STP 8-91X14-SM-TG

SOLDIER'S MANUAL AND TRAINER'S GUIDE

MOS 91X

MENTAL HEALTH SPECIALIST

SKILL LEVELS 1/2/3/4

APRIL 2003

HEADQUARTERS, DEPARTMENT OF THE ARMY

*SOLDIER TRAINING PUBLICATION
No. 8-91X14-SM-TG

HEADQUARTERS
DEPARTMENT OF THE ARMY
Washington, DC, 30 April 2003

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TABLE OF CONTENTS

PAGE

* This publication supersedes STP 8-91X14-SM-TG, 29 September 1997.

PREFACE

This publication is for skill level 1, 2, 3, and 4 soldiers holding military occupational specialty (MOS) 91x 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 holding MOS/SL 91X1/2/3/4 have access to this publication. This STP is available for download from the Reimer Digital Library (RDL).

This manual applies to both Active and Reserve Component soldiers.

The proponent of this publication is HQ, TRADOC. Send comments and recommendations on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Academy of Health Sciences, ATTN: MCCS-HTI, 1750 Greeley Rd, STE 135, Fort Sam Houston, TX 78234-5078.

CHAPTER 1

Introduction

1-1. General

This manual identifies the individual MOS training requirements for soldiers in MOS 91X. Commanders, trainers, and soldiers should use it to plan, conduct, and evaluate individual training in units. This manual is the primary MOS reference to support the self-development and training of every soldier.

Use this manual with Soldier's Manuals of Common Tasks (STP 21-1-SMCT and STP 21-24-SMCT), Army Training and Evaluation Programs (ARTEPs), and FM 25-101, Battle Focused Training, to establish effective training plans and programs that integrate soldier, leader, and collective tasks.

1-2. Battle Focused Training

As described in FM 25-100, Training the Force, and FM 25-101, Battle Focused Training, the commander must first define the mission essential task list (METL) as the basis for unit training. Unit leaders use the METL to identify the collective, leader, and soldier tasks which support accomplishment of the METL. Unit leaders then assess the status of training and lay out the training objectives and the plan for accomplishing needed training. After preparing the long- and short-range plans, leaders then execute and evaluate training. Finally, the unit's training preparedness is reassessed, and the training management cycle begins again. This process ensures that the unit has identified what is important for the wartime mission, that the training focus is applied to the necessary training, and that training meets established objectives and standards.

Additionally, the AMEDD is developing training products that will enhance medical preparedness in the case of a Chemical, Biological, Radiological, Nuclear, and High-Yield Explosive (CBRNE) event. To assist commanders and leaders in training their units, CBRNE-related information is being included in AMEDD Mission Training Plans (MTPs). Even though most collective tasks within an MTP may directly affect or support a CBRNE event, the ones that will most directly be impacted are clearly indicated with a statement in the CONDITION that reads: "THIS TASK MAY BE USED TO SUPPORT A CBRNE EVENT." These collective tasks and any supporting individual tasks in this soldier’s manual should be considered for training emphasis. Also included in the MTP is a CBRNE Appendix. The purpose of the appendix is to give a general overview of the Federal Response Plan, the AMEDD support role, and the command structure for those agencies and elements involved or participating in a CBRNE event. It is understood that military resources temporarily support and augment, but do not replace local, state, and federal civilian agencies having primary authority and responsibility for domestic disaster assistance.

1-3. Relationship of Soldier Training Publications (STPs) to Battle Focused Training

The two key components of enlisted STPs are the Trainer's Guide (TG) and Soldier's Manual (SM). The TG and SM give leaders important information to help in the battle focused training process. The TG relates soldier and leader tasks in the MOS and SL to duty positions and equipment. It provides information on where the task is trained, how often training should occur

to sustain proficiency, and who in the unit should be trained. As leaders go through the assessment and planning stages, they should use the TG as an important tool in identifying what needs to be trained.

The execution and evaluation of soldier and leader training should rely on the Armywide training objectives and standards in the SM task summaries. The task summaries ensure that soldiers in any unit or location have the same definition of task performance and that trainers evaluate the soldiers to the same standard.

1-4. Task Summaries

Task summaries contain information necessary to conduct training and evaluate soldier proficiency on tasks critical to the MOS. A separate task summary is provided for each critical task. These task summaries are, in effect, standardized training objectives that ensure that soldiers do not have to relearn a task on reassignment to a new unit. The format for the task summaries included in this manual is as follows:

- Task Title. The task title identifies the action to be performed.
- Task Number. A 10-digit number identifies each task or skill. Include this task number, along with task title, in any correspondence relating to the task.
- Conditions. The task conditions identify all the equipment, tools, references, job aids, and supporting personnel that the soldier needs to perform the task in wartime. This section identifies any environmental conditions that can alter task performance, such as visibility, temperature, and wind. This section also identifies any specific cues or events that trigger task performance.
- Standards. The task standards describe how well and to what level you must perform a task under wartime conditions. Standards are typically described in terms of accuracy, completeness, and/or speed.
- Performance Steps. This section includes a detailed outline of information on how to perform the task.
- 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 instruction that should be given to the soldier before evaluation.
- Performance Measures. This evaluation guide identifies the specific actions that 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 a feedback statement that indicates the requirements for receiving a GO on the evaluation.
- References. This section identifies references that provide more detailed and thorough explanations of task performance requirements than that given in the task summary description.

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. Notes provide a small, extra supportive explanation or hint relative to the performance measures.

1-5. Soldier's Responsibilities

Each soldier is responsible for performing individual tasks which the first-line supervisor identifies based on the unit's METL. The soldier must perform the tasks to the standards listed in the SM. If a soldier has a question about how to do a task or which tasks in this manual he or she must perform, it is the soldier's responsibility to ask the first-line supervisor for clarification. The first-line supervisor knows how to perform each task or can direct the soldier to the appropriate training materials.

1-6. NCO Self-Development and the Soldier's Manual

Self-development is one of the key components of the leader development program. It is a planned progressive and sequential program followed by leaders to enhance and sustain their military competencies. It consists of individual study, research, professional reading, practice, and self-assessment. Under the self-development concept, the NCO, as an Army professional, has the responsibility to remain current in all phases of the MOS. The SM is the primary source for the NCO to use in maintaining MOS proficiency.

Another important resource for NCO self-development is the Army Correspondence Course Program (ACCP). Refer to DA Pamphlet 350-59 for information on enrolling in this program and for a list of courses, or write to: AMEDDC&S, ATTN: MCCS-HSN, 2105 11TH STREET SUITE 4191, FORT SAM HOUSTON TX 78234-5064.

Unit learning centers are valuable resources for planning self-development programs. They can help access enlisted career maps, training support products, and extension training materials. A life cycle management diagram for MOS 91X soldiers is on page 1-4. You can find more information and check for updates to this diagram at http://das.cs.amedd.army.mil/ooc.htm (scroll down to LIFE CYCLE MANAGEMENT, select ENLISTED, and find the appropriate tab along the bottom.) This information, combined with the MOS Training Plan in Chapter 2, forms the career development model for the MOS.

1-7. Trainer's Responsibilities

Training soldier and leader tasks to standard and relating this training to collective mission-essential tasks is the NCO trainer's responsibility. Trainers use the steps below to plan and evaluate training.

- Identify soldier and leader training requirements. The NCO determines which tasks soldiers need to train on using the commander's training strategy. The unit's METL and ARTEP and the MOS Training Plan (MTP) in the TG are sources for helping the trainer define the individual training needed.

- Plan the training. Training for specific tasks can usually be integrated or conducted concurrently with other training or during "slack periods." The unit's ARTEP can assist in identifying soldier and leader tasks which can be trained and evaluated concurrently with collective task training and evaluation.

- Gather the training references and materials. The SM task summary lists all references which can assist the trainer in preparing for the training of that task.

MOS 91X MENTAL HEALTH SPECIALIST CAREER/TRAINING LIFE CYCLE										
RANK	**AMEDD Course NR**	**TRAINING**	**LENGTH**	**LOCATION**	**ATTENDANCE REQUIREMENT**	**Self-Development Course NR**	**SELF-DEVELOPMENT**	**LENGTH**	**LOCATION**	**ATTENDANCE REQUIREMENT**
E1 - E5		**Basic Combat Training Course**	**9 wks**	**Ft. LW/Ft. Sill Ft. Jackson Ft. Benning**	**IET**		**Army Correspondence Course Program**			
						081-CBRNE-W	***Introduction to CBRNE Also taught in AIT/IET***		**On-Line**	**Just in Time**
	302-91X10	**Mental Health Specialist 91X10**	**19 wks, 4 Days**	**FSH, TX**	**AIT/MOS**	**081-MD0010**	**Basic Medical Terminology**		**Correspondence**	**Sustainment**
	5H-F4/302-F4	**USADART (Individual)**	**2 wks**	**FSH, TX**	**Prerequisite for USDART Group**	**081-MD1690**	**ASMART (self-paced)**		**Unit Training**	**Just in Time**
	5H-F5/302-F5	**USADART (Group)**	**2 Wks**	**FSH, TX**	**ASI/M8**	**081-ENHANC**	**Combat Life Saver (CLS)**		**Unit Training**	**Just in Time**
		PLDC	**4 wks**	**Multiple sites**	**Leadership**		**PPSCP**			
	6-8-C40(91X30)	**AMEDD NCO BASIC (NCOES)**	**4 Wks 4 Days**	**FSH, TX**	**Leadership**	**300-A0704**	**75/71 Personnel/Retention Legal/EO**	**4 days**	**SA, TX**	**Just in Time**
	5H-F7/302-F7	**USAADAPCP Family Counseling**	**2wks**	**FSH, TX**	**Just in Time**	**300-A0720(DL)**	**91X/71M NCO Short Course**	**5 days**	**SA, TX**	**Just in Time**
	5H-F10/302-F10	**USAADAPCP Advanced Counseling**	**1 wk**	**FSH, TX**	**Just in Time**	**340-A0715**	**MEDCOM CSM/SGM SR NCO**	**4 Days**	**SA, TX**	**Optional**
		BASELINE	**REQUIRED**	**RECOMMENDED**	**PROFIS**	**340-A0743**	**CSM/SGM SR NCO Course**	**4 days**	**Landstuhl, Germany**	**Leadership**
		Basic Life Support (BLS) - Current	X			**6A-A0150**	**AMEDD Behavioral Science Postgraduate**	**5 days**	**Atlanta, GA**	**Just in Time**
		Basic Critical Incident Stress Debriefing Training		X			**Specialty Courses**			
		Advance Drug & Alcohol Training		X		**5K-F13/520-F10**	***CBRNE TRAINER EVALUATOR***	***2 Days***	**Fort Sam Houston, TX**	**Just in Time**
		Family Drug & Alcohol Training		X		**5K-F7/520-F7**	**ADVANCED INSTRUCTOR TRAINING COURSE (Ph 1&2)**	**1 Wk, 3 Days**	**FSH, TX**	
		Train the Trainer Critical Incident Stress Debriefing		X		**5K-F8/520-F8**	**EDUCATION AND TRAINING FOR THE 21ST CENTURY**	**4 wks**	**FSH, TX**	
		Emergency Medical Training (EMT)		X		**6H-F17/322-F17**	**Force Health Protection Conference**	**1 Wk, 3 Days**	**Albequerque, NM**	**Just in Time**
		Instructor Courses								
	5K-F3/520-F3	**Instructor Training Course**	**2 weeks**	**AHS**	**JIT/SI (5K)**					
	5K-F6/520-F6	**Sm Grp Ldr Crse**	**2 weeks**	**AHS**	**JIT**					
E6 - E9	**250-ASI2S**	**Battle Staff NCO**	**4 Wks, 1 Day**	**USASMA (Ft. Bliss)**	**Optional**					
		Recruiter	**6 wks**	**USAREC**	**Just in time**					
		Master Fitness Trainer	**2 wks**	**Multiple Sites**	**Just in time ASI P5**					
		Drill Sgt School	**9 wks**	**Multiple Sites**	**Just in Time SQI-X**					
	6-8-C42	**AMEDD NCO Advanced (NCOES)**	**2 Wks, 3 Days**	**FSH, TX**	**Leadership**					
	521-SQIM	**First Sergeant Course**	**8 wks**	**USASMA**	**Just in time SQI-M**					
	1-250-C5	**U.S. ARMY SERGEANTS MAJOR**	**38 Wks, 2 Days**	**USASMA (Ft. Bliss)**	**Just in time MEL-A**					
	521-F1	**Command Sergeant Major Course**	**1 wk**	**USASMA**	**Leadership**					
NOTE: Delete 91B prerequisite. Becomes 91W at MSG (E8) Expert Field Medical Badge and DEPMEDS if assigned PROFIS										

- Determine risk assessment and identify safety concerns. Analyze the risk involved in training a specific task under the current conditions at the time of scheduled training. Ensure that your training preparation takes into account those cautions, warnings, and dangers associated with each task.

- Train each soldier. Show the soldier how the task is done to standard, and explain step-by-step how to do the task. Give each soldier one chance to do the task step-by-step.

- Emphasize training in mission-oriented protective posture (MOPP) level 4 clothing. Soldiers have difficulty performing even the very simple tasks in an NBC environment. The combat effectiveness of the soldier and the unit can degrade quickly when trying to perform in MOPP 4. Practice is the best way to improve performance. The trainer is responsible for training and evaluating soldiers in MOPP 4 so that they are able to perform critical wartime tasks to standards under NBC environment conditions.

- Check each soldier. Evaluate how well each soldier performs the tasks in this manual. Conduct these evaluations during individual training sessions or while evaluating soldier proficiency during the conduct of unit collective tasks. This manual provides an evaluation guide for each task to enhance the trainer's ability to conduct year-round, hands-on evaluations of tasks critical to the unit's mission. Use the information in the MTP as a guide to determine how often to train the soldier on each task to ensure that soldiers sustain proficiency.

- Record the results. The leader book referred to in FM 25-101, appendix B, is used to record task performance and gives the leader total flexibility on the method of recording training. The trainer may use DA Forms 5164-R (Hands-On Evaluation) and 5165-R (Field Expedient Squad Book) as part of the leader book. The forms are optional and locally reproducible. STP 21-24-SMCT contains a copy of the forms and instructions for their use.

- Retrain and evaluate. Work with each soldier until he or she can perform the task to specific SM standards.

1-8. Training Tips for the Trainer

Prepare yourself.

- Get training guidance from your chain of command on when to train, which soldiers to train, availability of resources, and a training site.

- Get the training objective (task, conditions, and standards) from the task summary in this manual.

- Ensure you can do the task. Review the task summary and the references in the reference section. Practice doing the task or, if necessary, have someone train you on the task.

- Choose a training method.

- Prepare a training outline consisting of informal notes on what you want to cover during your training session.

- Practice your training presentation.

Prepare the resources.

- Obtain the required resources identified in the conditions statement for each task.
- Gather equipment and ensure it is operational.
- Coordinate for use of training aids and devices.
- Prepare the training site according to the conditions statement and evaluation preparation section of the task summary, as appropriate.

Prepare the soldiers.

- Tell the soldier what task to do and how well it must be done. Refer to the standards statement and evaluation preparation section for each task as appropriate.
- Caution soldiers about safety, environment, and security.
- Provide any necessary training on basic skills that soldiers must have before they can be trained on the task.
- Pretest each soldier to determine who needs training in what areas by having the soldier perform the task. Use DA Form 5164-R and the evaluation guide in each task summary to make this determination.

NOTE: Deficiencies noted in soldiers' ability to perform critical tasks taught in schools or by extension training materials should be reported to the proponent school.

Train the soldiers who failed the pretest.

- Demonstrate how to do the task or the specific performance steps to those soldiers who could not perform to SM standards. Have soldiers study the appropriate materials.
- Have soldiers practice the task until they can perform it to SM standards.
- Evaluate each soldier using the evaluation guide.
- Provide feedback to those soldiers who fail to perform to SM standards and have them continue to practice until they can perform to SM standards.

Record results in the leader book.

1-9. Training Support

This manual includes the following information which provides additional training support information.

- Appendix A, DA Form 5165-R (Field Expedient Squad Book). This appendix provides an overprinted copy of DA Form 5165-R for the tasks in this MOS. The NCO trainer can use this form to set up the leader book described in FM 25-101, appendix B. The use of this form may help preclude writing the soldier tasks associated with the unit's mission essential task list, and can become a part of the leader book.

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

- References. This section contains two lists of references, required and related, which support training of all tasks in this SM. Required references are listed in the conditions statement and are required for the soldier to do the task. Related references are materials which provide more detailed information and a more thorough explanation of task performance.

CHAPTER 2

Trainer's Guide

2-1. General. The MOS Training Plan (MTP) 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 MTP should be used as a guide for conducting unit training and not a rigid standard. The MTP consists of two parts. Each part is designed to assist the commander in preparing a unit training plan which satisfies integration, cross training, training up, and sustainment training requirements for soldiers in this MOS.

Part One of the MTP 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.

Section I lists subject area numbers and titles used throughout the MTP. These subject areas are used to define the training requirements for each duty position within an MOS.

Section II 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 column**. This column lists the duty positions of the MOS, by skill level, which have different training requirements.
- **Subject Area column**. This column lists, by numerical key (see Section I), the subject areas a soldier must be proficient in to perform in that duty position.
- **Cross Train column**. This column lists the recommended duty position for which soldiers should be cross trained.
- **Train-up/Merger column**. This column lists the corresponding duty position for the next higher skill level or MOSC the soldier will merge into on promotion.

Part Two lists, by general subject areas, the critical tasks to be trained in an MOS and the type of training required (resident, integration, or sustainment).

- **Subject Area column**. This column lists the subject area number and title in the same order as Section I, Part One of the MTP.
- **Task Number column**. This column lists the task numbers for all tasks included in the subject area.
- **Title column**. This column lists the task title for each task in the subject area.
- **Training Location column**. This column identifies the training location where the task is first trained to soldier training publications standards. If the task is first trained to standard in the unit, the word “Unit” will be in this column. If the task is first trained to standard in the training base, it will identify, by brevity code (ANCOC, BNCOC, etc.), the resident course where the task was taught. Figure 2-1 contains a list of training locations and their corresponding brevity codes.

AIT	Advanced Individual Training
UNIT	Trained in the Unit
BNCOC	Basic NCO Course

Figure 2-1. Training Locations

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

BA - Biannually
AN - Annually
SA - Semiannually
QT - Quarterly
MO - Monthly
BW - Bi-weekly
WK - Weekly

Figure 2-2. Sustainment Training Frequency Codes

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

2-2. Part One, Section I. Subject Area Codes.

Skill Level 1

1 Interviewing
2 Client Assessment
3 Counseling
4 Combat Stress
5 Psychological Testing
6 Patient Interventions
7 Patient Processing
8 Supporting Tasks
9 Basic Medical Treatment
10 Drug and Alcohol Counselor (ASI M8)

Skill Level 2

11 Admin (SL2)

Skill Level 3

12 Admin (SL3)

2-3. Part One, Section II. Duty Position Training Requirements.

	DUTY POSITION	SUBJECT AREAS	CROSS TRAIN	TRAIN-UP/ MERGER
SL 1	Mental Health Specialist Mental Health Specialist (ASI M8)	1-9 1-10	NA	91X2 Mental Health NCO
SL 2	Mental Health NCO Mental Health NCO (ASI M8)	1-9, 11 1-11	NA	91X3 Mental Health NCO
SL 3	Mental Health NCO Mental Health NCO (ASI M8)	1-9, 11-12 1-12	NA	NA
SL 4	Mental Health NCO Mental Health NCO (ASI M8)	1-9, 11-12 1-12	NA	91W5 Operations SGT 91W5M Medical 1st SGT

2-4. Part Two. Critical Tasks List.

MOS TRAINING PLAN
91X14

CRITICAL TASKS

Subject Area	Task Number	Title	Training Location	Sust Tng Freq	Sust Tng SL
Skill Level 1					
1. Interviewing	081-832-0062	COLLECT COLLATERAL INFORMATION FROM RECORDS	AIT	AN	1-4
	081-832-0063	CONDUCT AN INFORMATION GATHERING INTERVIEW	AIT	AN	1-4
	081-832-0011	CONDUCT A COLLATERAL INTERVIEW	AIT	AN	1-4
	081-832-0013	PRESENT A CASE FOR SUPERVISION	AIT	AN	1-4
	081-832-1028	CONDUCT AN ADMISSION INTERVIEW WITH A PSYCHIATRIC PATIENT	AIT	AN	1-4
2. Client Assessment	081-832-0065	ASSESS SUBSTANCE USE, ABUSE, OR DEPENDENCY	AIT	AN	1-4
	081-832-0073	ASSESS A PATIENT/CLIENT'S PROGRESS IN MENTAL HEALTH TREATMENT	AIT	AN	1-4
	081-832-0038	ASSESS A PATIENT FOR ELOPEMENT TENDENCIES/BEHAVIOR	AIT	AN	1-4
	081-832-0034	DOCUMENT A PSYCHIATRIC PATIENT'S INITIAL ASSESSMENT IN WRITING	AIT	AN	1-4
	081-832-0031	ASSESS CLIENT'S POTENTIAL FOR FAMILY VIOLENCE	AIT	AN	1-4
	081-832-0005	ASSESS A CLIENT'S MENTAL STATUS	AIT	AN	1-4
	081-832-0006	ASSESS A CLIENT'S SOCIAL FUNCTIONING	AIT	AN	1-4
	081-832-0064	ASSESS CLIENT PSYCHOPATHOLOGY	AIT	AN	1-4
	081-832-0023	DETERMINE A CLIENT'S HOMICIDAL POTENTIAL	AIT	AN	1-4
	081-832-0026	DETERMINE A CLIENT'S SUICIDAL POTENTIAL	AIT	AN	1-4
	081-832-1031	ASSESS A PSYCHIATRIC PATIENT'S SUICIDAL POTENTIAL	AIT	AN	1-4
	081-832-1029	ASSIST IN ASSESSMENT OF A PSYCHIATRIC PATIENT	AIT	AN	1-4
3. Counseling	081-832-1030	ASSIST IN THE IDENTIFICATION OF TREATMENT GOALS AND INTERVENTIONS	AIT	AN	1-4

CRITICAL TASKS

Subject Area	Task Number	Title	Training Location	Sust Tng Freq	Sust Tng SL
	081-832-0066	CONDUCT A COUNSELING SESSION	AIT	AN	1-4
	081-832-0014	PERFORM COUNSELING INTERVENTIONS	AIT	AN	1-4
4. Combat Stress	081-832-0030	ASSIST IN A CRITICAL EVENT DEBRIEFING	AIT	AN	1-4
	081-832-0068	TREAT BATTLE FATIGUE	AIT	AN	1-4
	081-832-0024	PERFORM SIX FUNCTIONS OF COMBAT STRESS CONTROL (CSC)	AIT	AN	1-4
5. Psychologi-cal Testing	081-832-0069	ADMINISTER THE MINNESOTA MULTIPHASIC PERSONALITY INVENTORY-2 (MMPI-2)	AIT	AN	1-4
6. Patient Interventions	081-833-0076	APPLY RESTRAINING DEVICES TO PATIENTS	AIT	AN	1-4
	081-832-1011	RESPOND TO AN AGITATED PATIENT	AIT	AN	1-4
	081-832-1012	ASSIST IN MANUAL RESTRAINT PROCEDURES	AIT	AN	1-4
	081-832-1013	ASSIST IN MECHANICAL RESTRAINT PROCEDURES	AIT	AN	1-4
	081-832-0029	CONDUCT CRISIS INTERVENTION	AIT	AN	1-4
	081-832-1014	INVOLVE PATIENTS IN THERAPEUTIC RECREATIONAL ACTIVITIES	AIT	AN	1-4
	081-832-1024	CARE FOR A PATIENT RECEIVING ELECTROCONVULSIVE THERAPY	AIT	AN	1-4
	081-832-1021	COFACILITATE A GROUP THERAPY SESSION	AIT	AN	1-4
7. Patient Processing	081-832-0007	CONDUCT REFERRAL SERVICE FOR INDIVIDUALS	AIT	AN	1-4
	081-832-1003	PERFORM ADMISSION PROCEDURES ON A PSYCHIATRIC WARD	AIT	AN	1-4
	081-832-1001	ENSURE A PATIENT'S FUNDS AND VALUABLES ARE SECURED	AIT	AN	1-4
	081-832-1002	ENSURE A PATIENT'S PERSONAL EFFECTS ARE SECURED	AIT	AN	1-4
	081-832-1004	PREPARE A CLASS 1A OR 1B PATIENT FOR AEROMEDICAL EVACUATION	AIT	AN	1-4
	081-832-1005	PREPARE A CLASS 1C PATIENT FOR AEROMEDICAL EVACUATION	AIT	AN	1-4

CRITICAL TASKS

Subject Area	Task Number	Title	Training Location	Sust Tng Freq	Sust Tng SL
	081-832-0054	CONDUCT HOSPITAL DISCHARGE PLANNING FOR A MENTAL HEALTH PATIENT/CLIENT	AIT	AN	1-4
	081-832-1027	PERFORM DISCHARGE PROCEDURES ON A PSYCHIATRIC WARD	AIT	AN	1-4
8. Supporting Tasks	081-832-0077	FACILITATE WARD COMMUNITY MEETINGS	AIT	AN	1-4
	081-832-0056	ASSIST AEROMEDICAL PSYCHOLOGISTS IN PROVIDING MENTAL HEALTH SERVICES TO ARMY AIRCREW MEMBERS	AIT	AN	1-4
	081-832-0055	CONDUCT MENTAL HEALTH CONSULTATIONS WITH CHAINS OF COMMAND	AIT	AN	1-4
	081-832-1025	PLACE A PATIENT IN SECLUSION	AIT	AN	1-4
	081-832-1026	MONITOR A PATIENT'S RESPONSE TO PSYCHOTROPIC MEDICATIONS	AIT	AN	1-4
	081-832-1006	MONITOR A PATIENT'S USE OF A POTENTIALLY DANGEROUS ITEM	AIT	AN	1-4
	081-832-1007	PERFORM LINE OF SIGHT OBSERVATION OF A PSYCHIATRIC PATIENT	AIT	AN	1-4
	081-832-1008	PERFORM 1:1 OBSERVATION OF A PSYCHIATRIC PATIENT	AIT	AN	1-4
	081-832-1009	ACCOUNT FOR THE LOCATION OF PSYCHIATRIC PATIENTS	AIT	AN	1-4
	081-832-1010	ESCORT A PSYCHIATRIC PATIENT	AIT	AN	1-4
	081-832-1020	DETERMINE PATIENT CARE ASSIGNMENTS	AIT	AN	1-4
9. Basic Medical Treatment	081-831-0007	PERFORM A PATIENT CARE HANDWASH	AIT	AN	1-4
	081-831-0008	PUT ON STERILE GLOVES	AIT	AN	1-4
	081-831-0013	MEASURE A PATIENT'S TEMPERATURE	AIT	AN	1-4
	081-831-0011	MEASURE A PATIENT'S PULSE	AIT	AN	1-4
	081-831-0010	MEASURE A PATIENT'S RESPIRATIONS	AIT	AN	1-4
	081-831-0012	MEASURE A PATIENT'S BLOOD PRESSURE	AIT	AN	1-4
	081-833-0156	PERFORM A MEDICAL PATIENT ASSESSMENT	AIT	AN	1-4

CRITICAL TASKS

Subject Area	Task Number	Title	Training Location	Sust Tng Freq	Sust Tng SL
	081-833-0155	PERFORM A TRAUMA CASUALTY ASSESSMENT	AIT	AN	1-4
	081-833-0082	TRIAGE CASUALTIES ON AN INTEGRATED BATTLEFIELD	AIT	AN	1-4
	081-831-0018	OPEN THE AIRWAY	AIT	AN	1-4
	081-831-0019	CLEAR AN UPPER AIRWAY OBSTRUCTION	AIT	AN	1-4
	081-831-0048	PERFORM RESCUE BREATHING	AIT	AN	1-4
	081-831-0046	ADMINISTER EXTERNAL CHEST COMPRESSIONS	AIT	AN	1-4
	081-833-0161	CONTROL BLEEDING	AIT	AN	1-4
	081-833-0045	TREAT A CASUALTY WITH AN OPEN ABDOMINAL WOUND	AIT	AN	1-4
	081-833-0052	TREAT A CASUALTY WITH AN OPEN OR CLOSED HEAD INJURY	AIT	AN	1-4
	081-833-0047	INITIATE TREATMENT FOR HYPOVOLEMIC SHOCK	AIT	AN	1-4
	081-833-0092	TRANSPORT A CASUALTY WITH A SUSPECTED SPINAL INJURY	AIT	AN	1-4
	081-833-0154	PROVIDE BASIC EMERGENCY TREATMENT FOR A PAINFUL, SWOLLEN, DEFORMED EXTREMITY	AIT	AN	1-4
	081-833-0062	IMMOBILIZE A SUSPECTED FRACTURE OF THE ARM OR DISLOCATED SHOULDER	AIT	AN	1-4
	081-831-0044	APPLY A PNEUMATIC SPLINT TO A CASUALTY WITH A SUSPECTED FRACTURE OF AN EXTREMITY	AIT	AN	1-4
	081-833-0070	ADMINISTER INITIAL TREATMENT FOR BURNS	AIT	AN	1-4
	081-833-0095	DECONTAMINATE A CASUALTY	AIT	AN	1-4
	081-833-0083	TREAT A NERVE AGENT CASUALTY IN THE FIELD	AIT	AN	1-4
	081-833-0056	TREAT FOREIGN BODIES OF THE EYE	AIT	AN	1-4
	081-833-0054	IRRIGATE EYES	AIT	AN	1-4
	081-831-0037	DISINFECT WATER FOR DRINKING	AIT	AN	1-4
	081-831-0035	MANAGE A CONVULSIVE AND/OR SEIZING PATIENT	AIT	AN	1-4

CRITICAL TASKS

Subject Area	Task Number	Title	Training Location	Sust Tng Freq	Sust Tng SL
	081-831-0038	TREAT A CASUALTY FOR A HEAT INJURY	AIT	AN	1-4
	081-831-0039	TREAT A CASUALTY FOR A COLD INJURY	AIT	AN	1-4
	081-831-0033	INITIATE A FIELD MEDICAL CARD	AIT	AN	1-4
10. Drug and Alcohol Counselor (ASI M8)	081-838-0016	CONDUCT AN INDIVIDUAL COUNSELING SESSION FOR A SUBSTANCE ABUSING INDIVIDUAL	AIT	AN	1-4
	081-838-0058	FACILITATE A GROUP THERAPY SESSION FOR SUBSTANCE ABUSING INDIVIDUALS	AIT	AN	1-4
Skill Level 2					
11. Admin (SL2)	081-832-0091	SUPERVISE MENTAL HEALTH STAFF ORIENTATION PROGRAM	UNIT	AN	2-4
	081-832-0084	SUPERVISE PSYCHIATRIC UNIT SECURITY PROCEDURES	UNIT	AN	2-4
	081-832-0080	CONDUCT REHABILITATION TEAM MEETINGS	UNIT	AN	2-4
	081-832-0052	SUPERVISE PERSONNEL CONDUCTING PSYCHIATRIC CLIENT INTERVIEWS	UNIT	AN	2-4
	081-832-0020	MANAGE MASS MENTAL HEALTH CASUALTIES IN CONVENTIONAL ENVIRONMENTS	UNIT	AN	2-4
	081-832-0018	INSTRUCT PERSONNEL IN PSYCHOSOCIAL HISTORY INTERVIEWING	UNIT	AN	2-4
Skill Level 3					
12. Admin (SL3)	081-832-0049	PLAN BEHAVIORAL SCIENCE FIELD OPERATIONS	BNCOC	AN	3-4

CHAPTER 3

MOS/Skill Level Tasks

Skill Level 1

Subject Area 1: Interviewing

COLLECT COLLATERAL INFORMATION FROM RECORDS
081-832-0062

Conditions: You are preparing to conduct an information gathering interview. You need additional or corroborative information to clarify the presenting problem. You will need SF 600.

Standards: Summarized and recorded all collateral information on SF 600 accurately.

Performance Steps

1. Identify which records provide the necessary information.
   a. Further define the presenting problem.
   b. Corroborate information provided by the client.

NOTE: Information may be collected from various sources such as medical, law enforcement, military personnel, family advocacy, drug and alcohol, psychiatric, and exceptional family member program records.

2. Obtain the client's permission to review the records, as required by regulation.

3. Obtain records in accordance with the appropriate regulation.

NOTE: Skill level one soldiers should coordinate this step with their supervisor.

4. Extract pertinent information.

5. Record an information summary in the client's case record--
   a. Accurately.
   b. Chronologically, or by subject area.
   c. In the proper location.

6. Filed copies of the collateral records chronologically on the left-hand side of the case file.

Performance Measures	**GO**	**NO GO**
1. Identified which records provide the necessary information.	____	____
2. Obtained the client's permission to review the records, as required by regulation.	____	____
3. Obtained records in accordance with the appropriate regulation.	____	____
4. Extracted pertinent information.	____	____
5. Recorded an information summary in the client's case record.	____	____

Performance Measures	GO	NO GO
6. Filed copies of the collateral records chronologically on the left-hand side of the case file.	____	____

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	Related
None	AR 25-55 AR 340-21 AR 600-85 AR 608-18 AR 930-5

CONDUCT AN INFORMATION GATHERING INTERVIEW

081-832-0063

Conditions: You are required to interview a client and record the results of the interview. You will need note paper, SF 600, consultation request or referral form, and completed client personal data questionnaire.

Standards: Interviewed client to include obtaining background information, recording relevant information, and assessing client's presenting problem using appropriate interviewing techniques.

Performance Steps

1. Prepare for the interview.
2. Establish a working relationship with the client.
   a. Explain to the client--
      (1) The role of the agency, your job title, your role as an interviewer, and review the Privacy Act and get the client's signature.
      (2) The types of questions you will ask and the kinds of information you will gather.
      (3) The approximate time the interview will require--about 45 to 60 minutes.
      (4) Administrative and staffing procedures which may affect the client.
   b. Resolve any questions the client may have about the interview.
   c. Inform the client that you may be taking some notes and he or she is free to look at them after the interview.
3. Establish rapport.
   a. Encourage the client to talk by asking routine, nonthreatening questions to verify personal history data.
   b. Demonstrate empathy with the client.
      (1) Recognize the client's expression of emotions.
      (2) Respond with sensitivity to the client's full range and intensity of feelings.
      (3) Give open, honest responses.
   c. Display "objective" but "interested" behavior.
   d. Encourage the client to talk freely about the problem.
4. Employ appropriate interview techniques.
   a. Use appropriate questioning techniques.
      (1) Initiate the conversation by extending an open invitation to the client to express his or her views and feelings.
      (2) Use single, brief, concisely stated questions to encourage response to one idea.
         (a) Use open-ended questions to get the client to discuss a topic at length.
             EXAMPLES:
             "How would you describe your father?"
             "What was your reaction to that situation?"
         (b) Use closed-ended questions to get brief factual responses.
             EXAMPLES:
             "How old are you?"
             "Do you like your job?"
         (c) Use vocabulary and construction of questions tailored to the client's level of comprehension.
      (3) Keep the interview moving by not dwelling on areas already explored.

Performance Steps

(4) Keep the interview on target by asking pertinent questions and preventing digressions.

b. Use appropriate attentive listening techniques.

(1) Use reflections to summarize and verify the client's feelings. For example, a client says that one moment he or she hates someone and loves them the next. To reflect his or her feelings, you might respond by saying that you feel all confused.

(2) Use paraphrasing to summarize and verify the client's response content. For example, a client says that one moment he or she hates someone and loves them the next. To paraphrase you might respond by saying that your feelings towards your loved one keep changing.

5. Elicit information from the client to define the presenting problem.
   a. Ask the client to describe in his or her own words the nature of the problem.
   b. Compare the stated description of the problem with the written description in the personal data questionnaire. If there are any discrepancies, ask the client to explain.
   c. Elicit the following information from the client:
      (1) The client's perception of the problem.
      (2) The client's attitude toward resolving the problem.
      (3) Coping techniques used in previous attempts to resolve the problem.
      (4) Successes and failures in trying to resolve the problem.
      (5) Possible solutions defined by the client.
      (6) What prompted the client to seek help at this time.
      (7) How the client believes other people perceive his or her problem.
      (8) Concerns other than the original presenting problem.

6. Obtain relevant background information.
   a. Family history.
   b. Occupational history.
   c. Medical history.
      (1) Significant injuries and illnesses.
      (2) Physical fitness.
   d. Marital history.

7. Terminate the interview.
   a. Summarize the main points covered in the interview.
   b. Obtain feedback from the client to verify the accuracy of points covered.
   c. Inform the client of disposition alternatives.
      (1) Referral to another agency or staff member.
      (2) Reason for referral.
      (3) Continue follow-up services at the intake agency.
      (4) Recommendations and anticipated plans for treatment.
      (5) Consultation with your supervisor.
   d. Encourage the client to participate in the selection of disposition alternatives.
   e. Inform the client of emergency services that are available.
   f. Ask the client if he or she has any questions.
   g. Escort the client to the exit.

8. Record the interview.
   a. Use SF 600.
   b. Sign your name on the line following your disposition entry.

Performance Steps

c. On the line following your signature, include your name, rank, and MOS title--Mental Health Specialist.

Performance Measures	**GO**	**NO GO**
1. Prepared for the interview.	____	____
2. Established a working relationship with the client.	____	____
3. Established rapport.	____	____
4. Employed appropriate interview techniques.	____	____
5. Elicited information from the client to define the presenting problem.	____	____
6. Obtained relevant background information.	____	____
7. Assessed social functioning.	____	____
8. Assessed mental status.	____	____
9. Terminated the interview.	____	____
10. Recorded the interview.	____	____

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	**Related**
None	AR 25-55
	AR 340-21
	AR 600-85
	AR 608-18

CONDUCT A COLLATERAL INTERVIEW

081-832-0011

Conditions: You are to conduct an information gathering interview, to include a need to interview a third person to substantiate and expand on the information obtained. You will need the client's case file, SF 600, notepaper, and access to a telephone.

Standards: Obtained and accurately recorded all relevant information on SF 600.

Performance Steps

1. Plan for the interview.
   a. Review the case record and list areas to be discussed with the resource person.
   b. Identify the appropriate source of information - one who you would expect to have knowledge of the client's current or past situation.
   c. Obtain the client's permission to interview the collateral resource, if required by regulation.
      (1) The client's permission is not required for command referred clients.
      (2) The client's permission is required for self-referred soldiers and family members.
   d. Make an appointment with the collateral resource to see him or her in person.
2. Establish rapport.
3. Employ appropriate interviewing and attentive listening techniques.
   a. Move the interview systematically through the opening, middle, and closing stages.
   b. Use reflection to summarize and verify the collateral resource's feelings.
   c. Use paraphrasing to summarize and verify statements made by the collateral resource.
   d. Use questioning techniques appropriate for obtaining the desired information.
4. Obtain necessary information.
   a. Identify the collateral resource person's relationship to the client.
   b. Elicit information to define the collateral resource person's perception of the client's problem.
5. Summarize the main points covered in the interview to verify the content.
6. Record information obtained as part of subsequent interviews in the "Objective" section of the progress notes.

Performance Measures	**GO**	**NO GO**
1. Planned for the interview.	____	____
2. Established rapport.	____	____
3. Employed appropriate interviewing techniques.	____	____
4. Obtained the necessary information.	____	____
5. Summarized the main points of the interview.	____	____
6. Recorded the information obtained accurately.	____	____

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	**Related**
None	AR 25-55
	AR 340-21
	AR 600-85
	AR 608-18

PRESENT A CASE FOR SUPERVISION

081-832-0013

Conditions: You have identified a case that requires supervision. You will need the client's case file, SF 600, and notepaper.

Standards: Presented a case for supervision in a well-organized manner to include all required information.

Performance Steps

1. Determine whether the case requires immediate or prompt supervision.
    a. Criteria for immediate supervision.

NOTE: Cases requiring immediate supervision must be staffed before the client leaves the clinic.

        (1) High suicide potential.
        (2) High homicide potential.
        (3) Psychosis.
        (4) High potential to be physically dangerous.

    b. Criteria for prompt supervision.

NOTE: Cases requiring prompt supervision should be staffed prior to the client's return appointment.

        (1) Cases that involve violations of legal statutes.
        (2) Cases that the Mental Health Specialist lacks the skills to handle.
        (3) Cases that the Mental Health Specialist feels uncomfortable with.

2. Prepare for staffing.
    a. Review the case record.
    b. List the significant areas needed to present the case.

3. Present the information orally using the following format:
    a. Client's identification data.
    b. Referral data.
    c. Brief statement of the client's problem.
    d. Relevant background information.
    e. Significant mental status aspects.
    f. Progress notes.
    g. Specialist's impressions.
        (1) Social and psychological functioning.
        (2) Supported, substantiated facts written in the case record.
    h. Recommended disposition.
        (1) Alternatives discussed and the basis for their acceptance or rejection.
        (2) Impressions and facts in the case record which support the disposition alternatives.

4. Take notes regarding the supervisor's comments.

5. Record the staffing procedure to include the following information:
    a. Date of case presentation.
    b. Supervisor's name.
    c. Suggestions made by the supervisor.
    d. Specialist's intended actions.

Performance Steps

NOTE: This information should be recorded in the "Disposition" section if the case is an intake interview or in the "Objective" section of the progress notes if the case is on-going.

6. The supervisor should sign the client case record after reviewing the case.

Performance Measures	**GO**	**NO GO**
1. Determined whether the case requires immediate or prompt supervision.	____	____
2. Prepared for staffing.	____	____
3. Presented the information orally using the correct format.	____	____
4. Took notes regarding the supervisor's comments.	____	____
5. Recorded the staffing procedure to include all required information.	____	____
6. Ensured supervisor signed the client case record after reviewing the case.	____	____

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	**Related**
None	AR 600-85 AR 608-1 AR 608-18 AR 930-4

CONDUCT AN ADMISSION INTERVIEW WITH A PSYCHIATRIC PATIENT

081-832-1028

Conditions: A patient has been admitted through the admissions office to the psychiatric ward. The patient has been searched and admitted by the mental health specialist, and vital signs have been taken. You will need clinical record.

Standards: Conducted the admission interview and documented the information. Performed steps 1 through 5 in order.

Performance Steps

1. Provide a comfortable, secure atmosphere for the interview.
    a. Ensure the physical setting allows for some privacy.

NOTE: Generally a treatment room or office area is used.

    b. Allow the patient to talk freely and frankly.
    c. Avoid unnecessary interruptions.
    d. Allow for a comfortable distance between the patient and yourself, to avoid making the patient feel threatened.

NOTE: This will vary depending on the type of patient being interviewed.

2. Explain the purpose of the interview to the patient.

3. Conduct the admission interview in accordance with the admission interview objectives.
    a. Obtain information with which to assess the patient's current level of functioning.
    b. Establish a therapeutic relationship with the patient. (See task 081-832-1023.)
    c. Obtain information to assist in identification of the patient's problem and formulation of a treatment plan.

4. Obtain identifying data.
    a. Verify the patient's basic data.
        (1) Name.
        (2) Rank.
        (3) Social security number.
        (4) Sex.
        (5) Age.
        (6) Race.
        (7) Marital status.
        (8) Military status (active duty, retired, or reservist).
        (9) Eye color.
        (10) Hair color and length.
    b. Ask the patient about any known allergies or distinguishing features, such as scars or tattoos.
    c. Measure and weigh the patient.

NOTE: Also, check the patient's health record or ID card for this information, if available.

5. Obtain information regarding how the patient was admitted to the ward.
    a. Identify whether the patient was admitted to the ward ambulatory, in a wheelchair, or on a litter.
    b. Identify the type of admission.
        (1) Transfer--from another ward.
        (2) Routine--processed through the admissions office.

Performance Steps

(3) Direct--bypassed the admissions office.

6. Obtain current medical information.
   a. Ask the patient about any physical problems he or she is currently experiencing or receiving treatment for.
   b. Ask the patient about any medications he or she is currently taking.
      (1) Prescribed and over-the-counter medications.
      (2) The amount and frequency of the medications he or she is currently taking.

7. Obtain a history of the patient's present illness.
   a. Identify the chief complaint by asking the patient about the following:
      (1) Why he or she thinks he or she was admitted to the ward.
      (2) What events or behavior led up to his or her hospitalization.
      (3) What symptoms he or she was experiencing.
         (a) Suicidal or homicidal thoughts.
         (b) Psychotic symptoms, such as hallucinations or delusions.
      (4) When the symptoms or behaviors first began.
   b. Assess the level of functioning the patient was able to maintain prior to his or her hospitalization.
      (1) Work performance.
      (2) Ability to perform activities of daily living (ADL).
      (3) Ability to interact with others--family, friends, and coworkers.
   c. Ask what the patient's feelings are about his or her illness and being in the hospital.
   d. Ask the patient whether he or she has used alcohol or illicit and/or nonprescribed drugs within the past 72 hours.
      (1) Date and time the substance was ingested.
      (2) Type and amount of substance ingested.

8. Obtain a history of previous psychiatric illness.
   a. Ask the patient if he or she has ever received psychiatric treatment in the past, and obtain the following information, if applicable:
      (1) Outpatient or inpatient psychiatric treatment and where.
      (2) Alcohol or drug detoxification or rehabilitation.
      (3) Previous diagnosis, if known.
      (4) Psychiatric medications prescribed, if known.
   b. Ask the patient about previous suicidal ideations or attempts.
      (1) Have the patient describe ideations.
      (2) Obtain information regarding suicide attempts.
         (a) How.
         (b) When.
         (c) Where.
         (d) Outcome--whether medical treatment was required or any psychiatric evaluation or treatment was done at the time.

9. Observe the patient's behavior and appearance throughout the interview, to include the following:
   a. Hygiene and grooming.
   b. Facial expression.
   c. Eye contact.
   d. Motor activity.
   e. Posture.

Performance Steps

f. Mannerisms and gestures.
g. Verbal and nonverbal communication.

10. Document in the clinical record your observations and the information obtained from the patient.

NOTE: Documentation will be done on SF 509 or SF 510 IAW local policy.

11. Report to your supervisor any information obtained that causes concern for the safety of the patient or others.

Performance Measures	**GO**	**NO GO**
1. Provided a comfortable, secure atmosphere for the interview.	____	____
2. Explained the purpose of the interview to the patient.	____	____
3. Conducted the admission interview IAW interview objectives.	____	____
4. Obtained identifying data.	____	____
5. Obtained information regarding how the patient was admitted to the ward.	____	____
6. Did steps 1 through 5 in order.	____	____
7. Obtained current medical information.	____	____
8. Obtained a history of the patient's present illness.	____	____
9. Obtained a history of the patient's previous psychiatric illness.	____	____
10. Observed the patient's behavior and appearance throughout the interview.	____	____
11. Documented in the clinical record, observations and the information obtained from the patient.	____	____
12. Reported to the supervisor any information obtained that causes concern about the safety for the patient or others.	____	____

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	**Related**
None	AR 40-407

Subject Area 2: Client Assessment

ASSESS SUBSTANCE USE, ABUSE, OR DEPENDENCY
081-832-0065

Conditions: You are conducting an information gathering interview for suspected substance use, abuse, and dependency. All collateral information has been obtained. You will need client's case file, SF 600, and notepaper.

Standards: Made an assessment of the client's substance use, abuse, or dependency and recorded the information accurately.

Performance Steps

1. Assess the client for symptoms of substance abuse.

NOTE: The three criteria below must be met in order to diagnose alcohol or other drug abuse.

   a. Pattern of pathological use of alcohol or other drugs manifested by--
      (1) Intoxication throughout the day.
      (2) Inability to decrease or stop use.
      (3) Repeated efforts to control use through periods of temporary abstinence or by restricting use to certain times of the day.
      (4) Continued use despite knowledge of a serious physical disorder that is aggravated by use of the substance.
      (5) Need for daily use to function adequately.
      (6) Complications of substance intoxication such as blackouts.
   b. Impairment of social or occupational functioning due to the pattern of pathological use described in steps 1a(1) through 1a(6).
      (1) Loss of job or absence from work.
      (2) Loss of friends.
      (3) Frequent arguments with family members or friends that may result in incidents of violence.
      (4) Legal difficulties.
   c. Minimum duration of symptoms--1 month.

NOTE: Signs of a disturbance need not be continuously present throughout the month, but frequent enough for impairment of functioning to be apparent.

2. Assess the client for symptoms of substance dependence--evidence of tolerance or withdrawal.
   a. Tolerance--markedly increased amounts of the substance are required to achieve the desired effect or a markedly diminished effect from regular use of the same dose.
   b. Withdrawal--substance specific syndrome follows the cessation or reduction of intake of the substance that was regularly used by the client to induce a state of intoxication.
3. Consult with the supervisor regarding your recommendations for disposition or treatment.
4. Inform the client of disposition or treatment.
5. Record the assessment and the supporting criteria accurately in SF 600.

Performance Measures	GO	NO GO
1. Assessed the client for symptoms of substance abuse.	____	____
2. Assessed the client for symptoms of substance dependence.	____	____
3. Consulted with the supervisor.	____	____
4. Informed the client of disposition/treatment.	____	____
5. Recorded the assessment and the supporting criteria.	____	____

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	Related
None	AR 600-85

ASSESS A PATIENT/CLIENT'S PROGRESS IN MENTAL HEALTH TREATMENT

081-832-0073

Conditions: You are to assess a patient's progress in mental health treatment. You will need documented patient treatment plan and clinical record.

Standards: Assessed the patient's progress in writing according to treatment plan set up for the patient.

Performance Steps

1. Perform an assessment including comprehensive, accurate, and systematic collection of data, both subjective and objective, which is related to the patient.
2. Perform an assessment involving two major processes.
    a. Data collection.
        (1) All information relevant to each problem is collected.
        (2) Sources of data collection.
            (a) Physical assessment.
            (b) Patient/family/significant other interviews.
            (c) "Patient-friendly" assessment forms.
            (d) Lab values.
        (3) Collect all comprehensive assessment data available.
            (a) Medically defined conditions.
            (b) Medical history.
            (c) Physical and mental status.
            (d) Any sensory or physical impairments.
            (e) Nutritional status and requirements.
            (f) Special treatments or procedures, past and present.
            (g) Mental and psychosocial status.
            (h) Discharge potential.
            (i) Dental condition.
            (j) Rehabilitation potential.
            (k) Activities potential.
            (l) Cognitive status.
            (m) Drug therapy--any drugs the patient is now taking or previously took.

NOTE: Some assessment information is beyond your scope to attain, e.g., defining the patient's rehabilitation potential, but it is the health care team's responsibility to ensure the data is completed by the responsible professional.

    b. Data analysis.
        (1) Problems. State problems clearly, e.g., "Confusion at night only."
        (2) Causes. Identifying the root cause(s) of a problem will point the health care team toward correct patient interventions.

NOTE: Suicidal ideations related to marital discord may require different interventions than suicidal ideations related to HIV diagnosis.

        (3) Risks and complications must be identified during the assessment process in order to plan prevention measures and strategies.

Performance Measures	GO	NO GO
1. Performed an assessment including comprehensive, accurate, and systematic collection of data, both subjective and objective, which is related to the patient.	____	____
2. Performed an assessment involving two major processes. a. Data collection. b. Data analysis.	____	____
3. Collected all comprehensive assessment data available.	____	____

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	Related
None	JCAHO MANUAL

ASSESS A PATIENT FOR ELOPEMENT TENDENCIES/BEHAVIOR

081-832-0038

Conditions: You are tasked with assessing a patient for elopement potential.

Standards: Assessed a patient for elopement risk based on available information and ward policies.

Performance Steps

1. Perform the four general areas of responsibilities of the Mental Health Specialist working on an inpatient ward.
   a. Supervision.
      (1) Provide patients with a safe, secure, and comfortable environment.
      (2) Assist in controlling unacceptable behavior.
      (3) Accompany patients to appointments and therapeutic activities.
   b. Observation. Observe, report, and document significant patient behavior.
   c. Communication.
      (1) Establish rapport and develop therapeutic relationships.
      (2) Share information concerning patients with other staff members.
   d. Safety/security (e.g., patient accountability).
      (1) Remain alert when on duty.
      (2) Perform Irregular counts of patients.
2. Perform periodic searches of the ward and patients when appropriate.
   a. The way searches are performed may be different at various installations.
   b. New patient on the ward.
   c. Returned escaped patient.
   d. Suicidal/homicidal patients.
   e. Actively psychotic, hallucinatory, or delusional behavior.
3. Perform key control maintenance.
   a. Keys are accounted for IAW local hospital policy.
   b. All ward keys must be secured (i.e., key control box).
   c. Maintain possession of keys issued to you. Never release keys to a patient.
4. Follow the proper procedure in the event of patient escape.
   a. Inform Head Nurse and Wardmaster of the patient's escape.
   b. Determine reason for patient escape.

Performance Measures	GO	NO GO
1. Performed the four general areas of responsibilities of the Mental Health Specialist working on an inpatient ward.	____	____
2. Performed periodic searches of the ward and patients when appropriate.	____	____
3. Performed key control maintenance.	____	____
4. Followed the proper procedure in the event of patient escape.	____	____

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 None

DOCUMENT A PSYCHIATRIC PATIENT'S INITIAL ASSESSMENT IN WRITING

081-832-0034

Conditions: You are to document a psychiatric patient initial assessment in writing. You will need Write-up Assessment Grade Sheet.

Standards: Wrote information for the psychiatric patient's initial assessment on the Write-up Assessment Grade Sheet accurately. Included a statement in the mental status examination accurately addressing the presence and/or absence of homicidal, suicidal, physically endangering ideations, and perceptual distortions.

Performance Steps

1. Record the patient's ID/Referral data.
    a. Rank or Title.
    b. Name.
    c. Date of the interview.
    d. Age.
    e. Race.
    f. Marital Status.
    g. Sex.
    h. Time in Service.
    i. Component.
    j. Unit.
    k. MOS, Duty Location, Duty Description.
    l. Time in present duty assignment.
    m. Referral Source.
    n. Chief Complaint.
    o. Service Requested.

2. Record the history of present problem.
    a. Client's presenting problem and emotions/feelings.
    b. Client's behaviors associated with the problem.
    c. When the presenting problem began.
    d. Where the problem/behavior usually occurs.
    e. How often the problem/behavior occurs.
    f. Client's thoughts, beliefs, or perceptions concerning the presenting problem.
    g. Client's physical or somatic complaints associated with the presenting problem.
    h. Client's eating habits.
    i. Client's sleeping habits.
    j. How client's relationship with others is affected.
    k. How others are being affected.
    l. What makes the problem better.
    m. What makes the problem worse.
    n. How the client spends a typical day.
    o. How the client spends leisure time.
    p. Client's reason for seeking assistance at this time.
    q. Client's sources of strength, and/or support system.
    r. Actions the client has taken to resolve the problem.
    s. Results of attempts (better, worse, unchanged).
    t. Client's desired outcome.

Performance Steps

u. How client thinks clinic can help resolve problem.

3. Record the patient's background history.
   a. Family History.
      (1) Client's birthplace and where they were raised.
      (2) Client's primary caretaker.
      (3) Client's description of the relationship with his or her mother.
      (4) Client's description of the relationship with his or her father.
      (5) The ages and sex of all siblings and client's feelings about his or her place in the family.
      (6) Client's description of relationships with siblings.
      (7) Family history of mental illness and/or substance abuse.
   b. Marital/Dating History.
      (1) Client's current marital status.
      (2) Client's previous marital/dating history.
      (3) Client's description of current or last relationship.
      (4) The number of children the client has.
      (5) Special problems the children may present.
   c. Educational and Occupational History.
      (1) Client's highest level of education.
      (2) The year and client's age at completion of that program.
      (3) Record the client's GPA.
      (4) Disciplinary problems while attending school.
      (5) Relationships with other students.
      (6) Client's participation in activities outside of school.
      (7) Client's documented learning disabilities.
      (8) Description of jobs held prior to entering the military.
      (9) Client's description of relationships with coworkers and supervisors.
      (10) Client's reason for leaving each of the jobs.
      (11) Client's goals/career plans (short and long term).
   d. Military History.
      (1) Client's reason for joining the military.
      (2) Any breaks in service.
      (3) Client's highest rank attained by the client.
      (4) Client's current duty description.
      (5) Client's previous assignments.
      (6) Client's description of relationships with previous military supervisors and coworkers.
      (7) Client's awards and decorations.
      (8) History of negative administrative actions.
      (9) Client's description of how they adjusted to the military.
   e. Medical History.
      (1) Client's significant medical history.
      (2) Client's previous mental health treatment.
      (3) Client's alcohol and other substance use history.

4. Record the Mental Status Examination.
   a. Client's appearance as compared to their age.
   b. Description of the client's general appearance.
   c. Description of the client's motor behavior.

Performance Steps

d. Assessment of the client's overall level of eye contact.
e. Assessment of the client's speech.
f. Description of the client's overall behavior toward the interviewer.
g. Client's predominant mood during the interview, and the intensity of the mood as mild, moderate, or severe.
h. Appropriateness of the client's affect to mood and thought content.
i. Assessment of the client's thought process.
j. Assessment of the client's thought content.
k. Assessment of the client's level of alertness and orientation.
l. Assessment and evidence of the client's level of intellectual functioning.
m. Assessment and evidence of the client's memory functioning.
n. Assessment and evidence of the client's insight as good, fair, or poor.
o. Record assessment and evidence of the client's judgment as good, fair, or poor.

NOTE: (MANDATORY) Soldier must record a statement accurately addressing the presence and/or absence of homicidal, suicidal, physically endangering ideations, and perceptual distortions. Failure to do so will result in an overall NO GO for the write-up.

5. Record a Case Formulation.
   a. Summary of client's reported history of presenting problem.
   b. Client's observed behavior from the MSE.
   c. The chronicity based on the onset of the history of the presenting problem (acute is less than 60 days, chronic is greater than 60 days).
   d. Make an axis I entry.
   e. Make an axis II entry.
   f. Make an axis III entry.
   g. Make an axis IV entry.
   h. Make an axis V entry.
   i. Does case formulation support the provisional multiaxial assessment?
   j. Restate the client's insight as recorded in the MSE.
   k. Restate the client's judgment as recorded in the MSE.

6. Record the Disposition and Signature Block
   a. Nature of and with whom staffing occurred.
   b. Client as returned to duty or retained.
   c. Time and date of the next appointment.
   d. Agency and person to be seen at next appointment.
   e. Sign the write-up.
   f. Print signature block.
   g. Is signature/signature block correctly placed?

7. Use correct format.
   a. Are statements contributed to the client written in third person past tense?
   b. Is the write-up in the proper format?
   c. Are corrections made properly?
   d. Spelling and grammar.
   e. Order and organization.

Performance Measures	GO	NO GO
1. Recorded ID/Referral Data.	____	____
2. Recorded History of Present Problem.	____	____
3. Recorded Background Histories.	____	____
4. Recorded Mental Status Examination.	____	____
5. Included a statement in the Mental Status Examination accurately addressing the presence and/or absence of homicidal, suicidal, physically endangering ideations, and perceptual distortions.	____	____
6. Recorded Case Formulation.	____	____
7. Recorded Disposition and Signature Block.	____	____

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 None

ASSESS CLIENT'S POTENTIAL FOR FAMILY VIOLENCE

081-832-0031

Conditions: You have a client to assess for the potential for family violence.

Standards: Assessed the client's potential for family violence before a violent family incident occurred.

Performance Steps

1. Select type of abuse.
   a. Child abuse--a type of maltreatment that refers to physical acts that caused or may have caused physical injury to the victim.
   b. Child sexual abuse--the employment, use, persuasion, inducement, or coercion of any child to engage in, or having a child assist any other person to engage in, any sexually explicit conduct (or any simulation of such conduct) or the rape, molestation, prostitution, or other such forms of sexual exploitation of children or incest of children.
   c. Physical spouse abuse--use of physical force that caused physical injury to the spouse; the forcing of one spouse by the other spouse to engage in any sexual activity through the use of physical violence, intimidation, or the explicit or implicit threat of future violence.
   d. Emotional spouse abuse--a pattern of acts or omissions, such as violent acts that may not cause observable injury (e.g., hitting a wall), that adversely affect the psychological well-being of the victim. Also includes intentional berating, disparaging remarks, passive-aggressive inattention to the victim's emotional needs, nurturing, or psychological well-being. (This also applies to emotional child abuse.)

NOTE: Arguments alone are not sufficient to substantiate emotional maltreatment.

2. Consider factors associated with the abuse of children.
   a. Child factors.
      (1) Younger boys were more likely to be abused than older boys.
      (2) Older girls were more likely to be victimized than younger girls.
      (3) Researchers suggest that handicapped, retarded, or developmentally disabled children were all described as being at greater risk of being abused by their parents or caretakers.
   b. Parent factors.
      (1) Parents who scored low on intelligence tests may/might have been more likely to abuse their children.
      (2) Parents tended to have unrealistically high expectations for their children.
   c. Family factors. Single parents and stepparents may/might have been at a higher risk to abuse their children.
      (1) Single parents often have had to meet the demands of child rearing without the assistance of another adult.
      (2) Single parents are more likely to have lived in poverty than dual caretaker couples.
      (3) Stepparents may not have had the emotional or nurturing attachments that parents had.
   d. Demographic factors.
      (1) Clinical, official reports and survey data showed that mothers were more likely to abuse their children than fathers.
      (2) Young adults were more likely to abuse their children than older parents.

Performance Steps

e. Economic factors.
   (1) Lower income families have had the highest rates of physical abuse and the abuse was the most likely reported.
   (2) Blue collar workers had higher rates of the use of physical punishment and abuse.
   (3) Children whose fathers were unemployed or worked part-time were more likely to be abused compared with children of fathers with full-time jobs.

f. Stress. Stressful situations such as a new baby, presence of a handicapped person in the home, illness, death of a family member, and child care problems were all found to be linked to higher rates of abuse and violence.

g. Social isolation.
   (1) Parents who abused their children tended to be socially isolated from both formal and informal social networks.
   (2) Abusive mothers had fewer contacts with their parents, relatives, neighbors, or friends and they engaged in few social or recreational activities. They were less likely to change their behavior to conform with community values and standards.

3. Identify risk factors for abuse specific to the client.

4. Assess the quality of interaction among family members while in session.
   a. Did family members engage in eye contact and normal physical contact with one another?
   b. Do family members have positive things to say about one another or mention negative characteristics?
   c. Did they speak civilly or yell and become angry and upset?
   d. Is the parent able to protect and manage the child?
   e. Were the family members able to engage in appropriate activities together?

5. Chose the stressors in military families specific to the client.
   a. Job stress.
      (1) Competitive and aggressive urges must be channeled into fairly narrow behavioral norms.
      (2) Job mastery is broken by frequent moves and promotions.
      (3) Assignment beyond skills or knowledge level.
      (4) High turnover.
   b. Family life.
      (1) Unfamiliar military and culture settings.
      (2) Low pay.
      (3) Limited housing (availability, quality, privacy, and family autonomy).
      (4) Frequent moves.
   c. Military life.
      (1) Attention to regimentation, rules, and standards.
      (2) Authoritarian-authoritative modes of discipline.
      (3) Constraints on individual expression.

Performance Measures	**GO**	**NO GO**
1. Selected the type of abuse.	____	____
2. Considered factors associated with the abuse of children.	____	____
3. Identified risk factors for abuse specific to the client.	____	____

Performance Measures	GO	NO GO
4. Assessed the quality of interaction among family members while in session.	____	____
5. Chose the stressors in military families specific to the client.	____	____

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 None

ASSESS A CLIENT'S MENTAL STATUS

081-832-0005

Conditions: You are required to interview a client and assess the client's mental status. You will need notepaper and SF 600.

Standards: Recorded a client mental status assessment in an ordered, narrative style to Include appropriate comments, justifying the conclusions drawn, in all assessments.

Performance Steps

NOTE: The areas of assessment listed below are not all inclusive.

1. Assess the client's appearance.
   a. Client is unclean, unkempt, or overly meticulous.
   b. Clothing is dirty, disheveled, has missing items such as buttons or insignias, or is unusually neat.
   c. Clothing is atypical, unusual, or bizarre.
   d. Client has unusual physical characteristics such as bruises, scars, burns, tattoos, blindness, broken arm, obesity, or physical deformities.
   e. Client appears much older or younger than his or her stated age.

2. Assess the client's behavior.
   a. Posture is relaxed, tense, rigid, slumped, recumbent, atypical, or inappropriate.
   b. Facial expressions display anxiety, apprehension, fear, anger, hostility, sadness, depression, decreased variability of expression, bizarreness, or inappropriateness.
   c. Body movements are accelerated, slowed, repetitive, peculiar, inappropriate, restless, or anxious.
   d. Speech patterns are abnormal in -
      (1) Quality - rate of production, volume, pitch, tone, and pronunciation.
      (2) Quantity - poverty of speech, monosyllabic answers, and pressure of speech.
      (3) Organization - poverty of content of speech, circumstantiality, tangentiality, incoherence, clanging, echolalia, perseveration, flight of ideas, and loosening of associations.
         (a) Poverty of content of speech - adequate in amount but vague, empty, or obscure.
         (b) Circumstantiality - indirect and delayed because of tedious, unnecessary details.
         (c) Tangentiality - replying in an irrelevant manner.
         (d) Incoherence - not understandable, no meaningful connections, excessive irrelevancies, or abrupt changes.
         (e) Clanging - sounds govern word choices. May include puns or rhyming.
         (f) Echolalia - repetition of the words or phrases of others.
         (g) Perseveration - persistent repetition of particular words, subjects, or ideas.
         (h) Flight of ideas - continuous but fragmented speech with abrupt changes.
         (i) Loosening of associations - shifting between unrelated subjects without awareness of doing so.
   e. Client and interviewer interaction is cooperative, friendly, interested, trusting, attentive, guarded, suspicious, evasive, defensive, uncooperative, hostile, domineering, ingratiating, provocative, or seductive.
   f. Poor eye contact or excessive staring.

Performance Steps

NOTE: The client's behavior sometimes varies significantly with the topic being discussed. If this occurs, it should be noted.

3. Assess the client's emotional state.
   a. Appropriate or inappropriate to thought content.
   b. Affect is normal, blunted, flat, or labile.
      (1) Blunted - a severe reduction in intensity.
      (2) Flat - absence or near absence of any signs of affect.
      (3) Labile - rapid emotional changes unrelated to emotional stimuli.
   c. Mood is normal, dysphoric, elated, euphoric, or irritable.
      (1) Dysphoric - unpleasant sense of being.
      (2) Elated - feeling of joy.
      (3) Euphoric - exaggerated sense of emotional or physical well-being.
      (4) Irritable - easily upset.

4. Assess the client's perceptual functioning.
   a. Presence or absence of illusions, hallucinations, or depersonalization.
      (1) Illusions - misperception of a real external stimulus.
      (2) Hallucinations - false sense of perceptions in the absence of actual external stimulus.
      (3) Depersonalization - feelings of unreality or strangeness concerning the environment and oneself.
   b. Contents and circumstances under which they occur.

5. Assess the client's cognitive functioning.
   a. Orientation to person, place, time, and situation.
   b. Memory is intact, or immediate recall and recent and remote memory is impaired.
   c. Client is attentive or easily distracted.
   d. Estimation of intelligence as evidenced by general knowledge, sophistication of vocabulary, level of education, abstract thinking, and calculation ability.
   e. Estimation of judgment as evidenced by the client's ability to evaluate a problem situation and to respond in a practical and socially acceptable manner.
   f. Estimation of insight as evidenced by the degree of awareness that problems exist and the degree to which he or she contributes to the situation.
   g. Thought process is intact or fragmented by blocking or loose associations and whether thought flow is decreased or increased.
   h. Thought content is normal or characterized by phobias, obsessions, compulsions, delusions, ideas of reference, ideas of influence, suicidal ideation, homicidal ideation, paranoid ideation, magical thinking, repetitive themes, somatic complaints, or poor self-image.

6. Record the assessments.
   a. Describe the following impressions and observations of the client in the following order using a narrative style:
      (1) Appearance.
      (2) Behavior.
      (3) Emotional state.
      (4) Perceptual functioning.
      (5) Cognitive functioning.
   b. If the interview is an intake interview, record the assessments in the "Mental Status" section of the intake recording.

Performance Steps

c. If the interview is a follow-up interview, record the assessments in the "Objective" section of the progress notes.
d. Include comments that justify the conclusions drawn.

Performance Measures	**GO**	**NO GO**
NOTE: This task should be evaluated in conjunction with task 081-832-0063.		
1. Assessed the client's appearance.	____	____
2. Assessed the client's behavior.	____	____
3. Assessed the client's emotional state.	____	____
4. Assessed the client's perceptual functioning.	____	____
5. Assessed the client's cognitive functioning.	____	____
6. Recorded the assessments.	____	____

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	**Related**
None	AR 340-21 AR 600-85 AR 608-1 AR 608-18 AR 930-4 MMPI-2 MANUAL

ASSESS A CLIENT'S SOCIAL FUNCTIONING

081-832-0006

Conditions: You are conducting an information gathering interview. You will need SF 600 and notepaper.

Standards: Made an accurate assessment of the quality of current and past social and occupational functioning and recorded the information, to include supporting criteria.

Performance Steps

NOTE: This task should be evaluated in conjunction with task 081-832-0063.

NOTE: The current level of social and occupational functioning is determined as it pertains to the client's present situation or presenting problem. The previous level of functioning should indicate how the client was functioning prior to the present situation or presenting problem.

1. Evaluate the client's current and past social functioning based on the following areas:
    a. Personal.
        (1) Physical care.
        (2) Psychosocial development.
        (3) Acceptance of self.
        (4) Adaptation to stress.
        (5) Impulse control.
        (6) Productivity.
        (7) Involvement in activities of personal growth.
    b. Family.
        (1) Relationship with parents.
        (2) Relationship with siblings.
        (3) Relationship with current or former spouse.
            (a) Quality of communication.
            (b) Quality of time.
            (c) Marital satisfaction.
            (d) Adaptation to marital stressors.
        (4) Relationship with children.
            (a) Quality of communication.
            (b) Quality of time.
            (c) Response to children's physical, social, and psychological needs.
            (d) Response to children's physical, social, and psychological needs.
    c. Other interpersonal relationships.
        (1) Choice and quality of relationship with friends.
        (2) Amount and type of involvement with community members, other membership group organizations, associates, and authority figures.
2. Utilize background information obtained from social and occupational functioning areas to increase understanding of the current problem.
3. Evaluate the client's current and past occupational functioning.
    a. Educational.
        (1) Highest level completed.
        (2) Academic performance.
        (3) Adjustment to school.

Performance Steps

(4) Relationship with students, teachers and administrators.
(5) Involvement in school activities.

b. Occupational.
(1) Relationship with coworkers, subordinates, supervisors and management.
(2) Job satisfaction.
(3) Job performance.
(4) Frequency of job changes.
(5) Achievements and failures.
(6) Career goals.
(7) Financial stability.

NOTE: When evaluating social and occupational functioning, the client's entire life cycle should be considered.

4. Assess social and occupational functioning as good, fair, or poor in all areas listed in 1a through 1c, and 3a and 3b above.
   a. Determine functioning as good based on--
      (1) Absence of or minimal presence of psychological and physical symptoms affecting the client.
      (2) Impairment of interpersonal relationships limited to occasional problems such as arguments with family members.
      (3) Client's general satisfaction and success with life.
      (4) Client's interest and involvement in a wide range of activities.
   b. Determine functioning as fair based on--
      (1) Psychological and physical symptoms moderately affecting the client such as depression, restlessness or difficulty concentrating.
      (2) Impaired family, marital, occupational and other interpersonal relationships.
      (3) Involvement in minor violations of the law.
   c. Determine functioning as poor based on--
      (1) Serious psychological and physical symptoms affecting the client such as suicidal ideation and attempts, extreme anxiousness and passive or aggressive actions.
      (2) Serious impairment in personal, family, educational and occupational functioning.

5. Record the assessment in the "Specialist's Impressions" section of the interview recording, to include supporting criteria.

Performance Measures	**GO**	**NO GO**
1. Evaluated the client's current and past social functioning.	____	____
2. Utilized background information obtained from social and occupational functioning areas to increase understanding of the current problem.	____	____
3. Evaluated the client's current and past occupational functioning.	____	____
4. Assessed social and occupational functioning as good, fair, or poor in all areas evaluated in steps 1 and 3.	____	____
5. Recorded the assessment in the "Specialist's Impressions" section of the interview recording, to include supporting criteria.	____	____

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	Related
None	AR 40-407
	AR 600-85
	AR 608-18
	AR 930-4
	FM 4-02
	MMPI-2 MANUAL
	WAIS-R MANUAL

ASSESS CLIENT PSYCHOPATHOLOGY

081-832-0064

Conditions: You are under clinical supervision and have been instructed to interview a client to identify indicators of psychopathology. You will need notepaper, client's collateral information, and SF 600.

Standards: Interviewed client to identify psychopathology disorders to include observation of the psychopathological behavior and classified the mental disorder as Functional or Organic. Recorded the impressions and observations and provided them to the clinical supervisor with the appropriate recommendations.

Performance Steps

1. Review collateral information.
2. Interview the client. (See task 081-832-0063.)
3. Assess the client for Psychopathological Disorders--manifestations of mental disorders.
    a. Identify the presence of the characteristics of Functional Disorders - mental disorders in which no organic cause has been identified. (Personality Disorders, Anxiety Disorders, Somatoform Disorders, Dissociative Disorders, Mood Disorders, Schizophrenic Disorders, Paranoid Disorders, Adjustment Disorders, Sexual Disorders, and Psychotic Disorders not covered elsewhere.)
        (1) Personality Disorders.
            (a) Life-long pattern of inflexible, maladaptive personality traits.
            (b) Significant impairment in social or occupational functioning.
            (c) Little or no motivation to change behavior.
            (d) Behaviors occur by adolescence or early adulthood.
            (e) Behaviors continue throughout adult life and diminish in middle or old age.
            (f) Recommended treatment and management options include group therapy, consultation with the client's supervisor, and military administrative action.
        (2) Anxiety Disorders.
            (a) Feeling of apprehension, tension, or uneasiness from the anticipation of danger, which may be internal or external.
            (b) Avoids anxiety provoking places or situations.
            (c) Usually identifiable in childhood or adolescence.
            (d) Exhibits symptoms such as obsessions, compulsions, or phobias which elicit emotional discomfort (primarily anxiety, sometimes depression).
            (e) No loss of contact with reality.
            (f) No gross personality disorganization.
            (g) Recommended treatment and management options include group therapy and marital counseling.
        (3) Somatoform Disorders.
            (a) Physical symptoms that suggest a physical disorder, but show no organic cause.
            (b) Symptoms are linked to psychological factors.
            (c) Symptoms are not intentionally produced.
            (d) Emotional discomfort is often experienced along with the physical complaints, except in a few instances where there seems to be a complete indifference to the physical symptoms.

Performance Steps

(e) No loss of contact with reality.
(f) No gross personality disorganization.
(g) Clients suffering from this condition often refuse to be seen in mental health facilities for treatment.

(4) Dissociative Disorders.
(a) Disturbance or change in the normally integrative functions of identity, memory, or consciousness.
(b) Onset may be sudden, gradual, transient, or chronic.
(c) If occurrence is mainly in identity, an individual's identity is temporarily forgotten and a new one is assumed.
(d) Client's customary feeling of his or her own reality is lost and replaced by a feeling of unreality.
(e) If the occurrence is primarily in memory, important events can not be remembered.
(f) Recommended treatment and long term management is long term mental health counseling.

(5) Mood Disorders.
(a) Disturbance of mood accompanied by a full or partial manic or depressive syndrome.
(b) Involves either prolonged depression or elation.
(c) Symptoms may exist with or without psychotic features.
(d) An increase or decrease in motor activity is common.
(e) Sleep disturbances may occur such as insomnia, hypersomnia, and feeling no need for sleep.
(f) Recommended treatment and long term management options include hospitalization, psychotropic medications, and supportive psychotherapy.

NOTE: Use care to safeguard the depressed client against suicide.

(6) Schizophrenic Disorders.
(a) Disturbance in multiple processes of thought and behavior.
(b) Presence of hallucinations, delusions, or illusions in the active phase of the illness.
(c) Deterioration from a previous level of functioning in areas of occupation, interpersonal relationships, and self-care.
(d) Grossly disorganized thought with bizarre content and loosening of associations.
(e) Gross disorganization of personality.
(f) Onset usually occurs during adolescence or early adulthood, but the disorder may begin in middle or late adult life.
(g) Duration of symptoms at least 6 months.
(h) Recommended treatment options include medication, individual and group psychotherapy, recreational and occupational activities, and family counseling.

(7) Paranoid Disorders.
(a) Presence of persistent, nonbizarre delusion that is not due to any other mental disorder.
(b) Behavior is not obviously odd or bizarre.
(c) Auditory or visual hallucinations, if present, are not prominent.
(d) No apparent loss of intellectual or occupational functioning.
(e) Impairment of social and marital functioning is usually present.
(f) Emotions and behavior are usually appropriate to the content of the delusion.

Performance Steps

(g) Onset is usually in middle or late adult life.
(h) Rarely seek treatment on their own.
(i) Recommended treatment and management options include required hospitalization for dangerous paranoid clients, chemotherapy, and psychotherapy.

(8) Adjustment Disorders.
(a) Maladaptive reaction to psychological stressor occurring within 3 months of the stressor and persisting no more than 6 months.
(b) External factors cause sudden, severe or chronic stress.
(c) Impairment in social and occupational functioning.
(d) Symptoms are in excess of a normal and expected reaction to the stressor.
(e) Disturbance will remit soon after the stressor is removed or when a new level of adaptation is achieved.
(f) Stressors and symptoms of stress are often associated with the client's psychosocial stage of development of adolescence, adulthood, and late adulthood.
(g) Recommended treatment and management options include crisis intervention and guidance and extended supportive counseling.

(9) Psychotic Disorders not elsewhere classified.
(a) Maladaptive reactions characterized by impairment in social or occupational functioning that cannot be classified as any of the disorders previously discussed.
(b) Symptoms are in excess of a normal and expected reaction to the stressor.
(c) Reaction remits after the stressor ceases or, if the stressor persists, when a new level of adaptation is achieved.
(d) Stressors may be single, multiple, and recurrent.
(e) The severity of a stressor is affected by its duration, timing, and context in a person's life.
(f) Stressors may affect an individual, group, and community.
(g) Severity of reaction is not completely predictable from the severity of the stressor.

(10) Sexual Disorders.
(a) Sexual Dysfunctions.
1) Persistent or recurrent inability to experience the "normal" desires or psycho physiological changes involved in the complete sexual response cycle.
2) Problems in experiencing sexual desires by being constantly preoccupied with sexual urges or absences of them for a long period of time.
3) Sexual arousal difficulties while undergoing or maintaining the physical changes in the body and genital organs.
4) Can not control orgasm or have too much control to the extent of not being able to release orgasm.
5) Persistent or recurrent pain during intercourse.

Performance Steps

(b) Paraphilia.
1) Arousal in response to sexual objects or situations that are not part of normative arousal activity patterns.
2) Degree of severity may interfere with the capacity for reciprocal affectionate sexual activity.
3) Recurrent, intense, sexual urges and sexually arousing fantasies involving nonhuman objects, the suffering or humiliation of oneself or one's partner, or children or other nonconsenting persons.
4) Duration is of at least 6 months.
5) Acts on these urges and is markedly distressed by them.
(c) Recommended treatment and management options include referral for medical examination, sex therapy, individual counseling, and sex education.

b. Identify the presence of characteristics of Organic Disorders--mental disorders caused by or associated with impairment of brain function which may be psychotic or nonpsychotic.
(1) The condition may be acute (temporary and reversible) or chronic (permanent and irreversible).
(2) Symptoms are a result of--
(a) Head trauma or injury.
(b) Exposure to toxic substances.
(c) Intoxication with withdrawals from alcohol and other drugs.
(d) Cardiovascular disorder such as a stroke and heart failure.
(e) Systemic medical condition such as the effects of general anesthetics, pneumonia, or typhoid.
(f) Diffuse atrophy of brain tissue.
(g) Intracranial conditions such as tumors, infections, and arteriosclerosis.
(h) Degenerative diseases of the nervous system.
(3) Impairment of recent, remote memory or immediate recall.
(4) Disorientation in time, place, situation, or person.
(5) Changed and impaired level of awareness.
(6) Impaired attention and ability to concentrate.
(7) Perceptual disturbance.
(8) Irritability, labile affect, and anxiety.
(9) Impaired judgment.
(10) Impaired intellect such as inability to count, subtract, or interpret a familiar proverb.

c. Identify the presence of the characteristics of V Codes--Conditions not Attributable to Mental Disorders.
(1) Thorough evaluation has failed to uncover any mental disorders.
(2) Diagnostic evaluations may not have been adequate to determine the presence or absence of a mental disorder.
(3) There is a need to note the reasons for contact with the mental health system.
(4) Conditions may be culturally engendered and may produce severe emotional distress in otherwise psychologically normal people.

4. Record impressions and observations.

5. Provide the clinical supervisor with the impressions and observations.

Performance Measures	**GO**	**NO GO**
1. Reviewed collateral information. (See task 081-832-0062.)	____	____
2. Interviewed the client. (See task 081-832-0063.)	____	____
3. Assessed the client for Psychopathological Disorders.	____	____
4. Recorded impressions and observations.	____	____
5. Provided the clinical supervisor with the impressions and observations.	____	____

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 None

DETERMINE A CLIENT'S HOMICIDAL POTENTIAL

081-832-0023

Conditions: You are conducting an information gathering interview with a client whose presenting problem indicates homicidal tendencies. You will need the client's case file, SF 600, and notepaper.

Standards: Made an assessment of the client's potential for homicide to include recording the information accurately.

Performance Steps

1. Identify behaviors that indicate an increased potential for homicide.
    a. Verbal--such statements as, "I got so angry I wanted to kill him", or "We'd all be better off without the captain."
    b. Situational--arguments or ongoing conflicts with spouse, friends, neighbors, or authority figures.
    c. Psychological.
        (1) Psychotic symptoms.
            (a) Delusional jealousy. Client is convinced that spouse or lover is unfaithful with no real evidence.
            (b) Other delusions. For example, other people are demons and/or that he or she has been chosen to rid the world of evil.
            (c) Hallucinations. Hearing voices that tell the client to kill someone.
        (2) Personality traits.
            (a) Strong feelings of inadequacy or weakness.
            (b) Strong need to control one's environment.
            (c) Poor impulse control.
            (d) Expects gratification without responsibility.
    d. Indicators from childhood history.
        (1) Absence of role models.
        (2) Parental aggression or seduction.
        (3) Fire setting.
        (4) Bed-wetting.
        (5) Cruelty to animals.
        (6) Cruelty to other children.
    e. Behavioral indicators.
        (1) Addiction.
        (2) Excessive use of alcohol.
        (3) Driving while intoxicated.
        (4) Sexual acting out.
        (5) Assault or disorderly conduct.
        (6) Bizarre behavior.
        (7) Childish grandiosity.
        (8) Homicidal fantasies.
    f. Social and cultural indicators.
        (1) Cultural belief that one's honor (or the family's honor) must be defended.
        (2) Cultural values that support use of violence to settle arguments.
        (3) Absence of membership to institutions that impose controls on the individual's behavior such as the church, school, or family.

Performance Steps

2. Question the client about homicidal potential.
   a. Ask the client about homicidal ideation--thoughts of resolving the situation by hurting someone.
   b. Inquire about homicidal plans.
      (1) Time.
      (2) Place.
      (3) Method.
   c. Determine if the method is consistent with the available means. For example, if the client says he or she is going to shoot someone, find out if the client has a gun.
3. If the client exhibits homicidal ideation or plans, consult with your supervisor before releasing the client.
4. Record the assessment and the supporting criteria accurately in SF 600.

Performance Measures	**GO**	**NO GO**

NOTE: This task may be evaluated at the same time as task 081-832-0063.

1. Identified behaviors that indicate an increased potential for homicide.	____	____
2. Questioned the client about homicidal potential.	____	____
3. Consulted with the supervisor before releasing the client.	____	____
4. Recorded the assessment and the supporting criteria.	____	____

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	**Related**
None	AGUILERA OTHMER & OTHMER VOLLAND

DETERMINE A CLIENT'S SUICIDAL POTENTIAL

081-832-0026

Conditions: You are conducting an information gathering interview with a client whose presenting problem or collateral information indicates suicidal behaviors. You will need the client's case file, SF 600, and notepaper.

Standards: Made an assessment of the client's potential for suicide to include recording the information accurately.

Performance Steps

1. Identify indicators of suicidal potential.
    a. Verbal.
        (1) Direct, such as, "I'm going to kill myself."
        (2) Indirect, such as, "They'll be sorry when I'm gone."
    b. Behavioral.
        (1) Direct, such as suicide gesture or attempt.
            (a) Gesture--any deliberate attempt at self-harm that is nonfatal.
            (b) Attempt--an act by which the client actually intends to die.
        (2) Indirect.
            (a) Writing a will.
            (b) Giving away prized possessions.
            (c) Talking about taking a long trip.
            (d) Increase in alcohol use.
            (e) Social withdrawal.
            (f) Lack of concern for others' reaction to the suicidal ideation.
            (g) Taking unusual risks.
            (h) Increased antisocial behavior--stealing, child and spouse abuse, truancy from school or work, and irresponsible financial behavior.
    c. Physical.
        (1) Change of appetite, usually decreased.
        (2) Weight loss.
        (3) Insomnia or other sleep disturbance.
        (4) Decrease in sexual interest or energy.
        (5) Frequent complaints of headaches, lower back pain, or indigestion.
    d. Psychological.
        (1) Deterioration of personal hygiene and appearance.
        (2) Agitated behavior or psychomotor retardation.
        (3) Feelings of depression.
            (a) Helplessness and hopelessness.
            (b) Pervasive sense of low self-esteem or worthlessness.
            (c) Loss of interest in usually pleasurable activities.
            (d) Extreme anger and severe nervousness.

NOTE: Occasionally a sudden uplift in spirits indicates the decision to commit suicide. The uplift creates enough energy to carry out the act.

        (4) Hallucinations--hearing voices telling the client to kill himself or herself.
        (5) Cognitive functioning.
            (a) Disorientation or confusion.
            (b) Impulsiveness.

Performance Steps

(c) Suicidal ideation.

e. Recent stressors.
   (1) Rejection by a loved one.
   (2) Death of a close friend, spouse, or family member.
   (3) Terminal illness.
   (4) Disfiguring surgery or accident.
   (5) Financial loss.
   (6) Significant career or employment changes.
   (7) Retirement.

f. Past history.
   (1) Failure to maintain productive work.
   (2) Inability to maintain meaningful interpersonal relations.
   (3) Suicidal gestures as a means of coping.
   (4) Suicide or suicidal attempts by a family member or close friend.

NOTE: Anniversaries of losses are high risk periods. Inquire into dates of family deaths, retirements, and other significant events.

2. If the client exhibits any clues that indicate an increased potential for suicide, ask the client directly about thoughts of hurting or killing himself or herself.

3. If the client exhibits suicidal ideation, determine whether the client has a suicide plan.
   a. Inquire about--
      (1) Time.
      (2) Place.
      (3) Method.

NOTE: The more lethal the method, the greater the risk.

   b. Determine if the method is consistent with the available means. For example, if the client says he or she plans to use a gun, determine if the client has a gun.

NOTE: If the client exhibits suicidal behavior, suicidal ideation, or has a suicide plan, do not leave the client unattended.

4. Consult with your supervisor immediately to determine appropriateness of--
   a. Behavioral contract with the client.
      (1) If so, encourage the client to sign a written agreement to contact a trusted member of his or her unit, a supervisor, emergency room, or a counselor from your agency prior to attempting a self-destructive act.
      (2) Give the client telephone numbers of persons to contact.
   b. Further evaluation or hospitalization for the client.
   c. Client's return to duty with close supervision/observation.

5. Ensure the client is escorted to the proper location once the appropriate disposition is made.

6. Record the assessment and supporting criteria accurately in SF 600.

Performance Measures	**GO**	**NO GO**
NOTE: This task may be evaluated at the same time as task 081-832-0063.		
1. Identified indicators of suicidal potential.	____	____
2. Confronted the issue of suicide directly.	____	____
3. Determined whether the client has a suicide plan.	____	____
4. Consulted with the supervisor before releasing the client.	____	____
5. Ensured the client is properly escorted according to disposition.	____	____
6. Recorded the assessment and supporting criteria accurately.	____	____

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	**Related**
None	AGUILERA OTHMER & OTHMER VOLLAND

ASSESS A PSYCHIATRIC PATIENT'S SUICIDAL POTENTIAL

081-832-1031

Conditions: A psychiatric patient is expressing suicidal ideation (verbally or behaviorally). You will need clinical record.

Standards: Conducted an assessment of the patient's suicidal potential. Performed interventions to prevent the patient from harming himself or herself.

Performance Steps

1. Recognize the warning signs of self-destructive behavior.
    a. The patient may express direct or indirect verbal warnings of suicide intent by making remarks such as--
        (1) "I can't take it anymore."
        (2) "I won't be seeing you again."
        (3) "I wish I were dead."
    b. The patient may demonstrate behavioral signs of suicide intent by--
        (1) Making or changing a will.
        (2) Giving away valuables or prized possessions.
        (3) Organizing personal or business matters as if planning to be away for an extended period.
        (4) Suddenly recovering from a severe depression.
    c. The patient may demonstrate or express feelings of--
        (1) Helplessness--inability to change or alter the situation.
        (2) Guilt--responsible for others' or their own dilemma.
        (3) Rage and/or agitation towards others, but directed towards himself or herself.

2. Assess the patient's risk for suicide.
    a. Question the patient about his or her suicidal intent.

NOTE: Be direct and specific when questioning the patient.

        (1) Does the patient have a specific plan or thoughts of harming himself or herself? If so, attempt to get the specific details of the plan--time, place, and method.
        (2) Does the patient have a history of previous suicide attempts? If so, when, where, and what method was used?
    b. Determine the risk factors that increase the patient's likelihood for suicide.
        (1) Age. Persons 15 to 24 years of age and over age 50 are at higher risk.
        (2) Sex. Males are more likely to commit suicide.
        (3) Physical illness. Persons suffering from physical illness, especially chronic or terminal illness, are at higher risk.
        (4) Alcohol or drug abuse. It decreases impulse control and places the patient at higher risk.
        (5) Psychotic symptoms. Persons suffering from hallucinations and delusions are at higher risk.

3. Perform technician interventions.
    a. Protect the patient from himself or herself.
        (1) Directly intervene if the patient attempts to harm himself or herself.
            (a) Perform immediate first aid.
            (b) Call for assistance, if necessary.
        (2) Take necessary precautions.

Performance Steps

(a) Search the patient and belongings for hazardous items.

NOTE: Simply asking the patient if he or she has a hazardous item is not sufficient as the patient may conceal it for later use.

(b) Ensure cleaning equipment and supplies are stored in a locked area.
(c) Monitor the patient's use of potentially dangerous items. (See task 081-832-1006.)
(d) Check the ward for potential hazards such as exposed pipes, drapery cords, glass fixtures, and extension cords.

b. Perform 1:1 or line of sight observation, if ordered by the doctor. (See tasks 081-832-1007 and 081-832-1008.)
c. Utilize crisis intervention steps.
(1) Assess the patient, focusing on his or her immediate problem and/or situation.
(a) Explore any precipitating events or current stressors.
(b) Determine the patient's perception of his or her current situation.
(c) Assess the factors affecting the patient's ability to cope.
(d) Determine what kinds of outside support the patient has (family, friends, clergy).
(e) Assess the patient's individual strengths and coping skills.
(2) Plan the intervention.
(a) Determine how the crisis has affected the patient's life (work, family, daily activities).
(b) Explore the additional environmental and social support available to the patient.
(3) Implement the intervention.
(a) Define the problem as seen by the mental health specialist and reflect this back to the patient.
(b) Encourage the patient to express his or her feelings and thoughts.
(c) Discuss and offer alternative coping skills and problem solving behaviors.
(d) Encourage utilization of other resources for support.
(e) Test or rehearse new problem solving approaches.

4. Record and report observations of the patient.
a. Promptly report specific patient conversation and behavior to the nurse.
b. Document the patient's specific behavior, appearance, and conversation accurately and promptly.

NOTE: This will be done on SF 509 or SF 510 IAW local policy.

Performance Measures	**GO**	**NO GO**
1. Recognized the warning signs of self-destructive behavior.	____	____
2. Assessed the patient's risk for suicide.	____	____
3. Performed technician interventions.	____	____
4. Recorded and report observations of the patient.	____	____

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 None

ASSIST IN ASSESSMENT OF A PSYCHIATRIC PATIENT

081-832-1029

Conditions: You are asked to assist the professional nurse in the assessment of a psychiatric patient. The patient has been admitted and oriented to the psychiatric ward. You will need clinical record.

Standards: Assisted the professional nurse in the assessment of the psychiatric patient's physical state, to include the patient's cognitive functioning, interpersonal relations, affective state, adaptation skills, and self-concept accurately.

Performance Steps

1. Collect data to assess the patient's physical state.
   a. Activities of daily living.
      (1) Identify problems associated with the patient's diet, such as weight, appetite, fluid intake, and poor nutrition.
      (2) Identify problems with elimination, such as constipation, diarrhea, or incontinence.
      (3) Identify sleep and rest difficulties, to include quality of sleep, amount of sleep, and difficulties falling to sleep and staying asleep.
      (4) Identify activity level problems associated with the types of exercise and activities the patient is involved in.
   b. Identify any personal appearance problems, indicated by the patient's personal hygiene, grooming, dress, and posture.
   c. Identify any physical health problems utilizing the findings of the patient's physical exam, lab results, and health history.

2. Collect data to assess the patient's cognitive functioning.
   a. Identify any problems with sensorium and perception.
      (1) Hallucinations.
      (2) Illusions.
      (3) Delusions.
   b. Identify any problems with memory.
      (1) Recent memory.
      (2) Remote memory.
   c. Identify any problems with orientation to--
      (1) Time.
      (2) Place.
      (3) Person.
   d. Identify any problems with judgment and insight in relation to--
      (1) Social norms.
      (2) Money management.
      (3) Future plans.
      (4) The patient's awareness of his or her problems.
   e. Identify any problems with communication due to--
      (1) Abnormal thought processes such as loose associations or flight of ideas.
      (2) Amount and content of verbalization.

3. Collect data to assess the patient's interpersonal relations.
   a. His or her ability to interact with others.
   b. Examine the patient's relationships with others in terms of--

Performance Steps

(1) Trust vs. mistrust.
(2) Dependence vs. independence.
(3) Compatibility vs. conflict.

4. Collect data to assess the patient's affective state.
   a. Identify any abnormalities in expression of mood and affect.
   b. Identify any difficulties in expressing feelings.
5. Collect data to assess the patient's self-concept.
   a. Identify any problems related to body image, sexuality, and spirituality.
   b. Identify any problems related to the patient's self-esteem and feelings of self-worth.
6. Collect data to assess the patient's adaptation skills.
   a. Identify the patient's previous and current coping skills.
   b. Identify any factors that interfere with the patient's ability to adapt to change.
7. Document the data collected.
   a. Assist in formulating the patient problem list, based on data collected.
   b. Assist in completing the assessment section of DA Form 3888.
   c. Report and record the significant observations and findings.

Performance Measures	**GO**	**NO GO**
1. Collected data to assess the patient's physical state.	____	____
2. Collected data to assess the patient's cognitive functioning.	____	____
3. Collected data to assess the patient's interpersonal relations.	____	____
4. Collected data to assess the patient's affective state.	____	____
5. Collected data to assess the patient's self-concept.	____	____
6. Collected data to assess the patient's adaptation skills.	____	____
7. Documented the data collected.	____	____

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	**Related**
None	AR 40-407

Subject Area 3: Counseling

ASSIST IN THE IDENTIFICATION OF TREATMENT GOALS AND INTERVENTIONS
081-832-1030

Conditions: You have been assigned a psychiatric patient who has been assessed with more than one problem. A nurse is available for assistance. You will need Identified Problem List and the patient's clinical record.

Standards: Assisted in identifying realistic, specific, and measurable treatment goals that are related to the patient's identified problems.

Performance Steps

1. Involve the patient in planning the treatment goals, if possible.

NOTE: This will depend on the degree of the patient's impairment and insight regarding his or her illness.

2. Assist in identifying treatment goals which are--
   a. Realistic, based on the individual patient's current needs, problems, and functioning.
   b. Clearly stated in behavioral terms and can be measured in terms of expected outcome.

3. Establish a specific time frame for the patient to achieve the goals.

NOTE: Goals are usually divided into two categories - short and long term goals. Short term goals refer to sequential steps necessary for achievement of the broader long term goal.

4. Assist in planning the interventions.
   a. Identify specific therapeutic approaches that will assist the patient in achieving the treatment goals.
   b. State the intervention in specific terms so that other treatment team members can carry out the intervention effectively, by stating--
      (1) What will be done.
      (2) How it will be done.
      (3) Where it will be done.
      (4) Who will do it.
      (5) How often it will be done.
   c. Take into consideration the personnel and resources available, as well as the individual patient's strengths and weaknesses.

5. Document the goals and interventions.

NOTE: Frequency, where, and by whom this information is documented will be IAW local policy. Generally it will be done on DA Form 3888.

Performance Measures	**GO**	**NO GO**
1. Involved the patient in planning the treatment goals, if possible.	____	____
2. Assisted in identifying treatment goals which are realistic and clearly stated in behavioral terms.	____	____
3. Established a specific time frame for the patient to achieve the goals.	____	____

Performance Measures	GO	NO GO
4. Assisted in planning the interventions.	____	____
5. Documented the goals and 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	Related
None	AR 40-407

CONDUCT A COUNSELING SESSION

081-832-0066

Conditions: You have been instructed to provide counseling for a client experiencing situational problems. The client has had a thorough initial evaluation and is able to function in a nonhospital environment. You will need client case file, collateral records, and notepaper.

Standards: Counseled patient with an intervention plan as the goal.

Performance Steps

1. Prepare for counseling.
    a. Gather available information concerning the client.
        (1) Obtain the client's case record.
        (2) Talk with the interviewer for any information not written in the case record, if someone else did the initial interview.
        (3) Obtain any tests (MMPI-2, others) not included in the case record.
        (4) Obtain the client's medical records, if applicable.
    b. Review the client's case record.
        (1) Perform any collateral interviews if deemed necessary after viewing the case record.
        (2) Read the client's case record and note the referral source.
        (3) Note the type of problem, its onset and duration, and its effect on the client.
        (4) Note any attempts on the part of client to resolve the situation.
        (5) Note the "Specialist's Impressions" section.
        (6) Note any other information helpful in formulating an initial approach.
        (7) Information in the case record should not be taken at face value, but used as a starting point. If this is the first counseling session, the information should be reviewed with the client. Look for inconsistencies.
    c. Prepare the counseling site.
        (1) Locate an appropriate area for counseling. If your own office is not available, borrow an office for the specific time of the counseling session.
        (2) Maximize privacy. Use privacy screens if you must use a ward.
        (3) Minimize possible distractions by--
            (a) Coordinating with the staff to hold your telephone calls.
            (b) Notifying the staff to avoid unnecessary interruptions during your session.
            (c) Displaying an "interview or counseling session in progress" sign on the door.
            (d) Being aware of, preventing, and/or managing any possible environmental or physical interruptions such as noise and room temperature.
        (4) Provide for the client's comfort by having facial tissues near the client's chair.

2. Initiate the session.
    a. Greet the client.
        (1) Walk out to meet the client.
        (2) Address the client by rank or title and name.
        (3) Introduce yourself including your name, rank, job title, and role.
        (4) Escort the client to the counseling area. Ask him or her to be seated.
    b. Explain the counseling role.
        (1) Explain the purpose of the first session.
            (a) Review of the problem(s).
            (b) Set counseling goals.

Performance Steps

(2) Explain the relationship of the client and counselor as one in which they work together to find solutions.
(3) Explain counseling rules regarding the limits on privacy and confidentiality of information.

c. Begin each session with a brief summary of what transpired the preceding session and during the interval between sessions.

3. Review and clarify the problem.
   a. Ask the client to describe his or her views and feelings regarding the problem.
   b. Ask the client to discuss the frequency of the problem and the situation and duration in which it occurs.
   c. Ask the client about the effects of the problem on activities of daily living.
      (1) Social functioning.
      (2) Occupational functioning.

4. Select the appropriate intervention.
   a. Crisis intervention.
      (1) The problem is a situational crisis of recent onset.
      (2) The problem is generalized, affecting many areas of the client's life.
      (3) The client's level of discomfort (stress, anxiety, depression) is too high to permit effective coping.
      (4) The client's level of adjustment and social functioning before the onset of crisis was good.
   b. Guidance counseling.
      (1) The problem is situational, specific, and is affecting few areas of the client's life.
      (2) The client perceives, and is able to resolve, the problem with minimal counselor intervention.
      (3) The client is likely to have no further need for intervention once the presenting problem is resolved.
      (4) The client shows at least moderate motivation for resolution.
      (5) The client's level of adjustment and social functioning before the onset of the problem was good.
   c. Extended supportive counseling.
      (1) The client's adjustment problems have generalized to most areas of functioning.
      (2) The client does not see actual resolution of the problem as being within his or her control, or resolution is actually not within his or her control.
      (3) The client has had the same or similar presenting problems in the past. It can be predicted he or she will be likely to have them in the future, irrespective of the current solution.
      (4) The client's level of adjustment and social functioning was only fair prior to the onset of the presenting problem.

5. Set counseling goals.
   a. Summarize the problem(s) to be worked on.
   b. Obtain the client's concurrence on the summary of the problem area(s).
   c. Obtain the client's input on what kind of outcome he or she would like to see as a result of counseling.
   d. Formulate goals in concrete behavioral terms. For example, the client attends monthly counseling sessions, keeps appointments, and participates in the counseling process.

NOTE: Goals should be flexible. They may be modified or discontinued as new information emerges during the counseling process.

Performance Steps

6. Terminate the counseling session.
   a. Briefly summarize the highlights of the session.
   b. Obtain the client's concurrence on the summary.
   c. Discuss the actions to be taken by the client prior to the next counseling session.
   d. Agree on a definite return appointment.
   e. Assist the client in making a return appointment by providing an appointment slip that indicates the date, time, place, phone number, and your name.
   f. Escort the client to the appropriate exit.
7. Record notes of the counseling session in the client's case file IAW local SOP.

Performance Measures	**GO**	**NO GO**
1. Prepared for counseling.	____	____
2. Initiated the session.	____	____
3. Reviewed and clarified the problem.	____	____
4. Selected the appropriate intervention.	____	____
5. Set counseling goals.	____	____
6. Terminated the session.	____	____
7. Recorded notes of the counseling session.	____	____

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	**Related**
None	AGUILERA AR 608-1 AR 608-18 AR 621-5 AR 930-4 AR 930-5 OTHMER & OTHMER PATTERSON & WELFEL

PERFORM COUNSELING INTERVENTIONS

081-832-0014

Conditions: You are assigned to care for and counsel a patient.

Standards: Selected the appropriate counseling interventions when counseling the patient.

Performance Steps

1. Use the four dimensional analysis to identify appropriate client interventions to be used.
2. Perform interpersonal/systemic interventions - what are the client's personal relationships like?
   a. Negotiation and conflict management. The role of the counselor is to help the family establish ground rules for negotiation and conflict resolution, seek mutual respect for differing opinions, seek consensus on solutions, and monitor family follow-up in regards to agreed upon solutions.
   b. Altering family structure. The goals of structural family interventions include: establish rapport with the family, observe family interactions, diagnose the family structure, modify interactions and reconstruct family boundaries.
3. Perform behavioral interventions - help client develop adaptive and supportive behavior to multifaceted situations. What the client does when "the problem is in charge."
   a. Social modeling - involves learning by observing others.
   b. Behavior rehearsal - uses role-play and practice attempts to help people acquire new skills.
   c. Skills training - is utilized to help a client learn the certain skills that they are deficit in.
   d. Self-management - self-management interventions are most easily applied to help client's acquire more effective interpersonal, cognitive, and emotional behaviors.
4. Perform cognitive interventions - alter a client's manner of thinking about a particular event, person, self, or life. What kinds of things is the client saying to himself?
   a. A-B-C-D analysis.
      (1) Identify the "Activating event" which begins the faulty thinking pattern.
      (2) The client's "Belief system" is through which all life experiences including the activating event are filtered.
      (3) "Consequence," either cognitive or emotional, that is produced by the interaction of A and B.
      (4) After conducting an A-B-C analysis, the client and counselor are ready to perform "Disputing of irrational beliefs" that are leading to the consequence and replace those irrational beliefs with more accurate rational beliefs.
   b. Cognitive Restricting - involves identifying and altering irrational or negative self-statements of clients.
   c. Reframing - the gentle art of viewing or thinking about a situation differently.
   d. Symptom Prescription - if the client follows the instruction they discover that behaviors once believed to be "uncontrollable" are indeed "controllable" and manageable.
5. Perform affective interventions to help the client express feelings or feeling states. How does the problem make the client feel?
   a. Feelings inventory/checklist - the client is instructed to indicate, from a given list/inventory of feelings words, those feelings that describe their life experience in the past 3 months or feelings that are of greatest concern.

Performance Steps

b. Role reversal - is useful when a client is experiencing a conflict of taluses or feelings or a conflict with his/her self-image but is unable to isolate or understand the nature of the conflict.
c. Empty chair - the counselor defines the two principals for the client and asks the client to begin the dialogue with an empty chair across from the client. The counselor directs the client to change to the empty chair every time the client begins to speak as the 'other voice' to help the client change or integrate their feeling states.
d. Dream work - dream work requires an understanding and thorough assessment of the client and the 91X should always be supervised.

Performance Measures	**GO**	**NO GO**
1. Identified appropriate client interventions to be used.	____	____
2. Performed interpersonal/systemic intervention.	____	____
3. Performed behavioral interventions.	____	____
4. Performed cognitive interventions.	____	____
5. Performed affective 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	**Related**
None	HACKNEY & CORMIER

Subject Area 4: Combat Stress

ASSIST IN A CRITICAL EVENT DEBRIEFING
081-832-0030

Conditions: You are to assist in a critical event debriefing concerning a serious traumatic event that happened in the unit.

Standards: Assisted in a critical event debriefing that restored and enhanced unit cohesion and effectiveness.

Performance Steps

1. Assist in the CED process.
    a. Debriefings are conducted as soon as possible after the action.
    b. Prior to the debriefing session, the debriefer collects information about the unit's background, structure, and role in the battle and the outcome of the action.
    c. The participants are told that the debriefing consists of a chronological reconstruction of the event in its minutest details (to understand and learn from the action, not as fault-finding).
    d. The entire group takes part in the reconstruction of the action in all its details. Each soldier is encouraged (but not forced) to add his version to the other soldiers' accounts.
    e. All those who took part in the action participate in the session.
    f. The debriefer creates and maintains a congenial atmosphere and facilitates communication and openness throughout the session.
    g. Emotional reactions are recognized and validated, but are not emphasized.
    h. Criticism and attempts to teach are discouraged. No open disbelief in any witness' testimony is expressed by the interviewer.
    i. That the entire process is confidential and that every one is urged to maintain a pact of confidentiality with one another regarding whatever is said during the session.
    j. That all personnel are equal during the debriefing.
    k. That every person is asked to speak only for himself or herself and no one else.
    l. That the critical incident stress debriefing team member will be available after the debriefing if someone wants to talk individually.

NOTE: It is essential that the facilitators be perceived as impartial, friends of the units, trustworthy, and privileged to maintain confidentiality about what is shared in the debriefing. They must NOT be perceived as investigators or "spies" from the higher headquarters, inspector generals, or criminal investigators.

2. Determine purposes of a critical event debriefing.
    a. Quickly restore and enhance unit cohesion and effectiveness.
    b. Reduce short term emotional and physical distress.
    c. Prevent long term distress and burnout.
    d. Safeguard future unit effectiveness, happiness, and family well-being.

3. Determine need for a critical event debriefing.
    a. Death of a unit member (by combat, accident, suicide).
    b. Death or suffering of noncombatants (especially women and children).
    c. Having to handle dead bodies, other horrible sights, or smells.
    d. Friendly fire incidents, especially if they caused casualties.

Performance Steps

e. Situation involved a serious error, injustice, or atrocity.
f. Situation involved the feeling of total helplessness.
g. Evident distress of many participants.
h. A consensus of the participants at the after-action debriefing (AAD) that they want to "talk more" about the event.
i. Evident reluctance of unit members to talk through the event in the after-action debriefing under their own leadership.
j. The expressed wish for a consolidated or combined debriefing, bringing the unit together with representatives of other involved units, such as the survivors of a friendly fire incident with the perpetrators.

4. Assist in the phases of a critical event debriefing.
   a. Introductory phase.
   b. Fact phase--to reconstruct the event in detail.
   c. Thought phase--participants are asked to share what "thoughts" they had.
   d. Reactive phase--to identify feelings raised by the event.
   e. Symptom phase--shift focus back from emotional to factual.
   f. Teaching phase--reassurance by educating that feelings and stress symptoms are normal reactions to abnormal conditions.
   g. Re-entry phase--closure.

Performance Measures	**GO**	**NO GO**
1. Assisted in the phases of a critical event debriefing. a. Introductory phase. b. Fact phase. c. Thought phase. d. Reactive phase. e. Symptom phase. f. Teaching phase. g. Reentry phase.	____	____
2. Assisted in the closure of the critical event debriefing.	____	____

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	**Related**
None	FM 22-51 FM 8-51

TREAT BATTLE FATIGUE

081-832-0068

Conditions: You are to treat an emotionally battle fatigued patient who has been sent to your combat stress control unit.

Standards: Treated emotional battle fatigued patient with the appropriate treatment procedures.

Performance Steps

1. Identify combat stress behaviors.
    a. Positive combat stress behaviors.
        (1) Heightened alertness.
        (2) Strength, endurance.
        (3) Increased tolerance to hardship, discomfort, and pain.
        (4) Loyalty to buddies, leaders, and unit.
        (5) Courage/heroic acts.
    b. Negative (misconduct) combat stress behaviors.
        (1) Minor breeches of orders to serious violations of the UCMJ and the Law of Land and Warfare.
        (2) Substance abuse and misuse.
        (3) Self-inflicted wounds.
        (4) Excessive sick call and malingering.
        (5) Most prevalent in poorly trained/undisciplined soldiers.
2. Identify emotional symptoms of battle fatigue.
    a. Hyperalertness.
    b. Fear and anxiety.
    c. Irritability, anger, and rage.
    d. Grief, self-doubt, and guilt.
3. Identify physical symptoms of battle fatigue.
    a. Tension, aches, and pains.
    b. Jitters and shakiness.
    c. Cold sweat, dry mouth, pale skin, and eyes hard to focus.
    d. Pounding heart, may feel dizzy and light headed.
    e. Out of breath.
    f. Upset stomach, diarrhea, or constipation.
    g. Emptying bowels and bladder at instant of danger.
    h. Fatigue, feel tired, drained and takes effort to move.
    i. Distant, haunted ("1000 yard") stare.
4. Conduct combat psychiatry treatment principles.
    a. Treat BF using the acronym "PIES".
        (1) Proximity - treat as close to their units as possible.
        (2) Immediacy - treat BF immediately.
        (3) Expectancy - the positive expectation that BF casualties will reach full recovery and early RTD.
        (4) Simplicity - use simple, brief, and straight forward methods to restore physical and emotional well-being using nonmedical terminology and techniques.

Performance Steps

NOTE: Life or function threatening medical or surgical conditions sometimes mimic symptoms of battle fatigue. A thorough exam by a qualified provider can identify medical conditions which require immediate attention. Let response to PIES treatment sort out the true NP disorders.

5. Conduct generic battle fatigue treatment principles.
    a. Initial assessment.
        (1) Brief but adequate medical and mental status examination performed.
        (2) Refer to echelon of care.
    b. All BF is treated using the four Rs.
        (1) Reassure service member of normality of all BF situations.
        (2) Rest (respite from battle and work).
        (3) Replenish - allow the soldier an opportunity to eat, bathe, clean uniforms, and rest.
        (4) Restore confidence through structured military details, physical exercise, and recreation.

Performance Measures	**GO**	**NO GO**
1. Identified combat stress behaviors.	____	____
2. Identified BF behaviors.	____	____
3. Identified physical symptoms of BF.	____	____
4. Conducted combat psychiatry treatment principles.	____	____
5. Conducted generic BF treatment principles.	____	____

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 None

PERFORM SIX FUNCTIONS OF COMBAT STRESS CONTROL (CSC)

081-832-0024

Conditions: You are to perform the six functions of combat stress control to supported units. You will need notepaper.

Standards: Performed the six functions of a combat stress control to supported units in a timely manner.

Performance Steps

1. Establish rapport with supported units.
    a. Consultation is best initiated through face-to-face contact, preferably at the supported unit's location.
    b. Consultation is an ongoing process that is performed in both peacetime and wartime. It is conducted before, during, and after combat.
    c. CSC personnel are the primary resource for advice and training on ways to control stressors and stress.
2. Perform restoration.
    a. Further referral of restoration cases.
        (1) Referral for administrative actions.
        (2) Referral to hospital.
        (3) Referral to a reconditioning program.
    b. Generic tactics, techniques, and procedures of restoration.
        (1) Provide debriefing, ventilation, and counseling.
        (2) Assign duties and work details.
        (3) Support the soldier's military identity.
        (4) Replenishment of physiologic status.
        (5) Reassurance.
        (6) Reprieve from extreme stress.
3. Establish stabilization.
4. Perform combat neuropsychiatric (NP) triage.
    a. Four categories of combat NP triage.
        (1) REFER cases.
            (a) This echelon cannot provide the acceptable level of diagnostic and treatment capability of an emergency.
            (b) Refer cases are too disruptive and burdensome for this medical echelon, given its mission and resources.
            (c) Present problems similar to the Hold cases.
        (2) HOLD cases.
            (a) This is the medical echelon where resources must be available for potential emergency or emergency situations.
            (b) Their symptoms are potentially too disruptive or burdensome for any available CSS unit or element.
            (c) Their symptoms could be caused by a medical, surgical, or NP condition, which could suddenly worsen and require emergency treatment.
            (d) Require close medical observation and evaluation.
        (3) REST cases.

Performance Steps

(a) Someone in the receiving unit must take responsibility for ensuring the soldier is fed, rested, allowed to perform some useful work, and kept accounted for.
(b) This option, also depends on the resources and mission of the available CSS units as well as on the soldier's symptoms.
(c) The respite and replenishment can be provided in a non-medical CSS element that supports their original unit.
(d) These cases do not require close medical or mental health observation or full-time treatment.
(e) Rest cases need brief respite, physical replenishment, and less demanding duties for hours to days at a less dangerous or better-resources setting.

(4) DUTY cases.
(a) The triager must be familiar with the unit's situation and take that into account.
(b) This option depends on the unit's mission, resources, and soldier's symptoms.
(c) Return to their original unit for full duty or for light duty with extra rest and replenishment.

5. Perform reconstitution support.
a. Phases of CSC reconstitution support.
(1) Phase V: Perform final CSC requirements for reconstitution support.
(a) Close out support--officially close out role with each unit and leave unit with the positive expectation they will continue to perform missions.
(b) Encourage and monitor unit confidence building programs such as training and recreational programs.
(c) Monitor ongoing work to ensure unit cohesion is being built.
(2) Phase IV: Rebuild unit cohesion.
(a) Assist individuals with battle fatigue.
(b) Assist leaders to rapidly integrate new personnel.
(c) Advise commander and staff on reassignment of survivors and integration of replacements.
(3) Phase III: After-action debriefings (AADs).
(a) Conduct critical event debriefings.
(b) Provide large group and attached/support personnel debriefings.
(c) Ensure AADs continue throughout the chain of command.
(d) Facilitate and assist unit leaders to perform AADs as soon as mission/time permits.
(4) Phase II: Reduction of human physical/physiologic and cognitive stressors.
(a) Monitor and encourage ample rest for survivors.
(b) Monitor sufficient quantity and ensure access to food, shelter, and bathing facilities.
(5) Phase I: Preparation and deployment to reconstitution site.
(a) CSC personnel familiarize themselves with the unit, it's history, chain of command, and support personnel.
(b) CSC personnel coordinate with higher headquarters and supported units.

6. Perform recondition unit training.
a. Reconditioning program methods.
(1) Facilitate group training in life skills.

Performance Steps

(2) Provide group training in relaxation techniques.
(3) Conduct individual counseling and therapy.
(4) Maintain military structure.

b. Reconditioning Program.
(1) Skills deal with concentration, team work, work tolerance, psychological endurance, and physical fitness.
(2) Treatment strategies assist recovering soldiers in regaining skills needed for combat duty.
(3) Emphasis on highly structured military unit environment and schedule of activities.
(4) Is similar to restoration but is more intensive and requires a higher staff-to-case ratio.

Performance Measures	**GO**	**NO GO**
1. Established rapport with supported units.	____	____
2. Performed reconstitution support.	____	____
3. Performed combat neuropsychiatric triage.	____	____
4. Performed stabilization.	____	____
5. Performed restoration.	____	____
6. Performed reconditioning.	____	____

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 None

Subject Area 5: Psychological Testing

ADMINISTER THE MINNESOTA MULTIPHASIC PERSONALITY INVENTORY-2 (MMPI-2)
081-832-0069

Conditions: You are in a clinical setting under the supervision of a psychologist. You will need MMPI-2 Manual for Administration and Scoring, test booklet, answer sheet, scoring keys, profile sheet, dictionary, and a testing area with a desk or table and a chair.

Standards: Administered, to include the scoring and profiling, an MMPI-2 by MMPI-2 manual procedures.

Performance Steps

1. Prepare for the test.
   a. Gather the test booklet, answer sheet, and pencils.
   b. Ensure the testing area is--
      (1) Well lighted.
      (2) Well ventilated.
      (3) Free from distractions.
      (4) As comfortable as possible.

2. Greet the client.
   a. Address the client using the client's appropriate rank.
   b. Introduce yourself using your rank and last name.
   c. Seat the client behind the desk or table.

3. Explain the purpose of the test.
   a. Be truthful.
   b. Use general but positively stated reasons.

4. Tell the client who will provide feedback on the results of the test.

5. Prepare the answer sheet.
   a. Ask the client to fill in the appropriate identification data.
   b. Place the answer sheet on the metal buttons of the test booklet.
   c. Place the answer sheet and test booklet in front of the client.

6. Tell the client to read the instructions silently while you read them aloud.
   a. Ask the client if there are any questions regarding the instructions.

NOTE: Repeat the instructions as needed.

   b. Tell the client to begin.
   c. Watch the client complete the first few items to ensure the numbers on the answer sheet line up with the numbers in the test booklet.

7. Answer questions and objections posed by the client during the test.
   a. Allow the client to use the dictionary to determine the definition of a word.
   b. Encourage the client to mark all of the items. If the client has difficulty deciding how to mark one or more items, use a general statement such as, "Do not leave a blank space unless you really cannot decide how to mark the item."
   c. If the client requests guidance on how to respond, tell the client that the answer should reflect his or her own feelings or opinions.

Performance Steps

d. If the client questions the need for taking the test, restate the purpose of the test, encourage the client to continue, and assure the client that the test will be used for his or her benefit.

NOTE: Consult with the supervisor immediately if the client's behavior raises questions on how or if testing should continue.

e. Answer factual and procedural questions directly.

f. Tell the client to answer the questions according to his or her current feelings towards a particular subject instead of some earlier feeling.

NOTE: The client may have experienced a traumatic incident, such as the death of a family member. The client should be encouraged to respond how he or she currently feels regarding the incident, not how he or she felt when the incident occurred.

g. If the client has questions about how he or she should answer items that are only true some of the time, tell the client to answer the item as it generally applies to him or her. For example, if it is false most of the time, then the client should be encouraged to answer false.

8. Terminate testing when the client states that he or she is through.
   a. Check the client's answer sheet for completeness of answers and identification data.
   b. Encourage the client to go back and answer every question if there are many omissions.

NOTE: More than 30 omissions may invalidate the test.

   c. Collect all test materials.
   d. Check the test booklet for missing pages and pencil marks.
   e. Terminate the testing session and release the client.

NOTE: Release the client to his or her duty section if the client is active duty.

9. Record any significant behavior, questions, or statements made by the client during the testing session.

10. Examine the answer sheet.
    a. Draw a solid line through the T and F circles for unanswered or double answered items.
    b. Look for obvious patterns such as all T's or all F's or repeated sequences.

NOTE: Such patterns indicate that the client did not take the test seriously or may not have read the questions.

11. Score the MMPI-2.
    a. Count the unanswered and double answered questions and record the number counted as the "?" score.

NOTE: The unanswered and double answered questions are not to be used on any other scales.

    b. Place the L scale scoring key over the answer sheet.
       (1) Line up the black bars on the bottom of the scoring key with the black bars on the bottom of the answer sheet.
       (2) Follow the line on the scoring key and count every mark showing through the squares on the key.
       (3) Record the number of marks counted as the raw score for the L scale.
    c. Repeat steps 11b(1) and 11b(2) to score the following six scales.
       (1) F scale.
       (2) K scale.
       (3) Hs (1) scale.

Performance Steps

(4) D (2) scale.
(5) Hy (3) scale.
(6) Pd (4) scale.
(7) Record the number of marks counted for each scale as the raw score.

d. Score the Mf (5) scale.
(1) Select the scoring key to match the sex of the client.
(2) Repeat steps 11b(1) and 11b(2).
(3) Record the number of marks counted as the raw score for the Mf (5) scale.

e. Repeat steps 11d(1) and 11d(2) to score the following five scales.
(1) Pa (6) scale.
(2) Pt (7) scale.
(3) Sc (8) scale.
(4) Ma (9) scale.
(5) Si (0) scale.
(6) Record the number of marks counted for each scale as the raw score.

f. Determine which side of the profile sheet is needed according to the sex of the client and make a large "X" on the side not used. (See Figure 3-1.)

g. Write the raw score for each of the scales at the bottom of the profile sheet on the appropriate line.

NOTE: One side is for males and the other side is for females.

12. Fill out the client's identification data at the top of the profile sheet.

Performance Steps

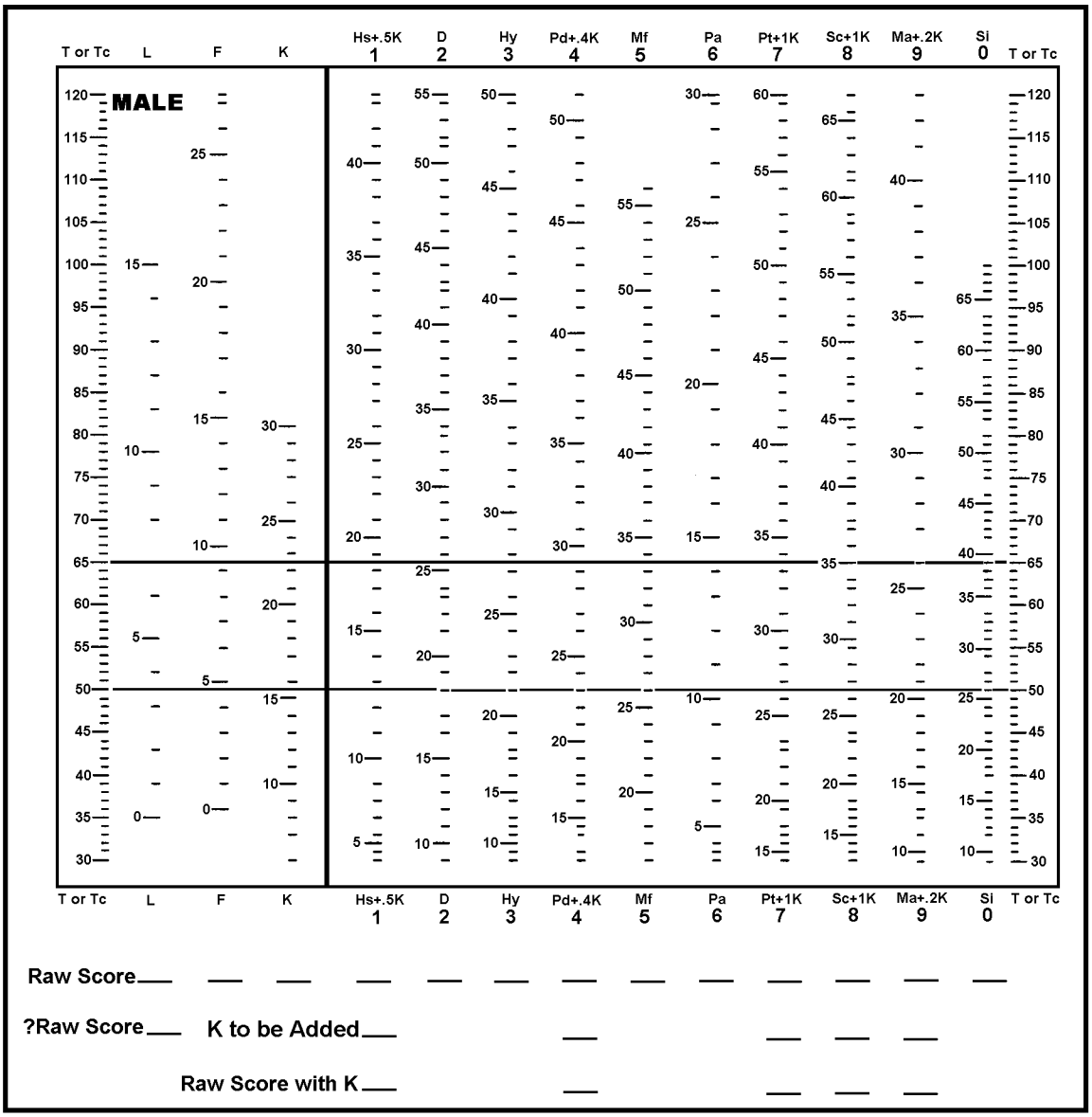

Figure 3-1

13. Make the K corrections.
    a. Locate the Fractions of K chart on the profile sheet. (See Figure 3-2.)

NOTE: The "Fractions of K" chart was removed from the profile sheet for clarity purposes.

    b. Find the number in the left-hand column of the Fractions of K chart which corresponds to the raw score of K.
    c. Draw a line through the Fractions of K, underlining the appropriate raw K score.
    d. Find the number which corresponds to .5K in the Fractions of K chart. Record this number below the raw score for HS (1) scale.
    e. Find the number which corresponds to .4K in the Fractions of K chart. Record this number below the raw score for Pd (4) scale.

Performance Steps

Fractions of K

K	.5	.4	.2
30	15	12	6
29	15	12	6
28	14	11	6
27	14	11	5
26	13	10	5
25	13	10	5
24	12	10	5
23	12	9	5
22	11	9	4
21	11	8	4
20	10	8	4
19	10	8	4
18	9	7	4
17	9	7	3
16	8	6	3
15	8	6	3
14	7	6	3
13	7	5	3
12	6	5	2
11	6	4	2
10	5	4	2
9	5	4	2
8	4	3	2
7	4	3	1
6	3	2	1
5	3	2	1
4	2	2	1
3	2	1	1
2	1	1	0
1	1	0	0
0	0	0	0

Figure 3-2

f. Write the raw "K" score below the raw score for Pt (7) scale.
g. Write the raw "K" score below the raw score for Sc (8) scale.
h. Find the number which corresponds to .2K in the Fractions of K chart. Record this number below the raw score for Ma (9) scale.
i. Add the raw scores and K corrections for scales 1, 4, 7, 8, and 9.
j. Record the sum on the bottom line for each scale.

14. Profile the scores.
    a. Place a dot on the profile sheet to represent the scores for scales L, F, and K.

Performance Steps

NOTE: These are the validity scales.

b. Draw a line connecting the three dots.

c. Place a dot on the profile sheet to represent the scores for scales 1 through 0.

NOTE: These are the clinical scales.

(1) Use the "K" corrected scores for scales 1, 4, 7, 8, and 9.

(2) Invert the score for the Mf (5) scale if the client is a female -- the higher the score the lower the dot.

d. Draw a line connecting the dots which represent scales 1 through 0.

NOTE: Do not connect the validity scales to the clinical scales when drawing the line.

15. Give the answer sheet, the profile sheet, and any recorded observations to the psychologist.

Performance Measures	**GO**	**NO GO**
1. Prepared for the test.	____	____
2. Greeted the client.	____	____
3. Explained the purpose of the test.	____	____
4. Told the client who will provide feedback on the results of the test.	____	____
5. Prepared the answer sheet.	____	____
6. Told the client to read the instructions silently while they are read aloud.	____	____
7. Answered questions and objections posed by the client.	____	____
8. Terminated testing when the client states that he or she is through.	____	____
9. Recorded any significant behavior, questions, or statements made by the client during the testing session.	____	____
10. Examined the answer sheet.	____	____
11. Scored the MMPI-2.	____	____
12. Filled out the client's identification data.	____	____
13. Made the K corrections.	____	____
14. Profiled the scores.	____	____
15. Provided testing results to the psychologist.	____	____

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	**Related**
MMPI-2 MANUAL	None

Subject Area 6: Patient Interventions

APPLY RESTRAINING DEVICES TO PATIENTS
081-833-0076

Conditions: You have identified the patient and explained the procedure. An assistant is available. You will need a bed, wrist and ankle restraining devices, ABD pads, padding materials, litters, flexible gauze (Kerlix/Kling), rifle slings, web belts, elastic bandages, bandoleers, cravats, and sheets.

Standards: Applied restraining devices to a patient without causing injury to the patient or yourself.

Performance Steps

NOTE: In a field environment, the need for restraints may be your own decision, especially in the absence of senior medical personnel.

1. Apply wrist and ankle restraints.

NOTE: If you apply ankle restraints, also apply wrist restraints.

WARNINGS: 1. Do not attempt to apply restraining devices by yourself. Get adequate help. 2. A patient who is depressed or has an altered level of consciousness should be positioned on the stomach with the head turned to the side. 3. Position restraints to avoid causing further injury to a wound or interfering with IV lines, catheters, and tubes.

a. Adjustable limb holders (cuff and strap).
   (1) Clean and powder the skin around the wrists and ankles, if possible.
   (2) Pad the limb with ABD pads or similar material.
   (3) Position the restraint cuff over the padded limb.
   (4) Thread the strap through the loop on the cuff. Pull the straps snugly enough to restrict free movement of the limb.

NOTE: If two fingers can be comfortably inserted under the cuff, the restraint is snug enough. The patient, however, must not be able to wiggle his or her hand out of the cuff.

   (5) Wrap the strap around the bedframe.
   (6) Lock the buckle and position it facing the outside of the bedframe for quick access.
   (7) Repeat steps 1a(2) through 1a(6) for each limb.

NOTE: The keys to the locked restraints must be readily available.

b. Improvised restraints.
   (1) Clean and powder the skin around the wrists and ankles, if possible.
   (2) Pad the limb with any soft cloth such as towels, gauze, cravats, clean handkerchiefs, or clothing.
   (3) Secure the restraining material (gauze or roller bandage) to the limb with a clove hitch.
   (4) Pull the knot to fit the limb snugly.
   (5) Using a bow knot, tie both free ends to the bedframe in a location inaccessible to the patient.
   (6) Repeat steps 1b(2) through 1b(5) for each limb.

2. Apply mitt restraints.
   a. Place the patient's hand in a naturally flexed position.

Performance Steps

b. Place a soft rolled dressing or similar material in the patient's hand and close the hand.
c. Wrap the entire hand snugly with a flexible gauze bandage (Kerlix, Kling).
d. Secure the bandage with tape, not clips.

CAUTION: Remove and replace mitts at least every 8 hours. Clean the skin and perform range-of-motion exercises.

3. Apply sheet restraints.

NOTE: This procedure requires the assistance of another person.

a. Litter or stretcher.
(1) Unfold a sheet. Hold it at opposite corners and fold it lengthwise.
(2) Twirl the sheet into a tight roll.
(3) Place the patient on his or her stomach on a litter. Turn the head to the side.

WARNING: Check the patient frequently because he or she may suffocate while in the prone position.

(4) Place the middle of the rolled sheet diagonally across the patient's upper back and one shoulder.
(5) Bring both ends of the sheet under the litter, cross the ends, and bring the ends up over the other shoulder and upper back. Tie snugly in the middle of the upper back.
(6) Secure one wrist to the litter, parallel to the thigh, using a wrist restraint.
(7) Secure the other wrist above the head by attaching it to the nearest litter handle using a wrist restraint.

CAUTION: Use litter or stretcher restraints only as a temporary restraint for a patient who is combative or uncontrollable.

b. Bed.
(1) Fold a sheet in half lengthwise.
(2) Tuck approximately 2 feet of one end of the sheet under one side of the mattress at the patient's chest level.
(3) Bring the other end of the sheet over the patient's chest, keeping the sheet over the arms. Tuck the free end of the sheet snugly under the other side of the mattress.
(4) If further restriction is necessary, apply sheets in the same manner at the level of the patient's abdomen, legs, knees, and ankles.

NOTE: Use this method of restraint only for limiting movement. It is not a secure method of restraining a violent patient.

4. Apply field expedient restraints.

NOTE: Field expedient restraints should not be used for long periods of time and should be replaced with regular restraining devices as soon as possible.

a. Mixed equipment. Restraints may be improvised from such items as rifle slings, web belts, bandoleers, or cravats.
(1) Restrain the patient's arms and legs tight enough to restrict movement but not so tight as to restrict circulation.
(2) Lay the patient on the ground.
b. Double litters.
(1) Place the patient on his or her stomach on a litter. Turn the head to the side.
(2) Place the patient's hands alongside the thighs and secure them to the litter with wrist restraints.
(3) Place the other litter, carrying side down, on top of the patient.

Performance Steps

(4) Bind the litters together with two or more litter straps.
(5) Place the litter strap buckles in a location inaccessible to the patient.

5. Check the patient at least once every half hour for signs of distress and security of restraints.

WARNING: The use of restraints has the following hazards: 1. Tissue damage under the restraints. 2. Development of pressure areas. 3. Nerve damage. 4. Injury or death in case of fire or other emergencies. 5. Inability to effectively resuscitate a patient. 6. Possibility of shoulder dislocations in combative patients or those with seizure activity.

6. Change the patient's position at least once every 2 hours, day and night. Exercise the limbs through normal range-of-motion activities.

7. Evacuate the patient, if necessary.

Performance Measures	**GO**	**NO GO**
1. Applied wrist and ankle restraints, as applicable.	____	____
2. Applied mitt restraints, as applicable.	____	____
3. Applied sheet restraints, as applicable.	____	____
4. Applied field expedient restraints, as applicable.	____	____
5. Checked the patient.	____	____
6. Changed the patient's position.	____	____
7. Evacuated the patient, if necessary.	____	____
8. Did not cause further injury to the patient.	____	____

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	**Related**
None	EMERGENCY CARE

RESPOND TO AN AGITATED PATIENT

081-832-1011

Conditions: You responded to a patient who is verbally belligerent, hostile, and exhibiting behavior that indicates that he or she is beginning to lose control. You will need the patient's clinical records and mechanical restraints.

Standards: Performed interventions in response to an agitated patient, starting with the least restrictive.

Performance Steps

1. Utilize the appropriate interventions beginning with the least restrictive form.
    a. Verbal intervention--least restrictive.
        (1) Approach the patient in a calm manner, aware of the need for an enlarged "Buffer Zone".

NOTE: Agitated patients tend to need extra personal space between themselves and the mental health specialist to avoid feeling threatened.

        (2) Maintain eye contact.
        (3) Present a nonthreatening posture.
            (a) Place yourself at an angle to the patient, keeping a distance of at least one leg length (3 feet) from the patient as a personal safety margin.
            (b) Keep your hands in plain view, at your sides, if possible.

NOTE: Avoid placing hands on hips, folding arms against your chest, or clenching your fists.

        (4) Speak in a firm nonthreatening tone of voice with moderate volume.
        (5) Encourage the patient to gain self-control.
            (a) Allow the patient to express his or her feelings, without getting into an argument or power struggle.

NOTE: Let the patient know he or she can express feelings such as anger in an acceptable way. You must remain in control without responding with anger or defensiveness.

            (b) Set limits on his or her behavior by providing the patient with clear expectations regarding acceptable behavior.
            (c) Inform the patient of enforceable consequences if his or her behavior is not controlled.
            (d) Offer the patient positive reinforcement for complying with the limits set.
    b. Chemical intervention--the use of medication to sedate the patient.

NOTE: The medication must be ordered, verbally or in writing, by a physician.

        (1) Use when a patient does not respond to verbal intervention.
        (2) Utilize in conjunction with other forms of intervention, such as verbal or physical.

NOTE: Chemical intervention should not be used to discipline or punish the patient, or for the convenience of the staff.

    c. Physical intervention--most restrictive form.
        (1) Use as a last resort.
            (a) Use to protect the patient from injuring himself or herself or others.
            (b) Use to prevent serious disruption of the therapeutic environment.
        (2) Manual restraint--controls the patient physically.
        (3) Mechanical restraint--restricts or limits the patient's movement through use of mechanical restraints.
        (4) Seclusion--places a patient in a hazard-free room.

2. Perform psychological aftercare for the patient who has lost control.

Performance Steps

a. Explain the staff's responsibility to take action to control the patient's behavior, after the patient has failed to control himself or herself.
b. Reorient the patient to the behaviors and circumstances that necessitated the staff action.
c. Point out similar behavior patterns and circumstances that have precipitated a loss of control.
d. Discuss possible alternatives to the patient's previous means of coping.
e. Negotiate with the patient for changes in his or her behavior to promote more effective coping skills.
f. Give the patient support, respect, and encouragement to assist him or her in learning to cope.

3. Record and report the patient's conversation and behavior and the staff interventions.
   a. Report the incident to your supervisor, if not already informed of the situation.
   b. Document the patient's behavior.
   c. Document the staff interventions.

NOTE: Documentation is done on SF 509 or SF 510 IAW local policy.

Performance Measures	**GO**	**NO GO**
1. Utilized the appropriate interventions beginning with the least restrictive form.	____	____
2. Performed psychological aftercare for the patient who has lost control.	____	____
3. Recorded and reported the patient's conversation and behavior and the staff 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 None

ASSIST IN MANUAL RESTRAINT PROCEDURES

081-832-1012

Conditions: A patient is acting out by being physically abusive. Verbal and chemical interventions have not been effective. The assistance of at least three other staff members is available. You will need clinical record and SF 509 or SF 510.

Standards: Manually restrained a patient without causing undue pain or injury to the patient.

Performance Steps

1. Obtain assistance.

NOTE: Manual restraint means to physically control the patient. Doctor's orders are required. When a patient must be manually restrained in the absence of doctor's orders, the authorization must be obtained by supervisory personnel immediately after the patient is restrained.

   a. Use a minimum of four personnel, to include yourself, to manually restrain a patient of moderate stature and strength.
   b. Use additional personnel to assist in the restraint depending on the situation and the availability of staff.
   c. Make a plan with the other team members and appoint a team leader, if time permits.

2. Remove sharp and/or dangerous items (name tags, watches, eyeglasses, and pens), if time permits.

3. Clear other patients from the immediate area, if possible.

4. Approach the patient.
   a. The team leader approaches the patient from the front.
      (1) Talk to the patient, causing the patient to focus attention on you.
      (2) Move toward the patient and get as close as possible without the patient being able to strike you.
   b. Direct the other staff members to approach the patient from each side and the back.
   c. Modify action to fit the situation.

5. Immobilize the patient.
   a. Move on an agreed upon command.
   b. Direct simultaneous assistance from the other staff members.
   c. Take the patient down, lowering the patient to the floor, face down.
   d. Control the patient's limbs.
      (1) Straighten the patient's arms along his or her sides, palm up.

NOTE: This reduces the patient's ability to get leverage and resist the restraint.

      (2) Straighten the patient's legs to keep the patient from kicking.

NOTE: Grasp the patient's limbs above or below the joints to avoid undue injury or pain to the patient.

6. Assess the need for additional control.
   a. Consult with the supervisor if time and the situation permit.
   b. Determine if additional control is necessary by considering--
      (1) The patient's history of assaultive or abusive behavior.
      (2) The patient's current level of functioning and ability to gain control.

7. Intervene with additional control, if determined to be necessary.
   a. Apply mechanical restraints. (See task 081-832-1013.)

Performance Steps

b. Place the patient in a seclusion room. (See task 081-832-1025.)

8. Record and report the patient's conversation and behavior and the staff interventions.
   a. Report the incident to the supervisor, if not already informed of the situation.
   b. Document the patient's behavior that resulted in manual restraint.
   c. Document the patient's behavior and response to being manually restrained.
   d. Document staff interventions prior to and after manually restraining the patient.

NOTE: Documentation is done on SF 509 or SF 510 IAW local policy.

Performance Measures	**GO**	**NO GO**
1. Obtained assistance.	____	____
2. Removed sharp and/or dangerous items (name tags, watches, eyeglasses, and pens), if time permits.	____	____
3. Cleared other patients from the immediate area, if possible.	____	____
4. Approached the patient.	____	____
5. Immobilized the patient.	____	____
6. Assessed the need for additional control.	____	____
7. Intervened with additional control, if determined to be necessary.	____	____
8. Recorded and reported the patient's conversation and behavior and the staff 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 None

ASSIST IN MECHANICAL RESTRAINT PROCEDURES

081-832-1013

Conditions: You are about to restrain a physically abusive patient using mechanical restraints. Verbal and chemical interventions have not been effective. The assistance of at least three other staff members is available. You will need complete set of leather restraints and two additional leather belts, gauze for padding, and clinical record.

Standards: Restricted the patient's movement using mechanical restraints, without causing undue pain or harm to the patient.

Performance Steps

1. Obtain the necessary equipment.
   a. Complete set of leather restraints.
      (1) Two leather wrist cuffs.
      (2) Two leather ankle cuffs.
      (3) Two leather belts, one long and one short.
      (4) One restraint key.
   b. Two additional leather belts if the patient is to be restrained to a bed.

2. Apply 2-point restraints.
   a. Place wrist cuffs around the patient's wrists.
      (1) The cuffs must be tight enough to hold the patient securely without interfering with blood circulation.
      (2) The cuffs should be positioned on the patient's wrists so the metal loop is on the inner side of the wrist. (See Figure 3-3.)

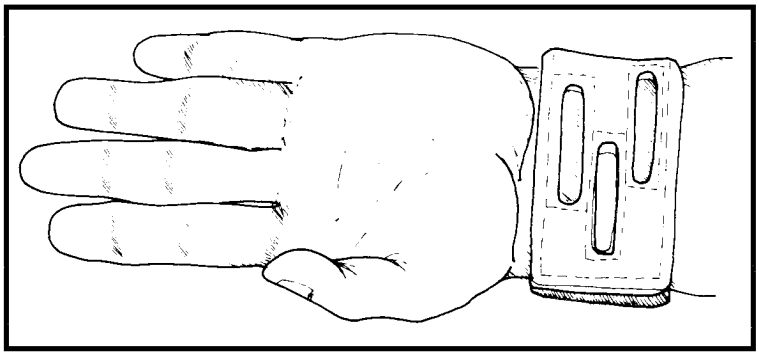

Figure 3-3

   b. Secure the wrist cuffs by passing the long leather belt through the wrist cuff loop, around the patient's stomach, and through the other wrist cuff loop.
   c. Adjust the belt for the desired movement, and then lock the buckle in place at the rear of the patient.
   d. Place ankle cuffs around the patient's ankles.
      (1) The cuffs should be tight enough to hold the patient securely without interfering with circulation.
      (2) The metal loops on the cuffs should be positioned to the inside of the patient's ankles.

Performance Steps

e. Secure the ankle cuffs by passing the short leather belt through the ankle cuff loops.
f. Adjust the belt for the desired movement.
g. Lock the buckle in place.

3. Apply 4-point restraints.

NOTE: This is done when the patient is to be restrained to a bed. Four belts are needed.

a. Position the patient on the bed.

NOTE: The patient is restrained to the bed lying on his or her stomach if he or she is combative, since this allows for less movement and decreases the leverage the patient can exert. The patient is also positioned on the stomach if there is a risk of aspiration. However, if these are not an issue, the patient may be more comfortable and feel more secure if positioned lying on his or her back.

b. Explain to the patient that he or she will be restrained to the bed.
c. The team leader will direct the release of one limb at a time while maintaining control of the other limbs.
d. Secure each wrist cuff by passing a leather belt through each wrist cuff loop and around the bed frame.

NOTE: Ensure the belts are anchored to a secure part of the bed that will not easily break or move.

e. Adjust the belts for desired movement.
f. Lock the buckles.
g. Secure each ankle cuff by passing a leather belt through each ankle cuff loop and around the bed frame.
h. Adjust the belts for desired movement.
i. Lock the buckles in place.

4. Perform follow-up care for the restrained patient.
   a. Explain the reason for the restraints being applied.
   b. Check the patient for injuries.
   c. Observe the patient closely.

5. Record and report the patient's conversation and behavior and the staff interventions.
   a. Report unusual behavior or abnormalities to the supervisor immediately.

NOTE: This will include any abnormalities you observe when performing follow-up care.

b. Document the patient's behavior that resulted in placement into restraints.
c. Document the patient's behavior and response after placement into restraints.
d. Document the staff interventions prior to and after applying restraints to the patient.

NOTE: Frequency of documentation and where documentation is done will be IAW local policy.

Performance Measures	**GO**	**NO GO**
1. Obtained the necessary equipment.	____	____
2. Applied 2-point restraints as applicable.	____	____
3. Applied 4-point restraints as applicable.	____	____
4. Performed follow-up care for the restrained patient.	____	____
5. Recorded and reported the patient's behavior and conversation and the staff 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 None

CONDUCT CRISIS INTERVENTION

081-832-0029

Conditions: You have a crisis situation where a patient is besieged by an unexpected situation for which his or her learned coping skills are inadequate. The problem may be a temporary set back or a life changing event, but it is overwhelming for the patient.

Standards: Performed crisis intervention within the stated guidelines and objectives.

Performance Steps

1. Establish a helping relationship.
    a. It is crucial that the counselor develop a clear understanding of the event that precipitated the crisis and the meaning of that event to the client.
    b. The counselor needs to use basic relationship-building skills including active listening and the core conditions of empathy, positive regard, and geniuses which form the bedrock on which crisis intervention is built.
    c. The counselor should also maintain calm confidence and hopeful expectation which is reassuring to the client in that the counselor does not appear overwhelmed by the client's problem.
    d. If the client is very emotional and out of control it is helpful for the counselor to settle down the client by making a direct statement to bolster hope in the client.

2. Assure safety.
    a. Ask questions to determine if the client is a danger to himself or others.
        (1) How and when will the person take action?
        (2) Does the client have a plan?
        (3) Is it a relatively lethal method?
        (4) Does the individual have the means available?
        (5) Is the plan specific?
        (6) Does the person have a time, place, and the means?
        (7) Has the person been spending time alone brooding over the problem?
        (8) Inquire about the person's social support network.
    b. In instances of family violence, specific questions need to be asked about whether the client is personally in danger, whether children are in danger, whether the attacker is returning to the home or present in the home, whether police or medical evaluation are needed, and whether the client wants to leave and can safely do so.
    c. Whenever the safety of the client or others is in question, seek consultation with a supervisor or colleague.
    d. Regardless of the nature of the destabilizing event, the client may be experiencing symptoms of stress that are so severe that they disrupt normal patterns of eating, sleeping, and working. In such circumstances, an assessment for appropriate medication for anxiety, depression, or psychotic symptoms must be done.

3. Conduct an assessment.
    a. In the assessment process the counselor secures information about the event that precipitated the crisis, what the event means to the client, the client's support system, and his or her functioning prior to the crisis.

Performance Steps

b. This information will help the counselor decide whether the consequences of the event might be moderated or reversed, whether the client's own coping skills can be mobilized to meet the challenge, who else might help, and how and what the counselor might need to do.
c. The counselor asks specifically, "What are your (the client's) reasons for seeking help today?" The important aspect of this is to find out what the reasons are today; what was the "last straw" that overwhelmed the client's coping abilities.
d. The precipitating event usually has occurred in the last two weeks and often within the last 24 hours, but it may also extend back as far as a few months or to an anniversary reaction to a major loss.
e. In the initial session the counselor must have the client focus on the precipitating event and not on other chronic problems that preceded the crisis. The purpose of crisis intervention counseling is to restore the client to a prior level of functioning and involvement with other pre-existing problems will only complicate and delay planning of an intervention.
f. Whiled focusing on the problem, it is also important to encourage the client to expand on its personal impact. Ask the client what feelings he or she is experiencing. Has there been an impact on daily routines, sleep pattern, physical functioning, or relationship with others? Has the precipitating event threatened the client's life goals?
g. Though questioning is a necessary part of the assessment process in crisis intervention, the core of listening skills of empathy, genuineness, and acceptance are also essential so that the counselor gains access to the client's world of inner meaning.
h. As the counselor comes to understand the meaning of an event to the client, it is necessary to listen for and note cognitive distortions (overgeneralizations, catastrophizing), misconceptions, and irrational belief statements. Don't make a premature direct confrontation of the distortion so as not to impede progress, but gentle attempts at cognitive restructuring may be tried.

NOTE: Example. A young man who has been dropped by his girlfriend may hold the views that he can't go on without her, he is not a desirable person, and therefore is doomed to spend his unhappy life alone unless he gets her back. The counselor might respond, "Right now, you are consumed with thinking about her."

i. During the assessment process the counselor also observes the client's physical appearance, behavior, mood, speech pattern, attention span, and any signs of distress to estimate the extent of the client's preoccupation with the crisis.
j. Finally, it is important to develop an understanding of the client's level of functioning before the crisis. The counselor needs to ask specific questions about the client's--
   (1) Perceptual skills (seeing problematic situations clearly, as challenging or dangerous, and as solvable).
   (2) Cognitive change skills (restructuring thoughts and altering self-defeating thinking).
   (3) Support networking skills (assessing, strengthening, and diversifying external sources of support).
   (4) Stress management and wellness skills (reducing tensions through environmental and self-management).
   (5) Problem-solving skills (increasing problem-solving competence through applying decision-making models to diverse problems).
   (6) Description and expression of feelings (accurate apprehension and articulation of anger, fear, guilt, love, depression, and joy.

Performance Steps

k. Compiling all the information in the assessment helps the counselor in working with the client to maximize the client's pre-crisis strengths and to minimize dependence on skills the client may not have.

4. Give support.
   a. Assess the client's support system for others who care about the client and provide a favorable opinion about his or her worth.
   b. When support systems are scarce the counselor needs to make it clear that there is an emergency contact the client can seek out. This can be the counselor or an emergency worker in off hours.

NOTE: After duty hours crisis intervention resources in the military setting include the emergency room on-call community mental health or social work personnel and the Chaplain. In the case of suicidal ideation, the commander is always contacted and made aware of the potential danger.

5. Assist with action plans.
   a. The action-planning step in crisis intervention is different than most forms of therapy. By definition the client's coping skills have failed and the counselor must take a direct and active role in the process.
   b. By the time the action-planning stage is reached the client is likely to have experienced some canning as a result of sharing the problem. Because of this the client's own coping abilities are likely to be more available to him or her than at the beginning of the session.
   c. The search for possible actions begin with alternative ideas or solutions the client can think of initially. It is useful to use brainstorming where all possibilities that the two parties can come up with without evaluation.
   d. Some ideas of the client may need to be added upon, but as the alternative list grows so does the awareness level of the client.
   e. As the list is put together the counselor should use open-ended questions to try to elicit, identify, and modify coping behaviors that have worked for the client before in similar situations.
   f. Once all alternatives are listed the counselor encourages the client to select one or more actions that he or she feels capable of accomplishing.
   g. The counselor now tries to come up with a short-term plan that will help the client get through the immediate crisis, as well as making the transition to long-term coping.
   h. The counselor helps the client identify specific positive actions that will help the client regain control of his or her life.
   i. The best plans at this time are ones that the client truly owns or comes up with himself or herself although the counselor may give specific directions to what are identified as tentative or possible solutions.
   j. The final part of the action plan includes cognitive mastery. This means helping the client restructure, rebuild, or replace irrational beliefs and erroneous cognitions with rational beliefs and new cognitions.
   k. Among actions that may be appropriate are referrals to other sources of material assistance and support, such as housing, food, clothing, financial assistance, legal advice, or emergency contact. The counselor serves as a resource to help the client identify resources such as the Red Cross, public assistance, legal aid, hot lines, and other community agencies. (A reference to locate these agencies is M PBX00057, Referral to Other Helping Agencies.)

Performance Steps

l. Before concluding the counseling session, it is important to judge whether the client's anxiety has decreased, whether the client can describe the plan of action on his or her own, and whether there is hope in the client's demeanor. Also re-addressing the question of who else the client knows, how the client has been feeling, and whether the client is willing for the counselor to make direct contact with that person. If that person can be reached they can provide some support and hope to reduce tension for the client and encourage him or her to take the actions that have been planned.

6. Arrange for follow-up.
   a. A follow-up appointment or telephone call should be arranged at a specific time and date to check on the client's progress toward resolution of the crisis.
   b. Even though clients in crisis are usually well motivated to escape from the discomfort that they are feeling, some plans are hard to execute and no plan comes with a guarantee of success. If the client has not begun to manage his or her problem by the time of the follow-up conversation, then recycling through any or all of the above steps is in order.

Performance Measures	**GO**	**NO GO**
1. Established a helping relationship.	____	____
2. Assured safety.	____	____
3. Conducted an assessment.	____	____
4. Gave support.	____	____
5. Assisted with action plans.	____	____
6. Arranged for follow-up.	____	____

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	**Related**
None	AGUILERA DUNNER KAPLAN & SADOCK(2) PATTERSON & WELFEL

INVOLVE PATIENTS IN THERAPEUTIC RECREATIONAL ACTIVITIES

081-832-1014

Conditions: You are requested to involve a bored and restless psychiatric patient on the ward in a therapeutic recreational activity. You will need clinical records.

Standards: Involved the patient in a therapeutic recreational activity which is related to the patient's interests and within the limitations of the patient's physical and emotional capabilities.

Performance Steps

1. Determine the patients' areas of interest.
   a. Explain the activities that are available to the patients.
   b. Encourage feedback from the patients regarding the activities they would be interested in participating in.
2. Obtain the necessary equipment for the activity, if necessary.
3. Escort the patients to the activity, if necessary. (See task 081-832-1010.)
4. Explain the instructions or rules for the activity.
5. Encourage and guide patient participation.
   a. Attempt to instill in each patient a desire to participate by demonstrating an enthusiastic attitude toward the activity.
   b. Give the patients encouragement and support during the activity.
   c. Assist patients who are having difficulty participating in the activity.
   d. Participate in the activity, only after taking into consideration whether staff coverage of the activity permits adequate supervision of all patients, to include nonparticipants.
6. Observe each patient's behavior, noting his or her--
   a. Interest and participation in the activity.
   b. General attitude toward participating in the activity.
   c. Interactions with other patients and staff.
7. Escort the patients back to the ward, if necessary. (See task 081-832-1010.)
8. Return the equipment, if applicable.
9. Record significant observations about each patient in his or her clinical record.

Performance Measures	**GO**	**NO GO**
1. Determined the patients' areas of interest.	____	____
2. Obtained the necessary equipment for the activity, if necessary.	____	____
3. Escorted the patients to the activity, if necessary.	____	____
4. Explained the instructions or rules for the activity.	____	____
5. Encouraged and guided patient participation.	____	____
6. Observed each patient's behavior.	____	____

Performance Measures	GO	NO GO
7. Escorted the patients back to the ward, if necessary.	____	____
8. Returned the equipment, if applicable.	____	____
9. Recorded significant observations about each patient in his or her clinical 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 None

CARE FOR A PATIENT RECEIVING ELECTROCONVULSIVE THERAPY

081-832-1024

Conditions: You are asked by the doctor to care for a severely depressed patient who has signed a consent form to receive electroconvulsive therapy (ECT). The doctor's order has been received. You will need blood pressure cuff, stethoscope, and the clinical record.

Standards: Cared for a patient before, during, and after ECT.

Performance Steps

1. Care for a patient before ECT.
    a. Inform and remind the patient of the need to remain NPO (nothing by mouth) after 2400 hours the night prior to treatment.
    b. Ensure the patient removes dentures, prosthetic devices, jewelry, and glasses, as applicable.
    c. Ensure the patient empties his or her bowel and bladder immediately prior to the treatment.
    d. Display a warm, supportive attitude to reduce the patient's apprehension.
        (1) Provide realistic reassurance to the patient.
        (2) Answer questions regarding the treatment, procedures, and effects.

2. Care for the patient during ECT.
    a. Escort the patient to the treatment area.
    b. Assist the patient in getting onto the stretcher in a supine position.
    c. Put the side rails up.
    d. Stay with the patient during the treatment.
    e. Take the patient's blood pressure, pulse, and respirations as directed by the physician.
    f. Notify the physician of any changes in the patient's blood pressure, pulse, and respirations.
    g. Assist with equipment, as directed.
    h. Observe the patient's limbs for seizure activity.

NOTE: Due to muscle relaxant medications given to the patient prior to the treatment, it is usually difficult to see any movement. A slight flexion of the feet or movement of the toes may be the extent of seizure activity noted.

3. Care for the patient after ECT.
    a. Speak quietly to the patient as he or she becomes alert. Explain what has happened and reduce the patient's fears by reassuring him or her that the confusion and memory loss are only temporary.
    b. Check the patient for side effects of ECT.
        (1) Nausea.
        (2) Headache.
        (3) Amnesia.
        (4) Disorientation.
    c. Orient the patient to time, place, and events.
    d. Take the patient back to his or her hospital room to recover.
    e. Offer the patient food and drink, as tolerated.
    f. Encourage the patient to--
        (1) Express his or her feelings about the treatment.
        (2) Return to normal activities as soon as possible.

Performance Steps

4. Document the care performed, the patient's response, and the staff interventions.
    a. Document the patient's response during the treatment.
    b. Document the patient's level of awareness, communication, and activity level after the treatment.
    c. Document staff interventions performed.

NOTE: Documentation is done on SF 509 or SF 510 IAW local policy.

Performance Measures	**GO**	**NO GO**
1. Cared for a patient before ECT.	____	____
2. Cared for the patient during ECT.	____	____
3. Cared for the patient after ECT.	____	____
4. Documented the care performed, the patient's response, and the staff 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 None

COFACILITATE A GROUP THERAPY SESSION

081-832-1021

Conditions: You are to cofacilitate a group therapy session, consisting of a qualified group therapist and 5 to 10 psychiatric patients seated in a circle in a quiet area. The group is an open group scheduled for 1 hour, three times a week. You will need clinical records.

Standards: Cofacilitated the group therapy session within the stated guidelines and objectives.

Performance Steps

1. Start the group at the scheduled time.
2. Ensure that new group members are introduced to the group.
3. Explain the ground rules of the group to include--
   a. The start and stop times of the group.
   b. The procedures for speaking--one person speaks at a time.
   c. Participation expectations.
   d. Confidentiality issues of the group.
4. Explain the purposes of the group therapy session.
5. Perform leadership tasks during the group session.
   a. Observe the group process.
      (1) Summarize and make verbal comments on the group process.
      (2) Assess the level of anxiety of the group members.
         (a) Encourage examination of the cause(s) of the anxiety and the group members' response to it.
         (b) Encourage group members to deal with the anxiety in a constructive manner.
   b. Establish direction for the group.
      (1) Clarify the goals of the group.
      (2) Redirect the group members toward the purpose of the group, as necessary.
   c. Act as a role model for appropriate behavior.
      (1) Listen attentively.
      (2) Respond honestly.
      (3) Give support and encouragement to other group members.
      (4) Confront group members who demonstrate unhealthy behavior such as monopolizing the group, putting oneself down, or manipulation of other group members.
   d. Direct the group members towards closure of the group session.

NOTE: This is done 5 to 10 minutes prior to the scheduled time for the group to end.

      (1) If a group issue is not able to be completed, reassure the group members that it will be continued at the next session, if appropriate.
      (2) Summarize the content of the group session.
      (3) End the group session on time.

NOTE: If a group member appears distraught or upset at the end of the group session, one of the group facilitators should remain with the patient to ensure his or her safety.

6. Document the group therapy session in the clinical records.
   a. Document each individual's interaction in the group session.

Performance Steps

b. Document incidents or behavior demonstrated by each group member during the group session.

Performance Measures	**GO**	**NO GO**
1. Started the group at the scheduled time.	____	____
2. Ensured that new group members are introduced to the group.	____	____
3. Explained the ground rules of the group.	____	____
4. Explained the purposes of the group therapy session.	____	____
5. Performed leadership tasks during the group session.	____	____
6. Documented the group therapy session in the clinical records.	____	____

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 None

Subject Area 7: Patient Processing

CONDUCT REFERRAL SERVICE FOR INDIVIDUALS
081-832-0007

Conditions: You have determined the need to refer a client based on the nature or severity of the problem. You will need SF 600, telephone directory, and access to a telephone.

Standards: Referred the client to the appropriate agency. Documented the referral procedure accurately.

Performance Steps

1. Determine the urgency for the referral.

NOTE: If it is suspected that the client is psychotic, suicidal, homicidal, or if the situation is life-threatening, seek immediate supervision. (See task 081-832-0013.)

2. Determine the specific type of services needed.
   a. Financial planning or assistance.
   b. Marital or family counseling.
   c. Spiritual or religious assistance.
   d. Educational assistance.
   e. Substance abuse counseling.
   f. Medical services.
   g. Legal services.

3. Identify the agency that is best able to provide the service required.
   a. The Army Continuing Education Program, Army Correspondence Course Program, and the Army Education Centers provide assistance with education and career development.
   b. The Army Community Service provides financial counseling, debt liquidation, consumer education, welcome services which include post information and loaning household items, relocation assistance, exceptional family member assistance, sole parent assistance, family advocacy, foster care, child care, referral, follow-up assistance, and emergency food locker.
   c. The Army Emergency Relief provides emergency loans.
   d. The Alcohol and Drug Abuse Prevention and Control Program provides education, prevention, identification, and treatment services.
   e. The Army Medical Department, the Uniformed Services Health Benefits Program, and the Civilian Health and Medical Program for the Uniformed Services provide for medical care.
   f. The American Red Cross--
      (1) Collects information to verify emergency leaves and reports on health, welfare, and whereabouts of family members.
      (2) Provides supplementary information for deferments, compassionate reassignments, discharges, and financial assistance.
   g. The Community Mental Health Activity provides consultation, outpatient counseling services, diagnosis, and referral.

Performance Steps

h. The Social Work Service in an Army hospital provides consultation, discharge planning, and counseling services to inpatients and outpatients, marital and family counseling, crisis intervention, treatment services for family advocacy cases, counseling for unplanned pregnancies and single parents, and referral.
i. The Army finance officer will assist in solving pay problems.
j. The chaplain provides assistance with spiritual and religious needs.
k. The Staff Judge Advocate and the Army Legal Assistance Program provide legal assistance.

NOTE: The Inspector General handles complaints or grievances. Always consider whether problems may be solved more quickly and simply by referring them to the soldier's immediate commanding officer. Soldiers should also be referred to their commander when they have questions or problems of an administrative nature.

NOTE: If possible, clients should be referred to a military agency rather than a nonmilitary agency.

4. Explain the recommendation for referral to the client.
   a. Agency being referred to.
   b. Purpose of the referral.
   c. Services available from the agency.
5. Ask the client to sign a privacy statement.
6. Contact the selected agency.
   a. Provide the agency with information about the client on a "need to know" basis, releasing only the information necessary for the agency to provide the services requested.
   b. Identify the point of contact for the client.
   c. Identify any special procedures that the client may have to follow to receive service. For example, scheduling appointments, bringing medical records, and completing any special forms.
7. Ensure that the client understands the referral instructions.
   a. Ask the client to repeat the instructions.
   b. If the client has any difficulties, write down the instructions.
   c. Prior to ending the session, encourage the client to follow the instructions.
8. Document the referral recommendation and action taken in the client's case file.
9. Follow up.
   a. Contact the referral agency.
      (1) Ask whether the client's appointment was kept.
      (2) Ask what disposition was made.
   b. Contact the client.
      (1) Ask whether his or her needs were met by the services rendered.
      (2) Ask if other needs or situations exist with which you may be of assistance.
      (3) If it is your impression that other needs exist which the client is not aware of or is not addressing, discuss the needs openly.
   c. When all needs have been met, close the client's case file.

Performance Measures	GO	NO GO
1. Determined the urgency for the referral.	____	____
2. Determined the type of service needed.	____	____
3. Identified the agency for referral.	____	____
4. Explained the recommendations for the referral to the client.	____	____
5. Asked the client to sign a privacy statement.	____	____
6. Contacted the selected agency.	____	____
7. Ensured that the client understands the referral instructions.	____	____
8. Documented the referral recommendation and action taken.	____	____
9. Followed up.	____	____

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	Related
None	AR 20-1 AR 27-1 AR 27-3 AR 40-4 AR 600-85 AR 608-1 AR 608-18 AR 621-5 AR 930-4 AR 930-5 DA PAM 350-59 DOD 6010.8-R

PERFORM ADMISSION PROCEDURES ON A PSYCHIATRIC WARD

081-832-1003

Conditions: You are to admit a patient to the psychiatric ward you are assigned to. You will need hospital and ward regulations and policies, clinical record, patient identification band, SF 509, SF 510, SF 511, and patient identification plate, if available.

Standards: Conducted admission procedures, oriented the patient to the ward, and prepared the clinical record in the Standard Form 509, 510, and 511 format.

Performance Steps

1. Process the patient for admission to the ward.
    a. Verify the patient's identity and greet the patient by--
        (1) Rank and last name, if military.
        (2) Title and last name, if civilian.
    b. Introduce yourself by rank and name.
    c. Explain the role and function of the mental health specialist on the ward.
    d. Explain each step of the admission procedure to the patient prior to doing it.
    e. Search the patient for weapons, hazardous items, medications, contraband, or other unauthorized items.
    f. Have the patient change into hospital pajamas.
    g. Place a patient identification band on the patient's wrist.

NOTE: If the patient has any known allergies, an allergy identification band will also be placed on the patient's wrist.

    h. Take the patient's vital signs.
        (1) Chart the patient's vital signs on SF 511.
        (2) Notify your supervisor if vital signs are abnormal.
    i. Conduct an admission interview with the patient. (See task 081-832-1023.)
    j. Secure the patient's funds and valuables. (See task 081-832-1001.)
    k. Secure the patient's personal effects. (See task 081-832-1002.)

2. Orient the patient.
    a. Allow the patient to read the ward and hospital policies and rules, or read them to him or her if the patient is unable.

NOTE: If the patient is incoherent or confused, review the policies and rules with the patient at a later time.

        (1) Explain the policies and rules to the patient, if he or she has any questions.
        (2) Explain fire and safety procedures to be followed.
        (3) Have the patient sign to acknowledge that he or she has read and understands the ward policies and rules.
    b. Explain the schedule and ward activities that occur on a regular basis, to include--
        (1) Time and location of therapeutic activities.
            (a) Group therapy meetings.
            (b) Occupational therapy.
            (c) Recreation therapy.
            (d) Community meetings.
        (2) Visiting hours.
    c. Introduce the patient to other staff members and patients.
    d. Walk the patient through the areas of the ward that he or she needs to be familiar with, and explain any particular policies regarding those areas.

Performance Steps

3. Prepare and complete the clinical record.
    a. Ensure all forms in the clinical record are stamped with the patient identification plate, if available.

NOTE: If the patient identification plate is not available, write in the required patient information.

    b. Record the admission interview.

NOTE: This is generally done on SF 509 or SF 510.

    c. Assemble the clinical record by arranging all forms in numerical order as prescribed by the hospital commander.
    d. Ensure all routine or doctor ordered laboratory forms are stamped with the patient identification plate, if available.

4. Inform your supervisor that the admission is complete.

5. Verify that the patient's name is added to the--
    a. Ward census roster.
    b. Patient sign in and out board.
    c. Admission and Disposition Report.
    d. Nursing Unit 24-hour Report.

Performance Measures	**GO**	**NO GO**
1. Processed the patient for admission to the ward.	____	____
2. Oriented the patient.	____	____
3. Prepared and completed the clinical record.	____	____
4. Verified that the patient's name is added to the correct 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	**Related**
None	AR 40-66

ENSURE A PATIENT'S FUNDS AND VALUABLES ARE SECURED

081-832-1001

Conditions: You are securing funds and valuables of a patient being admitted to a psychiatric ward. The patient trust fund (PTF) representative is available. You will need DA Form 3696, clinical record, and patient identification plate, if available.

Standards: Ensured that the patient's funds and valuables are secured adhering to local ward policy.

Performance Steps

1. Contact the PTF custodian.
   a. If the patient is allowed to leave the ward, escort the patient to the PTF. (See task 081-832-1010.)
   b. If the patient is restricted to the ward, summon the PTF custodian to the ward.

NOTE: After duty hours call the designated PTF representative to come to the ward.

2. Stamp DA Form 3696, in duplicate, with the patient identification plate, if available.

NOTE: If DA Form 3696 is completed by a designated representative, it is done in triplicate. If the patient identification plate is not available, write in the required patient information.

3. Ensure the patient's funds and valuables are inventoried.
   a. Ensure a description of each item is entered on DA Form 3696.
   b. Witness the transaction, if the patient is mentally capable and willing to assist the PTF custodian with the inventory and sign DA Form 3696.
   c. Assist the PTF custodian with the inventory and sign all copies of DA Form 3696, if the patient is unable or unwilling to sign it.

NOTE: Enter a brief statement as to why the patient's signature was not obtained on the PTF copy of DA Form 3696.

4. Secure the patient's copy of DA Form 3696.
   a. Ensure the patient receives a copy of DA Form 3696, if the patient is capable of keeping it secure.
   b. Place the patient's copy of DA Form 3696 in the clinical record, if the patient is not capable of securing it.

NOTE: Personal weapons, to include pocket knives (with blades beyond the length permitted by law or regulations), and any other items considered a menace to safety or health, will be turned over to the Commander, Medical Holding Unit, or his or her designated representative, and a receipt will be obtained. Any government property (government owned or organizational equipment) should be returned to the patient's unit, if possible.

Performance Measures	GO	NO GO
1. Made contact with the PTF custodian.	____	____
2. Stamped DA Form 3696, in duplicate, with the patient identification plate, if available.	____	____
3. Ensured the patient's funds and valuables are inventoried.	____	____
4. Secured the patient's copy of DA Form 3696.	____	____

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	**Related**
AR 40-2	None

ENSURE A PATIENT'S PERSONAL EFFECTS ARE SECURED

081-832-1002

Conditions: You must ensure personal effects of a patient being admitted to the psychiatric ward are secured. The patient clothing room clerk or designated representative is available. You will need DA Form 4160, DD Form 599, clinical record, and patient identification plate, if available.

Standards: Ensured that the patient's personal effects are secured with the proper documentation..

Performance Steps

1. Make contact with the patient clothing room clerk.

2. Stamp DA Form 4160, in duplicate, with the patient identification plate, if available.

NOTE: If the patient identification plate is not available, write in the required patient information.

3. Ensure the patient's personal effects, other than funds and valuables, are inventoried.

NOTE: Funds and valuables will be deposited in the patient trust fund. (See task 081-832-1001.)

   a. Ensure all items are listed on DA Form 4160 and placed in a bag tagged for identification using DD Form 599.
   b. Witness the transaction, if the patient is mentally capable and willing to assist the clothing room clerk with the inventory and sign DA Form 4160.
   c. Assist the clothing room clerk with the inventory and sign all copies of DA Form 4160, if the patient is unable or unwilling to sign it.

4. Secure the patient's copy of DA Form 4160.
   a. Ensure the patient receives a copy of DA Form 4160, if the patient is capable of keeping it secure.
   b. Place the patient's copy of DA Form 4160 in the patient's clinical record, if the patient is not capable of securing it.

NOTE: The patient clothing room clerk retains the original copy of DA Form 4160.

Performance Measures	**GO**	**NO GO**
1. Made contact with the patient clothing room clerk.	____	____
2. Stamped DA Form 4160, in duplicate, with the patient identification plate, if available.	____	____
3. Ensured the patient's personal effects, other than funds and valuables, are inventoried.	____	____
4. Secured the patient's copy of DA Form 4160.	____	____

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	Related
None	AR 40-2

PREPARE A CLASS 1A OR 1B PATIENT FOR AEROMEDICAL EVACUATION
081-832-1004

Conditions: A psychiatric patient classified as 1A or 1B is to be transferred to another medical facility by aeromedical evacuation. You will need DD Form 600, DD Form 602, SF 510, a folding canvas litter, litter mattress, one pillow, two blankets, one sheet, one pillowcase, two litter straps, and a leather restraint set.

Standards: Prepared a class 1A or 1B patient for aeromedical evacuation.

Performance Steps

1. Ensure that the patient has been briefed (either verbally or in writing) on the following:
    a. Destination hospital.
    b. Approximate date and time of departure.
    c. Approximate routing (when known).
    d. Baggage limitation.

NOTE: The standard baggage allowance is 66 pounds per patient.

    e. The necessity for RON (remain overnight), if applicable.

NOTE: The amount of information given to the patient is dependent upon the patient's ability to comprehend the information.

2. Prepare the litter.
    a. Obtain a folding canvas litter.
    b. Place a litter mattress on the litter.
    c. Cover the litter mattress with a sheet.
    d. Place a pillow, with pillowcase, at one end of the litter.
    e. Have one sheet and two blankets available to cover the patient.

NOTE: The comfort and safety of the patient, as well as climatic conditions, should be considered.

3. Prepare the patient.
    a. Ensure the patient changes into clean hospital pajamas and slippers.
    b. Ensure the patient has a legible patient identification band on his or her wrist.
    c. Identify the aeromedical classification assigned to the patient.

NOTE: The classification is determined by a medical officer.

        (1) 1A--severe psychiatric litter patient requiring restraints, sedation, and close supervision at all times.
        (2) 1B--psychiatric litter patient of intermediate severity, requiring sedation. Restraints must be available for use.

NOTE: This is done in case the patient reacts badly to air travel or begins to endanger himself or herself, others, or the safety of the aircraft.

    d. Check the patient's personal effects to ensure the patient does not have items which may be used to harm himself or herself, or others.

NOTE: Items such as matches, neck chains, lighters, or sharp items should be removed from the patient's possession.

NOTE: A physician may give written permission for a patient to wear eyeglasses, rings, and other articles considered necessary for the health and welfare of the patient.

    e. Ensure the patient's valuables are forwarded by registered mail to the destination hospital.

Performance Steps

f. Tag the patient's baggage with DD Form 600. Send it ahead or deliver it with the patient to the departure area.
g. Ensure the patient receives the prescribed medication.
(1) Read the preflight medication listed on the front of DD Form 602 in the block "Treatment Recommended."
(2) Compare that list to the medication listed on the back of the form in the block "Treatment and Progress Report" to ensure the prescribed medication has been administered.
(3) Ask qualified medical personnel to administer the medication, if it has not been administered.
(4) Ensure a 3-day supply of medication is provided to the flight nurse for the patient on flights within CONUS.

NOTE: A minimum of a 5-day supply of medications is provided for patients traveling from overseas areas to CONUS.

4. Prepare the patient's medical records for transfer.
a. Ensure all available medical records are prepared to accompany the patient, to include the following:
(1) Clinical record.
(2) Health record.
(3) X-rays.
(4) U.S. Field Medical Card.
b. Place the patient's medical records, along with DD Form 602, in an envelope and write the following patient information on the outside of the envelope:
(1) Name.
(2) Rank.
(3) Social security number.
(4) Organization.
(5) Date of departure.
(6) Destination.

5. Place the patient on the litter.
a. Class 1A patient.
(1) If the patient is cooperative, position the patient face-up on the litter and apply mechanical restraints. (See task 081-832-1013.)
(2) If the patient is uncooperative, manually restrain the patient, apply mechanical restraints, and place the patient face-up on the litter. (See tasks 081-832-1012 and 081-832-1013.)

CAUTION: Do not restrain the patient to the litter.

b. Class 1B patient.
(1) Position the patient face-up on the litter.
(2) Place a set of restraints on the litter.

6. Ensure patient comfort and safety.
a. Place a sheet and blanket, if required by climatic conditions, over the patient.

NOTE: If climatic conditions warrant covering the patient, the mechanical restraints must be placed on the outside of the covers.

b. Apply litter straps across the patient's chest and thighs.
c. Remain with the patient until properly relieved of responsibility for the patient.

7. Relinquish responsibility for the patient to the flight nurse.

Performance Steps

a. Deliver the patient to the designated departure area.
b. Provide the flight nurse with the medications and medical records.
c. Report to the flight nurse on the patient's current condition.

Performance Measures	**GO**	**NO GO**
1. Ensured that the patient has been briefed verbally or in writing.	____	____
2. Prepared the litter.	____	____
3. Prepared the patient.	____	____
4. Prepared the patient's medical records for transfer.	____	____
5. Placed the patient on the litter.	____	____
6. Ensured patient comfort and safety.	____	____
7. Relinquished responsibility for the patient to the flight nurse.	____	____

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	**Related**
None	AR 40-535

PREPARE A CLASS 1C PATIENT FOR AEROMEDICAL EVACUATION

081-832-1005

Conditions: You are about to prepare a class 1C psychiatric patient for aeromedical evacuation. The patient has an appropriate service uniform. You will need DD Form 600 and DD Form 602.

Standards: Prepared a class 1C psychiatric patient for aeromedical evacuation fulfilling aeromedical guidelines.

Performance Steps

1. Ensure that the patient has been briefed (either verbally or in writing) on the following:
   a. Destination hospital.
   b. Approximate date and time of departure.
   c. Approximate routing (when known).
   d. Baggage limitation.

NOTE: The standard baggage allowance is 66 pounds per patient.

   e. The necessity for RON (remain overnight), if applicable.

2. Ensure the patient receives the prescribed medication, if applicable.
   a. Read the medication listed on the front of DD Form 602 in the block "Treatment Recommended."
   b. Compare that list to the medication listed on the back of the form in the block "Treatment and Progress Report" to ensure the prescribed medication has been administered.
   c. Ask qualified medical personnel to administer the preflight medication, if necessary.
   d. Ensure a 3-day supply of patient medications is provided to the flight nurse for the patient on flights within CONUS.

NOTE: A minimum of a 5-day supply is prepared if the patient is traveling from overseas to CONUS.

3. Check to see that the patient has a legible patient identification band on his or her wrist.
4. Check the patient's baggage for hazardous items and contraband.
5. Ensure the patient's baggage is tagged with DD Form 600 and accompanies the patient.
6. Encourage the patient to send funds and valuables by registered mail.
7. Have the patient change into his or her service uniform.
8. Prepare the patient's medical records for transfer.
   a. Ensure all available medical records are prepared to accompany the patient, to include the following:
      (1) Clinical record.
      (2) Health record.
      (3) X-rays.
      (4) U.S. Field Medical Card.
   b. Place the patient's medical records, along with DD Form 602, in an envelope and write the following information on the outside of the envelope:
      (1) Name.
      (2) Rank.

Performance Steps

(3) SSN.
(4) Organization.
(5) Date of departure.
(6) Destination.

9. Escort the patient to the aeromedical evacuation departure area.
10. Provide the aeromedical evacuation clerk with the patient's medical records and medications.

NOTE: Local policy may require that the patient be escorted to the flight and that the medical records and medications be turned over to the flight nurse.

Performance Measures	**GO**	**NO GO**
1. Ensured that the patient has been briefed.	____	____
2. Ensured the patient receives the prescribed medication, if applicable.	____	____
3. Checked to see that the patient has a legible patient identification band on his or her wrist.	____	____
4. Checked the patient's baggage for hazardous items and contraband.	____	____
5. Ensured the patient's baggage is tagged with DD Form 600 and accompanies the patient.	____	____
6. Encouraged the patient to send funds and valuables by registered mail.	____	____
7. Had the patient change into his or her service uniform.	____	____
8. Prepared the patient's medical records for transfer.	____	____
9. Escorted the patient to the aeromedical evacuation departure area.	____	____
10. Provided the aeromedical evacuation clerk with the patient's medical records and medications.	____	____

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	**Related**
AR 40-535	None

CONDUCT HOSPITAL DISCHARGE PLANNING FOR A MENTAL HEALTH PATIENT/CLIENT

081-832-0054

Conditions: You are asked to conduct the discharge of a patient from the hospital by developing a discharge plan.

Standards: Conducted a discharge plan for a patient assigned to the hospital using local SOP guidelines.

Performance Steps

1. Apply the correct phases of care in discharge planning.
    a. Acute phase.
        (1) Patients need for care cannot be met without additional resources.
        (2) Requires medical and nursing intervention - inpatient admission.
    b. Transitional phase.
        (1) Occurs as acute care is still needed; however, its urgency is reduced.
        (2) This is the time to initiate the discharge plan.
        (3) Provide patient and family education.
        (4) Discuss continuing care options.
        (5) Coordinate services and resources needed to support the discharge plan.
        (6) The physical transfer of the patient (discharge) to a new care setting marks the final part of the transitional phase.
2. Follow the process of discharge planning.
    a. Discharge planning begins the moment a patient is admitted into the facility.
    b. The plan considers all aspects of the patient's needs from time of admission to discharge.
    c. The plan includes participation by the patient and/or legal guardian, as well as family members.
    d. The plan ensures that the needed services are available at the appropriate level of care and reflects efficient utilization of hospital, long-term care facility, and community resources.
3. Identify the discharge planning team.
    a. Physician.
    b. Social worker.
    c. Physical therapist.
    d. Occupational therapist.
    e. Speech therapist.
    f. The clergy "Chaplain"
4. Select the appropriate community resources.
    a. Investigate available resources and ask relevant questions to assess the availability of other services.
        (1) Medical and health care services.
        (2) Support services.
            (a) Financial.
            (b) Legal.
        (3) Community groups.
        (4) Recreation and education.

Performance Steps

b. Locate the local government or community centers published directories of resources, to include supportive group counseling available in the area.

5. Evaluate the discharge plan.
   a. Ask the following questions:
      (1) Were patient needs and risks identified early in the patient's acute care?
      (2) Were patient learning goals identified and teaching provided documented?
      (3) Were referrals complete and made in a timely fashion?
      (4) Was the patient able to verbalize continuing care goals and the steps to take to reach them?
      (5) Was the patient satisfied with his role in the discharge planning process and the decisions made as part of it?
      (6) Did the patient comply with medical advice and follow through on continuing care plans?
      (7) Is responsibility for initiating discharge planning and accountability for the completed process clear in the policies of the institution?
      (8) Does the reporting system used support discharge planning need identification and patient teaching documentation?
      (9) Are in-service education programs in place that give staff member discharge planning knowledge and skills?

Performance Measures	**GO**	**NO GO**
1. Applied the correct phase of patient discharge planning.	____	____
2. Performed all the steps in the process of discharge planning.	____	____
3. Identified the discharge planning team.	____	____
4. Selected the appropriate community resource(s).	____	____
5. Evaluated the discharge plan.	____	____

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 None

PERFORM DISCHARGE PROCEDURES ON A PSYCHIATRIC WARD

081-832-1027

Conditions: You are to perform a discharge on a psychiatric patient that a physician has recommended for discharge. You will need clinical record, DA Form 4029, and DA Form 4700.

Standards: Performed all necessary steps to discharge a patient IAW AR 40-2 and AR 40-407.

Performance Steps

1. Prepare the patient for discharge from the hospital.
    a. Inform the patient of impending discharge.
    b. Assist the patient in packing personal effects, if necessary.

NOTE: Ensure the patient takes any other personal items not kept at bedside such as OT projects and razor.

    c. Assist the patient in clearing the hospital using DA Form 4029.
        (1) Patient trust fund.
        (2) Baggage room.
        (3) Patient administration.
        (4) Medical holding company, if applicable.
        (5) Ensure the patient receives prescriptions for any discharge medications.

2. Complete the discharge paperwork on the patient.
    a. Write a discharge note which includes:
        (1) Date and time of discharge.
        (2) Manner of discharge.
            (a) Discharge destination.
            (b) How and with whom the patient leaves the hospital.
        (3) Status of the patient at the time of discharge.
            (a) Current problems.
            (b) Resolved issues and problems.
        (4) Patient teaching performed regarding--
            (a) Discharge follow-up.
            (b) Medications.
            (c) Dietary or activity restrictions.
        (5) The patient's comprehension of the instructions given.

NOTE: The discharge note is generally recorded on the SF 509 or SF 510 or lAW local policy.

    b. Assist in the completion of the patient discharge plan.

NOTE: This may be done with assistance from the nurse on an over printed DA Form 4700, completed in duplicate.

        (1) Document the preparation of the patient for discharge.
            (a) Instructions given to the patient.
            (b) Follow-up appointments and medication.
        (2) Write the information in a language understood by the patient.
        (3) Sign the form and have the patient sign it to acknowledge receipt of the information.
        (4) Place the original copy in the clinical record.
        (5) Give the patient the duplicate copy to take with him or her.

3. Complete the patient's discharge.
    a. Assist the patient in obtaining transportation, if necessary.

Performance Steps

b. Allow the patient time to say good-byes to the staff and other patients.
c. Verify the patient's name is placed on the Nursing Unit 24-Hour Report.
d. Delete the patient's name from the Admission and Disposition Report, the ward census roster, and the patient sign in and out board.
e. Notify food service of the patient's discharge.

Performance Measures	**GO**	**NO GO**
1. Prepared the patient for discharge from the hospital.	____	____
2. Completed the discharge paperwork on the patient.	____	____
3. Completed the patient's discharge.	____	____

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	**Related**
None	AR 40-2
	AR 40-407

Subject Area 8: Supporting Tasks

FACILITATE WARD COMMUNITY MEETINGS
081-832-0077

Conditions: You are required to facilitate a ward community meeting.

Standards: Facilitated a ward community meeting with appropriate interactions.

Performance Steps

1. Start the meeting at the scheduled time.
2. Define the purpose of the meeting.
3. Conduct introductions of staff and patients.
4. Review the activities of the day/week based upon ward schedule.
5. Investigate issues of communal living.
6. Perform leadership tasks during the meeting.
   a. Review rules of ward.
   b. Clarify boundaries for patients.
   c. Provide structure.
   d. Promote appropriate interactions.
   e. Keep patients focused on purpose of meeting.
7. Act as a model for appropriate behavior.
   a. Support patients' initiative, clarify the situation, and model acceptance of question asking.
   b. Demonstrate functional communication.
8. Share relevant information not available to patients and offer solutions as necessary.
9. Direct members toward closure of meeting.
10. Document meeting attendance and relevant issues in clinical chart.

Performance Measures	**GO**	**NO GO**
1. Started the meeting at the scheduled time.	____	____
2. Defined the purpose of the meeting.	____	____
3. Conducted introductions of staff and patients.	____	____
4. Reviewed the activities of the day/week based upon ward schedule.	____	____
5. Investigated issues of communal living.	____	____
6. Performed leadership tasks during the meeting.	____	____
7. Acted as a model for appropriate behavior	____	____

Performance Measures	GO	NO GO
8. Shared relevant information and offered solutions as necessary.	____	____
9. Directed members toward closure of meeting.	____	____
10. Documented meeting attendance and relevant issues in clinical chart.	____	____

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 None

ASSIST AEROMEDICAL PSYCHOLOGISTS IN PROVIDING MENTAL HEALTH SERVICES TO ARMY AIRCREW MEMBERS

081-832-0056

Conditions: You are asked to assist aeromedical psychologists in providing mental health services to Army aircrew members.

Standards: Assisted aeromedical psychologists in providing mental health services to Army aircrew members.

Performance Steps

1. Assist in the services provided by aeromedical psychologists.
    a. Assessment and treatment.
        (1) Perform psychological evaluations of aircrew members referred by command and/or flight surgeon.
        (2) Evaluation of, monitoring of, and protection from psychological stresses of the flight environment.
        (3) Provide psychotherapy to aircrew members.
    b. Consultation.
        (1) Provide consultation to unit commanders, safety officers, and flight surgeons on human factors affecting readiness, safety, performance, and retention of aviation personnel.
        (2) Conduct critical incident stress debriefings (CISD) and provide psychological support following aviation mishaps and other traumatic events.
        (3) Conduct surveys of unit stressors, morale, and cohesion and provide feedback to command.
    c. Psychoeducation. Provide consultation to unit commanders, safety officers, and flight surgeons on human factors affecting readiness, safety, performance, and retention of aviation personnel.
    d. Accident investigation.
        (1) Serve as a member of a US Army Safety Center Aviation Mishap Investigation Board.
        (2) Conduct human factors analysis segment of the mishap investigation in conjunction with the flight surgeon.
        (3) Conduct enhanced recall procedure.

NOTE: Only APTC graduates with civilian training in clinical hypnosis and forensic hypnosis may hold this privilege.

2. Determine psychiatric standards and grounding conditions for aircrew members.
    a. Army psychiatric standards for aviation personnel can be found in AR 40-501, Chapter 4. Essentially, any emotional reaction to stress that interferes with the "efficient and safe performance of an individual's flying duties" is reason for temporary medical suspension (grounding).
    b. Army aeromedical waiver guidelines for psychiatry are published in the U.S. Army Aeromedical Center's Aeromedical Policy Letters (APLs). These can be found on the web at http://usasam.amedd.army.mil/_aama/policyLetter.htm.
    c. Navy aeromedical psychiatry standards are very similar to Army standards. The principle Navy resource is the Navy Operational Medicine Institute website at http://www.nomi.med.navy.mil. The Navy's Aeromedical Reference and Waiver Guide and the U.S. Naval Flight Surgeon's Manual are additional references.

Performance Steps

3. Determine "Unsatisfactory Aeromedical Adaptability."
    a. Sociobehavioral factors that are considered unsuitable for or not adaptable to Army aeronautics.
    b. The unsatisfactory AA may be a manifestation of underlying psychiatric disease or may be accompanied by nonmedical disqualifying factors.
    c. The unsatisfactory AA is not a diagnosis, but is a determination by the flight surgeon and aviation commander or supervisor of suitability or adaptability. An unsatisfactory AA may be revealed by interviews, records review, command referral, security investigations, or other documented sources.
    d. An unsatisfactory AA may exist if any of the conditions listed below are present.
        (1) Deliberate or willful concealment of significant and/or disqualifying medical conditions on medical history forms or during FS interview.
        (2) An attitude toward flying that is clearly less than optimal. For example, the person appears to be motivated overwhelmingly by the prestige, pay, or other secondary gains rather than the skill, achievement, and professionalism of flying itself.
        (3) Clearly noticeable personality traits such as immaturity, self-isolation, difficulty with authority, poor interpersonal relationships, impaired impulse control, or other traits which may interfere with group functioning as a team member in an operational aviation setting, even though there are insufficient criteria for a personality disorder diagnosis.
        (4) Review of the history or medical records reveals multiple or recurring physical complaints that strongly suggest either a somatization disorder or a propensity for physical symptoms during times of psychological stress.
        (5) A history of arrests, illicit drug use, or social "acting out" which may indicate immaturity, impulsiveness, or antisocial traits. Persons with experimental use of drugs during adolescence, minor traffic violations, or clearly provoked isolated impulsive episodes may be found fit after review by Commander, USAAMC.
        (6) Significant prolonged or currently unresolved interpersonal or family problems, marital dysfunction, or significant family opposition or conflict concerning the soldier's aviation career.
    e. An unsatisfactory AA may be given for lower levels (symptoms and signs) than those mentioned above if, in the opinion of the flight surgeon and aviation commander, the following applies: (1) mental or physical factors might be exacerbated under the stresses of Army aviation, or (2) the air crew member might not be able to carry out his or her duties in a mature and responsible fashion.
    f. A person may be disqualified for any of a combination of factors listed above and/or due to personal habits or appearance indicative of attitudes of carelessness, poor motivation, or other characteristics which may be unsafe or undesirable in the aviation environment.
    g. The Navy definition of aeromedical adaptability, specifically called "Aeronautical Adaptability," is more restrictive than the Army's definition. For the Navy, to be NAA (not aeronautically adapted).

4. Ensure appropriate actions for addressing confidentiality with Army aircrew members are taken.
    a. Inform aircrew members of their duty to inform the flight surgeon about their psychological treatment before beginning treatment.

Performance Steps

b. Be honest, direct, thorough, and supportive in discussing the limits of confidentiality. Reassure the patient that you will protect his or her confidentiality as much as possible, but also explaining the importance of counseling as a preventive measure in the interest of aviation safety. In other words, the aviator may not wish to pursue treatment because of the limited confidentiality, but you must point out that such a decision may pose a serious risk to aviation safety.
c. Consult closely with your supervisor about communicating mental health information to the flight surgeon.

Performance Measures	**GO**	**NO GO**
1. Assisted with services provided by aeromedical psychologists.	____	____
2. Determined psychiatric standards and grounding conditions for aircrew members.	____	____
3. Determined unsatisfactory aeromedical adaptability.	____	____
4. Ensured appropriate actions for addressing confidentiality with Army aircrew members was taken.	____	____

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	**Related**
None	AR 40-501

CONDUCT MENTAL HEALTH CONSULTATIONS WITH CHAINS OF COMMAND
081-832-0055

Conditions: You are to conduct a mental health consultation with the chain of command.

Standards: Conducted a command consultation with the chain of command in a timely manner.

Performance Steps

1. Research the unit.
   a. Type of unit--combat arms, combat support, or combat service support.
   b. History of unit--origin of unit, number of deployments and awards.
   c. Mission--unit's mission and mission essential task list.
   d. Unit size--number and MOSs of personnel. Is the unit under or over strength?
   e. Chain of command. Who is the chain of command and how long have the personnel worked together?
   f. Location. How remote from home station is the unit? Is the unit dispersed over a wide area? How accessible is the unit is to its members?
   g. Constraints--limitations of equipment; skill limitations of personnel, security clearances needed in the unit.
   h. Identify possible indicators of excessive stress within a unit.
      (1) Number and type of disciplinary actions.
      (2) AWOL rates.
      (3) IG complaints.
      (4) Transfer requests.
      (5) Sick call rates.
      (6) Suicide threats, attempts, and completions.
      (7) Substance abuse/misuse incidents.
   i. Other significant characteristics of the unit:
      (1) Do members of the unit work in shifts or odd hours?
      (2) Does the unit have a population that is largely transitory?
          EXAMPLE: Training units.

2. Establish entry into the unit.
   a. The process of consultation may begin with a request from the unit commander, 1SG, or from an official outside a unit.
   b. After obtaining permission to enter the unit, you must establish rapport with the commander and with members of the unit to gain their willingness to disclose factual and emotional material relevant to the subject of the consultation.

3. Gather information on the problem/situation.
   a. Getting as much information as possible aids in clarifying the presented situation or problem.
   b. The gathering of information includes listening, observing, standardized questionnaires, unit survey interviews, and group meetings.

4. Define the problem.
   a. Assess all the information and define the problem in terms of a solvable, workable issue.
   b. Present the problem to the consultee and both parties reach an agreement on problem definition.

Performance Steps

5. Identify and select solutions(s) to the problem.
   a. Base solutions on analysis and synthesis of all the information obtained.
   b. Use brainstorming to develop a number of possible solutions to the problem. This step is often accomplished with just you and the commander, but others in the unit can also be involved.
   c. Assess the feasibility, acceptability, and suitability (FAS) of each solution.
   d. Rank order the solutions on a priority list with the unit commander.
   e. The commander and the consultant team agree upon the best solution. The commander is the final decision authority.
6. Implement the solution.
7. Evaluate the effectiveness of the solution. This step includes monitoring the activities undertaken to solve the problem and measuring outcome. A decision may be made at this time to implement other solutions and continue with evaluations.

NOTE: Do not be offended if the commander does not always act on your recommendation.

8. Terminate consultation when the consultation team and the consultee agree to discontinue direct contact concerning the problem. Decisions at this stage include determining if objectives have been met and to what degree.

Performance Measures	**GO**	**NO GO**
1. Researched the unit.	____	____
2. Established entry into the unit.	____	____
3. Gathered information on the problem/situation.	____	____
4. Defined the problem.	____	____
5. Identified and selected solution(s) to the problem.	____	____
6. Implemented the solution.	____	____
7. Evaluated the effectiveness of the solution.	____	____
8. Terminated consultation.	____	____

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	**Related**
None	FM 8-51

PLACE A PATIENT IN SECLUSION

081-832-1025

Conditions: You are about to place a psychiatric patient into seclusion due to assaultive behavior and causing serious disruption to the therapeutic environment. Verbal and chemical interventions were utilized and were not effective. Other staff members are available to assist you. You will need clinical record.

Standards: Placed a patient into seclusion to include monitoring and documenting related interventions of the patient in seclusion by taking all reasonable steps to protect the patient from harm. Performed steps 1 through 5 in order.

Performance Steps

1. Explain the reason he or she is being placed in seclusion.
2. Search the patient and room for objects that might be harmful.
3. Remove the patient's shoes, jewelry, and glasses, if applicable.
4. Place the patient into seclusion.
5. Ensure that staff members leave the seclusion room one at a time, by backing out. Quickly close the door after the last staff member leaves.
6. Observe the patient frequently and provide for his or her basic needs.
   a. Observe the patient's behavior.
   b. Call for assistance, if needed.
   c. Directly intervene if the patient is in danger of causing harm to himself or herself or others.
7. Record and report the patient's conversation and behavior and the staff interventions.
   a. Report unusual behavior or abnormalities to the supervisor.
   b. Document the specific patient behavior which resulted in his or her placement into seclusion.
   c. Document the patient's response to seclusion and to the staff interventions performed.
   d. Document the staff interventions and nursing care performed.

NOTE: Frequency of documentation and where documentation is done will be IAW local policy.

Performance Measures	**GO**	**NO GO**
1. Explained to the patient the reason he or she is being placed in seclusion.	____	____
2. Searched the patient and room for objects that might be harmful.	____	____
3. Removed the patient's shoes, jewelry, and glasses, if applicable.	____	____
4. Placed the patient into seclusion.	____	____
5. Did steps 1 through 5 in order.	____	____
6. Observed the patient frequently and provided for his or her basic needs.	____	____
7. Recorded the patient's conversation, behavior, and staff 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 None

MONITOR A PATIENT'S RESPONSE TO PSYCHOTROPIC MEDICATIONS
081-832-1026

Conditions: A patient is prescribed a form of psychotropic medication. You will need clinical record.

Standards: Recognize the effects and side effects of psychotropic medications and perform necessary interventions.

Performance Steps

1. Identify the trade names and intended uses of commonly used psychotropic medications.
    a. Antipsychotic medications--used primarily to treat psychotic symptoms, also used to treat extreme behaviors such as rage and agitation.
        (1) Thorazine.
        (2) Haldol.
        (3) Navane.
        (4) Prolixin.
    b. Antidepressant medications--used to treat depression.
        (1) Tricyclics.
            (a) Elavil.
            (b) Tofranil.
        (2) Tetracyclic--Ludiomil.
        (3) MAO inhibitors.
            (a) Nardil.
            (b) Parnate.
        (4) Desyrel.
    c. Antianxiety medications--used to treat anxiety and symptoms of acute alcohol withdrawal.
        (1) Librium.
        (2) Valium.
    d. Antimania medication (lithium carbonate)--used to treat mania and bipolar disorders.

2. Recognize the desired effects of the psychotropic medications on the patient.
    a. Antipsychotic medication.
        (1) A decrease in disorganized thoughts and/or aggressive behavior.
        (2) A decrease in, or absence of, violent behavior.

NOTE: Optimal desired effects may take weeks or months of being on the medication.

    b. Antidepressant medication.
        (1) A decrease in feelings of depression.
        (2) An increase in energy level.

NOTE: Full therapeutic response may take 3 to 4 weeks of being on the medication.

    c. Antianxiety medication.
        (1) A reduction in symptoms of anxiety--restlessness, irritability, hyperalertness.
        (2) A reduction in symptoms of acute alcohol withdrawal.
    d. Antimania medication.
        (1) Diminish the excitement, euphoria, and insomnia associated with mania.
        (2) Establish a stable mood state.

NOTE: The effects are closely related to therapeutic serum levels.

Performance Steps

3. Recognize the unpleasant side effects a patient on psychotropic medication is experiencing and intervene accordingly.

NOTE: The mental health specialist should discuss common side effects with the patient and encourage him or her to report any unusual signs or symptoms.

a. Antipsychotic medication.
   (1) Dry mouth. Offer the patient fluids or suggest he or she suck on sugarless candy or chew gum.
   (2) Constipation. Encourage the patient to increase fluid intake, fiber intake, and activity level.
   (3) Blurred vision. Reassure the patient that this is a temporary side effect.
   (4) Drowsiness.
      (a) Reassure the patient that this may diminish as tolerance to the medication develops.
      (b) Caution the patient to avoid activities requiring mental alertness, such as driving.
   (5) Urinary retention. Instruct the patient to report changes in frequency and amount of urination.
   (6) Weight gain.
      (a) Encourage proper nutrition and dietary habits.
      (b) Provide an opportunity to increase activity level.
   (7) Orthostatic hypotension.
      (a) Instruct the patient to rise slowly when getting up.
      (b) Monitor the patient's blood pressure as directed.

NOTE: This is normally done with the patient sitting and in a supine position.

   (8) Photosensitivity.
      (a) Caution the patient to limit direct exposure to the sun.
      (b) Encourage the patient to wear sunglasses, sunscreen, and a hat in the sun.
   (9) Extrapyramidal side effects.

NOTE: The technician should immediately report these symptoms to the nurse so the symptoms can be treated with medication.

      (a) Acute dystonia. The patient may experience involuntary muscular movements, such as tongue protrusion, grimacing, gait abnormalities, abnormal eye movements, and neck twisting.
      (b) Akathisia. The patient may experience restlessness, uncontrolled pacing, difficulty sitting still, and agitation.
      (c) Tardive dyskinesia. The patient may experience involuntary movement of the extremities and trunk, single muscle jerks or tics, tongue protrusion, and chewing motion of the mouth.
      (d) Pseudoparkinsonism. The patient may experience tremors, shuffling gait, masklike expression, drooling, and cogwheel rigidity.

b. Antidepressant medication.
   (1) Drowsiness.
      (a) Reassure the patient that this may diminish as tolerance to the medication is developed.
      (b) Caution the patient to avoid activities which require mental alertness, such as driving.
   (2) Constipation. Encourage the patient to increase fluid intake, fiber intake, and activity level.
   (3) Blurred vision. Reassure the patient that this is a temporary side effect.

Performance Steps

(4) Weight gain.
(a) Encourage proper nutrition and dietary habits.
(b) Provide the opportunity to increase activity level.
(5) Orthostatic hypotension.
(a) Instruct the patient to rise slowly when getting up.
(b) Monitor blood pressure as directed.
(6) Increased potential for seizures. Observe the patient for any fine tremors or ataxia (loss of coordination of muscles).
(7) Sexual dysfunction.
(a) Demonstrate sensitivity regarding the patient's reluctance to discuss the sexual problems he or she is experiencing.
(b) Observe the patient for compliance with medication treatment, as the patient may discontinue the medication on his or her own instead of reporting this side effect.
(8) Hypertensive crisis--caused when a patient on MAO inhibitors eats tyramine-rich foods.
(a) Instruct and remind the patient to avoid foods containing tyramine if taking an MAO inhibitor.

NOTE: A list of foods containing tyramine should be made available to the patient.

(b) Inform the patient to report immediately any symptoms of a tyramine-induced hypertensive crisis, such as headaches, palpitations, nausea, or vomiting.

c. Antianxiety medication.
(1) Drowsiness.
(a) Reassure the patient that this may diminish as tolerance to the medication is developed.
(b) Caution the patient to avoid activities which require mental alertness, such a driving.
(2) Ataxia. Alert the patient to the danger of potential injury.
(3) Itchy rash. Report the condition to the nurse.
(4) Gastric irritation. Have the patient take medication with meals or a light snack, if possible.
(5) Central nervous system depression, when combined with other depressants or alcohol. Seek assistance immediately.

d. Antimania medication.

NOTE: Patients on lithium carbonate must be reminded of the signs of lithium toxicity, the importance of having serum levels measured, and taking in adequate amounts of fluids.

(1) Tremors. Encourage the patient to decrease caffeine consumption.
(2) Diarrhea. Encourage the patient to increase fluid intake.
(3) Weight gain.
(a) Encourage proper nutrition and dietary habits.
(b) Provide an opportunity to increase activity level.
(4) Nausea. Have the patient take medication with food, if possible.
(5) Polyuria (excessive urination).
(a) Monitor the patient's output of urine.
(b) Encourage the patient to increase intake of fluids.
(6) Toxic levels may induce symptoms such as slurred speech, dizziness, confusion, and impaired consciousness. Report these symptoms immediately to the nurse.

4. Report and record observed effects and side effects of the psychotropic medication.
a. Report abnormal observations to the nurse.

Performance Steps

b. Document observed effects and side effects in the patient's clinical record IAW local policy.

Performance Measures	**GO**	**NO GO**
1. Identified the purpose and the trade names of commonly used psychotropic medications.	____	____
2. Recognized the desired effects of the psychotropic medications on the patient.	____	____
3. Recognized the unpleasant side effects of the psychotropic medications and intervened accordingly.	____	____
4. Reported and recorded the observed effects and unpleasant side effects of psychotropic medications.	____	____

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 None

MONITOR A PATIENT'S USE OF A POTENTIALLY DANGEROUS ITEM

081-832-1006

Conditions: A psychiatric patient needs to use an item that is potentially dangerous. You will need a logbook.

Standards: Monitored a patient's use of a potentially dangerous item in a specified area without causing injury to the patient or other personnel. Ensured that the item is turned in immediately after use.

Performance Steps

1. Explain to the patient the procedures to be followed.
   a. Authorized times to sign items in and out.
   b. Utilization of the item is to be in the presence of a staff member.
   c. A staff member documents items signed out and in by logging the following:
      (1) The name of the patient using the item.
      (2) The type of item to be used.
      (3) The time and date the item was signed out and in.
      (4) The staff member's signature.
2. Inspect the item to ensure that it is complete and operable before the patient uses it.
3. Explain and demonstrate proper use of the item, if necessary.
4. Constantly observe the patient's use of the item.
   a. Ensure that the patient uses the item in a safe manner.
   b. Intervene if the patient begins to use the item in an unsafe manner.
5. Account for the item.
   a. Ensure the patient returns it complete and cleaned.
   b. Log the item in as having been returned by the patient.

Performance Measures	**GO**	**NO GO**
1. Explained to the patient the procedures to be followed.	____	____
2. Inspected the item to ensure that it is complete and operable before the patient uses it.	____	____
3. Explained and demonstrated proper use of the item, if necessary.	____	____
4. Constantly observed the patient's use of the item.	____	____
5. Accounted for the item.	____	____

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 None

PERFORM LINE OF SIGHT OBSERVATION OF A PSYCHIATRIC PATIENT
081-832-1007

Conditions: You are performing a line of sight observation on a psychiatric patient who has been assessed as needing close observation by doctor's orders. You will need clinical record.

Standards: Observed a patient placed on line of sight observation protecting the patient and others from harm. Performed steps 1 through 4 in order.

Performance Steps

1. Inform the patient that he or she is on line of sight observation.
2. Explain to the patient what line of sight observation is.
3. Explain to the patient the behaviors that caused placement on line of sight observation.
4. Explain to the patient the behavior that must be exhibited to be taken off line of sight observation.
5. Observe the patient's behavior.
   a. Keep the patient within view at all times.
   b. Obtain assistance if the patient does not respond to verbal intervention.

NOTE: Manual and/or mechanical restraint may be necessary depending on the situation. (See tasks 081-832-1012 and 081-832-1013.)

   c. Inform the patient when his or her behavior is appropriate.
      (1) Give the patient reassurance and support for specific positive behaviors demonstrated.
      (2) Encourage the patient to continue his or her positive behavior.
6. Terminate line of sight observation only when properly relieved.
   a. Brief the relief staff member regarding the reason the patient was placed on line of sight observation.
   b. Describe the patient's current behavior to the relief staff member.
7. Document the patient's behavior and conversation IAW local policy.

NOTE: Some wards require that a checklist be initialed by the assigned staff member at certain intervals throughout the watch. This is in addition to documentation in the clinical record.

8. Make recommendations to the nurse for the patient's removal from line of sight observation, if applicable, taking into consideration--
   a. The patient's observed behavior over a period of time.
   b. The patient's previous behavior patterns.

Performance Measures	**GO**	**NO GO**
1. Informed the patient that he or she is on line of sight observation.	____	____
2. Explained to the patient what line of sight observation is.	____	____
3. Explained to the patient the behaviors that caused placement on line of sight observation.	____	____

Performance Measures	GO	NO GO
4. Explained to the patient the behavior that must be exhibited to be taken off line of sight observation.	____	____
5. Did steps 1 through 4 in order.	____	____
6. Observed the patient's behavior.	____	____
7. Terminated line of sight observation only when properly relieved.	____	____
8. Documented the patient's behavior and conversation IAW local policy	____	____
9. Made recommendations to the nurse for the patient's removal from line of sight observation.	____	____

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 None

PERFORM 1:1 OBSERVATION OF A PSYCHIATRIC PATIENT

081-832-1008

Conditions: You are performing a 1:1 observation on a psychiatric patient who has been assessed as being a potential danger to himself or herself, or others. The doctor has placed the patient on 1:1 observation. You will need clinical record.

Standards: Observed a patient on 1:1 observation taking all reasonable steps to protect the patient and others from harm.

Performance Steps

1. Inform the patient that he or she is on 1:1 observation.
   a. Explain to the patient what 1:1 observation is.
      (1) The assigned staff member will remain within arm's reach of the patient at all times.
      (2) The patient's behavior will be closely monitored.
   b. Explain the reason for placement on 1:1 observation.
   c. Explain to the patient the behaviors that must be exhibited to be taken off 1:1 observation.
2. Observe the patient's behavior.
   a. Intervene if the patient requires redirection or control.
   b. Remove hazardous items within reach of the patient, if applicable.
   c. Prevent the patient from doing bodily harm to himself or herself or others.
   d. Inform the patient when his or her behavior is appropriate.
3. Terminate 1:1 observation only when properly relieved.
   a. Brief the relief staff member as to why the patient was placed on 1:1 observation.
   b. Describe the patient's current behavior to the relief staff member.
4. Document the patient's behavior and conversation IAW local policy.
5. Make recommendations to the nurse for removal of the patient from 1:1 observation, if applicable, taking into consideration--
   a. The patient's observed behavior over a period of time.
   b. The patient's previous behavior patterns.

Performance Measures	GO	NO GO
1. Informed the patient that he or she is on 1:1 observation.	____	____
2. Observed the patient's behavior.	____	____
3. Terminated 1:1 observation only when properly relieved.	____	____
4. Documented the patient's behavior and conversation IAW local policy.	____	____
5. Made recommendations to the nurse for removal of the patient from 1:1 observation.	____	____

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 None

ACCOUNT FOR THE LOCATION OF PSYCHIATRIC PATIENTS
081-832-1009

Conditions: You need to account for psychiatric patients that have been scheduled for activities and appointments off of the ward. You will need ward census roster, Admission and Disposition Report, and patient sign in and out board.

Standards: Accounted for the location of patients assigned to the ward with 100% accuracy.

Performance Steps

1. Verify the accuracy of the ward census roster.
   a. Compare the ward census roster to the daily Admission and Disposition Report.
   b. Add the names of newly admitted patients to the ward census roster, if necessary.
   c. Delete the names of discharged patients from the ward census roster, if necessary.

2. Update the patient sign in and out board by comparing it to the ward census roster.
   a. Add to the patient sign in and out board the names of patients who have been admitted to the ward.
   b. Delete from the patient sign in and out board the names of patients who have been discharged from the ward.

3. Account for patients on the ward.

NOTE: Accountability of all patients assigned to a psychiatric ward should be done at irregular periods throughout each shift, IAW local policy.

   a. Count the number of the patients in the ward area.
   b. Compare the ward census roster to the number and names of the patients currently on the ward.

4. Account for the patients who are not present on the ward.
   a. Check the patient sign in and out board for the location of patients not present on the ward.
   b. Check with other staff members for knowledge regarding the whereabouts of any patients not accounted for and verify the information.

NOTE: If the patient is accounted for as being off the ward with permission, but forgot to sign out, the mental health specialist will sign him or her out on the patient sign in and out board.

   c. Verify the names of the patients not accounted for.
   d. Inform the immediate supervisor of the names of the patients not accounted for, if applicable.

Performance Measures	**GO**	**NO GO**
1. Verified the accuracy of the ward census roster.	____	____
2. Updated the patient sign in and out board by comparing it to the ward census roster.	____	____
3. Accounted for patients on the ward.	____	____
4. Accounted for the patients who are not present on the ward.	____	____

Performance Measures	GO	NO GO
5. Informed the immediate supervisor of the names of the patients not accounted for, if applicable.	____	____

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 None

ESCORT A PSYCHIATRIC PATIENT

081-832-1010

Conditions: You are assigned to escort a psychiatric patient who is scheduled to leave the ward area to a specific destination. You will need patient sign in and out board and clinical record.

Standards: Escorted a psychiatric patient to and from a specific destination in an orderly manner. Performed all steps in order.

Performance Steps

1. Prepare for departure from the ward.
   a. Familiarize yourself with the patient's history.
   b. Obtain the following information:
      (1) Scheduled time for the appointment or activity.
      (2) Destination.
      (3) Mode of transportation to be used, if necessary.
      (4) Necessary items to accompany the patient, such as health and clinical records.
      (5) When the next routine dose of medication should occur.
   c. Explain to the patient--
      (1) When and where he or she is going.
      (2) The procedure to be followed.
   d. Sign the patient out on the patient sign in and out board.
2. Depart the ward for the destination.
   a. Utilize only approved modes of transportation.
   b. Ensure safety of the patient at all times.
   c. Take the patient directly to the destination.
3. Remain with the patient while at the destination.
   a. Observe the patient closely.
   b. Intervene if the patient--
      (1) Exhibits inappropriate behavior.
      (2) Endangers self or others.
      (3) Attempts to elope.
4. Return the patient to the ward following the guidelines in step 2.
5. Sign the patient in on the patient sign in and out board.
6. Search the patient upon return to the ward for hazardous items or contraband.
7. Record any significant patient behavior in the clinical record.

Performance Measures	**GO**	**NO GO**
1. Prepared for departure from the ward.	____	____
2. Departed the ward for the destination.	____	____
3. Remained with the patient while at the destination.	____	____

Performance Measures	GO	NO GO
4. Returned the patient to the ward.	____	____
5. Signed the patient in on the patient sign in and out board.	____	____
6. Searched the patient upon return to the ward for hazardous items or contraband.	____	____
7. Recorded any significant patient behavior in the clinical record.	____	____
8. Did all steps in order.	____	____

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 None

DETERMINE PATIENT CARE ASSIGNMENTS

081-832-1020

Conditions: You have been designated, as shift leader, to assign patient care duties to mental health specialists on duty. You will need DA Form 4677, DA Form 3888, and DA Form 4015.

Standards: Assigned patient care duties to available mental health specialists based on the patient's Nursing Assessment and Care Plan and the ward schedule.

Performance Steps

1. Review the patient's DA Form 3888.
   a. Identify the patient's problems.
   b. Review the short and long range goals.
   c. Review the nursing history.
2. Review the patient's DA Form 4677.
   a. The type of interventions or care to be performed.
   b. The frequency and time the interventions or care are to be performed.
3. Complete DA Form 4015.
   a. Assign patient care duties to a mental health specialist, taking into consideration--
      (1) The individual needs of the patient.
      (2) The skills of the mental health specialist.
      (3) Escort duties.
      (4) Admission and discharge duties.
      (5) Mealtime supervision.
      (6) Number of patients in seclusion or restraints.
      (7) Number of patients on special watch.
      (8) Scheduled patient treatments and activities.
      (9) Staff meetings and conferences.
   b. Indicate the time and frequency the care or intervention is to be performed, if applicable.
   c. Indicate which patient charting the mental health specialist is responsible for.
4. Review DA Form 4015 with the mental health specialist.
   a. Ensure the mental health specialist understands the assignment.
   b. Tell the mental health specialist to review the patient's problems, goals, and history on DA Forms 3888 and 4677, if not familiar with the plan of care for the patient.
5. Conduct a review of the patient care charting when completed and provide feedback to the specialist.

Performance Measures	**GO**	**NO GO**
1. Reviewed the patient's DA Form 3888.	____	____
2. Reviewed the patient's DA Form 4677.	____	____
3. Completed DA Form 4015.	____	____
4. Reviewed DA Form 4015 with the mental health specialist.	____	____

Performance Measures	GO	NO GO
5. Conducted a review of the patient care charting when completed and provided feedback to the specialist.	____	____

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	Related
AR 40-407	None

Subject Area 9: Basic Medical Treatment

PERFORM A PATIENT CARE HANDWASH
081-831-0007

Conditions: You are about to administer patient care or have just had hand contact with a patient or contaminated material. You will need running water or two empty basins, a canteen, a water source, soap, towels (cloth or paper), and a towel receptacle or trash can.

Standards: Performed a patient care handwash without recontaminating the hands.

Performance Steps

1. Remove wristwatch and jewelry, if applicable.

NOTE: Rings should not be worn. If rings are worn, they should be of simple design with few crevices for harboring bacteria. Fingernails should be clean, short, and free of nail polish.

2. Roll shirt sleeves to above the elbows, if applicable.

3. Prepare to perform the handwash.
   a. If using running water, turn on the warm water.
   b. If running water is not available, set up the basins and open the canteen.

4. Wet your hands, wrists, and forearms.
   a. If using running water, hold your hands, wrists, and forearms under the running water.
   b. If running water is not available, fill one basin with enough water to cover your hands and refill the canteen.

5. Cover your hands, wrists, and forearms with soap.

NOTE: For routine patient care, use regular hand soap. For an invasive procedure such as a catheterization or an injection, use antimicrobial soap.

6. Wash your hands, wrists, and forearms.
   a. Use a circular scrubbing motion, going from the fingertips toward the elbows for at least 15 seconds..
   b. Give particular attention to creases and folds in the skin.
   c. Wash ring(s) if present.

7. Rinse your hands, wrists, and forearms.
   a. If using running water.
      (1) Hold your hands lower than the elbows under the running water until all soap is removed.
      (2) Do not touch any part of the sink or faucet.
   b. If not using running water.
      (1) Use a clean towel to grasp the canteen with one hand.
      (2) Rinse the other hand, wrist, and forearm, letting the water run into the empty basin. Hold your hands lower than the elbows.
      (3) Repeat the procedure for the other arm.
      (4) Do not touch any dirty surfaces while rinsing your hands.

8. Dry your hands, wrists, and forearms.
   a. Use a towel to dry one arm from the fingertips to the elbow without retracing the path with the towel.

Performance Steps

b. Dispose of the towel properly without dropping your hand below waist level.
c. Repeat the process for the other arm using another towel.

9. Use a towel to turn off the running water, if applicable.
10. Reinspect your fingernails and clean them and rewash your hands, if necessary.

Evaluation Preparation:
Setup: None

Brief soldier: Tell the soldier to perform a patient care handwash. You may specify which method to use. The soldier need not perform both.

Performance Measures	**GO**	**NO GO**
1. Removed wristwatch and jewelry, if applicable.	____	____
2. Rolled shirt sleeves to above the elbows, if applicable.	____	____
3. Prepared to perform the handwash.	____	____
4. Wet the hands, wrists, and forearms.	____	____
5. Covered the hands, wrists, and forearms with soap.	____	____
6. Washed the hands, wrists, and forearms.	____	____
7. Rinsed the hands, wrists, and forearms.	____	____
8. Dried the hands, wrists, and forearms.	____	____
9. Used a towel to turn off the running water, if applicable.	____	____
10. Reinspected the fingernails and cleaned them and rewashed the hands, if necessary.	____	____

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	**Related**
None	BTLS FOR PARAMEDICS EMERGENCY CARE

PUT ON STERILE GLOVES

081-831-0008

Conditions: You will need handwashing facilities, sterile gloves, and a flat, clean, dry surface.

Standards: Put on and removed sterile gloves without contaminating self or the gloves.

Performance Steps

1. Select and inspect the package.
    a. Select the proper size of glove.
    b. Inspect the package for possible contamination.
        (1) Water spots.
        (2) Moisture.
        (3) Tears.
        (4) Any other evidence that the package is not sterile.
2. Perform a patient care handwash.
3. Open the sterile package.
    a. Place the package on a flat, clean, dry surface in the area where the gloves are to be worn.
    b. Peel the outer wrapper open to completely expose the inner package.
4. Position the inner package.
    a. Remove the inner package touching only the folded side of the wrapper.
    b. Position the package so that the cuff end is nearest you.
5. Unfold the inner package.
    a. Grasp the lower corner of the package.
    b. Open the package to a fully flat position without touching the gloves.
6. Expose both gloves.
    a. Grasp the lower corners or designated areas on the folder.
    b. Pull gently to the side without touching the gloves.
7. Put on the first glove.
    a. Grasp the cuff at the folded edge and remove it from the wrapper.
    b. Step away from the table or tray.
    c. Keeping your hands above the waist, insert the fingers of the other hand into the glove.
    d. Pull the glove on touching only the exposed inner surface of the glove.

NOTE: If there is difficulty in getting your fingers fully fitted into the glove fingers, make the adjustment after both gloves are on.

8. Put on the second glove.
    a. Insert the fingertips of the gloved hand under the edge of the folded over cuff.

NOTE: You may keep the gloved thumb up and away from the cuff area or may insert it under the edge of the folded over cuff with the fingertips.

    b. Keeping your hands above the waist, insert the fingers of the ungloved hand into the glove.
    c. Pull the glove on.
    d. Do not contaminate either glove.

Performance Steps

9. Adjust the gloves to fit properly.
    a. Grasp and pick up the glove surfaces on the individual fingers to adjust them.
    b. Pick up the palm surfaces and work your fingers and hands into the gloves.
    c. Interlock the gloved fingers and work the gloved hands until the gloves are firmly on the fingers.

NOTE: If either glove tears while putting them on or adjusting the gloves, remove both gloves and repeat the procedure.

10. Remove the gloves.
    a. Grasp one glove at the heel of the hand with the other gloved hand.
    b. Peel off the glove, retaining it in the palm of the gloved hand.
    c. Reach under the cuff of the remaining glove with one or two fingers of the ungloved hand.
    d. Peel off the glove over the glove being held in the palm.
    e. Do not contaminate yourself.

CAUTION: Do not "snap" the gloves while removing them.

11. Discard the gloves IAW local SOP.

12. Perform a patient care handwash.

Evaluation Preparation:
Setup: If performance of this task must be simulated for training and evaluation, the same gloves may be used repeatedly as long as they are properly rewrapped after each use. You may give the soldier a torn or moist glove package to test step 1.

NOTE: If the soldier does not know his or her glove size, have several different sizes available to try on to determine the correct size.

Brief soldier: Tell the soldier to put on and remove the sterile gloves.

Performance Measures	**GO**	**NO GO**
1. Selected and inspected the package.	____	____
2. Performed a patient care handwash.	____	____
3. Opened the sterile package.	____	____
4. Positioned the inner package.	____	____
5. Unfolded the inner package.	____	____
6. Exposed both gloves.	____	____
7. Put on the first glove.	____	____
8. Put on the second glove.	____	____
9. Adjusted the gloves to fit properly.	____	____
10. Removed the gloves.	____	____

Performance Measures	GO	NO GO
11. Discarded the gloves IAW local SOP.	____	____
12. Performed a patient care handwash.	____	____

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	Related
None	BASIC NURSING

MEASURE A PATIENT'S TEMPERATURE

081-831-0013

Conditions: You have performed a patient care handwash. You will need disinfected mercury oral and rectal thermometers or an electronic thermometer, canisters marked "used," water soluble lubricant, gauze pads, a watch, and appropriate forms.

Standards: Recorded the patient's temperature to the nearest 0.2° F.

Performance Steps

1. Determine which site to use.
    a. Take an oral temperature if the patient is a conscious adult or a child who can follow directions, and can breathe normally through the nose.

CAUTION: Do not take an oral temperature when the patient--

1. Has had recent facial or oral surgery.
2. Is confused, disturbed, or heavily sedated.
3. Is being administered oxygen by mouth or nose.
4. Is likely to bite down on the thermometer.
5. Has smoked, chewed gum, or ingested anything hot or cold within the last 15 to 30 minutes.

    b. Tympanic method can be used with conscious or unconscious patients and is preferred temperature if the patient has recently had something to eat or drink.

CAUTION: Do not take a tympanic temperature if the patient has had recent facial or aural surgery, or has cerumen (ear wax).

    c. Take a rectal temperature if the oral or tympanic site is ruled out by the patient's condition.

CAUTION: Do not take a rectal temperature on a patient with a cardiac condition, diarrhea, a rectal disorder such as hemorrhoids, or recent rectal surgery. Do not take a rectal temperature on an infant unless directed to by medical guidance.

    d. Take an axillary temperature if the patient's condition rules out using the other methods.

2. Select the proper thermometer.
    a. Tympanic thermometer.
    b. An oral thermometer has a blue tip and may be labeled "Oral."
    c. A rectal thermometer has a red tip and may be labeled "Rectal."
    d. Axillary temperatures are taken with oral thermometers.

3. Explain the procedure and position the patient.
    a. Take a tympanic temperature with the patient s head turned toward side so that the ear canal is easily viewed.
    b. Take an oral temperature with the patient seated or lying face up.
    c. Take a rectal temperature with the patient lying on either side with the top knee flexed.
    d. Take an axillary temperature with the patient lying face up with the armpit exposed.

4. Measure the temperature.
    a. Shake the thermometer down to below 94° F.
    b. Place the thermometer at the proper site.
        (1) If you are taking an oral temperature, place the thermometer in the heat pocket under the tongue and tell the patient to close his or her lips and not to bite down.
        (2) If you are taking a rectal temperature on an adult, insert the thermometer 1 to 2 inches into his or her rectum.

Performance Steps

CAUTION: Lubricate the tip prior to insertion. Hold the thermometer in place.

(3) If you are taking a tympanic temperature, pull the ear pinna back, up, and out; insert the speculum into the ear canal snugly to make a seal, pointing toward the nose.

(4) If you are taking an axillary temperature, pat the armpit dry and then place the bulb end in the center with the glass tip protruding to the front of the patient's body. Place the arm across his or her chest.

c. Leave the thermometer in place for the required time.

(1) Oral--at least 3 minutes.

NOTE: Leave digital thermometers in place until testing is complete. The unit will normally have an audible tone.

(2) Rectal--at least 2 minutes.

(3) Tympanic--until an audible signal occurs and the patient's temperature appears on the digital display.

(4) Axillary--at least 10 minutes.

5. Remove the thermometer and wipe it down with a gauze square or discharge the protective plastic sheath.

6. Read the scale.

7. Put the thermometer in the proper "used" canister or dispose of the plastic sheath as appropriate.

8. Record the temperature to the nearest 0.2° F on the appropriate forms and report any abnormal temperature change immediately to the supervisor.

NOTES: 1. The normal temperature range is--Oral - 97.0° to 99.0° F; Rectal - 98.0° to 100.0° F; Axillary - 96.0° to 98.0° F. 2. Record an axillary temperature with an "A" on the patient's record. Record a rectal temperature with an "R" on the patient's record.

Evaluation Preparation:

Setup: To test step 1 for evaluation purposes, create a scenario in which the patient's condition will dictate which site the soldier must choose.

Brief soldier: Tell the soldier to measure, evaluate, and record a patient's temperature.

Performance Measures	**GO**	**NO GO**
1. Determined which site to use.	____	____
2. Selected the proper thermometer.	____	____
3. Explained the procedure and positioned the patient.	____	____
4. Measured the temperature.	____	____
5. Removed the thermometer and wiped it down with a gauze square.	____	____
6. Read the scale.	____	____
7. Placed the thermometer in the proper "used" canister or disposed of the plastic sheath as appropriate.	____	____

Performance Measures	GO	NO GO
8. Recorded the temperature to the nearest 0.2° F on the appropriate forms and reported any abnormal temperature change immediately to the supervisor.	____	____

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	Related
None	EMERGENCY CARE

MEASURE A PATIENT'S PULSE

081-831-0011

Conditions: You will need a watch, stethoscope, and appropriate forms.

Standards: Counted a patient's pulse for 1 full minute. Identified any abnormalities in the pulse rate, rhythm, and strength.

Performance Steps

1. Position the patient so that the pulse site is accessible.

2. Palpate the pulse site.
    a. Place the tips of your index and middle fingers on the pulse site.

NOTE: You must use a stethoscope to monitor the apical site.

    b. Press the fingers, using moderate pressure, to feel the pulse.

3. Count for 1 full minute and evaluate the pulse.

NOTE: To detect irregularities, you must count for 1 full minute.

    a. Pulse rate.
        (1) Normal adult rate--60 to 100 beats per minute.
        (2) Infants and Children
            (a) Adolescent 11-14 years--60 to 105
            (b) School age 6-10 years-- 70 to 110
            (c) Preschooler 3-5 years-- 80 to 120
            (d) Toddler 1-3 years-- 80 to 130
            (e) Infant 6-12 months--80 to 140
            (f) Infant 0-5 months-- 90 to 140
            (g) Newborn--120 to 160
        (3) Bradycardia--less than 50 beats per minute.

WARNING: When a patient presenting with bradycardia, the medic must consider the physical condition of the patient. For example, the patient is an athlete and their normal at-rest pulse rate is between 40 to 50 beats per minute.

        (4) Tachycardia--more than 100 beats per minute.
    b. Pulse rhythm.
        (1) Regular.
            (a) Usually easy to find.
            (b) Has a regular rate and rhythm.
            (c) Varies with the individual.
        (2) Irregular/intermittent--any change from a regular beating pattern.

NOTE: If a peripheral pulse is irregular or intermittent, you should take a second pulse at the carotid, femoral, or apical site. (See Figure 3-4.)

Performance Steps

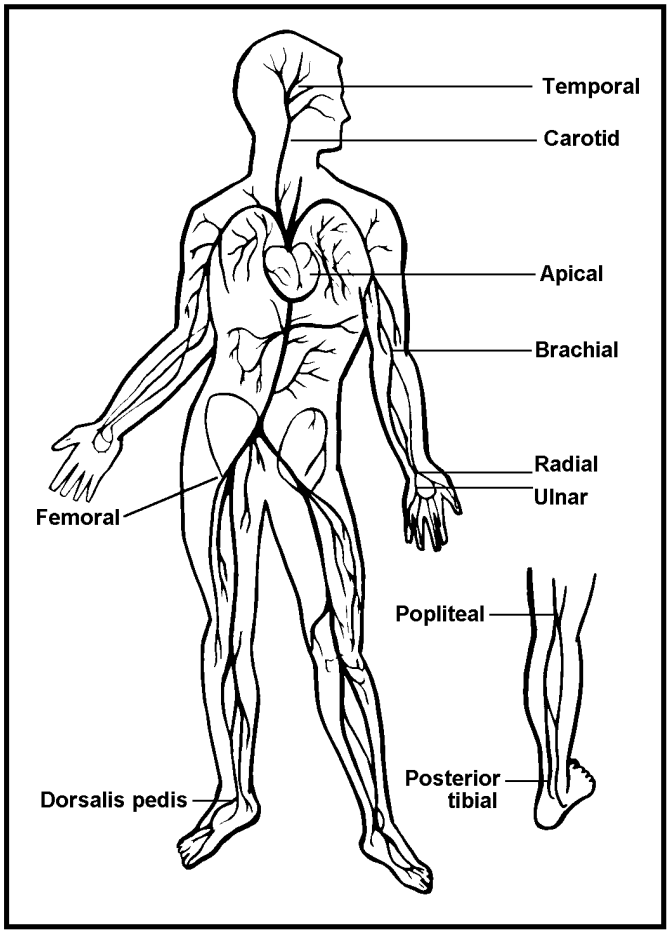

Figure 3-4

c. Pulse strength.
   (1) Strong or full pulse.
      (a) Easy to find.
      (b) Has even beats with good force.
   (2) Bounding.
      (a) Easy to find.
      (b) Exceptionally strong heartbeats which make the arteries difficult to compress.
   (3) Weak/thready
      (a) Weak and thin
      (b) Difficult to find

4. Record the rate, rhythm, strength, and any significant deviations from normal on the appropriate forms.

5. Report any significant pulse abnormalities to the supervisor immediately.

Evaluation Preparation:
Setup: While the soldier is palpating a pulse site, you must palpate the corresponding site. Specify which site the soldier is to palpate. If the apical site is chosen, either a double stethoscope or separate stethoscopes may be used. A tolerance of plus or minus two beats will be allowed.

Brief soldier: Tell the soldier to count, evaluate, and record the patient's pulse.

Performance Measures	GO	NO GO
1. Positioned the patient so that the pulse site is accessible.	____	____
2. Palpated the pulse site.	____	____
3. Counted for 1 full minute and evaluated the pulse.	____	____
4. Recorded the rate, rhythm, strength, and any significant deviations from normal on the appropriate forms.	____	____
5. Reported any significant pulse abnormalities to the supervisor immediately.	____	____

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	Related
None	EMERGENCY CARE

MEASURE A PATIENT'S RESPIRATIONS

081-831-0010

Conditions: You will need a watch and appropriate forms.

Standards: Counted a patient's respirations for 1 full minute. Identified any abnormalities in respiration rate, depth, rhythm, pattern, and quality.

Performance Steps

1. Count the number of times the chest rises in 1 minute. Normal respirations for each age group are as follows:

NOTE: The patient should not be aware that respirations are being counted. If the patient is aware, he or she often becomes tense, and an accurate count becomes extremely difficult.

   a. Adult and adolescent (11-14 years old) = 12-20.
   b. School age (6-10 years old) = 15-30.
   c. Preschooler (3-5 years old) = 20-30.
   d. Toddler (1-3 years old) = 20-30.
   e. Infant (6-12 months old) = 20-30.
   f. Infant (0-5 months old) = 25-40.
   g. Newborn = 30-50.

2. Evaluate the respirations.
   a. Depth.
      (1) Normal--deep, even movement of the chest.
      (2) Shallow--minimal rise and fall of the chest and abdomen.
      (3) Deep--the rib cage expands fully, and the diaphragm descends to create a maximum capacity.
   b. Rhythm and pattern.
      (1) Healthy--exhalations are twice as long as inhalations.
      (2) Irregular.
      (3) Hypoventilation--slow and shallow respirations.
      (4) Hyperventilation--sustained increased rate and depth of respiration.
      (5) Sigh--deep inhalation followed by a slow audible exhalation.
      (6) Apnea--temporary absence of breathing.
      (7) Tachypnea--increased respiration rate, usually 24 or more breaths per minute.
   c. Quality.
      (1) Normal--effortless, automatic, regular rate, even depth, noiseless, and free of discomfort.
      (2) Dyspnea--difficult or labored breathing.
      (3) Wheezing or whistling sound.
      (4) Rattling or bubbling.

3. Check for the physical characteristics of abnormal respirations.
   a. Appearance--the casualty may appear restless, anxious, pale, ashen, or cyanotic.
   b. Position--the casualty may alter his or her position by leaning forward or may be unable to lie flat.
   c. Cough.
      (1) Acute--comes on suddenly.
      (2) Chronic--has existed for a long time.
      (3) Dry--coughs without sputum.

Performance Steps

(4) Productive--coughs which expel sputum.
   (a) Normal sputum--clear, semiliquid mucus which may appear watery, frothy, or thick.
   (b) Abnormal sputum--may be green, yellow, gray, or blood-tinged, and may have a foul or sweetish smell.

4. Record the rate of respirations and any observations noted on the appropriate forms.
5. Report any abnormal respirations to the supervisor immediately.

Evaluation Preparation:
Setup: You must count the rate with the soldier. If you are using a simulated patient, you may test step 2 by having him or her purposely exhibit abnormal breathing characteristics. A tolerance of plus or minus two counts will be allowed.

Brief soldier: Tell the soldier to count, evaluate, and record a patient's respirations.

Performance Measures	GO	NO GO
1. Counted the number of times the chest rose in 1 minute.	____	____
2. Evaluated the respirations.	____	____
3. Checked for the physical characteristics of abnormal respirations.	____	____
4. Recorded the rate of respirations and any observations noted on the appropriate forms.	____	____
5. Reported any abnormal respirations to the supervisor immediately.	____	____

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	Related
None	EMERGENCY CARE

MEASURE A PATIENT'S BLOOD PRESSURE

081-831-0012

Conditions: You will need a sphygmomanometer, clean stethoscope, and appropriate forms.

Standards: Measured a patient's blood pressure and recorded the measurement on the appropriate forms.

Performance Steps

1. Explain the procedure to the patient, if necessary.
   a. The length of time the procedure will take.
   b. The site to be used.
   c. The physical sensations the patient will feel.

2. Select the proper size of sphygmomanometer cuff.

NOTE: The cuff width should be two-thirds of the upper arm length if using the brachial artery and two-thirds of the upper leg if using the popliteal artery.

3. Check the equipment.
   a. Ensure that the cuff is deflated completely and fully retighten the thumbscrew.
   b. Ensure the sphygmomanometer gauge reads zero.

NOTE: Steps 2, 3, and 4 describe the procedure for taking the blood pressure at the brachial site. If the brachial site cannot be used, measure the blood pressure using a larger cuff applied to the thigh. The patient should be lying down (preferably on the stomach; otherwise, on the back with one knee flexed). Apply the cuff at mid-thigh, and place the stethoscope over the popliteal artery. The remainder of the procedure is the same as for the brachial artery site.

4. Position the patient.
   a. Place the patient in a relaxed and comfortable sitting, standing, or lying position.

NOTE: A reading obtained from a standing position will be slightly higher.

   b. Place the patient's arm palm up at approximately heart level. Support the arm so that it is relaxed.

5. Place the cuff at the brachial artery site.
   a. Place the cuff so the lower edge is 1 to 2 inches above the elbow and the bladder portion is over the artery.
   b. Wrap the cuff just tightly enough to prevent slippage.
   c. If applicable, clip the gauge to the cuff in alignment with the palm.

6. Position the stethoscope, if used.
   a. Palpate for the brachial pulse.
   b. Place the diaphragm of the stethoscope over the pulse site.

7. Inflate the cuff until the gauge reads at least 140 mm Hg or 10 mm Hg higher than the usual range for that patient, if known.

NOTE: If a pulsation is heard when the gauge reaches 140 mm Hg, continue to inflate the cuff 10 mm Hg beyond the point at which the last pulsation was heard.

CAUTION: The cuff should not remain inflated for more than 2 minutes.

8. Determine the blood pressure.
   a. If a stethoscope is used, complete the following steps:

Performance Steps

(1) Rotate the thumbscrew slowly in a counterclockwise motion, allowing the cuff to deflate slowly.
(2) Watch the gauge and remember the reading when the first distinct sound is heard (systolic pressure).
(3) Continue to watch the gauge and remember the reading where the sound changes again and becomes muffled or unclear (diastolic pressure).
(4) Release the remaining air.

b. If a stethoscope is not used, complete the following steps:
(1) Palpate for the radial pulse.
(2) Rotate the thumbscrew slowly in a counterclockwise motion, allowing the cuff to deflate slowly.
(3) Watch the gauge and remember the point at which the pulse returns (systolic pressure).

NOTES: 1. The diastolic pressure cannot be determined using this method. 2. If the procedure must be repeated, wait at least 1 minute before repeating steps 6 through 8.

9. Record the blood pressure on the appropriate forms.
   a. Record the systolic reading over the diastolic reading, for example 120/80.
   b. Record the readings in even numbers.

10. Evaluate the blood pressure reading by comparing it with one of the following:
   a. The patient's previous reading.
   b. An average of the patient's previous readings.
   c. The normal range: 100-140/60-90 for males and 90-130/50-60 for females.

11. Report abnormal readings to the supervisor.

Evaluation Preparation:

Setup: A double stethoscope should be used if available. A tolerance of ± 4 mm Hg will be allowed. If other methods are used, such as independent measurements on different sites or at different times, the evaluator must apply discretion in applying the ± 4 mm Hg standard. You will allow the soldier to retake the blood pressure at least once if the soldier feels that it is necessary to obtain an accurate reading. You will use discretion in allowing additional repetitions based upon the difficulty of obtaining a reading on the patient.

Brief soldier: Tell the soldier to take a patient's blood pressure. Tell the soldier that the blood pressure may be retaken, if necessary, to obtain an accurate reading.

Performance Measures	**GO**	**NO GO**
1. Explained the procedure to the patient, if necessary.	____	____
2. Selected the proper size of sphygmomanometer cuff.	____	____
3. Checked the equipment.	____	____
4. Positioned the patient.	____	____
5. Placed the cuff just tightly enough to prevent slippage.	____	____
6. Positioned the stethoscope, if used.	____	____

Performance Measures	GO	NO GO
7. Inflated the cuff until the gauge read at least 140 mm Hg or 10 mm Hg higher than the usual range for that patient, if known.	____	____
8. Determined the blood pressure.	____	____
9. Recorded the blood pressure on the appropriate forms.	____	____
10. Evaluated the blood pressure.	____	____
11. Reported any abnormal readings to the supervisor.	____	____

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	Related
None	EMERGENCY CARE

PERFORM A MEDICAL PATIENT ASSESSMENT

081-833-0156

Conditions: You have a patient with a complaint that is medical in nature and no significant mechanism of injury. You have available the necessary materials and equipment to treat or stabilize the patient.

Standards: Assessed the patient and identified and treated the present illness without causing further injury.

Performance Steps

1. Take body substance isolation precautions.
2. Perform scene size-up.
    a. Determine the safest route to access the casualty.
    b. Determine the mechanism of injury/nature of illness.
    c. Determine the number of patients.
    d. Request additional help if necessary.
    e. Considers stabilization of the spine.
3. Perform an Initial Assessment.
    a. Verbalize general impression of the patient and the patient's environment.
    b. Assess the patient's mental status using the AVPU scale.
        (1) A - Alert and oriented.
        (2) V - Responsive to verbal stimuli.
        (3) P - Responsive to painful stimuli.
        (4) U - Unresponsive (see task 081-833-0048).
    c. Determine the chief complaint/apparent life threatening condition.
    d. Assess the airway.
        (1) Perform an appropriate maneuver to open and maintain the airway if necessary (see task 081-831-0018).
        (2) Insert an appropriate airway adjunct, if necessary. (See tasks 081-833-0016, 081-833-0142, and 081-833-0169. If skill level 30, see task 081-830-3016 also.)
    e. Assess breathing.
        (1) Determine the rate, rhythm, and quality of breathing.
        (2) Administer oxygen if necessary using the appropriate delivery device (see tasks 081-833-0158 and 081-831-0048).
    f. Assess circulation.
        (1) Skin color and temperature.
        (2) Assess the pulse for rhythm and force.
            (a) Check the radial pulse in adults.
            (b) Check the radial pulse and capillary refill in children under 6 years old.
            (c) Check the brachial pulse and capillary refill in infants.
        (3) Check for major bleeding.
        (4) Control major bleeding (see tasks 081-833-0161 and 081-833-0046).
        (5) Treat for shock (see task 081-833-0047).
    g. Identify priority patients and make a transport decision (load and go or stay and play).

Performance Steps

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 rapid physical exam if the patient is unconscious. Inspect each of the following areas for deformities, contusions, abrasions, punctures or penetration, burns, tenderness, lacerations, swelling (DCAP-BTLS).
   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.

5. Gather a SAMPLE history from the patient.

NOTE: If the patient is unable to give you this information, gather as much information about the SAMPLE history as you can from the patient's family and/or bystanders.

   a. Signs and symptoms. Gather history of the present illness (OPQRST) from the patient.
      (1) RESPIRATORY.
         (a) Onset - When did it begin?
         (b) Provocation - What were you doing when this came on?
         (c) Quality - Can you describe the feeling you have?
         (d) Radiation - Does the feeling seem to spread to any other part of your body? Do you have pain or discomfort anywhere else in your body?
         (e) Severity - On a scale of 1 to 10, how bad is your breathing trouble (10 is worst, 1 is best)?
         (f) Time - How long have you had this feeling?
         (g) Interventions - Have you taken any medication to help you breathe? Did it help?
      (2) CARDIAC.
         (a) Onset - When did it begin?
         (b) Provocation - What were you doing when this came on?
         (c) Quality - Can you describe the feeling you have?
         (d) Radiates - Does the feeling seem to spread to any other part of your body? Do you have pain or discomfort anywhere else in your body?
         (e) Severity - On a scale of 1 to 10, how bad is your breathing trouble (10 is worst, 1 is best)?
         (f) Time - How long have you had this feeling?
         (g) Interventions - Have you taken any medication to help you? Did it help?
      (3) ALTERED MENTAL STATUS.
         (a) Description of the episode - Can you tell me what happened? How did the episode occur?
         (b) Onset - How long ago did it occur?
         (c) Duration - How long did it last?
         (d) Associated symptoms - Was the patient sick or complaining of not feeling well before this happened?
         (e) Evidence of trauma - Was the patient involved in falls or accidents recently?

Performance Steps

(f) Interventions - Has the patient taken anything to help with this problem? Did it help?
(g) Seizures - Did the patient have a seizure?
(h) Fever - Did the patient have a fever? What was the patient's temperature?

(4) ALLERGIC REACTION.
(a) History of allergies - Do you have any allergies?
(b) What were you exposed to - Is there any chance that you were exposed to something that you may be allergic to?
(c) How were you exposed - How did you come into contact with _____ (whatever the patient is allergic to)?
(d) Effects - What kind of symptoms are you having? How long after you were exposed did the symptoms start?
(e) Progression - How long after you were exposed did the symptoms start? Are they worse now than they were before?
(f) Interventions - Have you taken anything to help? Did it help?

(5) POISONING/OVERDOSE.
(a) Substance - What substance was involved?
(b) When did you ingest/become exposed - When did the exposure/ingestion occur?
(c) How much did you ingest - How much did the patient ingest?
(d) Over what time period - Over how long a period did the ingestion occur?
(e) Interventions - What interventions did the family or bystanders take?
(f) Estimated weight - What is the patient's estimated weight?

(6) ENVIRONMENTAL EMERGENCY.
(a) Source - What caused the injury?
(b) Environment - Where did the injury occur?
(c) Duration - How long were you exposed?
(d) Loss of consciousness - Did you lose consciousness at any time?
(e) Effects (general or local) - What signs and symptoms are you having? What effect did being exposed have on the patient?

(7) OBSTETRICS.
(a) Are you pregnant?
(b) How long have you been pregnant?
(c) Are you having pain or contractions?
(d) Are you bleeding? Are you having any discharge?
(e) Do you feel the need to push?
(f) When was your last menstrual period?

(8) BEHAVIORAL.
(a) How do you feel?
(b) Determine suicidal tendencies - Do you have a plan to hurt yourself or anyone else? .
(c) Is the patient a threat to self or others?
(d) Is there a medical problem?
(e) Interventions?

b. Allergies.
c. Medications.
d. Past pertinent history.
e. Last oral intake.
f. Event(s) leading to present illness.

Performance Steps

6. Perform a focused physical examination on the affected body part/system.
7. Obtain baseline vital signs (see tasks 081-831-0013, 081-831-0011, 081-831-0010, and 081-831-0012).
8. Provide medication interventions and treatment as needed (see tasks 081-831-0035, 081-833-0103, 081-833-0116, 081-833-0143, 081-833-0144, 081-833-0159, 081-833-0160, 081-833-0163, 081-833-0166, 081-833-0054, 081-831-0038, 081-831-0039, 081-833-0031, 081-833-0073, and 081-833-3206) .
9. Reevaluate the transport decision.
10. Consider completing a detailed physical examination.
11. Perform Ongoing Assessment.
    a. Repeat the initial assessment.
    b. Repeat vital signs.
    c. Repeat the focused assessment regarding the patient's complaint or injuries.

Performance Measures	**GO**	**NO GO**
1. Took body substance isolation precautions.	____	____
2. Performed a scene size up.	____	____
3. Obtained medical direction or used standing orders for medical interventions.	____	____
4. Provided high concentration of oxygen.	____	____
5. Found and managed problems associated with the airway, breathing, hemorrhage, or shock.	____	____
6. Differentiated the patient's need for transportation versus continued assessment at the scene.	____	____
7. Performed a detailed or focused history/physical examination before assessing the airway, breathing, and circulation.	____	____
8. Asked questions concerning the present illness.	____	____
9. Administered appropriate 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	**Related**
None	EMERGENCY CARE

PERFORM A TRAUMA CASUALTY ASSESSMENT

081-833-0155

Conditions: You find a casualty with multiple injuries. You are not in an NBC environment. You have available the necessary materials and equipment.

Standards: Assessed the casualty, identified all life threatening injuries, and treated them appropriately without causing further injury. Performed the assessments in the correct order.

Performance Steps

1. Take body substance isolation precautions.

2. Perform a Scene Assessment.
   a. Determine the safest route to access the casualty.
   b. Determine the mechanism of injury.
   c. Determine the number of casualties.
   d. Request additional help, if necessary.
   e. Consider stabilization of the spine.

NOTE: If the mechanism of injury is significant, direct other soldiers to provide in line stabilization of the cervical spine.

3. Perform an Initial Assessment.

NOTE: Life threatening injuries should be treated as they are identified.

   a. Verbalize a general impression of the patient and of the patient's environment.
   b. Assess the patient's mental status using the AVPU scale.
      (1) A - Alert and oriented.
      (2) V - Responsive to verbal stimuli.
      (3) P - Responsive to painful stimuli.
      (4) U - Unresponsive (see task 081-833-0048).
   c. Determine the chief complaint.
   d. Assess the airway.
      (1) Perform appropriate maneuver to open and maintain the airway (see task 081-831-0018).
      (2) Insert an appropriate airway adjunct, if necessary. (See tasks 081-833-0016, 081-833-0142, and 081-833-0169. If skill level 30, see task 081-830-3016 also.)
   e. Assess breathing.
      (1) Determine the rate, rhythm, and quality of breathing.
      (2) Administer oxygen if necessary using the appropriate delivery device (see tasks 081-833-0158 and 081-831-0048).
   f. Assess circulation.
      (1) Skin color, condition, and temperature.
      (2) Assess the pulse for rhythm and force.
         (a) Check the radial pulse in adults.
         (b) Check the radial pulse and capillary refill in children.
         (c) Check the brachial pulse and capillary refill in infants.
      (3) Check for major bleeding.
      (4) Control major bleeding (see tasks 081-833-0161 and 081-833-0046).
      (5) Treat for shock (see task 081-833-0047).
   g. Identify patient priority and make a transport decision (load and go or stay and play).

Performance Steps

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. If the mechanism of Injury is significant, perform a Rapid Trauma Assessment.

NOTE: Significant mechanisms of injury include ejection from a vehicle, death in the same passenger compartment, falls of more than 15 feet or three times the patient's height, roll over of vehicle, high-speed vehicle collision, vehicle-pedestrian collision, motorcycle crash, unresponsive or altered mental status, and penetrations of the head, chest, or abdomen (e.g., stab and gunshot wounds). Additional significant mechanisms of injury for a child include falls from more than 10 feet, bicycle collision, and vehicles in medium speed collision.

a. Head.
   (1) Inspect for deformities, contusions, abrasions, punctures or penetration, burns, tenderness, lacerations, swelling (DCAP-BTLS).
   (2) Inspect for crepitus.
b. Neck.
   (1) Inspect for DCAP-BTLS.
   (2) Palpate spine step-offs.
   (3) Inspect for jugular vein distention (JVD).
   (4) Inspect for tracheal deviation.
   (5) Apply a cervical collar, if necessary
c. Chest.
   (1) Inspect for DCAP-BTLS.
   (2) Inspect for crepitus.
   (3) Inspect for paradoxical motion.
   (4) Inspect breath sounds (absent/present, equal).
d. Abdomen.
   (1) Inspect for DCAP-BTLS.
   (2) Inspect for tenderness.
   (3) Inspect for rigidity.
   (4) Inspect for distention.
e. Pelvis.

NOTE: If a conscious patient complains of pain or if an unconscious patient responds as if in pain at anytime during the assessment, do not continue the exam. Treat for pelvic fracture.

CAUTION: Do not log roll patients suspected of having a pelvic fracture.

   (1) Inspect for DCAP-BTLS.
   (2) Gently compress to detect instability and crepitus.
   (3) Determine the level of pain.
   (4) Inspect for priapism.
f. Extremities.
   (1) Inspect for DCAP-BTLS.
   (2) Check the distal pulse.
   (3) Check distal motor function.
   (4) Check distal sensation.
g. Posterior.

Performance Steps

NOTE: The patient must be log rolled to do this portion of the assessment. If necessary, the patient should be placed on a long spine board after assessment. If PASGs were deemed necessary, they should be positioned on the long spine board before patient placement. If a patient has a suspected pelvic fracture, place in a scoop litter and then assess the posterior.

(1) Inspect for DCAP-BTLS.
(2) Inspect for rectal bleeding.

5. If there is no significant mechanism of injury, perform a Focused History and Physical Exam.
   a. Based on chief complaint.
   b. Focus on the areas that the patient tells you are painful or that you suspect may be painful due to the mechanism of injury.

6. Obtain baseline vital signs (see tasks 081-831-0013, 081-831-0011, 081-831-0010, and 081-831-0012).

7. Obtain a SAMPLE history.

NOTE: A SAMPLE history is obtained by questioning the patient. If the patient is unable to answer, search the scene or ask bystanders and/or family members for information.

a. Signs/Symptoms.
   (1) Ask the patient what's wrong.
   (2) Observe the patient.
b. Allergies.
   (1) Ask the patient if there are any allergies to medications, foods, or environmental.
   (2) Look for a medical identification tag.
c. Medications.
   (1) Ask the patient if he or she is taking any medications (prescription, over the counter, or illegal).
   (2) Ask a female patient if she is taking birth control pills.
   (3) Search for an identification tag with medications on it or medications in the area.
d. Pertinent past history.
   (1) Ask the patient if there are any medical problems (past and present).
   (2) Ask the patient if he or she has been feeling ill.
   (3) Ask the patient about recent surgery or injuries.
   (4) Ask the patient if he or she is currently seeing a doctor and, if so, what is the doctor's name.
e. Last oral intake.
   (1) Ask the patient when his or her last meal or drink was.
   (2) Ask the patient what he or she drank or ate.
f. Events leading to the injury or illness.
   (1) If the patient is unable to answer, search the scene for anything that may help.
   (2) Ask about the sequence of events that led up to the current problem.

8. Perform a Detailed Physical Examination

NOTE: This is done only if time permits during evacuation or while waiting for evacuation. Do not delay evacuation to perform this exam.

a. Assess the scalp and cranium.
   (1) Inspect for DCAP-BTLS.
   (2) Inspect for crepitation.
b. Assess the ears.
   (1) Inspect for DCAP-BTLS.

Performance Steps

(2) Inspect for drainage.
(a) Blood.
(b) Clear fluid.

c. Assess the face for DCAP-BTLS.
d. Assess 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.
e. Assess the nose.
(1) Inspect for DCAP-BTLS.
(2) Inspect for drainage of blood and/or clear fluid.
f. Assess 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.
(6) Inspect for discoloration.
g. Assess the neck.
(1) Inspect for DCAP-BTLS.
(2) Inspect for jugular vein distention (JVD).
(3) Inspect for tracheal deviation.
(4) Inspect for crepitation.
h. Reassess the chest.
(1) Inspect for DCAP-BTLS.
(2) Palpate.
(3) Auscultate breath sounds.
(4) Assess for flail chest.
i. Reassess the abdomen.
(1) Inspect for DCAP-BTLS.
(2) Inspect for tenderness.
(3) Inspect for rigidity.
(4) Inspect for distention.
j. Reassess the pelvis.

NOTE: If pain, instability, or crepitus was noticed in the rapid trauma assessment, ensure the pelvis is properly stabilized and do not reassess.

(1) Inspect for DCAP-BTLS.
(2) Inspect for instability.
(3) Inspect for crepitation.
(4) Determine the level of pain.

k. Reassess the extremities.
(1) Inspect for DCAP-BTLS.
(2) Inspect motor function.
(3) Check sensation.
(4) Check circulation.
l. Reassess the posterior.

NOTE: If the patient 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 patient.

Performance Steps

(1) Inspect for DCAP-BTLS.
(2) Inspect for rectal bleeding.

m. Manage secondary injuries and wounds appropriately (see tasks 081-831-0044, 081-833-0045, 081-833-0046, 081-833-0049, 081-833-0050, 081-833-0052, 081-833-0056, 081-833-0057, 081-833-0058, 081-833-0060, 081-833-0062, 081-833-0064, 081-833-0154, and 081-833-3011.
n. Reassess vital signs.

Evaluation Preparation:

Setup: For training and evaluation, have another soldier act as the casualty or use a trauma manikin. Describe a general scenario to the soldier. The casualty must have more than one injury or condition. Wounds may be simulated using moulage or other available materials. A "conscious" casualty can be coached to show signs of such conditions as shock, and to respond to the soldier's questions about the location of pain and other symptoms of injury. The evaluator will cue the soldier during the assessment of an "unconscious" casualty as to whether the casualty is breathing, and describe such conditions as shock to the soldier as he or she is making the checks.

Brief soldier: Tell the soldier to tell you what action he or she would take for each wound or condition identified.

Performance Measures	**GO**	**NO GO**
1. Took body substance isolation precautions.	____	____
2. Performed a Scene Assessment.	____	____
3. Assessed for spinal protection.	____	____
4. Performed an Initial Assessment.	____	____
5. Administered high concentration of oxygen, if necessary.	____	____
6. Managed problems associated with the airway, breathing, hemorrhage, or shock (hypovolemic).	____	____
7. Differentiated the patient's need for transportation versus continued assessment at the scene.	____	____
8. If the mechanism of injury was significant, performed a Rapid Trauma Assessment.	____	____
9. If there was no significant mechanism of injury, performed a Focused History and Physical Exam.	____	____
10. Obtained baseline vital signs.	____	____
11. Obtained the SAMPLE history.	____	____
12. Performed a Detailed Physical Exam.	____	____
13. Performed the assessments in order.	____	____

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	**Related**
None	BTLS FOR PARAMEDICS EMERGENCY CARE

TRIAGE CASUALTIES ON AN INTEGRATED BATTLEFIELD

081-833-0082

Conditions: You are in a chemical environment and have casualties with conventional injuries and/or signs and symptoms of chemical agent poisoning. Both you and the casualties are in MOPP level 4. You will need an aid bag.

Standards: Completed all the steps necessary to correctly establish priorities for the treatment and evacuation of casualties on an integrated battlefield.

Performance Steps

1. Assess the situation.
    a. Number and location of the injured.
    b. Severity of the injuries.
    c. Assistance available (self-aid or buddy-aid).
    d. Evacuation support capabilities.
    e. Type of chemical agents used, if known.

2. Assess the individual casualties.
    a. Assess for conventional injuries.
    b. Assess for signs and symptoms of chemical agent poisoning.
        (1) Determine if the casualty responds to commands.
            (a) Check the casualty's response to simple directions, such as "Hold up your right arm."
            (b) Ask the casualty to describe any symptoms.
        (2) Check for symptoms of chemical agent poisoning. (See tasks 081-833-0083 through 081-833-0086.)

3. Establish priorities for treatment.
    a. Immediate.
        (1) No signs and symptoms of chemical agent poisoning.
        (2) Presence of life-threatening conventional injuries.
    b. Chemical immediate.
        (1) Presence of signs and symptoms of severe chemical agent poisoning.
        (2) No conventional injuries.
    c. Delayed.
        (1) Presence of mild signs and symptoms of chemical agent poisoning.
        (2) Presence of conventional injuries that are not life-threatening.
    d. Minimal.
        (1) No signs and symptoms of chemical agent poisoning.
        (2) Presence of minor conventional injuries.
    e. Expectant.
        (1) Presence of severe signs and symptoms of both chemical agent poisoning and life-threatening conventional injuries.
        (2) No conventional injuries and not breathing due to chemical agent poisoning.

NOTE: Expectant casualties are so critically injured that only prolonged and complicated treatment may offer increased life expectancy.

4. Initiate treatment in the following order.
    a. Chemical agent poisoning.
    b. Conventional injuries.

Performance Steps

NOTES: 1. Employ casualties who have only minor injuries or minimal chemical agent exposure to provide buddy-aid for those with more severe injuries. 2. Sorting and treatment should be done almost simultaneously.

5. Move the casualties to the collection point.
6. Record all observations and treatment on the appropriate form.
7. Establish evacuation priorities. (See task 081-833-0080.)

Evaluation Preparation:

Setup: You will need several soldiers in MOPP level 4 to act as the casualties. Use a moulage kit or similar materials to simulate conventional wounds. Coach the soldiers on signs and symptoms of nerve agent poisoning to exhibit.

Brief soldier: Tell the soldier to triage casualties on an integrated battlefield.

Performance Measures	**GO**	**NO GO**
1. Assessed the situation.	____	____
2. Assessed the individual casualties.	____	____
3. Established priorities for treatment.	____	____
4. Initiated treatment.	____	____
5. Moved the casualties to the collection point.	____	____
6. Recorded all observations and treatment on the appropriate form.	____	____
7. Established evacuation priorities.	____	____

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	**Related**
None	FM 4-02

OPEN THE AIRWAY

081-831-0018

Conditions: You are evaluating a casualty who is not breathing. You are not in an NBC environment.

Standards: Completed all of the steps required to open the casualty's airway without causing unnecessary injury.

Performance Steps

1. Roll the casualty onto his or her back if necessary.
   a. Kneel beside the casualty.
   b. Raise the near arm and straighten it out above the head.
   c. Adjust the legs so that they are together and straight or nearly straight.
   d. Place one hand on the back of the casualty's head and neck.
   e. Grasp the casualty under the arm with the free hand.
   f. Pull steadily and evenly toward yourself, keeping the head and neck in line with the torso.
   g. Roll the casualty as a single unit.
   h. Place the casualty's arms at his or her sides.

2. Establish the airway using the head-tilt/chin-lift or jaw thrust method.
   a. Head-tilt/chin-lift method.

CAUTION: Do not use this method if a spinal or neck injury is suspected.

NOTE: Remove any foreign material or vomitus seen in the mouth as quickly as possible.

(1) Kneel at the level of the casualty's shoulders.
(2) Place one hand on the casualty's forehead and apply firm, backward pressure with the palm of the hand to tilt the head back.
(3) Place the fingertips of the other hand under the bony part of the casualty's lower jaw, bringing the chin forward.

CAUTIONS: 1. Do not use the thumb to lift the lower jaw. 2. Do not press deeply into the soft tissue under the chin with the fingers. 3. Do not completely close the casualty's mouth.

   b. Jaw thrust.

CAUTION: Use this method if a spinal or neck injury is suspected.

(1) Kneel at the top of the casualty's head.
(2) Rest the elbows on the surface on which the casualty is lying.
(3) Place one hand on each side of the casualty's lower jaw at the angle of the jaw, below the ears.
(4) Stabilize the casualty's head with your forearms.
(5) Use index fingers to push the angles of the patient's lower jaw forward.
(6) Use thumb to keep the casualty's mouth open, if necessary.

CAUTION: Do not tilt or rotate the casualty's head.

3. Check for breathing within 3 to 5 seconds. While maintaining the open airway position, place an ear over the casualty's mouth and nose, looking toward the chest and stomach.
   a. Look for the chest to rise and fall.
   b. Listen for air escaping during exhalation.
   c. Feel for the flow of air on the side of your face.

4. Take appropriate action.

Performance Steps

a. If the casualty resumes breathing, maintain the airway and place the casualty in the recovery position.
   (1) Roll the casualty as a single unit onto his or her side.
   (2) Place the hand of the upper arm under his or her chin.
   (3) Flex the upper leg.

NOTE: Check the casualty for other injuries, if necessary.

b. If the casualty does not resume breathing, perform rescue breathing. (See task 081-831-0048.)

Evaluation Preparation:

Setup: Place a CPR mannequin or another soldier acting as the casualty face down on the ground. For training and evaluation, you may specify to the soldier whether the casualty has a spinal injury to test step 2, or you may create a scenario in which the casualty's condition will dictate to the soldier how to treat the casualty. After step 3 tell the soldier whether the casualty is breathing or not and ask what should be done.

Brief soldier: Tell the soldier to open the casualty's airway.

Performance Measures	**GO**	**NO GO**
1. Rolled the casualty onto his or her back, if necessary.	____	____
2. Established the airway using the head-tilt/chin-lift or jaw thrust method.	____	____
3. Checked for breathing within 3 to 5 seconds.	____	____
4. Took appropriate action.	____	____
5. Did not cause further injury 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	**Related**
None	EMERGENCY CARE

CLEAR AN UPPER AIRWAY OBSTRUCTION

081-831-0019

Conditions: You are evaluating a casualty who is not breathing or is having difficulty breathing, and you suspect the presence of an upper airway obstruction.

Standards: Completed, in order, all the steps necessary to clear an object from a casualty's upper airway. Continued the procedure until the casualty could talk and breathe normally or until relieved by a qualified person.

Performance Steps

1. Clear the airway.
    a. Conscious casualty.
        (1) Determine whether or not the casualty needs help. Ask the casualty whether he or she is choking.
            (a) If the casualty has good air exchange (is able to speak, coughs forcefully, or wheezes between coughs), do not interfere except to encourage the casualty.
            (b) If the casualty has poor air exchange (weak, ineffective cough; high-pitched noise while inhaling; increased respiratory difficulty; and possible cyanosis), continue with step 1a(2).
            (c) If the casualty has a complete airway obstruction (is unable to speak, breathe, or cough and may clutch the neck between the thumb and fingers), continue with step 1a(2).
        (2) If the casualty is lying down, bring him or her to a sitting or standing position.
        (3) Apply abdominal or chest thrusts.

NOTE: Use abdominal thrusts unless the casualty is in the advanced stages of pregnancy, is very obese, or has a significant abdominal wound.

            (a) Abdominal thrusts.
                1) Stand behind the casualty and wrap your arms around his or her waist.
                2) Make a fist with one hand and place the thumb side of the fist against the casualty's abdomen in the midline slightly above the navel and well below the tip of the xiphoid process.
                3) Grasp the fist with your other hand and press the fist into the casualty's abdomen with quick backward and upward thrusts.
                4) Continue giving thrusts until the blockage is expelled or the casualty becomes unconscious.

NOTE: Make each thrust a separate, distinct movement given with the intent of relieving the obstruction.

            (b) Chest thrusts.
                1) Stand behind the casualty and encircle his or her chest with your arms just under the armpits.
                2) Make a fist with one hand and place the thumb side of the fist against the middle of the casualty's breastbone.
                3) Grasp the fist with your other hand and give backward thrusts.
                4) Continue giving thrusts until the blockage is expelled or the casualty becomes unconscious.

Performance Steps

CAUTION: Do not position the hand on the xiphoid process or the lower margins on the rib cage.

NOTES: 1. Administer each thrust with the intent of relieving the obstruction. 2. If the casualty becomes unconscious, position the casualty on his or her back, perform a finger sweep (see step 1b(2)), open the airway (see task 081-831-0018), and then start rescue breathing procedures (see task 081-831-0048).

b. Unconscious casualty.

NOTE: Perform abdominal or chest thrusts on the unconscious casualty only after attempts to open the airway and ventilate the casualty indicate that the airway is obstructed.

(1) Apply abdominal or chest thrusts.

NOTE: Use abdominal thrusts unless the casualty is in the advanced stages of pregnancy, is very obese, or has a significant abdominal wound.

(a) Abdominal thrusts.

1) Kneel astride the casualty's thighs.

2) Place the heel of one hand against the casualty's abdomen in the midline slightly above the navel and well below the tip of the xiphoid process.

3) Place the other hand directly on top of the first.

4) Press into the abdomen with quick upward thrusts up to five times.

(b) Chest thrusts.

1) Kneel close to either side of the casualty's body.

2) With the middle and index fingers of the hand nearest the casualty's legs, locate the lower margin of the casualty's rib cage on the side nearest you.

3) Move the fingers up the rib cage to the notch where the ribs meet the sternum in the center of the lower part of the chest.

4) With the middle finger on this notch, place the index finger next to it on the lower end of the sternum.

5) Place the heel of the other hand on the lower half of the sternum next to the index finger of the first hand.

6) Remove the first hand from the notch and place it on top of the hand on the sternum so that the hands are parallel to each other.

NOTE: You may either extend or interlace your fingers but keep the fingers off the casualty's chest.

7) Lock your elbows into position, straighten your arms, and position your shoulders directly over your hands.

8) Press straight down depressing the sternum 1.5 to 2 inches and then release the pressure completely without lifting the hands from the chest.

9) Repeat the chest thrust up to five times.

NOTE: Make each thrust a separate, distinct movement given with the intent of relieving the obstruction.

(2) Perform a finger sweep.

(a) Open the casualty's mouth by grasping both the tongue and lower jaw with your thumb and fingers and lifting.

(b) Insert the index finger of your other hand down along the inside of the cheek and deeply into the throat to the base of the tongue.

(c) Use a hooking motion to attempt to dislodge the foreign body and maneuver it into the mouth for removal.

CAUTION: Do not force the object deeper into the airway.

Performance Steps

(3) Attempt to ventilate. If the airway is still not clear, repeat the sequence of thrusts, finger sweep, and attempt to ventilate until the airway is cleared or you are relieved by qualified personnel.

2. When the object is dislodged, check for breathing. Perform rescue breathing, if necessary (see task 081-831-0048) or continue to evaluate the casualty for other injuries.

Evaluation Preparation:

NOTE: Only the procedure for clearing an airway obstruction in a conscious casualty will be evaluated. The procedure for an unconscious casualty can be evaluated as a part of task 081-831-0048.

Setup: You will need another soldier to play the part of the casualty.

Brief soldier: Describe the symptoms of a casualty with good air exchange, poor air exchange, or a complete airway obstruction. Ask the soldier what should be done and score step 1 based on the answer. Then, tell the soldier to clear an upper airway obstruction. Tell the soldier to demonstrate how to position the casualty, where to stand, and how to position his or her hands for the thrusts. The soldier must tell you how they should be done and how many thrusts should be performed. Ensure that the soldier understands that he or she must not actually perform the thrusts. After completion of step 5, ask the soldier what must be done if the casualty becomes unconscious.

Performance Measures	**GO**	**NO GO**
1. Determined whether the casualty needs help.	____	____
2. Moved the casualty to a sitting or standing position, if necessary.	____	____
3. Stood behind the casualty.	____	____
4. Positioned arms and hands properly to perform the thrusts.	____	____
5. Stated how to perform the thrusts and how many should be performed.	____	____
6. Stated that the following actions would be taken if the casualty becomes unconscious. a. Reposition the casualty. b. Perform a finger sweep. c. Open the airway. d. Perform rescue breathing procedures.	____	____
7. Completed all necessary steps in order.	____	____

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	**Related**
None	EMERGENCY CARE

PERFORM RESCUE BREATHING

081-831-0048

Conditions: You are treating a casualty who is unconscious and is not breathing. You are not in an NBC environment.

Standards: Completed, in order, all the steps necessary to restore breathing. Continued the procedure until the casualty started to breathe or until relieved by another qualified person, stopped by a physician, required to perform CPR, or too exhausted to continue.

Performance Steps

1. Position yourself at the casualty's head.
2. Open the airway (see task 081-831-0018).
   a. Head-tilt/chin-lift when no trauma is suspected.
   b. Jaw thrust when trauma is suspected.
3. Ventilate the casualty using the mouth-to-mouth, mouth-to-nose, mouth-to-mask, bag-valve-mask, or flow-restricted oxygen-powered ventilation device (FROPVD or demand-valve), as appropriate.
   a. Mouth-to-mouth method.
      (1) Maintain the chin-lift while pinching the nostrils closed using the thumb and index fingers of the hand on the casualty's forehead.
      (2) Take a deep breath and make an airtight seal around the casualty's mouth with your mouth.
      (3) Blow one full breath (1.5 to 2 seconds) into the casualty's mouth, watching for the chest to rise and fall and listening and feeling for air to escape during exhalation.
      (4) If the chest rises and air escapes--
         (a) Give a second full breath.
         (b) Go to step 6.
      (5) If the chest does not rise or air does not escape, go to step 4.
   b. Mouth-to-nose method.

NOTE: The mouth-to-nose method is recommended when you cannot open the casualty's mouth, there are jaw or mouth injuries, or you cannot maintain a tight seal around the casualty's mouth.

      (1) Maintain the head-tilt with the hand on the forehead while using the other hand to lift the casualty's jaw and close the mouth.
      (2) Take a deep breath and make an airtight seal around the casualty's nose with your mouth.
      (3) Blow one full breath (1.5 to 2 seconds) into the casualty's nose while watching for the chest to rise and fall and listening and feeling for air to escape during exhalation.

NOTE: It may be necessary to open the casualty's mouth or separate the lips to allow air to escape.

      (4) If the chest rises--
         (a) Give a second full breath.
         (b) Go to step 6.
      (5) If the chest does not rise, go to step 4.
   c. Mouth-to-mask.

Performance Steps

NOTE: The face mask is an important part of infection control to the rescuer. Rescuer breaths are delivered to the casualty through the one-way valve of the mask. There is no direct contact with the casualty's mouth.

(1) Insert an airway adjunct as necessary.
(2) Place the mask on the casualty.
    (a) Position the apex of the mask on the bridge of the nose.
    (b) Place the base of the mask at the chin between the lower lip and the chin prominence.
(3) Create a seal while maintaining the airway.
    (a) Place your thumbs over the top half of mask.
    (b) Place your index and middle fingers over the bottom half of the mask.
    (c) Use your fourth and fifth fingers to bring the jaw toward the mask.
(4) Take a deep breath and exhale into the mask.

NOTES: 1. Remove your mouth from the valve to allow for exhalation. 2. Some masks have oxygen inlets. Providing supplemental oxygen significantly increases the concentration of oxygen delivered to the patient. Oxygen concentrations can reach 50% when the flow is set to 15 LPM.

    (a) If the breath goes in, give a second breath and go to step 6.
    (b) If the breath fails to go in, go to step 4.

d. Bag-valve-mask (BVM).

NOTE: Supplemental oxygen can be given while using the BVM to increase oxygen concentration levels to 50%. When BVM systems have a reservoir supply, oxygen concentrations can reach almost 100%.

(1) Insert an airway adjunct as needed.
(2) Select the proper size of mask.
(3) Position the mask on the casualty's face.
(4) Form a "C" around the ventilation port. Use 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 a BVM 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.

(5) Squeeze the bag.
(6) Release pressure from the bag and allow the patient to exhale passively.
    (a) If the chest rises and air goes in, squeeze the bag again to give a second breath and then go to step 6.
    (b) If the chest fails to rise, go to step 4.

e. Flow-restricted oxygen-powered ventilation device.

CAUTION: Use caution when using the FROPVD on patients with chest injuries. Be careful not to force excess air into the stomach instead of the lungs. This may cause gastric distention and vomiting. Do not use on children.

(1) Follow the same steps to position and seal the mask as with the BVM.
(2) Push the trigger on the device once.
    (a) If the chest rises, push the button again and proceed to step 6
    (b) If the chest fails to rise, go to step 4.

4. Reposition the head to ensure an open airway and attempt the breath again.

NOTE: When using a BVM or FROPVD, it is also important to check the mask seal.

a. If the chest rises, give another breath and go to step 6.
b. If the chest does not rise, continue with step 5.

Performance Steps

5. Clear an airway obstruction, if necessary (see task 081-831-0019). When the obstruction has been cleared, continue with step 6.
6. Check the carotid pulse for 5 to 10 seconds.
   a. While maintaining the airway, place the index and middle fingers of your hand on the casualty's throat.
   b. Slide the fingers into the groove beside the casualty's Adam's apple and feel for a pulse for 5 to 10 seconds.
   c. If a pulse is present, go to step 7.
   d. If a pulse is not found, begin CPR (see task 081-831-0046).
7. Continue rescue breathing.
   a. Ventilate the casualty at the appropriate rate.
      (1) Adult - 10-12 per minute.
      (2) Adolescent - 15 per minute.
      (3) Children greater than a year of age - 20 per minute (mouth-to-mouth or mouth-to-nose).
      (4) Children less than one year of age - 40 per minute (mouth-to-nose).
   b. Watch for rising and falling of the chest.
   c. Recheck for pulse and breathing after every 12 breaths.

NOTE: Although not evaluated, continue rescue breathing as stated in the task standard. When breathing is restored, watch the casualty closely, maintain an open airway, and check for other injuries. If the casualty's condition permits, place him or her in the recovery position. (See task 081-831-0018.)

Evaluation Preparation:

Setup: For training and evaluation, a CPR mannequin must be used. Position the mannequin on its back. To test step 3, you may specify to the soldier whether to use the mouth-to-mouth or mouth-to-nose method, or you may create a scenario in which the casualty's condition dictates which method is to be used. You may determine how much of the task is tested by telling the soldier whether the airway is clear or a pulse is found as the soldier proceeds through the task. However, you should ensure that the soldier is routed through the task far enough to continue rescue breathing after checking the carotid pulse.

Brief soldier: Tell the soldier to perform rescue breathing.

Performance Measures	**GO**	**NO GO**
1. Opened the airway	____	____
2. Ventilated the casualty using the mouth-to-mouth, mouth-to-nose, mouth-to-mask, BVM, or FROPVD method, as appropriate.	____	____
3. Repositioned the head to ensure an open airway and repeated ventilation attempt, if necessary.	____	____
4. Cleared an airway obstruction, if necessary.	____	____
5. Checked the carotid pulse for 5 to 10 seconds.	____	____
6. Continued rescue breathing.	____	____

Performance Measures	GO	NO GO
7. Completed all necessary steps in order.	____	____

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	Related
None	EMERGENCY CARE

ADMINISTER EXTERNAL CHEST COMPRESSIONS

081-831-0046

Conditions: You are treating a casualty who is not breathing and has no pulse. The airway is open and is clear. Another soldier who is CPR qualified may be available to assist or may arrive while you are performing one-rescuer CPR. You are not in an NBC environment.

Standards: Continued CPR until the pulse was restored or until the rescuer(s) were relieved by other qualified persons, stopped by a physician, or too tired to continue.

Performance Steps
Perform one-rescuer CPR.

1. Ensure that the casualty is positioned on a hard, flat surface.

2. Position the hands for external chest compressions.
   a. With the middle and index fingers of the hand nearest the casualty's feet, locate the lower margin of the casualty's rib cage on the side near the rescuer.
   b. Move the fingers up the rib cage to the notch where the ribs meet the sternum in the center of the lower part of the chest.
   c. With the middle finger on the notch, place the index finger next to it on the lower end of the sternum.
   d. Place the heel of the other hand on the lower half of the sternum, next to the index finger of the first hand.
   e. Remove the first hand from the notch and place it on top of the hand on the sternum so that both hands are parallel to each other.

NOTE: You may either extend or interlace your fingers but keep the fingers off the casualty's chest.

3. Position your body.
   a. Lock your elbows with the arms straight.
   b. Position your shoulders directly over your hands.

4. Give 15 compressions.
   a. Press straight down to depress the sternum 1.5 to 2 inches.
   b. Come straight up and completely release pressure on the sternum to allow the chest to return to its normal position. The time allowed for release should equal the time required for compression.

CAUTION: Do not remove the heel of your hand from the casualty's chest or reposition your hand between compressions.

   c. Give 15 compressions in 9 to 11 seconds (at a rate of 100 per minute).

5. Give two full breaths.
   a. Move quickly to the casualty's head and lean over.
   b. Open the casualty's airway. (See task 081-831-0018.)
   c. Give two full breaths (1.5 to 2 seconds each).

6. Repeat steps 2 through 5 four times.

7. Assess the casualty.
   a. Check for the return of the carotid pulse for 3 to 5 seconds.
      (1) If the pulse is present, continue with step 7b.
      (2) If the pulse is absent, continue with step 8.

Performance Steps

b. Check breathing for 3 to 5 seconds.
   (1) If breathing is present, monitor breathing and pulse closely.
   (2) If breathing is absent, perform rescue breathing only. (See task 081-831-0048.)

8. Resume CPR with compressions.

9. Recheck for pulse every 3 to 5 minutes.

10. Continue to alternate chest compressions and rescue breathing until--
    a. The casualty is revived.
    b. You are too tired to continue.
    c. You are relieved by competent person(s).
    d. The casualty is pronounced dead by an authorized person.
    e. A second rescuer states, "I know CPR," and joins you in performing two-rescuer CPR.

NOTE: A qualified second rescuer joins the first rescuer at the end of a cycle after a check for pulse by the first rescuer. The new cycle starts with one ventilation by the first rescuer, and the second rescuer becomes the compressor. Two-rescuer CPR is then initiated.

11. Perform two-rescuer CPR, if applicable.
    a. Compressor: Give 15 chest compressions at the rate of 100 per minute.
       Ventilator: Maintain an open airway and monitor the carotid pulse occasionally for adequacy of chest compressions.
    b. Compressor: Pause.
       Ventilator: Give two full breaths (over 2 seconds).
    c. Compressor: Continue to give chest compressions until a change in positions is initiated.
       Ventilator: Continue to give ventilations until the compressor indicates that a change is to be made.
    d. Compressor: Give a clear signal to change positions.
       Ventilator: Remain in the rescue breathing position.
    e. Compressor: Give the 15th compression.
       Ventilator: Give two breaths following the 15th compression.
    f. Compressor and ventilator simultaneously switch positions.
    g. New Ventilator: Check the casualty's carotid pulse for 5 seconds.
       * If present state, "There is a pulse," and perform rescue breathing.
       * If not present state, "No pulse." Tell the new compressor to give chest compressions.
       New compressor: Position the hands to begin chest compressions as directed by the ventilator.
    h. Ventilator: Continue to give two breaths on each 15th upstroke of chest compressions and ensure that the chest rises.
       Compressor: Continue to give chest compressions at the rate of 100 per minute.

NOTE: If signs of gastric distension are noted, do the following: 1. Recheck and reposition the airway. 2. Watch for the rise and fall of the chest. 3. Ventilate the casualty only enough to cause the chest to rise.

CAUTIONS: 1. Do not push on the abdomen. 2. If the casualty vomits, turn the casualty on the side, clear the airway, and then continue CPR.

NOTE: If the patient is intubated, the ratio of breaths to compressions becomes asynchronous. Give 100 compressions per minute with a ventilation rate of approximately 10 to 12 per minute.

Performance Steps

12. Continue to perform CPR as stated in the task standard.

NOTE: The rescuer doing rescue breathing should recheck the carotid pulse every 3 to 5 minutes.

13. When the pulse and breathing are restored, continue to evaluate the casualty. If the casualty's condition permits, place him or her in the recovery position. (See task 081-831-0018.)

CAUTION: During evacuation, CPR or rescue breathing should be continued en route if necessary. When pulse and breathing are restored, the casualty should be watched closely.

Evaluation Preparation:

Setup: For training and evaluation a CPR mannequin must be used. Place the mannequin face up on the floor. One-rescuer CPR, two-rescuer CPR, or a combination of both (see NOTE after step 10e) can be evaluated. If two soldiers are involved, they will be designated as "rescuer #1" and "rescuer #2." Rescuer #1 will start in the chest compression position and will be the only one scored during performance of the task. The evaluator will ensure that all aspects of the task are evaluated by indicating whether pulse is present and when the rescuers should change positions.

Brief soldier: If two soldiers are involved, tell them about their roles as rescuer #1 and #2. Ask rescuer #1 on what kind of surface the casualty should be positioned. Then, tell the soldier(s) to perform one-rescuer or two-rescuer CPR, as appropriate.

Performance Measures	**GO**	**NO GO**
1. Positioned the casualty on a hard flat surface.	____	____
2. Properly positioned the hands during chest compressions.	____	____
3. Administered the correct number of chest compressions.	____	____
4. Gave the chest compressions at the rate of 80 to 100 per minute.	____	____
5. Administered the correct number of breaths.	____	____
6. Gave the breaths at the correct rate.	____	____
7. Checked the carotid pulse for about 5 seconds approximately 1 minute after starting CPR.	____	____
8. Rechecked the carotid pulse every 3 to 5 minutes.	____	____
9. Performed the transition to two-rescuer CPR correctly, if applicable.	____	____
10. Changed positions during two-rescuer CPR correctly, if applicable.	____	____
11. Continued CPR as stated in the task standard.	____	____

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	Related
None	EMERGENCY CARE

CONTROL BLEEDING

081-833-0161

Conditions: You have encountered a casualty who is bleeding externally and may also be bleeding internally. Body substance isolation precautions have been taken, as appropriate. You will need field dressings, cravats, gauze pads, gauze roller bandage, and materials for a tourniquet.

Standards: Controlled bleeding without further harming the casualty.

Performance Steps

1. Determine if the bleeding is external or internal.
    a. External bleeding (go to step 2).
    b. Internal bleeding (see tasks 081-833-0047, 081-833-0062, 081-833-0064, and 081-833-0154).
        (1) Large bruises on the trunk or abdomen indicating injury to underlying organs.
        (2) Painful, swollen or deformed extremities indicating underlying fractures.
        (3) Rigid and/or tender abdomen.
        (4) Bleeding from the mouth, rectum, or other body orifice.
        (5) Vomiting bright red or dark (like coffee grounds) blood.
        (6) Bloody stool that is dark and tarry or bright red.

2. Apply direct pressure to the wound with a gauze pad or field dressing.

NOTE: If bleeding is profuse, apply direct pressure to the wound with your gloved hand. Do not waste time looking for a dressing.

3. Elevate the affected extremity above the level of the heart.

CAUTION: Do not elevate if there are suspected musculoskeletal injuries, impaled objects in the extremity, or spinal injury.

4. Apply additional dressings if the wound continues to bleed.

CAUTIONS: 1. Never remove a dressing once it has been applied to a wound. Removing the dressing may destroy any clotting that has begun, thus causing further injury to the site. In some cases, leaving the blood soaked dressing in place allows more bleeding. In this instance, remove the dressing and redress once to be sure direct pressure is being placed on the wound. 2. Once bleeding has been controlled it is important to check a distal pulse to make sure that the dressing has not been applied too tightly. If a pulse is not palpable, adjust the dressing to reestablish circulation.

NOTE: If using gauze pads or similar material to dress a wound, bandage the dressing in place.

5. Locate and apply pressure to the appropriate arterial pressure point, if the wound continues to bleed.

NOTE: Pressure points may not be effective if the wound is at the distal end of the limb. Blood is being sent to these areas from many smaller arteries.

    a. Brachial artery--used to control bleeding from the distal end of an upper extremity.
        (1) Hold the casualty's arm out at a right angle to his or her body with the palm facing up.

NOTE: Do not use force to raise the arm if the movement causes pain.

        (2) Locate the groove between the humerus and the biceps muscle.

Performance Steps

(3) Hold the upper arm in the palm of your hand with your fingers positioned in the medial groove.
(4) Press your fingers into the groove to compress the artery against the underlying bone.

NOTE: If pressure is applied properly, the radial pulse will not be palpable.

b. Femoral artery--used to control bleeding of a lower extremity.
(1) Locate the femoral artery on the medial side of the anterior thigh, just below the groin.
(2) Place the heel of your hand over the site and apply pressure toward the bone.

NOTE: More pressure is needed to compress the femoral artery than the brachial artery due to the amount of tissue and muscle in the thigh. Greater force is needed for obese and muscular individuals. If pressure is applied properly, a distal pulse will not be palpable.

6. Consider other conjunctive therapies to slow bleeding if necessary.
a. Splinting (see task 081-831-0044).

NOTE: Airsplints are effective in controlling venous and capillary bleeding. They are not usually effective in high pressure arterial bleeds. Airsplints are effective, however, in maintaining pressure once other manual methods, such as pressure dressings, have been applied.

b. Cold application.

NOTE: Cold minimizes swelling and constricts blood vessels.

CAUTION: Never apply icepacks directly to the skin. Always wrap cold packs in cloth before applying to the skin. Do not apply ice for more than 20 minutes at a time.

c. Pneumatic anti-shock garments (PASG) (see task 081-833-3011).

NOTE: Though controversial, PASG can be useful in controlling bleeding to lower extremities. Refer to local SOP for guidance on application.

CAUTION: Never inflate only the abdominal section. PASG are contraindicated in chest injuries.

7. Apply a tourniquet if the wound continues to bleed. See task 081-833-0047.

CAUTION: A tourniquet is a last resort for life-threatening injuries. Tourniquets cut off blood flow to and from the extremity and are likely to cause permanent damage to vessels, nerves, and muscles. Never loosen or remove the tourniquet after it has been applied.

NOTE: A blood pressure cuff can provide a temporary tourniquet to control bleeding until a pressure dressing is applied. Place the cuff above the wound and inflate it to 150 mm Hg. Deflate the cuff slowly once a bandage has been applied.

8. Initiate treatment for shock as needed (see task 081-833-0047).

9. Assess the need for evacuation.

10. If the source of bleeding was due to a traumatic amputation--
a. Wrap the amputated part in a sterile dressing.
b. Wrap or bag the amputated part in plastic.
c. Label the bag or plastic.
d. Transport the amputated part in a cool container with the patient.

CAUTION: Do not place the amputated part directly on ice. Do not submerge it directly in water. Do not allow the part to freeze.

Performance Measures	GO	NO GO
1. Determined the type of bleeding (internal or external).	____	____
2. Performed measures to control external bleeding. a. Applied direct pressure to the wound. b. Elevated the extremity. c. Applied additional dressings to the wound, if needed. d. Located and applied pressure to the appropriate arterial pressure point, if needed. e. Applied a tourniquet, if needed.	____	____
3. Initiated treatment for shock.	____	____
4. Assessed the need for transport.	____	____
5. Performed measures for continuous monitoring.	____	____
6. Caused no further injury.	____	____

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	Related
None	BTLS FOR PARAMEDICS EMERGENCY CARE

TREAT A CASUALTY WITH AN OPEN ABDOMINAL WOUND

081-833-0045

Conditions: All other more serious injuries have been treated. You are not in an NBC environment. You will need field dressings, cravats, scissors, gauze, saline solution, and intravenous (IV) equipment.

Standards: Treated an open abdominal wound, minimized the effects of the injury, and stabilized the casualty without causing additional injury.

Performance Steps

1. Treat for shock. (See task 081-833-0047.)

WARNING: The most important concern in the initial management of abdominal injuries is shock. Shock may be present initially or develop later. Neither the presence nor absence of a wound, nor the size of the external wound are safe guidelines for judging the severity of the wound.

   a. Ensure the casualty has a patent airway.
   b. Initiate two large bore (16 gauge) IVs if the casualty is exhibiting signs and symptoms of shock.

2. Position the casualty.
   a. Place the casualty on his or her back (face up).
   b. Flex the casualty's knees.
   c. Turn the casualty's head to the side and keep the airway clear if vomiting occurs.

3. Expose the wound.

CAUTION: Do not attempt to replace protruding internal organs or remove any protruding foreign objects.

4. Stabilize any protruding objects. (See task 081-833-0046.)

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.

   a. Using the sterile side of the dressing, or other clean material, place any protruding organs near the wound.
   b. Ensure that the dressing is large enough to cover the entire mass of protruding organs or area of the wound.
   c. If large enough to cover the affected area, place the sterile side of the plastic wrapper directly over the wound.
   d. Place the dressing directly on top of the wound or plastic wrapper, if used.
   e. Tie the dressing tails loosely at the casualty's side.

CAUTION: Do not apply pressure on the wound or expose internal parts.

   f. If two dressings are needed to cover a large wound, repeat steps 5a through 5e. Ensure that the ties of additional dressings are not tied over each other.
   g. If necessary, loosely cover the dressings with cravats. Tie them on the side of the casualty opposite that of the dressing ties.

6. Do not cause further injury to the casualty.
   a. Do not touch any exposed organs with bare hands.
   b. Do not try to push any exposed organs back into the body.

Performance Steps

c. Do not tie the dressing tails tightly or directly over the dressing.
d. Do not give the casualty anything by mouth (NPO).

NOTE: Continue to assess the casualty, if necessary.

7. Prepare the casualty for evacuation.
   a. Place the casualty on his or her back (face up) with the knees flexed.
   b. If evacuation is delayed, check the casualty for signs of shock every 5 minutes.
8. Record the treatment given on the Field Medical Card.

Performance Measures	**GO**	**NO GO**
1. Treated for shock.	____	____
2. Positioned the casualty.	____	____
3. Exposed the wound.	____	____
4. Stabilized any protruding objects.	____	____
5. Applied a sterile abdominal dressing.	____	____
6. Prepared the casualty for evacuation.	____	____
7. Recorded the treatment given on the Field Medical Card.	____	____
8. Did not cause further injury 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	**Related**
None	BTLS FOR PARAMEDICS EMERGENCY CARE

TREAT A CASUALTY WITH AN OPEN OR CLOSED HEAD INJURY

081-833-0052

Conditions: The casualty you are assessing has a head injury. All other more serious injuries have been treated. You will need field dressings, cravats, stethoscope, sphygmomanometer, oxygen tank set up, oropharyngeal airway, nonrebreather, bag-valve-mask, and intravenous (IV) setup.

Standards: Treated a head injury, minimizing the effects of the injury, and stabilized the casualty without causing additional injury.

Performance Steps

WARNING: Treat casualties with any type of traumatic head injury or loss of consciousness as if they have a spinal injury

1. Take appropriate body substance isolation precautions.
2. Check for the signs and symptoms of head injuries.
    a. Superficial wound.
        (1) Lacerated, torn, ragged, or mangled skin tissue.
        (2) Copious bleeding, possible exposed skull.

WARNING: Do not manipulate the wound to observe the skull.

    b. Closed head injury--caused by a direct blow to the head.

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) Deformity of the head.
        (2) Clear fluid or blood escaping from the nose and/or ear(s).
        (3) Periorbital discoloration (raccoon eyes).
        (4) Bruising behind the ears, over the mastoid process (battle 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, and/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 hasn't 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.

    c. 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.

Performance Steps

d. 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.
e. 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.

3. Direct manual stabilization of the casualty's head.

4. Check the casualty's vital signs.

5. Assess the casualty's level of consciousness using the AVPU scale.
a. A--alert. The casualty responds spontaneously to stimuli and is able to answer questions in a clear manner.
b. V--verbal. The casualty does not respond spontaneously but is responsive to verbal stimuli.
c. P--pain. The casualty does not respond spontaneously or to verbal stimuli but is responsive to painful stimuli.
d. U--unresponsive. The casualty is unresponsive to any stimuli.

6. Assess the casualty's pupil size.
a. Observe the size of each pupil.

NOTE: A variation of pupil size may indicate a brain injury. In a very small percentage of people, unequal pupil size is normal.

b. Shine a light into each eye to observe the pupillary reaction to light.

NOTE: The pupils should constrict promptly when exposed to bright light. Failure of the pupils to constrict may indicate brain injury.

7. Assess the casualty's motor function.
a. Evaluate the casualty's strength, mobility, coordination, and sensation.
b. Document any complaints, weakness, or numbness.

NOTE: Progressive loss of strength or sensation is an important indicator of brain injury.

8. Treat the head injury.
a. Treat a superficial head injury.
(1) Apply a dressing.
(2) Observe for abnormal behavior or evidence of complications.
b. Treat a head injury involving deep trauma.
(1) Maintain a patent airway using the jaw thrust maneuver (see task 081-831-0018).
(2) If the patient is unconscious, insert an oropharyngeal airway without hyperextending the neck (see task 081-833-0016).
(3) Administer high concentration oxygen by nonrebreather mask and evaluate the need for artificial ventilations with supplemental oxygen.

NOTE: If the casualty shows signs of brain injury (increased pulse, decreased blood pressure, and an decreased level of consciousness), hyperventilate the patient with supplemental oxygen at a rate of at least 25 ventilations per minute.

(4) Apply a cervical collar (see task 081-833-0092).

Performance Steps

(5) Dress the head wound(s).
(6) Control bleeding.

WARNING: Do not apply pressure to or replace exposed brain tissue.

(7) Treat for shock.
(8) Monitor the casualty for convulsions or seizures. (See task 081-831-0035.)
(9) Position the casualty with the head elevated 6 inches to assist with the drainage of blood from the brain.

CAUTION: Do not give the casualty anything by mouth.

9. Continue to monitor the casualty and check and record the following at 5 minute intervals.
   a. Level of consciousness.
   b. Pupillary responsiveness and equality.
   c. Vital signs.
   d. Motor functions.
10. Record the treatment on the appropriate form.
11. Evacuate the casualty.

Evaluation Preparation:

Setup: For training and evaluation, have another soldier act as the casualty. Use a moulage kit or similar materials to simulate a head wound. To test steps 2 and 7, coach the simulated casualty on how to answer the soldier's questions regarding such symptoms as headache. Tell the soldier what signs, such as changes in pupil size, the casualty is exhibiting.

Brief soldier: Tell the soldier to identify the type of head injury and treat the casualty for a head injury.

Performance Measures	**GO**	**NO GO**
1. Took appropriate body substance isolation procedures.	____	____
2. Checked for the signs and symptoms of head injuries.	____	____
3. Directed manual stabilization of the casualty's head.	____	____
4. Checked the casualty's vital signs.	____	____
5. Assessed the casualty's level of consciousness using the AVPU scale.	____	____
6. Assessed the casualty's pupil size.	____	____
7. Assessed the casualty's motor function.	____	____
8. Treated the head injury.	____	____
9. Continued to monitor the casualty at 5 minute intervals.	____	____
10. Recorded the treatment on the appropriate form.	____	____
11. Evacuated the casualty.	____	____
12. Did not cause further injury 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	**Related**
None	BTLS FOR PARAMEDICS EMERGENCY CARE

INITIATE TREATMENT FOR HYPOVOLEMIC SHOCK

081-833-0047

Conditions: You are in the field and are assessing a casualty who is suffering from a severe loss of body fluids. All other more serious injuries have been treated. You will need intravenous (IV) infusion set, IV fluids, splints, stethoscope, sphygmomanometer, and a blanket or poncho.

Standards: Initiated treatment for hypovolemic shock, stabilized the casualty, minimized the effect of shock, and prepared for immediate evacuation without further injury to the casualty.

Performance Steps

NOTE: Hypovolemic shock results when there is a decrease in the volume of circulating fluids (blood and plasma) in the body. If dehydration (loss of body water) is present at the time of injury, shock will develop more rapidly.

1. Maintain the airway.

NOTE: Administer oxygen, if available. (See task 081-833-0019).

2. Reassure the casualty to reduce anxiety.

NOTE: Anxiety increases the heart rate, which worsens the casualty's condition.

3. Initiate two large bore (16 gauge) IVs. (See task 081-833-0033).

NOTE: To replace fluid loss accompanying injury, Ringer's lactate is the fluid of choice. Normal saline is the second choice.

4. Maintain the IV flow.
    a. Continue the flow wide open until the systolic blood pressure stabilizes at greater than 90 mm Hg.
        (1) The usual amount is 1 to 2 liters of fluid or 300 ml for each 100 ml of blood loss.
        (2) A palpable radial pulse usually indicates that the casualty has a systolic blood pressure of about 80 mm Hg.
    b. Once the blood pressure has stabilized, decrease the IV flow rate to maintain the systolic blood pressure above 90 mm Hg.

5. Elevate the casualty's legs.
    a. Elevate the casualty's legs above chest level, without lowering the head below chest level.

NOTE: Splint leg or ankle fractures before elevating the legs, if necessary.

    b. If the casualty is on a litter, elevate the foot of the litter.

6. Maintain normal body temperature.
    a. Watch for signs of sweating or chilling.
    b. Cover the casualty in cold weather.
    c. Do not cover the casualty in hot weather unless signs of chilling are noted.

7. Monitor the casualty.

NOTE: Give nothing by mouth. Moisten the casualty's lips with a wet cloth.

    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.
    c. Check capillary refill.

NOTE: If the blood pressure is unstable or drops, the pneumatic anti-shock garment should be applied by qualified personnel.

Performance Steps

8. Record the procedure on the Field Medical Card.
9. Evacuate the casualty.

Evaluation Preparation:
Setup: For training and evaluation, have another soldier act as the casualty. For step 3, have the soldier state what actions are taken when an IV infusion is initiated.

Brief soldier: Tell the soldier to initiate treatment for hypovolemic shock.

Performance Measures	GO	NO GO
1. Maintained the airway.	____	____
2. Reassured the casualty to reduce anxiety.	____	____
3. Initiated two large bore IVs.	____	____
4. Maintained the IV flow.	____	____
5. Elevated the casualty's legs.	____	____
6. Maintained normal body temperature.	____	____
7. Monitored the casualty.	____	____
8. Recorded the procedure on the Field Medical Card.	____	____
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	Related
None	BTLS FOR PARAMEDICS EMERGENCY CARE

TRANSPORT A CASUALTY WITH A SUSPECTED SPINAL INJURY

081-833-0092

Conditions: All other more serious injuries or conditions have been treated. Three or four soldiers are available for assistance. You will need straps, cravats, towels, long and short spine boards, safety pins, and materials to improvise a cervical collar and head supports.

Standards: Completed all the steps necessary to immobilize and transport a casualty with a suspected spine injury without causing additional injury to the casualty.

Performance Steps

1. Check for the signs and symptoms of a spinal injury.

WARNING: If you suspect that the casualty has a spinal injury, treat him or her as though he or she does have a spinal injury.

   a. Spinal deformity. Its presence indicates a severe spinal injury, but its absence does not rule one out.
   b. Tenderness and/or pain in the spinal region.
      (1) Detect it by palpation or ask the casualty.
      (2) The presence of any pain is sufficient cause to suspect the presence of a spinal injury.
   c. Lacerations and/or contusions in the spinal region indicate severe trauma and usually accompany a spinal injury.

NOTE: The absence of lacerations and/or contusions does not rule out a spinal injury.

   d. Weakness, loss of sensation, and/or paralysis.
      (1) A neck level (cervical) spine injury may cause numbness or paralysis in all four extremities.
      (2) A waist level spinal injury may cause numbness or paralysis below the waist.
      (3) Ask the casualty to try to move the fingers and toes to check for paralysis.
   e. Palpate the spine for pain.
      (1) Carefully insert the hand under the neck and feel along the cervical spine as far as can be done without disturbing the casualty's spine.
      (2) Carefully insert the hand into the cavity formed by the small of the back and feel along the thoracic spine and down the lumbar spine as far as possible without disturbing the spine.
      (3) If the casualty says that an area of the spine is tender, consider that he or she has a spinal injury.

2. Secure the casualty to a short spine board (if using Kendrick Extrication Device (KED) go to step 3).

NOTE: Apply a short spine board when extricating a casualty from a vehicle or location that will not accommodate the use of a long spine board. If available use a KED which is a commercial spine board.

   a. Direct an assistant to immobilize the casualty's head and neck using manual stabilization.
      (1) Place the hands on both sides of the casualty's skull, with the palms over the ears.
      (2) Support the jaw (mandible) with the fingers.
      (3) Maintain manual stabilization until directed to release the stabilization.
   b. Apply a cervical collar, if available, or improvise one.
   c. Push the board as far into the area behind the casualty as possible.

Performance Steps

d. Tilt the upper end of the board toward the head.
e. Direct the assistant to position the back of the casualty's head against the board, maintaining manual 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.

f. 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, sandbags, 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.

g. Secure the casualty to the short spine board.
(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.

h. Tie the casualty's hands together and place them in his or her 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.

3. Secure the casualty to a KED.
a. Direct an assistant to immobilize the casualty's head and neck using manual stabilization.
(1) Place the hands on both sides of the casualty's skull, with the palms over the ears.
(2) Support the jaw (mandible) with the fingers.
(3) Maintain manual stabilization until directed to release the stabilization.
b. Position the immobilization device behind the patient.
c. Secure the device to the patient's torso.
(1) Immobilize the torso, from the top to the bottom strap.
(2) Apply the pelvic straps, ensuring to pad the groin area.
d. Secure the patient's head to the device.
(1) Pad behind the patient's head as necessary.
(2) Place one cravat across the chin angle towards the ear, ensuring the cravat does not interfere with the airway. Tie cravats to the side of the device.
(3) Place a cravat across the forehead angle towards the base of the head, and tie it to the side of device.
e. Evaluate and adjust the straps. They must be tight enough so the device does not move excessively up, down, left, or right, but not so tight as to restrict the patient's breathing.

NOTE: The pelvic straps must be released after being placed on a long spine board.

Performance Steps

4. Place the casualty on a long spine board.

NOTE: If a 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) Place the spine board next to, and parallel with, the casualty.
   (2) Immobilize the casualty's head and neck using manual stabilization.
      (a) Place your hands on both sides of the casualty's skull, with the palms over the ears.
      (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. (See steps 2b(1) through 2b(5).)
   (4) Brief each of the three assistants on their duties and instruct them to kneel on the same side of the casualty, with the 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 your command, and in unison, the assistants roll the casualty slightly toward them. Turn the casualty's head slightly, keeping it in a straight line with the spine.
   (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. Keep the head and spine in a straight line.
   (8) Place the casualty's wrists together at the waist and tie them together loosely.

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.

b. The straddle-slide technique.

NOTE: Use this method when limited space makes it impossible to use the log roll technique.
   (1) Stand at the head of the casualty with your feet wide apart.
   (2) Apply stabilization to the casualty's head and apply a cervical collar. (See steps 3a(2) through 3a(3).)
   (3) Instruct the first assistant to stand behind you (facing your back), to line up the spine board, and to gently push 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.
   (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.

Performance Steps

WARNING: Complete all movements simultaneously, keeping the head and spine in a straight line.

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.

5. Secure the casualty to the long spine board.
    a. Secure the casualty's head and head supports to the board with straps or cravats.

WARNING: Do not release manual stabilization until the cravats or head straps are firmly in place.

(1) Apply head supports.
(2) Use two rolled towels, blankets, sandbags, 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. (See Figure 3-5.)

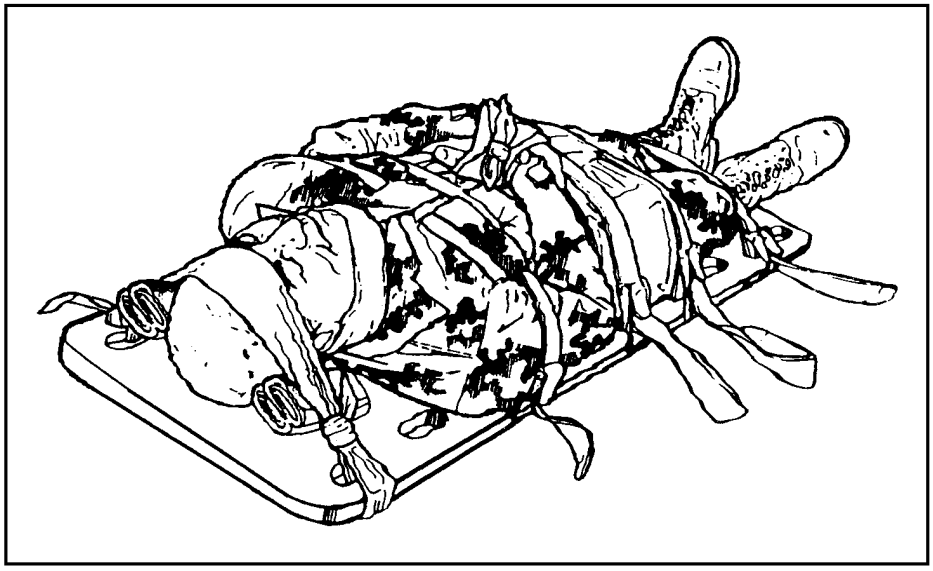

Figure 3-5

    b. Secure the casualty with straps across the chest, hips, thighs, and lower legs.

NOTE: Include the arms if the straps are long enough. If the spine board is not provided with straps and fasteners, use cravats or other long strips of cloth.

WARNING: Securely immobilize the casualty's head and neck. Fill socks with sand and place them on both sides of the head and neck to keep it from moving.

6. Record the treatment on the Field Medical Card.
7. Evacuate the casualty.

Evaluation Preparation:
Setup: For training and evaluation, have another soldier act as the casualty. You will need three or four soldiers to act as the assistants. The soldier being tested is to act as the team leader and direct the actions of the assistants. The casualty may be placed in a vehicle or other scenario, depending on available resources and the technique you are testing. Tell the casualty not to assist the soldiers in any way.

Brief soldier: To test step 1, tell the soldier to state the signs and symptoms of a spinal injury. Tell the soldier that the casualty has a suspected spinal injury. Then tell the soldier to position the casualty on a spine board and to direct the actions of the assistants.

Performance Measures	GO	NO GO
1. Checked for signs and symptoms of a spinal injury.	____	____
2. Secured the casualty on a short spine board or KED, if appropriate.	____	____
3. Placed the casualty on the long spine board.	____	____
4. Secured the casualty on the long spine board.	____	____
5. Recorded the treatment on the Field Medical Card.	____	____
6. Evacuated the casualty.	____	____
7. Did not cause further injury 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	Related
None	BTLS FOR PARAMEDICS EMERGENCY CARE

PROVIDE BASIC EMERGENCY TREATMENT FOR A PAINFUL, SWOLLEN, DEFORMED EXTREMITY

081-833-0154

Conditions: You have encountered a patient who presents with a musculoskeletal injury. You have already taken body substance isolation precautions and done your initial assessment. You will need cravats, splinting materials, oxygen, nonrebreather mask, and IV materials.

Standards: Provided treatment without causing further injury to the patient. Immobilized the extremity, minimizing the effect to the patient.

Performance Steps

1. Identify the signs and symptoms of a musculoskeletal injury.
    a. Pain and tenderness, especially when the injured part is touched or moved.
    b. Deformity or angulation.

NOTE: When in doubt, look at the uninjured side and compare it to the injured one.

    c. Crepitus.
    d. Swelling.
    e. Bruising.
    f. Exposed bone ends.
    g. Joints locked into position.
    h. Impaired circulation, motor function, and sensation.

2. Splint the extremity (see tasks 081-833-0141, 081-831-0044, 081-833-0061, 081-833-0062, and 081-833-0064).

NOTES: 1. In order for any splint to be effective, it must immobilize the adjacent joints and bone ends.

2. If the patient is unstable, immobilize on a long spine board and transport immediately.
    a. Manually stabilize the injury site. This can be done by you, your assistant, or the patient.

NOTE: Maintain manual stabilization or traction during positioning and until the splinting process is complete.

    b. Assess pulse, motor function, and sensation.
        (1) Check for a pulse.
        (2) Ask if the patient can feel your touch distal to the injury.
        (3) Ask the patient to wiggle the fingers or toes, grasp your fingers, or push the feet against your hands.
    c. Attempt to realign once, if necessary.

NOTE: Attempt to realign only if there is impaired circulation or the extremity is so deformed that splinting would not be effective.

        (1) Gently grasp the distal extremity while your assistant places one hand above and one hand below the injury site.
        (2) Gently pull manual traction in the direction of the long axis of the bone.
        (3) If resistance is felt or it appears that the bone ends will come through the skin, stop and splint the extremity in the position found.
        (4) If no resistance is felt, maintain gentle traction until the extremity is properly splinted.
    d. Measure or adjust the splint.
    e. Apply and secure the splint to immobilize adjacent bones.
    f. Reassess pulse, motor function, and sensation distal to the injury.

Performance Steps

3. Treat for shock (see task 081-833-0047).
4. Consider administration of pain medication.
5. Transport to the nearest medical treatment facility.
6. Document all care given (see tasks 081-833-0145 and 081-831-0033).

Evaluation Preparation:
Setup: For training and evaluation, have one soldier be the patient with a musculoskeletal injury. Brief the patient on the location and complaints of a musculoskeletal injury. Use moulage if available.

Brief soldier: Ask the soldier for signs and symptoms of a musculoskeletal injury and have him perform the appropriate treatment.

Performance Measures	GO	NO GO
1. Identified the signs and symptoms of a musculoskeletal injury.	____	____
2. Splinted the extremity.	____	____
3. Treated for shock.	____	____
4. Considered administration of pain medication.	____	____
5. Transported to the nearest medical treatment facility.	____	____
6. Documented all care given.	____	____

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	Related
None	BTLS FOR PARAMEDICS EMERGENCY CARE

IMMOBILIZE A SUSPECTED FRACTURE OF THE ARM OR DISLOCATED SHOULDER
081-833-0062

Conditions: You will need a wire ladder splint, cravat bandages, basswood splint, and materials for improvising a splint.

Standards: Completed all the steps necessary to immobilize a suspected fracture of the arm or dislocated shoulder without causing additional injury.

Performance Steps

1. Check the casualty's radial pulse. If no pulse is felt, bandage and/or splint the extremity and arrange for immediate evacuation.

2. Positioned the injury.
    a. Position a fractured arm by having the casualty support it with the uninjured arm and hand in the least painful position, if possible.

CAUTION: Do not try to reduce or set the fracture. Splint it where it lies unless a severe deformity makes it necessary to reposition the limb to keep it within the confines of the litter and/or evacuation vehicle.

    b. Position the arm for shoulder dislocations.

CAUTION: Do not use force when moving the limb.

        (1) Posterior. Position the forearm across the midsection of the casualty's body with the hand or wrist slightly higher than the elbow.
        (2) Anterior. Maintain the arm in a fixed, locked position away from the body.
        (3) Turn the palm of the hand in towards the body, if possible.

3. Immobilize the injury.
    a. Use an arm sling to immobilize a dislocated shoulder.
    b. Use a basswood or an improvised splint for a fractured forearm.
        (1) Pad the splint.
        (2) Place the padded splint under the casualty's forearm so that it extends from the elbow to beyond the fingertips.
        (3) Place a rolled cravat or similar material in the palm of the cupped hand.
        (4) Apply the cravats in the following order and recheck the radial pulse after each cravat is applied.
            (a) Above the fracture site near the elbow.
            (b) Below the fracture site near the wrist.
            (c) Over the hand and tied in an "X" around the splint.
        (5) Apply an arm sling and swathe.

NOTE: Ensure that the fingernails are left exposed so that a blanch test may be performed.

    c. Use a wire ladder splint for a fractured humerus, and for multiple fractures of an arm or a forearm when the elbow is bent.
        (1) Prepare the splint using the uninjured arm for measurements.
            (a) Bend the prong ends of the splint away from the smooth side, about 1 1/2 inches down on the outside of the splint.
            (b) With the smooth side against the elbow, place one end of the splint even with the top of the uninjured shoulder.
            (c) Select a point slightly below the elbow.
            (d) Remove the splint from the arm and bend the splint at the measured point to form an "L".

Performance Steps

(e) Pad the splint.

NOTE: If padding is unavailable, apply the splint anyway.

(2) Position the splint on the outside of the injured arm, extending from the shoulder to beyond the fingertips.

NOTES: 1. Extend the "L" angle of the splint beyond but do not touch the elbow of the injured arm. Extend the leg of the angle touching the forearm beyond the ends of the fingers. If the splint is too short, extend it with a basswood splint. 2. If possible, have the casualty support the splint.

(3) Place a rolled cravat or similar material in the palm of the cupped hand.

(4) Check the radial pulse. Make a note on the Field Medical Card if the pulse is absent or if the pulse was lost after treatment.

(5) Apply the cravats in the following order and recheck the radial pulse after each cravat is applied.

(a) On the humerus above any fracture site.

(b) On the humerus below any fracture site.

(c) On the forearm above any fracture of the forearm.

(d) On the forearm below any fracture site.

(e) Around the hand and splint.

(6) Tie each cravat on the outside edge of the splint.

NOTE: If the pulse is weaker or absent after tying the cravat, loosen and retie the cravat.

(7) Apply an arm sling and swathe.

d. Use a wire ladder splint for a fractured or dislocated humerus, elbow, or forearm when the elbow is straight.

(1) Prepare the splint as in step 3c(1) but bend it only enough to fit the injured arm.

(2) Position the splint on the outside of the arm against the back of the hand.

(3) Apply the cravats in the following order and recheck the radial pulse after each cravat is applied.

(a) Above the injury.

(b) Below the injury.

(c) High on the humerus, above the first cravat.

(d) Around the hand and wrist.

(4) Tie each cravat on the outside of the splint.

NOTE: If the pulse is weaker or absent after tying the cravat, loosen and retie the cravat.

(5) Apply swathes.

(a) Place the arm toward the midline in front of the body. Bind the forearm to the pelvic area with a cravat. Tie the knot on the uninjured side.

(b) Apply an additional cravat above the elbow. Secure it on the uninjured side at breast pocket level.

4. Record the treatment given on the Field Medical Card (FMC).

5. Evacuate the casualty.

Performance Measures	**GO**	**NO GO**
1. Positioned the injury.	____	____
2. Checked the radial pulse.	____	____
3. Immobilized the injury.	____	____

Performance Measures	GO	NO GO
4. Recorded the treatment on the FMC.	____	____
5. Evacuated the casualty.	____	____
6. Did not cause further injury 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	Related
None	BTLS FOR PARAMEDICS

APPLY A PNEUMATIC SPLINT TO A CASUALTY WITH A SUSPECTED FRACTURE OF AN EXTREMITY

081-831-0044

Conditions: You are evaluating a casualty who has a suspected fractured extremity. You will need a pneumatic splint.

Standards: Immobilized an extremity without causing unnecessary injury or impairing circulation.

Performance Steps

1. Check the equipment both visually and manually for the following:
   a. Holes.
   b. Function of the air valve.
   c. Function of the zipper.
2. Open the splint completely and place it next to the injured extremity.
3. Lift and support the injured extremity.
4. Place the splint under the injured extremity and position the splint around the injured area.
5. Inflate the splint.
   a. Draw the zipper completely closed.
   b. Inflate the splint by mouth until a slight indentation can be made with a thumb or finger.

CAUTION: Do not use an air pump.

6. Monitor the splint.
   a. Partially deflate the splint every 20 to 30 minutes to reestablish peripheral circulation.
   b. In an aircraft limit the inflation pressure to that which is adequate for fracture support only.

CAUTION: Do not overinflate. Temperature and air pressure may cause too much pressure to be exerted, thereby cutting off circulation to the extremity.

7. Check for peripheral circulation.
   a. Check the color and temperature of the limb distal to the splint.
   b. Question the casualty about numbness and tingling sensations.
   c. If the circulation is impaired, partially deflate the splint.

Evaluation Preparation:
Setup: For training and evaluation have another soldier act as the casualty and specify the location of the fracture.

Brief soldier: Tell the soldier to apply the pneumatic splint to the specified fractured extremity. To test step 6, have the soldier tell you what he or she would do to monitor the splint under normal conditions and in an aircraft.

Performance Measures	GO	NO GO
1. Checked the equipment both visually and manually.	____	____
2. Opened the splint completely and placed it next to the injured extremity.	____	____
3. Lifted and supported the injured extremity.	____	____
4. Placed the splint under the injured extremity and positioned the splint around the injured area.	____	____
5. Inflated the splint.	____	____
6. Monitored the splint.	____	____
7. Checked for peripheral circulation.	____	____
8. Did not cause further injury 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	Related
None	BTLS FOR PARAMEDICS

ADMINISTER INITIAL TREATMENT FOR BURNS

081-833-0070

Conditions: You are in a field environment. You will need field dressings, sterile dressings, Ringer's lactate or normal saline, and an intravenous (IV) setup. You are not in an NBC environment.

Standards: Administered initial treatment IAW the type and extent of the casualty's burns. Stabilized the casualty without causing further injury to the casualty or injuring self.

Performance Steps

1. Determine the cause of the burns.
    a. Assess the scene.
    b. Question the casualty and/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. He or she 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, and/or splash with water.
        (2) Remove all smoldering clothing and articles that retain heat, if possible.
        (3) Cut away clothing to expose the burned area.

CAUTIONS: 1. Do not remove clothing that is stuck to the burned area. If the clothing and skin are still hot, immerse in clean, cold water or cover with a wet dressing, if available. Do not immerse the burned area for more than 10 minutes. Prolonged cold water immersion, particularly of an extensive burn, can cause hypothermia (loss of body heat). 2. Immerse third degree burns only if they are still burning. Infection is the greatest danger of a third degree burn. Immersion other than to stop the burning may increase the risk of infection.

    b. Electrical burns.
        (1) Turn off the current, if possible.
        (2) If the current cannot be turned off, stand on a dry surface and move the casualty with nonconductive material such as rubber gloves or a wooden pole.

WARNING: Do not directly touch a casualty receiving a shock. To do so will conduct the current to you.

        (3) If necessary and/or possible, remove the electrical source from the casualty.

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.

    c. Chemical burns.

WARNING: A chemical will burn as long as it is in contact with the skin.

Performance Steps

(1) Flush the area of contact immediately with water. Do not delay flushing by removing 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.

(2) Flush with cool water for 10 to 15 minutes while removing contaminated clothing or other articles.

NOTES: 1. Flush longer for alkali burns because they penetrate deeper and cause more severe injury. 2. Many chemicals have a delayed reaction. They will continue to cause injury even though the casualty no longer feels pain.

WARNING: Do not use a hard blast of water. Extreme water pressure can add mechanical injury to the skin.

d. White phosphorus burns.

NOTE: White phosphorus (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: Do not use any type of petroleum product to smother the WP. This will cause it to be more rapidly absorbed into the body.

3. Maintain an open airway, if necessary. (See task 081-831-0018.)

NOTE: As long as 30 to 40 minutes may elapse before edema obstructs the airway and respiratory distress is noted.

a. Check for signs and symptoms of inhalation injury.
   (1) Facial burns.
   (2) Singed eyebrows, eyelashes, and/or nasal hairs.
   (3) Carbon deposits and/or redness in the mouth and/or oropharynx.
   (4) Sooty carbon deposits in the sputum.
   (5) Hoarseness, noisy inhalation, brassy sounding cough, or dyspnea.

b. Check for signs and symptoms of carbon monoxide poisoning.
   (1) Dizziness, nausea, and/or headache.
   (2) Cherry-red colored skin and mucous membranes.
   (3) Tachycardia or tachypnea.
   (4) Respiratory distress or arrest.

c. Administer humidified oxygen at a high flow rate. (See tasks 081-833-0018 and 081-833-0019.)

4. Determine 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. (See Figure 3-6.)

Performance Steps

Rule of Nines		
1. Head and neck	=	9%
2. Anterior trunk	=	18%
3. Posterior trunk	=	18%
4. Upper extremities	=	18% (each 9%)
5. Lower extremities	=	36% (each 18%)
6. Perineum	=	1%

Figure 3-6

5. Determine the degree of the burns.
    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 a 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.
        (7) Subcutaneous fat may be visible.

CAUTIONS: 1. Check for entry and exit burns when treating electrical burns and lightning strikes. 2. 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 as extent that amputation may eventually be necessary.)

6. Treat for shock those casualties who have second or third degree burns of 20% BSA or more.
    a. Initiate treatment for hypovolemic shock. (See task 081-833-0047.)
    b. Keep the casualty flat.
    c. Initiate an IV. (See task 081-833-0033.)
        (1) Use Ringer's lactate, if available. Normal saline is the second fluid of choice.

Performance Steps

(2) Use a large gauge (#16 or #18) needle.
(3) Initiate the IV in an unburned area, if possible.
(4) Use a large peripheral vein.

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 fluid replacement calculations.
(1) Calculate the casualty's body weight in kilograms (kg).
(a) Determine or estimate the casualty's body weight in pounds.
(b) Divide the casualty's body weight by 2.2. For example, the casualty weighs about 165 pounds.
165/2.2 = 75 kg.
(2) Calculate the amount of fluid to infuse per hour for the next 8 hours.
(a) Determine the percentage of BSA burned (see step 4b). For example, the casualty's BSA burned is 36%.
(b) Multiply 1 milliliter of fluid (1.00 cc) by the percentage of BSA burned. For example, 1.00 cc X 36 = 36 cc.
(c) Multiply the above figure by the casualty's weight, found in step 6d(1). For example, 36 cc X 75 kg = 2700 cc. The casualty will require this much fluid over the next 8 hours.
(d) Divide the above figure by 8 to determine the amount of fluid to give per hour. For example, 2700/8 = 337.5, rounded to 338 cc of fluid per hour (cc/hr).
e. Assess the circulatory blood volume.

NOTE: Urine output is a reliable guide to assess circulating blood volume.

(1) Measure the casualty's urine output in cc per hour.
(2) Adjust the IV fluid flow to maintain 30 to 50 cc of urine output per hour.

7. Stabilize the casualty and perform a secondary assessment.
a. Measure and record the casualty's vital signs.
b. Assess the casualty for associated injuries. (See task 081-833-0151)
c. Check the distal circulation by checking pulses in all extremities.

8. Remove potentially constricting items such as rings and bracelets.

CAUTION: The swelling of burns on extremities can cause a tourniquet-like effect, and the swelling of a burned throat can impair breathing.

9. Apply cold soaks, if applicable.
a. Use for casualties with second degree burns of 10% BSA or less only.
b. Apply the soaks for 10 to 15 minutes only.

CAUTION: Do not immerse or apply cold water to a casualty with extensive burns.

10. Dress the burns.
a. Apply a dry sterile dressing to the burns.

CAUTION: Do not put ointment on the burns and do not break blisters.

b. Cover extensive burns with a sterile sheet, if available, or clean linen.

11. Administer oxygen, if available. (See task 081-833-0019.)

12. Record the treatment given.

13. Evacuate the casualty.

Evaluation Preparation:
Setup: For training and evaluation, have another soldier act as the casualty. You may use a moulage kit or similar material to simulate burns on the casualty, or you may describe to the soldier the area(s) of the body burned. Create a scenario which describes the cause and depth of the burns. For step 2, have the soldier describe what actions should be taken to prevent further injury. To test step 5, describe the depth of the burns and have the soldier tell you if they are first, second, or third degree. When testing step 6, have the soldier describe what actions should be taken when administering IV therapy, if necessary. When testing step 7, have the soldier describe what action is taken.

Brief soldier: Tell the soldier to determine the extent of the casualty's burns and the treatment required.

Performance Measures	GO	NO GO
1. Determined the cause of the burns.	____	____
2. Stopped the burning process.	____	____
3. Maintained the airway, if necessary.	____	____
4. Determined the percent of BSA burned.	____	____
5. Determined the degree of the burns.	____	____
6. Treated the casualty for shock, if necessary.	____	____
7. Stabilized the casualty and performed a secondary assessment.	____	____
8. Removed potentially constricting items.	____	____
9. Applied cold soaks, if applicable.	____	____
10. Dressed the burns.	____	____
11. Administered oxygen, if available.	____	____
12. Recorded the treatment given.	____	____
13. Evacuated the casualty.	____	____
14. Did not cause further injury 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	Related
None	BTLS FOR PARAMEDICS

DECONTAMINATE A CASUALTY

081-833-0095

Conditions: You are supervising the contaminated side of an established chemical decontamination station. Medical personnel and nonmedical augmentees are in MOPP level 4. Chemically contaminated casualties have been triaged by the senior medic and have been routed to your area for decontamination. You will need M258A1 or M291 decontamination kit, 5% chlorine solution, 0.5% chlorine solution, butyl rubber aprons, butyl rubber gloves, stainless steel buckets, cellulose sponges, water source, plastic bags, litters, litter stands, bandage scissors, M8 chemical detection paper, chemical agent monitor (CAM), contaminated disposal containers, bandages, gauze, and tourniquets.

Standards: Removed the casualty's clothing without further contaminating the casualty or contaminating decontamination team personnel. Removed dressings, replaced tourniquets, and decontaminated splints. Effectively decontaminated and transferred the casualty across the shuffle pit without contaminating the clean side of the hot line.

Performance Steps

NOTES: 1. The supported unit must provide a minimum of 8 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. 2. Steps 1 through 17 will be performed by personnel in the clothing removal area. At the clothing removal area two to four persons will be working together as a team, one or two on either side of the casualty.

1. Decontaminate the casualty's hood.
    a. Cover the mask air inlets with your hand. Instruct the casualty to do this if he or she is able.
    b. Wipe off the front, sides, and top of the hood with a cellulose sponge soaked with 5% calcium hypochlorite solution or use the M258A1 or M291 skin decontaminating kit.

NOTE: The medical equipment set (MES) for chemical agent patient decontamination contains powdered calcium hypochlorite (high test hypochlorite or HTH). It is mixed with water to make the 5% and 0.5% decontaminating solutions. Liquid chlorine bleach (household bleach), a 5% solution of sodium hypochlorite, may also be used.

    c. Uncover the mask air inlets.

2. Cut off the casualty's hood.

    a. Dip scissors in the 5% solution.

CAUTION: Dip and scrub the scissors in the 5% solution after each separate cutting procedure and rinse your gloves in the same solution in order to reduce the spread of contamination.

    b. Cut the neck cord.
    c. Cut away the drawstring below the voicemitter.
    d. Release or cut the hood shoulder straps.
    e. Unzip the hood zipper.
    f. Begin cutting at the zipper, below the voicemitter.
    g. Proceed cutting upward, close to the filter inlet covers and eye lens outserts.
    h. Cut upward to the top of the eye lens outserts.
    i. Cut across the forehead to the outer edge of the next eye outsert.

Performance Steps

j. Cut downward toward the patient's shoulder, staying close to the eye lens outserts and filter inlet covers.
k. Cut across the lower part of the voicemitter to the zipper.
l. Dip the scissors and rinse your gloves in the 5% solution.
m. Cut from the center of the forehead, over the top of the head.
n. Fold the left and right sides of the hood to the sides of the casualty's head, laying the sides of the hood on the litter.

3. Decontaminate the casualty's mask and exposed skin.
   a. Use the M258A1 or M291 skin decontamination kit or 0.5% solution.
   b. Cover the mask air inlets as in step 1a.

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

   c. Decontaminate the exterior of the mask.
   d. Wipe down all the exposed skin areas, to include the neck and behind the ears.
   e. Uncover the mask air inlets.

4. Remove the casualty's Field Medical Card (FMC).
   a. Cut the FMC tie-wire, allowing the FMC to fall into a plastic bag. If possible, do not allow any of the tie-wire to remain attached to the card. This will prevent the wire from poking a hole in the bag.
   b. Seal the plastic bag and rinse the plastic bag with the 0.5% solution.
   c. Place the plastic bag under the protective mask head straps.

5. Remove gross contamination on the overgarment by wiping all visible contamination spots with a sponge soaked in 5% solution.

6. Remove the casualty's protective overgarment jacket.

CAUTION: Dip and scrub the scissors in the 5% solution before doing each cutting procedure to avoid contaminating the inner garment or the casualty's skin.

   a. Cut the sleeves from the cuff up to the shoulder of the jacket, and then through the collar. Keep the cuts close to the inside of the arms so that most of the sleeve material can be folded outward.

CAUTION: Medical items are not removed at the clothing removal area. Cut around medical items such as dressings, splints, and tourniquets.

   b. Unzip the jacket (or cut alongside the jacket's zipper).
   c. Roll the chest sections to the respective sides, with the inner black liner outward. Carefully tuck the cut jacket between the arm and the chest.
   d. Roll the cut sleeves away from the arms, exposing the black liner.

7. Remove the casualty's protective overgarment trousers.

CAUTION: Dip and scrub the scissors in the 5% solution before doing each cutting procedure to avoid contaminating the inner garment or the casualty.

   a. Cut the trouser legs from the ankle to the waist. Keep the cuts near the insides of the legs, along the inseam, to the crotch.
      (1) Cut up the right leg and across the crotch of the trousers.
      (2) Cut up the left leg, cross over the crotch cut, and continue to cut up through the waistband.

NOTE: Avoid cutting through the pockets.

   b. Fold the cut trouser halves onto the litter with the contaminated sides away from the casualty. Make sure the outer side of the protective overgarment does not touch the skin or undergarments of the casualty.

Performance Steps

c. Roll the inner leg portion under and between the legs.

8. Remove the casualty's butyl rubber gloves.
   a. Decontaminate your butyl rubber gloves in the 5% solution.
   b. Lift the casualty's arm up and out of the cutaway sleeve unless contraindicated by the casualty's condition.
   c. Pull the butyl rubber gloves off by rolling the cuff over the fingers, turning the glove inside out. Do not remove the white glove liners at this time.
   d. Lower the casualty's arms and fold them across the chest.

CAUTION: Do not allow the arms to come into contact with the exterior of the protective overgarments.

   e. Place the gloves in a contaminated disposal container.
   f. Decontaminate your butyl rubber gloves in the 5% solution.

9. Remove the casualty's protective overboots.
   a. Stand at the foot of the litter facing the casualty.
   b. Cut the protective overboot laces.
   c. Grasp the heel of the protective overboot with one hand and the toe of the protective overboot with the other hand.
   d. Pull the heel downward, and then toward you until the overboot is removed.

NOTE: While you and another team member hold the casualty'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.

   e. Place the overboots in a contaminated disposal container.

10. Remove and secure the casualty's personal effects.
    a. Remove the casualty's personal articles from the overgarment and BDU pockets.
    b. Place the articles in plastic bags.
    c. Label the bags with the casualty's name and SSN. (Print the information on a piece of paper and place the paper in the plastic bag.)
    d. Seal the plastic bags.
    e. If the articles are not contaminated, return them to the casualty. If the articles may be contaminated, place the bags in the contaminated holding area until they can be decontaminated. The articles will then be returned to the casualty.

11. Remove the combat boots following the same procedures as for removing the protective overboots.

NOTE: Remove the boots without touching the patient's inner clothing or exposed skin.

12. Cut off the casualty's battle dress uniform (BDU).

CAUTION: Decontaminate your butyl rubber gloves in the 5% solution before you touch the casualty's garments or exposed skin.

    a. Cut off the BDU shirt.
       (1) Uncross the patient's arms.
       (2) Cut the BDU shirt using the same procedure as for the protective overgarment jacket.
       (3) Recross the casualty's arms over the chest.
    b. Unbuckle or cut the belt material.
    c. Cut off the BDU trousers following the same procedure as for the protective overgarment trousers.

13. Cut off the casualty's undergarments.

Performance Steps

CAUTION: Decontaminate your butyl rubber gloves in 5% solution before you touch the casualty's garments or exposed skin.

a. Cut off the underpants.
b. Cut off the T-shirt.
c. Cut off the brassiere, if necessary.
   (1) Lift the casualty's arm off the chest.
   (2) Cut between the cups.
   (3) Cut both shoulder straps where they attach to the cup.
   (4) Lay the cups away from the casualty onto the litter.
   (5) Lay shoulder straps up and over the shoulders onto the litter.

NOTE: At this point, the white glove inner liners for a female may be removed while the casualty's arms are lifted off her chest.

14. Remove the casualty's glove inner liners.
    a. Remove the glove liners using the same procedure as for removing butyl rubber gloves.
    b. Cross the casualty's arms over the chest.

15. Remove the casualty's socks.
    a. Decontaminate your butyl rubber gloves in 5% solution.
    b. Position yourself at the foot of the litter.
    c. Remove each sock by rolling it down over the foot, turning it inside out or by cutting the sock off.
    d. Place the socks into a contaminated disposal container.

16. Decontaminate the casualty's ID tags.
    a. Decontaminate your butyl rubber gloves in the 5% solution.
    b. Wipe the ID tags with the 0.5% solution.

17. Move the casualty to the skin decontamination area.

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

a. Decontaminate your butyl rubber aprons and gloves in the 5% solution.
b. Lift the casualty out of the cutaway garments, using a three person arms carry.
   (1) Lifter #1 slides his or her arms (palms turned upward) under the casualty's head/neck and shoulders.
   (2) Lifter #2 slides his or her arms (palms turned upward) under the casualty's back and buttocks.
   (3) Lifter #3 slides his or her arms (palms turned upward) under the casualty's thighs and calves.
   (4) On the command of Lifter, bearer #1, lift the casualty. (PREPARE TO LIFT: LIFT.)
c. Once the casualty has been lifted off the litter, all three lifters stand upright and turn the casualty in against their chests.

NOTE: At this point, the casualty has nothing on his or her body except the protective mask and medical items (dressings, splints, tourniquets).

d. While the casualty is being held, another team member quickly removes the contaminated litter and replaces it with a clean litter. A decontaminatable mesh litter should be positioned, if available.
e. Lower the casualty onto the clean litter, in a supine position, on the command of lifter #1.

Performance Steps

f. Carry the litter to the skin decontamination area, and then return to the clothing removal area.
g. Dispose of all contaminated material at the clothing removal area.
   (1) The casualty's contaminated clothing is placed in a bag and put in a contaminated disposal container.
   (2) The dirty litter is rinsed with the 5% decontamination solution and placed in a dirty litter storage area.

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

NOTE: Steps 18 through 23 are performed by personnel in the skin decontamination area. At the skin decontamination area, two to four persons will be working together as a team, one or two on either side of the casualty.

18. Perform spot skin decontamination.
    a. Spot decontaminate potential areas of chemical contamination with the M258A1 or M291 Skin Decontaminating Kit or the 0.5% solution.
    b. Pay particular attention to areas where gaps exist in the MOPP gear, such as the neck, lower part of the face, waistline, wrists, and ankles.

19. Remove field dressings and bandages.

NOTE: This step must be performed by medical personnel.

    a. Carefully cut off dressings and bandages.
    b. Cut off any remaining clothing that was covered by the dressings and bandages.
    c. Decontaminate the exposed areas of skin with the 0.5% solution.
    d. Irrigate the wound with the 0.5% solution if the wound is suspected to be contaminated.

NOTE: Bandages are not replaced unless there is a critical medical need (for example, to control bleeding). Bandages are replaced when the casualty is in the clean (uncontaminated) treatment area.

    e. Place removed dressings and clothing in a contaminated disposal container.

20. Replace any tourniquets.

NOTE: Medical personnel must perform this step.

    a. Decontaminate an area above the existing tourniquet.
    b. Place a new tourniquet 1/2 to 1 inch above the old tourniquet.
    c. Remove the old tourniquet.
    d. Remove any remaining clothing or dressings covered by the old tourniquet.
    e. Decontaminate the newly exposed areas.
    f. Place the removed tourniquet, dressings, and clothing in a contaminated disposal container.

21. Decontaminate any splints.

NOTE: Splints are only removed by a physician.

    a. Stabilize the splinted extremity.
    b. Decontaminate the splint and the extremity by liberally flushing them with the 0.5% solution.

CAUTION: Do not remove any part of a traction splint from a femoral fracture.

22. Check the casualty for contamination.
    a. Use M8 chemical agent detector paper or the chemical agent monitor (CAM).

Performance Steps

b. Decontaminate any areas of detected contamination, as necessary.

CAUTION: Under no circumstances should a casualty who has not been entirely decontaminated be moved across the hot line. If a wound or splinted area cannot be entirely decontaminated, inform the senior medic. Do not move the casualty across the hot line. He must be treated on the contaminated side of the casualty decontamination station.

23. Transfer the casualty to the shuffle pit.
    a. Personnel decontaminate themselves by rinsing their butyl rubber gloves and apron with the 5% solution.
    b. Carry the patient to the shuffle pit on the skin decontamination litter.
    c. Place the litter on the litter stand located in the shuffle pit.
    d. Lift the casualty from the decontamination litter using the same technique described in step 17.
    e. Remove the decontamination litter from the stand and a medic from the clean side will replace it with a clean litter.
    f. Lower the casualty onto the clean litter and move back from the hot line.

NOTE: Do not step across the hot line. Personnel from the clean side of the hot line will take the casualty to the clean treatment station.

Performance Measures	**GO**	**NO GO**
1. Decontaminated the casualty's hood.	____	____
2. Cut off the casualty's hood.	____	____
3. Decontaminated the casualty's mask and exposed skin.	____	____
4. Removed the casualty's Field Medical Card (FMC).	____	____
5. Removed gross contamination.	____	____
6. Removed the casualty's protective overgarment jacket.	____	____
7. Removed the casualty's protective overgarment trousers.	____	____
8. Removed the casualty's butyl rubber gloves.	____	____
9. Removed the casualty's protective overboots.	____	____
10. Removed and secured the casualty's personal effects.	____	____
11. Removed the casualty's combat boots.	____	____
12. Removed the casualty's battle dress uniform (BDU).	____	____
13. Cut off the casualty's undergarments.	____	____
14. Removed the casualty's glove inner liners.	____	____
15. Removed the casualty's socks.	____	____
16. Decontaminated the casualty's ID tags.	____	____
17. Moved the casualty to the skin decontamination area.	____	____
18. Performed spot skin decontamination.	____	____

Performance Measures	GO	NO GO
19. Removed field dressings and bandages.	____	____
20. Replaced any tourniquets.	____	____
21. Decontaminated any splints.	____	____
22. Checked the casualty for contamination.	____	____
23. Transferred the casualty to the shuffle pit.	____	____

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 steps, show what was done wrong and how to do it correctly.

References

Required	Related
None	STP 21-1-SMCT

TREAT A NERVE AGENT CASUALTY IN THE FIELD

081-833-0083

Conditions: You are in a chemical environment and have a casualty who is lying on the ground wearing protective outergarments, overboots, and mask carrier. You are wearing MOPP level 4 gear. You will need an aid bag, impermeable litter cover, litter, and blanket.

Standards: Completed all the steps necessary to treat a nerve agent casualty in the field without causing further injury to the casualty. Did not kneel when providing treatment.

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 will be delayed or absent.

a. Vapor exposure.

NOTE: Effects from vapor exposure will occur within seconds to minutes after being exposed and will not normally worsen after being removed from the exposure for 15 to 20 minutes.

(1) Mild.

NOTE: Exposure to small amounts 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 drooling.
(d) Difficulty in seeing (dimness of vision and miosis).
(e) Tightness in the chest or difficulty in breathing.
(f) Stomach cramps.
(g) Nausea with or without vomiting.
(h) Tachycardia or bradycardia.

(2) Moderate.

(a) All or most of the mild symptoms.
(b) Fatigue.
(c) Weakness.
(d) Muscular twitching.

(3) Severe.

NOTE: Effects may occur after one breath but normally take place within several seconds of a large vapor exposure.

(a) All or most of the mild and moderate symptoms.
(b) Strange or confused behavior.
(c) Wheezing, dyspnea, and coughing.
(d) Severely pinpointed pupils.
(e) Red eyes with tearing.
(f) Vomiting.
(g) Severe muscular twitching and general weakness.
(h) Involuntary urination and defecation.
(i) Convulsions.
(j) Unconsciousness.
(k) Respiratory failure.
(l) Bradycardia.

Performance Steps

(m) Paralysis.

b. Skin (percutaneous) exposure.

NOTES: 1. 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. 2. The greater the amount 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 and nausea.

(2) Moderate exposure.
   (a) Fatigue.
   (b) Weakness.
   (c) Muscular twitching.

(3) Severe exposure.
   (a) Sudden loss of consciousness.
   (b) Vomiting.
   (c) Convulsions.
   (d) Severe muscular twitching and general weakness.
   (e) Difficulty breathing or cessation of respirations.

NOTE: Death would be the result of complete respiratory system failure.

2. Mask the casualty.
   a. Instruct the casualty to mask self if he or she is able.
   b. Position the casualty face up and mask the casualty. Do not fasten the hood at this time.

3. Check the casualty's pocket flaps and the area around the casualty for expended autoinjectors.

4. Administer the antidote.
   a. Mild symptoms. Instruct the casualty to administer one Mark I Nerve Agent Antidote Kit. (See STP 21-1-SMCT, task 081-831-1044.)
   b. Severe symptoms. Administer three Mark I Nerve Agent Antidote Kits and one Convulsant Antidote for Nerve Agent (CANA) autoinjector to the casualty. (See STP 21-1-SMCT, task 081-831-1044.)

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.
   a. Atropinization.
      (1) Heart rate above 90 beats per minute (carotid pulse).
      (2) Reduced bronchial secretions.
      (3) Reduced salivation.
   b. Cessation of convulsions.

6. Administer additional atropine or CANA, if needed.
   a. Administer additional atropine at approximately 15 minute intervals until atropinization is achieved.

Performance Steps

b. Administer additional atropine at intervals of 30 minutes to 4 hours to maintain atropinization or until the casualty is evacuated to an MTF.
c. Administer a second and, if needed, a third CANA at 5 to 10 minute intervals to casualties suffering convulsions.

CAUTION: Do not give more than two additional CANA injections for a total of three.

NOTE: Additional atropine and the two additional CANA injections can be administered by a Combat Lifesaver, the combat medic, or other medical personnel.

7. Provide assisted ventilation for severely poisoned casualties, if equipment is available.

NOTE: Far forward in the field, a cricothyroidotomy is the most practical means of providing an airway for assisted ventilation using a hand-powered ventilator equipped with an NBC 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 given on the FMC.
9. Evacuate the casualty.

Performance Measures	**GO**	**NO GO**
1. Assessed the casualty for the signs and symptoms of nerve agent poisoning.	____	____
2. Masked the casualty.	____	____
3. Checked the casualty's pocket flaps and the area around the casualty for expended autoinjectors.	____	____
4. Administered the antidote.	____	____
5. Checked the casualty for signs of effectiveness of treatment.	____	____
6. Administered additional atropine or CANA, if needed.	____	____
7. Provided assisted ventilation for severely poisoned casualties, if equipment was available.	____	____
8. Recorded the number of injections given and all other treatment given on the FMC.	____	____
9. Evacuated the casualty.	____	____
10. Did not kneel while treating the casualty.	____	____
11. Did not cause further injury 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	Related
None	STP 21-1-SMCT

TREAT FOREIGN BODIES OF THE EYE

081-833-0056

Conditions: You have performed a patient care handwash. You will need cotton-tipped swabs, clean cloth, sterile irrigation solution (normal saline, water, or other prescribed solution), bandages, and a paper cup or cardboard cone.

Standards: Treated foreign bodies of the eye, minimizing the effects of the injury, without causing additional injury to the eye.

Performance Steps

WARNING: Wear gloves for self-protection against transmission of contaminants whenever handling body fluids.

1. Locate the foreign bodies.
    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.
        (4) Look for the foreign bodies or damage to the eyeball.

CAUTION: If the foreign bodies cannot be located, bandage both eyes and seek further medical aid immediately.

2. Remove the foreign bodies.

CAUTION: Do not put pressure on the eyeball.

    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.

CAUTION: Bandage both eyes if foreign bodies are not easily removed by these methods or if there is pain or loss of vision in the eye. Seek further medical aid immediately.

NOTE: In hazardous conditions, leave the good eye uncovered long enough to ensure the casualty's safety.

    c. Foreign body stuck or impaled in the eye.

CAUTION: Do not attempt to remove a foreign body stuck to or sticking into the eyeball. A physician must remove such objects.

        (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.

Performance Steps

NOTE: In hazardous conditions, leave the good eye uncovered long enough to ensure the casualty's safety.

(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.

3. Obtain details about the injury.
   a. Source and type of the foreign bodies.
   b. Whether the foreign bodies were wind-blown or high velocity.
   c. Time of onset and length of discomfort.
   d. Any previous injuries to the eye.
4. Record the procedure on the appropriate form.
5. Evacuate the casualty, as required.
6. Do not cause additional injury to the eye.
   a. Do not probe for foreign bodies.
   b. Do not put pressure on the eyeball.
   c. Do not remove an impaled object.

Performance Measures	**GO**	**NO GO**
1. Located the foreign bodies.	____	____
2. Removed the foreign bodies.	____	____
3. Obtained details about the injury.	____	____
4. Recorded the procedure on the appropriate form.	____	____
5. Evacuated the casualty, as required.	____	____
6. Did not cause additional injury to the eye.	____	____

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	**Related**
None	EMERGENCY CARE

IRRIGATE EYES

081-833-0054

Conditions: You have performed a patient care handwash. You will need draping materials, catch basin, light source, gauze or cotton balls, irrigating syringe or similar equipment, gloves, and irrigating solution (normal saline, water, or other prescribed solution).

Standards: Irrigated the eyes without contaminating or injuring the eyes.

Performance Steps

1. Identify the casualty and explain the procedure.
2. Verify the type, strength, and expiration date of the medication, as appropriate.

CAUTION: Do not irrigate an eye that has an impaled object.

3. Ask the casualty to remove contact lenses or glasses, if necessary.
4. Position the casualty.
   a. If lying on the back, tilt the head slightly to the side that is to be irrigated.
   b. If seated, tilt the head slightly backward and to the side that is to be irrigated.
5. Position the equipment.
   a. Drape the areas of the casualty that may be splashed by the solution.
   b. Place a catch basin next to the face on the affected side.
   c. Position the light so that it does not shine directly into the casualty's eyes.
6. Put on gloves.

WARNING: Wear gloves for self-protection against transmission of contaminants whenever handling body fluids.

7. Clean the eyelids with gauze or cotton balls, and rinse debris from the outer eye.
8. Separate the eyelids using the thumb and forefinger, and hold the lids open.

CAUTION: Do not put pressure on the eyeball.

9. Irrigate the eye.
   a. Hold the irrigating tip 1 to 1 1/2 inches away from the casualty's eye.
   b. Direct the irrigating solution gently from the inner canthus to the outer canthus.
   c. Use only enough pressure to maintain a steady flow of solution and to dislodge the secretions or foreign bodies.
   d. Instruct the casualty to look up to expose the conjunctival sac and lower surface of the eye.
   e. Instruct the casualty to look down to expose the upper surface of the eye.
10. Dry the area around the eye by gently patting with gauze sponges.

CAUTION: Do not touch the eye.

11. Remove the gloves, and perform a patient care handwash.
12. Record the treatment given on the appropriate form.

Performance Measures	GO	NO GO
1. Identified the casualty and explained the procedure.	____	____
2. Verified the type, strength, and expiration date of the medication, as appropriate.	____	____
3. Asked the casualty to remove contact lenses or glasses, if necessary.	____	____
4. Positioned the casualty.	____	____
5. Positioned the equipment.	____	____
6. Put on gloves.	____	____
7. Cleaned the eyelids with gauze or cotton balls, and rinsed debris from the outer eye.	____	____
8. Separated the eyelids using the thumb and forefinger, and held the lids open.	____	____
9. Irrigated the eye.	____	____
10. Dried the area around the eye by gently patting with gauze sponges.	____	____
11. Removed the gloves and performed a patient care handwash.	____	____
12. Recorded the treatment given on the appropriate form.	____	____
13. Did not injure or contaminate the eye.	____	____

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	Related
None	BASIC NURSING

DISINFECT WATER FOR DRINKING

081-831-0037

Conditions: You are a member of a field sanitation team. You have just filled a Lyster bag or Water Buffalo from a source that is not safe for drinking. You will need calcium hypochlorite, clean stirring implement, mess kit spoon, a canteen cup, and a field chlorination kit.

Standards: Disinfected water to a chlorine residual of 5 parts per million (ppm) or as ordered by the command surgeon.

Performance Steps

1. Mix the stock disinfecting solution.
   a. Add the prescribed dosage of calcium hypochlorite to 1/2 canteen cup of water.
      (1) 3 ampules per 36 gallons of water.
      (2) 22 ampules or 3 plastic MRE spoonfuls (from a bulk container) in 400 gallons of water.
   b. Stir the stock solution.
2. Add the stock solution to the water container.
   a. Pour the stock solution into the water container.
   b. Mix the solution vigorously with a clean implement.
   c. Cover the container.
3. Flush the faucets.
4. Test the chlorine residual after 10 minutes.
   a. Follow the manufacturer's instructions on the color comparator in the chlorination kit to test the chlorine residual.
   b. Retest the chlorine residual after 20 minutes.
5. Retest the water two or three times daily.

Evaluation Preparation:
Setup: Test this task only when there is a need to disinfect water for drinking. Do not simulate this task for training or evaluation.

Brief soldier: Tell the soldier to disinfect the water. After the soldier completes step 5, ask him or her how often the water should be retested.

Performance Measures	GO	NO GO
1. Mixed the stock disinfecting solution.	____	____
2. Added the stock solution to the water container.	____	____
3. Flushed the faucets.	____	____
4. Tested the chlorine residual after 10 minutes.	____	____
5. Retested the chlorine residual after 20 minutes.	____	____
6. Retested the water two or three times daily.	____	____

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 None

MANAGE A CONVULSIVE AND/OR SEIZING PATIENT
081-831-0035

Conditions: You have already taken the appropriate body substance isolation precautions.

Standards: Completed all steps to manage a convulsive and/or seizing patient without allowing or causing unnecessary injury to the patient.

Performance Steps

1. Identify the type of convulsions and/or seizures based upon the following characteristic signs and symptoms:
   a. Petit mal.
      (1) Brief loss of concentration or awareness without loss of motor tone.
      (2) Found chiefly in children and rarely an emergency.
   b. Focal.
      (1) No loss of consciousness.
      (2) Tingling, stiffening, or jerking in just one part of the body (arm, leg or face).
      (3) May rapidly progress to generalized convulsions.
   c. Grand mal (generalized).
      (1) May be preceded by an aura.
      (2) Has three distinct phases.
         (a) Tonic phase--characterized by rigidity and stiffening of the body.
         (b) Colonic phase--characterized by jerking about violently, foaming at the mouth, drooling, and cyanosis around the face and lips.
         (c) Postictal phase--begins when convulsions stop. The patient may regain consciousness and enter a state of drowsiness and confusion or remain unconscious for several hours.
      (3) May involve incontinence, biting of the tongue (rare), cyanosis, or mental confusion.

CAUTION: Never place anything in the mouth of a seizing patient.

   d. Status epilepticus.
      (1) Two or more seizures without an intervening period of consciousness.
      (2) A dire medical emergency, if untreated it may lead to--
         (a) Aspiration of secretions.
         (b) Cerebral or tissue hypoxia.
         (c) Brain damage or death.
         (d) Fractures of long bones.
         (e) Head trauma.
         (f) Injured tongue from biting.

NOTE: Mentally note the aspects of seizure activity for recording after the seizure.

2. Place the patient on his or her side, if possible.
   a. Observe the patient to prevent aspiration and suffocation.
   b. The patient's mouth and throat should be suctioned by trained personnel, if possible.

CAUTIONS: 1. Do not elevate the patient's head. 2. Do not restrain the patient's limbs during seizures.

3. Prevent injury to tissue and bones by padding or removing objects on which the patient may injure himself or herself.

4. Manage the patient after the convulsive state has ended.

Performance Steps

a. Place the patient on his or her side, if necessary.
b. Continue to maintain the patient's airway.

NOTE: A patient who has just had a grand mal seizure will sometimes drool and will usually be drowsy so you must be prepared to suction, if equipment is available.

c. Administer supplemental oxygen, if available, via nonrebreather mask or bag-valve-mask as appropriate.
d. If possible, place the patient in a quiet, reassuring atmosphere.

CAUTION: Sudden, loud noises may cause another seizure.

5. Record the seizure activity.
   a. Duration of the seizure.
   b. Presence of cyanosis, breathing difficulty, or apnea.
   c. Level of consciousness before, during, and after the seizure.
   d. Whether preceded by aura (ask the patient).
   e. Muscles involved.
   f. Type of motor activity.
   g. Incontinence.
   h. Eye movement.
   i. Previous history of seizures, head trauma, and/or drug or alcohol abuse.
6. Evacuate the patient.
   a. Position the patient on his or her side.
   b. Arrange for the administration of oxygen or suction, if available and necessary.

Evaluation Preparation:

Setup: For training and evaluation, have another soldier act as a patient.

Brief soldier: Tell the soldier to manage the patient.

Performance Measures	**GO**	**NO GO**
1. Identified the type of convulsions and/or seizures.	____	____
2. Maintained the airway of a patient exhibiting tonic-clonic movement.	____	____
3. Placed the patient on his or her side, if possible.	____	____
4. Prevented injury to tissue and bones by padding or removing objects on which the patient may injure himself or herself.	____	____
5. Managed the patient after the convulsive state ended.	____	____
6. Recorded the seizure activity.	____	____
7. Evacuated the patient.	____	____
8. Did not cause further injury to the patient.	____	____

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	Related
None	EMERGENCY CARE

TREAT A CASUALTY FOR A HEAT INJURY

081-831-0038

Conditions: A casualty is suffering from a heat injury. No other more serious injuries or conditions are present. You will need water, salt, a thermometer, a stethoscope, and a sphygmomanometer.

Standards: Provided the correct treatment based upon the signs and symptoms of the injury.

Performance Steps

1. Identify the type of heat injury based upon the following characteristic signs and symptoms:
    a. Heat cramps--muscle cramps of the arms, legs, and/or abdomen.
    b. Heat exhaustion.
        (1) Often--
            (a) Profuse sweating and pale (or gray), moist, cool skin.
            (b) Headache.
            (c) Weakness or faintness.
            (d) Dizziness.
            (e) Loss of appetite or nausea.
        (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. Heat stroke.
        (1) Rapid onset with the core body temperature rising to above 106° F within 10 to 15 minutes.
        (2) Hot, dry skin.
        (3) Headache.
        (4) Dizziness.
        (5) Nausea (stomach pains).
        (6) Confusion.
        (7) Weakness.
        (8) Loss of consciousness.
        (9) Possible seizures.
        (10) Pulse and respirations are weak and rapid.

2. Provide the proper first aid 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 he or she is in a chemical environment.
        (3) Give the casualty at least one canteen of salt solution. Dissolve 1/4 teaspoon (one MRE packet) of salt in one canteen of water. If salt is unavailable, give plain water.
        (4) Evacuate the casualty if the cramps are not relieved after treatment.
    b. Heat exhaustion.
        (1) Conscious casualty.

Performance Steps

(a) Move the casualty to a shaded area, if possible.
(b) Loosen and/or remove the casualty's clothing and boots unless he or she is in a chemical environment.
(c) Pour water on the casualty and fan him or her, if possible.
(d) Slowly give the casualty one canteen of salt solution. (See step 2a(3).)
(e) Elevate the casualty's legs.

(2) An unconscious casualty or one who is nauseated, unable to retain fluids, or whose symptoms have not improved after 20 minutes.
(a) Cool the casualty as in step 2b(1).
(b) Evacuate the casualty to an MTF for IV therapy or if qualified, initiate an IV infusion of Ringer's lactate or sodium chloride.

c. Heat stroke.

CAUTION: Heat stroke is a medical emergency. If the casualty is not cooled rapidly, the body cells, especially the brain cells, are literally cooked; irreversible damage is done to the central nervous system. The casualty must be evacuated to the nearest medical treatment facility immediately.

(1) Conscious casualty.
(a) Remove the casualty's outer garments and/or protective clothing, if possible.
(b) Keep the casualty out of the direct sun, if possible.
(c) Immerse the casualty in cold water, if available, and massage him or her.

WARNING: Cooling with cold water immersion may produce shivering, increasing the core temperature.

(d) Lay the casualty down and elevate his or her legs.
(e) Have the casualty slowly drink at least one canteen of salt solution. (See step 2a(3).)
(f) Evacuate the casualty to an MTF for IV therapy or, if qualified, initiate an IV infusion of Ringer's lactate or sodium chloride to maintain a systolic blood pressure of at least 90 mm Hg.

(2) Unconscious casualty or one who is vomiting or unable to retain oral fluids.
(a) Cool the casualty as in step 2c(1) but give nothing by mouth.
(b) Initiate an IV, if qualified.
(c) Evacuate the casualty.

3. Record the treatment given. (See task 081-831-0033.)

Evaluation Preparation:

Setup: For training and evaluation, describe to the soldier the signs and symptoms of heat cramps, heat exhaustion, or heat stroke and ask the soldier what type of heat injury is indicated.

Brief soldier: Ask the soldier what should be done to treat the heat injury.

Performance Measures	**GO**	**NO GO**
1. Identified the type of heat injury.	____	____
2. Provided the proper first aid for the heat injury.	____	____
3. Recorded the treatment given.	____	____

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	**Related**
None	EMERGENCY CARE

TREAT A CASUALTY FOR A COLD INJURY

081-831-0039

Conditions: No other more serious injuries or conditions are present. You will need dry clothing or similar material, sterile dressings, and a thermometer.

Standards: Provided correct treatment based upon the signs and symptoms of the injury.

Performance Steps

1. Recognize the signs and symptoms of cold injuries.
    a. Chilblain is caused by repeated prolonged exposure of bare skin to low temperatures from 60° F down to 32° F.
        (1) Acutely red, swollen, hot, tender, and/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. Frostbite is indicated when the face, hands, or feet stop hurting.

        (1) Superficial (first and second degree).
            (a) 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.
            (b) Blister formation 24 to 36 hours after exposure followed by sheet-like sloughing of the superficial skin (second degree).
        (2) Deep.
            (a) Loss of feeling.
            (b) Pale, yellow, waxy look if the affected area is unthawed.
            (c) Solid feel of the frozen tissue.
            (d) Blister formation 12 to 36 hours after exposure unless rewarming is rapid.
            (e) Appearance of red-violet discoloration 1 to 5 days after the injury.

NOTE: Gangrene and residual nerve damage will result without proper treatment.

    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.

CAUTION: With generalized hypothermia, the entire body has cooled with the core temperature below 95° F. This is a medical emergency.

        (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 heart beat or irregular heart rhythm.
            (d) Unobtainable blood pressure.
            (e) Unreactive pupils.

Performance Steps

(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) First phase (anesthetic).
      (a) There is no pain sensation, but the affected area feels cold.
      (b) The pulse is weak at the affected area.
   (2) Second phase (reactive hyperemic)--limbs feel hot and/or burning and have shooting pains.
   (3) Third phase (vasospastic).
      (a) Affected area is pale.
      (b) Cyanosis.
      (c) Pulse strength decreases.
   (4) Check for blisters, swelling, redness, heat, hemorrhage, or gangrene.

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. Chilblain.
   (1) Apply local rewarming within minutes.
   (2) Protect lesions (if present) with dry sterile dressings.

CAUTION: Do not treat with ointments.

b. Frostbite.
   (1) Apply local rewarming using body heat.

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

   (2) Loosen or remove constricting clothing and remove jewelry.
   (3) Increase insulation and exercise the entire body as well as the affected body part(s).

CAUTION: Do not massage the skin or rub anything on the frozen parts.

   (4) Move the casualty to a sheltered area, if possible.
   (5) Protect the affected area from further cold or trauma.
   (6) 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) If available, apply heating pads to the casualty's armpits, groin, and abdomen.

NOTE: If far from a medical treatment facility and the situation and facilities permit, immerse the casualty in a tub of 105° F water.

      (e) If available, slowly give sugar and sweet warm fluids.

CAUTION: Do not give the casualty alcohol.

Performance Steps

(f) Wrap the casualty from head to toe.
(g) Evacuate the casualty lying down.
(2) Severe.

CAUTION: Handle the casualty very gently.

(a) Cut away wet clothing and replace it with dry clothing.
(b) Maintain the airway. (See task 081-831-0018.)
1) Administer oxygen if trained personnel and equipment are available.
2) Assist with ventilation if the casualty's respiration rate is less than five per minute.

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 per minute.

(c) Monitor the patient's pulse. (See task 081-831-0011.) If none is detected, apply AED, if available. (See task 081-833-3027.) Begin CPR. (See tasks 081-831-0046 and 081-831-0048.)
(d) Evacuate the casualty positioned on his or her back with the head in a 10 degree head-down tilt.

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 his or her 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.
(1) Dry the affected part immediately and gradually rewarm it in warm air.

CAUTION: Never massage the skin. After rewarming the affected part, it may become swollen, red, and hot. Blisters usually form due to circulation return.

(2) Protect the affected part from trauma and secondary infection.
(3) Elevate the affected part.
(4) 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.

Evaluation Preparation:

Setup: For training and evaluation have another soldier act as the casualty. Select one of the types of cold injuries on which to evaluate the soldier. Coach the simulated casualty on how to answer questions about symptoms. Physical signs and symptoms that the casualty cannot readily simulate, for example blisters, must be described to the soldier.

Brief soldier: Tell the soldier to determine what cold injury the casualty has. After the cold injury has been identified, ask the soldier to describe the proper treatment.

Performance Measures	**GO**	**NO GO**
1. Identified the type of cold injury.	____	____
2. Provided proper first aid treatment for the injury.	____	____

NOTE: Although not evaluated, the soldier would record the treatment given on the appropriate form and evacuate the casualty as necessary.

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	**Related**
None	EMERGENCY CARE

INITIATE A FIELD MEDICAL CARD

081-831-0033

Conditions: You have treated a casualty and must record the treatment given. You will need DD Form 1380 (Field Medical Card) and a pen or pencil.

Standards: Completed, as a minimum, blocks 1, 3, 4, 7, 9, and 11. Completed blocks 2, 5, 6, 8, 10, 12, 13, 14, 15, 16, and 17 as appropriate. Completed other blocks as time permits.

Performance Steps

1. Remove the protective sheet from the carbon copy.
2. Complete the minimum required blocks.
   a. Block 1. Enter the casualty's name, rank, and complete social security number (SSN). If the casualty is a foreign military person (including prisoners of war), enter his or her military service number. Enter the casualty's military occupational specialty (MOS) or area of concentration for specialty code. Enter the casualty's religion and sex.
   b. Block 3. Use the figures in the block to show the location of the injury or injuries. Check the appropriate box(es) to describe the casualty's injury or injuries.

NOTES: 1. Use only authorized abbreviations. Except for those listed below, however, abbreviations may not be used for diagnostic terminology.
Abr W--Abraded wound.
Cont W--Contused wound.
FC--Fracture (compound) open.
FCC--Fracture (compound) open comminuted.
FS--Fracture (simple) closed.
LW--Lacerated wound.
MW--Multiple wounds.
Pen W--Penetrating wound.
Perf W--Perforating wound.
SL--Slight.
SV--Severe.
2. When more space is needed, attach another DD Form 1380 to the original. Label the second card in the upper right corner "DD Form 1380 #2." It will show the casualty's name, grade, and SSN.

   c. Block 4. Check the appropriate box.
   d. Block 7. Check the yes or no box. Write in the dose administered and the date and time that it was administered.
   e. Block 9. Write in the information requested. If you need additional space, use Block 14.
   f. Block 11. Initial the far right side of the block.

3. Complete the other blocks as time permits. Most blocks are self-explanatory. The following specifics are noted:
   a. Block 2. Enter the casualty's unit of assignment and the country of whose armed forces he or she is a member. Check the armed service of the casualty, that is, A/T = Army, AF/A = Air Force, N/M = Navy, and MC/M Marine.
   b. Block 5. Write in the casualty's pulse rate and the time that the pulse was measured.
   c. Block 6. Check the yes or no box. If a tourniquet is applied, you should write in the time and date it was applied.

Performance Steps

d. Block 8. Write in the time, date, and type of IV solution given. If you need additional space, use Block 9.
e. Block 10. Check the appropriate box. Write in the date and time of disposition.
f. Block 12. Write in the time and date of the casualty's arrival. Record the casualty's blood pressure, pulse, and respirations in the space provided.
g. Block 13. Document the appropriate comments by the date and time of observation.
h. Block 14. Document the provider's orders by date and time. Record the dose of tetanus administered and the time it was administered. Record the type and dose of antibiotic administered and the time it was administered.
i. Block 15. The signature of the provider or medical officer is written in this block.
j. Block 16. Check the appropriate box and enter the date and time.
k. Block 17. This block will be completed by the United Ministry Team. Check the appropriate box of the service provided. The signature of the chaplain providing the service is written in this block.

Evaluation Preparation:
Setup: For training and evaluation have another soldier act as a casualty and have him or her respond to the soldier's questions on personal data.

Brief soldier: Tell the soldier to complete the FMC by asking appropriate questions of the casualty. Tell the soldier being tested any necessary information such as the nature of the wound and the treatment given. To test step 2, you may either have the soldier complete the minimum required blocks, or you may require the completion of all blocks. After step 2 ask the soldier what must be done with each copy of the FMC.

Performance Measures	**GO**	**NO GO**
1. Removed the protective sheet from the carbon copy.	____	____
2. As a minimum, completed blocks 1, 3, 4, 7, 9, and 11.	____	____
3. Made proper distribution of the FMC copies.	____	____

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	**Related**
None	AR 40-66

Skill Level 2

Subject Area 11: Admin (SL2)

SUPERVISE MENTAL HEALTH STAFF ORIENTATION PROGRAM
081-832-0091

Conditions: You are assigned to supervise the mental health staff orientation program in a DOD medical treatment facility.

Standards: Supervised the mental health staff orientation program of the medical treatment facility in a organized manner.

Performance Steps

1. Ensure types of military facilities are covered.
    a. Medical Center (MEDCEN) - is a large hospital, staffed and equipped to perform the following:
        (1) Broad treatment scope--provide a wide range of specialized and consultative support to authorized persons.
        (2) Regional services--serve as a referral hospital for the Medical Department Activity (MEDDAC) within its health service area.
        (3) Professional training programs--when designated, conduct post graduate education in health professions.
        (4) Medical disposition authority--determine the medical fitness, mental competence, and disposition of patients.
    b. Medical Department Activity (MEDDAC) - is staffed and equipped to perform the following:
        (1) Limited treatment scope--provides diagnostic and therapeutic services in the field of general medicine, surgery, and preventive medicine services. Contracts local civilian hospitals or refers to MEDCEN for specialized care.
        (2) Local services--provides care to assigned area, usually within a hundred mile radius.
        (3) No primary training function--usually does not have a teaching mission but may serve as a teaching facility if specified in its assigned mission.
        (4) No primary disposition authority--submits cases to medical board for disposition.
    c. Combat Stress Control (CSC) units.
        (1) Prevent and treat battle fatigue casualties.
        (2) Prevention of stress related casualties and combat stress reaction.
        (3) Treatment and early return to duty of soldiers suffering from battle fatigue.

2. Ensure short term care policy is covered.
    a. Maintain high combat-ready strength.
    b. Long term care is the responsibility of the Veterans Administration.

NOTE: Although we will be dealing with a limited treatment policy, we still will accomplish our mission - that being, diagnosis, treatment, and disposition of the patient.

3. Ensure personnel eligible for care in a military hospital are addressed.
    a. Active duty.
    b. Reservists and national guard on active duty.
    c. Dependents.

Performance Steps

d. Retired.

NOTE: Personnel eligible are listed in order of priority.

4. Ensure that the disposition of psychiatric patients in the military is addressed.
   a. Discharge from hospital - to duty, or home.
   b. Ground or air evacuation - to a military facility with enhanced treatment capabilities, or VA hospital.
   c. Discharge from service - may involve direct transfer to VA facility.
   d. Medical Evaluation Board/Physical Evaluation Board - determination of retainability, award of profiles and disability.

Performance Measures	**GO**	**NO GO**
1. Ensured types of military facilities were covered.	____	____
2. Ensured short-term care policy was covered.	____	____
3. Ensured persons that are eligible for military care were addressed.	____	____
4. Ensured the different dispositions of psychiatric patients were covered.	____	____

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	**Related**
None	AR 40-3
	AR 40-4
	FM 8-51

SUPERVISE PSYCHIATRIC UNIT SECURITY PROCEDURES

081-832-0084

Conditions: You are a supervisor and need to monitor psychiatric unit security procedures.

Standards: Ensured the staff performed all duties in ward security procedures as prescribed by local policies.

Performance Steps

1. Ensure staff performed periodic searches of the unit and patients and looked for weapons, hazardous items, medications, contraband, or other unauthorized items.

NOTE: As a supervisor, areas of general responsibility are, but not limited to, the safe, secure, and comfortable environment in which the patient's and subordinates function on a daily basis.

2. Supervise the control of all hazardous items.
   a. All hazardous items are labeled and stored.
   b. Items are signed out of a log book.
   c. Staff supervised patients when using hazardous items (razors, tools, etc.).
3. Ensure staff responded to an agitated patient IAW task 081-832-1011.
4. Ensure staff placed a patient in seclusion IAW task 081-832-1025.
5. Ensure staff performed line of sight observation of a psychiatric patient IAW task 081-832-1007.
6. Supervise staff performing 1:1 observation of a psychiatric patient IAW task 081-832-1008.
7. Ensure staff accounted for the location of psychiatric patients IAW task 081-832-1009.
8. Monitor staff escorting psychiatric patients IAW task 081-832-1010.
9. Review current key control maintenance.
   a. Keys will be accounted for IAW local hospital policy.
   b. All ward keys must be secured (i.e., key control box).
   c. Maintain possession of keys issued to you.

CAUTION: Never release keys to a patient.

10. Supervise staff to ensure physical unit is free from safety hazards for psychiatric patients.
    a. Assessed shower heads and curtains, guaranteeing there was a break-a-way mechanism.
    b. Assessed light fixtures and outlets for potential of shock injury.
    c. Assessed windows for nonbreakable plexiglass.
    d. Assessed ceiling for potential safety problems such as nonretractable sprinkler system, ceiling support brackets, etc.
11. Ensure staff complied with facility safety/security management.
    a. Perform facility safety/security IAW local hospital policy.
    b. Maintain unit safety/security IAW JCAHO guidelines.
12. Review safety/security procedures with subordinate staff members.
    a. Patient accountability.
       (1) Remain alert when on duty.
       (2) Conduct irregular counts of patients.

Performance Steps

(3) Special situations.
(a) 1:1 Supervision IAW task 081-832-1008.
(b) Line of sight observation IAW task 081-832-1009.

b. Control of hazardous items IAW task 081-832-1006.
c. Maintain key control IAW local hospital policy.

Performance Measures	**GO**	**NO GO**
1. Ensured staff performed periodic searches of the unit and patients and looked for weapons, hazardous items, medications, contraband, or other unauthorized items.	____	____
2. Supervised the control of all hazardous items	____	____
3. Ensured staff responded to an agitated patient IAW task 081-832-1011.	____	____
4. Ensured staff placed a patient in seclusion IAW task 081-832-1025.	____	____
5. Ensured staff performed line of sight observation of a psychiatric patient IAW task 081-832-1007.	____	____
6. Supervised staff performing 1:1 observation of a psychiatric patient IAW task 081-832-1008.	____	____
7. Ensured staff accounted for the location of psychiatric patients IAW task 081-832-1009.	____	____
8. Monitored staff escorting psychiatric patients IAW task 081-832-1010.	____	____
9. Reviewed current key control maintenance.	____	____
10. Supervised staff to ensure physical unit is free from safety hazards for psychiatric patients.	____	____
11. Ensured staff complied with facility safety/security management.	____	____
12. Reviewed safety/security procedures with subordinate staff members.	____	____

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 None

CONDUCT REHABILITATION TEAM MEETINGS

081-832-0080

Conditions: You are asked to conduct a rehabilitation team meeting.

Standards: Conducted a rehabilitation team meeting using local policy and guidelines.

Performance Steps

1. Review all assessment data.
   a. Mental status exam--overview of patient status.
   b. Substance history--current and historical use of substance(s) use or abuse.
   c. Duty performance--from the command perspective. Note any changes in SMs behavior.
   d. Off-duty behavior--especially not alcohol and other drug-related incidents.
   e. Supervisor's evaluation--helps determine retainability.
   f. Family history--substance abuse, physical abuse, and treatment.

2. Complete all necessary areas prior to staffing with the Clinical Director.
   a. Based on assessment review, determine recommendations to Commander.
      (1) Unit counseling by the Commander or the designated command representative.
      (2) Other action (e.g., referral to other agencies).
      (3) Determine if ASAP services are required at the present time.
      (4) Refer to Alcohol and Drug Abuse Prevention Training (ADAPT)--8 to 12 hours of classroom instruction but no enrollment in the ASAP program.
      (5) Enroll in the ASAP program based on severity of substance abuse/dependence history.
         (a) Outpatient rehabilitation (Track II)--nonresidential program that involves intensive individual, group, family, or marital counseling. Requires a 30 day minimum enrollment and usually includes ADAPT.
         (b) Inpatient rehabilitation (Track III)--residential or intensive outpatient program that requires physician concurrence with a mandatory nonresidential follow-up. Requires a 360 day enrollment and typically includes ADAPT.
      (6) Mental Health Specialist also coordinates any remaining appointments (e.g., medical exams if needed).

3. Conduct the rehabilitation team meeting (RTM).
   a. Introductions, agenda setting, and confidentiality guidelines review of all individuals involved.
      (1) Thank all group members for attending, introduce yourself, and ask for introductions from all other members.
      (2) Advise the group of the current objective which is to determine the SM's ASAP status.
      (3) Ensure the command is aware of all limits of confidentiality to include not revealing to any other sources that the SM is or has been an abuser of alcohol or other drugs.
   b. Present recommendations. These are recommendations staffed with and approved by the Clinical Director.
   c. Obtain command concurrence and the patient's feedback.

NOTE: If the command does not support your recommendation then consult your supervisor. The patient's feedback helps to determine the patient's level of motivation.

Performance Steps

d. Discuss added recommendations. Additional services can be suggested by ASAP, command or the patient.
e. Record the plan on the back of DA Form 8003 (Referral Form).
f. Discuss command consultation.
   (1) Encourage the command to periodically check progress with ASAP.
   (2) ASAP will contact the command at least every 90 days for input.

4. Schedule next RTM.
   a. Tentatively set for 90 days.
   b. Remind the command the RTM can be called at any time to discuss enrollment or treatment issues.

Performance Measures	**GO**	**NO GO**
1. Reviewed all assessment data.	____	____
2. Completed necessary areas prior to staffing with the clinical director.	____	____
3. Conducted the rehabilitation team meeting.	____	____
4. Scheduled next rehabilitation team meeting.	____	____

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	**Related**
None	AR 600-85

SUPERVISE PERSONNEL CONDUCTING PSYCHIATRIC CLIENT INTERVIEWS

081-832-0052

Conditions: You are assigned as a supervisor in a clinical or field setting.

Standards: Supervised staff personnel during the gathering of appropriate information while counseling patients by establishing and maintaining rapport with the supervisees.

Performance Steps

1. Instruct supervisee as to the categories of supervision before the patient interview/counseling session began.
   a. Immediate--for patients with high potential for dangerousness, psychosis, or medical emergencies.
   b. Prompt supervision--for cases that involve ethical dilemmas or other aspects that make the interviewer uneasy, such as seductive client behavior.
   c. Routine supervision--all other cases.
2. Staff the case (after supervisee conducts the interview/counseling session).
   a. Patient's identifying information.
   b. Referral source.
   c. History of present problem.
   d. Relevant background information (such as psychiatric history, medical history, family or social history, etc.).
   e. Result of mental status exam.
   f. Supervisee provides diagnostic impressions.
   g. Supervisee provides recommended disposition.
   h. Supervisor either concurs or makes corrections.
3. Supervisee returned to patient and discussed disposition.
4. After supervisee documents the interview, supervisor checked it for accuracy and completeness.

Performance Measures	**GO**	**NO GO**
1. Reviewed categories of supervision.	____	____
2. Staffed the case.	____	____
3. Sent supervisee back to discuss disposition with patient.	____	____
4. Checked interview documentation for accuracy and completeness.	____	____

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 None

MANAGE MASS MENTAL HEALTH CASUALTIES IN CONVENTIONAL ENVIRONMENTS
081-832-0020

Conditions: You are assigned to a field medical unit that must plan for a very large number of mental health casualties. You will need unit SOP, disaster plan, mass casualty (MASCAL) packets, and FM 8-10.

Standards: Managed MASCAL mental health casualties IAW the unit SOP and disaster plan.

Performance Steps

1. Identify concepts and planning requirements concerning mental health MASCAL situations.
    a. Identify causes of MASCAL.
        (1) Warfare.
        (2) Natural disasters.
        (3) Failure of man-made devices.
        (4) Accidents.
    b. Identify the change in the mental health mission of MASCAL situations.
        (1) Normal mental health support is directed to the quality of care with the goal of optimal care for each patient.
        (2) MASCAL mental health support is directed to quantity as well as quality care.
    c. Anticipate major problems in MASCAL situations other than just mental health support.
        (1) Disruptions in supply, transportation, and communication.
        (2) Confusion or chaos.
        (3) Shortages of personnel.
    d. Prepare for internal disasters.

NOTE: Examples are explosions and fire. They may curtail treatment which can involve evacuation of the mental health facilities.

        (1) Review the emergency plans.
        (2) Provide periodic training for internal disasters.
        (3) Determine priorities for treatment or evacuation.
    e. Prepare for external disasters.

NOTE: These occur outside the medical unit and result in a large number of casualties requiring help.

        (1) Review the MASCAL plans.
        (2) Coordinate with other elements for additional support.
        (3) Conduct MASCAL interventions as directed and IAW ARTEP standards.
        (4) Conduct the AAR after each training exercise and provide written results to units involved.

2. React to a mental health MASCAL situation.
    a. Assist triage (casualty sorting) activities.

NOTE: Triage is designed to provide the greatest service to the greatest number.

        (1) Identify casualties.
        (2) Evaluate casualties.
        (3) Place casualties in treatment categories according to their conditions.
            (a) Minimal--minor treatment only.
            (b) Immediate--life threatening or a moderate injury treatable with minimal expenditure of time and personnel.
            (c) Delayed--after minimum resuscitative care, definitive treatment can be delayed without significant jeopardy.

Performance Steps

(d) Expectant--extensive therapy is required beyond the means immediately available.

(4) Determine priorities for treatment or evacuation.

b. Provide support to patient administration division (PAD).

(1) Maintain patient accountability.
(2) Furnish required reports to company commander.
(3) Provide for administrative personnel and supplies to support admission of patients.
(4) Use MASCAL packets.
(5) Activate the system for transfer of patients.
(6) Provide for soldier's prompt return to duty as appropriate.
(7) Coordinate casualty information.
(8) Record final disposition of all patients.

Performance Measures	**GO**	**NO GO**
1. Identified concepts and planning requirements concerning mental health MASCAL situations.	____	____
2. Reacted to a mental health MASCAL situation.	____	____
a. Assisted triage activities.		
b. Provided support to patient administration division (PAD).		

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	**Related**
FM 4-02	None

INSTRUCT PERSONNEL IN PSYCHOSOCIAL HISTORY INTERVIEWING
081-832-0018

Conditions: You must instruct personnel in psychosocial history interviewing techniques.

Standards: Instructed the soldiers to conduct a psychosocial history interview that gathers relevant information while addressing issues of confidentiality and maintaining rapport with the client.

Performance Steps

1. Explain the importance of rapport.
    a. Acceptance--treating the client as an equal in the process (e.g., allowing the client to make decisions concerning their situation).
    b. Respect the client's feelings (neither rejecting nor discouraging the client's emotional responses).
    c. Being nonjudgmental (neither praising nor degrading the client).
    d. Being empathetic--projecting an understanding of the client's situation and feelings.
    e. Being attentive (good eye contact, body posture, using verbal and nonverbal responses such as nodding or "uh-huh," reflecting client's feelings, clarifying communications).

2. Explain how to prepare for the interview.
    a. Schedule 45-60 uninterrupted minutes for the interview. Instruct the student to close the door, take no phone calls, and prevent interruptions.
    b. Arrange the seating so that the client and interviewer are about 3-5 feet apart, facing each other at a slight angle (not directly facing each other, but facing each other enough for easy eye contact), and with no barriers such as desks or tables between the interviewer and client.

3. Demonstrate how to review paperwork.
    a. Check identification and background data.
    b. Check the reason for referral/chief complaint.
    c. Ensure that if command referred, the correct documentation is in the chart IAW Department of Defense Instruction 6490.1.
    d. Review medical records.

4. Demonstrate introduction phase of the interview.
    a. Greet the patient and introduce yourself.
    b. Explain your role and the purpose of the initial interview.
    c. Describe limits of confidentiality and ask for questions.

5. Demonstrate the history of presenting problem phase of the interview.
    a. Ask what brought the client here today.
    b. Ask when the problem began.
    c. Ask how the client has been affected by this problem emotionally, behaviorally, socially, and physically.
    d. Ask the patient what contexts make the problem worse (place, time, people, events, etc.).
    e. Ask the patient the frequency, duration, and intensity of distress associated with the problem.

Performance Steps

f. Ask the patient what they do to cope with the problem. Have these efforts been helpful?
g. Has this problem (or emotional reaction) ever happened before and what did the patient do then?

6. Demonstrate background history phase of the interview.
   a. Ask the patient about his family background, to include where raised, relationships with family members, and family history of mental illness and/substance abuse.
   b. Ask the patient about marital/dating history.
   c. Ask the patient about educational and occupational history.
   d. Ask the patient about military history, to include adjustment to the military and negative administrative actions.
   e. Ask the patient about significant medical history, to include mental health treatment and alcohol/substance use.

7. Demonstrate the mental status examination phase of the interview.
   a. Observe the patient's general appearance, motor behavior, and eye contact.
   b. Assess the patient's mood and affect.
   c. Assess the client's speech.
   d. Assess dangerousness.
   e. Assess if the client suffers any perceptual distortions.
   f. Assess the client's thought content and thought process.
   g. Assess the client's sensorium and cognition.
   h. Assess the client's insight and judgment.

8. Demonstrate the termination phase of the interview.
   a. Signal that the end of the interview is approaching.
   b. Review information gathered during the interview.
   c. Explain that all cases must be staffed; demonstrate case presentation.
   d. Demonstrate how to make a follow-up appointment and RTD if appropriate.

Performance Measures	**GO**	**NO GO**
1. Explained rapport.	____	____
2. Explained interview preparation.	____	____
3. Demonstrated paperwork review.	____	____
4. Demonstrated introduction phase of interview (confidentiality must be addressed).	____	____
5. Demonstrated history of presenting problem phase of interview.	____	____
6. Demonstrated background history phase of interview.	____	____
7. Demonstrated mental status examination phase of the interview.	____	____
8. Demonstrated termination phase of the interview.	____	____

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	**Related**
None	DODD 6490.1 KAPLAN & SADOCK(3) OTHMER & OTHMER

Skill Level 3

Subject Area 12: Admin (SL3)

PLAN BEHAVIORAL SCIENCE FIELD OPERATIONS

081-832-0049

Conditions: Your unit is preparing to deploy to the field. You will need the battalion OPLAN identifying unit locations and strengths.

Standards: Developed a support plan using appropriate field manuals.

Performance Steps

1. Write a mental health support plan that includes the following:
   a. Movement, establishment, disestablishment, and operations of the mental health unit or facility.
   b. Utilization of available resources.
   c. Coordination with supporting and supported elements.
   d. Monitoring of command mental health program and informing commander on mental health of the unit.
   e. Projected supply requirements.
   f. Coordination to obtain services or support not otherwise provided from organic resources.
2. Brief the plan to appropriate personnel.
3. Monitor the support plan in use.

Performance Measures	**GO**	**NO GO**
1. Wrote a mental health support plan.	____	____
2. Briefed the mental health support plan.	____	____
3. Monitored the mental health support plan.	____	____

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	**Related**
None	FM 101-5
	FM 3-0
	FM 8-55

CHAPTER 4

Duty Position Tasks

Subject Area 10: Drug and Alcohol Counselor (ASI M8)

CONDUCT AN INDIVIDUAL COUNSELING SESSION FOR A SUBSTANCE ABUSING INDIVIDUAL

081-838-0016

Conditions: You have been instructed to provide counseling for a substance abuse client experiencing situational problems. The client has had a thorough initial evaluation and is able to function in a nonhospital environment. You will need client case file, collateral records, and notepaper.

Standards: Conducted an individual counseling session IAW the Army Substance Abuse Program (ASAP).

Performance Steps

1. Formulate and state appropriate agenda to staff.
   a. Review patient data to date.
   b. Set agenda based on patient's progress to date.
   c. Identify agenda and rationale to staff prior to session.
2. Greet client.
   a. Give appropriate greeting.
   b. If first visit with client introduce self and identify job.
3. Evaluate substance abuse since last session.
   a. Assess client's use of alcohol since last session.
   b. Assess client's use of illicit drugs since last session.
   c. Assess client's use of prescription drugs since last session.
   d. Make determination if any intervention is necessary based on this information.
4. State and maintain therapeutic agenda with patient.
   a. Identify for patient topic(s) to be focused on this session, unless superseded by patient need.
   b. Identify unfinished business from last session.
   c. Process plan from last session.
5. Perform counseling tasks during the session.
   a. Reinforce patient's positive actions.
   b. Evaluate patient's behavior in nonjudgmental way.
   c. Clarify, as appropriate.
   d. Reflect patient data, as appropriate.
   e. Summarize session information, as appropriate.
   f. Utilize effective questioning techniques.
   g. Utilize confrontation techniques when appropriate.
   h. Utilize attending behaviors.
   i. Utilize appropriate eye contact.

Performance Steps

j. Display an understanding of ASAP procedures.
k. Display knowledge of AA and other support groups.
l. Display knowledge of abuse and dependence.
m. Display understanding of appropriate patient responsibility for treatment plan goals.
n. Relate substance abuse history to treatment issues.
o. Develop behavioral plan for next session.
p. Obtain patient commitment to the behavioral plan.
q. Establish and maintain rapport with patient.

6. Terminate the session.
   a. Summarize key points of the session, to include behavioral plan.
   b. Ask if patient has any unfinished business.
   c. Schedule next appointment.

Performance Measures	**GO**	**NO GO**
1. Formulated and stated appropriate agenda to staff.	____	____
2. Greeted the patient in an appropriate manner.	____	____
3. Evaluated substance abuse since last session.***	____	____
4. Established and maintained rapport with the patient.***	____	____
5. Stated and maintained therapeutic agenda with the patient.***	____	____
6. Addressed unfinished business from last session.	____	____
7. Reinforced patient's positive actions.	____	____
8. Evaluated patient's behavior in nonjudgmental way.	____	____
9. Displayed professional counseling skills.	____	____
10. Demonstrated effective questioning techniques.	____	____
11. Demonstrated appropriate confrontations.	____	____
12. Demonstrated effective listening skills.	____	____
13. Demonstrated an understanding of ASAP procedures.	____	____
14. Displayed knowledge of abuse and dependence.	____	____
15. Displayed knowledge of AA and other support groups.	____	____
16. Related substance abuse history to treatment issues.	____	____
17. Left patient with responsibility for treatment plan goals.	____	____
18. Developed appropriate behavioral plan for next session.***	____	____
19. Obtained patient commitment to behavioral plan.***	____	____
20. Terminated the session appropriately.	____	____

Evaluation Guidance: Score the student GO if a total 14 points are achieved including all of the critical items (***). Points are counted one for each item checked as GO, and 1/2 for each needs improvement. To attain a GO ALL critical items must be a GO. Score the student (NO GO) if less than 14 points total are achieved or any of the critical items are missed regardless of total points. If the student fails any step, show what was done wrong and how to do it correctly.

References

Required	**Related**
None	AR 600-85

FACILITATE A GROUP THERAPY SESSION FOR SUBSTANCE ABUSING INDIVIDUALS

081-838-0058

Conditions: You are to facilitate a group therapy session, consisting of a qualified group therapist and 5 to 10 substance abusing clients seated in a circle in a quiet area. The group is an open group scheduled for 1 hour, three times a week. You will need clinical records.

Standards: Facilitated a group counseling session.

Performance Steps

1. Select an appropriate group exercise for the stage of the group.
   a. Assess the stage of the group based on class material and group interactions.
   b. Select an exercise that will move the group forward toward the next stage of development.
   c. Prepare material necessary for the group exercise.
2. Explain rationale for exercise to members of the group.
   a. Give detailed information to group participants about how the exercise will benefit them.
   b. Answer questions as necessary.
   c. Ensure safety issues are addressed, as necessary.
   d. Reinforce participants right to not participate if they feel unable to do so.
3. Conduct the exercise.
   a. Hand out necessary material for exercise as appropriate.
   b. Observe group member interactions.
   c. Intervene when appropriate.
      (1) Conceptual interventions.
      (2) Procedural interventions.
      (3) Process interventions.
      (4) Structural interventions.
4. Process the exercise.
   a. Attend to stages of processing within the group.
      (1) Experiencing the event.
      (2) Identifying and/or publishing the data.
      (3) Analysis of the dynamic(s).
      (4) Generalization of material.
      (5) Application of the learning to outside behavior.
   b. Encourage group participation in each step of processing.
5. Perform leadership tasks during the group session.
   a. Pose questions constructively.
   b. Make constructive comments.
   c. Focus on keeping interactions among group members.
   d. Reinforce productive contributions on the part of group members.
   e. Invite self-disclosures from members.
   f. Maintain group focus.
   g. Adjust leadership style in accordance with group stage.
   h. Display objectivity with regard to ideas expressed.

Performance Steps

6. Terminate the group.
   a. Summarize key points of group discussion.
   b. Conduct a final check with each member prior to closure.

Performance Measures	**GO**	**NO GO**
1. Selected an appropriate group exercise for the stage of the group.	____	____
2. Gave appropriate rationale for exercise selection.	____	____
3. Gathered appropriate information and material for exercise.	____	____
4. Explained exercise to group members.	____	____
5. Conducted the exercise.	____	____
6. Processed the exercise.***	____	____
7. Terminated the group.	____	____
8. Posed questions/comments constructively.	____	____
9. Kept interaction among group members.***	____	____
10. Interventions were appropriate.	____	____
11. Reinforced productive contributions.	____	____
12. Invited self-disclosure from members.	____	____
13. Kept group focused.	____	____
14. Adjusted leadership style to group stage.	____	____
15. Displayed objectivity with regard to ideas expressed.***	____	____

Evaluation Guidance: Score the student GO if a total of 9 points are achieved including all of the critical items (***). Points are counted one for each item checked as GO and 1/2 for each needs improvement. To attain a GO, all critical item must be a GO. Score the student NO GO if less than 9 points total are achieved or any of the critical items are missed regardless of total points. If the student fails any step, show what was done wrong and how to do it correctly.

References

Required	**Related**
None	AR 600-85

APPENDIX A

FIELD EXPEDIENT SQUAD BOOK

FIELD EXPEDIENT SQUAD BOOK

For use of this form, see AR 350-57; the proponent agency is DCSOPS

SHEET 1 OF 8

USER APPLICATION

SOLDIER'S NAME

TASK NUMBER AND SHORT TITLE	STATUS																	
	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO
Skill Level 1																		
081-832-0062 Collect Collateral Information from Records																		
081-832-0063 Conduct an Information Gathering Interview																		
081-832-0011 Conduct a Collateral Interview																		
081-832-0013 Present a Case for Supervision																		
081-832-1028 Conduct an Admission Interview with a Psychiatric Patient																		
081-832-0065 Assess Substance Use, Abuse, or Dependency																		
081-832-0073 Assess a Patient/Client's Progress in Mental Health Treatment																		
081-832-0038 Assess a Patient for Elopement Tendencies/ Behavior																		
081-832-0034 Document a Psychiatric Patient's Initial Assessment in Writing																		
081-832-0031 Assess Client's Potential for Family Violence																		
081-832-0005 Assess a Client's Mental Status																		
081-832-0006 Assess a Client's Social Functioning																		

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SHEET 2 OF 8

USER APPLICATION

SOLDIER'S NAME

TASK NUMBER AND SHORT TITLE	STATUS																	
	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO
081-832-0064 Assess Client Psychopathology																		
081-832-0023 Determine a Client's Homicidal Potential																		
081-832-0026 Determine a Client's Suicidal Potential																		
081-832-1031 Assess a Psychiatric Patient's Suicidal Potential																		
081-832-1029 Assist in Assessment of a Psychiatric Patient																		
081-832-1030 Assist in the Identification of Treatment Goals and Interventions																		
081-832-0066 Conduct a Counseling Session																		
081-832-0014 Perform Counseling Interventions																		
081-832-0030 Assist in a Critical Event Debriefing																		
081-832-0068 Treat Battle Fatigue																		
081-832-0024 Perform Six Functions of Combat Stress Control (CSC)																		
081-832-0069 Administer the Minnesota Multiphasic Personality Inventory-2 (MMPI-2)																		
081-833-0076 Apply Restraining Devices to Patients																		

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SHEET 3 OF 8

USER APPLICATION

SOLDIER'S NAME

TASK NUMBER AND SHORT TITLE	STATUS																	
	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO
081-832-1011 Respond to an Agitated Patient																		
081-832-1012 Assist in Manual Restraint Procedures																		
081-832-1013 Assist in Mechanical Restraint Procedures																		
081-832-0029 Conduct Crisis Intervention																		
081-832-1014 Involve Patients in Therapeutic Recreational Activities																		
081-832-1024 Care for a Patient Receiving Electroconvulsive Therapy																		
081-832-1021 Cofacilitate a Group Therapy Session																		
081-832-0007 Conduct Referral Service for Individuals																		
081-832-1003 Perform Admission Procedures on a Psychiatric Ward																		
081-832-1001 Ensure a Patient's Funds and Valuables Are Secured																		
081-832-1002 Ensure a Patient's Personal Effects Are Secured																		
081-832-1004 Prepare a Class 1A or 1B Patient for Aeromedical Evacuation																		
081-832-1005 Prepare a Class 1C Patient for Aeromedical Evacuation																		

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SHEET 4 OF 8

USER APPLICATION

SOLDIER'S NAME

TASK NUMBER AND SHORT TITLE	STATUS																	
	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO
081-832-0054 Conduct Hospital Discharge Planning for a Mental Health Patient/Client																		
081-832-1027 Perform Discharge Procedures on a Psychiatric Ward																		
081-832-0077 Facilitate Ward Community Meetings																		
081-832-0056 Assist Aeromedical Psychologists in Providing Mental Health Services to Army Aircrew Members																		
081-832-0055 Conduct Mental Health Consultations with Chains of Command																		
081-832-1025 Place a Patient in Seclusion																		
081-832-1026 Monitor a Patient's Response to Psychotropic Medications																		
081-832-1006 Monitor a Patient's Use of a Potentially Dangerous Item																		
081-832-1007 Perform Line of Sight Observation of a Psychiatric Patient																		
081-832-1008 Perform 1:1 Observation of a Psychiatric Patient																		
081-832-1009 Account for the Location of Psychiatric Patients																		
081-832-1010 Escort a Psychiatric Patient																		
081-832-1020 Determine Patient Care Assignments																		

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SHEET 5 OF 8

USER APPLICATION

SOLDIER'S NAME

TASK NUMBER AND SHORT TITLE	STATUS																	
	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO
081-831-0007 Perform a Patient Care Handwash																		
081-831-0008 Put On Sterile Gloves																		
081-831-0013 Measure a Patient's Temperature																		
081-831-0011 Measure a Patient's Pulse																		
081-831-0010 Measure a Patient's Respirations																		
081-831-0012 Measure a Patient's Blood Pressure																		
081-833-0156 Perform a Medical Patient Assessment																		
081-833-0155 Perform a Trauma Casualty Assessment																		
081-833-0082 Triage Casualties on an Integrated Battlefield																		
081-831-0018 Open the Airway																		
081-831-0019 Clear an Upper Airway Obstruction																		
081-831-0048 Perform Rescue Breathing																		
081-831-0046 Administer External Chest Compressions																		

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SHEET 6 OF 8

USER APPLICATION

SOLDIER'S NAME

TASK NUMBER AND SHORT TITLE	STATUS																	
	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO
081-833-0161 Control Bleeding																		
081-833-0045 Treat a Casualty with an Open Abdominal Wound																		
081-833-0052 Treat a Casualty with an Open Or Closed Head Injury																		
081-833-0047 Initiate Treatment for Hypovolemic Shock																		
081-833-0092 Transport a Casualty with a Suspected Spinal Injury																		
081-833-0154 Provide Basic Emergency Treatment for a Painful, Swollen, Deformed Extremity																		
081-833-0062 Immobilize a Suspected Fracture of the Arm or Dislocated Shoulder																		
081-831-0044 Apply a Pneumatic Splint to a Casualty with a Suspected Fracture of an Extremity																		
081-833-0070 Administer Initial Treatment for Burns																		
081-833-0095 Decontaminate a Casualty																		
081-833-0083 Treat a Nerve Agent Casualty in the Field																		
081-833-0056 Treat Foreign Bodies of the Eye																		
081-833-0054 Irrigate Eyes																		

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SHEET 7 OF 8

USER APPLICATION

SOLDIER'S NAME

TASK NUMBER AND SHORT TITLE	STATUS																	
	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO
081-831-0037 Disinfect Water for Drinking																		
081-831-0035 Manage a Convulsive and/or Seizing Patient																		
081-831-0038 Treat a Casualty for a Heat Injury																		
081-831-0039 Treat a Casualty for a Cold Injury																		
081-831-0033 Initiate a Field Medical Card																		
Drug and Alcohol Counselor (ASI M8)																		
081-838-0016 Conduct an Individual Counseling Session for a Substance Abusing Individual																		
081-838-0058 Facilitate a Group Therapy Session for Substance Abusing Individuals																		

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SHEET 8 OF 8

USER APPLICATION

SOLDIER'S NAME

TASK NUMBER AND SHORT TITLE	STATUS																	
	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO	GO	NO-GO
Skill Level 2																		
081-832-0091 Supervise Mental Health Staff Orientation Program																		
081-832-0084 Supervise Psychiatric Unit Security Procedures																		
081-832-0080 Conduct Rehabilitation Team Meetings																		
081-832-0052 Supervise Personnel Conducting Psychiatric Client Interviews																		
081-832-0020 Manage Mass Mental Health Casualties in Conventional Environments																		
081-832-0018 Instruct Personnel in Psychosocial History Interviewing																		
Skill Level 3																		
081-832-0049 Plan Behavioral Science Field Operations																		

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GLOSSARY

AA
aeromedical adaptability

AA
Alcoholics Anonymous

AAD
after-action debriefing

AAR
after action review

ACCP
The Army Correspondence Course Program

ADAPT
alcohol and drug abuse prevention training

ADL(MED)
activities of daily living

AED
automatic external defibrillator

APL
Aeromedical Policy Letter

Army Training and Evaluation Program (ARTEP).
The Army's collective training program that establishes unit training objectives critical to unit survival and performance in combat. They combine the training and the evaluation process into one integrated function. The ARTEP is a training program and not a test. The sole purpose of external evaluation under this program is to diagnose unit requirements for future training.

ARTEP
Army Training and Evaluation Program

ASAP
Army Substance Abuse Program

ASI
additional skill identifier

AVPU
alertness, responsiveness to vocal stimuli, responsiveness to painful stimuli unresponsiveness

AWOL
absent without leave

BAS
battalion aid station

Battle focus
A process to guide the planning, execution, and assessment of the organization's training program to ensure they train as they are going to fight.

BDU
battle dress uniform

BF
battle fatigue/beginning of radioactive fallout (depends on use)

BSA(MED)
body surface area

BVM
bag-valve-mask

CAM
chemical agent monitor

CANA
convulsant antidote for nerve agents

CBRNE
chemical, biological, radiological, nuclear, and high-yield explosive

cc
cubic centimeter

cc/hr
cubic centimeters of fluid per hour

CISD
critical incident stress debriefing

Collective training.
Training, either in institutions or units, that prepares cohesive teams and units to accomplish their combined arms and service missions on the battlefield.

Common task.
A critical task that is performed by every soldier in a specific skill level regardless of MOS.

CONUS
continental United States

CPR
cardiopulmonary resuscitation

Cross training.
The systematic training of a soldier on tasks related to another duty position within the same military occupational specialty or tasks related to a secondary military occupational specialty at the same skill level.

CSC
combat stress control

DCS(MED)
division clearing station

ECT
electroconvulsive therapy

F
frequency; fail; Fahrenheit; full; failed

FMC
field medical card

FROPVD
flow-restricted oxygen-powered ventilation device

GPA
grade point average

HIV
human immunodeficiency virus

HTH
high test hypochlorite

IAW
in accordance with

ID
identification; infantry division

IG
inspector general

Individual training.
Training which prepares the soldier to perform specified duties or tasks related to the assigned duty position or subsequent duty positions and skill levels.

Integration training.
The completion of initial entry training in skill level 1 tasks for an individual newly arrived in a unit, but limited specifically to tasks associated with the mission, organization, and equipment of the unit to which the individual is assigned. It may be conducted by the unit using training materials supplied by the school, by troop schools, or by inservice or contract mobile training teams. In all cases, this training is supported by the school proponent.

IV
intravenous

JCAHO
Joint Commission on Accreditation of Healthcare Organizations

JVD
jugular vein distention

KED
Kendrick Extrication Device

kg
kilogram(s)

LPM
liters per minute

MAO
monoamine anoxidase

MASCAL
mass casualties

MEDCEN
medical center

MEDDAC
medical department activity

Merger training.
Training that prepares noncommissioned officers to supervise one or more different military occupational specialties at lower skill levels when they advance to a higher level in their career management field.

MES
medical equipment set(s)

METL
mission essential task list

Mission essential task list.
A compilation of collective mission essential tasks which must be successfully performed if an organization is to accomplish its wartime mission(s).

ml
milliliter

mm Hg
millimeters of mercury

MOPP
mission-oriented protective posture

MOS
military occupational specialty

MOSC
military occupational specialty code

MRE
meal, ready to eat

MSE
mental status examination

MTF
medical treatment facility

NAA
not aeronautically adapted

NBC
nuclear, biological, and chemical

NCO
noncommissioned officer

NP
neuropsychiatric

NPO
nothing by mouth

OPLAN
operation plan

OT
occupational therapy

PAD
patient administration division

PASG
pneumatic anti-shock garments

ppm
parts per million

PTF
patient trust fund

RON
remain overnight

RTD
return to duty

RTM
rehabilitation team meeting

Self-development.
Self-development is a planned, progressive, and sequential program followed by leaders to enhance and sustain their military competencies. Self-development consists of individual study, research, professional reading, practice, and self-assessment.

SL
squad leader; skill level

SM
soldier's manual

SMCT
soldier's manual of common tasks

SOP
standing operating procedures

SSN
social security number

Sustainment training.
The provision of training to maintain the minimum acceptable level of proficiency required to accomplish a critical task.

TG
trainer's guide

Train-up.
The process of increasing the skills and knowledge of an individual to a higher skill level in the appropriate MOS. It may involve certification.

UCMJ
Uniform Code of Military Justice

Unit training.
Training (individual, collective, and joint or combined) conducted in a unit.

VA
Department of Veterans Affairs

WP
white phosphorus

REFERENCES

New reference material is being published all the time. Present references, as listed below may become obsolete. To keep up-to-date, see DA Pam 25-30. Many of these publications and forms are available in electronic format from the sites listed below:

U.S. Army Publishing Agency
Administrative Departmental Publications and Forms
(ARs, Cirs, Pams, OFs, SFs, DD & DA Forms)
General Dennis J. Reimer Training and Doctrine Digital Library (RDL)
Army Doctrinal and Training Publications
(FMs, PBs, TCs, STPs)

Required Publications

Required publications are sources that are listed in task conditions statements and are required for the soldier to perform the task.

Army Regulations

AR 40-2	Army Medical Treatment Facilities: General Administration 3 March 1978
AR 40-407	Nursing Records and Reports 15 August 1991
AR 40-535	Worldwide Aeromedical Evacuation 1 December 1975

Department of Army Forms

DA FORM 3696	Patient's Deposit Record
DA FORM 3888	Medical Record - Nursing History and Assessment
DA FORM 4029	Patient's Clearance Record
DA FORM 4160	Patient's Personal Effects and Clothing Record
DA FORM 4677	Therapeutic Documentation Care Plan [Non-medications]
DA FORM 4700	Medical Record - Supplemental Medical Data

Field Manuals

FM 4-02	Force Health Protection in a Global Environment 13 February 2003

Other Product Types

DD FORM 1380	US Field Medical Card
DD FORM 599	Patient's Effects Storage Tag
DD FORM 600	Patient's Baggage Tag
DD FORM 602	Patient Evacuation Tag
MMPI-2 MANUAL	Minnesota Multiphasic Personality Inventory-2 Manual for Administration and Scoring
SF 509	Medical Record - Progress Notes
SF 510	Medical Record - Nursing Notes
SF 511	Medical Record - Vital Signs Record

SF 600	Health Record - Chronological Record of Medical Care

Related Publications

Related publications are sources of additional information. They are not required in order to perform the tasks in this manual.

Army Regulations

AR 20-1	Inspector General Activities and Procedures 29 March 2002
AR 25-55	The Department of the Army Freedom of Information Act Program 1 November 1997
AR 27-1	Legal Services, Judge Advocate Legal Services 1 September 1996
AR 27-3	The Army Legal Assistance Program 21 February 1996
AR 340-21	The Army Privacy Program 5 July 1985
AR 40-3	Medical, Dental, and Veterinary Care 12 November 2002
AR 40-4	Army Medical Department Facilities/Activities 1 January 1980
AR 40-501	Standards of Medical Fitness 30 September 2002
AR 40-66	Medical Record Administration and Health Care Documentation 3 May 1999
AR 600-85	Army Substance Abuse Program (ASAP) 1 October 2001
AR 608-1	Army Community Service Program 31 August 2000
AR 608-18	The Army Family Advocacy Program 1 September 1995
AR 621-5	Army Continuing Education System (ACES) 17 November 1993
AR 930-4	Army Emergency Relief 30 August 1994
AR 930-5	American National Red Cross Service Program and Army Utilization 19 November 1969

Department of Army Forms

DA FORM 2028	Recommended Changes to Publications and Blank Forms
DA FORM 5164-R	Hands-On Evaluation
DA FORM 5165-R	Field Expedient Squad Book
DA FORM 8003	Alcohol and Drug Abuse Prevention and Control Program

Department of Army Pamphlets

DA PAM 25-30	Consolidated Index of Army Publications and Blank Forms 1 January 2003
DA PAM 350-59	Army Correspondence Course Program Catalog 1 October 2002

Department of Defense Publications

DOD 6010.8-R	Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) 1 July 1991
DODD 6490.1	Mental Health Evaluations of Members of the Armed Forces 1 October 1997

Field Manuals

FM 101-5	Staff Organization and Operations 31 May 1997
FM 22-51	Leader's Manual for Combat Stress Control 29 September 1994
FM 25-101	Battle Focused Training 30 September 1990
FM 3-0	Operations 14 June 2001
FM 7-0	Training the Force 22 October 2002
FM 8-51	Combat Stress Control in a Theater of Operations, Tactics, Techniques, and Procedures 29 September 1994
FM 8-55	Planning for Health Service Support 9 September 1994

Other Product Types

JCAHO MANUAL	JCAHO Accreditation Manual for Hospitals
WAIS-R MANUAL	Wechsler Adult Intelligence Scale-Revised (WAIS-R) Manual

Soldier Training Publications

STP 21-1-SMCT	Soldier's Manual of Common Tasks Skill Level 1 1 October 1994
STP 21-24-SMCT	Soldier's Manual of Common Tasks (SMCT) Skill Levels 2-4 1 October 1992

Special Texts

AGUILERA	Aguilera, Crisis Intervention: Theory and Methodology, 8th Edition, Mosby-Year Book (ISBN 0815126042) 15 January 1998
BASIC NURSING	Rosdahl, Textbook of Basic Nursing, 6th Edition, Lippincott 1 August 1997
BTLS FOR PARAMEDICS	Campbell, Basic Trauma Life Support for Paramedics and Other Advanced Providers, 4th Edition, Prentice Hall. 1 August 1999
DUNNER	Dunner, Current Psychiatric Therapy, W B Saunders Co (ISBN 0721639739) 1 September 1992
EMERGENCY CARE	O'Keefe (Editor), Brady Emergency Care, 8th Edition, Prentice Hall 1 July 1997
HACKNEY & CORMIER	Hackney and Cormier, The Professional Counselor: A Process Guide to Helping, 3rd Edition, Allyn & Bacon (ISBN 0205191924) 20 November 1995
KAPLAN & SADOCK(2)	Kaplan and Sadock, Comprehensive Textbook of Psychiatry VI, Lippincott Williams & Wilkins (ISBN 0683045326) 1 February 1995
KAPLAN & SADOCK(3)	Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences, Clinical Psychiatry, 8th Edition, Lippincott Williams & Wilkins (ISBN 0683303309) 1 October 1997
OTHMER & OTHMER	Othmer and Othmer, The Clinical Interview Using DSM-IV: Fundamentals Vol. 1, American Psychiatric Press Inc (ISBN 0880485418) 1 June 1994
PATTERSON & WELFEL	Patterson and Welfel, The Counseling Process, 4th Edition, Brooks/Cole Publishing Co (ISBN 053423268X) 1 May 1994
VOLLAND	Volland, Discharge Planning: An Interdisciplinary Approach to Continuity of Care, National Health Publishing (ISBN 0932500730) 1 January 1988

STP 8-91X14-SM-TG
30 April 2003

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PIN: 080794-000