not be underestimated. Considering spinal immobilization, Not insufficient consideration given the high-energy trauma mechanism.

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(P2-94) How One Group of Physicians Helped a Busy Emergency Department

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A pilot admission leadership physician (ALP) program was experimented within a 693-bed, tertiary medical center with a 60-bed emergency department. This trial was intended to investigate whether having a physician triage potential patients would shorten patients' length-of-stay in the emergency department. After a emergency physician evaluated patients, ALP triaged them. The ALP ordered the appropriate bed for the patients if they qualified for the inpatient criteria, choosing among medical, medical telemetry, cardiac telemetry, intermediate care, or intensive care bed. The mean patient door-to-bed order time (time between patients reaching the emergency department to time to bed ordered by ALP) is 330.7 minutes (n = 234, SD = 151.68, 95% CI = 310.21–351.28) with ALP involvement. Compared with the mean door-to-bed order time of 337.8 minutes (n = 827, SD = 149.71, 95%CI = 326.98–348.57) without ALP, ALP shortened the waiting time by 7.09 minutes. During the same period, the door-to-physician time was 41.38 minutes (SD = 38.87 95%CI = 36.38–46.39), compared with 39.52 minutes (SD = 40.32, 95%CI = 36.77–42.27) before ALP. The time for patients waiting in the emergency department for other services such as surgery, psychiatry, and pediatrics also have decreased accordingly. Incorrect medical admissions such as scrambling to get the patient to the intensive care unit right after seeing patients has decreased (data not provided). Identifying physicians as physicians in the emergency department who triage potential admissions also has improved efficiencies within the hospital medicine group and bonding with ER physicians.

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(P2-95) Pre-Decontamination Triage for Hazmat Casualties Involving an Unknown Chemical

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Pre-decontamination triage aims to prioritize the use of decontamination facilities for casualties based on their severity of injuries. Pre-decontamination triage aims to: (1) ensure severe casualties undergo early decontamination, in order for them to receive early definitive medical treatment post-decontamination; (2) provide basic life support measures, e.g., stopping external hemorrhage, use of bag valve mask ventilation, even before decontamination; (3) early administration of antidotes for organophosphate poisoning (if present). Triage during the pre-decontamination takes place in the warm zone. Triage personnel must don personnel protective equipment (PPE) of level C or above. Donning PPE will decrease the visual, aural and tactile senses of triage personnel, adversely affecting their ability to carry out effective triage. With these limitations in mind, a pre-decontamination triage system was devised, modified from the Simple Triage and Rapid Treatment (START) protocol. Assessment will be based on the presence of airway, breathing, or circulatory compromises, or changes in mental status, similar to the START protocol. Recognition of organophosphate poisoning prior to decontamination is emphasized, as the toxidrome is recognizable and specific. Once organophosphate poisoning is diagnosed, the severity of the poisoning is graded and antidote administration is carried out using the Mark I Kits. The need to be certain of the diagnosis of organophosphate poisoning before administration of Mark I Kits is emphasized. The diagnosis may not be apparent initially to the triage personnel till a spectrum of patients with toxidromes suggestive of organophosphate poisoning has been seen.

Keywords: decontamination; organophosphate poisoning; pre-decontamination; toxidrome; triage
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(P2-96) A Single, Simple Triage Method

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Introduction: At this time, no triage method is considered better than another in comparison to the outcome of the casualties. It is important and useful to identify a triage method that can be used for both adults and children at the same time. It should consider the anatomical and physiological differences between adults, children, and infants.
Objectives: To revise and adapt the current triage system in use in the Piemonte Emergency Medical Services for the first triage in a validated method that is effective for adults, children, and babies in order to unify and simplify the triage system.
Methods: In accordance with pediatricians, the "Triage Sieve" procedure and parameters were revised into a single method.
Results: Setting the height of the casualty was considered to be both quick and easy. In this revised method, all the casualties are classified with the sieve methods, but some changes have been introduced. Casualties with a stature < 59 cm are classified as infants, and are therefore priority T1 (red) in every case. Casualties > 60 cm but < 120 cm in stature are classified as children. Children with a respiratory rate < 15 or > 40 breaths per minute and a heart rate < 80 or > 160 beats per minute are classified as T1.
Conclusions: Children will probably be over-triaged in this method, but the authors do not consider that a substantial problem. This first triage system is simple and effective. But, it has not yet been tested effectively during an actual mass-casualty incident or disaster.

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