GORDON'S SCHOOL

HEAD INJURY AND CONCUSSION POLICY

The core principle that guides everything we do is **Putting Students First**.

1. Introduction

1.1. The aim of this policy is to ensure that Gordon's School students receive the highest possible standard of care following a head Injury. The welfare of the student both short and long term must always come first.

1.2. This policy refers to head injuries and/or concussion sustained during any activity or incident, sporting or otherwise.

1.3. This policy will reflect current guidelines from the England Rugby (RFU), World Rugby (formerly the International Rugby Board), the National Institute for Health and Care Excellence and the Medical Officers for Schools Association (MOSA).

1.4. This policy is for staff, parents, guardians and students at Gordon's School.

1.5. All concussions must be taken seriously to safeguard the health and welfare of children and young people. Failing to do so can have serious consequences including, in extremely rare cases, death.

2. Terminology

2.1. It is important to distinguish between the terms 'Head Injury' and 'Concussion'.

2.1.1. Head injury is a trauma to the head, face, jaw or nose that may or may not include injury to the brain. (MOSA)

2.1.2. Concussion is a traumatic brain injury resulting in a disturbance of the normal working of the brain. It is usually the result of one of the following:

- A direct blow to the head (e.g. a clash of heads or the head hitting the ground)
- The head being shaken when the body is struck (e.g. a high impact tackle) (RFU 2016)

3. Assessing the student

3.1. Any student sustaining a head injury should be **immediately removed from that activity** and referred to the school nurse or other healthcare/medical professional. In the absence of a school nurse or healthcare/medical professional, the student should be assessed by a qualified first aider and referred for a medical opinion according to the referral guidelines in section 4 and 5 of this policy.

3.2. Where immediate medical attention is not indicated (as per section 4 and 5 of this policy), parents of Day Boarders will be contacted and expected to collect their child immediately and seek further medical assessment if indicated. It is the responsibility of the parents of Day Boarders to secure suitable assessment and treatment of the head injury. It is also the responsibility of the parents of Day Boarders to oversee the Return to Play process.

3.3. Following initial assessment, Residential Boarders requiring head injury management will be managed by the school Medical Centre team including the school nurses, school physiotherapist and school GP.

4. Emergency management

4.1. The following situations indicate a medical emergency and require emergency medical assistance.

- A student who exhibits any of the following symptoms;
  - Unconsciousness or lack of full consciousness
  - Decreasing level of consciousness
  - Rapid deterioration of neurological function
  - Decrease or irregularity of breathing
  - Any signs or symptoms of neck or spine injury
  - Any signs of skull fracture or bleeding
    - Signs include clear fluid running from the ears or nose, black eye with no associated damage around the eyes, bleeding from one or both ears, bruising behind one or both ears, penetrating injury signs, visible trauma to the scalp or skull of concern to the professional.
  - Seizure activity
  - High energy head injury
- Any student with a witnessed prolonged loss of consciousness and who is not stable (i.e. condition is worsening)

The student should be transported immediately to the nearest emergency department via emergency vehicle.

5. Referral to Hospital

5.1. The school nurse or, in the absence of the school nurse, the qualified first aider should refer any student who has sustained a head injury to a hospital emergency department, using the ambulance service if deemed necessary, if any of the following are present:

- GCS score of less than 15 on initial assessment. (See appendix A)
- Any loss of consciousness as a result of the injury.
- Any focal neurological deficit - problems restricted to a particular part of the body or a particular activity, for example, difficulties with understanding, speaking, reading or writing; decreased sensation; loss of balance; general weakness; visual changes; abnormal reflexes; and problems walking since the injury.
- Any suspicion of a skull fracture or penetrating head injury - signs include clear fluid running from the ears or nose, black eye with no associated damage around the eyes, bleeding from one or both ears, bruising behind one or both ears, penetrating injury signs, visible trauma to the scalp or skull of concern to the professional since the injury.
- Amnesia for events before or after the injury (assessment of amnesia will not be possible in preverbal children and is unlikely to be possible in children aged under 5 years).
- Persistent headache since the injury.
- Any vomiting episodes since the injury.
- Any seizure since the injury.
- Any previous brain surgery.
- A high-energy head injury. For example, pedestrian struck by motor vehicle, occupant ejected from motor vehicle, fall from a height of greater than 1 meter or more than 5 stairs, diving accident, high-speed motor vehicle collision, rollover motor accident, accident involving motorised recreational vehicles, bicycle collision, or any other potentially high-energy mechanism.
- Any history of bleeding or clotting disorders.
- Current anticoagulant therapy such as warfarin.
- Current drug or alcohol intoxication.
- There are any safeguarding concerns (for example, possible non-accidental injury or a vulnerable person is affected).
- Continuing concern by the professional about the diagnosis.

(NICE Head Injury Guidelines 2014 relating to referral to hospital)

5.2. In the absence of any of the risk factors above, consider referral to an emergency department if any of the following factors are present, depending on judgement of severity:

- Irritability or altered behaviour, particularly in infants and children aged under 5 years.
- Visible trauma to the head not covered above but still of concern to the healthcare professional.

- No one is able to observe the injured person at home.
- Continuing concern by the injured person or their family or carer about the diagnosis.

(NICE Head Injury Guidelines 2014 relating to referral to hospital)

6. Communications – Day Boarders

Students with head injuries must be handed over to their parent or guardian. Students are not allowed to walk/drive home alone. It is not enough to leave telephone messages about head injuries – an actual conversation must take place.

6.1. The adult supervising the activity is responsible for notifying;
- The student's parent or guardian – This must be done at the time
- The School Medical Centre – This can be done via email
- Medical-centre@gordons.school

6.2. The adult could be a member of Gordon's School staff or a person acting on behalf of Gordon's School such as a sports assistant/tutor engaged for Gordon's School students.

6.3. Parents of Day Boarders are responsible for informing the student's external sports club that their child has sustained a head injury.

6.4. The head injury must be logged on the Return2Play Head Injury website. This injury must be logged within 24 hours of the injury occurring by the coach/staff member in charge of the activity.

6.5. A student injury form must be completed by the member of staff supervising the student at the time and sent to the school Medical Centre.

6.6. A head injury advice sheet should be given to each pupil that has sustained a head injury.

6.7. If a head injury occurs outside of school time, parents are responsible for informing school and keeping school updated with any relevant information.

7. Communications - Residential Boarders

Students with head injuries must be handed over to the Residential House staff member or parent/guardian. Students are not allowed to walk/drive home alone. It is not enough to leave telephone messages about head injuries – an actual conversation must take place.

7.1. The adult supervising the activity is responsible for notify;
- The student's House Parents – This must be done at the time and in person
- The school Medical Centre – This can be done via email:
- medical-centre@gordons.school

House Parents of Residential Boarders must inform the Medical Centre and/or the school on call nurse.

7.2. The adult could be a member of Gordon's School staff or a person acting on behalf of Gordon's School such as a sports assistant/tutor engaged for Gordon's School students.

7.3. House Parents of Residential Boarders are responsible for notifying the student's parent or guardian.

7.4. House Parents of Residential Boarders are responsible for informing the student's external sports club that the student has sustained a Head Injury.

7.5. A student injury form should be completed by the member of staff supervising the student at the time and sent to the school Medical Centre.

7.6. The head injury must be logged on the Return2Play Head Injury website. This injury must be logged within 24 hours of the injury occurring by the coach/staff member in charge of the activity.

7.7. A head injury advice sheet should be given to each pupil that has sustained a head injury.

7.8. If the head injury occurs outside of school time, parents are responsible for informing Gordon's School and keeping the school updated with any relevant information.

8. Return to play/participation

Concussion must be taken extremely seriously to safeguard the short and long-term health and welfare of players, and especially young players.

The majority (80-90%) of concussions resolve in a short (7-10 days) period. This may be longer in children and adolescents and a more conservative approach should be taken with them. During this recovery time however, the brain is more vulnerable to further injury, and if a player returns too early, before they have fully recovered this may result in:

- Prolonged concussion symptoms
- Possible long term health consequences e.g. psychological and/or brain degenerative disorders
- **Further concussive event being FATAL, due to severe brain swelling – known as second impact syndrome.**

The school strongly recommends that students with concussion, and all students who have lost consciousness due to a head injury, should follow the RFU's Graduated Return to Play (GRTP) Pathway (see Appendix B). To facilitate this, Gordon's School work in partnership with the specialist concussion management team 'Return2Play'. Unless parental permission has been withdrawn, all Students are registered with Return2Play.

In the event of a head injury and/or suspected concussion, the Student's injury will be registered with Return2Play who will conduct an initial assessment and confirm diagnosis. If concussion is confirmed, the progression between each stage of the graduated return to play (GRTP) is managed by Return2Play via online appointments.

Any questions regarding Return2Play should be communicated to the Medical Centre:

Medical-Centre@gordons.school

8.1. The Return2Play process will be overseen by the School staff for Residential Boarders during term time and by parents during the School holidays

8.2. The Return2Play process will be overseen by parents of Day Boarders. If parents do not follow the Return2Play process, they will need to sign a disclaimer before their child returns to contact sport **at the end of the 23-day period. The disclaimer does not negate the need for students to abstain from sport for 23 days. School will enforce rest from sport during this time.**

8.3. Progress along the return to play pathway should be documented on the Gordon's School GRTP handover sheet. (Appendix C). This helps staff and the student to see where they are within the process and pass on any pertinent information throughout.

8.4. **Students will not be allowed to take part in contact sports until the full GRTP period has been observed. The successful completion of the GRTP pathway is verified by the school medical centre along with the appropriate documentation the Return2Play system.**

8.5 Heads of House should inform the student's teachers when concussion has been diagnosed. Teachers and other adults supervising students who appear unfit to be in class should make their concerns known to the student's Head of House or the school Medical Centre. It is rare but reasonable for a student to miss a day or two of academic studies, but extended absence is uncommon.

8.5. The GRTP should be undertaken on a case-by-case basis and with the full cooperation of the player and their parents/guardians.

9. Training

9.1. The Head of Rugby should ensure that all rugby coaches complete the England Rugby on-line training course.

9.2. The Head of Rugby should ensure that all rugby players in Y10 and above complete the England Rugby on-line training course.

9.3. The Head of Rugby should ensure that all rugby players in Y9 and below watches a video about head injury and concussion.

9.4. All coaches should be aware of the updated guidance from the RFU - HEADCASE_Essential-Guide_Aug_2023.pdf (keepyourbootson.co.uk)

Julie Unsworth

Lead Nurse

January 2024

Appendix A – Glasgow Coma Scale (GCS)

The GCS is a very simple, easy to administer technique which is used to rate the severity of coma. It assesses the patient's ability to open their eyes, move and speak. The total score is calculated by adding up the scores from the different categories, shown below, and ranges from a minimum of 3 to a maximum of 15.

Best motor response

6 Obeying commands
5 Movement localised to stimulus
4 Withdraws
3 Abnormal muscle bending and flexing
2 Involuntary muscle straightening and extending
1 None

Verbal responses

5 Orientated response
4 Confused conversation
3 Inappropriate words
2 Incomprehensible sounds
1 None

Eye opening

4 Spontaneous
3 To speech
2 To pain
1 None

Appendix B – Graduated Return to Play Pathway (RFU 2016)

HEADCASE

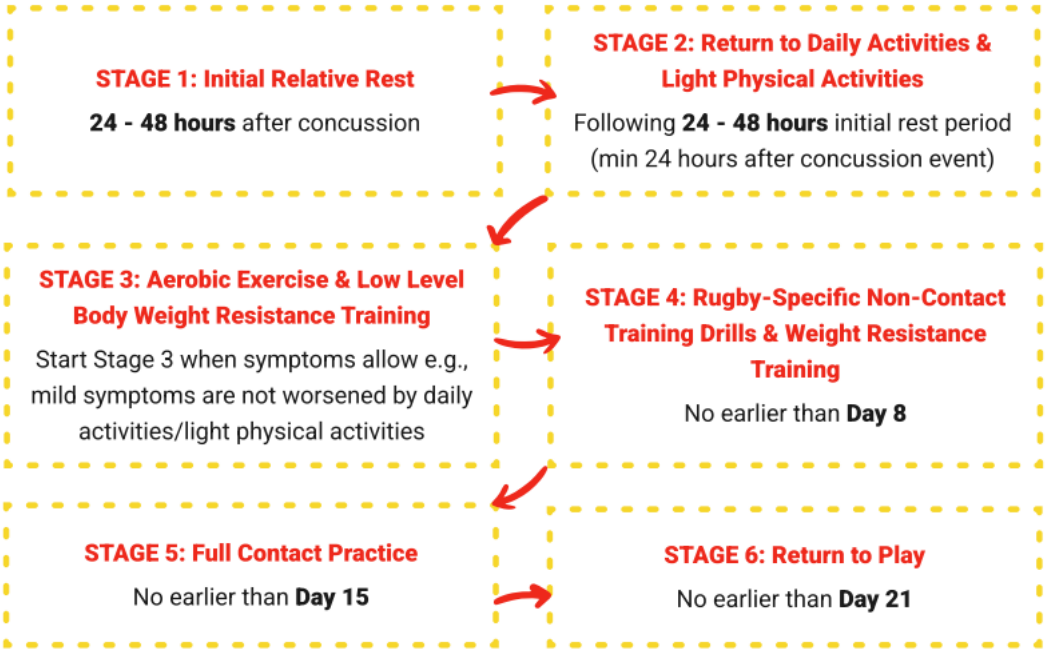
RECOVER & RETURN

GRADUATED RETURN TO ACTIVITY & SPORT

Following a concussion ALL PLAYERS should follow the **Graduated Return to Activity and Sport (GRAS) programme**. This provides a standard framework for all community level players which is designed to safely allow a return to education, work, and sport after a concussion.

Download a detailed version of the GRAS programme.

The overview below sets out the different stages:



Appendix C – Gordon's School Graduated Return to Play Handover Sheet

Duration	Rehabilitation Stage	Medical action point	Comments Add Tick	Sports Coach Signature
0-2 days	**Relative Rest** Minimise screen time and no exercises			
	Medical Assessment *To confirm diagnosis and give recovery advice*			
3-7 days	**Light activity** Gentle walks etc. Activity level shouldn't leave you breathless			
8 days onwards	**Low risk exercise & training** Gradual increase in self-directed exercise – running, stationary bike, swimming, supervised weight training etc. Focus on fitness Can introduce static training drills (eg passing/kicking). Only drills with NO predictable risk of head injury			
	R2P Doctor Assessment *To assess fitness to start a formal return to sport and advise on timeframes*			
15 days onwards	**Gradual return to sports training** Starting with non-contact and gradually building up complexity and intensity.			
18 days onwards	**Introduction of contact in the final stages** Prior to returning to fixtures, you will need to complete a contact training session and have this signed off by your rugby coach Contact session date – Coaches notes:			
	R2P Doctor Assessment – After contact session Date *To assess fitness to return to unrestricted sport, including matches*			
Day 21 earliest	**Earliest return to competitive sport/matches** Only if symptom free at rest for at least 14 days and has completed gradual return to sports training without any recurrence in symptoms			