DISASTER TRIAGE

Administrative 1.10

I. SPECIFIC INFORMATION

During instances of Multi-Casualty Incidents, integration of disaster scene operations as provided by Law, Fire, and EMS agencies is a high priority.

A. Triage: Triage is the sorting of casualties and is, therefore, one of the most important functions to be performed at the scene of a disaster. Triage is a continuous process; it is necessary to re-evaluate all patient priorities, as resources become available. The most seriously injured persons can be quickly identified by:

   1. Evaluating respiratory rate
   2. Evaluating perfusion
   3. Evaluating mental status

B. Establish Priorities: Casualties are sorted into four (4) categories:

   1. Immediate (RED); Those who have serious injuries or medical problems (salvageable life threatening problems, taking into account the resources available);

      a. Airway and breathing difficulties which can be readily alleviated with head tilt and OPA insertion
      b. Gross bleeding controlled by direct pressure

   2. Delayed (YELLOW): Those for whom treatment and transportation can be delayed while more seriously injured persons receive care.

   3. Minor (GREEN): Those patients who can ambulate to an alternative location without assistance.

   4. Dead/Dying (BLACK): Those patients who do not resume spontaneous breathing after positioning of the head and insertion of an OPA, and have no spontaneous pulse. These patients should be retriaged, as resources become available.

II. IDENTIFICATION PROCEDURE

The Triage Tag is to be the identification tag used during a disaster situation. This is an organized system that incorporates the use of a heavy cardboard, color-coded tag with removable tabs.

A. Four (4) tabs are color coded for expedient identification of priority:

   1. IMMEDIATE (Red): Highest priority
   2. DELAYED (Yellow): Second priority
   3. MINOR (Green): Third priority
   4. DEAD/DYING (Black): Lowest priority

B. The tags also contain a bar code and numbers on each tab and the main body of the tag. These identifiers are maintained by the triage officer, the transport officer, and the hospital to facilitate patient tracking.

III. DISASTER SCENE OPERATIONS

Follow approved area or agency specific Incident Management System procedures. Integrate activities of Law, Fire, and EMS agencies.

A. When removing patients from a hazardous area:

1. Survey scene for potential hazards, number of patients, need for specialized help
2. Call for medical or technical backup as needed
3. Protect rescuers first; treat gas spills, remove power lines, etc.
4. Implement hazardous materials management procedures
5. Stabilize vehicle prior to entry
6. Perform primary survey and treat airway difficulties and severe bleeding first
7. If patient has no pulse or respirations and extrication is necessary before CPR can be provided, the patient should be considered dead
8. Triage patients and assign to available medical personnel
9. Apply cervical collar, immobilize spine prior to extrication
10. Perform quick secondary survey as possible; splint extremity fractures, if possible
11. Expedite safe extrication by specialists after management of life-threatening problems.
12. Perform or repeat complete secondary survey once patient is extricated.

B. Triage area: The triage area should be safely located away from the dangers of the hazard, generally uphill and upwind of the hazard.

C. Incoming ambulances: As incoming ambulances arrive, they should be directed to the staging officer at the staging area. They should not be driven to the triage area.

D. Ambulance assignments: Ambulance crews should remain with their ambulances until given an assignment by the medical commander. Keys are to remain in the vehicles.

E. Ambulance supplies: The ambulance supplies and equipment should be placed in a supply pool that is near the treatment area, and a responsible EMT provider placed in charge of the pool.

F. Volunteers: Volunteers can and should be used at a disaster scene to free firefighters, rescuers, and ALS personnel from activities that take them away from rescue and patient care duties. Volunteers may be used to:

a. Block or control the flow of traffic if there are not enough police officers on the scene.
b. Assist medical personnel in carrying patients from the wreckage to the triage and treatment point.
c. Help to load the ambulances
d. Assist the “walking wounded”
e. Comfort victims and care for children
f. Carry items from the supply pool to the treatment area

G. Sorting for transportation: As soon as victims are treated, a second triage sorts patients for transportation.

H. After Discharge of Patient: As ambulances discharge their patients and return to the scene, they should report directly to the staging officer

I. Special Area for Relatives: A special area should be provided for relatives and friends away from the patient treatment area.

J. Temporary Morgue: Since bodies will not be removed from the scene until all the injured have been transported, a temporary morgue should be established.

IV. COMMUNICATION

A. Communication Network: The command post determines the channel for scene radio communications and informs dispatch.

B. Command will ascertain hospital bed availability and communicate to the transport group.

1. Upon verification of a multi-casualty, multi-facility incident involving trauma patients by a responding EMS agency within SAEMS, MEDS Communication will conduct an area hospital "all-call" to ascertain patient capability/bed availability using START Triage patient classification terminology. Incident Command will distribute patients between the area hospitals according to this capability.

2. The Incident Commander shall be responsible for insuring that the Trauma Center is contacted at the first available opportunity with the following information:
   a. Nature of incident
   b. Number of patients
   c. START Triage category
   d. Adult versus pediatric (if known/available)
   e. Any additional pertinent information (relatives, burns, decon)

3. Once en-route, direct, on-line communication between the transporting unit and the receiving facility is ideal; however, hospitals may only receive a courtesy notification of incoming patients.

4. The Trauma Center is able to assist in determining patient distribution and communication with the receiving hospitals.

C. Once a disaster or multi-casualty incident is declared, appropriate regional treatment algorithms may be implemented without further receiving facility contact. Patients requiring ALS level care can be transported by BLS providers if absolutely necessary.

D. Transporting: As soon as the victims are ready for transportation, ambulances should be called from the staging area. Radio Amateur Civil Emergency Services (RACES) volunteers may provide additional support to the transport sector for communicating patient and resource information between the hospitals and the disaster scene.

E. In outlying areas (> 30 min transport to Level 1 Trauma Center):

Outside the Tucson metropolitan area, follow the above protocol if the patient is to be transported directly from the scene to a Tucson Level 1 Trauma Center. If this is not the case, contact and transport to the closest hospital for stabilization. In these circumstances, the

receiving facility, provided it is a medical direction authority, will provide on-line medical direction. If the patient is not being transported directly to the Trauma Center, and the receiving facility is not a medical direction authority, the EMS crew will contact their administrative medical direction authority for treatment and destination orders.

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