Introduction for Emergency Medicine

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Emergency medicine (EM) is a medical specialty in which a physician receives practical training to care for pts with acute illnesses or injuries which require immediate medical attention. While not usually providing long-term or continuing care, emergency medicine physicians diagnose a variety of illnesses and undertake acute interventions to stabilize the patient.
Definition

EM physicians practice in hospital emergency departments, in pre-hospital settings via emergency medical services, other locations where initial medical treatment of illness takes place, and recently the intensive-care unit. Just as clinicians operate by immediacy rules under large emergency systems, emergency practitioners aim to diagnose emergent conditions and stabilize the patient for definitive care.
Definition

“EM is a medical specialty -- a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting pts of all age groups with a full spectrum of undifferentiated physical and behavioral disorders. It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development.”

International Federation for Emergency Medicine 1991
<table>
<thead>
<tr>
<th>EM in Hungary</th>
<th>Oxyology</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ the word is of greek origin;</td>
<td></td>
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<tr>
<td>☐ it means emergency medicine or critical care;</td>
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</tr>
<tr>
<td>☐ created by Aurél Gábor, famous Hungarian emergency doctor in 1973;</td>
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<tr>
<td>☐ spread in Hungary and in France;</td>
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<tr>
<td>☐ in <strong>everyday practice oxyology includes the prehospital part of emergency medicine.</strong></td>
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</tbody>
</table>
Topics of EM

1) Cardiovascular emergencies in adults and children
2) Dermatological emergencies in adults and children
3) Endocrine and metabolic emergencies in adults and children
4) Fluid and electrolyte disturbances
5) Ear, nose, throat, oral and neck emergencies in adults and children
6) Gastrointestinal emergencies in adults and children
7) Gynecological and obstetric emergencies
8) Hematology and oncology emergencies in adults and children
9) Immunological emergencies in adults and children
Topics of EM

10) Infectious diseases and sepsis in adults and children
11) Musculo-skeletal emergencies
12) Neurological emergencies in adults and children
13) Ophthalmic emergencies in adults and children
14) Pulmonary emergencies in adults and children
15) Psychiatric and behavior disorders
16) Renal and urological emergencies in adults and children
17) Trauma in adults and children
18) Common presenting symptoms
This section of the Curriculum lists the more common presenting SYMPTOMS of patients in the emergency setting. The differential diagnoses are listed according to the systems involved and then in alphabetical order. The diagnoses requiring immediate attention, in terms of potential severity and need of priority, are highlighted in bold. These lists of possible diagnoses cannot be exhaustive.
Symptoms based EM

1) Acute abdominal pain
2) Altered behavior and agitation
3) Altered level of consciousness in adults and children
4) Back pain
5) Bleeding (non traumatic)
6) Cardiac arrest
7) Chest pain
8) Crying baby
9) Diarrhea
10) Dyspnoe
11) Fever and endogenous increase in body temperature
12) Headache in adults and children
13) Jaundice
14) Pain in arms
15) Pain in legs
16) Palpitations
Symptoms based EM

17) Seizures in adults and children
18) Shock in adults and children
19) Skin manifestations in adults and children
20) Syncope
21) Urinary symptoms (dyspraxia, oligo--anuria, polyuria)
22) Vertigo and dizziness
23) Vomiting
Specific aspects of EM

1) Abuse and assault in adults and children
2) Injury prevention and health promotion
3) Analgesia and sedation in adults and children
4) Disaster medicine
5) Environmental accidents in adult and children
6) Forensic issues
7) Patient management issues in emergency medicine
8) Toxicology in adults and children
9) Pre-hospital care
10) Psycho-social problems
Core clinical procedures and skills

1) CPR skills
2) Airway management skills
3) Analgesia and sedation skills
4) Breathing/ventilation management skills
5) Circulatory support and cardiac skills and procedures
6) Diagnostic procedures and skills
7) ENT skills and procedures
8) Gastrointestinal procedures
Core clinical procedures and skills

9) Genitourinary procedures
10) Hygiene skill's and procedures
11) Musculoskeletal techniques
12) Neurological skill's and procedures
13) Obstetric/gynecological skill's and procedures
14) Ophthalmic skill's and procedures
15) Temperature controls procedures
16) Transportation off the critically ill patient
17) Wound management
What is Emergency Medicine?

EM is the specialty concerned with the

- stabilization,
- management,
- diagnosis, and
- disposition of individuals
  with acute illness/injury.
What is Emergency Medicine?

It also includes the management of

- trauma resuscitation,
- advanced cardiac life support,
- advanced airway management,
- poisonings,
- pre-hospital care and
- disaster (medicine) preparedness.
What is Emergency Medicine?

It may include

- screening, intervention, and treatment and referral for a variety of illnesses and behaviors such as
  - substance use disorders,
  - interpersonal violence,
  - depression and other
  - mental health disorders, and

undiagnosed illnesses such as
  - hypertension,
  - diabetes, and
  - HIV.
What is Emergency Medicine?

EM encompasses a large amount of general medicine but involves the technical and cognitive aspects of virtually all fields of medicine and surgery including the surgical sub-specialties.
Emergency physicians require a broad knowledge base and possess the skills of many specialists

- the ability to manage a

- difficult airway (anesthesia),
- suture a complex laceration (plastic surgery),
- reduce a fractured bone/dislocated joint (orth. Surg.),
- treat a heart attack (internist),
- delivery a baby (Obstetrics/Gynecology),
Emergency physicians require a broad knowledge base and possess the skills of many specialists.

- the ability to manage a
  - stop a bad nosebleed (ENT),
  - manage suicide attempts and complex overdoses (Psychiatry & Toxicology),
  - tap a septic joint (Rheumatology),
  - protect an abused child (Pediatrics),
  - place a chest tube (Cardiothoracic Surgery).
Emergency Physicians

In 1979 EM was recognized as the 23rd medical specialty by the American Board of Medical Specialties. The American Board of Emergency Medicine, the independent certifying body for the specialty, was established and the first certification examination was given in 1980. Currently there are 76 full academic Departments of EM at medical schools across the country.
Emergency room work-up

trauma-leader

Rad tech 1

rad-tech 2

trauma-leader

nurse

nurse

nurse

nurse

spectators

Surgeon

Patient

Ortho surgeon

radiologist

Anesth nurse

Anesth doc
Emergency Medicine Models
Emergency Medicine Models

- 2 major models of emergency care delivery exist in the world today:
  - the Anglo-American and the Franco-German model.
- A global network of international EM is assisting the development of EM worldwide and now includes international organizations, academic institutions, and individuals in countries where EM is mature and their counterparts in countries where EM is developing.
Two fundamental approaches of the prehospital care

„scoop and run”

- Canada, GB, USA
- Bring the patient to the hospital in as short time as it is possible and do not waste time on the scene with unnecessary or risky maneuvers.

„stay and play”

- In areas where medicine had been developed under franco-german influence (in Hungary as well)
- Emphasizes the necessity of stabilization on the scene, allows more interventions and more time spending on the field for the sake of stabilization
Anglo-American model

- Pts are brought to the hospital-based EDs so that they may be provided a higher level of care.
- Emergency care is initiated by physician extenders (e.g., EMS or paramedics) and continues into the ED, where emergency physicians provide definite emergency care.
- EM in this model is an officially recognized specialty under the control of emergency physicians.
- Australia, Canada, China, Hong Kong, Ireland, Israel, Japan, New Zealand, the Philippines, South Korea, Taiwan, the UK, and the US.
Franco-German model

- Physicians/technology are sent to the scene in the hope of providing a higher level of emergency care before the patient’s arrival at the hospital.
- EM is practiced exclusively in the prehospital setting, where physicians (usually anesthesiologists) provide most care (usually limited to resuscitation and pain control).
- EDs are often rudimentary because pts are triaged in the field and admitted directly to inpatient specialty services.
- EM in this model is not an officially recognized specialty and is usually controlled by anesthesiologists.
- Austria, Belgium, Finland, France, Germany, Latvia, Norway, Poland, Portugal, Russia, Slovenia, Sweden, Switzerland, and Hungary.
Star of Life

The Rod of Asclepius - Ancient Greek symbol of healing
This common theme in medicine is demonstrated by the "Star of Life".

The Star of Life shown here, where each of the 'arms' to the star represent one of the 6 points. These 6 points are used to represent the six stages of high quality pre-hospital care, which are:

Early detection: Members of the public, or another agency, find the incident and understand the problem.

Early reporting: The first persons on scene make a call to the emergency medical services (EMS) and provide details to enable a response to be mounted.

Early response: The first professional (EMS) rescuers arrive on scene as quickly as possible, enabling care to begin.
This common theme in medicine is demonstrated by the "Star of Life".

The Star of Life shown here, where each of the 'arms' to the star represent one of the 6 points. These 6 points are used to represent the six stages of high quality pre-hospital care, which are:

**Good on-scene care:** The EMS provides appropriate and timely interventions to treat the patient at the scene of the incident.

**Care in transit:** the EMS load the patient in to suitable transport and continue to provide appropriate medical care throughout the journey.

**Transfer to definitive care:** the patient is handed over to an appropriate care setting, such as the ED at a hospital, in to the care of physicians.
Early detection

EMS is anchored upon 6 general principles:

Early detection - early detection of the incident is important since it's the first step towards understanding the situation and seeking for help. Once a medical emergency is confirmed, a report can then be made to the proper authorities.
Early reporting - early detection then leads to early reporting. Everyone should be made aware of their area's emergency number so in an emergency situation, an emergency call to report the incident can immediately be made. All details and observations should be reported to the operator handling the call so that the control facility will be able to brief the responding EMS team of what they're about to face.

EMS is anchored upon 6 general principles:
Early response

EMS is anchored upon 6 general principles:

Early response - the dispatched EMS team then urgently responds to the location of the emergency so that proper care can be given as soon as possible. An early response can sometimes be crucial in emergency cases that require immediate attention such as a patient suffering from a stroke or a heart attack.
Good on scene care

EMS is anchored upon 6 general principles:

**Good on scene care** - the responding EMS team should be able to provide the proper medical assistance that is needed in the situation. Proper **first aid**, which is the main purpose of EMS, should be given in order to stop further damage from developing. The EMTs in charge will have the necessary certifications in order to take full control over any medical emergency. It's also up to them to decide whether the patient would require further treatment in the hospital.
Care in transit

EMS is anchored upon 6 general principles:

Care in transit - once the need for definitive care has been established, the responding EMS team uses an ambulatory vehicle in order to transport the patient to the nearest facility.

The EMS team should continue providing the necessary first aid medical attention throughout the transport.
Transfer to definitive care

EMS is anchored upon 6 general principles:

Transfer to definitive care - responsibility over the patient should be handed over to a medical facility that is equipped to handle the case. More often than not, pts are transported to the emergency facility of the nearest hospital. It's then up to the physicians in charge to take care of the patient. This is where definitive care will commence.

EMS provides people with immediate medical care with the hopes of prolong life, as well as providing a chance to get definitive care if there is a need for it.
Importance of the prehospital care

Eventually all cells will die if deprived of oxygen. Brain and heart are the most sensitive.

Time is Critical!

- 0–1 min: cardiac irritability
- 0–4 min: brain damage not likely
- 4–6 min: brain damage possible
- 6–10 min: brain damage very likely
- More than 10 minutes: irreversible brain damage
Chain of Survival in Patients with Cardiac Arrest

- Early Access
- Early CPR
- Early Defibrillation
- Early Advanced Care

© American Heart Association
Treatment Delayed is Treatment Denied

Symptom Recognition
Call to Medical System
PreHospital
ED
Cath Lab

Increasing Loss of Myocytes

Delay in Initiation of Reperfusion Therapy
The necessary/compulsory treatment

- to eliminate danger of life;
- to prevent damage of organs;
- to diminish pain;
- to secure transportability.
The patient is not transportable **without treatment** if any of the followings exists (1):

- cardiac arrest (except for hypothermia);
- apnoe;
- airway obstruction;
- uncontrolled external bleeding;
- acute left ventricular failure;
- life-threatening cardiac arrhythmias;
- unmeasurably low or high BP;
The patient is not transportable without treatment if any of the followings exists (2):

- seizure;
- severe compression of the lungs (tension ptx, htx with severe respiratory failure);
- severe pain;
- some types of poisoning - intoxication (organophosphates, nicotine, death-cup-amanita phalloid, etc.);
- second stage of labour;
- fracture without fixation.
Transportation trauma

- **Physical components:**
  - acceleration - deceleration;
  - lifting movement;
  - vibration.

- **Psychological components:**
  - fear of death;
  - suddenly changed situation of life.

- Transportation trauma can be reduced:
  - stabilization before transport;
  - fixation in the appropriate bodily position under transport;
  - careful transport;
  - airborne transport.
## What Happens When You Call 911?

### Best Case Scenario

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify emergency/Activate emergency response plan</td>
<td>30 seconds</td>
</tr>
<tr>
<td>911 call</td>
<td>1 minute</td>
</tr>
<tr>
<td>Alert ambulance and rescue squads (dispatch)</td>
<td>30 seconds</td>
</tr>
<tr>
<td>Responders to their units</td>
<td>30 seconds</td>
</tr>
<tr>
<td>Travel time to location</td>
<td>5 minutes*</td>
</tr>
<tr>
<td>Unload equipment/ Distance to patient</td>
<td>2 minutes</td>
</tr>
<tr>
<td>Assess patient/ Apply defibrillator/ Deliver shock</td>
<td>1.1 minutes**</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>10.6 minutes</strong></td>
</tr>
</tbody>
</table>

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*Travel time varies depending on weather, traffic, distance (vertical and horizontal), and ambulance (with defibrillator capability) availability.

**Cummins RO, et.al. Automatic external defibrillators used by emergency medical technicians: a controlled clinical trial. JAMA, 1987; 257:1605-10
Why “Early” Treatment?

Chances of success reduced 7% to 10% each minute

An emergency department (ED), also known as accident & emergency (A&E), emergency room (ER), emergency ward (EW), or casualty department is a medical treatment facility specializing in acute care of pts who present without prior appointment, either by their own means or by ambulance. The ED is usually found in a hospital or other primary care center.
Emergency Department

- Immediate care
- Triage
- Delayed care
- To casualty-collection point
- To hospital
- Walking wounded
- Entry
- Dead
Due to the unplanned nature of patient attendance, the ED must provide initial treatment for a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention. In some countries, emergency departments have become important entry points for those without other means of access to medical care. The EDs of most hospitals operate 24 hours a day, although staffing levels may be varied in an attempt to mirror patient volume.
An ED **requires different equipment** and **different approaches** than most other hospital divisions. Pts frequently arrive with **unstable conditions**, and so must be treated quickly. They may be unconscious, and **information such as their medical history, allergies, and blood type may be unavailable**. ED staff are trained to work quickly and effectively even with minimal information.
ED staff must also interact efficiently with pre-hospital care providers such as EMTs, paramedics, and others who are occasionally based in an ED.

The pre-hospital providers may use equipment unfamiliar to the average physician, but ED physicians must be expert in using specialized equipment.
Because **TIME IS SUCH AN ESSENTIAL FACTOR** in ED, EDs have their own diagnostic equipment to avoid waiting for equipment installed elsewhere in the hospital. Nearly all have an X-ray room, and many now have full radiology facilities including CT and ultrasonography, MRI equipment. Laboratory services may be handled on a priority basis by the hospital lab, or the **ED may have its own "STAT Lab"** for basic labs (blood counts, blood typing, toxicology screens, etc.) that must be returned very rapidly.
As patients can present at any time and with any complaint.

The key part of the operation of an emergency department is the **PRIORITIZATION** of cases based on clinical need.

This is usually achieved though the application of **TRIAGE**.
Triage tools

- Discriminators:
  - Demographics
    - Old or young triaged out
  - Mechanism of injury
    - Only for trauma
  - Anatomy
    - Dependent upon examination - time consuming
  - Physiology
    - Most reliable

Intended use:
- Hospital vs Pre-hospital
- Day-to-day vs MCI
- Trauma vs Other
- Adult vs Child
Principles of triage

- Urgency refers to the need for time-critical intervention - it is not synonymous with severity
- Triage assessment is not necessarily intended to make a diagnosis
- Pts triaged to lower acuity categories may be safe to wait longer for assessment and treatment but may still require hospital admission
Goals of Triage

1. Rapidly identify urgent conditions.
2. Determine most appropriate ED area.
3. Facilitate patient flow.
4. Provide ongoing assessments.
5. Inform pts and families re: services, expected care, waits.
6. Define departmental acuity.

Triage is a dynamic process and is usually done more than once.
Triage

Triage is normally the FIRST STAGE the patient passes through, and most EMs have a DEDICATED AREA for this to take place, and may have staff dedicated to performing nothing but a triage role. In most EDs, this role is fulfilled by a NURSE, although dependant on training levels in the country and area, other health care professionals may perform the triage sorting, including PARAMEDICS or MEDICAL DOCTORS.
Triage

is the process of determining the priority of pts' treatments based on the severity of their condition. This rations patient treatment efficiently when resources are insufficient for all to be treated immediately.

The term comes from the French verb trier, meaning to separate, sift or select.
Triage originated in World War I by French doctors treating the battlefield wounded at the aid stations behind the front. Much is owed to the work of Dominique Jean Larrey during the Napoleonic Wars. Until recently, triage results, whether performed by a paramedic or anyone else, were frequently a matter of the 'best guess', as opposed to any real or meaningful assessment.
Triage may also be used for pts arriving at the emergency department, or to telephone medical advice systems, among others, including the prehospital setting, disasters, and during emergency room treatment.
Triage

Two types of triage exist: simple and advanced.

Triage may result in determining the order and priority of emergency treatment, the order and priority of emergency transport, or the transport destination for the patient.
Triage

At its most primitive, those responsible for the removal of the wounded from a battlefield or their care afterwards have divided victims into three categories:

- Those who are likely to live, regardless of what care they receive;
- Those who are likely to die, regardless of what care they receive;
- Those for whom immediate care might make a positive difference in outcome.
Simple triage is usually used in a scene of a "mass-casualty incident" (MCI), in order to sort pts into those who need critical attention and immediate transport to the hospital and those with less serious injuries. This step can be started before transportation becomes available. The categorization of pts based on the severity of their injuries can be aided with the use of printed triage tags or colored flagging.
Triage Categories

- **Red:** Life-threatening but treatable injuries requiring rapid medical attention
- **Yellow:** Potentially serious injuries, but are stable enough to wait a short while for medical treatment
Triage Categories

☐ Green:

Minor injuries that can wait for longer periods of time for treatment

☐ Black:

Dead or still with life signs but injuries are incompatible with survival in austere conditions
Triage
simple tape can be used as a last resort

light picture
"The broken leg may be new but I’m afraid the stupidity was a pre-existing condition."
Modern approaches to triage are more scientific. The outcome and grading of the victim is frequently the result of physiological and assessment findings. Some models, such as the START model, are committed to memory, and may even be algorithm-based.
SIMPLE TRIAGE

S.T.A.R.T. (Simple Triage and Rapid Treatment) is a simple triage system that can be performed by lightly trained lay and emergency personnel in emergencies.
It is not intended to supersede or instruct medical personnel or techniques. It has been (2003) taught to California emergency workers for use in earthquakes. It was developed at Hoag Hospital in Newport Beach, California for use by emergency services. It has been field-proven in mass casualty incidents such as train wrecks and bus accidents, though it was developed for use by community emergency response teams (CERTs) and firefighters after earthquakes.
S.T.A.R.T. separates the injured into 4 groups:

1) The *expectant* who are beyond help

2) The injured who can be helped by *immediate* transportation

3) The injured whose transport can be *delayed*

4) Those with *minor* injuries, who need help less urgently
START First Step

Can the Patient Walk?

YES

Green (Minor)

NO

Evaluate Ventilation (Step-2)
START Step-2

Ventilation Present?

NO

Open Airway

Ventilation Present?

NO

Black

YES

Red/ Immediate

YES

> 30/Min

Red/ Immediate

< 30/min

Evaluate Circulation (Step-3)
START Step-3

Circulation

Absent Radial Pulse
- Control Hemorrhage
  - Red/ Immediate

Present Radial Pulse
- Evaluate Level of Consciousness
  - Red/ Immediate
START Step-4

Level of Consciousness

Can’t Follow Simple Commands
- Red/ Immediate

Can Follow Simple Commands
- Yellow/ Delayed
In advanced triage, doctors may decide that some seriously injured people should not receive advanced care because they are unlikely to survive. Advanced care will be used on pts with less severe injuries. Because treatment is intentionally withheld from pts with certain injuries, advanced triage has ethical implications.

It is used to divert scarce resources away from pts with little chance of survival in order to increase the chances of survival of others who are more likely to survive.
### Australasian Triage Scale (ATS)

<table>
<thead>
<tr>
<th>Category</th>
<th>Response</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>immediate</td>
<td>Immediately life threatening</td>
</tr>
<tr>
<td>2</td>
<td>Within 10 minutes</td>
<td>Imminently life threatening</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Important time critical treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Very severe pain</td>
</tr>
<tr>
<td>3</td>
<td>Within 30 minutes</td>
<td>Potentially life threatening</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Situational urgency</td>
</tr>
<tr>
<td>4</td>
<td>Within 60 minutes</td>
<td>Potentially serious</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Situational urgency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Significant complexity or severity</td>
</tr>
<tr>
<td>5</td>
<td>Within 120 minutes</td>
<td>Less urgent</td>
</tr>
</tbody>
</table>
Australasian Triage Scale (ATS)

1. **Safety**
   - Time to treatment objectives commensurate with objective clinical criteria
   - Sensitive enough to capture “novel” presentations

2. **Utility**
   - Quick and easy to use
   - Enhances patient flow through the system

3. **Validity**
   - Clinical urgency
   - Time-to-treatment objectives

4. **Reliability**
   - Studies into consistency of triage have produced mixed results
   - Interventions to improve reliability are underdeveloped worldwide
Triage Categories

□ Red:

Life-threatening but treatable injuries requiring rapid medical attention

□ Yellow:

Potentially serious injuries, but are stable enough to wait a short while for medical treatment
Triage Categories

- **Green:**
  
  Minor injuries that can wait for longer periods of time for treatment

- **Black:**
  
  Dead or still with life signs but injuries are incompatible with survival in austere conditions
Canadian ED Triage and Acuity Scale CTAS

- Adapted from ATS
- Endorsed by CAEP in 1997
- Built by expert consensus

I. **Resuscitation**: immediate threat to life or limb; immediate aggressive intervention.

II. **Emergent**: requires immediate attention; time delay is harmful.

III. **Urgent**: possible danger; disorder is acute.

IV. **Semi-urgent**: potentially serious, but non-life threatening.

V. **Non-urgent**: non-acute or minor severity.

# CTAS Guidelines

<table>
<thead>
<tr>
<th>Level</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to MD</td>
<td>Immediate</td>
<td>&lt;15 min</td>
<td>&lt;30 min</td>
<td>&lt; 60 min</td>
<td>&lt;120 min</td>
</tr>
<tr>
<td>Fractile response</td>
<td>98%</td>
<td>95%</td>
<td>90%</td>
<td>85%</td>
<td>80%</td>
</tr>
</tbody>
</table>

Canadian ED Triage and Acuity Scale (CTAS)

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<table>
<thead>
<tr>
<th>Triage</th>
<th>Acuity level</th>
<th>Time to physician</th>
<th>Usual presentation</th>
<th>Sentinel diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESUSCITATION</td>
<td>IMMEDIATE</td>
<td></td>
<td>Code arrest</td>
<td>Traumatic shock</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Major shock</td>
<td>Ptx (traumatic/ tension)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Shock states</td>
<td>Facial burns with airway compromise</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Near-fatal asthma</td>
<td>Severe burns &gt; 30% body surface area</td>
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<td></td>
<td></td>
<td></td>
<td>Severe respiratory distress</td>
<td>Overdose with hypotension or unconsciousness</td>
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<td></td>
<td>Altered mental state</td>
<td>AMI with complications (CHF or hypotension)</td>
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<td></td>
<td></td>
<td></td>
<td>(unconscious or delirious)</td>
<td>Status asthmaticus</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Head injury (major or unconscious)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>Status epilepticus</td>
</tr>
</tbody>
</table>
Goals of Triage

Summary

1. Rapidly identify urgent conditions.
2. Determine most appropriate ED area.
3. Facilitate patient flow.
4. Provide ongoing assessments.
5. Inform pts and families re: services, expected care, waits.
6. Define departmental acuity.

Crisis Intervention for Physicians
“Emergency & medical personnel are the ones who are running toward, what everybody else is running away from”
CELLULAR PHONE
ADHESIVE TAPE
TWEEZERS
GAUZE
ANTISEPTIC OINTMENT
GAUZE PADS
RUNNING SHOES
SMALL FLASHLIGHT AND EXTRA BATTERIES
HAND CLEANER
FIRST AID KIT
DISPOSABLE GLOVES
BAND-AIDS (ASSORTED SIZES)
COLD PACK
EMERGENCY PHONE NUMBERS
Suggested readings