Mobile Triage Team in a Community Disaster Plan

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Experience has shown poor predisaster planning, inadequate communication and the absence of an on-scene commander to be common and recurring problems during disaster rescue efforts. A mobile on-scene triage team (MOTT) operating in Sacramento has demonstrated the following advantages: immediate access; mobility, coordinated evacuation, treatment, and disposition of mass casualty victims; control of facility overload, and appropriate initial disposition to definitive care facilities. The advantages realized with this approach arise from greater community awareness and participation in a coordinated plan for medical care in disasters.

Fisher CJ Jr Mobile triage team in a community disaster plan *JACEP* 6:10-12 January 1977 *disaster planning community*

INTRODUCTION

Mass casualty accidents are no longer a fear of the future, but are occurring with frightening regularity. Mass air transit via DC 10s, 747s and L-1011s, as well as rapid transit by rail are frequent contributors to the mass casualty problem. Tornadoes, fires, hurricanes, floods, and other natural disasters play a significant role as do sabotage and civil disturbances.

In Florida, the crash of an L-1011 into the Everglades demonstrated the need for adequate communication, air transportation and an on-scene commander. In California an earthquake proved that ground line communication and ground transportation are fallible.

These experiences illustrate that poor predisaster planning, inadequate or nonexistent communication, and the absence of an on-scene commander are major recurrent problems during disaster rescue efforts.

SACRAMENTO EXPERIENCE

Recently in Sacramento, California, a jet plane crashed into an ice cream parlor occupied by children attending a birthday party, a 50-passenger high-speed bus crashed into a bridge abutment, and a knife and gun fight followed a large rock concert.

Each of these events yielded mass casualties and a massive influx of patients to local hospitals. Communications during each incident failed to provide adequate information to the hospitals regarding number, type and severity of injuries, or even forewarning of arrival.

For example, the Sacramento Medical Center was acutely overloaded with 20 patients requiring immediate surgery, while other hospitals capable of handling these problems received none. Burn patients were sent to other hospitals only to be transferred to the University Burn Unit.

ORGANIZATION

A critique of these disasters with county health officials made it obvious that an individualistic approach to disaster planning was inadequate. Sacramento County health and general services officials, metropolitan airport personnel, emergency physicians, administrators from private hospitals, and faculty from the University hospital worked together to develop a plan to maximize resources, expedite patient transportation to definitive care facilities, and minimize hospital overload. Initially, this plan was developed for the Sacramento County Metropolitan Airport. It has now been incorporated as

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