Trauma
SPINAL MOTION RESTRICTIONS
Practice Guideline

Patient Care Goals:
1. Minimize unwanted movement of the potentially injured spine
2. Minimize risk of SCI from an unstable fracture
3. Reduce harm from backboard when possible

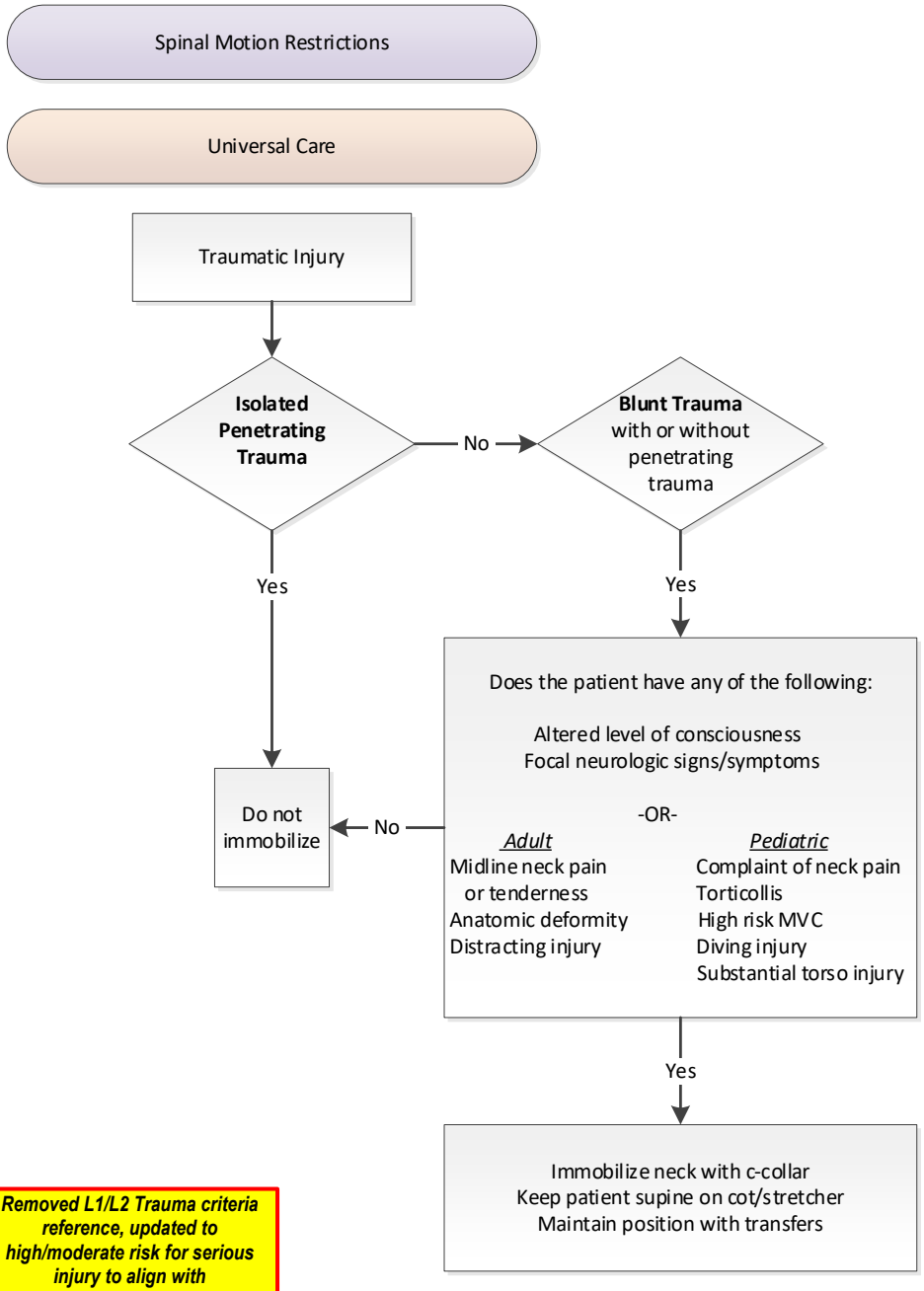
Patient Presentation:
Inclusion Criteria
Blunt trauma
Mechanism with potential for spinal injury

Quality Improvement:
Key Documentation Elements
1. Neurological exam before and after movement (A statement such as 'pt's neurologic exam remained unchanged throughout all transfers' would suffice for stable transfers)
2. Spinal exam
3. Mechanism of injury
4. Level of consciousness

Patient Safety Considerations:
SMR should apply to the entire spine
- C-collar is a critical component
- Stabilization can be accomplished via scoop stretcher, vacuum mattress, cot/stretcher
- **Backboard may be an adjunct to movement but should be removed after transfer to cot.**
- To elevate head, elevate entire stabilization device while maintaining alignment of neck/torso
- SMR cannot be properly performed with pt in sitting position
- Ambulatory pt w/minor spine pain may be gently assisted directly to a stretcher brought to their side

Altered level of consciousness
Includes GCS <15, intoxication, not following commands, etc
Focal neurological signs or symptoms
Numbness, motor weakness, etc
Distracting injury or circumstances
Long bone fracture, burns, emotional distress, communication barrier, etc that impairs the patient's ability to contribute to a reliable exam
Torticollis
Painfully twisted and tilted neck
High risk MVC
Blunt trauma meeting high or moderate risk for serious injury per Trauma Field Triage PG
Age ≤5 (and ≥65) may be considered high risk when considering other major trauma factors

Removed L1/L2 Trauma criteria reference, updated to high/moderate risk for serious injury to align with Trauma Field Triage Guidelines



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