Διαλογή – Triage

Paraskevi Nella , Military Nurse (RN),MSc)

June 2016

Triage/ Διαλογή


25

Mass casualty – earthquake

Triage

Triage

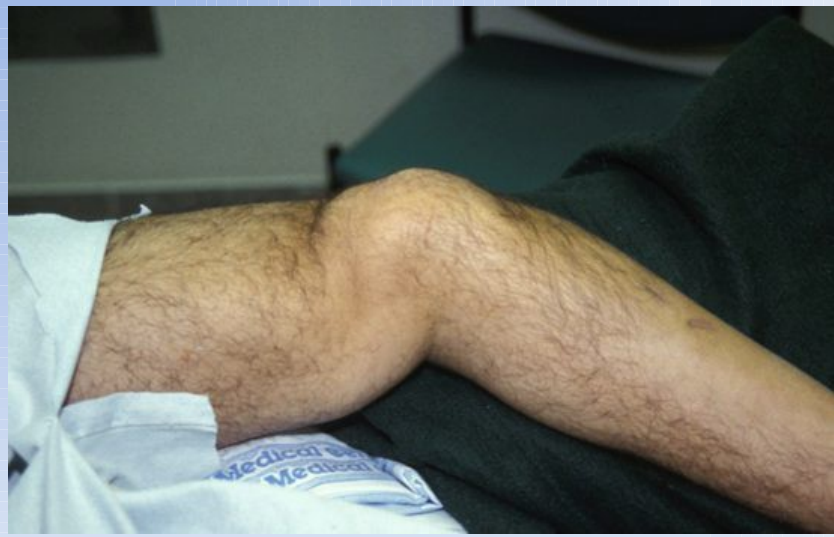
Triage refers to the evaluation and categorization of the sick or wounded when there are insufficient resources for medical care of everyone at once

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.

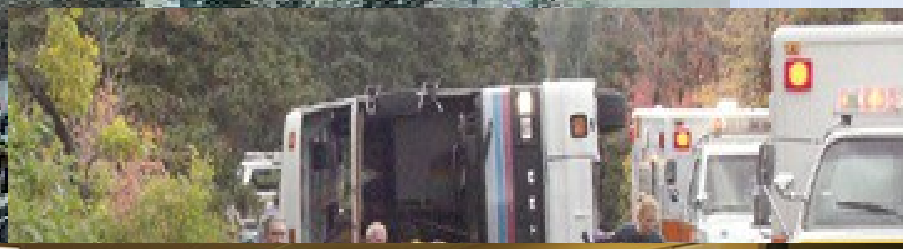
Color-Coding scheme

- White tags - (dismiss) are given to those with minor injuries for whom a doctor's care is not required.

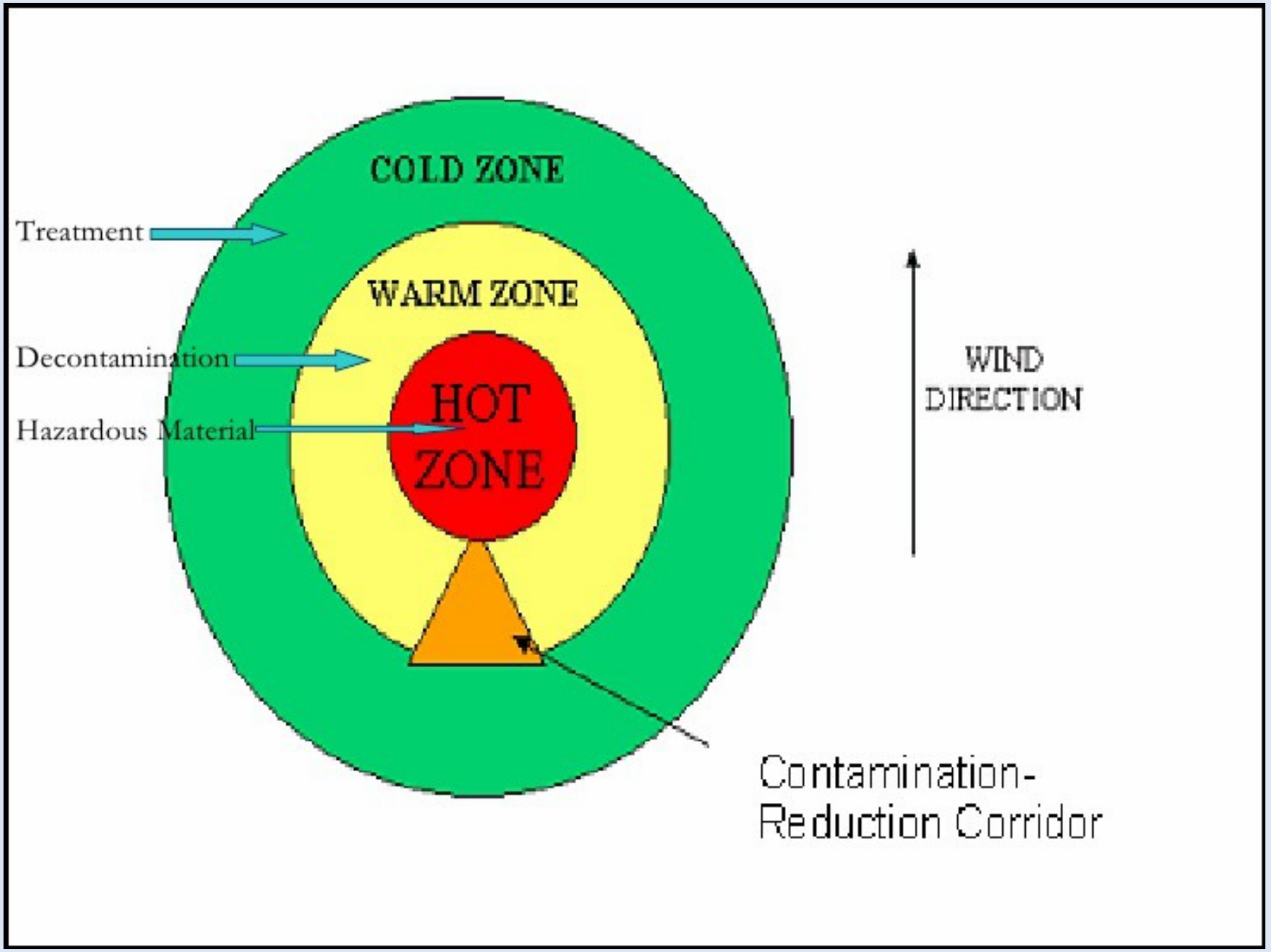
- Grey tags – for those whose injuries are so extensive that they will not be able to survive given the care that is available.

Mass Casualty Incident

The first person / unit on the scene does:



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


COLD ZONE
Treatment
WARM ZONE
Decontamination
HOT ZONE
Hazardous Material
WIND DIRECTION
Contamination-Reduction Corridor

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

Technical Decontamination

Shielded Area

COLD ZONE

Debrief

Advanced Triage

Medical Treatment

Transport

MASS Triage

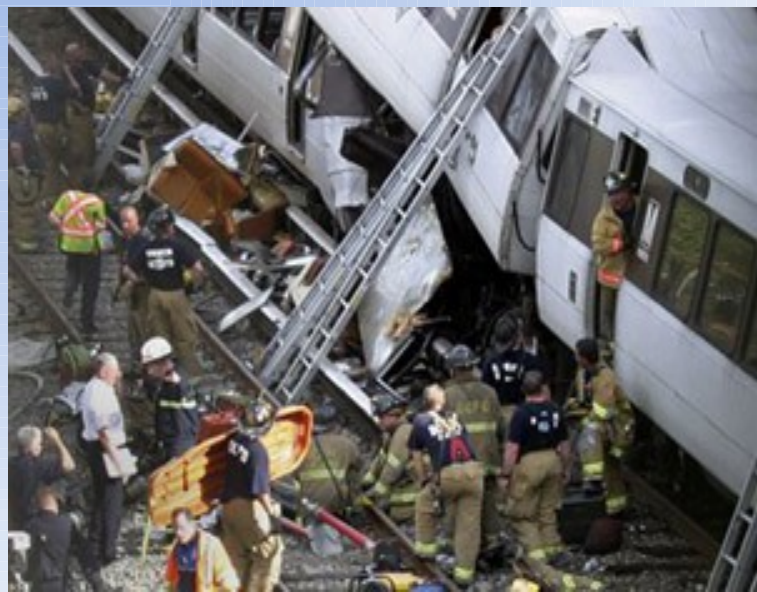
- Move, Assess, Sort, & Send
- Performed in the hot zone
- Offensive responders wearing appropriate PPE
- Based on the patients ability to move and respond
- Utilize triage ribbons (colored-coded strips) first

MASS Triage

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

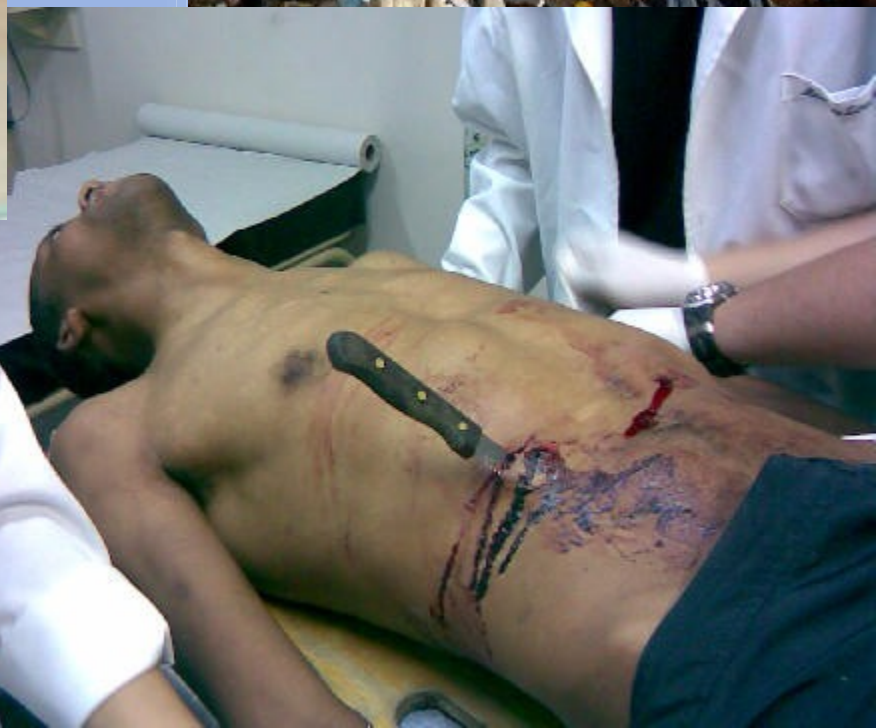
(Green) Minimal or ambulatory

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



MASS Triage

to remaining victims.



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MASS Triage

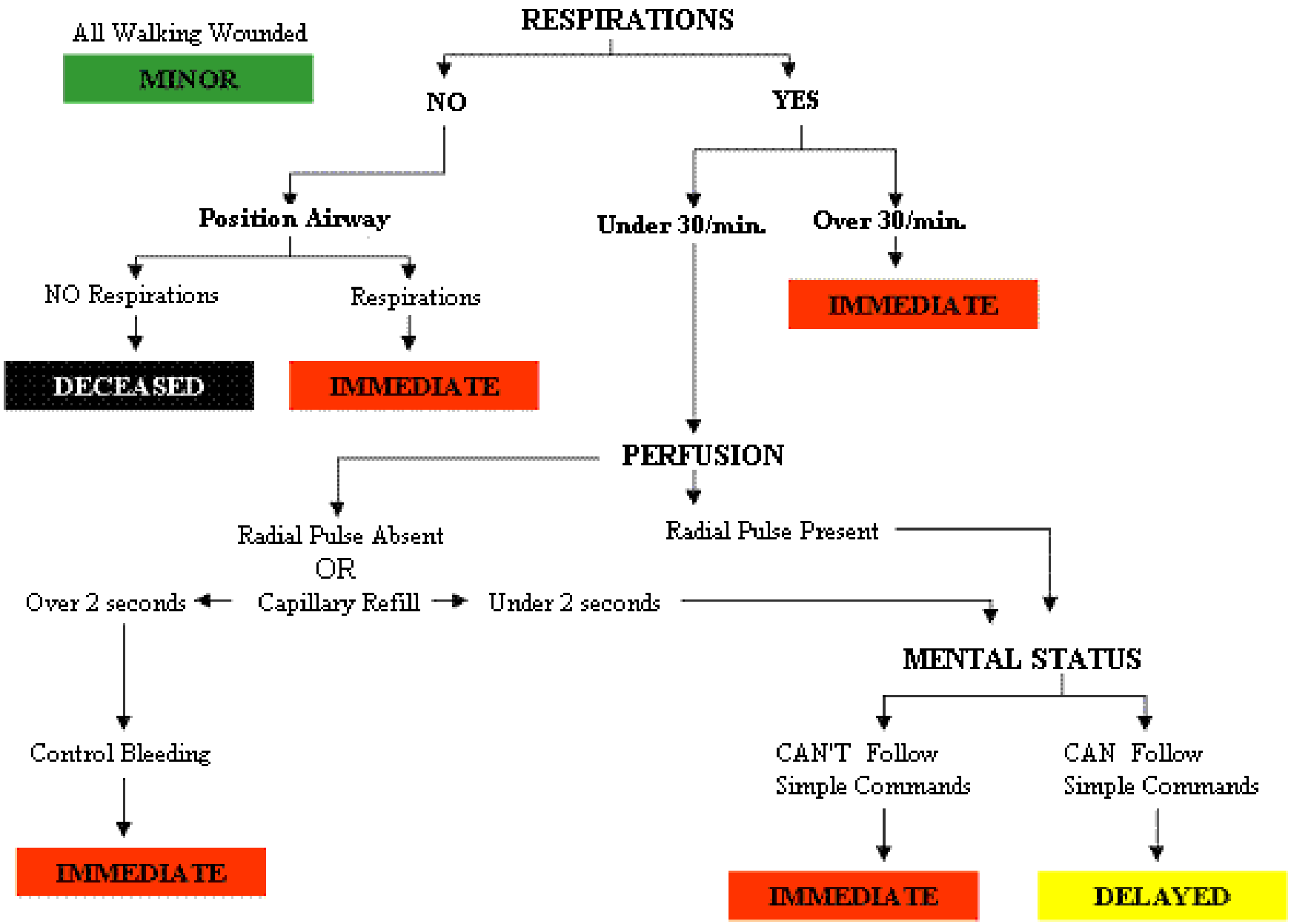
Send

- 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 causalities
- 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
Capillary Refill
Radial Pulse Present
Over 2 seconds
Under 2 seconds
MENTAL STATUS
Control Bleeding
CAN'T Follow
Simple Commands
CAN Follow
Simple Commands
IMMEDIATE
IMMEDIATE
DELAYED

S.T.A.R.T. Triage

Treatments

- Open the airway / insert OPA

- Stop the bleeding.

- Elevate the legs for shoc

START Triage

- Respiratory Status

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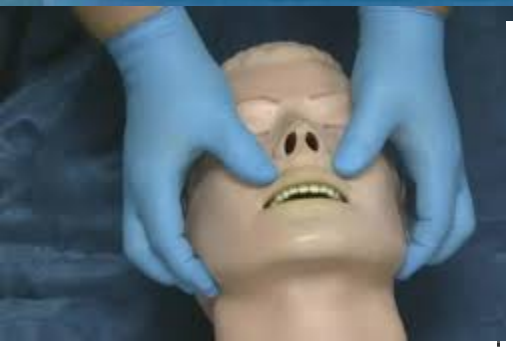
IMMEDIATE



RFUSION

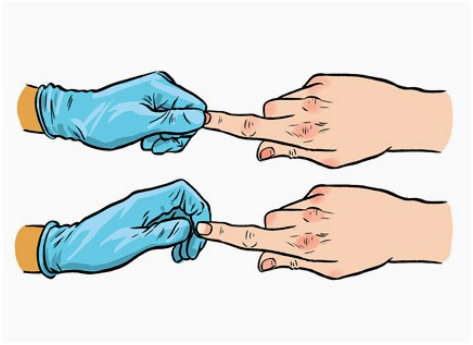
Radial Pulse Absent

OR

apillary Refill → Under 2 seconds

Radial Pulse Prese

IMMEDIATE



MENTAL ST

CAN'T Follow
Simple Commands

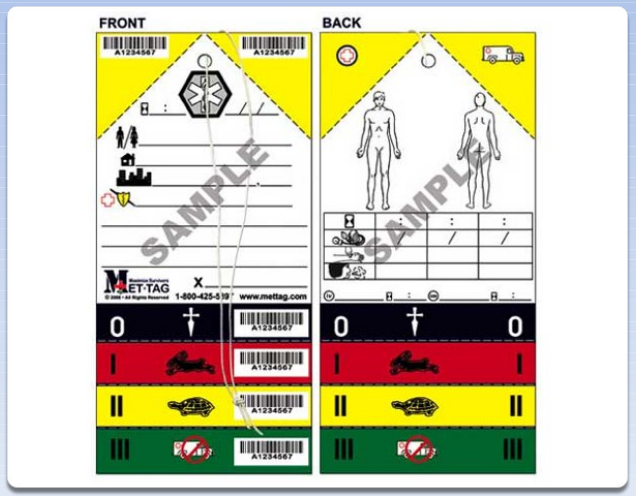
IMMEDIATE

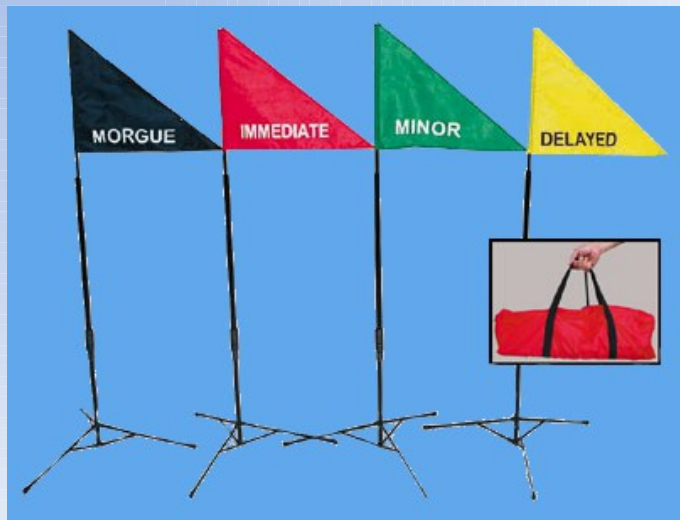
DELAYED

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
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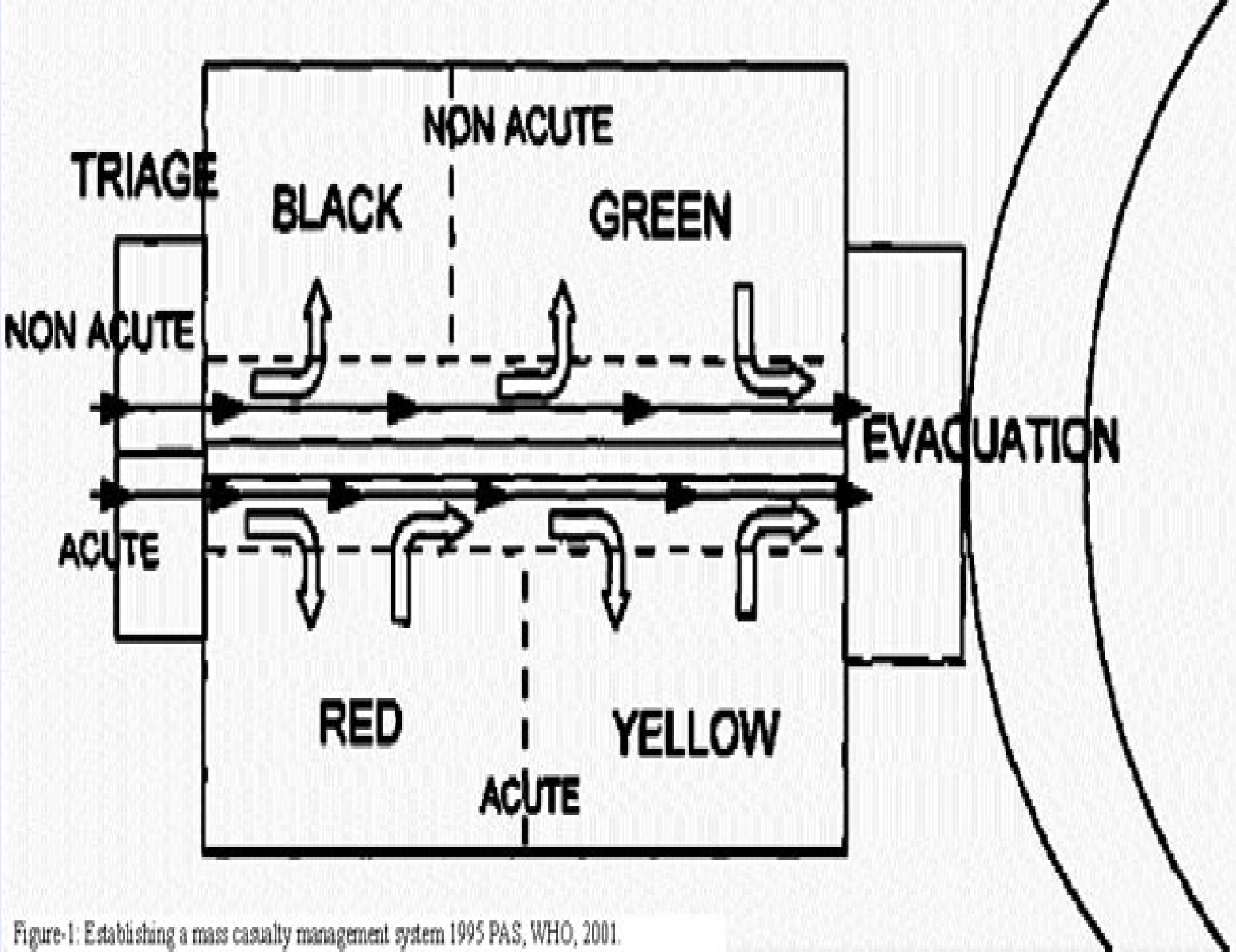

Figure-1: Establishing a mass casualty management system 1995 PAS, WHO, 2001.

Transport/ Μεταφορά

Emergency Department – Triage multicasualty /disaster

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- V
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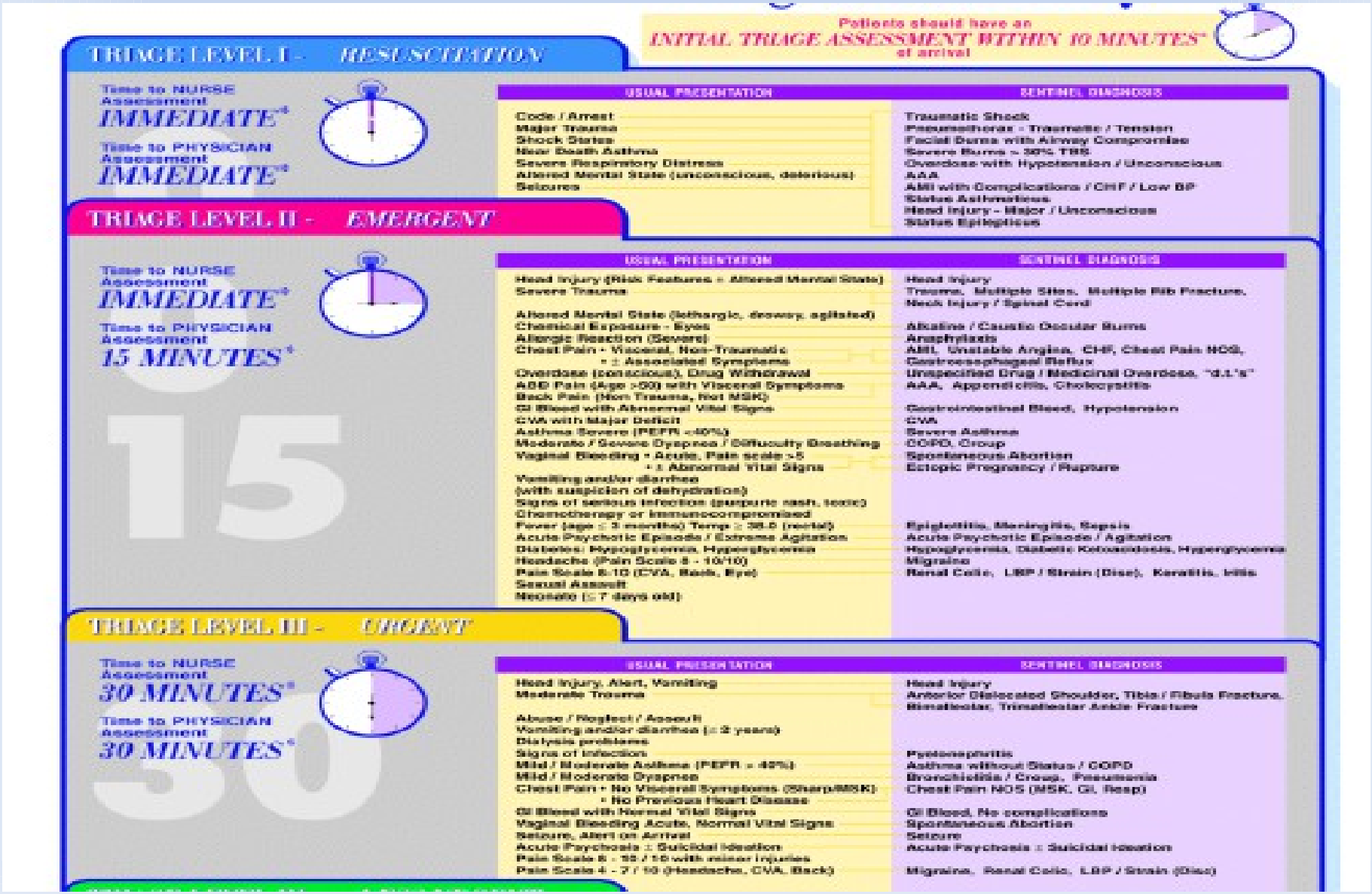
FIVE LEVEL TRIAGE

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)	Danger Zone Vitals? 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

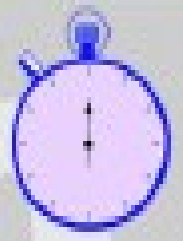


Canadian Triage and Acuity Scale (CTAS)
Non disaster

TRIAGE LEVEL IV - *LESS URGENT*

Time to NURSE Assessment
60 MINUTES*

Time to PHYSICIAN Assessment
60 MINUTES*



USUAL PRESENTATION	SENTINEL DIAGNOSIS
Head Injury, Alert, No Vomiting	Head Injury, Alert, No Vomiting
Minor Trauma	Colles Fracture, Ankle Sprain
ABD Pain (Acute)	Appendicitis, Cholecystitis
Earache	Otitis Media / Otitis Externa
Chest Pain, Minor Trauma or MSK, No Distress	Chest Pain NOS (MSK, GI, Resp), Gastroesophageal Reflux
Vomiting and diarrhea (>2 years/no dehydration)	
Suicidal Ideation / Depression	Suicidal Ideation / Depression
Allergic Reaction (Minor)	Urticaria
Corneal Foreign Body	Corneal Foreign Body
Back Pain (Chronic)	LBP/Strain
URI Symptoms	URI
Pain Scale 4 - 7	
Headache (Non Migraine / Not Sudden)	

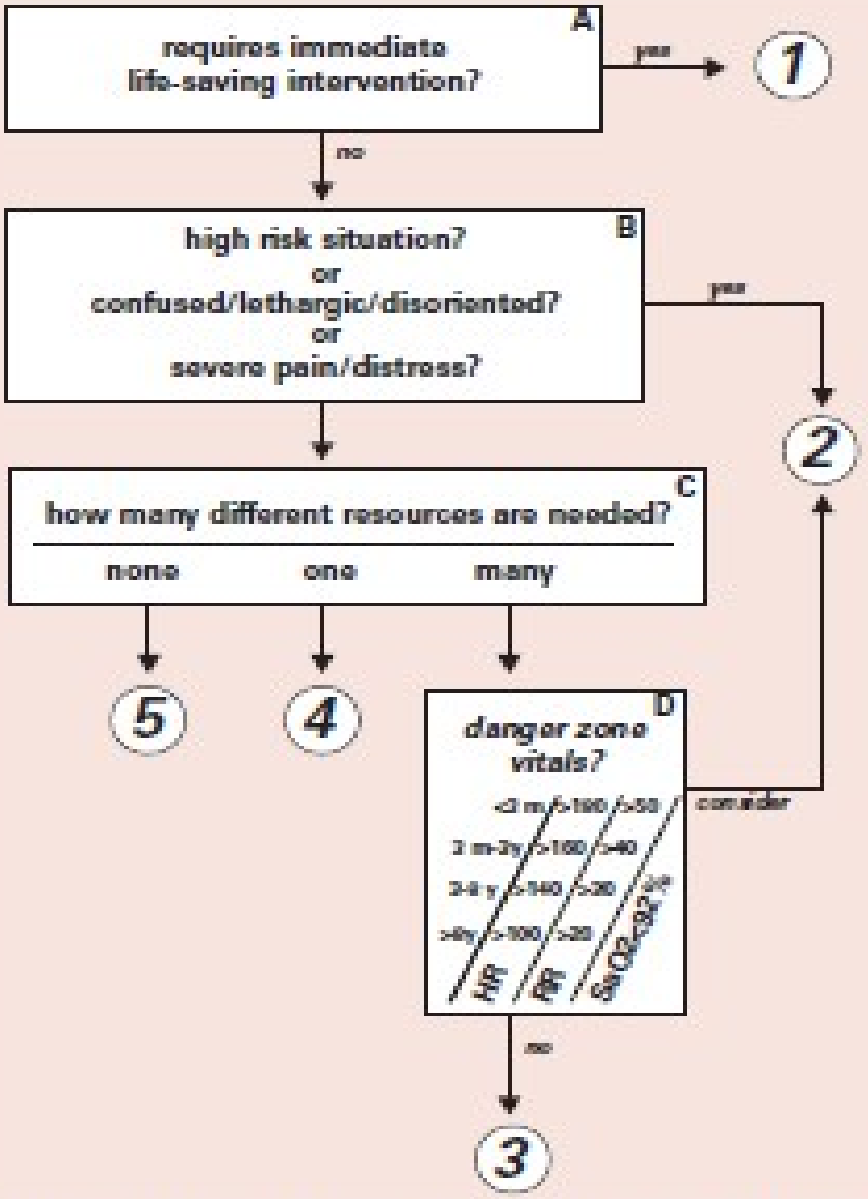
TRIAGE LEVEL V - *NON URGENT*

Time to NURSE Assessment
120 MINUTES*

Time to PHYSICIAN Assessment
120 MINUTES*

USUAL PRESENTATION	SENTINEL DIAGNOSIS
Minor Trauma, Not Necessarily Acute	LBP / Strain
Sore Throat, No Resp Symptoms	URI
Diarrhea alone (no dehydration)	Gastroenteritis
Vomiting alone normal mental status (no dehydration)	Vomiting
Menses	Disorders of Menstruation
Minor Symptoms	Dressing Changes
ABD Pain (Chronic)	Cast Changes
Psychiatric complaints	Constipation
Pain Scale < 4	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, SPO_2<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) to...

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 (example: CBC, electrolytes and cxr=2 equals one resource; CBC plus chest x-ray equals two resources).

Resources:	Not Resources:
• Labs (blood, urine) • ECG, X-rays • CT-MRI-ultrasound-angiography	• History & physical (including pelvic) • Point-of-care testing
• IV fluids (hydration)	• saline or heplock
• IV or sc or nebulized medications	• PO medications • Tetanus immunization • Prescription meds
• specialty consultation	• Phone call to PCP
• simple procedure = 1 (ex: splint, foley cath) • complex procedure = 2 (conscious sedation)	• simple wound care (dressings, tetanus) • crutches, splints, slings

D. Danger Zone Vital Signs:
Consider upTriage 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 3 if: temp >39.0 C (102.2 F), or incomplete immunizations, or no obvious source of fever

Triage

1. **You DO NOT decide who lives or dies**
2. The sooner your 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

ΚΟΚΚΙΝΟ/ 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

ΚΙΤΡΙΝΟ/ 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**

ΚΟΚΚΙΝΟ/ RED


MCI -1