UNIVERSITY OF HEALTH SCIENCES LAHORE

EMERGENCY TRIAGE, ASSESSMENT, AND TREATMENT (ETAT)

STUDENT HANDOUT 2025

Emergency Triage, Assessment, & Treatment (ETAT)

STUDENT's HANDSOUT

2025

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Contents

Case Vignettes (For Group Activity)

Case 1:

A 28-year-old female arrives with chest pain and shortness of breath. Vitals: HR 110, RR 28, BP 140/90.

Question: What is the ETAT level, and why?

Answer: Level 2 – potentially serious condition (cardiac/respiratory)

Case 2:

A 6-year-old is brought in with minor lacerations on the arm after a fall. He is active and playful.

Answer: Level 4 – less urgent, needs sutures, but stable

Case 3:

A 70-year-old man arrives unconscious, with no pulse, and CPR is in progress.

Answer: Level 1 – resuscitation required

Case 4:

A 20-year-old male complains of nasal congestion for 3 days. No fever, vitals normal.

Answer: Level 5 – non-urgent

Case 5:

2-month-old infant, lethargic and not feeding. baby is pale, feels cold, and is barely responsive; breathing is shallow, and pulse very rapid and weak.
Answer ;s. resuscitation /**Emergency case** – possibly septic shock. priority is to start oxygen, keep warm, and begin IV fluids urgently.

Quick Reference Handout

Level	Category	Examples (Adult)	Examples (Pediatric)
2	Emergent	Syncope, severe burns, eye injuries	Severe dehydration, moderate respiratory distress
3	Urgent	Head injury with brief LOC, major blunt trauma	Foreign body aspiration (no distress)
4	Non Urgent	Laceration needing sutures, mild asthma	Minor head injury, low-risk fever

Emergency Signs Checklist:

Sign	Description	Action
Airway Obstruction	Stridor, choking	Position, suction, oxygen
Severe Breathing Difficulty	Grunting, cyanosis	Oxygen, bag-mask if needed
Shock	Cold extremities, delayed capillary refill	IV fluids
Altered Consciousness	Coma, convulsions	Glucose, anticonvulsants

Colour Card

What is Triage?

The definition of Triage is:

A sorting process utilizing critical thinking and a standardized set of guidelines in which an experienced Registered Nurse assesses patients quickly upon their arrival in an Emergency Department to:

- Assess and determine severity of presenting problems
- Process patient into a Triage category and streaming to an appropriate location
- Determine access to appropriate treatment
- Effectively and efficiently assign appropriate human health resources.

Evolution of Triage

- Military roots
- Introduced in hospitals in early 1960s.
- No of cases increasing in hospitals
- People with non-urgent condition come to EDs for treatment
- Initially, a 3-Level Triage (Emergent, Urgent and Non-Urgent) was used

TriageArea/Room

- Nearest to ED main entrance
- Adequate space
- Ventilated, Heating, Cooling
- Equipment availability
- Infection control equipment

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Self-Reflection Questions

1. What is the first action when a patient is gasping and cyanosed?

- **Answer:** Ensure a **patent airway and provide oxygen** immediately.
- **Explanation:** Gasping and cyanosis are signs of severe hypoxia and possible airway obstruction. According to the ABCDE approach, **A = Airway** comes first. Suction, airway positioning (e.g., head tilt–chin lift if no C-spine injury), and oxygen therapy are life-saving.

2. When do you apply the "ABCDE" approach?

- **Answer:** During **initial assessment** of any patient to rapidly identify life-threatening conditions.
- **Explanation:** The **ABCDE approach** (Airway, Breathing, Circulation, Disability, Exposure) is a **structured, rapid evaluation method** used during triage and emergency care to assess and stabilize critically ill or injured patients.

3. How would you categorize a conscious patient with a deep laceration and bleeding controlled?

- **Answer: Level 3 – Urgent** (depending on depth and location of laceration).
- **Explanation:** The patient is stable, conscious, and bleeding is controlled, so not emergent. However, a deep laceration could require prompt wound care or suturing—thus considered urgent but not life-threatening

4. What are signs of poor perfusion in infants?

- **Answer:**
    - Cold extremities
    - Capillary refill > 3 seconds
    - Weak or thready pulse
    - Pallor
    - Altered mental status (lethargy, irritability)

Explanation: These signs indicate **shock** or **circulatory compromise**, which require immediate attention and fluid resuscitation.

5**. What basic life-saving interventions can a student initiate during triage?**

- **Answer:**
  - Positioning and clearing the airway
  - Administering oxygen
  - Applying pressure to control bleeding
  - Starting IV fluids (under supervision)
  - Administering glucose for hypoglycemia
  - Keeping the patient warm (especially in shock or in infants)
- **Explanation:** Students trained in ETAT can recognize emergency signs and initiate **first-line stabilization** under supervision. These actions help prevent deterioration until advanced care is available.

References/Reading Material

i. THE CANADIAN TRIAGE AND ACUITY SCALE Combined Adult/ Paediatric Educational Program PARTICIPANT'S MANUAL.

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