CHIPPENHAM HOCKEY CLUB
WELFARE POLICY APPENDIX 6 - CONCUSSION POLICY

CONCUSSION GUIDELINES/PROTOCOLS FOR ALL SUSPECTED CONCUSSION

These guidelines/protocols have been taken from England Hockey 2022, RFU HEADCASE 2021, 2022 Consensus Statement on Concussion in Sport, World Rugby, the Department of Education, FA, FIFA, IOC, IIHF, FEI, FIA, RFU's Independent Concussion Expert Panel (ICEP) (leading independent medical practitioners) and BMJ.

Concussion results in a disturbance of brain function (e.g. memory disturbance, balance problems or symptoms) rather than damage to structures such blood vessels, brain tissue or fractured skull. Loss of consciousness occurs in less than 15% of concussion cases and whilst a feature of concussion, loss of consciousness is not a requirement for diagnosing concussion. Medical assessment of a head injury, if there is any doubt with regards to diagnosis, is recommended to exclude a potential structural brain injury particularly if symptoms are worsening. Standard neuro-imaging such as MRI or CT scan is not routinely performed as part of the assessment of a concussion injury as these investigations are typically normal. However, in some cases it may be deemed necessary by a medical practitioner in order to rule out a structural brain injury. All head injuries should be considered associated with cervical spine injury until proven otherwise.

Head injuries / Concussion must be taken seriously to safeguard the short- and long-term health and welfare of players. The majority (80-90%) of concussion symptoms resolve in around 7-10 days, with symptoms resolving within 1 - 2 days in around a third of cases. A small minority of individuals may have persistent symptoms. However, irrespective of how quickly symptoms resolve, it is paramount that every case goes through appropriate Graduated Return to Play programme. The protocol requirements differ per age group. Players U18 have been shown to take longer to recover and are more susceptible to concussions and complications from head injuries.

Minimising any potential future risk of neurodegeneration (such as CTE) is why it is so important to manage concussion in accordance with best practice, in particular as the link between repetitive concussions and long-term effects are still not fully understood. Not managing a concussion correctly may put a player at higher risk of developing progressive neurodegenerative problems that may lead to problems with memory, other mild cognitive impairments or CTE in later life. (Position Statement from RFU Independent Concussion Expert Panel)

It is important that a cautious approach is taken following a suspected concussion and that it is treated appropriately as they are not always visible or conclusive. It can be difficult in the initial stages to differentiate concussion from other serious brain injuries, which at its most extreme, can lead to death. Exposure to further head impacts before full recovery can increase the risk of a more serious brain injury and lead to Second Impact Syndrome.

THE FOLLOWING SHOULD BE ADHERED TO WHEN THERE IS A KNOWN OR SUSPECTED CONCUSSION:

- Any head injury must be taken extremely seriously to safeguard the safety and long-term health of players.
- Players suspected of having concussion should be removed from play/training immediately.
- All players who have sustained a head injury or are suspected of having concussion should be assessed by a suitably trained **Healthcare Professional** within 24hours of the sustained injury.
- Players suspected of having concussion or diagnosed with concussion should go through a **Graduated Return to Play programme (GRTP).**
- Players should be reviewed by **a suitably trained Healthcare Professional before returning to play.**
- Players may also get concussion/head injuries outside of their sport but present with the symptoms and signs at training or before a match. It is important that these situations are recognised, as it may put them at risk of more serious consequences if they sustain another concussion before recovery.
- Coaches, teammates, and parents should encourage players to report all concussions/head injuries whether they occur during games and training sessions or outside of their sport.
- Players / Parents / Guardians are responsible for informing sports clubs/schools of suspected concussions/head injuries.
- It is important that relevant parties communicate following a concussion/head injury to ensure there is full understanding and cooperation in the management of any suspected concussion, along with returning to learning/work and playing.
- Day 1 of the RTP starts from the day after the sustained injury.
- Players who experience two or more concussion in 12 months or multiple concussions over the course of their career should be reviewed on an individual basis. The severity of the concussion, nature, timescale and recovery can affect the approach that is taken; some players may require an extended period out of the game. It is recommended that they are seen by a doctor specialising in concussion management (through a GP referral).
- Each concussion should be considered on its own merits but a more conservative timescale for recovery or directed rehabilitation may be recommended especially if each time the force required to cause the concussion is lessened and/or the symptoms are prolonged.

POSSIBLE SIGNS & SYMPTOMS

ANY ONE OF THE FOLLOWING OBSERVABLE SIGNS:	PRESENCE OF ANY ONE OR MORE OF THE FOLLOWING SYMPTOMS:	RED FLAGS IF ANY OF THE FOLLOWING ARE REPORTED OR DEVELOP, SEEK URGENT MEDICAL ATTENTION
Loss of consciousness or responsiveness	Loss of consciousness	Deteriorating conscious state
Lying motionless on ground / Slow to get up	"Don't feel right"	Increasing confusion or irritability
Unsteady on feet / Balance problems or falling over / Incoordination	Headache, or "Pressure in head"	Severe or increasing headache
Grabbing / Clutching of head	Seizure or convulsion	Repeated vomiting
Dazed	Dizziness or balance problems	Unusual behaviour change
Blank or vacant look	Confusion	Seizure or convulsion
Confused / Not aware of plays or events	Difficulty concentrating or feeling like"in a fog "	Double vision or deafness
	Nausea or vomiting	Weakness or tingling/burning in arms or legs
	Drowsiness, feeling slowed down, fatigue or low energy	
	More emotional or sadness	
	Blurred vision, or sensitivity to light or noise	
	Nervous, anxious or irritable	
	Difficulty remembering or amnesia	
	Neck pain	

THE IMMEDIATE DOS AND DON'TS FOLLOWING A SUSPECTED CONCUSSION.

DO

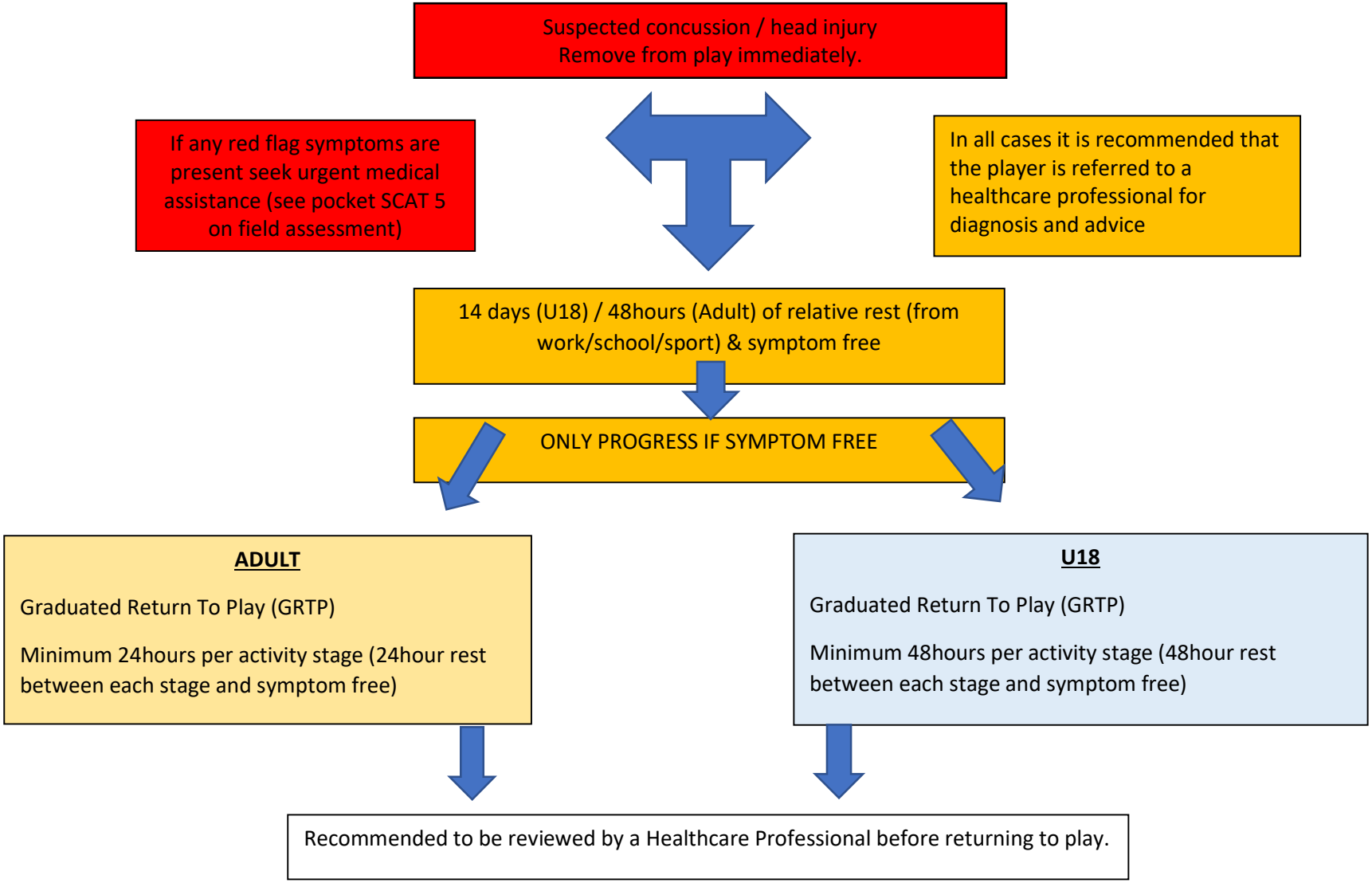
- Remove from play immediately.
- Be assessed by a suitably trained health care professional within 24 hours of the incident to ensure that there are no significant underlying medical issues.
- Rest & Sleep – this is good for recovery.

DON'T

- Be left alone in the first 24 hours.
- Consume alcohol in the 24 hours and/or until symptom free.
- Drive a motor vehicle in the first hours and/or until symptom free.

RETURN TO PLAY (RTP)

There are 2 different Graduated Return to Play programmes, one for adults and one those playing at U18s and below. The Return to Play is aligned across other sports in the UK, with NHS guidelines and are endorsed by the Sport and Recreational Alliance. These guidelines can therefore be used across sports in managing return to play when the concussion has occurred in sport or in everyday activities.



HEALTHCARE PROFESSIONALS

INITIAL REVIEW – IMMEDIATELY AFTER A SUSPECTED CONCUSSION

Following a suspected concussion, all players must be initially assessed by a health care professional to ensure that there are no significant underlying medical issues. The healthcare professional is required to follow the guidelines listed below:

- All signs and symptoms (S&S) of a suspected concussion are to be documented. If the suspected concussion was witnessed any of reported S&S from coaches/players to also be documented as the S&S may be short lived and only apparent at the time of injury. Players should be encouraged to be honest in their reporting as well of S&S.
- If at the time of the HCP assessment the S&S have resolved, there are no underlying issues and the player has no ongoing symptoms the player should undertake the RTP.
- HCP should use the SCAT 5 symptom check list and King Devick Test to monitor recovery.
- If symptoms follow the Red Flag list or worsen HCP to seek further medical help immediately.

HCP RETURN TO PLAY REVIEW

- Having completed the 14 days (U18), 48 hours (Adult) of relative rest the player is reviewed by the HCP to start their GRTP.
- HCP should ensure that all symptoms have subsided and the individual has returned to academic studies/work successfully before commencing the GRTP
- Ensure that the appropriate GRTP programme is followed.
- All players must be reviewed/assessed by a HCP before returning to contact activities and other activities with a predictable risk of head injury level 5 on GRTP. Complete SCAT 5 / King Devick and a Buffalo Test.
- Before returning to competition / game a review by a HCP should confirm recovery and that there are no other underlying conditions or ongoing issues. The HCP/GP does not need to provide a letter, but should document confirmed recover in the medical notes,
- Clear communication between all those involved in the management of the player should be kept at all times, with everything documented.
- After returning to play all involved with the player, should remain vigilant for the return of symptoms even if the GRTP has been successfully completed.

The following should also return to their GP for review:

- Individuals who struggle to return to their work or studies.
- Those who persistently fail to progress through the GRTP because symptoms return.
- If symptoms reoccur the player should consult a HCP asap as they may need specialist referral.
- It is recommended that anyone who sustains two or more concussions in a 12-month period should seek advice from their GP for a specialist opinion in case they have an underlying pre-disposition or risk factors.

GRADUAL RETURN TO PLAY

Following the relative rest stage, the player should return to sport by following a graduated return to play (GRTP) programme.

STAGE	**1** **Initial Rest (Body & Brain**	**2a** **Relative Rest (Symptoms limited activities)**	**2b** **Light Aerobic Exercise**	**3** **Sport Specific Training**	**4** **Restricted Training**	**5** **Full Training**	**6** **Return to Play**
Objective	Recover	Return to normal activities (as symptoms permit) No symptoms at the end of the 14days (U18) / 48hours (Adult)	Increase Heart Rate	Add movement	Exercise, co-ordination and cognitive load. Return to academic studies/work needs to be achieved before returning to sport	Restore confidence and assess functional skills	Exercise, co-ordination and cognitive load
Exercise / Activities Allowed	No driving /exercise. Limit screen time. Adapt time work/studies	Initially daily activities that do not provoke symptoms	Low to moderate Eg: 10-15mins light jogging, swimming, stationary bike. No resistance training	Eg: Running drills No head impact activities	Eg: Skills / Passing drills Progressive resistance training may start	Following medical review return to normal training activities	Normal Game Play
Duration (mins)	No Training	No Training	Less than 20mins	Less than 40mins	Less than 60mins		
% MHR	No Training	No Training	Less than 70%	Less than 80%	Less than 90%		

ADULT	24-48 hours Review by HCP advised	48hours including stage 1. Must be symptom free before progressing to stage 2b		Min 24 hours	Min 24 hours	Min 24 hours		Min 24 hours	Min 24 hours Earliest return 7 DAYS
If any symptoms occur during any stage in the GRTP the player must rest for 24hours and until symptoms free may return to the previous stage									
U18 & below	24-48 hours Review by HCP advised	14 days including stage 1. Must be symptom free before progressing to stage 2b		Min 48 hours	Min 48 hours	Min 48 hours		Min 48 hours	Min 48 hours Earliest return 23 DAYS
If any symptoms occur during any stage in the GRTP the player must rest for 24hours and until symptoms free may return to the previous stage									

	Must be symptom free
	Must see HCP

After the 24-48hrs of initial rest, the U19 player undertakes a period of relative rest (minimum 14 days) and should gradually look to return to their normal daily activities during this time.

• If symptoms are found to worsen during the relative rest stage, activities should be limited to a level where this does not occur, and activities are reintroduced on a more gradual basis.

• If symptoms do not resolve with Rest (Stage 1) then progression to symptom limited activities (Stage 2) is recommended.

The GRTP Stage 2b should only be started when the person:

• Has had 14 days of symptom free relative rest

• Is off all medication that modifies symptoms e.g. painkillers

• Has returned to normal studies or work