

Developing and introducing a new triage sieve for UK civilian practice

The UK Ambulance services are constantly reviewing their capability to respond to different emergency scenarios. Following the international terrorism incidents involving marauding gunmen in Mumbai and the attack on the Sri Lanka cricket team in Lahore combined with the two high-profile English incidents of Derek Bird in Cumbria and Raoul Moat in Northumberland, it was identified that there was a requirement to develop a capability to be able to deploy appropriately trained ambulance staff at a firearms incident capable of providing immediately necessary treatment in an area that would previously have been regarded as within the inner cordon and the preserve of the armed response officers until the area had been declared completely safe. *'The lack of a standardised mass-casualty triage system that is well validated, reliable, and uniformly accepted, remains an important gap'*.¹

The UK Ambulance Services developed a training package for staff to work within the inner cordon, once the armed response officers had cleared an area of immediately obvious threat. During this training, it was realised that ambulance staff needed a new way of working, triaging the patients, providing immediately necessary treatment and moving on to the next casualty. This was a big step away from previous civilian practice, and it was soon apparent that the triage sieve in use from JRCALC 2006² needed updating to take account of changes in clinical practice particularly around the widespread introduction of training and equipment to manage catastrophic haemorrhage.

Initial changes to the triage sieve were made in 2011, referring to the UK military Clinical Guidelines for Operations,³ to include an earlier identification and treatment of catastrophic haemorrhage. Changes were made with the advice and support of the Royal Centre

for Defence Medicine (RCDM) using evidence from recent experience in Afghanistan and Iraq. These were initially developed by the East of England Ambulance service, then refined and adopted by the UK Ambulance Services for use only at a firearms incident.

During 2012, the National Ambulance Service Medical Directions (NASMeD) Group agreed that a revised triage sieve should be developed. The goal was to achieve a triage sieve that could be used in any mass casualty situation and one that was simple to follow for all users. Following the report on the 7/7 bombings there was a Rule 43 recommendation from the coroner (Lady Justice Hallett) that there should be changes to the existing triage sieve so that there was an emphasis on triage and immediate treatment, which is facilitated by triage being a two-person procedure.

One of the shortcomings identified through exercises was that the original sieve was that if applied rigidly any walking person would be identified as a P3 (priority 3) casualty even if there were no obvious injuries rather than identified as an uninjured survivor and directed to a survivor reception centre they would be classed as having minor injuries.

The new sieve now identifies uninjured survivors as well as recognising the <C>ABC approach that promotes the early management of catastrophic haemorrhage.

After several revisions, the NASMeD triage sieve was agreed in May 2013 and formally designed with funding from the National Ambulance Resilience Unit. This sieve has now superseded the JRCALC 2013 triage sieve.⁴

Posters have been distributed to all UK Ambulance Services to be used to promote the new sieve. The NASMeD sieve is freely available (Figure 1).

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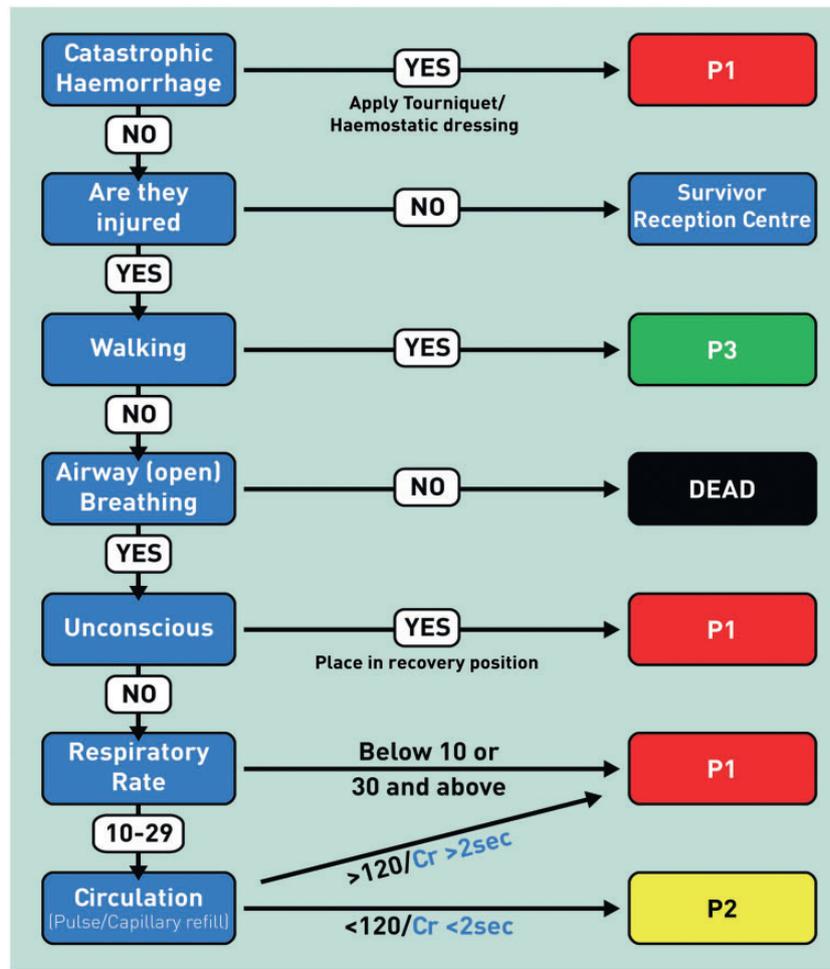


Figure 1. NASMeD Triage Sieve.

for their experience, advice and support during the development of the sieve and the accompanying clinical training package.

References

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