



GRAND TRAVERSE HOCKEY ASSOCIATION

SAFETY PROGRAM OVERVIEW

GTHA is committed to maintaining a safe environment for all players, coaches, and referees. One of the things that GTHA will emphasize is concussion awareness. Concussions are difficult to spot, and signs/symptoms change by the hour and from day-to-day. The goal of our concussion safety program is that no child skates while concussed and that parents are armed with as much information as possible. We follow and supplement the USA Hockey Concussion Management Plan. Here are the basics:

Baseline- King-Devick Test

Each player will be required to undergo a pre-season baseline test known as the King-Devick Test. King-Devick is a timed reading of flip cards, which takes about 5 minutes at the rink and is administered by team volunteers called Injury Liaisons.

Injury Liaisons or "ILs"

Every team has at least one designated Injury Liaison ("IL") or safety person, who is a volunteer. The ILs job is to assist coaches with player safety throughout the season.

Pull from Play

The IL will watch for potential injuries during games and be available to the bench if coach suspects injury. The IL will administer the King-Devick Test and compare the results against the player's baseline time as well as run through a standard checklist of concussion signs/symptoms with the player. If a player shows delay/errors of the King-Devick baseline or shows signs/symptoms of concussion, the IL will recommend pull from play as a precaution.

Coaches are **required** to pull players for the day if they are injured on the ice and cannot then achieve their preseason King-Devick baseline time.

ILs do not diagnose concussions -- they only recommend pull from play. The guiding principle is: "WHEN IN DOUBT, SIT THEM OUT." ILs also will assist players with non-head injuries.

Return to Play

If a player has been pulled from play, it is the responsibility of the parent/guardian to take that player for full medical evaluation by a medical professional experienced in concussions before returning to play.

For any player who has been diagnosed with a concussion, written medical clearance for full contact play is **required** for that player to return to practices or games. All other players return at the discretion of their parents. Bringing your child to a practice or game means you think s/he is 100% ready for full contact play. Coaches will remove players from play if there is any concern that a player is injured.



GRAND TRAVERSE HOCKEY ASSOCIATION-- INJURY POUICY

Effective September 2018

HEAD INJURIES

GTHA follows the USA Hockey 2017 Concussion Management Program, which is attached. The Program contains the following instructions for players with any symptoms or signs of concussion, disorientation, impaired memory, concentration, balance or recall:

WHEN IN DOUBT, SIT THEM OUT

- Remove immediately from play (training, practice or game)
- Inform the player's parents
- Refer the athlete to a qualified health-care professional
- Medical clearance is required

GTHA supplements the USA Hockey Program, as follows:

- Injury Liaison ("IL") for each team -- assists coaches in detecting and assessing potential concussions. ILs are parent volunteers.
- Use of King-Devick test and CDC concussion checklists by coaches and ILs to look for concussion signs/symptoms, which are utilized in locations appropriate to the situation
- Concussion information and resources available at Safety Info tab of GTHA website

Parents/guardians must understand that assessments of injured players by GTHA coaches, ILs or other parents using CDC checklists and/or the King-Devick test are **not** the equivalent of a medical diagnosis. Rather, these tools are used only to determine if a player should be pulled from the ice and taken by his/her parents for a thorough medical evaluation. If a player is pulled *off* the ice for a suspected concussion, it is the responsibility of the parent/guardian to get proper medical evaluation of the player and to obtain written medical clearance to return that player to the game. In addition, parents/ guardians should always be on the lookout for signs/symptoms of concussion in their own child throughout the season, regardless of whether their player was pulled from the ice. Symptoms of concussion are hard to detect and can develop over time. **Parents/Guardians must not rely solely on sideline evaluations of their child during a practice or game.**



2017 Concussion Management Program

Michael Stuart MD
Alan Ashare MD
Kevin Margarucci ATC

The standard of care for current medical practice and the law in most states requires that any athlete with a suspected Sports Related Concussion (SRC) is immediately removed from play.

- A Sports Related Concussion is a traumatic brain injury- **there is no such thing as a minor brain injury**.
- A player does not have to be “knocked-out” to have an SRC- **less than 10% of players actually lose consciousness**.
- An SRC can result from a blow to head, neck **or body**.
- SRCs often occur to players who don’t have or just released the puck, from open-ice hits, unanticipated hits and illegal collisions.
- The **youth** hockey player’s brain is **more susceptible** to SRC.
- In addition, the SRC in a young athlete may be **harder** to diagnosis, takes **longer** to recover, is **more likely** to have a recurrence, which can be associated with serious long-term effects.
- The strongest predictor of slower recovery from a concussion is the severity of a person’s **initial symptoms in the first day or 2** after the injury.
- Treatment is individualized, and it is impossible to predict when the athlete will be allowed to return to play- **there is no standard timetable**.
- Baseline or pre-season **neuropsychological testing** is not mandatory but may be helpful for return-to-plan decision making when an athlete feels normal.

- The use of helmet-based or other **sensor systems** to diagnose or assess SRC cannot be supported at this time.

A player with **any symptoms/signs** or a **worrisome mechanism of injury** has an SRC until proven otherwise:

“When in doubt, sit them out”

Remember these steps:

1. Remove immediately from play (training, practice or game)
2. Inform the player's coach/parents
3. Refer the athlete to a qualified health-care professional
4. Initial treatment requires physical and cognitive rest
5. The athlete begins a graded exertion and schoolwork protocol.
6. Medical clearance is required for return to play

Diagnosis

Players, coaches, officials, parents and health care providers should be able to recognize the symptoms and signs of a sport related concussion. (refer to the attached ***Concussion Recognition Tool 5***)

Symptoms

- Headache
- Nausea
- Poor balance
- Dizziness
- Double vision
- Blurred vision
- Poor concentration
- Impaired memory
- Light Sensitivity
- Noise Sensitivity
- Sluggish
- Foggy
- Groggy
- Confusion

Signs

- Appears dazed or stunned
- Confused about assignment
- Moves clumsily
- Answers slowly
- Behavior or personality changes
- Unsure of score or opponent
- Can't recall events after the injury
- Can't recall events before the injury

Management Protocol

1. If the player is unresponsive- call for help & dial 911
2. If the athlete is *not breathing*: start CPR
 - ✓ DO NOT move the athlete
 - ✓ DO NOT remove the helmet
 - ✓ DO NOT rush the evaluation
3. Assume a neck injury *until proven otherwise*
 - ✓ DO NOT have the athlete sit up or skate off until you have determined:
 - no neck pains
 - no pain, numbness or tingling
 - no midline neck tenderness
 - normal muscle strength
 - normal sensation to light touch
4. If the athlete is conscious & responsive without symptoms or signs of a neck injury...
 - help the player off the ice to the locker room
 - perform an evaluation
 - do not leave them alone
5. Evaluate the player in the locker room: **SCAT5** or other sideline assessment tools
 - Ask about concussion **symptoms** (How do you feel?)
 - Examine for **signs**
 - Verify **orientation** (What day is it? What is the score?, Who are we playing?)
 - Check **immediate memory** (Repeat a list of 5 words)
 - Test **concentration** (List the months in reverse order)
 - Test **balance** (have the players stand on both legs, one leg and one foot in front of the other with their eyes closed for 20 seconds)
 - Check **delayed recall** (repeat the previous 5 words after 5-10 minutes)

→ If a healthcare provider is not available, the player should be safely removed from practice or play and urgent referral to a physician arranged.
6. A player with any symptoms or signs, disorientation, impaired memory, concentration, balance or recall has an SRC and should not be allowed to return to play on the day of injury.

7. The player should not be left alone after the injury, and serial monitoring for deterioration is essential over the initial few hours after injury. If any of the signs or symptoms listed below develop or worsen: go to the **hospital emergency department** or dial **911**.

- Severe throbbing headache
- Dizziness or loss of coordination
- Ringing in the ears (tinnitus)
- Blurred or double vision
- Unequal pupil size
- No pupil reaction to light
- Nausea and/or vomiting
- Slurred speech
- Convulsions or tremors
- Sleepiness or grogginess
- Clear fluid running from the nose and/or ears
- Numbness or paralysis (partial or complete)
- Difficulty in being aroused

8. An athlete who is *symptomatic* after a concussion initially requires **physical** and **cognitive rest**.

- A concussed athlete **should not** participate in physical activity, return to school, play video games or text message if he or she is having symptoms at rest.
- Concussion symptoms & signs *evolve over time*- the severity of the injury and estimated time to return to play are unpredictable.

9. A qualified health care provider guides the athlete through **Graduated Return-to-School** and **Graduated Return-to-Sport** strategies

Graduated Return-to-Sport Strategy

Stage	Aim	Activity	Goal of each step
1	Symptom-limited activity	Daily activities that do not provoke symptoms	Gradual reintroduction of work/school activities
2	Light aerobic exercise	Walking or stationary cycling at slow to medium pace. No resistance training	Increase heart rate
3	Sport-specific exercise	Running or skating drills. No head impact activities	Add movement
4	Non-contact training drills	Harder training drills, e.g., passing drills. May start progressive resistance training	Exercise, coordination and increased thinking
5	Full contact practice	Following medical clearance, participate in normal training activities	Restore confidence and assess functional skills by coaching staff
6	Return to sport	Normal game play	

- After a brief period of rest (24–48 hours after injury), patients can be encouraged to become gradually and progressively more active as long as these activities do not bring on or worsen their symptoms.
- There should be at least 24 hours (or longer) for each step of the progression. If any symptoms worsen during exercise, the athlete should go back to the previous step.
- Resistance training should be added only in the later stages (stage 3 or 4 at the earliest).

Graduated Return-to-School Strategy

Stage	Aim	Activity	Goal of each step
1	Daily activities at home that do not give the child symptoms	Typical activities of the child during the day as long as they do not increase symptoms (eg, reading, texting, screen time). Start with 5–15 min at a time and gradually build up	Gradual return to typical activities
2	School activities	Homework, reading or other cognitive activities outside of the classroom	Increase tolerance to cognitive work
3	Return to school part-time	Gradual introduction of schoolwork. May need to start with a partial school day or with increased breaks during the day	Increase academic activities
4	Return to school full time	Gradually progress school activities until a full day can be tolerated	Return to full academic activities and catch up on missed work

