Triage

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Derived from the French verb trier , triage means ‘to sort’ and is the cornerstone of the management of mass casualties. It aims to identify those patients who will benefit the most by being treated the earliest, ensuring ‘the greatest good for the greatest number’. Numerous studies show that only 10–15% of disaster casualties are serious enough to require hospitalisation. By sorting out the minor injuries, triage lessens the immediate burden on medical facilities. Deciding who receives priority when faced with hundreds of seriously injured victims is a daunting prospect. Triage should be undertaken by someone senior, who has the experience and authority to make these critical decisions. To keep pace with the changing clinical picture of an injured person, triage needs to be undertaken in the field, before evacuation and again at the hospital. Triage areas For e ffi cient triage the injured need to be brought together into any undamaged structures that can shelter a large number of wounded. A good water supply , good lighting and ease of Triage is the earliest e xample of clinical risk management. This is done on the basis of was first used in 1792 by Baron Dominique Jean Larrey , Surgeon in Chief to Napoleon’s Imperial Guard. The concept of triage emerged fr de Santé des Armées so that resources could be used to the optimum – ‘most for the most’. holding, emergency treatment and decontamination (in the event of discharge of hazardous materials). Practical triage Emergency life-saving measures should proceed alongside triage and can actually help the decision-making process. The assessment and restoration of airway , breathing and circulation are critical and are discussed in Chapter 27 . Vital signs and a general physical examination should be combined with a brief history , taken by a paramedic or by a volunteer worker if one is available. Documentation for triage Accurate documentation is an inseparable part of triage and should include basic patient data, vital signs with timing, brief details of injuries (preferably on a diagram) and treatment given. A system of colour-coded tags attached to the patient’s wrist or around the neck should be employed by the emergency medical services. The colour denotes the degree of urgency with which a patient requires treatment (Figure 33.7). Triage categories All methods of triage use simple criteria based on vital signs. A rapid clinical assessment should be made taking into account the patient’s ability to walk, their mental status and the presence or absence of ventilation or capillary perfusion. A commonly used four-tier system is presented in Table 33.1 .

TABLE 33.1 Triage categories. Priority Colour Medical need Clinical status First (I) Red Immediate Critical, but likely to survive if treatment given early Second (II) Yellow Urgent Critical, likely to survive if treatment given within hours Third (III) Green Non-urgent Stable, likely to survive even if treatment is delayed for hours to days Last (0) Black Unsalvageable Not breathing, pulseless, so severely injured that no medical care is likely to help

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