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**Care of Spinal Injury Policy**

**[Date of Issue]**

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# Introduction

Spinal cord injuries can be immediate or insidious and result from either a traumatic insult, vascular disruption, or a disease process. The height of injury dictates the degree of affect to movement and sensation, with damage to the T-spine causing paraplegia and reduced movement. Sensation in the legs is affected and potentially some stomach muscles. Damage to the C-spine can occur causing tetraplegia and reduced movement in all four limbs, as well as the stomach and some chest muscles. A spinal cord injury can be either complete (no muscle function, voluntary movement or sensation from the level of injury and below) or incomplete (some muscle function and sensation below the level of injury).

# Policy Statement

[Company Name] is committed to providing the accurate and timely initial assessment and management of clients with suspected and existing spinal cord injuries.

# Scope

This policy and the procedures apply to all healthcare professionals providing direct client care.

The Registered Manager is responsible for supporting staff in the care of clients with spinal cord injuries and for ensuring that the contents of this policy remain current and in line with the standards for best practice.

# Procedures

Staff at [Company Name] are responsible for ensuring that they remain competent and confident in the initial assessment and management of clients with suspected and existing spinal cord injuries.

# Unexpected Potential Spinal Cord Injury

Should an unexpected potential spinal cord injury occur, staff at [Company Name] should call 999 immediately. The client should be encouraged and supported to stay as still as possible.

Clients should then be checked for whether the client has any of the following:

* significant distracting injuries
* is under the influence of drugs or alcohol
* is confused or uncooperative
* a reduced level of consciousness
* any spinal pain
* any hand or foot weakness
* any altered or absent sensation in the hands or feet
* a history of past spinal problems, including previous spinal surgery or conditions that predispose to instability of the spine.

**Assessment for cervical spine injury**

The Canadian C spine rule should be used to assess whether a client is at high, low or no risk of cervical spine injury. Clients are considered to be at high-risk if they have at least one of the following:

* age of 65 years or older
* dangerous mechanism of injury (fall from a height of greater than 1 metre or 5 steps)
* paraesthesia in the upper or lower limbs.

Clients are at low risk if they have at least one of the following:

* involved in a minor rear end motor vehicle collision
* comfortable in a sitting position
* ambulatory at any time since the injury
* no midline cervical spine tenderness
* delayed onset of neck pain.

The client remains at low risk where they have no high-risk factors but are unable to actively rotate their neck 45 degrees to the left and right. The client has no risk if they have one of the above low risk factors and can actively rotate their neck 45 degrees to the left and right.

**Assessment for thoracic or lumbosacral spine injury**

If spine injury is suspected, the staff member must call 999 immediately. Clients will be assessed for suspected thoracic or lumbosacral spine injury by the emergency services, based upon the following:

* age 65 years or older and reported pain in the thoracic or lumbosacral spine
* dangerous mechanism of injury (fall from a height of greater than 3 metres)
* pre-existing spinal pathology, or known or at risk of osteoporosis
* suspected spinal fracture in another region of the spine
* abnormal neurological symptoms (paraesthesia, weakness, or numbness)
* on examination:
	+ abnormal neurological signs i.e., confused, enlarged pupils
	+ new deformity or bony midline tenderness
	+ bony midline tenderness on percussion
	+ midline or spinal pain on coughing
* pain or abnormal neurological symptoms on mobilisation (stop if this occurs).

**Clients at Risk of Autonomic Dysreflexia**

Clients with a spinal cord injury above the T6 region of the spine are at risk of developing autonomic dysreflexia. Autonomic dysreflexia is a life-threatening condition and is usually caused by bladder and bowel distention.

Signs and symptoms of autonomic dysreflexia are:

* a raised blood pressure
* bradycardia
* headache
* flushing of the skin
* sweating or blotching above the area of injury
* change in pallor
* the client is cold to touch
* displaying goosebumps below the area of injury

If a member of staff at [Company Name] suspects that a client is at risk of autonomic dysreflexia, and is qualified and competent, then the following actions should be taken and the emergency services called immediately:

* sit the client upright and check their blood pressure
* keep the client sat upright until their blood pressure returns to a normal range for them
* loosen or remove any tight clothing
* monitor the clients blood pressure every 2-5 minutes
* if staff are qualified and competent, check the client’s rectum for constipation and/or haemorrhoids and the client’s bladder for signs of distention, and/or if a catheter is in place, check the catheter for kinks and/or obstructions and empty the client’s leg bag.

If a member of staff is not qualified or competent to undertake the above procedures, the member of staff must call 999 immediately.

# Full In-Line Spinal Immobilisation

Full in-line spinal immobilisation should be undertaken by securing the clients head with a staff member’s hands or maintained if:

* a high-risk factor for cervical spine injury is identified as indicated by the Canadian C spine rule
* a low-risk factor for cervical spine injury is identified as indicated by the Canadian C spine rule and the person is unable to actively rotate their neck 45 degrees left and right
* indicated by one or more of the factors listed under the thoracic and lumbosacral assessment.

In this instance, another staff member must call 999 immediately.

Full in-line spinal immobilisation need not be carried out or maintained in clients if:

* they have low risk factors for cervical spine injury, as identified and indicated by the Canadian C spine rule, are pain free and able to actively rotate their neck 45 degrees left and right
* they do not have any of the factors listed under the thoracic and lumbosacral assessment.

Full in-line spinal immobilisation can only be undertaken thoroughly by a paramedic, who will have access to a head brace and/or spinal board. In uncooperative, agitated or distressed clients, consider continuing manual in-line stabilisation using your hands, whilst waiting for the emergency services to arrive. Ensure that the client is in a position with which is comfortable.

For visiting children to the client’s home, manually stabilise the head with the spine in line using the above approach while involving family members and call 999 immediately.

# Extrication

Where rapid extrication is needed due to immediate threat to the client’s life, all efforts should be made to limit spinal movement and a member of staff must call 999 immediately. For those not physically trapped with none of the following, consider asking the client to self-extricate:

* significant distracting injuries
* abnormal neurological symptoms (paraesthesia, weakness or numbness)
* spinal pain
* high-risk factors for cervical spine injury as assessed by the Canadian C spine rule.

If a self-extricating client develops any spinal pain, numbness and/or tingling or weakness, they should stop moving and wait to be moved by the emergency services. After self-extrication, ask the client to lay supine until the emergency services arrive.

# Pain Management

Pain should be regularly assessed using the same validated tool appropriate to the client.

Pain relief should be offered to clients with a spinal cord injury in line with the client’s prescribed analgesia and [Company Name]’s Medicines Management Policy and Procedures.

# Immediate Destination after Injury

All clients with suspected or definite spinal cord injury must be transported by the emergency services to hospital immediately for appropriate assessment. Staff at [Company Name] should regularly liaise with the ward in which the client is staying and document any updates from the ward within the client’s care plan in line with [Company Name]’s Information Governance and Record Keeping Policy and Procedures. Staff must also ensure that they communicate and update the wider relevant team at [Company Name] and the client’s family in line with [Company Name]’s Consent Policy and Procedures.

# Monitoring

The effectiveness of this policy will be monitored through routine audit and investigation into any adverse events and in line with all of [Company Name]’s relevant policies and procedures.

# Related Policies

* Complaints Policy
* Consent Policy
* Continuity of Care Policy
* Dementia Policy
* Dignity and Privacy Policy
* Duty of Candour Policy
* Falls Policy
* Governance and Risk Policy
* Handover Policy
* Incident Management Policy
* Information Governance and Record Keeping Policy
* Medicines Management Policy
* Moving and Handling Policy
* Pressure Ulcers Policy
* Quality Assurance Policy
* Safeguarding Policies
* Training and Induction Policy

# Legislation and Guidance

**Guidance**

* Spinal injury Association, Understanding spinal cord injury: <https://www.spinal.co.uk/learn/understanding-sci/>
* NHS Clinical Advisory Groups, 2011: Management of People with Spinal Cord Injury
* NICE Guideline [NG41]: Spinal injury: assessment and initial management
* <https://www.england.nhs.uk/2018/07/patients-at-risk-of-autonomic-dysreflexia/>
* <https://www.bmj.com/content/371/bmj.m3596>

# Summary of Review

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