FIRST AID STANDARDS

INDEX

Disclaimer

The RFL has taken every care to ensure that the content of this booklet is current and correct at the time of going to print and it has been produced in good faith. However the RFL cannot guarantee its correctness and completeness and no responsibility is taken for any errors or omissions.

The information provided in this booklet has been provided to assist those with responsibility for running clubs and providing first aid cover and related medical issues in the Rugby League Community Game, in doing so it, by necessity, touches on Health & Safety and Risk Assessment but is not intended to be a guide to either of these topics. The final section of this booklet gives information about how to find out more about the areas of Health & Safety and Risk Assessment.

NB The term FA&/orEFA is used throughout this document when the information is relevant to both First Aiders and Emergency First Aiders. Where information is specific to either a First Aider or an Emergency First Aider the title is written in full.

1 RESPONSIBILITY FOR FIRST AID IN COMMUNITY CLUBS

Rugby League is a high speed contact sport in which it is inevitable that players will occasionally be injured. All those involved in the game have a legal duty of care to ensure that appropriate health & safety and first aid cover is available for protection of players. In addition a club has certain legal obligations to volunteers and if it allows the public access to its premises there are wider obligations to ensure their safety. The Community Game First Aid Standards focus solely on First Aid for playing, training and related matters.

1.1 What is "Duty of Care"?

"The duty which rests upon an individual or organisation to ensure that all reasonable steps are taken to ensure the safety of any person involved in any activity for which that individual or organisation is responsible"

1.2 What are the Club's Responsibilities?

The Club (or other body) who runs clubs or organise matches which in practice usually means the Management Committee, is responsible for ensuring that it:

- Completes a risk assessment to determine the appropriate level of first aid provision
- Draws up an Emergency Action Plan
- Ensures that any FA&/orEFAs are appropriately trained and keep up to date with refresher courses as recommended by the qualification body
- Ensures that RFL policies relating to injuries are followed
- Makes sure that recording and reporting of incidents takes place
- Ensures that suitable first aid facilities and equipment are available
- Makes sure that FA&/orEFAs, coaches and other volunteers comply with its risk assessment, Emergency Action Plan and RFL policies

1.3 What are the Volunteers' Responsibilities?

Volunteers have a responsibility to:

- Follow their club's risk assessment, Emergency Action Plan and procedures
- Follow the relevant RFL policies
- Be aware of their own Duty of Care to players and other volunteers

2 RISK ASSESSMENT & RISK MANAGEMENT

Clubs and other bodies who run clubs or organise matches have responsibilities with respect to health and first aid as follows:

2.1 Risk Assessment

During any activity, the number and type of first aid personnel and facilities should be based on a risk assessment. This process is no different from other risk assessments carried out for Health and Safety purposes. Guidance on this is provided in Appendix 1.

In assessing the need, the club/organiser should consider the following:

- Playing and non-playing hazards and risks.
- The club's history of injuries and accidents, including any relevant research.
- The number of people involved (players and spectators).
- The needs of players at away matches
- The nature (adult/child) and distribution of the players (size of site or more than one site).
- The remoteness of the site from emergency medical services.
- Use of shared facilities and first aid resources
- Holiday and other absences of first aid trained personnel.
- Additional requirements for special groups i.e. children, disabled players.

2.2 Risk Management

Once the risk assessment is complete and the level of first aid cover has been decided additional risk management measures should be considered:

- A person (or group of people) with appropriate qualifications (preferably a First Aider rather than an Emergency First Aiders) to take day to day responsibility for First Aid
- Write an Emergency Action Plan
- Emergency procedures should be developed as part of the Emergency Action Plan and be readily available (for further guidance on emergency procedures visit Appendix 1.
- Emergency services contact details must be readily available;
- Ambulance access to the pitch/training ground must be maintained at all times.
- Establish contacts with the local NHS Ambulance Trust and Hospital Emergency Department. Maintain a good of level of communication with them on the club's activities, especially festivals.
- Appropriate first aid facilities and equipment based on their risk assessment and level of training of personnel.
- Regular training of personnel in assisting FA&/orEFAs should be carried out.
- First aid equipment must be appropriately, stored, maintained, and cleaned.

2.3 First Aid Emergency Action Plan

Clubs will now be in a position to draw up a First Aid Emergency Action Plan (EAP) (see Appendix 2 for a template)

All Rugby League clubs should have a clearly documented plan that outlines the actions and processes that need to be fulfilled in an emergency situation for home and away matches and on training nights.

Having simple, safe and systematic approach to an incident could make a tremendous difference to the outcome of an emergency at a home or away event.

Once an EAP has been created it must be communicated to coaches, FA&/orEFAs and any other relevant volunteers.

Creating & Implementing an EAP:

1 Decide who is going to take responsibility for the EAP, its creation, implementation and review. A First Aider(s) with a First Aid at Work (three day course)or equivalent qualification would be the usual choice.

2 Ensure a system is in place for ensuring that FA&/orEFAs have relevant qualifications and a system to record these qualifications, keep a track of expiry dates and make sure that refresher training is undertaken.

3 The responsible person needs to make sure they are familiar with the club's risk assessments, the main ground and any other areas used for matches and/or training.

4 Prepare notices to be displayed on noticeboards (particularly in the dressing room area), given to volunteers, visiting teams and FA&/orEFAs and stored in first aid kits. These should have all appropriate emergency information on them. An example of an EAP is shown in Appendix 2.

3 FIRST AID PROVISION

3.1 FIRST AID & EMERGENCY ACTION TEAM RESPONSIBILITIES CHECKLIST

The following is a sample list of the Emergency Action Team's responsibilities. Clubs will of course amend this to reflect their own risk assessments and EAP.

- Creating and maintaining the necessary emergency communication documents
- Making sure all FA&/orEFAs understand their responsibilities and are aware of how the club wishes them to behave on match days
- Maintaining the accident book and looking after completed accident reports
- Distributing the Emergency Communication document to visiting teams
- Requesting the same information from visiting teams before playing away matches allocating a room for first aid treatment on match days
- Undertaking periodic checks of first aid kits to ensure they are fully stocked & that all contents are within their expiry date
- Ensuring sufficient numbers of qualified FA&/orEFAs are on duty on training days, home matches and away matches
- Having a timetable making sure that the FA&/orEFA role is always allocated
- Defining the roles and responsibilities of the FA&/orEFA and make sure that they have the full support of the club for decisions that they choose to make.
- Making sure that all FA&/orEFAs:

    - have attended a relevant first aid training course
    - are familiar with the RFL First Aid Standards including Concussion Rules
    - are familiar with the contents of the first aid kits
    - have their first aid kit with them at all times that they are acting as a FA&/orEFA and have checked that it is fully stocked
    - understand what actions need to be completed after an incident has taken place
    - understand the RFL First Aid Standards with particular emphasis on the Concussion Rules
    - can administer appropriate treatments to ill or injured casualties both on-pitch and off-pitch
    - understand that they have the authority to stop play if they deem it necessary
    - wear a tabard to clearly identify themselves as the FA&/orEFA
    - introduce themselves to visiting teams as the duty FA&/orEFA and make sure that their contact number is entered into the necessary persons phone
    - have the postcode and directions to the club ground and any other pitches which are used
    - will provide details of local hospitals and directions if necessary
    - will provide names and contact details of key club officials if necessary

3.2 LEVEL OF FIRST AID PROVISION

The level of First Aid provision at each club and event should be determined by the Risk Assessment process as set out above.

However as a minimum the RFL states that each club should have:

- An Emergency FA&/orEFA qualified to Rugby League First Aid Level 3 (or equivalent) on duty at every game;

and the RFL recommends that each club should have a Mental Health First Aider (see Section 8.7)

FA&/orEFAs should be appropriately trained persons and a list of all qualified FA&/orEFAs should be displayed and registered on LeagueNet.

3.3 DIFFERENT LEVELS OF FIRST AID COVER

First Aid falls into three main categories: First Aiders, Allied Health Care Professional and Health Care Professionals and Emergency First Aiders holding a valid qualification.

3.3.1 First Aiders

First Aiders - Role Description

A First Aider holds a current First Aid certificate from a recognised awarding body (see below). A First Aider may be the person who writes the club's Emergency Action Plan.

First Aiders - Relevant Courses

HSE Three Day First Aid at Work (or equivalent) & the RFL Concussion Course

3.3.2 Emergency First Aider

Emergency First Aider - Role Description

An Emergency First Aider will have been trained to:

- Take charge when someone is injured or ill, including calling an ambulance if required;
- Provide emergency first aid to the injured or ill person until more expert help arrives;
- Understand and apply the RFL Concussion Rules;
- Look after the first aid equipment, e.g. restocking the first aid box

Emergency First Aiders should not attempt to give first aid for which they have not been trained. Every team should have an Emergency First Aider to help any injured or ill player until more expert help arrives. The Emergency First Aider should be close to the pitch during the match.

Emergency First Aider - Relevant Courses

FA Level 1 – Introduction to First Aid in Football (IFAiF)
RFL Emergency First Aid*
HSE EFAW Course
Equivalent Emergency First Aid course to the RFL Emergency First Aid course

FA&/orEFA– Duties on Match Day

The FA&/orEFAer should introduce themself to the team manager, venue officials (where relevant), match officials, opposing team's FA&/orEFA, coaches and players and make them aware of where the FA&/orEFA will be stationed during the match

- Have immediate access to a charged mobile phone in case of emergency 999 request
- If using a mobile phone check that it has reception
- Have details of the address and directions to venue for emergency services
- Have list of other essential phone numbers e.g. parents of under 18's, local health centre, NHS Direct, venue caretaker.
- Have appropriate first aid kit and access to first aid room during an event

Emergency First Aider – Duties on Match Day

As for First Aider see above.

3.3.3 Allied Health Professional & Health Care Professional

Clubs may have access to an Allied Health Professional and/or Health Care Professional who is prepared to act in a voluntary capacity. This includes Sports Therapists, Sports Rehabilitators, Paramedics, Nurses, Physiotherapists, doctors, osteopaths and chiropractors. In each case they should be members of the appropriate professional body and have appropriate experience and training in First Aid. In this case they may provide First Aid cover acting within their competencies.

3.4 QUALIFICATIONS

Clubs should always see confirmation that any person used to cover the First Aid role has the qualifications that they claim to hold.

For FA&/orEFAs clubs should see their certificate and make sure that they attend refresher courses as recommended by the awarding body. Holders of the FA/RFL Emergency First Aid Course should attend another course as a refresher every three years.

For Allied Health Professionals and Health Care Professionals clubs should ask for their professional body registration or HCPC registration number which allows the club to check that they are qualified online. Clubs should also check the Health Care Professional is covered by their own medical malpractice/treatment insurance.

Please remember that it is not unknown for individuals to masquerade as a FA&/orEFA or Health Care Professional – clubs must always check.

3.5 INSURANCE & LIABILITY

The Resuscitation Council UK said in August 2010 that *'Although there have been a few cases in the United Kingdom where a claim has been brought against a 'rescuer', there have been no reported cases where a victim has successfully sued someone who came to their aid in an emergency.'*

However both the RFL and the Affiliated Clubs Public Liability policies extend to indemnify volunteers. In the context of first-aiders the policies do contain a medical malpractice/treatment exclusion but this only relates to Doctors (as they will have their own medical malpractice cover in place). As such volunteer FA&/orEFAs will have protection under the policies.

3.6 POSITION ON MATCH DAYS

A FA&/orEFA should be situated on or near the team benches. Other than to treat a casualty the FA&/orEFA should remain in situ until the match is complete.

3.7 DBS DISCLOSURES

FA&/orEFAs (or Health Care Professionals) who will work with Junior or Youth teams should always be subject to an enhanced Disclosure & Barring Service check through the RFL.

4 FIRST AID EQUIPMENT & FACILITIES

4.1 FIRST AID KIT

A fully equipped first aid kit should be available for each FA&/orEFA, please note FA&/orEFAs should only use those parts of a first aid kit for which they have received training. Clubs should make sure that no items in the first aid kit are past their expiry or use by date.

A well-stocked first aid box should contain the following:

- Guidance card
- 4 pairs of latex free (nitrile) disposable gloves
- Hand sanitiser/alcohol gel
- Face-shield or pocket mask (disposable resuscitation aid)
- 'Tufcut' scissors
- Water/spray bottle (and clean preferably sterile water)
- Gauze swabs
- 6 crepe bandages (2x5cm/2x10cm/2x15cm)
- Cotton wool roll (or Gamgee)
- 2 large, sterile, unmedicated wound dressings (non adhesive)
- 6 medium, sterile unmedicated wound dressings (non adhesive)
- 1 roll zinc oxide tape (to secure wound dressings)
- 20 plasters (assorted sizes) sterile, individually wrapped, hypoallergenic
- 4 triangular bandages
- Sterile, saline cleansing wipes
- 2 sterile eye pads
- 2 sterile water "sachets"/"pods"
- 1 litre sterile water (normal saline) in a sealed disposable container
- 2 yellow disposable clinical waste bags
- Material and foil blanket
- Umbrella
- Pen/notebook
- Information sheet (Emergency Action Plan) including details of local hospital and directions to the ground

NB when using a 3G pitch it is also recommended that a proprietary eyewash is available

Under no circumstances should over the counter or prescription drugs be administered by FA&/orEFAs/ or kept in the first aid box. Boxes should be clearly labelled and easily accessible.

4.2 RECOMMENDED ADDITIONAL ITEMS

4.2.1 Automated External Defibrillator (AED)

An AED (or defibrillator) is a relatively expensive piece of equipment, however it is easy to use and can save lives. Clubs that run a large of teams and/or attract significant numbers of spectators may wish to fund raise in order to purchase one for the club. Where a club has access to an AED it is important that key personnel including FA&/orEFAs know where it is stored and how to use it. However, the UK Resuscitation Council Position Statement on the use of Automated External Defibrillators states that:

"An AED can be used safely and effectively without previous training; its use should not be restricted to trained rescuers. Training should however be encouraged to help improve the time to shock delivery and correct pad placement".

Clubs can get help in purchasing an AED through the Danny Jones Defib Fund https://www.dannyjonesdefibfund.co.uk/

4.2.2 Bleach Solution

The recommended spray container with 15mls of standard washing-up liquid and 32mls of standard household bleach should be present on the touchline and in both dressing rooms for use on game days and present at during training for use by FA&/orEFAs and kit-room staff.

4.2.3 Soiled Dressings & Strapping

Please be aware of the club's duty of care to other volunteers at the Club such as groundstaff and cleaners who may come into contact with blood stained dressings and strapping post game/training.

These volunteers should be trained in procedures to handle such items and understand the risks involved and should be provided with adequate bleach solution as per regulations and disposable gloves.

4.3 FIRST AID ROOM

Where clubs have a First Aid room this should be well signed and should be kept clean and tidy at all times.

4.4 AMBULANCE ACCESS

Wherever possible training and matches should take place on areas which have vehicular access so that an ambulance can drive onto the playing area. Where this is not possible it is important to work out how emergency services will be able to reach seriously injured players on the pitch and to make sure that everyone is aware of the route.

4.5 COMMUNICATION

It is important that the FA&/orEFA can call for an ambulance or other assistance immediately so a FA&/orEFA should have a fully charged mobile phone and check that there is a signal prior to the match. If the ground does not have mobile phone receptions an alternative means of emergency communication must be arranged. In addition, calls may need to be made to the casualties' parents, guardian or next of kin.

4.6 DIRECTIONS

It is vital that FA&/orEFAs have details of the postcode and directions to the ground as this information must be available to be provided to the ambulance service.

Where grounds have more than one access point it is essential that the correct information is given to the emergency services and it may be worthwhile having a volunteer at the entrance to the ground to direct the ambulance on arrival.
Where matches are played on pitches away from the clubhouse make sure that FA&/orEFAs operating on those pitches have the correct postcode.

5 RECORDS

5.1 Recording Injuries

It is essential to get the Club's FA&/orEFAs to record any injuries they deal with. Using the accident book required under the Health & Safety at Work Regulations is a good option to use. Alternatively use the RFL Injury Template (see Appendix 5). As a minimum FA&/orEFAs should record:

- Date, time and place of incident
- Name (and age if under 18) of the injured or ill person
- Details of the injury and the first aid given
- What happened to the person immediately after the incident eg continued playing, went to hospital etc
- Name & signature

This information should be provided to the Club Management Committee on a regular basis to inform its risk assessment and risk management processes.

5.2 Information about Players

All players should complete Consent & Medical forms which ask for information about any relevant medical conditions and give FA&/orEFAs the right to act *in loco parentis* in the event of an incident where parents are not present or cannot be contacted in time. Where a player has a medical condition, it would be good practice to ask for any further information which would assist in the event of an emergency and make sure this is available for FA&/orEFAs.

5.3 Reporting Death or Serious Injury

When a player has died or has been admitted to hospital (not admitted to A&E when he/she is subsequently discharged) or has suffered a catastrophic injury the RFL should be notified immediately using the emergency numbers provided below: -

- Kelly Barratt 07739 819750
- Emma Rosewarne 07850 483736

Please make sure the RFL has the name of the player, where possible contact details for the player's family, and any initial prognosis.

The RFL will:

- Inform the Benevolent Fund who will provide moral and financial support to the player and his/her family
- Handle any enquiries from the media
- Inform the RFL's insurance brokers where relevant

5.4 Witness statements.

Following incidents where a potential insurance or personal injury claim may arise, clubs are advised to retain on file witness statements. These statements must confine themselves to the facts and not include opinion or hearsay or apportion or infer blame. They must be signed and dated by the person making them

6 MANAGING HEAD INJURIES & CONCUSSION IN RUGBY LEAGUE

There are two types of head injury both of which are serious and potentially life threatening, they are **concussion** and **structural brain injuries**. Everyone in the game has a responsibility to understand head injuries and what action they should take.

6.1 CONCUSSION

6.1.1 What is Concussion?

Concussion may be caused either by a direct or indirect blow to the head, face, neck or elsewhere on the body which causes the brain to be shaken inside the skull.

Concussion usually leads to a temporary impairment of the brain's function. If concussion is not treated properly this can lead to permanent damage and in some cases can be fatal.

Concussion is more serious in children (under the age of 19) where the brain is still developing.

6.1.2 How is concussion identified?

It is difficult to recognise concussion and only trained medical staff should attempt to do so. Coaches and FA&/orEFAs must assume that where a player has had a bang to the head that the player is concussed. In addition, if the player shows any of the signs below concussion should be suspected (even if a head impact has not been seen) and the player removed from play for his own protection. Coaches and/or FA&/orEFAs may also use the **Pocket CONCUSSION RECOGNITION TOOL** (see Appendix 7 or available as a resource from the RFL).

It is important to realise that a player does not need to be knocked out (lose consciousness) to have a concussion. Less than 15% of concussion cases involve a player being knocked out.

Any of the following may be signs of concussion:

The player:

- Doesn't know the venue, last scorer, opposing team or the score
- Shows signs of confusion, disorientation or is easily distracted
- Cannot remember things that happened before and/or after the injury
- Has a delayed response to verbal commands
- Is not playing as well as expected
- Has been (or may have been) knocked out
- Headache/localised pain
- A fit or convulsion (arms and legs jerking uncontrollably)
- Dizziness/light-headedness/dazed expression
- Unsteady on feet/loss of balance/uncoordinated movement
- A blank stare/glassy eyed
- Loss of vision, seeing double or blurred vision, seeing stars or flashing lights
- Ringing in the ears
- Nausea and/or vomiting
- Slurring of speech
- Poor concentration
- Strange or inappropriate emotions (laughing, crying, getting angry easily)
- Generally feeling unwell

6.1.3 Why is it important to diagnose Concussion?

Players who continue to play or return to play before they are recovered from concussion face significant risks:

- A second concussion including Second Impact Syndrome which is a rapid swelling of the brain usually resulting in death or at least severe brain damage
- An increased risk of other injuries (to self, teammates & opposition players) due to poor decision making or reduced reaction time
- Serious injury or death due to an unidentified structural brain injury such as bleeding on the brain or a fracture
- Potential increased risk of developing long term brain damage such as chronic traumatic encephalopathy (punch drunk)

6.1.4 What to do when Concussion is suspected?

If it is suspected that a player has a Concussion they must be removed from play straightaway. Continuing to play increases their risk of more severe, longer lasting concussion symptoms as well as increasing their risk of other injury:

- **Remove the player from play immediately**
- **Do not let them return to play that day**
- Don't leave them on their own
- Make sure they see a doctor or go to an A&E department
- Don't let them drive

It is also important that parents, friends and/or family are informed so that they can ensure that the player gets rest and that they aren't left on their own. Use the RFL Head Injury Form in Appendix 8.

6.1.5 How is concussion treated?

The most important thing is for the player to get plenty of rest. This includes not just physical rest but also mental rest which includes avoiding computers, game consoles, reading etc. Once the player is completely symptom free and cleared to do so by a medical practitioner they can begin to take part in physical exercise again in a Graduated Return to Play (GRTP).

The majority of concussions resolve in a short period although this will be longer in children and adolescents as their brain is still developing and is more susceptible to the adverse effects of concussion.

6.1.6 What is a Graduated Return to Play (GRTP)?

GRTP is a system of gradually increasing physical exercise when returning from concussion, checking that the player doesn't have any concussion symptoms after each stage.

ADULT GRADUATED RETURN TO PLAY (GRTP)				
Stage	**Minimum time at each Stage of GRTP**	**Activity Level**	**Suggested Exercise at each stage of GRTP**	**Objective**
1	14 days	No activity for 14 days	Symptom limited physical & mental rest	Recovery
Clearance by Health Care Professional recommended				
2	24 hours	Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity <70% maximum predicted heart rate.	Increase heart rate
3	24 hours	Sport specific exercise	Running drills – no impact.	Add movement
4	24 hours	Non-contact training drills	More complex training drills eg passing drills. May start progressive resistance training.	Exercise, co-ordination and cognitive load.
5	24 hours	Full contact practice	Normal training activity	Restore confidence & coaching staff to assess functional skills
Clearance by Doctor				
6	**Earliest RTP is 19 days**	Return to play	Normal training and/or match activity	Recovery complete

UNDER 19 & BELOW GRADUATED RETURN TO PLAY (GRTP)				
Stage	**Minimum time at each stage of GRTP**	**Activity Level**	**Exercise at each stage of GRTP**	**Objective**
1	14 days	No activity for 14 days	Symptom limited physical & mental rest	Recovery
Clearance by Doctor Recommended				
2	48 hours	Light aerobic exercise	Walking, swimming or stationary cycling keeping intensity <70% maximum predicted heart rate.	Increase heart rate
3	48 hours	Sport specific exercise	Running drills – no impact.	Add movement
4	48 hours	Non-contact training drills	More complex training drills eg passing drills. May start progressive resistance training.	Exercise, co-ordination and cognitive load.
5	48 hours	Full contact practice	Normal training activity	Restore confidence and coaching staff to assess functional skills
Clearance by Doctor				
6	**Earliest RTP is 23 days**	Return to play	Normal training and/or match activity	Recovery complete

6.1.7 What can be done to prevent players getting concussed?

Concussion can't be prevented completely as it is often caused by a complete accident, however, coaches should ensure that their players are encouraged to play within the rules and that high tackles, dangerous throws, shoulder charges and spear tackles are not allowed within their team. Tackling technique is also important as players can be concussed by their head coming into contact with the ball carrier. It is important that the playing surface is not too hard (frost or drought) and that there are no dangerous structures such as unpadded posts or fences close to the pitch.

6.1.8 Should all players wear head guards?

The view of international experts in sport-related head injury is that soft helmets do not prevent brain injury (as opposed to superficial head injury) and because of the phenomenon of 'risk compensation' there is a risk that encouraging helmet use in players may paradoxically increase the head injury rates. Because of this medical consensus, the RFL does not support the mandatory wearing of protective head guards in Rugby League.

6.1.9 Concerns about concussion management?

If a player, coach, FA&/orEFA, volunteer or parent is worried about concussion management either at their club or at another this concern should be raised with club officials or match officials at the time. Concerns should also be reported to the RFL Community Game Delivery Department.

6.2 STRUCTURAL BRAIN INJURIES

A player who has had a bang to the head may have structural brain injuries such bleeding or swelling inside the brain, again these injuries may well be invisible but can be fatal.

If a player has any of the following symptoms they should be referred to a hospital immediately and must be accompanied by a responsible adult. If in doubt call an ambulance.

- A headache that is getting worse
- Vomiting or prolonged nausea
- Drowsiness or can't be woken or develops slow or noisy breathing
- Slurred speech or difficulty in speaking or understanding
- Abnormal behaviour/restlessness/irritability/aggression
- Weakness, numbness
- Decreases in coordination and/or balance
- Increased confusion
- Loss of consciousness
- A fit or convulsions (arms & legs jerking uncontrollably)
- Acutely painful/stiff neck which increases in severity
- Sensitivity to light and/or noise
- Blurred or double vision or pupils which vary in size
- Clear fluid coming out of ears or nose
- Deafness in one or both ears

Return to play in these cases must follow the medical advice given by the hospital.

6.3 THE RFL HEAD INJURY CARD

FA&/orEFAs should complete the RFL Head Injury Card (attached and available to download on the RFL website) and make sure that a parent/guardian/relative/carer is given a copy.

7 BLOOD BORNE DISEASES

There are several Blood Borne Diseases (BBD) which can be transmitted by coming into contact with the blood of an infected person. In particular hepatitis B has a relatively long life outside the body so dried blood remains potentially dangerous for several days. This is why the RFL has BBD Guidelines and Rules as set out below to prevent the spread of disease via infected blood and other bodily fluids.

7.1 BBD GUIDELINES - MATCHES & TRAINING

7.1.1 Bleeding Injuries

Players should report all bleeding wounds and are responsible for wearing appropriate protective bandaging or strapping to prevent blood contamination of other players or volunteers.

If a player suffers a cut at training or during the course of a match, the player must leave the field straightaway and blood bin procedures will apply

7.1.2 Blood Bin Procedure

The following procedure will apply in all cases where a Player is bleeding on their person, clothing or equipment has been contaminated by blood

- If the Referee notices a bleeding or blood contaminated Player the Referee will immediately stop play and signal to the FA&/orEFA to attend to the Player.

- The FA&/orEFA will immediately enter the field of play to assess whether the Player can be quickly treated on the field or whether the Player will require treatment off the field.

- If the FA&/orEFA advises that the Player can be treated on the field, the Referee will instruct the player to drop out behind play for that purpose and the match will immediately recommence.

- If the FA&/orEFA advises the Referee that the Player will have to be treated off the field, the match will not restart until the player has left the field. The Player may be interchanged, or alternatively the team can elect to temporarily play on with 12 players. (Note: other than for the initial assessment, the match will not be held up while the bleeding player receives treatment or is interchanged).

- If the Referee stops play twice for the same player and the same wound, the Player must be taken from the field for treatment and either interchanged or the team may elect to play on with 12 players until the bleeding player returns.

- If a bleeding player has left the field for treatment and is not interchanged, they may return to the field of play at any time provided they do so from an on-side position. If the bleeding Player has been interchanged, they may only return to the field as a normal interchange player.

- A bleeding player returning to the field of play who has not been interchanged, is not to be regarded as a replacement/interchange player and therefore may take a kick for goal. Conversely, a bleeding player returning to the field of play who has been interchanged may not take a kick for goal at that time.

7.1.3 Contaminated Clothing

Where a player has blood on themselves or their clothing the Player must be free of blood contamination before the Referee will allow them to rejoin play. Until those steps have been taken, the player shall, at the minimum, drop out behind play. Contaminated clothing and / or equipment should be treated with a solution of detergent and bleach.

7.1.4 Dressing Rooms

Hand basins, toilets, showers and benches should be cleaned with disinfectant after each training session and game.

Dressing rooms should be maintained well and kept clean. Sharing of equipment, including towels should be avoided. Communal baths are to be strongly discouraged.

7.1.5 First Aid Room

The first aid room must be cleaned after each match.

The rubbish bin must contain plastic liners, which are to be disposed of after each training session/match.

7.2 BBD GUIDELINES BLOOD CONTAMINATION

7.2.1 Use of Detergent/Bleach Sprays

- A spray container with 15mls of standard washing up liquid and 32 mls of standard household bleach should be standard equipment for each team, on the touchline and in the dressing rooms.

- Minor contamination of clothing and equipment must be sprayed and thoroughly soaked, with the solution immediately the player leaves the field.

- The decontamination solution should be in contact with the blood spill for between one and five minutes.

- Prior to return to the field, the area must be thoroughly rinsed off with water.

- All but minor blood contamination of clothing and equipment must result in the contaminated clothing and equipment being replaced prior to the player returning to the field.

- As standard household bleach deteriorates with time, the decontamination solution should be made up on the day of the game. Typically a solution of one part household bleach to ten parts water should be prepared fresh daily and used as a disinfectant for contaminated areas.

- A 0.5% concentration of bleach is not considered hazardous, however care must be taken to avoid contact with eyes or wounds and prolonged contact with the skin. Thorough rinsing with water will further reduce the risk.

7.2.2 Contaminated clothing/equipment

- Contaminated clothing/equipment must be sealed in a plastic bag within a clearly marked bin and laundered separately in a hot wash at a minimum temperature of 80°C.

7.3 EQUIPMENT GUIDELINES

7.3.1 First Aid Kit

- The kit must contain disposable protective gloves, hibiscrub (or equivalent) and plastic bags for disposal of contaminated equipment/clothing.

7.3.2 Drink Containers

- Players are to be supplied with and use their own drink containers which they must bring with them and use at every training session

- During matches, Players must drink only from recommended water containers possessing spouts.

- Players should not make contact with or touch the nozzle of squeeze bottles.

WARNING: The potentially life threatening meningococcal disease can be transmitted by sharing drink containers.

7.3.3 Team Kit Bag

- Spare jerseys, shorts and socks should be available in the event that blood contaminated clothing needs to be replaced. The kit bag should also contain plastic bin liners to bag up any blood contaminated clothing.

7.4 HEPATITIS B VACCINATION

The RFL recommends that players and officials are vaccinated against Hepatitis B. Advice should be sought from the individual's GP or Sexual Health Clinic.

7.5 BLOOD BORNE INFECTIOUS DISEASES - RULES

This is a synopsis of the most relevant regulations, the full Rules are available on the RFL website.

The RFL has adopted these Blood Borne Diseases Rules ("the Rules") to protect the rights and the health and safety of other participants in the sport.

These Rules shall only apply to Blood Borne Diseases (including HIV and Hepatitis) and shall apply to all Participants.

Any Participant agrees to:

- be bound by and abide strictly by these Rules;
- provide all requested assistance to the RFL in the application and enforcement of these Rules;
- waive medical confidentiality only in so far as it is necessary to apply and enforce these Rules
- the processing of data, including sensitive and personal data, pursuant to the Data Protection Act 1998
- make him/herself available to undergo any necessary medical examination and or non-invasive test, including blood test, or sample collection, including blood sample collection;
- submit to the jurisdiction of the Blood Borne Disease Tribunal and/or Appeal Tribunal.

It is the responsibility of each Participant to:

- be as fully aware of their medical condition as is reasonable in all of the circumstances
- ensure that they protect the rights and the health and safety of other participants in the sport.

A Participant who becomes aware that they have been diagnosed as having contracted and/or have contracted a blood borne disease shall notify the Blood Borne Diseases Officer (BBDO) currently Emma Rosewarne, RFL Welfare Director, of their medical status as soon as possible.

Where any Club Official is advised that a Participant has contracted a blood borne disease they shall notify the BBDO of this as soon as possible.

When the BBDO is informed that a Participant is suffering from a Blood Borne Disease, the BBDO shall issue a Provisional Suspension preventing participation in the game until the matter has been investigated.

In that case a Blood Borne Disease Tribunal will carry out a risk assessment as to whether or not the Participant should be permitted to participate in the sport having regard to the need to protect the rights and the health and safety of other participants in the sport. Until the Blood Borne Disease Tribunal has issued its decision the Provisional Suspension shall continue.

The Participant may have a review of the decision or appeal depending on the circumstances.

8 OTHER RELATED ISSUES

8.1 MEDICALS/CARDIAC SCREENING

Players may wish to consider visiting their GP for a medical prior to participation in Rugby League.

Players may also wish to undergo cardiac screening. Players and parents should be aware that young healthy people may still be at risk of cardiac arrest. Sudden death syndrome (SDS) is an umbrella term used for the many different causes of cardiac arrest in young people. The charity CRY http://www.c-r-y.org.uk/index.htm provides information and screening services. In addition the Danny Jones Defib Fund may provide clubs with a grant towards the costs https://www.dannyjonesdefibfund.co.uk/

8.2 PLAYERS WITH AN EXISITING MEDICAL CONDITION

Where a player has an existing medical condition it is the responsibility of the player and/or the player's GP to advise whether he/she is medically fit to play Rugby League.

See Consent & Medical forms above.

8.3 TURNING PLAYERS OVER ON THE FIELD OF PLAY

Players may, with all good intentions, attempt to turn an injured player onto their side following an injury. However this could potentially make the injury more severe particularly in the case of spinal injuries.

The RFL would suggest that Coaches and FA&/orEFAs should explain to players the potential hazards to injured players of attempting this and reassure players that injured players are not at risk of "swallowing their own tongue". Players should wait for the FA&/orEFA to attend to the player.

8.4 ABANDONING A MATCH

Where a player has suffered an injury which prevents them from being safely moved from the pitch then play should cease. UNDER NO CIRCUMSTANCES should any pressure be put on the player or the FA&/orEFA to allow play to continue by removing the player from the pitch. Where necessary the match should be abandoned, player safety must be put before results or fixture backlogs.

8.5 PROTECTIVE & OTHER EQUIPMENT

8.5.1 HEAD GUARDS

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) and because of the phenomenon of 'risk compensation' there is a risk that encouraging helmet use in players may paradoxically increase the head injury rates. Because of this medical consensus, the RFL does not support the mandatory wearing of protective head guards in Rugby League.

8.5.2 MOUTH GUARDS

It is strongly recommended that players wear a mouth guard when playing or taking part in contact training sessions. It is recommended that Players wear a custom mouth guard which has been made by a Dentist, rather than a generic mouth guard of the 'boil and bite' variety.

8.5.3 TAGS

Players may play with electronic tags as long as these can be padded and strapped so as not to cause a danger to other participants. The Referee shall be the final arbiter in this regard.

8.5.4 SPORTS GOGGLES

The RFL sanction the use of protective goggles for use in games and training within Rugby League providing the goggles have no rigid components which could cause harm to a player. These goggles will usually be made of soft plastic with an elastic head band to keep them in place. The RFL recommend that head guards are worn by players wearing goggles to reduce the chance of the head band from the goggles sliding down the player's neck.

Any player wearing goggles should seek written clarification from their optician that the goggles are suitable for contact sport. This letter from the optician, together with this RFL policy, may prove useful on match days to reassure match officials and opponents. However, despite this policy, the final decision on the suitability of any player equipment is ultimately the referee's decision.

8.5.5 BOXES

Boxes may be worn provided that they have sufficient external padding not to cause a danger to opponents.

8.6 WEATHER

8.6.1 HOT WEATHER CODE

When a FA&/orEFA believes that the heat and/or humidity is such that players require additional water they should approach the Referee to request one or both of the special measures below. The Referee shall grant this request and shall ensure that both teams are aware of his decision.

• The positioning of water containers around the ground (ensuring that there is no danger to players or spectators) to enable players to help themselves.

• A two minute break at an appropriate natural pause in the game approximately half way through the first and second halves to allow players to take on extra water.

8.6.2 SUNSCREEN

FA&/orEFAs should reinforce messages about using sunscreen to all players and in particular juniors. Cancer Research recommends using a sunscreen with a sun protection factor (SPF) of at least 15 with the higher the SPF, the better. Go for broad-spectrum sunscreens, which protect against harmful UVA and UVB rays.

No sunscreen, no matter how high the factor, can provide 100% protection. And no sunscreen, whether it's factor 15 or 50, will provide the protection it claims unless it is applied properly. Therefore, it is crucial that sunscreen is applied generously and regularly.

Research has shown that people apply much less sunscreen than they need to. And, worryingly, many people burn more frequently when they use higher factors of sunscreen because they stay out in the sun for longer. There is a concern that higher factor sunscreens may lure people into a false sense of security. Make sure the product is not past its expiry date. Most sunscreens have a shelf life of two to three years.

8.7 MENTAL HEALTH

The RFL would recommend that all clubs have at least one volunteer who has attended Mental Health First Aid Lite. Details about this course are included in Appendix 9.

In addition State of Mind can deliver workshops for players and/or volunteers to raise awareness about Mental Health issues see Appendix 9 for how to book a workshop.

9 ANTI DOPING

The RFL is committed to the principles of drug-free sport for the following reasons:

- To uphold and preserve the ethics of the Game.
- To safeguard the physical and mental health of players.
- To ensure that all players have an opportunity to compete equally.

To underpin that commitment the RFL will:

Provide information on its website about the dangers of drugs and consequences of taking drugs or breaching the Anti-Doping Regulations.
- Comply with the WADA Code.

This is a summary of the information available in full on the RFL website.

9.1 Anti-Doping Rules

All sports including Rugby League are governed by the World Anti-Doping Code (WADA Code). All players, coaches and volunteers have to abide by the Code and are subject to the RFL Anti-Doping Regulations which can be downloaded from the RFL Website www.rfl.uk.com . The Regulations allow the RFL to carry out anti-doping tests at any level of the game although in practice the majority of testing will be carried out at professional level.

9.2 Responsibilities of Volunteers in Rugby League

All volunteers should support the principle of anti-doping and should:

- Make it clear to all players that doping in Rugby League is simply not acceptable and is not necessary in order to win
- Ensure that players understand the Anti-Doping Regulations of the RFL
- Discourage and challenge the use of “performance enhancing” or illegal substances or “legal highs” amongst all players
- Not put pressure on players to change their body shape (i.e. to bulk up or slim down) without giving clear direction how to achieve this in a healthy way without resort to doping

Volunteers should not:

- Ignore possible evidence of doping in their team
- Avoid enforcing rules or enforce rules selectively
- Ignore doping because the team needs a particular player
- Ignore drug misuse by coaches or volunteers

9.3 Prohibited Substances

The Prohibited List is available on WADA’s website: www.wada-ama.org Players and officials can also find out the status of a particular substance according to the rules by visiting the Global Drug Reference Online website at www.GlobalDRO.com

The current Prohibited List includes the following:

- Anabolic Agents
- Hormones & related substances
- Beta-2 agonists
- Agents with anti-estrongenic activity
- Diurectics & other masking agents
- Stimulants

9.3.1 Steroids

Steroids stimulate the development of male sexual characteristics and the build up of muscle tissue. Perceived benefits of steroid use are increased muscle tissue leading to increased strength and power.

However steroids affect the body's natural balance and can have very serious effects including:

- Increased violence, mood swings, depression and personality changes (Roid-Rage)
- Serious liver damage
- Increased risk of heart disease and kidney damage
- Increased risk of muscle injury – the muscle mass gets bigger but the supporting tendons and ligaments do not and may not be able to cope
- Adolescents may stop normal growth
- Development of breasts in men
- Shrinking of the testicles
- Impotence & infertility

Steroids can be injected and this poses other risks associated with syringes including infections, HIV and Hepatitis B.

9.3.2 Stimulants

Stimulants act on the central nervous system by speeding up parts of the brain and the body's reactions. Stimulants also suppress hunger and give the impression of increased concentration.

However stimulants can cause difficultly sleeping, sweating, shaking, anxiety, depression and mood swings. Stimulants can also cause overheating of the body leading to organ failure, put undue pressure on the heart and lead to cardiac arrhythmias.

Some pre-workout/energy boosting supplements contain stimulants so players should be extra vigilant with supplements of that nature and should seek advice prior to using them.

Common stimulants are ephedrine, pseudoephedrine, methylhexaneamine, cocaine, ecstasy, and amphetamines.

9.3.3 Social Drugs

In addition to being banned by WADA the following drugs are also illegal under the Misuse of Drugs Act.

Marijuana (cannabis, weed, hash) is usually smoked to give a relaxed (stoned) feeling, however it can lead to mental health problems including schizophrenia, paranoia and depression. It can also affect co-ordination and make users drowsy.

Cocaine (Coke, Charlie, Crack) can be snorted, smoked or injected in order to give users a "buzz" where they feel really alert followed by down periods after use. Cocaine can cause heart problems, overheating and convulsions.

Amphetamine (speed, whizz) has similar effects and risks to cocaine

Ecstasy gives a sense of energy, alertness and happiness but can induce panic attacks, raise body temperature to a dangerous level and put pressure on the heart.

Heroin (H, smack) is usually injected or smoked and is highly addictive. It gives a sense of relaxation and well-being but includes the dangers of lethal overdoses and infections.

9.4 SUPPLEMENTS

Many high-performance athletes use supplements, after consulting with relevant experts, to optimise their nutrition for performance purposes. Supplements work in addition to a balanced nutritious diet, a good hydration strategy, effective training and plenty of rest. Without these factors, players are unlikely to see any benefit just by taking supplements. Prior to taking supplements players should try to optimise the other performance factors and should seek advice.

The effectiveness of many supplements cannot be effectively proven and players must also be aware that approximately 45% of positive drug tests have been linked to the use of contaminated supplements.

The RFL advises players to fully assess the need for and the risk of any supplements prior to use.

9.5 EDUCATION

It is mandatory that the Chair and Club Welfare Officer at each club has qualified as a UKAD Advisor, this course gives enough knowledge to allow that person to play an essential role in giving players important anti-doping information. It is a basic level of knowledge which will allow support personnel to provide accurate advice about key anti-doping issues and to signpost players to further resources (e.g. Global DRO). The Advisor course can be taken online by registering on the UKAD website.

In addition, all Community Players over the age of 18 must be made aware of and undertake the education module for Community players. This will be directly communicated to players; however, it is the Club's responsibility to ensure they are aware of the module at the beginning of each Season. The Club Chair, Club Welfare Officer and Head Coach must also have completed the education module.

10 APPENDICES

APPENDIX 1 – RISK ASSESSMENT

Risk Assessments

A risk assessment is simply a careful examination of what, in a club, could cause harm to people, so that club officials can weigh up whether they have taken enough precautions or should do more to prevent harm. Workers, volunteers and others have a right to be protected from harm caused by a failure to take reasonable control measures.

In order to create a safe environment, a club must carry out regular risk assessments. A risk assessment is a formal and recorded process to weigh up the suitability and safety of any activity by identifying the hazards that could potentially cause harm and taking the appropriate precautions or actions required to prevent harm or injury.

A risk assessment enables a club to:

- Identify an unsafe condition
- Decide what corrective action is required
- Determine who is responsible for correcting it
- Follow up to ensure that it was corrected properly

The frequency of assessment will be determined by a number of factors, such as the nature of the group; experience of volunteers; location or weather. Therefore risk assessments should be a regular process and not a one-off exercise.

The risk assessment should be undertaken by a competent person, although they do not have to be a health and safety expert. Ask other club members or committee members what they think as they may have noticed things which are not immediately obvious.

Risk assessment process

The following is a suggested process intended as a guide to undertaking a risk assessment:

- Make an inventory of club activities and tasks.
- Identify the hazards for each of these activities – on and off site – and decide if the hazards are minor or significant.
- Evaluate the risks and decide whether the existing precautions are adequate or whether more should be done.
- Decide if the risk is acceptable and prioritise the significant hazards - identify whether the risk is high, medium or low by deciding which could result in serious harm or affect several people.
- Select method of control – check that all reasonable precautions have been taken to reduce the risk and avoid injury, however be aware that even after all precautions have been taken, some risk usually remains.
- Record the findings – keep the written record for future reference, it can help if you become involved in any action for civil liability. It can also remind the Club to keep an eye on particular hazards and precautions.

- Implement measures to reduce the risk.
- Record and react to near misses
- Monitor – ensure that the standards are maintained.
- Regularly review – it is good practice to review the assessment to make sure that the precautions are still working effectively.

Risk Assessment Resources

The government's Health and Safety Executive has a useful risk assessments webpage and there is a downloadable Risk Assessment Template (PDF 52kB).

Also, to help clubs with risk assessment decisions, there is a Risk Probability Matrix (PDF 13kB).

APPENDIX 2 – FIRST AID EMERGENCY ACTION PLAN

RFL EMERGENCY ACTION PLAN			
Club Name			
Club Address			
		Postcode	
Pitch address			
		Postcode	
Pitch address			
		Postcode	
FA&/OREFA INFORMATION			
NAME	**MOBILE NUMBER**		
FIRST AID EQUIPMENT & FACILITIES			
ITEM	**LOCATION**		
First Aid Kits			
AED			
Stretcher			
First Aid Room			
ACCESS ROUTES			
For Ambulance			
First Aid Room to Ambulance			
Pitch to Ambulance			
OTHER INFORMATION			
Nearest Hospital with A&E address			
Directions to hospital			
Journey time			
Nearest Walk In Centre Address			

APPENDIX 3

To book on a Rugby League First Aid Level 3 course please go to the website http://www.rugby-league.com/the_rfl/rugby_league_learning_

APPENDIX 4 – AED

Please contact the Danny Jones Defib Fund through the website https://www.dannyjonesdefibfund.co.uk/

APPENDIX 5 – ACCIDENT OR INJURY REPORT FORM

RFL ACCIDENT OR INJURY REPORT FORM					
Date		Time			
Match					
Venue					
INJURED PERSON'S DETAILS					
Surname		First Name			
Address					
		Postcode			
DOB		Tel No			
DETAILS OF PERSON(S) ACTUALLY INVOLVED IN ACCIDENT OR INJURY					
Full name of person		**Contact number**			
DETAILS OF WITNESSES WHO ACUTALLY SAW THE ACCIDENT OR INJURY					
Full name of person		**Contact number**			
INCIDENT DETAILS					
Time		Date			
DESCRIBE THE INCIDENT					
TREATMENT GIVEN					
Loss of consciousness?		Yes		No	
Person sent to hospital?		Yes		No	
Ambulance called?		Yes		No	
If yes which hospital					
DETAILS OF PERSON GIVING FIRST AID					
Name		Role			
Signed		Date			

APPENDIX 6 – CONSENT & MEDICAL FORM

Please use this link to the RFL website.

http://rflmedia.therfl.co.uk/docs/Parental%20Consent.pdf

http://rflmedia.therfl.co.uk/docs/T2%20-%20Player%20Profile%20&%20Parental%20Consent.pdf

APPENDIX 7 – POCKET CONCUSSION RECOGNITION TOOL

See RFL website and separate hand-out.

APPENDIX 8 – HEAD INJURY FORM

THE RFL HEAD INJURY CARD			
Name			
Address			
Tel No			
Time of Head Injury		Date of Head Injury	
Emergency Telephone Numbers			
Hospital			
Ambulance			
FA&/orEFA			
GP			
I have given a completed Head Injury Card to a parent/guardian/relative/carer of the player			
Name of FA&/orEFA			
Date			
IMPORTANT WARNING			
He/she should be taken to a hospital or a doctor immediately if any of the following occurs: – Vomiting – Headache develops or increases – Becomes restless or irritable – Becomes dizzy, drowsy or cannot be roused – Has a fit or convulsion – Anything else unusual happens			
FOR THE REST OF TODAY HE/SHE SHOULD:			
– Rest quietly – Not consume alcohol – Not drive a vehicle			

APPENDIX 9 – MENTAL HEALTH

A9.1 MENTAL HEALTH FIRST AID (MHFA) LITE

The RFL in conjunction with Rugby League Cares delivers the Mental Health First Aid (MHFA) Lite course.

The course which lasts for 2-3 hours is aimed at club welfare officers, coaches, team managers, volunteers and those with an interest in learning about Mental Health issues and who have a role supporting the welfare of players and/or volunteers. The courseis certificated by MHFA and is delivered by Rugby League Cares from time to time..More details about MHFA can be seen on their website www.mhfaengland.org

The course is ideal to allow volunteers to support players or volunteers who have identified that they may have mental health issues. The aims of the course are to enable participants to:

- Gain a wider understanding, for the attendee and others, of some issues surrounding mental health
- Gain a greater understanding of how and why positive and negative mental health affects Rugby League – people and clubs
- Effectively support people experiencing mental health problems
- Communicate with and educate people

By the end of the course attendees will be able to:

- Identify the discrimination surrounding mental health problems
- Define mental health & some mental health problems
- Relate to people's experiences
- Help support people with mental health problems
- Look after their own mental health

The course would also be particularly useful as a foundation for those who would like to go on to become Mental Health First Aiders or those who provide support in clubs especially where that club has had a State of Mind presentation.

The courses are limited to 16 people per session.

A9.2 STATE OF MIND WORKSHOPS

State of Mind deliver workshops aimed specifically at rugby league players and/or volunteers which raise awareness about mental health issues. To book a workshop contact State of Mind through their website.

http://www.stateofmindrugby.com/cmspages/contact/contact-us/

CONTACTS

Drug Information Line: +44 (0) 800 528 0004
Drug Information Email: drug-free@ukad.org.uk
Confidential TUE Fax: +44 (0) 800 298 3362
TUE Email: tue@ukad.org.uk