Selective Spine Assessment Clinical Policy

In accordance with Massachusetts Department of Public Health’s Office of Emergency Medical Services EMS Pre-Hospital Treatment Protocol Appendix I, Selective Spinal Assessment, EMTs of all levels employed by __________ _____ are authorized to perform selective spinal assessment on appropriate patients as defined in MDPH/OEMS EMS Pre-Hospital Treatment Protocol 4.7, Appendix I, and this policy:

1. This authorization applies only to those EMT’s (at all levels of certification) who have completed a spinal assessment training program approved by the service’s Affiliate Hospital Medical Director (AHMD) as designated by the hospital with which the service maintains a current Affiliation Agreement.
2. The service will maintain a roster of EMTs who have completed the required spinal assessment training and make it available to the AHMD.
3. Authorized EMTs will ensure all elements supporting their treatment decision are thoroughly documented on the patient care report for all patients where spinal assessment occurs under this protocol whether or not immobilization is performed, specifically:
   a. Reliable Patient
   b. Focal Neurological Signs
   c. Distracting Injury
   d. MIDLINE Cervical Spine Tenderness
   e. Decision to immobilize or not.
4. EMTs will also ensure reasons for spine immobilization is documented in the patient care report for patients where spine immobilization is indicated and performed.
5. The service will review all patient care reports for the following chief complaints to assess whether appropriate utilization of the selective immobilization protocol was performed. The service will make these results available to the AHMD each month.
   a. MVC/MCC/Bicycle/ATV
   b. Fall
   c. Diving Accident
   d. Pedestrian Accident
   e. Other blunt trauma
6. It is the opinion of the AHMD that utilization of an appropriate spinal immobilization device includes the ambulance stretcher with an appropriately-sized cervical collar.

______________________________________________________  ______________
Affiliate Hospital Medical Director Signature                  Date

AHMD Name (print): ____________________________________________________________