Memorandum

To: SIREMS Participants

CC: Brad Robinson, Nathan Bressner

From: Dr. Joseph R. Haake, MD, FACEP

Date: 12/31/2013

Re: Spinal Immobilization Policies

Spinal Immobilization Policy Changes

This memo is intended to clarify the changes made to the Spinal Immobilization Protocol.

A recent Position Statement from the National Association of EMS Physicians and American College of Surgeons Committee on Trauma has highlighted the need to change the current culture which has resulted in overuse of the long backboard. Substantial data now exists that reveals long backboards may actually cause harm to patients, do a substandard job of truly immobilizing the spine, and no literature has been shown to reveal a clear benefit to their use. Backboards have been shown to cause skin breakdown, respiratory compromise, aspiration of oropharyngeal contents, pressure ulcers, and increased need for analgesics.

The literature and recommendations portray a clear distinction between immobilization with a cervical collar and long backboard VERSUS a cervical collar and an EMS stretcher, with the understanding that spinal precautions and careful transfers can still maintain safe spinal motion restriction in either case.

The following points summarize the recommendations regarding patients that can be transported WITHOUT a long backboard:

- GCS of 15 (normal level of consciousness plus the ability to communicate well)
- No spine tenderness or anatomic abnormality
- No neurologic findings or complaints
- No distracting injury
- No intoxication

Additionally, a cervical collar and careful transportation on an EMS stretcher without a rigid backboard is appropriate for:

- Patients found to be ambulatory on scene
- Patients who face an extended transport time

With the above points in mind, please continue to use backboards, KEDs, short boards, vacuum mattresses, scoop stretchers, or other spinal protective adjuncts to move the patients from the point of injury to the EMS stretcher. The care to limit movement and prevent further injury to one's spine can still be maintained even without using a long board to transport the patient to a hospital. Once the

patient is moved to the stretcher, please lay the patient flat on the stretcher with their cervical collar still in place by using the log roll technique or lift and slide technique. It is safe to eliminate the "standing take-down" technique for patients who are ambulatory after an injury. If they are already standing, direct the stretcher next to the patient, have them sit upright on the edge of the stretcher, and assist them by positioning them in a seated upright position on the stretcher.

Another important point of the policy changes is that patients with PENETRATING trauma, such as a gunshot wound or stab wound, should NOT be immobilized unless they had blunt spinal injury occur after the penetrating injury.

With these evidence-based changes, it is our hope to improved patient outcomes in multiple ways, including reducing complications, reducing pain and suffering, reducing injuries to EMS personnel attempting spinal immobilization in unsafe environments, and decreasing scene times.

I welcome any questions about these changes and look forward to the progressive care of our potential spine injury patients in Southern Illinois.