

Διαλογή – Triage



Triage/ Διαλογή





Mass casualty – earthquake



Triage



Triage

Triage refers to the evaluation and categorization of the sick or wounded when there are insufficient resources for medical care of everyone at once

Triage, is a dynamic process, as the patient's status can change rapidly.



Color-Coding scheme

- **Red tags** - (immediate) are used to label those who cannot survive without immediate treatment but who have a chance of survival.
- **Yellow tags** - (observation) for those who require observation (and possible later re-triage). Their condition is stable for the moment and, they are not in immediate danger of death.



Color-Coding scheme

- **Green tags** - (wait) are reserved for the "walking wounded" who will need medical care at some
- **Black tags** - (expectant) are used for the deceased and for those whose injuries are so extensive that they will not be able to survive given the care that is available.



Color-Coding scheme

- White tags - (dismiss) are given to those with minor injuries for whom a doctor's care is not required.
- Grey tags – for those whose injuries are so extensive that they will not be able to survive given the care that is available.

Mass Casualty Incident

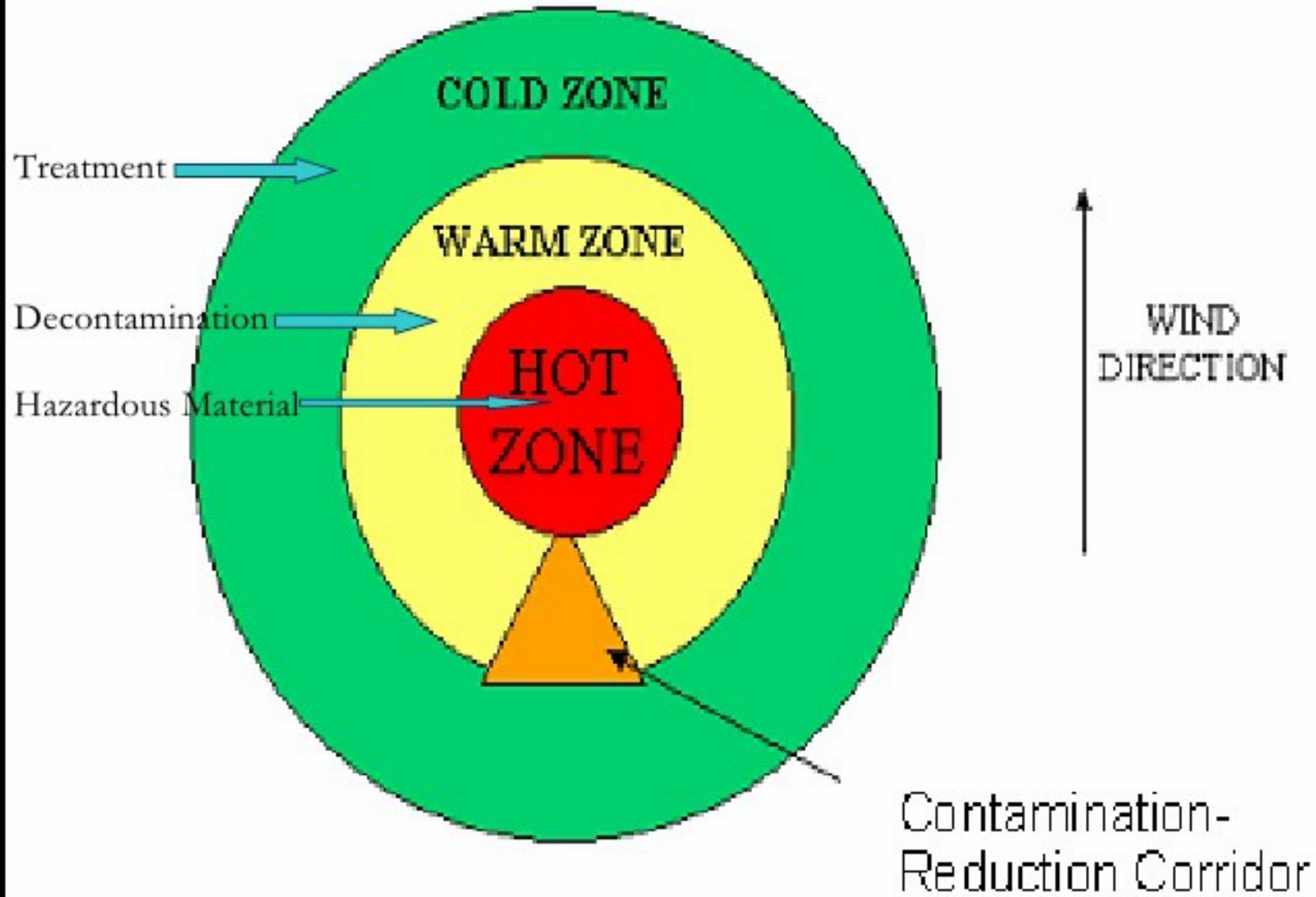
The first person / unit on the scene does:





- S.T.A.R.T (Triage)





Triage

- MASS triage (divides patients into triage categories ***based on their ability to move***)
- S.T.A.R.T. triage (***determines the severity of injuries***)
- ADVANCED triage (more fully assess injury priorities)

Triage (phase)

- Triage (hot zone)

Διαλογή πρώτης φάσης ή διαλογή επόπτευσης (τόπος συμβάντος)

- Triage (warm zone)

Διαλογή δεύτερης φάσης (Χώρος συγκέντρωσης τραυματιών)

- Triage (cold zone)

Διαλογή τρίτης φάσης (Νοσοκομείο Υποδοχής)

HOT ZONE

MASS Triage

Contaminated Waste

Emergency Treatment
(If needed)

Simple Triage

Wind Direction

Responders

WARM ZONE

Log-in



Shaded Area

Technical Decontamination

COLD ZONE

Debrief

Advanced Triage

Medical
Treatment

Transport

MASS Triage

- Move, Assess, Sort, & Send
- Performed in the hot zone
- Offensive responders wearing appropriate PPE
- Based on the patients ability to move and respond
- Utilize triage ribbons (colored-coded strips) first



MASS Triage

- **Move:** “Everyone who can hear me and needs medical attention, please move to a designated area now!”

(Green) Minimal or ambulatory

- **Assess:** Nonambulatory
“Everyone who can raise an arm or leg.” Doing the most good for the most victims



MASS Triage

to remaining victims.



d on



MASS Triage

Send

- Victims are sent (evacuated) both safely & promptly to the decon area / or treatment area.
- Send to hospitals or secondary treatment facilities
- Send to morgue facilities

Search and rescue/ Έρευνα και Διάσωση



S.T.A.R.T. Triage

- Simple Triage & Rapid Treatment
- Rapid approach to triaging large numbers of casualties
- Occurs just inside the warm zone prior to decontamination to assess the victims & their injuries
- Initial patient assessment & treatment should take less than one minute for each patient, 30 seconds is preferred

All Walking Wounded

MINOR

RESPIRATIONS

NO

YES

Position Airway

Under 30/min.

Over 30/min.

NO Respirations

Respirations

IMMEDIATE

DECEASED

IMMEDIATE

PERFUSION

Radial Pulse Absent

OR

Radial Pulse Present

Over 2 seconds

Capillary Refill

Under 2 seconds

Control Bleeding

IMMEDIATE

MENTAL STATUS

CAN'T Follow
Simple Commands

CAN Follow
Simple Commands

IMMEDIATE

DELAYED

S.T.A.R.T. Triage

Treatments

- Open the airway / insert OPA
- Stop the bleeding.
- Elevate the legs for shock



- Place the victim in shock position
- Keep the person warm and comfortable
- Turn the victim's head to one side if neck injury is not suspected



START Triage

- Respiratory Status



(blood)





min.



REFUSION

IMMEDIATE



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Radial Pulse Absent

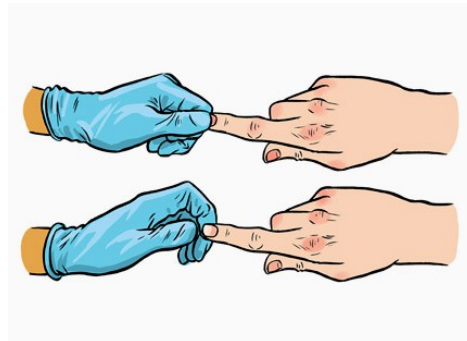
OR

capillary Refill → Under 2 seconds

Radial Pulse Present



IMMEDIATE



MENTAL STATUS

CAN'T Follow
Simple Commands

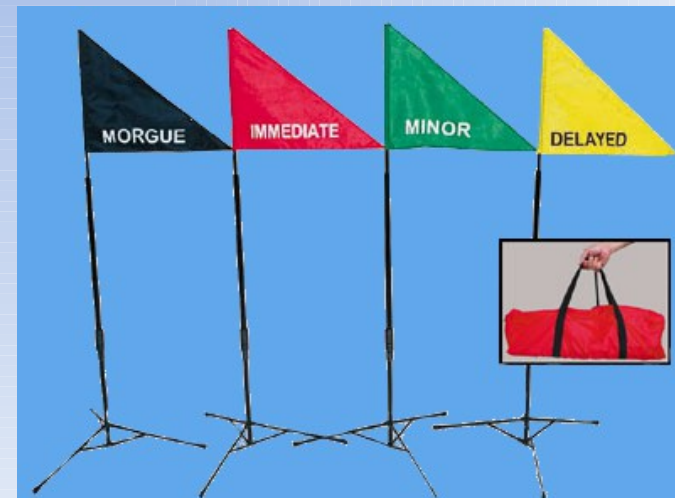
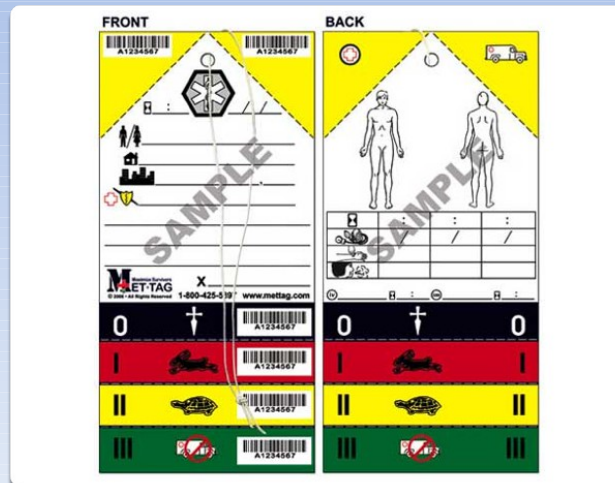
IMMEDIATE



DELAYED

Triage

- If borderline decision are encountered, always triage to the most urgent priority
- Example: If unsure whether the patient is green or yellow, the patient should be tagged yellow



Advanced Triage

- Advanced Triage will be performed on all victims in the Treatment Area by medical teams



No. 239352 TRIAGE TAG No. 239352	
PART I	
No. 239352	
CALIFORNIA FIRE CREWS ASSOCIATION	
Leave the correct Triage Category (on the end of the Triage Tag)	
Move the Walking Wounded	MINOR
No respirations after head tilt	DECEASED
☐ Respirations - Over 30	IMMEDIATE
☐ Perfusion - Capillary refill Over 2 seconds	IMMEDIATE
☐ Mental Status - Unable to follow simple commands	IMMEDIATE
Otherwise-	DELAYED
MAJOR INJURIES:	
HOSPITAL DESTINATION:	
ORIENTED ☐ ☐	DISORIENTED ☐ UNCONSCIOUS ☐
TIME	PULSE B/P RESPIRATION
DECEASED	
IMMEDIATE No. 239352	
DELAYED No. 239352	
MINOR No. 239352	

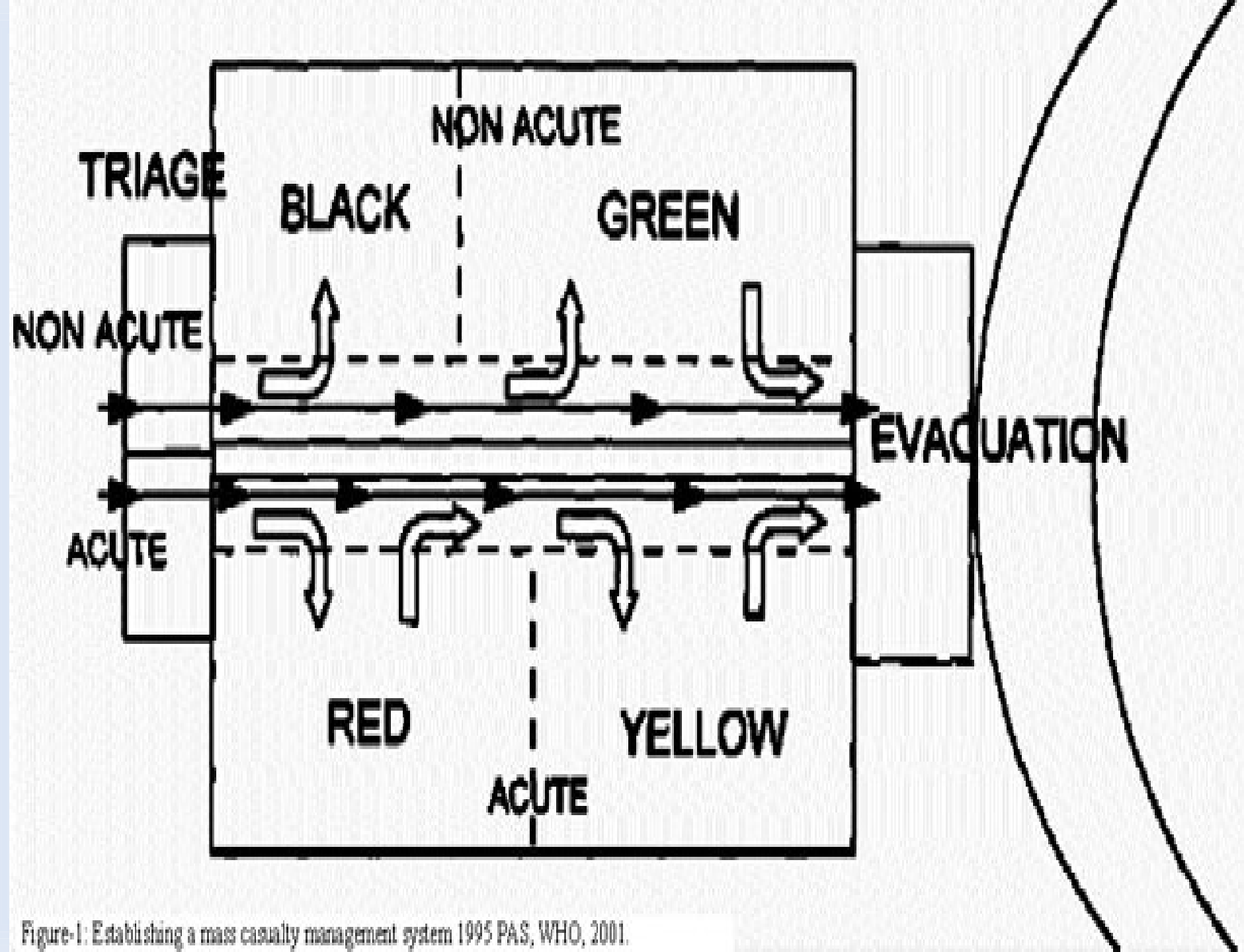


Figure-1: Establishing a mass casualty management system 1995 PAS, WHO, 2001.

Transport/ Μεταφορά



LIFE

- **Hydrolysis**
- **Yeast**
- **to**
- **to**



FIVE LEVEL TRIAGE

LEVEL 1	IS THE PATIENT DYING?	Cardiac Arrest, Respiratory Arrest Trauma, Anaphylaxis, Unresponsiveness-ETOH Hypoglycemia, Imminent Childbirth, Limb Amputations												
LEVEL 2	HIGH RISK SITUATION? IS THIS A PATIENT WHO SHOULDN'T WAIT	Confused, Lethargic, Disoriented, Severe Pain, Distress, Active Chest Pain, Suspicious for Coronary Syndrome, Signs of Stroke, Immunocompromised with fever, Suicidal, Homicidal, Amputations												
LEVEL 3	HOW MANY RESOURCES-(2 or more) CONSIDER VITAL SIGNS AS PART OF CRITERIA. TEMPERATURE- BIRTH-36 MOS. (Consider upgrading to 2)	<u>Danger Zone Vitals?</u> <table> <tr> <th>Age</th><th>Pulse</th><th>RR</th></tr> <tr> <td><3m</td><td>>180</td><td>> 50</td></tr> <tr> <td>3-8y</td><td>>160</td><td>> 40</td></tr> <tr> <td>>8y</td><td>>100</td><td>>20</td></tr> </table>	Age	Pulse	RR	<3m	>180	> 50	3-8y	>160	> 40	>8y	>100	>20
Age	Pulse	RR												
<3m	>180	> 50												
3-8y	>160	> 40												
>8y	>100	>20												
LEVEL 4	HOW MANY RESOURCES?-(ONE) STABLE VITAL SIGNS	Ankle sprain, Strept Throat, UTI, Migraines with CT head, Simple Lacerations, IV/IM Meds												
LEVEL 5	HOW MANY RESOURCES?- NONE	Medication Refill, MSE, Illness requiring a Prescription												

Canadian Triage and Acuity Scale (CTAS)

Non disaster

TRIAGE LEVEL I - RESUSCITATION	
Time to NURSE Assessment IMMEDIATE*	USUAL PRESENTATION Code / Arrest Major Trauma Shock States Near Death Asthma Severe Respiratory Distress Altered Mental State (unconscious, delirious) Seizures
Time to PHYSICIAN Assessment IMMEDIATE*	SENTINEL DIAGNOSIS Traumatic Shock Pneumothorax - Tension / Tension Facial Burns with Airway Compromise Severe Burns - 30% TBSA Overdose with Hypotension / Unconscious AAA AMI with Complications / CHF / Low BP Status Asthmaticus Head Injury - Major / Unconscious Status Epilepticus
TRIAGE LEVEL II - EMERGENT	
Time to NURSE Assessment IMMEDIATE*	USUAL PRESENTATION Head Injury (Risk Features + Altered Mental State) Severe Trauma Altered Mental State (lethargic, drowsy, agitated) Chemical Exposure - Eyes Allergic Reaction (Severe) Chest Pain - Vascular, Non-Traumatic + ± Associated Symptoms Overdose (conscious), Drug Withdrawal ABE Pain (Age >50) with Visceral Symptoms Back Pain (Non Trauma, Not MSK) GI Bleed with Abnormal Vital Signs CVA with Major Deficit Asthma Severe (PEFR <40%) Moderate / Severe Dyspnea / Difficulty Breathing Vaginal Bleeding - Acute, Pain scale >5 + ± Abnormal Vital Signs Vomiting and/or diarrhea (with suspicion of dehydration) Signs of serious infection (purpura rash, toxic) Chemotherapy or immunocompromised Fever (age < 2 months) Temp > 38.6 (rectal) Acute Psychotic Episode / Extreme Agitation Diabetes: Hypoglycemia, Hyperglycemia Headache (Pain Scale 8 - 10/10) Pain Scale 8-10 (CVA, Back, Eye) Sexual Assault Neonate (< 7 days old)
Time to PHYSICIAN Assessment 15 MINUTES*	SENTINEL DIAGNOSIS Head Injury Trauma, Multiple Sites, Multiple Rib Fracture, Neck Injury / Spinal Cord Alkaline / Caustic Ocular Burns Anaphylaxis AMI, Unstable Angina, CHF, Chest Pain NOS, Gastroesophageal Reflux Unspecified Drug / Medication Overdose, "d.i.s" AAA, Appendicitis, Cholecystitis Gastrointestinal Bleed, Hypotension CVA Severe Asthma COPD, Croup Spontaneous Abortion Ectopic Pregnancy / Rupture Epiglottitis, Meningitis, Sepsis Acute Psychotic Episode / Agitation Hypoglycemia, Diabetic Ketoacidosis, Hyperglycemia Migraine Renal Colic, LBP / Strain (Disc), Keratitis, Iritis
TRIAGE LEVEL III - URGENT	
Time to NURSE Assessment 30 MINUTES*	USUAL PRESENTATION Head Injury, Alert, Vomiting Moderate Trauma Abuse / Neglect / Assault Vomiting and/or diarrhea (< 2 years) Dialysis problems Signs of infection Mild / Moderate Asthma (PEFR = 40%) Mild / Moderate Dyspnea Chest Pain - No Visceral Symptoms (Sharp/MSK) + No Previous Heart Disease GI Bleed with Normal Vital Signs Vaginal Bleeding Acute, Normal Vital Signs Seizure, Alert on Arrival Acute Psychosis ± Suicidal Ideation Pain Scale 6 - 10 / 10 with minor injuries Pain Scale 4 - 7 / 10 (Headache, CVA, Back)
Time to PHYSICIAN Assessment 30 MINUTES*	SENTINEL DIAGNOSIS Head Injury Anterior Dislocated Shoulder, Tibia / Fibula Fracture, Bimalleolar, Tri-malleolar Ankle Fracture Pyelonephritis Asthma without Status / COPD Bronchiolitis / Croup, Pneumonia Chest Pain NOS (MSK, GI, Resp) GI Bleed, No complications Spontaneous Abortion Seizure Acute Psychosis ± Suicidal Ideation Migraine, Renal Colic, LBP / Strain (Disc)

Canadian Triage and Acuity Scale (CTAS)

Non disaster

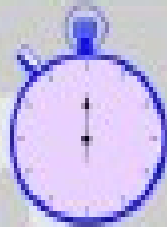
TRIAGE LEVEL IV - LESS URGENT

Time to NURSE
Assessment

60 MINUTES*

Time to PHYSICIAN
Assessment

60 MINUTES*



USUAL PRESENTATION

Head Injury, Alert, No Vomiting
Minor Trauma
ABD Pain (Acute)
Earache
Chest Pain, Minor Trauma or MDK, No Distress

Vomiting and diarrhea (>2 years)w/o dehydration)
Suicidal Ideation / Depression
Allergic Reaction (Minor)
Corneal Foreign Body
Back Pain (Chronic)
URI Symptoms
Pain Scale 4 - 7
Headache (Non Migraine / Not Sudden)

SENTINEL DIAGNOSIS

Head Injury, Alert, No Vomiting
Clavicle Fracture, Ankle Sprain
Appendicitis, Cholecystitis
Otitis Media / Otitis Externa
Chest Pain NOS (MDK, GI, Resp.)
Gastroesophageal Reflux

Suicidal Ideation / Depression
Urticaria
Corneal Foreign Body
LBP / Strain
URI

TRIAGE LEVEL V - NON URGENT

Time to NURSE
Assessment

120 MINUTES*

Time to PHYSICIAN
Assessment

120 MINUTES*



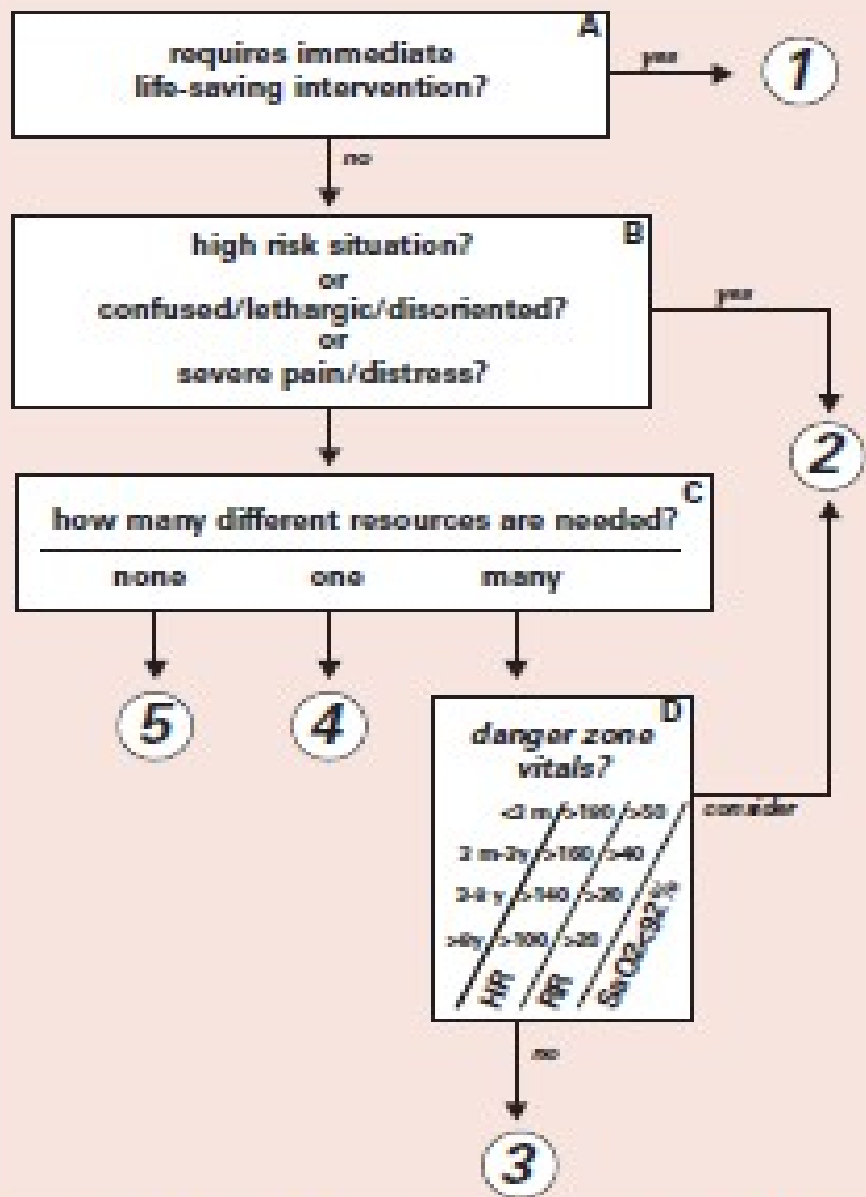
USUAL PRESENTATION

Minor Trauma, Not Necessarily Acute
Sore Throat, No Resp Symptoms
Diarrhea alone (no dehydration)
Vomiting alone normal mental status
(no dehydration)
Monocles
Minor Symptoms
ABD Pain (Chronic)
Psychiatric complaints
Pain Scale < 4

SENTINEL DIAGNOSIS

LBP / Strain
URI
Gastroenteritis
Vomiting
Disorders of Menstruation
Breast Changes
Ear Changes
Constipation
Symptoms / Neurotic, Personality and
Nonpsychotic Mental Disorders
Unspecified Superficial Laceration(s)

Figure 3-1a. ESI Triage Algorithm



A. Immediate life-saving intervention required: airway, emergency medications, or other hemodynamic interventions (IV, supplemental O₂, monitor, ECG or labs DO NOT count); and/or any of the following clinical conditions: intubated, apneic, pulseless, severe respiratory distress, SpO₂<90, acute mental status changes, or unresponsive.

Unresponsiveness is defined as a patient that is either:
(1) nonverbal and not following commands (acutely); or
(2) requires noxious stimulus (P or U on AVPU) scale.

B. High risk situation is a patient you would put in your bed open bed.

Severe pain/distress is determined by clinical observation and/or patient rating of greater than or equal to 7 on 0-10 pain scale.

C. Resources: Count the number of different types of resources, not the individual tests or x-rays (examples: CBC, electrolytes and coags equals one resource; CBC plus chest x-ray equals two resources).

Resources	Not Resources
• Labs (blood, urine) • scans, x-rays • catheters-vascular-angiography	• history & physical (including pelvic) • point-of-care testing
• IV lines (hydration)	• same or repeat
• IV or IM or nebulized medications	• IMC medications • patient immunization • prescription refills
• specialty consultation	• phone call to PCP
• simple procedure =1 (pic repair, nail care) • complex procedure =2 (conscious sedation)	• simple wound care (pressure, incision) • cultures, swabs, smears

D. Danger Zone Vital Signs

Consider upstage to ESI 2 if any vital sign criterion is exceeded.

Pediatric Fever Considerations

1 to 28 days of age: assign at least ESI 2 if temp >38.0 C (100.4F)

1-3 months of age: consider assigning ESI 2 if temp >38.0 C (100.4F)

3 months to 3 yrs of age: consider assigning ESI 2 if temp >38.0 C (100.2 F), or incomplete immunizations, or no obvious source of fever

Triage

1. **You DO NOT decide who lives or dies**
2. The sooner you start Triage the sooner the medical care process starts
3. Triage is an ongoing process that is repeated many times
4. If you forget any of the above rules, go back to rule number 1.

ORGANIZED



CHAOS

Let's Practice/ Άσκηση

- A 30 years old woman/ Γυναίκα 30 ετών
- Patient asks for help/

Ζητάει να τη βοηθήσουμε

- Respiration 20bpm/

Αναπνοές 20/min

- Radial pulse present/

Ψηλαφητός κερκιδικός σφυγμός

- Minor abrasions to arm/hands/

Μικρής έκτασης αμυχές στα χέρια

- Patient is walking /

Η ασθενής περπατάει

Πράσινο/ Green

Let's Practice/ Άσκηση

A 50 years old men / Άντρας 50 ετών

Airway is open/

Αεραγωγός ανοικτός

Breathing 30bpm/

Αναπνοές 30/min

Absent radial pulses /

Μη ψηλαφητός κερκιδικός σφυγμός

Lying on the road/

Ξαπλωμένος πάνω στην άσφαλτο

KOKKINO/ RED

Let's Practice/ Άσκηση

- Men 45 years old/ Άντρας ετών 45
- Respirations 22 / Αναπνοές 22/min
- Radial pulse present/
Ψηλαφητός κερκιδικός σφυγμός
 - Follows commands/ Εκτελεί εντολές
 - Cannot walk/ Δεν μπορεί να περπατήσει
 - Burns to one arm / Έγκαυμα στο ένα χέρι

KITRINO/ YELLOW

Let's Practice/ Άσκηση

- A 25 yr. old male / Άνδρας 25 ετών
- He is able to follow commands but has trouble hearing/ Εκτελεί εντολές αλλά δεν ακούει καλά
- His Cap Refill is **<2 seconds** /
Τριχοειδική επαναπλήρωση **<2 seconds**
- His Radial Pulse is nonexistent/
Μη ψηλαφητός κερκιδικός σφυγμός
- Can't move due to a left femur fracture/

Δεν μπορεί να κινηθεί εξαιτίας ενός κατάγματος στην Αρ κνήμη

- Respirations are **>30 and he is coughing** /
- Αναπνοές **>30** και βήχει

KOKKINO/ RED

