1. **General Guidelines**
	1. SALT stands for Sort, Assess, Life-Saving Intervention, and Treatment/Transport.
	2. Developed by the Centers for Disease Control and Prevention to address limitations in other systems, CDC has proposed SALT as the national standard for MCI triage.
	3. SALT has the advantage of being the **fastest mass casualty triage system**.
	4. **Notify hospitals of any MCI, especially an MCI involving contaminated victims.**
		1. **Consider use of the Regional Hospital Notification System (RHNS).**
2. **Primary and Secondary Triage Prior to Transport**
	1. Initial Triage:
		1. Use triage ribbons (color-coded strips), not ~~triage~~ Treatment Tags, during initial triage.
		* Do **not** use Tags initially – they slow the triage process. That’s why we now call them Treatment Tags.
		* During an MCI, Treatment Tags are often the only documentation of EMS assessments and treatments.
		1. Tie the triage ribbon to an upper extremity in a VISIBLE location (on the right wrist, if possible).
		2. SALT Triage Levels:
			1. **RED – Immediate**
			2. **YELLOW – Delayed**
			3. **GREEN – Minimal**
			4. **GRAY – Expectant** (The patient is unlikely to survive given the *current* resources)
			5. **BLACK – Dead** (black & white zebra stripe for easier visibility in low light)
			6. **ORANGE and Polka Dot** - used in addition to one of the above ribbons to indicate victim has been contaminated with a hazardous material.
		3. Move as quickly and safely as possible; make quick decisions.
		4. Victims will be re-triaged, probably multiple times. Revise the triage category as often as indicated.
		5. Over-triage can be as harmful as under-triage. If everyone is tagged red, those who are truly red will receive delayed treatment, delayed transport, and delayed definitive care.
		6. Treatment and transport should NOT be delayed, especially for critical patients. “Get the Reds out!”
		7. If there are *extensive* delays in the field, consider requesting orders for palliative care, e.g., pain medications if time and resources allow.
	2. Secondary Triage:
		1. Reassess (i.e., perform secondary triage) as often as practical, including when the patient is moved to the Casualty Collection Point (CCP) or Treatment Area, and on all victims prior to transport.
			1. Also reassess patients when their condition or resources change.
		2. Apply Treatment Tags after patients enter CCP, or in the Transport Area (by the Transport Officer/Group) if the patient is being directly removed without going to the Treatment Area.
		3. Crews can also fill in pertinent and available information on the Tag during transport.
		4. Use the patient’s Ribbon to tie on the ~~triage~~ Treatment Tag.
			1. Use Triage Tags with individual barcodes consistent with this Standing Order and the Ohio patient tracking system (OHTrac).
		5. Orange & Polka-dot ribbons (indicating contaminated patients) are removed after decontamination.
			1. Each contaminated patient initially receives two ribbons: one with the triage category (**Red, Yellow, Green, Gray,** or **Black)**, and the second, the **Orange & Polka-dot** ribbon indicating contamination.
			2. EMS is are responsible for performing primary decontamination prior to transport. However, the hospital must be made aware of both contamination and the decontamination procedures taken.
			3. Make sure to decontaminate under the ribbons.
			4. After decontamination, remove the **Orange & Polka-dot** ribbon.
			5. Mark Treatment Tags for contaminated patients with two check marks on the orange strip:
				1. Mark *both* the “dirty” and “decontaminated” boxes.
				2. This indicates to the hospital personnel that the patient has had field decontamination, but may still be somewhat “dirty”.
	3. Transport
		1. Treatment Area or Transport Group personnel determine priority for transport.
		2. Distribution of patients among various hospitals is one of EMS’ most crucial tasks.
		3. **Do not overload any hospital**, regardless of transport distance to other hospitals.
		4. In an MCI, transport trauma patients to non-Trauma Centers as necessary.
			1. All hospitals will accept and stabilize trauma patients during MCIs.
			2. Consider transporting minor (**GREEN**) patients to Freestanding EDs to relieve pressure on Trauma Centers and other hospitals.
		5. As Transport assigns patient allocation, consider the likelihood that the closest hospitals may be overwhelmed by patients who were not transported by EMS.
		6. In large scenarios, consider activation of the Forward Movement of Patients Plan as defined in [3021.0 Crisis Standards of Care in Massive Events](file:///G%3A%5CCurrent%20DFD%20Projects%5C3021%20-%20Regional%20Hospital%20Notification%20System.docx).
3. **Sort, Assess, Life-Saving Intervention, Treatment/Transport Process**
	1. **S**ort
		1. Global Sorting: Action 1
			1. Action: “Everyone who can hear me please move to [designated area] and we will help you” (use loudspeaker if available)
			2. Goal: Group ambulatory patients using voice commands
			3. Result: Those who follow commands are *last* priority for individual assessment (Green)
			4. Assign someone to keep them together and notify Incident Command or EMS Group/Branch of number of patients and their location.
			5. Do not forget these victims.
			6. Someone must re-triage them as soon as possible.
			7. In smaller incidents, such as a motor vehicle crash with few victims that you do not want to move on their own, skip Action 1, and go to Global Sorting Action 2.
		2. Global Sorting: Action 2
			1. Action: “If you need help, wave. We will be there to help as soon as possible.”
			2. Goal: Identify non-ambulatory patients who can follow commands or make purposeful movements.
			3. Result: Those who follow this command are *second* priority for individual assessment.
		3. Global Sorting: Result
			1. Casualties are now prioritized for individual assessment
				1. Priority 1: Still, and those with obvious life threat
				2. Priority 2: Waving or purposeful movements
				3. Priority 3: Walking
		4. Begin assessing all non-ambulatory victims where they lie, performing Life Saving Interventions (LSIs) as needed, but only within your scope of practice, and only using equipment that is readily available.
	2. **A**ssess
		1. Is the patient breathing?
			1. If not, open the airway. In children, consider giving two rescue breaths.
			2. If the patient is still not breathing, triage them to **BLACK** (dead).
			3. Do not move patients triaged **BLACK** except to gain access to a living patient.
			4. If patient is breathing, conduct next assessment.
		2. Assess for the following:
			1. Can the patient follow commands or make purposeful movements?
			2. Does the patient have a peripheral pulse?
			3. Is the patient not in respiratory distress?
			4. Is hemorrhaging under control?
		3. Grading the Assessment
			1. If the answer to **any** of those questions is no (***bad***) and the patient **IS** likely to survive given current resources, tag them as **RED** (Immediate).
			2. If the answer to **any** of those questions is no (***bad***) and the patient is **NOT** likely to survive given *current* resources, tag them as **GRAY** (Expectant)**.**
			3. If the answer to **all** of those questions is yes but injuries are not minor and require care, tag patient as **YELLOW** (Delayed).
				1. **YELLOWs** have serious injuries and need care, though not as urgently as **REDs**.
				2. On secondary triage, some **Yellows** will need higher priority transport than others.
			4. If the answers to **all** of those questions is yes and the injuries are minor, tag patient as **GREEN** (Minimal).

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| Two mnemonics to remember the four assessment questions |
| C – follows CommandsR – No Respiratory distressA – No (uncontrolled) Arterial bleedingP – Peripheral Pulse Present | Think of the questions in terms of “bad” or “good”If the answer to any of the questions is “bad” then the patient is tagged either **RED** (Immediate) or **GRAY** (Expectant) |

* 1. **L**ife Saving Interventions
		1. Only correct life-threatening problems during triage.
			1. Control major hemorrhage
			2. Open airway (if child, consider giving two rescue breaths)
			3. Needle chest decompression
			4. Auto injector antidotes
			5. See “3017.5 Special Situations”
	2. **T**reatment/Transport
		1. Transport/treatment priority is typically given (in order) to
			1. **RED** (Immediate)
			2. **YELLOW** (Delayed)
			3. **GREEN** (Minimal)
			4. However, **GRAY** (Expectant) patients should be treated and transported as resources allow and in consideration of condition.
1. **General Considerations**
	1. Patients must be reassessed periodically, including when moved to the CCP, or when their condition or resources change.
	2. Even after applying Triage Tags, the main indicator of patient condition is the Triage Ribbon.
	3. Continue to use the same tag, even if the condition changes repeatedly, changing the ribbon to indicate the patient’s current condition.
	4. If the patient’s condition or the triage priority changes, indicate that on the tag.
2. **Special Situations**
	1. SALT is a clinical guideline, not an absolute.
	2. Every MCI is extraordinary - use your clinical judgement
	3. A patient who is Gray initially can become Red as soon as resources are available.
	4. MCIs with patients suffering traumatic (aka, compression) asphyxia who are not breathing initially, may start breathing after just a few ventilations. In a situation such crowding and as the crowd surge a the Houston Astroworld Fest, it is worth attempting a few ventilations during the LSI step, even in adults.
	5. In MCIs due to lightning strikes, the pathology can be very complex. Consider attempting ventilation or defibrillation, depending on resources and the conditions of other victims.

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| **END OF SECTION** |