PURPOSE:

The purpose of this policy is to provide direction to prehospital personnel on the application of cervical spine immobilization and to reduce the risk of negative effects caused by traditional spinal immobilization.

AUTHORITY:

Health and Safety Code, Division 2.5, Section 1797.220 & 1798 et seq.;

POLICY:

I. The San Joaquin County EMS Agency is supporting efforts to decrease unnecessary immobilizations in the field and reduce the risks and complications associated with spinal immobilization. Studies show immobilizing trauma patients may cause more harm than good to the patient especially penetrating trauma patients (stabblings and gunshot wounds) which benefit most from rapid assessment and transport to a trauma center.

II. Prehospital personnel shall apply cervical spine immobilization to patients injured from blunt force trauma in the following circumstances:
   A. Conscious patients exhibiting one or more of the following signs or symptoms:
      1. Posterior midline cervical tenderness or pain;
      2. Distal numbness, tingling, weakness, or paresthesia;
      3. Paralysis;
      4. Neck guarding or restricted range of motion;
      5. Glasgow Coma Scale (GCS) motor score of less than 5 as a result of blunt force trauma or intoxicants, e.g. alcohol or other drugs.
   B. Unconscious adult patients suffering a blunt force mechanism of injury, except ground level falls.

III. Prehospital personnel shall not apply cervical spine immobilization to patients in the following circumstances:
   A. Patients injured solely from penetrating trauma;
   B. Unconscious adult patients experiencing a ground level fall;
   C. Patients in cardiac arrest.

IV. Pediatric cervical spine immobilization shall be performed as follows:
   A. Cervical spine immobilization shall be conducted using soft collars and should be immobilized using a Kendrick Extrication Device (KED) or other
B. Pediatric Patients and Car Seats:
   1. Infants restrained in a rear-facing care seat may be immobilized and extricated in the care seat. The child may remain in the car seat if the immobilization is secure and his/her condition allows (no signs of respiratory distress or shock.)
   2. Children restrained in a car seat (with a high back) may be immobilized and extricated in the car seat; however, once removed from the vehicle, the child should be placed in a padded pediatric immobilization device or other commercially available immobilization device approved by the EMS Agency.
   3. Children restrained in a booster seat (without back) need to be extricated using standard techniques and immobilized using a padded pediatric immobilization device or other commercially available immobilization device approved by the EMS Agency.
   4. If applying spinal immobilization to a patient in a car seat, prehospital personnel shall conduct a posterior assessment by palpation.

V. Adult cervical spine immobilization shall be performed as follows:
   A. Cervical spine immobilization shall be conducted using soft collars and should be immobilized using a Kendrick Extrication Device (KED) or other commercially available immobilization device approved by the EMS Agency.
   B. Unconscious prone and supine patients may be immobilized using a long backboard with padding or a water extrication device e.g. Miller Board. Patients presenting with anatomical constraints limiting conformity to a KED (e.g. curvature of the spine) should be secured for transport by using any combination equipment including pillows and blankets or other commercially available immobilization device approved by the EMS Agency to ensure comfort and spinal immobilization on the gurney.

VI. Movement on scene:
   A. Pull sheets, other flexible devices, scoops, scoop-like devices may be used. Unpadded long backboards should have limited utilization.
   B. If an unpadded longboard or scoop stretcher device is used to move patients on scene due to issues of space or distance, such devices should only be used as a temporary means of transporting the patient to a gurney prior to the application of the KED or other approved immobilization method.
   C. Keeping with the goals of restricting gross movement of the cervical spine...
and preventing further pain and discomfort, patient self-extrication is allowable.

VII. Special Considerations:
A. Patients who are agitated or restless due to shock, hypoxia, head injury or intoxication may be impossible to immobilize adequately. It may be necessary to remove immobilization devices or modify immobilization techniques to reduce the risk of further injury.
B. Paramedics may discontinue or clear spinal immobilization initiated by BLS personnel, if in the opinion of the paramedic cervical spine is not required by policy or compromises the ability to render patient care. Paramedics are required to document on the patient care record each instance of discontinuing cervical spine immobilization and their basis for removal.
C. When using spinal immobilization, patients may be placed in semi or high fowlers position to address respiratory conditions or for patient comfort.
D. Prohibited equipment and practices:
   1. Hard collars;
   2. Adhesive tape applied to the patient’s skin.

VIII. EMS Policy No. 5506 BLS Spinal Immobilization is hereby rescinded.