	COUNTY OF SACRAMENTO EMERGENCY MEDICAL SERVICES AGENCY	Document #	8044.13
	PROGRAM DOCUMENT: **Selective Spinal Immobilization**	Draft Date:	06/01/92
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EMS Medical Director

EMS Administrator

Purpose:

A. To serve as the prehospital care standard for the establishment of spinal immobilization.

Authority:

A. California Health and Safety Code, Division 2.5
B. California Code of Regulations, Title 22, Division 9

Indications:

A. Patients suffering from traumatic injuries shall normally have spinal immobilization performed if they have a complaint and meet any of the following conditions in the below chart.
B. Unless they meet some other criteria for spinal immobilization, patients sustaining stab wound injuries, gunshot wounds or any other penetrating injury, to anybody site, do not require spinal immobilization.
C. If the above criteria are not met, but there is still suspicion of spinal column or spinal cord injury, the patient should be immobilized.
D. Prehospital providers may elect to immobilize any trauma patient who based on their clinical assessment may have suffered a spinal injury.

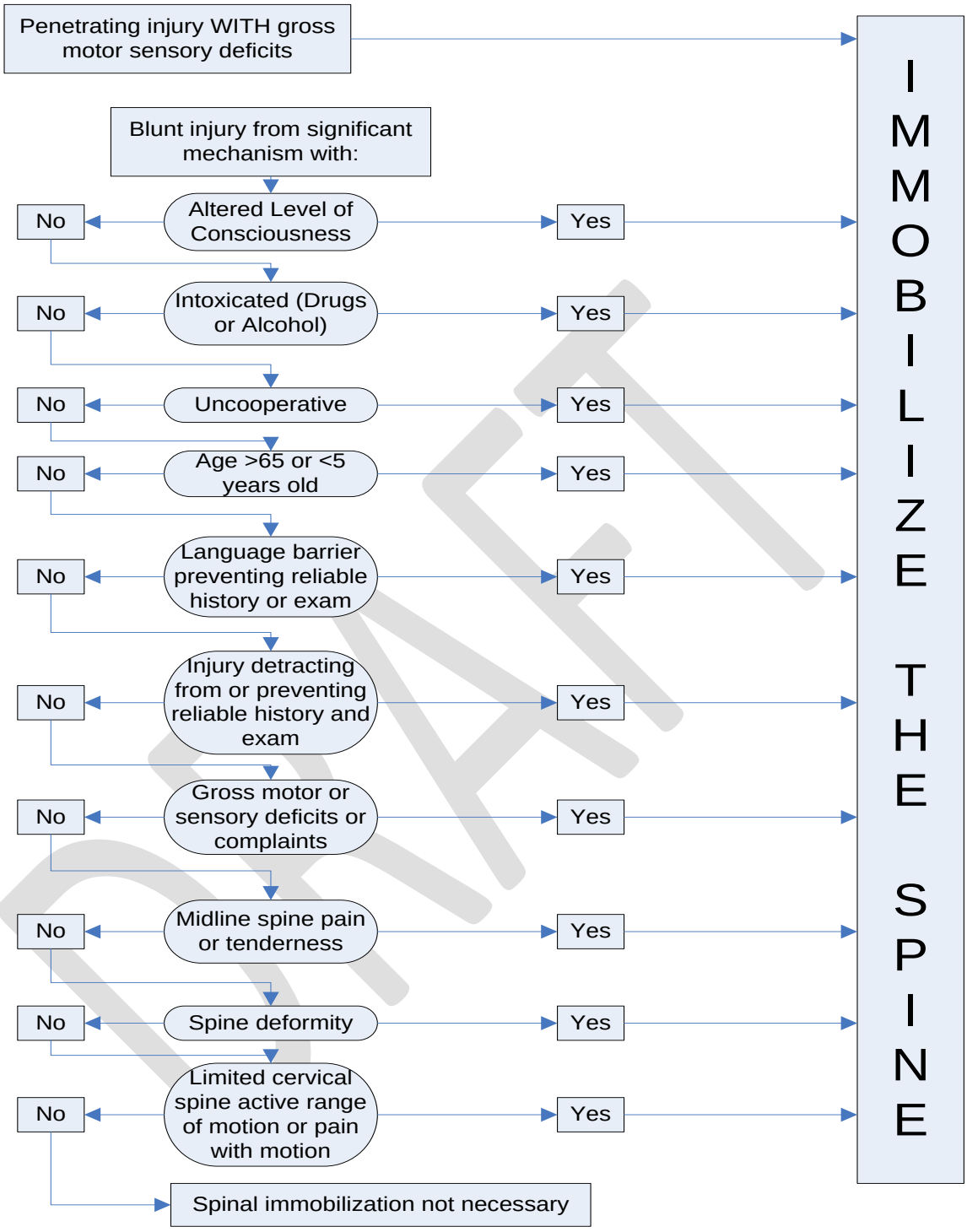
Special Notes:

A. Moving the head into a neutral in-line position is contraindicated if:
   1. There is pain upon starting movement
   2. There's muscle spasm or back pressure upon attempting movement
   3. Patient holds head angulated (tilted) to the side and patient cannot move head
   4. The head is rigidly held to one side
   5. The maneuver cannot be safely achieved due to space or other considerations
   6. In these cases the patient shall be immobilized in the position in which he/she is found
B. Spinal immobilization does not take precedence over airway, respiratory, and cardiovascular stabilization of the critical trauma patient.

Procedure:

A. All patients suffering traumatic injuries shall be assessed for the possibility of spinal injury, including history and exam including neurologic exam of all extremities, and inspection and palpation of the entire spine.
B. Establish and secure airway while maintaining neutral inline immobilization.

C. Access the head and neck for obvious injuries and distended neck veins while providing neutral in-line immobilization for the head and neck.
D. Apply an extrication or rigid collar and continue to maintain neutral in-line immobilization.
E. Secure the patient to a long spine board, short board, or Kendrick Extrication Device as appropriate.
    1. The best use of long spine boards (LSB) may be for extricating the unconscious patient, or providing a firm surface for compressions
    2. Patients who are ambulatory at the scene of blunt trauma in general do not require immobilization via LSB but may require cervical collar and spinal precaution
    3. Whether or not LSB is utilized, spinal precautions are still very important in patients at risk for spinal injury. Adequate spinal precautions may be achieved by placement of a hard cervical collar and ensuring that the patient is secured tightly to the stretcher, ensuring minimal movement and patient transfers, and manual in-line stabilization during any transfers
F. Transport.


Penetrating injury WITH gross motor sensory deficits
Blunt injury from significant mechanism with:
Altered Level of Consciousness
Intoxicated (Drugs or Alcohol)
Uncooperative
Age >65 or <5 years old
Language barrier preventing reliable history or exam
Injury detracting from or preventing reliable history and exam
Gross motor or sensory deficits or complaints
Midline spine pain or tenderness
Spine deformity
Limited cervical spine active range of motion or pain with motion
No
Yes
Spinal immobilization not necessary
IMMOBILIZE THE SPINE