Subject: SPINAL TRAUMA ***(BLS & ALS providers)***

MEDICAL PROGRAM DIRECTOR: ____Signed copy on file._____(J. Horsley, MD)_____

EFFECTIVE DATE: _10-1-2016_____

Specific information needed:

A. Mechanism of injury and forces involved: be suspicious with falls, decelerations, diving incidents, and motor vehicle incidents
B. Past medical problems and medications

Specific objective findings:

A. Vital signs, including neurologic assessment
B. Level of sensory and motor deficit: presence of any evidence of neurologic function below level of injury ***(attempt GCS)***
C. Physical exam, with careful attention to organs or limbs which may not have sensation

General treatment:

A. Assess airway and breathing: treat life-threatening difficulties, use controlled ventilations for high cervical cord injury associated with abdominal breathing, and maintain inline cervical immobilization while managing ABC's
B. Administer O2
C. Control hemorrhage
D. Immobilize cervical, thoracic and lumbosacral spine ***as indicate below.***
E. Obtain initial vital signs and neruologic assessment

Avanced Skills (F & G)-

F. Establish venous access. If signs of hyovolemia, fluid bolus 10-20cc/kg to maintain SBP>100
G. Consider narcotic analgesia per protocol
H. Monitor airway, vital signs and neurologic status frequently at scene and during transport

CLINICAL INDICATIONS FOR LONG SPINE BOARD IMMOBILIZATION:

A. Immobilize patient with a LSB and cervical collar for any of the following conditions:

- ***Blunt trauma and altered level of consciousness***
- ***Thoracic or lumbar spinal pain or tenderness***
- ***Neurologic complaint (e.g. numbness or motor weakness) following trauma***
- ***Anatomic deformity of the spine following trauma***
- ***High energy mechanism of injuy AND:***
  - ***Alcohol intoxication or drug induced impairment***
  - ***Inability to communicate***
  - ***Distracting injury***
- ***GSW to head or neck (in general stab wounds do not require LSB)***

B. Patients complaining of isolated cervical pain or tenderness following trauma can be managed by application of a cervical collar and securing the patient firmly to the stretcher, if the following criteria are met:

- ***Normal level of consciousness (GCS-15)***
- ***No thoracic or lumbar spine tenderness or anatomic abnormality***
- ***No neurologic findings or complaints***
- ***No intoxication or drug induced impairment***

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C. Patients who have no complaints of cervical or back pain and no tenderness should not be placed in a cervical collar or on a LSB if they meet the following:

- ***Normal level of consciousness (GCS-15)***
- ***No neurologic findings or complaints***
- ***No intoxication or drug induced impairment***

D. These guidelines do not preclude use of LSB for extrication or moving the patient.

E. Efforts should be made, especially in the light of extended transport times, to minimize the discomfort associated with LSBs. Padding under the knees if appropriate, light padding on the board such as a blanket or a Back Raft and other comfort measures may benefit the patient without compromising the goal of putting someone on the LSB. Also the clam stretcher provides spinal stabilization while extricating and can be removed once on the stretcher and is an excellent option.

Specific precautions:

A. Be prepared to turn entire board on side if patient vomits

B. Neurogenic shock is likely with significant spinal cord injury. Raise the foot of the spine board, ***if no indication of head injury***. Be sure respirations remain adequate.

D. If hypotension is unresponsive to simple measures, it is likely due to other injuries. Neurologic deficits make these other injuries hard to evaluate. Cord injury above the level of T-8 removes tenderness, rigidity and guarding as clues to abdominal injury

E. Spinal immobilization in patients with penetrating trauma is required only when neurologic deficits or altered mentation exists.

F. Providers may consider clearing the spine if (documentation of findings required):

- No spine or neck pain/tenderness/***deformity*** on palpation or otherwise
- No neurologic deficit
- No major distracting pain or long bone injuries
- No altered mental status / ***head injury of any significance***
- Not chemically altered (alcohol or drugs)
- No pain ***to back or neck*** with cough
- ***No priapism***
- ***No language or communications barrier***

NOTE: Pertinent negatives for clearing spine are to be documented in patient care report.

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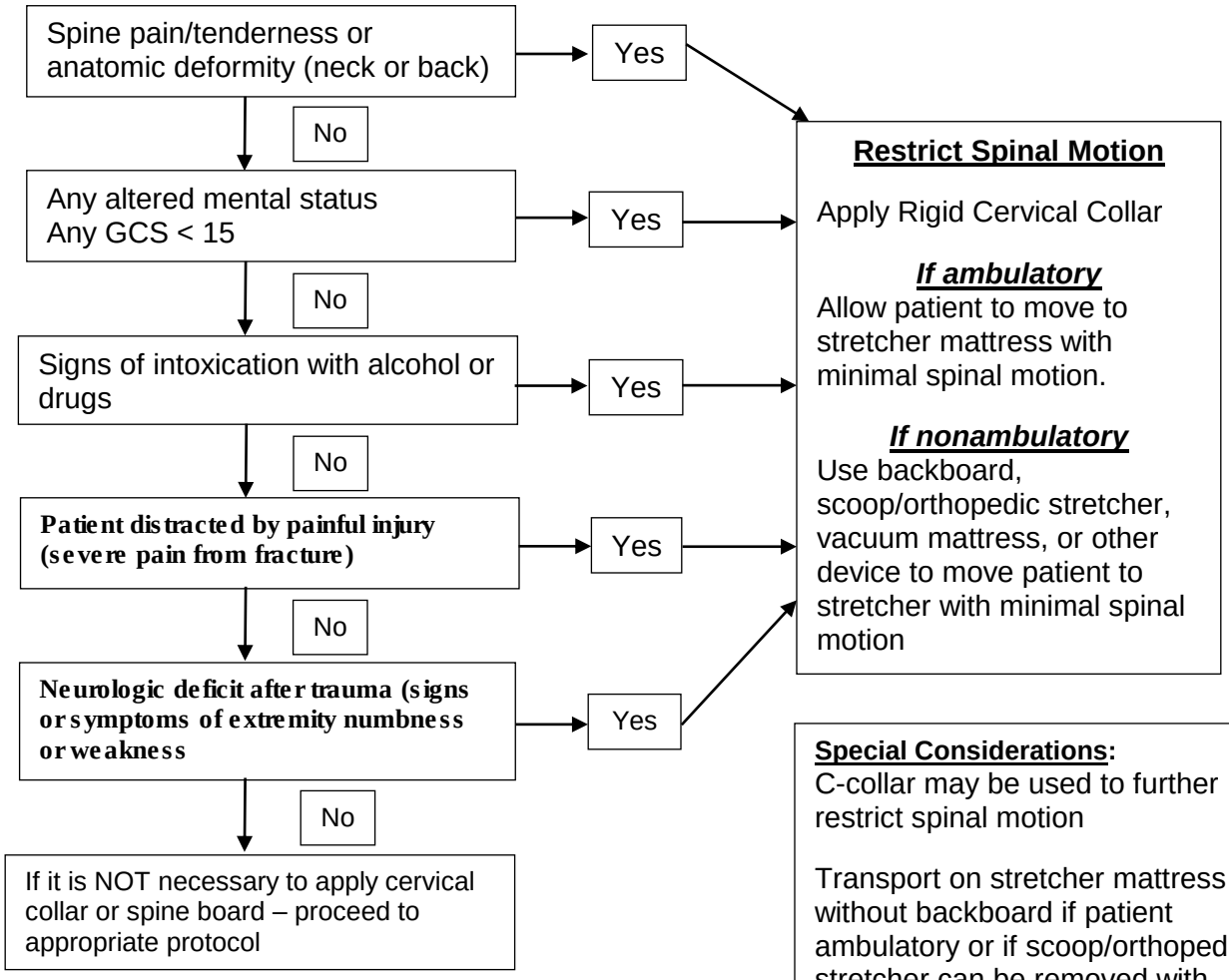
SPINAL IMMOBILIZATION ALGORITHM

ASSESSMENT OF SPINAL INJURIES

A. Patients with the following symptoms or mechanisms of injury should be assessed to determine whether restriction of spinal motion is required.



Special Considerations:
C-collar may be used to further restrict spinal motion

Transport on stretcher mattress without backboard if patient ambulatory or if scoop/orthopedic stretcher can be removed with minimal patient motion

In the event that standard c-collar sizes are not appropriate for your patient(s) the following may be utilized:

1. Blocks and tape.
2. Towel rolls on either side of patients head and tape.
3. Other approved device for c-spine immobilization.

WARNING: Criteria cannot be assessed on any patient with a language or communications barrier that prevents understanding and appropriately responding to the assessment questions. If there is any doubt about whether the patient meets any of the clinical criteria listed above restrict spinal motion.

NOTE: Exclusion criteria should be used to assess the use of spinal immobilization and is not a definite assessment of whether the patient has a spinal injury. Exclusion criteria should be documented.