HOCKEY AUSTRALIA

CONCUSSION POLICY

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Contents

1. Introduction

1.1. Hockey Australia (**HA**) is the peak body responsible for developing and promoting hockey in Australia. In Australia, hockey programs, events and activities are implemented and conducted by a number of different hockey organisations across the country. Accordingly, Hockey Australia has developed this policy to apply to each of the following Australian Hockey Organisations (**AHO**) and the hockey programs, events and activities of those AHOs:

a. Hockey Australia;

b. Member Associations, being those governing bodies of hockey in each Australian State and Territory known as Hockey ACT, Hockey NSW, Hockey NT, Hockey Queensland, Hockey SA, Hockey Tasmania, Hockey Victoria and Hockey WA that have adopted this policy;

c. Regional Associations, being those regional or metropolitan hockey associations which are members of, or affiliated to, a Member Association that have adopted this policy; and

d. Affiliated Clubs, being those hockey clubs that are a member of or affiliated to a Regional Association and/or Member Association that have adopted this policy.

1.2. The AHOs endorse the 6th Consensus Statement on Concussion in Sport and support and promote the International Hockey Federation (FIH) and Australian Institute of Sport (AIS) Position Statements on Concussion in Sport. It is the aim for this policy to be consistent with the Consensus and Position Statements to the fullest extent practicable.

1.3. This policy sets out the guiding principles regarding the diagnosis and management of concussion in hockey in Australia, including:

a. How to diagnose concussion or suspected concussion;

b. The principles of concussion management (recognise, remove, refer); and

c. The return to play protocol following a diagnosis of concussion.

2. Player and Participant Welfare

In considering the management of hockey-related concussion, each AHO is committed to protecting the health and welfare of hockey players and participants at all levels. AHOs have a duty of care to provide safe training and playing environments. This policy and its related protocols should be implemented to the fullest extent possible by AHOs. AHOs should also take steps to increase awareness of this policy and its related protocols – see section 8.

3. What is Concussion?

3.1. Concussion is caused by trauma to the brain, which can be either direct or indirect (e.g., whiplash injury). When the forces transmitted to the brain are high enough, they can injure or 'stun' the nerves and affect how the brain functions.

3.2. Concussion is characterised by a range of observable clues and signs (e.g., lying motionless on the ground, blank or vacant look, balance difficulties or motor incoordination) or symptoms reported by the player (e.g., headache, blurred vision, dizziness, nausea, balance problems, fatigue and feeling 'not quite right').

3.3. Other common features of concussion include confusion, memory loss and reduced ability to think clearly and process information. It is important to understand that a player does not have to lose consciousness to have a concussion.

3.4. The effects of concussion evolve or change over time. Whilst in most cases symptoms improve, in some cases effects can worsen in the few hours after the initial injury. It is important that a player suspected of sustaining a concussion be monitored for worsening effects and be assessed by a medical professional as soon as possible after the injury.

3.5. The risk of complications is thought to increase when a player returns to sport before being fully recovered. This is why it is important to recognise a concussion and ensure the player only returns when they have fully recovered.

4. Management Guidelines for Suspected Concussions

4.1. Concussion Management

The most important steps in the early management of concussion include:

- Recognising the injury may be a concussion or suspected concussion;
- Removing the player from play or training; and
- Referring the player to a medical professional.

4.2. Recognise

a. Recognising concussion is critical to correctly managing and preventing any short or long-term injury or damage. All AHO coaches and club officials should be made aware of concussion symptoms and when a player should be removed from play, training or other related activity.

b. Diagnosis of concussion can be difficult because symptoms and signs can change rapidly and may emerge and evolve over time. Many clinical features are not specific to concussion. Concussion symptoms may be delayed and appear over the first 24-48 hours following a head trauma. Over the next several days, additional symptoms may become apparent (e.g., mood changes, sleep disorders, problems with concentration).

4.3. Remove

a. Any player **must** be removed from play or training immediately if safe to do so following trauma and **not return to play or training** if any of the following clinical features are present:

Loss of consciousness	Dazed, blank or vacant stare
No protective action in falling to the ground	Behaviour change atypical of player
Seizure/convulsion or lying rigid/motionless due to muscle spasm	Confusion or disorientation
Motor incoordination	Memory impairment

b. Any player **must** be removed from play or training immediately if safe to do so following trauma **for further assessment** if any of the following clinical features are present:

Possible occurrence of any of the clinical features in clause 4.3(a)	Facial or head injury
Lying motionless for over two seconds	Balance problems/dizziness
Headache	Nausea
Blurred vision	Any other features that the player is “not quite right”

c. Australian hockey recommends a conservative approach to removal of players. Continuing to play following a concussion can be dangerous and lead to a longer recovery period. Players should be honest with how they feel and report any symptoms immediately to your coach, other club official, medical professional and/or family member. HA encourages players during training and matches to always watch out for teammates and encourage them to be honest and report any concussion symptoms.

d. When responding to a player, the basic principles of first aid should be adhered to (Danger, Response, Send for help, Airway, Breathing, CPR and Defibrillation).

e. Structural head injuries may present mimicking a concussion. The signs and symptoms of a structural head injury will usually persist or deteriorate over time, e.g., abnormal neurological signs, persistent or worsening headache, increased drowsiness, persistent vomiting, increasing confusion and seizures. In these instances, unless a qualified medical professional is on site, do not attempt to treat or move the player - call an ambulance immediately and await its arrival.

f. A neck injury should be suspected if there is any loss of consciousness. If a neck or spine injury is suspected, the player should not be moved (other than where airway support is required or by a qualified medical professional trained in immobilisation techniques), and any protective equipment such as a helmet or face mask should not be removed unless trained to do so. If no qualified medical professional is on site, do not attempt to move the player – call an ambulance and await its arrival.

g. Club and State hockey training and matches may not have a dedicated medical professional available at the venue. In the absence of assessment and clearance by a qualified medical professional, any player with a concussion or suspected concussion must not return to play, training or activity on the same day. **If in doubt, sit them out!**

h. In all hockey matches at which no dedicated medical professional acting in a match-day medical role is available at the venue:

   i. The welfare of each player is the responsibility of their club/team through their nominated representative (who may be a coach, manager, captain or official).

   ii. If, following a head impact or collision, a player is observed with any visible sign or symptom of concussion (refer to clause 4.3(a) and (b) for a detailed list of concussion signs and symptoms), play must be stopped.

   iii. It is not the responsibility of the match officials involved with the match to assess players for any injury. However, the match officials can stop the match for an injury (including a suspected concussion) subject to the rules of hockey applicable to that match. The club/team remains responsible for the safety and welfare of the player. Australian hockey recommends a conservative approach to the removal of the player.

   iv. The nominated club/team representative or, in the absence of the nominated club/team representative, the team coach or captain, must ensure the player showing any visible sign or symptom of concussion is removed from the field before play may recommence. Under no circumstances should the removed player be allowed to resume their participation in the match (unless a medical professional acting in a dedicated match-day role assesses and clears the player of concussion if removed under clause 4.3(b)).

i. The removed player must be monitored regularly for possible signs of deterioration or other warning signs of a potential underlying structural brain injury.

4.4. Refer

a. Any player with a suspected concussion must referred to a medical professional as soon as possible after the injury for assessment. Ideally, this medical professional should have experience in the diagnosis and management of sports concussion.

b. Assessment may occur at the playing or training venue (if a medical professional is present), local general practice or hospital emergency room/department.

c. It is useful to have a list of local doctors and emergency departments near the venue at which each match or training session is taking place. This resource can be confirmed by the relevant club or venue operator at the start of each season.

   A “medical professional” under this policy means a medically qualified doctor. Physiotherapists, paramedics and sport trainers are not able to act as medical professionals for the purposes of this policy unless approved in writing by HA’s Chief Medical Officer.

4.5. Reporting

a. Any concussion or suspected concussion that occurs at a training or match venue must be reported by the relevant individual's nominated club/team representative using the online HA concussion reporting **form**, and sent by email to HA at **concussion@hockey.org.au**. This report should be made as soon as possible following the incident and include as much detail as possible. A separate incident form should be submitted if subsequent concussion assessments on a player leads to a diagnosis of deterioration of the player's condition.

b. All reports sent to this email address will be received by the HA Integrity Unit and managed confidentially in line with the HA privacy policy. HA may disclose such information in the report as is necessary to ensure the return to play protocol is followed by the concussed player.

c. HA may use the report as part of aggregated and anonymised reporting used to assist Australian hockey's management of concussion and the review of this policy.

4.6. Additional High-Performance Considerations

a. At all HA-sanctioned events (including the Hockey One League, matches involving Australian national teams, national championships) at which a dedicated match day medical professional is present, that medical professional may conduct an assessment of a player suspected of having a concussion using tools such as the Sport Concussion Assessment Tool – 6th edition. Assessment should take place in a distraction-free environment, such as the change rooms. If there is any doubt about whether the player is concussed, that player should not be allowed to return to hockey activity that day.

b. In conducting a concussion assessment, the medical professional may refer to any online neurocognitive testing the player has undertaken (such as a Cognigram and annual SCAT6 assessments). Assessment results will be used as a baseline for players returning to play post-concussive episode/injury. If baseline testing has been undertaken, this must return to baseline before a player can return to play.

c. For training and matches played outside of Australia or under the auspices of an organisation other than an AHO (such as the Federation Internationale de Hockey (**FIH**)), AHOs are strongly encouraged to follow the concussion diagnosis and management principles set out in this policy.

5. Return to Play Protocol

5.1. Players returning to play following a diagnosis of concussion should follow a graded program with stages of progression. The objective of this graded program is to allow the brain to recover sufficiently. This program should be based on the advice of a medical professional and encompass the following steps for a return to play:

a. **Rest** – a brief period of relative rest;

b. **Recovery** – symptom-limited increase in physical and cognitive activity; and

c. **Graded return** to full activity with monitoring.

5.2. The table in Schedule 1 outlines the minimum process to follow in returning to play following a concussion. However, a more conservative approach is strongly recommended to allow a longer period of time for recovery where there is a lack of baseline testing and the absence of regular contact between players and a medical professional limits the ability to assess recovery following concussion.

5.3. If symptoms return at any phase/step, the player should return to the previous stage until all symptoms have been resolved.

5.4. Players who are removed from training or playing under clause 4.3(a) should not:

(a) resume training before 14 days from the date of suspected concussion (if free of symptoms at rest); and

(b) return to playing before 21 days from the date of the suspected concussion

unless cleared in writing by a specialist concussion doctor such as a neurologist, neurosurgeon or sport and exercise physician.

5.5. AHOs who manage competitions and/or events should ensure this return to play protocol is observed in relation to concussion occurring in those competitions/events.

5.6. Medical clearances must be in writing, and if received by a player to resume training/playing should be provided to the AHO representative responsible for the activity in which the player wishes to resume. This includes, without limitation:

a. The HA Tournament Director for Hockey One League matches, national championships and other events staged by HA; and

b. The local association general manager (or similar) for local club competitions.

These clearances should also be reported to HA via the **concussion@hockey.org.au** email address. These clearances will be managed confidentially by the HA Integrity Unit.

6. Return to Play Considerations

6.1. Children and Adolescents

Children and adolescents may be more susceptible to concussion and take longer to recover. A more conservative approach to concussion management should be taken with those aged under 18 years. Return to learning should take priority over a return to sport. School programs may need to be modified to include more regular breaks, rests and increased time to complete tasks.

6.2. Multiple Concussions

Current research and data indicate some correlation between a history of multiple concussions and cognitive deficits post-sport and later on in life. However, the full impacts are still largely unknown.

Therefore, a conservative approach for players with a history of multiple concussions should be adopted. Before recommencing any physical activities, players having a history of multiple concussions should receive a medical clearance.

6.3. Difficult Concussions

If a concussion continues for more than three weeks with persistent symptoms, the player should be medically referred to a neurologist, neurosurgeon or other specialist who is experienced in the management of concussion. The player may be referred for a full neuropsychological assessment and may require a standard MRI to exclude structural brain damage. Other investigations may be undertaken as determined by the specialist examination.

7. Protective Equipment

There is no definitive research to suggest that protective equipment such as helmets and face masks prevent concussions.

However, protective equipment such as helmets, face masks, and mouthguards play an important role in preventing head injuries such as skull and facial fractures, lacerations, dental injuries, and trauma. AHOs recommend the use of face masks and other equipment in training and matches in accordance with the requirements of local and FIH rules.

8. Concussion Tools and Resources

8.1. Concussion Identification and Reporting Tools

The following resources and tools may assist AHOs in recognising suspected concussions. These resources and tools are not intended to be used as stand-alone offerings and should not be substituted for comprehensive medical assessment, treatment and advice.

Concussion Group Consensus Statement
https://bjsm.bmj.com/content/bjsports/57/11/695.full.pdf

Concussion in Sport Australia Website
https://www.concussioninsport.gov.au

Sport Concussion Assessment Tool – 6th edition (SCAT6)
https://sma.org.au/wp-content/uploads/2023/07/SCAT6.pdf

Sport Concussion Assessment Tool for Children Ages 8–12 (Child SCAT6)
https://sma.org.au/wp-content/uploads/2023/07/Child-SCAT-6.pdf

Pocket Concussion Recognition Tool
http://bjsm.bmj.com/content/bjsports/47/5/267.full.pdf

HeadCheck App
The app is available from the Apple and Google Play stores to assist parents, coaches, and first aiders in recognising and managing children and adolescents' safe return to school, play, and organised sport.

8.2. Concussion Policy Awareness Tools

HA also provides resources on its website at **www.hockey.org.au/integrity**. These resources include a Concussion Toolkit to assist AHOs in implementing this policy and provides tools for AHOs to report concussion incidents and support awareness of concussion within Australian hockey. These tools include:

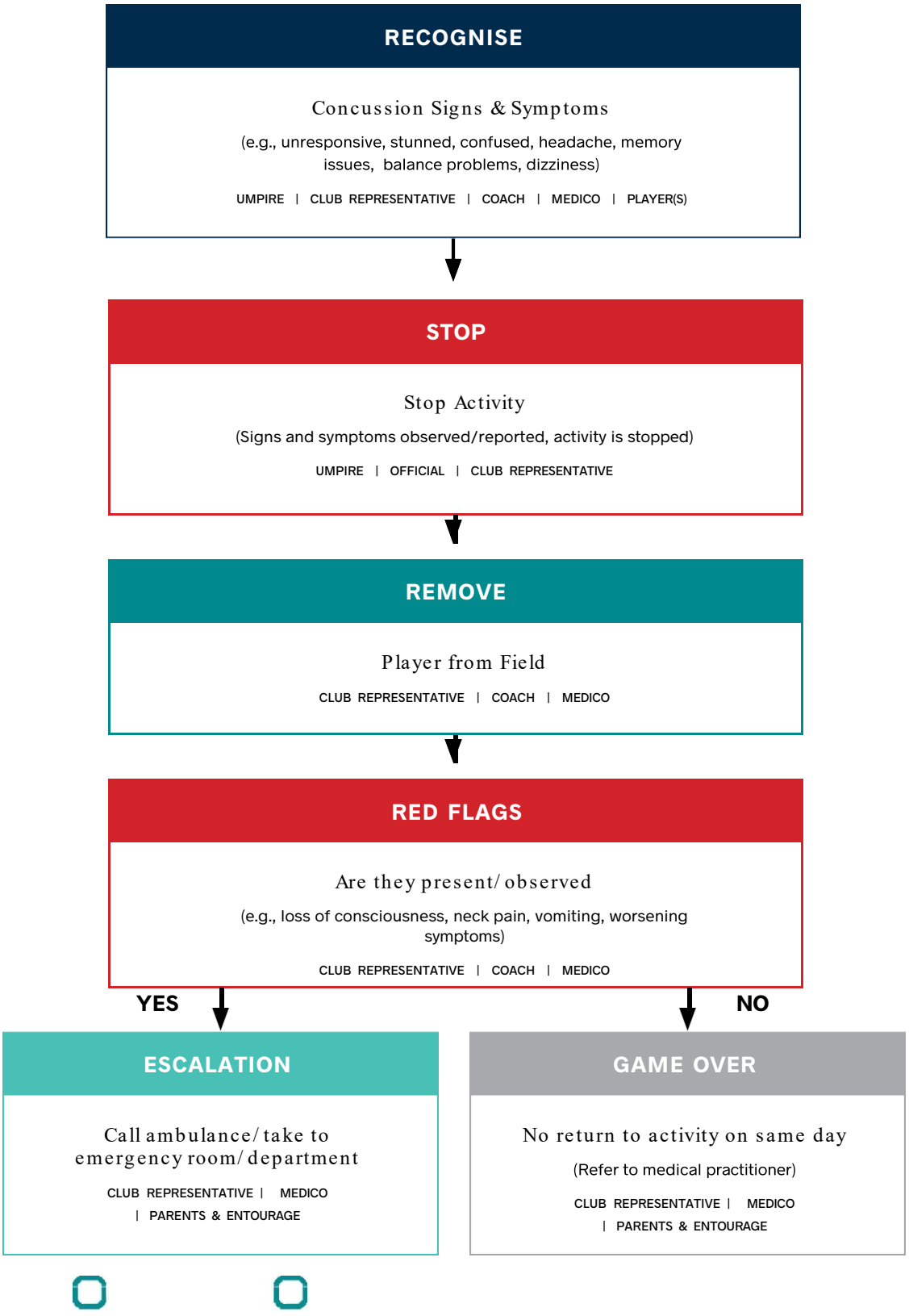
a. A concussion management workflow (see Schedule 2) for display in and around hockey facilities – including in change and medical rooms and dugouts/player benches.
b. A concussion report form to be completed by AHO officials and returned to HA with details of the concussion incident.
c. A concussion awareness poster for display in and around hockey facilities – including in change and medical rooms and dugouts/player benches.
d. Concussion policy FAQs and key messaging for use by AHOs in communicating about the topic of concussion.

9. Schedule 1: Return to Play Protocol Phases

FOCUS	ACTIVITY & AIMS	OTHER CONSIDERATIONS
REST		
Relative rest period (physical and mental rest, allowing the brain time to recover)	• Take it easy within the first 24 – 48 hours of a suspected concussion. • Where possible, minimise activity to 10 to 15-minute intervals. • Try to limit screen time to an absolute minimum to assist with recovery.	• Children and adolescents may require additional time.
RECOVERY		
Return to non-sport activities	• Increase mental activities (e.g., light reading, games, and limited screen use). • Gradually introduce normal activities at home. • Advance the volume of mental activities if they don't increase any symptoms more than mildly. • Increase daily activities (e.g., moving around the house, simple chores and short walks). Rest if these activities more than mildly increase symptoms.	• There may be some mild symptoms as activity is increased. If they increase above mild, consider returning to rest until they subside.
GRADUAL RETURN – INDIVIDUAL ACTIVITIES		
Light-moderate aerobic exercise	• Undertaking light-moderate aerobic exercises (e.g., walking, jogging and stationary cycling). • . Start at an intensity where you can easily speak in short sentences.	• If symptoms more than mildly increase, or new symptoms appear, stop and return to rest. • Progressing too quickly through this phase when symptoms significantly worsen can slow recovery.

Sport-specific exercise.	• Increase aerobic exercise intensity and duration.	
GRADUAL RETURN – TEAM ACTIVITIES		
Non-contact training drills and activities.	• Return to training activities once not experiencing symptoms at rest. • Initially avoid any training activities where there may be a risk of head injury. • If there is no recurrence of symptoms progress to more complex training drills with contact restrictions (e.g., passing drills within 3v2, 4v3 or small-sided games and activities).	• Players should remain completely symptom-free before progressing to the next phase.
Full contact training and activities.	• When symptom-free at rest from the suspected concussion for 14 days, consider commencing full unrestricted training activities.	
RETURN TO PLAY		
Full return to play/competition.	• Return to play should not occur before day 21 post suspected concussion (at the earliest) and only if no symptoms at rest have been experienced in the preceding 14 days following return to full training.	• Children and adolescents may require additional time.

10. Schedule 2: Concussion Injury Management Workflow



Need to report a concussion?

Scan the QR code here