THE FA INTRODUCTION TO FIRST AID BRIDGING DOCUMENT

JANUARY TO AUGUST 2018

The FA FOR ALL

Contents

PURPOSE OF THIS FIRST AID 'BRIDGING' DOCUMENT

This document has been created for the first aider providing first aid pitch-side in football who has undertaken a generic first aid course. The aim of the courses and this supplementary text is to save a life in football. First aid is essential, your role as the first aid provider is essential , it is important to get it right and be prepared to safe a life in the football environment.

Sport specific and finer tuned football specific components have been included in this document to add to the competencies already gained during a generic first aid course.

Generic first aid and first aid at work are specific courses whose content aligns to the needs of their own working-environment. The football specific first aid courses; The FA's Introduction to First Aid In Football (IFAiF) and The FA's Emergency First Aid in Football (EFAiF) have used the same criterion of risk assessment specific to the football environment in their course design and inclusion that generally do not form essential components of generic first aid for obvious reasons, they are applicable in the main to the work place environment.

The football specific courses focus on injuries or illnesses that are a risk to life or limb within football. The focus outside in a sports setting, specifically pitch side first aid intervention both at training and in matches requires additional component skills. Whilst this bridging document cannot include all the additional competencies, the main ones have been chosen to supplement the generic first aid course skills already attained via your first aid training. The ones chosen to include in this document are:

- The jaw thrust as an airway opening technique for a contact sport such as football
- Manual in line stabilisation of the head and neck
- Sudden cardiac arrest in football
- Concussion management in football – The FA concussion guidelines
- The Asthmatic footballer
- Dispelling the myths of first aid in football
- Emergency action planning for football
- The football specific first aid kit , the role of the first aider in football and record keeping

It will outline elements of The FA's Introduction to First Aid in Football Course, that are applicable to those operating at pitchside, and is designed to provide additional information to enable the first aider to prevent illness and injury, plan for a medical emergency, manage medical conditions and ensure that appropriate care is given until the emergency medical services arrive and take over (or until an alternate healthcare professional assumes responsibility for the player).

It is a resource that should complement the training you have already undertaken. It is not a substitute for appropriate first aid training and does not sanction first aid management in any area where competency has not been established. Reading a document does not make you competent.

Note: the term 'player' is interchangeable with the term 'patient'. It is acknowledged that the player may be a coach, parent or a spectator not always a player – however the emphasis of this document and FA Medical Education is Player Welfare. For those wishing to cover specific crowd care then attention should be given to major incident planning and attendance on a course of that nature is strongly advised, this is beyond the scope of this document.

Confirmation of Reading the Bridging Document

Upon reading the document it is essential you email your County FA or **FA Education at education@thefa.com** to acknowledge that you have read and understood the document. By acknowledging that you have read the document and by providing a copy of your current and in-date generic First Aid qualification certificate (see list of approved courses on The FA website **www.thefa.com/get-involved/coach/courses/all-courses**) or proof of being a health care professional, will result in you not having to attend The FA's IFAiF course for FA Coach Licensing and FA Charter Standard purposes.

It is expected that all new coaches attend The FA's IFAiF course as part of their initial FA qualification to establish a base level of understanding of first aid in the football environment.

INTRODUCTION

Every club has a duty to ensure that every player should be able to participate in football-related activities with the reassurance that their medical welfare has been considered and that should they succumb to injury or illness, they will receive prompt, safe, appropriate and effective pre-hospital emergency medical care.

Effective first aid is simple and requires minimal equipment. Even when a player has a serious injury (or illness) the basic things still need to be done. Knowing what to do can influence a player's recovery. Calling 999 or 112 for an ambulance is simple, but it saves lives.

As a pitchside first aider you should be in a location where you can see the field of play and all the participants. What have you witnessed? What was the mechanism of injury? Is anyone's life in immediate danger? Does a player's behaviour or appearance suggest something is wrong? You should always be ready to deal with any eventuality. Your equipment should be with you at all times and gloves must always be worn.

When employed to perform the specific role of pitchside first aider, you owe a duty of care to the players and must exercise all due care, skill and attention when assessing, treating and managing their injury or medical condition. You also owe a duty to 'do no further harm'. The health, safety and welfare of a player must prevail above the achievements of a club; you must not put the outcome of a game (e.g. returning an injured player to the field of play) before your medical obligations. The player's welfare always comes first.

You should not be fearful of litigation. If you have a duty to act, and have accepted the role of pitchside first aider, you will not be found negligent if you

i) respond

ii) operate within the scope of your practice and training

iii) act with 'reasonable' care and skill (comply with current FA protocols and follow accepted logical process and FA guidelines)

iv) act in the player's best interests and

v) do your best

At all times you should err on the side of caution and seek assistance from the Emergency Medical Services or medical personal in attendance if present when in doubt.

Healthcare professionals who are operating at the pitchside should realise that any professional indemnity insurance that they have, will be only be valid if they have undertaken an appropriate course in pre-hospital emergency care which is applicable to their professional background and chosen sport.

On a final note, do not allow yourself to be compromised by others who do not have a first aid qualification or who may have other motives for moving an injured player. You are responsible for any decision regarding treating and/or moving a player, whilst the arrival of emergency services is awaited.

As the first aider, you should ensure you can contact the emergency services if necessary. Make sure you have a mobile phone that is charged. If network coverage is patchy, make yourself aware of where the nearest point is where a network signal is accessible.

GENERAL GUIDANCE - ON-FIELD INJURY

Players should always be approached and managed using the A-E approach (taught on your generic first aid course). If any life threatening injury is found it should be dealt with immediately before moving onto the next stage e.g if the player is not breathing normally commence CPR and apply an AED as soon as it arrives. Stop any activity if a player appears seriously injured., closely consider the mechanism of injury.

In all situations that involve trauma it is important to immobilize the head and neck until a cervical spine injury is ruled out. The method of dealing with the players airway will be different where trauma has occurred and spinal injury is suspected.

In the lower leg, bleeding may conceal an 'open' fracture of the lower leg or a fracture/dislocation of the ankle joint; such injuries are usually apparent by the reaction of the player (and others in the vicinity) and require immediate first aid. The management of limb threatening injuries and first aid for fracture management will have been covered in your generic first aid course. If you don't feel it was covered in full then please consider attending The FA's EFAiF course at the next available opportunity.

In football environments, life-threatening bleeding is uncommon, however refer to your first aid training course for the management of arterial bleeding which when present takes priority over the airway unless two persons are present one to deal with each.

There are many reasons that a footballer may become unconscious on the field of play, some you will have covered in your generic training. Causes may be hypoglycaemia, heat exhaustion, post ictal following a seizure in a diagnosed epileptic player, asphyxia, sudden cardiac arrest, fainting, shock and head injuries. It is important to establish the route cause as early as possible, correct management in the acute stages can save a life.

Use your Emergency Action Plan for each of these different scenario's to ensure correct initial management is applied and the emergency services called.

The jaw thrust for opening a players airway where suspicion exists to the presence of a potential spinal injury or the mechanism of injury has caused reason for concern.

The jaw thrust is applied whilst maintaining manual inline stabilization of the head and neck.

Place 2 fingers of each hand behind each side of the jaw bone and push the jaw forwards .

PIC 1 If the athlete has noisy breathing (snoring) it implies that the airway is being partially obstructed, apply a jaw thrust to open the airway

The jaw thrust can be done in any position

PIC 2 Jaw thrust in side lying

Manual in Line Stabilization of the Head and Neck

Injuries to the head and neck in football can be very serious and occasionally fatal, fortunately these injuries are rare in football. It is important that the first aid management of these injuries is prompt and correct. Proper management and immobilization may mean the difference between complete recovery and lifelong paralysis or even death.

A neck injury should be considered for

- Any injury occurring above the collar bone
- Any head injury with loss of consciousness
- Where the mechanism has caused abnormal flexion or extension of the neck to occur

This technique is used for both the conscious and unconscious player. The first aiders hands should be placed on either side of the players head cupped around the ears (not over the ears) to allow the player to hear your instructions. Always talk to your player to reassure them and ask them to keep still. The same technique is used to apply immobilisation regardless of the position the player lands in. The A-E approach follows, ensuring normal breathing (where no breathing is established, the player is turned onto their backs and CPR with AED commenced immediately).

You should never attempt to move a player with a suspected spinal injury unless they are in severe danger (which should not occur on the field of play). Manual immobilisation is paramount and applied immediately on arrival to the player on the field and not released until the emergency services have arrived and taken over control. Where noisy breathing is present the jaw thrust technique should be the airway opening manoeuvre of choice.

PIC 3 Manual in line stabilisation of the head and neck in prone

SUDDEN CARDIAC ARREST IN FOOTBALL

THE ONLY EXCEPTION TO PERFORMING 1 MINUTE OF CPR BEFORE GOING FOR HELP IS IF YOU HAVE WITNESSED A SUDDEN COLLAPSE OF A CHILD AND YOU SUSPECT A SUDDEN CARDIAC ARREST. IN THIS SITUATION A SHOCKABLE RHYTHM IS LIKELY AND THE CHILD MAY NEED DEFIBRILLATION.

SEEK HELP IMMEDIATELY IF THERE IS NO ONE PRESENT TO GO FOR YOU!

As a first aider you must be able to recognise life threatening cardiac conditions and take the necessary action for the players in your care. Consideration is provided in this chapter to the specific cardiac conditions that affect predominantly the young male player between the ages of 14-35 known as sudden cardiac arrest in the young.

Players may be predisposed to a cardiac injury and the early recognition will allow for early emergency ambulance being called to the scene. A calm, reassuring approach from the first aider will assist in calming the player in these situations, which will assist in their management.

Sudden Cardiac Arrest (SCA) in Football

The death of an apparently healthy young player is a dramatic and stressful event but fortunately it is rare in relation to the number of young people involved in sport. Within the UK alone there are 12 sudden cardiac deaths per week (not specific to football or sport but in the general population), so it is extremely important to be vigilant and to know the signs to look out for in a young player.

Male athletes appear to be at increased risk of exercise-related SCA (9:1 ratio male to female) with black players much more susceptible than caucasian.

There are several inherited cardiovascular diseases and electrical pathway conduction problems (whose explanation is beyond the scope of this manual) that are the leading causes of sudden cardiac arrest. The majority of these players (>80%) do not know they suffer from these underlying conditions and only suffer symptoms just prior to their cardiac arrest. 40% of victims are less then 18 years of age, with the mean average age in Europe of 23 years. Less than 20% who have these conditions have warning symptoms that allow the conditions to be investigated. Whilst exercise is not a cause of SCA, any stress applied to an underlying heart condition can intensify the condition and those that exercise are 2-3 times more likely to suffer an arrest than those that do not exercise. Therefore it is imperative we are vigilant.

Signs and symptoms that indicate a player may be at risk for SCA

- Chest tightness during or after exercise
- Chest pain during or after exercise
- Chest palpitations during or after exercise (feel like their heart will pop out of their chest)
- Dizziness – unexplained episode of dizziness during or after exercise
- Episodes of **syncope** (unexplained fainting) during or after exercise, but can occur at rest. Syncope should be treated with suspicion, healthy fit individuals do not faint for no apparent reason – consider underlying cardiac conditions, do not wait, send the player to their GP for investigation
- Shortness of breath disproportionate with exercise they are doing e.g. not in line with what the other players are doing
- Unable to keep up with the other players (often labelled lazy) due to fatique, during or after exercise
- If you become suspicious – if the player presents with any of the above, then do not hesitate to refer them to their doctor/ GP immediately

One of the main features is a positive familial history! Usually a player will have had a close relative that has died young from natural causes (not trauma). Asking about their relevant past medical history and family history may help save a life! Don't forget with young players, speak with parents to learn of relevant family history.

APPARENTLY HEALTHY YOUNG PLAYERS WITH CHEST PAIN OR SYNCOPE DURING EXERCISE ARE OFTEN TREATED WITH INAPPROPRIATE REASSURANCE THAT THEY ARE FIT AND WELL RATHER THAN BEING INVESTIGATED

Some of these underlying conditions can be detected with cardiac screening. Cardiac screening should be a consideration within grass roots football.

Simple screening questions you can ask your players are:

- Has anyone in your family died at a young age? (Speak to parents to verify this)
- Have you ever suffered from unexplained syncope (fainting)?
- Do you suffer any shortness of breath?
- Do you ever suffer from palpitations?
- Do you ever suffer exertional chest pains?
- Have you ever been diagnosed as having a heart murmur or arrhythmia?
- Check – is the player unusually tall or have extremely long fingers?

Abstract taken from resuscitation guidelines for clarity. All providers should be encouraged to initiate CPR in children even if they haven't been taught specific paediatric techniques. CPR should be started with the ratio that is familiar and for most, this will be 30:2. The specific paediatric sequence incorporating the 15:2 ratio is primarily intended for those who have the potential to resuscitatechildren as part of their role.

The above do not replace cardiac screening, but can be used as a simple means of establishing which players may require consideration for screening in the absence of a club screening policy. Any positive from the list above should be immediately referred to their GP. Consideration should be closely applied to asking these questions at the start of every season and where younger players are concerned also asking the same questions to parents/carers of every player and all information recorded.

Myocarditis

Another cause of SCA is acute myocarditis. This is an inflammation of the heart muscle with no initial underlying risk factors and thus cannot be screened for. Training or playing with an illness, especially an infection e.g. upper respiratory infection or flu, can lead to the development of myocarditis. Be cautious and **do not allow** players to train or play with infections or temperatures.

Commotio Cordis

This is another condition with no underlying risk factors and a perfectly normal heart and thus cannot be screened for. This is caused by a direct blow to chest wall at a particular time in cardiac cycle which sends the heart into an abnormal rhythm. This blow is not related to the impact force but to the timing of the blow, so it can appear fairly innocuous, be vigilant and consider commotio cordis if the mechanism is suggestive.

For example, a ball, knee, head or elbow hitting a player in the chest during contact. It is more prevalent in younger players' as they do not have the muscle bulk in their chest wall to absorb some of the impact of the blow. Early recognition is vital to treat this as less than 15% of these victims have been known to survive usually due to lack of recognition and attendees not treating the signs. ABC should be established immediately and if not present, start CPR.

Treatment of Sudden Cardiac Arrest (SCA)

The initial signs of a SCA are usually what is termed an 'arrhythmia'. Essentially this means that the heart is no longer beating normally but is fibrillating in an uncoordinated manner. The aim of the AED, is to stun the heart - therefore in essence stop this uncoordinated anarchy within the heart and allow the normal pacemaker of the heart to take over. This is essential treatment and is required immediately or as soon as is possible which is why AEDs should be close by at every training session ideally placed with the first aid kit in the dug-out or in a locked cabinet that is easily accessible from every pitch.

- Call for help –someone needs to call for an ambulance immediately and if there is an automated external defibrillator available inside the stadium/club, send someone immediately to fetch it and bring it to you
- Check for signs of life using the A,B,C approach. Begin CPR with chest compressions being done at a fast rate (more or less 2 compressions every second) and as hard as possible (at same time as set-up of AED if more than one rescuer is present). Once the AED is working, follow its instructions exactly
- The time taken to initiate CPR and AED defibrillation is an important determinant of successful cardiac resuscitation, thus any delay in entering the field-of-play and identifying the player who has collapsed without contact must be minimised. The Rules of the Game state that medical personnel should only enter the field-of-play following a signal from the referee, except in the case of a serious injury. Any player who collapses without any prior contact is therefore regarded as a SCA until proven otherwise and must be classified as a serious injury
- If the player presents with a brief seizure-like activity, these slow involuntary movements on-top of the above history i.e. collapse with no contact should not be mistaken and treated as a seizure, but dealt with as a cardiac arrest and resuscitation started. The aim is to get the first shock in within 3 minutes of their collapse
- The decision to transfer the player will be that of the ambulance when they arrive. Do not attempt to move the player, priority is to continue with CPR and AED on the field-of-play until the ambulance arrives

Why AEDs should be present on the pitch side at training and matches...

- Sudden cardiac arrest is not rare – it may happen
- Only effective treatment is BLS with very early defibrillation (AED)
- Chance or successful resuscitation diminishes by 10% each minute you wait
- Should ideally be present at all levels of football!
- Outside in a heated cabinet, with ease of access for use by all teams

If you have any concerns regarding any of your players please speak directly with them or their parents (if younger) and ask them to be taken to their own Doctor (GP). There are screening tests that can be conducted on players to test the heart and this might be appropriate for their doctor to arrange – if in doubt and you suspect something it is better to have them reviewed than collapse at a later date.

Please be aware (this is repeated for clarity and retension)

- Occasional gasps, slow, laboured or noisy breathing is common in the early stages of a sudden cardiac arrest (the term medically applied is **agonal breathing**/gasping/abdominal breathing) – it is a sign of cardiac arrest and should not be mistaken for a sign of life. **Normal breathing is at least ten breaths every minute**
- How to recognise this
  - Stomach rises and falls – **not** the chest
- Exercising players may use accessory muscles if breathing hard, but in addition to the stomach appearing to move the chest would definitely be moving
  - Agonal breaths are irregular and can be accompanied by a snoring sound, present in up to 40% of arrest victims
- **This is not normal breathing**

Other common first signs of a cardiac arrest on the field of play are:

- **witnessed collapse** for no apparent reason (the player just falls to the ground)
  - any witnessed sudden collapse is a cardiac arrest until proven otherwise

and

- **presence of a seizure / fit**
  - the player will appear to be having a fit as blood flow to the brain is reduced
  - It is not uncommon for a first sign to be a 'fit/seizure' type episode. Do not be drawn into myths that the immediate treatment for a fit is the recovery position – it is not! All seizures what ever the cause should be assessed to ensure the player has an open airway, is breathing normally and at risk of on further harm. **A fit/seizure does not mean it is epilepsy – suspect cardiac arrest in a player with no diagnosis of epilepsy**
  - For management of players with epilepsy
  - For a player who is fitting, airway is open but is NOT breathing normally start CPR

If in doubt start CPR.

The usual heart conditions taught on first aid causes relate to those conditions that are acquired due to health issues or lifestyle and may affect in the majority of cases the older generation, although youngsters can also suffer. Below is a brief summary for inclusivity.

Heart attack – this is when the blood supply to a part of the heart is obstructed suddenly causing severe pain. The player may have no previous cardiac history that you are aware of. This is more common in players older than 35 years of age.

Signs and symptoms of a heart attack

- Severe crushing central chest pain
- Pain spreading into the jaw and down left arm
- Breathlessness
- Pale, cold and clammy skin
- Sudden collapse

Treatment

- Always start with your ABCDE approach
- Minimize the workload of the heart i.e. sit the player down
- If conscious, place the player in a comfortable position
- Do not allow the player to move around
- Loosen any tight clothing
- Reassure the player, in a calm voice
- If player has their own medication, encourage them to take it. This may be the case in players/coaches who have known heart conditions or if you work in masters or walking football
- If they collapse, they will need CPR, so look for this and begin immediately. If an AED is present this is required urgently
- Call an ambulance

If you have players who already have a known diagnosis and who play with their own ICD in situ. In the situation of a sudden collapse if the ICD has not fired within several seconds, assume it is not working and prepare to provide BLS with an AED as normal.

If in doubt start CPR.

Notes

CONCUSSION MANAGEMENT IN FOOTBALL

Head Injuries and Concussion Management in Football

A head injury is any trauma that leads to injury of the scalp, skull or brain usually resulting from an injury above the collar bone, but can be transmitted from other body parts to the head. The injuries can range from a minor bump (bruise or laceration) on the skull to serious brain injury. Head injuries are a very common sporting injury and do occur in football from direct contact with another player, the ball, the goal posts or the ground.

All head injuries are serious even if the player appears normal and unaffected. Any injury or blow to the head is suspect. Some head injuries take time to develop and it could take several hours before symptoms develop, resulting in collapse and possible death. If you have not directly witnessed the incidence, obtain the history from another player or official at an early stage, or review video evidence if present as the player may lose consciousness or have no recollection of the injury (amnesia). Video evidence may be available for parent's videoing if the team doesn't officially record matches.

Players who have received a blow to the head, sufficient to render them unconscious but have apparently recovered, should always have a medical examination in hospital, please refer to The FA concussion guidelines.

Head injuries may be present in conscious or unconscious players.

This section will focus on how to manage head injuries in football and what advice players and carers should be given by the first aider.

The incidence of head injuries in football has been shown to increase with age and level of play. Injuries at the elite level occur four times more often than at amateur level. The majority of these injuries are minor and occur in aerial duals due to contact with another players elbow or from head to head contact.

There are two main types of head injuries that this chapter will focus on. These are structural brain injuries and concussive brain injuries. They differ in that the former is a structural brain injury that can rapidly deteriorate and become fatal. This injury usually requires neurosurgery and fortunately is extremely rare in football. The latter injury is **concussion**, which is also a **brain injury** that results in the player suffering problems related to awareness, memory and attention reflecting a functional disturbance rather than a structural injury. Injuries leading to concussion occur about two to three times more often in female football players.

Even for experienced medical staff it is difficult to distinguish between the types of head injury, which is why both should be managed with great care and in exactly the same way by the first aider.

Structural Brain Injury

A structural injury is usually a "bleed" within the head that causes pressure on the brain. This pressure results in the brain becoming starved of oxygen and due to the enclosed nature of the skull, the pressure continues to build up inside the head. This build up of pressure can lead to fatal results if not dealt with immediately by transferring the player to hospital for treatment.

If any player who has taken a knock or blow to the head and who is not fully alert and orientated for time, place and person, transfer to the hospital immediately.

Signs and Symptoms – many listed below are later signs. A bleed can occur over a matter of hours or days. Your main signs are that your player is not improving, in fact he is deteriorating.

- May complain of headaches due to the pressure in his head building up
- Continue to be confused and suffer continued memory loss
- Vomits repeatedly
- Appear drowsy and does not improve
- May have convulsions (begin to fit as his brain is starved of oxygen)
- Pupils becoming unequal (this is usually a very late sign)
- Decreasing levels of consciousness
- May have suffered prolonged loss of consciousness after the incident (>1 minute)

NB: All players who have had trauma to their heads are also regarded as having an injury to the neck as well and must be treated as such by also immobilising the neck.

Remember your ABCDE approach, assessment and management.

Concussion

Concussion can be caused by a blow to the head region. In football, this can be from contact with another player's head, knee, hip, elbow etc or contact with the pitch or contact with the football itself.

Concussion has a rapid onset of symptoms that usually last from 7 to 10 days in duration and that may or may not involve the player losing consciousness. The recovery in children and adolescents may be longer.

The FA Concussion guidelines and The FA Concussion e-learning module have been written to help and advise all those working within football how to manage a player who may have suffered a concussive event.

Please visit **https://learning.thefa.com/totara/program/index.php?categoryid=69&viewtype=program** and complete the e-learning module, this is an essential component of the 'first aid tools' for anyone caring for player welfare. To access the module you will need to log in with your FAN first which they can do here: **www.thefa.com/account/signin**

Summary Points

A concussion is an injury to the brain

While injury to the brain can be fatal, most concussions recover completely with correct management

All concussions should be regarded as potentially serious and should be managed in accordance with the appropriate guidelines

Incorrect management of concussion can lead to further injury

Anyone with any concussion symptoms following a head injury **must** be removed from playing or training

Loss of consciousness does not occur in the majority of concussions

Return to education or work must take priority over return to play

There must be no return to play on the day of any suspected concussion

A progressive exercise program that introduces an individual back to sport in a step-wise fashion is recommended after a concussion

An injury to the cervical spine (neck) may occur at the same time as a concussion and normal principles of cervical spine care should also be followed

What is concussion?

Concussion is an injury to the brain resulting in a disturbance of brain function. There are many symptoms of concussion, common ones being headache, dizziness, memory disturbance or balance problems.

What causes concussion?

Concussion can be caused by a direct blow to the head, but can also occur when a blow to another part of the body results in rapid movement of the head e.g. whiplash type injuries.

Onset of Symptoms

The symptoms of concussion typically appear immediately, but their onset may be delayed and can appear at any time after the initial injury

Loss of consciousness does not always occur in concussion (in fact it occurs in less than 10% of concussions).

A concussed player may still be standing up and may not have fallen to the ground after the injury.

Who is at risk?

Concussions can happen to players at any age.

However, **children and adolescents (18 and under)**:

- are more susceptible to brain injury
- take longer to recover
- have more significant memory and mental processing issues
- are more susceptible to rare and dangerous neurological complications, **including death caused by a single or second impact**

Studies indicate that concussion rates in **women** are higher than in men in football.

A history of **previous concussion** increases the risk of further concussions, which may also take longer to recover.

How to recognise a concussion

If any of the following signs or symptoms are present following an injury the player should be **suspected** of having a concussion and **immediately removed from play or training and must not return to play that day. The Pocket Recognition tool may be used as an aid to the pitchside assessment (see Useful Links section)**

If in doubt sit them out.

Visible clues (signs) of concussion
What you may see

Any one or more of the following visual clues can indicate a concussion:

- Dazed, blank or vacant look
- Lying motionless on ground / slow to get up
- Unsteady on feet / balance problems or falling over / poor coordination
- Loss of consciousness or responsiveness
- Confused / not aware of play or events
- Grabbing / clutching of head
- Seizure (fits)
- More emotional / irritable than normal for that person

Symptoms of concussion
What you may be told by the injured player

Presence of any one or more of the following symptoms may suggest a concussion:

- Headache
- Dizziness
- Mental clouding, confusion, or feeling slowed down
- Visual problems
- Nausea or vomiting
- Fatigue
- Drowsiness / feeling like "in a fog" / difficulty concentrating
- "Pressure in head"
- Sensitivity to light or noise

Questions to ask a player

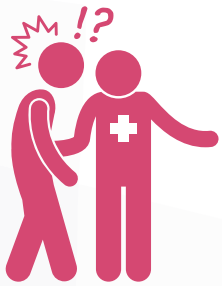
These should be tailored to the particular activity and event, but failure to answer any of the questions correctly may suggest a concussion. Examples with alternatives include:

What venue are we at today?	**Which half is it now?**	**Who scored last in this game?**	**What team did you play last game?**	**Did your team win the last game?**
or	or	or	or	or
Where are we now?	Approximately what time of day is it?	How did you get here today?	Where were you on this day last week?	What were you doing this time last week?

Video footage: If video footage of the incident is available this may be of assistance in establishing the mechanism and potential severity of the injury and can be used to contribute to the overall assessment of the player. This may be viewed by the person assessing the injured player or can be commented on by a third party, such as the tunnel doctor in an elite professional setting. A coach or parent may have video footage that could be helpful in a non-elite setting. However video evidence must not be used to contradict a medical decision to remove the player.

What to do next

Anyone with a suspected concussion MUST be IMMEDIATELY REMOVED FROM PLAY.



Once safely removed from play they must not be returned to activity that day.

Team-mates, coaches, match officials, team managers, administrators or parents who **suspect** someone may have concussion MUST do their best to ensure that they are removed from play in a safe manner.

?

If a neck injury is suspected suitable guidelines regarding the management of this type of injury at pitchside should also be followed (see useful links for pitchside injury management training)

If ANY of the following are reported then the player should be transported for urgent medical assessment at the nearest hospital emergency department:

- Severe neck pain
- Deteriorating consciousness (more drowsy)
- Increasing confusion or irritability
- Severe or increasing headache
- Repeated vomiting
- Unusual behaviour change
- Seizure (fit)
- Double vision
- Weakness or tingling/ burning in arms or legs

In **all** cases of **suspected concussion** it is recommended that the player is referred to a medical or healthcare professional for diagnosis and advice, even if the symptoms resolve.

Ongoing management

Rest the body rest the brain.

Rest is the cornerstone of concussion treatment. This involves resting the body, 'physical rest', and resting the brain, known as 'cognitive rest'. The period of rest allows symptoms to recover and in the non-professional setting allows a return to work or study prior to resuming training and playing.

Rest means avoiding:

- **Physical activities** such as running, cycling, swimming, physical work activities etc.
- **Cognitive activities (thinking activities)**, such as **school work, homework, reading, television, video games**. Students with a diagnosis of concussion may need to have allowance made for impaired cognition during recovery, such as additional time for classwork, homework and exams

Anyone with a concussion or suspected concussion should NOT:

- **be left alone** in the first 24 hours
- **consume alcohol** in the first 24 hours, and thereafter should avoid alcohol until free of all concussion symptoms
- **drive a motor vehicle** and should not return to driving until provided with medical or healthcare professional clearance or, if no medical or healthcare professional advice is available, should not drive until free of all concussion symptoms

Returning to play after a concussion

The graduated return to play (GRTP) protocol should be followed in all cases. This staged programme commences at midnight on the day of injury and stage 1 (initial rest period) is 14 days in all players unless they are in an enhanced care setting. In all cases, progression to stage 2 of the GRTP can only occur if the player has no symptoms.

Return to work and study after a concussion

At the non-professional level, adults must have returned to normal education or work and students must have returned to school or full studies before starting physical activity (stage 2) in a GRTP program.

Graduated return to play protocol

A graduated return to play (GRTP) protocol is a progressive exercise program that introduces an individual back to sport in a step-wise fashion.

Stage 2 of the GRTP protocol should only be started when a player

- is symptom-free at rest and has completed the initial rest period (14 days in a standard care setting and modified in an enhanced care setting)
- has returned to normal education or work if not a professional footballer
- is not receiving treatments and medications that may mask concussion symptoms, e.g. drugs for headaches or sleeping tablets.

The GRTP Protocol contains six distinct stages

Stage 1	Stage 2	Stage 3	Stage 4	Stage 5	Stage 6
Stage 1 is an initial rest period during which symptoms should resolve. This stage must be extended if symptoms persist	The next four stages are restricted, training based activity				Return to full training and match play

Under the GRTP Protocol, the individual can advance to the next stage **only if there are no symptoms** of concussion at rest and at the level of physical activity achieved in the current GRTP stage.

If any symptoms occur while going through the GRTP program, the individual must return to the previous stage and attempt to progress again after a minimum 24-hour period of rest without symptoms (this is 48 hours in players under 19 years of age).

It is recommended that a medical practitioner confirms recovery before an individual enters Stage 5 (full-contact practice).

The 6 stage GRTP protocol should be followed in all cases.

Further information can be found in The FA Concussion Guidelines here:
www.thefa.com/get-involved/coach/concussion

For information regarding the online FA Concussion course please visit:
learning.thefa.com/totara/program/index.php?categoryid=69&viewtype=program

Immediate management of a player suffering a concussion on the field-of-play

D	Danger	Ensuring that there are no immediate environmental dangers which may potentially injure the player or you. This may involve stopping the football match
R	Response	ResponseIs the player conscious? Can he/she talk?
A	Airway	Ensuring a clear and unobstructed airway. Removing any mouth guard or dental device which may be present (if they are not well fitting). 'A' is always done **with manual immobilisation of the neck as discussed above,** when a head injury occurs as an associated neck injury cannot be ruled out by a first aider.
B	Breathing	Ensure the player is breathing adequately and normally
C	Circulation	Ensure an adequate circulation, check players colour
D	Dysfunction	Is the player alert i.e. talking and acting normally, responding only to your voice, responding only to pain or totally unresponsive.
E	Expose/examine	Look for other injuries once the above have all be dealt with and it is safe to do so.

The major priorities at this early stage are the basic principles of first aid as you learnt in your training.

Initial on-field assessment of concussion
If the mechanism of injury leaves you with a high suspicion of a neck injury and the player is confused and unable to answer your questions, you must treat them as a neck injury and secure the head and neck as previously discussed. Remember to call an Ambulance the player will require medical attention.

If the player is unconscious, then a neck injury should be assumed until proven otherwise. Remember to open and protect the airway whilst also protecting the spine.

- Support the head and neck (manual immobilisation)
- Perform you assessment as above. Assuming A, B and C are fine then progress as follows (if there is no A, B or C then resuscitate as being resuscitation)
- Keep the player still until the ambulance arrives, do not attempt to move them (treat as for a neck injury)
- **First aiders are not qualified to diagnose or rule out a neck injury, only doctors can do so**
- The removal of helmets or other head protectors should only be performed by individuals who have been trained in this. If the player is wearing a soft helmet and it is not restricting the airway, leave it alone. If the airway is obstructed then loosen the fastening only, do not attempt to remove until qualified medical help arrives
- Keep the player warm
- Reassure them whether they are conscious or unconscious speak to them to keep them calm
- **Wait until an ambulance arrives to move the player and transport to hospital**

If the player is unconscious, a neck injury must be suspected. DO NOT MOVE THEM, keep them still until medical help arrives.

For the footballer that is conscious post head injury - the following management should be followed:

You can assume that a conscious player who is talking to you and responding to you has a clear airway, is breathing and has an adequate circulation. Continue to monitor this for signs of deterioration.

If an alert player complains of neck pain, has evidence of neck tenderness or deformity (e.g. you can feel a step in the back of his neck as you are supporting it) or has neurological signs (i.e. complains of numbness or tingling/pins and needles) suggestive of a spinal injury, this requires qualified medical personnel i.e. an ambulance to manage them with spinal immobilisation and transport to hospital. **Optimum care** is the same as you would provide for an unconscious player – keep them still, immobilise the head and neck, keep them warm, reassure them until an ambulance arrives.

However, in a conscious player, the management may involve the treatment of a disorientated, confused, uncooperative player. These are the typical symptoms of concussion and the player will not be able to control these. The immediate treatment priorities remain the basic first aid principles of 'ABC - airway, breathing and circulation'. In this situation, especially if the player is fighting your help or is uncooperative, it is unwise to try to restrain them or support the head, unless you can reassure them, have them lie down and allow you to support the head until such time as medical help arrives.

In a concussed player, it is difficult to rule out a neck injury because the player may be confused. In this instance **assume a neck injury** and transfer the player to hospital by ambulance (as advised above). If you cannot get the player to lie down then keep an eye on them to ensure they don't collapse, try to reassure them and explain what you want them to do, wait until they calm down and then have them assessed by a doctor in hospital.

For a conscious player who suffers no signs of neck pain, it is still advisable to have them checked out at the local hospital. This may not however require the use of an ambulance, unless the mechanism of injury leaves you with a high suspicion of neck injury.

Management of the head and neck is as shown above.

Assessing the Concussed Player's Progression in the First 30-Minutes After the Injury

After you have recognised the concussion and removed the player safely from the field-of-play, all symptoms and signs should gradually begin to resolve (but not go away completely) to a manageable state within 30-minutes post the incident, that is to say the player will stop vomiting or feeling as sick, will be able to make and retain new memories and stop asking you "what happened?" Although the player will still be unable to remember the incident itself or arriving at the match/training session they will remember what you have told them happened, you may have had to repeat this several times but eventually they will retain the new memory – this is a good sign that the player is improving. The player may still have a headache and show other symptoms for days to come, but at this stage the symptoms and signs are not deteriorating.

Please note concussive signs and symptoms may be delayed – a player may seem orientated and satisfactory on initial checking on the field-of-play, but several moments later may become confused or lose their balance. Continue to monitor your player **after an incident that had the potential to cause a head injury, they should be removed from the playing field.** Any player who has been concussed (received a injury to the head) should be assessed by a doctor/hospital as soon as practical.

Any player who has suffered an injury which includes any one of the symptoms described above should NOT be returned to the field-of-play on the day of injury.

Don't forget to educate your players and the coaching staff, the last person anyone wants on the field of play is the player who doesn't know where he is or what you want them to do (which is very common in concussion) regardless of the fact that you cannot distinguish it from a potential head bleed. **If in doubt, sit them out – spread the word!**

Picture 4 shows a brief concussion tool that can be kept in your first aid to assist you in remembering the information in this section.


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
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 so do
- Do not remove helmet (if present) unless trained to do so.
from McCrory et. al. Consensus Statement on Concussion in Sport. Br J Sports Med 47 (5). 2013

PIC 4 Concussion Recognition Tool
For a bigger copy or printable version see page 36

Indications for Referral Immediately to Hospital via Ambulance

Any player who has or develops any of the following:

- High risk injury mechanism (e.g. penetrating skull trauma e.g. severe stud injury from a football boot to the head, high velocity injury)
- Deterioration in conscious state following injury e.g. progressively loses consciousness
- Focal neurological signs e.g. pins and needles in the hands or feet or loss of sensation in one of the limbs
- Confusion or impairment of consciousness which lasts greater than 30 minutes e.g. does not remember anything that has been said to them and is unable to make new memories post the incident
- Loss of consciousness for more than 1 minute
- Persistent vomiting (is sick more than once) or has an increasing headache after the injury
- Any convulsive movements (the player who fits after receiving a blow on the head)
- More than one episode of concussive injury in a match or training session (should not occur as players should never be allowed back onto the field if they have suffered a concussion)
- Where there is assessment difficulty (e.g. an intoxicated player)
- All children with head injuries (below age 19years. There is evidence to show children behave differently to adults with brain trauma and have different risks and prolonged signs and symptoms)
- High risk athletes (e.g. haemophilia, anticoagulant use)
- Inadequate post injury supervision, e.g. no one to take them home and stay overnight with them to monitor them

Convulsion Management

Convulsive movements (fitting) may result from a concussion/ head injury. This is not a seizure that would occur for example in an epileptic person, but as a result of the blow to the head. Although dramatic, these clinical features are generally benign.

The player's airway remains the main priority and assisting the player to maintain their airway will ensure the convulsion (fit) is short lived. Support and protect the head and neck but do not restrain the player. Ensure that the airway is open, this may help assist with early resolution of the fitting activity. Once the convulsion has ceased, manage the player as for any other concussion i.e. manual immobilisation, reassurance and keep warm until the ambulance arrives. Transfer to hospital via ambulance is essential to be assessed by a doctor.

Usually the player will have some signs or symptoms as with any other acute concussion. In this instance, even if the player is confident that they are fine, they still require referral to a hospital.

The hospital will provide head injury advice on discharge, unless the player is admitted, which is usually the following:

- The player should return to hospital immediately if any signs or symptoms develop that were not there initially or if those present deteriorate i.e. his headache increases
- If the player vomits more than once within a few hours of each other
- If the player suffers any other signs and symptoms such as pins and needles or loss of sensation in his limbs
- If he develops severe neck or head pains
- If he becomes drowsy or very sleepy

Whilst managing any player with concussion please inform family and friends of all advice as the player may not recall what you have said at a later stage. It does require family members to observe the player for a minimum of 24-hours post head injury and usually they are the only ones who notice if a player is becoming more drowsy or sleeping more – this may require another visit to the emergency department.

Never let a player who has suffered a head injury go alone to a hospital or home alone. They must not be allowed to drive a motor vehicle even if family members are present. Please remember players who have suffered a blow to the head are by definition cognitively impaired, so in medical terms they are unable to decide for themselves the next action – be safe and refer to the local emergency department either via ambulance with associated neck injury or isolated concussion (where a player is already ambulatory and thus clearing their own neck) attended with another first aider or family member.

For all instances that require an ambulance to attend, do not move the player unless the environment has life threatening implications. Even if you are on a wet and boggy field, do not attempt to move the player to a firmer location for the ambulance crew, they will decide what is best for the extrication of the player and may even drive the ambulance directly onto the field-of-play.

The management of Concussion is the management of the "Invisible Injury" as we cannot see the actual injury only the signs and symptoms. Female footballers could be at a greater risk of sustaining a concussive injury, and therefore for those who are managing female footballers this is something to be aware of. **Return to play** has been covered in The FA concussion guidelines, please ensure you continue to regularly update yourself with The FA guidelines and any changes to the guidelines printed in this manual that The FA may release will supercede the guidance printed here.

Concussion in Children and Adolescents

Guidelines discussed above can be applied to all children down to the age of 13 years. However for safety it is advisable to be cautious with children and adolescents below the age of 19. The assessment of a child or adolescent may require the input of a parent. Children are generally at a higher risk of receiving a concussive injury because they have:

- Decreased neck muscle strength compared with adults
- Thinner skull bones compared to adults

All concussive incidents in children must likewise be referred for medical evaluation and management before return to play is allowed. Children and adolescents are slower to recover and have prolonged memory effects. Children should not be returned to practice or matches until clinically completely symptom-free, which may require a longer time frame than for adults. In addition for children you need to limit exertion with activities of daily living as well as football and other sports they may do at school or at home home, for a short time period 24-48 hours or if these activities exacerbate their symptoms.. It is also advisable to limit scholastic and other cognitive stressors (e.g. text messaging, videogames, television) while symptomatic. School attendance and activities may also need to be modified to avoid provocation of symptoms in the first day or so post injury. Return to play should not occur before return to school.

Please refer to The FA return to play guidelines in U19.

Always have appropriate medical advice and a medical decision before returning a child player back to participation. This is not a decision for a first aider to make.

Head Guards and Mouth Guards

Mouth guards have a definite role in preventing dental and orofacial injuries but neither mouth guards or soft helmet head guards have an effect on preventing concussive injuries.

The overwhelming view of international experts in sport-related head injury is that soft helmets do not prevent brain injury (as opposed to superficial head injury e.g. cuts and bruises) and there is a risk that encouraging helmet use in children and adolescents may paradoxically increase the head injury rates as children feel the head guard protects them and thus are not as careful.

For the first aid provision to other injuries that may occur to the head and neck, inclusive of eye, dental, jaw and nasal injuries please review The FA's EFAiF manual and attend the associated course.

THE ASTHMATIC FOOTBALLER

This sectionwill briefly focus on the 'other' conditions that might require first aid attention that are not a direct result of football participation but are conditions that the player may suffer from during football training or matches that could result in a catastrophic outcome.

In this section the acute (first aid) management of the most common medical conditions such as asthma and anaphylaxis will be included. Other conditions and illnesses (such as diabetes, epilepsy, heat stroke are NOT discussed, for first aid management of those please refer to The FA's EFAiF course).

It is advisable when working as a first–aider in a team environment, that every new player signing, and also at the start each season, that you ask the players to complete a questionnaire asking about their previous medical history and illnesses so that you are aware of any underlying medical conditions your players might have as well as previous injuries that they have suffered. If your players are below the age of 16, you might wish parents to complete the form.

Asthma

Asthma is an inflammatory reaction of the airways. It is a condition that is characterised by difficulty in breathing as the passages of the lungs become narrow. It can be a life threatening emergency.

Signs and symptoms of an acute asthma attack:

- Difficulty in breathing and shortness of breath.
- Wheezing on breathing out – noisy breathing as the air is forced through the narrow passageways into the lungs
- Accessory muscles may be used to breathe i.e. use of neck muscles and shoulders to try to get air into and out of the lungs
- Player may look pale, clammy, sweaty and cyanotic (blue) around lips
- The player will speak in broken sentences (inability to finish a sentence as cannot catch their breath, totally opposite to an anxious player who may be shouting for their medication)
- Player is often quiet, subdued and if the attack is severe, may become unconscious

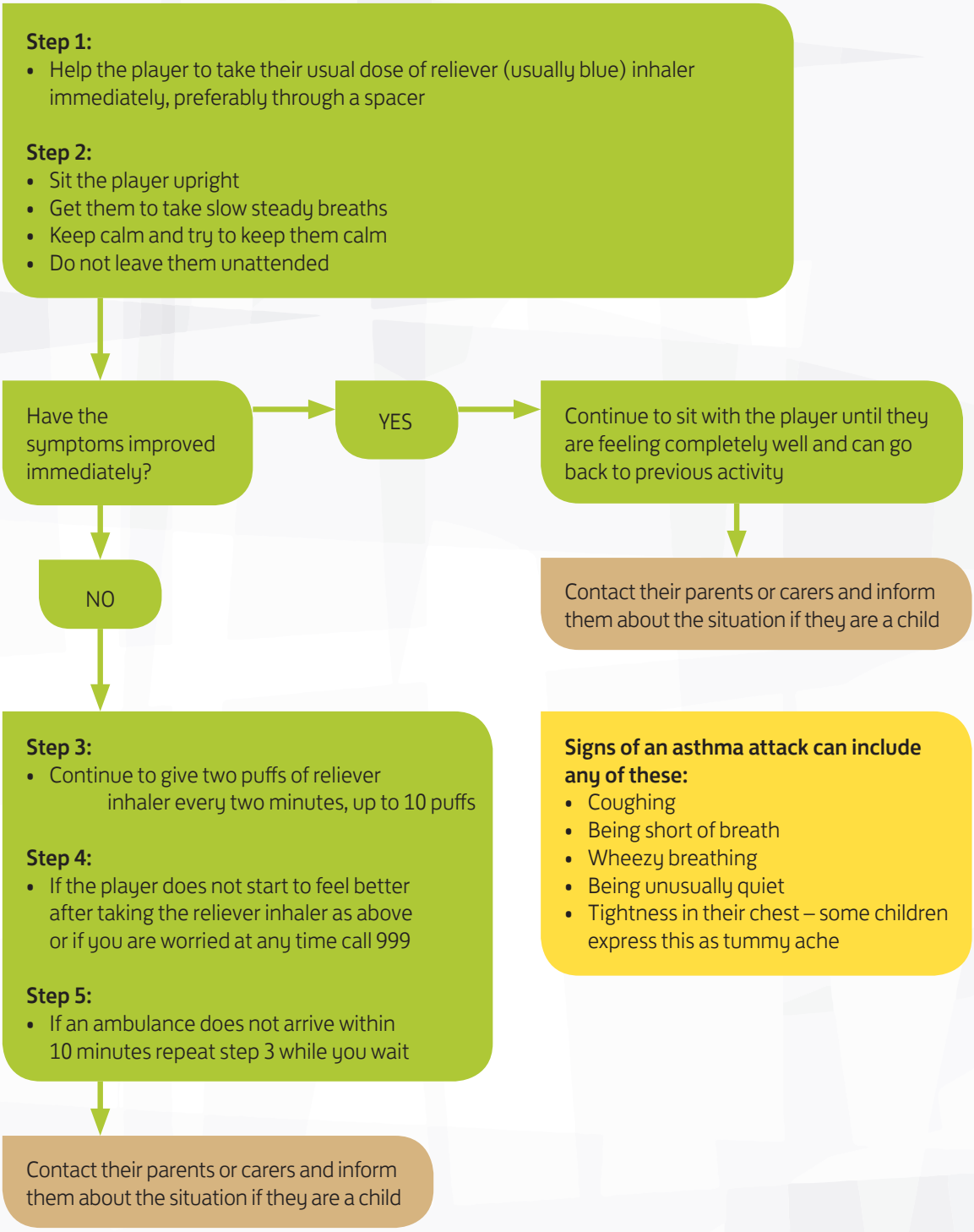
As the first aider within your team, know your players and be aware of any triggers that might affect certain players within your team. Remember asthma is a medical condition, when a player is noticeably suffering with their asthma they should not even be contemplating playing or training. Send them home with adequate supervision or if concerned send them to hospital.

Treatment

- **Always start with ABCDE**
- **The best treatment is prevention.** Check that your players understand their medical condition, what each of their prescribed medication is used for and that they carry emergency medications (usually an inhaler) always with them
- **The best prevention is the use of the medication prior to exercise for exercise induced symptoms.** Players usually have their own medication. *It is essential to know which of your players use inhalers and check the medication is at the field-of-play side if required during training or matches. Dependent on the age of the player, it may be a requirement for you to keep hold of the medication if the players are too young to self medicate (discuss this with parents and record on their player information)*
- Help to give the players their own medication if they require it urgently
    - For young players have consent at the start of the season to help them administer their medication, especially in situations where they may require help for example when they are suffering from an exacerbation of their asthma
- If your player is too short of breath to take their medication adequately a spacer device can be used. Take a 500ml plastic soft drink bottle, cut a hole in the bottom to fit the pressurised dose inhaler. The player can add his dose into the bottle by depressing the spray and then allow him/her to breath in the medication by placing their lips around the screw top ending and breathing in and out

PICS 5a and 5b Making a spacer device

How to deal with an asthma attack



- If after the first dose of medication there is no improvement, take another 'two-puffs' every 2 minutes (up to a maximum of 10 puffs) preferably with the spacer device if possible
- If possible advise them to breath slow deep steady breaths
- Reassure and calm your player
- Help the player to sit down and lean forwards – this will help free the chest and allow the player to take in deeper breaths
- Do not get the player to lay down flat – this will NOT help their breathing
- **Seek urgent medical help –** this may be calling an ambulance, especially if:
  - the player's medication does not relieve their symptoms or
  - if the player has not got their medication with them
  - Or if due to the severity of the acute asthma attack they cannot get their required medication into them

It is most important that you are aware of any players under your care who are asthmatic. Checking that they satisfactorily understand the nature of their condition, what the inhaler does and that they know to always carry a supply of their inhalers.

Any player who has an asthma attack and which is not successfully treated within 10 minutes with an inhaler must be sent to hospital for medical assessment and treatment.

Anaphylaxis

Anaphylaxis and Allergic reactions

Players who are allergic to a specific substance (allergens) will show a pattern of disease known as allergic reactions when exposed to that substance. Allergic reactions can occur immediately after exposure or sometimes even a few days later. Generally allergic reactions can be easily managed but on occasion a very serious life threatening allergic reaction can occur called Anaphylaxis. .

Anaphylaxis is characterised by rapidly developing life-threatening airway and/or breathing and/or circulation problems, associated with a rash.

Signs and symptoms of anaphylaxis

- Sudden swelling of the face, tongue, lips, eyes or neck that can quickly lead to airway compromise and total airway blockage if early treatment is not provided
- Hoarse sounding voice
- Wheezing – asthma type symptoms
- Difficulty speaking – unable to speak in sentences
- Difficulty breathing - breathlessness
- Itchiness
- Flushing/redness
- Red rashes on the skin
- Nausea and vomiting
- Diarrhoea
- Abdominal pain/cramps

Not all of these symptoms will be necessarily present at the same time.

Anaphylaxis is caused by a very broad range of substances, often peanuts, penicillin, bites and stings from insects particularly bees.

Treatment

- Anyone suffering an anaphylactic reaction requires immediate hospital treatment. A player suffering a severe allergic reaction (anaphylaxis) will present with **immediate and progressive swelling** of the lips and tongue, with tingling of lips and tongue. There may be obvious noisy breathing, increased breathing rate, audible wheeze, difficulty swallowing, unable to talk in sentences, feel light headed, clammy, sweaty and may faint or go unconscious
- Call an ambulance – this is a medical emergency
- ABCDE approach. Protect their airway and ensure it is open and clear
- Players with a breathing difficulty may prefer to sit up and lean forwards to aid their breathing
- Lie them down and elevate their legs if they begin to lose consciousness
- If the player deteriorates, you may have to provide CPR – monitor their ABC and be prepared
- If they are breathing but unconscious, lay them on their side, but sit so you can always see their face and monitor their breathing until the ambulance arrives

DISPELLING THE FIRST AID MYTHS IN FOOTBALL

Myth 1

"Every unconscious player is at risk of swallowing their tongue"

You cannot physically swallow your own tongue. In these instances due to the unconscious state of the player the tongue, like all muscles, will be in a very relaxed state, which means it relaxes back onto the back of the throat essentially blocking the passage to the airways if the player lands in a position such as onto their back or curled onto their side. All that is required to effectively manage this, is that the tongue is lifted 'away from' the back of the throat. The means of doing this is called the Jaw Thrust (as explained earlier in this document). Equally effective is the head tilt chin lift maneovre of all first aid courses that is the manoeuvre of choice where there is no risk of associated trauma (spinal injury) or where a jaw thrust is either ineffective or cannot be applied for other reasons (example broken jaw).

Where a player is unconscious due to a contact sport like football it is not advisable for the first action to be to move the player forcefully onto their side. The above paragraph describes the most sensible method of opening the airway of a player who is unconscious.

Never put your fingers into a players mouth to bring the tongue forwards.

First aid responsibility – to educate your players and their parents on the above.

Myth 2

"Every unconscious player should be placed into the recovery position"

The recovery position is not a default position of action and it is not a treatment for every unconscious player. The recovery position and its modifications have their essential uses like any other first aid intervention but unfortunately it is prone to miss-use on too many occasions where bystanders or First Aiders mean well but chose the wrong course of action.

The recovery position should be considered to be used in the following situations;

- the conscious and/or unconscious player where the player is breathing normally (rescue breathing not required) and at risk of losing their airway and it cannot be maintained by the Jaw Thrust or Head Tilt Chin Lift manoeuvres or where there is suspicion of fluid (secretions, blood or vomit) occluding the airway.
- the player is breathing normally and has to be left alone for any reason (e.g to go and get help or in a multi-casualty triage situation).

The recovery position is not the default position for every unconscious player, or every fitting player or every player who has suffered a blow to the head.

It should ONLY be used where first an assessment has taken place ensuring that the player has no blockage of their airway visible and is breathing normally, more than 10 breaths per minute. For known epileptic players who are post-ictal (lethargic and altered level of consciousness post seizure activity) it is the position of choice once ABC established.

Once the player has been positioned in the recovery position, they should be closely and permenantly monitored for any signs of deterioration and as a minimum every minute their airway checked to ensure remained open (care with position) and the breathing rate reassessed.

The recover position is not a 'for-all' treatment. It will not prevent the player from deteriorating if the cause of the unconsciousness is unrelated to the airway. It has been known that the placement into the recovery position has delayed essential interventions happening such as CPR.

Myth 3

"Every seizure/fit is an epileptic event i.e. everyone who suffers from a fitting episode is epileptic"

It is a misconception that anybody convulsing is suffering from epilepsy. There are many other causes for a player to convulse such as low blood sugar, low levels of oxygen, heat stroke, head injury/concussion or initial sign of a cardiac arrest. It is beyond the scope of this documeny to go into each in detail, please refer to The FA's EFAiF course for information.

If a player is known to have epilepsy, check with the player's doctor (if possible) and/or parents of young players prior to sanctioning participation in football. Exercise has been shown to be effective in reducing seizure frequency in diagnosed epileptics.

It is not uncommon for players to suffer from a seizure if they

- Receive a direct blow the head (called a concussive convulsion)
- Are unconscious and their airway becomes compromised. This can happen for a number of reasons, they are on their back and their tongue partially blocks their airway passages
- Are suffering from cardiac arrest

All players who suffer a seizure should be sent to hospital, via ambulance and the following management principles followed.

The management of the fitting player;

- ABCDE approach – ensure the player has an open airway (Jaw Thrust/HTCL)
- Loosen any tight clothing so as not to compromise the airway
- Check that the player is breathing normally
- Call an ambulance, advise them you have a fitting player
- If B is not present, commence BLS with AED
- If A and B are present - the player can be managed in the position you found them if you are comfortable and can manage the airway effectively
    - You can however consider turning the player into the recovery position
- Take a note of the length of the fit (time the fits duration so you can advise the ambulance crew)
- Do not restrain the player i.e. do not hold them down
- Do not attempt to place anything in the mouth, especially your fingers
- Consider the cause of the fit – it is not necessarily epilepsy especially in an undiagnosed player, consider heart conditions, unobserved head injury or an underlying medical condition

Prolonged seizures require the player to receive medication that is beyond the remit of a First Aider to carry.

Send the player to hospital by ambulance

Myth 4

"Every person that faints has low blood sugar and should eat before training."

Please be aware that healthy individuals do not faint for no apparent reason, especially healthy young men. If there is no obvious trigger, such as low blood sugar (not eaten), frightened of blood or severe pain due to an injury, then the player should be medically assessed. The player may have an underlying cardiac disorder that requires follow-up. Syncope/fainting has been shown to be early warning signs of an underlying heart problem, please do not ignore the signs.

EMERGENCY ACTION PLANNING

The EAP

All clubs should have a medical emergency action plan in place that is integral to the overall function of their club. The plan will have standard operating procedures (SOP's) or protocols for the actions to be taken to ensure an effective medical response in the event of a player, member of staff, match official or spectator being injured or becoming ill whilst on their site(s) or hired pitches.

Benefits of a Medical Emergency Action Plan (EAP) are it:

- Supports the minimum standard of care for all eventualities
  - You do not need to know the whole EAP, but ensure you know the ones relating to first aid and medical provision for the players, the team and the facility
- Facilitates a prompt organized appropriate response
  - Who does what / who goes where / etc
- Minimises any delay in commencing effective life preserving first aid (the ultimate aim of your role)
- Promotes optimal care and prevents deterioration of the player
- Organization and efficiency will have the added benefit of also relieving player and parental anxiety
- Facilitates effective teamwork
  - Reduces the stress on those involved
  - Allows a routine that can be practiced in anticipation of
- Promotes recovery of the player
- Reduces risk of potential further damage or disability
  - e.g. Manual in line stabilisation considerations for a sport like football
- Reduces the chances of errors by being prepared with personnel and equipment
  - Drills and skill practice will ensure competency is maintained
  - Equipment checking will ensure a fully stocked first aid kit and a working AED required for every session of football training or competition
- Facilitates incidence review, audit and constructive learning
  - Every incident, however minor, should be reviewed and improvements, if required, introduced immediately in preparation for future occurrences
  - EAP's are fluid and should be updated accordingly as and when necessitated
  - An example EAP form to populate see Appendix II

In essence for an EAP related to first aid, it will revolve around

- Pre- activity preparation
  - Medical EAP (MEAP) for different situations
  - Consider writing for your club if you do not have them. What would be the actions of the personnel within your club for example if a cardiac arrest occurred / what would be the actions if a player suffered a broken leg as another example
  - Expand on this with what would be your role as a first aider within the club if a member of the crowd suffered an injury or illness? Is this within your role or is this the role of someone else as your duty of care is to the team?
- The club environment
  - Access to venue / directions to venue / access to specific areas / contact details
  - Attire – are you and your helpers appropriately clothed for the environment and
  - Do you have the correct personal protective equipment for example gloves
- The grounds
  - Work with the Health and Safety Officer, are the ground/ field(s)/ pitches and facilities safe for football?
  - Ensure there are no risks to health from a collision with an advertising board or perimeter fence.
  - Ensure there are no foreign substances on the field e.g. dog excrement, cans, bottles, stones
  - Injuries have been known to happen that can be quite serious from a lack of awareness of hazards of this kind.
- The first aiders
  - How many / who is located where in the ground / who covers which event(s) / first aid updates
- Helpers
  - Trained to assist the first aiders as and when required, with regular practice – advised monthly
- Do you consider your players and coaching staff helpers? If you do – advise and educate them on why we don't want injured players moving "they should not move an injured teammate, the first person to touch the player will be the first aider. Dispel the myths of swallowing ones tongue
- First aid kit, equipment and facilities
  - Ensure fully stocked and in working order and enough kits to cover all games and training sessions necessary. Remember as a first aider there is a limit to the kit you can carry, you can only carry that which you are trained to use
  - Have a check list to ensure everyone is signing to say it has been checked and restocked

- Communication
  - Who needs to be advised at what point
  - How will this be done, radio or mobile phone
- Transport
  - Ambulance
  - Designated drivers
- Hospitals
  - Location with nearest Emergency Department – remember to have typed out for visiting times
- Record Keeping
  - Essential part of any first aider role, to document what you have done and to hand that over to the ambulance or hospital on arrival. Please refer to Appendix III

The role of the first aider involves a position of trust and confidentiality and is a large part to the commitment of that role. Player details, medical information and treatment should never be discussed with ANYONE not directly involved with their care.

Should you wish for the player's requiring parental consent to gain parental permission to apply such items as plasters and ice, then store those records with the medical records.

Accident/Incident Book
As many players at clubs, particularly junior sides, will not be employees of the club, there may be confusion over the requirement for completion of accident books. It is good practice and can provide documented evidence to the benefits of the first aider, if an accurate record of any untoward incidence or injury and treatment of is recorded at the time.

It is advisable to discuss the requirements of an Accident Book with both your club and The FA to ensure the compliance of your sport or team with any health legislation or Governing Body Byelaws and recommendations. This would be good practice.

The Medical Emergency Action Plan

Club Name:	STURMINSTER MARSHALL FOOTBALL CLUB
Club Address:	CHURCHILL CLOSE STURMINSTER MARSHALL BH21 4BQ
Postcode:	BH21 4BQ

FIRST AIDER/ HELPER INFORMATION	
Name	**Mobile Number**
CHRIS HUMPHREYS	07957 142948
ANDY FALL/JON BEST/JULIAN FLOWER	07872 601715/07955 856389/07876 193645
MIKE JAMES	07855 430940
MARTIN JOB/PAT BROWN	07795 401405/07766 056905
ERKAN METE	07771 742892

FIRST AID EQUIPMENT AND FACILITY	
Item	**Location**
Defibrillator	ENTRANCE TO MEMORIAL HALL - OUTSIDE/PHONE REQUIRED
Stretcher	N/A
First Aid Room	INSIDE MEMORIAL HALL

Access Routes:

1. For Ambulance
2. First Aid Room to Ambulance
3. Pitch to Ambulance

OTHER INFORMATION	
Nearest hospital address: (with Emergency Department) **Note:** include contact no.	POOLE HOSPITAL LONGFLEET ROAD POOLE BH15 2JB 01202 665511
Directions to hospital:	IN POOLE TOWN CENTRE ON THE WAY TO PARKSTONE
Journey time:	25 MINUTES
Nearest Walk in Centre (WIC) address:	WIMBORNE HOSPITAL VICTORIA ROAD WIMBORNE BH21 1ER MON-FRI ONLY

THE FOOTBALL SPECIFIC FIRST AID KIT, THE ROLE OF THE FIRST AIDER IN FOOTBALL AND RECORD KEEPING

An important role is PREVENTION. Prevention of harm to oneself as the first aider and prevention of further harm to the player requiring assistance.

In order to achieve this, each of the following points should be followed by the first aider in charge of training or a match:

- Ensure scene safety and provide a safe environment for players and officials
    - If responsibility is also for the crowd then that also has to be factored into safety decisions with the club safety officer
    - Remember you cannot help if you are a victim, so the first aider must ensure their own safety first
- Be present at all football events inclusive of training and matches
- Always carry a suitably stocked first aid box or have one easily accessible at all times
- Have access to clean (sealed)/sterile water (and ice)
- Have a working knowledge of the club/team Emergency Action Plan relevant to emergency care of your players. This includes:
    - Advise the local hospital emergency department of the match to be played so that they are aware of potential injuries that may come into their department during or after the match
    - Have access to a telephone (mobile or landline) for emergency calls
    - Advise the visiting team coach or first aider / medic of where you will be standing if they require first aid, and give to them details and directions of the local hospital emergency department, and the location and access to a (mobile or landline) telephone
- Keep records of all treatments administered to any player or persons
- Injury prevention pertaining to medical emergencies

Remember, that no matter how well equipped or qualified the first aider is, in serious medical emergencies the best place for the player to be treated is the nearest hospital.

Do not forget to request ambulance assistance as early as possible (call 999). If you are in a stadium where an ambulance is on standby, be sure to request for it to come to assist you.

Below is a recommended list that deals with the majority of injuries described in The FA Level 1 and 2 courses. The football clubs should be responsible for providing this first aid equipment. However it is your responsibility as a first aider, to check the contents of the first aid kit before each match or training so that you are sure that all the items of first aid equipment is in date, sterile and present. Please ensure a system is in place to record and order replenishment items as and when required.

Minimal Contents:

- Protective disposable gloves, (2 pairs minimum consider hypoallergenic)
- Rescusi Face Shield or Pocket Mask for rescue breathing
- Plasters* (various sizes, waterproof and conforming so not to restrict movement) (consideration to hypoallergenic if required)
- Sterile trauma type clean dressings (variety of sizes)
- Tape – variety of sizes (elastic and zinc oxide)
- Gauze swabs – sterile and non-sterile
- Yellow clinical waste bags or similar to dispose of soiled dressings and plasters (following local authority guidance)
- Access to ice on the day or ice packs
- Crepe bandages – individually wrapped so sterile
- Triangular bandage – individually wrapped so sterile
- Foil space blankets or preferably ambulance type blankets to keep players warm when injured
- Rescue type scissors
- Paper and Pencil/Pen and spare copies of injury report forms
- Packet of sugar or sachet full sugar jam
- Tweezers
- Sterile water pods (to clean wounds or irrigate eyes)
- Sterile eye pads or suitable dressing
- Mobile phone
- Printed directions to the nearest Emergency Department for any player (home or away) that requires transfer to hospital
- Post code and directions to your venue

This is not a fully inclusive list but a suggested minimum list, this can be added to, to suit the needs of your players and your particular environment.

** where concerns of allergies to plasters may exist, ensure player*

medical records detail allergies in full and ask players/parents before applying plasters if they are allergic to them before they are applied. Stocking hypoallergenic plasters will help.

It is **HIGHLY RECOMMENDED** that you also have access to the following equipment for a match of football

- **An Automated External Defibrillator (AED)** that is kept in a position that is accessible at all times (preferably outdoor heated cabinet) for match and training sessions for all teams within your club
- **A first aid room or space to treat players** away from direct sunlight, that is accessible with a stretcher and has a doorway that will allow for stretcher entry. Inside should be a sink with **access to hot and cold running water and/or sterile water** and a **clinical waste bin** to dispose of soiled dressings
- A stretcher or bed or trolley. If you do not have these keep the player still and warm on the field-of-play until the ambulance arrives
- A copy of this first aid manual
- Player injury record forms (player medical history must be kept inside lockable cupboard)
- A concussion recognition tool aligned to The FA Concussion Guidelines

If you have a health care professional affiliated with your club (doctor or physiotherapist) they may wish to give further advanced treatment to an injury and it may therefore be advisable to have access to other items, that they alone can use or items such as sun-tan lotions etc that you may also be able to provide with prior permission. Signed permission can be taken annually from parents for the supply or application of sun tan lotion and similar items as and when required as they update their child's health form for current conditions and medications taken/required.

As a first aider you CANNOT provide the player with medications. You may however be able to assist a player in taking their own prescribed medication for certain illnesses that can threaten life such as asthma and anaphylaxis. Whilst it is beyond the scope of the Level 1 to discuss in detail, a brief summary has been included for clarity.

Medical Consent Form

Status (Please tick) Mr ☐ Mrs ☐ Ms ☐ Other ☐

First Name:		**Surname:**	
Emergency Telephone No:		**Mobile No:**	
Email:			

Parental Consent:
In the event that my son/daughter is injured whilst playing football/travelling to and from football events and I cannot be contacted on the above number, I hereby give my consent for my child to receive medical attention.

Signed:

Print Name:

Date:

In the event that the above named person cannot be reached, please give two extra emergency contact names and numbers.

Name:	Emergency Contact Number:
Name:	**Emergency Contact Number:**

Player Injury Report Form

Date:		**Time:**	
Event:			

Injured Person's Details

First Name:			
Surname:			
Date of Birth:			
Address:			
Postcode:		**Tel Number:**	

Details of all persons involved in incident

Full Name of Person:	**Contact Number:**
1.	
2.	
3.	

Full Name of Witness:	**Contact Number:**
1.	
2.	
3.	

Incident Details

Time of Injury:		**Date:**	

Describe the Incident

Treatment Given

Details of Person Giving Treatment:	**Role of Person Giving Treatment:**

Loss of consciousness?	YES	NO
Person sent to hospital?	YES	NO
Ambulance called?	YES	NO
If Yes, which hospital?		

Name of First Aider:	
Signed (First Aider):	
Date:	

The Medical Emergency Action Plan

Club Name:	
Club Address:	
Postcode:	

FIRST AIDER/ HELPER INFORMATION	
Name	**Mobile Number**

FIRST AID EQUIPMENT AND FACILITY	
Item	**Location**
Defibrillator	
Stretcher	
First Aid Room	

Access Routes:

1. For Ambulance
2. First Aid Room to Ambulance
3. Pitch to Ambulance

OTHER INFORMATION	
Nearest hospital address: (with Emergency Department) **Note:** include contact no.	
Directions to hospital:	
Journey time:	
Nearest Walk in Centre (WIC) address:	

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

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 so do
- Do not remove helmet (if present) unless trained to do so.

from McCrory et. al, Consensus Statement on Concussion in Sport. Br J Sports Med 47 (5), 2013

Notes

Coaching
Education
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Psychology
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