Maryland Triage System
Tag, START, and JumpSTART

INSTRUCTOR NOTES:
Introduction slide. The program may be taught in a group setting or self-taught.

Enabling Objectives

Upon completion of this training the participant will be able to:

- Define TRIAGE and explain when it is appropriate for use
- List three reasons a patient triage and tracking system is required for successful operations
- Categorize the Triage status of patients utilizing the START and JumpSTART Triage Systems
- Explain the design and use of paper Triage Tags
- Identify five capabilities of the paper Maryland Triage Tags

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INSTRUCTOR NOTES:
Enabling objectives define the specific knowledge, skills, and/or abilities to be demonstrated, compared, listed, described, etc.

Triage

The sorting of and allocation of treatment to patients and especially battle and disaster victims according to a system of priorities designed to maximize the number of survivors
(from the French *trier*, to sort)
(Merriam-Webster)
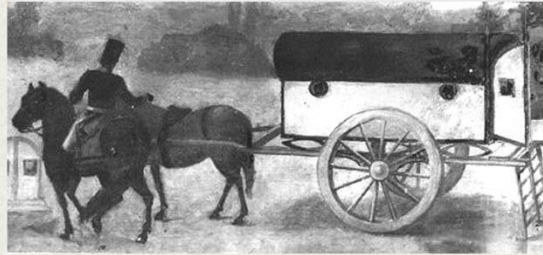
Developed by Baron Dominique-Jean Larrey, Napoleon's Chief Surgeon, for use by the first ambulance corps—the *ambulances volantes*—during the early 1800s

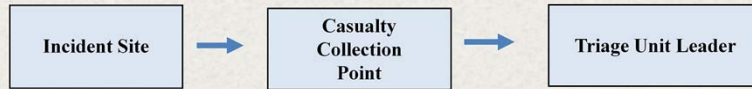*Maryland Institute for Emergency Medical Services Systems*

Why Triage and Tag?

- **Sorting of patients to provide for the survival of the most patients**
- **Assignment of resources in the most efficient method**
- **Most severe survivable injuries receive rapid treatment**
- **Accountability of patients**
- **Family reunification**

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Triage: A rapid approach to prioritizing a large number of patients

Incident Site → Casualty Collection Point → Triage Unit Leader

Simple **T**riage **A**nd **R**apid **T**reatment

JumpSTART

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INSTRUCTOR NOTES:
This subject matter should be familiar to the student and is provided here as both a brief refresher and to tie together the components of the training program.

Triage

- Triage should be performed RAPIDLY

- Utilize START/ JumpSTART Triage to determine priority

- 30–60 seconds per patient

- Affix tag on left upper arm or leg

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INSTRUCTOR NOTES:

MOVE QUICKLY!

Use S.T.A.R.T. to determine the priority of the patient:

No more than 30–60 seconds per patient

Check:
- Respiration
- Pulse
- Mental Status

Attach ribbon to UPPER ARM, if possible. The next option would be HIGH on a THIGH. The goal is to be consistent so they are easily recognized as the priority flag.

START – JumpSTART Triage

- Clear the "**walking wounded**" with verbal instruction:

  If you can hear me and you can move, walk to…

- Direct patients to the **casualty collection point (CCP)** or treatment area for detailed assessment and medical care

- Assign a Green Minor Manager to the area to control patients and manage area

- Tag will be issued at the CCP

- These patients may be classified as **MINOR**

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INSTRUCTOR NOTES:
Talk the students through the triage process using these guidelines. Essentially, if a patient can hear you, understand and follow your commands, and has the physical ability to walk on their own, their injuries are non-emergent and can be tended to later. Of course, triage is a dynamic process and these patients should be re-assessed at the treatment area for any deterioration in their condition. The action of moving the MINOR patients from the scene also helps clear space and reduce confusion so the remaining patients can be quickly categorized.

INSTRUCTOR NOTES:

Basic, quick patient care

START/JumpSTART

Categorize the patients by assessing each patient's RPMs...

✓**R**espirations

✓**P**ulse/perfusion

✓**M**ental Status

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INSTRUCTOR NOTES:
These are the three decision criteria to be used in categorizing those patients who have not already been determined to be "walking wounded."

START/JumpSTART—RPM

RESPIRATIONS
Is the patient breathing?

Yes

Adult – respirations > 30 = **Red/Immediate**

Pediatric – respirations < 15 or > 45 = **Red/Immediate**

Adult – respirations < 30 = check perfusion

Pediatric – respirations > 15 and < 45 = check perfusion

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INSTRUCTOR NOTES:
Address respirations first. Many triage decisions can be made on this assessment alone.
This corresponds to the "A" and "B" of the ABCs of patient care.
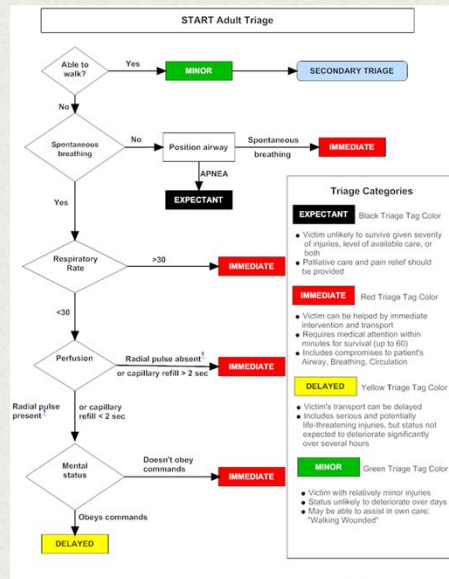
INSTRUCTOR NOTES:
Address respirations first. Many triage decisions can be made on this assessment alone.
This corresponds to the "A" and "B" of the ABCs of patient care.

START/JumpSTART—RPM

PULSE/PERFUSION

Is the *RADIAL* pulse present?

Is capillary refill (CR) *LESS* than < 2 seconds?

Yes
Check mental status

No
Adult: Pulse absent or
CR > 2 seconds patient
= **IMMEDIATE/RED**
Pediatric: No palpable
pulse patient =
IMMEDIATE/RED
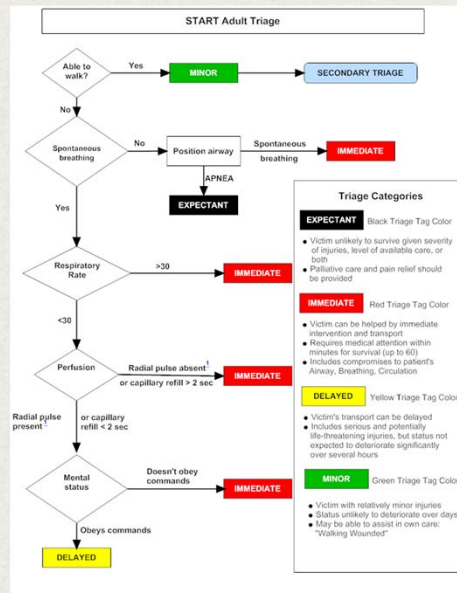
INSTRUCTOR NOTES:
This assessment corresponds to the "C" of the ABCs.

START/JumpSTART—RPM

MENTAL STATUS...

Can the patient follow simple commands?

Yes

Adult = DELAYED / YELLOW

Pediatric: alert, verbal, or pain response is appropriate
= DELAYED / YELLOW

No

Adult = IMMEDIATE / RED

Pediatric – "P" pain causes inappropriate posturing or "U" unresponsive to noxious stimuli = IMMEDIATE/ RED
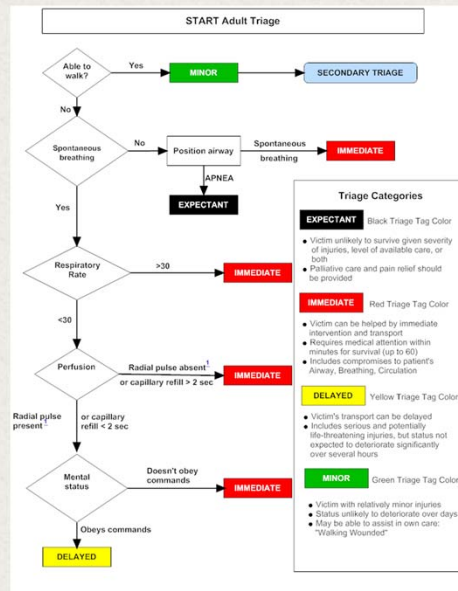
INSTRUCTOR NOTES:
Patients that have respirations more than 30/minute and capillary refill greater than 2 seconds, but who can follow commands, are still categorized as IMMEDIATE.

START/JumpSTART

If the patient is **IMMEDIATE/RED** upon initial assessment...then, before moving the patient to the treatment area, attempt only life-saving interventions:

Airway, Needle Decompression, Tourniquet, Antidote

DO NOT ATTEMPT ANY OTHER
TREATMENT AT THIS TIME

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INSTRUCTOR NOTES:
Only emergent and immediately life-saving interventions should be performed at this stage.
All other interventions should be made at the treatment area.
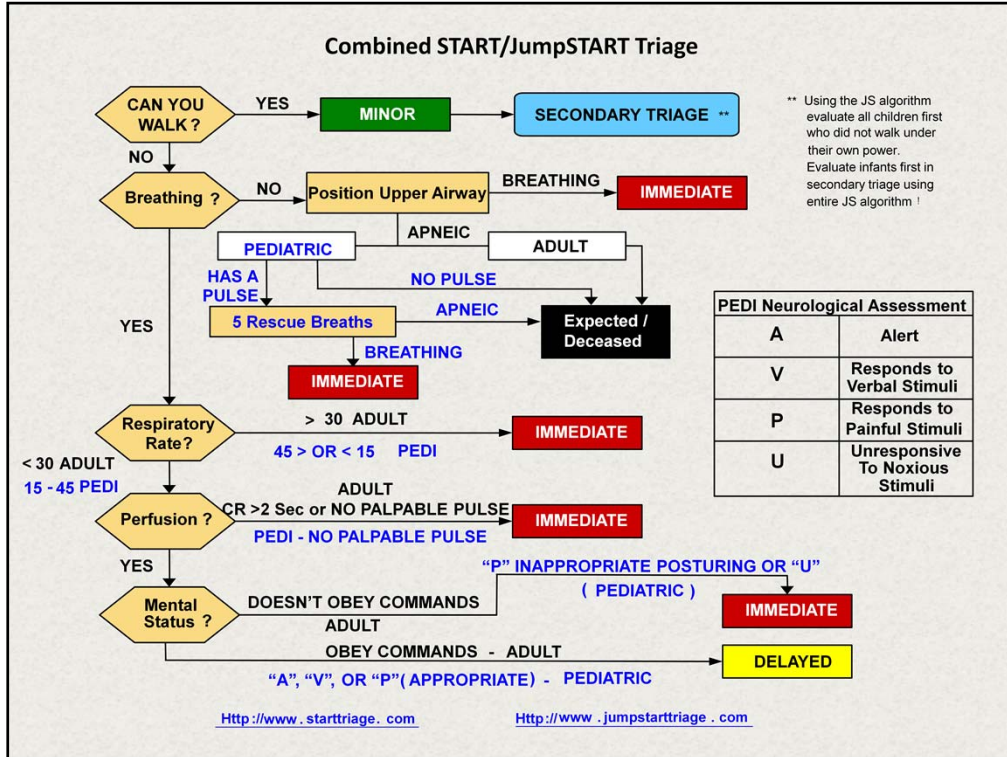
This is the combination START/JumpSTART algorithm. Separate START and JumpSTART algorithms are located at the end of this slide show, but hidden from the regular slide show.

Fast Triage – Ribbon Applied First

Apply ribbon to upper arm or upper thigh

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INSTRUCTOR NOTES:
The first round of patient contact will be performed in triage and category designation made with the colored ribbon.

RED Triage Category (Immediate)

Adult

Respirations > 30 BPM
CR > 2 seconds or
no palpable radial pulse
Cannot follow simple
commands

Pneumothorax
Hemorrhagic Shock
Closed Head Injury

Pediatric

Respirations < 15 or > 45
CR > 2 seconds or no palpable
radial or brachial pulse
Inappropriate "Pain"
(e.g., posturing) or
"Unresponsive"

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INSTRUCTOR NOTES:
The RED category is also referred to as IMMEDIATE and follows START criteria.
• Requires medical attention within minutes for survival (up to 60 minutes)
• Victim can be helped by immediate intervention and transport
• Includes compromises to patient's Airway, Breathing and Circulation

YELLOW Triage Category (Delayed)

Adult: respirations, capillary refill, and mentation are normal

- Isolated burns
- Extremity fractures
- Stable other trauma
- Most patients with medical complaints

Pediatric: "A," "V," or appropriate "P"
(e.g., withdrawal from pain stimulus)

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INSTRUCTOR NOTES:
The YELLOW category is also referred to as DELAYED.
• Victim's transport can be delayed
• Includes serious and potentially life-threatening injuries, but status not expected to deteriorate significantly over several hours

GREEN Triage Category (Minor)

- "Walking wounded"
- Psychological casualties
- Always look for children being carried and assess them

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INSTRUCTOR NOTES:

The GREEN category is also referred to as MINOR.

Victim with relatively minor injuries

- Status unlikely to deteriorate over days
- May be able to assist in own care
- "Walking Wounded"

GREY Triage Category (Expectant)

- This category is not currently in use and <u>must not</u> be utilized until approved by MIEMSS

- It is included on the paper tags in anticipation of national recognition and acceptance in the future

- GREY is for the patient that is not likely to survive even with emergent interventions

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INSTRUCTOR NOTES:
GREY is the new category for patients who are encountered alive but not expected to survive. This may be very short term survival (minutes) or may also include patients that could live for hours (such as extensive third degree burns), but ultimately not survive. It is anticipated that the GREY category will ultimately be adopted nationally but, until it is, will not be employed until notice is given by MIEMSS. There are no Grey ribbons in use currently.

BLACK Triage Category (Deceased)

- Obvious mortality or death (pulseless and apneic)
    - Decapitation
    - Blunt trauma arrest
    - Injuries incompatible with life (future GREY)
    - Brain matter visible (future GREY)

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INSTRUCTOR NOTES:
The BLACK category is for DECEASED or patients EXPECTED to die.
• Victim unlikely to survive given severity of injuries, level of available care, or both
• Palliative care and pain relief should be provided

Revised Paper Triage Tag

FRONT ← → BACK
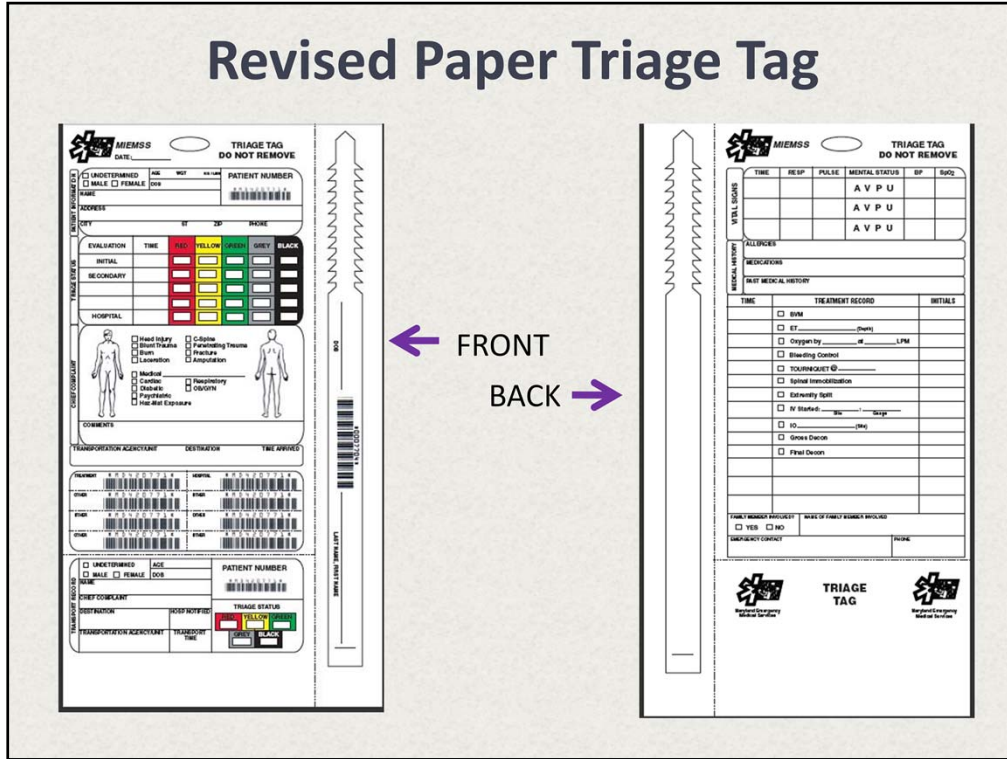
INSTRUCTOR NOTES:

The triage tags now have a GREY triage status category. This category is not currently approved for use but is printed on the tag in anticipation of its approval for use in the future. The criteria for its application will be presented a the time of its anticipated acceptance. The paper tags will be compared and contrasted with the screens of the HC handheld in the course of this program. The paper tags have a tear off wrist/ankle tag on the right side (when viewed from the front) that have a bar code for use in patient tracking with the handheld device.

Triage Tag Sections

- **Patient information**
- **Triage status**
- **Chief complaint**
- **Transporting unit**
- **Peel-off bar codes**
- **Transport record**

- **Vital signs**
- **Medical history**
- **Treatment**
- **Family contact**
- **Wrist band**

* Triage tags should be used in all MCI scenarios, even when handheld device is employed

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INSTRUCTOR NOTES:
These are the different sections of the triage tags.

INSTRUCTOR NOTES:

This information is important not only for patient identification but can also help with family reunification. Frequently, the urgency of the situation prevents obtaining this information "up front." It can be entered when time allows.

The paper triage tag includes a **GREY** category for *future use* based on *anticipated* national acceptance.

IT WILL NOT BE USED IN THE TRIAGE OF PATIENTS UNTIL APPROVED BY MIEMSS.

- Patient information
- <mark>TRIAGE STATUS</mark>
- Chief complaint
- Transporting unit
- Peel-off bar codes
- Transport record
- Vital signs
- Medical history
- Treatment
- Family contact
- Wrist band

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INSTRUCTOR NOTES:
Tags with a GREY category are in use but the category itself has not been approved for use in the triage of patients.

- Patient information
- Triage status
- **CHIEF COMPLAINT**
- Transporting unit
- Peel-off bar codes
- Transport record
- Vital signs
- Medical history
- Treatment
- Family contact
- Wrist band
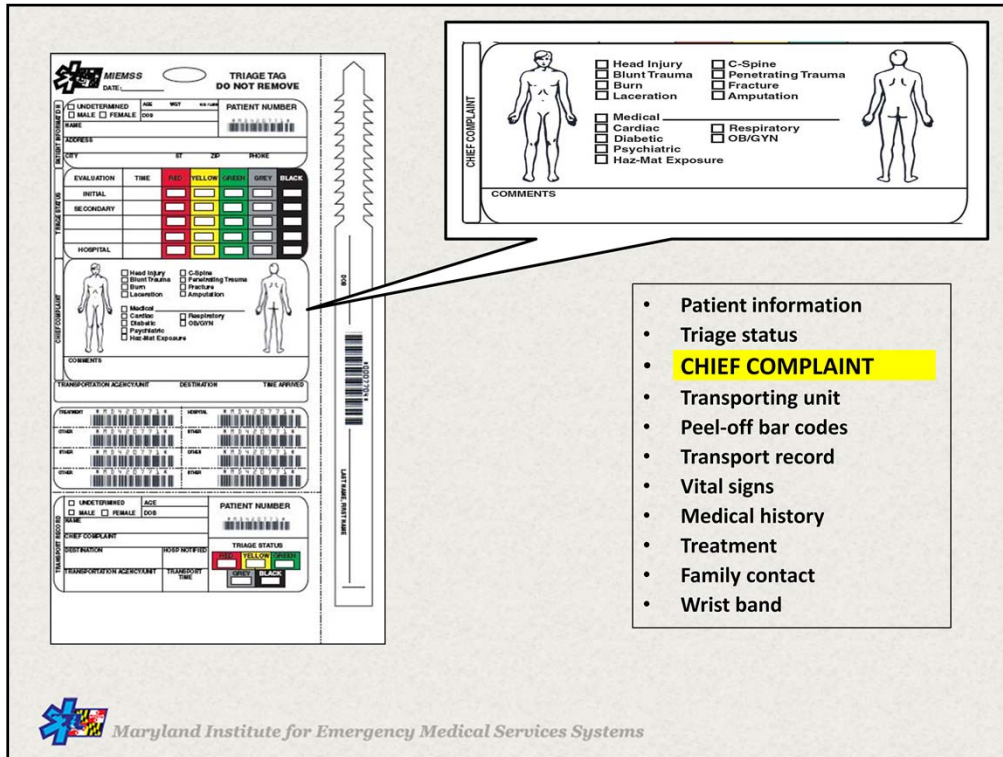
INSTRUCTOR NOTES:
The Chief Complaint section allows for the categorization of trauma or medical illness along with the opportunity to note the body part or region involved. The Comment section provides the opportunity to include additional or more specific information. For example, the burn category is demarcated by a circle and/or "X," but you can describe the burns as first, second, or third degree in the comments section.

INSTRUCTOR NOTES:

This section is filled out by Transportation Group Supervisor or Ambulance Disposition Coordinator or designee.

INSTRUCTOR NOTES:
The peel off bar codes are to be utilized to track a patient through the triage and transport process. They can also be used to identify and track patient belongings.

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INSTRUCTOR NOTES:
This section has come to be known as the "Ticket" and contains a synopsis of the patient's personal information, medical status, and transport history.

INSTRUCTOR NOTES:
This is the new removable wrist band. It can be placed on the patient to assist while utilizing the HC Standard Patient Tracking System.

INSTRUCTOR NOTES:
This section allows the care provider to sequentially document the R(espiration), P(ulse), and M(ental status) critical to the START (Simple Triage And Rapid Treatment) and JumpSTART process described earlier.

Mental status is indicated by the common AVPU system: Alert, responsive to erbal stimuli, responsive to Painful stimuli, or Unresponsive.

Blood pressure and oxygen saturation, while not part of the START process, provide information that can help in making decisions for medical care.

There are three sections to allow information to be recorded at different times. After all, triage is a dynamic process.

INSTRUCTOR NOTES:
Medical history is usually obtained as time allows.

INSTRUCTOR NOTES:
This section allows for the documentation of the treatments provided by multiple providers at different times in the patient's course of care. Timed delivery of care is especially important for something like tourniquet application.

- Patient information
- Triage status
- Chief complaint
- Transporting unit
- Peel-off bar codes
- Transport record
- Vital signs
- Medical history
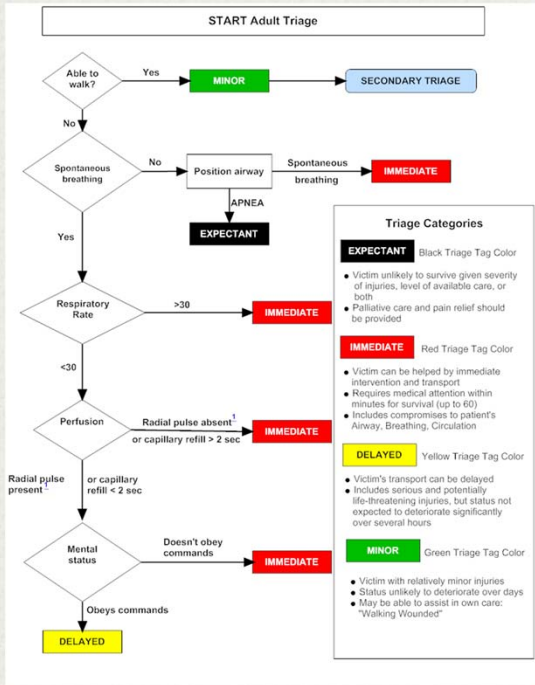- Treatment
- **FAMILY CONTACT**
- Wrist band

INSTRUCTOR NOTES:
This information is also critical to family reunification efforts.

Triage Summary

- **Triage allows for effective and efficient care, helping to increase the survivability for as many patients as possible**
- **Assignment of resources will increase efficiency**
- **Most severely injured patients will receive rapid treatment and transport in logical order**
- **Ensures accountability of all patients**
- **Allows for family reunification**

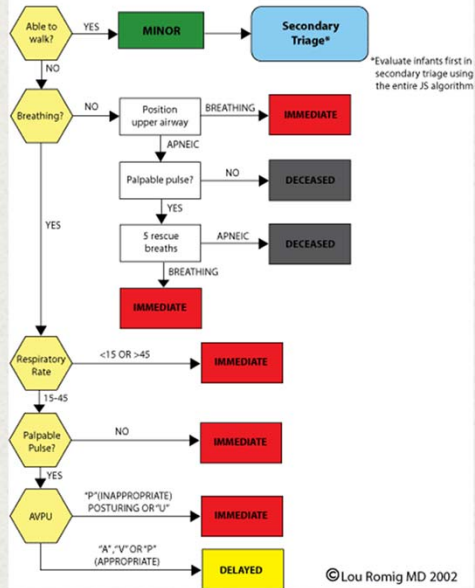*Maryland Institute for Emergency Medical Services Systems*

START Adult Triage

JumpSTART Pediatric MCI Triage©

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*Evaluate infants first in secondary triage using the entire JS algorithm

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Maryland Triage System

MIEMSS gratefully acknowledges the following individuals for their efforts in the development of this program:

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