This international standard was developed in accordance with internationally recognized principles on standardization established in the Decision on Principles for the Development of International Standards, Guides and Recommendations issued by the World Trade Organization Technical Barriers to Trade (TBT) Committee.

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# Standard Guide for Scope of Performance of Triage in a Prehospital Environment[1]

This standard is issued under the fixed designation F1653; the number immediately following the designation indicates the year of original adoption or, in the case of revision, the year of last revision. A number in parentheses indicates the year of last reapproval. A superscript epsilon (ε) indicates an editorial change since the last revision or reapproval.

## INTRODUCTION

Triage is a word taken from the French verb *trier*, that means "to sort." During the time of the Napoleonic wars, a technique for assigning priorities to the treatment of battlefield casualties was established in order to maximize the use of limited resources. The basic principle of triage is to do the greatest good for the greatest number of casualties. Care is provided first to those with the most serious emergencies and to those who are most salvageable. This technique is identified as essential for good disaster medical care.

## 1. Scope

1.1 This guide covers minimum requirements for the scope of performance for individuals who perform triage at an emergency medical incident involving multiple casualties in a pre-hospital environment.

1.2 This guide acknowledges objectives based on an individual's required knowledge of signs and symptoms, patient assessment, and basic life support.

1.3 Operating within the framework of this guide may expose personnel to hazardous materials, procedures, and equipment. For additional information see Practice F1031 and Guides F1219, F1253, F1285, F1287, F1288, F1489 and F1651.

1.4 *This standard does not purport to address all of the safety concerns, if any, associated with its use. It is the responsibility of the user of this standard to establish appropriate safety, health, and environmental practices and determine the applicability of regulatory limitations prior to use.* For specific precautionary statements, see Footnote 2.[2]

1.5 *This international standard was developed in accordance with internationally recognized principles on standardization established in the Decision on Principles for the Development of International Standards, Guides and Recommendations issued by the World Trade Organization Technical Barriers to Trade (TBT) Committee.*

## 2. Referenced Documents

2.1 *ASTM Standards:*[3]

F1031 Practice for Training the Emergency Medical Technician (Basic)

F1177 Terminology Relating to Emergency Medical Services (Withdrawn 2018)[4]

F1219 Guide for Training the Emergency Medical Technician (Basic) to Perform Patient Initial and Detailed Assessment (Withdrawn 2006)[4]

F1253 Guide for Training the Emergency Medical Technician (Basic) to Perform Patient Secondary Assessment (Withdrawn 1999)[4]

F1285 Guide for Training the Emergency Medical Technician to Perform Patient Examination Techniques

F1287 Guide for Scope of Performance of First Responders Who Provide Emergency Medical Care

F1288 Guide for Planning for and Response to a Multiple Casualty Incident (Withdrawn 2018)[4]

F1489 Guide for Performance of Patient Assessment by the Emergency Medical Technician (Paramedic) (Withdrawn 2003)[4]

F1651 Guide for Training the Emergency Medical Technician (Paramedic) (Withdrawn 2018)[4]

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[1] This guide is under the jurisdiction of ASTM Committee F30 on Emergency Medical Services and is the direct responsibility of Subcommittee F30.02 on Personnel, Training and Education.

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[2] Most recent "Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac Care," as reprinted from the *Journal of the American Medical Association*, available from American Heart Association, 7272 Greenville Ave., Dallas, TX 75231.

[3] For referenced ASTM standards, visit the ASTM website, www.astm.org, or contact ASTM Customer Service at service@astm.org. For *Annual Book of ASTM Standards* volume information, refer to the standard's Document Summary page on the ASTM website.

[4] The last approved version of this historical standard is referenced on www.astm.org.

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## 3. Terminology

3.1 *Definitions of Terms Specific to This Standard:*

3.1.1 *ongoing triage, n*—the continuing process of patient assessment and prioritization in a multiple casualty incident. (Also known as *secondary* and *tertiary*.)

3.1.2 *primary triage, n*—the initial process of rapid assessment, provision of life-saving interventions, and assignment of visual priority identification to each patient in a multiple casualty incident.

3.1.3 *triage, n*—the process of sorting and prioritizing care of the sick and injured on the basis of urgency and type of condition present, as well as the number of patients and resources available. The objective is to properly treat and transport patients to medical facilities appropriately situated and equipped for their care.

3.2 For definitions of other terms used in this guide, refer to Terminology F1177.

## 4. Significance and Use

4.1 This guide is not intended to be used by itself, but as a component of Guide F1288. Merely conforming to the guidelines described herein will not ensure that adequate triage is carried out in a multiple casualty incident.

4.2 The purpose of this guide is to establish a methodology for performing triage.

4.3 Individuals responsible for performing triage must be proficient in triage methods and related life-saving techniques.

4.4 A basic concept of triage is to do the greatest good for the greatest number of casualties.

4.5 The assessment process must be focused so as to identify those most at risk of early death who are likely to be salvaged by rapid medical intervention.

4.6 Triage allows the most efficient use of available resources.

4.7 This guide acknowledges many types of individuals with varying levels of emergency medical training. It also establishes a minimum scope of performance and encourages the addition of optional knowledge, skills, and attitudinal objectives.

4.8 A vital role in the development of and operational application of triage is that of medical control. This guide should be used by medical directors in the determination of operational and medical protocols for use during MCIs.

4.9 This guide is intended to assist those who are responsible for defining the scope of performance of individuals who perform triage.

4.10 For the purpose of this guide the word "injured" includes both sick or injured patients, or both.

## 5. Objectives

5.1 *Required Objectives*—These objectives are in an order suggesting a particular performance sequence, although some may be performed concurrently. Some incidents may not require performance of all objectives. Individuals who perform triage shall be able to:

5.1.1 Identify health and safety hazards and initiate appropriate actions.

5.1.2 Recognize an incident that may require triage.

5.1.3 Determine the need for and request additional resources.

5.1.4 Initiate incident command Guide F1288.

5.1.5 Identify conditions which may dictate a decision to treat patients at the scene or transfer them to a designated treatment area.

5.1.6 Initiate Primary Triage.

5.1.6.1 Identify victims who appear to be uninjured or minimally injured and able to help themselves, and direct them to a designated area of safety.

5.1.6.2 Perform a rapid assessment of the remaining victims. Check respiratory status, circulatory status and level of consciousness.

5.1.6.3 Immediate medical interventions should be limited to opening the airway and controlling gross hemorrhage. These interventions should not stop the process of triage.

5.1.6.4 Assign a triage priority to each victim, including the uninjured, and use a visual marker for individual identification. Patients are placed into the following categories in accordance with the assessment outcome and in accordance with the local standard of medical care:

*(a) First Priority/Immediate (RED)*—Those patients with serious injuries that are life threatening but have a high probability of survival.

*(b) Second Priority/Delayed (YELLOW)*—Those patients who are seriously injured and whose lives are not immediately threatened. The triage category of these patients may change to first priority based on medical resources at any time during an incident.

*(c) Third Priority/Minor (GREEN)*—Those patients who are injured but do not require immediate medical attention and those apparently not physically injured.

*(d) Fourth Priority/Dead/Mortally Wounded (BLACK)*—Those patients who are obviously dead as determined by medical protocol or those patients with severe injuries and a low probability of survival, despite immediate care. As this is a difficult field decision, actual practice may be to provide treatment and transportation.

5.1.6.5 Arrange for transfer of patients based on highest priority first, to a location where they can receive the appropriate level of care.

5.1.7 Initiate Ongoing Triage.

5.1.8 Document triage priority, assessment, treatment rendered, and patient identification.

5.1.9 Continue transferring patients by highest priority as resources become available.

5.1.10 Triage is a dynamic process. It will be repeated and performed as necessary during an event and in other phases of the continuum of care.

5.2 *Optional Objectives:*

5.2.1 Demonstrate a knowledge of the principles of the Incident Command System (ICS).

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