

CHAPTER 14

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MULTI-CASUALTY BRANCH

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MULTI-CASUALTY BRANCH

DEFINITION:

The purpose of this portion of the Florida Field Operations Guide (FOG) is to define the organizational plan to efficiently triage, treat and transport victims of multiple casualty incidents (MCI's). This procedure is intended for incidents involving a number of injured that exceeds the capabilities of the first arriving unit(s). This portion of the Florida Field Operations Guide is intended to enhance the local jurisdiction's ability to transition from MCI response protocols contained in the Uniform Pre-Hospital Multiple Casualty Incident Procedure to large scale incidents involving overwhelming numbers of sick and/or injured casualties not addressed by the Uniform Pre-Hospital Multiple Casualty Incident Procedure.

The Multi-Casualty Branch Structure is designed to provide the Incident Commander with a basic expandable system for handling any number of patients in a multi-casualty incident.

MODULAR DEVELOPMENT

A series of examples of modular development are included to illustrate one possible method of expanding the incident organization.

Initial Response Organization (Page 14-6)

The Initial Response Organization will be in accordance with Uniform Pre-Hospital MCI Initial Response Procedure currently in use by many public and private agencies in the State of Florida.

Initial response resources are managed by the Incident Commander who will handle all Command and General Staff responsibilities. Under the Uniform Pre-Hospital MCI Initial Response Procedure the Incident Commander assigns the following functional responsibilities:

- Triage Vest Color Yellow
- Treatment Vest Color Red
- Transportation Vest Color Green
- Staging Vest Color Orange
- Medical Vest Color Blue
- All Command Staff Vest Color White
(Safety, Rehab, PIO, Accountability, etc.)

The first arriving resource with the appropriate communications capability should establish communications with the appropriate hospital or other coordinating facility and become the Medical Communications Coordinator. Other first arriving resources would be assigned to the Triage Group Supervisor and/or the Treatment Group Supervisor as appropriate.

*Uniform Pre-Hospital Multiple Casualty Incident Procedure
Predetermined Response Plan*

An MCI will be classified by different levels depending on the number of victims. The number of victims will be based on the initial size-up, prior to triage. The number of casualties may exceed the capabilities of the local jurisdiction and will require assistance from other EMS Providers.

Levels of response will be in addition to the units already on the scene or enroute. All units will respond to the staging area unless otherwise directed by the Incident Commander.

MCI Level 1 (5- 10 Victims): 4 ALS Transport Units, 2 Engine Companies, and Command Staff per local protocol, with the following notifications:

NOTE: The Incident Commander or local Communications Center will notify the 2 nearest hospitals and the nearest Trauma Center.

MCI Level 2 (11- 20 Victims): 6 ALS Transport Units, 3 Engine Companies, and Command Staff per local protocol, with the following notifications:

NOTE: The Incident Commander or local Communications Center will notify the 3 nearest hospitals, Trauma Center and local Emergency Management Office.

MCI Level 3 (21 -100 Victims): 8 ALS Transport Units, 4 Engine Companies, and Command Staff per local protocol, with the following notifications:

NOTE: The Incident Commander or local Communication Center will notify the 4 closest hospitals, Trauma Center and local Emergency Management Office.

MCI Level 4 (101-1000 Victims): 5 MCI Task Forces (25 units each TF may consist of 2 ALS Units, 2 BLS Units and 1 Fire Suppression Unit) 2 ALS Transport Units Strike Teams (10 units), 1 Suppression Unit Strike Team (5 units), 2 BLS Transport Units Strike Teams (10 units), 2 Mass Transit Buses Supply Trailer, Communication Trailer, and Command Staff per local protocol. The 10 closest hospitals and 5 Trauma centers will be notified by Medical Control. The local Warning Point will notify the Emergency Management Agency. Metropolitan Medical Response System (MMRS) may be notified.

MCI Level 5 (over 1,000 Victims, or when regional resources are overwhelmed or exhausted): 10 MCI Task Forces (50 units), 4 ALS Transport Units Strike Teams (20 units), 2 Suppression Unit Strike Team (10 units), 4 BLS Transport Units Strike Teams (20 units), 4 Mass Transit Buses Command Vehicle, Supply Trailer (s), Communication Trailer Command Staff per local protocol, Medical Control will notify the 20 closest hospitals and 10 Trauma centers. The local Warning Point will notify the State Warning Point which may activate one, or more. Disaster Medical Assistance Teams (DMAT) and MMRS shall be notified.

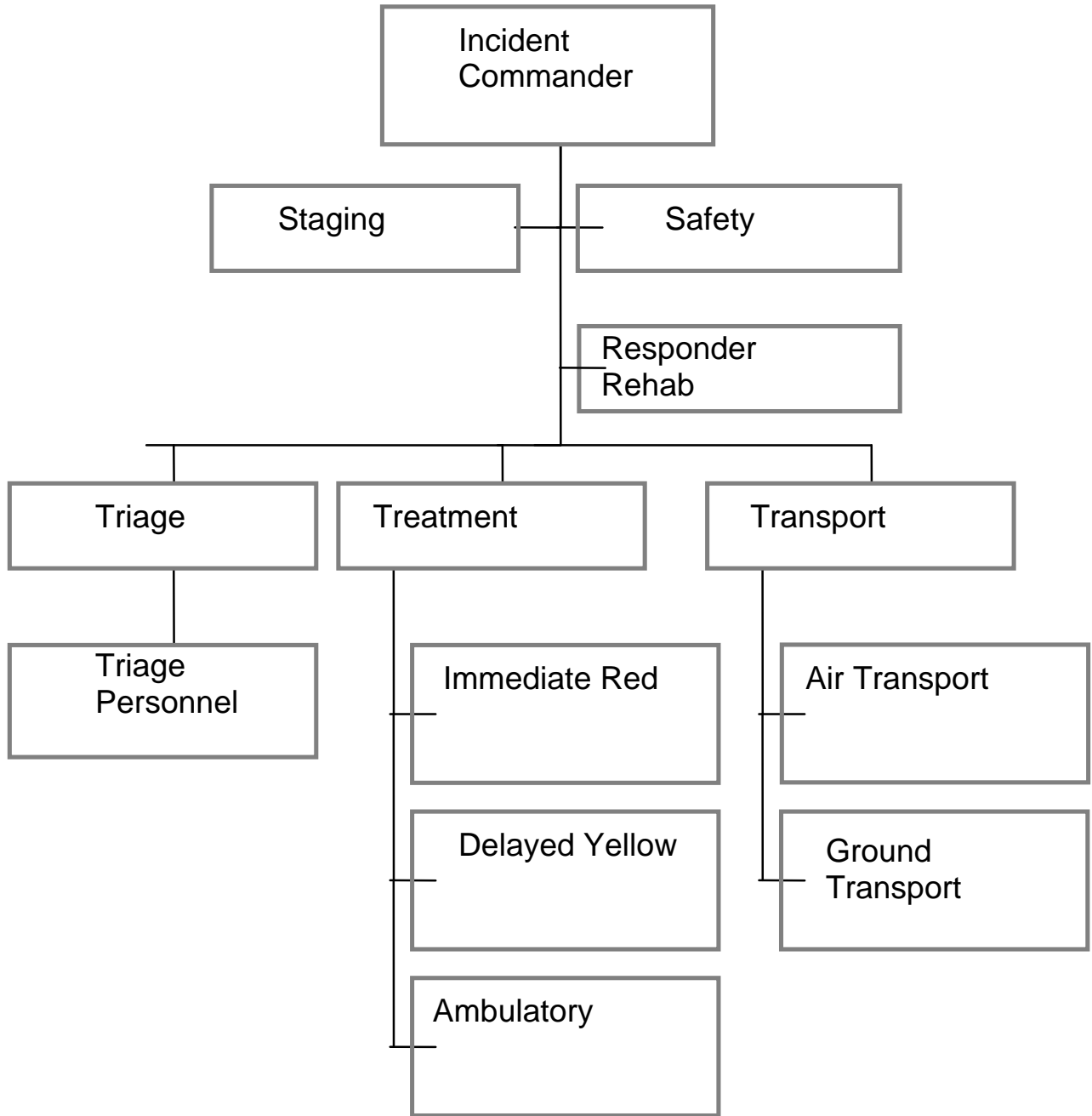
SPECIAL NOTES

1. All responding units are to report to the staging area(s) unless otherwise directed.
2. The Incident Commander can downgrade or upgrade the assignment at any time.
3. The Incident Commander should consider the use of air transport for special needs, mass transit providers for multiple minor injuries, and private EMS providers to augment the response.
4. Strike Team is a combination of the same kind and type of resources with common communications and a leader. (i.e. ALS Transport Unit Strike Team may be 5 ALS Transport Units with a leader and communications).
5. Task Force is a group of resources with common communications and a leader (i.e. MCI Task Force may be 2 Transport Units, 2 BLS Transport Units and 1 Suppression Unit with a leader and communications).
6. Litter Bearer is a team of personnel assigned to the Triage Officer to move victims from the incident site to the Treatment Area or Transport Units.

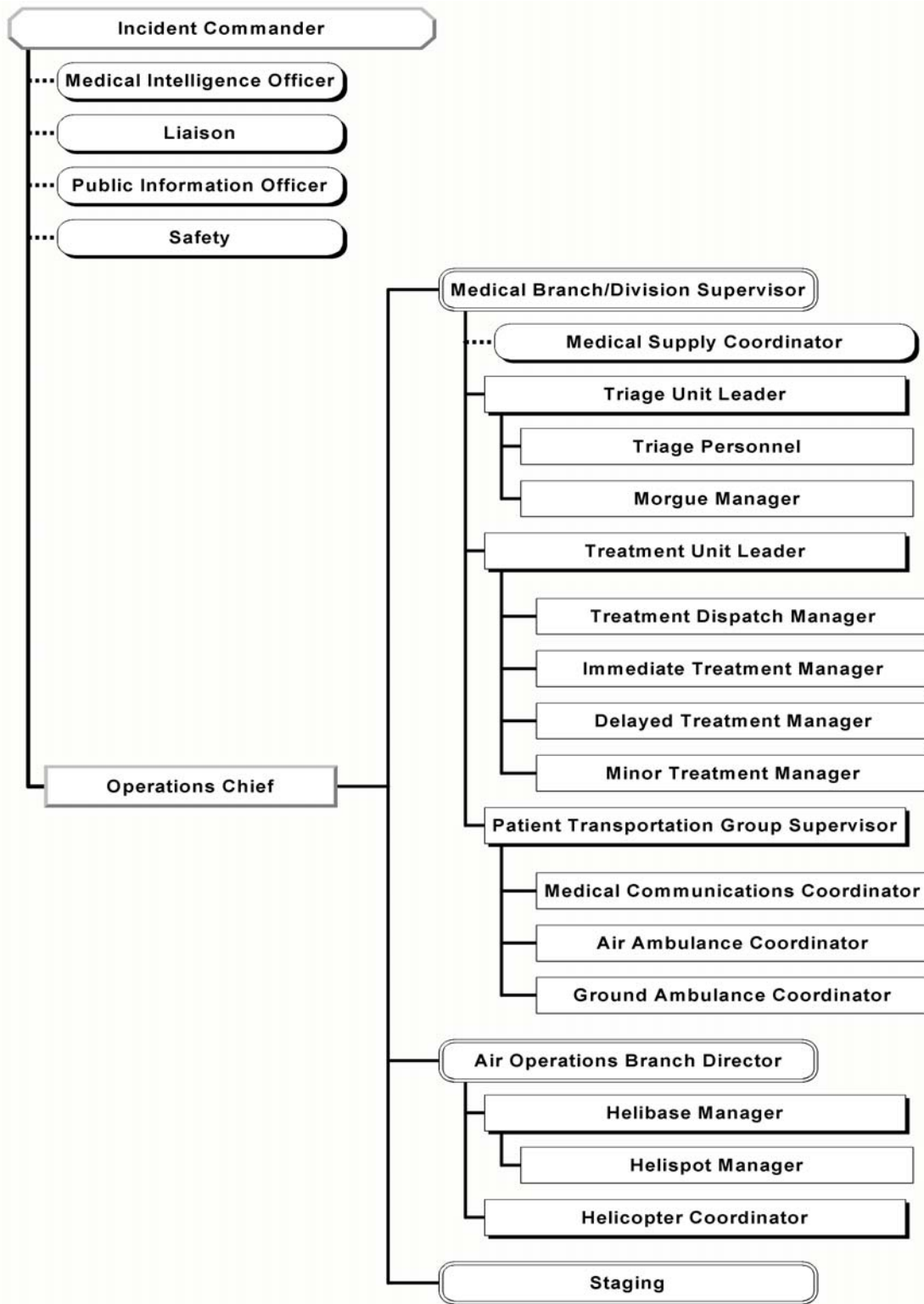
Multi-Branch Response (Page 14-7)

All positions within the Medical Branch are now filled. Air Operations Branch is shown to illustrate the coordination between the Air Ambulance Coordinator and the Air Operations Branch. An Extrication Group is freeing trapped victims.

Uniform Pre-Hospital MCI Initial Response Procedure



MULTI-BRANCH RESPONSE



POSITION CHECKLISTS

MEDICAL BRANCH DIRECTOR: The Medical Branch Director is responsible for the implementation of the Incident Action Plan within the Branch. This includes the direction and execution of branch planning for the assignment of resources within the Branch. The Branch Director reports to the Operations Section Chief and supervises the Triage, Treatment and Patient Transportation Group Supervisors as well as the Medical Supply Coordinator. The Medical Branch establishes command and controls the activities within the Medical Area, in order to assure the best possible emergency medical care to patients during a multi-casualty incident

1. Review Common Responsibilities (page 1-2).
2. Review Group/Division Assignments for effectiveness of current operations and modify as needed.
3. Provide input to Operations Section Chief for the Incident Action Plan.
4. Supervise Branch activities.
5. Report to Operations Section Chief on Branch activities.
6. Maintain Unit/Activity Log (ICS Form 214).
7. Participate in the development of the Incident Action Plan and review the general control objectives including alternate strategies as appropriate.
8. Designate Group Supervisors and Treatment Area locations as appropriate.
9. Recommend Treatment Area locations as appropriate Isolate Morgue (black) and Minor (green) Treatment Area away from Immediate (Red) and Delayed (Yellow) Treatment Areas.
10. Request law enforcement/Medical Examiner involvement as needed.
11. Collect, review and compile casualty information
12. Recommend additional personnel and resources sufficient to handle the magnitude of the incident.

13. Determine amount and types of additional medical resources and supplies needed to handle the magnitude of the incident (medical caches, backboards, litters, cots).
14. Establish communications and coordination with Patient Transportation Group Supervisor.
15. Ensure activation of hospital alert system, local EMS/health agencies.
16. Direct and/or supervise on-scene personnel from agencies such as Medical Examiners Office, Red Cross, law enforcement, private ambulance companies, county health agencies, and hospital volunteers.
17. Ensure proper security, traffic control, and access for the area.
18. Direct medically trained personnel in coordination with the appropriate Treatment Group Supervisor.
19. Maintain Unit/Activity Log (ICS Form 214).

MEDICAL INTELLIGENCE OFFICER: The Medical Intelligence Officer is a Technical Specialist in the Planning Section who is assigned to the Incident Commander to advise on the decontamination, antidotes and treatment of casualties caused by nuclear, chemical or biological agents. (See general description of Technical Specialist under the Planning Section).

1. Review Common Responsibilities (page 1-2).
2. Check in.
3. Obtain briefing from supervisor.
4. Obtain personal protective equipment (PPE) as appropriate.
5. Determine coordination procedures with other sections, units and local agencies.
6. Establish work area and acquire work materials
7. Provide agent(s) information
8. Obtain appropriate transportation and communications if special needs arise

TRIAGE GROUP SUPERVISOR: The Triage Group Supervisor reports to the Medical Branch Director and supervises Triage Personnel/Litter Bearers and the Morgue Unit Leader. The Triage Group Supervisor assumes responsibility for providing triage management and movement of patients from the triage area. When triage has been completed, the Group Supervisor may be reassigned as needed.

1. Review Common Responsibilities (page 1-2).
2. Review Group Supervisor Responsibilities (page 1-3).
3. Develop organization sufficient to handle assignment.
4. Inform Medical Branch Director of resource needs.
5. Implement triage process.
6. Coordinate movement of patients from the Triage Area (incident site) to the appropriate Treatment Area.
7. Give periodic status reports to Medical Branch Director.
8. Maintain security and control of the Triage Area.
9. Establish Morgue with Medical Examiner personnel when possible.

TRIAGE PERSONNEL: Triage Personnel report to the Triage Group Supervisor and triage patients on-scene and assign them to appropriate treatment areas.

1. Review Common Responsibilities (page 1-2).
2. Report to designated on-scene triage location.
3. Triage and tag injured patients with triage ribbons. Classify patients according to the Simple Triage and Rapid Treatment (START) protocols for adults, and the JumpSTART protocols for pediatrics.
4. Direct movement of patients to proper Treatment areas.
5. Provide appropriate medical treatment (ABC's) to patients prior to movement as incident conditions dictate.

TREATMENT GROUP SUPERVISOR: The Treatment Group Supervisor reports to the Medical Branch Director and supervises the Treatment Unit Leaders and the Treatment Dispatch Unit Leader. The Treatment Group Supervisor assumes responsibility for treatment, preparation for transport, and coordination of patient treatment in the Treatment Areas and directs movement of patients to loading location(s).

1. Review Common Responsibilities (page 1-2).
2. Review Unit Leader Responsibilities (page 1-3).
3. Develop organization sufficient to handle assignment.
4. Direct and supervise Treatment Dispatch, Immediate (Red), Delayed (Yellow), and Minor (Green) Treatment Areas.
5. Coordinate movement of patients from Triage Area to Treatment Areas with Triage Unit Leader.
6. Request sufficient medical caches and supplies as necessary.
7. Establish communications and coordination with Patient Transportation Group.
8. Ensure continual triage of patients throughout Treatment Areas.
9. Direct movement of patients to ambulance loading area(s).
10. Give periodic status reports to Medical Branch Director.

TREATMENT DISPATCH UNIT LEADER: The Treatment Dispatch Unit Leader reports to the Treatment Group Supervisor and is responsible for coordinating with Patient Transportation Group Supervisor, the transportation of patients out of the Treatment Area.

1. Review Common Responsibilities (page 1-2).
2. Establish communications with the Immediate (Red), Delayed (Yellow), and Minor (Green) Treatment Unit Leaders.
3. Establish communications with Patient Transportation Group Supervisor.
4. Verify that patients are prioritized for transportation.
5. Advise Medical Communications Coordinator of patient readiness and priority for dispatch.

6. Coordinate transportation of patients with Medical Communications Coordinator.
7. Assure that appropriate patient tracking information is recorded.
8. Coordinate ambulance loading with Treatment Manager and ambulance personnel.

IMMEDIATE TREATMENT UNIT LEADER (RED): The Immediate Treatment Unit Leader reports to the Treatment Group Supervisor and is responsible for treatment and re-triage of patients assigned to the Immediate Treatment Area.

1. Review Common Responsibilities (page 1-2).
2. Request or establish Medical Teams as necessary.
3. Assign treatment personnel to patients received in the Immediate Treatment Area.
4. Ensure treatment of patients triaged to the Immediate Treatment Area.
5. Assure that patients are prioritized for transportation.
6. Coordinate transportation of patients with Treatment Dispatch Unit Leader.
7. Notify Treatment Dispatch Unit Leader of patient readiness and priority for transportation.
8. Assure that appropriate patient information is recorded.

DELAYED TREATMENT UNIT LEADER (YELLOW): The Delayed Treatment Unit Leader reports to the Treatment Group Supervisor and is responsible for treatment and re-triage of patients assigned to the Delayed Treatment Area.

1. Review Common Responsibilities (page 1-2).
2. Request or establish Medical Teams as necessary.
3. Assign treatment personnel to patients received in the Delayed Treatment Area.
4. Ensure treatment of patients triaged to the Delayed Treatment Area.

5. Assure that patients are prioritized for transportation.
6. Coordinate transportation of patients with Treatment Dispatch Unit Leader.
7. Notify Treatment Dispatch Unit Leader of patient readiness and priority for transportation.
8. Assure that appropriate patient information is recorded.

MINOR TREATMENT UNIT LEADER (GREEN): The Minor Treatment Unit Leader reports to the Treatment Group Supervisor and is responsible for treatment and re-triage of patients assigned to the Minor Treatment Area.

1. Review Common Responsibilities (page 1-2).
2. Request or establish Medical Teams as necessary.
3. Assign treatment personnel to patients received in the Minor Treatment Area.
4. Ensure treatment of patients triaged to the Minor Treatment Area.
5. Assure that patients are prioritized for transportation.
6. Coordinate transportation of patients with Treatment Dispatch Unit Leader.
7. Notify Treatment Dispatch Unit Leader of patient readiness and priority for transportation.
8. Assure that appropriate patient information is recorded.
9. Coordinate volunteer personnel/organizations through Agency Representatives and Treatment Group Supervisor.

PATIENT TRANSPORTATION GROUP SUPERVISOR:

Transportation Group Supervisor reports to the Medical Branch Director and supervises the Medical Communications Coordinator, Air and Ground Ambulance Coordinators. This supervisor is responsible for the coordination of patient transportation and maintenance of records relating to patient identification, injuries, mode of off-incident transportation and destination.

1. Review Common Responsibilities (page 1-2).
2. Establish communications with hospital(s).

3. Designate ambulance staging areas(s).
4. Direct the transportation of patients as determined by Treatment Group Supervisor or Unit Leaders.
5. Assure that patient information and destination is recorded.
6. Establish communications with Ambulance Coordinator(s).
7. Request additional ambulances, as required.
8. Notify Ambulance Coordinator(s) of ambulance requests.
9. Coordinate requests for air ambulance transportation through the Air Operations Director.
10. Establish Air Ambulance Helispot with the Medical Branch Director and Air Operations Director.
11. Maintain Unit/Activity Log (ICS Form 214).

MEDICAL COMMUNICATIONS COORDINATOR: The Medical Communications Coordinator reports to the Patient Transportation Group Supervisor and supervises the Transportation Recorder and maintains communications with the hospital alert system and/or other medical facilities to assure proper patient transportation and destination and coordinates information through Patient Transportation Group Supervisor and the Transportation Recorder (also known as the Documentation Aide).

1. Review Common Responsibilities (page 1-2).
2. Establish communications with hospital alert system.
3. Determine and maintain current status of hospital/medical facility availability and capability.
4. Receive basic patient information and injury status from Treatment Dispatch Unit Leader.
5. Communicate hospital availability to Treatment Dispatch Unit Leader.
6. Coordinate patient off-incident destination with the hospital alert system.
7. Communicate patient transportation needs to Ambulance Coordinators based upon requests from Treatment Dispatch Unit Leader.
8. Maintain appropriate records.

AIR/GROUND AMBULANCE COORDINATOR: The Air/Ground Ambulance Coordinators report to the Patient Transportation Group Supervisor and manage the Air/Ground Ambulance Staging Areas and dispatch ambulances as requested.

1. Review Common Responsibilities (page 1-2).
2. Establish appropriate staging area for ambulances.
3. Establish routes of travel for ambulances for incident operations.
4. Establish and maintain communications with the Air Operations Branch Director.
5. Establish and maintain communications with the Medical Communications Coordinator and Treatment Dispatch Unit Leader. Provide ambulances upon request from the Medical Communications Coordinator.
6. Maintain records as required.
7. Assure that necessary equipment is available in the ambulance for patient needs during transportation.
8. Establish immediate contact with ambulance agencies at the scene.
9. Request additional transportation resources as appropriate.
10. Provide an inventory of medical supplies available at ambulance staging area for use at the scene through the Medical Supply Coordinator.

MEDICAL SUPPLY COORDINATOR: The Medical Supply Coordinator reports to the Medical Branch Director and acquires and maintains control of appropriate medical equipment and supplies from units assigned to the Medical Branch.

1. Review Common Responsibilities (page 1-2).
2. Acquire, distribute and maintain status of medical equipment and supplies within the Medical Branch.
3. Request additional medical supplies (medical caches).*
4. Distribute medical supplies to the Treatment and Triage Areas, and if needed, to the Staging Area.
5. Maintain Unit/Activity Log (ICS Form 214).

*If Logistics Section is established, this position would coordinate with the Supply Unit Leader.

MORGUE UNIT LEADER: The Morgue Unit Leader reports to the Triage Group Supervisor and assumes responsibility for Morgue Area activities until relieved of that responsibility by the Office of the Medical Examiner.

1. Review common Responsibilities (page 1-2).
2. Assess resource/supply needs and order as needed.
3. Coordinate all Morgue Area activities.
4. Keep area off limits to all but authorized personnel.
5. Coordinate with law enforcement and assist the Medical Examiner's Office as necessary.
6. Keep identity of deceased persons confidential.
7. Maintain appropriate records.

MULTI-CASUALTY ICS FORMS

The forms listed below may be used in addition to the adopted forms utilized in the Uniform Pre-Hospital Multiple Casualty Incident Procedure Predetermined Response Plan.

ICS-MC-305	Multi-Casualty Branch Worksheet
ICS-MC-306	Multi-Casualty Recorder worksheet
ICS-MC-308	Multi-Casualty Hospital Resource Availability
ICS-MC-310	Multi-Casualty Ambulance Resource Status
ICS-MC-312	Medical Supply Receipt and Inventory Form

MULTI-CASUALTY GLOSSARY OF TERMS

ALS (Advanced Life Support). Allowable procedures and techniques utilized by Paramedic personnel to stabilize critically sick and injured patient(s) which exceed Basic Life Support procedures.

A.V.P.U. Acronym for patient assessment.

A – Alert; **V** – responds to verbal stimuli;

P – Responds only to painful stimuli; **U** – unconscious.

BLS (Basic Life Support). Basic non-invasive first-aid procedures and techniques utilized by EMT personnel to stabilize critically sick and injured patient(s).

CASUALTY COLLECTION POINT (CCP) In a large scale disaster some patients may be transported to an off-site treatment area called the CCP. This will provide surge capacity for area hospitals.

CATASTROPHIC DISASTER. Refers to a MCI Level 5 (over 1000 victims) in this level resources in the region, responders and hospitals will be totally overwhelmed or have been exhausted. Some patients that are not expected to survive may be termed non-salvageable/expectant and may be moved to separate area and not transported to medical facility.

DELAYED TREATMENT (YELLOW). Second priority in patient treatment. These people require aid, but injuries are less severe.

HOSPITAL ALERT SYSTEM. A communications system between medical facilities and on scene incident medical personnel, which provides available hospital patient receiving capability and/or medical control, as defined in the Florida Emergency Medical Services Communication Plan.

IMMEDIATE TREATMENT (RED). A patient who requires rapid assessment and medical intervention for survival.

JumpS.T.A.R.T. Pediatric-specific evaluation in addition to the Simple Triage and Rapid Treatment triage protocol. This is the initial triage system for pediatric casualties that has been adopted for use by the Florida Fire Chief's Association.

MEDICAL INTELLIGENCE OFFICER. Chemical and/or biological warfare agents require specific antidotes and decontamination procedures that are not usually found available on first response vehicles. The Medical Intelligence Officer is a Technical Specialist in the Planning Section who is assigned to the Incident Commander to advise on the decontamination, antidotes and treatment of chemical and or biological casualties.

MINOR TREATMENT (GREEN). These patient's injuries require simple rudimentary first-aid.

START – S.T.A.R.T. Acronym for Simple Triage And Rapid Treatment. This is the initial triage system for adult casualties that have been adopted for use by the Florida Fire Chief's Association.

STANDING ORDERS. Policies and Procedures approved by the local Agency EMS Medical Director for use by an EMT or paramedic in situations where direct voice contact with on-line medical control cannot be established or maintained.

TRIAGE. The screening and classification of sick, wounded, or injured persons to determine priority needs in order to ensure the efficient use of medical personnel, equipment and facilities.

MCI APPENDIX A - S.T.A.R.T. SYSTEM OF TRIAGE

1. INTRODUCTION

This procedure will be 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 effectively by personnel with limited medical training.

2. PROCEDURE

A. Initial triage - Using the START Method (See 3):

- 1) Utilize the Triage Ribbons (color coded plastic strips). One should be tied to an upper extremity in a VISIBLE location (wrist if possible).
 - a) RED - Immediate
 - b) YELLOW - Delayed
 - c) GREEN - Ambulatory (Minor)
 - d) BLACK - Deceased (Expectant/non-salvageable)
- 2) Independent decisions should be made for each victim. Do not base triage decisions on the perception of too many reds, not enough greens, etc.
- 3) If borderline decisions are encountered, always triage to the most urgent priority (Green/Yellow patient, tag Yellow).

B. Secondary Triage

- 1) Will be performed on all victims during the Treatment Phase. If a victim is identified in the initial triage phase as a Red and transport is available do not delay transport to perform a secondary assessment.
- 2) Utilize the Triage Tags and attempt to assess for and complete all information required on the tag (time permitting). Affix the tag to the victim and remove the ribbon.
- 3) The Triage priority determined in the Treatment Phase should be the priority used for transport.

START

- a) Locate and remove all of the walking wounded into one location away from the incident if possible. Assign someone to keep them together (police, other fire department personnel, or initially a competent bystander) notify COMMAND/MEDICAL of their location - do not forget these victims. Someone should triage them as soon as possible.
- b) Begin assessing all non-ambulatory victims where they lay if possible.

NOTE: Remember the pneumonic RPM. (Respiration, Perfusion, Mental Status).

1) Assess RESPIRATIONS:

- a) If respiratory rate is 30/min or less go to PERFUSION assessment.
- b) If respiratory rate is over 30/min, Tag RED.
- c) If victim is not breathing open the airway, remove obstructions if seen and assess for (a) or (b) above.
- d) If victim is still not breathing. Tag BLACK.

2) Assess PERFUSION:

- a) Performed by palpating a radial pulse or assessing capillary refill (CR) time.
- b) If radial pulse is present or CR is 2 seconds or less, go to MENTAL STATUS assessment.
- c) If no radial pulse is present or the CR is greater than 2 seconds, Tag RED.

NOTE: In addition, any major external bleeding should also be controlled.

3) Assess **MENTAL STATUS**:

- a) Assess the victim's ability to follow simple commands and their orientation to time, place, and person (oriented X3).
- b) If the victim follows commands, oriented X 3, Tag GREEN.
- c) If the victim does not follow commands, is unconscious, or is disoriented, Tag RED

NOTE: Depending on injuries (burns, fractures, bleeding) it may be necessary to Tag YELLOW.

SPECIAL CONSIDERATIONS

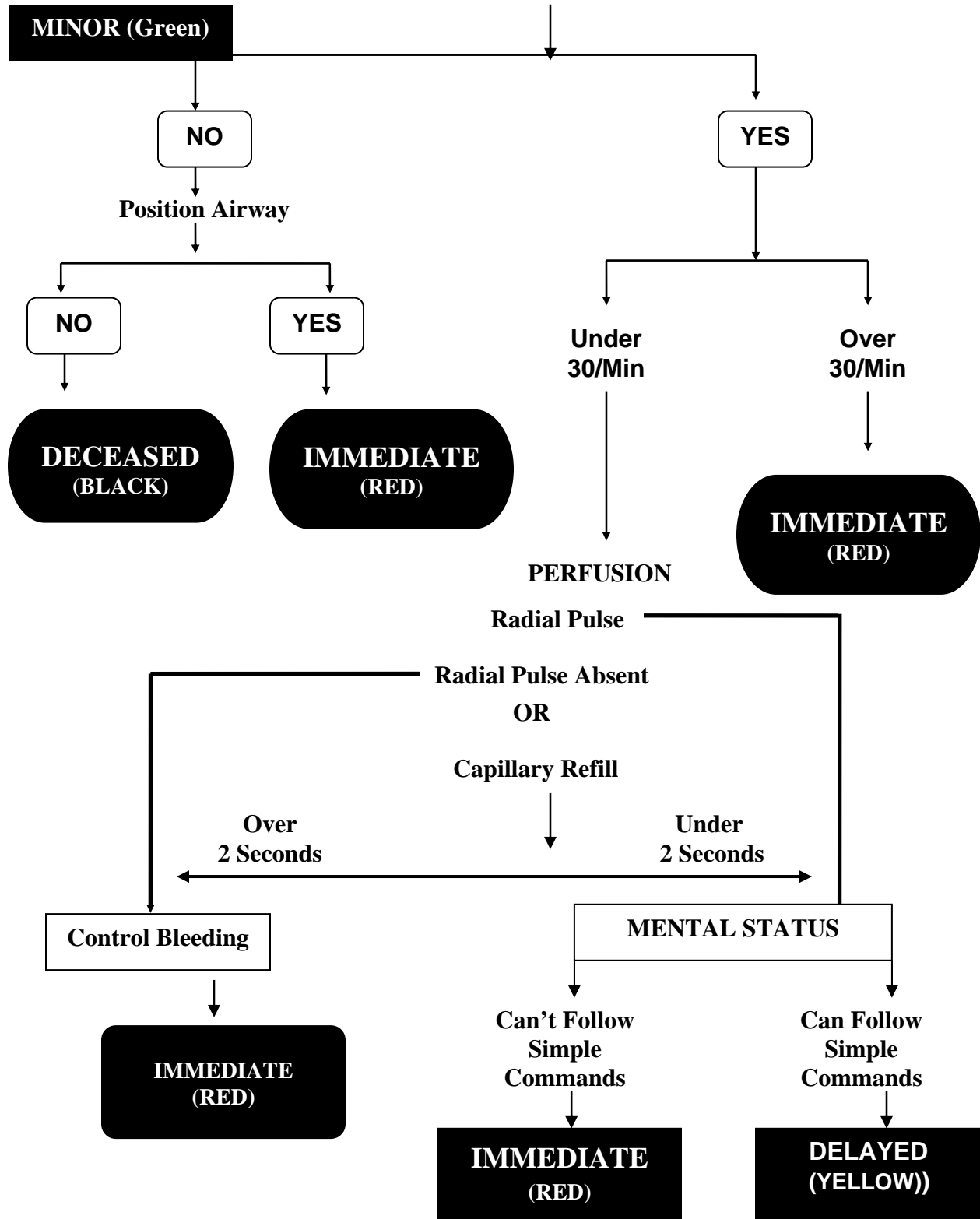
The first assessment that produces a RED Tag stops further assessment.

Only correction of life-threatening problems, such as airway obstruction or severe hemorrhage should be managed during triage.

All Walking Wounded
(After triage)

START TRIAGE

RESPIRATIONS



MCI APPENDIX B - JumpS.T.A.R.T. SYSTEM OF TRIAGE

1. 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 effectively by personnel with limited medical training.

Physiological differences in pediatric patients necessitate the need to adapt the standard S.T.A.R.T. triage method for pediatric patients up to eight (8) years of age, under 100 pounds or those patients with the anatomical or physiological features of a child in this age group. The same three (3) parameters will be utilized with the adaptations indicated below.

2. PROCEDURE

A. Initial triage - Using the JumpSTART Method (See 3):

1. Utilize the Triage Ribbons (color coded plastic strips). One should be tied to an upper extremity in a VISIBLE location (wrist if possible).
 - a. RED - Immediate
 - b. YELLOW - Delayed
 - c. GREEN - Ambulatory (Minor)
 - d. BLACK - Deceased (Expectant/non-salvageable)
2. Independent decisions should be made for each victim. Do not base triage decisions on the perception of too many reds, not enough greens, etc.
3. If borderline decisions are encountered, always triage to the most urgent priority (Green/Yellow patient, tag Yellow).

B. Secondary Triage

1. Will be performed on all victims during the Treatment Phase. If a patient is identified in the initial triage phase as a Red and transport is available do not delay transport to perform a secondary assessment.
2. Utilize the Triage Tags and attempt to assess for and complete all information required on the tag (time permitting). Affix the tag to the patient and remove the ribbon.
3. The Triage priority determined in the Treatment Phase should be the priority used for transport.

3. JumpSTART

- A.** Locate and remove all of the walking wounded into one location away from the incident if possible. Assign someone to keep them together (police, other fire department personnel. or initially a competent bystander) notify COMMAND/MEDICAL of their location - do not forget these victims. Someone should triage them as soon as possible.
- B.** Begin assessing all non-ambulatory victims where they lay if possible.

NOTE: Remember the pneumonic RPM. (Respiration, Perfusion, Mental Status).

1. Assess **RESPIRATIONS**:
 - a. If respiratory rate is between 15 and 45/minute go to PERFUSION assessment.
 - b. If respiratory rate is over 45/min, or less than 15/min, Tag RED.
 - c. If victim is not breathing open the airway, remove obstructions if seen and assess for (a) or (b) above.
 - d. If the victim is not breathing and no obstructions are present, check for a peripheral pulse. If a pulse is present, provide five (5) ventilations via any type of barrier device. If spontaneous respirations resume, tag RED. If victim is still not breathing, Tag BLACK. If there is no breathing and no pulse, Tag BLACK

2. Assess **PERFUSION**:
 - a. Performed by palpating a peripheral pulse.
 - b. If a peripheral pulse is present, go to MENTAL STATUS assessment.
 - c. No peripheral pulse is present, Tag RED.

NOTE: In addition, any major external bleeding should also be controlled.

3. Assess **MENTAL STATUS**:
 - a. Assess the victim's mental status through the AVPU scale. Assess whether the patient is ALERT, responds to VERBAL stimuli, responds only to PAINFUL stimuli, or is UNCONSCIOUS.
 - b. If the patient is unconscious or responds only to painful stimuli, tag RED.
 - c. If the patient is alert, or responds to verbal stimuli, assess for further injuries.

SPECIAL CONSIDERATIONS

The first assessment that produces a RED Tag stops further assessment.

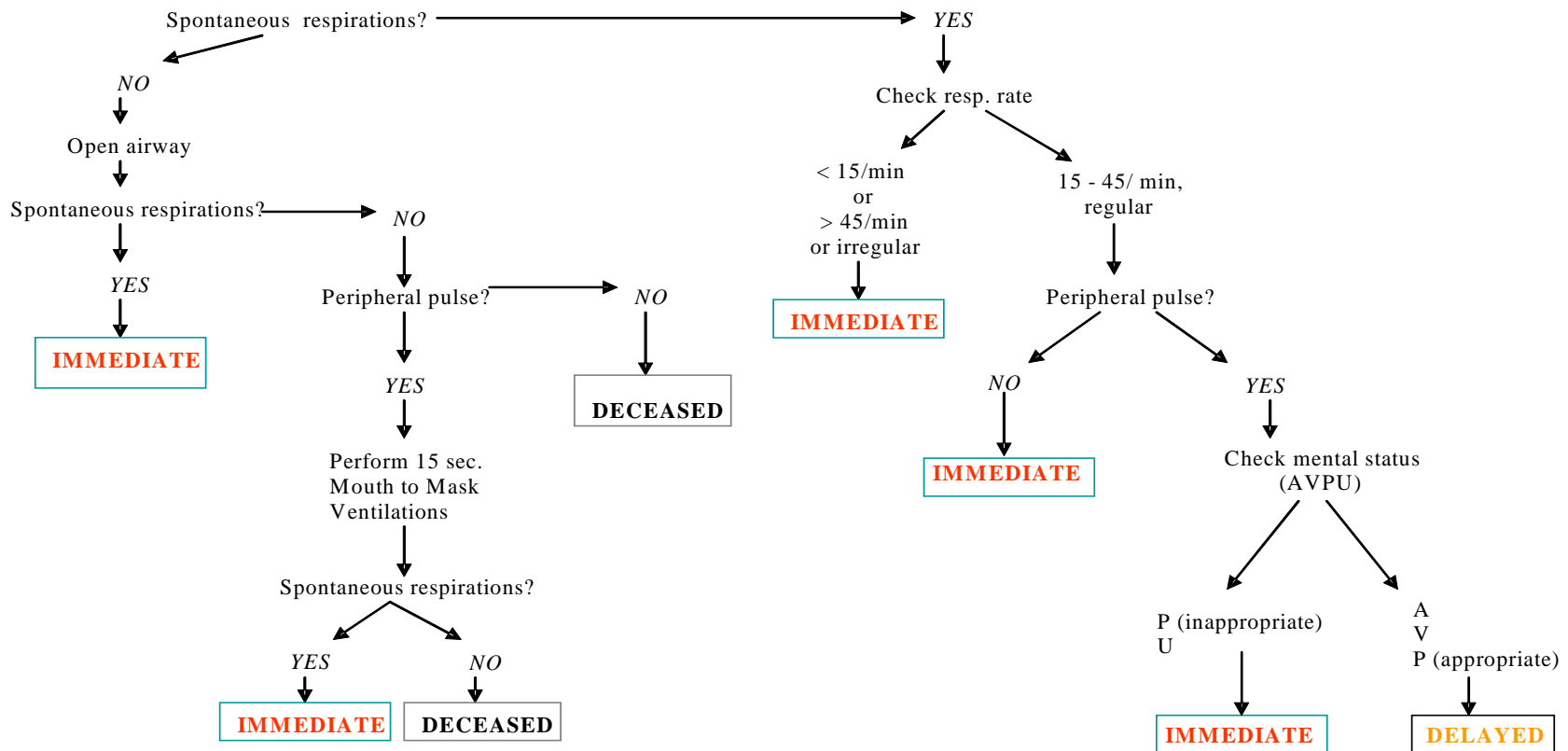
Only correction of life-threatening problems, such as airway obstruction or severe hemorrhage; or the attempted ventilation of the apneic pediatric patient should be managed during triage.

JumpSTART Flow Chart The JumpSTART Field Pediatric Multicasualty Triage System ©

Identify and direct all ambulatory patients to designated Green area for secondary triage and treatment. Begin assessment of nonambulatory patients as you come to them. Proceed as below:

MINOR

Black	= Deceased/expectant
Red	= Immediate
Yellow	= Delayed
Green	= Minor/Ambulatory



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