Meeting with Mohamed Shawqi

Personal MS

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SM

Seif Mosaad

M

MN (Unverified)

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menna (Guest)

SA

sohaila abdelfatah

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عبدالفتاح جمال (Guest)

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Meeting with Mohamed Shawqi

Personal MS

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D

do7a (Guest)

S

sara193286@fmed.bu.edu.eg

Taha Refaat

AN

Aisha Nasser

SS

Samaa SalahEldin (Guest)

Shrouk Nabil

صالح دعبس

A

Abeer (Guest)

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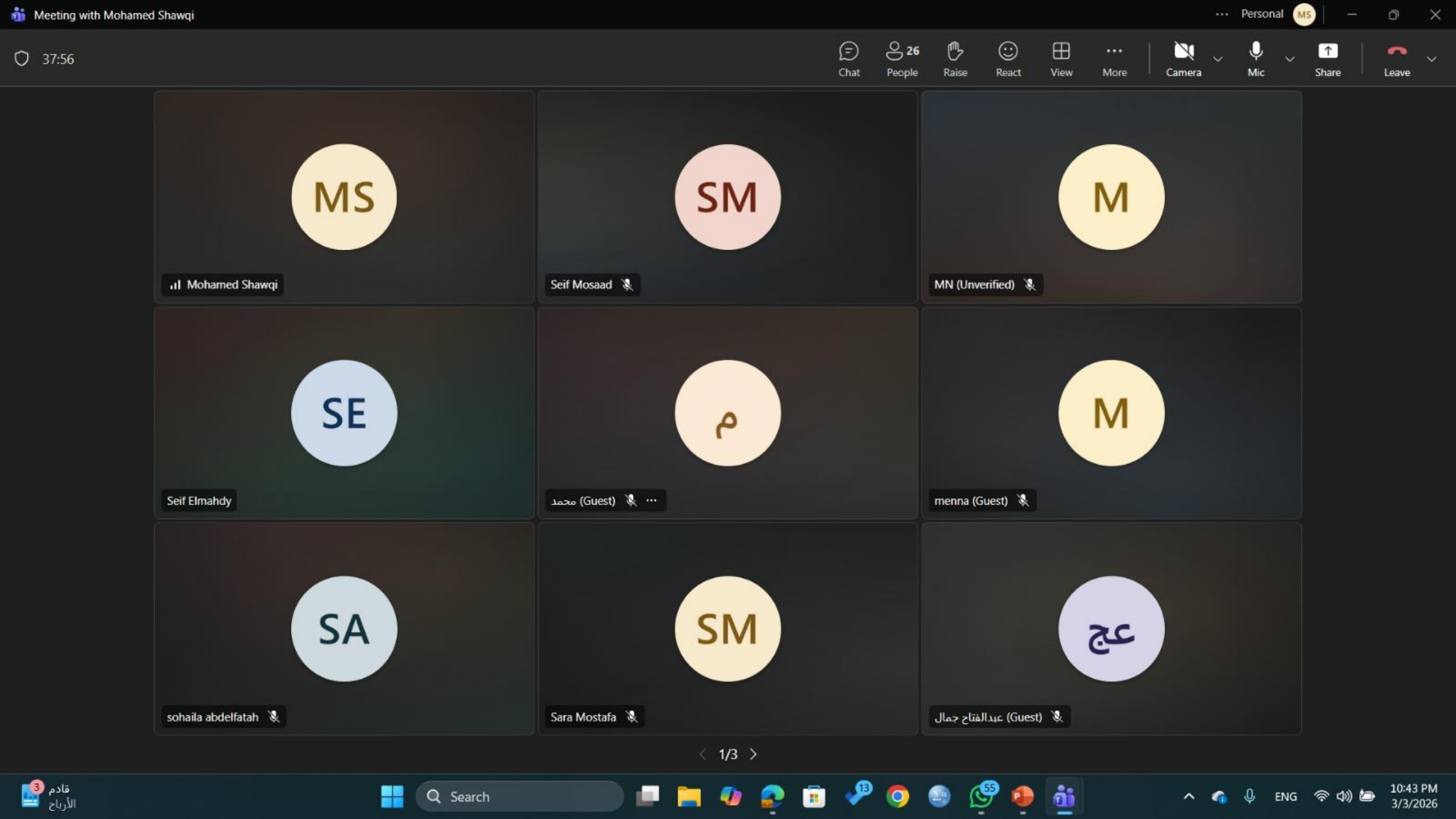
Meeting with Mohamed Shawqi
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Meeting with Mohamed Shawqi

Personal MS

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Send a reaction

Z

zainab193265@fmed.bu.edu.eg

SM

soly mhmd

SS

Shimaa Saad

AH

Abdulrahman Hesham (Guest)

3/3

Snipping Tool

Screenshot copied to clipboard
Automatically saved to screenshots folder.

Markup and share

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Emergency Medicine Triage System

Mohamed Mohamed Shawqi
Emergency Medicine, Faculty of Medicine, Benha University

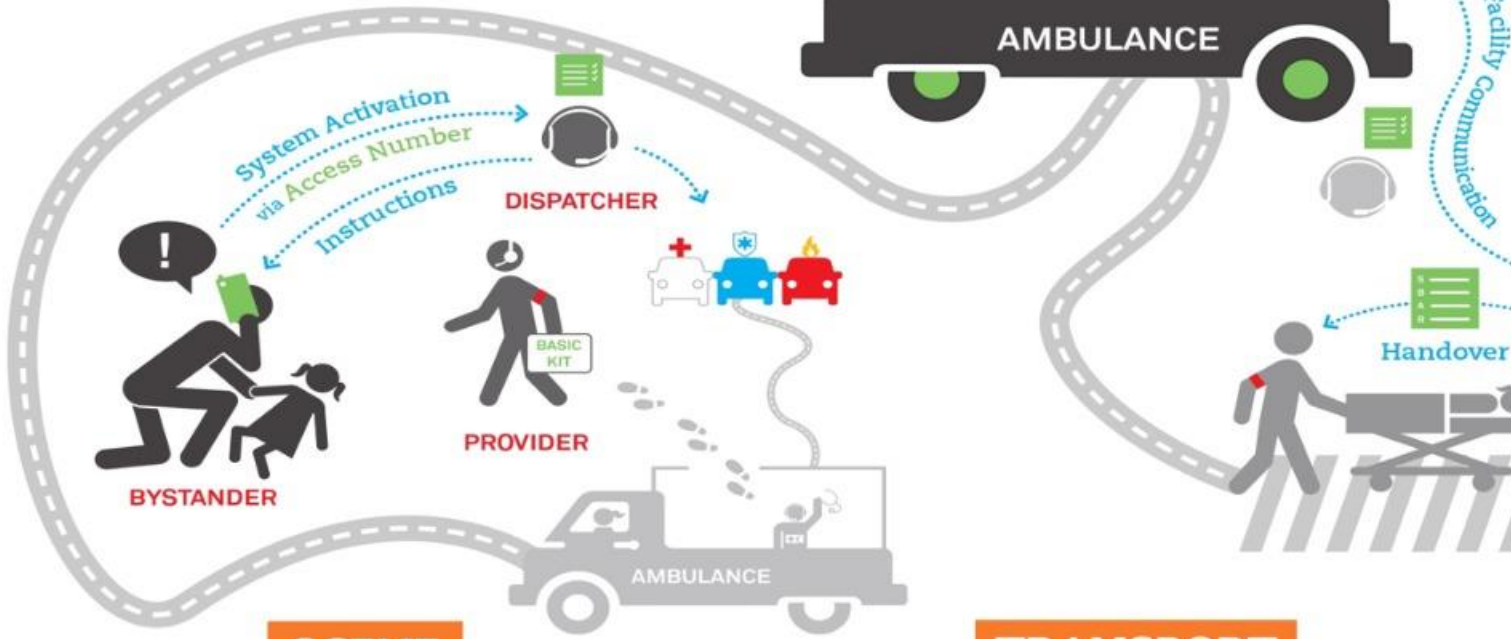
May 2025

World Health Organization

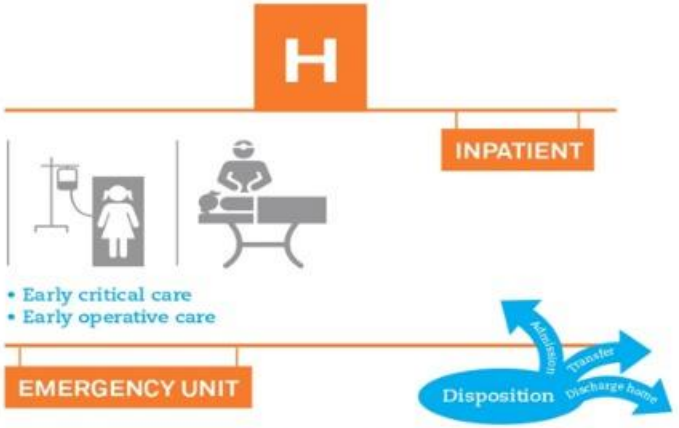
EMERGENCY CARE SYSTEM FRAMEWORK

All around the world, acutely ill and injured people seek care every day. Frontline providers manage children and adults with injuries and infections, heart attacks and strokes, asthma and acute complications of pregnancy. An integrated approach to early recognition and management saves lives. This visual summary illustrates the essential functions of a responsive emergency care system, and the key human resources, equipment, and information technologies needed to execute them. The reverse side adresses elements of governance and oversight.

HUMAN RESOURCES · FUNCTIONS · VEHICLES, EQUIPMENT, SUPPLIES, INFORMATION TECHNOLOGIES



Field to Facility Communication



Reception of Patients

SCENE

- BYSTANDER RESPONSE
- DISPATCH
- PROVIDER RESPONSE

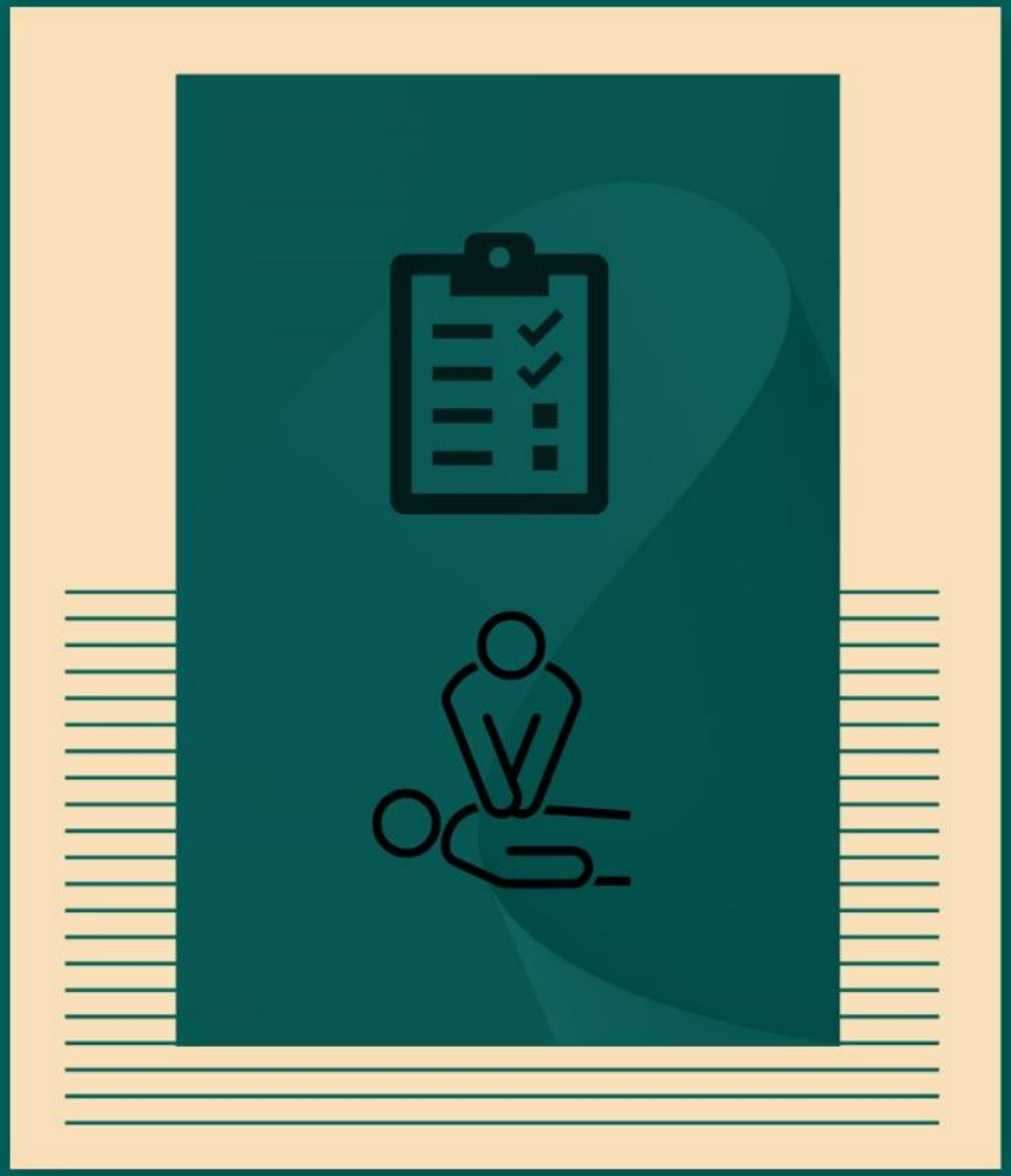
TRANSPORT

- PATIENT TRANSPORT
- TRANSPORT CARE

FACILITY

- RECEPTION
- EMERGENCY UNIT CARE
- DISPOSITION
- EARLY INPATIENT CARE

www.who.int/emergencycare · emergencycare@who.int



Importance of Triage

1) **Saves Lives** – Ensures patients with time-sensitive conditions (e.g., arrested, heart attacks, strokes, severe trauma) get treated first.
2) **Prevents Overcrowding** – Helps manage ED patient flow, reducing delays for critical cases.
3) **Resource Efficiency** – Allocates staff, equipment, and beds to those most in need.
4) **Disaster Preparedness** – Essential in mass casualty incidents (MCIs) where resources are overwhelmed.
5) **Standardized Care** – Provides a structured approach to patient assessment, reducing errors.

Interagency Integrated Triage Tool

Patient arrives at health facility

SCREEN for any disease of public health concern. If suspect or confirmed case, continue the rest of the algorithm in an ISOLATION AREA and wear appropriate Personal Protective Equipment (PPE).

Step 1 TRIAGE

(The objective is to sort patients according to severity of illness or injury and initiate medical care in order of priority)

Does the patient have any RED signs?

- Unresponsive

AIRWAY AND BREATHING

- Stridor
- Respiratory distress* or central cyanosis

CIRCULATION

- Capillary refill >3 sec
- Weak and fast pulse
- Heavy bleeding
- HR <50 or >150

DISABILITY

- Acute convulsions
- Any two of:
  - Altered mental status
  - Stiff neck
  - Hypothermia or fever
  - Headache
- Hypoglycaemia

OTHER

- High-risk trauma*
- Poisoning/ingestionon or dangerous chemical exposure*
- Threatened limb*
- Snake bite
- Severe acute chest or abdominal pain (> 50 years)
- ECG with acute ischaemia (if done)
- Violent or aggressive

PREGNANT WITH ANY OF:

- Heavy bleeding
- Severe abdominal pain
- Seizures or altered mental status
- Severe headache
- Visual changes
- SBP ≥160 or DBP ≥110
- Active labour
- Trauma

YES

This is an EMERGENCY case
- Categorize as RED patient
- Move to Resuscitation Area or RED area
- Initiate first line management within 10 minutes*

NO

Does the patient have any YELLOW signs?

AIRWAY AND BREATHING

- Any swelling/mass of mouth, throat or neck
- Wheezing (no red criteria)

CIRCULATION

- Vomits everything or ongoing diarrhoea
- Unable to feed or drink
- Severe pallor (no red criteria)
- Ongoing bleeding (no red criteria)
- Recent fainting

DISABILITY

- Altered mental status or agitation (no red criteria)
- Acute general weakness
- Acute focal neurologic complaint
- Acute visual disturbance
- Severe pain (no red criteria)

OTHER

- New rash worsening over hours or peeling (no red criteria)
- Visible acute limb deformity
- Open fracture
- Suspected dislocation
- Other trauma/burns (no red criteria)
- Known diagnosis requiring urgent surgical intervention
- Sexual assault
- Acute testicular/scrotal pain or priapism
- Unable to pass urine
- Exposure requiring time-sensitive prophylaxis (eg. animal bite, needlestick)
- Pregnancy, referred for complications

YES

This is an URGENT case
- Categorize as YELLOW patient
- Move to YELLOW area
- Initiate first line management within 2 hours*

NO

Did the patient arrive dead?

Move to mortuary. Notify police as required. Fill in necessary documentation.

Check for high-risk vital signs

Heart Rate (HR) <60 or >130
Respiratory Rate (RR) <10 or >30
Temperature (T) <36° or >39° C
Oxygen Saturation (SpO2) <92%
Alert, Verbal, Pain, Unresponsive other than A

Does the patient have any high-risk vital signs?

YES

This is an URGENT case
- Categorize as YELLOW patient
- Move to YELLOW area
- Initiate first line management within 2 hours*

NO

This is an NON-URGENT case
- Categorize as GREEN patient
- Move to GREEN area or OPD
- Initiate first line management within 4 hours*

*Or according to local time targets

REFERENCE CARD

World Health Organization

Medical Resuscitation Algorithm

1 Recognize

Recognize an acutely ill patient using the **Interagency Integrated Triage Tool (IITT).**

Move patient to red or resuscitation area.

2 Resuscitate

Use the **ABCDE approach** to systematically evaluate the patient, identify and correct immediate life threats.

Remember:
- If suspected TRAUMA: maintain spine precautions & follow trauma algorithm
- Special considerations in paediatric, elderly or pregnant patients.

ABCDE Approach

Is the patient talking normally with no signs of obstruction?

AIRWAY — A

LOOK FOR:	ACT:
• Unconscious with limited or no air movement	• Open the airway (Use jaw thrust or head tilt and chin lift). • Insert OPA or NPA. • Place in recovery position.
• Foreign body in airway	• Encourage coughing. Remove visible foreign body. • If unable to cough, chest/abdominal thrust/back blow as indicated. • If patient becomes unconscious, start CPR per local protocols.
• Gurgling	• Open airway as above, suction (avoid gagging).
• Stridor	• Keep patient calm and allow position of comfort. • For signs of anaphylaxis: give IM adrenaline. • For hypoxia: give oxygen.

CHECK: Is airway clear? → X: Re-evaluate. Consult for assistance. Reach out to advanced provider

Does the patient have increased work of breathing, abnormal breathing pattern, abnormal breath sounds, cyanosis, chest wounds? *Check oxygen saturation.

BREATHING — B

LOOK FOR:	ACT:
• Signs of abnormal breathing or hypoxia	• Give oxygen. Assist ventilation with BVM if breathing NOT adequate.
• Wheezes	• Give salbutamol. For signs of anaphylaxis: give IM adrenaline.
• Signs of tension pneumothorax	• Perform needle decompression, give oxygen and IV fluids.
• Signs of opiate overdose (altered mental status and slow breathing with small pupils)	• Arrange for chest tube. • Give naloxone.
• Signs of organophosphate poisoning (difficulty in breathing, sweating, vomiting, diarrhoea, salivation)	• Give atropine.

CHECK: Is breathing adequate? → X: Re-evaluate. Consult for assistance. Reach out to advanced provider

Does the patient have external or internal bleeding, distended neck veins, muffled heart sounds or poor perfusion? *Check BP, HR, capillary refill. *Always adjust fluids for malnutrition.

CIRCULATION — C

LOOK FOR:	ACT:
• Signs of poor perfusion/shock	• Give oxygen and IV fluids. If no pulse, follow relevant CPR protocols.
• Signs of internal or external bleeding	• Control external bleeding. Give IV fluids.
• Signs of pericardial tamponade (poor perfusion with distended neck veins and muffled heart sounds)	• Give IV fluids, oxygen. Arrange for rapid pericardial drainage. • Arrange urgent referral and/or handover.

CHECK: Is perfusion adequate? → X: Re-evaluate. Consult for assistance. Reach out to advanced provider

Does the patient have head trauma, convulsions, unequal or fixed pupils, movement in all extremities? *Check AVPU. *Always check blood glucose.

DISABILITY — D

LOOK FOR:	ACT:
• Altered mental status (AMS)	• Place in recovery position. • Check glucose.
• Convulsion	• Check glucose. Give benzodiazepine.
• Convulsion in pregnancy (or after recent delivery)	• Give magnesium sulphate.
• Suspected hypoglycaemia	• Check glucose. Give glucose if <3.5mmol/L (<63 mg/dL) or unknown.
• Signs of life-threatening brain mass or bleed (AMS with unequal pupils)	• Monitor airway, raise head of bed. Avoid hypoxia, hypotension, hyperthermia. • Rapid transfer for neurosurgical services.

CHECK: Is mental status improved? → X: Re-evaluate. Consult for assistance. Reach out to advanced provider

Does the patient have hidden injuries, rashes or other lesions? *Expose and examine the entire body.

EXPOSURE — E

LOOK FOR:	ACT:
• Wet or constrictive clothing	• Remove wet clothing and dry skin thoroughly. • Remove jewellery, watches & constrictive clothing. • Prevent hypothermia and protect dignity.

3 Review

Review patient status and interventions using the **WHO Medical Emergency checklist.**

- Recheck vital signs.
- If patient condition changes, repeat ABCDE.
- If no further interventions needed, take a SAMPLE history and perform a SECONDARY exam.
- Document care in a WHO Standardised Clinical Form or locally available option.

4 Refer

If health facility unable to provide on going care, arrange for safe transfer to appropriate facility as soon as possible.

REMEMBER: PREPARATION is key. Use the elements of the WHO Emergency Care Toolkit to prepare your unit to better manage emergencies.

Contact **emergencycare@who.int** for more information

World Health Organization

Trauma Resuscitation Algorithm

1 Recognize

Recognize a seriously injured patient using the **Interagency Integrated Triage Tool (IITT).**

Move patient to red or resuscitation area.

2 Resuscitate

Use the **ABCDE approach** to systematically evaluate the patient, identify and correct immediate life threats.

Remember special considerations in paediatric, elderly or pregnant patients.

ABCDE Approach

Is the patient talking normally with no signs of obstruction?

For major external haemorrhage, control bleeding first!

AIRWAY AND CERVICAL SPINE IMMOBILIZATION — A

LOOK FOR:	ACT:
• Not speaking, with limited or no air movement	• Use jaw thrust with c-spine protection. • Suction if needed, remove visible foreign objects. • Place OPA to keep the airway open.
• Signs of possible airway injury (neck haematoma or wound, crepitus, stridor)	• Give oxygen. Monitor closely – swelling can rapidly block the airway. • Arrange for urgent advanced airway management.
• Signs of possible airway burns (soot around the mouth or nose, burned facial hair, facial burns)	• Give oxygen. Monitor closely – swelling can rapidly block the airway. • Arrange for urgent advanced airway management.

CHECK: Is airway clear? → X: Re-evaluate. Consult for assistance. Reach out to advanced provider

Does the patient have increased work of breathing, abnormal breathing pattern, abnormal breath sounds, cyanosis, chest wounds? *Check oxygen saturation.

BREATHING — B

LOOK FOR:	ACT:
• Signs of tension pneumothorax (hyperresonance on affected breath sounds/hyperresonance on one side, distended neck veins)	• Perform needle decompression. • Give oxygen, IV fluids. • Arrange for urgent chest tube.
• Open (sucking) chest wound	• Give oxygen, place 3-sided dressing, monitor for tension pneumothorax. • Arrange for urgent chest tube.
• Breathing not adequate	• Give oxygen, assist ventilation with BVM.
• Large burns of chest or abdomen (or circumferential burn to limb)	• Give IV fluids per burn size, give oxygen, remove constricting clothing/jewellery. • May need escharotomy.
• Signs of 'flail chest' (section of chest wall moving in opposite direction with breathing)	• Give oxygen and provide pain medication. • May need advanced airway management and assisted ventilation.
• Signs of haemothorax (decreased breath sounds on one side, dull sounds with percussion)	• Give oxygen, IV fluids. • Arrange for urgent chest tube.

CHECK: Is breathing adequate? → X: Re-evaluate. Consult for assistance. Reach out to advanced provider

Does the patient have external or internal bleeding, distended neck veins, muffled heart sounds or poor perfusion? *Check BP, HR, capillary refill.

CIRCULATION — C

LOOK FOR:	ACT:
• Signs of shock (capillary refill >3 sec, hypotension, tachycardia)	• Give oxygen, IV fluids, control external bleeding, splint fem/tib/pelvis as indicated.
• Uncontrolled external bleeding	• Apply pressure, deep wound packing or tourniquet as indicated.
• Signs of tamponade (poor perfusion, distended neck veins, muffled heart sounds)	• Give IV fluids, oxygen. Urgently refer to surgeon.

CHECK: Is perfusion adequate? → X: Re-evaluate. Consult for assistance. Reach out to advanced provider

Does the patient have head trauma, convulsions, unequal or fixed pupils, movement in all extremities. *Check AVPU. *Always check blood glucose.

DISABILITY — D

LOOK FOR:	ACT:
• Signs of brain injury (AMS with wound, deformity or bruising of head/face)	• Immobilise cervical spine, check glucose, give nothing by mouth. • Will need neurosurgical care.
• Signs of open skull fracture (as above, with blood or fluid from the ears/nose)	• As above, and give IV antibiotics per local protocol.

CHECK: Is mental status improved? → X: Re-evaluate. Consult for assistance. Reach out to advanced provider

Does the patient have hidden injuries, rashes or other lesions? *Expose and examine the entire body.

EXPOSURE — E

LOOK FOR:	ACT:
• Wet or constrictive clothing	• Remove wet clothing and dry skin thoroughly. • Remove jewellery, watches & constrictive clothing. • Prevent hypothermia and protect dignity.
• Snake bite	• Immobilise extremity. Arrange for early anti-venom if relevant and available.

3 Review

Review patient status and interventions using the **WHO Trauma Care Checklist.**

- Recheck vital signs.
- If patient condition changes, repeat ABCDE.
- If no further interventions needed, take a SAMPLE history and perform a SECONDARY exam.
- Document care in a WHO Standardised Clinical Form or locally available option.

4 Refer

If health facility unable to provide on going care, arrange for safe transfer to appropriate facility as soon as possible.

REMEMBER: PREPARATION is key. Use the elements of the WHO Emergency Care Toolkit to prepare your unit to better manage emergencies.

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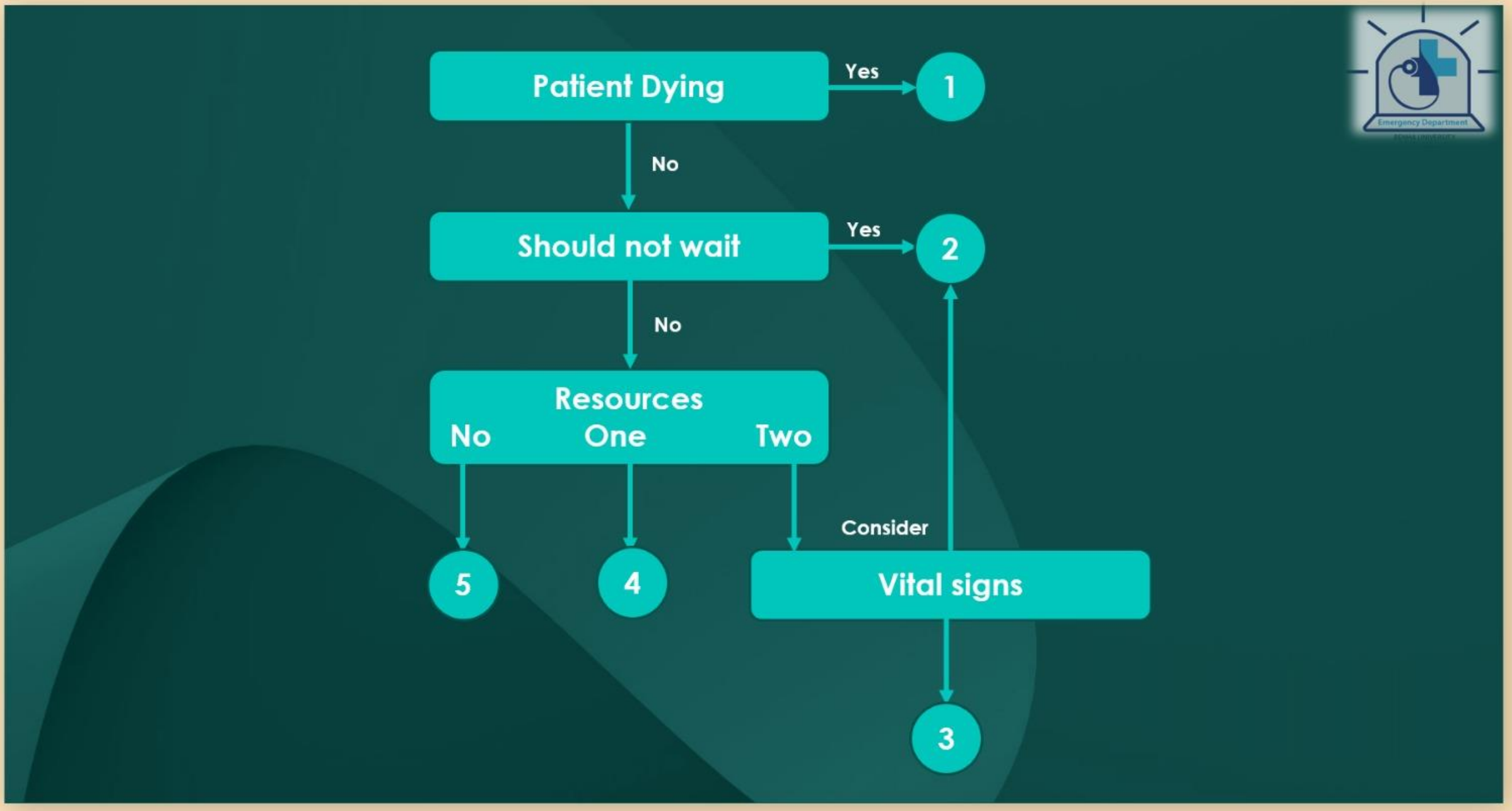
Triage

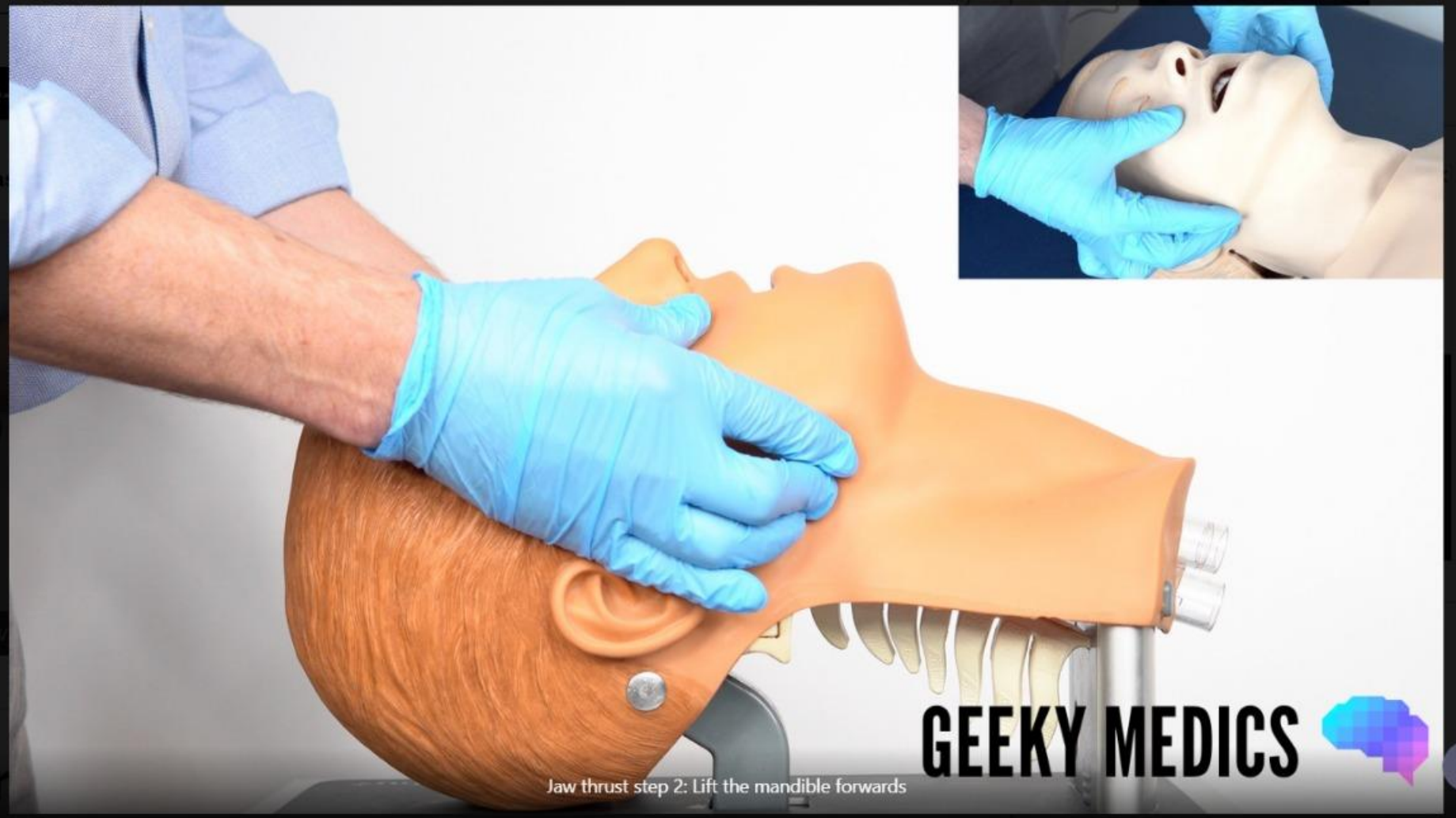
- ✓ Emergency Severity Index
- ✓ Manchester Triage System
- ✓ Australian Triage Scale
- ✓ Canadian Triage and Acuity scale
- ✓ The Cap Triage Score
- ✓ START Score
- ✓ Suez Canal Triage System


Patient Dying
Yes
1
No
Should not wait
Yes
2
No
Resources
No
One
Two
Consider
Vital signs
5
4
3

Manchester triaging

MTS has good sensitivity (87-95%) for identifying critically ill patients

- The Manchester Triage System (MTS) prioritizes patients based on clinical urgency rather than arrival time.
- A typical assessment takes 2–3 minutes, with complex cases requiring more time.
- Patients are categorized into five priority levels: Immediate (Red), Very Urgent (Orange), Urgent (Yellow), Standard (Green), and Non-Urgent (Blue), each with a corresponding maximum waiting time.



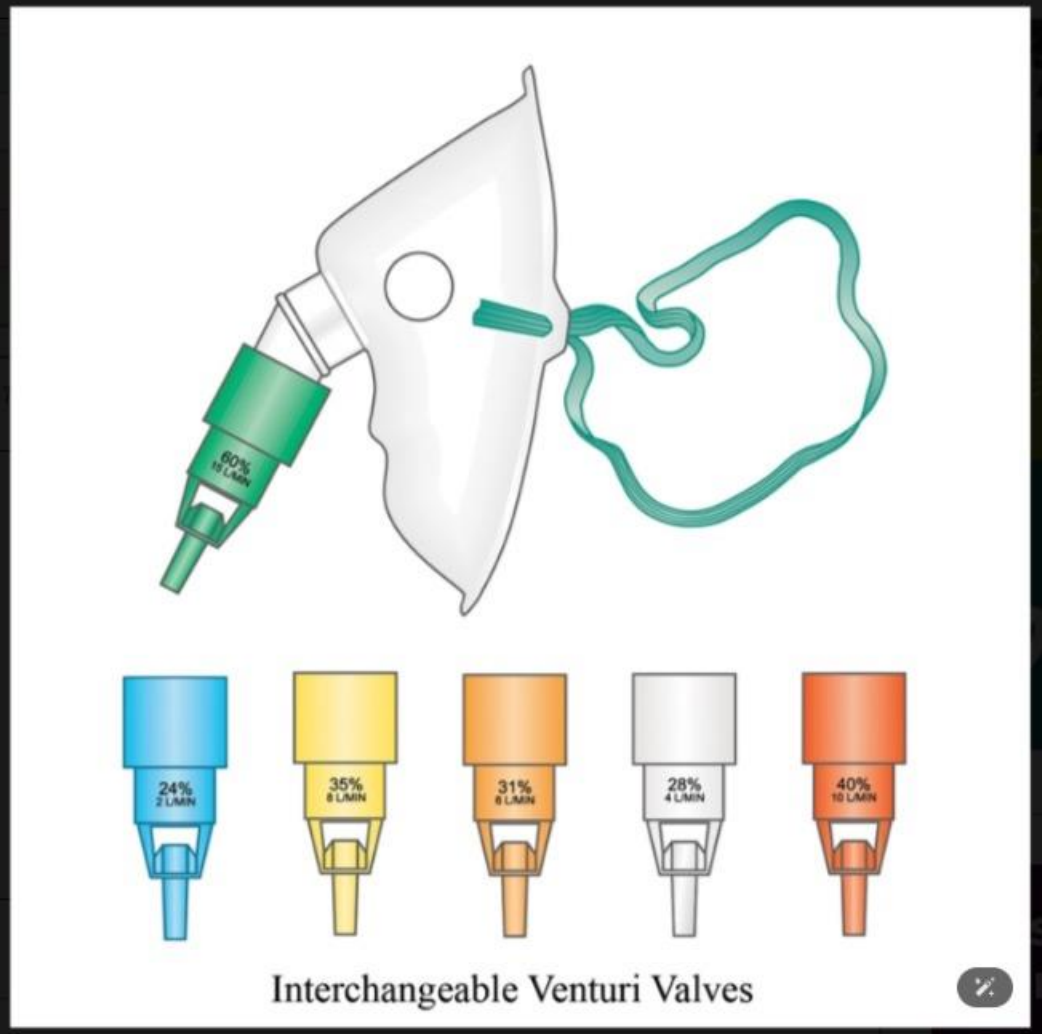


Figure 3. Venturi masks

Triaging systems

Questions Responses 13 Settings