

Draft position statement 10/4/07

This field triage decision scheme, originally developed by the American College of Surgeons Committee on Trauma, was revised by an expert panel representing emergency medical services, emergency medicine, trauma surgery, and public health. The panel was convened by the Centers for Disease Control and Prevention (CDC), with support from the National Highway Traffic Safety Administration (NHTSA).

Mass casualty triage is a critical skill. Although many systems exist to guide providers in making triage decisions, there is little scientific evidence available to demonstrate that any of the available systems have been validated. Furthermore, in the United States there is little consistency from one jurisdiction to the next in the application of mass casualty triage methodology. There are no nationally agreed upon categories or color designations. To address this need, a consensus committee evaluated and compared commonly used triage systems to develop a new national mass casualty triage guideline. This new proposed guideline, entitled SALT (Sort, Assess, Life-saving interventions, Treatment and/or transport) Triage, was developed based on the best available science and consensus opinion. It incorporates aspects from all of the existing triage systems to create a single overarching guide for unifying the mass casualty triage process across the United States. (Disaster Med Public Health Preparedness. 2008; 2 (1): S25-S34)

The SALT Triage guideline was supported by the Department of Health and Human Services, Centers for Disease Control and Prevention as part of the Terrorism Injuries: Information Dissemination and Exchange (TIIDE) grant. The consensus committee included an expert panel of work group participants that included members from:

- The American College of Emergency Physicians
- The American Medical Association
- The American College of Surgeons-Committee on Trauma
- The National Association of Emergency Medical Technicians
- The National Association of State Emergency Medical Service Officials
- The National Association of EMS Physicians
- The Native American Emergency Medical Services Association
- Other additional participants

This group recognized that there is the need for a national standard for mass casualty triage, as disasters frequently cross jurisdictional lines involving responders from multiple agencies. The committee workgroup reviewed existing triage systems in the United States and evaluated the scientific evidence available to support each system. An exhaustive literature review was performed identifying nine existing triage systems. SALT represents the committee's position on which elements of those nine triage systems were most effective and could be included in a proposed national all-hazards mass casualty triage guideline that can be utilized on adults, children, and special populations.

SALT Triage consists of four activities: global sorting of patients using voice commands, life-saving interventions that can be quickly performed, individual assessment and assignment of a priority category, and provision for treatment and/or transport.

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, such as obvious uncontrolled hemorrhage, should be assessed first since they are the most likely to need life saving interventions.

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. A consensus committee 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.

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. they should be easy to identify rather than having to be found amongst the victims who are dead.

STEP 1: Group Sorting

- Priority 1:** Still/Obvious life threat
- Priority 2:** Wave/Purposeful movement
- Priority 3:** Walk

STEP 2: Assess

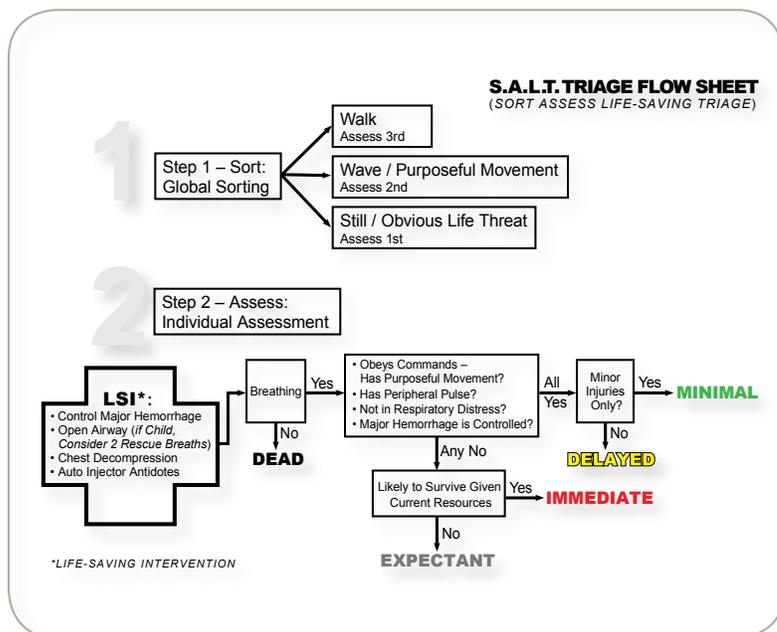
The first priority during the individual assessment is to provide lifesaving interventions. These include controlling major hemorrhage; opening the patient's airway; decompressing the chest of patients with a tension pneumothorax; and providing antidotes for chemical exposures. These interventions were identified because they can be performed quickly and can have a significant impact on patient survival. Life-saving interventions are to be completed before assigning a triage category and should only be performed within the responder's scope of practice and if the equipment is readily available.

Once the lifesaving interventions are provided, patients are prioritized for treatment based on assignment to one of five color-coded categories. 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 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 deteriorated.

In general, treatment and/or transport should be provided for immediate patients first, then delayed, and then minimal. The Expectant category will be needed only if there are not enough resources available to handle the demand and allows providers to focus on those casualties with potentially survivable injuries. This category is flexible and dynamic to ensure that should additional resources become available, they should be reevaluated and have their triage categorization changed as appropriate. 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



- Lerner, E. Brooke, Schwartz, Richard, Wedmore, Ian, et al: Mass casualty triage: an evaluation of the data and development of a proposed national guideline. Disaster Med Public Health Preparedness. 2008; 2 (Suppl 1): S25-S34.
- Wedmore, I. & Schwartz, R. (2007). Development of a national standard for mass casualty triage: SALT Triage. Power point presentation.

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.

Will receiving hospitals and 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 cannot 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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