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Administer Medication
Status: Approved

Security Classification: U - Unclassified

Distribution Restriction: Approved for public release; distribution is unlimited.

Destruction Notice: None

Foreign Disclosure: FD1 - This training product has been reviewed by the training developers in coordination with the Joint Base San Antonio, Fort Sam Houston/US Army Medical Center of Excellence (MEDCoE) foreign disclosure officer. This training product can be used to instruct international military students from all approved countries without restrictions.

Conditions: In an operational environment, you are given the medical provider's order 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, nonrebreather mask, airflow tubing, a source of compressed air or oxygen with flowmeter, nebulizer kit, metered dose inhaler mouthpiece, Department of Army (DA) Form 4678, Therapeutic Documentation Care Plan, Medications, DA Form 3949, Controlled Substances Record, Department of Defense (DD) Form 1380, Tactical Combat Casualty Care (TCCC) Care, Electronic Medical Record (EMR), and a pen. A patient care handwash has been performed. Some iterations of this task should be performed in MOPP 4. This task should be trained under IED Threat conditions.

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 and the Army Techniques Publication (ATP) 4-02.10; Theater Hospitalization, Tactical Combat Casualty Care (TCCC) Guidelines, Clinical Practice Guidelines, utilizing the GO/NO-GO criteria.

Special Conditions: None

Safety Risk: Low

MOPP 4: Sometimes

Task Statements

Cue: None

DANGER

None

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.

Remarks: 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, and/or with degraded, denied, and disrupted space operations environment (D3SOE).

Notes: 68W, Combat Medic Specialist is the proponent for this task.

Performance Steps

1. Confirm the medical provider's orders.

Note: Always use body substance isolation (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 (DOD) 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/Powdered Inhalation medication.

(2) Nose drop/spray.

(3) Ointment.

d. Ocular Medication.

(1) Drops.

(2) Ophthalmic ointment.

e. Otic Medication.

f. Dermal Medication.

(1) Topical Cream/Lotion/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/Vaginal Medication.

(1) Suppository.

(2) Enema.

(3) Cream/ointment.

(4) Vaginal Irrigation/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 amounts 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 slows 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/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 his 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 his 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/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/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.

Remarks: Do not allow the applicator to touch the eye, eye lids, lashes, or skin.

(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 3rd 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/Lotion/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.
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 Intradermal (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 (1mL) 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" (5cm).

_3_ Allow the skin to dry completely before administering injection.

Note: This will avoid a stinging sensation from introducing alcohol into subcutaneous 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 Intramuscular (IM) injection.

(a) Gather appropriate supplies.

Note: IM injections are to administer medication into muscle tissue. Syringe size may vary depending on medication (3mL to 10mL). 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 1mL). Avoid use of the deltoid muscle in infants or in children/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 3mL. 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 hands width below the hip joint to one hand's 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 debilitates 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' standard operating procedure (SOP).

_5_ Place an antiseptic pad (or 2 x 2 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 Subcutaneous (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 1mL. 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 1mL.

_2_ Vastus Lateralis.

Note: Medication volume should not exceed 1mL.

_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" (5cm).

_3_ Allow the skin to dry completely before administering injection.

Note: This will avoid a stinging sensation from introducing alcohol into subcutaneous 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 non-dominant 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 operating procedure (SOP) and infection control guidelines.

_4_ Place an antiseptic pad (or 2 x 2 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 IV Push.

(a) Gather appropriate supplies.

Note: Administration may be through an injection port using needle or by connecting syringe to luer-lock connection site.

(b) Draw appropriate amount of medication into syringe according to medical provider's order.

(c) Locate vessel access.

_1_ Intravenous (IV).

_2_ Intraosseous (IO).

_a_ EZ IO - Placement will be in the proximal humerus, proximal tibia, or distal tibia.

Note: May be placed in distal femur in pediatric patients.

_b_ FAST 1 - 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 luer-lock syringe onto the luer-lock connection site.

(f) Slowly push the syringe plunger to administer medication.

(g) Document procedure on medical record.

(2) Administer medication by IV Piggyback (IVPB).

(a) Gather appropriate supplies.

Note: Administration may be through an injection port using needle or by connecting syringe to luer-lock 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_ Intravenous (IV).

_2_ Intraosseous (IO).

_a_ EZ IO - Placement will be in the proximal humerus, proximal tibia, or distal tibia.

_b_ FAST 1 - 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 luer-lok syringe onto the luer-lok connection site.

(i) Begin the IVPB by opening the roller.

(j) document procedure on medical record.

i. Administer Rectal/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 she is 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 ½ 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/Ointment.

(a) Explain the procedure to the patient.

(b) Ask the patient if she is 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/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/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/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/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.

(Asterisks indicates a leader performance step.)

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 (MOS) or assigned position and available equipment.

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

PERFORMANCE MEASURES	GO	NO-GO	N/A
1. Confirmed the medical provider's orders.			
2. Selected the Right medication.			
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.			

Supporting Reference(s):

Step Number	Reference ID	Reference Name	Required	Primary	Source Information
	ATP 4-02.10	Theater Hospitalization	Yes	No	
	DA FORM 3949	CONTROLLED SUBSTANCES RECORD	Yes	No	
	DA FORM 4678	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATION)	Yes	No	
	DD FORM 1380	TACTICAL COMBAT CASUALTY CARE (TCCC) CARD	Yes	No	
	ISBN 1605477725	Textbook of Basic Nursing, 10th ed. (Lippincott's Practical Nursing)	Yes	No	
	TCCC Guidelines 2020	Tactical Combat Casualty Care (TCCC) Guidelines; by Joint Trauma System (JTS) Committee on Tactical Combat Casualty Care (CoTCCC)	Yes	Yes	

TADSS : None

Equipment Items (LIN): None

Materiel Items (NSN) :

Step ID	NSN	LIN	Title	Qty
	6510-00-584-4421		GAUZE 2X2	1
	6515-00-324-5205		Weder Tongue Blade	1
	6530-01-379-1464		MEDICINE CUP 1 OZ PLAS MEASUREMENTS/CC'S ML'S DRAMS TEASPOONS500	1
	H559-50002-20		GLOVES, SM 100S	1
	H559-50003-30		GLOVES, MED 100S	1
	H559-50004-40		GLOVES, LRG 100S	1
	0000-01-174-6662		CYLINDER, OXYGEN	1
	1660-00-810-5794		REGULATOR,OXYGEN	1
	6515-01-319-5613		Mouthpiece, Drug Delivery, Compatible with Reservoir Bags	1
	6515-01-535-5953		NONREBREATHER MASK	1
	6505-01-117-7829		SURGILUBE, INDIVIDUAL USE PACKET	1
	6505-00-004-6666		Sodium Chloride Injection, USP, 0.9%, 250ML Bag	1
	6505-01-349-3540		Nitroglycerin Transdermal System, 40MG Bandage 30S	1
	6510-00-043-4316		Adhesive Tape, Surgical, Transparent, 2 Inches X 5 Yards, 6 Rolls	1
	6515-00-055-2155		TUBE,OXYGEN	1
	6515-00-562-8308		TUBING,OXYGEN CONNECTOR	1
	6515-01-267-1490		Nebulizer, Medicinal, Plastic, Compressed Air Line, Clear, Disposable	1
	6515-01-392-6761		Nebulizer Kit, Inhalation Therapy Apparatus, Neonatal Use, Disposable	1

Environment: Environmental protection is not just the law but the right thing to do. It is a continual process and starts with deliberate planning. Always be alert to ways to protect our environment during training and missions. In doing so, you will contribute to the sustainment of our training resources while protecting people and the environment from harmful effects. Refer to the current Environmental Considerations manual and the current GTA Environmental-related Risk Assessment card.

Safety: In a training environment, leaders must perform a risk assessment in accordance with current Risk Management Doctrine. Leaders will complete the current Deliberate Risk Assessment Worksheet in accordance with the TRADOC Safety Officer during the planning and completion of each task and sub-task by assessing mission, enemy, terrain and weather, troops and support available-time available and civil considerations, (METT-TC). Note: During MOPP training, leaders must ensure personnel are monitored for potential heat injury. Local policies and procedures must be followed during times of increased heat category in order to avoid heat related injury. Consider the MOPP work/rest cycles and water replacement guidelines IAW current CBRN doctrine.

Prerequisite Individual Tasks : None

Supporting Individual Tasks : None

Supported Individual Tasks : None

Supported Collective Tasks : None

Knowledges :

Knowledge ID	Knowledge Name
K1050	Uses of Common Medications
081-C2-68W-0975	Identify the indications and contraindications for the medications used.
081-NP-68C-0137	Knowledge of medication dose calculation formulas.
K23251	Knowledge of selecting the appropriate medication for a patient
081-NP-68C-0136	Use of conversion tables
k23253	Knowledge of medication administration, including factors to consider before administering medications
081-SR-68P-R256	Knowledge to draw medications into a syringe
081-NP-68C-0135	Knowledge of equivalents in measurement systems.

Skills :

Skill ID	Skill Name
081-C2-68W-0372	Demonstrate ability to administer various types of drugs.
081-VC-68T-SK0056	Amount of medication to be administered.

ICTL Data : None