***Just a little…***

***Crisis***

***Triage Basics for the Healthcare Provider***

***What is triage?***

Triage is the act of “sorting” patients for the purpose of determining priority for receiving healthcare services. Usually, this entails sorting by medical acuity in order prioritize access to emergency services. In disasters, we may have to make triage decisions or apply triage criteria that limit access to care, or prioritize certain interventions over others. The goal in these cases is to do the greatest good for the greatest number of patients.

***When and where does triage occur?***

Triage is performed to determine access to services based on priority to assure those with greatest needs are treated first. A classic example is prioritizing patients arriving at an emergency department or triage conducted at the scene of a mass casualty incident in order to determine which patients should be transported ahead of others. Triage is conducted in three phases: the initial encounter (*primary triage)*; triage after initial stabilization (*secondary triage),* often to help determine patient access to operating rooms or a CT scan; and triage during definitive care *(tertiary triage)* which may occur if there is high demand for scarce resources including access to critical care or operating room resources. Most of the time the goal is to prioritize the sickest patients, but in a crisis situation, we may have to prioritize those that will have the best outcomes with the least resources consumed.

***What are the factors that should be considered?***

Time, Treater, and Treatment – how much time will it take to provide the care, how much expertise will be required to manage the patient, and how many treatment resources will be needed to obtain a good outcome. By this calculus, a tourniquet is the optimal intervention – a life saved with minimal time, treater, and treatment resources. On the opposite end of the spectrum would be interventions like extra-corporeal membrane oxygenation (ECMO) which are incredibly intensive efforts that still may not save the patient’s life.

***What is the difference between reactive and proactive triage?***

Reactive triage is performed by the initial providers when they do *not* yet understand the full scope of the event, the resources required to manage patients, and their availability. In a sudden onset disaster this typically occurs over the first hour or so but may last longer if communications are poor or there is damage to the hospital itself. Reactive triage is performed by the bedside provider based on their understanding of the situation, the patient’s prognosis, and their medical expertise about likely treatment required. Proactive triage occurs when additional situational awareness has been achieved, or during a prolonged event, when more structured guidance can be provided by the hospital, health department or other entity that facilitates triage decisions. An example of this would be adaptive strategies employed during a medication shortage, or patient treatment guidance during a pandemic.

***What are some key ethical considerations?***

In all cases, medical providers should be careful to adhere to the following principles:

* Fairness – the decisions should be fair and applied equally to all persons, regardless of their role in the community or other non-medical considerations
* Accountability – the medical provider should document any triage decisions made (particularly secondary or tertiary) and be able to provide reasonable answers as to why the decisions were made
* Transparency – the provider should be clear to everyone about how the decision(s) were made. Any guidelines or other information should be made available to the patients and their families.
* Duty to care – every provider has a duty to care for every patient to the degree that they can offer resources (including palliative care).
* Duty to steward resources – every provider has a duty to responsibly use resources that are in short supply and make allocation decisions based on the needs of the community and not just on their individual patient.
* Consistency – triage decisions should be consistently made – both by the provider as well as within the facility and within the region when the incident affects a large area and the resource deficits cannot be rapidly addressed.
* Proportionality – the minimum restrictions on care required to address the situation should be applied, and re-evaluated as more resources become available (for example, if an operating room is not available, the patient should be supported by all other means until one becomes available).

***What are some common pitfalls during disaster triage?***

Some of the most common pitfalls in disaster triage are:

* Not re-evaluating the patient over time – some patients will do better than expected and should receive resources as they become available – and some will do worse
* Triaging based on the provider’s assessment of quality of life, or age, rather than medical prognosis – though age may be considered relative to medical impact and prognosis it is *not* an independent variable for triage
* Failure to understand resources available – additional resources may be rapidly available in the area – transferring the patient or requesting additional resources may allow you to rapidly meet the patient’s needs
* Failure to understand the options – generally, if the patient requires too much of a single resource (e.g. blood products), restrict access to just that resource and continue to assess and provide other cares. If the patient is certain to die, provide palliative care only. If there are no differences between the arriving patients it *is* fair to provide care on a first-come, first-served basis as long as the prognosis and resource needs are similar

***How can I learn more?***

Link to MDH CSC healthcare / hospital annex

Link to the MDH CSC healthcare ethics annex

Link to 2009 IOM Letter Report, Crisis Standards of Care