis.

**CAUTION:** An abscess is a collection of pus that forms near an area of infected skin or to the soft tissue. The abscess can cause pain, swelling, and may block the throat.

(2) Signs and symptoms.

**CAUTION:** An abscess is a collection of pus that forms near an area of infected skin or to the soft tissue. The abscess can cause pain, swelling, and may block the throat.

(a) The abscess usually affects one side of the mouth resulting in a tonsil deviating toward the midline.

**NOTE:** A PTA forms in the throat tissues next to one of the tonsils.

(b) Ear pain on the same side as the abscess.

(c) Severe sore throat that is isolated to one side.

(d) Spasm in the muscles of the jaw or trismus (difficulty in opening the mouth).

(e) Difficulty swallowing saliva.

(f) Muffled voice, often described as “hot potato” voice (sounds as if you have a mouthful of hot potato when you talk).

(g) Fever may be present.

(h) Chills.

d. Infectious mononucleosis – a viral infection that usually presents as a sore throat.

(1) Common cause – viral.

(2) Signs and symptoms.

(a) Lymph node (gland) enlargement of the neck.

(b) Shaggy, white-purple tonsillar exudate.

(c) Abdominal pain may indicate inflammation of the spleen.

6. Provide treatment.

a. URI.

(1) Referral to medical officer (MO).

(2) A cough suppressant, decongestant, throat lozenges and an analgesic for fever and body aches will be prescribed.

**NOTE:** Antibiotics are not indicated for viral URIs.

b. Strep pharyngitis.

(1) Referral to MO.

**NOTE:** Diagnosis is confirmed with a throat culture however the MO may treat for this condition based on symptoms alone.

(2) Antibiotics will be prescribed by the MO.

**NOTE:** Penicillin has been traditionally recommended and is still very effective.

**CAUTION:** Even though the sore throat usually gets better on its own, individuals who have strep throat must take antibiotics to prevent more serious complications of this infection, including rheumatic fever.

c. PTA.

**WARNING:** This is a surgical emergency.

(1) Referral to MO immediately.

(2) PTAs require urgent surgical drainage and antibiotic therapy.

d. Infectious mononucleosis.

(1) Referral to MO.

**CAUTION:** Patients are advised to avoid contact sports (football) for at least 30 days after diagnosis due to the increased risk of splenic rupture (rupture of the spleen).

(2) The MO may order a blood test or rapid mononucleosis test along with a throat culture to rule out “strep” and confirm mononucleosis.

7. Document treatment on appropriate form.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 1 | Obtained supplies and equipment. | _____ | _____ |
| 2 | Identified the patient. | _____ | _____ |
| 3 | Explained the procedure to the patient. | _____ | ____ |
| 4 | Performed an otolaryngology exam (see task 081-68W-0254, Perform an Otolaryngology Exam). | _____ | _____ |
| 5 | Identified throat disorders. | _____ | _____ |
| 6 | Provided treatment. | _____ | _____ |
| 7 | Documented treatment on appropriate form. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
SF 600. *Chronological Record of Medical Care*.
Tintinalli's Emergency Medicine.

**Related**
None

Perform a Knee Examination

081-68W-0268

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you have a patient that requires a knee examination. You are provided with a physical examination table or a flat surface, an SF 600, (*Chronological Record of Medical Care*) and a pen.

**Standards:** Perform a knee examination in accordance with *Bates' Guide to Physical Examination and History Taking*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Identify the patient.

2. Obtain the patient history.
   a. Record past medical injuries and conditions.
   b. Record past surgical procedures including date of procedure.
   c. Record current medications (to include supplements).
   d. Record drug allergies.
   e. Record social history including tobacco, alcohol, and illegal drug use.
   f. Record family medical history.
   g. Record military occupational specialty and duty description.

3. Obtain history of present illness.
   a. Record the mechanism of injury.
   b. Location of pain, if any.
   c. Record onset of symptoms (specify date when possible).
   d. Was a pop or snap heard or felt?
   e. Was there any locking of the knee?
   f. Ability to walk after the injury?
   g. Was there immediate or delayed swelling? Is the knee hot to the touch?
   h. Record severity of symptoms on a 10-point pain scale.
   i. Record provocating activities. (Does anything make the pain better or worse?)
   j. Record referred or radiating symptoms.
   k. Record previous attempts to treat the condition. (For example, nonsteroidal anti-inflammatory drugs (NSAIDs), physical therapy, and activity modification.)

4. Screen for red flags. (Systemic symptoms, fever, joint instability, inability to bear weight, inability to straighten leg or perform full range of motion [ROM]).

5. Record any systemic or rheumatological symptoms. (Fever, eye pain or history of uveitis, dysphagia or odynophagia, chest pain, irritable bowel or abdominal symptoms, polymyalgia, and distal paresthesia.)

6. Perform a physical examination of the knee.
   a. Observe gait – watch the patient walk, if able. Record abnormalities. (Trendelenburg)
   b. Inspection – have the patient place one finger on the spot that hurts the most. Compare the affected extremity to the unaffected one, looking for the following:

**NOTE:** Compare the affected extremity to the unaffected one.

      (1) Edema.
      (2) Erythema.
      (3) Deformity.
      (4) Ecchymosis.
      (5) Effusion (escape of fluid into a body cavity).
      (6) Obvious deformity.

   c. Palpation – palpate the following:
      (1) Joint lines – (border of patella, tibial tuberosity, medial joint line, lateral joint line, medial condyle of femur, lateral condyle of femur, proximal head of the fibula, insertion and origin of quadriceps. Insertion and origin of hamstrings, insertion and origin of gastrocnemius, insertion and origin of tibialis anterior, pes anserine.)
      (2) Ligaments – medial collateral, lateral collateral.
      (3) Patella.
      (4) Pulses distal to the knees – anterior tibialis, dorsalis pedis.
      (5) Is there sensation distal to the injury?
   d. Perform neuromuscular examination.
      (1) Test nerve roots L4-S1.
      (2) Test dermatomes L1-S1.
      (3) Perform deep tendon reflexes on L4 and S1.

**WARNING:** You or the patient should never force a motion.

   e. Record active and passive ROM – ask the patient to complete the ROM movements. (Compare ROM of the affected knee with the unaffected one.)
      (1) Flexion – and associated aggravation of symptoms.
      (2) Extension – and associated aggravation of symptoms.
   f. Perform special tests – documenting all findings.
      (1) Perform straight leg raise test.
      (2) Perform valgus stress test at 0 and 30 degrees.
      (3) Perform varus stress test at 0 and 30 degrees.
      (4) Perform anterior drawer.
      (5) Perform posterior drawer.
      (6) Perform Lachman’s test.
      (7) Perform McMurray’s test.

(8) Perform Thessaly's test.
(9) Perform dial test.
(10) Perform patellar apprehension test.

7. Document patient medical history, history of present illness, and physical examination on SF 600 in subjective, objective, assessment, and plan note format.

8. Present patient to a medical provider with a differential diagnosis and proposed treatment plan. Should consider medications, physical therapy, profiling, and further diagnostic tests as indicated.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Identified the patient. | _____ | _____ |
| 2 | Obtained the patient history. | _____ | _____ |
| 3 | Obtained history of present illness. | _____ | _____ |
| 4 | Screened for red flags. (Systemic symptoms ever, joint instability, inability to bear weight, inability to straighten leg or perform full range of motion [ROM]). | _____ | _____ |
| 5 | Recorded any systemic or rheumatological symptoms. (Fever, eye pain or history of uveitis, dysphagia or ondynophagia, chest pain, irritable bowel or abdominal symptoms, polymyalgia, and distal paresthesia.) | _____ | _____ |
| 6 | Performed a physical examination of the knee. | _____ | _____ |
| 7 | Documented patient medical history, history of present illness, and physical examination on SF 600 in subjective, objective, assessment, and plan note format. | _____ | _____ |
| 8 | Presented patient to a medical provider with a differential diagnosis and proposed treatment plan. Should have considered medications, physical therapy, profiling, and further diagnostic tests as indicated. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
Bates' Guide to Physical Examination and History Taking.
SF 600. *Chronological Record of Medical Care*.

**Related**
None

Perform a Shoulder Examination

081-68W-0269

**Conditions:** In an operational environment you have a patient that requires a shoulder examination. You will have a physical examination table or flat surface, a SF 600, (*Chronological Record of Medical Care*) and a pen.

**Standards:** Perform a shoulder examination in accordance with *Bates' Guide to Physical Examination and History Taking* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Identify the patient.

2. Obtain the patient history.
   a. Record past surgical procedures including date of procedure.
   b. Record current medications.
   c. Record drug allergies.
   d. Record social history including tobacco, alcohol, and illegal drug use.
   e. Record family medical history.
   f. Record military occupational specialty or duty description.

3. Obtain history of present illness.
   a. Record the mechanism of injury.
   b. Record onset of symptoms. (specify date when possible)
   c. Record provocating activities. (Does anything make the pain better or worse?)
   d. Record referred or radiating symptoms.
   e. Record severity of symptoms on a 10-point pain scale.
   f. Location of pain, if any.
   g. Is there any numbness or tingling in the arm or hand?
   h. Ability to move the shoulder or arm or hand after the injury?
   i. Was there immediate or delayed swelling? Is the shoulder hot to touch?
   j. Record previous attempts to treat the condition. (For example, nonsteroidal anti-inflammatory drugs (NSAIDs), physical therapy, and activity modification.)

4. Screen for red flags. (scoliosis, atrophy, swelling from synovial fluid accumulation)

5. Perform a physical examination of the shoulder.
   a. Observe gait and record abnormality. (Trendelenburg)
   b. Inspection – have the patient place one finger on the spot that hurts the most. Look for the following:

**NOTE:** Compare the affected shoulder to the unaffected one.

(1) Edema.

(2) Erythema.
(3) Ecchymosis.
(4) Obvious deformity.
(5) Effusion.

c. Palpation – palpate the following:
(1) Bony prominences.
(2) Joint lines.
(3) Pulses – radial.
(4) Is there sensation in the arm?

d. Palpate key anatomy and record associated pain, crepitus, masses (manubrium, the sternoclavicular joint, and the clavicle. Also identify the tip of the acromion, the greater tubercle of the humerus, and the coracoid process, which are important landmarks of shoulder anatomy).

e. Perform neuromuscular examination.
(1) Test nerve roots C3-C8.
(2) Test dermatomes C4.
(3) Perform deep tendon reflexes on C3-C8.

**WARNING:** You or the patient should never force a motion.

f. Record range of motion and associated aggravation of symptoms:

**NOTE:** Compare range of motion of the affected shoulder with the unaffected one.

(1) Flexion.
(2) Extension.
(3) Abduction.
(4) Adduction.
(5) Internal rotation.
(6) External rotation.

6. Perform special tests.
a. Neer's test.
b. Speed's test.
c. Lag's test.
d. Empty can test.
e. Painful arc test.
f. Hawkin's test.
g. Drop arm test.
h. External rotation resistance test

7. Document findings on SF 600.

8. Present exam findings of patient to a medical provider with a differential diagnosis and proposed treatment plan. (Consider medications, physical therapy, profiling, and further diagnostic tests as indicated.)

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Identified the patient. | _____ | _____ |
| 2 | Obtained the patient history. | _____ | _____ |
| 3 | Obtained history of present illness. | _____ | _____ |
| 4 | Screened for red flags. (scoliosis, atrophy, swelling from synovial fluid accumulation) | _____ | _____ |
| 5 | Performed a physical examination of the shoulder. | _____ | _____ |
| 6 | Performed special tests. | _____ | _____ |
| 7 | Documented findings on SF 600. | _____ | _____ |
| 8 | Presented exam findings of patient to a medical provider with a differential diagnosis and proposed treatment plan. (Considered medications, physical therapy, profiling, and further diagnostic tests as indicated.) | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Bates' Guide to Physical Examination and History Taking.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

Perform an Elbow Examination

081-68W-0270

**Conditions:** In an operational environment you have a patient that requires an elbow examination. You are provided with an SF 600 (*Chronological Record of Medical Care*) and a pen.

**Standards:** Perform an elbow examination in accordance with *Bates' Guide to Physical Examination and History Taking*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Identify the patient.

2. Obtain the patient history.
   a. Record past medical injuries or conditions.
   b. Record past surgical procedures including date of procedure and complications.
   c. Record current medications and dosages.
   d. Record drug allergies and the associated reactions.
   e. Record social history including tobacco, alcohol, and illegal drug use.
   f. Record family medical history pertinent to neuromuscular conditions.
   g. Record military occupational specialty or duty description.

3. Obtain history of present illness or injury (HPI).
   a. Record onset of symptoms (specify date when possible).
   b. Location of pain, if any.
   c. Record the mechanism of injury.
   d. Was a pop or snap heard or felt?
   e. Was there immediate or delayed swelling? Is the elbow hot to the touch?
   f. Ability to move the arm after the injury?
   g. Was there immediate or delayed swelling? Is the elbow hot to the touch?
   h. Record provocating activities.
   i. Record referred or radiating symptoms.
   j. Record severity of symptoms on a 10-point pain scale.
   k. Record previous attempts to treat the condition. (For example, nonsteroidal anti-inflammatory drugs (NSAIDs), physical therapy, and activity modification.)

4. Screen for red flags. (previous dislocations, acute high energy injury, elbow pain, movement restriction.)

5. Record any systemic or rheumatological symptoms. (fever, eye pain or history of uveitis, dysphagia or odynophagia, chest pain, irritable bowel or abdominal symptoms, polymyalgia, polyarthralgia, and distal paresthesia.)

6. Perform a physical examination of the elbow.

**NOTE:** Compare the affected extremity to the unaffected one.

a. Observe the skin and record abnormalities. Note any abnormalities on the SF 600.

b. Inspection – Have the patient place one finger on the spot that hurts the most. Look for the following:

(1) Swelling.

(2) Erythema.

(3) Ecchymosis.

(4) Effusion.

(5) Obvious deformity.

c. Palpate key anatomy and record associated pain, crepitus, masses.

(1) Skeletal: olecranon, medial epicondyle, lateral epicondyle, and radial head.

(2) Muscular: biceps tendon, olecranon bursa, arcade of Frohse (radial tunnel), and ulnar nerve in cubital tunnel.

(3) Circulation: radial pulse.

d. Perform neuromuscular examination.

(1) Is there sensation distal to the injury?

(2) Test muscular strength of the ulnar nerve.

(a) Perform the ulnar Tinnel test.

(b) Assess by checking 2-point discrimination.

(3) Test dermatomes C6/7/8.

(4) Perform deep tendon reflexes on C5 thru C7 and grade on 5-point scale (4+ to 0).

**WARNING:** You or the patient should never force a motion.

e. Record range of motion in degrees:

**NOTE:** Compare range of motion of the affected elbow with the unaffected one.

(1) Flexion.

(2) Extension.

(3) Supination.

(4) Pronation.

(5) Associate aggravation of symptoms.

7. Perform special tests.

a. Perform special tests for distal biceps rupture: hook test, passive pronation and supination test.

b. Perform special tests for medial collateral ligament tear: valgus stress test, modified milking maneuver, and moving valgus test.

c. Perform special tests for cubital tunnel: Tinel’s sign and elbow flexion test.

d. Posterolateral rotation: lateral pivot shift, push-up test, and stand-up test.

e. Lateral epicondylitis: chair test.

8. Document patient medical history, HPI, and physical examination on SF 600 in subjective, objective, assessment, and plan note format.

9. Present exam findings of patient to a medical provider with a differential diagnosis and proposed treatment plan. (Should consider medications, physical therapy, profiling, and further diagnostic tests as indicate.)

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Identified the patient. | _____ | _____ |
| 2 | Obtained the patient history. | _____ | _____ |
| 3 | Obtained history of present illness or injury. | _____ | _____ |
| 4 | Screened for red flags such as previous dislocations, acute high energy injury, elbow pain, movement restriction. | _____ | _____ |
| 5 | Recorded any systemic or rheumatological symptoms for example fever, eye pain, history of uveitis, dysphagia, ondynaphagia, chest pain, irritable bowel or abdominal symptoms, polymyalgias, polyarthralgias, distal paresthesias. | _____ | _____ |
| 6 | Performed a physical examination of the elbow. | _____ | _____ |
| 7 | Performed special tests. | _____ | _____ |
| 8 | Documented patient medical history, history of present illness, and physical examination on SF 600 in subjective, objective, assessment, and plan note format. | _____ | _____ |
| 9 | Presented exam findings of patient to a medical provider with a differential diagnosis and proposed treatment plan. Should consider medications, physical therapy, profiling and further diagnostic tests as indicated. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Bates' Guide to Physical Examination and History Taking.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

**Subject Area 12: Medication Management**

Treat a Poisoned Casualty

081-000-0025

This individual task was presented earlier in the STP on page 3-115 as a readiness requirements task. The content requirements are the same.

Treat an Allergic Reaction

081-000-0032

This individual task was presented earlier in the STP on page 3-108 as a readiness requirements task. The content requirements are the same.

Manage Intravenous Access

081-000-0038

This individual task was presented earlier in the STP on page 3-111 as a readiness requirements task. The content requirements are the same.

## Perform a Digital Block Anesthesia

081-68W-3036

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You have a patient who requires an anesthetic digital block. You will be provided 2% lidocaine solution without epinephrine, a 3 to 5 milliliter (ml) syringe, an 18-gauge needle, a 25-gauge needle, alcohol and gauze pads, draping, sterile gloves, and SF 600 (*Chronological Record of Medical Care*) or electronic equivalent. You have verified the medical officer's orders, the medication (using the six rights) and the patient. You have performed a patient care handwash and taken BSI precautions.

**Standards:** Perform an anesthetic digital block without causing injury to patient in accordance with *Emergency Medicine*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Obtain a patient history.

2. Gather equipment.

**NOTE:** Local anesthetics are to be used without epinephrine in the digits to avoid vasoconstriction of adjacent arteries, which may lead to ischemia or infarction of local tissues.

3. Prepare an injection for administration.

**NOTE:** Prepare the injection by drawing up 3 ml of 2% lidocaine from the vial.

4. Prepare the site.
   a. Position the patient with the effected digit easily accessible, hand in the prone (palm down) position.
   b. Clean the injection site at the base of the digit just above the metacarpal-phalangeal (MCP) joint (bottom knuckle) into the web spaces on both sides of the digit with an alcohol pad or antimicrobial solution.

**NOTE:** Do not touch the injection site after cleansing.

5. Perform the digital block anesthesia.
   a. Insert the needle perpendicularly into the web space, at the base of the finger, just distal to the MCP joint.

**NOTE:** Be careful not to push the needle out of the bottom of the finger or through the volar aspect of the web space.

   b. Advance the needle into the layer of fat under the skin. This can easily be determined by the "give" you will feel when you have penetrated the skin.
   c. Aspirate a small amount to ensure you are not in a digital artery.

d. Inject about one ml of lidocaine into the fatty layer under the skin while withdrawing the needle back to the skin surface (the nerve you are numbing runs through this space and must be surrounded by lidocaine to prevent the transmission of nerve signals).

e. Repeat the procedure on the opposite side of the digit. Wait about five minutes and check the digit for sensation (pressure is a normal sensation but if any pain is felt, the process can be repeated with another ml of lidocaine on each side of the digit).

f. Allow 10-20 minutes for the anesthetic to take effect.

g. All digits except the great toe can be effectively anesthetized in the same manner. The three-sided digital block technique is most effective on the great toe.

(1) Place the patient's extremity plantar side down.

(2) Insert the needle at a 90-degree angle at the medial aspect of the digit, just distal to the MCP joint.

(3) Aspirate a small amount to ensure you are not in a digital artery.

(4) Slowly inject the anesthetic as the needle is advanced toward the plantar side, without piercing the volar skin.

(5) Prior to pulling the needle out of the skin, slowly redirect the needle laterally under the surface of the skin.

(6) Aspirate a small amount to ensure you are not in a digital artery.

(7) Slowly inject the anesthetic while the needle is being withdrawn medially. Withdraw the needle.

(8) Make another injection over the already anesthetized skin at the lateral aspect of the digit, with the needle at 90 degrees distal to the metatarsophalangeal joint.

(9) Aspirate a small amount to ensure you are not in a digital artery.

(10) Slowly inject the anesthetic, withdrawing plantar to dorsal, as was done medially.

6. Remove gloves.

7. Document the procedure.
   a. Consent.
   b. Description of the area of interest prior to performing the procedure.
   c. Give a description of the procedure; to include the type and quantity of anesthesia used.
   d. How the patient tolerated the procedure.
   e. Any follow-up care or instructions given to the patient.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Obtained a patient history. | _____ | _____ |
| 2 | Gathered equipment. | _____ | _____ |
| 3 | Prepared an injection for administration. | _____ | _____ |
| 4 | Prepared the site. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 5 | Performed the digital block anesthesia. | _____ | _____ |
| 6 | Removed gloves. | _____ | _____ |
| 7 | Documented the procedure. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Emergency Medicine.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

Administer Local Anesthesia

081-68W-3090

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You have a patient requiring local anesthesia. You are provided with the ordered anesthetic, sterile needle, syringe, pen, sterile gloves, and SF 600 (*Chronological Record of Medical Care*) or electronic medical record. You have verified the medical officer's orders, the medication (using the six rights) and the patient. You have performed a patient care handwash and taken BSI precautions.

**Standards:** Administer local anesthesia in accordance with *Tintinalli's Emergency Medicine*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Prepare the site.

2. Apply anesthesia to area.
   a. Cryoanesthesia.
      (1) Apply an ice cube to the skin for about 5 minutes.
      (2) Spray the area with commercial refrigerants, as directed.
   b. Topical applications.
      (1) Apply the agent directly to the mucus membrane, serous surface, or onto the open wound.
      (2) Slightly saturate a gauze with the appropriate agent and place it on the wound for 5 to 10 minutes.
      (3) Check the area for tissue blanching which indicates adequate anesthesia.

**NOTE:** Often topical application is suboptimal for suture replacement.

   c. Simple infiltration.
      (1) Ensure the casualty does not have an allergy to the agent.
      (2) Using a needle and syringe, draw up an adequate amount of 1% lidocaine.

**WARNING:** Lidocaine with epinephrine is never used on the tip of the nose, ears, fingers, toes, or genitalia due to vasoconstriction.

      (3) The anesthetic solution is injected near the wound edge extending approximately 1 centimeter (cm) around the wound margin.
      (4) Aspirate prior to injecting the solution to ensure the needle is not in a vessel. (If blood returns into the syringe, withdraw, change the needle, and try a new site.
      (5) Slowly inject solution beneath the skin surface, raising a wheal in the area to be anesthetized.
      (6) Repeat steps 2c (3) through 2c (5) depending on the size of the laceration.

3. Document the procedure on SF 600.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Prepared the site. | _____ | _____ |
| 2 | Applied anesthesia to area. | _____ | _____ |
| 3 | Documented the procedure on SF 600. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
SF 600. *Chronological Record of Medical Care*.
*Tintinalli's Emergency Medicine.*

**Related**
None

Prepare an Injection for Administration

081-000-0056

This individual task was presented earlier in the STP on page 3-137 as a readiness requirements task. The content requirements are the same.

Administer Medication

081-000-1006

This individual task was presented earlier in the STP on page 3-119 as a readiness requirements task. The content requirements are the same.

Treat Paronychia

081-68W-0024

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment; you are required to treat a patient with paronychia. You are provided with a scalpel handle, scalpel blades of various sizes, antibiotic ointment, sterile dressing, gloves pen, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*) or SF 600 (*Chronological Record of Medical Care*) or an electronic medical record (EMR).

**Standards:** Treat a patient with paronychia in accordance with *Clinical Dermatology*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Obtain a history of the patient's complaint.
2. Gather the materials for the procedure.
3. Perform a patient care handwash.
4. Put on gloves.
5. Explain the procedure to the patient.
6. Drain the paronychia.
    a. Insert the tip of a #11 blade approximately 5 millimeters (mm) around the cuticle of the nail, uplifting the cuticle.

**NOTE:** This procedure alone provides for adequate drainage in most paronychia.

    b. Allow the pus to drain.

**NOTE:** Culture and antibiotic therapy are usually unnecessary unless the patient shows signs of systemic infection.

    c. Irrigate the cavity with normal saline.

7. Apply antibiotic ointment and absorbent dry, sterile dressing.
8. Provide instructions to the patient.
    a. Perform frequent soaks in warm tap water at home.
    b. Continue to keep the wound covered as long as drainage persists.

**NOTE:** Instruct the patient to follow up earlier if there are signs of systemic infection.

    c. Instruct the patient to follow up in 24-48 hours.

9. Remove gloves.

10. Record all treatment given on SF 600 or EMR.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in a field condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Obtained a history of the patient's complaint. | _____ | _____ |
| 2 | Gathered the materials for the procedure. | _____ | _____ |
| 3 | Performed a patient care handwash. | _____ | _____ |
| 4 | Put on gloves. | _____ | _____ |
| 5 | Explained the procedure to the patient. | _____ | _____ |
| 6 | Drained the paronychia. | _____ | _____ |
| 7 | Applied antibiotic ointment and absorbent dry, sterile dressing. | _____ | _____ |
| 8 | Provided instructions to the patient. | _____ | _____ |
| 9 | Removed gloves. | _____ | _____ |
| 10 | Recorded all treatment given on SF 600 or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
*Clinical Dermatology.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

## Treat a Patient for High Altitude Illness

081-68W-0035

**CAUTION:** Anecdotal evidence suggests that acetazolamide 125 to 250 milligrams (mg) per oral (PO) twice a day (bid) or 500-mg sustained-release capsule every 24 hours prevents high-altitude pulmonary edema (HAPE) in persons with a history of recurrent episodes. Agents that limit hypoxic pulmonary hypertension might block the onset of HAPE. One example is nifedipine 20 mg sustained-release capsule every 8 hours or 30 mg sustained-release capsule every 12 hours. Studies suggest that the inhaled β-adrenergic agonist salmeterol metered-dose inhaler two puffs every 8-12 hours may prevent HAPE. The PDE-5 inhibitors sildenafil 50 mg every 8 hours, or tadalafil 10 mg every 12 hours may effectively prevent HAPE. Dexamethasone has been shown to prevent HAPE in susceptible subjects. The dose used was 8 mg every 12 hours starting 2 days before exposure.

**Conditions:** In an operational environment, you have a casualty requiring treatment for altitude illness. You have a stethoscope, ibuprofen, acetaminophen, acetazolamide, dexamethasone, humidified oxygen (O2), O2 delivery equipment, and a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*).

**Standards:** Treat a casualty for high altitude illness in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines*; by Joint Trauma System Committee on Tactical Combat Casualty Care (CoTCCC), while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Differentiate the signs and symptoms of various types of high-altitude illness.
    a. High-altitude headache.
        (1) Often the first symptom of altitude exposure.
        (2) May be the only symptom following altitude exposure.
    b. Acute mountain sickness (AMS).

**NOTE:** There may be absence of altitude diuresis expected with normal acclimatization. During acclimatization, diuresis is expected; for example, a well-hydrated person who is acclimatizing appropriately should awaken at least once during the night to urinate. A person who does not awaken to urinate or infrequently urinates during the daytime is possibly dehydrated and also should be watched closely for signs of AMS.

(1) Headache.
(2) Fatigue.
(3) Nausea.
(4) Dyspnea.
(5) Sleep disturbances.
(6) Symptoms are aggravated by exertion.

**NOTE:** AMS may evolve into HAPE, high-altitude cerebral edema (HACE), or both.

(7) Anorexia.

(8) Dizziness or lightheadedness.

c. HACE.

**NOTE:** HACE is believed to be present to a mild degree in all forms of altitude sickness. HACE can occur within 3-5 days after arrival at 9,000 feet (ft.), but generally occurs at altitudes above 12,000 ft.

(1) Gait ataxia is a reliable early warning sign.

(2) Headache.

(3) Mental confusion.

(4) Hallucinations.

**WARNING:** Coma and death may develop within a few hours of the first warning signs of HACE.

(5) Irrational behavior progressing to coma.

d. HAPE.

**NOTE:** HAPE usually develops 24 to 96 hours after rapid ascent above 8,000 ft.

(1) HAPE is characterized by increasing dyspnea.

(2) Irritative cough that produces frothy, often bloody sputum.

(3) Weakness.

(4) Cyanosis.

(5) Low-grade fever.

(6) Tachycardia.

(7) Fine or coarse rales.

(8) Coma.

(9) Cyanotic nail beds and lips.

(10) Audible chest rales, classically beginning in the right middle lobe (auscultate right lateral chest between fourth and sixth intercostal spaces) and becoming bilateral and diffuse.

2. Manage high-altitude illnesses.

a. High-altitude headache and mild AMS.

(1) Stop ascent, rest, and acclimatize at same altitude. Acetazolamide, 125 to 250 mg bid, to speed acclimatization.

(2) Symptomatic treatment as needed with non-narcotic analgesics and antiemetics OR descend 500 meters (m) (1640 ft.) or more.

b. Moderate to severe AMS.

(1) Low-flow oxygen (0.5 to 2 liters per minute [lpm] by nasal cannula to raise arterial oxygen saturation [SaO2] to greater than 90%). Acetazolamide, 250 mg bid (pediatric dose: 2.5 mg/kg/dose bid to a maximum dose of 250 mg) or immediate descent of at least 1000 m (3281 ft.) (or more if feasible).

(2) Hyperbaric therapy.

c. HACE.

(1) Immediately descend at least 500 to 1000 m (1640 to 3281 ft.) or more. There is no upper limit to descent rate or distance. For example, if a person is able to descend rapidly to sea level, this is preferred.

(2) Administer dexamethasone 8 mg IV, IM, or PO, followed by 4 mg every 6 hours (pediatric dose: 0.15 mg/kg/dose every 6 hours to a maximum dose of 4 mg).

(3) Administer oxygen 2 to 4 lpm by nasal cannula or simple (open type) face mask, to maintain SaO2 greater than 90%. Higher O2 concentrations and a non-rebreather mask may be required.

(4) If the patient is comatose, manage the airway and drain the bladder.

(5) Only after descent or if descent is not feasible, consider undertaking a 2- to 6-hour treatment in a portable hyperbaric bag (for example, portable hyperbaric chamber) inflated to 2 pounds per square inch (psi). Maintaining 2 psi inside the bag is equivalent to a descent of 1000 to 3000 m or (3281 to 9843 ft.), depending on the starting altitude. The hyperbaric bag can be used with or without supplemental oxygen. Most portable bags require constant pumping, so recruit additional persons for assistance.

d. HAPE.

(1) Immediately descend at least 500 to 1000 m (1640 to 3281 ft.). Because of augmented pulmonary hypertension and greater hypoxemia with exercise, exertion must be minimized.

(2) Administer oxygen 2 to 4 lpm by nasal cannula or simple (open type) face mask to maintain SaO2 greater than or equal to 90%. Higher O2 concentrations and a non-rebreather mask may be required.

(3) If supplemental oxygen is not available, consider giving nifedipine 20 mg sustained-release capsule every 8 hours or 30 mg sustained-release capsule every 12 hours to reduce pulmonary arterial pressure.

(4) Keep the patient warm because cold stress elevates pulmonary arterial pressure.

(5) Consider using pursed-lip breathing or continuous positive airway pressure delivered by face mask.

(6) Consider undertaking a 2- to 6-hour treatment in a portable hyperbaric bag (for example, portable hyperbaric chamber) inflated to 2 psi. Maintaining 2 psi inside the bag is equivalent to a descent of 1000 to 3000 m (3281 to 9843 ft.), depending on the starting altitude. The hyperbaric bag can be used with or without supplemental oxygen. Most portable bags require constant pumping, so recruit additional persons for assistance.

3. Record all episodes of altitude illness and treatment on a casualty's DD Form 1380.

4. Consult a medical officer whenever possible.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|
| 1 Differentiated the signs and symptoms of various types of high-altitude illness. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 2 | Managed high-altitude illnesses. | _____ | _____ |
| 3 | Recorded all episodes of altitude illness and treatment on a casualty's DD Form 1380. | _____ | _____ |
| 4 | Consulted a medical officer whenever possible. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
Joint Trauma System website.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Administer Tranexamic Acid

081-68W-0311

This individual task was presented earlier in the STP on page 3-142 as a readiness requirements task. The content requirements are the same.

**Subject Area 13: Trauma Management**

Manage a Chest Tube

081-000-3006

**WARNING:** Risks associated with chest tube placement are malpositioning or bleeding which may result in infection, recurrent pneumothorax, and tension pneumothorax.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have a casualty that requires a chest tube. Given a chest tube (16-36 French), vented chest seal, sterile gloves, one-way Heimlich valve, disposable scalpel, forceps, large hemostat, betadine solution, suture material (size 0 nylon), lidocaine 1% for injection, needle, syringe, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*), SF 600 (*Chronological Record of Medical Care*), or an electronic medical record. Some iterations will include assisting with the insertion, maintenance, and the removal of a chest drainage system.

**Standards:** Manage a chest tube system without causing further injury to the casualty in accordance with the *Joint Trauma System Clinical Practice Guideline ID:74*, and *Committee on Tactical Combat Casualty Care (CoTCCC)* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Explain the procedure to a conscious casualty.
2. Record baseline vital signs.
3. Prepare the casualty.
    a. Position the casualty on their back and raise the arm on the affected side above the casualty's head.
    b. Mark the insertion site at the mid-axillary line over the 4th or 5th intercostal space.

**NOTE:** The point of insertion in the chest most commonly occurs on the side (lateral thorax), at a line drawn from the armpit (anterior axillary line) to the side (lateral) of the nipple in males, or to the side about 2 inches or 5 centimeters (cm) above the sternoxiphoid junction (lower junction of the sternum, or chest bone) in females.

    c. Cleanse the site with antiseptic solution (betadine).
    d. Put on sterile gloves.
    e. Drape the area.
    f. Liberally infiltrate the area with 10 milliliters (ml) 2% lidocaine solution.
4. Make an incision.

**WARNING:** The intercostal artery, vein, and nerve run on the underside of the rib, injury to these vessels can result in a significant amount of bleeding.

a. Make a 2-3 cm transverse incision on the marked site.

**NOTE:** Incision should be 2 to 3 cm transverse incision over the selected site and extend it down to the intercostal muscles and 1 to 2 cm below the interspace through which the tube will be placed.

b. Use a finger to widen the tract confirming access to the pleural space.

**NOTE:** Identify the rib below the insertion site to find the pleural space above the rib.

c. Perforate the pleura by advancing a clamped instrument such as forceps.

**NOTE:** Hold the forceps with two finger curved side down 1/2 inch from the tip. The fingers will be used to prevent the forceps from going too far into the pleural space.

d. Perform a finger sweep to ensure access to the pleural space.

**NOTE:** You may not be able to palpate the lung parenchyma and detect lung inflation or deflation if casualty is receiving positive pressure ventilation.

e. Apply a vented chest seal to complete a finger thoracostomy.

**NOTE:** If only conducting a thoracostomy move to step 8.

5. Insert a chest tube.
   a. Perform a finger sweep to ensure access to the pleural space.
   b. Insert a chest tube.
      (1) Clamp the chest tube on the outside end.
      (2) Insert a chest tube with another clamp grasping the tip guided with your finger, through the track inferior-posteriorly.
      (3) Advance the tube as you withdraw your finger until all the tube's holes are inside the chest wall.
      (4) Remove forceps.
      (5) Assess for the release of air or blood.
      (6) Apply the seal over the incision site.
   c. Secure the tube.
      (1) Connect the end of the tube to a one-way drainage valve (such as Heimlich value), to suction, or to a water seal chest drainage system.
      (2) Suture the chest tube to the skin of the chest wall.
      (3) Apply an occlusive dressing containing the petroleum gauze to help seal the wound over the site.

6. Maintain a chest tube drainage system.
   a. Transition chest tube drainage system to a water seal drainage system (if available).
   b. Ensure patency of chest tube system is maintained.
   c. Check system for proper function.

**NOTE:** If connected to suction, note bubbling in water chamber. If not connected to suction, bubbling indicates air leak to system.

d. Monitor casualty continuously.
   (1) Monitor respiratory effort.
   (2) Monitor drainage.

**NOTE:** Document the color and amount.

   (3) Monitor dressing site.

**NOTE:** Document the drainage on dressing, color, amount, and change dressing as needed.

   (4) Monitor radiological imaging.
   (5) Monitor laboratory results.

e. Provide casualty care.
   (1) Provide oral care as needed to keep mucous membranes moist if casualty is receiving oxygen.
   (2) Encourage effective coughing and deep breathing techniques.
   (3) Provide respiratory treatments as needed.
   (4) Encourage casualty to request assistance with activities of daily living.

7. Discontinue chest drain.
   a. Verify discontinuation order by medical provider.
   b. Educate casualty on procedure.
   c. Gather necessary supplies.
   d. Position casualty.
   e. Clamp tubing and disconnect from water seal.
   f. Assist provider with chest tube removal.
   g. Assist with closure of insertion site.

8. Continue to monitor casualty.
   a. Monitor insertion site.

**NOTE:** Look for drainage, signs, and symptoms of infection.

   b. Check for difficulty breathing.
   c. Assess casualty's pain.
   d. Trend vital signs every 5-10 minutes.
   e. Notify provider of any unexpected outcomes.

9. Document procedures, interventions, and all findings on DD Form 1380 or EMR.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 1 | Explained the procedure to a conscious casualty. | _____ | _____ |
| 2 | Recorded baseline vital signs. | _____ | _____ |
| 3 | Prepared the casualty. | _____ | _____ |
| 4 | Made an incision. | _____ | _____ |
| 5 | Inserted a chest tube. | _____ | ____ |
| 6 | Maintained a chest tube drainage system. | _____ | _____ |
| 7 | Discontinued chest drain. | _____ | _____ |
| 8 | Continued to monitor casualty. | _____ | _____ |
| 9 | Documented procedures, interventions, and all findings on DD Form 1380 or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions). Committee on Tactical Combat Casualty Care (TCCC).*
Joint Trauma System website.
*Joint Trauma System Clinical Practice Guideline ID:74.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

Perform an Emergency Medical Technician Trauma Patient Assessment

081-68W-0053

**CAUTION:** All body fluids should be considered potentially infectious. Always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you encounter a patient who was subjected to a significant mechanism of injury (MOI), and you must perform an emergency medical technician (EMT) trauma patient assessment. You have a sphygmomanometer, stethoscope, airway adjuncts, oxygen, non-rebreathing mask, cervical collar, long spine board, scoop stretcher, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*) or electronic medical record.

**Standards:** Perform an EMT trauma patient assessment in accordance *Emergency Care* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Take BSI precautions.

2. Perform a scene size-up.
    a. Determine the safest route to access the casualty.
    b. Determine the MOI.
    c. Determine the number of casualties.
    d. Request additional help, if necessary.
    e. Consider the need for spinal stabilization.

**NOTE:** If the MOI is significant, direct another Soldier to provide manual, in-line stabilization of the cervical spine.

3. Perform a primary assessment.

**NOTE:** Life-threatening injuries should be managed as they are identified.

a. Form a general impression (global overview) of the casualty's condition and environment.

b. Assess the casualty's mental status using the alert, verbal, pain, unresponsive (AVPU) scale.

(1) A - Alert and oriented (eyes open spontaneously as you approach; casualty appears aware and responsive to the environment).

(2) V - Responsive to verbal stimuli (sound).

(3) P - Responsive to painful stimuli (touch, such as tapping the casualty on the shoulder or pinching the casualty's ear).

(4) U - Unresponsive (does not respond to any stimuli).

c. Determine the chief complaint or apparent life-threatening conditions. Apparent life-threats: airway, breathing, and circulation, or circulation (hemorrhaging), airway, and breathing.

d. Assess the airway.

(1) Perform appropriate maneuver to open and maintain the airway. (see task 081-COM-1004, Perform Airway Management)

(2) Insert an appropriate airway adjunct, if necessary (see tasks 081-000-0034, Place an Oropharyngeal Airway, and 081-000-0067, Insert a Nasopharyngeal Airway).

e. Assess breathing.

(1) Determine the rate, depth, and ease of respirations (breathing).

(2) Administer supplemental oxygen by non-rebreathing mask, if available (see tasks 081-000-0073, Administer Oxygen, and 081-000-0019, Perform Rescue Breathing).

f. Assess circulation.

(1) Skin color, condition, and temperature.

(2) Assess the pulse for rhythm and strength.

(a) Check the radial pulse in adults.

(b) Check the radial pulse and capillary refill in children under 6 years old.

**NOTE:** Capillary refill should only be checked in children less than 6 years old.

(c) Check the brachial pulse and capillary refill in infants.

(3) Check for significant hemorrhage (bleeding).

(4) Control bleeding (see task 081-000-0064, Control Bleeding).

(5) Treat for shock. (see task 081-000-0043, Initiate Treatment for Hypovolemic Shock)

g. Determine casualty priority and make a transport decision.

**NOTE:** High priority conditions that require immediate transport include a poor general impression, unresponsive, responsive but not following commands, difficulty breathing, shock, complicated childbirth, chest pain with systolic blood pressure less than 100 millimeter (mm) of Mercury (Hg), uncontrolled bleeding, and severe pain.

4. Obtain baseline vitals.

5. Obtain symptoms, allergies, medications, pertinent past medical history, last oral intake, and event(s) leading up to injury (SAMPLE), if possible.

6. Perform a secondary rapid trauma assessment if the MOI is significant.

**NOTE:** A significant MOI includes for an adult fall greater than 20 feet (one story = 10 feet) children age less than 15 years 10 feet or two to three times child's height. High risk auto crash Intrusions: greater than 12 inches to the occupant site or greater than 18 inches to any site. Ejections (partial or complete) from the automobile. Death in same passenger compartment vehicle with high risk of injury auto versus pedestrian or bicyclist thrown, run over, or with significant (greater than 20 miles per hour [mph] impact) or motorcycle crash greater than 20 mph.

a. Head.

(1) Inspect for deformities, contusions, abrasions, punctures or penetration, burns, tenderness, lacerations, and swelling (DCAP-BTLS).

(2) Palpate for tenderness, instability, or crepitus (TIC).

b. Neck.

(1) Inspect for DCAP-BTLS.

(2) Palpate cervical spine (C-spine) for step-offs.

(3) Inspect for jugular vein distention (JVD).

(4) Inspect to ensure the trachea is midline (without deviation).

(5) Apply a cervical collar, if necessary.

c. Chest.

(1) Inspect for DCAP-BTLS.

(2) Palpate for TIC.

(3) Inspect for the presence of paradoxical motion.

(4) Auscultate (listen) for breath sounds (present, diminished, absent, equal).

d. Abdomen.

(1) Inspect for DCAP-BTLS.

(2) Palpate for tenderness, rigidity, and distension and pulsating masses (TRDP).

**CAUTION:** Do not “log roll” casualties suspected of having a pelvic fracture.

e. Pelvis.

**NOTE:** If a conscious casualty complains of pain or if an unconscious casualty responds as if in pain at any time during the assessment, do not continue the exam. Treat for pelvic fracture.

(1) Inspect for DCAP-BTLS.

(2) Gently compress (downward or inward) to detect TIC.

(3) Inspect for priapism (male casualties only), wetness which may be caused by blood or loss of bladder control.

f. Extremities.

(1) Inspect for DCAP-BTLS.

(2) Palpate for TIC.

(3) Assess the hands and feet for circulation, sensation, and motor function (CSM).

g. Posterior.

**NOTE:** The casualty must be “log rolled” to do this portion of the assessment. If necessary, the casualty should be placed on a long spine board after assessment. The pelvic binder should be positioned on the long spine board before casualty placement. If the casualty has a suspected pelvic fracture or bilateral femoral fractures, lift the casualty using a scoop stretcher, assess the posterior and place the casualty on the long spine board.

(1) Inspect for DCAP-BTLS.

**NOTE:** If penetrating wounds were noted during the anterior assessment, check for posterior exit wounds while the casualty is log-rolled or lifted with the scoop stretcher.

(2) Inspect for wetness which can be caused by loss of bladder control and rectal bleeding.

7. Perform a secondary trauma assessment if there is no significant MOI.
   a. Based on chief complaint.
   b. Focus on the areas the casualty tells you are painful or that you suspect may be painful due to the MOI.

8. Obtain a baseline set of vital signs (see tasks 081-000-0008, Assess a Patient's Respirations, and 081-000-0011, Measure a Patient's Temperature).

9. Obtain a SAMPLE history.
   a. Signs and symptoms.
      (1) Ask the casualty what is wrong.
      (2) Observe the casualty.
   b. Allergies.
      (1) Ask the casualty if there are any allergies to medications, foods, or environment.
      (2) Look for a medical identification tag.
   c. Medications.
      (1) Ask the casualty if they are taking any medications (prescription, over the counter, or illegal.)
      (2) Search for an identification tag with medications on it or medications in the area.
   d. Pertinent past history.
      (1) Ask the casualty if there are any medical problems (past and present).
      (2) Ask the casualty if they have been feeling ill.
      (3) Ask the casualty about recent surgery or injuries.
      (4) Ask the casualty if they are currently under the care of a medical officer and, if so, what's their name and what type of care is being provided.
   e. Last oral intake.
      (1) Ask the casualty when their last meal or drink was.
      (2) Ask the casualty what they ate or drank.
   f. Events leading to the injury or illness.
      (1) Ask about the sequence of events that led up to the current event.
      (2) If the casualty is unable to answer, search the scene for anything that may indicate what occurred.

10. Perform a detailed physical exam en route to hospital if time permits.
    a. Reassess the scalp and cranium.
       (1) Inspect for DCAP-BTLS.
       (2) Palpate for TIC.
    b. Reassess the face for DCAP-BTLS.
    c. Reassess the eyes.

(1) Inspect for DCAP-BTLS.
(2) Inspect for discoloration.
(3) Inspect for unequal pupils.
(4) Inspect for foreign bodies.
(5) Inspect for blood in anterior chamber.

d. Reassess the nose.
(1) Inspect for DCAP-BTLS.
(2) Inspect for drainage of blood or clear fluid.

e. Reassess the mouth.
(1) Inspect for DCAP-BTLS.
(2) Inspect for loose or broken teeth.
(3) Inspect for objects that could cause obstruction.
(4) Inspect for swelling or laceration of the tongue.
(5) Inspect for unusual breath odor (alcohol and acetone).

f. Reassess the ears.
(1) Inspect for DCAP-BTLS.
(2) Inspect for drainage.
(a) Blood or serous fluids.
(b) Clear fluids.

g. Reassess the neck.
(1) Inspect for DCAP-BTLS.
(2) Inspect for JVD.
(3) Inspect to ensure the trachea is still midline (without deviation).

h. Reassess the chest.
(1) Inspect for DCAP-BTLS.
(2) Palpate for TIC.
(3) Auscultate breath sounds.
(4) Assess for flail chest.

i. Reassess the abdomen.
(1) Inspect for DCAP-BTLS.
(2) Palpate for TRDP.

j. Reassess the pelvis.
(1) Inspect for DCAP-BTLS.
(2) Inspect for TIC.

k. Reassess the extremities.
(1) Inspect for DCAP-BTLS.
(2) Palpate for TIC.
(3) Check the CSM.

l. Reassess the posterior.

**NOTE:** If the casualty is secured to a long spine board, do not remove from the board. Reassess the flanks and as much of the spine as you can without moving the casualty unnecessarily.

(1) Inspect for DCAP-BTLS.

(2) Inspect for wetness which can be caused by loss of bladder control or rectal bleeding.

m. Manage secondary injuries and wounds appropriately.

11. Perform reassessment.
    a. Repeat the primary assessment.
    b. Reassess and record vital signs.
    c. Repeat pertinent parts of the secondary assessment.
    d. Check interventions.

12. Document all assessment findings and care provided on the DD Form 1380 (see task 081-000-0013, Initiate a Tactical Combat Casualty Card).

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Took BSI precautions. | _____ | _____ |
| 2 | Performed a scene size-up. | _____ | _____ |
| 3 | Performed a primary assessment. | _____ | _____ |
| 4 | Obtained baseline vitals. | _____ | _____ |
| 5 | Obtained symptoms, allergies, medications, pertinent past medical history, last oral intake, and event(s) leading up to injury (SAMPLE), if possible. | _____ | _____ |
| 6 | Performed a secondary rapid trauma assessment, if the MOI was significant. | _____ | _____ |
| 7 | Performed a secondary trauma assessment, if there was no significant MOI. | _____ | _____ |
| 8 | Obtained a baseline set of vital signs (see tasks 081-68W-0010, Assess a Patient's Respirations, and 081-000-0011, Measure a Patient's Temperature). | _____ | _____ |
| 9 | Obtained a SAMPLE history. | _____ | _____ |
| 10 | Performed a detailed physical exam en route to hospital, if time permitted. | _____ | _____ |
| 11 | Performed reassessment. | _____ | _____ |
| 12 | Documented all assessment findings and care provided on the DD Form 1380 (see task 081-COM-0013). | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*. *Emergency Care.*

**Related**
None

Perform Needle Decompression of the Chest

081-68W-0075

This individual task was presented earlier in the STP on page 3-154 as a readiness requirements task. The content requirements are the same.

Treat a Casualty with an Inguinal Wound

081-68W-0081

This individual task was presented earlier in the STP on page 3-157 as a readiness requirements task. The content requirements are the same.

Treat an Open Abdominal Wound

081-000-0127

**Conditions:** In an operational environment you are required to treat a casualty with an open abdominal wound. You are providing with field dressings sterile abdominal dressings, cravats, scissors, gauze, saline solution, intravenous (IV) equipment, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*) or electronic medical record. This task should not be trained in mission-oriented protective posture 4. This task should be trained under improvised explosive device threat conditions.

**Standards:** Treat an open abdominal wound, with 100% accuracy and in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines*. by Joint Trauma System Committee on Tactical Combat Casualty Care (CoTCCC), without error, using the task GO/NO GO checklist.

**DANGER:** None.

**WARNING:** Ensure all other more serious injuries have been assessed and treated prior to treating an open abdominal wound.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**NOTE:** This task should be performed under all environmental conditions. Four or more mission variables (mission, enemy, terrain & weather, troops & support available, time available, civil considerations [information]) should be present. Some iterations of this task should be performed with degraded mission command networks, degraded conditions in the electromagnetic spectrum, or with degraded, denied, and disrupted space operations environment.

**Performance Steps:**

1. Take BSI precautions.
2. Position the casualty.
    a. Place the casualty on their back.
    b. Flex the casualty's knees.
    c. Turn the casualty's head to the side.
    d. Keep the airway clear if vomiting occurs.

**CAUTION:** Do not attempt to replace protruding internal organs or remove any protruding foreign objects.

3. Expose the wound.
4. Inspect for distention, contusions, penetration, evisceration, and obvious bleeding.
5. Apply a sterile abdominal dressing.

**NOTE:** Protruding abdominal organs should be kept moist to prevent the tissue from drying out. A moist, sterile dressing should be applied if available.

6. Open the casualty's field dressing and place the white sterile side of the dressing over the wound and any protruding organs.

7. Secure the dressing.
   a. Hold the dressing with one hand to keep it from slipping.
   b. Grasp one tail and slide it under the casualty.
   c. Reach down on the other side of the casualty, grasp the tail under the casualty, and pull.
   d. Bring the tail up the casualty's side, over the dressing, and to the other side.
   e. Wrap the other tail in the opposite direction (down the side, under the back, and up the side).
   f. Tie the tails in a nonslip knot on the casualty's side away from the wound.

**CAUTION:** Do not apply pressure on the wound or expose internal parts.

8. Reinforce dressing.

**NOTE:** If two dressings are needed to cover a large wound, repeat steps 7a through 7e. Ensure that the ties of additional dressings are not tied over each other.

   a. Cover dressing with cravats or other clean material.
   b. Tie the tails of the reinforcement bandages on the opposite side of the field dressing knot.

9. Prepare the casualty for evacuation.

10. Document treatment on a DD Form 1380.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Took BSI precautions. | _____ | _____ |
| 2 | Positioned the casualty. | _____ | _____ |
| 3 | Exposed the wound. | _____ | _____ |
| 4 | Inspected for distention, contusions, penetration, evisceration, and obvious bleeding. | _____ | _____ |
| 5 | Applied a sterile abdominal dressing. | _____ | _____ |
| 6 | Opened the casualty's field dressing and placed the white sterile side of the dressing over the wound and any protruding organs. | _____ | _____ |
| 7 | Secured the dressing. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 8 | Reinforced dressing. | _____ | _____ |
| 9 | Prepared the casualty for evacuation. | _____ | _____ |
| 10 | Documented treatment on a DD Form 1380. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
Joint Trauma System website.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Apply a Junctional Tourniquet

081-68W-0092

This individual task was presented earlier in the STP on page 3-163 as a readiness requirements task. The content requirements are the same.

Apply a Traction Splint

081-68W-0141

**CAUTION:** All body fluids should be considered potentially infectious. Always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment and are required to apply a traction splint to a patient with a suspected femur fracture. You will be provided a Committee on Tactical Combat Casualty Care (CoTCCC) recommended traction splint, gloves, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*).

**Standards:** Apply a traction splint in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines* and the *Committee on Tactical Combat Casualty Care (CoTCCC)* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Assess the injury.
    a. Expose the wound.
    b. Check for pulse on the injured leg (dorsalis pedis).
2. Remove splint from bag.
3. Assemble the split by connecting unlinked sections.
4. Size the splint.
    a. Place unit alongside the uninjured leg.
    b. Ischial cap align with the top of pelvic crest.
    c. Make sure ankle hitch is at least 6 inches below the patient's ankle.
5. Adjust the length if the split is too short or too long. Remove the ischial cap and adjust the length by folding back the sections and reattaching the ischial cap.
6. Align traction split and straps next to patient.

**NOTE:** Do not strap over the injury or on the knee.

    a. Move split alongside the injured leg.
    b. Align two straps above the knee and two straps below the knee.
    c. Unclip one end of the strap from the ischial cap and place the strap under the patient's upper inner thigh reattach the appropriate end to the ischial cap ensure the buckle is on top of the patient's thigh so adjustments can be made and then tighten the buckle strap.

7. Attach the ankle hitch. Unwrap the hook-and-loop fastener strap, align the hitch with the patient's leg. Gently lift the patent's foot to allow the hitch to slide under the patient's ankle. The thicker strap should be positioned to be wrapped around the patient's ankle directly above the foot. The second strap should run beneath the patient's foot and align equally on

opposite sides of the patient's ankle. Tighten the strap to minimize the distance between itself and the bottom of the patient's foot.

8. Apply minimal traction.

**NOTE:** While applying gentle traction, the assistant may lift the casualty's leg far enough to fit the splint into place.

a. Pull the line to apply a minimum amount of traction so that the split is resting in its appropriate position. Pull the loose end of the line exiting the purchase block and line mechanism below the patient's foot.

b. Lift the line up into the V jam cleat to achieve tension and the V jam cleat will hold the line.

9. Secure and apply traction.

**NOTE:** You are trying to apply enough tension to have the injured leg the same length as the uninjured leg.

a. The first strap is applied to the upper inner thigh ideally above the fracture. The second strap is wrapped above the knee below the fracture. The third strap is applied below the knee. The fourth strap is applied directly above the ankle hitch.

b. Apply traction as required by readjusting the tension until the patient's comfort is achieved.

c. Lift the line and relock into the V jam cleat.

10. Final adjustment. Tuck excess line under the leg strap. Check each strap.

11. Document the procedure on a DD Form 1380.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Assessed the injury. | _____ | _____ |
| 2 | Removed splint from bag. | _____ | _____ |
| 3 | Assembled the splint by connecting unlinked sections. | _____ | _____ |
| 4 | Sized the splint. | _____ | _____ |
| 5 | Adjusted the length if the split was too short or too long. Removed the ischial cap and adjusted the length by folding back the sections and reattaching the ischial cap. | _____ | _____ |
| 6 | Aligned traction split and straps next to patient. | _____ | _____ |
| 7 | Attached ankle hitch. Unwrapped the hook-and-loop fastener strap, aligned the hitch with the patient's leg. Gently lifted the patent's foot to allow the hitch to slide under the patient's ankle. The thicker strap should have been positioned to be wrapped around the patient's ankle directly above the foot. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| | The second strap should have ran beneath the patient's foot and aligned equally on opposite sides of the patient's ankle. Tightened the strap to minimize the distance between itself and the bottom of the patient's foot. | | |
| 8 | Applied minimal traction. | _____ | _____ |
| 9 | Secured and applied traction. | _____ | _____ |
| 10 | Finalized adjustment. Tucked excess line under the leg strap. Checked each strap. | _____ | _____ |
| 11 | Documented the procedure on a DD Form 1380. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Committee on Tactical Combat Casualty Care (CoTCCC).*
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
Deployed Medicine website.
Joint Trauma System website.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Manage Shock

081-68W-0231

This individual task was presented earlier in the STP on page 3-168 as a readiness requirements task. The content requirements are the same.

Apply a Sling and Swath

081-68W-0265

**WARNING:** Treat any radial or ulnar fractures before applying a sling and swath.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment and encounter a patient whose injuries require a sling and swath. All life-threating injuries have been treated. You are provided with a cravat bandages or elastic bandage, other gauze material, safety pin, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*).

**Standards:** Apply a sling and swath in accordance with *Trauma System Clinical Practice Guideline (JTS CPG) Orthopedic Trauma: Extremity Fractures (CPG ID:56),* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**NOTE:** A sling is a triangular bandage used to support the shoulder and arm. Once the casualty's arm is placed in a sling, a swath can be used to hold the arm against the side of the chest.

**Performance Steps:**

1. Check patient's distal pulse, motor, and sensation (PMS) functions of the extremity.
2. Prepare the sling by folding cloth into a triangle.

**NOTE:** A triangular bandage makes an ideal arm sling.

3. Direct the patient to hold injured arm across their chest.

**NOTE:** If casualty cannot hold their arm, have someone assist them until you tie the sling.

4. Place the sling between the patient's injured arm and chest.
5. Place one point of the triangle beyond the elbow on the injured side.
    a. Take the bottom point and bring it up over the casualty's arm.
    b. Continue to take it over the top of the injured shoulder.
    c. If appropriate, draw up the ends of the sling so that the casualty's hand is about 4 inches above the elbow.

**CAUTION:** If a spinal injury is suspected, do not tie the sling around the casualty's neck, instead, pin the ends to the casualty's clothing securely.

6. Connect the two ends of the sling together.
    a. Make sure that the knot does not press against the back of the casualty's neck.
    b. Pad with bulky dressings.
    c. Confirm the casualty's fingertips are left exposed.

7. Check distal PMS.
   a. If the pulse has been lost, take off the sling and repeat the procedure.
   b. If procedure was repeated, recheck PMS.

8. Construct a pocket for the casualty's elbow.
   a. Take hold of the point of material at the elbow and fold it forward, pinning it to the front of the sling.
   b. If you do not have a pin, twist the excess material, and tie a knot in the point.

9. Construct a swath from a second piece of material by tying it around the chest and the injured arm, over the sling.

**NOTE:** Do not place it over the casualty's arm on the uninjured side.

10. Check for distal PMS functions of the extremity.

11. Monitor casualty until evacuation.

12. Record procedure on DD Form 1380 or electronic medical record.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Checked patient's distal pulse, motor and sensation (PMS) functions of the extremity. | _____ | _____ |
| 2 | Prepared the sling by folding cloth into a triangle. | _____ | _____ |
| 3 | Directed the patient to hold injured arm across their chest. | _____ | _____ |
| 4 | Placed the sling between the patient's injured arm and chest. | _____ | _____ |
| 5 | Placed one point of the triangle beyond the elbow on the injured side. | _____ | _____ |
| 6 | Connected the two ends of the sling together. | _____ | _____ |
| 7 | Checked distal PMS. | _____ | _____ |
| 8 | Constructed a pocket for the casualty's elbow. | _____ | _____ |
| 9 | Constructed a swath from a second piece of material by tying it around the chest and the injured arm, over the sling. | _____ | _____ |
| 10 | Checked for distal PMS functions of the extremity. | _____ | _____ |
| 11 | Monitored casualty until evacuation. | _____ | _____ |
| 12 | Recorded procedure on DD Form 1380 or electronic medical record. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all

performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
Joint Trauma System website.
*Trauma System Clinical Practice Guideline (JTS CPG) Orthopedic Trauma: Extremity Fractures (CPG ID:56).*

**Related**
None

## Treat a Seizing Patient

081-000-0005

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you have a patient suffering from a seizure. You may have available padding materials, oxygen, suction equipment, non-rebreather, or bag valve mask, intravenous (IV) start kit, diazepam, lorazepam, or midazolam, a pen, and SF 600 (*Chronological Record of Medical Care*) or electronic medical record (EMR). You have performed a patient care handwash and put on gloves.

**Standards:** Treat a seizing patient in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Confirm patient is having a seizure.
    a. Absence seizure (formerly called petit mal seizure).
    b. Tonic colonic (formerly called grand mal seizure).
    c. Status epilepticus.

**CAUTION:** Never place anything in the mouth of a seizing patient.

2. Obtain signs and symptoms, allergies, medications, pertinent past medical history, last oral intake, and events (SAMPLE) history from bystanders or family members.

**NOTE:** If the seizure is witnessed, be sure to ask if they saw the patient fall, how they landed, how the patient was moving during the seizure and how long the seizure lasted.

    a. Determine the duration of the seizure.
    b. Determine the patient's level of consciousness (being able to communicate).
    c. Remember to look for physical signs such as muscle rigidity, muscle involvement, incontinence, and eye movement.
    d. Determine if the patient has past history with seizures.
    e. Remember to interview any witnesses.
    f. Check the patient for an allergy band.
    g. Review the patient's medical records, if available.

3. Maintain the airway of a patient exhibiting tonic-clonic movement.

**NOTE:** A patient who has just had a generalized seizure will sometimes drool and will usually be very drowsy for a little while, so you may need to suction the airway.

    a. Once the seizure has subsided, open the airway using the chin-lift or jaw-thrust method (if there is a suspected spinal injury).

b. Check for obstructions.
c. Suction as needed.
d. Maintain the patient's airway by placing an airway adjunct:
(1) Insert a nasopharyngeal airway in a conscious or semiconscious patient who has a gag reflex.
(2) Insert an oropharyngeal airway in an unconscious patient with no gag reflex.

4. Place the patient on their side if possible.
a. Observe the patient to prevent aspiration and suffocation.

**CAUTION:** Do not elevate the patient's head and do not restrain the patient's limbs during seizures.

b. Place patient on high-flow oxygen at 15 liter(l) per minute via non-rebreathing mask if available.

5. Prevent injury to tissue and bones by padding or removing objects on which the patient may injure themselves.

6. Administer medication to stop prolonged seizure activity.
a. Midazolam 5 milligram (mg) intravenous (IV) or intraosseous (IO) or intramuscular (IM) every 5 minutes until seizure stops.
b. Diazepam 5 mg IV every 5 minutes until seizure stops.
c. Lorazepam 4 mg IV every 5 minutes until seizure stops.

7. Record the seizure activity on SF 600 or EMR.
a. Duration of seizure.
b. Presence of cyanosis, breathing difficulty, or apnea.
c. Level of consciousness before, during and after the seizure.
d. Whether preceded by an aura (ask patient).
e. Muscles involved.
f. Type of motor activity.
g. Incontinence.
h. Eye movement.
i. Previous history of seizures, head trauma or drug or alcohol abuse.

8. Evacuate the patient on their side in the recovery position.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|
| 1 Confirmed patient was having a seizure. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 2 | Obtained signs and symptoms, allergies, medications, pertinent past medical history, last oral intake, and events (SAMPLE) history from bystanders or family members. | _____ | _____ |
| 3 | Maintained the airway of a patient exhibiting tonic-clonic movement. | _____ | _____ |
| 4 | Placed the patient on their side if possible. | _____ | _____ |
| 5 | Prevented injury to tissue and bones by padding or removing objects on which the patient might injured themselves. | _____ | _____ |
| 6 | Administered medication to stop prolonged seizure activity. | _____ | _____ |
| 7 | Recorded the seizure activity on SF 600 or EMR. | _____ | _____ |
| 8 | Evacuated the patient on their side in the recovery position. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
Deployed Medicine website.
SF 600. *Chronological Record of Medical Care.*
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Manage a Mild Traumatic Brain Injury

081-000-0023

This individual task was presented earlier in the STP on page 3-171 as a readiness requirements task. The content requirements are the same.

Treat a Thoracic Injury

081-000-0037

This individual task was presented earlier in the STP on page 3-144 as a readiness requirements task. The content requirements are the same.

Treat a Head Injury

081-000-0040

This individual task was presented earlier in the STP on page 3-176 as a readiness requirements task. The content requirements are the same.

## Treat a Casualty with Burns

081-000-0044

**DANGER:** Do not directly touch a casualty receiving a shock. To do so will conduct the current to you. This could cause death to the person rendering aid, as well.

**WARNING:** Electrical shock may cause the casualty to go into cardiac arrhythmia or arrest. Initiate cardiopulmonary resuscitation (CPR) as appropriate. Casualties of lightning strikes may require prolonged CPR and extended respiratory support. A chemical will burn as long as it is in contact with the skin. Do not use a hard blast of water. Extreme water pressure can add mechanical injury to the skin.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection. Do not remove clothing that is stuck to the burned area. If the clothing and skin are still hot, irrigate with copious amounts of room-temperature water or cover with a wet dressing, if available. The swelling of burns on extremities can cause a tourniquet-like effect, and the swelling of a burned throat can impair breathing.

**Conditions:** In an operational environment, you are required to treat a burn casualty. You have treated all other immediate life threats and are provided with a surgical airway kit, dry sterile gauze, heat reflective shield or blizzard survival blanket, intravenous (IV) or intraosseous (IO) fluids and administration kit, analgesics, a pen, and a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*) or electronic medical record (EMR).

**Standards:** Treat a casualty with burns in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines* while adhering to all warnings and cautions, without error or causing further harm to the patient, using the GO/NO GO checklist.

**Performance Steps:**

1. Identify the cause of the burn.
    a. Assess the scene.
    b. Question the casualty or bystanders.
    c. Determine if the casualty has been exposed to smoke, steam, or combustible products.
    d. Determine if the cause was open flame, hot liquid, chemicals, or electricity.
    e. Determine whether the casualty was struck by lightning.

**NOTE:** If the burn was caused by an explosion or lightning, the casualty may also have been thrown some distance from the original spot of the incident. They may, therefore, have associated internal injuries, fractures, or spinal injuries.

2. Stop the burning process.
    a. Thermal burns.
        (1) Have the casualty STOP, DROP, and ROLL.
            (a) Do not permit the casualty to run, as this will fan the flames.
            (b) Do not permit the casualty to stand, as the flames may be inhaled, or the hair ignited.

(c) Place the casualty on the ground or floor and roll the casualty in a blanket or in dirt, or splash with water.

(2) Remove all smoldering clothing and articles that retain heat, if possible.

**CAUTION:** Do not remove clothing that is stuck to the burned area. If the clothing and skin are still hot, irrigate with copious amounts of room-temperature water or cover with a wet dressing, if available.

(3) Cut away clothing to expose the burned area.

b. Electrical burns.

**DANGER:** Do not directly touch a casualty receiving a shock. To do so will conduct the current to you. This could cause death to the person rendering aid, as well.

(1) Turn off the current, if possible.

**WARNING:** Electrical shock may cause the casualty to go into cardiac arrhythmia or arrest. Initiate CPR as appropriate. Casualties of lightning strikes may require prolonged CPR and extended respiratory support.

(2) If necessary and possible, remove the electrical source from the casualty.

**WARNING:** A chemical will burn as long as it is in contact with the skin.

c. Chemical burns.

(1) Flush the area of contact immediately with water. When flushing, be careful not to let the runoff contaminate other areas of the body. Do not delay flushing to remove the casualty's clothing first.

**NOTE:** If a solid chemical, such as lime, has been spilled on the casualty, brush it off before flushing. A dry chemical is activated by contact with water and will cause more damage to the skin.

**WARNING:** Do not use a hard blast of water. Extreme water pressure can add mechanical injury to the skin.

(2) Flush with cool water for 10 to 15 minutes while removing contaminated clothing or other articles.

**NOTE:** Flush longer for alkali burns because they penetrate deeper and cause more severe injury. Many chemicals have a delayed or prolonged reaction. They will continue to cause injury even though the casualty no longer feels pain.

d. White phosphorus (WP) burns.

**NOTE:** WP will stick to the skin and continue to burn until it is deprived of air. WP burns are usually multiple and deep, usually producing second- and third-degree burns.

(1) Deprive the WP of oxygen.

(a) Splash with a nonpetroleum liquid (such as water, mud, or urine).

(b) Submerge the entire area.

(c) Cover the affected area with a moistened cloth, if available or mud.

(2) Remove the WP particles from the skin by brushing with a wet cloth or using forceps, stick, or knife.

**WARNING:** 30 to 40 minutes may elapse before edema obstructs the airway and respiratory distress is noted. Always suspect an inhalation injury with a closed-space fire.

3. Maintain an open airway.
   a. Check for signs and symptoms of inhalation injury.
      (1) Facial burns.
      (2) Singed eyebrows, eyelashes, or nasal hairs.
      (3) Carbon deposits or redness in the mouth or oropharynx.
      (4) Sooty carbon deposits in the sputum.
      (5) Hoarseness, noisy inhalation, cough, or dyspnea.
   b. Check for signs and symptoms of carbon monoxide poisoning.
      (1) Dizziness, nausea, or headache.
      (2) Cherry-red colored skin and mucous membranes.
      (3) Tachycardia or tachypnea.
      (4) Respiratory distress or arrest.
      (5) Change in mental status, especially increased confusion, or lack of coordination.
   c. Administer humidified oxygen at a high flow rate.

4. Calculate the percent of body surface area (BSA) burned.
   a. Cut the casualty's clothing away from the burned areas.
   b. Determine the percentage of BSA burned using the rule of nines.

5. Identify the degree of the burn.
   a. First degree.
      (1) Superficial skin only.
      (2) Red and painful, like a sunburn.
   b. Second degree.
      (1) Partial thickness of the skin.
      (2) Penetrates the skin deeper than first degree.
      (3) Blisters and pain.
      (4) Some subcutaneous edema.
   c. Third degree.
      (1) Damage to or the destruction of full thickness of skin.
      (2) Involves underlying muscles, bones, or other structures.
      (3) The skin may look leathery, dry, and discolored (charred, brown, or white).
      (4) Nerve ending destruction causes a lack of pain.
      (5) Massive fluid loss.

(6) Clotted blood vessels may be visible under the burned skin.

**CAUTION:** Check for entry and exit burns when treating electrical burns and lightning strikes. The amount of injured tissue in an electrical burn is usually far more extensive than the appearance of the wound would indicate. Although the burn wounds may be small, severe damage may occur to deeper tissues. (High voltage can destroy skin and muscles to such an extent that amputation may eventually be necessary.)

(7) Subcutaneous fat may be visible.

6. Treat casualties for shock who have second- or third-degree burns of 20% BSA or more.
   a. Initiate treatment for hypovolemic shock.
   b. Keep the casualty flat.
   c. Initiate an IV infusion.
      (1) Use Lactated Ringer's, if available. Normal saline is the second fluid of choice.
      (2) Casualty may have shock secondary to other injuries.
      (3) Use an 18-gauge catheter needle.
      (4) Initiate the IVs in an unburned area, if possible.
      (5) Use large peripheral veins.

**NOTE:** The presence of overlying burned skin should not deter the use of an accessible vein. The upper extremities are preferable to lower extremities.

   d. Infuse fluids for a casualty based on rule of tens.

**NOTE:** The objective is to determine an appropriate rate or amount of fluids to prevent hypovolemia after burn injury. Initiate fluid resuscitation as soon as IV or IO access is established. Total body surface area >20% may require acute fluid resuscitation in prehospital setting.

(1) Estimate the total body surface area (TBSA) burned to the nearest 10% (using the rule of nines or rule of palm).

(2) Percentage TBSA (to the nearest 10%) x 10 milliliters per hour (ml/hr) for adults weighing 88-176 pounds.

(a) Example: 80-kilogram (kg) male has burned approximately 30% of their body.

(b) 30 (TBSA%) x 10 ml/hr = 300 ml/hr.

(3) For every 25 pounds above 175, increase the initial rate by 100 ml/hr. Add 100 ml to IV fluid rate for each 10 kg > 80 kg.

(a) Example: A 90-kg male has burned approximately 50% of their TBSA.

(b) 50 (TBSA%) x 10 ml/hr = 500 ml/hr + 100 ml/hr = 600 ml/hr.

(4) Assess the circulatory blood volume.

**NOTE:** Urine output is a reliable guide to assess circulating blood volume.

(a) Measure the casualty's urine output in cubic centimeters (cc) per hour.

(b) Adjust the IV fluid flow to maintain 30 to 50 cc of urine output per hour.

(5) Pediatrics: 3 ml x TBSA x body weight (kg) gives volume for initial 24 hours. Monitor urine output with goal of 0.5 to 1 ml/kg/hr in children.

e. Parkland formula.

(1) Give half of total volume over 1st 8 hours from time of burn.

(2) Adult: 70 kg patient with 50% TBSA 2 ml Lactated Ringer's (LR) x 70 kg x 50% TBSA = 7,000 ml LR in 1st 24 hours. 3,500 ml (half of 7,000) is given over 1st 7 hours from time of burn. 3,500 ml/8 hrs = 437 ml/hr over 1st 8 hrs.

7. Perform either an emergency medical technician trauma assessment or a combat casualty assessment depending on the situation.
   a. Measure and record the casualty's vital signs.
   b. Assess the casualty for associated injuries.
   c. Check the distal circulation by checking pulses in all extremities.

**CAUTION:** The swelling of burns on extremities can cause a tourniquet-like effect, and the swelling of a burned throat can impair breathing.

8. Remove potentially constricting items such as rings and bracelets.

9. Dress the burns.
   a. Apply a dry sterile dressing to the burns.
   b. Cover extensive burns with a sterile sheet, if available, or clean linen.

10. Record the treatment given on the DD Form 1380 or EMR.

11. Evacuate the casualty.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Identified the cause of the burn. | _____ | _____ |
| 2 | Stopped the burning process. | _____ | _____ |
| 3 | Maintained an open airway. | _____ | _____ |
| 4 | Calculated the percent of body surface area (BSA) burned. | _____ | _____ |
| 5 | Identified the degree of the burn. | _____ | _____ |
| 6 | Treated casualties for shock who had second- or third-degree burns of 20% BSA or more. | _____ | _____ |
| 7 | Performed either an emergency medical technician trauma assessment or a combat casualty assessment depending on the situation. | _____ | _____ |
| 8 | Removed potentially constricting items such as rings and bracelets. | _____ | _____ |
| 9 | Dressed the burns. | _____ | _____ |

| Performance Measures: | GO | NO GO |
|---|---|---|
| 10 Recorded the treatment given on the DD 1380 or EMR. | _____ | _____ |
| 11 Evacuated the casualty. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
Deployed Medicine website.
*Tactical Combat Casualty Care (TCCC) Guidelines*.

**Related**
None

## Replace an Extremity Tourniquet

081-000-0048

**CAUTION:** All body fluids should be considered potentially infectious. Always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You have a patient with a hasty tourniquet applied during the care under fire (CUF) phase. The tactical situation allows you to replace it with a deliberate tourniquet; you have a *Committee for Tactical Combat Casualty Care (CoTCCC)* recommended tourniquet, marker, pen, tape, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*).

**Standards:** Replace an extremity tourniquet to control bleeding in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines* without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Expose the wound.
2. Place tourniquet 2-3 inches above the wound on the injured extremity.
3. Pull the free end of the self-adhering band through the buckle and route through the friction adapter buckle (unless arm wound).

**NOTE:** Attach buckle into the clip if using tourniquet with this feature.

4. Pull the self-adhering band tight around the extremity and fasten it back on itself as tightly as possible.
5. Twist the windlass until the bleeding stops.
6. Lock the windlass in place within the windlass clip.
7. Secure the windlass with the windlass strap.
8. Assess for absence of a distal pulse.
9. Place a “T” and the time of the application on the casualty with a marker.
10. Secure the tourniquet in place with tape.
11. Remove the proximal tourniquet.
12. Record the treatment on a DD Form 1380 or electronic medical record.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 1 | Exposed the wound. | _____ | _____ |
| 2 | Placed tourniquet 2-3 inches above the wound on the injured extremity. | _____ | _____ |
| 3 | Pulled the free end of the self-adhering band through the buckle and routed through the friction adapter buckle (unless arm wound). | _____ | _____ |
| 4 | Pulled the self-adhering band tight around the extremity and fastened it back on itself as tightly as possible. | _____ | _____ |
| 5 | Twisted the windlass until the bleeding stopped. | _____ | _____ |
| 6 | Locked the windlass in place within the windlass clip. | _____ | _____ |
| 7 | Secured the windlass with the windlass strap. | _____ | _____ |
| 8 | Assessed for absence of a distal pulse. | _____ | _____ |
| 9 | Placed a “T” and the time of application on the casualty with a marker. | _____ | _____ |
| 10 | Secured the tourniquet in place with tape. | _____ | _____ |
| 11 | Removed the proximal tourniquet. | _____ | _____ |
| 12 | Recorded the treatment on a DD Form 1380 or electronic medical record. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier’s military occupational specialty or assigned position and available equipment.

**References:**

**Required**
*Committee for Tactical Combat Casualty Care (CoTCCC).*
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
Deployed Medicine website.
Joint Trauma System website.
*Tactical Combat Casualty Care (TCCC) Guidelines*.

**Related**
None

Perform a Combat Casualty Assessment

081-000-0049

This individual task was presented earlier in the STP on page 3-179 as a readiness requirements task. The content requirements are the same.

Manage a Minor Laceration

081-000-0051

**WARNING:** The laceration does not involve the face, hands, feet, or genitalia. Injuries to these areas should be managed by medical provider or, if necessary, by a specialist.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have a casualty with a minor laceration requiring closure, and after healing, removal of selected closure material. You have the required equipment, an SF 600 (*Chronological Record of Medical Care*), DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*), or electronic medical record (EMR).

**Standards:** Manage a minor laceration without causing further harm to the patient in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Gather appropriate equipment dependent on type of wound closure material, explain procedure to patient, and take appropriate BSI precautions.

2. Prepare the injury area.
    a. Assist the patient into the appropriate position for skin preparation of the injury site.
    b. Expose the preparation area.
    c. Assess the patient's skin condition in the preparation area.
    d. Position a (linen-saver pad) beneath the patient to catch spills.
    e. Proceed with a 10-minute scrub to ensure a clean preparation area.

**NOTE:** Use a benzalkonium chloride antiseptic cleaning agent solution in case the patient has an allergy to betadine or iodine.

    f. Wash the area with a gauze pad dipped in the antiseptic soap solution.
    g. Using a circular motion, start at the injury site and work outward toward the periphery of the area to avoid recontaminating the clean area.
    h. Apply light friction while washing to improve the antiseptic effect of the solution.

3. Anesthetize the area using lidocaine 1% with or without epinephrine.

4. Demonstrate the proper method of closure.
    a. Skin adhesive.
        (1) Hold the wound edges together and slightly everted with tissue forceps.
        (2) Apply adhesive with the applicator tip by lightly wiping along the long axis of the wound.

**NOTE:** Three to four thin layers should be applied successively. Avoid droplets or a single thick layer.

(3) Hold the wound edges together for approximately 1 minute.

(4) Instruct the casualty not to apply ointment or dressing to the wound.

b. Adhesive skin closures.

(1) Apply benzoin to a 2- to 3-centimeter (cm) area beyond the wound edges. Do not allow benzoin to enter the wound.

(2) Using forceps, attach the strip to the skin on one side and then pull the adhesive skin closures across the wound to close the wound edges.

(3) Start in the center and progress toward each end. Leave some space between individual strips.

(4) Instruct the casualty not to get the area wet.

c. Staples.

(1) Hold the wound edges together with tissue forceps.

(2) Place the stapling device gently against the skin surface.

(3) Slowly squeeze the trigger.

(4) Evenly place only the necessary amount of staples to close the wound.

**NOTE:** There is little to no benefit to locally infiltrating an area for 1 to 2 staples to be placed. The anesthetic is more discomforting than the procedure.

d. Suture.

(1) Select the proper size and type of material.

(2) Check for adequate anesthesia by grasping the wound edges with tissue forceps. Note if the casualty can feel pain.

(3) Grasp the needle with the needle holder about 1/2 to 1/3 the distance from where the suture is attached.

(4) Hold the needle holder in the palm, using the index finger for fine control.

(5) Enter the skin at approximately a 90-degree angle on the far side of the wound and exit on the near side.

**NOTE:** You should enter and exit the skin about 2 millimeters (mm) from the edge. Entry and exit points should be directly across from each other.

(6) Pull the suture through the wound until approximately a 2 cm tail remains on the far side of wound.

(7) Hold the end of the suture attached to the needle in the nondominant hand.

(8) Hold the needle holder in the dominant hand.

(9) Loop the suture twice around the needle holder.

(10) Grasp the free end of the suture with the blades of the needle holder.

(11) Cross the hands so that the hand holding the swaged end is on the far side and the hand holding the needle holder and free end are on the near side of the wound.

(12) Pull upward on the suture ends when clinching the first throw.

(13) Adjust the tension of the first throw so that the wound edges come together snugly but not tightly.

(14) For the second throw of the knot, the needle end is on the far side of the wound and the free end on the near side.

(15) Hold the needle end of the suture in the nondominant hand and lay the needle holder on top.

(16) Loop the suture only once around the needle holder.

(17) Grasp the free ends with the blades of the holder.

(18) Cross the hands so that the sutures smoothly intertwine.

**CAUTION:** Take care not to cinch down too tightly on the second throw because the tightness will be transmitted to the wound.

(19) Cinch down the throw.

(20) Pull the knot to the side so that it will not directly overlie the laceration.

(21) The pattern of looping the suture around the holder on alternate sides of the wound is repeated until the desired number of throws are completed.

(22) Cut the ends of the suture material to approximately 3 to 5 cm length.

5. Apply antibiotic ointment to the site.

6. Apply a sterile dressing to the site.

7. Document the procedure on an SF 600, DD Form 1380, or the EMR.

8. Gather appropriate equipment dependent on type of wound closure material, explain procedure to patient, and take appropriate BSI precautions.

9. Clean the wound site.

**NOTE:** This should be done in order to remove any dried blood and crusting from wound.

a. Drape patient as necessary.
b. Pour antiseptic cleaning solution into emesis basin.
c. Dip cotton tipped applicator (CTA) into solution.
d. Gently rub wound with CTA.
e. Repeat process until wound is generally free of blood and crusting.

**CAUTION:** Large incisions will require removal of every other suture due to tension along incision site. Carefully inspect the wound edges after removal of each suture. If there is any evidence of the wound edges pulling apart, stop the procedure immediately and inform the medical provider.

10. Remove sutures, if applicable.

**NOTE:** Patient may feel some slight pain or tingling at extraction site.

a. Pick up first suture with sterile forceps, cut with scissors.
b. Remove the suture by pulling straight up on the knot.
c. Repeat process until all sutures have been removed.

**CAUTION:** Large incisions will require removal of every other staple due to tension along incision site. Carefully inspect the wound edges after removal of each staple. If there is any evidence of the wound edges pulling apart, stop the procedure immediately and inform the medical provider.

11. Remove staples, if applicable.

**NOTE:** Patient may feel some slight pain or tingling at extraction site.

a. Insert staple remover's lower jaw under the first staple.
b. Depress remover handle until staple retracts from skin.
c. Repeat process until all staples are removed.

12. Have medical provider inspect the wound site.

**NOTE:** Perform any additional care as directed by the medical provider.

13. Apply adhesive strips if directed by medical provider.

**NOTE:** Adhesive strips should extend 1/2 to 1 inch on either side of wound.

a. Open adhesive strip package.
b. Remove inner adhesive strip sheet.
c. Cut adhesive strip sheet to desired length.
d. Apply adhesive to the uninjured area on opposing sides of the wound.
e. Apply adhesive strips evenly over entire wound.

14. Document procedure on the patient's SF 600 or a DD Form 1380.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Gathered appropriate equipment dependent on type of wound closure material, explained procedure to patient, and took appropriate BSI precautions. | _____ | _____ |
| 2 | Prepared the injury area. | _____ | _____ |
| 3 | Anesthetized the area using lidocaine 1% with or without epinephrine. | _____ | _____ |
| 4 | Demonstrated the proper method of closure. | _____ | _____ |
| 5 | Applied antibiotic ointment to the site. | _____ | _____ |
| 6 | Applied a sterile dressing to the site. | _____ | _____ |
| 7 | Documented the procedure on an SF 600, DD Form 1380, or the EMR. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 8 | Gathered appropriate equipment dependent on type of wound closure material, explained procedure to patient, and took appropriate BSI precautions. | _____ | _____ |
| 9 | Cleaned the wound site. | _____ | _____ |
| 10 | Removed sutures, if applicable. | _____ | _____ |
| 11 | Removed staples, if applicable. | _____ | _____ |
| 12 | Had medical provider inspect the wound site. | _____ | _____ |
| 13 | Applied adhesive strips if directed by medical provider. | _____ | _____ |
| 14 | Documented procedure on the patient's SF 600 or a DD Form 1380. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
Deployed Medicine website.
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC) Guidelines*.
.

**Related**
None

## Apply a Cervical Collar

081-000-0083

**CAUTION:** All body fluids should be considered potentially infectious. Always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You have a patient that has experienced traumatic injuries and now complains of neck pain. You may have available an additional Soldier to assist, a rigid cervical collar device, head supports, bandage gauze, field dressing, emergency dressing, elastic bandage, bandage scissors, adhesive tape, pen, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*), SF 600 (*Chronological Record of Medical Care*), or an electronic medical record (EMR).

**Standards:** Apply a cervical collar in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines*, while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**Performance Steps:**

1. Take BSI precautions.

2. Complete a primary assessment and care for all life-threatening injuries before applying the cervical collar.

**WARNING:** Treat all suspected spinal injuries, as though they are spinal injuries.

3. Use the mechanism of injury, level of responsiveness, and location of injuries to determine the need for cervical immobilization.

4. Maintain manual cervical spine stabilization and neutral neck alignment while assessing the casualty's neck prior to placing the collar.

**NOTE:** Once the collar is in place, you will not be able to assess or palpate the back of the neck.

5. Reassure the casualty and explain the procedure.

6. Determine the size of collar to apply.
   a. The front height of the collar should fit between the point of the chin and the chest at the suprasternal notch.
   b. Once in place, the collar should rest on the shoulder girdle and provide firm support under both sides of the mandible without obstructing the airway or any ventilation efforts.
   c. If the collar is too large, the casualty's neck may be placed in hyperextension.
   d. If the collar is too small, the casualty's neck may be placed in hyperflexion.

7. Apply the collar to a seated casualty, if applicable.
   a. Have the other Soldier apply in-line stabilization of the head and neck from behind the casualty.

b. Place the chin support first.

c. Wrap the collar around the neck.

d. Secure the hook-and-loop fastener strap in place.

e. Maintain manual stabilization of the head and neck until the casualty is immobilized on a long spine board.

**NOTE:** Cervical collars do not fully immobilize the cervical spine; therefore, you must maintain manual stabilization of the casualty's neck until the casualty is fully immobilized on a long spine board.

8. Apply the collar to a supine casualty, if applicable.

   a. Have the other Soldier kneel at the casualty's head and manually apply in-line stabilization of the head and neck.

   b. Set the collar in place around the neck.

   c. Secure the hook-and-loop fastener strap in place.

   d. Maintain manual stabilization of the head and neck until the casualty is immobilized on a long spine board.

9. Document care on a DD Form 1380, SF 600, or EMR.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Took BSI precautions. | _____ | _____ |
| 2 | Completed a primary assessment and cared for all life-threatening injuries before applying the cervical collar. | _____ | _____ |
| 3 | Used the mechanism of injury, level of responsiveness, and location of injuries to determine the need for cervical immobilization. | _____ | _____ |
| 4 | Maintained manual cervical spine stabilization and neutral neck alignment while assessing the casualty's neck prior to placing the collar. | _____ | _____ |
| 5 | Reassured the casualty and explained the procedure. | _____ | _____ |
| 6 | Determined the size of collar to apply. | _____ | _____ |
| 7 | Applied the collar to a seated casualty, if applicable. | _____ | _____ |
| 8 | Applied the collar to a supine casualty, if applicable. | _____ | _____ |
| 9 | Documented care on a DD Form 1380, SF 600, or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
Deployed Medicine website.
*SF 600. Chronological Record of Medical Care.*
*Tactical Combat Casualty Care (TCCC) Guidelines*.

**Related**
None

Treat Subungual Hematoma

081-000-0107

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have a patient requiring treatment for a subungual hematoma. You will be provided with the patient's SF 600 (*Chronological Record of Medical Care*) or electronic medical record, a #11 scalpel blade or a paper clip, and a lighter.

**Standards:** Treat a subungual hematoma in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines*, while adhering to all warnings and cautions, without error, using the GO/NO GO checklist.

**Performance Steps:**

1. Obtain a history of the patient's complaint.
2. Gather the materials for the procedure.
3. Perform a patient care handwash.
4. Put on gloves.
5. Explain the procedure to the patient.
6. Provide treatment for the subungual hematoma.
   a. Scalpel blade. Place the tip of the scalpel blade on the nail and twist until blood drains.
   b. Paper clip.
      (1) Heat the paper clip until the tip is red-hot.
      (2) Applying gentle pressure, puncture the nail with the hot paper clip and drain the blood.
7. Inform patient to soak the affected finger or toe in antibacterial soap and water twice a day for 2 to 3 days.
8. Record all treatment given in the patient's SF 600.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Obtained a history of the patient's complaint. | _____ | _____ |
| 2 | Gathered the materials for the procedure. | _____ | _____ |
| 3 | Performed a patient care handwash. | _____ | _____ |
| 4 | Put on gloves. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 5 | Explained the procedure to the patient. | _____ | _____ |
| 6 | Provided treatment for the subungual hematoma. | _____ | _____ |
| 7 | Informed patient to soak the affected finger or toe in antibacterial soap and water twice a day for 2 to 3 days. | _____ | _____ |
| 8 | Recorded all treatment given in the patient's SF 600. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
Deployed Medicine website.
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC) Guidelines*.

**Related**
None

Apply an Elastic Bandage

081-000-0110

**CAUTION:** All body fluids should be considered potentially infectious. Always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment, and you have been given guidance to apply an elastic bandage. You are provided gauze bandages, scissors, surgical tape, an elastic bandage, ballpoint pen, and a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*) or SF 600 (*Chronological Record of Medical Care*) or an electronic medical record (EMR).

**Standards:** Apply an elastic bandage in accordance with the *Tactical Combat Casualty Care (TCCC) Guidelines*; by Joint Trauma System (JTS) Committee on Tactical Combat Casualty Care (CoTCCC), while adhering to all warnings and cautions with 100% accuracy utilizing GO/NO GO criteria.

**Performance Steps:**

1. Select the appropriate bandaging material for the injury.

**NOTE:** The width of the bandage to use is determined by the size of the part to be covered. As a general rule, the larger the part or area, the wider the bandage.

a. Use gauze or a flexible roller for injuries of the forearm, upper arm, thigh, and lower leg.

b. Use a flexible roller gauze bandage for injuries of the hand, wrist, elbow, shoulder, groin, knee, ankle, and foot.

c. Use an elastic roller bandage for amputations, arterial bleeding, sprains, and torn muscles.

**NOTE:** Bandage sizes to be used are as follows:

Hand – 2-inch bandage

Lower arm, lower leg, and foot – 3-inch bandage

Thigh and chest – 4- to 6-inch bandage

2. Prepare the patient for bandaging.

**NOTE:** Ensure that the body part to be bandaged is clean and dry.

a. Position the body part to be bandaged in a normal resting position (position of function).

**NOTE:** Bending a bandaged joint changes the pressure of the bandage in places of stress (elbow, knee, and ankle).

b. Place pads over bony places or between skin surfaces to be bandaged (such as fingers and armpits).

**CAUTION:** Do not wrap too tightly. The roller bandage may act as a tourniquet on an injured limb, causing further damage.

3. Apply the anchor wrap.
   a. Lay the bandage end at an angle across the area to be bandaged.
   b. Bring the bandage under the area, back to the starting point, and make a second turn.
   c. Fold the uncovered triangle of the bandage end back over the second turn.
   d. Cover the triangle with a third turn, completing the anchor.

4. Apply the bandage wrap to the injury.
   a. Use a circular wrap to end other bandage patterns, such as a pressure bandage, or to cover small dressings.
   b. Use a spiral wrap for a large cylindrical area such as a forearm, upper arm, calf, or thigh. The spiral wrap is used to cover an area larger than a circular wrap can cover.
   c. Use a spiral reverse wrap to cover small to large conical areas, for example, from ankle to knee.
   d. Use a figure eight wrap to support or limit joint movement at the hand, elbow, knee, ankle, or foot.
   e. Use a spica wrap (same as the figure eight wrap) to cover a much larger area such as the hip or shoulder.
   f. Use a recurrent wrap for anchoring a dressing on fingers, the head, or on a stump.

**NOTE:** Bandage width depends on the site: 1 inch wide for fingers and 3, 4, or 6 inches wide for the stump or head.

5. Check circulation after application of the bandage.
   a. Check the pulse distal to the injury.
   b. Check for capillary refill (<2 seconds is normal), if applicable.
   c. Inspect the skin below the bandaging for discoloration.
   d. Ask the patient if any numbness, coldness, or tingling sensations are felt in the bandaged part.
   e. Remove and reapply the bandage, if necessary.

6. Check for irritation.
   a. Ask the patient if the bandage rubs.
   b. Check for bandage wrinkles near the skin surface.
   c. Check for red skin or sores (ulcers) when the bandage is removed.
   d. Remove and reapply the bandage, if necessary.

7. Elevate injured extremities to reduce swelling (edema) and control bleeding, if appropriate.

8. Annotate treatment provided on the DD Form 1380, SF 600, or EMR.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 1 | Selected the appropriate bandaging material for the injury. | _____ | _____ |
| 2 | Prepared the patient for bandaging. | _____ | _____ |
| 3 | Applied the anchor wrap. | _____ | _____ |
| 4 | Applied the bandage wrap to the injury. | _____ | _____ |
| 5 | Checked circulation after application of the bandage. | _____ | _____ |
| 6 | Checked for irritation. | _____ | _____ |
| 7 | Elevated injured extremities to reduce swelling (edema) and controlled bleeding, if appropriate. | _____ | _____ |
| 8 | Annotated treatment provided on the DD Form 1380, SF 600, or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
Deployed Medicine website.
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC) Guidelines*.

**Related**
None

## Treat a Pelvic Injury

081-000-0111

**WARNING:** Certain pelvic fractures can cause significant internal hemorrhaging. Many times, when casualties experience pelvic fractures, there are also significant internal injuries to the organs protected by the pelvis. Hemodynamic stability and rapid transport should be a main consideration when treating these types of casualties.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You are required to treat a casualty with a pelvic injury. You will be provided with a litter, cravats, or commercial straps, padding material and a spine board or other rigid object or a pelvic binder device (pelvic sling), and a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*), or electronic medical record.

**Standards:** Treat a pelvic injury in accordance with the *PHTLS Prehospital Trauma Life Support,* while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**NOTE:** Pain control should be considered early when managing hip or pelvic injuries.

**Performance Steps:**

**CAUTION:** Both a dislocated and a fractured hip or pelvis are accompanied by considerable pain. The casualty will resist any movement because of pain. It is essential that medical personnel take all possible precautions, using the best available materials at hand while preparing the casualty to be immediately evacuated.

1. Check for the signs and symptoms of a hip or pelvic injury.
    a. Anterior hip dislocation.

**NOTE:** Anterior dislocation is very rare and is caused by the legs suddenly being forced widely apart and locked in this position. Compare against the unaffected leg.

(1) Check for hip pain.
(2) Observe for severe deformity of the affected leg.

**NOTE:** Indications of injury can be: The knee is turned outward. The affected leg is shortened. The hip is drawn away from the midline of the body. The leg has rotated away from the midline of the body.

(3) Check for impaired circulation in the affected extremity.
    (a) Loss of pulse distal to the injury
    (b) Coolness or cyanosis.
    (c) Swelling due to internal blood loss.

**WARNING:** Significant blood loss may occur before swelling is evident. Take the casualty's vital signs as soon as possible and monitor them during stabilization and transport.

(d) Hypovolemic shock.

(4) Check for impaired sensation in the affected extremity.

(a) Tingling or other abnormal sensations (paresthesia).

(b) Loss of sensation.

b. Check for posterior hip dislocation.

**NOTE:** Posterior dislocation is the most common type of hip dislocation.

(1) Check for hip pain.

(2) Observe for severe deformity of the affected leg.

**NOTE:** Possible injuries may present as: The hip joint is flexed with the knee drawn up. The hip is drawn toward the midline of the body. The leg has rotated toward the midline of the body.

(3) Check for impaired circulation in the affected extremity.

(a) Loss of pulse distal to the injury.

(b) Coolness or cyanosis.

(c) Swelling due to internal blood loss.

(4) Check for impaired sensation in the affected extremity.

(a) Paresthesia.

(b) Loss of sensation.

**NOTE:** Weakness of muscles that raise the foot may occur. This condition, known as “foot drop,” may be a sign of damage to the sciatic nerve.

c. Hip fracture.

**NOTE:** Some of the most common fractures are those that occur at the proximal (upper) end of the femur. These have been called “hip fractures” even though the hip joint is rarely involved.

(1) Check for hip pain.

(2) Observe if the casualty is able to walk on or move the affected leg.

(3) Check for deformity.

**NOTE:** Deformities may appear as: The affected leg has rotated toward the midline of the body. The affected leg will usually be shorter than the uninjured one.

(4) Check for impaired circulation in the affected extremity.

(a) Loss of pulse in the femoral or popliteal arteries distal to the injury.

(b) Coolness or cyanosis.

(c) Swelling due to internal blood loss.

(5) Check for impaired sensation in the affected extremity.

(a) Paresthesia.

(b) Loss of sensation.

**WARNING:** Inspect the casualty’s pelvis prior to palpation. When palpating the casualty’s pelvis only gentle palpation should be used and the pelvis should only be palpated once. If upon

physical inspection deformity, ecchymosis or edema is visible, palpation of the pelvis is not necessary, and a pelvic fracture should be suspected.

d. Check for pelvic fractures.

**NOTE:** There are three types of pelvic fractures, rami fractures, acetabular fractures, and pelvic ring fractures. Pelvic ring fractures usually involve massive hemorrhage and are considered a life threat.

(1) Pain.
(2) Deformity.
(3) Ecchymosis.

2. Check for circulation in the affected leg(s).
   a. Check the femoral and popliteal pulses.
   b. Observe for swelling or cyanosis.

3. Check for impaired sensation.
   a. Ask the casualty if they have tingling in the affected limb.
   b. Ask the casualty if they have abnormal sensations, or loss of sensation in the affected limb.

**CAUTION:** Do not log roll a casualty with a hip injury onto the injured side. If available, place the casualty on a spine board using a scoop litter.

4. Immobilize the injury.
   a. Hip dislocations.
      (1) Place the casualty on a long spine board.
      (2) Support the leg in its abnormal position using pillows, blankets, or similar material.
      (3) Secure the support material with cravats.
   b. Hip fracture.
      (1) Place the casualty on a long spine board.
      (2) Place support material under the buttocks to reduce abdominal pain only if there are no other major fractures in the lower extremities.
      (3) Place bulky support material between the casualty's legs and strap them together.
      (4) Place bulky support material underneath the knees.
   c. Pelvic fracture.

**NOTE:** The lower extremities should be adducted and internally rotated.

(1) Place pelvic binder on the casualty.
(2) Gently apply the scoop stretcher to the casualty.
(3) Move the casualty (on the scoop stretcher) to the long spine board and remove the scoop stretcher.
(4) Secure the casualty to the long spine board.

5. Check for complications.
    a. Impaired circulation in the affected limb.
    b. Neurological deficit.
    c. Hypovolemic shock.

**WARNING:** Spontaneous reduction of dislocation may occur during any movement. This may be accompanied by additional damage to nerves and blood vessels. The receiving facility must be informed if this occurs.

6. Record the treatment given on a DD Form 1380 or a patient care report.

**WARNING:** Avoid any bumping or jerking during transport. Excessive movement of a fracture or dislocation can increase blood loss and pain. Hip and leg injuries allow for a greater area of pooling of blood that is not evident early on and may result in the casualty going into hypovolemic shock.

7. Evacuate the casualty.
    a. Position the casualty and spine board on a litter.
    b. Load litter on evacuation platform.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Checked for the signs and symptoms of a hip or pelvic injury. | _____ | _____ |
| 2 | Checked for circulation in the affected leg(s). | _____ | _____ |
| 3 | Checked for impaired sensation. | ____ | _____ |
| 4 | Immobilized the injury. | _____ | _____ |
| 5 | Checked for complications. | _____ | _____ |
| 6 | Recorded the treatment given on a DD Form 1380 or a patient care report. | _____ | _____ |
| 7 | Evacuated the casualty. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
*PHTLS Prehospital Trauma Life Support.*

**Related**
None

## Manage a Suspected Spinal Injury

081-000-0112

**CAUTION:** All body fluids should be considered potentially infectious. Always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You are required to manage treatment of a casualty with a suspected spinal injury. You will be provided with litter straps, cravats, long and short spine boards, immobilization vest-type device, cervical collar, or materials to improvise a cervical collar, padding materials, towels, blankets, head supports, a pen, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*), or electronic medical record (EMR).

**Standards:** Manage a suspected spinal injury in accordance with the *PHTLS Prehospital Life Support*, while adhering to all warnings and cautions with 100% accuracy utilizing GO/NO GO criteria.

**NOTE:** This task should be performed under all environmental conditions. Four or more operational variables of political, military, economic, social, information, infrastructure, physical environment, time should be present. Some iterations of this task should be performed with degraded mission command networks, degraded conditions in the electromagnetic spectrum, or with degraded, denied, and disrupted space operations environment.

**Performance Steps:**

1. Inform casualty to not move and explain procedure prior to performing.

**NOTE:** An important factor to consider in the casualty with a possible spine injury is the mental status.

2. Provide manual in-line stabilization.
    a. Ask one of the Soldiers available for assistance.

**WARNING:** Manual in-line stabilization should not be released until the casualty is immobilized onto the long spine board.

    b. Instruct Soldier to manually hold in-line spinal stabilization and to not let go.

**NOTE:** In-line neutral position that is, the casualty's head should be facing forward and not turned to either side nor tilted forward or backward. You must be careful not to pull or twist the casualty's head but rather to hold it perfectly still and to remind the casualty not to try to move it.

**WARNING:** If you suspect the casualty has a spinal injury, you must treat the Soldier as though they have a spinal injury; when in doubt, immobilize.

3. Check for the signs and symptoms of a spinal injury.

**NOTE:** Attempt to identify the mechanism of injury for unresponsive casualties.

a. If possible, inspect the spine for deformities, contusions, abrasions, punctures or penetrations, burns, tenderness, lacerations, and swelling.

b. Lacerations or contusions in the spinal region indicate severe trauma and usually accompany a spinal injury.

c. Palpate for tenderness, instability, or crepitus in the spinal region.

**NOTE:** The ability to walk, move the extremities, feel sensation, and the absence of pain does not necessary rule out a spinal cord injury.

(1) Carefully insert your hand under the casualty's neck and palpate along the cervical spine as far as can be done without moving the casualty.

(2) Carefully insert your hand into the area of the small of the back and palpate along the thoracic spine and down the lumbar spine as far as possible without moving the casualty.

d. Check for weakness, loss of sensation, paresthesia (tingling), or paralysis.

**NOTE:** Various levels of injuries present as: A cervical spine injury may cause numbness or paralysis in all four extremities. A waist level (thoracic) spinal injury may cause numbness or paralysis below the waist.

4. Immobilize a sitting casualty using a short spine board.

**WARNING:** Manipulation must be stopped if movement results in any of the following: Neck muscle spasm. Increased pain. Increase in numbness, tingling, or loss of motor ability. Compromise of the airway or ventilation.

a. Have your assistant carefully move the casualty's head into a proper, neutral in-line position. Continue manual stabilization until the casualty is secured to a long spine board. Whenever possible, kneel behind the casualty and place hands around the base of the skull on either side. Carefully movement of the head and neck into a neutral position.

b. If complications of movements develop: the casualty's head must be immobilized in the position in which it was initially found.

c. Stabilize the head and neck.

(1) Place your hands on both sides of the casualty's skull, with the palms above the ears.

(2) Support the jaw (mandible) with the fingers.

(3) Maintain manual stabilization until directed to release the stabilization.

d. Assess circulation, motor, and sensory function (CMS).

e. Apply a rigid cervical collar, if available, or improvise one.

**NOTE:** Measure the rigid cervical collar according to the manufacturer's specifications (see task 081-000-0083, Apply a Cervical Collar). An improperly sized device has a potential for further injury.

f. Push the board as far into the area behind the casualty as possible.

g. Tilt the upper end of the board toward the head.

h. Direct the assistant to position the back of the casualty's head against the board, maintaining manual in-line stabilization, by moving the head and neck as one unit.

**NOTE:** If the cervical collar or improvised collar does not fit flush with the spine board, place a roll in the hollow space between the neck and board. The roll should only be large enough to fill the gap, not to exert pressure on the neck.

i. Secure the short spine board to the casualty's torso.

(1) Place the buckle of the first strap in the casualty's lap.

(2) Pass the other end of the strap through the lower hole in the board, up the back of the board, through the top hole, under the armpit, over the shoulder, and across the back of the board at the neck.

(3) Buckle the second strap to the first strap and place the buckle on the side of the board at the neck.

(4) Pass the other end over the shoulder, under the armpit, through the top hole in the board, down the back of the board, through the lower hole, and across the lap. Secure it by buckling it to the first strap.

j. Secure the casualty's head and head supports to the board with straps or cravats.

**WARNING:** Ensure that the cravats or head straps are firmly in place before the assistant releases stabilization.

(1) Apply head supports.

(2) Use two rolled towels, blankets, or similar material.

(3) Place one close to each side of the head.

(4) Using a cravat-like material across the forehead, make the supports and head one unit by tying to the board.

k. Reassess CMS.

l. Tie the casualty's hands together and place them in their lap.

**NOTE:** When positioning a casualty who is secured to a short spine board, on a long spine board, line up the hand grip holes of the short spine board with the holes of the long spine board, if possible, and secure the two boards together with straps.

5. Immobilize a sitting casualty using a vest-type device, such as a seated extrication device.

a. Stabilize and assess the sitting casualty as in steps 4a through 4e.

**NOTE:** Before placing the vest-type device behind the casualty, the two long straps (groin straps) are unfastened and placed behind the device.

b. Position the immobilization device behind the casualty. The side flaps are placed around the casualty's torso and moved until they are in contact with the casualty's armpits.

c. Secure the vest-type device to the casualty's torso.

(1) Immobilize the torso, beginning with the middle strap, followed by the lower strap and finally the upper strap. Tighten each strap after attachment.

(2) Position and tighten each groin strap; ensure you pad the groin area.

**CAUTION:** The straps must be tight enough, so the device does not move up, down, left or right excessively, but not so tight as to restrict the casualty's breathing.

d. Secure the casualty's head to the vest-type device.

(1) Pad behind the casualty's head as necessary.

(2) Place the first strap or cravat across the chin angling upward toward the ear. Attach to the head flaps on either side of the head. Ensure the strap or cravat does not interfere with the airway.

(3) Place the second strap or cravat across the forehead angling downward toward the base of the head. Attach to the head flaps on either side of the head.

**NOTE:** The pelvic straps must be released after being placed on a long spine board in order to place the casualty in a supine position.

6. Place the casualty on a long spine board.

**NOTE:** If a long spine board is not available, utilize a standard litter or improvised litter made from a board or door. A hard surface is preferable to one that gives with the casualty's weight.

a. The log-roll technique.

(1) Position the long spine board next to, and parallel with, the casualty.

(2) Maintain manual stabilization of the casualty's head and neck. This individual will direct all movements while maintaining in-line support of the head and neck.

(a) Spread your fingers and thumbs around the sides of the casualty's head to hold it steady.

(b) Support the jaw (mandible) with the fingers.

(c) Maintain manual stabilization until the casualty has been placed on the spine board.

(3) Apply a cervical collar, if available, or improvise one.

(4) Brief each of the three assistants on their duties and instruct them to kneel on the same side of the casualty, with the long spine board on the opposite side of the casualty.

(a) First assistant. Place the near hand on the shoulder and the far hand on the waist.

(b) Second assistant. Place the near hand on the hip and the far hand on the thigh.

(c) Third assistant. Place the near hand on the knee and the far hand on the ankle.

(5) On the command of the team leader stabilizing the casualty's head, and in unison, the assistants roll the casualty slightly toward them. The head and neck must be maintained in-line with the casualty's spine during all movements.

(6) Instruct the assistants to reach across the casualty with one hand, grasp the spine board at its closest edge, and slide it against the casualty. Instruct the number two assistant to reach across the board to the far edge and hold it in place to prevent board movement.

(7) Instruct the assistants to slowly roll the casualty back onto the board, keeping the head and spine in a straight line.

(8) Reassess CMS.

b. The straddle-slide technique.

**NOTE:** Use this method when limited space makes it impossible to use the log roll technique.

(1) Stand (team leader) at the head of the casualty with your feet wide apart.

(2) Apply stabilization to the casualty's head and apply a cervical collar, if available, or improvise one.

(3) Instruct the first assistant to stand behind you (facing your back), to line up the spine board, and to gently slide the spine board under the casualty at your command.

(4) Instruct the second assistant to straddle the casualty while facing you and gently elevate the shoulders so that the spine board can be slid under them.

(5) Instruct the third assistant (facing you) to carefully elevate the hips while the spine board is being slid under the casualty.

**WARNING:** Complete all movements simultaneously, keeping the head and spine in a straight line.

(6) Instruct the fourth assistant (facing you) to carefully elevate the legs and ankles while the board is being slid into place under the casualty.

**NOTE:** If the cervical collar or improvised collar does not fit flush with the spine board, place a roll in the hollow space between the neck and board. The roll should only be large enough to fill the gap, not to exert pressure on the neck.

7. Secure the casualty to the long spine board.

   a. While maintaining manual stabilization, secure the torso to the long spine board by applying straps across chest, pelvis, and legs. Adjust these straps as needed.

   b. While continuing to maintain manual stabilization, apply the head supports to each side of the casualty's head.

   c. Fasten a strap or cravat-like material tightly over the head supports and the lower forehead. A second strap or cravat is placed over the pads and the rigid cervical collar and is fastened securely to the long board.

   d. Reassess CMS.

8. Record the treatment on the DD Form 1380 or EMR.

9. Evacuate the casualty.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Informed casualty to not move and explained procedure prior to performing. | _____ | _____ |
| 2 | Provided manual in-line stabilization. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 3 | Checked for the signs and symptoms of a spinal injury. | _____ | _____ |
| 4 | Immobilized a sitting casualty using a short spine board. | _____ | _____ |
| 5 | Immobilized a sitting casualty using a vest-type device, such as a Kendrick extrication device. | _____ | _____ |
| 6 | Placed the casualty on a long spine board. | _____ | _____ |
| 7 | Secured the casualty to the long spine board. | _____ | _____ |
| 8 | Recorded the treatment on the DD 1380 Form or EMR. | _____ | _____ |
| 9 | Evacuated the casualty. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
PHTLS *Prehospital Trauma Life Support.*

**Related**
None

Assess Patient Vital Signs

081-000-1001

This individual task was presented earlier in the STP on page 3-147 as a readiness requirements task. The content requirements are the same.

Treat Compartment Syndrome

081-68W-0020

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, treat a patient exhibiting compartment syndrome. You have a patient monitor, patient monitor paper, intravenous catheter, intravenous tubing, Lactated Ringer's, alcohol pads, a tourniquet, SF 600 (*Chronological Record of Medical Care*), and a pen.

**Standards:** Treat compartment syndrome in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines*; by Joint Trauma System Committee on Tactical Combat Casualty Care (CoTCCC*),* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Maintain an open airway; apply high-flow oxygen, as necessary.
2. Assess pulse, motor, and sensory functions.
3. Place ice packs over the extremity.
4. Initiate intravenous fluids to maintain peripheral perfusion.
5. Loosen constrictive splint material or clothing, as needed.
6. Administer pain medications, as needed or per physician's orders.
7. Identify signs of rhabdomyolysis, hyperkalemia, and myoglobinuria.

**NOTE:** Rhabdomyolysis – Damage to the sarcolemma (muscle-membrane) from any cause. This damage allows an influx of calcium and sodium, followed by water, to the cells and a release of myoglobin, aspartate transaminase, lactate, creatine kinase, potassium, uric acid, and phosphorus.

8. Treat for rhabdomyolysis, hyperkalemia, and myoglobinuria, if present.
9. Document all findings and treatment given.
10. Reassess patient every 30 minutes or as required by the physician.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Maintained an open airway; applied high-flow oxygen, as necessary. | _____ | _____ |

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 2 | Assessed pulse, motor, and sensory functions. | _____ | _____ |
| 3 | Placed ice packs over the extremity. | _____ | _____ |
| 4 | Initiated intravenous fluids to maintain peripheral perfusion. | _____ | _____ |
| 5 | Loosened constrictive splint material or clothing, as needed | _____ | _____ |
| 6 | Administered pain medications, as needed or per physician's orders. | _____ | _____ |
| 7 | Identified signs of rhabdomyolysis, hyperkalemia, and myoglobinuria. | _____ | _____ |
| 8 | Treated for rhabdomyolysis, hyperkalemia, and myoglobinuria, if present. | _____ | _____ |
| 9 | Documented all findings and treatment given. | _____ | _____ |
| 10 | Reassessed patient every 30 minutes or as required by the physician. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
Deployed Medicine website.
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Treat Crush Injury

081-68W-0021

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, treat a patient with a crush injury. You have a physician orders, patient monitor, patient monitor paper, intravenous catheter, intravenous tubing, Lactated Ringer's, alcohol pads, a tourniquet, SF 600 (*Chronological Record of Medical Care*), and a pen.

**Standards:** Treat a crush injury with 100% accuracy and in accordance with *Tactical Combat Casualty Care (TCCC) Guidelines*; by Joint Trauma System Committee on Tactical Combat Casualty Care (CoTCCC), without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Maintain an open airway; apply high-flow oxygen, as necessary.
2. Assess pulse, motor, and sensory functions.
3. Place ice packs over the extremity.
4. Initiate intravenous fluids to maintain peripheral perfusion.
5. Loosen constrictive splint material or clothing, as needed.
6. Administer pain medications, as needed or per physician's orders.
7. Identify signs of rhabdomyolysis, hyperkalemia, and myoglobinuria.

**NOTE:** Rhabdomyolysis – Damage to the sarcolemma (muscle-membrane) from any cause. This damage allows an influx of calcium and sodium, followed by water, to the cells and a release of myoglobin, aspartate transaminase, lactate, creatine kinase, potassium, uric acid, and phosphorus.

8. Treat for rhabdomyolysis, hyperkalemia, and myoglobinuria, if present.
9. Document all findings and treatment.
10. Reassess patient every 30 minutes or as required by the physician.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Maintained an open airway; applied high-flow oxygen, as necessary. | _____ | _____ |
| 2 | Assessed pulse, motor, and sensory functions. | _____ | _____ |

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 3 | Placed ice packs over the extremity. | _____ | _____ |
| 4 | Initiated intravenous fluids to maintain peripheral perfusion. | _____ | _____ |
| 5 | Loosened constrictive splint material or clothing, as needed. | _____ | _____ |
| 6 | Administered pain medications, as needed or per physicians orders. | _____ | _____ |
| 7 | Identified signs of rhabdomyolysis, hyperkalemia, and myoglobinuria. | _____ | _____ |
| 8 | Treated for rhabdomyolysis, hyperkalemia, and myoglobinuria, if present. | _____ | _____ |
| 9 | Documented all findings and treatment given. | _____ | _____ |
| 10 | Reassessed patient every 30 minutes or as required by the physician. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
Deployed Medicine website.
*SF 600.* Chronological Record of Medical Care.
*Tactical Combat Casualty Care (TCCC) Guidelines*.

**Related**
None

Treat a Casualty with an Impaled Object

081-68W-0036

**WARNING:** Do not exert any force on or attempt to remove the impaled object unless the object is impaled in the cheek, and both ends of the object can be seen or unless the object is blocking the airway. Severe bleeding or nerve and muscle damage may result.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment during the Tactical Field Care phase treat a casualty with an impaled object. You will have a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*), an emergency trauma dressing, muslin bandage, gauze bandage, scissors, abdominal and trauma bandage, vascular access material, and an additional Soldier may be available for assistance.

**Standards:** Treat a casualty with an impaled object in accordance with the *Tactical Combat Casualty Care (TCCC) Guidelines*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Don personal protective equipment.
    a. Don gloves.
    b. Don eye protection.

2. Control bleeding.
    a. Expose the injury by cutting away or removing clothing or equipment around wound and assess the impalement for bleeding.
    b. Apply a tourniquet if the impalement is through an extremity and pulsatile hemorrhage is observed.
    c. Check the extremities pulse, motor, sensory, prior to and after impaled object stabilization.
    d. Remove the object.

3. Immobilize the impaled object, if not removed.

**NOTE:** If an assistant is available, one person should immobilize the object while the other applies the dressings and bandages.

    a. Place several layers of bulky dressing around the injury site so that the dressings surround the object.
    b. Use additional bulky materials or dressings to build up the area around the object.
    c. Position the casualty to allow for drainage and be prepared to suction the casualty.
    d. Secure bulky dressings.

4. Check circulation after securing the bulky dressing.

**NOTE:** If a pulse was palpated and it cannot be palpated after the bandage has been applied, the bandage must be loosened until a pulse can be palpated.

**WARNING:** Do not anchor a splint or sling to the impaled object. Avoid undue motion of the impaled object when applying a splint.

5. Immobilize the impaled extremity with a splint or sling, if applicable.

6. Check pulse, motor, and sensory after bulky dressing application if the impalement occurred through an extremity.

7. Use pain management as necessary.

8. Record the treatment on the DD Form 1380 (see task 081-000-0013, Initiate a Tactical Combat Casualty Card).

9. Evacuate the casualty (see task 081-COM-0101, Request Medical Evacuation).

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Donned personal protective equipment. | _____ | _____ |
| 2 | Controlled bleeding. | _____ | _____ |
| 3 | Immobilized the impaled object, if not removed. | _____ | _____ |
| 4 | Checked circulation after securing the bulky dressing. | _____ | _____ |
| 5 | Immobilized the impaled extremity with a splint or sling, if applicable. | _____ | _____ |
| 6 | Checked pulse motor and sensory after bulky dressing application if the impalement occurred through an extremity. | _____ | _____ |
| 7 | Used pain management as necessary. | _____ | _____ |
| 8 | Recorded the treatment on the DD Form 1380 (see task 081-COM-0013, Record Treatment on a DD Form 1380). | _____ | _____ |
| 9 | Evacuated the casualty (see task 081-COM-0101, Request Medical Evacuation). | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.

**Related**
None

Treat Eye Injuries

081-68W-0040

**WARNING:** Wear gloves for self-protection against transmission of contaminants whenever handling body fluids.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment and must treat a casualty with an injury to their eye. All other injuries have been assessed and treated. You have performed a patient care handwash. Provided with cotton-tipped swabs, clean cloth, sterile irrigation solution (normal saline, water, or other prescribed solution), bandages, dry sterile dressings, eye patch, a paper cup or cardboard cone, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*).

**Standards:** Treat an eye injury in accordance with *PHTLS Prehospital Trauma Life Support*, while adhering to all warnings and cautions, without error, using the GO/NO GO checklist.

**Performance Steps:**

1. Perform gross vision examination.
2. Assess eyes: pupils, equal and round, regular in size, and react to light.
3. Locate the foreign body.
    a. Method one.
        (1) Pull the lower lid down.
        (2) Tell the casualty to look up and to both sides and check for foreign bodies.
        (3) Pull the upper lid up.
        (4) Tell the casualty to look down and to both sides and check for foreign bodies.
    b. Method two.
        (1) Tell the casualty to look down.
        (2) Grasp the casualty's upper eyelashes and gently pull the eyelid away from the eyeball.
        (3) Place a cotton-tipped swab horizontally along the outer surface of the upper lid and fold the lid back over the swab.

**CAUTION:** Covering both eyes, is not recommended in a combat environment. Covering both eyes renders the casualty defenseless against enemy and is completely dependent on others. (This is only if one eye is injured.)

        (4) Look for the foreign bodies or damage on the globe.

**CAUTION:** Do not put pressure on the globe.

4. Remove the foreign body.

a. Small foreign body on an anterior surface.
   (1) Hold the casualty's eye open.
   (2) Irrigate the eye.
b. Foreign body stuck to the cornea or lying under the upper or lower eyelid.
   (1) For a foreign body under the lower eyelid, pull the lower lid down.
   (2) For a foreign body under the upper eyelid, pull the upper lid up.
   (3) Remove the foreign body with a moistened, sterile cotton-tipped swab.

**NOTE:** In hazardous conditions, leave the good eye uncovered long enough to ensure the casualty's safety.

**CAUTION:** Do not attempt to remove a foreign body stuck to or sticking into the eyeball. A medical officer must remove such objects.

c. Foreign body stuck or impaled in the eye.
   (1) Apply dry sterile dressings to build around and support the object.

**NOTE:** This will help prevent further contamination and minimize movement of the object.

   (2) Cover the injured eye with a paper cup or cardboard cone.
   (3) Cover the uninjured eye with a dry dressing or eye patch.
   (4) Reassure the casualty by explaining why both eyes are being covered.

**NOTE:** The eyes move together. If the casualty uses (moves) the uninjured eye, the injured eye will move as well. Covering both eyes will keep them still and will prevent undue movement on the injured side.

   (5) Seek further medical aid immediately.

5. Obtain details about the injury.
   a. Source and type of the foreign bodies.
   b. Whether the foreign bodies were windblown or high velocity.
   c. Time of onset and length of discomfort.
   d. Any previous injuries to the eye.
6. Record the procedure on the DD Form 1380.
7. Evacuate the casualty, as required.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Performed gross vision examination. | _____ | _____ |
| 2 | Assessed eyes: pupils, equal and round, regular in size, and react to light. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 3 | Located the foreign body. | _____ | _____ |
| 4 | Removed the foreign body. | _____ | _____ |
| 5 | Obtained details about the injury. | _____ | _____ |
| 6 | Recorded the procedure on the DD Form 1380. | _____ | _____ |
| 7 | Evacuated the casualty, as required. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
*PHTLS Prehospital Trauma Life Support.*

**Related**
None

Treat a Casualty with an Axillary Wound

081-68W-0079

This individual task was presented earlier in the STP on page 3-186 as a readiness requirements task. The content requirements are the same.

Treat a Casualty with a Neck Wound

081-68W-0091

This individual task was presented earlier in the STP on page 3-160 as a readiness requirements task. The content requirements are the same.

**Subject Area 14: Triage and Evacuation**

Establish a Helicopter Landing Point

071-334-4662

**Conditions:** You are a leader in a unit that is expecting inbound helicopters and must establish a landing point. You have a landing site and materiel to mark the landing site which may include: smoke grenades, strobe lights, flashlights or vehicle lights, and a marker panels. Your unit has the equipment to clear the site, as required.

**Standards:** Secure the landing site. Select a suitable landing point for the type of inbound helicopter to land and takeoff without exposing it to risk. Prepare the landing site and mark the landing site and touchdown point.

**NOTE:** Comply with unit standard operating procedure and local environmental regulations concerning the cutting of live vegetation, the digging of holes, and comply with erosion prevention measures.

**Performance Steps:**

1. Establish security for the landing site.

2. Select a landing point.
    a. Select a landing point large enough for the type aircraft.

**NOTE:** The landing zone must be at least 50 meters in diameter for a UH-60 series aircraft and 80 meters in diameter for a CH-47 series aircraft.

    b. Ensure ground slope is safe for landing.

**NOTE:** Helicopters cannot safely land on a slope of more than 15 degrees. When the ground slope is under 7 degrees, the helicopter should land upslope. When the ground slope is 7 to 15 degrees, the pilot is advised and the helicopter must land side slope.

    c. Ensure the landing point has sufficient clearance for approach and departure.
    d. Ensure the ground is firm enough that the helicopter does not become mired or stuck during loading or unloading.

**NOTE:** If firm ground cannot be found, issue the pilot an advisory. If necessary, the pilot can hover at the landing site during loading or unloading.

    e. Ensure landing site will provide adequate security.

**NOTE:** Landing sites should offer some security from enemy observation and direct fire. Good landing sites will allow the helicopter to land and depart without exposing it to unneeded risks. Security is normally established around the entire landing site.

    f. Avoid areas which may cause the pilot to lose visual contact with the ground.

**NOTE:** Example Rotor wash on dusty, sandy, or snow-covered surfaces will limit or cause loss of visual contact.

3. Prepare the landing site.

**CAUTION:** Loose debris can cause damage to the blades or engines.

a. Remove all loose debris from landing site.
b. Clear the entire landing point of any loose material that the rotors could blow up.

**WARNING:** Rotor wash stirs up any loose dirt, sand (brownout), or snow (whiteout). This can obscure the ground and other aircraft, especially at night. If a site must be used with obscuring conditions, the helicopter must be advised of conditions.

**WARNING:** You can cut down on dust by wetting down dry dirt. Snow should be reduced to ensure there are no hazards and then packed down firmly, which will also reduce the amount blowing around.

c. Identify all obstacles within the landing site.

**NOTE:** An obstacle is any object that is 18 inches or more in height, width, or depth.

d. Clearly mark unmovable obstructions and advise the pilot.
e. Remove all obstacles such as stumps and rocks if possible.
f. Fill in all holes if possible.

**CAUTION:** Whenever possible, pilots should land upslope rather than downslope.

4. Mark the landing site and touchdown point.
   a. Mark the landing site for day operations.
      (1) Use color smoke to give pilot information on the wind direction and speed.

**CAUTION:** Do not move any closer than 50 feet to the touchdown point.

      (2) Use a signalman.
      (3) Use VS-17 marker panels to mark the landing site.
   b. Mark the landing site for night operations.

**NOTE:** Pilot's night vision goggles have filtered lenses that do not allow them to see blue or green chemical lights.

      (1) Mark landing site by an inverted "Y" composed of four lights or NATO "T."
      (2) Use strobe lights, or chemical lights, flashlights, or vehicle lights to mark the landing site.
      (3) Fully explain the marking system to the pilot when contact is made.

**Evaluation Preparation:** Setup: Provide the Soldier with the equipment and materials described in the conditions statement.

**Brief the Soldier:** Tell the Soldier what is required to successfully complete the task by reviewing the conditions and standards. Stress the importance of observing cautions, warnings, and dangers, as applicable.

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 1 | Established security for the landing site. | _____ | _____ |
| 2 | Selected a landing point. | _____ | _____ |
| 3 | Prepared the landing site. | _____ | _____ |
| 4 | Marked the landing site and touchdown point. | _____ | _____ |

**Evaluation Guidance:** Score the Soldier GO if all performance measures are passed. Score the Soldier NO GO if any performance measure is failed. If the Soldier scores a NO GO, show the Soldier what was done wrong and how to do it correctly.

**References:**

**Required**
None

**Related**
None

## Prepare an Aid Bag

081-000-0093

**Conditions:** In an operational environment you are required to prepare an aid bag for an upcoming mission. Provided with type and length of the mission, airway, breathing devices, circulation and fracture supplies, antibiotics, pain medications, and a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*), or electronic medical record.

**Standards:** Prepare an aid bag in accordance with *PHTLS Prehospital Trauma Life Support* and *Tactical Combat Casualty Care (TCCC) Guidelines* ensuring appropriate supplies for the mission, while adhering to all warnings, and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Identify the type of aid bag for mission required.

**NOTE:** The contents of the aid bag will be based on the type and length of the mission, and the skill level of the combat medic. There is no standard packing list for an aid bag.

   a. M-5 aid bag.
   b. Other approved combat trauma bag.

2. Prepare aid bag (based on the skill level of individual medic).
   a. Airway supplies.
      (1) Nasopharyngeal airways.
      (2) Oropharyngeal airways.
      (3) Surgical cricothyroidotomy kit.
   b. Breathing supplies.
      (1) Chest seal(s).
      (2) 14-gauge 3.25-inch needle catheter unit (for needle chest decompression).
   c. Circulation supplies.
      (1) Rolled gauze.
      (2) Emergency bandages.
      (3) Cravats.
      (4) Tourniquet.
      (5) Intravenous (IV) infusion sets.
      (6) IV fluids.
      (7) Intraosseous infusion device.
      (8) Constricting band.
      (9) Alcohol pads.
      (10) Transparent film dressings.
      (11) 18-gauge IV catheters.
      (12) Saline locks.
      (13) Hemostatic bandages.

(14) Junctional tourniquet.

d. Fracture supplies.
   (1) Sam splints.
   (2) Elastic bandages (2, 4, or 6 inch).

e. Antibiotics.
   (1) Gatifloxacin tablets 400 milligrams (mg).
   (2) Cefotetan, 2-grams (g) injection (IV antibiotics).

f. Pain medications.
   (1) Ketamine (IV or intramuscular).
   (2) Oral transmucosal fentanyl citrate.
   (3) Combat wound medication pack.

g. Miscellaneous supplies.
   (1) Large abdominal pad.
   (2) Tape nylon 1-2-3-inch size.
   (3) Gauze pads 4x4 inch.
   (4) Gauze pads 2x2 inch.
   (5) Eye pads.
   (6) Cotton-tipped applicators.
   (7) Adhesive bandage.
   (8) Ear, nose, throat kit.
   (9) Stethoscope.
   (10) Burn packs.
   (11) Lubricant surgical sterile.
   (12) Tincture of benzoin.
   (13) Exam gloves.
   (14) Adjustable C-collar.
   (15) DD Form 1380.
   (16) Bandage scissors.
   (17) Needles (various sizes).
   (18) Syringes (various sizes).
   (19) Chemical lights.
   (20) Space blanket.
   (21) Oral hydration solution packs.
   (22) Tongue depressors.
   (23) Tranexamic acid 2-g IV.
   (24) Panel marker, orange medical marking panel.

3. Inspect aid bag to ensure mission essential preparation.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 1 | Identified the type of aid bag for mission required. | _____ | _____ |
| 2 | Prepared aid bag (based on the skill level of individual medic). | _____ | _____ |
| 3 | Inspected aid bag to ensure mission essential preparation. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
*PHTLS Prehospital Trauma Life Support.*
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Load Casualties onto Nonstandard Vehicles

081-000-0151

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have completed treating and triaging multiple casualties. You are in charge of evacuating patients. Load casualties onto a nonstandard vehicle. You are provided with litters, litter straps, securing material and one of the following vehicles: M1085, M1093, M1081 or a 1 1/4-ton M998 high mobility multipurpose wheeled vehicle (HMMWV) Truck.

**Standards:** Load casualties onto nonstandard vehicle in accordance with ATP 4-02.13, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Determine vehicle load capacities.
    a. Long wheelbase, 5 ton, M1085: 12 litters or 22 ambulatory.
    b. Light vehicle air drop or air delivery, 5 ton, M1093: 8 litters or 14 ambulatory.
    c. Light vehicle air drop or air delivery, 2 1/2 ton, M1081: 7 litters or 12 ambulatory.
    d. HMMWV, 1/4 ton, M998 (four-seat configuration): 3 litters.
    e. HMMWV, 1/4 ton, M998 (two-seat configuration): 5 litters.

2. Prepare the nonstandard vehicle to receive the casualties.
    a. Place tailgate in proper position.
        (1) For the M1085, M1093, M1081, and the 5 ton, 6x6 cargo truck, lower the tailgate.
        (2) For the HMMWV, 1/4 ton, M998 (four-seat configuration) and the M998 (two-seat configuration), place the tailgate in the open position, level with the bed of the truck, and supported by the two tailgate chain hooks.
    b. Lower the bench seats and secure the vertical support brackets in place.
    c. For the HMMWV, 1/4 ton, M998 (two- and four-seat configuration) remove the cargo cover, metal bows, and secure them. The M1085, M1093, M1081, and the 5 ton (6x6 cargo truck) do not require the cargo cover and metal bows to be removed.

3. Direct nonmedical Soldiers to load vehicle.

**NOTE:** The combat medic or combat lifesaver rides in the center of the vehicle to monitor the casualties. If the vehicle is loaded with the maximum number of casualties, the combat medic will not be able to attend to the casualties.

    a. Direct nonmedical Soldiers to load litter casualties onto a 5 ton, M1085.
        (1) Place four litters (litter numbers 1 through 4) crosswise on the seats, forward, next to the cab. Secure the litters individually to the seats.

(2) Place two litters (litter numbers 5 and 6) lengthwise on the floor, forward toward the cab, feetfirst, ensuring that casualty's heads are exposed from under the upper litters. Secure the litters together and to the vertical seat supports.

(3) Place litter number 7 crosswise on the seats near the rear of the vehicle. Slide the litter as far forward as possible. Do not secure the litter at this time.

(4) Follow the same procedures in step 3.a.(2) above for litter numbers 8 and 9.

(5) Place litter number 10 crosswise on the furthest seat rearward. Secure the litter to the seat.

(6) Slide litters (litter numbers 7, 8, and 9) rearward next to litter number 10. Secure the litters to the seats individually.

(7) Place two litters lengthwise on the floor (litters 11 and 12), headfirst, ensuring that the casualty's head is exposed to the center opening, between the upper litters. Secure the litters together and to the vertical seat supports.

(8) Raise and secure the tailgate.

b. Direct nonmedical Soldiers to load litter casualties onto an M1093.

(1) Place three litters (litter numbers 1 through 3) crosswise on the seats, forward, next to the cab. Secure the litters individually to the seats.

(2) Place two litters (litter numbers 4 and 5) lengthwise on the floor, forward toward the cab, feetfirst. Secure the litters together and to the vertical seat support.

(3) Place litter number 6 crosswise on the seats near the rear of the vehicle. Slide the litter as far forward as possible. Do not secure the litter at this time.

(4) Place litter number 7 crosswise on the seats near the rear of the vehicle and slide it forward. Secure the litter to the seats.

(5) Place litter number 8 crosswise on the seats as far rearward as possible. Secure the litter to the seats.

(6) Glide litter numbers 6 and 7 rearward next to litter number 8. Secure the litters to the seats.

(7) Raise and secure the tailgate.

c. Direct nonmedical Soldiers to load litter casualties onto an M1081.

(1) Place three litters (litter numbers 1 through 3) crosswise on the seats, forward, next to the cab. Secure the litters individually to the seats.

(2) Place two litters (litter numbers 4 and 5) lengthwise on the floor, forward toward the cab, feetfirst. Secure the litters together and to the vertical seat support.

(3) Place litter number 6 crosswise on the seats near the rear of the vehicle. Slide the litter as far forward as possible. Do not secure the litter at this time.

(4) Place litter number 7 crosswise on the seats as far rearward as possible. Secure the litter to the seats.

(5) Slide litter number 6 rearward next to litter number 7. Secure the litter to the seats.

(6) Raise and secure the tailgate.

d. Direct nonmedical Soldiers to load a 1 1/4 ton, 4x4 M998 (four-seat configuration).

(1) Place two litters side-by-side across the back of the truck with the litter handles resting on the sides of the truck.

(2) Secure the litters to the vehicle with any available material.

(3) Place one litter lengthwise, headfirst, in the bed of the truck. Secure it in place.

(4) Leave the tailgate open. It is supported by the two tailgate chain hooks.

e. Direct nonmedical Soldiers to load a 1 1/4 ton, 4x4 M998 (two-seat configuration).

(1) Place three litters side-by-side across the sideboards. Secure them in place with any material available.

(2) Place two litters lengthwise, headfirst, in the bed of the truck. Secure them in place.

(3) Leave the tailgate open. It is supported by the two tailgate chain hooks.

4. Do not cause further injury to the casualties.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Determined vehicle load capacities. | _____ | _____ |
| 2 | Prepared the nonstandard vehicle to receive the casualties. | _____ | _____ |
| 3 | Directed nonmedical Soldiers to load vehicle. | _____ | _____ |
| 4 | Did not cause further injury to the casualties. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
ATP 4-02.13 *Casualty Evacuation*.

**Related**
None

## Unload Casualties from Nonstandard Vehicles

081-000-0152

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have completed treating and triaging multiple casualties. You are in charge of evacuating patients. Unload casualties from a nonstandard vehicle. You are provided with litters, litter straps, securing material and one of the following vehicles: M1085, M1093, M1081, or a 1 1/4-ton M998 high mobility multipurpose wheeled vehicle (HMMWV) Truck.

**Standards:** Unload casualties from a nonstandard vehicle in accordance with ATP 4-02.13, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Prepare the vehicle and casualties for off-loading.
    a. Unsecure and lower the tailgate (if applicable).
    b. Remove securing materials from each litter.

2. Assist ambulatory patients off the vehicle.

3. Direct nonmedical Soldiers to unload the vehicle in reverse sequence.
    a. M1085 off-loading sequence.
        (1) Remove the first two litters that are placed lengthwise on the bed of the truck closest to the tailgate.
        (2) Remove the first four litters that are crosswise supported by the bench seats closest to the tailgate.
        (3) Remove the next two litters that are placed lengthwise on the bed of the truck closest to the vehicle cab.
        (4) Remove the last four litters that are crosswise supported by the bench seats closest to the vehicle cab.
    b. M1093 5 ton, 6x6 cargo truck off-loading sequence.
        (1) Remove the first three litters that are crosswise supported by the bench seats.
        (2) Remove the two litters that are placed lengthwise on the bed of the truck, closest to the tailgate.
        (3) Remove the last three litters that are crosswise supported by the bench seats, closest to the vehicle cab.
    c. M1081 off-loading sequence.
        (1) Remove the first two litters that are crosswise supported by the bench seats (M1081 only).
        (2) Remove the two litters that are placed lengthwise on the bed of the truck closest to the vehicle cab.
        (3) Remove the last three litters that are crosswise supported by the bench seat, closest to the vehicle cab.

d. 1 1/4 ton, 4x4, M998 HMMWV (two- and four-seat configuration).

(1) Remove the litter or litters from the bed of the truck (M998 two-seat and four-seat configuration).

(2) Remove the litter or litters that are placed crosswise on the cargo sideboards (M998 two-seat and four-seat configuration).

4. Secure the tailgate.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Prepared the vehicle and casualties for off-loading. | _____ | _____ |
| 2 | Assisted ambulatory patients off the vehicle. | _____ | _____ |
| 3 | Directed nonmedical Soldiers to unload the vehicle in reverse sequence. | _____ | _____ |
| 4 | Secured the tailgate. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
ATP 4-02.13. *Casualty Evacuation*.

**Related**
None

Unload Patients from an Air Ambulance

081-68W-0294

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, a UH-60 series helicopter has arrived at your medical treatment facility, and you must unload the patients. You are given a UH-60 series helicopter with a medical evacuation kit installed, 4 litters, 8 litter straps, and 4 nonmedical Soldiers to act as litter bearers.

**Standards:** Unload casualties from an air ambulance (UH-60 series helicopter) in the correct sequence in accordance with ATP 4-02.2, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Follow the principles of unloading patients from a rotary-wing aircraft.
    a. Responsibility for unloading a rotary-wing aircraft.
        (1) The pilot in command has the overall responsibility for the proper unloading of the aircraft, as well as all safety considerations inside and around the aircraft.
        (2) The flight medic is responsible for ensuring that the litter squad follows the prescribed methods for unloading litter and ambulatory casualties and securing litters and related medical equipment.
        (3) The flight medic also determines which casualties are unloaded first.
    b. Safety measures.
        (1) Litter bearers must present as low a silhouette as possible and must keep clear of the main and tail rotors at all times.
        (2) The helicopter must not be approached until a crew member signals to do so.
        (3) The litter bearers should approach the aircraft at a 90-degree angle from the side of the helicopter ensuring that no litter bearers pass behind the cargo doors of the aircraft.
        (4) If the helicopter is on a slope and conditions permit, unloading personnel should approach the aircraft from the downhill side.
        (5) Directions given by the crew must be followed, and litters must be carried parallel to the ground.
        (6) All casualty equipment such as blankets should be secured to the litter to prevent any potential damage to the aircraft.
        (7) Smoking is not permitted within 50 feet of the aircraft.

2. Unload casualties from the rotary-wing aircraft.
    a. When off-loading casualties from a UH-60 series helicopter, follow all guidance from the helicopter crew members.
    b. The litter support unit (pedestal) is rotated 90-degrees clockwise to unload the casualties.
    c. The unloading sequence for the four-litter configuration.

(1) On the right side of the aircraft, the unloading sequence is bottom right, bottom left, top right, and top left.

(2) If you are unloading from the left side of the aircraft, the unloading sequence is bottom left, bottom right, top left, and top right.

d. The unloading sequence for the six-litter configuration.

(1) Remove the casualty that has been placed on the floor on the left side.

(2) Remove the casualty that has been placed on the floor of the right side.

(3) Turn the litter support unit 90 degrees.

(4) Once the litter support unit has been turned 90 degrees the last four litters are unloaded in the normal sequence.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in a field condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Followed the principles of unloading casualties from a rotary-wing aircraft. | _____ | _____ |
| 2 | Unloaded casualties from the rotary-wing aircraft. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, demonstrate what was done wrong and how to do it correctly.

**References:**

**Required**
ATP 4-02.2. *Medical Evacuation.*

**Related**
None

Perform Casualty Triage

081-000-0055

This individual task was presented earlier in the STP on page 3-204 as a readiness requirements task. The content requirements are the same.

Establish a Casualty Collection Point

081-000-0070

This individual task was presented earlier in the STP on page 3-208 as a readiness requirements task. The content requirements are the same.

Establish an Ambulance Exchange Point

081-000-0088

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You have been directed to establish an ambulance exchange point (AXP). You will be provided with your unit's tactical standard operating procedures, a battle drill plan including combat service support, operation overlays, and an ambulance.

**Standards:** Establish an AXP in accordance with ATP 4-02.2, while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**Performance Steps:**

1. Select the site for an AXP based on the tactical mission.
    a. The location of the AXP will depend on the location and number of units being supported.

**NOTE:** : An AXP can be established between any roles of care in order to mitigate distance and sustain proximity to the supported population. An AXP may also be used between the Role 1 and Role 2.

    b. This location should provide the required support to reduce ambulance turnaround time to supported units.
    c. When supporting tracked vehicles, the AXP should be located as close as possible to the supported unit to reduce the time and distance requirements for the tracked vehicles.
    d. The AXP may be an established point in an ambulance system, or it may be designated independently.

2. Establish the AXP.
    a. AXPs may or may not be staffed.
        (1) Points that are not staffed may serve as rendezvous points for the rapid transfer of a patient from one transportation mode to another.
        (2) In most cases AXPs will not be staffed.
        (3) The ambulance platoon leader or sergeant coordinates and establishes the AXPs as required by the medical evacuation mission.
    b. The medical evacuation plan should include an overlay depicting (at a minimum) the location of supported units, casualty collection points, Role I facilities, and AXPs. May also include ambulance loading points, ambulance relay points, and ambulance control points.
    c.
        (1) The platoon leader should also obtain the protection and sustainment warfighting functions operations overlays for the tactical operation. These overlays provide valuable information on:

(a) Mine fields.

(b) Obstacles and barriers.

(c) Artillery target reference points.

(d) Air corridors.

(2) Supported units.

(a) An AXP may serve two to three battalions or squadrons (brigade support medical company or medical troop) or a specific number of non-divisional Role I facilities (medical company, area support).

(b) In these cases, the AXP should be centrally located to reduce ambulance turnaround and enhance the timely execution of the medical evacuation mission.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Selected a site for an AXP based on the tactical mission. | _____ | _____ |
| 2 | Established the AXP. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
ATP 4-02.2. *Medical Evacuation*.

**Related**
None

## Load Casualties onto Ground Ambulances

081-000-1015

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You are in charge of loading litter and ambulatory casualties onto one of the following ground medical evacuation vehicles: high mobility multipurpose wheeled vehicle (HMMWV) M997 Series, M113A3 tracked ambulance, M1133 Stryker medical evacuation vehicle, M1266A1 long wheel base (LWB) mine-resistant ambush protected (MRAP), or armored multi-purpose vehicle medical evacuation. You have access to one of the ground medical evacuation vehicles, litters, and litter straps. You will need the assistance of at least one other Soldier to aid in loading litter patients. All other previous medical interventions are completed.

**Standards:** Load casualties onto a ground ambulance in accordance with (IAW) ATP 4-02.2, ATP 4-02.4, ATP 4-02.2, and local standard operating procedure, in the correct sequence for the evacuation platform with 100% accuracy and without causing further harm to the casualties, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Determine the number of patients by type (litter or ambulatory) and prioritize the sequence of loading.

2. Verify the litter straps are secure.

3. Configure and prepare the medical evacuation vehicle to support the number of casualties for the vehicle platform.
    a. HMMWV M997 Series has an evacuation capacity of 4 litter patients or 6-8 ambulatory patients or a combination of 2 litter or 3-4 ambulatory patients.
    b. M113A3 tracked ambulance has an evacuation capacity of 4 litter patients or 6-8 ambulatory patients or a combination of 2 litter or 3-4 ambulatory patients.
    c. M1133 Stryker medical evacuation vehicle has an evacuation capacity of 4 litter patients or 6 ambulatory patients or a combination of 2 litter or 2-4 ambulatory patients.
    d. M1266A1 LWB MRAP has an evacuation capacity of 2 litter patients or 4 ambulatory patients or 1 litter or 2 ambulatory patients.
    e. Armored multi-purpose vehicle medical evacuation has an evacuation capacity of 4 litter patients or 6 ambulatory patients or a combination of 2 litter or 3 ambulatory patients.

**CAUTION:** Some casualties must be loaded feetfirst based on injury for example, fractured femur with a traction splint.

4. Load the litter patients, headfirst, onto the vehicle in proper sequence.

**NOTE:** The loading sequence for litter patients will vary based on the vehicle used and the number of litter patients being evacuated. The most seriously injured patient is loaded last to ensure they are the first to be taken out of the ambulance. Casualties are normally loaded

headfirst to go with the direction of travel. This decreases the likelihood of motion sickness or nausea.

5. Load ambulatory casualties.
6. Check security of casualties for transport.
7. Secure doors and hatches for departure.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Determined the number of patients by type (litter or ambulatory) and prioritize the sequence of loading. | _____ | _____ |
| 2 | Verified the litter straps were secure. | _____ | _____ |
| 3 | Configured and prepared the medical evacuation vehicle to support the number of casualties for the vehicle platform. | _____ | _____ |
| 4 | Loaded the litter patients, headfirst, onto the vehicle in proper sequence. | _____ | _____ |
| 5 | Loaded ambulatory casualties. | _____ | _____ |
| 6 | Checked security of casualties for transport. | _____ | _____ |
| 7 | Secured doors and hatches for departure. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
ATP 4-02.2. *Medical Evacuation*.
ATP 4-02.4. *Medical Platoon*.
ATP 4-02.13. *Casualty Evacuation*.

**Related**
None

## Unload Casualties from Ground Ambulances

081-000-1016

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You are in charge of unloading litter and ambulatory casualties of one of the following ground medical evacuation vehicles: high mobility multipurpose wheeled vehicle (HMMWV) M997 Series, M113A3 tracked ambulance, M1133 Stryker medical evacuation vehicle, M1266A1 long wheel base (LWB) mine-resistant ambush protected (MRAP), or armored multi-purpose vehicle medical evacuation. You have access to one of the ground medical evacuation vehicles. You will need the assistance of at least one other Soldier to aid in unloading litter patients.

**Standards:** Unload casualties from ground ambulances in accordance with ATP 4-02.2 in the correct sequence for the evacuation platform with 100% accuracy and without causing further harm to the casualties, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Prepare the medical evacuation vehicle to unload casualties.
    a. Open rear doors.
    b. Lower the ramp or tailgate.
    c. Ensure there are no obstructions.
2. Unload ambulatory casualties.
    a. Release the restraints.
    b. Direct the ambulatory casualties exit the ambulance.
3. Unload litter casualties.

**NOTE:** Direct nonmedical personnel to unload the litter casualties in the correct sequence for the vehicle platform.

a. HMMWV M997 Series unloading sequence is lower left, lower right, then upper left and finally lower right.

b. M113A3 tracked ambulance unloading sequence is lower left, lower right, upper left, and upper right.

c. M1133 Stryker medical evacuation vehicle unloading sequence is the bottom left, top left, bottom right and top right.

d. LWB MRAP unloading sequence is commander’s berth then driver’s side berth.

e. Armored multi-purpose vehicle medical evacuation unloading sequence is lower left, lower right, upper left, and upper right.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 1 | Prepared the medical evacuation vehicle to unload casualties. | _____ | _____ |
| 2 | Unloaded ambulatory casualties. | _____ | _____ |
| 3 | Unloaded litter casualties. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
ATP 4-02.2. *Medical Evacuation*.

**Related**
None

Perform Casualty Movement

081-68W-0282

This individual task was presented earlier in the STP on page 3-189 as a readiness requirements task. The content requirements are the same.

Load Patients on an Air Ambulance

081-68W-0293

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment during tactical evacuation care you must load casualties on an air ambulance. You are provided with litters, litter straps, and a UH-60 Blackhawk.

**Standards:** Load casualties on an air ambulance in the correct sequence for the UH-60 Blackhawk in accordance with ATP 4-02.13 without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Follow principles of loading casualties aboard a rotary-wing aircraft.

**NOTE:** The UH-60 Blackhawk has a number of possible seating or cargo configurations. A major difference in preparing the UH-60A to carry litters is that a medical evacuation kit must be installed. This kit consists of a seat and converter assembly unit and a litter support unit. The seat and converter assembly unit provides for three rear-facing seats which allow the medical attendant and crew chief to monitor casualties. The litter support unit consists of a center pedestal which can be rotated 90 degrees about the vertical axis for the loading and unloading of casualties.

   a. Responsibility for loading and securing a rotary-wing aircraft.

      (1) The pilot has the overall responsibility for the proper loading and securing of litter and ambulatory casualties and related equipment on board the aircraft.

      (2) The flight medic crew member is responsible for ensuring that the litter squad follows the prescribed methods for loading litter or ambulatory casualties and securing litters and related medical equipment.

      (3) The final decision regarding how many casualties may be safely loaded rests with the pilot.

   b. Safety measures.

      (1) Litter bearers must present as low a silhouette as possible and must keep clear of the main and tail rotors at all times.

      (2) The helicopter must not be approached until a crew member signals to do so.

      (3) The litter bearers should approach the aircraft at a 90-degree angle from the front of the helicopter.

      (4) If the helicopter is on a slope and conditions permit, loading personnel should approach the aircraft from the downhill side.

      (5) Directions given by the crew must be followed, and litters must be carried parallel to the ground.

      (6) Smoking is not permitted within 50 feet of the aircraft.

2. Determine UH-60 rotary-wing aircraft load capacities.
   a. Four to six litter casualty capability of the support unit.

b. If litter casualties are not being evacuated, a maximum of six ambulatory casualties can be seated on the litter support unit (three on each side). A seventh casualty can be seated on a troop seat.

3. Determine the loading sequence.

a. The most seriously injured casualties are loaded last on the bottom pans of the litter support unit. However, if it is anticipated that a casualty's medical condition may require in-flight emergency medical care (such as cardiopulmonary resuscitation), the casualty should be loaded onto either of the top pans to facilitate access.

b. Casualties in traction splits should be loaded last and on a bottom pan.

c. The UH-60 has the capability to be loaded on both sides simultaneously. Casualties should be loaded so that upon rotating the litter support, the casualty's head will be forward in the cabin. To accomplish this, casualties loaded on the left side of the aircraft should be loaded headfirst and casualties loaded on the right side of the aircraft should be loaded feetfirst (left and right sides are determined from the position of the pilot in command's seat, looking forward).

d. When the six-litter configuration is used, the fifth and sixth litter casualties are loaded with the carousel in the fly position. The head of each casualty should face toward the front of the aircraft.

4. Direct nonmedical Soldiers to load and secure casualties.

a. In loading four litter casualties with a four-man litter squad, the litters are loaded from the top to bottom. The sequence for loading litters from one side of the aircraft with the carousel turned is upper right, upper left, lower right, and then lower left. To load litters from both sides of the aircraft simultaneously, the sequence is upper then lower.

(1) The litter support unit is rotated 90-degrees clockwise to receive the litter casualties. The flight crew lowers the top pan to accept the litter and stands by to assist. This is accomplished as the litter squad approaches the aircraft.

(2) The litter squad moves into the semi overhead carry, lifting the litter just high enough for the litter stirrups of one end to slide onto the litter pan. The litter squad slides the litter forward. The flight crew member guides and assists the litter squad, until the litter stirrups of both ends are secured on the pan. The litter squad departs as the flight crew member raises the pan back to its upright position and secures it. The flight crew member fastens the litter straps attached to the litter support assembly.

(3) After the first litter is loaded, the squad leaves the aircraft as a team to obtain another litter casualty. The second, third, and fourth litters are loaded in the same manner, except that the bottom pans are not tilted to receive casualties.

(4) After having loaded four litter casualties, the litter support unit is rotated 90-degrees counterclockwise and locked in the in-flight position. The cargo doors must be closed for flight.

b. The loading of six litter casualties requires the repositioning of the litter support prior to loading. The loading procedure remains the same as the four-litter configuration except for the following:

(1) The top litter support no longer tilts. This necessitates overhead loading and may require additional assistance.

(2) After four litters are loaded, the pedestal must be rotated back to the locked position. The restraint and tube assembly modification kit are then installed. The last

two litters are side loaded between the restraints, with the casualty's heads toward the front of the aircraft. They are then secured.

c. When the aircraft is to receive a mixed load of litter and ambulatory casualties, one top pan of the litter support is removed and repositioned just above the bottom pan on the same side. The aircraft can now accommodate two or three litter and four ambulatory casualties.

(1) The litter support unit is rotated clockwise to receive the litter casualties, except for the third litter in the six-litter configuration. Upon loading and securing the litter casualties, the litter support unit is rotated counterclockwise to the in-flight position. The third litter is then loaded when the six-litter configuration is used.

(2) Ambulatory casualties are escorted to the aircraft by ground personnel. They are assisted into their seats and secured with the seat belts attached to the litter support unit.

**WARNING:** To prevent further injury to casualties, all end support pins of the installed litter pans must be in the locked position for flight.

(3) The cargo doors are now closed for flight.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Followed principles of loading casualties aboard a rotary-wing aircraft. | _____ | _____ |
| 2 | Determined UH-60 rotary-wing aircraft load capacities. | _____ | _____ |
| 3 | Determined the loading sequence. | _____ | _____ |
| 4 | Directed nonmedical Soldiers to load and secure casualties. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
ATP 4-02.13. *Casualty Evacuation*.

**Related**
None

Transport a Casualty Using a Litter

081-68W-0298

This individual task was presented earlier in the STP on page 3-194 as a readiness requirements task. The content requirements are the same.

## Transport a Casualty Using a Modular Sled Based Rescue System or SKED ® Basic Rescue System

081-68W-0299

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment, and you have a litter casualty that must be packaged in a rescue system complete litter for transport. You have a rescue system complete litter assemblage, pen, and DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*) or a SF 600 (*Chronological Record of Medical Care*) or the electronic medical record.

**Standards:** Transport a casualty using a modular sled-based rescue system or basic rescue system complete in accordance with ATP 4-02.13, *Tactical Combat Casualty Care (TCCC) Guidelines* and the *Committee on Tactical Combat Care (Co TCCC)* by Joint Trauma Systems while adhering to all warnings and caution, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Evaluate the casualty according to the tactical situation and determine if a spinal injury is suspected.

**NOTE:** If a spinal injury is suspected, the patient should be immobilized with a seated device prior to being placed in the rescue system complete stretcher.

2. Open the carrying case backpack, remove the rolled rescue system complete litter, and place on the ground.

3. Unroll completely to the opposite end (head end) of the rescue system complete litter.
    a. While keeping your foot on the foot end of the rescue system complete litter, pull the head end of the litter up to your chest and bend the rescue system complete litter in half (away from you) and back roll.
    b. Place your foot on the head end of the rescue system complete litter while pulling the foot end of the litter up to your chest, bend the rescue system complete litter in half, and back roll.

**NOTE:** Laying the rescue system complete litter out in this manner is important in order for the rescue system complete litter to lay flat on the ground.

4. Slide the casualty onto the rescue system complete litter.
    a. Place the foot of the rescue system complete litter at the top of the casualty's head.

**NOTE:** Ensure that the four cross straps are not laying on the rescue system complete litter surface so that they do not lie under the casualty when the casualty is applied to the rescue system complete litter.

    b. Slide and center the casualty onto the rescue system complete litter.

5. Buckle the cross straps.
    a. Lift the sides of the rescue system complete litter and feed the four cross straps to the buckles directly opposite the cross straps.
    b. Pull the four cross straps until each one is secured thru the buckles.
    c. Half hitch (tie excess in a series of half knots) and tuck the excess on the inside of the rescue system complete litter with the casualty.

6. Buckle the foot straps.
    a. Feed the foot straps thru the unused grommets, located closest to the fourth cross strap, at the foot end of the rescue system complete litter.
    b. Buckle the two-foot straps and fasten securely.
    c. Half hitch (half knot) and tuck the excess on the inside of the rescue system complete litter with the casualty.

7. Insert horizontal lift slings.
    a. Insert the horizontal lift sling, labeled head strap, thru the angled lift slot at the head of the rescue system complete litter located just inferior to the first cross strap, starting from the inside thru to the outside of the rescue system complete litter.
    b. Run the horizontal lift sling around the outside of the rescue system complete litter to the opposite angled lift slot.
    c. Insert the horizontal lift sling thru the angled lift slot, located closest to the third cross strap, from the outside in.
    d. Extend both ends of the horizontal lift slings and ensure that both have equal length.
    e. Insert the horizontal lift sling, not labeled head strap, thru the angled lift slot at the foot end of the rescue system complete litter starting from the inside thru to the outside of the rescue system complete litter.
    f. Run the horizontal lift sling around the outside of the rescue system complete litter to the opposite angled lift slot.
    g. Insert the horizontal lift sling thru the angled lift slot from the outside in.
    h. Extend both ends of the horizontal lift slings and ensure that both have equal length.

8. Prepare the head portion of the rescue system complete litter for hoist operations.
    a. Bend the head portion of the rescue system complete litter over the casualty and remove the excess slack, from the drag strap, until the litter maintains its curve over the casualty's head.
    b. Tie the drag strap to the middle of the second cross strap in a half knot.
    c. Tuck the excess of the drag strap into the litter with the casualty.

**NOTE:** Make sure that the curved portion of the stretcher, at the casualty's head, does not make contact with casualty's skin. This will prevent further injury to the casualty during actual hoisting of the rescue system complete litter.

9. Insert the large locking 'D' steel carabineer.
    a. Insert the large locking 'D' steel carabineer thru one of the open ends of the head horizontal lift slings.

b. Insert the large locking ‘D’ steel carabineer thru both open ends of the foot horizontal lift slings.

c. Insert the large locking ‘D’ steel carabineer thru the remaining head horizontal lift sling.

d. Screw down the gate screw completely and lock it in place.

10. Perform final safety checks.

a. Check all four cross straps.

b. Check the two-foot straps.

c. Ensure that the horizontal lift strap labeled head strap is actually at the head of the rescue system complete litter.

d. Ensure that all four horizontal lift slings are even in length so the load will be lifted evenly.

e. Ensure that the large locking ‘D’ steel carabineer has been feed thru all four ends of the horizontal lift slings.

f. Ensure that gate screw on the large locking ‘D’ steel carabineer has been screwed down completely and the keeper is not able to freely open.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Evaluated the casualty according to the tactical situation and determined if a spinal injury was suspected. | _____ | _____ |
| 2 | Opened the carrying case backpack, removed the rolled rescue system complete litter, and placed on the ground. | _____ | _____ |
| 3 | Unrolled completely to the opposite end (head end) of the rescue system complete litter. | _____ | _____ |
| 4 | Slid the casualty onto the rescue system complete litter. | _____ | _____ |
| 5 | Buckled the cross straps. | _____ | _____ |
| 6 | Buckled the foot straps. | _____ | _____ |
| 7 | Inserted horizontal lift slings. | _____ | _____ |
| 8 | Prepared the head portion of the rescue system complete litter for hoist operations. | _____ | _____ |
| 9 | Inserted the large locking ‘D’ steel carabineer. | _____ | _____ |
| 10 | Performed final safety checks. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
ATP 4-02.13. *Casualty Evacuation.*
*Committee on Tactical Combat Care (CoTCCC).*
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
Deployed Medicine website.
Joint Trauma System website.
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

**Skill Level 2**

**Subject Area 15: Force Health Protection**

Change a Sterile Dressing

081-000-1030

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment and have been directed to change a sterile dressing on a patient. You will need a pen, clipboard, sterile gloves, face mask, protective pad, scissors, forceps, basin, sterile gauze, medical adhesive tape, sterile dressing, sterile cleaning solution, SF 600 (*Chronological Record of Medical Care*), and electronic medical record (EMR).

**Standards:** Change a sterile dressing in accordance with (IAW), *Joint Trauma System Clinical Practice Guidelines* while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Review the patient order.
2. Verify the patient.
3. Brief the patient on the procedure.
4. Ensure the work area is clean and free of obstructions.
5. Set-up the workspace for the procedure in a sterile environment.
6. Perform a patient care handwash.
7. Put on a mask and exam gloves.
8. Prepare the patient.
    a. Place a protective pad under the patient.
    b. Position the patient to ensure maximum exposure of the wound.
    c. Remove the clothing to expose the wound.
9. Remove the dressing.
    a. Outer dressing.
    b. Inner packing material using sterile forceps.
10. Assess the wound.
    a. Check for redness, swelling, foul odor, or bleeding.

**CAUTION:** Notify the supervisor if any of the above conditions are present.

b. Check for drainage that contains blood, serum, or pus (usually yellow but may be blood-tinged, greenish, or brown).

**NOTE:** If drainage is present, inform the medical officer and request orders to irrigate the wound (see task 081-000-0031, Perform a Wound Irrigation).

11. Clean the wound with a sterile gauze or surgical sponge soaked in a benzoin tincture or other approved cleaning solution.
    a. Use the cleaning technique for a linear wound.
        (1) Clean the area directly over the wound with one wipe and discard the gauze.
        (2) Clean the skin area on one side next to the wound with one wipe and discard the gauze.
        (3) Clean the skin area on the other side next to the wound with one wipe and discard the gauze.
        (4) Continue cleaning the wound while alternating sides and working away from the wound itself, until it is cleaned.
    b. Use the cleaning technique for a circular wound.
        (1) Wipe the wounded area beginning at the center of the wound in an outward spiral motion and then discard the gauze.
        (2) Clean the skin area next to the wound in an outward spiral motion for one- and one-half revolutions while discarding the gauze upon completion.
        (3) Continue outward spiral strokes of one- and one-half revolutions until the entire area around the wound is clean.

12. Insert wound packing material as required.

13. Apply the sterile gauze and wound dressing to the cleaned wound.

**NOTE:** If the wound has a drain inserted, cut the dressing halfway through and position it around the drain.

14. Secure the dressing by applying tape to the edge of the dressing with half of the tape on the dressing and the other half on the skin.

**NOTE:** Write the date and time the dressing was changed on a piece of tape, initial it, and secure the tape to the dressing.

15. Annotate the date and time the dressing is changed on a piece of tape with initials and secure the tape to the dressing.

16. Dispose of contaminated materials IAW local standard operating procedures.

17. Perform a patient care handwash.

18. Annotate the sterile dressing change on the SF 600 or EMR.
    a. Annotate the date and time of the dressing change.
    b. Document the assessment of the wound appearance before and after cleaning.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 1 | Reviewed the patient order. | _____ | _____ |
| 2 | Verified the patient. | _____ | _____ |
| 3 | Briefed the patient on the procedure. | _____ | _____ |
| 4 | Ensured the work area was clean and free of obstructions. | _____ | _____ |
| 5 | Set-up the workspace for the procedure in a sterile environment. | _____ | _____ |
| 6 | Performed a patient care handwash. | _____ | _____ |
| 7 | Put on a mask and exam gloves. | _____ | _____ |
| 8 | Prepared the patient. | _____ | _____ |
| 9 | Removed the dressing. | _____ | _____ |
| 10 | Assessed the wound. | _____ | _____ |
| 11 | Cleaned the wound with a sterile gauze or surgical sponge soaked in a benzoin tincture or other approved cleaning solution. | _____ | _____ |
| 12 | Inserted wound packing material as required. | _____ | _____ |
| 13 | Applied the sterile gauze and wound dressing to the cleaned wound. | _____ | _____ |
| 14 | Secured the dressing by applying tape to the edge of the dressing with half of the tape on the dressing and the other half on the skin. | _____ | _____ |
| 15 | Annotated the date and time the dressing was changed on a piece of tape with initials and secured the tape to the dressing. | _____ | _____ |
| 16 | Disposed of contaminated materials IAW local standard operating procedures. | _____ | _____ |
| 17 | Performed a patient care handwash. | _____ | _____ |
| 18 | Annotated the sterile dressing change on the SF 600 or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
Joint Trauma System website.

SF 600. *Chronological Record of Medical Care*.

**Related**
None

Remove a Toenail

081-000-0095

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, a patient requires you to perform a toenail removal. You have been provided with a medical provider's orders for a toenail removal (partial or complete), appropriate antimicrobial solution, sterile normal saline or sterile water, non-adherent dressing, 3-5 milliliters (ml) syringe with two long (1-1.5 inch) needles 25 gauge and 21 gauge, 1% lidocaine local anesthetic without epinephrine, nail anvil splitter (English), two sterile forceps or hemostats (straight), sterile cotton-tipped applicators, penrose drain used as a tourniquet, 4x4 sterile gauze sponges, dressing materials, infectious waste receptacle, sharps container, tape, and SF 600 (*Chronological Record of Medical Care*) or electronic medical record, DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*), and pen.

**Standards:** Remove a toenail in accordance with (IAW) *Tactical Combat Casualty Care (TCCC) Guidelines*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Solicit a patient history for verification of patient's signature on consent form.
2. Gather equipment.
3. Prepare the patient.
   a. Explain procedure.
   b. Place the patient supine with knees flexed and feet flat.
   c. Cleanse the digit with an antimicrobial scrub.
   d. Exsanguinate the toe by squeezing or wrapping and apply a tourniquet at the base of the toe.
   e. Apply sterile drapes to completely surround the wound and to cover all unprepared areas adjacent to the site.
   f. Administer local anesthetic by ring block technique.
      (1) Digital cutaneous nerves run along the medial and lateral aspects of each digit and can be blocked at any level above the distal phalanx.
      (2) Use the 25-gauge needle to raise a skin wheal by administering approximately 0.25 ml of the anesthetic directly over the lateral and medial cutaneous nerve.
      (3) Change to 21-gauge needle and advance the needle perpendicular to the nerve until bone is reached; inject approximately 1 ml of the anesthetic.
      (4) Slide the needle up and down on the dorsal and volar aspects of the digit, injecting approximately 0.5 ml of the anesthetic in each side.
      (5) Discard used needles and syringe in sharps container immediately after use.
      (6) It takes 5 to 10 minutes for complete anesthesia to develop.
4. Remove partial toenail.

a. Perform a patient care handwash and put on sterile gloves.

b. Once anesthesia has been achieved, use a straight hemostat to firmly secure a wide rubber band around the base of the digit to serve as a tourniquet.

c. Stabilize the digit in the nondominant hand.

**CAUTION:** Take care to perform a controlled division along the longitudinal lines of the nail for several millimeters past the proximal nailfold (cuticle).

d. Insert a single blade of the other straight hemostat between the nail bed and the nail to loosen and lift the nail. Split the nail with nail splitter in a longitudinal direction (distal to proximal) to include the base of the nail that rests beneath the cuticle.

**NOTE:** An English anvil nail splitter is desirable to begin the procedure, but sharp scissors or a No.11 blade will work.

e. With the second straight hemostat, grasp the portion of the loosened nail and remove it using a steady pulling motion with a simultaneous upward twist of the hand toward the affected side completely removing the section of the nail.

f. Debride the nail groove.

(1) Inspect the remnant to be certain that the entire piece of nail of has been removed as desired.

(2) Sharply remove any remaining or swollen or heaped-up skin and all hyperkeratotic debris.

g. Remove the tourniquet and assess for hemostasis.

h. Apply a topical antibiotic ointment (not containing neomycin) to the nail bed and cover the digit with a sterile nonadherent dressing, followed by a dry sterile wrap or tubular gauze and tape in place.

i. Discard soiled or blood-soaked gauze and disposable drapes in infectious waste receptacle, IAW infection control guidelines and local facilities standard operating procedures (SOPs).

j. Cleanse all instruments used in procedure IAW local facilities SOP.

k. Remove gloves.

l. Wash hands.

5. Remove complete toenail.

a. Perform a patient care handwash and put on sterile gloves.

b. Once anesthesia has been achieved, use a straight hemostat to firmly secure a wide rubber band around the base of the digit to serve as a tourniquet.

c. Stabilize the digit in the nondominant hand.

**CAUTION:** It is important to completely free the proximal nail at its base (under the edge of the cuticle) to allow removal and to expose the germinal tissue of the nail bed.

d. Insert a single blade of the other straight hemostat (or the periosteal elevator) between the nail bed and the toenail to loosen and lift the nail; advance the instrument with a continued upward pressure against the nail and away from the nail bed to minimize injury and bleeding.

e. With the second straight hemostat, grasp the loosened nail and remove it using a steady pulling motion with a simultaneous upward twist of the hand toward the affected side completely removing the nail.

f. Debride the nail grooves as needed.

(1) Inspect the remnant to be certain that the entire piece of nail has been removed as desired.

(2) Sharply remove any remaining or swollen or heaped-up skin and all hyperkeratotic debris.

g. Remove the tourniquet and assess for hemostasis.

h. Apply a topical antibiotic ointment to the nail bed and cover the digit with a sterile gauze sponge dressing or tubular gauze and tape in place.

i. Discard soiled or blood-soaked gauze and disposable drapes in infectious waste receptacle, IAW infection control guidelines and local facilities SOP.

j. Cleanse all instruments used in procedure IAW local facilities SOP.

k. Remove gloves.

l. Wash hands.

6. Provide patient follow-up instructions.

a. Rest the foot (toe) during the initial 24 hours after the procedure.

b. Elevate the extremity when possible.

c. Return in 24 hours for dressing change, at which time you should reapply the topical antibiotic ointment, apply a less bulky dressing, and encourage ambulation and a return to normal activity within the next 48 hours.

d. Soaking the open wound in warm water for 20 minutes, twice a day is soothing and allows the patient to view the healing process.

e. Tell patient to expect some clear to yellow fluid drainage (exudate) from the toe that may continue for three weeks. Complications include nail regrowth, infection, growth of an inclusion cyst, and delayed healing.

**NOTE:** If the condition returns, podiatric referral is recommended for more extensive nail bed ablation.

f. Emphasize proper toenail hygiene and schedule a follow-up visit for 30 days to assess healing.

7. Document the procedure on the appropriate form.

a. Patient's tolerance of procedure.

b. Teaching instructions given patient.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Solicited a patient history for verification of patient's signature on consent form. | _____ | _____ |
| 2 | Gathered equipment. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 3 | Prepared the patient. | _____ | _____ |
| 4 | Removed partial toenail. | _____ | _____ |
| 5 | Removed complete toenail. | _____ | _____ |
| 6 | Provided patient follow-up instructions. | _____ | _____ |
| 7 | Documented the procedure on the appropriate form. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
Deployable Medicine website.
SF 600. *Chronological Record of Medical Care*.
*Tactical Combat Casualty Care (TCCC) Guidelines.*

**Related**
None

Process an Infectious Sample

081-68W-2004

**WARNING:** All specimens must be treated as if infectious and capable of transmitting a serious infectious disease.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You have orders to obtain an infectious sample from a patient to be processed and sent to the lab. You will be provided with the required laboratory equipment for the type of specimen ordered by the medical officer (MO), personal protective safety equipment such as gloves and goggles, and the patient's SF 600 (*Chronological Record of Medical Care*) or electronic medical record (EMR).

**Standards:** Process an infectious sample in accordance with (IAW) *Bailey & Scott's Diagnostic Microbiology*, and local lab standard operating procedure (SOP), while adhering to all warnings, and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Complete the laboratory request IAW local SOP.
    a. Patient identification.
    b. Requesting MO's name.
    c. Unit identification.
    d. Date and time of specimen collection.
    e. Test(s) requested by the MO.
    f. Specimen source (blood, urine, or tissue).
    g. Any remarks that pertain to the patient (spider or tick bite).
    h. Complete the "urgency" box (routine, today, preop, stat, or as soon as possible).
2. Provide for the patient's safety and comfort.
3. Collect the specimen IAW lab SOP (blood, urine, or tissue).
4. Forward the specimen to the laboratory.

**NOTE:** Pay particular attention to specimens that are time or temperature dependent.

    a. Attach the lab request to the specimen container with a rubber band or paper clip.
    b. Arrange for the specimen to be sent to the lab or transport the specimen to the lab IAW local SOP.

5. Record the procedure on the appropriate form(s).
6. Dispose of waste materials IAW local infection control SOP.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 1 | Completed the laboratory request IAW local SOP. | _____ | _____ |
| 2 | Provided for the patient's safety and comfort. | _____ | _____ |
| 3 | Collected the specimen IAW lab SOP (blood, urine, or tissue). | _____ | _____ |
| 4 | Forwarded the specimen to the laboratory. | _____ | _____ |
| 5 | Recorded the procedure on the appropriate form(s). | _____ | _____ |
| 6 | Disposed of waste materials IAW local infection control SOP. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment. Evaluation guidance for shared task.

**References:**

**Required**
*Bailey & Scott's Diagnostic Microbiology.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

**Subject Area 16: Medical Management**

Place an Orogastric Tube

081-68W-2005

**WARNING:** Orogastric (OG) tube insertion is contraindicated in patients with esophageal strictures, ingested caustics, significant facial or head trauma or patients with bleeding disorders.

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection. Insertion of an OG tube into trachea and lung, patient may experience respiratory distress. If this occurs at any time during the procedure, remove the tube immediately.

**Conditions:** You are in an operational environment. You have a patient requiring insertion of an OG tube. You will be provided surgical lubricant, a large (50 or 60 milliliter [ml]) syringe, an OG tube, towel or protective cover pad, an emesis basin, a small (10 to 20 ml) syringe, a container for contaminated waste, adhesive tape, stethoscope, gloves, water, small cup, a drinking straw, pen, and SF 600 (*Chronological Record of Medical Care*), electronic medical record (EMR) or DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*). You have performed a patient care handwash.

**Standards:** Place an OG tube, in accordance with *Lippincott Manual of Nursing Practice*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Determine if the indicators for performing OG intubation are present.
    a. Patient with midfacial trauma.
    b. Gastric distention which impedes airway, breathing and circulation.
    c. Intestinal obstruction.
    d. Preoperative and postoperative care.
    e. Patient requires a gastrointestinal lavage.
    f. Patient requires a gavage.
    g. Need to analyze stomach contents.

**WARNING:** Wear gloves for self-protection against transmission of contaminants whenever handling body fluids.

2. Take appropriate BSI precautions.

3. Identify the patient.
    a. Ask the patient’s name.
    b. Ask the patient’s date of birth.
    c. Check the identification band against the chart as appropriate.

4. Explain the procedure to the patient.

**NOTE:** It is not advisable to explain the procedure too far in advance because the patient's anxiety about the procedure may interfere with its success. It is important that the patient relax, swallow, and cooperate during the procedure.

a. Explain the reason for the OG tube.

b. Explain the procedure and assess their capability of cooperating with the procedure.

c. Tell the patient that a tube will be inserted along the oral passage and that they may feel some discomfort.

d. Tell the patient that breathing through the nose or mouth, panting, and swallowing can help in passing the tube.

e. Ask the patient about any history of oral or esophageal injury.

f. Tell the patient that the tube must be placed about 20 inches down the oral passageway.

g. Tell the patient that the procedure may cause them to gag.

5. Prepare the equipment.

**NOTE:** Each patient will have a slightly different terminal insertion point. Measurements must be made for each individual's anatomy. The mucosa is less likely to be damaged during insertion. Add (8 to 10 inches) or more for intestinal placement.

a. Select the correct type and size of OG tube to use.

b. Cut four or five pieces of tape 3 to 4 inches long and attach one end of each where they will be easily accessible.

c. Unwrap the tube from the plastic wrapper.

d. Measure the combined distance from the tip of the nose to the earlobe and from the earlobe to the xiphoid process, (8 to 10 inches) or more for intestinal placement. Mark this spot with a small piece of temporary tape.

e. Lubricate 5 to 6 centimeters (cm) of the distal end of the tube with water-soluble lubricant.

6. Examine the patient's oral cavity. Ensure that there are no obstructions in the oral cavity.

7. Position the patient.

**NOTE:** The oropharynx can be sprayed with an anesthetic agent to numb the mouth and suppress the gag reflex if orders are written by the medical officer.

a. Position the responsive, awake, and alert patient in the Fowler's position. Elevate the head of the bed to about 30 to 45 degrees.

b. Place a clean towel or protective cover pad over the patients' chest as a bib-type protection. This is used to protect the patient's clothing or bed linen.

c. Place a comatose or unconscious patient in the lateral position (turn the patient onto their side).

8. Insert the lubricated tip of the tube into the oropharynx.

9. Advance the tube into the esophagus.

10. Continue advancing the tube until the tape marker touches the lips.

11. Check and confirm the tube is correctly placed by at least five methods.

**NOTE:** It is necessary to measure the length of the exposed portion of the tube and document the length. This is to ensure proper tube length and must be done every shift. Gastric aspirate is most frequently cloudy and green, tan, off-white, or brown and may be of large volume. Intestinal aspirate is primarily clear and yellow to bile (green or dark green) colored and typically smaller volume. Lung aspirate is usually clear and of small volume. The c.Potential of hydrogen (pH) of gastric aspirate is acidic (1 to 5). The pH of intestinal aspirate is typically 6 or higher and the pH of respiratory aspirate is more alkaline (7 or greater). Injection of 30-60 milliliters (ml) of air into tube as you auscultate for the sound of air over the epigastric region. Placement of these tubes must still be confirmed by x-rays to ensure that the tips have reached the stomach rather than the esophagus.

a. Measurement of tube.
b. Visual assessment of aspirate color and volume.
c. (pH measurement of aspirate.
d. Air auscultation.
e. X-ray confirmation.

12. Secure the tube to the patient's cheek using tape.

**NOTE:** The goal of securing the tube in place is to prevent peristaltic movement from advancing the tube or from accidentally being pulled out.

13. Connect the tube to the suction apparatus when required.

14. Remove the gloves and wash hands.

15. Record the procedure and patient's tolerance of procedure on the SF 600 or clinical information system.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Determined if the indicators for performing OG intubation were present. | _____ | _____ |
| 2 | Took appropriate BSI precautions. | _____ | _____ |
| 3 | Identified the patient. | _____ | _____ |
| 4 | Explained the procedure to the patient. | _____ | _____ |
| 5 | Prepared the equipment. | _____ | _____ |
| 6 | Examined the patient's oral cavity. Ensured that there were no obstructions in the oral cavity. | _____ | _____ |
| 7 | Positioned the patient. | _____ | _____ |

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 8 | Inserted the lubricated tip of the tube into the oropharynx. | _____ | _____ |
| 9 | Advanced the tube into the esophagus. | _____ | _____ |
| 10 | Continued advancing the tube until the tape marker touched the lips. | _____ | _____ |
| 11 | Checked and confirmed the tube is correctly placed by at least five methods. | _____ | _____ |
| 12 | Secured the tube to the patient's cheek using tape. | _____ | _____ |
| 13 | Connected the tube to the suction apparatus when required. | _____ | _____ |
| 14 | Removed the gloves and washed hands. | _____ | _____ |
| 15 | Recorded the procedure and patient's tolerance of procedure on the SF 600 or clinical information system. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
*Lippincott Manual of Nursing Practice.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

Remove an Orogastric Tube

081-68W-2006

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, you have been tasked to remove an orogastric tube. You have a pen, a clipboard, sterile gloves, a protective cover pad, an emesis basin, surgical lubricant, a towel, and an SF 600 (*Chronological Record of Medical Care*) or electronic medical record (EMR).

**Standards:** Remove an orogastric tube in accordance with (IAW) *Brunner & Suddarth's Textbook of Medical-Surgical Nursing*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Gather equipment.
2. Greet the patient.
3. Verify the patient identity with the medical records.
4. Brief the patient on the performance of the procedure.
5. Perform appropriate handwashing techniques.
6. Don sterile gloves.
7. Turn off the suction or continuous feeding (if applicable).
8. Instruct the patient to sit up in bed with their head at a 30-degree angle with their feet.

**NOTE:** If removing the tube from a pediatric patient, be sure to place them in the supine position.

9. Place a linen-saver protective cover pad across the patient's chest.
10. Flush the orogastric tube with air to clear any fluids water or nutritional supplements that may be at the distal end of the tube.

**NOTE:** The tube should be flushed every 4 hours with 20 to 30 milliliters (ml) of normal saline.

11. Remove the tape from the patient's cheek.

**NOTE:** Use adhesive remover if necessary, to prevent irritating the skin.

12. Clamp the tube by pinching it closed, bending it, and holding it with the thumb and index finger.

**CAUTION:** Also let the patient know that they may feel like vomiting.

13. Instruct the patient to take a deep breath and hold it.

**NOTE:** This will decrease the possibility of aspiration when the tube is being withdrawn.

**CAUTION:** If patient vomits, stop the procedure immediately. Hand the patient an emesis basin or place it under their chin. Hand the patient a clean towel and wipe the patient's chin and face with the towel. Continue the procedure when the patient is ready.

14. Pull the tube out of the mouth using a swift and consistent motion.

**NOTE:** If resistance is felt, do not attempt to remove the tube and notify the medical officer immediately. Be sure to cover the tube with a towel when pulling it out.

15. Provide the patient with materials for oral care and lubricant for dryness of lips.

16. Dispose of soiled equipment and medical waste IAW local policies and infection control guidelines.

17. Annotate the procedure on the SF 600 or EMR.
    a. Annotate the color of drainage in the tube.
    b. Annotate the consistency of drainage.
    c. Annotate the remainder of feeding in bag or the amount of drainage in the suction canister.
    d. Annotate the patient's level of pain and tolerance of the procedure.
    e. Annotate the time of removal.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Gathered equipment. | _____ | _____ |
| 2 | Greeted the patient. | _____ | _____ |
| 3 | Verified the patient identity with the medical records. | _____ | _____ |
| 4 | Briefed the patient on the performance of the procedure. | _____ | _____ |
| 5 | Performed appropriate handwashing techniques. | _____ | _____ |
| 6 | Donned sterile gloves. | _____ | _____ |
| 7 | Turned off the suction or continuous feeding (if applicable). | _____ | _____ |
| 8 | Instructed the patient to sit up in bed with their head at a 30-degree angle with their feet. | _____ | _____ |
| 9 | Placed a linen-saver protective cover pad across the patient's chest. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 10 | Flushed the orogastric tube with air to clear any fluids water or nutritional supplements that may have been at the distal end of the tube. | _____ | _____ |
| 11 | Removed the tape from the patient's cheek. | _____ | _____ |
| 12 | Clamped the tube by pinching it closed, bending it, and holding it with the thumb and index finder. | _____ | _____ |
| 13 | Instructed the patient to take a deep breath and hold it. | _____ | _____ |
| 14 | Pulled the tube out of the mouth using a swift and consistent motion. | _____ | _____ |
| 15 | Provided the patient with materials for oral care and lubricant for dryness of lips. | _____ | ____ |
| 16 | Disposed of soiled equipment and medical waste IAW local policies and infection control guidelines. | _____ | _____ |
| 17 | Annotated the procedure on the SF 600 or EMR. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Brunner & Suddarth's Textbook of Medical-Surgical Nursing.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

**Subject Area 17: Medication Management**

Treat an Abscess

081-68W-0192

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You must treat a patient with an abscess. You have performed handwashing and don sterile gloves. You are provided with povidone-iodine antimicrobial solution, 10-milliliter (ml) syringe, 25-gauge needle, 1/2 plain or iodoform sterile gauze packing, 4x4-inch sterile gauze sponge, adhesive tape, #11 or #15 scalpel blade with handle, hemostat (curved), tissue forceps, surgical scissors, cotton-tipped sterile applicators, gloves, a culture swab, draping, lidocaine, SF 600 (*Chronological Record of Medical Care*), or electronic medical record, and a patient consent form.

**Standards:** Treat an abscess in accordance with *Clinical Procedures in Emergency Medicine,* while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**Performance Steps:**

1. Obtain a patient history.

**NOTE:** Smaller (<5 millimeter in diameter) abscesses may resolve with conservative measures (warm soaks) to promote drainage. Larger abscesses will require incision to drain them. As the increased inflammation, pus collection and walling off the abscess cavity diminishes, so does the effectiveness of conservative measures.

2. Gather equipment.

3. Prepare the site.

**NOTE:** Do not inject the anesthetic directly into the abscess because it will not be effective in the acidic medium.

   a. Position the patient with the abscess easily accessible.
   b. Prepare the abscess and surrounding area with the antimicrobial solution.
   c. Apply sterile drapes to completely surround the abscess and to cover all unprepared areas adjacent to the abscess.
   d. Perform a field block by anesthetizing the perimeter surrounding the abscess with 1%-2% lidocaine with epinephrine.
   e. Hold the syringe parallel to the skin and insert a 25-gauge needle into the middle of the dome of the abscess so the needle is just slightly under the skin (the anesthetic will spread within the subcutaneous plane of the entire abscess).
   f. Wait 2-3 minutes for the anesthetic to take effect.

4. Perform the incision, drainage, and packing of abscess.

**NOTE:** Do not use a gloved finger to break up loculations in an abscess that may contain a sharp or jagged foreign body.

a. Using the #11 or #15 blade, incise the abscess deeply from one side of the fluctuant area to the opposite side of the fluctuant area. This is necessary to ensure complete evacuation of the purulent drainage.

b. Allow the material to drain, using the 4x4 gauze sponges to soak up any purulence and blood. Use the sterile cotton-tipped applicator to swab the inside of the abscess cavity for culture.

c. Use the hemostat, wrapped with gauze, to gently explore the abscess cavity and to break up any sacs or adhesions within the abscess.

d. Clean the cavity with 4-6 sterile cotton-tipped applicators soaked with 3% hydrogen peroxide. You may also irrigate the cavity with 0.9% normal saline solution under moderate pressure.

e. Loosely pack the abscess with 1/4-inch to 1-inch iodoform or plain sterile gauze packing allowing a small portion of the packing to protrude outside the cavity and dress the incision site with sterile gauze.

f. Remove gloves.

5. Document the procedure on the SF 600, EMR, or patient consent form.

6. Reevaluate the patient in 24-72 hours after the incision and drainage procedure.

**NOTE:** Most lesions are reevaluated 48 hours after the procedure; with the first packing change occurring at this time, if drainage is present (facial abscesses should be reevaluated within 24 hours, after which, warm soaks should be started). Small abscesses can be cleaned with a cotton swab swirled in the cavity that is left open. Anesthesia is rarely necessary.

a. Consent.

b. Description of the abscess prior to performing the procedure.

c. Give a description of the procedure (type and quantity of anesthesia used, length of incision, approximate amount of material exuded and culture if made).

d. Type of packing and dressing material.

e. How the patient tolerated the procedure.

f. Any follow-up care or instructions given to the patient.

(1) Stress the importance of keeping the area dry for the first 24 hours. Have the patient leave the packing in place and the initial dressing should not be disturbed until the following day. Elevate the affected extremity when possible.

(2) On the second day, the patient should remove the outside dressing, leaving the packing undisturbed and apply warm water compresses or submerge the site in a warm water bath for 20-30 minutes. This will hasten resolution of the inflammatory process and promote rapid healing.

(3) The patient should return as soon as possible if they develop a fever, if the area of erythema increases in size, or if flu-like symptoms develop.

(4) The patient may require medications for pain (rarely) and possibly antibiotics.

7. Document reevaluation of the patient on the SF 600, EMR, or patient consent form.

a. Perform a patient care handwash.
b. Put on gloves.
c. Remove the external dressing.
d. Gently remove the packing material from the abscess site.
e. Cleanse the abscess site with a sterile cotton-tipped applicator soaked in hydrogen peroxide 3%.
f. Do not repack the cavity, especially if it is clean and pain and tenderness are significantly diminished.
g. Reapply a sterile dressing to the open abscess site.
h. Remove gloves.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Obtained a patient history. | _____ | _____ |
| 2 | Gathered equipment. | _____ | _____ |
| 3 | Prepared the site. | _____ | _____ |
| 4 | Performed the incision, drainage, and packing of abscess. | _____ | _____ |
| 5 | Documented the procedure on the SF 600, EMR, or patient consent form. | _____ | _____ |
| 6 | Reevaluated the patient in 24-72 hours after the incision and drainage procedure. | _____ | _____ |
| 7 | Documented reevaluation of the patient on the SF 600, EMR, or patient consent form. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Clinical Procedures in Emergency Medicine.*
SF 600. *Chronological Record of Medical Care*.

**Related**
None

**Subject Area 18: Trauma Management**

Perform a Focused Assessment with Sonography for Trauma Exam

081-68W-0171

**Conditions:** You are in an operational environment and are required to perform an extended focused assessment with sonography in trauma (eFAST) exam on a casualty who experienced combat trauma. You have 70% isopropyl alcohol or ultrasound gel, portable ultrasound machine or equivalent ultrasound unit with C17/5-1-megahertz (MHz) transducer, power cord, battery pack, or ultrasound cart, portable ultrasound machine or equivalent printer with paper, SF 600, (*Chronological Record of Medical Care*). You have donned appropriate personal protective equipment (gloves and eye protection).

**Standards:** Perform an eFAST exam within six minutes and determine the presence or absence of fluid in the abdominal cavity in accordance with the standards of care outlined in the *Joint Trauma Systems Clinical Practice Guidelines*, while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**Performance Steps:**

1. Gather equipment.
2. Take personal protective equipment.
   a. Don gloves.
   b. Don eye protection.
3. Position the casualty in the supine position.
4. Expose the entire chest and abdomen.
5. Turn on ultrasound machine.
6. Input the patient information in appropriate menu.
7. Choose the optimal transducer to perform eFAST.

**NOTE:** Choose the curvilinear transducer for the abdomen and the phased or linear transducer for the heart and chest.

8. Perform eFAST exam.
   a. View right upper quadrant.
      (1) Probe on right mid axillary line around the 8th rib with probe marker to head.
      (2) Observe the Morrison's pouch area.

**NOTE:** This site is the most common site of fluid collection.

      (3) Scan the kidney from the superior pole to the inferior pole.
      (4) Look between liver and diaphragm.
      (5) Look above the diaphragm.

**NOTE:** Looking for fluid or spine sign.

b. View the left upper quadrant.
   (1) Probe on left mid axillary line around 8th rib with the probe marker to the head.
   (2) Scan between the spleen and diaphragm.

**NOTE:** Between the spleen and diaphragm is the most common area of fluid collection.

   (3) Scan the kidney from the superior to the inferior pole.
   (4) Look at the splenorenal recess.
   (5) Look above the diaphragm.

**NOTE:** Look for fluid or spine sign.

c. View the heart.
   (1) Probe inferior to the xyphoid process.
   (2) View the pericardium.

**NOTE:** When viewing the pericardium, observe the hyperechoic line around the heart to determine if there is pericardial effusion or tamponade.

   (3) Look for tamponade signs and if the chambers are filling.
d. Scan the entire bladder.
e. Scan the entire length of chest at mid clavicular line identifying lung sliding.

9. Review scan findings.
   a. Verbalize characteristics of free fluid in all views.
   b. Verbalize definition of positive, negative, or indeterminate exam results.

10. Document the medical exam procedure and results.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Gathered equipment. | _____ | _____ |
| 2 | Took personal protective equipment. | _____ | _____ |
| 3 | Positioned the casualty in the supine position. | _____ | _____ |
| 4 | Exposed the entire chest and abdomen. | _____ | _____ |
| 5 | Turned on ultrasound machine. | _____ | _____ |
| 6 | Input the patient information in appropriate menu. | _____ | _____ |
| 7 | Chose the optimal transducer to perform eFAST. | _____ | _____ |
| 8 | Performed eFAST exam. | _____ | _____ |
| 9 | Reviewed scan findings. | _____ | _____ |

| Performance Measures: | GO | NO GO |
|---|---|---|
| 10 Documented the medical exam procedure and results. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
Deployed Medicine website.
*Joint Trauma System Clinical Practice Guidelines*.
SF 600. *Chronological Record of Medical Care*.

**Related**
None

## Subject Area 19: Triage and Evacuation

Manage a Combat Lifesaver Program

081-68W-2003

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment. You are required to manage a combat lifesaver (CLS) program. You are provided with medical equipment set, combat lifesaver, version 2005, UA 245A pen, a clipboard, a notepad, and deliberate risk assessment worksheet.

**Standards:** Manage the CLS program in accordance with (IAW) AR 350-1, while adhering to all warnings, and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Research requirements required to conduct the CLS program IAW AR 350-1 and local standard operating procedures.

2. Annotate training on the unit training calendar.

3. Review course material and content to ensure it is current.

4. Submit the DA Form 1687 (*Notice of Delegation of Authority – Receipt for Supplies*) to order supplies and course equipment prior to the start of the course.

5. Identify the number of personnel that need to be trained and certified.

6. Submit the DA Form 1687 to request medical equipment and supplies in support of training.

7. Reserve the facilities for training.

8. Inspect the proper conditions and operability of training facilities, equipment, and systems.

9. Complete a DD Form 2977 (*Deliberate Risk Assessment Worksheet*) IAW AR 385-10.

10. Ensure the instructors meet all qualifications.

**NOTE:** This course does not limit the number of retests that can be administered to a student on a failed examination. However, the Soldier must be allowed at least one retest on each examination. The course manager may establish a maximum number of retests or procedures for approving more than one retest per examination.

a. Ensure the primary instructor at the division or brigade is a senior medical noncommissioned officer and the primary instructor at the battalion is at least an E-6 or SSG.

b. Verify instructors are fully military occupational specialty (MOS) qualified and have maintained the 68W MOS for a period of at least one year.

c. Verify all instructors are basic life support certified.

d. Verify an initial instructor evaluation was completed (by the course manager or medical director) no later than 30 days prior to the start of instruction.

e. Ensure each instructor has completed TC 8-800 (or equivalent) within the last twelve months.

f. Ensure that all instructors are placed on additional duty orders.

g. Ensure all instructors and assistant instructors are trained on equipment, course material and requirements.

11. Notify students of their selection to attend the CLS course at least two weeks prior to the start of instruction.

**NOTE:** To limit training time missed, ensure that students know to NOT schedule appointments during the course. The course is their place of duty, until course completion.

12. Ensure instructors and students comply with safety and environmental protection rules, regulation, laws, and course requirements.

13. Annotate student's certifications will be completed and entered into Army Training Requirements and Resources System by the instructing staff.

14. Submit a memorandum of completion to AIPD at the end of the course.

15. Monitor annual recertification requirements and training as needed.

**NOTE:** Field training exercise and deployment training are perfect times for combat casualty responders to use the skills taught throughout the course to maintain skill proficiency. On the battlefield is not the time to try and remember how to save a Soldier's life.

16. Update certification and recertification of trained personnel in the Digital Training Management System or local training records.

17. Brief command leadership on trained personnel and mission requirements as needed.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Researched requirements required to conduct the CLS program IAW AR 350-1 and local standard operating procedures. | _____ | _____ |
| 2 | Annotated training on the unit training calendar. | _____ | _____ |
| 3 | Reviewed course material and content to ensure it was current. | _____ | _____ |
| 4 | Submitted the DA Form 1687 (*Notice of Delegation of Authority – Receipt for Supplies*) to order supplies and course equipment prior to the start of the course. | _____ | _____ |

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 5 | Identified the number of personnel that needed to be trained and certified. | _____ | _____ |
| 6 | Submitted the DA Form 1687 to request medical equipment and supplies in support of training. | _____ | _____ |
| 7 | Reserved the facilities for training. | _____ | _____ |
| 8 | Inspected the proper conditions and operability of training facilities, equipment, and systems. | _____ | _____ |
| 9 | Completed a DD Form 2977 (*Deliberate Risk Assessment Worksheet*) IAW AR 385-10. | _____ | _____ |
| 10 | Ensured the instructors met all qualifications. | _____ | _____ |
| 11 | Notified students of their selection to attend the CLS course at least two weeks prior to the start of instruction. | _____ | _____ |
| 12 | Ensured instructors and students complied with safety and environmental protection rules, regulation, laws, and course requirements. | _____ | _____ |
| 13 | Annotated student's certifications would be completed and entered in Army Training Requirements and Resources System by the instructing staff. | _____ | _____ |
| 14 | Submitted a memorandum of completion to AIPD at the end of the course. | _____ | _____ |
| 15 | Monitored annual recertification requirements and training as needed. | _____ | _____ |
| 16 | Updated certification and recertification of trained personnel in the Digital Training Management System or local training records. | _____ | _____ |
| 17 | Briefed command leadership on trained personnel and mission requirements as needed. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
AR 350-1. *Army Training and Leader Development*.
AR 385-10. *The Army Safety and Occupational Health Program*.
DA Form 1687. *Notice of Delegation of Authority – Receipt for Supplies*.
DD Form 2977. *Deliberate Risk Assessment Worksheet*.
TC 8-800. *Medical Education and Demonstration of Individual Competence*.

**Related**
None

**Skill Level 3**

**Subject Area 20: Airway Management**

Place an Endotracheal Tube

081-68W-0100

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation (BSI) precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment, you are required to place an endotracheal (ET) tube for an unconscious, nonbreathing casualty with no gag reflex. You will be provided with an assistant, batteries (appropriate for laryngoscope size), laryngoscope with blades (straight and curved, sizes 1-4), ET tube (7 millimeter [mm]), bag valve mask, nonsterile gloves, pulse oximeter, 10-cubic centimeter (cc) syringe, 1/2-inch adhesive tape, scissors, stethoscope, and a DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*).

**Standards:** Place an ET tube, in accordance with *PHTLS Prehospital Trauma Life Support*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Don on BSI.

2. Open the airway using a manual maneuver.

**NOTE:** Use the head tilt chin lift or jaw thrust maneuver.

3. Elevate the tongue by insert simple airway adjunct (either oropharyngeal airway or nasopharyngeal airway).

4. Ventilate casualty with a bag-valve-mask device.

5. Attach oxygen reservoir to bag-valve-mask device and connect to high-flow regulator (12-15 liters per minute [lpm]) if available.

6. Ventilate casualty at a rate of 10-12 breaths per minute.

7. Direct assistant to preoxygenate casualty.

8. Inspect and prepare equipment for intubation (laryngoscope, ET tube, and stylet).
    a. Attach the laryngoscope blade to the laryngoscope.
        (1) Hook the blade to the connector on the top of the laryngoscope.
        (2) Lift the blade at a 90-degree angle to lock the blade in place.
    b. Select the appropriate size of ET tube for the casualty.

**NOTE:** Average adult male 8.0-8.5 centimeters (cm); average adult female 7.0-7.5 cm.

c. Fill the 10-cc syringe with air and attach the syringe to the ET tube cuff valve (pilot balloon), inflate the cuff, and inspect for leaks.

**NOTE:** If you detect a leak, discard ET tube in trash container and get a new one.

d. Deflate cuff by pulling back on the plunger until all the air is out.

e. Insert stylet into ET tube.

(1) The stylet should be inserted into the ET tube, so the tip of the stylet is recessed 1/2 inch from the tip of the ET tube.

(2) Bend the other end of the stylet at a 90-degree angle to prevent it from going further into the ET tube.

**NOTE:** Attempt to maintain oxygen saturation at 100%. This can be monitored through a pulse oximeter.

9. Position the casualty's head by hyperextending the neck.

**NOTE:** This will allow for visualization of the vocal cords.

10. Open the casualty's mouth and hold it open by pushing down on the jaw. Remove the airway adjunct.

11. Insert the laryngoscope blade into mouth and visualize vocal cords.

a. Stand or kneel at the top of the casualty's head.

b. Hold the laryngoscope with your left hand.

c. Open and lock the blade at a 90-degree angle.

d. Place the blade into the right side of the casualty's mouth.

e. Move the laryngoscope to the center of the mouth by sliding the laryngoscope to the left side of the mouth; this will in turn move the patient's tongue out of the way.

f. Advance the blade a short distance to observe the epiglottis.

g. Retract the epiglottis and observe the vocal cords.

(1) If using a Macintosh blade (curved), apply anterior pressure to the vallecula with the tip of the laryngoscope blade. This will fold back the epiglottis and expose the vocal cords.

(2) If using a Miller blade (straight), hook the blade tip under the epiglottis and pull up to fold back the epiglottis and expose the vocal cords.

12. Insert the ET tube into the trachea.

a. Grasp the ET tube with your right hand.

b. Carefully guide the tip of the tube between the vocal cords until the cuff is just below the level of the vocal cords.

13. Remove the laryngoscope from the airway.

14. Remove the stylet from the ET tube.

15. Inflate the cuff of the ET tube by injecting the required amount of air (5 to 10 cc).

16. Check placement of the ET tube.
    a. Instruct assistant to auscultate the casualty's lung fields and epigastric area while you manually ventilate the casualty.
    b. If casualty has strong bilateral breath sounds and no sounds of air movement are heard over the epigastric area, proceed to step 17.
    c. If sound is heard over one lung field only, you must partially deflate the cuff, withdraw the ET tube slightly, reinflate the cuff, and listen again.
    d. If a rushing sound is heard over the epigastric area, and breath sounds are not heard, deflate the cuff, withdraw the ET tube completely, reoxygenate the casualty, and repeat procedure.
17. Secure the ET tube with 1/2-inch adhesive tape.
18. Manually ventilate casualty.
19. Discard trash and gloves in trash can.
20. Perform a patient care handwash.
21. Record procedure on DD Form 1380.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Donned on BSI. | _____ | _____ |
| 2 | Opened the airway used a manual maneuver. | _____ | _____ |
| 3 | Elevated the tongue by inserted simple airway adjunct (either oropharyngeal airway or nasopharyngeal airway). | _____ | _____ |
| 4 | Ventilated casualty with a bag-valve-mask device. | _____ | _____ |
| 5 | Attached oxygen reservoir to bag-valve-mask device and connected to high-flow regulator (12-15 liters per minute [lpm]) if available. | _____ | _____ |
| 6 | Ventilated casualty at a rate of 10-12 breaths per minute. | _____ | _____ |
| 7 | Directed assistant to preoxygenate casualty. | _____ | _____ |
| 8 | Inspected and prepared equipment for intubation (laryngoscope, ET tube, and stylet). | _____ | _____ |
| 9 | Positioned the casualty's head by hyperextending the neck. | _____ | _____ |
| 10 | Opened the casualty's mouth and held it open by pushing down on the jaw. Removed the airway adjunct. | _____ | _____ |
| 11 | Inserted the laryngoscope blade into mouth and visualized vocal cords. | _____ | _____ |
| 12 | Inserted the ET tube into the trachea. | _____ | _____ |

| | Performance Measures: | GO | NO GO |
|---|---|---|---|
| 13 | Removed the laryngoscope from the airway. | _____ | _____ |
| 14 | Removed the stylet from the ET tube. | _____ | _____ |
| 15 | Inflated the cuff of the ET tube by injecting the required amount of air (5 to 10 cc). | _____ | _____ |
| 16 | Checked placement of the ET tube. | _____ | _____ |
| 17 | Secured the ET tube with 1/2-inch adhesive tape. | _____ | _____ |
| 18 | Manually ventilated casualty. | _____ | _____ |
| 19 | Discarded trash and gloves in trash can. | _____ | _____ |
| 20 | Performed a patient care handwash. | _____ | _____ |
| 21 | Recorded procedure on DD Form 1380. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*. *PHTLS Prehospital Trauma Life Support.*

**Related**
None

**Subject Area 21: Force Health Protection**

Manage a Team During Prolonged Care

081-68W-3008

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. You are required to manage a team during prolonged field care. You have a team of medical personnel and the *Joint Trauma System Clinical Practice Guidelines (JTS-CPGS).*

**Standards:** Manage a team during prolonged field care in accordance with the *Joint Trauma System Clinical Practice Guidelines (JTS-CPGS)* while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**Performance Steps:**

1. Understand the 10 Prolonged Care capabilities.

2. Identify resources.

**NOTE:** Items such as: suction machines, monitors, advanced airways, burn blankets, drugs, and others, to include personnel.

3. Assign roles.

**NOTE:** Carefully assign available personnel the care roles to assure that all tasks required to care for the patient are covered.

**Example:** If the patient requires manual ventilation with a bag valve mask. Designate who will perform that task and who might assist them. If then patient is placed on a vent, then who will monitor the vent.

   a. Care roles.
   b. Documentation role.

**NOTE:** Documentation is kept to managing a prolong care patient and a responsible person should be assigned this task. If you need to later repeat medications of therapies time intervals are important.

   c. Nursing role.

4. Assess patient(s).

5. Develop care plan.
   a. Prioritized by patient, injury, and intervention.
   b. Nursing care.
   c. Work and rest cycles.

6. Utilize telemedicine.
7. Document care.
   d. DD Form 1380 (*Tactical Combat Casualty Care (TCCC) Card (Instructions)*).
   e. Prolonged Care card.
8. Assess response and results.
9. Monitor the well-being of patients and team members.
10. Plan and execute evacuation and handover.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Understood the 10 Prolonged Care capabilities. | _____ | _____ |
| 2 | Identified resources. | _____ | _____ |
| 3 | Assigned roles. | _____ | _____ |
| 4 | Assessed patient(s). | _____ | _____ |
| 5 | Developed care plan. | _____ | _____ |
| 6 | Utilized telemedicine. | _____ | _____ |
| 7 | Documented care. | _____ | _____ |
| 8 | Assessed response and results. | _____ | _____ |
| 9 | Monitored the well-being of patients and team members. | _____ | _____ |
| 10 | Planned and executed evacuation and handover. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
DD Form 1380. *Tactical Combat Casualty Care (TCCC) Card (Instructions)*.
Joint Trauma System website.
*Joint Trauma System Clinical Practice Guidelines*.

**Related**
None

Interpret Running Estimates Tracking

081-68W-3009

**Conditions:** You are in an operational environment. You are required to perform running estimates to advise command teams. You will be provided a copy of the FM 6-0, a notepad, and pencil.

**Standards:** Interpret running estimates tracking in accordance with FM 5.0 and FM 6-0 without error, using the task GO/NO GO criteria.

**Performance Steps:**

1. Identify types of running estimates.

**NOTE:** A running estimate is the continuous assessment of the current situation used to determine if the current operation is proceeding according to the commander's intent and if planned future operations are supportable (ADP 5-0). The commander and each staff element maintain a running estimate. In their running estimates, the commander and each staff element continuously consider the effects of new information and update the following: facts, assumptions, friendly force status, enemy activities and capabilities, civil considerations, conclusions and recommendations.

    a. Commander's running estimate.

**NOTE:** Commanders maintain their running estimates to consolidate their understanding and visualization of an operation. The commander's running estimate summarizes the problem and integrates information and knowledge of the staff's and subordinate commander's running estimates.

    b. Subordinate staff running estimate.

**NOTE:** Each staff element builds and maintains running estimates. The running estimate helps the staff to track and record pertinent information and provide recommendations to commanders. Running estimates represent the analysis and expert opinion of each staff element by functional area. Staffs maintain running estimates throughout the operations process to assist commanders in the exercise of mission command.

2. Understand essential qualities of running estimates.

**NOTE:** A comprehensive running estimate addresses all aspects of operations and contains both facts and assumptions based on the staff's experience within a specific area of expertise. Each staff element modifies it to account for its specific functional areas. All running estimates cover essential facts and assumptions, including a summary of the current situation by the mission variables, conclusions, and recommendations. Once they complete the plan, commanders and staff elements continuously update their estimates.

3. Understand situation and considerations.
    a. Area of Interest. Identify and describe those factors of the area of interest that affect functional area considerations.
    b. Facts and assumptions. List all facts and assumptions that affect the functional area.

c. Characteristics of the area of operations.

(1) Terrain. State how terrain affects a functional area's capabilities.

(2) Weather. State how weather affects a functional area's capabilities.

(3) Friendly forces. List current functional area resources in terms of equipment, personnel, and systems. Identify additional resources available for the functional area located at higher, adjacent, or other units. List those capabilities from other military and civilian partners that may be available to provide support within the functional area. Compare requirements to current capabilities and suggest solutions for satisfying discrepancies.

(4) Civilian considerations. Describe civil considerations that may affect the functional area, including possible support needed by civil authorities from the functional area as well as possible interference from civil aspects.

(5) Enemy forces. Describe enemy disposition, composition, strength, and systems within a functional area. Describe enemy capabilities and possible courses of action (COAs) and their effects on a functional area.

4. Show the restated mission resulting from mission analysis.

5. Develop COAs.

a. List friendly COAs that were war-gamed.

b. List enemy actions or COAs that were templated that impact the functional area.

c. List the evaluation criteria identified during COA analysis. All staffs use the same criteria.

6. Analyze each COA using the evaluation criteria from COA analysis. Review enemy actions that impact the functional area as they relate to COAs. Identify issues, risks, and deficiencies these enemy actions may create with respect to the functional area.

7. Compare COAs. Rank order COAs for each key consideration. Use a decision matrix to aid the comparison process.

8. Provide recommendations and conclusions.

a. Recommend the most supportable COAs from the perspective of the functional area.

b. Prioritize and list issues, deficiencies, and risks and make recommendations on how to mitigate them.

9. Understand running estimates in the operations process.

**NOTE:** Commanders and staff elements immediately begin updating their running estimates upon receipt of a mission. They continue to build and maintain their running estimates throughout the operations process in planning, preparation, execution, and assessment.

10. Understand running estimates in planning.

**NOTE:** During planning, running estimates are key sources of information during mission analysis. Following mission analysis, commanders and staff elements update their running estimates throughout the rest of the military decision-making process. Based on the mission and the initial commander's intent, the staff develops one or more proposed COAs and continually refines its running estimates to account for the mission variables. The updated running

estimates then support COA analysis (war-gaming) in which the staff identifies the strengths and weaknesses of each COA. The staff relies on its updated running estimate to provide input to the war game. Following COA analysis, the staff compares the proposed COAs against each other and recommends one of them to the commander for approval. During all these activities, each staff element continues to update and refine its running estimate to give commanders the best possible information available at the time to support their decisions. The selected COA provides each staff element an additional focus for its estimates and the key information it will need during orders production. Key information recorded in the running estimate may be included in orders, particularly in the functional annexes.

11. Understand running estimates in preparation.

**NOTE:** The commander and staff transition from planning to execution. As they transition, they use running estimates to identify the current readiness of the unit in relationship to its mission. The commander and staff also use running estimates to develop, then track, mission readiness goals and additional requirements.

12. Understand running estimates in the execution.

**NOTE:** During execution, the commander and staff incorporate information included in running estimates into the common operational picture. This enables the commander and staff to depict key information from each functional area or warfighting function as it impacts current and future operations. This information directly supports the commander's visualization and rapid decision-making during operations.

13. Understand running estimates in assessment.

**NOTE:** Each staff element continuously analyzes new information during operations to create knowledge and to understand if operations are progressing according to plan. During planning, staffs develop measures of effectiveness and measures of performance to support assessment, including analysis of anticipated decisions during preparation and execution. The assessment of current operations also supports validation or rejection of additional information that will help update the estimates and support further planning. At a minimum, a staff element's running estimate assesses the following: Friendly force capabilities with respect to ongoing and planned operations. Enemy capabilities as they affect the staff element's area of expertise for current operations and plans for future operations. Civil considerations as they affect the staff element's area of expertise for current operations and plans for future operations.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Identified types of running estimates. | _____ | _____ |
| 2 | Understood essential qualities of running estimates. | _____ | _____ |
| 3 | Understood situation and considerations. | _____ | _____ |
| 4 | Showed the restated mission resulting from mission analysis. | _____ | _____ |
| 5 | Developed COAs. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 6 | Analyzed each COA using the evaluation criteria from COA analysis. Reviewed enemy actions that impacted the functional area as they related to COAs. Identified issues, risks, and deficiencies these enemy actions may have created with respect to the functional area. | _____ | _____ |
| 7 | Compared COAs. Ranked order COAs for each key consideration. Used a decision matrix to aid the comparison process. | _____ | _____ |
| 8 | Provided recommendations and conclusions. | _____ | _____ |
| 9 | Understood running estimates in the operations process. | _____ | _____ |
| 10 | Understood running estimates in planning. | _____ | _____ |
| 11 | Understood running estimates in preparation. | _____ | _____ |
| 12 | Understood running estimates in the execution. | _____ | _____ |
| 13 | Understood running estimates in assessment. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
ADP 5-0. *The Operations Process*.
FM 5-0. *Plans and Orders Production.*
FM 6-0. *Commander and Staff Organization and Operations*.

**Related**
None

Brief Mission Commander on Casualty Response Plan

081-68W-3016

This individual task was presented earlier in the STP on page 3-47 as a readiness requirements task. The content requirements are the same.

Manage a Unit's Medical Supply

081-68W-3012

**Conditions:** You are in an operational environment. You are tasked to manage a unit's medical supplies in a deployed environment. You will be provided with AR 40-61, AR 735-5, and a computer.

**Standards:** Manage a unit's medical supply in accordance with (IAW) AR 40-61 while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**Performance Steps:**

1. Stock and store medical supplies IAW Army, unit, and local regulations and policies.
2. Document administered medications IAW Army, unit, and local regulations and policies.
3. Maintain accounting and accountability records.
4. Conduct medical equipment and supply inventory.
    a. Notify all personnel affected by the inventory in advance.
    b. Gather all supply accounting and accountability records.
        (1) Consolidate all DA Forms 2062 (*Hand Receipt/Shortage Listing*) (and subcomponents).
        (2) Assemble all DA Forms 3161 (*Request for Issue or Turn-in*).
        (3) Applicable unit authorization.
    c. Assemble inventory count personnel.
    d. Close or reduce supply operations for the duration of the inventory.
    e. Inventory supplies and equipment.
        (1) Durables.

**NOTE:** Document condition and life expectancy of items.

        (2) Nonexpendable.

**NOTE:** Document condition and life expectancy of items.

        (3) Expendable.

**NOTE:** Expirations must be reviewed and updated on all documentation formats.

5. Report shortages on DA Form 2062.
6. Order replacements IAW primary references.
7. Turn-in excess or destroy expired or unserviceable medication and equipment IAW Army, unit, and local regulations and policies.
8. Restock and restore medical supplies IAW Army, unit, and local regulations and policies.

9. Document all expired and replaced items. Reorder expired or expended supplies.

10. Maintain copies of all accountability documents.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Stocked and stored medical supplies IAW Army, unit, and local regulations and policies. | _____ | _____ |
| 2 | Documented administered medications IAW Army, unit, and local regulations and policies. | _____ | _____ |
| 3 | Maintained accounting and accountability records. | _____ | _____ |
| 4 | Conducted medical equipment and supply inventory. | _____ | _____ |
| 5 | Reported shortages on DA Form 2062. | _____ | _____ |
| 6 | Ordered replacements IAW primary references. | _____ | _____ |
| 7 | Turned-in excess or destroyed expired or unserviceable medication and equipment IAW Army, unit, and local regulations and policies. | _____ | _____ |
| 8 | Restocked and restored medical supplies IAW Army, unit, and local regulations and policies. | _____ | _____ |
| 9 | Documented all expired and replaced items. Reordered expired or expended supplies. | _____ | _____ |
| 10 | Maintained copies of all accountability documents. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
AR 40-61. *Medical Logistics Policies*.
AR 735-5. *Relief of Responsibility and Accountability*.
DA Form 2062. *Hand Receipt/Shortage Listing.*
DA Form 3161. *Request for Issue or Turn-In*.

**Related**
None

Develop Annex F to Appendix 3 Medical Plan

081-68W-3011

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment you must develop an annex F (sustainment) to appendix 3 (operations) for the medical plans that will be used in an operations order (OPORD). You are provided with FM 6-0, situation, intent of the mission, map overlays, pencil, and paper.

**Standards:** Develop annex F (sustainment) to appendix 3 (operations) medical plan in accordance with FM 6-0 while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. List documents essential to understanding the attachment.
    a. List maps and charts first. Map entries include series number, country, sheet names or numbers, edition, and scale.
    b. List other references in subparagraphs labeled as shown.
    c. Doctrinal references for sustainment include ADP 4-0, FM 3-09, FM 4-02, FM 5-0, FM 6-0,and ATP 4-02.55.

2. Select correct time zone used throughout the order: Write the time zone established in the base plan or order.

3. Identify situation.

**NOTE:** Include information affecting the sustainment operations that paragraph 1 of the operation plan or OPORD does not cover or that needs expansion.

    a. Area of interest. Describe the area of interest as it relates to the sustainment. Refer to annex B (intelligence) as required.
    b. Area of operations. Refer to appendix 2 (operation overlay) to annex C (operations) as required.
        (1) Terrain. Describe the aspects of terrain that impact sustainment operations. Refer to annex B (intelligence) as required.
        (2) Weather. Describe the aspects of weather that impact sustainment operations. Refer to annex B (intelligence) as required.

**NOTE:** Put the possibilities for heat and cold weather injuries. Also note if the terrain can cause possible injuries to forces.

    c. Enemy forces. Refer to base OPORD.
    d. Friendly forces. Refer to base OPORD.
    e. Interagency, intergovernmental, and nongovernmental organizations. See annex V (interagency coordination).

f. Civil considerations. See annex B (Intelligence) and annex K (civil affairs operations and civil-military cooperation).

g. Attachments and detachments. List units attached or detached only as necessary to clarify task organization. Refer to annex A (task organization) as required.

h. Assumptions. List any sustainment-specific assumptions that support the annex development.

4. State Mission.

**NOTE:** State the mission of sustainment in support of the base plan or order.

5. Understand execution.

a. Scheme of sustainment support. Describe how sustainment supports the commander's intent and concept of operations. Establish the priorities of sustainment support to units for each phase of the operation. Refer to annex C (operations) as required.

(1) Medical treatment.

(a) Point of injury care is provided by individual self-aid, buddy aid, combat lifesaver, or combat medic. Measures include maintaining the airway, stopping bleeding, and preventing shock, protecting wounds, immobilizing fractures, and providing other emergency measures as indicated.

(b) Role 1 care is provided by medical team or medical platoon with at least one medical provider (physician, physician assistant). Role 1 care includes primary health care, triage, resuscitation, and stabilization. Role 1 care is a responsibility of each battalion task force.

(c) Role 2 care includes triage, resuscitation, and treatment of shock to a higher level than Role 1, along with a patient hold capability, field laboratory, basic imaging, patient regulation, and patient evacuation. North Atlantic Treaty Organization (NATO) Role 2 care always includes damage control surgery (DCS). (U.S. Role 2 units do not always include DCS and are referred to as NATO Role 1 enhanced.) When supporting a brigade task force, Role 2 care should also include preventive medicine, dental, and stress management services.

(d) Role 3 care includes deployed hospitalization and the elements to support it. This includes primary surgery, intensive care unit, nursed beds, and diagnostic support. The 212th combat support hospital [notional] provides Role 3 medical care.

(e) Coalition forces use of host nation medical facilities is prohibited.

(2) Medical evacuation (MEDEVAC).

(a) State the commander's intent for MEDEVAC.

_1_ Casualties in the "urgent" evacuation category should be (state the standard outlined for the mission).

_2_ Casualties in the "priority" (state the standard outlined for the mission).

_3_ "Routine" casualties (state the standard outlined for the mission).

_4_ "Urgent" casualties must be evacuated from the Role 2 medical treatment facility (MTF) to the Role 3 (state the standard outlined for the mission).

_5_ "Priority" casualties may either be held in the Role 2 MTF's patient hold (state the standard outlined for the mission).

(b) The primary means of medical evacuation from POI and Role 1 MTF's (state the standard outlined for the mission).

(c) Use the NATO 9-line MEDEVAC request for all air MEDEVAC requests.

(d) Transport wounded Soldiers separate from deceased personnel (state the standard outlined for the mission).

(e) Physically transport wounded detainees separate from coalition forces. (If applicable state the standard outlined for the mission).

(f) State the theater evacuation policy.

b. Tasks to subordinate units. List sustainment tasks assigned to specific subordinate units not contained in the base order.

c. Coordinating instructions. State here what the plan is if host nation civilians are injured. What mechanism of injuries (MOI's) determine if our forces will treat civilian causalities.

6. Identify sustainment.
   a. Medical logistics CLVIII A and B (state the standard outlined for the mission).
   b. Mortuary affairs (state the standard outlined for the mission).

7. Control command and signal. Refer to base OPORD.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Listed documents essential to understanding the attachment. | _____ | _____ |
| 2 | Selected correct time zone used throughout the order: Wrote the time zone established in the base plan or order. | _____ | _____ |
| 3 | Identified situation. | _____ | _____ |
| 4 | Stated mission. | _____ | _____ |
| 5 | Understood execution. | _____ | _____ |
| 6 | Identified sustainment. | _____ | _____ |
| 7 | Controlled command and signal. Referred to base OPORD. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
ADP 4-0. *Sustainment*.
ATP 4-02.55. *Army Health System Support Planning.*
FM 3-09. *Fire Support and Field Artillery Operations*.

FM 4-02. *Army Health System*.
FM 5-0. *Plans and Orders Production.*
FM 6-0. *Commander and Staff Organization and Operations*.

**Related**
None

**Subject Area 22: Medical Management**

Treat Life Threatening Cardiac Arrhythmias

081-000-3011

**Conditions:** In an operational environment you must treat a life-threatening cardiac arrhythmia. You are provided a patient cardiac monitor, a list of principles governing electrocardiogram (EKG) interpretation, lifesaving cardiac drugs, 10 milliliters (ml) saline flushes, automated external defibrillators (AED) or defibrillator with monitoring capabilities and other expendable Class VIII.

**Standards:** Treat life-threatening cardiac arrhythmias by identifying the regularity, rate, P-wave, P-R Interval, QRS, rhythm interpretation and treating the lethal arrhythmia in accordance with *Advanced Cardiac Life Support (ACLS) Provider Manual*, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

**WARNING:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

1. Treat cardiac arrest (ventricular fibrillation, pulseless ventricular tachycardia, pulseless electrical activity and asystole).
    a. Check for responsiveness, breathing and pulse.

**NOTE:** Check for no longer than 10 seconds. If you are alone with no cell phone, leave the patient to activate the emergency response system and return with the biphasic AED before beginning cardiopulmonary resuscitation (CPR), otherwise send someone to get help and the AED.

    b. Perform continuous CPR to ventilation cycles for two minutes.
    c. Place the pads on the patient immediately.
    d. Instruct additional personnel to provide oxygen, initiate intravenous (IV) or intraosseous (IO) access and insert an advanced airway if needed.
    e. Recheck pulse while allowing AED to analyze the rhythm.
    f. Determine if the cardiac rhythm is shockable or not and treat appropriately.
        (1) Shock the shockable rhythm with 200 joules then resume CPR.
        (2) Administer 1 milligram (mg) epinephrine IV or IO every three to five minutes.
    g. Recheck pulse while allowing AED to analyze the rhythm.
        (1) Shock a shockable rhythm.
            (a) Resume CPR.
            (b) Administer 1 mg epinephrine IV or IO every three to five minutes.
        (2) Resume CPR on non-shockable rhythm.
        (3) Administer 1 mg epinephrine every three to five minutes.
    h. Continue CPR for two or more minutes.
    i. Administer Amiodarone 300 mg IV or IO bolus.

**NOTE:** Consider magnesium 1 to 2 gram (g) IV or IO over 1-2 minutes for Torsades de Pointes (TdP). Additionally, lidocaine 1.5 mg or kilograms (kg) may be given with an additional 0.5-0.75 mg/kg as an alternative to amiodarone. The max dose of lidocaine is 3 mg/kg.

j. Treat reversible causes.

(1) Hypovolemia – give fluids.

(2) Hypoxia – give oxygen, check for mucus plug, endotracheal tube, or suction.

(3) Hydrogen ion (acidosis) – ventilate and give sodium bicarbonate.

(4) Hypokalemia – rapid potassium infusion.

(5) Hyperkalemia – give sodium bicarbonate, calcium chloride, insulin or glucose, dialysis, and diuresis.

(6) Hypothermia – warm body to at least 92 degrees Fahrenheit before stopping code, may rewarm and warm IV fluids (IVFs).

(7) Tension pneumothorax – needle chest decompression into pleural space.

(8) Tamponade – decompress from pericardial sac, IVF bolus of 50-80 ml.

(9) Toxins – give specific antidote based on overdose agent.

(10) Thrombosis pulmonary – give fibrolytics, thrombolytics and perform embolectomy.

(11) Thrombosis coronary thrombolytics and anticoagulants.

k. Continue CPR until either termination of code or upon return of spontaneous circulation.

2. Treat tachycardia (atrial flutter, atrial fibrillation, Supraventricular tachycardia [SVT], Atrial tachycardia [A-Tach], and ventricular tachycardia [VT)] with a pulse.

a. Check for the appropriateness for the clinical condition.

b. Treat any underlying causes that have been identified.

c. Maintain the patient's airway and assist with breathing as necessary.

d. Administer oxygen.

e. Place patient on cardiac monitor to identify rhythm.

f. Monitor vital signs.

g. Initiate IV or IO access.

h. Perform immediate synchronize cardioversion while considering sedation.

i. Administer 6 mg adenosine rapid IV push prior to cardioversion.

**NOTE:** SVT and Aflutter generally respond to adenosine without the need for cardioversion.

j. Obtain a 12 lead EKG.

k. Administer adenosine 6 mg rapid IV push followed by normal saline (NS) flush.

**NOTE:** Do not use adenosine to treat polymorphic VT (TdP) as this rhythm requires emergent defibrillation and is unresponsive to adenosine. Treat TdP with magnesium 1 to 2 g IV or IO over 15 minutes for TdP with a pulse.

l. Administer adenosine 12 mg rapid IV push followed by NS flush.

m. Give amiodarone 150 mg over 10 minutes IV.

**NOTE:** Repeat if VT reoccurs.

n. Perform immediate synchronized cardioversion.

**NOTE:** Consider expert consultation for all wide complex tachycardia.

o. Obtain a 12 lead EKG.
p. Instruct the patient to perform vagal maneuvers.
q. Administer adenosine 6 mg rapid IV push followed by NS flush.
r. Administer adenosine 12 mg rapid IV push followed by NS flush.

**NOTE:** Consider β blocker or calcium channel blocker and expert consultation.

3. Treat symptomatic bradycardia.
   a. Check for the appropriateness for the clinical condition.
   b. Treat any underlying causes that have been identified.
   c. Administer oxygen.
   d. Place the patient on a cardiac monitor to identify the rhythm.
   e. Monitor blood pressure and pulse oximetry.
   f. Initiate IV or IO access.
   g. Prepare for transcutaneous pacing without delay for high degree AV heart blocks.

**NOTE:** That is, second-degree atrioventricular (AV) heart block Mobitz type II and third-degree AV heart blocks. Do not give atropine prior to transcutaneous pacing for second-degree AV heart block Mobitz type II and third-degree AV heart blocks as these rhythms require immediate transcutaneous pacing and is unlikely to be responsive to the atropine.

   h. Administer atropine 0.5 mg bolus.
   i. Transcutaneous pace the patient or administer dopamine 2 to 10 microgram (mcg) or kg per minute IV infusion.
   j. Consider epinephrine 2 to 10 mcg/kg per minute.
   k. Monitor and observe the patient.
   l. Consider expert consultation and transvenous pacing.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Treated cardiac arrest (ventricular fibrillation, pulseless ventricular tachycardia, pulseless electrical activity and asystole). | _____ | _____ |
| 2 | Treated tachycardia (atrial flutter, atrial fibrillation, SVT, A-tach, and VT with a pulse). | _____ | _____ |
| 3 | Treated symptomatic bradycardia. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
*Advanced Cardiovascular Life Support Provider Manual.*

**Related**
None

**Subject Area 23: Trauma Management**

Manage Canine Emergencies

081-68W-1653

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment. Manage canine emergencies for a military working dog (MWD) you encounter with an emergent medical condition. You will be provided with the canine tactical combat casualty care (K9TCCC) and the *Clinical Practice Guidelines (CPG)*. You have a fully stocked MWD medical aid bag and standard medical aid bag.

**Standards:** Manage a canine emergency in accordance with (IAW) the *Canine Tactical Combat Casualty Care (K9TCCC) Guidelines*, while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**Performance Steps:**

**WARNING:** Regardless to how well trained an MWD can be, an injury can cause them to act unpredictably and harm other team members providing assistance.

1. Ensure canine is muzzled and the muzzle remains on at all times unless critical to intermittently remove for assessment or patient management.

2. Treat massive hemorrhage; continue to control major bleeding.

**CAUTION:** Consider using a mouth gag to keep the MWD's mouth open to prevent damage to the endotracheal tube. Examples may include: 1-2-inch roll of medical tape; 2-inch roll of self-adhesive bandage, or use of a portion of a Kong between the MWD's teeth to keep the airway open.

3. Assess for evidence of upper airway obstructions.
    a. If an obstruction is detected clear oral cavity or perform abdominal thrusts.
    b. If the MWD is unconscious and there is no airway obstruction present, then intubate the dog.

4. Search for penetrating thoracic wounds and assess for pneumothorax.
    a. Place occlusive seal over open chest wounds.
    b. If there is no open chest wound, but the MWD is dyspneic, auscultate the chest to assess the heart rate and rhythm.

5. Assess heart rate, mucous membrane color, blood pressure and pulse strength.
    a. Treat for hypovolemic shock if needed.
    b. Place intravenous (IV) or intraosseous (IO) catheter.

6. Check patient's rectal temperature and treat for hypothermia if indicated.

7. Assess for skull fractures, contusions, and cranial neurologic signs or seizures.

8. Perform a 9-line medical evacuation (MEDEVAC) request IAW local standard operating procedure.

**NOTE:** The simplest option under fire is to drag the MWD out of the field of fire by its collar, vest, or legs. Give additional morphine in 10 milligrams (mg) increments to effect if MEDEVAC is delayed. Non-steroidal anti-inflammatory drugs (NSAIDs) should not be given.

a. Prepare casualty for evacuation.
b. Place on evacuation device, if not completed already.
c. While awaiting MEDEVAC support, continued patient support should include:
   (1) Further management of aforementioned conditions.
   (2) Splint fractured leg(s), if indicated.
   (3) Provide analgesia and antibiotics, if indicated.
      (a) Analgesia administer morphine auto-injector intramuscular (IM) (20 mg for 22-44 kilograms (kg); 30 mg if 45 kg or greater).
      (b) Antibiotics, administer broad-spectrum drug by mouth or IV.
   (4) Treat eye trauma if indicated.
   (5) Treat burn injuries if indicated.
d. Reassess the casualty. Many life-threatening injuries are not evident on initial presentation that you will only identify with careful and systematic reevaluation of the trauma patient.
   (1) Obtain baseline vital signs.
   (2) Verify known allergies, medications, previous medical or surgical history, when the injured last ate, events leading to the injury from those involved.
   (3) Continual reassessment surveys of the MWD's condition are indicated until MEDEVAC is complete.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Ensured canine is muzzled and it remained on at all times unless critical to intermittently removed for assessment or patient management. | _____ | _____ |
| 2 | Treated massive hemorrhage; continued to control major bleeding. | _____ | _____ |
| 3 | Assessed for evidence of upper airway obstructions. | _____ | _____ |
| 4 | Searched for penetrating thoracic wounds and assessed for pneumothorax. | _____ | _____ |
| 5 | Assessed heart rate, mucous membrane color, blood pressure and pulse strength. | _____ | _____ |
| 6 | Checked patient's rectal temperature and treated for hypothermia if indicated. | _____ | _____ |

| Performance Measures: | | GO | NO GO |
|---|---|---|---|
| 7 | Assessed for skull fractures, contusions and cranial neurologic signs or seizures. | _____ | _____ |
| 8 | Performed a 9-line medical evacuation (MEDEVAC) request IAW local standard operating procedure. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
*Canine Tactical Combat Casualty Care (K9TCCC) Guidelines.*

**Related**
None

## Subject Area 24: Triage and Evacuation

Establish a Casualty Decontamination Station

081-000-3058

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** In an operational environment, where chemical, biological, radiological, and nuclear agents are being used against the units supported by your medical treatment facility. The commander has ordered that a decontamination station and protective shelter be established. You are in a safe position, and you have a medical patient decontamination set, medical equipment patient holding set, portable medical shelter 18 by 25-foot, chemical agent monitor, and other associated items.

**Standards:** Establish a casualty decontamination station in a noncontaminated area upwind from the chemical hazard in accordance with ATP 4-02.7 while adhering to all warnings and cautions, without error, using the task GO/NO GO criteria.

**Performance Steps:**

1. Select site for the location of the operation.

**NOTE:** Alternate sites must be selected in conjunction with selection of the primary site. If the prevailing winds change direction by more than 30 degrees, use of the primary site may no longer be possible. A wait of 10 to 15 minutes to determine if the change is permanent should precede the move. When the station is moved, it must be moved at least 75 meters upwind from any contaminated area.

   a. Identify direction of the prevailing winds.
   b. Identify downwind chemical hazard.
   c. Identify the availability of protective shelters or buildings to house clean treatment facilities.
   d. Identify suitable terrain for site.
   e. Identify the availability of cover and concealment (where possible).
   f. Identify the availability of evacuation routes (contaminated and clean).
   g. Identify the location of troop decontamination lanes.

**NOTE:** Troop decontamination must not interfere with patient decontamination operations as timeliness of patient movement through decontamination once the patient is stabilized, is critical.

2. Identify core components of the patient decontamination site (PDS) (see ATP 4-02.7).

**NOTE:** When establishing a PDS, all component areas should be considered and addressed.

3. Designate locations of Entry Control Points and Drop Off Points.
   a. Place Entry Control Point along an access road to the drop-off point (when on land).

b. Place the Drop Off Point where patients are off loaded from vehicles and brought to the triage area.

4. Set up Warm Zone (Dirty Side) Triage Area.

**NOTE:** The triage area is located near the drop-off point in the PDS warm zone. Patients are moved to this area from the drop-off point.

5. Set up Warm Side (Dirty Side) Emergency Treatment Area.

**NOTE:** It is suggested that this area be located between the patient triage and the entrance to the litter decontamination lanes.

6. Designate location of Warm Side Disposition (Dirty Evacuation) area.

**NOTE:** This is an area located in the vicinity of the warm side emergency medical treatment (EMT) area.

7. Select area for Contaminated Waste Dump.

**NOTE:** This area is located away from the decontamination area and clean areas. On land, it is at least 75 meters downwind from the drop-off point.

8. Select location of Litter Patient Decontamination Line.

**NOTE:** This is an area located between the warm side EMT and the hot line.

9. Designate location of Ambulatory Patient Decontamination Line.

**NOTE:** This area is usually located parallel to the litter patient decontamination line.

10. Designate locations for Clean and Wastewater Storage Bladders.

11. Select location of Contamination Check Area.

12. Designate location of Litter Decontamination Station.

13. Designate location of Weapons and Contaminated Personal Effects Storage Area.

14. Select location for Warm (Dirty) Side Rest Area.

15. Emplace Hot Line and Shuffle Pit.
    a. Set up concertina wire at hot line to separate the dirty side from clean side of the PDS.
    b. Construct shuffle pit with a sand hypochlorite mixture.

16. Place Vapor Control Line.

17. Select location for Triage and EMT Area.

18. Select location for disposition area.

19. Select location for Clean Side Supply Point.

20. Designate area for temporary morgue.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Selected site for the location of the operation. | _____ | _____ |
| 2 | Identified core components of the patient decontamination site (PDS). | _____ | _____ |
| 3 | Designated locations of Entry Control Points and Drop Off Points. | _____ | _____ |
| 4 | Set up Warm Zone (Dirty Side) Triage Area. | _____ | _____ |
| 5 | Set up Warm Side (Dirty Side) Emergency Treatment Area. | _____ | _____ |
| 6 | Designated location of Warm Side Disposition (Dirty Evacuation) area. | _____ | _____ |
| 7 | Selected area for Contaminated Waste Dump. | _____ | _____ |
| 8 | Selected location of Litter Patient Decontamination Line. | _____ | _____ |
| 9 | Designated location of Ambulatory Patient Decontamination Line. | _____ | _____ |
| 10 | Designated locations for Clean and Wastewater Storage Bladders. | _____ | _____ |
| 11 | Selected location of Contamination Check Area. | _____ | _____ |
| 12 | Designated location of Litter Decontamination Station. | _____ | _____ |
| 13 | Designated location of Weapons and Contaminated Personal Effects Storage Area. | _____ | _____ |
| 14 | Selected location for Warm (Dirty) Side Rest Area. | _____ | _____ |
| 15 | Emplaced Hot Line and Shuffle Pit. | _____ | _____ |
| 16 | Placed Vapor Control Line. | _____ | _____ |
| 17 | Selected location for Triage and EMT Area. | _____ | _____ |
| 18 | Selected location for disposition area. | _____ | _____ |
| 19 | Selected location for Clean Side Supply Point. | _____ | _____ |
| 20 | Designated area for temporary morgue. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Training instructor determines if the entire task will be trained and evaluated or parts, based on a Soldier's military occupational specialty or assigned position and available equipment.

**References:**

**Required**
ATP 4-02.7. *Multi-Service Tactics, Techniques, and Procedures for Health Service Support in a Chemical, Biological, Radiological, and Nuclear Environment*.

**Related**
None

Coordinate Evacuation Plans

081-68W-3010

**CAUTION:** All body fluids should be considered potentially infectious so always observe body substance isolation precautions by wearing gloves and eye protection as a minimal standard of protection.

**Conditions:** You are in an operational environment and must coordinate evacuation plans, you have ATP 4-02.13.

**Standards:** Coordinate evacuation plans in accordance with ATP 4-02.13, while adhering to all warnings and cautions, without error, using the task GO/NO GO checklist.

**Performance Steps:**

1. Identify support requirements.
    a. Review the appropriate documents to identify all requirements.
    b. Determine the type and number of supported units and the type and number of supported equipment.
    c. If available, review the battle damage assessment and review report.
2. Identify available resources.
    a. Identify the resources on hand and the committed resources after the support requirements have been determined.
    b. Assets to consider include personnel; parts; tools; test, measurement, and diagnostic equipment; publications; and transport capabilities.
    c. Other assets to consider include operational readiness forward line of troops facilities, location of medical maintenance support teams, unit maintenance collection points, maintenance collection points, and recovery and evacuation capabilities.
3. Identify other considerations.
    a. Command priorities.
    b. Environmental impact.
    c. Maintenance workload.
    d. Exchange or cannibalization policy.
    e. Weather and terrain conditions.
    f. Safety.
    g. Security.
    h. Tactical situation.
    i. Operational tempo.
    j. Certifications and training.
4. Allocate assets to provide support.
5. Communicate with supported units.

**Evaluation Preparation:** You must evaluate the Soldiers on their performance of this task in an operational condition related to the actual task.

| | **Performance Measures:** | **GO** | **NO GO** |
|---|---|---|---|
| 1 | Identified support requirements. | _____ | _____ |
| 2 | Identified available resources. | _____ | _____ |
| 3 | Identified other considerations. | _____ | _____ |
| 4 | Allocated assets to provide support. | _____ | _____ |
| 5 | Communicated with supported units. | _____ | _____ |

**Evaluation Guidance:** Score each Soldier according to the performance measures in the evaluation guide. Unless otherwise stated in the task summary, the Soldier must pass all performance measures to be scored GO. If the Soldier fails any step, show what was done wrong and how to do it correctly.

**References:**

**Required**
ATP 4-02.13. *Casualty Evacuation*.

**Related**
None

# Glossary

| | |
|---|---|
| **°** | degrees |
| **AARs** | after action reviews |
| **AC** | alternating current |
| **ACH** | Army combat helmet |
| **ACLS** | advanced cardiac life support°° |
| **ADP** | Army doctrine publication |
| **AFTTP** | Air Force tactics, techniques, and procedures |
| **AFTTP(I)** | Air Force tactics, techniques, and procedures (instruction) |
| **AMS** | acute mountain sickness |
| **AN** | annually |
| **APD** | Army Publishing Directorate |
| **AR** | Army regulation |
| **ATNNA** | antidote treatment, nerve agent, autoinjector |
| **ATP** | Army techniques publication |
| **AVPU** | alert, verbal, pain, unresponsive |
| **AXP** | ambulance exchange point |
| **BAS** | battalion aid station |
| **BID** | twice a day |
| **BLS** | burns, lacerations, swelling |
| **BP** | blood pressure |
| **BSI** | body substance isolation |
| **BTLS** | burns, tenderness, lacerations, and swelling |
| **BVM** | bag valve mask |
| **C** | Celsius |
| **CANA** | Antidote for Nerve Agent |
| **CBRN** | chemical, biological, radiological, and nuclear |
| **CCA** | combat casualty assessment |
| **CCP** | casualty collection point |
| **CH** | cargo helicopter |
| **CLS** | combat livesafer |
| **CMS** | Centers for Medicare and Medicaid Services; circulation, motor, and sensory |
| **$CO_2$** | carbon dioxide |

| | |
|---|---|
| **COA** | courses of action |
| **CoTCCC** | Committee on Tactical Combat Casualty Care |
| **CPR** | cardiopulmonary resuscitation |
| **CRIC** | cricothyroidotomy |
| **CSM** | circulation, sensory, motor function |
| **CTA** | cotton tipped applicator |
| **CUF** | care under fire |
| **CV** | cardiovascular |
| **DA** | Department of the Army |
| **DA Form** | Department of the Army Form |
| **DCAP** | deformities, contusions, abrasions, punctures or penetration |
| **DCAP-BTLS** | deformities, contusions, abrasions, punctures or penetration, burns, tenderness, lacerations, and swelling |
| **DC** | direct current |
| **DCS** | damage control surgery |
| **DD Form** | Department of Defense form |
| **DOD** | Department of Defense |
| **DODI** | Department of Defense instruction |
| **DVT** | deep vein thrombosis |
| **D3SOE** | disrupted space operations environment |
| **ECAST** | exertional collapse associated with sickle cell trait |
| **EGA** | extraglottic airway |
| **EKG** | electrocardiogram |
| **EMT** | emergency medical technician |
| **ET** | endotracheal |
| **$EtCO_2$** | end-tidal carbon dioxide |
| **F** | Fahrenheit |
| **FAST** | focused assessment with sonography for trauma |
| **FM** | field manual |
| **FWB** | fresh whole blood |
| **G** | gastrointestinal |
| **GSW** | gunshot wound |
| **HACP** | high-altitude cerebral edema |
| **HAGA** | heavily armored ground ambulance |
| **HAPE** | high-altitude pulmonary edema |

| | |
|---|---|
| **HD** | mustard |
| **HLD** | high-level disinfectant |
| **HLZ** | helicopter landing zone |
| **HMMW** | high mobility multipurpose wheeled vehicle |
| **hr** | hour |
| **IAW** | in accordance with |
| **ID** | intradermal |
| **IED** | improvised explosive device |
| **IM** | intramuscular |
| **INST** | institutional |
| **IO** | intraosseous |
| **ITD** | impedance threshold device |
| **IV** | intravenous |
| **IVFs** | warm IV fluids |
| **IVPB** | IV piggyback |
| **JC** | Joint Commission |
| **JP** | Joint publication |
| **KIA** | killed in action |
| **L** | lewisite |
| **LCL** | lateral collateral ligament |
| **LR** | Lactated Ringer’s |
| **LTOWB** | low-titer O whole blood |
| **LWB** | long wheel base |
| **LZ** | Landing zone |
| **MACE** | military acute concussion evaluation |
| **MARCH** | massive hemorrhage, airway, respiration or breathing, circulation, and hypothermia |
| **MCL** | medial collateral ligament |
| **MCP** | metacarpal-phalangeal |
| **MCRP** | Marine Corps reference publication |
| **MCWP** | Marine Corps warfighting publication |
| **MEDEVAC** | Marine Corps reference publication |
| **METL** | mission-essential task list |
| **MO** | Medical officer |
| **MOI** | mechanism of injury |

| | |
|---|---|
| **MOS** | military occupational specialty |
| **MRAP** | mine-resistant ambush protected |
| **mTBI** | mild traumatic brain injury |
| **MTF** | medical treatment facility |
| **MWD** | military working dog |
| **NAAK** | Nerve Agent Antidote Kit |
| **NATO** | North Atlantic Treaty Organization |
| **NBR** | non-rebreather mask |
| **NCO** | noncommissioned officer |
| **NDC** | needle decompression of the chest |
| **NEX** | xiphoid |
| **NKDA** | North Atlantic Treaty Organization |
| **NPA** | nasopharyngeal airway |
| **NS** | normal saline |
| **NSID** | nonsteroidal anti-inflammatory drugs |
| **NTRP** | Navy tactical reference publication |
| **NTTP** | Navy tactics, techniques, and procedures |
| **O2** | oxygen |
| **O2-Sat** | oxygen saturation |
| **OF** | optional form |
| **oG** | Orogastric |
| **OM** | Otitis media |
| **OP** | operational |
| **OPA** | oropharyngeal airway |
| **OPORD** | operations order |
| **OTFC** | oral transmucosal fentanyl citrate |
| **PACE** | in accordance with |
| **PCM** | primary care manager |
| **PDD** | pressure deliver device |
| **PDS** | primary, alternate, contingency, and emergency |
| **PHTLS** | prehospital trauma life support |
| **PO** | by mouth |
| **PICC** | peripherally inserted central catheter |
| **PMS** | pulse, motor, and sensation |

| | |
|---|---|
| **PSG** | platoon sergeant |
| **PTA** | peri-tonsillar abscess |
| **RC** | Reserve Component |
| **RICE** | rest, ice, compression, elevation |
| **R/O** | rule out |
| **ROM** | range of motion |
| **RR** | readiness requirements |
| **RSDL** | reactive skin decontamination lotion |
| **SCT** | sickle cell trait |
| **S-D** | self-development |
| **SA** | semi-annually |
| **SAVe** | Simplified Automated Ventilator |
| **SAMPLE** | signs and symptoms, allergies, medications, pertinent past medical history, last oral intake, and events |
| **SF** | standard form |
| **SL** | skill level |
| **SM** | Soldier's manual |
| **SMCT** | Soldier's manual of common tasks |
| **SOAP** | subjective, objective, assessment, plan |
| **SOP** | standard operating procedure |
| **SPD** | sterile processing department |
| **SQ** | subcutaneous |
| **STP** | Soldier training publication |
| **SVT** | supraventricular tachycardia |
| **TBSA** | total body surface area |
| **TC** | Training Circular |
| **TCCC** | tactical combat casualty care |
| **TCD** | target compression device |
| **TdP** | Torsades de Pointes |
| **TG** | trainer's guide |
| **THR** | target heart rate |
| **TIC** | tenderness, instability, or crepitus |
| **TM** | technical manual |
| **TSOP** | tactical standard operating procedures |
| **TXA** | tranexamic acid |

| | |
|---|---|
| **UH** | utility helicopter |
| **URI** | upper respiratory infection |
| **U.S.** | United States |
| **VHF** | viral hemorrhagic fevers |
| **VOR** | vestibular-ocular reflex |
| **VOMS** | vestibular/ocular-motor screening |
| **VT** | ventricular tachycardia |
| **WIA** | wounded in action |
| **WP** | white phosphorus |
| **%** | percent |
| **cc** | cubic centimeter |
| **cGy** | centigrays |
| **cm** | centimeter(s) |
| **g** | grams |
| **kg** | kilogram(s) |
| **lbs** | pounds |
| **mg** | milligram(s) |
| **MHz** | megahertz |
| **ml** | milliliter(s) |
| **mmHg** | millimeters of mercury |
| **pH** | potential of hydrogen |
| **psi** | pounds per square inch |
| **u/ml** | unit per millimeter |
| **oz** | ounces |

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## PRESCRIBED FORMS

This section contains no entries.

## REFERENCED FORMS

Unless otherwise indicated, DA forms are available online at https://armypubs.army.mil/. DD forms are available online at https://www.esd.whs.mil/Directives/forms. SFs are available online at https://www.gsa.gov/reference/forms/.

DA Form 1156. *Casualty Feeder Card.*

DA Form 1687. *Notice of Delegation of Authority – Receipt for Supplies*.

DA Form 2028. *Recommended Changes to Publications and Blank Forms.*

DA Form 2062. *Hand Receipt/Shortage Listing.*

DA Form 3161. *Request for Issue or Turn-In.*

DA Form 3949. *Controlled Substances Record.*

DA Form 4678. *Therapeutic Documentation Care Plan (Medication).*

DA Form 4700. *Medical Record - Supplemental Medical Data.*

DD Form 792. *Nursing Service - Twenty-Four Hour Patient Intake and Output Worksheet.*

DD Form 1380. *Tactical Combat Casualty Care (TCCC)Card (Instructions).*

DD Form 2977. *Deliberate Risk Assessment Worksheet*.

OF 520. *Electrocardiographic Record.*

SF 510. *Medical Record - Nursing Notes.*

SF 518. *Blood or Blood Component Transfusion.*

SF 600. *Chronological Record of Medical Care.*

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**06 March 2025**

By Order of the Secretary of the Army:

**RANDY A. GEORGE**
*General, United States Army*
*Chief of Staff*

Official:

**MARK F. AVERILL**
*Administrative Assistant*
*to the Secretary of the Army*
2505902

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