EMERGENCY TRIAGE, ASSESSMENT, AND TREATMENT (ETAT)

Trainer's Manual 2025

Prepared by

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Emergency Triage, Assessment, and Treatment (ETAT) Trainer's Manual

2025

UNIVERSITY OF HEALTH SCIENCES LAHORE

Contents

Course Overview and Objectives

Duration & Audience: This is a one-day (8-hour) ETAT training workshop designed for facilitators who are consultants in medicine, nursing, and allied health. It provides interprofessional, hands-on learning so students can work as a team during emergency triage. By the end of the course, participants will be able to confidently triage patients, recognize emergency/priority signs, initiate life-saving interventions, and communicate effectively during emergencies.

Learning Objectives: By completion, trainees should be able to:

- **Define** emergency triage and explain its purpose in emergency care.
- **Identify** emergency vs. priority vs. non-urgent cases using the ETAT approach.
- **Perform** a rapid primary assessment using **ABCDE** (Airway, Breathing, Circulation, Disability, and Exposure) for any patient.
- **Provide** immediate life-saving treatments (airway management, oxygen, fluids, glucose, and seizure management) for patients with emergency signs.
- **Categorize** and **tag** patients with colour-coded triage tags (Red – immediate/emergency, Yellow – urgent/priority, Green – non-urgent) according to their condition.
- **Document** triage findings and hand over patients using clear communication, including explaining triage decisions to caregivers empathetically.
- **Work effectively in a team** setting, recognizing the roles of different professionals (nurse, doctor, etc.) during triage.

Course Modules: The training is organized into six modules that progressively build skills (see Session Plan below). Each module includes interactive activities and emphasizes teamwork across disciplines. Trainers should encourage participants to share their professional perspectives (e.g., nursing vs medical student) to enhance interprofessional understanding.

Instructor Qualification

- Clinical background in emergency medicine,
- Experience with triage and resuscitation
- Training in simulation–based teaching and feedback delivery
- Familiarity with the Canadian CTAS system

Instructor preparation checklist

- Review all sessions and case scenarios
- Setup skill station and simulation areas in advance
- Prepare printed materials , flow charts, triage tags, checklist
- Coordinate with co instructors to assign teaching roles

List of Abbreviations

Abbreviations	Subject
ETAT	Emergency Triage Assessment and Treatment
ABCDE	Airway, Breathing, Circulation, Disability , exposure
3TPR-MOB	Tiny baby (<2 MONTHS) temperature abnormal, trauma, pallor, poisoning, pain, respiratory distress, malnutrition, edema, burns
SBAR	Situation, Background, Assessment, Recommendation

Session Plan

Below is a structured session plan for trainers training . It allocates time for each module, including breaks and assessments:

Time	Module / Activity	Method	Assessment
08:30 – 09:00	**Introduction & Orientation** – Welcome, course objectives, pre-test MCQ (20 questions).	Brief interactive lecture; MCQ quiz	Pre-test (20 MCQs)
09:00 – 09:45	**Module 1: Introduction to Triage & ETAT** – Concepts, triage rationale, ethics & safety.	Interactive lecture, video case discussion	Q&A, group discussion
09:45 – 10:45	**Module 2: Emergency and Priority Signs** – Recognizing "ABCD" emergency signs and the **Critical First Look (ABCDE)** assessment.	Case-based group work, rapid recognition drills (images/videos of patients)	Case responses, facilitator feedback
10:45 – 11:00	*Tea Break* (15 minutes)		
11:00 – 11:30	**Module 3: Triage Flow and Classification** – Triage flowchart steps, tagging patients (Red/Yellow/Green).	Demonstration + Triage tagging exercise with cards/role-play	Observation checklist (triage decisions)
11:30 – 12:30	**Module 4: Immediate Emergency Treatments** – Airway management, breathing support, circulation (IV/IO fluids), seizures, hypoglycemia.	Hands-on skill stations (airway mannequin, IV arm, etc.)	Skills checklists (formative)
12:30 – 13:30	*Lunch Break* (60 minutes)		
13:30 – 14:00	**Module 5: Communication, Handover, Documentation** – Conveying triage decisions, caregiver communication, documentation.	Role-play scenarios (patient handover, parent communication)	Peer feedback, sample chart review
14:00 – 15:30	**Module 6: Simulation and Assessment** – Full-scale team simulation drills (mixed adult/pediatric cases) and debrief.	Simulation exercise with team roles, followed by debriefing	**Summative Assessment:** OSCE station + post-test MCQ
15:30 – 16:00	**Course Conclusion** – Review key takeaways, collect feedback forms, closing remarks.	Group discussion, Q&A wrap-up	Post-test results, feedback survey

Module 1: Introduction to Triage & ETAT

Module Duration: 45 minutes (including Q&A).

Key Content & Messages: This module establishes the foundation of triage and ETAT principles. Cover the following points:

- **What is Triage:** Definition of emergency triage as the rapid screening of patients upon arrival to identify those needing immediate care. Emphasize the goal: **"to get the right patient to the right resources at the right time."** All participants should understand that triage is about *prioritization* when resources are limited.
- **Purpose and Ethics:** Triage ensures the sickest patients are treated first to reduce preventable deaths. Discuss ethical considerations (fairness, doing the greatest good for the greatest number) and the emotional stress that can come with triage decisions. Reinforce the importance of *safety*: both patient safety and provider safety (e.g. standard precautions at triage).
- **ETAT Overview:**. Explain that ETAT categorizes patients into 3 groups: those with **Emergency signs** (need immediate treatment), **Priority signs** (need prompt evaluation), and **Non-urgent** (can safely wait).
- **Scope for Learners:** Clarify that this course will teach basic triage and first-response treatments. It is **not** about definitive diagnosis, but about recognizing critical signs and initiating care to stabilize patients. This is especially relevant for clinical-year students about to enter internships – they will likely encounter triage situations and need to act fast and as a team.

Teaching Method & Activities: This module uses an **interactive lecture** format with multimedia to keep students engaged. Suggested flow:

- **Introduction (5 min):** Trainer welcomes participants, introduces themselves and any co-facilitators. Do a quick icebreaker. Then present the **module objectives** so learners know what to expect.
- **Presentation (15 min):** Use slides to define triage and explain its importance. **Discussion (10 min):** Pose questions to the group to check understanding: "Why do we triage? What could go wrong without a triage system?" Encourage answers from both medical and nursing perspectives. Emphasise that proper triage can significantly reduce early hospital mortality by ensuring critical patients are treated within minutes of arrival.
- **ETAT Framework Overview (10 min):** Introduce the structure of the course modules (Emergency signs, ABCDE, etc.). Use a slide showing the **three triage categories** with a brief description of each:
    - Emergency (needs immediate intervention)
    - Priority (needs rapid assessment/treatment, not immediate threat)
    - Non-urgent (can wait safely) For context, mention color codes (Red, Yellow, Green, Black) and that we will practice using triage tags later.

Materials & Equipment Needed:

- Computer and **projector** for slides.
- **Whiteboard/flip chart** (to jot down participant input or key definitions during discussion).
- Short **triage video clip** embedded in slides (optional, but effective). Ensure audio is available if using video.
- **Participant Pre-test MCQ** sheets (if not done electronically) – though pre-test is listed as before Module 1, you may distribute and review quickly now if not already done.
- *Handouts:* If you have a one-page summary of triage concepts or the ETAT framework, distribute it for reference.

Facilitation Tips:

- **Engage the Room:**
- **Relate to All Professions:** Emphasize how triage is a team effort – for example, a nurse often performs initial triage; a doctor or senior student might be called for second assessment on borderline cases; allied health professionals (like paramedics) might do field triage. Make sure examples are inclusive (mention adult and pediatric scenarios, hospital and pre-hospital settings, etc.).
- **Check Understanding:** Use a quick verbal or show-of-hands quiz: e.g., "Triage category drill – If a patient is not breathing, what category? (Yes, Emergency!) If a patient is limping with a minor cut? (Likely Green/Non-urgent.)" This maintains energy and confirms their understanding of the concept.
- **Time Management:** Keep an eye on time; if discussions run long, note parking-lot questions to address later. Since this is the first module, set the pace so subsequent modules can stay on track.

Module 2: Emergency and Priority Signs (ABCDE Assessment)

Module Duration: 60 minutes.

Key Content & Messages: In this module, trainees learn to **recognize key emergency signs** using the airway-breathing-circulation approach, and practice the **"Critical First Look"** – a rapid initial assessment of any incoming patient. The content is divided into two parts (often labeled 2A and 2B):

- **2A: Emergency Signs ("ABCD" Approach):** Introduce the set of critical signs that designate an **Emergency** case. Frame this as checking **A, B, C, D, E** in sequence:

  - **Airway & Breathing (A & B):** Look for any obstruction or severe respiratory distress. Signs include obstructed airway (choking, stridor) or **severe respiratory distress** like very fast or labored breathing with cyanosis. Emphasize that airway obstruction or apnea is immediately life-threatening – if found, this patient is triaged *Emergency/Red* and needs intervention *now*.

  - **Circulation (C) – Signs of Shock:** Cold, clammy extremities, **capillary refill >3 sec**, very fast weak pulse, or hypotension indicate shock. In children, also consider

severe dehydration as a cause of shock – e.g., a child with sunken eyes, lethargy, very slow skin pinch response is in shock from dehydration. These signs also put a patient in Emergency category.

- **Disability (D) – Consciousness/Convulsions:** Check mental status quickly. **Coma or altered consciousness** and **active convulsions** are emergency signs.

- **Exposure/Environment (E):** Look for severe trauma or bleeding (massive hemorrhage), or extreme temperatures. Major Burns can also be an emergency. While "E" is often about preventing heat loss in trauma, in triage it also means **exposing** to find hidden injuries. Ensure modesty but do a quick check for any obvious life-threatening external issue.

Emphasize **Emergency vs Priority vs Non-urgent**: If any "ABC" emergency sign is present, the patient is Emergency (red). If no emergency signs but some concerning signs (fast breathing, fever, etc.), they might be Priority (yellow). If none, likely Green. **"Any one emergency sign is enough to categorize as Emergency – don't wait to find more."** This is a key message to instill.

2B: Critical First Look & Primary ABCDE Survey: Teach participants how to perform a rapid initial assessment on a patient in ~30–60 seconds, using the **ABCDE approach** that they may have learned in ACLS/BLS contexts. Reinforce that this systematic approach ensures they check for and address life threats in order:

1. **Airway:** Is the airway open? If not, open it (head tilt/chin lift or jaw thrust for trauma). Look for signs like stridor or silence (no air movement). Suction if needed. if blocked, clear it and consider airway adjuncts.
2. **Breathing:** Is the patient breathing? What is the respiratory rate and effort? Any cyanosis? If breathing is inadequate, start support (e.g., bag-valve-mask ventilation). *Give* high-flow oxygen for distress, assist ventilation if needed.
3. **Circulation:** Check pulse, capillary refill, and obvious bleeding. Is the pulse thready or absent? Skin pale, cold, and sweaty? Control any major external bleeding. Begin IV access, fluid bolus if signs of shock (except caution in trauma or malnutrition – we'll discuss details in Module 4).
4. **Disability (Neurologic):** Assess level of consciousness quickly (AVPU: Alert, responds to Voice, Pain, and Unresponsive). Any seizure activity or focal deficit? *Key* if unconscious, position to protect airway; if seizing, start seizure management (we'll cover specifics later).
5. **Exposure:** Expose the patient enough to look for injuries or rashes, etc., and check temperature. Prevent hypothermia (cover patient after exam), treat burns, etc.

Priority Signs (the 3TPR-MOB mnemonic): After covering the life-threatening signs, mention that certain other signs make a patient a **Priority** even if not immediately life-threatening. In pediatric ETAT, the mnemonic **3TPR MOB** is used for priority signs:

- **3T:** Tiny baby (infant < 2 months is automatically priority), Temperature abnormal (high fever), Trauma (significant injury).
- **PR:** Pallor (severe paleness), Poisoning, Pain (severe pain).

- **MOB:** Malnutrition (visible severe malnutrition), Oedema of both feet (sign of severe malnutrition), Burns (major burns). Explain that if any of these are present (without emergency signs), tag the patient as Priority (yellow) for quick attention. For example, an infant under 2 months with fever should be priority due to high risk, even if appearance is fairly good.

Teaching Method & Activities: This module is best taught with **case-based learning and hands-on recognition drills** rather than just slides. For example:

- **Interactive Lecture** Use slides to list emergency signs
- **Case-Based Small Groups** Break participants into small groups (3-5 per group, ideally mixing professions) and give each group a short written **case vignette Recognition Drill**
- **Discussion and Summary (remaining time):** Debrief key takeaways. Clarify any confusion between Emergency vs Priority signs.

Materials & Equipment Needed:

- **Slides/Pictures:** Slides with photos or illustrations of emergency signs
- **Case Vignettes:** Printouts of short cases for group activity or have them on slides. The user-provided curriculum includes example vignettes and answers which you can adapt. Have at least 3–4 cases covering different scenarios (adult, pediatric, trauma, medical).
- **ETAT Wall Chart:** This can serve as a quick visual summary for learners during exercises.

Facilitation Tips:

- Encourage Team Thinking: .
- Observation & Feedback:
- Adapt to Audience:
- **Time Check:** This module is content-heavy. Keep the lecture portions brisk by focusing on most common signs and leveraging the cases to cover the rest. Ensure at least 20-30 minutes are spent in interactive practice (cases/drills) as that's where learning is solidified.

Module 3: Triage Flow and Patient Classification

Module Duration: 30 minutes.

Key Content & Messages: This module focuses on the **process** of triage: the flow from patient arrival to assignment of a triage category and tagging. It translates the recognition of signs (from Module 2) into action using a triage algorithm and tagging system.

- **Triage Flowchart:** Present the standard triage flow. For example, on arrival: do the "first look" for emergency signs if any, immediately call for help and start treatment If no emergency signs, check for priority signs, if any, mark as priority and they wait in a priority area/fast track. If neither, mark as non-urgent they must be re-triaged to emergency. Use a simple flow diagram to illustrate this decision tree.
- **Roles and Location:** Explain who typically does triage (often a triage nurse initially, with backup from physicians for difficult decisions) and where it's done (triage station at ER entry, or in mass casualty an outdoor triage zone).

Categorization & Tagging: Introduce the triage **color-coding system** commonly used:

- **Red tag – Immediate/Emergency:** patient needs immediate intervention. In the hospital, this means taken straight to resuscitation area.
- **Yellow tag – Priority/Urgent:** patient is ill and needs quick attention, but not immediate life-saving intervention. They should be seen next.
- **Green tag – Non-urgent:** patient has minor issues, can safely wait or be seen in routine order.
- **Black tag – Dead Patient**

- **Using Triage Tags or Charts:** Show a sample **triage tag** and how to use it. Explain that in real settings, tags or triage forms document the triage category, time, and initial findings. In low-resource settings, **color-coded wristbands or cards** might be used instead of tags. The key is visibility: everyone in the team should instantly know the category by the tag color.

Teaching Method & Activities: Use a **demonstration and hands-on practice** here:

- **Mini-Lecture with Demonstration:** Show the triage flowchart on a slide or poster. Walk through it with a hypothetical patient scenario to illustrate each branch
- **Interactive Exercise – Triage Sorting Drill :**
- **Debrief/Q&A; Clarify** any confusion. Reinforce that triage decisions should be quick but can be adjusted if new information comes (dynamic process).
- **Materials & Equipment Needed:**
- **Printed triage flowcharts:** Give each student a one-page triage algorithm handout for reference. They can refer to this during exercises.
- **Triage tags or colored index cards**
- **Scenario/Case cards:**

Facilitation Tips:

- **Clarity and Simplicity:**
- **Use Participants as Props:** Involving volunteers to act as patients in the sorting drill not only makes it fun, it also emphasizes communication
- **Time Management:** This module is shorter; ensure the exercise doesn't drag. **Emphasize Communication:**

Module 4: Immediate Emergency Treatments

Module Duration: 60 minutes (could extend to 75 min if needed, as hands-on skills are critical).

Key Content & Messages: In this skills-focused module, participants learn and practice the **initial emergency treatments** that should be given to patients with emergency signs *while* awaiting further care or transport. The emphasis is on practical, **basic life-saving interventions** that fall within the scope of a first responder in the ER (Key topics include:

Airway Management: How to open and maintain an airway. Techniques:

- **Positioning:** Head-tilt chin-lift (for non-trauma) or jaw thrust (if trauma suspected) – demonstrate this on a mannequin. Emphasize protecting cervical spine in trauma. Show how proper positioning alone can relieve obstruction in an unconscious patient.

- **Suctioning:** Use of a suction device to clear secretions or vomit. If you have a suction catheter prop, show how to measure insertion distance (earlobe to mouth) and suction for no more than 5-10 seconds.
- **Airway Adjuncts:** Briefly mention oropharyngeal airway (OPA) and nasopharyngeal airway (NPA) – when to use them (unconscious without gag reflex for OPA, semi-conscious for NPA). Possibly let students handle these if available.

Breathing Support: If patient is not breathing adequately:

- **Oxygen delivery:** Show oxygen masks, nasal cannula, and bag-valve-mask (BVM). Teach when to use .Let participants practice assembling and holding a BVM mask with proper seal and technique
- **Ventilation:** Demonstrate how to deliver rescue breaths with a BVM – proper volume (just enough to see chest rise). Highlight common mistakes (e.g., over-ventilating).
- *If advanced:* mention that experienced providers would do intubation, but as students they should know how to assist (e.g., preparing the intubation kit, continuing BVM until tube is placed).+
- **Circulation Support (IV/IO access & Fluids):**
- **IV access:** Show IV cannulation equipment. While students may have done IVs in wards, emphasize doing it fast in emergencies. If available, use IV **training arms** for practice. Also mention **IO (intraosseous) access** as a backup in pediatric emergencies when IV is hard – show an IO needle or mention where it goes (tibia).
- **Fluid Resuscitation:** Teach the initial fluid bolus for shock: typically 20 ml/kg of isotonic fluid (Normal Saline or Ringers) in most cases, given as fast as possible (within 15-20 minutes). However, stress **caution in malnutrition** or certain contexts: e.g., a child with severe malnutrition should get slower, smaller boluses Also caution in trauma if internal bleeding (don't over-fluid resuscitate). These nuances can be mentioned but avoid too much complexity.
- Have participants practice connecting IV lines, calculating a simple bolus volume if weight given, etc. They can flush a line with saline if simulation allows.
- **Haemorrhage control:** Briefly cover applying pressure to external bleeding as an immediate treatment.

Seizure Management: If a patient is convulsing, what to do:

- **Positioning and Safety:** Do not restrain forcefully; position on the side (recovery position) to protect the airway. Padding under the head.
- **Medications:** The first-line anticonvulsant in many triage protocols is a benzodiazepine (e.g., **Diazepam** or **Midazolam**) given rectally, IV, or IM. For example, Diazepam 0.15-0.2 mg/kg IV (or 0.5 mg/kg rectally)
- Possibly let them practice drawing up a dose with an empty syringe if you have practice vials (without actual drug).

Hypoglycemia Management: "**Sugar is life**" for any unconscious or very sick patient; check glucose quickly (finger stick). If low (<3 mmol/L or <60 mg/dL), treat:

- **Glucose administration:** Show a vial of 50% dextrose (or glucose gel). Teach dose (children = 5 ml/kg of 10% dextrose IV, adults =25g bolus). A simpler rule: give one ampoule of D50 IV for adults, or dilute for kids. If IV is not ready, can give glucose gel or even sugar water orally if mild and the patient awake.

- Let participants taste a glucose gel or practice drawing up dextrose in a syringe (ensuring they know it's thick and needs a large-bore needle).

Other emergency actions: Depending on time, mention:

- **Temperature management:** if high fever, give antipyretics and tepid sponging; if hypothermic, and warm the patient.
- **Splinting fractures:** as a first aid measure to prevent pain/shock.
- **NPO and position:** e.g., if trauma, keep the patient NPO (nil per os) in case surgery is needed, and supine or in c-spine immobilization if neck injury is suspected.

Teaching Method & Activities: This is a **hands-on skills station module**. Organize it like a round-robin of mini-stations or a sequential demo with practice:

Skills Stations Setup: If you have enough equipment and space, set up different stations:

i. **Airway & Breathing Station:** Mannequin head for airway manoeuvres, BVM and masks, suction device, O_2 cylinder (or simulation). Trainer or assistant at this station demonstrates and supervises each participant trying head-tilt/chin-lift, placing OPA, ventilating with BVM.

ii. **IV/Fluids Station:** IV arm, IV cannulas, fluid bags, drip sets. Participant's practice inserting an IV (or at least the motions if arm is available) and setting up a fluid drip. Also demonstrate IO device if available (maybe just show).

iii. **Scenario Station (Seizures & others):** A scenario of a seizing patient (could use a mannequin or just describe), have participants go through actions: put in recovery position, pretend to give diazepam (maybe inject into a sponge or just simulate), check glucose (maybe using a glucometer on a dummy strip).

- **Hands-On Practice:** Rotate small groups (3-4 people) through each station, 10 minutes each. Ensure every participant gets to attempt critical skills (bag-mask ventilation, IV start, or at least spiking an IV bag, etc.). Trainers at each station give **immediate feedback** on technique (for example, "good head position" or "you need a better seal with the mask, let's adjust your hand position").
- **Peer Demonstration:** Encourage participants to learn from each other.
- **Summary** Recap the ABC priorities for treatment: **Airway open, Oxygen on, IV access, Glucose if needed** – these steps can save a life in the first 5 minutes. Encourage them to remember "ABC and Sugar" as core emergency responses. Also, remind them these skills require practice; they should seek opportunities in their clinical rotations to apply and refine them.

Materials & Equipment Needed: (This module has the most equipment needs)

- **Airway Mannequin or CPR dummy** – preferably pediatric and adult if teaching both. Include basic airway adjuncts (OPA, NPA) and a suction device (even a simple bulb suction for demo).
- **Bag-Valve-Mask (BVM)** for adult and child, plus various oxygen masks and tubing. Oxygen cylinder or concentrator for realism (can be empty, just for show). **A pulse oximeter** if available, to demonstrate monitoring.
- **IV supplies:** IV cannulation arm or dummy pads, IV catheters, tourniquets, IV fluids (use water or colored water in bags for practice), drip sets, tape, etc. Also an IO needle (even an expired one for show-and-tell) if possible.

- **Medication props:** Empty sample vials or labeled syringes for diazepam, glucose, etc. Also glucometer with test strips (even if not functional, for demo).
- **Other:** Gauze rolls, bandages (for bleeding control practice), a sample triage record to document what was given (optional).
- **Cleaning supplies:** Have alcohol pads or hand sanitizer at stations, gloves for participants to use (teach that PPE is important – they should wear gloves at least when practicing IVs even in sim).
- **Checklist/skills sheet:** A simple checklist for each skill can help trainers ensure they cover everything. For example, an **Airway Skill Checklist** (opens airway properly, inserts OPA correctly, ventilates with chest rise, etc.). You can use these for **formative assessment**, marking if each participant performed steps correctly (this also helps in giving feedback).

Facilitation Tips:

- **Safety in Training:** Remind everyone these are just simulations – no needles or sharps should be actually injected into people.
- **Time Warning:** Give a 2-minute warning before rotating stations so participants can wrap up what they're doing. Keep rotations smooth to cover all stations.
- **Connecting to Assessment:** Mention that the OSCE at the end will include performing some of these skills under time pressure. So they should pay attention and aim to be comfortable with at least the basics of each procedure.

Module 5: Communication, Handover, and Documentation

Module Duration: =30 minutes.

Key Content & Messages: This module addresses the often-overlooked **soft skills** in emergency triage: how to communicate effectively with patients, families, and the healthcare team during a high-stress triage situation, and how to document findings for continuity of care.

Triage Documentation: In triage, documentation might be brief but is critical. Key items to document:

- Triage category (Red/Yellow/Green/Black) and time of triage.
- Brief vital signs and emergency signs observed (e.g., "HR 140, cold extremities, weak pulse" for shock).
- Initial interventions given at triage (e.g., O_2 started at 5 L/min, IV line placed).
- Name of person who did triage and signature/initials.
- Any relevant history or info from caregivers (e.g., "Mother reports 2 days of vomiting").

Communication with Caregivers (Family Communication): Triage can be chaotic and frightening for patients and families. Key strategies:

- **Empathy and Reassurance:** Teach participants to make eye contact, use a calm tone, and simple language.
- **Honesty and Clarity:** Don't hide information, but also avoid medical jargon.
- **Setting Expectations:** If a non-urgent patient's family is waiting, advise them appropriately
- **De-escalation:** Teach simple de-escalation if a caregiver is angry/upset about waiting.

Cultural sensitivity*:* Remind that participants may encounter diverse backgrounds – be respectful of language or

Team Communication and Handover: Perhaps the most crucial communication is between health workers:

- **SBAR Technique for Handover:** (Situation-Background-Assessment-Recommendation) – Introduce this structured tool for giving handover to the next provider or team. .
- **Closed-loop communication:** In an emergency team, when you ask a colleague to do something, get acknowledgement.
- **Calling for help:** Make sure they know how and when to summon additional help (calling code blue, activating trauma team, etc., depending on context). Acknowledge that as students, their role might often be to alert superiors – and that **speaking up** early is vital if they spot a critical patient.

- **Writing & Legal Aspects:** Touch on why documentation and clear communication protect patient safety and also medico-legal safety. For instance, in court, a well-documented triage record showing the nurse's assessment and actions can be crucial. This underscores the professionalism expected even at triage.

Teaching Method & Activities: Role-play scenarios and interactive discussions are ideal for this module:

- **Role-Play 1 – Family Communication :** Divide into triads (3 people per group): one plays the triage nurse/doctor, one the patient (or parent), and one observes. Give a scenario card to each group, e.g., "You are triaging a 3-year-old with moderate fever (Priority). The mother is anxious and wants to be seen immediately, though more critical patients are present." The "triage officer" must explain and reassure the mother.
- **Role-Play 2 – Team Handover :** Pair participants as if one is triage nurse handing over to receiving doctor or to the next shift. Provide a clinical scenario data (like SBAR content). Have them practice a quick verbal handover. The receiver should then summarize to confirm understanding ("So in summary, this is a 5-year-old in shock, got fluids, needs ICU – got it).
- **Documenting Drill :** Hand out a blank sample triage form or a sheet with key items. Present a short scenario verbally (or from earlier modules). Ask participants to jot down how they would document it in 1 minute. Then show a model answer or discuss what should be included.

Materials & Equipment Needed:

- **Sample Triage Form or Chart:**
- **Role-play Scenario Cards**.
- **Timing device:** to keep role-plays short and focused (2-3 min each)..

Facilitation Tips:

- **Be Encouraging:** Communication skills can be uncomfortable to role-play, but emphasize that trying it in a safe class environment builds confidence for real-life. Praise participants for effective phrases they use
- **Share Personal Anecdotes:** As a trainer, a quick story of a communication challenge you faced in triage and how you handled (or mishandled) it can be very powerful
- **Manage Time:** Role-plays can run over if not monitored. Keep them brief. It's better to have multiple short scenarios than one long one, so they see various situations.

- **Highlight Team vs Individual:** Make the point that effective triage communication is **a team culture** – everyone being on the same page. For example, after initial triage, the whole team should know whose red, etc. Encourage students to foster that clarity when they join clinical teams (even as juniors, they can speak up if something's unclear).

Module 6: Simulation and Assessment

Module Duration: 90 minutes (including simulation, debrief, and formal assessments).

Key Content & Messages: This final module is the capstone experience – **integrating all skills and knowledge** in realistic emergency scenarios, followed by assessment of each participant's competency. It is both a learning exercise (simulation with debriefing) and a test (OSCE and MCQ evaluation).

- **Integrated Simulation Drills:** Conduct full-scale **team simulations** where students must triage and manage patients under time pressure. Include a **mix of cases**: adult, pediatric, trauma, medical, etc., to reflect a variety of emergency presentations. The scenarios should require them to perform triage, identify emergency/priority signs, carry out immediate treatments, and communicate as a team. For example:
  - *Case 1:* A child is brought in unresponsive with a history of diarrhea (pediatric shock scenario) – expected actions: recognize emergency (shock), start ABC (open airway, oxygen, IV fluids, check glucose), tag Red, call for help.
  - *Case 2:* An adult in a motorbike accident with open leg fracture but stable vitals (trauma priority scenario) – actions: bleeding control, pain management, tag Yellow, prepare for X-ray, etc.
  - *Case 3:* A febrile infant, irritable but not in overt distress (priority illness scenario) – actions: assess, tag Yellow, maybe start fever management.
  - *Case 4:* A multiple casualty simulation: 3 victims come at once (one Red, one Yellow, one Green, one Black) and the team must triage all quickly (to test coordination).
- **Time Constraints:** Incorporate realistic time limits to induce pressure. E.g., tell them "you have 5 minutes to triage and treat this patient." This will test their speed and prioritization.
- **Team Roles:** Assign roles such as primary triage leader, airway person, IV/meds person, recorder, etc. Or let them self-organize.
- **Simulation Fidelity:** Use as much realism as possible – full-body mannequins for patients, moulage for wounds, vital sign simulators or a person prompting vitals. If no mannequin for some scenarios, you can have an instructor or standardized patient act it out. Provide vital sign readings when asked, so participants practice asking for or measuring vitals.
- **Debriefing after Simulation:** After each simulation scenario, **debrief** immediately with the team while memory is fresh. Debriefing is crucial for turning the simulation into a learning experience rather than just a stress test.
- **Summative Assessment:** Following (or integrated with) the simulation, conduct formal assessments:
  - **OSCE (Objective Structured Clinical Examination) Station:** Each student (or pair if resources limited) will go through a practical station to test their ETAT skills. This could be one complex scenario or multiple mini-stations:

- **MCQ Test:** A written (or oral) multiple-choice exam of 20 questions covering key knowledge. This typically includes identification of triage categories from scenarios, steps of ABCDE, doses (like fluid bolus), etc. The post-test MCQ will gauge knowledge retention and has a passing threshold (often 70%). If someone scores below passing (or borderline), plan for remediation (as per curriculum: 60-69% can reappear for re-test).

- **Wrap-up:** End the module (and course) with a short reflection and Q&A. Encourage students to share one key insight they're taking away. Reiterate the importance of continued practice and learning in real clinical settings

Materials & Equipment Needed:

- **Simulation Setup:** For each scenario, have the necessary props:
  - Mannequins (adult and child) or live actors, with relevant moulage (fake blood, etc.) if trauma.
  - Monitors or charts to show vitals
  - All equipment from Module 4 (airway kit, IV kit, meds, etc.) should be available for use. Essentially the sim is a full "ER bay" setup.
  - Triage tags and documentation sheets for the scenario so students can actually tag and write if appropriate.
  - Any special props (e.g., C-collar for trauma, epinephrine autoinjector trainer for an anaphylaxis scenario if you include one, etc.).
- **Assessment Materials:**
  - OSCE checklists for examiners. Prepare a standardized checklist for the OSCE station. Each criterion is scored (see rubric below). Print enough copies for all examinees.
  - MCQ papers or digital quiz. Ensure answer keys are ready. If possible, separate answer sheet for easier grading.
  - If needed, pencils, clipboards for test-takers.

Facilitation Tips:

- **Keep Time & Realism**
- **OSCE Fairness**
- **Manage Nerves:** Acknowledge to the group that feeling nervous in an assessment is normal. Encourage them to treat the simulation as "real" but also as a learning chance, not just a test. Sometimes, running one scenario as pure practice (not graded) before a graded OSCE helps reduce anxiety and improve performance.
- **Flexibility:** Be prepared to adjust if running behind schedule. For example, if simulations took too long, the MCQ can be trimmed or given as take-home (not ideal for exam security, but perhaps acceptable in some training contexts). However, try to stick to plan so all elements (especially debrief and feedback) are not rushed – those are critical for learning consolidation.

Assessment & Evaluation Rubrics

Both **formative** (ongoing) and **summative** evaluations are used in this course to ensure that participants achieve competence:

- **Formative Assessment:** throughout the skills modules and simulations, instructors directly observe performance and provide feedback. This includes correcting

techniques during Module 4 stations, and giving feedback during Module 6 debriefings. It's informal and aimed at improvement, not grading.

Summative Assessment: at the end of the course, participants undergo a practical exam (OSCE) and a written exam (MCQ) to certify their learning.

Feedback Forms and Debriefing Tips for Trainers

Collecting feedback from participants and properly debriefing the teaching team are important to continuously improve the course and to support both learners and instructors.

Course Feedback Forms (Participants -> Trainers)

At the end of the training, ask participants to fill out a brief **course evaluation form**. This allows them to reflect on the learning experience and provides trainers with insight on what worked well and what could be improved. The feedback form can include:

Rating Scales: Use a Likert scale (1–5) for statements like:

Example, if several mention "would have liked more practice with real equipment," you can plan to add that next time.

Debriefing Tips for Trainers (Post-Course Evaluation)

1. Trainer Team Debrief: After the course, gather all facilitators/instructors for a short debrief meeting (even the same day, after participants leave, or next day). Much like debriefing simulations, use a structured approach:

- What went well
- What were the challenges?
- Solutions/Changes for next time:
- Emotional debrief for trainers**:**

2. Acknowledge Participant Stress and Growth: Debriefing isn't only for the simulation scenarios; it's also good to close the course by acknowledging to participants that what they did was challenging

3. Follow-up: Provide an opportunity for participants to reach out with questions even after the course (some might process later and have doubts). Perhaps share an email or resource list. This shows support beyond the day of training.

4. Debriefing Model for Simulations: For trainers who will conduct simulations, adhere to best-practice debriefing models:

5. Self-Reflection for Trainers

6. Document Lessons Learned: It's helpful to maintain a log or course report. Write down any key points from the debrief

By implementing feedback and thorough debriefing, the course quality will continuously improve, and trainers will grow more confident and effective in teaching ETAT. Moreover, trainees will feel heard and valued, seeing that their input can shape the training for those who follow.

References:

I. THE CANADIAN TRIAGE AND ACUITY SCALE Combined Adult/ Paediatric Educational Program PARTICIPANT'S MANUAL.
II. WHO ETAT Manual (2005 , updated 2016)

ANNEXURE 1

(OSCE Stations)

OSCE Station 1: Critical First Look (ABCDE Assessment)

- Goal: Assess ability to perform rapid primary assessment
- Scenario: A 4-year-old child is brought to the ER unconscious after seizure
- Task: Perform a rapid ABCDE assessment and verbalize next steps
- Time Allotted: 5 minutes

Checklist:

i. Checks airway and attempts to open it
ii. Assesses breathing rate and effort
iii. Assesses circulation: cap refill, pulse
iv. Evaluates consciousness (AVPU)
v. Mentions exposure and looks for signs of trauma

Assessment Rubric:

a. Pass: Completes all steps accurately
b. borderline: Misses 1 step
c. Remedial: Misses 2 or more steps or unsafe actions

OSCE Station 2: Triage Classification & Tagging

- Goal: Assess correct triage category identification and tagging
- Scenario: An adult with fractured femur, stable vitals
- Task: Classify the patient and apply the correct triage tag with justification
- Time Allotted: 4 minutes

Checklist:

i. Assesses vital signs and level of consciousness
ii. Identifies injury severity
iii. Chooses correct triage category (Yellow)
iv. Applies appropriate color-coded tag
v. Gives verbal reasoning

Assessment Rubric:

a. Pass: Correct tag and rationale
b. Borderline: Correct tag but unclear rationale
c. Remedial: Incorrect tag or poor judgment

OSCE Station 3: Airway & Breathing Management

- Goal: Assess basic airway opening and BVM use
- Scenario: A patient is unconscious and gasping
- Task: Open airway and provide bag-mask ventilation
- Time Allotted: 6 minutes

Checklist:

i. Opens airway correctly (jaw thrust/head tilt)
ii. Inserts airway adjunct (OPA if indicated)
iii. Assembles BVM and applies with proper seal
iv. Delivers 1 breath every 5 seconds
v. Checks for chest rise

Assessment Rubric:

a. Pass: Effective ventilation
b. Borderline: Acceptable with minor errors
c. Remedial: Unsafe or ineffective technique

OSCE Station 4: Shock Management and IV Fluid Bolus

- Goal: Manage pediatric patient with signs of hypovolemic shock
- Scenario: A dehydrated child, sunken eyes, lethargy, CRT >3s
- Task: Calculate fluid bolus and simulate IV fluid setup
- Time Allotted: 5 minutes

Checklist:

i. Identifies clinical signs of shock
ii. Calculates fluid bolus (20ml/kg)
iii. Selects correct fluid (NS or Ringer's)
iv. Sets up IV line (simulation)
v. States correct infusion rate

Assessment Rubric:

a. Pass: All steps accurate
b. Borderline: Minor calculation/setup errors
c. Remedial: Missed diagnosis or incorrect bolus

OSCE Station 5: Hypoglycemia Management

- Goal: Recognize and treat low glucose in unconscious patient
- Scenario: Unconscious adult, capillary glucose 40 mg/dL
- Task: Administer appropriate glucose treatment
- Time Allotted: 4 minutes

Checklist:

i. Interprets glucose result as hypoglycemia
ii. Selects 50% dextrose or glucose gel
iii. Calculates correct dose
iv. Prepares and simulates administration
v. Reassesses patient

Assessment Rubric:

a. Pass: Correct drug and administration
b. Borderline: Correct idea but dosage error
c. Remedial: Incorrect treatment or unsafe

OSCE Station 6: Communication & Handover (SBAR)

- Goal: Deliver clear patient handover using SBAR format
- Scenario: Handover of pediatric seizure case to senior
- Task: Verbally hand over case in <2 minutes using SBAR
- Time Allotted: 3 minutes

Checklist:

i. States situation clearly (S)
ii. Gives brief relevant background (B)
iii. Describes assessment findings (A)
iv. Makes recommendation/plan (R)
v. Uses calm and structured language

Assessment Rubric:

a. Pass: Clear and structured SBAR
b. Borderline: Minor content or sequence issue
c. Remedial: Incomplete or unclear communication

ANNEXURE 2

ETAT 0SCE STATIONS & RUBERICS

Skill/Task	Component Steps	Assessment Rubric
Initial Assessment: Critical First Look (ABCDE)	Checks A: Airway, B: Breathing, C: Circulation, D: Disability, E: Exposure	All steps correct = Pass; 1-2 missed = Borderline; >2 missed = Remedial
Triage Classification & Tagging	Assigns correct triage category (Red/Yellow/Green) & uses tag correctly	Correct category + tag = Pass; Minor confusion = Borderline; Wrong tag = Remedial
Airway Management (Positioning, OPA)	Performs head tilt/jaw thrust; inserts OPA appropriately if unconscious	Proper technique = Pass; Minor correction needed = Borderline; Unsafe = Remedial
Breathing Support (BVM ventilation)	Assembles BVM, creates proper mask seal, provides effective ventilation	Seal, rate, volume correct = Pass; Minor technique gap = Borderline; Ineffective = Remedial
Circulation Support (IV insertion, fluid bolus)	Identifies shock, selects correct IV size, calculates bolus, connects IV	All steps accurate = Pass; Minor step missed = Borderline; Missed critical step = Remedial
Hypoglycemia Management (Glucose admin)	Performs glucose test, selects appropriate dose, administers glucose	Correct dose, route = Pass; Minor calculation error = Borderline; Unsafe = Remedial
Seizure Management (Positioning, Meds)	Puts patient in recovery position, selects/pretends correct medication	Appropriate action = Pass; Confused meds/steps = Borderline; Missed/unsafe = Remedial
Communication & Handover (SBAR)	Follows SBAR format, concise and complete handover to team member	Clear, structured, timely = Pass; Minor gaps = Borderline; Disorganized = Remedial
Documentation (Triage record)	Accurate and complete charting of category, signs, vitals, time, actions	Complete, legible = Pass; Some gaps = Borderline; Incomplete/wrong = Remedial

ANNEXURE 3

PRE TEST MCQS

Emergency Triage Assessment and Treatment Course

Name: _____

Signature: _____ **Date:** _____

Venue: _____

Written Examination		**Pre-Test**	
A	**Questions**		
1	The triage nurse only documents the patient's presenting complaint.	True	False
2	The RAT model is suitable for quiet emergency departments.	True	False
3	The aim of triage is to identify non-urgent cases first.	True	False
4	Vital checks for levels 1 and 2 should be completed by the triage nurse.	True	False
5	Nurses must apply critical thinking during triage assessments.	True	False
6	Emergency patients typically experience a diagnosis upon arrival.	True	False
7	Triage was initially used in big hospital settings.	True	False
8	The triage nurse also documents the patient's allergies	True	False
9	The Triage Sieve implementation guidelines were published in 1995.	True	False
10	In categorization and color coding level 4 is less urgent.	True	False
B	**What is the Triage Level as per CTAS?**	**Triage Level?**	
11	In pediatric Seizure prior to ED, now alert.		
12	In Adult exposure to communicable diseases.		
13	In pregnant women possible leaking amniotic fluid.		
14	In Adult traumatic amputation.		
15	Adult with only respiratory arrest		

C	What is the Triage Level as per Sieve?	Triage Level?
16	A young adult arrives with a severe allergic reaction, including facial swelling and difficulty breathing.	
17	Lying; Fractured Right Leg, Respiration Rate 28, Pulse Rate 110	
18	32-year-old Female Patient, trapped by seats in bus, seat belt worn, Head injury and Unconscious, Respiration Rate 24, Pulse Rate 100	
19	A patient presents with flu-like symptoms, including moderate fever and body aches, but they are stable and not in distress.	
20	A young woman arrives in the ED with sudden onset of severe abdominal pain, nausea, and vomiting. She appears pale and in significant distress.	

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
5	**10**	**15**	**20**	**25**	**30**	**35**	**40**	**45**	**50**	**55**	**60**	**65**	**70**	**75**	**80**	**85**	**90**	**95**	**100**

ANNEXURE 4

POST TEST

Emergency Triage Assessment and Treatment Course

Name: _____

Signature _____**Date:** _____

Venue _____

Written Examination		Post-Test	
A	**Questions**		
1	The triage nurse only documents the patient's presenting complaint.	True	False
2	The RAT model is suitable for quiet emergency departments.	True	False
3	The aim of triage is to identify non-urgent cases first.	True	False
4	Vital checks for levels 1 and 2 should be completed by the triage nurse.	True	False
5	Nurses must apply critical thinking during triage assessments.	True	False
6	Emergency patients typically experience a diagnosis upon arrival.	True	False
7	Triage was initially used in big hospital settings.	True	False
8	The triage nurse also documents the patient's allergies	True	False
9	The Triage Sieve implementation guidelines were published in 1995.	True	False
10	In Categorisation and colour coding, level 4 is less urgent.	True	False
B	**What is the Triage Level ?**	**Triage Level?**	
11	In pediatric Seizure prior to ED, now alert.		
12	In Adult exposure to communicable diseases.		
13	In pregnant women possible leaking amniotic fluid.		
14	In Adult traumatic amputation.		
15	Adult with only respiratory arrest		
C	**What is the Triage Level as per Sieve?**	**Triage Level?**	
16	A young adult arrives with a severe allergic reaction, including facial swelling and difficulty breathing.		
17	Lying; Fractured Right Leg, Respiration Rate 28, Pulse Rate 110		
18	32-year-old Female Patient, trapped by seats in bus, seat belt worn, Head injury and Unconscious, Respiration Rate 24, Pulse Rate 100		
19	A patient presents with flu-like symptoms, including moderate fever and body aches, but they are stable and not in distress.		
20	A young woman arrives in the ED with sudden onset of severe abdominal pain, nausea, and vomiting. She appears pale and in significant distress.		

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
5	**10**	**15**	**20**	**25**	**30**	**35**	**40**	**45**	**50**	**55**	**60**	**65**	**70**	**75**	**80**	**85**	**90**	**95**	**100**

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