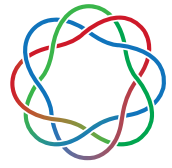




National Ambulance  
Resilience Unit  
**NARU**



**JESIP**

**Ten Second Triage (TST)  
– Non Clinical Responders**

# SUPPLEMENTARY INFORMATION

April 2023  
Version 1.0





## NARU DOCUMENT INFORMATION TABLE

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# TRAINING DELIVERY NOTES FOR ALL LEVELS

The following trainer's notes are intended to compliment the relevant PowerPoint presentation and video resources that are available to support the training of TST. There are 2 main Ten Second Triage (TST) Trainer Resource Packs: one for Clinicians and one for Non-Clinicians.

In addition it is anticipated that there will be two main groups of training for Non-Clinicians: the basic TST tool which is possible to teach to anyone with an absolute minimum of 30 mins lecture time and 30 mins practical training. There is no difference in the tool itself for any responder, but there are additional nuances that will require more training time to teach than afforded to some Core Responders.

## 1 Ten Second Triage (TST) for Core Non-Clinical Responders

'Core Responders' is the minimum standard of delivery for any responder expected to use TST. It is targeted at those with Emergency First Aid or First Aid at Work qualifications e.g. Police Officers and Fire and Rescue Service Officers.

## 2 Ten Second Triage (TST) for Non-clinical Responders with enhanced first aid training time

Any Non-Clinical Responders with additional allocated first aid training time. This is likely to be, but is not confined to, those with role specific requirements e.g. Specialist Police Officers (D13/F3), Search & Rescue, RNLI, Specialist Fire and Rescue (IEC). The main difference from other Core Responders is the familiarity with basic first aid interventions and the training time afforded to train the nuances of TST and its practical application.

## 3 Ten Second Triage (TST) for Clinical Responders

'Clinicians' is the term used to describe any Health Care Professional or responder on behalf of an NHS Ambulance Service.

It is recommended that training should take the form of a face to face classroom teaching session, utilising the relevant PowerPoint Presentation and integrated interactive case series. It is suggested that this is followed by a small scale low-fidelity walk through, where each student has the opportunity to individually triage a number of casualties. This 1:1 scenario ensures each student can demonstrate competency/understanding as well as allowing for individual feedback and remedial training prior to a larger scale incident – where errors may be harder to observe.

This small-scale walkthrough can be easily achieved using other students as casualties. Each of the other students can be tasked to make up and act out injuries consistent with a particular triage category (maybe splitting the class into a few groups if too big: it is ideal to do with 5 or 6 students). This gives students a better understanding of what constitutes each triage category as well as how to practically perform the triage.

Where applicable for those with enhanced training time, this should then be followed by a larger scale role-specific multi casualty scenario in order to cement the classroom training.





## INTRODUCTION

**Ten Second Triage (TST) is a new primary scene triage tool that has been developed for use by all first responders to any incident with multiple casualties.**

Triage originates from the French verb “trier” meaning to sift or sort. It was originally used in casualty care during the Napoleonic wars. In this initial form, triage decided which injured soldiers were fit to return to combat duties and which required evacuation to further medical treatment. In modern settings, primary scene triage is used in multiple casualty incidents to identify the most severely injured casualties, prioritise those who need immediate Life-Saving Interventions (LSIs) and to help guide evacuation decisions.

Previously, triage was limited to use only by Ambulance Services in the UK. As of April 2023, in addition to NHS Ambulance Services, other emergency services including Police, Fire and Rescue Services (FRS), Voluntary Aid Agencies and the UK Armed Forces will be able to adopt Ten Second Triage (TST) as the initial triage for any multiple casualty incident. TST should be used to direct casualty treatment and evacuation priorities for any multiple casualty scenario prior to arrival of health care assets or under the guidance of health care assets, when present.

TST is designed to align with an initial ‘<C>ABC/MARCH’ casualty assessment but to also include a search for central penetrating injury. It moves away from relying on physiological measurements such as pulse and breathing rates or capillary refill time, allowing for easier application in a high threat area and by all responders. To ensure interoperability with other primary triage systems, and subsequent triage tools such as the NHS Major Incident Triage Tool (MITT), the Ten Second Triage Tool has the same 3 triage categories as other tools: P1, P2, and P3. It also has a new category of ‘Not Breathing’ that replaces the “Dead” category used in other tools.

TST has been developed and tested with a focus on the human factors that optimise responders’ abilities to perform triage. This is especially relevant in any high threat or high stress environment where maintaining situational awareness is paramount, but bandwidth is easily exceeded. TST provides a simple framework from which to approach each casualty and ensure that the key LSIs required in the first ten minutes after injury are performed in a timely manner. It will assist all responders in having a simple process for dealing with what will undoubtedly be a chaotic and difficult scene in order to save as many lives as possible.

## PRACTICAL CONCEPTS

**TST is a single operator triage tool that incorporates the provision of two key life-saving interventions during the initial phases of an incident: control of severe external bleeding using direct pressure, tourniquets and wound packing with or without haemostatic gauze, and airway opening and maintenance by placement in the recovery (3/4 prone) position.**

If there are sufficient responders present, it is recommended that one of the responders stands back, maintaining their bandwidth and situational awareness in order to oversee the triage process. This has been shown to achieve multiple aims as follows:

- Ensures strictly only LSIs are being performed.
- Optimises the efficiency of the triage process.
- Ensures that casualty numbers and categories are collated, allowing them to be reported to the ambulance team leaders or commanders on scene.

During the early stages of an incident, the use of TST allows for early and accurate inter-agency reporting of casualties allowing Ambulance Services to make informed decisions regarding casualty management and resource deployment.

Once triage is complete, casualty evacuation should be facilitated in accordance with their triage categories. This means that Priority 1 (P1) casualties should be moved first, followed by the P2s. It is assumed that P3s will self-extricate as by default they are 'walking', but they may need direction to an appropriate place of safety or Casualty Collection Point (CCP). All casualties should be evacuated as soon as the triage process is complete to enable safe ongoing treatment, and rapid ongoing movement to definitive care in a hospital.

Arriving healthcare resources will understand and trust the previously performed TST, regardless of by whom it has been performed. They will reassess as required and will go on to ensure the next step of clinical interventions are appropriately prioritised and implemented.





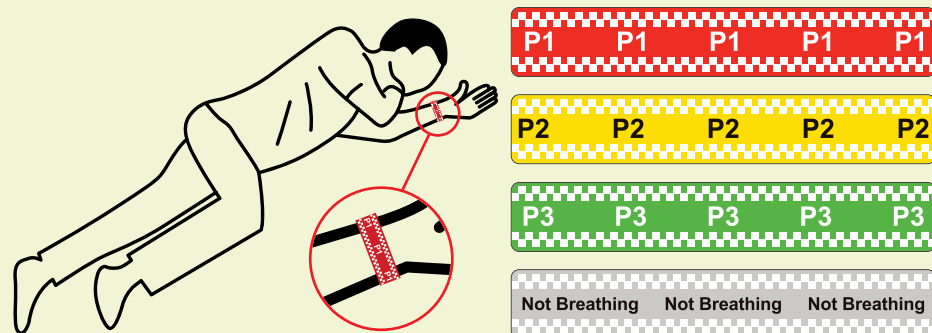
## TST TRIAGE BANDS

All casualties who have been triaged should be marked with a nationally agreed method. Currently this is with a 300mm x 50mm Triage Band in order to:

- Highlight the casualties that have been triaged (and had LSIs performed).
- Prevent unnecessary retriage.
- Optimise the efforts of subsequently arriving emergency services.
- Indicate the priority of the casualty for extrication and ongoing treatment.

TST triage bands should be attached to a casualty's wrist (unless injured or amputated – in which case an ankle or lower leg or would be a suitable compromise). Responders should endeavour to ensure bands are as visible as possible:

- Place triage band on the upper most limb if being rolled on the side / in a recovery position.
- Ensure the band is not obscured by clothing.



There are four colour bands available:

<b>WHITE ON RED</b>	P1 Priority One
<b>BLACK ON YELLOW</b>	P2 Priority Two
<b>WHITE ON GREEN</b>	P3 Priority Three
<b>BLACK ON SILVER</b>	Not Breathing

A white checked border is used to identify the TST bands, in order to differentiate them from the tagging used for the MITT system (or any other triage system) which have a solid coloured tag throughout.

TST is not a 'once only' assessment. Responders should re-triage if a casualty's condition has changed during reassessment, removing the original TST band and replacing it with the new category. The tactical situation will affect when re-triage will be possible, but on average approximately **every 15 minutes** is a reasonable starting point (especially if waiting for stretchers and / or sufficient responders to evacuate casualties).

Responders should also re-triage when:

- A casualty does not appear to match their Triage Band (e.g. P3 but not walking or P2 but not talking).
- A casualty's condition changes.
- A healthcare practitioner with appropriate time reassesses a casualty with a silver 'Not Breathing' and considers them a viable resuscitation (P1) or ROLE/PLE (DEAD).

## TST – Key Introduction Points

- TST Trainer Resource Packs are available for Clinical and Non-Clinical Responders.
- TST is a non-physiological triage system focused on life threatening injuries.
- TST is the recommended initial triage tool for all emergency services at any multiple casualty incident.
- TST assists in identifying casualty treatment and evacuation priorities.
- TST aligns with standard casualty assessment algorithms i.e. CABC / MARCH.
- TST utilises Red P1, Amber P2, Green P3 and Silver 'Not Breathing' categories.
- All casualties that have been triaged should be marked with a TST Triage Band.
- Triage Bands should be placed on uppermost wrists.
- A white checked border identifies TST bands.
- TST is not a 'once only' assessment.





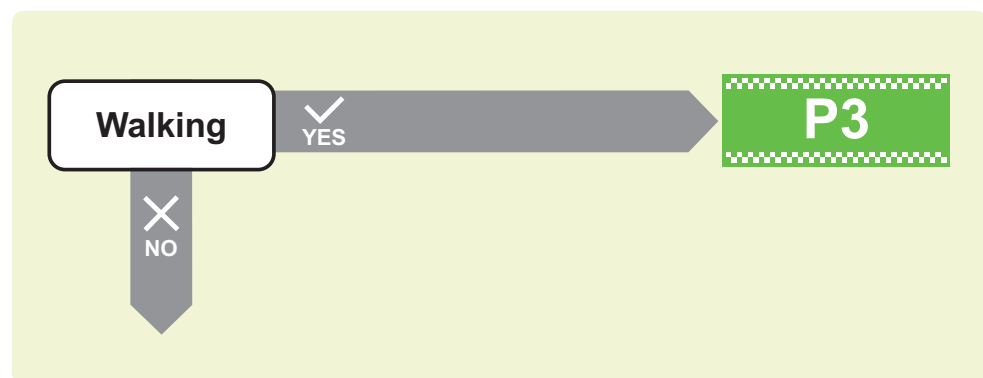
## A PRACTICAL GUIDE TO TEN SECOND TRIAGE (TST)

### WALKING

Injured casualties who are independently mobile or who can self-evacuate are categorised as P3.

People who are uninjured should be directed to a relative place of safety.

Those who are injured should be directed to a CCP.



Some casualties who are mobile may still be reluctant to walk if they are frightened or have been 'playing dead' or hiding. They may need some encouragement to move. Uninjured or mildly injured survivors may also wish to stay to help treat those injured, especially if they are family or friends. Responders should consider recruiting these 'bystanders' to assist with basic casualty care or evacuation if the bystander is considered 'competent' and is happy to remain on scene to help.

During the hyper-acute phase of an incident, those who are walking and willing to leave might be rapidly evacuated for their own safety. As these evacuations are likely to be safety driven, walking casualties may not have triage bands placed at this time. When safe to do so, these survivors should be triaged and directed to a CCP.

### CHILDREN AND WALKING

The majority of children under 2 years are unable to walk or talk independently. In the context of TST, this should be taken literally and any child under 2 should be automatically triaged as a P1. This ensures they are prioritised appropriately, as it is very difficult to assess the severity of injuries in children this young, who will often compensate physiologically and look less sick than in reality.

### CHILDREN AND WALKING

On occasion casualties with critical injuries may initially be able to walk, especially early in the incident. (e.g. the lucid phase of a significant head injury or a recent penetrating chest injury that has not yet caused the casualty to decompensate).



With large casualty numbers it is not practical to assess every walking casualty in the initial phase of the incident.

However, if a critically injured casualty is observed (e.g. obvious catastrophic bleeding from a limb or blood from a chest wound), responders are encouraged to employ common sense and to direct the casualty to sit down and treat them as a 'not walking' casualty (which is the likely situation that will rapidly ensue). This discretionary decision should only be used in extremis otherwise it risks overtriaging P3 casualties.

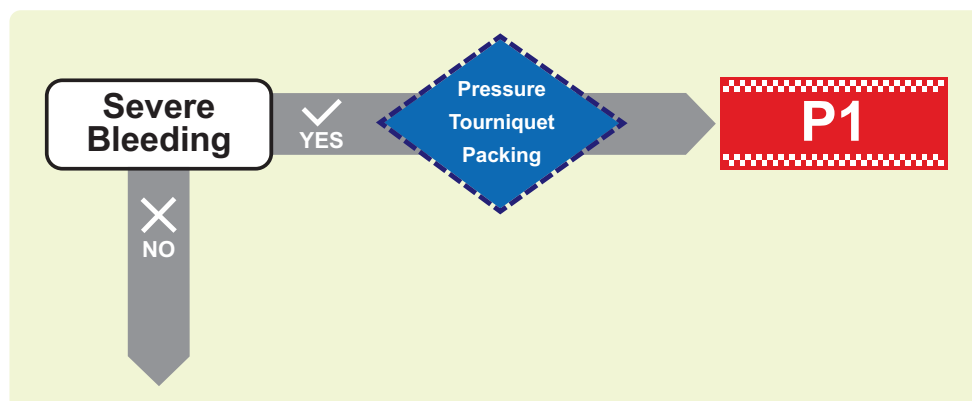
P3 casualties are observed/assessed/retriaged by clinical staff further in their journey and it is accepted that not all presentations will be identified in this initial phase. If a casualty's condition changes, this should prompt retriage at any stage.

### WALKING – Key Training Points

- Injured casualties who are independently mobile or who can self-evacuate are categorised as P3.
- People who are uninjured should be directed to a relative place of safety.
- Those who are injured should be directed to a CCP.
- Clearly critically injured casualties who are walking should be sat down and treated as **NOT Walking**
- Children who are too young to walk or talk (less than 2 years old) should be classed as **NOT Walking or Talking** = P1. This will ensure they do not have significant injuries that are missed.

### SEVERE BLEEDING

The next step in the assessment of a casualty who is **NOT Walking** is to look for **Severe Bleeding**. Although the terminology is different, this is the same as assessing for Catastrophic Bleeding / haemorrhage. The terminology has changed to ensure that life threatening bleeding is not missed. Not all life-threatening bleeding is spurting or obviously 'pouring' out, and it is vital that all types of significant blood loss, that could ultimately be fatal, are controlled before it is too late.





**Any casualty with Severe Bleeding is classified as a P1.**

All severe bleeding should be aggressively managed with one of the following haemorrhage control methods:

- **Manual Pressure using a bandage to control junctional (eg groin / armpit / neck) bleeds where a tourniquet cannot be placed high enough to control the bleed.**
- **Tight placement of a tourniquet (if able to get above the extremity bleed).**
- **Packing (with haemostatic gauze if available) for junctional bleeds followed by manual pressure using a bandage.**

Responders should expect that casualties may have more than one injury. Any casualty assessment as part of TST should be rapid but sufficiently thorough that all life threatening injuries are identified and treated. Training scenarios with casualties that only ever have one injury can sometimes lead students to incorrectly assume they only need to search for one injury when practical experience tells us there are often multiple wounds from penetrating mechanisms such as bladed weapon attacks or fragmentation injuries.

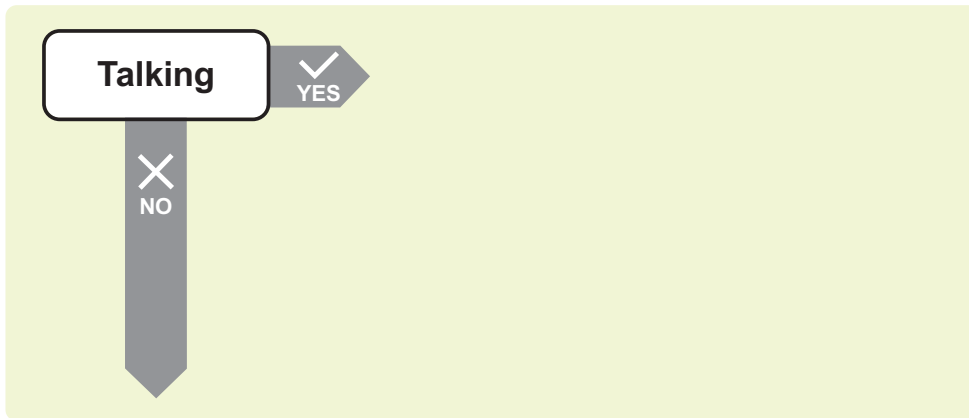
If presented with a junctional injury that requires packing, responders should pack the injury over which pressure should be applied for at least 3 minutes (or in line with product guidance). Where possible, 'competent bystanders' can be utilised in order to allow the responder to move on to triage the next casualty. If there is no bystander available, a responder may need to remain in-situ until the bleeding is controlled.

### **SEVERE BLEEDING – Key Training Points**

- **Any casualty with Severe Bleeding is classified as a P1.**
- **Responders should anticipate that casualties may have more than one injury.**
- **Not all life-threatening bleeds are pulsatile, or squirting 'up the wall'.**
- **Responders should aggressively manage any Severe Bleeding using tourniquets, packing (+/- haemostatic gauze) and pressure dressings as required.**
- **'Competent' bystanders should be used to assist where able and willing to do so.**

## TALKING

All casualties should undergo a response check. When using TST, the response check is simplified to 'are they **Talking?**' with yes or no as the options.



If casualties are **Talking**, then responders should continue onto the Penetrating Injury assessment.

If casualties are **NOT Talking**, then responders should continue onto the Breathing assessment.

(During initial triage, there is no requirement to search for a central penetrating injury in those who are not talking as they are already at least a P1, and so as this will not change their triage category).

When assessing **Talking**, the simple question of 'are they talking or not' is sufficient to ask for the basic level of TST training.

However, if there is time to discuss this further in training, this can be nuanced by asking 'are they talking normally?' or in other words 'are they spontaneously conscious, alert and orientated?' If they are 'not quite right' and confused or staring and only able to respond to specific questions, this can be a flag for a blunt injured casualty who may be showing the early effects of a significant head injury or internal bleeding. Anything other than a 'normally conscious', alert and orientated casualty should raise concern. These casualties should then be classed as **NOT Talking normally** and so would be a P1.





### CHILDREN AND TALKING

It is reasonable to consider that the majority of children under 2 years are unable to walk or talk independently. In the context of TST, this should be taken literally and any child under 2 should be automatically triaged as a P1. This ensures they are prioritised appropriately, as it is very difficult to assess the severity of injuries in children this young, who will often compensate physiologically, and thereby look less sick than they are in reality.

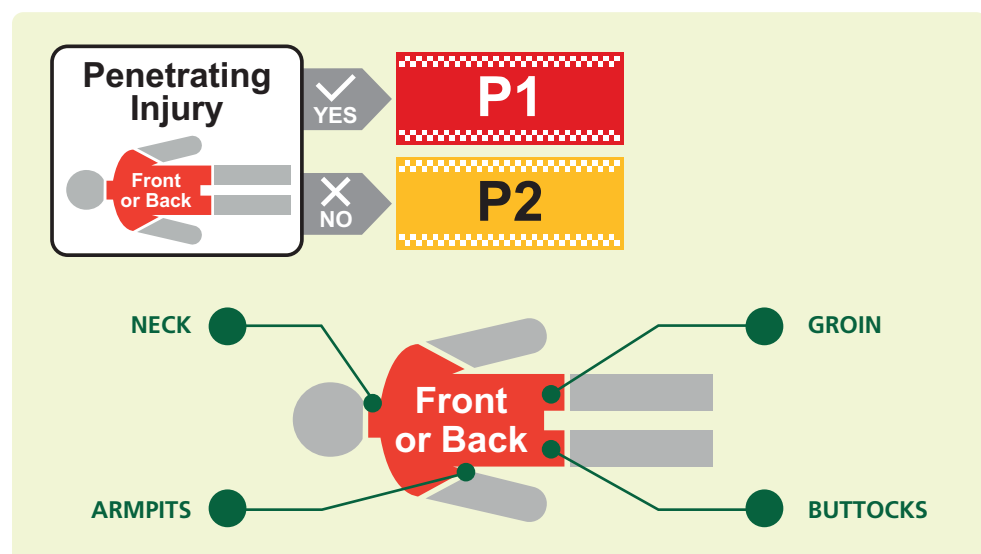
### TALKING – Key Training Points

- When assessing **Talking**, responders should consider whether a casualty is talking normally. Anything other than a 'normal' conscious, alert and orientated casualty should raise concern.
- Treat children who are too young to walk or talk (less than 2 years old) as **NOT Walking or Talking = P1**. This will ensure they do not have significant injuries that are missed.

### PENETRATING INJURY

Casualties with penetrating torso injuries are at risk of deterioration from internal non-compressible haemorrhage. This type of bleeding ideally needs to be in a hospital for damage control surgery to be performed, and therefore is a priority for rapid evacuation.

Casualties who are **Talking** will undergo a search for **Penetrating Injury** i.e. a deliberate targeted search for penetrating injuries to the 'torso'. In this case 'Torso' refers to the area in red on the person in the diagram below. This search must include the neck, chest, armpits, back, abdomen, groin and buttocks, (front back and sides). The check involves a rapid skin level search for injuries in these areas. The casualty's triage category depends on the findings of this check:



Talking casualties with **ANY Penetrating Injury** to their neck, chest, armpits, back, abdomen, groin or buttocks are classified as P1.

Talking casualties with **NO Penetrating Injury** to this area are classified as P2.

This is the only group where penetrating injury presence will change the triage category from P2 to P1 (hence not doing this check if a casualty is a P1 already from 'severe bleeding' or from 'not talking').

At this stage of the assessment, chest seals are not required in TST. Chest seals may help reduce mortality over time but they do not effectively manage any immediately life-threatening injuries. The priority should be triaging the casualty as a P1 and moving on quickly to ensure a rapid response to other casualties with uncontrolled severe bleeding or airway concerns. Once triage and initial LSIs are complete, it is appropriate for chest seals to be applied where needed as part of further ongoing assessment and treatment if evacuation to a CCP is delayed.

### PENETRATING INJURY – Key Training Points

- Talking casualties with **ANY Penetrating Injury** to their neck, chest, armpits, back, abdomen, groin or buttocks are classified as P1.
- Talking casualties with **NO Penetrating Injury** to this area are classified as P2.
- Casualties with penetrating torso injuries are at high risk of internal bleeding and rapid deterioration and need to be evacuated to enhanced medical services and damage control surgery as soon as possible.
- Chest seals do not need to be routinely applied during TST.

### BREATHING

Casualties who are not talking should undergo an airway and breathing check which should involve the manual opening and assessment of an airway and a 10-second breathing check. Although the breathing check is taught in all first aid sessions, trainers should take this opportunity to re-emphasise its importance here.

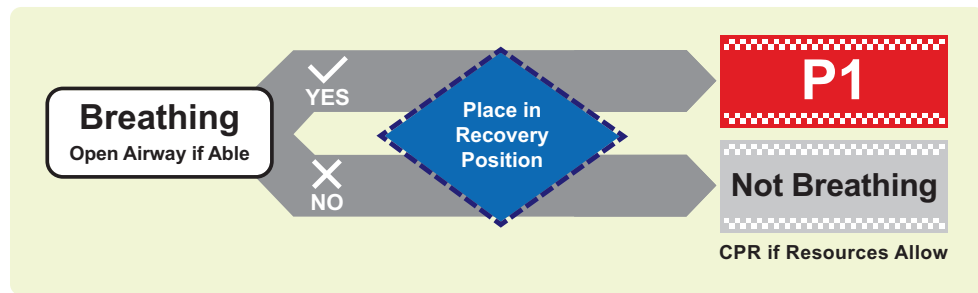
**In order to do a breathing check, the airway must be open.**

**Look** – for rise and fall of the chest or agonal activity.

**Listen** – For air movement or any additional airway sounds. This may be difficult with ear protection, communication equipment and helmets.

**Feel** – Feel for rise and fall of the chest. Best felt between the sternum and belly button (as more sensitive for abdominal breathing).





If a casualty is **Breathing**, they should be placed into the recovery position and categorised as a P1.

If a casualty is **NOT Breathing** despite having their airway opened, they should also be placed into the recovery position and categorised as Not Breathing.

This should reassure responders who are new to triage that they are not disadvantaging casualties by placing a **Not Breathing** band on them as they receive the same treatment as those with a P1 band. The importance of this 'Not Breathing' category however is to focus resources on those who are most salvageable where resources are limited and casualty numbers are significant.

Penetrating torso wound checks are not required on casualties who are **NOT Talking** during TST as the casualty will already be categorised as a P1 or **Not Breathing**. The priority should be triaging appropriately and moving on quickly to ensure a quick response to other casualties with uncontrolled external severe bleeding or airway concerns. Once triage is complete, it is appropriate to perform a more thorough assessment where needed as part of ongoing treatment if awaiting resources to start extricating the casualty.

In casualties requiring airway opening, some responders carry airway adjuncts that may be used as part of the airway opening procedures. Most responders are only likely to carry sufficient adjuncts for a limited number of casualties, and therefore should consider only using them where absolutely necessary in order to maintain an airway.

### BREATHING – Key Training Points

- If a casualty is **Breathing**, they should be placed into the recovery position and categorised as a P1.
- If a casualty is **NOT Breathing** despite having their airway opened, they should be placed into the recovery position and categorised as Not Breathing.
- The airway must be opened before performing a breathing assessment.
- If airway adjuncts are carried they may be used with discretion. Where supplies outweigh the number of casualties, consideration should be given to those who need them most to maintain an airway ie those casualties who are most deeply unconscious and snoring.
- Penetrating wound checks are not required on casualties **NOT Talking** during TST as the casualty will already be categorised as a P1 or Not Breathing.

## NOT BREATHING

TST does not have a DEAD category unlike other triage systems. In the first few minutes of responding to a multi-casualty incident, rapid assessment and provision of LSIs should take priority. It is considered that in this initial phase, even for healthcare professionals, the time required to fully and carefully assess whether a 'Not Breathing' casualty is amenable to any treatment is not sufficient to adequately make this important decision. This is a concern that has appropriately been raised by families at recent inquests and inquiries, and reinforces the appropriateness of CPR if resources allow, until a considered decision by a clinician can be made that a casualty is not amenable to further ongoing resuscitation.

Therefore, within TST, which will be used by all responders, the Not Breathing category is used to simply illustrate the objective finding of a breathing check, rather than to label a casualty as not amenable to ongoing treatment or 'Dead'.

If cardiac arrest is caused by bleeding, casualties are unlikely to be successfully resuscitated by basic life support alone. However cardiac arrest during multi-casualty incidents may be due to a number of different causes, a small number of which e.g. a 'heart attack' or crush injury may be amenable to basic life support. It is not appropriate to diagnose these causes in ten seconds, and so a DEAD tag which prevents any further consideration of treatment should not be placed by anyone this rapidly.

In the initial phases of a large-scale incident, where there are not enough resources to allow for resuscitation, and the most effective LSIs remain stopping severe external bleeding and opening an airway. Responders should mark the casualty as Not Breathing and continue to triage and provide LSIs to further casualties. Otherwise, those casualties who are least likely to survive will take up the efforts of responders who could be moving onto assess casualties who require life-saving interventions that could make a difference to their survival in the first few minutes of an incident. If resources allow, i.e. if there are many responders or 'competent bystanders' available to safely perform resuscitation while other responders continue to complete the triage process, resuscitative efforts should be commenced and / or encouraged.

### Re assessment of those with NOT BREATHING triage bands

TST will be followed by reassessment of those with silver 'Not breathing' triage bands by healthcare professionals when appropriate.

Some of those with silver triage bands may be considered to be amenable to ongoing resuscitation and will be retagged as P1s and prioritised for treatment and evacuation. For others, where a full assessment shows that ongoing resuscitation will be futile, or where the resources required to allow any chance of successful resuscitation are unavailable, then they will be recognised as dead at this point. An appropriately completed black DEAD tag must then be applied that will contain the time and date, and be signed and applied to the casualty.





## NOT BREATHING – Key Training Points

- It is not appropriate for any responder to recognise a casualty as dead in a rapid assessment during the initial response to an incident.
- Casualties who are Not Breathing receive the same treatment as those who are breathing but are Not Talking during TST.
- If resources allow CPR may be performed until TST is complete and a healthcare professional is subsequently available to make a considered assessment of the casualty.
- Resuscitation must not detract from more important LSIs of stopping external bleeding and opening an airway.



## TST COGNITIVE SHORTCUTS

Individuals learn in different ways. It is recommended that non clinicians run through the TST flowchart in order to ensure they do not miss a step. However some people may find it useful to remember that anyone who has had a life-saving intervention applied is automatically a P1:

- Pressure Dressing applied (to **Severe Bleeding**).
- A tourniquet applied.
- Packing of a junctional wound.
- Opening of an airway.
- Placement in the recovery position to maintain an airway.

In addition, others may find it useful to consider the three key clinical presentations that automatically trigger P1:

- Any **Severe Bleeding**.
- Any **Penetrating Injury** to the 'torso'.
- Any impaired level of conscious that results in a casualty **NOT Talking**.

This is illustrated in a slide towards the end of the training presentation.





## INTERACTIVE CASE SERIES GUIDE

At the end of the teaching presentation there is an interactive case series that allows instructors to take students through worked examples of casualty descriptions. This allows the class to work through the tool with a casualty in mind and workout what category they would be to ensure full understanding of how to use the tool and to cement an understanding of what category would equate to what type of casualty.

### 1 Casualty

This adult female is lying on the floor, therefore she is **NOT Walking**.

She has a **Severe Bleeding** injury to her right thigh.

She requires the LSI of a tourniquet.

The **Severe Bleeding** makes her a **P1**.

### 2 Casualty

This adult male is sat against a wall, therefore he is **NOT Walking**.

He has **NO Severe Bleeding**.

He is **Talking**.

A **Penetrating Injury** check identifies multiple stab wounds to the torso (back).

This makes him a **P1**.

### 3 Casualty

This adult female is lying on the floor, therefore she is **NOT Walking**.

She has **NO Severe Bleeding**.

She is **Talking**.

A **Penetrating Injury** check identifies multiple stab wounds to the torso (chest).

This makes her a **P1**.

**4 Casualty**

This adult male has an obvious head injury and is lying down on his back, therefore he is **NOT Walking**.

He has **NO Severe Bleeding**.

He is **NOT Talking**.

He is snoring, which confirms he is **Breathing**, BUT

He requires the LSI of airway management (ie opening his airway and placing in the recovery position).

He is **NOT Talking** but **Breathing** which makes him a **P1**.

**5 Casualty**

This adult female runs up to the responder, therefore she is **Walking**.

She has minor injuries of superficial injuries to her palms and there is no evidence of any critical injury requiring additional consideration.

She is a **P3** because she is **Walking**.

**6 Casualty**

This adult male has a gun shot wound to head and is lying face down; in other words he is **NOT Walking**.

He has **NO Severe Bleeding**.

He is **NOT Talking**.

He is **NOT Breathing**.

This casualty should be placed into the recovery position and receive a **Not Breathing** triage band.

In some circumstances, where there are sufficient / appropriate resources to consider starting resuscitation, it may be appropriate to do so. This decision will vary according to resources available and with each incident.



**7 Casualty**

This adult male is sat on the floor, therefore he is **NOT Walking**.

He has **Severe Bleeding** from a groin injury.

It is unlikely that a tourniquet will be high enough for a groin injury so he will require the LSI of wound packing (and pressure).

The **Severe Bleeding** makes him a **P1**.

**8 Casualty**

This adult female has been struck by large vehicle and is lying on the pavement, therefore she is **NOT Walking**.

She has **NO Severe Bleeding**.

She is awake, her eyes are open and staring however she is silent, therefore she is **NOT Talking**.

She is **Breathing**.

Not talking but breathing makes her a **P1**.

This scenario indicates TSTs use of 'NOT Talking' to identify and prioritise critically ill blunt trauma patients. If resources allow it would be appropriate to manage her on her back with a jaw thrust applied if the airway becomes compromised to minimise movement prior to any splinting that maybe required.

**9 Casualty**

This 12 week old male is too young to walk so is being carried by one of his parents, therefore he is **NOT Walking**.

He has **NO Severe Bleeding**.

As this child is less than 2, he is too young to talk, therefore he is **NOT Talking**.

Any child under 2 is unable to walk or talk and so is a **P1**.

In this instance, the recovery position is unlikely to be appropriate as the child is alert and with a parent, however responders should consider that airway management may be required for some children.

**10 Casualty**

This adult male is slumped in the drivers seat of a vehicle, therefore he is **NOT Walking**.

He has **NO Severe Bleeding**.

He is making grunting noises which is does **NOT** class as **Talking**.

He is **Breathing**.

He requires the LSI of airway management (opening his airway if able to and placing in a recovery position).

Not Walking, no Severe Bleeding, **Not Talking** but **Breathing** makes him a **P1**.

**11 Casualty**

This adult female has obvious lower limb fractures, therefore it is assumed that she is **NOT Walking** because she would be unable to do so on the fractures.

She has **NO Severe Bleeding**.

She is **Talking**.

She has **NO Penetrating Injury** to her torso.

Because she is not walking and has no penetrating injury to her torso this makes her a **P2**.

**12 Casualty**

This teenage female is lying in the street with two below knee amputations, therefore she is **NOT Walking**.

She two traumatic amputations that should be managed as **Severe Bleeding**.

She requires the LSI of a tourniquet to each leg.

This makes her a **P1**.

She is **NOT Talking**.

She is **Breathing**.

She also requires the LSI of airway management (opening airway if able to and placing in the recovery position).

She is already a **P1**.

This scenario identifies that some casualties may require more than one LSI.





## ACTIONS FOLLOWING TST COMPLETION

### CASUALTY FLOW

Once all casualties have been assessed and allocated a TST triage band, total numbers of each category should be reported to the ambulance service by the person standing back overseeing the triage.

In this case 'the ambulance service' may be

- The on scene ambulance service team leader or
- The ambulance service lead at the forward command point, or
- A radio message to the ambulance service control room if there are no ambulance responders yet on scene.

All responders may need to assist with casualty evacuation. P1 casualties will be moved first followed by P2 casualties. They will be moved to a safe temporary treatment area known as a CCP. P3 casualties, if not able or wishing to stay and help treatment of others, should be directed to a similar temporary place of safety, away from the sicker P1 casualties in order to allow some semblance of organisation and to allow space to treat the sickest casualties first.

This has usefully been called 'nesting' of casualties in some countries, and can be thought of as grouping casualties in a protected area to facilitate safe and efficient triage and treatment prior to further extrication. The aim of the process is to speed up evacuation of all casualties from the scene to a place of safety from where they can be reassessed, treated as required and rapidly moved to the most appropriate hospital or other healthcare facility.

Maintaining casualty flow is key and the aim of TST is to provide a structure to speed up this flow of casualties to the most appropriate and safe place in which they can receive definitive treatment for their injuries, which ultimately for the sickest casualties is in a hospital.

### Actions Following TST Completion – Key Introduction Points

- Ensure numbers are reported to the ambulance service if on scene or via the control room.
- Casualty flow is maintained by starting extrication as soon as possible.
- Start to move P1s and then P2s to allocated areas for safe treatment in a CCP.
- Allow P3s to be directed to a separate area of the CCP if they are not being utilised as 'competent bystanders'.

## THE NHS MAJOR INCIDENT TRIAGE TOOL (MITT)

**TST is recommended as the first line prehospital triage tool for all emergency services including ambulance services. It should be used by all responders until all casualties have received a TST assessment and band or until senior clinical decision making is available on scene.**

The MITT has been designed and validated as a unified replacement to existing NHS adult and paediatric major incident triage tools to be used by healthcare responders within established settings such as a CCP or a Casualty Clearing Station (CCS). It is intended to aid clinical decision making where demand/resourcing precludes senior clinician led decision making. It is mentioned here for an awareness of the tool and the follow on from TST.

The decision for ambulance responders to switch to MITT will be taken by the ambulance on scene commander and will not occur until all casualties have been triaged with TST and casualties have been evacuated to a CCP.

Casualties triaged with MITT will be marked with a traditional triage tag with a block colour (i.e. without a white checked border) to identify the tag as MITT rather than a TST band. It should also have space to write treatment notes as well.

If available, responders should aim to facilitate early scene access for senior clinicians from enhanced or 'critical' care teams. They should be utilised to deliver intuitive clinical triage to identify and prioritise those P1 casualties in need of rapid intervention or expedient transfer to definitive care.





National Ambulance  
Resilience Unit

**NARU**



Ten Second Triage (TST)  
– Non Clinical Responders

# SUPPLEMENTARY INFORMATION

For further information please contact:

National Ambulance Resilience Unit (NARU)

Website: [www.naru.org.uk](http://www.naru.org.uk)

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