WHITE PAPER

Field Triage

SALT MASS CASUALTY TRIAGE

It is recognized that there is a need for a national standard for mass casualty triage, as disasters frequently cross jurisdictional lines involving responders from multiple agencies. After reviewing all of the existing triage systems a consensus review panel found that there was insufficient evidence to support one system over the others. Using aspects of the existing systems and based on best evidence, SALT (Sort –Assess - Life Saving Interventions - Treatment and/or transport) was developed as a national all-hazards mass casualty initial triage standard for all patients (e.g., adults, children, special populations). SALT was designed to allow agencies to easily incorporate it into their current MCI triage protocol through simple modification.

STEP 1: SORT

SALT begins with a global sorting of patients, prioritizing them for individual assessment. Patients who can, should be asked walk to a designated area and should be assigned last priority for individual assessment. Those who remain should be asked to wave (i.e., follow a command) or be observed for purposeful movement. Those who do not move (i.e., are still) and those with obvious life threat should be assessed first since they are the most likely to need life saving interventions.

STEP 1: Group Sorting

Priority 1: Still/Obvious life threat

Priority 2: Wave/Purposeful movement

Priority 3: Walk

STEP 2: ASSESS

The individual assessment should begin with limited rapid lifesaving interventions:

- Controlling major hemorrhage through the use of tourniquets or direct pressure provided by other patients or other devices
- Opening the airway through positioning or basic airway adjuncts (no advanced airway devices should be used)
- If the patient is a child, consider giving 2 rescue breaths
- Chest decompression
- Auto injector antidotes

LSI should only be performed within the responder's scope of practice and only if the equipment is immediately available.

Patients should be prioritized for treatment and/or transport by assigning them to one of five categories: Immediate, Expectant, Delayed, Minimal, Dead. Patients who have mild injuries that are self-limited if not treated and can tolerate a delay in care without increasing their risk of mortality should be triaged as minimal and should be designated with the color green. Patients who are not breathing even after life-saving interventions are attempted should be triaged as dead and should be designated with the color black. Patients who do not obey commands, or do not have a peripheral pulse, or are in respiratory distress, or have uncontrolled major hemorrhage should be triaged as immediate and should be designated with the color red. Providers should consider if these patients have injuries that are likely to be incompatible with life given the currently

SALT Triage F.A.Q.

Why a national standard?
Standardizing triage technique and category names is expected to decrease confusion when crossing agency and jurisdictional lines. We know disasters frequently cross jurisdictional lines and/or require additional responders to be deployed from across the country, thus a national standard will allow all responders to use the same language and processes.

What makes this better than the other systems? How can you make a new system without validating it?
SALT triage is based on the existing triage systems. We critically evaluated all of the other triage systems and created a standardized system that is based on the others using the best scientific data available and expert opinion. SALT will be adjusted as more scientific data becomes available. Additionally, this triage system can be used by industry to develop products to support the system, but SALT is not proprietary and is in the public domain so it can be easily evaluated and improved.

Is this a proprietary system?
No, SALT is in the public domain.

What about communities that have made large investments in other systems?
For most systems only minor changes would be needed to make them compatible with SALT triage since SALT is based on the existing systems.

Who could be trained to use SALT?
Responders of all levels could be trained in SALT. The individual patient assessment is designed to be used by people with any level of training. Further, since there is an emphasis on re-evaluation, as higher trained responders arrive on scene they will be able to re-sort and refine the triage decisions that lower level providers have made.

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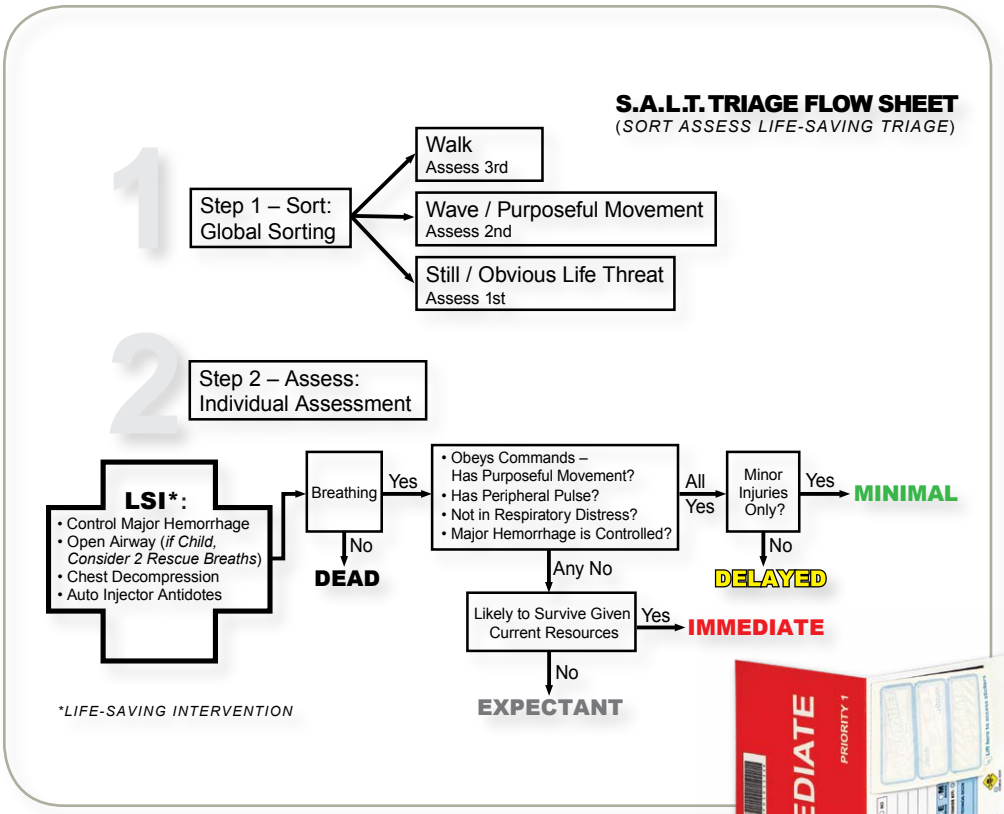
available resources; if they are then the provider should triage these patients as expectant and should be designated with the color gray. The remaining patients should be triaged as delayed and should be designated with the color yellow.

This prioritization process is dynamic and may be altered by changing patient conditions, resources, and scene safety. Triage labeling systems should account for the dynamic nature of triage and be easily modifiable for a single patient. After immediate patients have been cared for patients designated as expectant, delayed, or minimal should be re-assessed as soon as possible with the expectation that some patients will have improved and others will have decompensated. In general, treatment and/or transport should be provided for immediate patients first, then delayed, and then minimal. Expectant patients should be provided with treatment and/or transport when resources permit. Efficient use of transport assets may include mixing categories of patients and using alternate forms of transport. Some patients may only require treatment at the scene and not transport.

Figure 1: SALT Triage Scheme



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Why has an expectant category been included?
The expectant category is resource based. It is only needed if there are not enough resources at the scene to meet all of the demand. This allows providers to focus resources on potentially salvageable patients rather than applying resuscitation resources to those who are unlikely to survive. Further, we wanted to make sure that it was easy to find dying patients so they could receive resuscitation or comfort care when resources allow. These patients should be re-evaluated as resources become available and they should be easy to identify rather than having to be found amongst the victims who are dead.

Will receiving hospitals & treatment facilities be able to use SALT?
Although SALT was designed for use at the scene of an incident it can be used at treatment facilities as well. Particularly, for victims who self-refer to these locations. Facility staff can be trained to use SALT.

Does SALT apply to special patient populations?
Yes, SALT is intended to work for any patient regardless of their age, or physical or mental limitations. If a victim can not walk or follow commands they would simply be assessed individually sooner than those who can. Further, we have modified our individual assessment to account for the physiologic differences of children.

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