**Catastrophic Disaster Response Staff Officers Handbook 06-08**

**Triage**

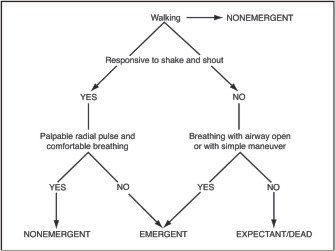
The key to managing MASCAL situations is triage. Triage is the process of sorting casualties based on the severity of injury and assigning priorities of care and evacuation in a situation with limited resources. The goal is to provide the greatest good for the greatest number of casualties. Medical providers, at all levels of care, must institute a uniformed system to classify casualties and assign treatment priorities..

**Triage categories.** Triage categories were originally developed for MASCAL management in combat environments. Most military medical personnel are familiar with this system. The same principles apply to the civilian disaster setting, with the major differences being primarily terminology and priority assignment. Table A1-1 depicts triage categories used in combat and natural disasters.

|  |  |  |
| --- | --- | --- |
| **Triage Category: Combat Setting** | **Triage Category: Civilian Setting** | **Category Description** |
| **Immediate** | **Critical** | This group includes those who require lifesaving surgery. The surgical procedures in this category should not be time consuming and should concern only those patients with high chances of survival. |
| **Delayed** | **Urgent** | This group includes casualties who are badly in need of time-consuming surgery, but whose general condition permits delay in surgical treatment without unduly endangering life. Sustaining treatment will be required. |
| **Minimal** | **Minor** | These casualties have relatively minor injuries and can effectively care for themselves or helped by non-medical personnel. Care can be delayed for hours to days. |
| **Expectant** | **Catastrophic** | Casualties in this category have wounds that are so extensive that even if they were the sole casualty and had the benefit of optimal medical resource application, their survival would be unlikely. |

**Table A2-1. Triage categories, combat vs. civilian casualties**

**Assigning triage categories.** Medical personnel must rapidly assess casualties and assign triage categories. A systematic process should be in place to ensure proper identification occurs. A simple algorithm is suggested in Figure A1-1 to assist with this process.



**Figure AB-1: Assigning triage categories**

**Treatment priorities.** When assigning treatment priorities, the first to receive care are those in most critical need (where there is an expectation that an intervention will prevent loss of life, limb, and/or eyesight) with minimal expenditure of time, personnel, and/or other resources.

In the combat setting, triage principles dictate treating casualties in the “expectant” category after all other wounded; thus “expectant” casualties have a high likelihood of dying. Civilian medical personnel, especially in the United States, view this as an unreasonable approach. It is unlikely that resources would be so constrained such that the seriously wounded should have care delayed for any significant amount of time. It is unreasonable to expect rescuers to “condemn” expectant casualties when not in a tactical combat environment.

Table A2-2 outlines treatment priorities for the different triage categories in the combat and civilian settings.

|  |  |  |
| --- | --- | --- |
| **PRIORITY** | **COMBAT CASUALTIES** | **CIVILIAN** **CASUALTIES** |
| 1st | IMMEDIATE | CRITICAL |
| 2nd | DELAYED | CATASTROPHIC |
| 3rd | MINIMAL | URGENT |
| 4th | EXPECTANT | MINOR |

**Table AB-2. Treatment priorities in a combat vs. civilian MASCAL setting**

**Management and treatment**

Every medical unit or facility that responds to a disaster situation requires a MASCAL plan appropriate to their unique operational needs and situation. However, there are several characteristics that are consistent for all MASCAL operations:

* **Triage area.** All casualties should flow through a single triage area. This area should be close to the receiving area (landing zone [LZ], ground routes, decontamination site), have one-way flow, and have clearly marked routes to the treatment areas.
* **Triage officer (TO).** Ideally the TO is a surgeon, but must be a person with clinical experience in evaluating casualties. The TO performs a rapid evaluation of every casualty, assigns them an appropriate category, and directs them to the proper treatment area. The TO is assisted by personnel dedicated to identifying, tagging, and recording triage assignments and disposition.
* **Immediate treatment area.** This area is set up close to and with direct access to the triage area and is composed of the staff and supplies necessary to administer immediate, life-saving aid.
* **Non-immediate treatment area.** All minor and delayed injuries are directed here. This area is staffed and supplied to treat all non-immediate injuries and to hold casualties awaiting evacuation to a higher level of care (i.e., a hospital).
* **Morgue.** This area must be set aside, climate controlled (if possible), and secured from view and interference.

**Techniques and procedures for MASCAL and triage**

* Ensure traffic flow is well marked so all casualties enter the triage area at one location.
* No significant treatment should occur in the triage area. Casualties are sent to the appropriate treatment area for interventions.
* An administrative recorder should walk with the TO to properly document all casualties in a log and use an indelible marker on the casualty’s forehead to mark his triage category.
* Post an administrative person at the entry of the treatment areas to document and regulate casualty flow.
* Dedicate someone to re-triage casualties as they enter each treatment area.
* Have as many non-medical augmentees as possible available to assist with casualty transport (i.e., litter bearers).
* Shift resources from the triage and emergent area to the non-emergent areas as the casualty flow lessens.
* Ensure proper rest cycles for personnel, especially if operations continue beyond 24 hours.
* Be prepared to divert casualties to another facility as resources are exhausted or overwhelmed.

For further, more detailed information on triage and MASCAL, see:

* Emergency War Surgery, 3rd US Revision, 2004, at www.bordeninstitue.army.mil
* Disaster Response: Principles of Preparation and Coordination; Erik Auf der Heide; 1989, at http://orgmail2.coe-dmha.org/dr/index.htm