EMERGENCY ACTION PLAN

STAY SAFE DON'T BE A CASAULTY.
ASSES YOUR AREA AT ALL TIMES

Club Name:	ELMDEN ROVERS YOUTH FOOTBALL CLUB
Club Address:	CROWLEY PARK RECREATION GROUND, MILL STREET, ST OSYTH,
Postcode:	CO16 8EJ What3Words ///Bombard.Streak.Sardine
Telephone:	No Land Line

FIRST AIDERS / HELPER INFORMATION	
Name	**Mobile Number**
For queries about this EAP: Chairman Mark Cox	07719020573
See relevant Football Manager for first aider on day of match	

FIRST AID EQUIPMENT AND FACILITIES	
Item	**Location**
Defibrillator	REFEREE'S ROOM. Key in Cafeteria Elmden Key Box.
Stretcher	NONE
First Aid Room	NONE

ACCESS ROUTES	
For Ambulance	See Diagram
From Pitch to Ambulance	See Diagram

OTHER INFORMATION	
Nearest A&E / Trauma Hospital:	Turner Rd, Mile End, Colchester CO4 5JL
Fastest Route to A&E / Trauma Hospital:	B1027 GT Bentley, A120, A12 Colchester Stadium, Follow Signs to Hospital 01206 747474
Distance & Journey Time:	Approximately 26 Minutes
Nearest Walk-in Centre:	Clacton Minor Injuries Unit.
Alternative Trauma Hospital:	Clacton Minor Injuries Unit. Tower Rd, Clacton-on-Sea CO15 1LH 01255 201717 X-ray facilities are available at the Minor Injuries Unit: Monday – Friday 09:00 -17:00 Weekends and Public Holidays 10:00 – 16:00
Doctors Surgery	St Osyth Surgery Church Square, St. Osyth, Clacton-on-Sea CO16 8NU 01255 820309 Not open at weekend
Pharmacy	Boots 19 Clacton Rd, St. Osyth, Clacton-on-Sea CO16 8PA 01255 820396 Not open on Sunday

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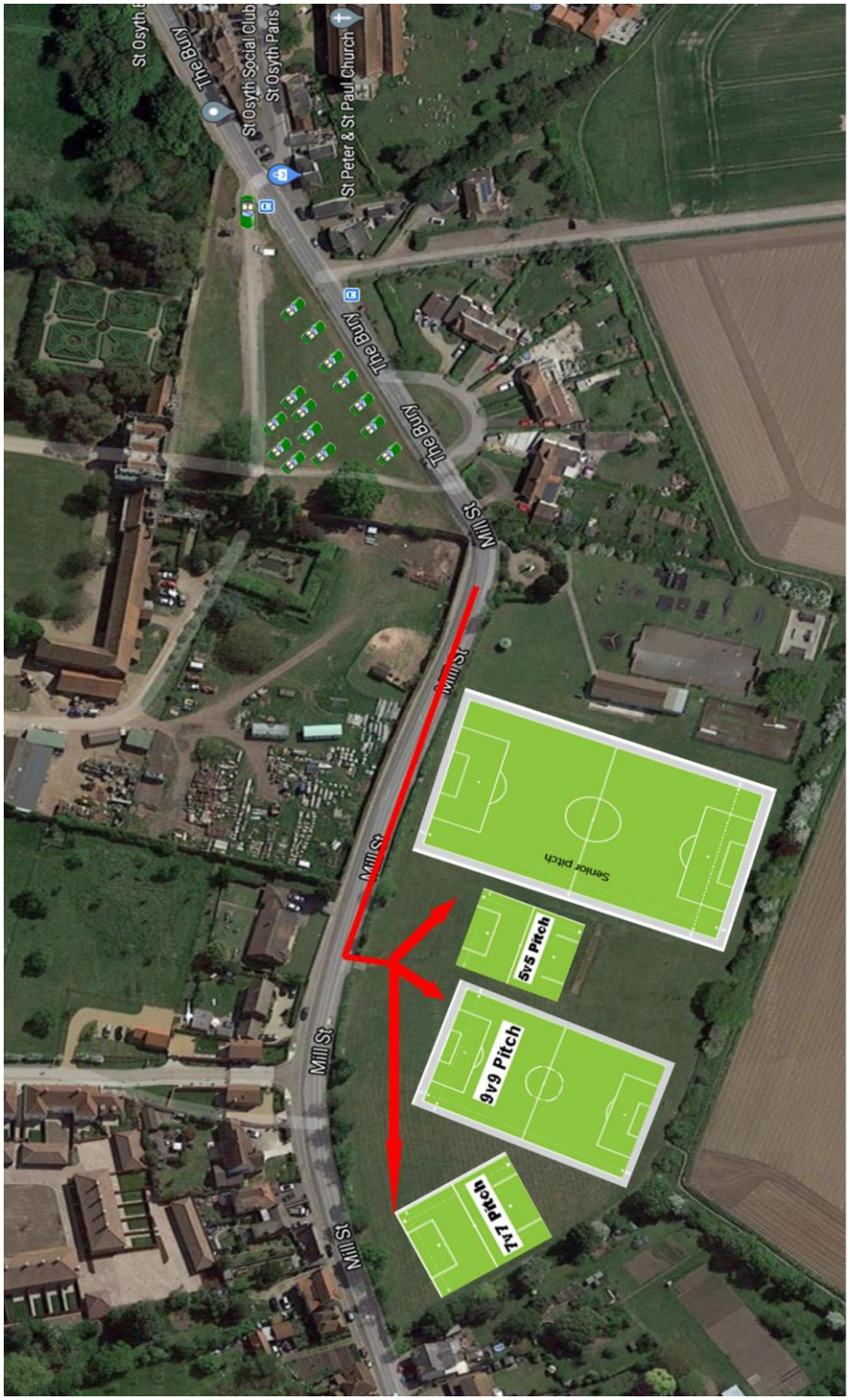
Elmden Rovers Youth FC Ambulance Emergency Access Gate key code Ambulance crew will know or Elmden Staff

Cowley Park Recreation Ground, Mill Street, St Osyth, CO16 8EJ.
Emergency Services Vehicle Access via no 3 Mill Street. What3Words ///Bombard.Streak.Sardine



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Procedure for Cardiac Arrest.

First Aider arrives on scene.

Disposable Gloves, Apron, Surgical Mask, Eye Protection.

Chest compressions are considered an aerosol generating procedure which has a higher risk of Covid-19 transmission, and so for the safety of the responders the following precautions are required: – Before commencing chest compressions a covering should be placed over the player's face, this can in the form of a hand towel or cloth. This covering should provide sufficient cover to cover the players mouth and nose whilst still permitting breathing to restart following successful resuscitation.

The responder should place their hands together in the centre of the chest and push hard and fast (a rate of 100- 120 compressions per minute, at a depth of 5-6cm of the chest width. Push down 4cm (for a baby or infant) or 5cm (a child), which is approximately one-third of the chest diameter.) Providing continuous chest compressions. – Compression-only CPR may be as effective as combined ventilation and compression in the first few minutes after cardiac arrest.

The assistant whilst moving as quickly and safely as possible to the cafeteria for the key for the refs room for the defibrillator.
Dials 999 and asks for the ambulance. Requesting immediate response due to cardiac arrest for child and give age. Use the locational directions as listed above.

If you have a second assistant calling of Ambulance should be past to them.

The Referee will be responsible for clearing the Pitch and keeping players and parents away. Parents of the child in question should be kept at reasonable distance unless they can be effective in CPR and must wear PPR same as listed above.

When your assistant returns he must put PPE on as listed above. The Defib must be deployed whilst chest compressions are still being done. Turn on DEFIB. Follow the SPEAKING directions of the DEFIB EXACTLY.
STAY SAFE DON'T BE A CASAULTY. ASSES YOUR AREA BEFORE DURING AND AFTER SHOCKING.

If the first responder is getting tired from CPR 2nd assistant takes over and First responder opens the gate for the Ambulance. The directions for the ambulance should be passed to a trusted parent who has attended the Match / training session.

If possible, swap responders providing chest compressions as often as required and at least following every AED analysis (or every two minutes in the absence of an AED) to ensure appropriate rate and depth is achieved.

Once the ambulance service arrives please hand over responsibility to the ambulance service. They will need to know the casualties details Name, Age, Home Address, Medical Conditions, Parents contact details.

After performing compression-only CPR, all rescuers should wash their hands (and face if no mask or eye protection worn) thoroughly with soap and water; alcohol-based hand gel is a convenient alternative. They should also seek advice from the NHS 111 coronavirus advice service and their club medical adviser if concerned about Covid-19 symptoms.

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IF THERE IS A COMPROMISED AIRWAY (LOSS OF CONSCIOUSNESS TONGUE OCCLUDING THE AIRWAY OR CHOKING)

A simple head tilt chin lift (in the absence of any suspected head or neck injury) or jaw thrust can be applied wearing appropriate PPE (gloves, apron, fluid-resistant face mask and goggles) after first ensuring there is nothing occluding the player's airway.

After the incident the Elmden Rovers incident_accident_form must be filled in. A copy is at the bottom of this document. Further copies can be found on the Elmden Rovers website.

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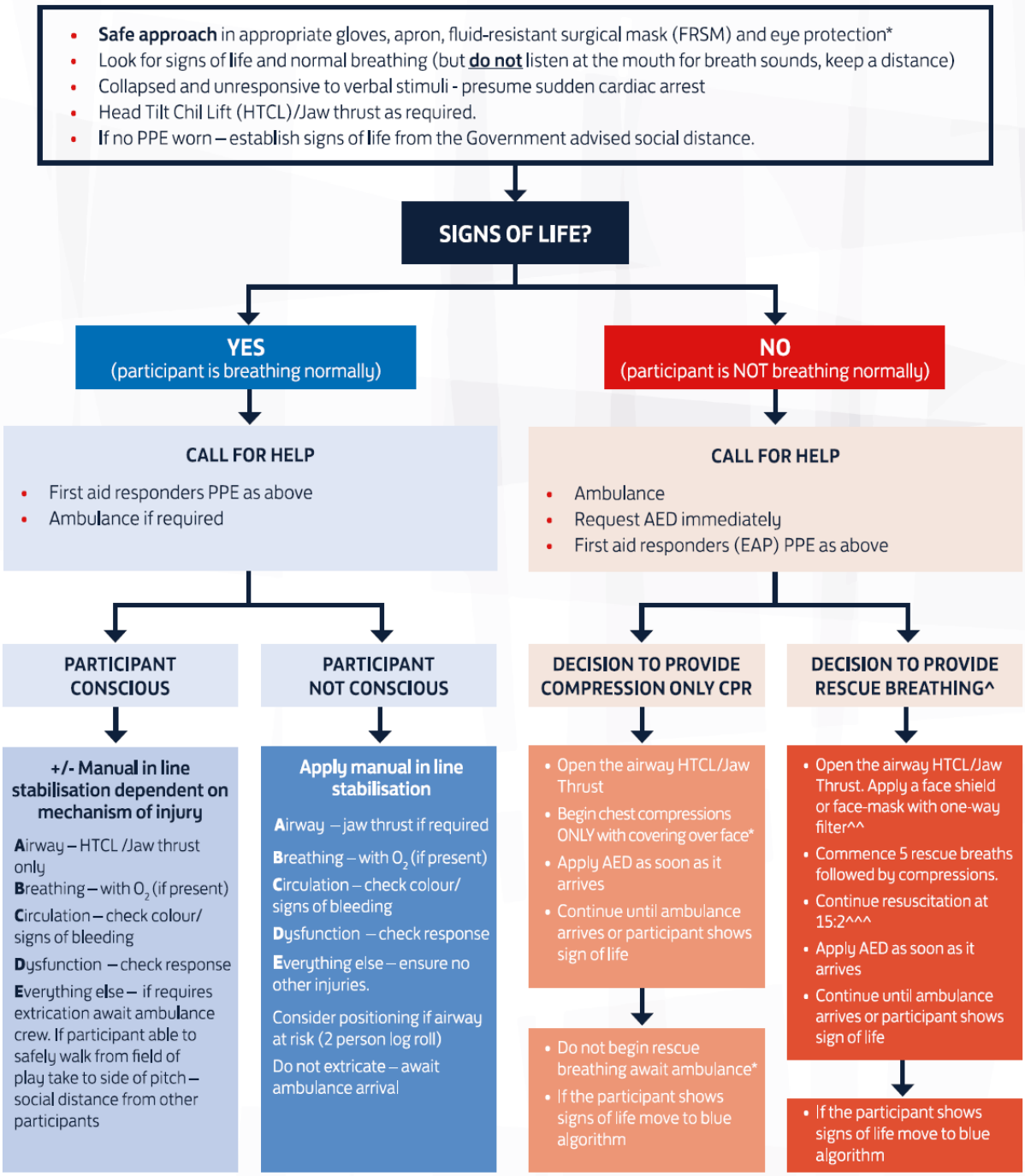
FIGURE 3: PAEDIATRIC EMERGENCY AND FIRST-AID CARE ALGORITHM FOR NON-ELITE FOOTBALL DURING COVID-19 IN ABSENCE OF LEVEL 3 PPE



** If the club has health care professionals (HCPs) on site a face covering can be a non-rebreather mask attached to oxygen at 15L/min. If suitably qualified and Level 3 PPE available rescue breathing with airway adjuncts can be commenced before ambulance arrives (elite sport framework[23]). Once airway intervention has occurred all staff in Level 2 PPE must move away 2m pitchside (or out of the room indoors), leaving only responders wearing Level 3 PPE.*

^ An individual decision to perform rescue breathing due to compression only CPR likely to be less effective if a respiratory problem is the cause in a child

^^ If rescuer is wearing a mask this will have to be removed. There are no additional actions to be taken after providing rescue breathing other than to monitor for symptoms of possible COVID-19 over the following 14 days. HCPs can use a bag valve mask with a viral filter.

^^^ The paediatric ratio of 15:2 (15 compressions to 2 rescue breaths) can be provided or if more familiar with the adult provision of 30:2 this can be equally applied. The emphasis is on the speedy provision of resuscitation. Breath provision is one second as per an adult and depress the chest 4-5cm in a younger child/adolescent.

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Procedure for Concussion or Head Injury.
IF IN DOUBT SIT THEM OUT.

The following guidance is intended to provide information on how to recognise concussion and on how concussion should be managed from the time of injury through to safe return to football.
At all levels in football, if a player is suspected of having a concussion, they must be immediately removed from the pitch, whether in training or match play.

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?
or
Where are we now?

Who scored last in this game?
or
How did you get here today?

Which half is it now?
or
Approximately what time of day is it?

Which half is it now?
or
Approximately what time of day is it?

Did your team win the last game?
or
What were you doing this time last week?

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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.

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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 Doctor or Health Care Practitioner confirms recovery before an individual enters Stage 5 (full-contact practice).

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

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Graduated return to play protocol

Stages 2-5 take a minimum of 24 hours in adults, 48 hours in those aged 19 and under.

	Stage 1 Initial rest period **14 days** *modified in enhanced care setting*	Stage 2 Light exercise	Stage 3 Football-specific exercise	Stage 4 Non-contact training	Stage 5 Full contact practice	Stage 6 Return to play
EXERCISE ALLOWED	• Complete body and brain rest. After the initial period of 24-48hrs rest, the player should gradually reintroduce their normal activities of daily living provided this does not lead to a worsening of their symptoms. If the symptoms do return the player should rest again until symptom free	• Walking, light jogging, swimming, stationary cycling or equivalent • No football, resistance training, weight lifting, jumping or hard running	• Simple movement activities e.g. running drills • Limit body and head movement • NO head impact activities including NO heading	• Progression to more complex training activities with increased intensity, coordination and attention e.g. passing, change of direction, shooting, small-sided game • May start resistance training • NO head impact activities including NO heading - goalkeeping activities should avoid diving and any risk of the head being hit by a ball	• Normal training activities e.g. tackling, heading, diving saves	• Player rehabilitated
% MAX HEART RATE	• No training	<70%	<80%	<90%		
DURATION (MIN)		<15	<45	<60		
OBJECTIVE	• Recovery • No symptoms at the end of 2 weeks	• Increase heart rate	• Add movement	• Exercise, coordination and skills/tactics	• Restore confidence and assess functional skills by coaching staff	• Return to play

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Standard Return to Play Pathway

The minimum time in which a player can return to play in the standard care setting is summarised in the table below. Each day comprises a 24-hour period. The pathway begins at midnight on the day of injury.

	Stage 1 Initial rest period			Stage 2 Light exercise	Stage 3 Football-specific exercise	Stage 4 Non-contact training		Stage 5 Full-contact practice	Stage 6 Return to play
ADULT	14 days beginning at midnight on the day of injury. The player must be symptom-free at the end of this period before progressing	Return to academic studies or work	Clearance by doctor recommended	Minimum duration **24 hours**	Minimum duration **24 hours**	Minimum duration **24 hours**	Clearance by doctor/health care professional	Minimum duration **24 hours**	**Day 19** Earliest return to play
				4 days if symptom-free					
UNDER 19	14 days beginning at midnight on the day of injury. The player must be symptom-free at the end of this period before progressing			Minimum duration **48 hours**	Minimum duration **48 hours**	Minimum duration **48 hours**	Clearance by doctor/health care professional	Minimum duration **48 hours**	**Day 23** Earliest return to play
				8 days if symptom-free					

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

It is recognised that players will often want to return to play as soon as possible following a concussion. Players, coaches, management, parents and teachers must exercise caution to:

a. Ensure that all symptoms have resolved before commencing GRTP
b. Ensure that the GRTP protocol is followed
c. Ensure that the advice of medical practitioners and other healthcare professionals is strictly adhered to

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

If symptoms recur the player must consult a healthcare practitioner as soon as possible as they may need a referral to a specialist in concussion management.

How are recurrent or multiple concussions managed?

Any player with a second concussion within 12 months, a history of multiple concussions, players with unusual presentations or prolonged recovery should be assessed and managed by a healthcare provider with experience in sports-related concussions working within a multidisciplinary team.

Outcomes in concussion are better if the injured player is well informed and understands what has happened. Measures to improve understanding and deal with emotional problems and anxiety should also be considered in the management of concussed players.

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Graduated return to play protocol

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