A. Introduction

This procedure is based on the Simple Triage and Rapid Treatment or START method. The START method of triage is designed to assess a large number of victims rapidly and can be used by all personnel regardless of their medical training. This procedure is intended for use by the first arriving unit whenever an MCI is declared and/or a Casualty Collection Point (CCP) is established. Due to physiological differences in children, an adaptation of the START triage method is used called JumpSTART.

B. Procedure

EMR/BLS

1. Initial Triage:

    a) Locate and direct all the walking wounded to one location away from the incident if possible. Assign someone to keep them together and for triage. Direct casualties to control bleeding by self-aide if available.

    b) Begin assessing **all non-ambulatory victims** where they are found.

    c) Use the START Method (**Section C**) for adult patients and JumpSTART (**Section D**) for pediatric patients.

    d) Use Triage Ribbons. Three rings of ribbons are located in the Triage kit.

    e) One ribbon should be tied to an upper extremity in a visible location. The ribbon colors represent the universal colors for triage:

        1. RED - First priority/Immediate Care
        2. YELLOW - Second priority/Delayed Care
        3. GREEN - Third priority/Ambulatory (minor)
        4. BLACK – Deceased (non-salvageable)

    f) Triage to the most urgent priority (e.g., for a Green/Yellow patient, tag as Yellow), when in doubt.

C. START System

1. Corral all the "walking wounded" into one location away from the incident if possible. DO NOT forget to triage these patients. Direct casualties to control bleeding by administering self-aide if available.

2. Begin assessing all non-ambulatory victims where they lay if possible. Each victim should be triaged in **60 seconds or less**.

3. Using the START System, use RPM (**R**espirations, **P**erfusion, **M**ental status) :

a) Assess RESPIRATIONS:

1. If respiratory rate is less than or equal to 30/minute, go to PERFUSION assessment.

2. If respiratory rate is greater than 30/minute, prioritize as RED.

3. If victim is not breathing open the airway, remove obstructions if seen, if patient starts breathing insert OPA/NPA and prioritize as RED.

4. If victim is still not breathing, prioritize as BLACK.

b) Assess PERFUSION:

1. Any major external bleeding should be controlled at this time.
    a. Apply a tourniquet to life-threatening bleeding in limbs. May apply tourniquet over clothing, proximal to the bleeding site, to save time. **(Procedure 48).**
    b. Ensure that the time of tourniquet application ("TK 20:30") is written on the tourniquet itself or written directly on the patient's forehead.

2. Palpate a radial pulse or assess capillary refill time (CR).

3. If radial pulse is present or CR is less than or equal to 2 seconds, go to MENTAL assessment.

4. If no radial pulse or CR is greater than 2 seconds, prioritize as RED.

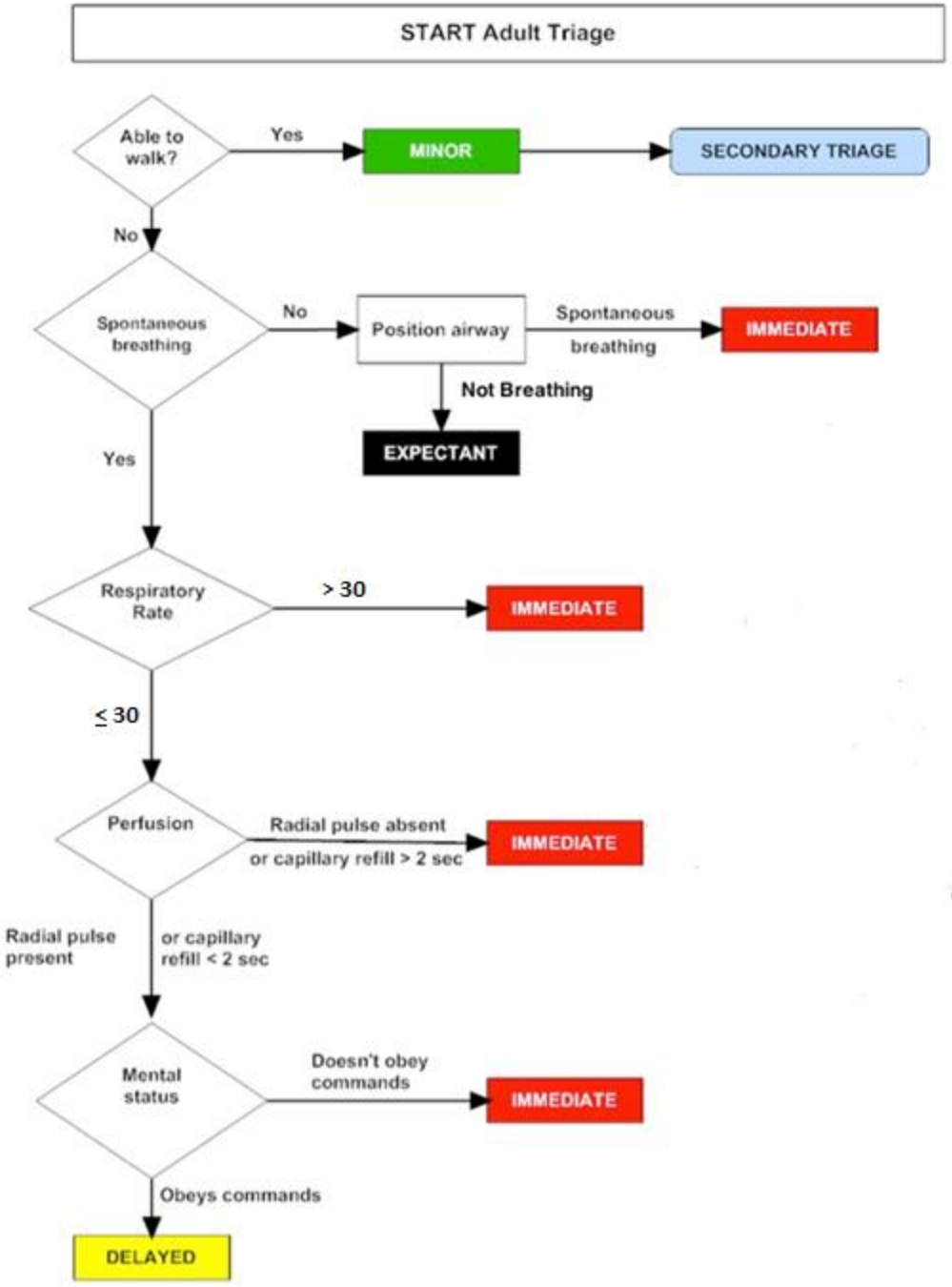
c) Assess MENTAL STATUS:

1. Assess the victim's ability to follow simple commands and their orientation to time, place, and person (Oriented X3).

2. If the victim is walking following commands and is (Oriented X3), prioritize as GREEN.

3. If the victim is **not** ambulatory following commands and is (orientedx3), prioritize as YELLOW.

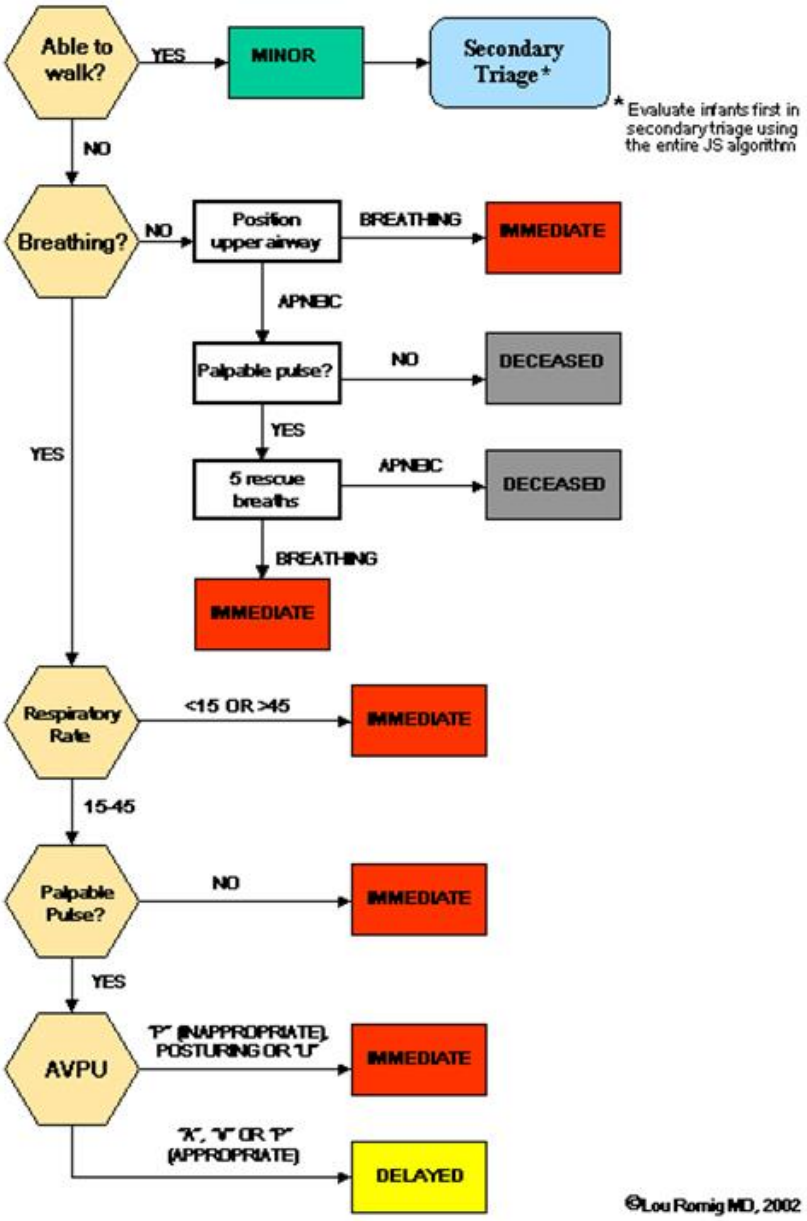
4. If the victim does not follow commands, is unconscious, or is disoriented, prioritize as RED.


START Adult Triage
Able to walk?
Yes
MINOR
SECONDARY TRIAGE
No
Spontaneous breathing
No
Position airway
Spontaneous breathing
IMMEDIATE
Not Breathing
EXPECTANT
Yes
Respiratory Rate
> 30
IMMEDIATE
≤ 30
Perfusion
Radial pulse absent or capillary refill > 2 sec
IMMEDIATE
Radial pulse present
or capillary refill < 2 sec
Mental status
Doesn't obey commands
IMMEDIATE
Obeys commands
DELAYED

D. JumpSTART- Pediatrics

1. Move the 'walking wounded.'
2. Stable RPM/Walking, prioritize as GREEN.
3. Stable RPM/non-ambulatory, prioritize as YELLOW.
4. If encountered with an infant and unable to walk or being carried, use JumpSTART. If the infant does not meet the RED criteria and has no signs of significant injury, infant may be prioritized as GREEN.
5. Using the JumpSTART System, use RPM (**R**espirations, **P**erfusion, **M**ental status) :
    1. Assess <u>RESPIRATIONS</u>:
        1. If respiratory rate is less than or equal to 45/minute or greater than or equal to 15/minute, go to PERFUSION assessment.
        2. If respiratory rate is greater than 45/minute or less than 15/minute, prioritize as RED.
        3. If pediatric victim is not breathing with pulse, open the airway and give 5 ventilations, if respirations RESUME, prioritize RED.
        4. If victim is still not breathing, prioritize as BLACK.
    2. Assess <u>PERFUSION</u>:
        1. Any major external bleeding should be controlled at this time.
            1. Apply a tourniquet to life-threatening bleeding in limbs. May apply tourniquet over clothing, proximal to the bleeding site, to save time. **(Procedure 48).**
            2. Ensure that the time of tourniquet application ("TK 20:30") is written on the tourniquet itself or written directly on the patient's forehead.
        2. Palpate a radial pulse or assess capillary refill time (CR).
        3. If radial pulse is present or CR is less than or equal to 2 seconds, go to MENTAL assessment.
        4. If no radial pulse or CR is greater than 2 seconds, prioritize as RED.
    3. Assess <u>MENTAL STATUS</u>:
        1. Assess Mental Status using (AVPU) Alert/Verbal, prioritize as YELLOW.
        2. Pain/Unresponsive, prioritize as RED.

JumpSTART Pediatric MCI Triage©



E. Special Considerations

1. The first assessment that produces a RED Ribbon stops further assessment. Tag the patient and move on to the next patient.

2. Only correction of life-threatening problems, such as airway obstruction or severe hemorrhage that can be controlled with tourniquet treatment should be managed during the triage phase.

3. Direct casualties to control bleeding by self-aide if available.

4. Triage personnel should carry only minimal equipment limited to ribbons, bandages, tourniquets/bleeding control kits and possibly airway adjuncts (oropharyngeal airways).

5. Do not waste time cutting off clothing to assess/locate the wound site of life-threatening bleeding during the triage phase. Apply tourniquet over clothing, proximal to the site of bleeding, and as high up the limb, tight as possible ("high & tight").

6. The use of wound packing, chest seals and needle decompression shall be instituted ONLY AFTER initial triage of accessible patients and tourniquet application in appropriate patients.

7. Bleeding control measures properly applied by non-MDFR personnel will be reassessed only AFTER all accessible patients have been triaged.