

## 2011 Updates to the Standing Orders

Section	Page	Edit	Description
Administrative	16-17	Death in the Field	Addition of Death in the Field Criteria subsection.
Protocols	42	Amputation	Overhaul of section to add soft tissue and tourniquet. See below for full page.
	51	Asystole	<del>Atropine 1 mg IV or IO – for asystole or slow PEA (heart rate &lt;60) – repeat twice at 3-5 minutes intervals</del>
		Automatic External Defibrillator (AED)	Added AED to the First Responder Scope
	71	Do not Resuscitate	Contains edits to include POLST Registry number and deletion of redundant insufficient “death in field” language.
	99	Trauma System Entry	Subjective and Objective paragraphs were lightly edited and text was added under discretionary criteria <u>“These criteria shall cause a high index of suspicion that a patient may have sustained a severe injury. Trauma system entry for patients meeting two or more of these criteria is strongly encouraged”</u>
Medications	109	Atropine	Asystole PEA or Removed
	117	Etomidate	Added to the indication subsection <u>“Although Versed is preferred, further dosage of Etomidate can be used for continued sedation”</u>
	123 - 124	Flu vaccine as injectable and mist	Added two entire sections on the flu vaccine
	140	Vecuronium	Added under Indications <u>“Sedation is required for all patients who receive Vecuronium”</u>
Procedures	143	12 Lead EKG	Obtain and Fax 12 lead was added to the First Responder scope. Obtain 12 lead prior to administration of Nitro
	146	CPAP	Combined the two Procedures into one order The two former procedures mirrored each other with only specific manufacturer procedures being different.
	153	Nasal Flu Mist	Added this section as it is different than an injection.
	167	Spinal Immobilization	Reworded to clarify the spinal immobilization clearance in the field, and detail added procedure steps.

Excerpt pages containing the above edits in order are attached but do not show proper page numbers.

# 2011 Updates to the Standing Orders

## Death in the Field

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1. ORS allows an EMT to determine “Death in the Field”; however, the EMT is encouraged to consult Medical Control if any doubt exists.
  - a. Trauma codes have a very low statistical save rate. However, if the mechanism of injury doesn’t fit a trauma death, such as a minor vehicle crash. Consider if the patient had a medical death that caused the accident. V-Fib should raise your index of suspicion for a medical event.
  - b. In a deteriorating trauma patient, no pulse and a viable rhythm may reflect hypovolemia or obstructive shock such as tamponade or tension pneumothorax, and aggressive care should be continued. A narrow complex rhythm (QRS < .12) may suggest profound hypovolemia, and the patient may respond to fluid resuscitation.
  - c. Consider the value of delivering a viable organ donor patient to the hospital
2. EMT Basics may withhold resuscitation efforts, or stop efforts started by bystanders, if the patient has no spontaneous pulse or respirations, and any one of the following conditions exist:
  - a. Valid “DNR” (POLST);
  - b. Decapitation;
  - c. Incineration of the face, neck or torso;
  - d. The patient has skin discoloration in dependent body parts (dependent lividity);
  - e. Any stage of body decomposition or putrefaction;
  - f. Pulseless and apneic in a mass casualty incident;
  - g. Rigor mortis in a warm environment;
  - h. Major blunt trauma after opening the airway; or
  - i. Avulsion or other traumatic removal of any vital body organ.
3. EMT Intermediates and Paramedics, in addition to the above, may withhold or stop resuscitation in patients without spontaneous pulse and respirations under the following circumstances: If there is a question, consult Medical Control.
  - a. PEA and an ETCO<sub>2</sub> of 10 or less after 20 minutes of ACLS.
  - b. Patient found in asystole, and if after the asystole protocol has been initiated the patient persists in asystole in three separate leads.
4. Under ORS 146.090 the following deaths must be investigated. EMTs should be aware of these situations and not let on-scene operations needlessly interfere or hamper the investigations.
  - a. Apparent homicide, suicide or death occurring under suspicious or unknown circumstances;
  - b. Resulting from the unlawful use of controlled substances or the use or abuse of chemicals or toxic agents;
  - c. Occurring while incarcerated in any jail, correction facility or police custody;
  - d. Apparent accidental or death following an injury;
  - e. By disease, injury or toxic agent during or arising from employment;
  - f. Unattended deaths (not under care of a physician within two weeks previous to the death)
  - g. Related to disease which might constitute a threat to the public health; or

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- h. A human body disposed of in an offensive manner.
- 5. When it is determined that the patient is deceased, if not already done, immediately request law enforcement. The body shall not be moved, and any invasive medical equipment such as IV's, IO's, ET tubes, etc. shall not be removed without prior approval from the Medical Examiner, or their deputy.
- 6. If available, consider chaplaincy for the family. If necessary, the body may be covered in a way that is appropriate in consideration of the weather, public decency and viewing by the family. For a body or bodies still in a vehicle near passing traffic, consider a tarp for the entire vehicle.
- 7. This section refers to either patients, or dead bodies. One cannot be treated under these standing orders as both at the same time. Dead bodies shall not be transported via ambulance, and care must be taken to avoid this situation.

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### **Amputation/Laceration/Soft Tissue Injury**

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#### **Subjective**

- Evaluate the time injury occurred, location and mechanism of injury. Consider the increased hemorrhagic potential if patient is on a daily aspirin regime, and/or Coumadin or other blood thinning medications. Find out if patient has previous injuries, medical history, bleeding disorders.

#### **Objective**

- Identify the type of injury: amputation (partial or complete), laceration, abrasion and bruising. For closed injuries with swelling, and deformity consider following "Fractures and Dislocations" protocol. Neurovascular system and circulatory function may be compromised distal to the injury especially in partial amputations.

#### **Assessment**

- Determine quantity of blood loss, if there is active bleeding, and evaluate for the presence of shock. Assess the patient to ensure they do not have any other injuries. Amputation and large lacerations may not be life threatening but may be psychologically traumatic for patient or family which can act as a distracting injury.

#### **Treatment**

##### **First Responder, EMT - B:**

- Control bleeding by direct pressure or if an extremity consider the use of a tourniquet.
- Oxygen
- If amputation (full or partial)
  - Cover stump with sterile dressing soaked with crystalloid
  - Splint partial amputations in position of function
  - Wrap severed portion in crystalloid soaked sterile dressing, place in sealed plastic bag, place bag in ice water

##### **EMT - I:**

- One or two large bore IVs with crystalloid
- Morphine or Fentanyl (Not for abdominal injuries)

##### **EMT - P:**

- Midazolam or Diazepam (Not for abdominal injuries)

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### **Asystole / Pulseless Electrical Activity (PEA)**

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#### **Subjective**

- Syncope & loss of consciousness.

#### **Objective**

- • Unconsciousness, unresponsive, pulseless & apneic
- • AED shows “non-shockable rhythm”
- • Cardiac monitor shows asystole in 2 leads or pulseless electrical activity (PEA)

#### **Assessment**

- Asystole or Pulseless Electrical Activity (PEA)

#### **Treatment**

##### **First Responder:**

- Oxygen
- CPR
- Automatic External Defibrillator (AED) as soon as available

##### **EMT - B:**

- Dual lumen airway device

##### **EMT - Basic can terminate resuscitation efforts if all of the following are met:**

- After 5 cycles of CPR and “No Shock Indicated”, and ALS is over 20 minutes from the scene.
- Online medical control consultation agrees with terminating resuscitation efforts.
- Current underlying (without CPR) rhythm is printed and attached to the PCR.

##### **EMT - I:**

- IV with crystalloid
- Epinephrine 1 mg IV or IO – repeat every 3-5 minutes
- Treatable causes:
  - Hypoxia; Hypoglycemia; Hypovolemia; Hypothermia; Preexisting acidosis; Hyper-/hypokalemia; Drug overdose
- If persistent Asystole, terminate resuscitation efforts after online medical control consultation

##### **EMT - P:**

- Endotracheal intubation
- Consider transcutaneous pacing
- Sodium bicarbonate (1 mEq/kg IV or IO) if overdose with tricyclic antidepressants
- Treatable causes:
  - Chest decompression for tension pneumothorax

# 2011 Updates to the Standing Orders

## **Do Not Resuscitate**

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### **Subjective**

- Some patients may decide in advance that heroic life saving measures would not be beneficial or desirable. This information must be obtained prior to withholding life sustaining or resuscitative care from the patient. The information must be in the form of a POLST form (Physician Orders for Life-Sustaining Treatment) or other recognized Advanced Directives signed by patient and physician.

### **Objective**

- Patient is unresponsive, apneic, and pulseless and does not meet death in the field criteria. Or patient has end of life signs of such as decreasing consciousness, impending respiratory or cardiac failure with death being imminent.

### **Assessment**

- The decision for a DNR (Do Not Resuscitate) order will be transmitted to EMS field personnel in Klamath County, Oregon via the POLST form or other recognized form signed by patient and physician. These are the only acceptable DNR instructions in Klamath County.

### **Treatment**

#### **FIRST RESPONDER, EMT-B, I, P**

- EXCEPT for patients that have a valid POLST form, or other recognized DNR documentation, that includes the patient's name, date of birth, signed and dated by a physician or nurse practitioner, or have a signed and dated Hospice stamp. All patients who are unresponsive, apneic and pulseless that do not meet the death in the field criteria, or who have impending cardiac or respiratory failure will receive full resuscitation efforts within the First Responder or EMT's scope of practice under these standing orders.
1. On POLST forms, EMS will follow only the instructions in Section A- CPR, when patient is pulseless and apneic to determine whether or not to initiate resuscitation, and Section B- Medical Interventions, in the case of a patient who is not apneic and pulseless to determine comfort measures, limited interventions, advanced interventions or full treatment.
  2. If documentation is not available, the OHSU/POLST Registry at 1-888-476-5787 (this is not a public number) can access any POLST on file. They can give direction over the phone or fax documents, however, prior to calling the OHSU/POLST Registry obtain as much patient information as possible such as patient name, POLST Registry #, birth date, address, or last 4 digits of social security number.
  3. If there is any confusion or discrepancy between the form and the patient, family or caretakers, begin care or resuscitation measures and contact the patient's physician, nurse practitioner, the emergency room physician or transport the patient to the hospital. Document your actions and include the DNR documentation as part of your pre-hospital care report.

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## **Atropine Sulfate**

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### **Trade Name**

- Atropine

### **Action**

- Parasympatholytic agent with the following effects: increases heart rate, increases conduction through A-V node, reduces motility and tone of GI tract, reduces tone of the urinary bladder, dilates pupils, dilates bronchi.

### **Indications**

- Symptomatic bradycardia.
- Antidote for symptomatic organophosphate poisoning. (See Mark I Autoinjector)
- Pretreatment for RSI in children < 10 years.

### **Contraindications**

- Known sensitivity to atropine sulfate.

### **Side Effects & Precautions**

- Relatively contraindicated in second degree type 2 A-V block and third degree block with wide QRS complexes in the presence of an acute MI.
- Bradycardia in the setting of an acute MI is common; do not treat rhythm unless the patient is symptomatic or there are signs of poor perfusion.

### **How Supplied**

1 mg/10 ml prefilled syringe

### **Route and Dosage**

EMT - I:

- Symptomatic bradycardia
  - 0.5 mg IV or IO push, every 3-5 minutes, maximum 3mg.

EMT - P:

**Adult:** 0.5 mg - 1 mg IV or IO push, every 3-5 minutes, maximum 3 mg. Double the dose for ET administration

**Pediatric:** 0.02 mg/kg, IV or IO, ET. Minimum single dose: 0.1 mg. Maximum single dose: 0.5 mg in child, 1.0 mg in adolescent, may repeat once. Double the dose for ET administration

- Organophosphate poisoning:
  - Double dose every 5 minutes until symptoms controlled. Use of auto-injector is indicated

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## **Etomidate**

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### **Trade Name**

Amidate

### **Action**

A short acting sedative hypnotic agent

### **Indications**

- Sedation for rapid sequence intubation.
- Although Versed is preferred, further dosage of Etomidate can be used for continued sedation.

### **Contraindications**

- ☠ Known sensitivity to Etomidate.

### **Side Effects & Precautions**

- Administer in a large bore, free flowing IV or IO.
- Respiratory depression, hypotension and cardiopulmonary arrest are more likely in the elderly, those with COPD, renal, heart or liver disease.
- Use with caution in the presence of alcohol, barbiturates, narcotics or benzodiazepines.
- Skeletal muscle jerking or movements occur commonly.
- Duration is 4-10 minutes.
- Increase risk of bruxism (masseter muscle spasm) with fast delivery.
- May cause vomiting without paralytic.

### **How Supplied**

2 mg/ml

### **Route and Dosage**

EMT - P:

**Adult:** 0.3 mg/kg IV or IO over 30 - 60 seconds. Typical adult dose is 20 mg. 0.15-0.2 mg/kg IV if elderly, debilitated or hypotensive.

**Pediatric:** 0.3 mg/kg IV or IO over 30 - 60 seconds.

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## **Influenza Vaccination Injection**

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### **Trade Name**

Fluzone; Flulaval; Agriflu; Fluarix

### **Action**

Prevention of seasonal or pandemic Influenza A and/or B infections

### **INDICATIONS**

- Pregnant women
- Household contacts and caregivers for children younger than 6 months of age
- Healthcare, Public Safety and Emergency Medical Service personnel
- All people from 6 months through 24 years old
- Persons aged 25 through 64 who have conditions associated with higher risk of complications from influenza that can compromise respiratory functions or the handling of respiratory secretions or that increase the risk for aspiration.

### **PRECAUTIONS**

- Persons with moderate or severe illnesses with or without fever should delay immunization until illness has resolved. However, minor illnesses with or without fever do not contraindicate use of influenza vaccine; e.g. children with mild URI or allergic rhinitis.
- Persons with a history of Guillain-Barre' syndrome (GBS) within 6 weeks following influenza vaccination has a likelihood of developing GBS with subsequent influenza vaccinations. Guillain-Barre syndrome is an uncommon disorder in which your body's immune system attacks your nerves. Weakness and numbness in your extremities are usually the first symptoms. These sensations can quickly spread, eventually paralyzing your whole body. People with history of developing GBS should be referred to their private health care professionals for consultation to determine if the risk of GBS would be less than complications from influenza.

### **CONTRAINDICATIONS**

- Persons with allergic reaction to a previous influenza vaccination
- Persons with history of anaphylactic reactions to eggs.

### **DOSE/ROUTES**

- Children - healthy children ages 36 months – 9 years = two doses of .5 ml vaccine, and healthy children ages 6 – 35 months = two doses of .25 ml vaccine.

*TWO DOSES MUST BE SEPARATED BY AT LEAST 28 DAYS, AND UPDATES SHOW 21 DAYS IS ACCEPTABLE. ALTHOUGH THE SAME TYPE OF VACCINE (FLUMIST OR INJECTABLE VACCINE) SHOULD BE USED IN A 2-DOSE SCHEDULE, MIXED SCHEDULES ARE PREFERABLE TO NOT COMPLETING THE SERIES.*

- Healthy children and adults ages 10 - 49 years = one dose of .5 ml vaccine.
- IM Injection

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## **Influenza Vaccination Nasal Mist**

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### **Trade Name**

Flu-Mist

### **Action**

Prevention of seasonal or pandemic Influenza A and/or B infections.

### **INDICATIONS**

Healthy non-pregnant persons 2 – 49 years of age who do not have any of the following:

- 2 – 4 year olds with history of asthma or wheezing within the last 12 months.
- History of asthma, reactive airway disease, chronic diseases of the pulmonary or cardiac or renal systems, diabetes, or hemoglobinopathies. (These people should receive injections.)
- History of immunodeficiency diseases or who are receiving immunosuppressive therapies. (These people should receive injections.)
- Children or adolescents receiving aspirin due to the risk of Reye syndrome.
- Hypersensitivity or anaphylaxis to previous flu mists or eggs.
- Household members of and healthcare workers who have close contact with immunosuppressed persons such as stem cell transplant patients requiring a protected environment.

### **PRECAUTIONS**

- Defer for patients with moderate or severe acute illness.
- Caution for nursing mothers as it is not known whether the vaccine is excreted in human milk.
- Do not administer the Seasonal and H1N1 vaccine at the same visit.
- If nasal congestion would impede vaccine delivery to nasopharyngeal.

### **CONTRAINDICATIONS**

- History of Guillain-Barre' syndrome.
- History of a severe allergic reaction to a previous influenza vaccination
- History of anaphylactic reactions to eggs, egg proteins, gentamicin, gelatin or arginine.

### **DOSE/ROUTE**

- **HEALTHY CHILDREN AGES 2 – 9 YEARS = TWO DOSES** *SEPARATED BY AT LEAST 28 DAYS, AND UPDATES SHOW 21 DAYS IS ACCEPTABLE. ALTHOUGH THE SAME TYPE OF VACCINE (FLUMIST OR INJECTABLE VACCINE) SHOULD BE USED IN A 2-DOSE SCHEDULE, MIXED SCHEDULES ARE PREFERABLE TO NOT COMPLETING THE SERIES.*
- **HEALTHY CHILDREN AND ADULTS AGES 10 - 49 YEARS = ONE DOSE.**
- **ROUTE IS NASAL DROPS SEE PROCEDURES**

# 2011 Updates to the Standing Orders

## **Vecuronium (Optional)**

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### **Trade Name**

Norcuron

### **Action**

Non-depolarizing skeletal muscle relaxant.

### **Indications**

- Sedation is required for all patients who receive Vecuronium.
- Pretreatment for rapid sequence intubation (defasciculating dose) in the presence of increased intracranial pressure and age  $\geq$  10 years.
- To provide paralysis (paralyzing dose) for rapid sequence intubation if Succinylcholine is contraindicated.
- To maintain paralysis (maintenance dose) after intubation.
- To relieve isolated Masseter muscle spasm.

### **Contraindications**

- ☠ Known sensitivity to Vecuronium.

### **Side Effects & Precautions**

- Vecuronium causes paralysis, not analgesia or amnesia; conscious patients must receive sedation.
- Patient will require airway management and ventilation.

### **How Supplied**

10 mg/10 ml premixed or

10 mg powdered

### **Route and Dosage**

EMT - P:

***Paralyzing Dose:*** 0.15 mg/kg IV or IO. Usual adult dose is 10 mg.

***Maintenance Dose:*** 0.01 -0.015 mg/kg 25-40 minutes after initial paralysis, then every 12-15 minutes as needed OR 1 mcg/kg/min IV or IO infusion

## 2011 Updates to the Standing Orders

### **12 Lead ECG**

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Obtain and Fax: First Responder EMT – B, I

Obtain and interpret: EMT – P

#### **Indications**

Patients having cardiac chest discomfort, palpitations, syncope, stroke, shortness of breath. EMT judgment that the patient may be having myocardial ischemia or infarction

#### **PRECAUTIONS**

- Do not delay treatment of life-threatening conditions to obtain a 12 lead ECG.
- 12 lead ECG best obtained with the patient not in a moving vehicle.
- Obtain 12 lead ECG before nitroglycerin administration.

#### **PROCEDURE**

- Obtain the 12 lead ECG
- First Responder, EMT B and I fax the ECG results to Sky Lakes ER regardless of findings.
- Label 2 copies of 12 lead ECGs with the patient's name and date of birth. (Most machines will print multiple copies.)
- At the receiving hospital leave one copy of the 12 lead ECG with the receiving physician
- Keep one copy of the 12 lead ECG with your PCR.

# 2011 Updates to the Standing Orders

## **Continuous Positive Airway Pressure (CPAP)**

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(BOUSSIGNAC™/or/ CARADYNE WHISPERFLOW FIXED FLOW GENERATOR™)

EMT-I, P

### **INDICATIONS**

Respiratory distress in the conscious patient suffering from pulmonary edema or CHF done in conjunction with or before medical therapy with nitroglycerin or Furosemide

### **PRECAUTIONS**

- Requires a cooperative, spontaneously breathing, patient with normal ventilatory drive
- May increase oral secretions
- Increased intracranial pressure.
- Extraordinarily high CPAP pressures can cause a decrease in venous return to the heart from high intrathoracic pressures resulting in decreased cardiac output.
- High alveolar pressures can cause an overextension of alveoli, resulting in barotrauma and or increase intrapulmonary shunting.
- Over distension of the lungs can reduce compliance.

### **CONTRAINDICATIONS**

- Age < 12 years
- Unconscious or uncooperative
- Respiratory failure with a need for immediate intubation and or BVM ventilation
- Facial deformity preventing adequate mask seal over the mouth and nose
- Respiratory rate < 25/minute
- Systolic blood pressure < 90 mm Hg
- Untreated pneumothorax
- Vomiting
- Upper airway abnormalities or trauma
- Tracheostomy used for normal respirations (the presence of a plugged tracheostomy is not a contraindication)

### **PROCEDURE**

1. Have the patient in an upright position of comfort.
2. Explain the procedure to the patient.
3. Instruct patient to breathe in through their nose slowly and exhale slowly out through their mouth.
4. Apply Oxygen to the CPAP mask: fixed flow generator system or venturi system
  - a. For the Caradyne WhisperFlow fixed flow generator. Set the flow rate at 15 lpm. The unit is set at 30% FiO<sub>2</sub>. Attach the filter and tubing to the flow generator and a 7.5 cm H<sub>2</sub>O pressure valve.
  - b. For the Boussignac CPAP, initiate flow at at 15 lpm (~5 cm H<sub>2</sub>O CPAP). Titrate the oxygen flow based on patient condition as tolerated: 15 lpm = 5 cm H<sub>2</sub>O 20 lpm = 7.5 cm H<sub>2</sub>O 25 lpm = 10 cm H<sub>2</sub>O.
5. Place the delivery mask over the mouth and nose and secure the mask with straps.
6. Consider placement of a nasopharyngeal airway.
7. If patient's respiratory status or level of consciousness deteriorates, remove the CPAP mask and if respiratory status / level of consciousness deteriorate, remove device, provide bag-valve-mask ventilation, and consider advanced airway management.
8. Monitor patient's respiratory status, vital signs, oximetry, and capnometry frequently.
9. Continue CPAP until transfer to the hospital ED staff unless patient is unable to tolerate the CPAP or the patient's clinical condition worsens despite CPAP use.

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### **Influenza Vaccination Nasal Mist**

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#### **INDICATION**

Prevention of Flu.

#### **PRECAUTIONS**

- Defer for patients with moderate or severe acute illness.
- Caution for nursing mothers as it is not known whether the vaccine is excreted in human milk.
- Do not administer the Seasonal and H1N1 vaccine at the same visit.
- If nasal congestion would impede vaccine delivery to nasopharyngeal.

#### **CONTRAINDICATIONS**

- History of Guillain-Barre' syndrome.
- History of a severe allergic reaction to a previous influenza vaccination
- History of anaphylactic reactions to eggs, egg proteins, gentamicin, gelatin or arginine.

#### **PROCEDURE**

EMT I and Paramedic only

Note: Each sprayer contains a single dose and about ½ of the contents should be administered into each nostril. Do not inject. Do not use a needle. Active inhalation or sniffing is not required by the patient during the vaccination process.

1. Remove the rubber tip protector, but not the dose-divider clip.
2. With the patient in an upright position, place the tip just inside the nostril to ensure the vaccine is delivered into the nose.
3. Deliver the vaccine intranasally with a single motion, depress plunger as rapidly as possible until the dose-divider prevents you from going further.
4. Pinch and remove the dose-divider clip from the plunger.
5. Repeat steps three and four in the second nostril.

# 2011 Updates to the Standing Orders

## **Spinal Immobilization**

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First Responders

EMT – B, I, P

### **INDICATIONS**

Spinal immobilization is indicated for actual, penetrating trauma of the spine, and cervical, thoracic, or lumbar spine injury. This can be based on finding surrounding soft tissue injury, pain or tenderness upon palpation to the spinal area, or neurologic abnormality found during the focused assessment.

### **PRECAUTIONS**

Spinal immobilization for longer than 3 hours can have adverse effects on patient care

### **CLEARING THE SPINE IN THE PRE-HOSPITAL SETTING**

Spinal immobilization is not required if a patient has only a mechanism of injury to suspect spinal injury, BUT the patient is experiencing no spine area pain, tenderness or obvious injury around the spine, AND they meet the following criteria:

1. Between the ages of 10 and 65 years
2. No altered mental status or evidence of intoxication
3. No distracting injury, such as significant fracture or laceration
4. No neurological deficit
5. No pain with active neck ROM limited to < 45°
6. EMT does not suspect spinal cord injury based on history or exam.

### **PROCEDURE**

1. Checks peripheral motor, sensory, and perfusion prior to immobilizing patient.
2. Once initiated, immobilization and stabilization of C-spine in a neutral position is maintained continually.
3. The patient may be placed in an extrication device prior to full spinal immobilization.
4. The patient is secured to a full spinal immobilization device such as a long board.
5. Checks peripheral motor, sensory and perfusion after patient is immobilized.