

Patients with a history of trauma
Is there a potential for spinal injury in an adult
>16 years old?

Yes ↓

- Under the influence of drugs or alcohol?
- Is confused or uncooperative?
- Has a reduced level of consciousness?
- Has any spinal pain (or pain elicited on coughing)?
- Any motor weakness in hands or feet?
- Any history of past spinal problems, including previous spinal surgery, severe osteoarthritis, ankylosing spondylitis?
- Any priapism?

No ↓

High Risk?

- Dangerous mechanism of injury (fall from a height of >1 metre or five steps, axial load to the head - e.g. diving, high-speed motor vehicle collision, rollover motor accident, ejection from a motor vehicle, accident involving motorised recreational vehicles, bicycle collision, horse riding accidents)

No ↓

Upon Examination:

- Any abnormal neurology (loss of sensation; numbness; 'pins and needles'; burning pain)?
- Any bony spinal pain anywhere along the spine (at rest or on coughing)?
- Any distracting injury?

No ↓

Low Risk?

- Was involved in a minor rear-end motor vehicle collision
- Is comfortable in a sitting position
- Has been ambulatory at any time since the injury
- Has no midline cervical spine tenderness (answer 'no' if patient has pain)
- Delayed onset of neck pain

Yes ↓

Is the patient able to actively rotate their head 45°
to the left and right?

and

Is the patient able to mobilise without pain or
abnormal neurology?

Yes ↓

Spine Cleared

Use of spinal immobilisation devices may be difficult (e.g. in people with short/wide necks, or people with a pre-existing deformity) and could be counterproductive (i.e. increasing pain, worsening neurological signs and symptoms). In uncooperative, agitated or distressed people, think about letting them find a position where they are comfortable with manual in-line spinal immobilisation.

Yes →

Yes →

Yes →

No →

No →

IMMOBILISE

Immobilise the entire spine.
If the patient is ambulatory or has been ambulatory at the scene, they can self-extricate if appropriate and may be guided to lie down onto the scoop stretcher to be immobilised.
The scoop should be placed on the trolley and located as close as practicable to the patient.
Patients MUST NOT be encouraged to walk up any steps (causes potential axial loading).

Patients with suspected spinal injury with abnormal neurology must be transferred to a Major Trauma Centre