ReachUp Ultimate Inc.

CONCUSSION POLICY

JANUARY 2017

Approvals/Amendments

- ***Approved January 30th, 2017***

1.1. Introduction

ReachUp Ultimate is a non-profit organization that encourages the sport of ultimate to inspire healthy and active lifestyles, confidence, sportmanship and fun for girls and boys in under-resourced communities.
We recognize that we have a fundamental duty of care towards children and we acknowledge our responsibility to keep children safe while engaged in our programs and activities.
We oppose all forms of abuse (including physical, sexual, emotional, and intentional neglect), discrimination, exploitation, and manipulation of children.
Everyone who participates in ReachUp Ultimate activities is entitled to do so in an enjoyable and safe environment. ReachUp is committed to following procedures that aim to protect its child participants.

A child is defined as any person under the age of 18 (UN Convention on Rights of a Child)

1.2. Background on Concussions in Ultimate

Please Note – These guidelines have been prepared for general informational purposes only. They are not intended to and do not constitute any medical advice and do not contain any medical diagnoses, symptom assessments or medical opinions.

Concussions in Ultimate are something that we all need to be aware of and take steps to avoid but at the same time understand so that we can identify and treat them if they occur.

We all have a role to play in ensuring the safety of those participating in physical activity and for encouraging and motivating participants to assume responsibility for their own safety and the safety of others. Concussions from sport-related injuries can have significant impacts on the health and well-being individuals.

It's important to be aware of the signs and symptoms of concussions and knowledge of how to properly manage a concussion, which is critical for recovery. Additionally, helping ensure the individual is not returning to physical activities too soon and risking further complications is an important step in concussion management. This has generally been referred to as "Return to Play". The risks of returning to activities requiring concentration (such as physical activity) too soon include worsening and

return of symptoms or delayed recovery. In very rare cases, early return to play has been reported to be a contributor to Second Impact Syndrome, a potentially fatal condition whereby a person who is not symptom-free is concussed a second time and experiences rapid swelling in the tissues of the brain.
It is important to acknowledge that a concussion is a clinical diagnosis made by an appropriately trained healthcare practitioner. It is critical that someone with a suspected concussion be examined by a trained practitioner. Examples of appropriately trained healthcare practitioners include medical doctors, nurse practitioners, and chiropractors. This list of healthcare practitioners may not be exhaustive but it is important that the healthcare provider has appropriate training and experience in the diagnosis and management of concussions.

1.3 Concussions Recognition

For the purposes of this guideline, the definition of a concussion is that same as the Consensus statement on concussion in sport, from the 4th International Conference on Concussion in Sport held in Zurich, November 2012:

> "Concussion is a brain injury and is defined as a complex pathophysiological process affecting the brain, induced by biomechanical forces"

The nature of a concussive head injury may include:

1. Concussion may be caused either by a direct blow to the head, face, neck or elsewhere on the body with an ‘‘impulsive’ force transmitted to the head. It is important to recognise that a concussion can occur without a blow directly to the head but that the force transmitted to the head is what is required to elicit concussive symptoms.

2. Concussion typically results in the rapid onset of short-lived symptoms that resolve spontaneously. Symptoms may be:
    - Physical (e.g., headache, dizziness)
    - Cognitive (e.g., difficulty concentrating or remembering)
    - Emotional/behavioural (e.g., depression, irritability)
    - Related to sleep (e.g., drowsiness, difficulty falling asleep)

    However, in some cases, symptoms and signs may evolve over a number of minutes to hours. This may make concussive symptoms difficult to recognize initially on-field or during a sideline evaluation. Evaluation of an injured player should raise suspicion of a concussion if the mechanisms of injury are

consistent with this type of injury despite a lack of immediate symptoms. Careful monitoring may be necessary with these athletes.

3. Concussion may result in changes to the brain and nervous system that are not always seen as a structural disturbance on standard clinical imaging. As a result, monitoring of symptoms and functional disturbances remains of utmost importance. Concussions are unlikely to be seen using x-rays, C/T scans or MRI images.

4. Concussion results in a graded set of clinical symptoms that may or may not involve loss of consciousness. In fact, most concussions do not involve a loss of consciousness.

1.4 Common Signs and Symptoms of a Concussion

Following a blow to the head, face or neck, or a blow to the body that transmits a force to the head, a concussion should be suspected in the presence of any one or more of the following signs or symptoms:

<u>Possible Signs Observed</u>

A sign is something that will be observed by another person (e.g., parent/guardian, teacher, coach, supervisor, peer)

Physical

- Vomiting
- Slurred speech
- Slowed reaction time
- Poor coordination or balance
- Blank stare/glassy-eyed/dazed or vacant look
- Decreased playing ability
- Loss of consciousness or lack of responsiveness
- Lying motionless on the ground or slow to get up
- Amnesia
- Seizure or convulsion
- Grabbing or clutching of head

Cognitive

- Difficulty concentrating

- Easily distracted
- General confusion
- Cannot remember things that happened before and after the injury
- Does not know time, date, place, class, type of activity in which he/she was participating
- Slowed reaction time (e.g., answering questions or following directions)

Emotional/Behavioural

- Strange or inappropriate emotions (e.g., laughing, crying, getting angry easily)

Sleep Disturbance

- Drowsiness
- Insomnia

<u>Possible Symptoms Reported</u>

A symptom is something the athlete will feel/report.

Physical

- Headache
- Pressure in head
- Neck pain
- Feeling off/not right
- Ringing in the ears
- Seeing double or blurry/loss of vision
- Seeing stars, flashing lights
- Pain at physical site of injury
- Nausea/stomach ache/pain
- Balance problems or dizziness
- Fatigue or feeling tired
- Sensitivity to light or noise

Cognitive

- Difficulty concentrating or remembering
- Slowed down, fatigue or low energy
- Dazed or in a fog

Emotional/Behavioural

- Irritable, sad, more emotional than usual
- Nervous, anxious, depressed

Sleep Disturbance

- Drowsy
- Sleeping more/less than usual
- Difficulty falling asleep

Additional information to remember:

- Signs/symptoms can appear right after the injury, or may appear within hours or days of the injury.
- The signs/symptoms may be different for everyone.
- An individual may be reluctant to report symptoms because of a fear that they will be removed from the activity, or their status on a team or in a game could be jeopardized.
- It may be difficult for younger children (under the age of 10) and those with special needs or where English/French is not their first language to communicate how they are feeling.
- Signs for younger children (under the age of 10) may not be as obvious as in older children/adults.

1.5 What to do Following a Suspected Concussion

If there is a loss of consciousness, progressive worsening or severe signs or symptoms

- Follow standard emergency first aid procedures.
- 911 or emergency paramedical services should be contacted immediately.
- Assume that the athlete is in an unstable condition.
- Assume that the athlete has also sustained a head/neck injury— Do not attempt to move the athlete or remove articles of clothing/equipment unless specifically trained to do so or there is a threat to the athlete's further safety e.g. an obstructed airway.
- If applicable, ensure the athlete's legal guardian/parent is aware that an injury where a concussion is suspected has taken place and that the athlete is being assessed/transported by emergency services.
- Monitor and document signs and symptoms including physical, emotional or cognitive changes.
- Even if consciousness is regained, paramedical services should be contacted and the athlete should be considered to be in an unstable condition.

Regardless of whether there is a loss of consciousness or not, it is important for those who are suspected of having sustained a concussion to be assessed by a healthcare provider who is appropriately trained to evaluate and manage concussions.
If there is no loss of consciousness, the athlete should be removed from play immediately.

A player who is suspected of sustaining a concussion should never be allowed to return to play until an adequately trained healthcare provider assesses their ability to return to play. If it is uncertain whether a player has sustained a concussion, it should be assumed that they have and the player should be adequately assessed. “When in doubt, sit them out.”

- Remove the player from activity immediately.
- Even in the absence of signs or symptoms, a concussion should be suspected if the mechanism of injury (see concussion recognition) is consistent with a concussion. Remember that signs and symptoms of a concussion can occur hours to days following a concussion injury.
- Do not administer medication unless the player’s condition requires it (e.g. insulin for diabetics).
- Contact the player’s emergency contact/parent/guardian and inform them that the player needs to be assessed by an adequately trained healthcare practitioner.
- Stay with the injured player until an emergency contact/parent/guardian arrives.
- Monitor and document all physical, emotional or cognitive changes.
- If applicable, ensure a parent/guardian is aware that they must inform the coach, administrator or supervisor of the player’s condition (concussed or not concussed) before returning to play (see return to play).

<u>Responsibility of Coach, Administrator and/or Supervisor</u>

If a participant has been identified as having a suspected concussion, it is the responsibility of coach, administrator and/or supervisor of that activity to notify all affected parties including the participant, a parent/guardian (when appropriate) as well as other coaches, administrators and/or supervisors of the suspected concussion. At this point the individual should not participate in any physical activity until he/she has visited a healthcare practitioner. Additionally, parents/guardians should contact the school principal of a child/youth under 18 to inform them that the child/youth is suspected of having a concussion.

1.6 Return to Play

The decision of when an athlete should return to play following a concussion is one that should be made in consultation with a healthcare professional. While most concussions resolve, it has been generally accepted that early return to play may put athletes at an increased risk of further injury or may delay healing effects.

While specific rehabilitation methods and goals are outside the scope of this document, it is helpful for coaches, trainers, parents and athletes to understand that an athlete's return to play should be gradual and follow a stepwise progression. The Return to Play (RTP) protocol has been adapted from the Consensus statement on concussion in sport: the 4th International Conference on Concussion in Sport held in Zurich, November 2012.

A typical RTP process will be made up of 6 steps. There must be a minimum of 24 hours before each step is assessed although this could be considerably longer than 24 hours.

Oversight should be provided by a healthcare professional. The athlete spends, at the minimum, 24 hours at each stage.

The 6 steps are as follows:

1. No activity, complete rest. Once the athlete is asymptomatic, they proceed to level two.
2. Light aerobic exercise such as walking or stationary cycling, no resistance training. Performing step two without symptoms allows the athlete to proceed to level three. If symptoms return, the athlete moves back one stage then continues.
3. Sport specific training (e.g. running and jumping in ultimate), progressive addition of resistance training at steps three or four. Performing step three without symptoms allows the athlete to proceed to level four.
4. Non-contact training drills. Performing step four without symptoms allows the athlete to proceed to level five.
5. Full contact training after medical clearance. Performing step five without symptoms allows the athlete to proceed to level six.
6. Game play.

An important concept to recognize is that if any post-concussive symptoms recur at any stage, the athlete should drop back to the previous asymptomatic level of activity and try to progress after a further 24hrs of rest has occurred. Full return to play should only be commenced once there is complete symptom resolution at the end of this graduated stepwise progression.

"Difficult" or "persistent" cases are reported to occur in 10-15% of reported concussions. Such cases are described as those lasting greater than 10 days. Athletes showing signs or symptoms of a concussion longer than 10 days should not return to play and should contact an appropriate healthcare provider.

Additional Resources

- Ontario Ministry of Tourism, Culture and Sport – Concussion Guidelines
- Sport 4 Ontario – Concussions
- Ontario Ministry of Health and Long-term Care – Concussions
- Ontario Physical Education Safety Guidelines – Concussion Protocols and Tools
- Concussion Awareness Training Tool
- Parachute Canada Concussion Toolkit
- Play Safe Initiative (Sunnybrook Health Center)
- Ontario Neurotrauma Foundation – Guidelines for concussion/mTBI & persistent symptoms:second edition
- CDC Heads Up Training Program for Coaches
- Concussion clinics

References

1. Reynolds, K. 2006. Injuries from Ultimate Frisbee. Wisconsin Medical Journal. 106 (6); 46-49.
2. Swedler, D. 2015. Incidence and descriptive epidemiology of injuries to college ultimate players. Journal of Athletic Training. 50(4); 419-425.
3. Yen, L. 2010 The Ultimate Frisbee Injury Study: The 2007 Ultimate Players Association College Championships. Clinical Journal of Sports Medicine. 20(4); 300-305.