World Health Organization

WHO Emergency Care Toolkit

Mass Casualty - Interagency Integrated Triage Tool

Frequently Asked Questions

1. **When do we use mass casualty triage?**
   Mass casualty incidents occur where patient needs exceed facility or system resources. Mass casualty triage is one of several processes that are activated during a mass casualty response. The decision to switch from routine triage to mass casualty triage should be taken when the mass casualty plan is activated. Staff receiving patients should be able to activate the plan as they are often the first to recognize that a mass casualty incident has occurred due to a surge of patients.

2. **Should any treatment be carried out at triage in a mass casualty incident?**
   Generally, treatment should not be carried out at triage points, but this depends on the magnitude and severity of the mass casualty incident (MCI). For example, in some settings the application of tourniquets for massive bleeding with limb amputations may be appropriate as a lifesaving treatment in triage.

3. **Who should perform triage in an MCI?**
   Ideally triage should be performed by a senior clinician (nurse or doctor) with experience in MCI triage. If staffing allows, having a minimum of two people at MCI triage – a triage officer who does the triage, and a triage assistant to help with registration, colour coding and labelling casualties – is extremely helpful.

4. **How should triaged patients in an MCI be colour coded?**
   Yes. Colour coding (e.g. with a lanyard around the neck or armband) should be affixed to the patient. In addition, clinical note sheets (e.g. plasticized notes) should follow the patient to enable patients to remain in and return to allocated areas. This also ensures clinical orders and notes are carried out and documented.

5. **Why are grey patients not always sent to the morgue at Step 1 or Step 2 triage?**
   In many locations Step 1 triage may be performed by a non-health professional such as a security guard who cannot and must not determine death in a patient. Step 1 triage personnel should direct body parts to the morgue.

   Step 2 triage requires medical assessment by trained clinical personnel, often a senior nurse or doctor. If death is obvious (e.g., decapitation), they can triage the patient as grey and send them directly to the morgue. Beyond obvious cases, determining grey criteria requires basic interventions that may take too long at Step 2 if there are significant patient volumes and the capacity of the health worker to declare death of patient.

6. **What type of patients go to the yellow zone?**
   During an MCI, the numbers of yellow and green patients usually far exceed red patients. Some examples of yellow patients include: a person with a closed long bone fracture (e.g., a broken leg that is not bleeding heavily and has good circulation); a patient with moderate burns (< 40%); a

patient with a stable abdominal injury but no signs of shock; an individual with a head injury who is awake and oriented but needs observation.

7. **What types of spaces can be used for green patients?**
   The green zone should be separate from the emergency unit to decongest high acuity areas and provide a safe space for treatment and monitoring of low acuity patients for potential deterioration. Some examples of common locations used include the outpatient department, the hospital waiting area or a separate tent.

8. **Is it important to have a yellow area? And where should that be?**
   During an MCI, having a designated yellow area is essential for managing patients with serious but not immediately life-threatening injuries. This space allows for the safe monitoring and treatment of delayed-care patients without overwhelming emergency or critical care zones reserved for red (critical) cases.

   The yellow area should be located near the emergency unit, but separate from the red zone, ideally in an area that can be quickly converted for patient care—such as a recovery room, outpatient clinic space, or adjacent ward. It must allow for easy access to staff, supplies, and transport pathways while avoiding crowding or bottlenecks that could disrupt care for more urgent patients. This setup supports effective triage, preserves resources, and helps maintain order during the surge.