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Title:	**SALT Triage System FAQ (Sort, Assess, Life-saving Interventions, Treat/Transport)**
Approved by:	COTS Board of Trustees; COTS Emergency Services Advisory Board: COTS Central Coalition Operations Advisory Board; COTS SE/SEC Coalitions Operations Advisory Board; COTS Trauma Advisory Board; RPAB Region 4; Franklin County Fire Chiefs; Central Ohio Fire Chiefs
Initial Approval Date:	2023
Revision Dates:	
Next Review Date:	2026

SALT Triage System FAQ / (01/24/2023)

Background

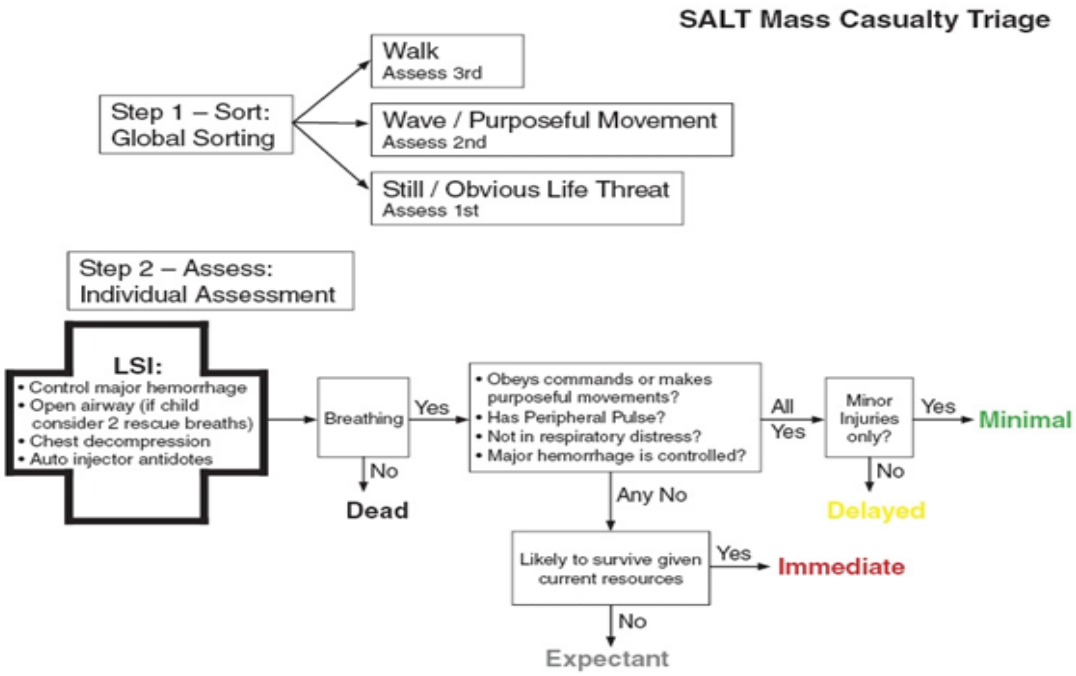
In 2008, a new triage paradigm was proposed by many of the major healthcare and disaster response organizations. Using aspects of the existing systems and based on best evidence, SALT (Sort-Assess-Lifesaving Interventions-Treatment and/or Transport) was developed as a national all-hazards mass casualty initial triage standard for all patients (eg, adults, children, special populations)[1]. SALT was designed to allow agencies to easily incorporate it into their current Mass Casualty Incident (MCI) triage protocol through simple modification.

Furthermore, hemorrhage is the leading preventable cause of death in trauma and causes 30–40 % of fatalities. The primary principle of the Hartford Consensus was that nobody should die from uncontrolled bleeding[4].

Endorsed By[1, 2, 3]:

- American Academy of Pediatrics
- American College of Emergency Physicians (ACEP)
- American College of Surgeons Committee on Trauma
- American Trauma Society
- EMSC
- HRSA/Maternal Child Health Bureau
- National Association of EMS Physicians (NAEMSP)
- National Disaster Life Support Education Consortium
- The Mayo Clinic
- Dayton Metropolitan Medical Response System

Process:



Advantages:

- Someone who is bleeding can bleed to death in as little as 3-5 minutes. SALT allows for early hemorrhage control. In START Triage, bleeding control doesn't occur until AFTER respirations are counted and perfusion (cap refill) is checked. This makes SALT faster than START overall AND in hemorrhage control.
- In SALT, the individual assessment begins with limited rapid lifesaving interventions[5]:
  - Control major hemorrhage with 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)
  - If the patient is a child, consider giving 2 rescue breaths
  - Chest needle decompression
  - CBRN Antidotes or Autoinjector antidotes
- START assumes that "All Walking Wounded" are Minor. We know that devastating wounds like upper extremity trauma or penetrating abdominal trauma patients may still be able to ambulate so this is a false assumption.
- START triage requires responders to count respirations and count and check capillary refill. Literature shows that Assessment must not require counting or timing vital signs and instead use yes–or-no criteria. This makes things easier and faster for responders in high stress environments.

- SALT includes an Expectant Category for patients who are still breathing but unlikely to survive given current resources.
- SALT allows for a quick global sorting of the patients so responders can more accurately identify patients who aren't responding or have an obvious life threat. START relies more on assessing the first person who isn't Minor.

References:

1. Lerner EB, Schwartz RB, Coule PL, et al. Mass casualty triage: an evaluation of the data and development of a proposed national guideline. Disaster Med Public Health Prep. 2008 Sep;2 Suppl 1:S25-34. doi: 10.1097/DMP.0b013e318182194e. PMID: 18769263.
2. https://www.mayoclinic.org/medical-professionals/trauma/news/mass-casualty-triage-guidelines-revised/mac-20512735
3. Goolsby C, Schuler K, Krohmer J, Gerstner DN, Weber NW, Slattery DE, Kuhls DA, Kirsch TD. Mass Shootings in America: Consensus Recommendations for Healthcare Response. J Am Coll Surg. 2022 Jul 18. doi: 10.1097/XCS.0000000000000312. Epub ahead of print. PMID: 36102547.
4. Turner CD, Lockey DJ, Rehn M. Pre-hospital management of mass casualty civilian shootings: a systematic literature review. Crit Care. 2016 Nov 8;20(1):362. doi: 10.1186/s13054-016-1543-7. Erratum in: Crit Care. 2017 Apr 13;21(1):94. PMID: 27825363; PMCID: PMC5101656.
5. Pepper M, Archer F, Moloney J. Triage in Complex, Coordinated Terrorist Attacks. Prehosp Disaster Med. 2019 Aug;34(4):442-448. doi: 10.1017/S1049023X1900459X. PMID: 31389325.

DATE	TRACKING / WHAT WAS CHANGED	STAFF MEMBER
11/15/2022	Approved by the COTS Board of Trustees after recommendation by ESAB, TAB, C-COAB, SE/SEC-COAB, FCFC, RPAB Region 4 chair, Central Ohio Fire Chiefs.	President
03/30/2023	Added cover page	