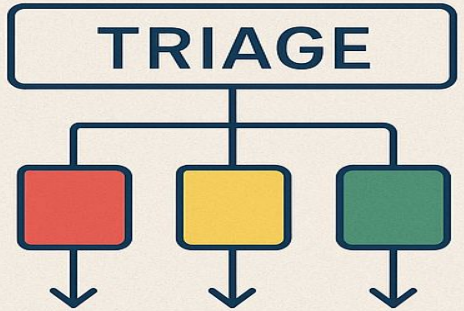
INTERNATIONAL DISASTER NURSING



TRIAGE SYSTEMS AND THE ROLE OF NURSES IN DISASTERS

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Learning Objectives

Understand key triage systems used globally

Describe the nurse’s role in disaster triage

Recognize cultural, ethical, and situational considerations in international contexts

Apply principles to real-world scenarios

Before we Begin…

Let’s do a poll

1 for Nurses

2 for Physicians

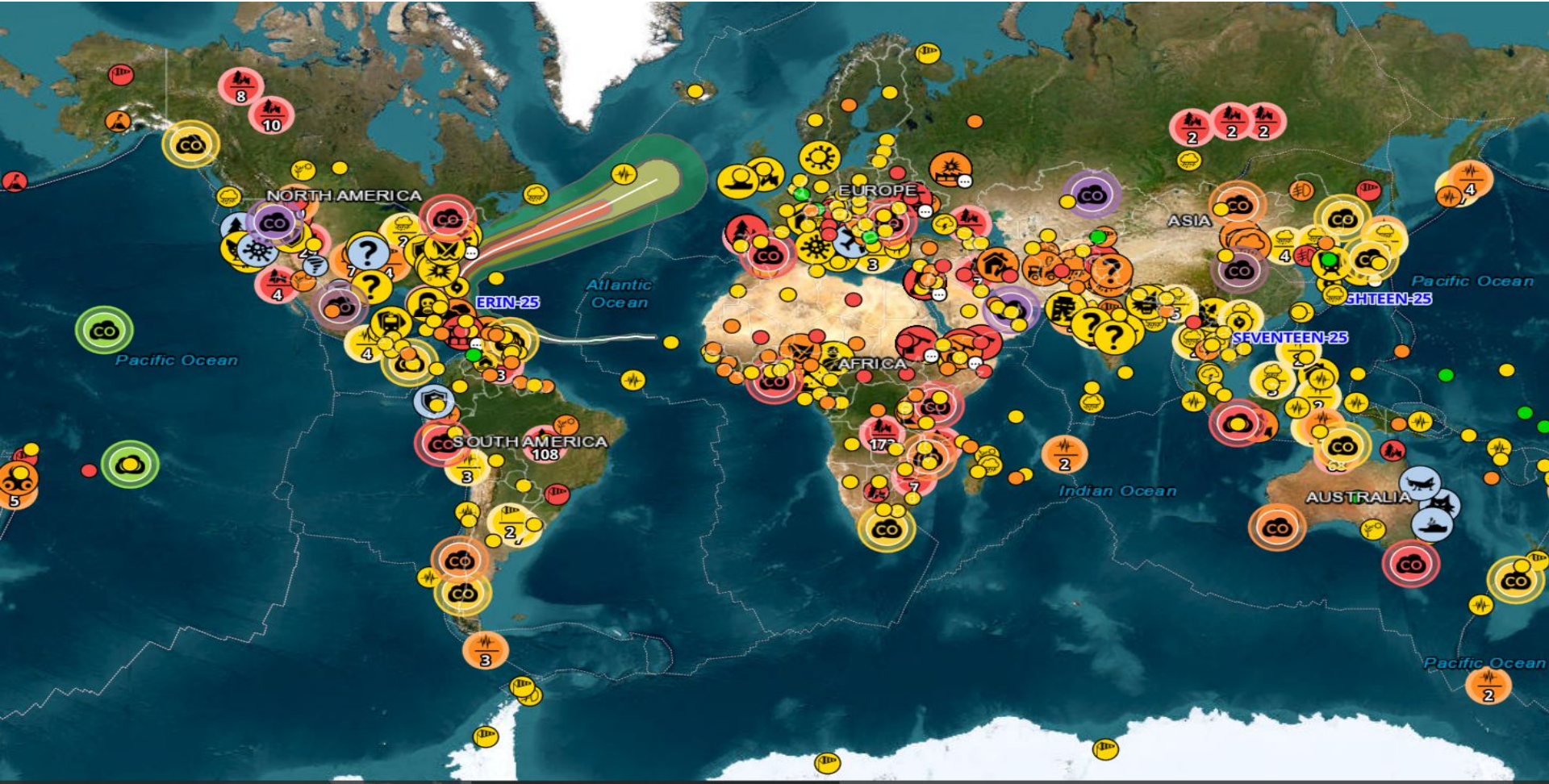
3 Paramedics

4 for other

One more Poll…

1. LATAC
2. Other
    a. Where?

Global Disaster Context



What is Disaster Triage?

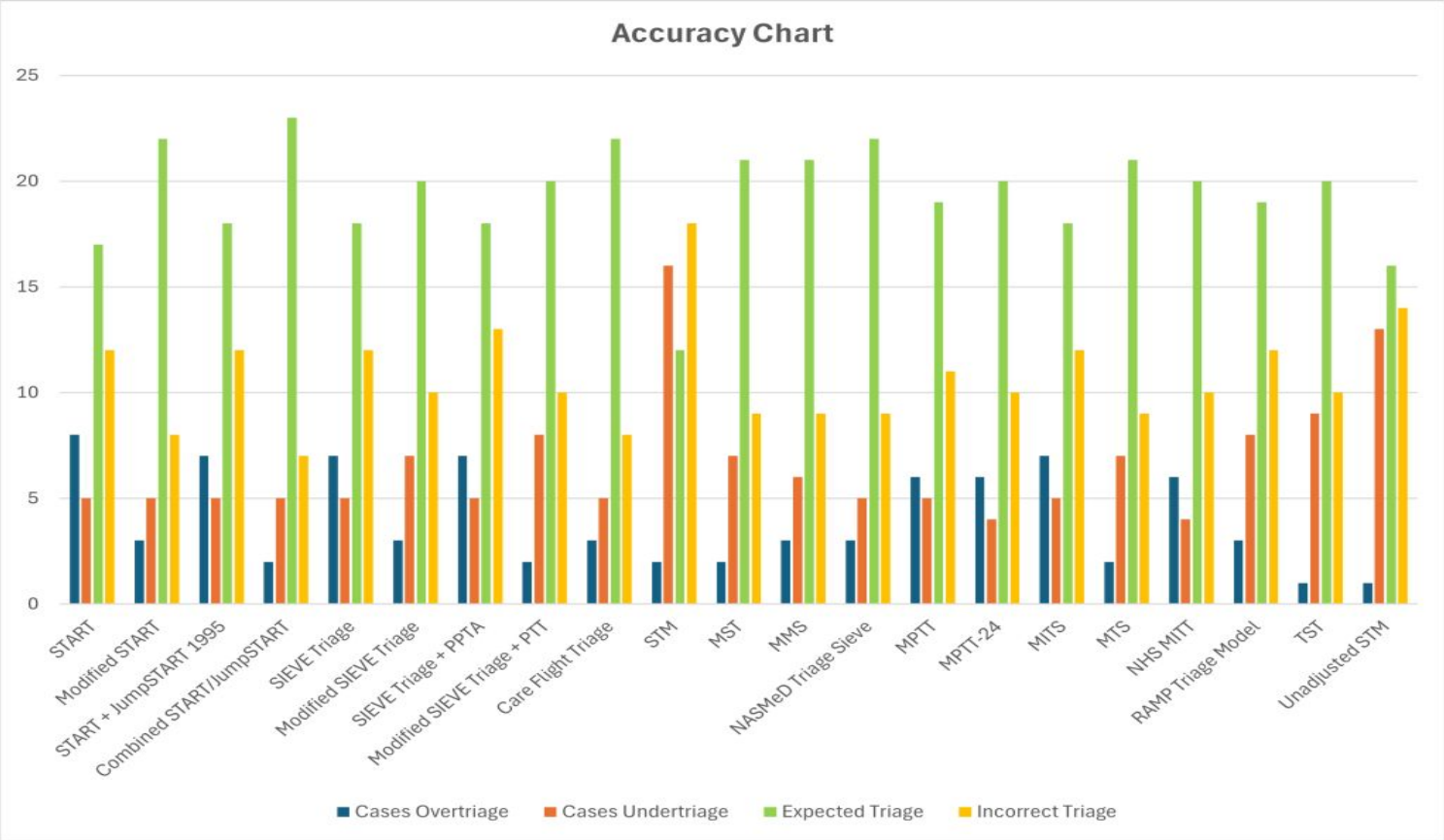
Sorting patients based on priority for treatment and transport

“Do the greatest good for the greatest number” principle

Differences between disaster triage and routine emergency department triage

Priority Number	Priority Color	Name	Description
1	Red	Immediate/Emergency	Life in imminent danger and require immediate treatment
2	Yellow	Delayed	Life not in immediate danger but requires urgent, not immediate, medical care
3	Green	Minimal	Minor injuries that will eventually require treatment
No priority	Black	Expectant/Dead	Injuries are too extensive to be treated with available resources

Algorithm Primary Triage Systems should not be used in Mass Casualty Incidents - medtigo Journal



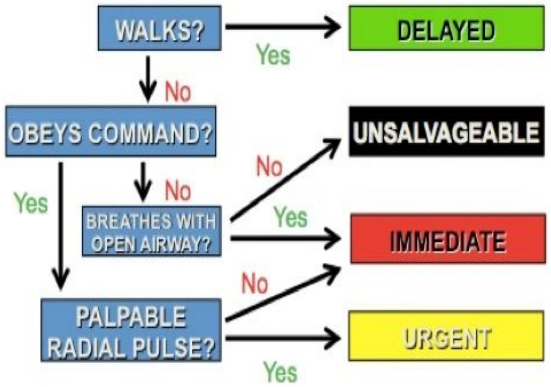
Key International Triage Systems

START (Simple Triage and Rapid Treatment) – widely used in mass casualty incidents

JumpSTART – pediatric adaptation

SALT Triage – Sort, Assess, Lifesaving interventions, Treatment/Transport

CareFlight – rapid color-tagging system

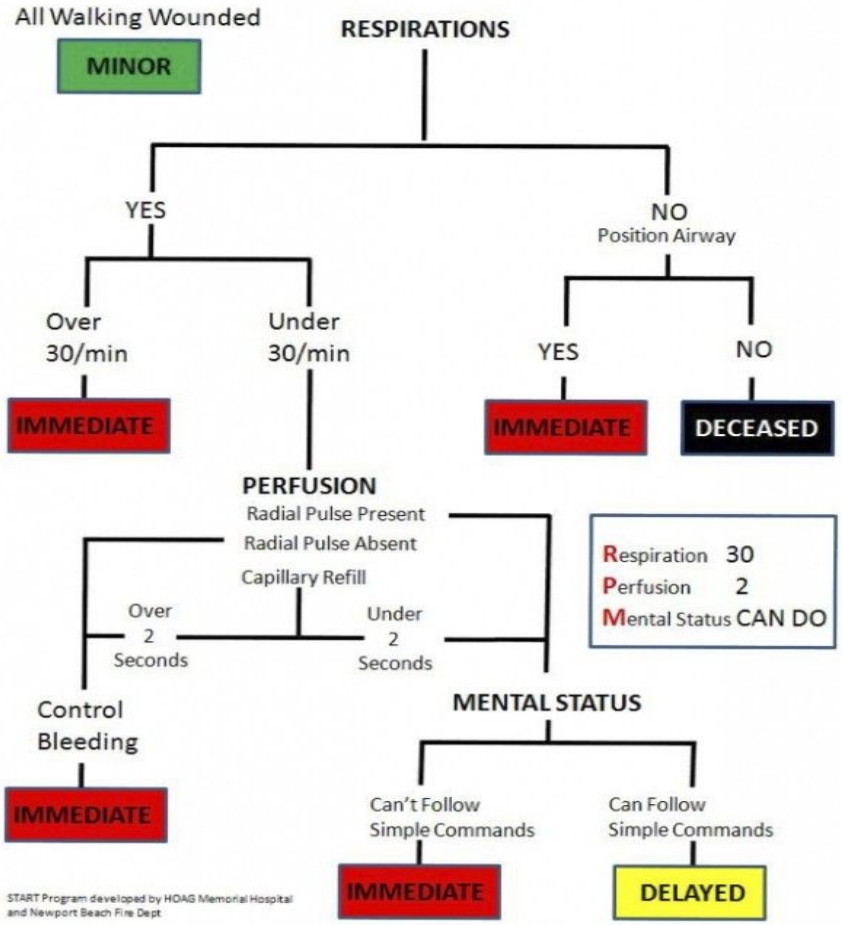


Other regional systems

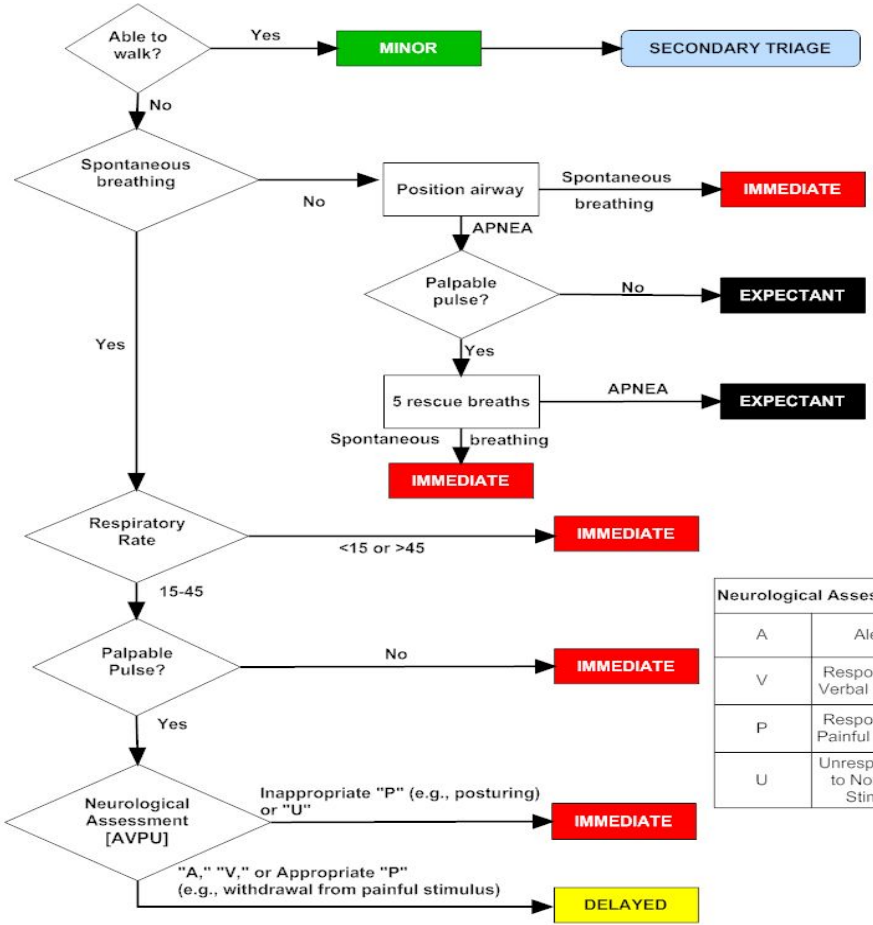
- UK: Triage Sieve / Triage Sort
- Australia: Primary/Secondary Survey adaptation
- Japan: Disaster Medical Assistance Team (DMAT) protocols

START TRIAGE

(Simple Triage and Rapid Treatment)



JumpSTART Pediatric Multiple Casualty Incident Triage

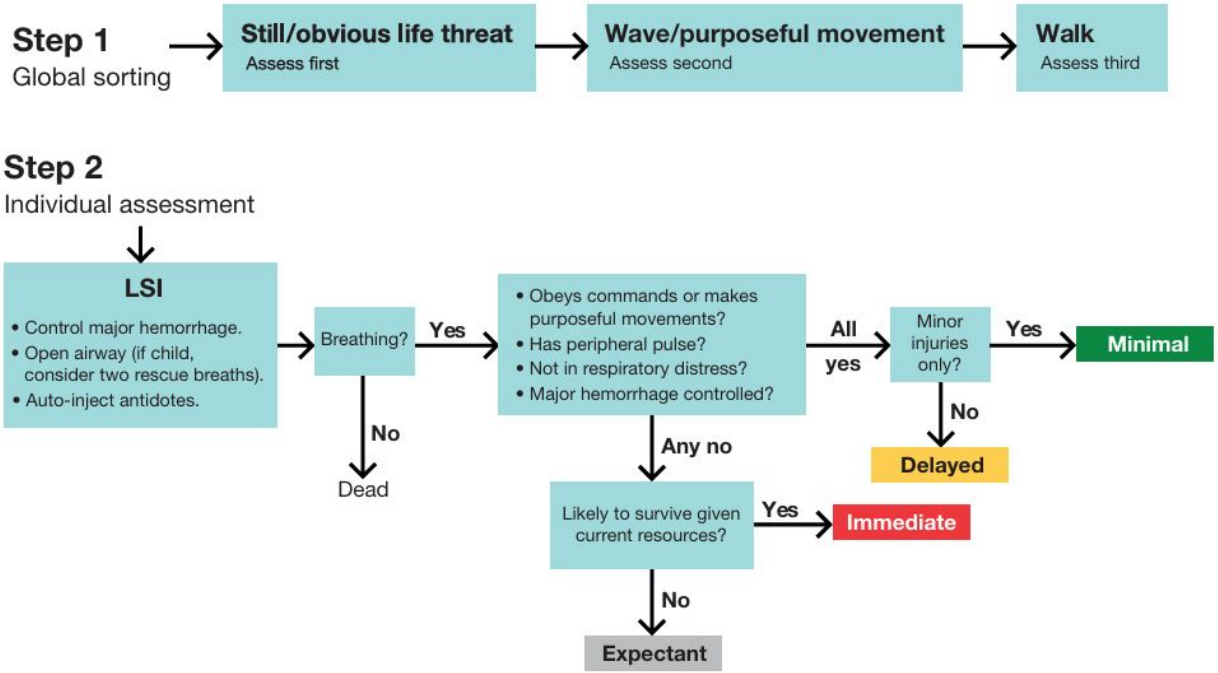


Neurological Assessment	
A	Alert
V	Responds to Verbal Stimuli
P	Responds to Painful Stimuli
U	Unresponsive to Noxious Stimuli

Use JumpSTART if the Patient appears to be a child.

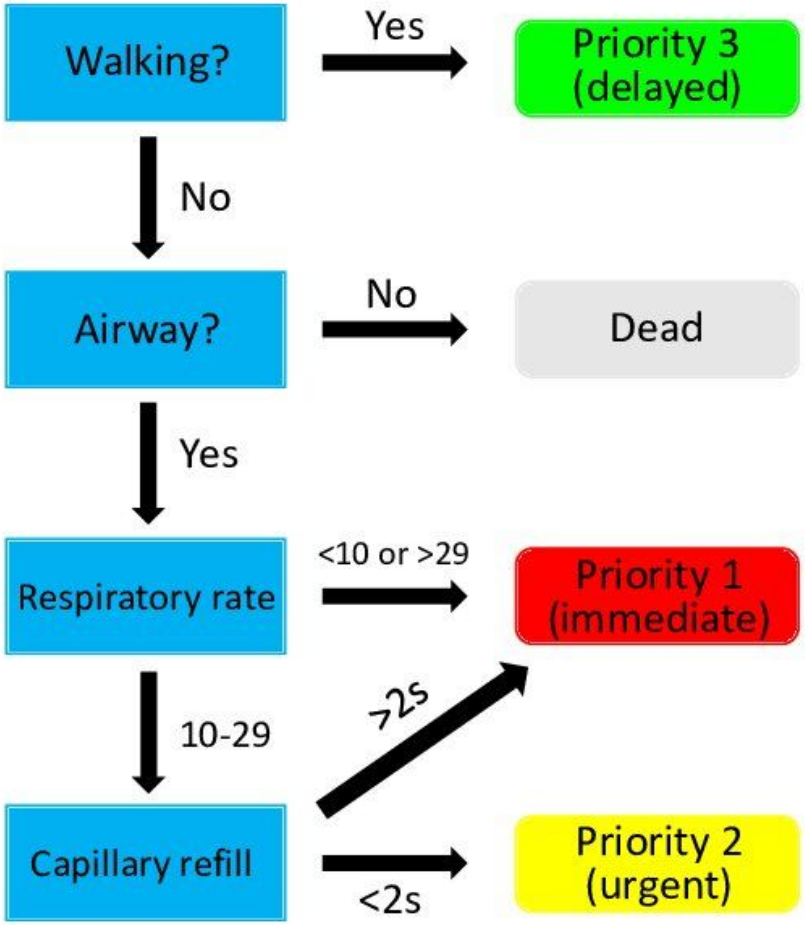
Use an adult system, such as START, if the patient appears to be a young adult.

SALT Mass Casualty Triage

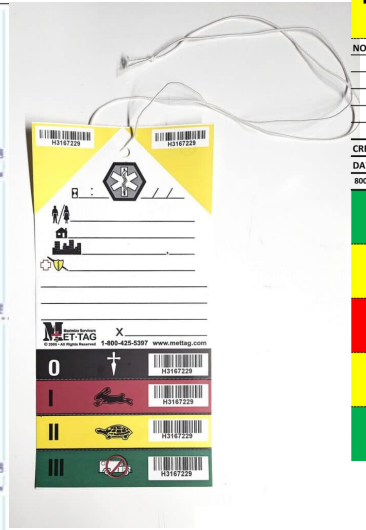


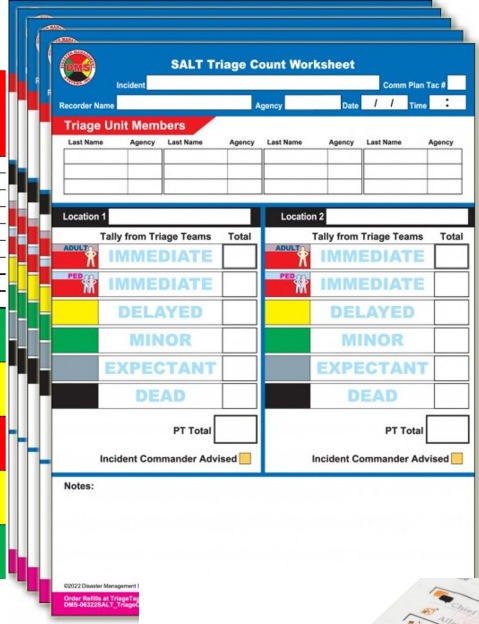
Sort, Assess, Lifesaving Interventions, Treatment/Transport (SALT) triage system replaces Simple Triage and Rapid Treatment (START).

Source: U.S. National Library of Medicine.


Walking?
Yes
Priority 3 (delayed)
No
Airway?
No
Dead
Yes
Respiratory rate
<10 or >29
Priority 1 (immediate)
10-29
>2s
Capillary refill
Priority 2 (urgent)
<2s

Types of Triage Tags





Role of Nurses in Triage

Rapid assessment under pressure

Integration into multidisciplinary teams

Communication/documentation

Leadership and coordination roles

Adapting in International Contexts

Working with unfamiliar infrastructure

Cultural sensitivity and language barriers

Resource scarcity adjustments

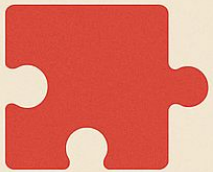
Ethical and Psychological Considerations

Moral distress during resource scarcity

Balancing fairness and urgency

Cultural considerations in prioritization

Key Takeaways



No one-size-fits-all triage system

Nurses are central to effective triage

Cultural awareness and adaptability are critical


ARE YOU
READY?

A tornado has struck a small town, and multiple victims are brought to a community shelter for rapid triage. You are the nurse assigned to initial SALT triage.

1. **35-year-old male** lying on the ground, not moving. When you call to him, he opens his eyes but cannot stand. Breathing is 24/min, cap refill >2 seconds, weak radial pulse, multiple deep lacerations.

2. **60-year-old female** walking toward you holding her arm. Severe bleeding from forearm, controlled with direct pressure. She is alert, talking clearly, and breathing normally.

3. **10-year-old boy** sitting in a chair crying loudly. No visible injuries. Vitals normal.

4. **40-year-old male** unresponsive, not breathing after airway repositioning.

5. **25-year-old female** awake, oriented, with abdominal pain and bruising. Respirations 30/min, pulse rapid, skin pale.

Use **SALT triage steps** (Sort, Assess, Life-Saving Interventions, Treatment/Transport) and assign categories: Immediate (Red), Delayed (Yellow), Minimal (Green), or Expectant/Dead (Black).

A school bus carrying 20 children has overturned. You arrive on scene with EMS and are assigned to pediatric triage using JumpSTART.

1. **5-year-old female** found crying and walking. Minor abrasions on knees, respirations 22/min, cap refill <2 sec.

2. **8-year-old male** not breathing when found. You reposition his airway—he begins breathing at 28/min with a weak cry.

3. **3-year-old male** breathing at 10/min, pulse weak, unresponsive to pain.

4. **6-year-old female** awake, alert, unable to walk due to obvious femur fracture. Respirations 30/min, pulse strong, skin warm.

5. **12-year-old male** walking around, helping others, only complaint is mild wrist pain.

Apply **JumpSTART algorithm** (walking wounded, breathing, rescue breaths if needed, respiratory rate/pulse/mental status checks) and assign triage tags.

A multi-vehicle accident occurs on a rural highway. Helicopter EMS (CareFlight) arrives and begins triage at the scene.

1. **45-year-old truck driver** found unresponsive, respirations 8/min, weak radial pulse.

2. **32-year-old pregnant female (28 weeks)** sitting on the roadside, complaining of abdominal pain, respirations 28/min, pulse strong, skin pale.

3. **18-year-old male** walking, multiple superficial lacerations, alert, vitals stable.

4. **70-year-old female** trapped in car, unresponsive to voice but moans with pain. Respirations 24/min, pulse weak, pupils sluggish.

5. **50-year-old male** complaining of chest pain and shortness of breath, respirations 32/min, skin cool and clammy.

Using **CareFlight triage categories** (Immediate, Urgent, Delayed, Deceased/Expectant), classify each patient.

Call to Action

Ongoing training in multiple systems

Participate in international drills

Build cultural awareness*


شكرا لكم
Thank you