

OREGON SOCCER CLUB

Emergency Action Plan (EAP)

An Emergency Action Plan (EAP) is a written set of systems and processes that are followed if a serious health or environmental condition occurs.

1. Notify the head coach immediately
2. Stop the game and begin assessment of player
 - a. Conscious or unconscious
Unconscious players should be considered to have a life-threatening condition. Check and establish airway, breathing, circulation (ABC)
3. Serious Injury
 - a. In the event of a serious injury, have a coach or a parent call 911 for emergency assistance. Caller should relay the following: 1) location, 2) type of emergency, 3) suspected injury, 4) present condition 5) current assistance being given.
 - b. Ask if there is a doctor or medical personnel on the field
 - c. Designate a parent to direct emergency service to the player. Do not move the player.
 - d. Contact the player's parent or guardian if on the field
 - e. If unable to do so, reference the Medical/Contact information for contact information, pre-existing injuries, allergies, date of birth, hospital preference
4. Minor Injury
 - a. If injury is minor, relocate to the sideline when the player is able to do so
 - b. Use the team first aid kit and treat to the level of training.
 - c. Contact the player's parent or guardian if available.
 - d. If not on the field, reference the Medical/Contact information for the parents contact information or at a minimum speak with the parent or guardian to inform them of the injury and discuss care before leaving the field.



RECOGNIZE TO RECOVER

ASSESSMENT & MANAGEMENT OF CONCUSSION IN SOCCER

CONCUSSION IDENTIFICATION

Outside of injury reported by the athlete or another individual, apparent signs from a potentially concussed athlete are listed below⁹. Even without overt signs of concussion, any athlete with a suspected injury should be removed from participation and evaluated by a medical provider with training and experience caring for concussions. The apparent signs of concussion may include, but are not limited to:

**Lying motionless on the playing surface
Motor incoordination including (but not limited to): balance and/or gait difficulties, stumbling, slow or labored movements**

Disorientation or confusion, or an inability to respond appropriately to questions

Blank or vacant look

Facial injury after head contact



CONCUSSION IDENTIFICATION

Identifying athletes with concussion or suspected of having a concussion is one of the greatest challenges faced by medical providers. Once considered a hallmark of the injury, loss of consciousness occurs in only 5% or fewer of injuries³. Other clinical signs and symptoms associated with concussion may not develop for minutes to hours after injury⁶. In addition, clinical signs may be difficult to detect and symptoms may not be disclosed by an athlete who desires to continue to play or is unaware they are concussed^{7,8}. As such, medical providers must be vigilant in their observation of athletes under their care, both on and off the field, and during and after events.

Nonetheless, concussive injuries often do not manifest overt signs, making it impossible for even the most diligent medical provider to identify all concussed athletes. Athletes, teammates, coaches, and officials, therefore, have an obligation to report concussions in a manner that is consistent with the “#TTPledge.” Concern expressed by other players and/or officials about an athlete should trigger an immediate medical response.

I TOOK THE PLEDGE.

CONCUSSION AWARENESS WEEK



RECOGNIZE TO RECOVER



THINKTAYLOR



RECOGNIZE TO RECOVER

ASSESSMENT & MANAGEMENT OF CONCUSSION IN SOCCER

CONCUSSION ASSESSMENT DURING TRAINING OR MATCH PLAY

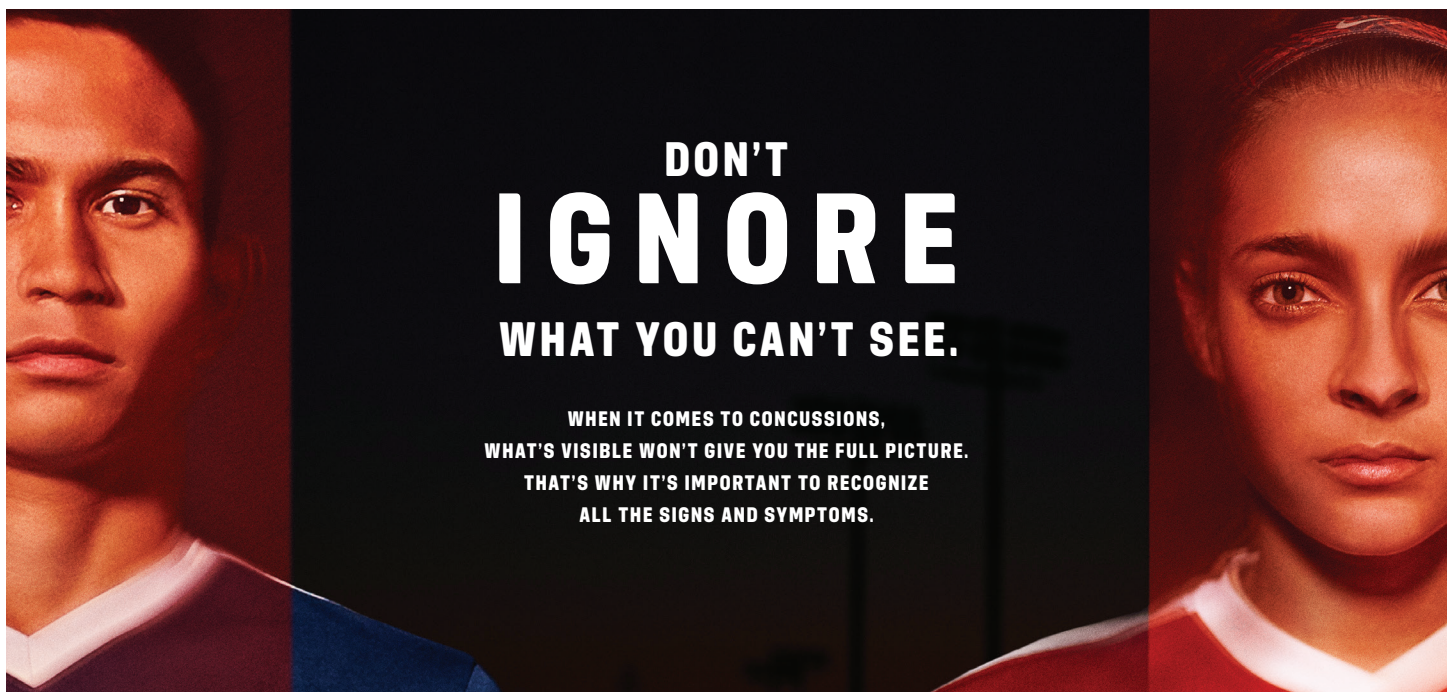
At the highest level of sport, a qualified medical provider (e.g., athletic trainer or physician) should be present at all conditioning sessions, practices and games. This individual is essential to not only the identification and management of concussion, but other orthopedic and general sports medical management conditions. It is recognized that support with personnel of this nature is highly dependent on resources, precluding their presence at all levels of participation.

Once removed from participation, the medical provider should initially screen for conditions requiring emergency intervention. The medical provider should consider activating the emergency action plan (EAP) and EMS transportation if any of the following, or other signs and symptoms of a life-threatening condition, are present:

Neck pain at rest or that limits range of motion	Double vision	Weakness or tingling/burning in the arms or legs	Severe or worsening headache	Seizure or convulsion
Loss of consciousness	Deteriorating state of consciousness	Vomiting	Increasingly restless, agitated or combative behavior	Glasgow Coma Scale less than 13

In the event of the above conditions, transportation by personal vehicle should only be used as an absolute last resort when EMS services (or equivalent) are not available.

Following removal from play and an evaluation to exclude life threatening injuries, the medical provider should evaluate the athlete for concussion.



CONCUSSION RECOGNITION TOOL 5[®]

To help identify concussion in children, adolescents and adults



RECOGNISE & REMOVE

Head impacts can be associated with serious and potentially fatal brain injuries. The Concussion Recognition Tool 5 (CRT5) is to be used for the identification of suspected concussion. It is not designed to diagnose concussion.

STEP 1: RED FLAGS – CALL AN AMBULANCE

If there is concern after an injury including whether ANY of the following signs are observed or complaints are reported then the player should be safely and immediately removed from play/game/activity. If no licensed healthcare professional is available, call an ambulance for urgent medical assessment:

- Neck pain or tenderness
- Double vision
- Weakness or tingling/ burning in arms or legs
- Severe or increasing headache
- Seizure or convulsion
- Loss of consciousness
- Deteriorating conscious state
- Vomiting
- Increasingly restless, agitated or combative

- Remember:**
- In all cases, the basic principles of first aid (danger, response, airway, breathing, circulation) should be followed.
 - Assessment for a spinal cord injury is critical.
 - Do not attempt to move the player (other than required for airway support) unless trained to do so.
 - Do not remove a helmet or any other equipment unless trained to do so safely.

If there are no Red Flags, identification of possible concussion should proceed to the following steps:

STEP 2: OBSERVABLE SIGNS

Visual clues that suggest possible concussion include:

- Lying motionless on the playing surface
- Slow to get up after a direct or indirect hit to the head
- Disorientation or confusion, or an inability to respond appropriately to questions
- Blank or vacant look
- Balance, gait difficulties, motor incoordination, stumbling, slow laboured movements
- Facial injury after head trauma

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STEP 3: SYMPTOMS

- Headache
- "Pressure in head"
- Balance problems
- Nausea or vomiting
- Drowsiness
- Dizziness
- Blurred vision
- Sensitivity to light
- Sensitivity to noise
- Fatigue or low energy
- "Don't feel right"
- More emotional
- More Irritable
- Sadness
- Nervous or anxious
- Neck Pain
- Difficulty concentrating
- Difficulty remembering
- Feeling slowed down
- Feeling like "in a fog"

STEP 4: MEMORY ASSESSMENT

(IN ATHLETES OLDER THAN 12 YEARS)

- Failure to answer any of these questions (modified appropriately for each sport) 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?"

Athletes with suspected concussion should:

- Not be left alone initially (at least for the first 1-2 hours).
- Not drink alcohol.
- Not use recreational/ prescription drugs.
- Not be sent home by themselves. They need to be with a responsible adult.
- Not drive a motor vehicle until cleared to do so by a healthcare professional.

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ANY ATHLETE WITH A SUSPECTED CONCUSSION SHOULD BE IMMEDIATELY REMOVED FROM PRACTICE OR PLAY AND SHOULD NOT RETURN TO ACTIVITY UNTIL ASSESSED MEDICALLY, EVEN IF THE SYMPTOMS RESOLVE

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RECOGNIZE TO RECOVER

US SOCCER ATHLETE COLLAPSE GUIDELINES

Non-contact collapse of an athlete, coach, referee or bystander is presumed to be sudden cardiac arrest.

While not common, an immediate and appropriate on-site response with bystander intervention is critical for a potential positive outcome. As part of your emergency action plan (EAP) “hands only CPR” with the use of an (AED) should be incorporated as part of your program. All staff and players should be educated and trained on this skill with access to an automated external defibrillator or AED either on site or within a rapid response by local emergency personnel.

STEP 1 IDENTIFY COLLAPSED INDIVIDUAL

STEP 2 CALL FOR HELP AND CALL 911,
SEND FOR AN AED

STEP 3 START CHEST COMPRESSIONS 100X
A MINUTE IN THE CENTER OF THE
CHEST “PUSH HARD AND FAST”

STEP 4 CONTINUE COMPRESSIONS AND PLACE
PADS OF THE AED (WHEN ARRIVES) AS
SHOWN BY THE DEVICE

STEP 5 THE AED WILL GUIDE YOU (BY VOICE) IF
A SHOCK IS NEEDED OR IF YOU NEED TO
CONTINUE COMPRESSIONS

STEP 6 IF NO AED IS AVAILABLE, CONTINUE
COMPRESSIONS AND SWITCH IF YOU
BECOME TIRED UNTIL EMERGENCY
PERSONNEL ARRIVE

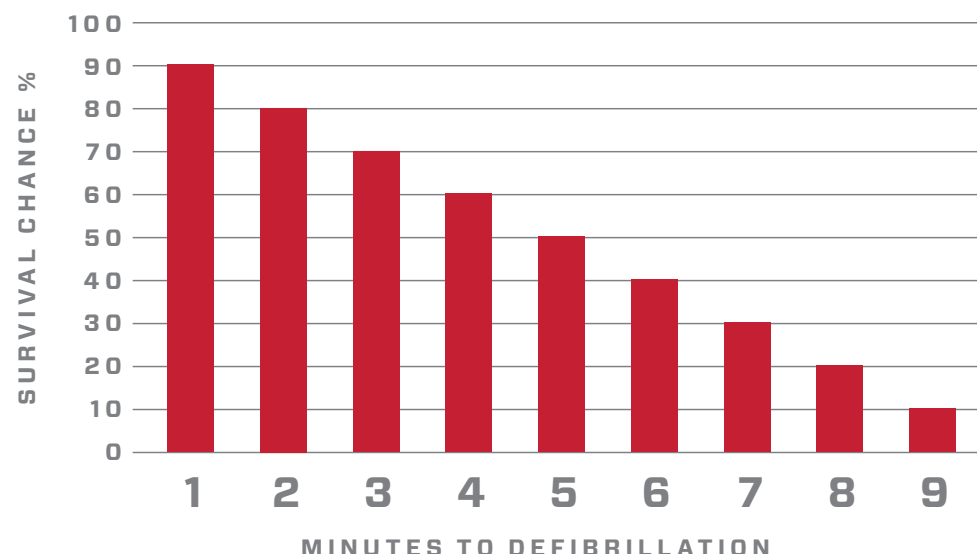
EQUIPMENT

Consider having an **Automated External Defibrillator** or AED on-site. Identify location at the fields for ease of access with sign highlighting the device. If no AED is available, assure Emergency Medical Services (EMS) locally can respond in a rapid response.



BASIC CARDIAC ARREST/AED STEPS**STEP 1 CALL 9-1-1****STEP 2 DO HANDS-ONLY CPR (CHEST COMPRESSIONS)**

- Push hard and fast on the chest
- 100 times per minute, 2 inches deep
- The 9-1-1 dispatchers can remind you how to do it if you don't know how

STEP 3 FIND AND USE AN AED (SEND SOMEONE TO FIND ONE)**CHANCE OF SURVIVAL FROM CARDIAC ARREST****TRADITIONAL CPR VS. HANDS-ONLY CPR****TRADITIONAL CPR**

1. Gently shake victim to check if conscious
2. Do mouth-to-mouth ventilations
3. Do chest compressions
4. Alternate cycles of mouth-to-mouth ventilations and chest compressions

Hard to remember, perform, teach, requires mouth-to-mouth contact and is useful for victims younger than 12 years old and drowning

HANDS-ONLY CPR

1. CHECK if victim is conscious
2. CALL 9-1-1 if not conscious
3. COMPRESS – Do Hands-Only CPR
4. NO mouth-to-mouth ventilation is needed

Easy to remember, perform, teach, does NOT require mouth-to-mouth contact and is useful for adults and non-drowning victims

AUTOMATED EXTERNAL DEFIBRILLATOR (AED)**An AED**

- Restarts the heart with a shock
- Talks to you! And tells you what to do
- Will not deliver an unnecessary shock
- If used correctly, it can save a life
- SAFE and EASY to use

How to use an AED:

1. Open the AED unit
2. Turn the AED unit ON
3. Listen to the voice prompts
4. Take out the Pads
5. Peel the pads off the lining
6. Place the pads on the patient's base skin exactly as shown on each pad
7. Follow the voice instructions

**AED TRAINING RECOMMENDATIONS**

- Implement a CPR and AED educational training program in your club
- Consider annual training for 10 years old and older
- Show or send the training video to all of the players and coaches
- Follow your state laws on AED requirements
- Consider having an on-site AED that is visible and accessible at all times
- Create a culture of safety around cardiac health

BREATHING DIFFICULTY

Asthma is the most common breathing problem that occurs with exercise. Another common, although lesser known, cause of shortness of breath experienced by athletes is exercise-induced laryngeal obstruction (EILO).

Asthma is a breathing problem defined by airway obstruction within the lungs caused by a combination of:

1. Inflammation (irritation and swelling) of the lining of the airways
2. Bronchospasm (tightening of the muscles that surround the airways)
3. Mucus production

The deep, rapid breathing that normally occurs during vigorous exercise leads to inhaling cooler, drier air, which can trigger bronchospasm in affected individuals.

EILO is a respiratory disease characterized by airway obstruction in the throat. Throat obstruction occurs due to the inappropriate, partial closure of the vocal cords and nearby structures during high-intensity exercise. EILO was previously known as vocal cord dysfunction (VCD).

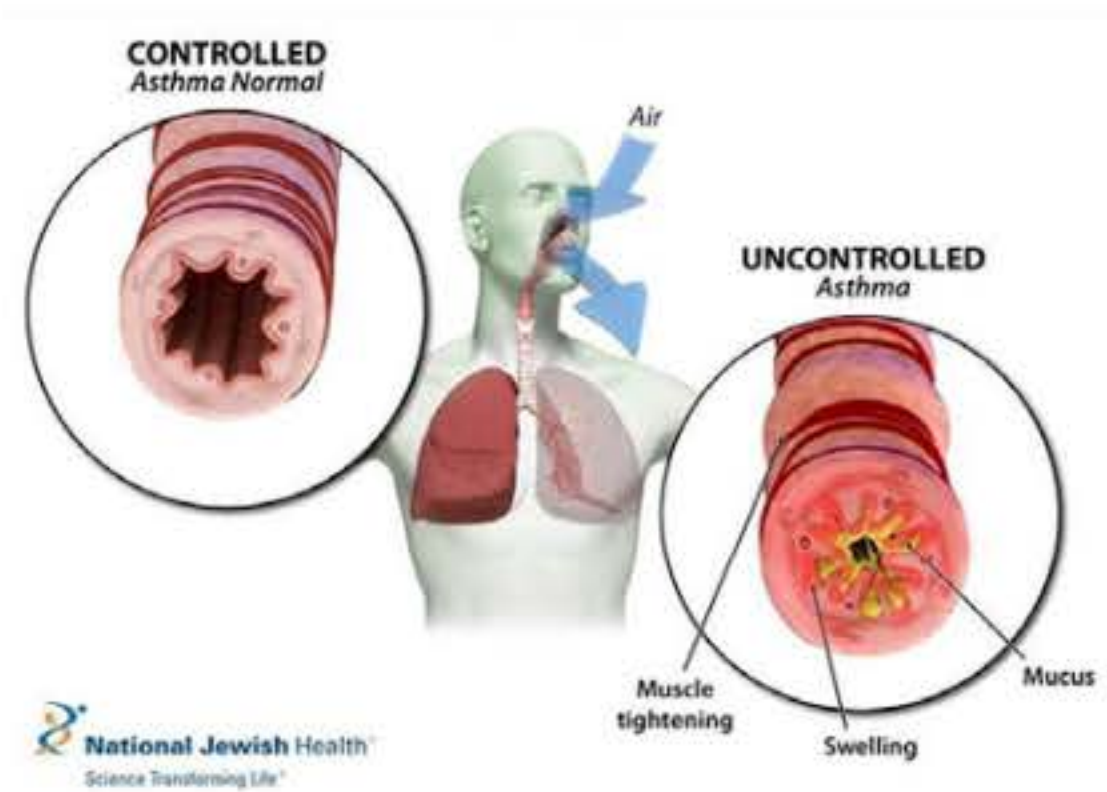
ASTHMA

RECOGNIZE

- Asthma affects more than 300 million people globally and roughly 10% of the youth population.
- There is an uneven distribution of asthma morbidity across race and ethnicity with slightly higher rates in African-American and Hispanic populations.
- Most people with asthma experience symptoms during exercise.
- Most people with exercise-induced asthma have the disease which is present outside of exercise as well.
- For most athletes with asthma, signs of a problem may not be obvious to observers.
- Athletes with mild acute asthma symptoms may experience coughing, chest tightness, shortness of breath, and wheezing.
- Athletes with more severe limitation from asthma may experience fast breathing, difficulty breathing or speaking, retractions, and cyanosis (turning blue). These are often referred to as signs of respiratory distress.

RECOVER

- Athletes or adults should administer a quick-relief bronchodilator medication such as albuterol.
- Most inhalers should be administered with a spacer device, unless otherwise specified by the inhaler instructions, to optimize medication delivery to the lungs.
- If there is no reduction in symptoms despite appropriate use of a quick-relief medication, or if signs of respiratory distress are observed, adults should refer the athlete for immediate medical attention or call 911.
- For the vast majority of athletes with asthma, baseline and exercise-induced symptoms should be well controlled with medication(s). If this does not seem to be the case, coaches, trainers, and parents should encourage further evaluation by a medical provider for optimization of therapy and consideration of other diagnoses that present with similar symptoms.



EXERCISE-INDUCED LARYNGEAL OBSTRUCTION (EILO)

RECOGNIZE

- EILO most commonly occurs in motivated, competitive, high-achieving athletes in their teens or 20s.
- EILO is often confused with asthma because the two respiratory diseases share similar symptoms. EILO symptoms and signs are typically more obvious to observers than asthma symptoms and signs.
- Common symptoms of EILO include: severe shortness of breath that is "scary" to the athlete and obvious/concerning to observers.
- The athlete with EILO may feel like he/she is "breathing through a straw" with symptoms of hyperventilation (fast breathing, pallor, dizziness, lightheadedness, nausea, numbness/tingling).
- Observers may hear stridor (a high-pitched gasping sound when the athlete inhales).
- Asthma medications do not help EILO.

RECOVER

- Athletes should perform controlled breathing and relaxation exercises (if known) to abort the symptoms without notable intervention from others.
- Coaches, trainers, parents, and teammates should be cognizant that drawing excessive attention to the problem can actually worsen symptoms.
- Athletes who present with these symptoms but are not receiving treatment specifically for EILO should consider seeking further evaluation.
- Athletes, parents, coaches and trainers should be aware that excellent control of this condition can be achieved with respiratory retraining therapy, typically directed by a speech pathologist and/or a pulmonologist with expertise in EILO evaluation and treatment.