EMS Policy Memorandum No. 2013-03

DATE: June 20, 2013

TO: All Prehospital Personnel and Providers
   Base Hospital Personnel
   Emergency Department Physicians and Nurse Liaisons

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SUBJ.: EMS Policy No. 5115 Cervical Spine Immobilization

The purpose of this Policy Memorandum is to clarify EMS Policy No. 5115 Cervical Spine Immobilization by presenting the following frequently asked questions (FAQs):

1. Why shouldn’t patients with penetrating trauma be placed in spinal immobilization?
   Studies have shown that the time spent placing penetrating trauma patients in spinal immobilization delays transport to the hospital to receive definitive care and may also interfere with the provision of treatment of penetrating trauma on-scene.

2. What is the best way to measure posterior midline cervical tenderness?
   While using a moderate amount of pressure, palpate down the spine from top to bottom, using both hands.

3. Are stiff neck c-collars allowed?
   No. The EMS agency is allowing EMS providers a transition period until October 1, 2013, and stiff neck c-collars may be used during this time period.

4. Must soft c-collar be used in every case that spine immobilization is necessary?
   While the goal is to place a c-collar on every patient, a c-collar may not be appropriate in every case. Instead, there may be circumstances that require the use of other adjuncts such as towel rolls, blankets, or other tools that fit the requirement of immobilizing a patient’s spine.
5. **What are some examples of the variety of methods that may be employed to secure spinal immobilization during extrication and care of a patient from a MVA?**

Depending upon the size of the patient, whether conscious or unconscious, the position of the patient and the amount of intrusion into the vehicle caused by the MVA, patients may or may not need to be extricated using a KED. EMS personnel should apply a soft collar and assist the patient to carefully self-extricate while guarding (preventing) their own neck movement; or be placed on a backboard for extrication purposes.

6. **When a patient has been placed on a backboard at the scene of an MVA or MCI, what are some ways to avoid transporting that patient on a backboard in the ambulance?**

The overall goal is to understand that there are a variety of tools and methods at your disposal in order to adapt and overcome the challenges presented on scene calls. When it is time to place the patient on the gurney, EMS personnel should do what is in the patient’s best interest and strive to reduce “gross movement” of the patient. Possible options include:

- Application of a soft collar on the patient to allow carefully assisted self-extrication and assistance to the gurney; no KED used. Note: this is an appropriate technique if the patient is negative for neurological deficits but has positive neck pain.
- The patient has been extricated on the backboard and is now next to the vehicle on the ground. After stripping and assessing the patient, a KED can be slid underneath the patient while on the backboard. With the backboard and patient placed on the gurney, remove the backboard by sliding it from underneath the patient along the vertical line of the patient. DO NOT log roll the patient off the backboard since such a method causes too much gross movement and weight shift of the patient.
- Use a scoop stretcher to pick up the patient from the backboard or slide the patient off the back board onto the gurney. If appropriate, place either a KED or Fasplint on the gurney prior the transition if such a tool is needed to immobilize the spine during ambulance transport.

7. **What examples of appropriate uses for a KED?**

The KED was designed to be both an extrication and immobilization device. A KED can be a particularly helpful tool to extricate and immobilize seated unconscious patients. The KED is highly recommended in such cases because the patient may be placed in the semi-fowlers position or turned laterally to address vomit in the airway. Whether or not the KED is used as an extrication device or simply to maintain spinal immobilization will depend upon the situation. However, if a patient’s spine can (or must) be effectively managed without a KED, such as a patient whose size or shape
negates the KED’s effectiveness, a KED is not recommended. If only used as an immobilization device, it may be appropriate to place the KED on the gurney and then place the patient on the KED.