

SELECTIVE SPINAL IMMOBILIZATION

OVERVIEW:

The impact of a spinal injury on a patient is immeasurable. For this reason, it should be our goal to assure that every patient who has or may have a spinal injury be properly immobilized and transported. It should also be noted that the act of spinal immobilization itself can be detrimental - increased pain, increase in decubitus ulcers, increased hospital stay times, and increased hospital bills all contribute to a need to reduce unnecessary spinal immobilizations. The best care for your patients is to immobilize those who need immobilization and to defer those who do not.

INDICATIONS:

- ❑ Spinal immobilization will be initiated in any patient who has experienced a mechanism with the potential of causing spinal injury (MVA, fall, etc.) and who displays ANY of the following:
 - Altered mental status
 - Presence of intoxicants by history or assessment.
 - Distracting injuries (fractures, drowning, large lacerations, burns >1%, pain which distracts the patient from your line of questioning).
 - Neurological deficit or complaint (weakness is the most common neurological sign of spinal injury).
 - Spinal pain or tenderness.
 - Comorbid age factors (< 12 or > 65 yrs) may impact the EMS Provider's ability to assess the patient's perception and communication of pain. A conservative approach to immobilizing these patients is strongly recommended.
 - Distracting situation (communication barrier, emotional distress, etc.)

CONTRAINDICATIONS:

- ❑ None

PROCEDURE:

- ❑ Initiate manual spinal immobilization.
- ❑ Determine if spinal immobilization is necessary.
- ❑ Apply appropriately sized cervical collar
- ❑ Extricate as needed while maintaining in-line spinal stabilization.
- ❑ Immobilize on long back board using spider straps or equivalent and appropriate head immobilizer.
- ❑ Patients should be immobilized in the following order: torso, head, and then legs.
- ❑ Discontinue manual stabilization.
 - Reassess sensation, circulation, and motor function during transport.
 - Treat for pain as needed per Pain Management Guideline.

CONSIDERATIONS:

- ❑ Use your judgment! If you feel a patient should be immobilized, then immobilize regardless of the above criteria.
- ❑ For isolated penetrating head, neck, or torso trauma, immobilization of the cervical spine is unnecessary unless there is overt neurologic deficit or an adequate physical examination cannot be performed.
- ❑ For patients who are awake and alert and who do not have neurological deficits, spinal precautions can be maintained by **application of a rigid cervical collar and securing the patient firmly to the EMS stretcher**, and may be most appropriate for:
 - Patients who are found to be ambulatory at the scene
 - Patients who must be transported for a protracted time, in particular inter-facility transfers
- ❑ Pad backboards for all inter-facility transports. If feasible, especially in prolonged scene transports, pad backboards
- ❑ Some patients cannot be spinally immobilized using standard techniques. These patients must be immobilized to the best of your ability, but may require innovation.
- ❑ Pregnant patients in spinal immobilization need to be transported in left lateral recumbent position.