

SALT Mass Casualty Triage

Concept Endorsed by the American College of Emergency Physicians, American College of Surgeons Committee on Trauma, American Trauma Society, National Association of EMS Physicians, National Disaster Life Support Education Consortium, and State and Territorial Injury Prevention Directors Association

It is recognized that there is a need for a national standard for mass casualty triage, because disasters frequently cross jurisdictional lines involving responders from multiple agencies. After reviewing all of the existing triage systems, a consensus review panel found that there was insufficient evidence to support 1 system over the others. Using aspects of the existing systems and based on best evidence, SALT (Sort-Assess-Lifesaving Interventions-Treatment and/or Transport) was developed as a national all-hazards mass casualty initial triage standard for all patients (eg, adults, children, special populations). SALT was designed to allow agencies to easily incorporate it into their current MCI triage protocol through simple modification.

STEP 1: SORT

SALT begins with a global sorting of patients, prioritizing them for individual assessment. Patients who can walk should

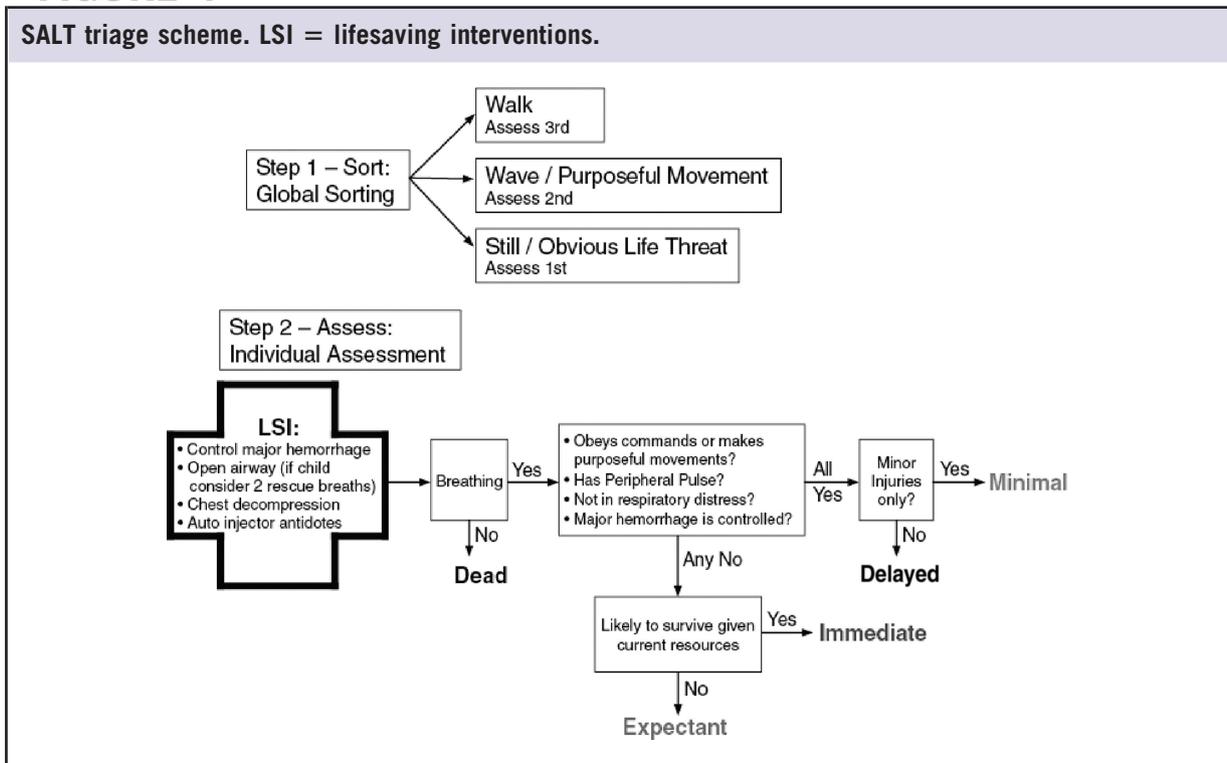
be asked to walk to a designated area and should be assigned last priority for individual assessment. Those who remain should be asked to wave (ie, follow a command) or be observed for purposeful movement. Those who do not move (ie, are still) and those with obvious life-threatening conditions should be assessed first because they are the most likely to need lifesaving interventions (Fig. 1).

STEP 2: ASSESS

The individual assessment should begin with limited rapid lifesaving interventions:

- Control major hemorrhage through the use of tourniquets or direct pressure provided by other patients or other devices
- Open the airway through positioning or basic airway adjuncts (no advanced airway devices should be used)

FIGURE 1



SALT Mass Casualty Triage

If the patient is a child, consider giving 2 rescue breaths

- Chest decompression
- Autoinjector antidotes

Lifesaving interventions should be performed only within the responder's scope of practice and only if the equipment is immediately available.

Patients should be prioritized for treatment and/or transport by assigning them to 1 of 5 categories: immediate, expectant, delayed, minimal, or dead. Patients who have mild injuries that are self-limited if not treated and can tolerate a delay in care without increasing their risk of mortality should be triaged as minimal and should be designated with the color green. Patients who are not breathing even after lifesaving interventions are attempted should be triaged as dead and should be designated with the color black. Patients who do not obey commands, or do not have a peripheral pulse, or are in respiratory distress, or have uncontrolled major hemorrhage should be triaged as immediate and should be designated with the color red. Providers should consider whether these patients have injuries that are likely to be incompatible with life given the currently available resources; if the injuries meet this qualification, then the provider should triage

these patients as expectant and they should be designated with the color gray. The remaining patients should be triaged as delayed and should be designated with the color yellow.

This prioritization process is dynamic and may be altered by changing patient conditions, resources, and scene safety. Triage labeling systems should account for the dynamic nature of triage and be easily modifiable for a single patient. After immediate patients have been cared for, patients designated as expectant, delayed, or minimal should be reassessed as soon as possible, with the expectation that some patients will have improved and others will have decompensated. In general, treatment and/or transport should be provided for immediate patients first, then delayed, then minimal. Expectant patients should be provided with treatment and/or transport when resources permit. Efficient use of transport assets may include mixing categories of patients and using alternate forms of transport. Some patients may only require treatment at the scene and not transport.

Received for publication May 17, 2008; accepted July 9, 2008.

ISSN: 1935-7893 © 2008 by the American Medical Association and Lippincott Williams & Wilkins.

DOI: 10.1097/DMP.0b013e31818d191e