

Assessment Feedback Sheet

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Module: Professional Development and Practice

Module Code: SHSS4062

Personal Evaluation – to support your academic progress please complete the section below BEFORE submitting your work.									
What do you consider to be the best aspects of this work?	I believe the structure of the assignment is the best aspect.								
Which aspects do you consider could have been improved in this piece of work?	Maybe going into more detail with more serious injuries.								
What have you found most satisfying whilst undertaking this submission?	Researching all the different articles involved in completing this assignment.								
ASSESSMENT CRITERIA	Learning Outcomes	GRADE							
		Poor 0-25%	Unsatisfactory 26-39%	Satisfactory 40 – 49%	Good 50 – 59%	Very Good 60 – 69%	Excellent 70 – 85%	Exceptional 86– 100%	%
Essay content and quality of resources used	1								30%
Referencing within the essay	1								20%
Correctly constructed reference list	1								20%
Structure of essay and clarity of writing	1								30%
It is expected that students will present work that is proof read, correctly referenced and adheres to the Assessment Checklist . Therefore a range of 0 – 10 marks will be deducted for non-completion of any of the points on the checklist below .									

TUTOR COMMENTS:**Submission date: 1/11/19
via Turnitin****Return date: 8/11/19
(at least within 4 weeks)****Tutor:****Mark:**

Professional Development and Practice Assignment

Discuss the role of a pitch side first aider in managing complex sports trauma injury.

This assignment will focus on the skills required in treating and managing different types of injuries as a pitch side first aider. There will be examples to illustrate the main points. For this purpose I am going to categorise injuries as minor, medium, severe or life threatening. Sporting injuries must be managed in a professional and appropriate manner. Advanced qualifications and training mean that pitch side first aiders are able to diagnose, manage and treat a range of complex injuries and are equipped to make decisions regarding player care and return to play (Hanson, 2010) cited by (Stuart 2018). Readers will also have an idea of injury severity as these will be considered in detail throughout.

There is a huge responsibility on the pitch-side first-aiders to recognise, manage and control a situation regarding a traumatic injury. The most crucial role of a first aider is prevention. Prevention both of harm to the first aider, and prevention of further harm to the player requiring medical assistance. (The Football Association (The FA), 2018). To effectively achieve this, the first aider should follow certain precautions as the pitch side first-aiders in charge of training and a game.

The first aider has a number of essential duties to perform. Firstly, scene safety is an important part of management ensuring the safety of both player and first aider. Secondly, the first aider should have a suitably stocked first-aid kit when present at all events including training and matches. It is highly recommended that the first aider has access to an automated External Defibrillator (AED) that is kept in a place where the first aider is familiar with. First Aid room for treatment of the injured player, stretcher, copy of the first aid manual, player injury records and a concussion recognition tool aligned to The FA concussion guidelines. (The FA) (2018).

Lastly, having a working knowledge of the club's emergency action plan relevant to emergency care of a player. Initial on-field management begins before the start of the game by being prepared for a complex traumatic injury. It is imperative that the covering first aider is aware of the available equipment, medical staff, and injury protocol in place. This entails having knowledge of the predetermined definitive medical facility and means of expedient transportation to the hospital.

An immobilisation backboard and adequate tools for a severe injury should be standard side line equipment. (Assenmacher, Shroeder and Patel, 2013).

Injuries can be categorised from minor and medium traumatic injuries which can include fractures and soft tissue damage through contact or a collision, to more serious and potentially a life threatening traumatic injuries. The standard procedure of DR ABCD would be used when assessing all injuries on the field of play. This will be further discussed in detail when addressing more serious injuries which are treated pitch side events. When treating a soft tissue injury it is critical not to be indecisive and to act instantly. Check that the player is alert with no signs of confusion or concussion and no injury to the neck or any other serious injuries. It is vital for first aiders to be aware of the initial checks for suspected fractures and also to have a good understanding of operative and non-operative management and strategies for recognising any fracture (Nambiar, West and Bingham, 2017). If a player with a soft tissue injury can be moved then that should be done as soon as possible. Bleeding and immediate inflammation on the soft tissue, however, can cause serious damage to the muscle in the surrounding area. In order to prevent further injury to the soft tissue compression, elevation and immediate application of ice is advised (The Football Association (FA), 2018). It is not always easy to differentiate between a soft tissue injury and a broken bone. The correct procedure here would be to feel the injury for warmth, deformity and swelling. Tenderness and some pain on the exact site of the injury may be felt by the player. If unsure about type of injury it should be treated as a broken bone and the player referred to the hospital.

When dealing with a dislocation Shah et al (2017) state that the incidence of acute traumatic shoulder dislocation varies within the sporting environment, commonly occurring following direct trauma. There is no standardised, published management protocol for the initial management of an anterior dislocated shoulder in a pitch-side setting. Although most are dealt with in the emergency department, pitch-side management by experienced first aiders does occur prior to referral (Shah et al, 2017). Patients may present with a history of their shoulder slipping out but may also only be able to report pain associated with making a tackle, for example. Therefore, when treating young athletes for shoulder instability a high degree of caution should be exercised.

In the case of a more serious and complex traumatic injury the player should not be moved and should be kept still, comfortable and warm. Reassurance of the player is key until medical assistance arrives for transfer to the hospital (THE FA) (2018). The DR ABC approach is a key protocol which the first aider-includes should observe and it the assessment of danger both to the first-aider and the player. The first D stands for Danger. It requires the first-aider to approach the player if safe to do so and remember to call the ambulance if required. R stands for response, the first-aider would next speak to the player in a clear and loud voice hoping to get a response. If trauma is suspected at this point the player should be approached with manual line stabilisation without moving the head and neck. A, represents the airway and this should then be checked , looking inside the player's mouth to see if anything is impeding the breathing. "The airway should then be opened using the head tilt chin lift manoeuvre" (THE FA , 2018, p.15). If trauma is suspected from falling onto his/her head, neck or face, then a potential neck injury may have occurred and in opening the airway the neck should not be moved. In this situation the jaw thrust method should be used. B is for breathing and after the airway has been cleared, checking the breathing would be the next step. The first-aider should look, listen and feel for breathing for a maximum of 10 seconds. This is done by placing the ear close to the player's mouth and looking down at the players chest to check for the rising of the chest. If a player is not breathing the first-aider will normally begin Cardio-Pulmonary Resuscitation (CPR)(Kramer et al, 2012). C stands for circulation and after the checking of breathing, the first aider will check circulation, looking for and stopping any life threatening bleeding. At this point the first aider looks for signs of life which includes checking for normal breathing, checking the eyes, unprompted movement of arms and legs and skin colour. The player would have been exercising therefore will not be pale or cold but will be red and warm. The last D in DR ABCD is Disability, which happens if a player is unresponsive. The first-aider will reassess and monitor the player's level of response for signs of improvement. This can be achieved by noticing if the player is fully alert and responsive or whether the player is unresponsive.

As a result of a more serious complex traumatic injury pitch side, when evaluating players with a possible spine injury an algorithmic approach is crucial. Injuries to the head and neck can be very serious and on occasion fatal. When dealing with a spine injury, the primary survey is conducted in the same fashion as it is in any significant trauma scenario. Careful handling and immobilisation of the spine throughout all steps of the initial evaluation is crucial.

A head injury or concussion is any trauma that leads to injury of the scalp, skull or brain usually resulting from an injury above the collar bone. Any player that has received a blow to the head should be managed very carefully by the pitch side first aider. Pitch side first aiders are responsible for recording and reporting concussion details for example, date of injury, return to play date, age, stature, body mass, playing position, starter or replacement player, what half of game concussed, activity at time of injury (collision, maul, ruck, scrum, tackled, tackling); removal from play immediate or delayed. (Fuller, Taylor, Raftery, 2015). It is an important factor in a concussion situation to remove the player from the field if showing any signs of concussion.

In a situation when Sudden Cardiac Arrest (SCA) is involved instant management needs to take place. In order to achieve a rapid response practically involves immediate collapse recognition, rescuer activation, retrieval of the defibrillator, arrival at the patient's side, attach the defibrillator with recognition of arrhythmia and defibrillator charge then a shock if advised by the defibrillator. (Kramer, Dvorak and Kloeck, 2010). The standard advanced trauma life-support protocol is employed to identify any life-threatening injuries as well as to allow for complete assessment of the athlete's condition (Assenmacher, Shroeder and Patel, 2013). It is essential that as the pitch side first aider is fully conversant and in control with the features of the AED.

In conclusion, having looked at managing different injuries the implications for first aider become apparent. The role and the way the injury is managed is a huge responsibility and the decision of the first aider is crucial. It is very important that the first aider is able to manage, control and determine if a player is fit to continue on the field of play by carefully going through a step by step procedure of managing the injury.

Word Count - 1,639

Referencing

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