



## AGENDA

### ICEMA MEDICAL ADVISORY COMMITTEE

April 28, 2016

1300

Purpose: Information Sharing

Meeting Facilitator: Phong Nguyen

Timekeeper: Chantae Wilson

Record Keeper: Chantae Wilson

	AGENDA ITEM	PERSON(S)	DISCUSSION/ACTION
I.	Welcome/Introductions	Phong Nguyen	
II.	Approval of Minutes	All	Discussion/Action
III.	Discussion/Action Items		
	A. Standing EMS System Updates		
	<ol style="list-style-type: none"> <li>1. Review of Action Items</li> <li>2. Trauma Program</li> <li>3. STEMI Program: STEMI Data               <ul style="list-style-type: none"> <li>• Chest Pain Society Accreditation</li> </ul> </li> <li>4. Stroke Program: Stroke Data</li> <li>5. CQI Report Update               <ul style="list-style-type: none"> <li>• Core Measures</li> </ul> </li> <li>6. SAC Update</li> </ol>	<ol style="list-style-type: none"> <li>1. Phong Nguyen</li> <li>2. Chris Yoshida-McMath</li> <li>3. Chris Yoshida-McMath</li> <li>4. Chris Yoshida-McMath</li> <li>5. Phong Nguyen               <ul style="list-style-type: none"> <li>• Ron Holk</li> </ul> </li> <li>6. Phong Nguyen</li> </ol>	<ol style="list-style-type: none"> <li>1. Discussion/Action</li> <li>2. Discussion</li> <li>3. Discussion</li> <li>4. Discussion</li> <li>5. Discussion</li> <li>6. Discussion</li> </ol>
	B. EMS Trends		
	<ol style="list-style-type: none"> <li>1. TXA Study Update</li> <li>2. Paramedicine Step I Research Update</li> <li>3. Cardiac Arrest Survival Enhancement Project (CARES/ART)</li> </ol>	<ol style="list-style-type: none"> <li>1. Reza Vaezazizi/ Michael Neeki</li> <li>2. Michael Neeki</li> <li>3. Reza Vaezazizi</li> </ol>	<ol style="list-style-type: none"> <li>1. Discussion</li> <li>2. Discussion</li> <li>3. Discussion</li> </ol>
	C. Use of UV Light for Disinfection	Phong Nguyen	Discussion
	D. Axial Spinal Immobilization	Dan Sitar	Discussion/Action
	E. ePCR User Interface Task Force	Ron Holk	Discussion
	F. Needle Cricothyrotomy	All	Discussion/Action
	G. Use of Fentanyl Outside of Protocol	Ron Holk	Discussion/Action
	H. Triage Tag vs ePCR	Ron Holk	Discussion/Action
	I. Continuity of Patient Care Policy	Ron Holk	Discussion
IV.	Public Comment	All	Discussion
V.	Round Table/Announcements	All	Discussion
VI.	Future Agenda Items	All	Discussion
VII.	Next Meeting Date: June 23, 2016	All	Discussion
VIII.	Adjournment	Phong Nguyen	Action

AGENDA - MEDICAL ADVISORY COMMITTEE

April 28, 2016

IX.	Closed Session		
	A. Case Reviews		



## MINUTES

### ICEMA MEDICAL ADVISORY COMMITTEE

December 17, 2015

1300

AGENDA ITEM		DISCUSSION/FOLLOW UP	RESPONSIBLE PERSON(S)
I.	WELCOME/INTRODUCTIONS	Meeting called to order at 1301.	Michael Neeki
II.	APPROVAL OF MINUTES	The October 22, 2015, minutes were approved.  Motion to approve. MSC: Michael Neeki/Lance Brown <b>APPROVED</b> Ayes: Debbie Bervel, Lance Brown, Sam Chua, Michael Guirguis, Susie Moss, Michael Neeki, Phong Nguyen, Leslie Parham, Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Rosemary Sachs, Todd Sallenbach	
III.	DISCUSSION ITEMS		
	A. Standing EMS System Updates		
	1. Review of Action Items	Action items were incorporated into the agenda.	Phong Nguyen
	2. Trauma Program	The trauma triage guidelines were altered in order to follow the CDC Trauma Triage guidelines.  The next TSAC/TAC meeting is February 24, 2016.	Chris Yoshida-McMath
	3. STEMI Program: STEMI Data	A beta test is scheduled to begin in March 2016 to transmit 12-lead ECGs to STEMI base hospitals.  The next STEMI meeting is February 18, 2016, at 1:00 pm at ICEMA.	Chris Yoshida-McMath
	4. Stroke Program: Stroke Data	A regional Stroke CQI meeting will occur in 2016.  The next Stroke meeting is February 4, 2016, at 1:00 pm at ICEMA.	Chris Yoshida-McMath

MINUTES - MEDICAL ADVISORY COMMITTEE

December 17, 2015

Page 2

	5. CQI Report Update		Ron Holk
	<ul style="list-style-type: none"> <li>Core Measures</li> </ul>	Nothing to report.	Ron Holk
	<ul style="list-style-type: none"> <li>Intubation and Capnography Data Task Force</li> </ul>	Nothing to report.	Pam Martinez/Joe Powell
	6. SAC Update	The last SAC meeting was canceled due to lack of quorum.	Kevin Parkes
	B. EMS Trends		
	1. TXA Study Update	<p>There have been 57 uses of TXA since the beginning of the study.</p> <p>Redlands Fire Department has joined the study.</p> <p>There has been a notable improvement in documentation since the documentation checklist was distributed.</p> <p>A regional data analysis meeting is scheduled for January 28, 2016. This meeting will include the three (3) LEMSAs participating in the study.</p>	Chris Yoshida-McMath
	2. Paramedicine Step I Research Update	Step 1 has concluded and the results are contrary to the hypothesis. Data analysis is in process.	Michael Neeki
	3. Cardiac Arrest Survival Enhancement Project (CARES/ART)	<p>CARES will begin in the east valley of San Bernardino County, both hospitals and EMS. CARES has begun training some of the hospitals.</p> <p>The State of California has approved the subscription model. A coordinator for this will be housed at ICEMA.</p>	Chris Yoshida-McMath
	C. ePCR User Interface Task Force	<p>A lengthy discussion occurred surrounding the proposed positions.</p> <p>Motion to accept the list after replacing Air Provider and Community Paramedicine with Member At Large for both.</p> <p>MSC: Lance Brown/Michael Neeki  Ayes: Debbie Bervel, Lance Brown, Sam Chua, Michael Guirguis, Susie Moss, Michael Neeki, Phong Nguyen, Leslie Parham, Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Rosemary Sachs, Todd Sallenbach</p>	
	D. Needle Cricothyrotomy	No motion from MAC following discussion. Discussion will continue at the next meeting.	
	E. Use of Fentanyl Outside of Protocol	Reza Vaezazizi, Ron Holk, Susie Moss, and Sandy Carnes will develop verbiage for Fentanyl in the MSO and present at the next meeting.	

MINUTES - MEDICAL ADVISORY COMMITTEE

December 17, 2015

Page 3

	F. Protocol Update Glucose		Ron Holk
	1. 5040 - Radio Communication Policy	Distributed in packet as informational only.	
	2. 6070 - Cardiovascular STEMI Receiving Centers Criteria and Destination Policy	Distributed in packet as informational only.	
	3. 6100 - Neurovascular Stroke Receiving Centers Criteria and Destination Policy	Distributed in packet as informational only.	
	4. 8130 - Destination Policy	Distributed in packet as informational only.	
	G. Protocol Review		Ron Holk
	1. 5030 - Procedure for Adoption of Protocols and Policies	Motion to accept with the change from 15 days to 30 days.  MSC: Michael Neeki/Joy Peters Ayes: Debbie Bavel, Lance Brown, Sam Chua, Michael Guirguis, Susie Moss, Michael Neeki, Phong Nguyen, Leslie Parham, Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Rosemary Sachs, Todd Sallenbach	
	2. 6090 - Fireline Paramedic	Motion to accept protocol as presented.	
	3. 7010 - BLS/LALS/ALS Standard Drug & Equipment List	Motion to accept protocol as presented.  MSC: Michael Neeki/Joy Peters Ayes: Debbie Bavel, Lance Brown, Sam Chua, Michael Guirguis, Susie Moss, Michael Neeki, Phong Nguyen, Leslie Parham, Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Rosemary Sachs, Todd Sallenbach	
	4. 7020 - EMS Aircraft Standard Drug & Equipment List	Motion to accept protocol as presented.  MSC: Michael Neeki/Joy Peters Ayes: Debbie Bavel, Lance Brown, Sam Chua, Michael Guirguis, Susie Moss, Michael Neeki, Phong Nguyen, Leslie Parham, Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Rosemary Sachs, Todd Sallenbach	

MINUTES - MEDICAL ADVISORY COMMITTEE

December 17, 2015

Page 4

5.	7040 - Medication - Standard Orders	<p>Motion to accept protocol as presented.</p> <p>MSC: Michael Neeki/Joy Peters  Ayes: Debbie Bavel, Lance Brown, Sam Chua, Michael Guirguis, Susie Moss, Michael Neeki, Phong Nguyen, Leslie Parham, Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Rosemary Sachs, Todd Sallenbach</p>	
6.	8120 - Continuation of Care (San Bernardino County Only)	<p>Motion to accept protocol as presented.</p> <p>MSC: Michael Neeki/Joy Peters  Ayes: Debbie Bavel, Lance Brown, Sam Chua, Michael Guirguis, Susie Moss, Michael Neeki, Phong Nguyen, Leslie Parham, Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Rosemary Sachs, Todd Sallenbach</p>	
7.	9080 - Care of Minors in the Field	<p>Motion to accept protocol as presented.</p> <p>MSC: Michael Neeki/Joy Peters  Ayes: Debbie Bavel, Lance Brown, Sam Chua, Michael Guirguis, Susie Moss, Michael Neeki, Phong Nguyen, Leslie Parham, Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Rosemary Sachs, Todd Sallenbach</p>	
8.	10190 - ICEMA Approved Skills	<p>Motion to accept protocol as presented.</p> <p>MSC: Neeki/Peters  Ayes: Debbie Bavel, Lance Brown, Sam Chua, Michael Guirguis, Susie Moss, Michael Neeki, Phong Nguyen, Leslie Parham, Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Rosemary Sachs, Todd Sallenbach</p>	
9.	11070 - Cardiac Arrest - Adult	<p>Motion to accept protocol as presented.</p> <p>MSC: Michael Neeki/Joy Peters  Ayes: Debbie Bavel, Lance Brown, Sam Chua, Michael Guirguis, Susie Moss, Michael Neeki, Phong Nguyen, Leslie Parham, Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Rosemary Sachs, Todd Sallenbach</p>	

MINUTES - MEDICAL ADVISORY COMMITTEE

December 17, 2015

Page 5

	10. 11110 - Stroke Treatment - Adult	Motion to accept protocol as presented. MSC: Michael Neeki/Joy Peters Ayes: Debbie Bervel, Lance Brown, Sam Chua, Michael Guirguis, Susie Moss, Michael Neeki, Phong Nguyen, Leslie Parham, Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Rosemary Sachs, Todd Sallenbach	
	11. 15030 - Trauma Triage Criteria and Destination Policy	Motion to accept protocol as presented. MSC: Michael Neeki/Joy Peters Ayes: Debbie Bervel, Lance Brown, Sam Chua, Michael Guirguis, Susie Moss, Michael Neeki, Phong Nguyen, Leslie Parham, Kevin Parkes, Stephen Patterson, Joy Peters, Joe Powell, Aaron Rubin, Rosemary Sachs, Todd Sallenbach	
	H. 2016 Meeting Dates	Distributed in packet.	
IV.	PUBLIC COMMENT	None	All
V.	ROUND TABLE/ ANNOUNCEMENTS	None	All
VI.	FUTURE AGENDA ITEMS	ePCR User Interface Task Force Needle Cricothyrotomy Use of Fentanyl Outside of Protocol	All
VII.	NEXT MEETING: February 25, 2016		
VIII.	ADJOURNMENT	Meeting adjourned at 1459.	Phong Nguyen
IX.	CLOSED SESSION		
	A. Case Review	None	

MINUTES - MEDICAL ADVISORY COMMITTEE

December 17, 2015

Page 6

Attendees:

NAME	MAC POSITION	EMS AGENCY STAFF	POSITION
<input type="checkbox"/> VACANT <input type="checkbox"/> Jeff Grange - LLUMC	Trauma Hospital Physicians (2)	<input checked="" type="checkbox"/> Reza Vaezazizi, MD	Medical Director
<input checked="" type="checkbox"/> Phong Nguyen - RDCH (Chair) <input checked="" type="checkbox"/> Todd Sallenbach - HDMC	Non-Trauma Base Physicians (2)	<input checked="" type="checkbox"/> Tom Lynch	EMS Administrator
<input checked="" type="checkbox"/> Aaron Rubin - Kaiser	Non-Base Hospital Physician	<input checked="" type="checkbox"/> Denice Wicker-Stiles	Assist. Administrator
<input checked="" type="checkbox"/> Michael Neeki - Rialto FD	Public Transport Medical Director	<input type="checkbox"/> George Stone	Program Coordinator
<input checked="" type="checkbox"/> Sam Chua - AMR	Private Transport Medical Director	<input checked="" type="checkbox"/> Ron Holk	EMS Nurse Specialist
<input checked="" type="checkbox"/> Debbie Bervel - SB City FD	Fire Department Medical Director	<input checked="" type="checkbox"/> Chris Yoshida-McMath	EMS Nurse Specialist
<input checked="" type="checkbox"/> Joy Peters - ARMC	EMS Nurses	<input checked="" type="checkbox"/> Danielle Ogaz	EMS Specialist
<input checked="" type="checkbox"/> Joe Powell - Rialto FD	EMS Officers		
<input checked="" type="checkbox"/> Leslie Parham	Public Transport Medical Rep (Paramedic/RN)		
<input checked="" type="checkbox"/> Susie Moss	Private Transport Medical Rep (Paramedic/RN)		
<input checked="" type="checkbox"/> Lance Brown	Specialty Center Medical Director		
<input type="checkbox"/> Joanna Yang - LLUMC	Specialty Center Coordinator		
<input type="checkbox"/> Troy Pennington	Private Air Transport Medical Director		
<input checked="" type="checkbox"/> Stephen Patterson - Sheriff's Air Rescue	Public Air Transport Medical Director		
<input checked="" type="checkbox"/> Michael Guirguis - SB Comm Center	PSAP Medical Director		
<input type="checkbox"/> VACANT	Inyo County Representative		
<input checked="" type="checkbox"/> Rosemary Sachs	Mono County Representative		
<input checked="" type="checkbox"/> Kevin Parkes	SAC Liaison		
<input type="checkbox"/> Andrea Thorp	Pediatric Critical Care Physician		

GUESTS	AGENCY
Sandy Carnes	Rancho Cucamonga FD
Carly Crews	SB City FD
Lisa Higuchi	AMR
Sara Morning	SB County FD
Miranda Mulhull	SB County FD
Christopher Linke	AMR
Mark Roberts	ICEMA
Ann Sandez	San Manuel FD

## Long Backboard Use for Spinal Motion Restriction

<b>Clinical Significance</b>	Long backboards (LBB) continue to be applied for spinal motion restriction (SMR) in trauma patients despite a lack of substantiated benefits. Judicious use of the LBB necessitates that healthcare providers ensure the benefits of application outweigh the potential risks.
<b>Populations</b>	Applies to the adult population.

Translation Into Practice:	
<b>Long Backboard Use for Spinal Motion Restriction</b>	<p><b><u>Recommended Clinical Practice</u></b></p> <p>The LBB is an extrication tool, whose purpose is to facilitate transfer of a patient to a transport stretcher/cart and is not intended or appropriate for achieving SMR.<sup>2,5,6,8-12</sup> <span style="float: right;">[Level A Recommendation]</span></p> <p>Judicious application of the LBB for purposes other than extrication necessitates that healthcare providers ensure the benefits outweigh the potential risks.<sup>3,5-8,10-12</sup> <span style="float: right;">[Level A Recommendation]</span></p> <p>If an LBB is applied, patients should be removed as soon as it is safe and practicable. This reduces complications, minimizes negative events, and prevents adverse patient outcomes.<sup>3,6-8,10-13</sup> <span style="float: right;">[Level A Recommendation]</span></p> <p>It is recommended that individual healthcare facilities develop their own policies, procedures, and guidelines to determine who should remove patients from the LBB and the technique(s) used to do it.<sup>6,8,10</sup> <span style="float: right;">[Level B Recommendation]</span></p> <p>Patients being transferred to another facility who have received cervical spine clearance by an advanced practice healthcare provider or physician do not need to be reapplied to an LBB for transport or while awaiting transfer.<sup>3,6-8,10-12</sup> <span style="float: right;">[Level A Recommendation]</span></p> <p>It is recommended that all trauma patients receive a spinal assessment whether or not an LBB is used;<sup>3,4,6-10,12,13,16</sup> spinal motion restriction (SMR) is not indicated in all trauma patients.<sup>2-11,14,16</sup> <span style="float: right;">[Level A Recommendation]</span></p> <p>Spinal motion restriction in penetrating trauma patients is associated with higher mortality, is unnecessary, potentially hazardous, and not recommended.<sup>2-11</sup> <span style="float: right;">[Level A Recommendation]</span></p> <p>Spinal motion restriction should be considered for patients in the following circumstances:<sup>3-6,8-10</sup></p> <ul style="list-style-type: none"> <li>• Blunt trauma and altered level of consciousness</li> <li>• Spinal deformity, pain, or tenderness</li> <li>• Focal neurological deficit</li> <li>• High energy mechanism of injury together with:               <ul style="list-style-type: none"> <li>– Alcohol and/or drug intoxication</li> <li>– Distracting, painful injury or communication barrier</li> </ul> </li> </ul> <p style="text-align: right;">[Level A Recommendation]</p>

## Long Backboard Use for Spinal Motion Restriction

### Supporting Rationale:

Historically, the long backboard (LBB) was presumed to provide spinal immobilization and stabilization in trauma patients. In fact, prehospital management of trauma patients included application of the LBB as the standard of practice.<sup>1-5</sup> However, the benefits of LBBs have been widely questioned.<sup>2-12</sup> Despite this, it is estimated that millions of patients still receive spinal immobilization each year in the United States, most of whom show no evidence of spinal injuries.<sup>7</sup>

The use of the LBB to immobilize the spine continues despite the lack of supporting scientific evidence.<sup>2-12</sup> While the LBB is a useful extrication tool, its application is not without risks.<sup>3,5-8,10-12</sup> Long backboard use has been shown to cause and lead to the following:<sup>7,8,11,14,15</sup>

- Agitation and anxiety
- Altered physical examination
- Delay in treatment
- Increased cranial pressure
- Pain
- Pressure sores
- Respiratory compromise
- Unnecessary radiographs

Use of the LBB requires judicious consideration of the risks of further complications. Evidence has shown that removal as soon as practicable reduces the probability of complications, adverse outcomes, and negative events.<sup>3,6-8,10-13</sup>

Guidelines for LBB removal may vary depending on staffing, equipment, training, and education. It is recommended that individual healthcare facilities use multidisciplinary teams focusing on the best clinical evidence to develop their own policies, procedures, and guidelines specifying which individuals and what technique(s) would be most effective in safely removing patients from the LBB.<sup>6,8,10</sup>

It is advocated that qualified staff receive the appropriate education, training, and frequent competency evaluations to ensure safe practice and care.<sup>6,8,10</sup>

There is overwhelming support for the view that all trauma patients should receive a spinal assessment whether or not an LBB has been implemented. This is because SMR is not indicated in every trauma patient.<sup>2-14,16</sup> In fact, in penetrating trauma cases, SMR is associated with higher mortality and is universally not recommended.<sup>2-11,16</sup>

Injury prevention measures such as legislation, education, car safety, evidence-based treatment guidelines, and establishment of regional trauma centers, along with medical advances have contributed to increased life expectancies of patients with cervical spinal injuries (CSI) and spinal cord injuries (SCI).<sup>16</sup>

Appropriately applied SMR is acceptable for patients in the circumstances in the bulleted list above (blunt trauma and altered level of consciousness, etc.).<sup>3,4,6-10,12,13,16</sup> However, when clinical assessment for the presence of qualifying SMR injuries cannot be adequately performed, for example, because of communication barriers, it is acceptable to apply SMR in this patient population.<sup>3,4,6-10,12,13,16</sup>

## Long Backboard Use for Spinal Motion Restriction

### References

- Domeier, R. M. (1999). Indications for prehospital spinal immobilization. *Prehospital Emergency Care*, 3(3), 251–253. Retrieved from <http://www.naemsp.org/Documents/Position%20Papers/POSITION%20IndicationsforSpinalImmobilization.pdf>
- Oteir, A. O., Smith, K., Stoelwinder, J. U., Middleton, J., & Jennings, P. A. (2015). Should suspected cervical spinal cord injury be immobilised? A systematic review. *Injury*, 46(4), 528–535. doi:10.1016/j.injury.2014.12.032
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### Key for Level of Evidence Recommendation

	<b>Level A (High) Recommendation:</b> Based on consistent and good quality of evidence; has relevance and applicability to emergency nursing practice.		<b>Not Recommended:</b> Based upon current evidence.
	<b>Level B (Moderate) Recommendation:</b> There are some minor inconsistencies in quality evidence; has relevance and applicability to emergency nursing practice.	<b>I/E:</b>	Insufficient evidence upon which to make a recommendation.
	<b>Level C (Weak) Recommendation:</b> There is limited or low-quality patient-oriented evidence; has relevance and applicability to emergency nursing practice.	<b>N/E:</b>	No evidence upon which to make a recommendation.

### Disclaimer

This document, including the information and recommendations set forth herein (i) reflects ENA's current position with respect to the subject matter discussed herein based on current knowledge at the time of publication; (ii) is only current as of the publication date; (iii) is subject to change without notice as new information and advances emerge; and (iv) does not necessarily represent each individual member's personal opinion. The information and recommendations discussed herein are not codified into law or regulations. Variations in practice and practitioner's best nursing judgment may warrant an approach that differs from the recommendations herein. ENA does not approve or endorse any specific sources of information referenced. ENA assumes no liability for any injury and/or damage to persons or property arising from the use of the information in this document.

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**Proposed policy language:**

The long backboard (LBB) is an extrication tool, whose purpose is to facilitate transfer of a patient to a transport stretcher and is not intended, or appropriate for achieving spinal stabilization.

Judicious application of the LBB for purposes other than extrication necessitates that healthcare providers ensure the benefits outweigh the risks.

If a LBB is applied for any reason, patients should be removed as soon as it is safe and practicable.

Interfacility transfer of patients who have received cervical spine clearance by an advanced healthcare provider or physician do not need to be reapplied to a LBB during transport.

**References:**

*Emergency Nurse's Association. Translation Into Practice, June 2015*

*Massachusetts State EMS policy manual, 2015*

*San Joaquin County EMS Cervical Stabilization Policy 2013*

*Morrisey, J. Research Suggests a Change in Pre-hospital Spinal Immobilization. JEMS 2013*

*NAEMSP Position Statement. EMS Spinal Precautions and the Use of The Long Backboard. 2012*