THE ROUNDHEGIANS RUGBY FOOTBALL CLUB LTD

First Aid Policy
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**Change History**

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<table>
<thead>
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<th>Author</th>
<th>Date</th>
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<tbody>
<tr>
<td>Rachel Howitt</td>
<td>21/03/2014</td>
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1 Introduction

Rugby is a contact sport and, as with all contact sports, playing the game carries a risk of injury. While serious injuries are rare, incidents can occur both on the training pitch, during matches or within the grounds and robust first-aid provision will enable the full range of potential incidents to be managed effectively.

First-aid information, including the location of equipment and a list of first-aider contacts, is displayed in the clubhouse bar, kitchen, changing rooms and sports hall.

1.1 Purpose and aims

Roundhegians RFC is committed to maintaining a high quality of first-aid provision across the full player-base and the wider membership. The Club seeks to ensure that all staff and voluntary first-aid helpers are able to deal with accidents or incidents involving injury where they occur.

This document aims to:

- Provide clear guidance relating to roles and responsibilities for staff and volunteers involved in first-aid;
- Outline the processes required for managing and reporting injuries;
- Provide the guidelines for conducting risk assessments related to first-aid and the management of injuries;
- Ensure all first-aid protocols are monitored and updated regularly;
- Provide the framework for training needs and monitoring of first-aiders and first-aid equipment and resources;
- Ensure clear information is available regarding access to first-aid facilities;
- Ensure that the minimum standards required for first-aiders are met and monitored;

2 Scope

This policy applies to all Roundhegians RFC paid staff, voluntary first-aid helpers, all coaching teams and administrative staff.
3 First-aider requirements

The following section outlines the requirements of minimum numbers of first-aiders across club facilities. There may be instances where it is not possible to retain two parent first-aiders at all times. Where this happens the lead coach must be assured there is adequate alternative first-aid provision until a further first-aider can be recruited. A current list of first-aiders and first-aid trainers is available on the RRFC website.

Clubhouse
- All bar staff must have a minimum ‘emergency first aid’ qualification and training in the use of the automated defibrillator.

Mini / Junior Rugby
- 1 coach per age group
- 1 other trained first-aider per age group
  o This may be a parent and / or team manager

Senior rugby
- 1 senior player per team
- Senior teams physiotherapist (for home games)
- 1st team physiotherapist (for away games)

Sports Hall
- Junior Badminton supervisors should be trained in first aid
- Badminton committee are responsible for ensuring sufficient first-aider provision for Badminton games

External use
- External users e.g. Karate and Gaelic Football are responsible for their own first-aid provision
- Any other groups hiring the RRFC facilities must provide their own first-aid cover

4 First-Aid Equipment location

All teams should have their own first-aid kit kept with the sports kit for that group across both Junior and Senior Rugby. All kits should conform to RFU guidelines. First-aid kits are located in the following areas:
• Bar – medium kit / burns care kit
• Physio room – AED / medium kit / stretcher / micro fleece blankets
• Sports hall – small kit
• Kitchen – small kit / burns care kit
• Garage – small kit
• Cellar – eyewash only

Ice cubes are available from the bar and the freezer in the kitchen.

5 Roles and responsibilities

5.1 Team coaches

The lead coach for each year-group has responsibility for:

• Identifying one coach for the age group to undertake first-aid training;
• Recruiting another person to undertake first-aid training or who holds a current first-aid qualification;
• Recruiting a volunteer to take on team-management duties and first-aid training (this may be one of the two parents mentioned above);
• Ensuring one senior player is trained in first-aid for senior groups;
• Ensuring there is adequate first-aid provision for the team at the start of any training session or rugby game both at home and away;
• If the first-aider is the coach, consideration should be given to the supervision of the rest of the group if the coach is required to deal with an injury;
• Ensuring that all steps to reduce the risk of concussion and head injuries are taken as outlined in section 7.3.1
• Advising players to remove all jewellery, watches and glass-lensed spectacles before play
• Ensuring that players have an appropriate warm-up before and warm-down after play or training, to reduce the risk of injury
• Ensuring that there is sufficient water freely available to all participants during and after a match or training session. This may be by either providing filled bottles or ensuring there is access to a water source.
5.2 First-Aiders

All first-aiders are responsible for:

- Ensuring their first-aid qualification/training is current and in date;
- Providing the first aid co-ordinators with evidence of training;
- Ensuring their teams (or facilities) first-aid kit and equipment, if appropriate, is well-stocked (see appendix 1) and within-date;
- Documenting what first-aid equipment has been used on the first-aid kit stock-request form (appendix 2) and performing a stock-check once every three months;
- Having copies of the incident report form available for use;
- Completing an RRFC incident report form (appendix 3) for any incidents they attend where players or members of the public have been injured.

5.3 First aid co-ordinators

First-aid co-ordinators are responsible for:

- Ensuring that all first-aiders provide evidence of the appropriate training (see section 6);
- Keeping a record of all first-aiders, relevant training/qualifications and expiry dates;
- Organising and/or facilitating training sessions for first-aiders who require initial training or refresher training;
- Ensuring that all first-aiders have access to current information and guidance on injury-management as supplied by the RFU and Resuscitation Council;
- Ensuring that any first-aid kit stock forms are reviewed and outstanding items are ordered;
- Reviewing the incident report forms and ensuring all serious injuries have been reported and followed up appropriately;
- Report to RRFC committee any injuries and outcomes;
- Ensuring that appropriate risk assessment relating to first-aid provision and practice is undertaken;
- Maintaining confidential records of player medical information (i.e. details of allergies and medical conditions as per RFU player registration forms);
- Liaising with safeguarding officers if any injury/illness raises concerns of a safeguarding nature;
• Undertaking an annual risk assessment of RRFC first-aid provision to reference against policy requirements;

5.4 Safeguarding officers
Safeguarding officers are responsible for:

• Liaising with first-aid co-ordinators to ensure that RRFC first-aid policies and procedures are linked into the overall RRFC safeguarding strategy;
• Taking forward any safeguarding concerns raised by first-aiders or first-aid co-ordinators as appropriate;

5.5 RRFC Chairman
The RRFC Chairman is responsible for:

• Reviewing and ratifying the first-aid policy;
• Ensuring that RRFC supports any essential training needs;
• Ensuring that the correct first-aid equipment and resources are provided and available for use;
• Undertaking annual risk assessment of first-aid provision with first-aid co-ordinators as appropriate.

6 Training

All first-aiders must have an appropriate and current certificate of first-aid training. A copy of this certificate must be presented to the club’s first-aid co-ordinator before commencing a first-aider role. Where possible first-aiders should complete the RFU emergency first-aid course (HSE emergency first-aid at work qualification). However other first-aid courses may be acceptable, such as:

• HSE emergency first-aid at work
• St John Ambulance sports first-aid
• Red Cross basic first-aid

Consideration of professional health qualification may also be appropriate such as current registered nurse with immediate-care training, registered medical practitioner with immediate-care training, registered therapist with immediate-care training.
7 Managing Injuries

7.1 Minor injuries
All minor injuries including cuts, bruises, strains, and sprains should be attended to by a first–aider at the pitchside in accordance with their first–aid training. When junior players are involved parents/carers should be informed as soon as possible following the incident.

If further intervention is required that cannot be administered at the pitchside, this should be arranged with parents, significant others or colleagues/coaches.

7.2 Major injuries
All major injuries should be managed in line with first–aid training and immediate appropriate help should be sought from emergency services.

7.3 Head injuries

7.3.1 Prevention
RRFC aims to prevent incidents of concussion and, although it may not be possible to eliminate concussion altogether, there are some measures that can be taken during training and games that could reduce the risks of concussion occurring.
Coaches and, where appropriate, referees should:

- Ensure the playing or training area is safe;
- Check ground conditions – do not play or train if the ground is frozen solid or rock–hard due to drought;
- Ensure all posts and barriers on or close to the pitch are protected with appropriate padding;
- Ensure correct tackle technique is coached and performed consistently by all players;
- Ensure that all players are able to perform correct tackle technique consistently, and correct any faulty technique immediately;
- Explain the dangers of high, tip and spear tackles, and penalise them immediately if they occur. Act similarly to incidents of tackling players in the air and jumping to catch the ball from kicks or lineouts;
- Take a zero–tolerance approach to actions that result in falling from height, which increases the risk of concussion and neck injuries;
- Advise players that rugby head guards DO NOT protect against concussion. They only protect against superficial injuries such as cuts and grazes and there is some evidence to suggest that they may increase risk–taking behaviours in some players;
Advise players that mouth guards/gum-shields do not protect against concussion, although they are strongly recommended as they do protect against dental and facial injuries;

7.3.2 Management

Any player that suffers a head injury and concussion or where concussion is suspected, must be immediately removed from play for assessment. First-aid assessment must be completed at pitchside to establish if hospital-transfer is required.

If hospital-transfer is not required, the player (and parents) must be given the RRFC head-injury advice sheet (appendix 4) and a return-to-training consent form for Junior Rugby (appendix 5). They should be verbally advised to seek medical attention immediately if any symptoms develop.

**Any player with suspected concussion must be removed from play immediately**

**When to go to hospital**

Someone with a head injury needs to go to the hospital's emergency department (A&E) immediately (via ambulance if needed) if any of the following apply:

- Unconsciousness or lack of full consciousness, even if the person has now recovered;
- Any clear fluid running from the ears or nose;
- Bleeding from one or both ears;
- Bruising behind one or both ears;
- Any signs of skull damage or a penetrating head injury;
- The injury was caused by a forceful blow to the head at speed (for example, a pedestrian hit by a car, a car or bicycle crash, a diving accident, a fall of 1 metre or more, or a fall down more than 5 stairs);
- The person has had previous brain surgery;
- The person has had previous problems with uncontrollable bleeding or a blood clotting disorder, or is taking a drug that may cause bleeding problems (for example, warfarin);
- The person is intoxicated by drugs or alcohol;
- There are safeguarding concerns, for example about possible non-accidental injury or because a vulnerable person is affected.
The injured person also needs to go to hospital as soon as possible if they have developed any of the following since the injury happened:

- Problems understanding, speaking, reading or writing;
- Loss of feeling in part of the body or problems with balancing or walking;
- General weakness;
- Changes in eyesight;
- A seizure (also known as a convulsion or fit);
- Problems with memory of events before or after the injury;
- A headache that won't go away;
- Any vomiting;
- Irritability or altered behaviour such as being easily distracted, not themselves, no concentration, or no interest in things around them. This is particularly important in babies and children under 5.

A concussion recognition tool (see appendix 6) is available for first aiders to assist with assessment of concussion. A laminated pocket version of this should be available in first aid kits.

7.3.3 Return to play
The RFU put into place new standards relating to the management of concussion and the return-to-play pathway in 2014. The return-to-play pathway for players who have sustained a concussion is dependent on the player's age and the medical resources that they can access.

The new routine minimum stand-down period is 19 days for adults and 23 days for Under 19s.

The minimum stand-down period for those in an Enhanced Care Setting – typically professional and elite age-group players – is six days for adults and 12 days for Under 17–19s. These are players whose return-to-play pathway is closely supervised by an appropriately-trained and suitably-experienced medical practitioner.

The return-to-play pathway is made up of rest and Graduated Return-to-Play (GRTP) phases. Taken together they form the minimum stand-down period. The length of these phases for an individual is determined by the player's recovery and informed by clinical assessment.

Details are given in the RFU graduated return-to-play protocol in appendix 7.
7.4 Resuscitation

In the event that a player or member of the public collapses and requires resuscitation, the first-aider must ensure that basic life support is commenced safely and in line with Resuscitation Council guidelines.

Help should be summoned immediately and a 999 ambulance request made. The RRFC automated defibrillator is kept in the physio room and must be utilised as appropriate. All first-aiders will have training in basic life-support and use of an automated defibrillator. Guidelines and information from the Resuscitation Council are available in appendix 8.

8 Reporting & Documentation

8.1 RRFC requirements

The Roundhegians Rugby Football Club expects that every injury or illness occurring on Roundhegians site, that is attended to by a first-aider is recorded on an RRFC Accident Record Form. These forms can be downloaded from the website, printed off from appendix 3 or obtained from behind the bar or from the clubs Physio/Treatment Room. First-aiders should also have copies of the incident report form available to them.

An incident report form should be completed by the first-aider attending to the injured person as soon as possible following first-aid intervention.

Completed forms should be left behind the club bar with staff to file in the insurance file located in the store room.

The club chairman and/or first-aid co-ordinator will review all forms to ensure any outstanding follow-up is completed. RFC reporting will be actioned if reportable criteria are reached.

Details should include the time and place of the injury, first-aid responder and any actions taken. Details of any follow-up or return-to-playing advice should also be included.

8.2 RFU requirements

The RFU requires the following types of injuries to be reported within 48 hours:
• An injury which results in the player being admitted to a hospital (this does not include those that attend an Accident or Emergency Department and are allowed home form there);

• Deaths which occur during or within 6 hours of a game finishing.

These incidents should be reported using the RFU reportable injury event form (appendix 9).

In the event of a visiting player being injured, or an injury occurring at an away ground, please liaise with the opposition club's representative to ensure all relevant details are noted and that the report is completed and sent.

9 Monitoring & compliance

9.1 Equipment audit
The first-aid kit for each age-group should be checked at least once every three months by the team first-aider/coach. Any stock used, missing or out-of-date should be ordered and replaced. The first-aid kit content list should be used as reference. Each first-aider will notify the first-aid co-ordinator of any problems or equipment required.

The AED check is automated but is also checked weekly, in season, by the RRFC physiotherapists who maintain a tick-list record that this has been completed.

The AED will have an annual check provided by EME services when they service the club’s ultrasound and short-wave equipment. Battery replacement will also be managed by this external arrangement.

RRFC physio staff should ensure that all equipment and stock in the physio room is replaced after use and that it is in-date.

9.2 Risk assessment
An annual risk assessment should be performed which will include first-aid provision, facilities and equipment. This will reference against the requirements of the first aid policy and inform actions to address outstanding risks. All actions will be documented in the RRFC first aid action plan and will be allocated an appropriate lead person to progress the action and a target date for completion.
10 Reference documents

RFU first aid and head injury guidelines
Resuscitation Council AED guidelines 2010
NICE guidance 176 (prev56)
RRFC health and safety policy
RRFC safeguarding policy

Further information:
http://www.rfu.com/managingrugby/firstaid/injuries
11 Appendices

11.1 Appendix 1 – First Aid Kit Contents

It is essential that first-aid equipment is checked frequently to ensure sufficient quantities and that all items are usable. Always replenish contents of first-aid box and kit as soon as possible after use. Items should not be used after the expiry date shown on packets.

First-aid boxes should be made of suitable material and designed to protect the contents from damp and dust.

A well-stocked first-aid box should contain the following:

- Guidance card including concussion assessment tool
- Assorted adhesive dressings (plasters) x 20
- Sterile eye pads (No. 16) x 2
- Medium sterile wound dressings (No. 8) x 6
- Large sterile wound dressings (No. 9) x 2
- Short life triangular bandages x 4
- Disposable gloves (pair) x 3
- Antiseptic wipes x 6
- Foil blanket x 1
- Disposable resuscitation aid x 1
- Instant ice pack x 2
- Cotton buds
- Blunt end scissors
- Steristrips

Under no circumstances should prescription drugs be administered by first-aiders or kept in the first-aid box. Boxes should be clearly labelled and easily accessible.

The following items MUST NOT be kept in first aid kits:

- Freeze sprays
- Heat sprays or heat rubs
- Smelling salts
- Painkillers
- Prescription drugs.

Take care over what ends up in First-Aid bags. Check regularly and make sure the bag is restocked after every use.
First aid equipment / kit should be checked frequently to ensure sufficient, useable quantities. Always replenish contents of first aid kit as soon as possible after use.

<table>
<thead>
<tr>
<th>Item</th>
<th>Pack Size</th>
<th>Quantity required</th>
<th>Reason / comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laminated concussion assessment tool</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assorted adhesive dressings (plasters)</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sterile eye pads (No. 16)</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium sterile wound dressings (No. 8)</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Large sterile wound dressings (No. 9)</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short life triangular bandages</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposable gloves</td>
<td>pair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antiseptic wipes</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foil blanket</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposable resuscitation aid</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instant ice pack</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cotton buds</td>
<td>multi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blunt end scissors</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steristrips</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other items not listed (please give reasons for request):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Under no circumstances should prescription drugs be administered by first aiders or kept in the first aid box. RFU guidance states that freeze sprays, heat sprays, heat rubs and painkillers MUST NOT be kept in first aid kits.

Please return completed forms to bar staff for the attention of Rachel Howitt / Stafford Smart
## Incident / Accident Report Form

<table>
<thead>
<tr>
<th>Date of Incident:</th>
<th>Time of incident:</th>
</tr>
</thead>
</table>

### Details of injured person:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of birth:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone:</th>
<th>Mobile:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Next of kin:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Contact number:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Relationship:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Rugby team / age group:</th>
</tr>
</thead>
</table>

### Injury details:

<table>
<thead>
<tr>
<th>Injury sustained:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>First aid / treatment given:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Treated by:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Outcome (please tick)</th>
<th>Carried on with session</th>
<th>Stayed and watched</th>
<th>Went home</th>
<th>Attended A&amp;E &amp; discharged</th>
<th>Admitted to hospital</th>
<th>Other (please state)</th>
</tr>
</thead>
</table>

### Hospital admission details (if known):

<table>
<thead>
<tr>
<th>Hospital:</th>
<th>Ward/Department:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Treatment:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Discharge date:</th>
</tr>
</thead>
</table>

### Incident details:

<table>
<thead>
<tr>
<th>Exact location:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>What activity was person involved in (please tick):</th>
<th>Other: (please state)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training</td>
<td>Getting changed</td>
</tr>
<tr>
<td>Home match</td>
<td>Pitch-side (non play)</td>
</tr>
<tr>
<td>Away match</td>
<td>Kitchen duties</td>
</tr>
</tbody>
</table>
Details of how injury occurred:

Name of person in charge of training / match:

Opposition club: Team:

Referee:

<table>
<thead>
<tr>
<th>Were any of the following contacted?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent / Guardian</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Details:

Report completed by:

Position / RRFC role:

Contact number:

Date of report:

Time of report:

Signature:

Please return completed form to the club bar staff to be placed in the insurance file ready for review

RRFC official use:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NO further action</td>
<td></td>
</tr>
</tbody>
</table>

Local follow up

Details:

RFU reportable

<table>
<thead>
<tr>
<th>Reported by:</th>
<th>Date RFU form sent:</th>
</tr>
</thead>
</table>

Form reviewed by: Date:
11.4 Appendix 4 – Head Injury Advice Sheet

CLUB: Roundhogan RFC

Head Injury Advice Sheet

Name: ___________________________ DoB: _____________________

This player sustained a head injury at ___________ on ___________.
They were assessed at pitch side by our First Aid after the incident and it
was felt that they were safe to go home and it was not required to attend
hospital at this stage.

When you get home it is unlikely that you will have further significant
problems, although you should remain in the supervision of a responsible
adult for the rest of today and overnight.

But if you are affected by any of the following, you should go / be taken to
the nearest hospital emergency department for further assessment as soon
as possible:

- Unconsciousness or lack of full consciousness (for example, problems
  keeping eyes open),
- confusion (not knowing where you are, getting things muddled up),
- drowsiness (feeling sleepy) that goes on for longer than 1 hour when
  you would normally be wide awake,
- problems understanding or speaking,
- loss of balance or problems walking,
- weakness in one or both arms or legs,
- problems with your eyesight,
- very painful headache that won’t go away,
- vomiting – getting sick,
- fits (collapsing or passing out suddenly),
- clear fluid coming out of your ear or nose,
- bleeding from one or both ears,
- new deafness in one or both ears.

Booklet produced using information from the National Institute for Health
& Clinical Excellence (NICE) Head Injury Guidelines 2007, the International
Rugby Board Concussion Guidelines 2011 and the Zurich Consensus
Statement on Concussion in Sport 2012.

Dr Andrew Hogg
Specialist Registrar in Sports & Exercise Medicine
Yorkshire Rugby Football Union Doctor
Mob: 07736944526
andrew.hogg@gmail.com
Concussion & Return to Play Advice

After a head injury there can be a delay in the appearance of symptoms of concussion. Therefore, one of more of the following common symptoms may develop over the next few days:
- Headache, dizziness, nausea, “feeling in a fog”, unsteadiness, slowed reactions, irritability, anxiety, poor attention or concentration, sleep disturbance and low energy.

Regardless of whether the player was actually ‘knocked out’ during the game, if they were removed from the pitch due to a suspected concussion or subsequently develop any of the above symptoms, they should be managed as a concussion.

For players with concussion (or suspected concussion) it is important that their activity be moderated for a period of time in order to aid a full recovery and minimize the chances of any longer term problems.

The first step in the recovery process is to avoid all physical activity and any activities which require concentration or attention until all symptoms have been absent for more than 24 hours. This should then be followed by a period of 14 days with no playing or training for sport, to allow the brain time to fully recover. [If they remain symptomatic after 14 days, they should seek medical advice from their own GP.]
After this time, they can then begin to follow a graduated return to play program, as detailed in the box below.

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### Step 1: No Activity
Complete physical & mental rest

### Step 2: Light aerobic exercise
eg. walk, swim, cycle (<70% max HR)
NO resistance training

### Step 3: Rugby specific exercise
eg. non-contact running drills

### Step 4: Non-contact training skills
eg. passing & resistance training

### Step 5: Full contact training
(After medical clearance)

### Step 6: Return to Play
(Not before day 21 post injury)

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Once the player has been symptom free for 14 days, they can move onto ‘Step 2’ and begin doing light aerobic exercise.

If any symptoms recur upon starting exercising, they should stop and return to ‘Step 1’ until they are again symptom free for 24 hours.

If they are able to train at ‘Step 2’ without developing any symptoms for 24 hours, then they can move onto ‘Step 3’.
They should repeat this pattern of spending at least 24 hours symptom free at each step before moving on to the next, higher level step.

If they develop symptoms at any stage, they should rest for 24 hours before then going back to the previous step in the chain.

Prior to reaching ‘Step 5’, they should see the team doctor or their own GP to gain medical clearance that it is now safe for them to return to full contact training.

For more information the IRB Concussion Guidelines are available at [www.irbplayerwelfare.com](http://www.irbplayerwelfare.com)
Head Injury Notification / Return consent form

Today your child has had a minor head injury whilst playing Rugby.

It is Roundhegians policy to make you aware of this so that you can keep an eye on your child for the next few hours. Symptoms may not develop for a while after a blow to the head.

Your child will now need plenty of rest and supervision for the next 48 hours.

If your child shows any of the following signs, then please seek professional medical advice from NHS direct on 08454 220220, your family GP or your local, minor injuries department / Accident and Emergency.

- Excessive sleeping, drowsiness or difficulty with breathing
- Confusion, strange behaviour, difficulty with concentration or speaking
- Loss of balance, dizziness or limb weakness
- Any convulsions (fits)
- Problems with their vision e.g. blurred vision, double vision etc
- Unusual or worsening headache
- Clear fluid or bleeding from their ears
- Or any hearing impairment or loss

It is recommended by medical guidelines that if your child has sustained a head injury then contact sports should not be played for 3 weeks. This includes training and playing.

When your child is ready to resume training please complete the form below and return to the coach at the start of the first session.

Return to Training/Playing Consent Form

This form must be completed and returned to the team coach before player resumes training / playing.

Parental consent form

Name of Player.............................................  Name of Parent.............................................
Address........................................................................................................................................
......................................................................................................................................................
Phone Number(s)............................................................................................................................

Following a recent head injury received on...................(date), I can confirm that............................. (name) is fit to recommence training with...........................(team/group).

Signed.......................................................  Date.................................................................

Please return form to the Lead Coach
Pocket CONCUSSION RECOGNITION TOOL™
To help identify concussion in children, youth and adults

RECOGNIZE & REMOVE
Concussion should be suspected if one or more of the following visible clues, signs, symptoms or errors in memory questions are present.

1. Visible clues of suspected concussion
Any one or more of the following visual clues can indicate a possible concussion:

- Loss of consciousness or responsiveness
- Lying motionless on ground / Slow to get up
- Unsteady on feet / Balance problems or falling over / Incoordination
- Grabbing / Clutching of head
- Dazed, blank or vacant look
- Confused / Not aware of plays or events

2. Signs and symptoms of suspected concussion
Presence of any one or more of the following signs & symptoms may suggest a concussion:

- Loss of consciousness
- Seizure or convulsion
- Balance problems
- Nausea or vomiting
- Drowsiness
- More emotional
- Irritability
- Sadness
- Fatigue or low energy
- Nervous or anxious
- “Don’t feel right”
- Difficulty remembering
- Headache
- Dizziness
- Confusion
- Feeling slowed down
- “Pressure in head”
- Blurred vision
- Sensitivity to light
- Amnesia
- Feeling like “in a fog”
- Neck Pain
- Sensitivity to noise
- Difficulty concentrating

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3. Memory function

Failure to answer any of these questions correctly may suggest a concussion.

“What venue are we at today?”
“Which half is it now?”
“Who scored last in this game?”
“What team did you play last week/game?”
“Did your team win the last game?”

Any athlete with a suspected concussion should be IMMEDIATELY REMOVED FROM PLAY, and should not be returned to activity until they are assessed medically. Athletes with a suspected concussion should not be left alone and should not drive a motor vehicle.

It is recommended that, in all cases of suspected concussion, the player is referred to a medical professional for diagnosis and guidance as well as return to play decisions, even if the symptoms resolve.

RED FLAGS

If ANY of the following are reported then the player should be safely and immediately removed from the field. If no qualified medical professional is available, consider transporting by ambulance for urgent medical assessment:

- Athlete complains of neck pain
- Increasing confusion or irritability
- Repeated vomiting
- Seizure or convulsion
- Weakness or tingling/burning in arms or legs
- Deteriorating conscious state
- Severe or increasing headache
- Unusual behaviour change
- Double vision

Remember:

- In all cases, the basic principles of first aid (danger, response, airway, breathing, circulation) should be followed.
- Do not attempt to move the player (other than required for airway support) unless trained to do so.
- Do not remove helmet (if present) unless trained to do so.


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Return to play after concussion

Concussion must be taken extremely seriously to safeguard the short and long term health and welfare of players, and especially young players.

The majority (80-90%) of concussions resolve in a short (7-10 days) period. This may be longer in children and adolescents and a more conservative approach should be taken with them. During this recovery time however, the brain is more vulnerable to further injury, and if a player returns too early, before they have fully recovered this may result in:

- Prolonged concussion symptoms
- Possible long term health consequences e.g. psychological and/or brain degenerative disorders
- Further concussive event being FATAL, due to severe brain swelling – known as second impact syndrome.

What should players do to return to play (RTP)?

The routine return to play pathway is shown in the diagram below:

A player’s age is deemed to be their age as at 1st September.
• Rest. Individuals should avoid the following initially and then gradually re-introduce them:
  o Reading
  o TV
  o Computer games
  o Driving

• It is reasonable for a student to miss a day or two of academic studies but extended absence is uncommon.

• Start Graduated Return to Play (GRTP) once all symptoms have resolved and cleared to do so by a healthcare professional (HCP) or doctor (for children).

• In young players a more conservative Graduated Return To Play approach is recommended, and it is advisable to extend the amount of rest (routinely this should be two weeks/14 days) and the length of the GRTP.

• As part of the process it is also prudent to consult with the young person’s academic teacher(s) or tutor to ensure that their academic performance has returned to normal prior to commencing their GRTP. The school environment obviously helps with this liaison with educational experts.

It must be emphasised that these are minimum return to play times and in players who do not recover fully within these timeframes, these will need to be longer.

Graduated Return to Play (GRTP)

The GRTP should be undertaken on a case by case basis and with the full cooperation of the player and their parents/guardians.

Where a club/school has their own medical resources the GRTP process should be carried out by the club/school coach, and overseen by the club/school healthcare professional/doctor. Parents should where possible also be actively involved in the process.

A summary of the GRTP is shown in the following diagram.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Rehabilitation Stage</th>
<th>Exercise Allowed</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Rest</td>
<td>Complete physical and cognitive rest without symptoms</td>
<td>Recovery</td>
</tr>
<tr>
<td>2</td>
<td>Light aerobic exercise</td>
<td>Walking, swimming or stationary cycling keeping intensity, &lt;70% maximum predicted heart rate. No resistance training.</td>
<td>Increase heart rate and assess recovery</td>
</tr>
<tr>
<td>3</td>
<td>Sport-specific exercise</td>
<td>Running drills. No head impact activities.</td>
<td>Add movement and assess recovery</td>
</tr>
<tr>
<td>4</td>
<td>Non-contact training drills</td>
<td>Progression to more complex training drills, e.g. passing drills. May start progressive resistance training.</td>
<td>Add exercise + coordination, and cognitive load. Assess recovery</td>
</tr>
<tr>
<td>5</td>
<td>Full Contact Practice</td>
<td>Normal training activities</td>
<td>Restore confidence and assess functional skills by coaching staff. Assess recovery</td>
</tr>
<tr>
<td>6</td>
<td>Return to Play</td>
<td>Player rehabilitated</td>
<td>Safe return to play once fully recovered.</td>
</tr>
</tbody>
</table>
Before a player can commence the exercise elements of the GRTP i.e. Stage 2, they must be symptom free for a period of 24 hours (adult) or 48 hours (U19) (This is Level 1)

The player can then progress through each stage as long as no symptoms or signs of concussion return. Where the player completes each stage successfully without any symptoms the player would normally proceed through each stage on successive days. In U19s, progression should take 2 days for each stage.

If any symptoms occur while progressing through the GRTP protocol, the player must consult with their medical practitioner before returning to the previous stage and attempting to progress again after a minimum 24-hour (adult) or 48 hour (U19) period of rest, without the presence of symptoms.

If it is not feasible for the coach to conduct Levels 2 - 4, these may be done by the player in their own time or in children supervised by parents with appropriate guidance. Alternatively the protocol may simply be extended with each level being conducted by the coach at training sessions or in the school setting by other PE staff during PE lessons, when they are able.

On completion of Level 4 the player may resume full contact practice (Level 5) with Medical Practitioner clearance.

It is the player’s or parent’s responsibility to obtain medical clearance before returning to play.

Schools and clubs are advised to keep a record of the player’s or parent’s confirmation that clearance has been obtained and a doctor’s letter is not necessarily required.

On completion of Level 5 without the presence of symptoms, the player may return to playing in full contact rugby games (Level 6).

**Note:**
If a player’s concussion resulted from poor tackle technique, their coach must also ensure that this is corrected before return to play.

If there are concerns about the player’s behaviour and approach to the game when playing or training that appears to put them at increased risk of concussion, then this should be addressed before return to play.

**Return to Play Pathway in an Enhanced Care Setting**

In some circumstances (such as Professional clubs and Rugby Academies) there is a doctor with training and experience in the management of concussion/traumatic brain injury available to closely supervise the player’s care and GRTP, and clear the player prior to RTP. In these instances, a shortened timeframe for RTP is possible, but only under strict supervision by the appropriate medical experts as part of a structured concussion management programme. In these circumstances ONLY, the following RTP pathway can be followed:
It must be emphasised again, that these are minimum return to play times and in players who do not recover fully within these timeframes, these will need to be longer.

Criteria for an Enhanced Care Setting:

1. There is a doctor with training and experience in the management of concussion/traumatic brain injury available to closely supervise the player’s care and GRTP, and clear the player prior to RTP.

   and

2. There is a structured concussion management programme in place including:
   a. Baseline SCAT 3 and/or Computerised Psychometric/Cognitive testing of players.
   b. Clinical serial multimodal concussion assessment of players post head impact event.
   c. Formalised GRTP programme with regular SCAT 3 or equivalent assessments recorded in players’ medical records.
   d. Access to neuropsychology/neurology/neurosurgery specialists if required
   e. Formal concussion education programme for coaches and players.
It is recognised that players will often want to return to play as soon as possible following a concussion. Players, coaches, management, parents and teachers must exercise caution to:

a. Ensure that all symptoms have subsided before commencing GRTP.
b. Ensure that the GRTP protocol is followed.
c. Ensure that the advice of Medical Practitioners and other Healthcare Professionals is strictly adhered to.

After returning to play all involved with the player, especially coaches and parents must remain vigilant for the return of symptoms even if the GRTP has been successfully completed.

If symptoms reoccur the player must consult a Healthcare Practitioner as soon as possible as they may need referral to a specialist in concussion management.

Additional resources
- Coaches Concussion Guide: rfu.com/concussion
- Pocket Concussion Recognition Tool: rfu.com/concussion
- Coaches, First Aiders, Match Officials and Administrators concussion education module: www.irbplayerwelfare.com/concussion
- Club/School Health Care Professionals concussion educational module: www.irbplayerwelfare.com/concussion
Introduction

This chapter contains guidelines for the use of automated external defibrillators (AEDs) by laypeople, first responders and healthcare professionals responding with an AED outside hospital. These guidelines are appropriate for all types of AED, including those that are fully automatic. Guidelines for in-hospital use of AEDs are provided in the electrical therapies section of the advanced life support guidelines.

In the UK approximately 30,000 people sustain cardiac arrest outside hospital and are treated by emergency medical services (EMS) each year. Electrical defibrillation is well established as the only effective therapy for cardiac arrest caused by ventricular fibrillation (VF) or pulseless ventricular tachycardia (VT). The scientific evidence to support early defibrillation is overwhelming; the delay from collapse to delivery of the first shock is the single most important determinant of survival. If defibrillation is delivered promptly, survival rates as high as 75% have been reported. The chances of successful defibrillation decline at a rate of about 10% with each minute of delay; basic life support will help to maintain a shockable rhythm but is not a definitive treatment.

The Resuscitation Council (UK) recommends strongly a policy of attempting defibrillation with the minimum of delay in victims of VF/VT cardiac arrest.

Guideline changes

There are no major changes to the sequence of actions for AED users in Guidelines 2010. The ILCOR Consensus on Science and Treatment Recommendations makes the following recommendations which are relevant to the RC(UK) AED guidelines:

1. An AED can be used safely and effectively without previous training. Therefore, the use of an AED should not be restricted to trained rescuers. However, training should be encouraged to help improve the time to shock delivery and correct pad placement.

2. Short video/computer self-instruction courses, with minimal or no instructor coaching, combined with hands-on practice can be considered as an effective alternative to instructor-led BLS and AED courses. Such courses should be validated to ensure that they achieve equivalent outcomes to instructor led courses.
3. When using an AED minimise interruptions in chest compression. Do not stop to check the victim or discontinue cardiopulmonary resuscitation (CPR) unless the victim starts to show signs of regaining consciousness, such as coughing, opening his eyes, speaking, or moving purposefully AND starts to breathe normally.

**Types of automated external defibrillator**

AEDs are sophisticated, reliable, safe, computerised devices that deliver electric shocks to victims of cardiac arrest when the ECG rhythm is one that is likely to respond to a shock. Simplicity of operation is a key feature: controls are kept to a minimum, voice and visual prompts guide rescuers. Modern AEDs are suitable for use by both lay rescuers and healthcare professionals.

All AEDs analyse the victim’s ECG rhythm and determine the need for a shock. The semi-automatic AED indicates the need for a shock, which is delivered by the operator, while the fully automatic AED administers the shock without the need for intervention by the operator. Some semi-automatic AEDs have the facility to enable the operator (normally a healthcare professional) to override the device and deliver a shock manually, independently of prompts.
AED algorithm

1. Unresponsive?
   - Call for help
   - Open airway
   - Not breathing normally
   - Send or go for AED
   - Call 999

2. CPR 30:2
   - Until AED is attached

3. AED assesses rhythm
   - Shock advised
   - No Shock advised

   - Shock advised:
     - 1 Shock
     - Immediately resume CPR 30:2 for 2 min

   - No Shock advised:
     - Immediately resume CPR 30:2 for 2 min

   - Continue until the victim starts to wake up, i.e. moves, opens eyes and breathes normally
Sequence of actions when using an automated external defibrillator

The following sequence applies to the use of both semi-automatic and automatic AEDs in a victim who is found to be unconscious and not breathing normally.

1. Follow the adult BLS sequence as described in the basic life support chapter. Do not delay starting CPR unless the AED is available immediately.

2. As soon as the AED arrives:
   - If more than one rescuer is present, continue CPR while the AED is switched on. If you are alone, stop CPR and switch on the AED.
   - Follow the voice / visual prompts.
   - Attach the electrode pads to the patient’s bare chest.
   - Ensure that nobody touches the victim while the AED is analysing the rhythm.

3A. If a shock is indicated:
   - Ensure that nobody touches the victim.
   - Push the shock button as directed (fully-automatic AEDs will deliver the shock automatically).
   - Continue as directed by the voice / visual prompts.
   - Minimise, as far as possible, interruptions in chest compression.

3B. If no shock is indicated:
   - Resume CPR immediately using a ratio of 30 compressions to 2 rescue breaths.
   - Continue as directed by the voice / visual prompts.

4. Continue to follow the AED prompts until:
   - qualified help arrives and takes over OR
   - the victim starts to show signs of regaining consciousness, such as coughing, opening his eyes, speaking, or moving purposefully AND starts to breathe normally OR
   - you become exhausted.

Placement of AED pads

Place one AED pad to the right of the sternum (breast bone), below the clavicle (collar bone). Place the other pad in the left mid-axillary line, approximately over the position of the V6 ECG electrode. It is important that this pad is placed sufficiently laterally and that it is clear of any breast tissue.
Although most AED pads are labelled left and right, or carry a picture of their correct placement, it does not matter if their positions are reversed. It is important to teach that if this happens ‘in error’, the pads should not be removed and replaced because this wastes time and they may not adhere adequately when re-attached.

The victim’s chest must be sufficiently exposed to enable correct pad placement. Chest hair will prevent the pads adhering to the skin and will interfere with electrical contact. Shave the chest only if the hair is excessive, and even then spend as little time as possible on this. Do not delay defibrillation if a razor is not immediately available.

Defibrillation if the victim is wet

As long as there is no direct contact between the user and the victim when the shock is delivered, there is no direct pathway that the electricity can take that would cause the user to experience a shock. Dry the victim’s chest so that the adhesive AED pads will stick and take particular care to ensure that no one is touching the victim when a shock is delivered.

Defibrillation in the presence of supplemental oxygen

There are no reports of fires caused by sparking where defibrillation was delivered using adhesive pads. If supplemental oxygen is being delivered by a face mask, remove the face mask and place it at least one metre away before delivering a shock. Do not allow this to delay shock delivery.

Minimise interruptions in CPR

The importance of early, uninterrupted chest compressions is emphasised throughout these guidelines. Interrupt CPR only when it is necessary to analyse the rhythm and deliver a shock. When two rescuers are present, the rescuer operating the AED applies the electrodes while the other continues CPR. The AED operator delivers a shock as soon as the shock is advised, ensuring that no one is in contact with the victim.

CPR before defibrillation

Provide good quality CPR while the AED is brought to the scene. Continue CPR whilst the AED is turned on, then follow the voice and visual prompts. Giving a specified period of CPR, as a routine before rhythm analysis and shock delivery, is not recommended.

Voice prompts

The sequence of actions and voice prompts provided by an AED are usually programmable and it is recommended that they be set as follows:
Resuscitation Council (UK)

- deliver a single shock when a suitable rhythm is detected;
- no rhythm analysis immediately after the shock;
- a voice prompt for resumption of CPR immediately after the shock;
- a period of 2 min of CPR before further rhythm analysis.

AED use by healthcare professionals

All healthcare professionals should consider the use of an AED to be an integral component of BLS. Early defibrillation should be available throughout all hospitals, outpatient medical facilities and clinics. Sufficient staff should be trained to enable a first shock to be provided within 3 min of collapse anywhere in the hospital. Hospitals should monitor collapse-to-first-shock intervals and monitor resuscitation outcomes.

The RC(UK) advises that untrained employees working in healthcare establishments not be prevented from using an AED if they are confronted with a patient in cardiac arrest. The administration of a defibrillatory shock should not be delayed while waiting for more highly trained personnel to arrive. The same principle should apply to individuals whose certified period of qualification has expired.

Further information on AED use by healthcare professionals is provided in the in-hospital cardiac arrest chapter of these guidelines.

Storage and use of AEDs

AEDs should be stored in locations that are immediately accessible to rescuers; they should not be stored in locked cabinets as this may delay deployment. Use of the UK standardised AED sign is encouraged, to highlight the location of an AED. People with no previous training have used AEDs safely and effectively. While it is highly desirable that those who may be called upon to use an AED should be trained in their use, and keep their skills up to date, circumstances can dictate that no trained operator (or a trained operator whose certificate of training has expired) is present at the site of an emergency. Under these circumstances no inhibitions should be placed on any person willing to use an AED.

Children

Standard AED pads are suitable for use in children older than 8 years. Special paediatric pads, that attenuate the current delivered during defibrillation, should be used in children aged between 1 and 8 years if they are available; if not, standard adult-sized pads should be used. The use of an AED is not recommended in children aged less than 1 year. However, if an AED is the only defibrillator available its use should be considered (preferably with the paediatric pads described above).
Public access defibrillation (PAD)

Public access defibrillation is the term used to describe the use of AEDs by laypeople. Two basic strategies are used. In the first, AEDs are installed in public places and used by people working nearby. Impressive results have been reported with survival rates as high as 74% with fast response times often possible when an AED is nearby.

In a complementary strategy, first responders are dispatched by an ambulance control centre when they might reach a patient more quickly than a conventional ambulance. The greater delay in defibrillation resulting from the need for such responders to travel to a patient has been associated with more modest success rates. However, this strategy does enable treatment of people who arrest at home, the commonest place for cardiac arrest to occur.

Further information may be found on the RC(UK) website.
11.9 Appendix 9 - RFU Reportable Injury Event Form

RFU REPORTABLE INJURY EVENT REPORT

Please use this form to report any injuries that occur whilst playing rugby or taking part in organised rugby squad training sessions that fit any of the following definitions:

1. An individual who sustains an injury which results in their being admitted to a hospital. This does not include those taken to an Accident or Emergency Department and allowed home from there.
2. Deaths occurring during or within 6 hours of the game finishing.

Date of report: ____________________  Time of report: ____________________
Date of injury: ____________________  Time of injury: ____________________
Player’s name: ____________________  DOB or Age: ____________________
Club/School: ____________________  Team: ____________________
Game: ☐  Training: ☐
Grass Pitch: ☐  Artificial Grass Pitch: ☐  Other Surface: ☐

Nature of suspected injury: __________________________________________

Category:
☐ 1. An injury which results in admission to a hospital.
☐ 2. A death which occurred during or within 6 hours of a game finishing.

Game Injuries Only
Opposition Club: ____________________  Team: ____________________
Venue: ____________________
Name of Referee: ____________________

Injured Player Contact Details:
Address: _______________________________________________________
Phone No: ____________________  Mobile: ____________________
Next of Kin: ____________________  Relationship: ____________________
Phone No: ____________________  Mobile: ____________________

Name of reporting person: _________________________________________
Position within Club/School: _______________________________________
Contact Telephone Numbers: _______________________________________

Once completed, please send this form to the RFU Sports Injuries Administrator:
Email: sportsinjuries.admin@therfu.com  Fax: 020 8831 7684, Tel: 0800 298 0102
Post: Sports Injuries Administrator, Rugby Football Union, Rugby House, Rugby Rd, Twickenham, TW1 1DS.

The RFU uses this data for contacting individuals and/or their clubs who are identified as requiring support in the case of a serious injury. Information regarding the method and type of injury is used anonymously to monitor injuries throughout the game.