Facilitator instructions for case scenarios: ETAT module 1, triage

1. **Preparation**
   a. Review learning objectives and case scenarios
   b. Review ETAT content that is illustrated in the scenarios
   c. Review process for using case scenarios
      i. Participants may work alone or as a group.
      ii. Participants may be asked to review each other’s performance at the end of the scenario.

2. **Equipment:** There is no equipment required for these scenarios. Manikins may be used as props.

3. **General principles**
   a. Begin by reviewing the learning objectives for Module 1:
      • Understand the importance of continually assessing the medical needs of all children from arrival at the healthcare facility until discharge
      • Recognize emergency (ABCD) and priority signs
      • Assign children triage categories, based on emergency and priority signs
      • Identify the appropriate immediate response for children in each triage category
   b. All of these objectives will be covered in this station, using case scenarios. The specific objectives illustrated in each scenario will be described at the beginning of the case.
   c. Describe how the case scenarios will be presented
      i. The idea is to present the case as it would unfold in a real clinical situation. The facilitator will provide clinical information and may ask questions that will prompt the participant to give the appropriate response.
      ii. The participant should respond as s/he would in a real clinical situation. The participant may ask for additional clinical information.
      iii. The facilitator may ask the participant to demonstrate interventions.
      iv. Learning objectives will be reviewed again at the end of the case.

4. **Record keeping:** complete participant evaluation forms

Case scenarios: ETAT Module 1, Triage

Case #1 Coma

Learning Objectives for Case Scenario #1:
- Importance of evaluating patient immediately upon arrival
- Recognize emergency sign (coma)
- Identify immediate response to patient with emergency sign
Facilitator says: A mother comes to the registration desk with her infant wrapped in a blanket.

Facilitator says: What should you do in order to assess the infant?

Participant says: Ask the mother to unwrap the baby.

Facilitator says: The baby is limp and unresponsive.

Facilitator says: What is the baby’s triage condition?

Participant says: Emergency (Coma).

Facilitator says: What should you do?

Participant says: Call for help.

Teaching points
- Must unwrap the infant in order to perform rapid assessment
- Recognize U (unresponsive), coma
- Immediate response should be to call for help.

Case #2: Convulsion

Learning Objectives for Case Scenario #2:
- Recognize emergency sign (convulsion)
- Identify immediate response to patient with emergency sign

Facilitator says: You are walking past the pharmacy waiting area and you see a child lying on the bench, unresponsive with rhythmic movements of arms and legs.

Facilitator says: Is this an emergency sign?

Participant says: Yes. The child is having a convolution.

Facilitator says: What is the child’s triage category?
Participant says: Emergency (Convulsion).

Facilitator says: What should you do?

Participant says: Call for help.

Teaching points

- Recognize convulsion (an emergency sign)
- Immediate response should be to call for help.

Case #3: Respiratory distress

Learning Objectives for Case Scenario #3:
- Recognize emergency sign (respiratory distress)
- Identify immediate response to patient with emergency sign

Facilitator says: A caretaker calls you to the waiting room because she is concerned about the child sitting next to her. The infant is pale and appears anxious.

Facilitator says: Is this baby sick or well?

Participant says: He is sick.

Facilitator says: What should you do next?

Participant says: Assess airway and breathing.

Facilitator says: There is no noisy breathing. The respiratory rate is rapid and there is marked indrawing of the chest.

Facilitator says: Describe his respiratory status.

Participant says: Increased work of breathing.

Facilitator says: What is his triage category?

Participant says: Emergency (Breathing-respiratory distress).

Facilitator says: What should you do?
Participant says: Call for help.

Teaching points

- Recognize respiratory distress (an emergency sign)
- Immediate response should be to call for help.

Case #4: Tiny baby

Learning Objectives for Case Scenario #4:
- Recognize priority sign (tiny baby)
- Identify immediate response to patient with a priority sign

Facilitator says: A mother sits down at the registration desk with her newborn infant. The baby is pink and alert.

Facilitator says: What is the baby’s overall condition?

Participant says: She is well-appearing, without emergency signs.

Facilitator says: The mother states that the baby is 3 weeks old and weighed 2.5 kilograms at birth.

Facilitator says: What is her triage category?

Participant says: Priority (tiny baby).

Facilitator says: What should you do?

Participant says: Notify the triage nurse.

Teaching points

- Recognize priority sign (tiny baby)
- Review why tiny baby is a priority
  - More difficult to assess properly
  - More likely to get serious infections
  - More likely to deteriorate quickly
- Immediate response of non-healthcare provider should be to notify triage nurse.
Case #5: Temperature

Learning Objectives for Case Scenario #5:
- Recognize priority sign (temperature)
- Identify immediate response to patient with a priority sign

Facilitator says: A caretaker runs up to the gate of the centre with her toddler. She is crying that the boy had a convulsion at home and that he has a fever. He is playing with his sister.

Facilitator says: Does the child have any emergency signs?

Participant says: No.

Facilitator says: What is his triage category?

Participant says: Priority (Temperature-fever).

Facilitator says: What should you do?

Participant says: Notify the triage nurse.

Teaching points
- Recognize priority sign (temperature)
- Review that history of convulsion is not an emergency sign
- Immediate response of non-healthcare provider should be to notify triage nurse.

Case #6: Severe dehydration

Learning Objectives for Case Scenario #:
- Recognize emergency sign (severe dehydration)
- Identify immediate response to patient with emergency sign

Facilitator says: As you walk through the waiting room, you notice a lethargic small child lying in his mother’s lap. His eyes are sunken. His mother says that he has had diarrhea for 3 days.

Facilitator says: What is his triage category?

Participant says: Emergency (Dehydration-He is lethargic, has sunken eyes, and has had diarrhea).
Facilitator says: What should you do?

Participant says: Call for help.

Teaching points

- Recognize emergency sign (severe dehydration)
- Immediate response should be to call for help.