# ***Multi-Casualty Incident Plan***

## ***Attachment B***

## ***Triage***

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Orange County Fire Chiefs' Association

Orange County Fire Services

Operational Plan

# PERFORMING TRIAGE

Triage will be performed using the Simple Triage and Rapid Treatment (START) Triage System.

Triage ribbons should be used for initial triage of patients on Multi-Casualty Incidents. Patients triaged with ribbons will be assigned a triage tag once a treatment team is committed to the patient.

***Note: A complete patient assessment will take place when a treatment team is assigned to the patient and every patient leaving the scene shall have a triage tag assigned to them.***

If appropriate resources are available, provide immediate spinal immobilization when dealing with potential spinal injuries.

Triage personnel will report the number of patients and triage category to their supervisor as soon as that information is available.

**Utilizing the Ribbons**

- Initial triage should be performed with Ribbons indicating patient acuity.
  - **Black/White** – Deceased or expectant
  - **Red** – Immediate
  - **Yellow** – Delayed
  - **Green** – Minor
- Ribbons should be placed on a visible limb of the patient and can also be used to identify vehicles or locations of patients.
- Patient catagories and numbers should be documented and returned to the Triage Unit Leader, if establihsed.

**Utilizing the Triage Tags**

- When using the triage tags for initial or secondary triage, tear off all tabs below the desired triage category and discard.
- Both halfs designated tabs should be left in place to designate the triage category.
- If the patient is moved to a treatment area, one tab may be torn off and given to the treatment area manager for tracking.
- The triage tag should be utilized for documentation of patient treatment and patient tracking.

**Litter Teams** - On incidents that require separate ambulance staging and loading areas or treatment areas, litter teams can be utilized to move patients from the triage area to the treatment or transport area. It takes 3 or 4 persons to make up a litter team.

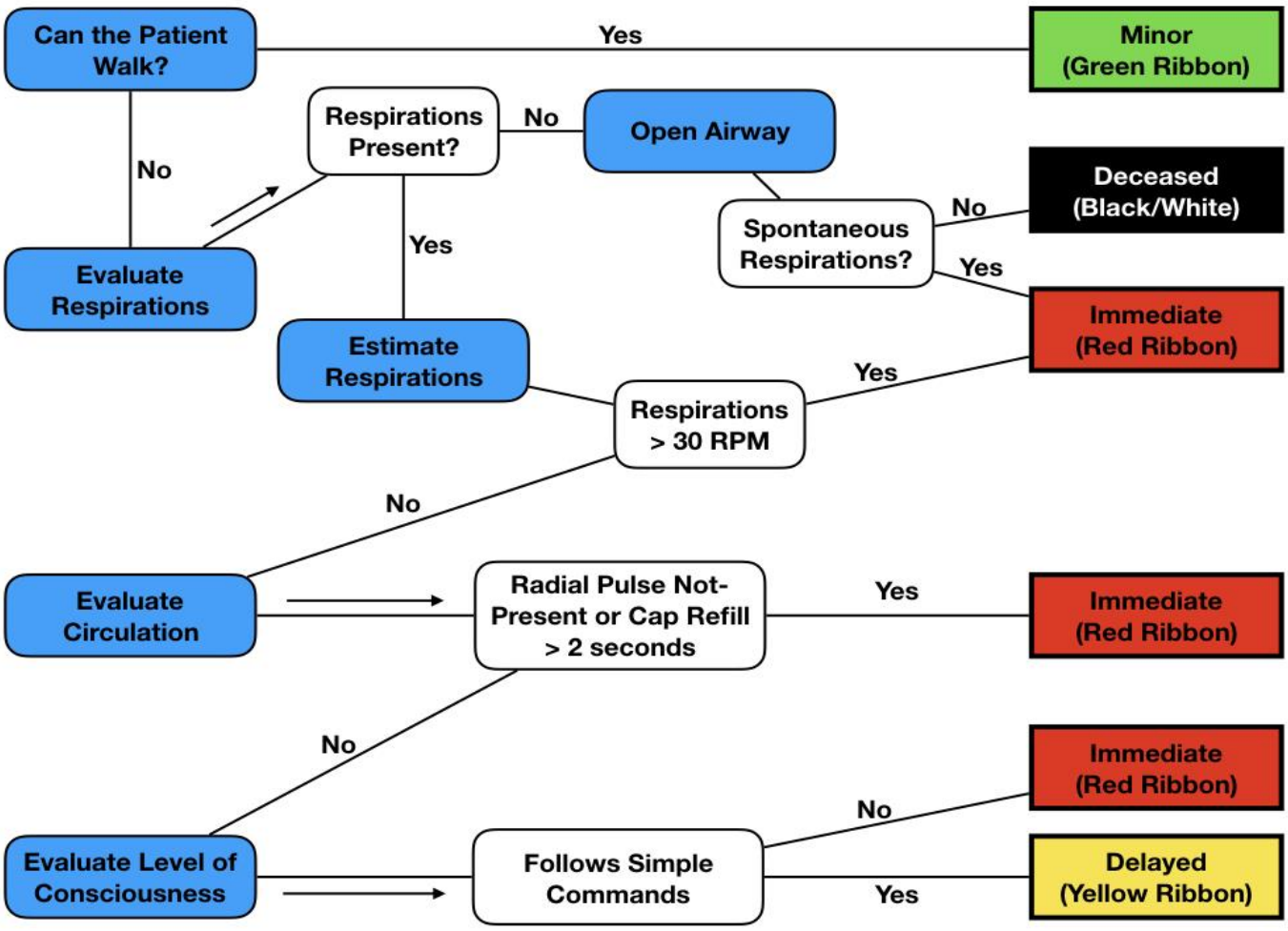
# START TRIAGE

***Simple Triage and Rapid Treatment***

Triage in an MCI should follow the "**30-2-CAN DO**" assessment to determine the acuity level of each patient and the need for immediate treatment and transport.

For smaller incidents, the use of a modified START triage system is necessary to ensure proper spinal precautions are taken when available.

- In traumatic events, when spinal immobilization and resources are available, do not have the patients stand up and walk to a designated area.
- All patients that self-extricate or move from the original place of injury may be designated a ***Minor***. Direct to a predetermined location for further evaluation.
- All patients that stay in their original positions will be designated ***Immediate*** or ***Delayed***.



# JUMP START TRIAGE

***JumpSTART©*** *Pediatric Mass Casualty Incident (MCI) Triage Tool* is an objective triage system that addresses the needs of children and can be a resource tool when planning a triage process for pediatric patients. Although the **JumpSTART©** system parallels the START system, it takes into consideration the developmental and physiological differences of children by using breathing as the cornerstone for triage decisions. Adding a respiratory component to the triage system may increase triage time by 15-25 seconds, however, since the number of patients requiring a ventilatory trial would most likely be small, it is not thought to significantly affect overall triage time for an incident.

Additionally, since the physiologic indicators specified for START are not generally applicable to the pediatric victim, different criteria are needed to assess young patients. For example, neurological status under START depends on the patient's ability to obey commands. This index is clearly not applicable to young children who lack the developmental ability to respond appropriately to commands.

The **JumpSTART©** Pediatric MCI triage system is designed for triaging infants and young children. Determining the appropriate system to use in the pre-adolescent and young teen population can be sometimes challenging, so the current recommendation is: If a victim appears to be a child, use **JumpSTART**; if a victim appears to be a young adult, use **START**.

**JumpSTART©** uses the same triage categories as **START**: **IMMEDIATE**, **DELAYED**, **MINOR**, and **EXPECTANT/ DECEASED**.

In children, because of anatomical/physiological reasons such as weak intercostal muscles or mechanical airway obstruction, apnea may occur rapidly. **Thus circulatory failure usually *follows* respiratory failure**. There may be a period of time when the child is apneic but continues to maintain a pulse. It is during this time that airway clearance and a ventilatory trial may stimulate spontaneous breathing. If spontaneous breathing begins, the child is categorized as **IMMEDIATE** for further treatment. If spontaneous breathing does not follow the initial ventilatory trial, the child is categorized as **EXPECTANT/DECEASED** or non-salvageable.

The triage steps of the JumpSTART© Pediatric MCI triage system are as follows:

**Step 1:** All children who are able to walk are directed to an area designated for minor injuries where they will undergo a secondary and more involved triage. Infants carried to this area or other non- ambulatory children taken to this area must undergo a complete medical and primary evaluation using modifications for non-ambulatory children to ascertain triage status

**Step 2:** a) All remaining non-ambulatory children are assessed for the presence/absence of spontaneous breathing. If spontaneous breathing is present, the rate is assessed and the triage officer moves on to step three.

b) If spontaneous breathing is not present and is not triggered by conventional positional techniques to open the airway, palpate for a pulse (peripheral preferred). If no pulse is present, patient is tagged **DECEASED/EXPECTANT** and the triage officer moves on.

c) If there is a palpable pulse, the rescuer gives five breaths (approximately 15 sec.) using mouth to mask barrier technique. If the ventilatory trial fails to trigger spontaneous respirations, the patient is tagged **EXPECTANT/DECEASED** and the triage officer moves on. However, if respirations resume, the patient is tagged **IMMEDIATE** and the triage officer moves on **without** providing any further ventilations.

**Step 3:** If the respiratory rate is 15-45/minute, proceed to checking perfusion. If the respiratory rate is less than 15 (less than 1/every 4 seconds) or faster than 45/minute or irregular, tag as **IMMEDIATE** and move on.

**Step 4:** Assess perfusion by palpating pulses on a (seemingly) uninjured limb. If pulses are palpable, proceed to Step 5. If there are no palpable pulses, the patient is tagged **IMMEDIATE** and the triage officer moves on.

**Step 5:** At this point all patients have “adequate” ABCs. The triage officer performs a rapid AVPU assessment of mental status. If the patient is Alert, responds to Voice, or responds appropriately to Pain (withdraws from stimulus or pushes away), the patient is tagged **DELAYED** and the triage officer moves on. If the patient does not respond to voice and responds inappropriately to pain (moans or moves in a non-localizing fashion) or is Unresponsive, an **IMMEDIATE** tag is applied and the triage officer moves on to the next patient.

**NOTE**: All patients tagged **EXPECTANT/DECEASED**, unless clearly suffering from injuries incompatible with life, should be reassessed once critical interventions for **IMMEDIATE** and **DELAYED** victims are completed.