



A.L.E.R.T. TRIAGE METHOD

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Disclosure statement

- Medical Director for PerSys medical

Background

- Ranger
- Special Forces Operator
- Paramedic
- EM Physician assigned to Tier 1 SMU
- SWAT/SRT Physician with Center for Tactical Medicine and TEMS instructor for NTOA
- Relevant mass casualty experience:
 - *Chimore, Bolivia, 1997. 24 wounded, 3 dead*
 - *Fort Hood, Texas, 2014. 14 wounded, 4 dead*

Triage in MCI

- Chaotic
- Typically 2-3 tier by default
- Triage of treatment and triage of transport may be different
- Must start sooner!
- We make it more complicated than it needs to be
- Note: A multi-vehicle MVC is not like a mass shooter MCI
 - *Penetrating trauma is not like blunt trauma (Humor me)*
 - *MVC: FF or Paramedic will likely be the first to see patient*
 - *Mass shooter: An LEO will likely be the first to see the patient*

We have already made progress!

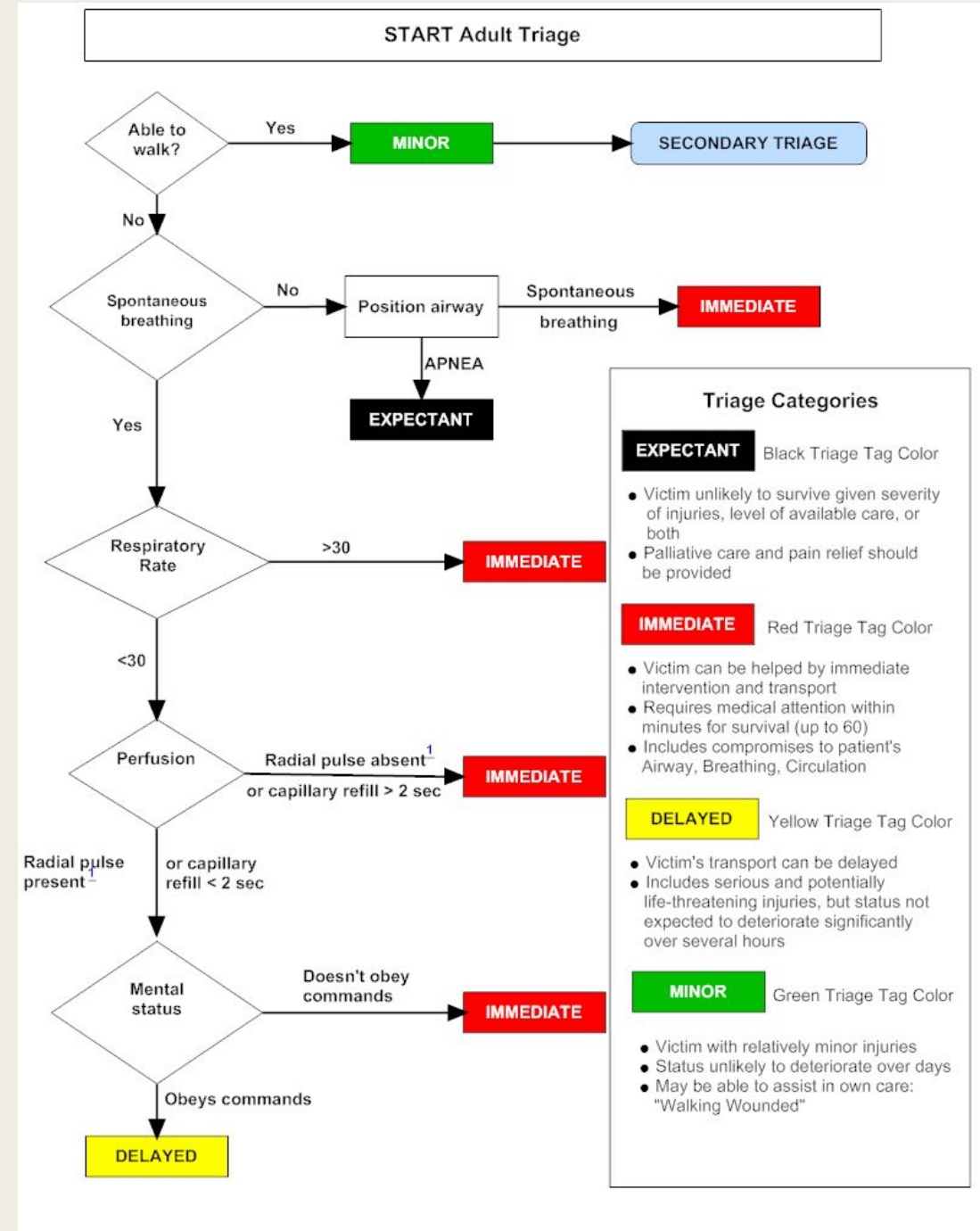
- Pushing TECC level care down to every LEO (in process)
- IFAKs becoming more common (get them out of the trunk!)
- Improving cooperability between LE and medical
- Next?
 - *Mandate that EVERY LEO carries and IFAK and is TECC trained*
 - *Teach preliminary triage (The ‘Fifth man’)*

Current triage models:

- START
- SALT
- RAMP

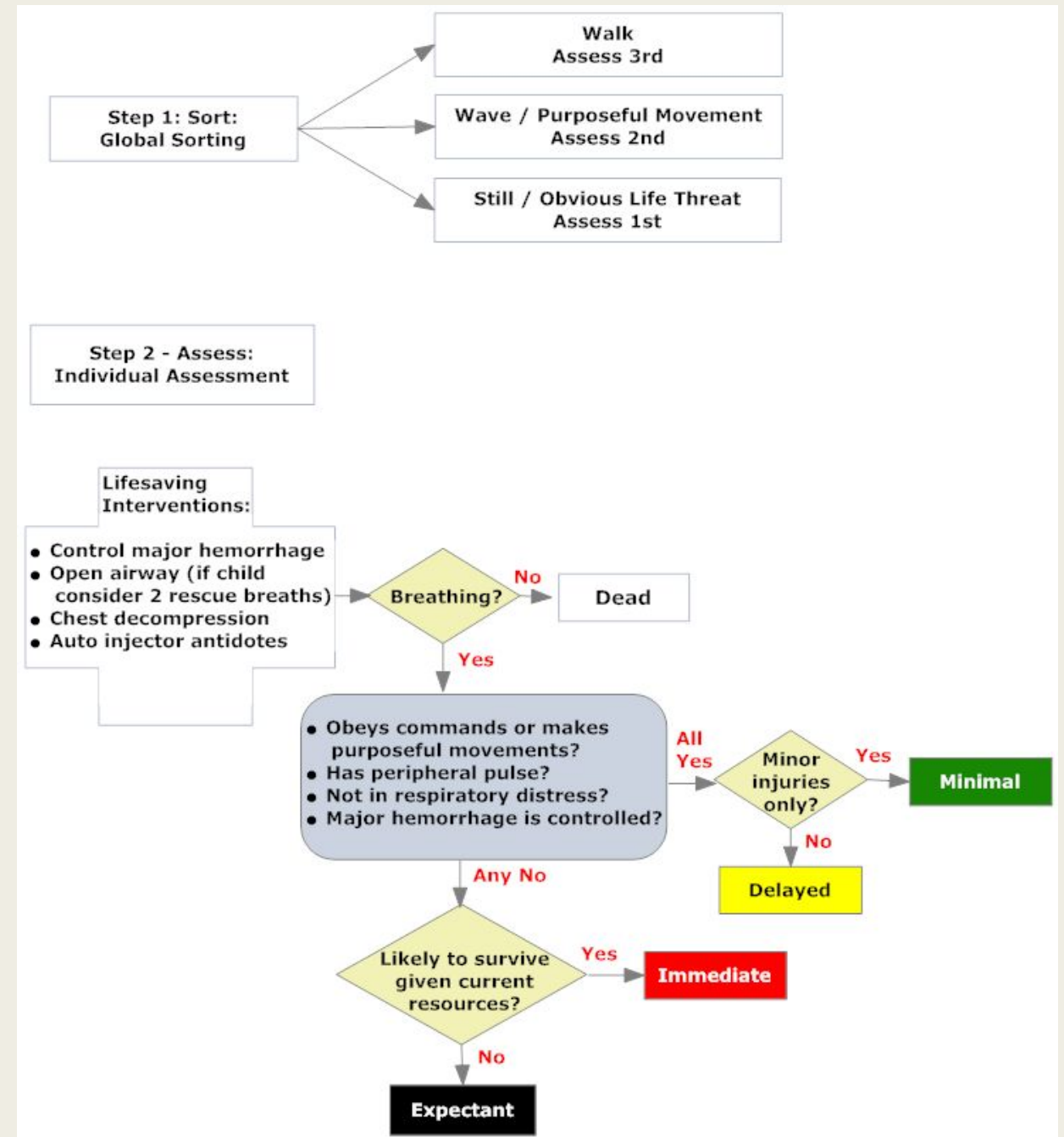
START Triage

- Cumbersome
- Time consuming
- Requires evaluation of respirations and cap refill
- Inaccurate



SALT Triage

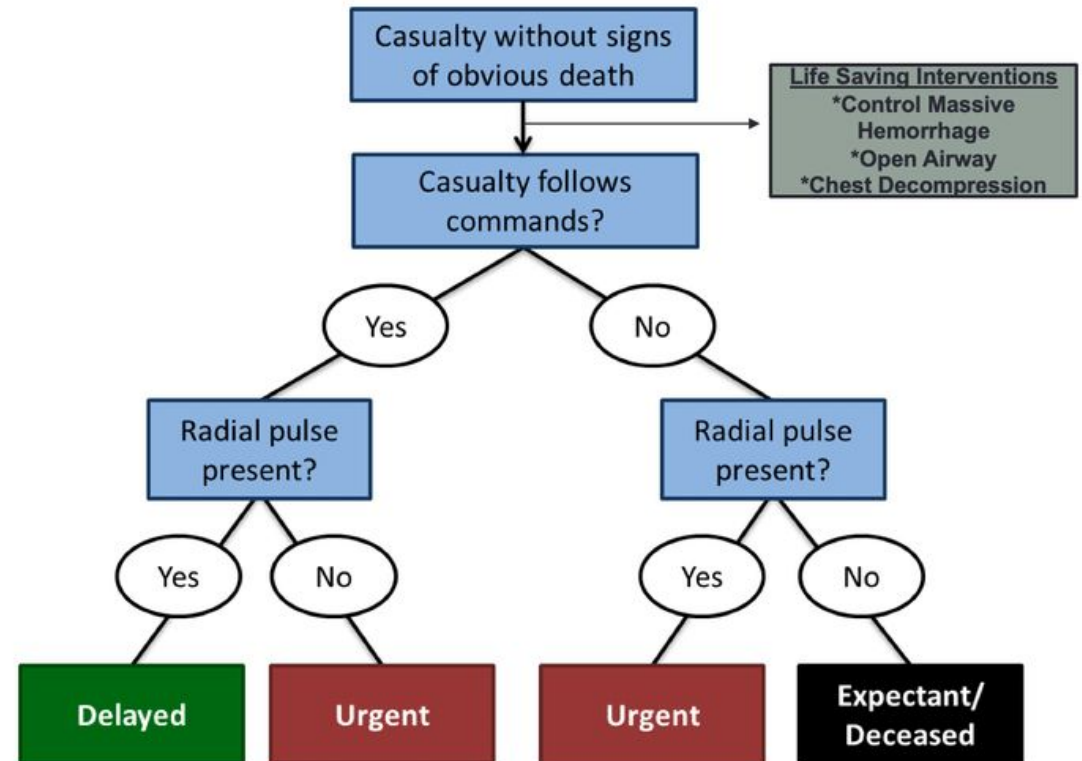
- Integrates treatment
- Multi-step
- Confusing
- Inaccurate
- More a treatment algorithm, than a triage system



RAMP Triage

- Recognizes the need for simplicity
- Evidence based approach
- Based on symptoms instead of causes (mental status, pulse, etc)
- Misses possible life threatening injuries

RAMP Triage Model (Rapid Assessment of Mentation and Pulse)



A.L.E.R.T.

Triage

- Specifically for penetrating trauma (Mass shooter MCI)
- Not for MVC, building collapse, etc
- Designed for non-medical personnel (LEOs or bystanders)
- Requires minimal clinical judgement
- Works on “Zones”



Civilian Mass Shooter MCI wounding/death

- 58% of wounds are to the head or chest
- 77% of DEATHS are from head/chest wounds
- 89% of potentially survivable wounds were to the chest**
- No deaths from exsanguination from extremity wounds

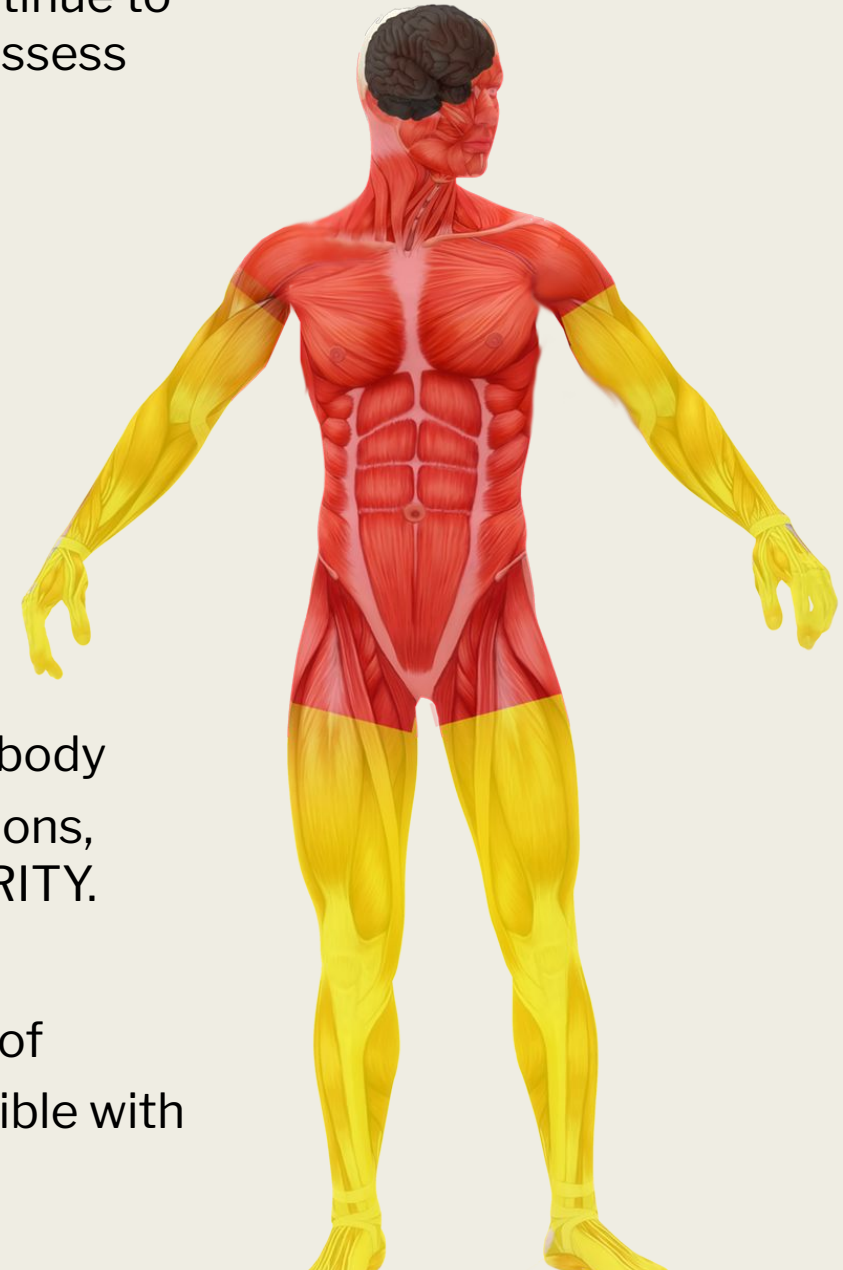
Assess casualties. Those obviously dead and those who are uninjured do not require triage. Treat immediate life threats (M.A.R.) and continue to assess each individual casualty to assign their triage category (Reassess throughout).

Life-threatening: Penetrating trauma in the junctional areas, chest, abdomen, face, or neck. **FIRST TRIAGE/TRANSPORT PRIORITY!**

Emergent: Penetrating injuries to the extremities which require a tourniquet or pressure dressing with bleeding controlled. **SECOND TRIAGE/TRANSPORT PRIORITY!**

Relatively-minor: Injuries in any region of the body that are superficial in nature and require minimal treatment (abrasions, minor cuts, etc.). **LOW TO VERY LOW TRIAGE/TRANSPORT PRIORITY.**

Terminal: Penetrating trauma to the cranium with loss of consciousness or any extreme injuries that are obviously incompatible with life. **LAST TRIAGE/TRANSPORT PRIORITY.**



Concept of Integration

- Three-tier system
 - *A.L.E.R.T. Triage and TECC/BLS intervention (LEOs/bystanders)*
 - *Professional triage and advanced care. i.e RAMP (FF Paramedics)*
 - *Final/surgical triage and definitive care (Receiving Trauma Center)*
- Two and three tiered triage is already occurring by default!

Pulse Nightclub, June 12th 2016

- 49 Casualties
- 16 died of survivable wounds:
 - *‘potentially survivable injury (defined as survival if prehospital care is provided within 10 minutes and trauma center care within 60 minutes of injury)’***
- Shooting began at 2:02am
- Police entered scene at 2:10am (8 minutes)
- The nearest Level 1 Trauma Center was/is 1/2 mile away (20 minute walk)
- Takeaway: TECC level care and proper triage could have saved lives!!

A.L.E.R.T. Triage

- So easy, a caveman can do it.



References

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