

APPENDIX: Q

TITLE: SELECTIVE SPINAL IMMOBILIZATION PROTOCOL

REVISED: August 1, 2013

1. BACKGROUND:

This protocol is intended to allow selective exclusion of full spinal immobilization in patients with a low index of suspicion for spinal injury and to use the long spine board and/or scoop stretchers for extrication purposes only.

2. INDICATIONS:**Cervical Spine:**

In order for providers to defer cervical spine immobilization in patients with mechanical potential for injury, ALL of the following criteria must be evaluated and individually documented.

1. No posterior neck pain or tenderness.
2. No intoxication.
3. No altered level of alertness.
4. No focal neurologic deficit.
5. No painful distracting injuries.

Note: Axial loading of cervical spine is not recommended.

Thoracic and Lumbar Spine:

In order for providers to defer thoracic and lumbar spine immobilization in patients with mechanical potential for injury, ALL of the following criteria must be evaluated and individually documented.

For any patient with:

1. No tenderness of midline upper, mid or lower back.
2. No intoxication.
3. No altered level of alertness.
4. No neurologic deficit or incontinence.
5. No painful distracting injuries.

3. PROCEDURE

Cervical Spine:

If the above exclusion criteria are met, then extricate/assist the patient to the stretcher with the least manipulation of the spine as possible.

If the patient does not meet the exclusion criteria, apply a c-collar. Then utilize the appropriate transfer/extrication device (long spine board, KED, slider board or scoop stretcher, *etc.*) to move the patient to the stretcher with the least manipulation of the spine as possible.

Thoracic and Lumbar Spine:

If the above exclusion criteria are met, then extricate/assist the patient to the stretcher with the least manipulation of the spine as possible.

If the patient does not meet the exclusion criteria, utilize the appropriate transfer/extrication device (long spine board, KED, slider board or scoop stretcher, *etc.*) to move the patient to the stretcher with the least manipulation of the spine as possible.

Once the patient with suspected/known cervical, thoracic or lumbar spine injury is placed on the stretcher, remove the extrication device *as soon as safely possible* (provider discretion). **Keep the patient in the supine position** for transport/transfer to the appropriate destination. Any further transfers of the patient with a known or suspected spinal injury should be done with a slider board observing precautions not to manipulate the spine.

4. DEFINITIONS:

Posterior neck pain or tenderness is present if the patient reports pain on palpation of the midline neck from the nuchal ridge to the prominence of the first thoracic vertebra or any cervical spinous process.

Patients should be considered intoxicated if they have either of the following:

1. A history provided by the patient or an observer of intoxication or recent ingestion of alcohol or other mind altering substances such as benzodiazepines, narcotics or recreational drugs.
2. Evidence of intoxication on physical examination such as an odor of alcohol, slurred speech, ataxia, dysmetria, or other cerebellar findings or behavior consistent with intoxication.

An altered level of alertness can include any of the following:

- A Glasgow Coma Scale score of 14 or less.
- Disorientation to person, place, time, or events.
- A delayed or inappropriate response to external stimuli, or other findings.

A focal neurologic deficit is any neurologic finding on motor or sensory examination that is abnormal. This includes sensory or motor abnormalities or autonomic dysfunction.

No precise definition of a painful distracting injury is possible. This category includes any condition thought by the provider to be producing pain or anxiety sufficient to distract the patient from a second (neck) injury. Such injuries may include, but are not limited to: any long-bone fracture, a significant abdominal injury, a large open wound or crush injury, large burns, or any other injury causing acute functional impairment.

Physician PEARLS:

In patients at extremes of age, or patients with any underlying baseline mental dysfunction such as: dementia, other chronic neurologic conditions, rheumatoid arthritis, chronic steroid therapy, severe osteoporosis, those who are chronically bedridden require a higher level of concern. For possible cervical spine injuries in these patients a lower threshold for using a c-collar should be instituted.

Padding (inflatable mattress, towel rolls, blankets, *etc.*) is recommended when appropriate for patient comfort.

SELECTIVE SPINAL IMMOBILIZATION