



THE ASCENSION PROJECT

Emergency Action Protocol (EAP)

INTRODUCTION

The Ascension Project USTA Professional tennis tournament has developed the following Emergency Action Plan (EAP) to better ensure the safety of athletes, coaches and staff. Visiting players are covered under the EAP and shall be provided with equal access to health care while competing in a USTA-sanctioned event. Following the National Collegiate Athletic Association (NCAA) and National Athletic Trainers Association (NATA) recommendations for emergency preparedness, the EAP is to be used as a guideline for any emergency situation.

Included in the EAP are emergency personnel, emergency communication and emergency medical service (EMS) activation, available emergency equipment, EMS access points, severe weather shelter areas and evacuation plans, and a facility map.

This policy has been reviewed in person with all medical staff involved in The Ascension Project Tennis Tournament. Roles and responsibilities have been discussed should an emergency situation arise. This document will be available on the Sun Oaks website for quick and easy access. In addition, a copy of each individual EAP will be available to all staff within each venue used by Sun Oaks. The medical staff will review this policy when necessary to implement any necessary changes.

EMERGENCY PERSONNEL

In most situations the first responder is a certified athletic trainer (ATC) or even a staff member employed by Sun Oaks Tennis & Fitness. However, in cases where coverage is limited, a trained non-medical staff member may be present to act as the first responder until a higher trained professional arrives. Sun Oaks Tennis & Fitness requires all staff members to be CPR and AED certified. The tournament physician will be mostly present at competition events, but their schedule will vary from day to day. The head ATC at the scene is in charge. In situations where the tournament physician is more qualified, management will be given to the tournament physician. The role of Sun Oaks staff and volunteers will be designated as seen fit by the person in charge (PIC), typically used as crowd control, EMS arrival and/or the gathering of needed emergency equipment.

SPORTS MEDICINE COVERAGE

Certain sports are deemed higher risk than others. Per WTA/USTA recommendations, for those sports deemed at lower risk such as tennis, the presence of at least one ATC trained in CPR, first aid and prevention of disease transmission is recommended at practice and matches. If an ATC is not able to be physically present, one must be available to respond within four minutes and must be accessible via any sort of communication medium at all times.



EMERGENCY EQUIPMENT

Emergency equipment present at sporting events will vary depending on type of sport. During competition coverage, emergency equipment, including AEDs, will be on site and quickly available to sports medicine staff. It is important that this equipment be in excellent working condition and checked regularly by a member of the sports medicine staff. Written documentation of regular maintenance checks of emergency equipment should be kept by a designated staff member at the front desk. See AED policy for additional information.

AED GUIDELINE-INTRODUCTION

The following policy on **Automated External Defibrillator (AED)** placement and use has been developed by the Sports Medicine Department to provide the highest quality healthcare with trained responders and early access to CPR/AED for the athletes and staff at the Ascension Project tennis tournament. This policy is reviewed annually and revised as needed.

BACKGROUND

An AED is a portable electronic device that can audibly prompt and deliver an electric shock that will disrupt or stop the heart's abnormal electrical activity. The shock will not start a dead heart, but it will stop certain lethal rhythms and give the heart a chance to spontaneously re-establish an effective rhythm on its own. According to the American Heart Association, CPR rescue attempt using electric defibrillation or AED's improves survival rates by as much as 49%.

Facts According to the American Heart Association (AHA)

- In the United States 1,000 adults die from Sudden Cardiac Arrest (SCA) per day, a total of 350,000 per year. SCA is the result of an arrhythmia, where the electrical pulse of the heart goes out of control, causing the heart to quiver. The mechanism is unknown in most cases, but shocking the fibrillating heart is the only effective treatment.
- The American Heart Association estimates that 20,000 to 100,000 SCA deaths could be prevented each year if defibrillation was readily available. Electrical shock restores a heartbeat and circulation, but to survive neurologically intact, rescue must be swift.
- Defibrillation within the first minute of sudden cardiac arrest can save the lives of up to 90% of its victims. However, with each minute of delay until defibrillation, the survival rate drops by 10%
- All AEDs are FDA approved. All AEDs use visual and voice prompts to easily guide the user through a rescue use. All come with a 5-year warranty. All use biphasic waveforms to deliver life-saving therapy. All AEDs perform electronic self-tests for circuitry and batteries regularly. The AED itself has a visual and/or audible indicator for ease of manufacturer's warranty.



GUIDELINE

This guideline serves to review and provide optimal strategies for the sports medicine team to locate and utilize the AED machines in an emergency situation. Sun Oaks Tennis & Fitness currently owns 1 total AED all made by Phillips. The AEDs are strategically placed at the front desk.

Designated Areas:

1. **Extension Front Desk** Sun Oaks Front Desk

During the tennis tournament, only the front desk AED will remain at the Front Desk as posted on the notifications around Sun Oaks. The ATC will be made aware of the location of the AED. An open communication and knowledge of the proper placement area when the AED is necessary during an emergency event.

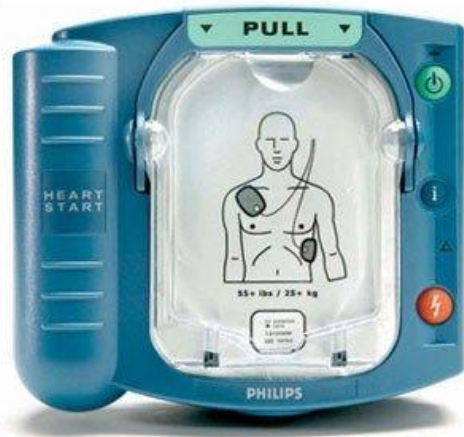
USER/PHYSICIAN POLICY

- All physicians and medical staff covering events must be aware of where to locate AED in case of Emergency.
- All physicians covering events also must check AED battery life prior to the event
- All current and new medical staff must undergo and complete the AED responder training program (BLS/AED/First Aid).
- Refresher training is done yearly for the medical staff and every 2 years for the support staff.

MANAGEMENT OF SUDDEN CARDIAC ARREST (SCA)

- SCA should be suspected in any collapsed and unresponsive athlete.
- The initial components of SCA management are early activation of EMS, early CPR, early defibrillation, and rapid transition to advanced cardiac life support.
- An AED should be applied as soon as possible to **any collapsed and unresponsive athlete** for rhythm analysis and defibrillation if indicated.
- The AED will automatically prompt the user on how to proceed when appropriately attached
- CPR should be provided while waiting for an AED.
- Interruptions in chest compressions should be minimized and CPR stopped only for rhythm analysis and shock.
- CPR should be resumed immediately after the first shock, beginning with chest compressions, with repeat rhythm analysis after every 2 minutes or 5 cycles of CPR, and continued until advanced life support providers take over or the victim starts to move.

- SCA in athletes can be mistaken for other causes of collapse, and rescuers should be trained to recognize SCA in athletes with special focus on potential barriers to recognizing SCA, including inaccurate rescuer assessment of pulse or respirations, occasional or agonal gasping, and myoclonic jerking or seizure-like activity.
- Young athletes who collapse shortly after being struck in the chest by a firm projectile or by player contact should be suspected of having SCA from commotio cordis.
- Rapid access to the SCA victim should be facilitated for EMS personnel.



AED BATTERY LIFE

Type Non-rechargeable, LiMnO₂ 12V, 2.6 Ah

Shelf Life at 25°C ± 15°C

10 years (5 years storage + 5 years standby)

5 years standby (after installation)

It takes up to Capacity 60 discharges at 360 Joules to reach low battery warning. It will take up to 90 discharges at 360 Joules to completely exhaust the battery or 125 discharges at 200 Joules or 150 discharges at 150 Joules or 5 hours ECG monitoring.

AED PACK CHECK

It is imperative that the AED pack be checked on a routine basis. The AED machine is non-functional if the proper attachments are not locatable. Every pack should have disposable **razor, and electrodes with attached adhesive pads**. Every AED needs to be checked on the 1st of every month by an assigned club staff member, and log in monthly checks on check list. Each AED is also checked just prior to practices and competitions.

AED Check Log Form

AED Number	1
Location	Front Desk AED
JAN	
FEB	
MAR	
APR	
MAY	
JUN	
JUL	
AUG	
SEP	
OCT	
NOV	
AED Maintenance Form	

EMERGENCY COMMUNICATION

Proper communication among members of the sports medicine staff, and in combination with EMS, is vital in the prompt care of a downed athlete. Prior to each practice or competition the established emergency communication line (cellular phone, two way radio or landline) should be checked to ensure proper function. It is important to always have a backup line ready in case of primary failure. All members of the sports medicine team should know the location of the nearest landline telephone within sporting venue, home or away. Access to this phone should be made available prior to start of event.

Primary communication within Sun Oaks Tennis & Fitness is done through the use of personal cellular phones, the use of two-way radios and landline phones.

ACTIVATING EMS

Once the ATC has made the decision to activate EMS at a venue where EMS is not present, the designated person uses the emergency communication device (cellular phone, stationary land line or two-way radio) to contact emergency services. This person should be one who is calm under pressure and capable of talking clearly over the phone. They should also be familiar with the location, facility address and EMS access point to direct them to the scene of the downed athlete. This is to ensure quick and precise arrival of EMS to the scene. Once in contact with dispatch:



- State name address and telephone number of caller
- State number of athletes, nature of injury or condition(s)
- State current care being given or initiated by first responder
- State specific directions to emergency scene
- Give other information requested by dispatcher
- Stay online until instructed to hang up

The ATC in charge of the situation should delegate another person, or two if needed, to meet EMS at major intersections to direct them to the location of the scene. This person should have keys to any locked doors or gates that may delay the arrival of EMS. A member Sun Oaks management team or designated staff member may be appropriate for this role.

EMERGENCY SIGNALS

A list of designated emergency signals has been established by the sports medicine staff and will be used to signal to other sports medicine staff members what is needed. The list is as follows:

- EMS on Field Point to the sky, make large arm circles overhead (when present)
- Call EMS Point to the sky, make large arm circles overhead (when not present and other staff to call EMS)
- AED Two fists on chest
- Splint Kit Mimic the action of an air pump in your hands
- Cart Mimic steering a wheel with two hands

These are discussed as a staff and reviewed regularly

EMERGENCY CARE FACILITIES

In order to provide the quickest and safest emergency care to athletes, the host athletic trainer should know the location of the available emergency care facilities located near the sporting venue. A list of these facilities is located within each EAP with written directions. If possible, a member of the team should accompany the athlete to the facility with needed medical information readily available.

When transferring an athlete to emergency or urgent care facilities, a copy of primary and secondary insurance should accompany the athlete. If possible personal identification of athlete should be readily available. In addition, notes, verbal or written, of previously administered care should be reported to care facility as soon as possible.

The ATC in charge will contact the tournament physician as soon as possible to inform him/her of the situation. Our tournament physician will call the emergency care facility in which the athlete was transferred and make contact with the physician in charge of the athlete.

MEDICAL EMERGENCIES

ALSO SEE SPECIFIC MEDICAL GUIDELINES PUBLISHED BY THE WTA/NCAA

- Sudden Cardiac Arrest Guideline
- Heat Illness Guideline
- Lightning Guideline
- Cervical Spine Injury Guideline
- Hydration Guideline
- AED guideline

SUDDEN CARDIAC ARREST (SCA)

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RESPIRATORY DISTRESS

Shortness of breath or difficulty breathing in an athlete may have different causes. The cause should be evaluated by the ATC or tournament physician if present. If necessary supplemental oxygen via nasal canula or a face mask should be started immediately. If pulse oximetry is available, SO₂ should be measured.

Auscultation of the lungs should be done, based on the findings and on other signs and symptoms the following diagnoses should be anticipated and therapy should be started:

- **Asthma or Exercise Induced Bronchospasm (EIB)**
 - If wheezing or bilateral diminished air entry-consider acute asthma exacerbation.
 - *Albuterol MDI 2 puffs*
 - Preferably, if patient is able, peak expiratory flow meters should be checked prior and after albuterol inhalation.
 - If patient improves, he should stop the athletic event on that day and follow up with with our tournament physicians for optimization of his/her asthma/EIB management.
 - If patient does not improve significantly and/or his SO₂ remains low he/she should be transported to the Emergency Department.
- **Anaphylactic reaction**
 - Shortness of breath with signs of anaphylaxis;
 - flushing, itching, hives, sneezing, lightheadedness;
 - Insect sting or history of previous anaphylaxis;
 - *EpiPen 0.3mg IM/SQ and transport to Emergency Department*
- **Tension pneumothorax**
 - Decreased breath sounds-unilateral;
 - Hyper-resonance to percussion-unilateral;
 - *If physician available, needle decompression on-site*
 - *Transport to Emergency Department*
- **Hyperventilation**
 - Rapid respiratory rate;
 - Lungs clear on auscultation;
 - Anxiety, lightheadedness, tingling in fingers and around mouth;
 - *Encourage patient to slow breathing*
 - *If no improvement, physician evaluation*

If patient's symptoms do not improve significantly or the cause remains unclear, he/she should be transported to the ED. Other less serious and less frequent causes of difficulty in breathing are:

- **Upper respiratory infections, Pneumonia**
- **Vocal cord dysfunction**
- **Pulmonary embolism**
- **Cardiac causes**
- **Hematologic causes, e.g. Anemia**

HEAD INJURY/INTRACRANIAL BLEED

Day-of-injury, notify tournament physician for evaluation.

- Loss of consciousness on the court
- Amnesia lasting longer than 15 min
- Deterioration of neurologic function*
- Decreasing level of consciousness*
- Decrease or irregularity in respirations*
- Decrease or irregularity in pulse*
- Increase in blood pressure
- Unequal, dilated, or nonreactive pupils*
- Cranial nerve deficits
- Any signs or symptoms of associated injuries, spine or skull fracture or bleeding*
- Mental status changes: lethargy, difficulty maintaining arousal, confusion or agitation*
- Seizure activity*
- Vomiting
- Motor deficits subsequent to initial on-field assessment
- Sensory deficits subsequent to initial on-field assessment
- Balance deficits subsequent to initial on-field assessment
- Cranial nerve deficits subsequent to initial on-field assessment
- Post-concussion symptoms that worsen
- Additional post-concussion symptoms as compared with those on the field
- Athlete is still symptomatic at the end of the game

***Requires that the athlete be transported immediately to the nearest emergency department.**

Delayed referral (after the day of injury), notify tournament physician for evaluation.

- Any of the findings in the day-of-injury referral category
- Post-concussion symptoms worsen or do not improve over time
- Increase in the number of post-concussion symptoms reported
- Post-concussion symptoms begin to interfere with the athlete's daily activities (i.e., sleep disturbances or cognitive difficulties)

CONCUSSION

On Court or Sideline Evaluation of Acute Concussion

If an athlete shows **ANY** sign of concussion:

- The athlete should be evaluated onsite using standard emergency principles. Particular attention should be given to excluding a cervical spine injury.

- The appropriate disposition of the student athlete must be determined by a health care provider in a timely manner. Athletic trainers should use the Physician Referral Checklist for Athletic Trainers to determine if the athlete needs day of injury referral to a physician. If no healthcare provider is available, the athlete should be removed from practice/play and urgent referral to a physician should be arranged.
- Once the first aid issues have been addressed, an assessment of the concussive injury should be performed using the SCAT2 or similar tool.
- The player should not be left alone following the injury and serial monitoring for deterioration is essential for the initial few hours following the injury.
- A student athlete diagnosed with a concussion will not be allowed to return to play on the same day as the injury.
- Sideline evaluation should include brief cognitive testing that assesses attention and memory function, balance assessment and assessment of signs and symptoms. It should be understood that these tests are not meant to replace comprehensive neuropsychological and clinical testing.
- Recognize that symptoms may be delayed for several hours following a concussive episode.

Concussion Management

- The cornerstone of management is complete rest from training, competition and cognitive activities until all symptoms resolve. Then, a graded program of exertion is completed before return to sport.
- Injury usually progressively resolves without complication over 7-10 days.
- Athlete typically resumes sport without further problems.
- Neuropsychological computerized screening will be used to assist return to play decisions, however it is not the sole tool used for management decisions.
- Most concussions can be appropriately managed by primary care physicians or by certified athletic trainers working under medical supervision.
- All concussions mandate evaluation by a medical doctor.

SPINAL INJURY

Initial Assessment:

- The presence of the following findings, alone or in combination, requires the initiation of the c-spine injury management protocol:
 - Unconsciousness
 - Bilateral neurologic findings or complaints
 - Midline spine pain or tenderness
 - Obvious spinal column deformity
- **In a suspected spine injury:**
 - Review mechanism of injury, consideration of BLS and activation of EMS
 - If unconscious, presumed unstable cervical fracture until proven otherwise
 - If unconscious and face down, must be rolled to supine w/o spine board but with c-spine stabilization to access airway rapidly
 - **APPLY AED TO ALL UNCONSCIOUS ATHLETES**
 - Cardiac emergencies can mimic head/cervical spine injuries
 - If conscious, face down but suspect c-spine injury, roll to supine onto the spine board

All players with suspected c-spine injury must have face mask removed

Airway:

- If unconscious, SOB, difficulty breathing, one team member to hold c-spine, athletic trainer to remove face mask rapidly with proper equipment
- If airway is necessary, and jaw thrust unsuccessful, ETT or King Laryngeal Tube Insertion must be performed by MD or EMS on the field

● **Breathing:**

- Ineffective breathing patterns, use of accessory muscles, apnea can be caused by high c-spine injury which inhibits output from phrenic nerve innervating the diaphragm
- C-spine injury must be ruled out before evaluation of rib fractures and/or pneumothorax

● **Circulation:**

- Check radial/brachial pulses, not carotid in suspected c-spine injuries. Circulation abnormality with inadequate peripheral perfusion is unlikely in the absence of a primary cardiac event
- If suspected cardiac event, apply AED immediately

● **See Cervical Spine Injury Guideline for management of 8 different scenarios:**

- Conscious patient, lying face up (supine)
- Conscious patient, lying face down (prone)
- Conscious patient, standing
- Conscious patient, sitting
- Unconscious patient, lying face up (supine)
- Unconscious patient, lying face down (prone)

SICKLE CELL TRAIT AND SICKLE CELL CRISIS

Sickle Cell Crisis is a **MEDICAL EMERGENCY** and can have serious complications. Prompt medical attention is of utmost importance

- The ATC should be aware of all athletes with sickle cell trait
- If a sickle cell trait (SCT) athlete begins to struggle in a practice, sickle cell crisis should be anticipated and the athlete should stop the practice and medical attention should be prompt:
- Have the athlete lay down
- Check vital signs, cool the athlete if elevated temperature (see Heat Illness EAP)
- Give supplemental O2 via facemask
- If patient has not improved by these measures, call 911
- Attach AED
- Start IV line with NaCl 0.9% solution
- Transport the student-athlete to the Emergency Department immediately
- Phone the ED doctors and tell them to expect rhabdomyolysis and grave metabolic complications

HEAT ILLNESS

Heat Syncope Treatment

- Place athlete in recumbent position with legs elevated above head level
- Place athlete in cool shaded environment
- Monitor vital signs
- Oral hydration if under hydrated

Heat Cramp Treatment

- Stop exercise
- Place athlete in cool shaded environment
- Passive stretching of painful muscles
- Remove constrictive clothing/equipment
- Re-establish normal hydration status with sodium containing fluid
- Additional sodium may be needed.
 - ***Drink 16 fl oz of sports drink with 2.5mL (1/2 tsp) of extra salt added at the first signs of muscle twitching and continue this throughout the event***

Heat Exhaustion Treatment

- Monitor core body temperature
- Place athlete in cool shaded environment
- Remove excess clothing and equipment
- Rehydrate orally with sports drink if athlete is not nauseated or vomiting, or experiencing CNS dysfunction. Evaluate for IV fluids.
- Transport to an emergency facility if recovery is not prompt

Heat Stroke Treatment

- Immediate whole body cooling and rapid reduction of core body temp is priority
- Remove clothing and immerse in a pool or tub of cool water. Cease when core body temperature < 38C or 100.5 F
- Activate EMS and transport immediately
- Avoid antipyretics due to normal hypothalamic set point and decrease hepatic or renal injury
- Consider diazepam or lorazepam to control shivering and seizures
- Maintain ABCs and monitor vital signs and CNS status
- Rehydrate with IV if staff is available

Lightning Injuries

Observe the following basic first aid procedures in managing victims of a lightning strike:

- Activate local EMS
- Lightning victims do not "carry a charge" and are safe to touch.
- If necessary, move the victim with care to a safer location.
- Evaluate airway, breathing, and circulation, and begin CPR if necessary.
- Apply and use AED if indicated

- AEDs are common, safe and effective means of reviving persons in cardiac arrest.
- AEDs are available at all ATC attended practices and competitions.
- Do not delay CPR while searching for an AED
- Evaluate and treat for hypothermia, shock, fractures, and/or burns.

FRACTURES/SPRAINS/STRAINS/BLEEDING

The athlete should be evaluated by a healthcare provider for the following:

Fractures

- Fractures are among the more serious injuries sustained in sports. Following signs/symptoms suggest a bone fracture:
 - Hearing or feeling a "snap"
 - Tenderness or pain, usually localized to a specific area of the body
 - Pain upon moving the injured part
 - Obvious deformity
- If a fracture is suspected, the athlete must be evaluated by an ATC or the Team Physician
 - Inspection, palpation, active and passive ROM
 - Check for pulses distal to suspected fracture
 - Check skin warmth and color distal to suspected fracture
 - Check for sensitivity and muscle strength distal to suspected fracture
 - *Immobilize the extremity using vacuum splint (or splint for smaller bones), if possible one joint proximal and distal to the suspected fracture should be immobilized*
 - After immobilization recheck warmth, color, pulse, sensitivity and muscle strength
 - If open fracture, transport the athlete to the Emergency Department

Sprains/Strains

- The athlete should be evaluated for a sprain or a strain.
 - Following symptoms are usual: localized pain, swelling, ecchymosis, decreased ability to move the joint.
 - Following joints are usually involved: ankle, knee, wrist, fingers, toes
- The athlete should be assessed by ATC or team physician
 - Inspect the painful area
 - Palpate to localize the tender area
 - Check for active and passive ROM
 - If no pain produced by active and passive range of motion, have the athlete demonstrate some game skills
 - *If no injury identified, able to perform game skills without problems, may return to play*
 - If pain is produced during the examination:
 - *Remove athlete from game/practice*
 - *Treat with Rest, Ice, Compression, Elevation (RICE)*

Bleeding

- Always use gloves when there is a chance of coming into contact with blood
 - *Apply direct pressure to the wound with a sterile dressing or bandage*
- The bleeding should be evaluated by ATC or Team Physician:
 - If superficial wound which doesn't need to be closed:
 - *Clean and cover the wound with gauze dressings using a roller bandage to maintain pressure, return to play*
 - *Re-evaluate the wound after the practice/game*
 - If superficial wound which needs to be closed:
 - *Clean the wound and close with sutures, stitches, steri-strips or Dermabond at the event OR consider cleaning and covering the wound with gauze dressings using a roller bandage and closing it at time out/after the match/or after the practice session*
 - If bleeding profusely, or bleeding from an artery or in wounds that show muscle or bone, involve joints or widely open, call 911 and transport to the Emergency Department
 - **Arterial blood is typically bright red in color and exits the wound in spurts, rather than in a steady flow. This is a medical emergency:**
 - *Apply manual pressure, keep extremity elevated*
 - *Monitor vital signs*
 - *Place IV line and start NS*
 - *Transport the athlete to Emergency Department*

HOW AND WHEN IS THE EMERGENCY ACTION PLAN (EAP) COMMUNICATED TO ATHLETES AND STAFF?

Our EAP is available on the Sun Oaks website. All our athletes and coaching staff have quick and easy access. In addition, a copy of each individual EAP will be available to all staff at each venue used by Sun Oaks.

INCLEMENT WEATHER

In the case of severe weather, a designated shelter area will be available during practices and competition. The location of the area will be stated in each EAP. Any member of the sports medicine staff has the unchallengeable authority to cancel or modify a workout if conditions (environmental or otherwise) are deemed unsafe.

Potential severe weather threats in Redding are lightening storms and extreme hot and cold weather. Sun Oaks Tennis & Fitness follows the recommendations given by the WTA in its Lightening Position Statement. Please refer to the WTA guideline for detailed descriptions of heat and air quality evaluations during the tournament.

DOCUMENTATION/FOLLOW UP

The PIC (ATC or physician) will be the one to document the events of the emergency situation. All persons involved in the care of the downed athlete will review the final write up to make sure no details were forgotten. At a convenient time shortly following the event, all persons involved will meet to follow up on management and response to situation. A review of what went smoothly and what could be improved upon will be completed. The ATC will document this meeting.



This EAP and other emergency care techniques (cervical spine boarding, AED use and CPR) will be rehearsed and reviewed twice a year—once prior to the start of the tournament. Persons included in this review are ATCs, physicians, athletic training students, and EMS personnel. Cervical spine boarding will be reviewed based on the NCAA Sports Medicine’s Cervical Spine Boarding Policy. EMS representative will be present to review policies and procedures that may have changed from previous in-service.

ROLE OF REDDING POLICE AND SAFETY OFFICERS

The role of Redding police and safety during an emergency situation is (1) to be of assistance to the PIC (athletic trainer, tournament physician, etc.) and (2) to serve as crowd control while EMS is directed to the scene and/or care of athlete is administered. This role will vary from situation to situation and will be instructed as needed.

CRISIS MANAGEMENT

In the case of a tragic incident (such as the death of an athlete, coach or Sun Oaks staff member) during an athletic sanctioned event, Sun Oaks has developed an emergency action protocol to ensure precise, quick and effective management of the situation university wide. In the majority of cases, the ATC supervising will contact the Director of Sports Medicine and as well as the owner Jeremiah Walsh only after the situation has been handled and all safety precautions have been met. The supervising ATC will document the incident in full and relay needed information to the Director of Sports Medicine as soon as possible.

The owner is responsible for informing the remaining staff members will choose to inform the media. The ATC and his/her involvement should be minimal.

OVERVIEW OF ALL VENUES

Outdoor Tennis court

Emergency Personnel: Certified Athletic Trainer(s), Sun Oaks Staff (s), Sports Medicine Physician(s)

Emergency Communication: Cellular phone. Backup landline is located in the front offices. The phone number is 530-221-4405.

Emergency Equipment: AED on site, Splint kit (containing small, medium and large), physician's medical kit (containing suture materials, IVs and medications for physician use only).

EMS Access: EMS vehicle entrance is located by the front entrance parking lot gate



- State name address and telephone number of caller
- State number of athletes, nature of injury or condition(s)
- State current care being given or initiated by first responder
- State specific directions to emergency scene
- Give other information requested by dispatcher
- Stay online until instructed to hang up

Emergency Care Facilities:

Mercy Medical Center
2175 Rosaline Ave,
Redding, CA 96001
(530) 225-6000

Shasta Regional Medical Center
1100 Butte St
Redding, CA 96001
(530) 244-5400



Map to Sun Oaks (see attached)

EMS Transport Route:

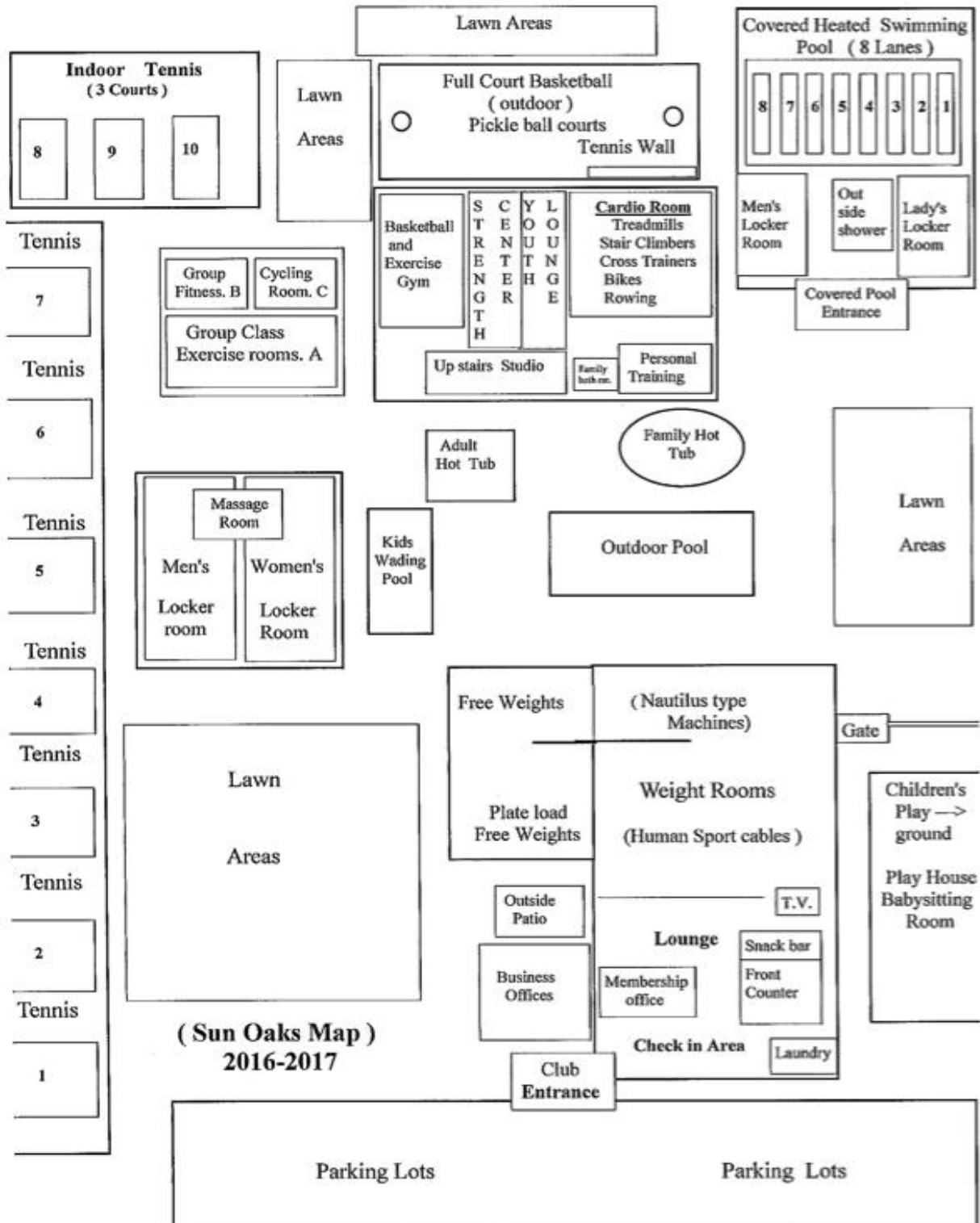
Ambulance will be called by staff that will be waiting for arrival at gate by front entrance.

Access will be granted, gate unlocked by staff member with key found in the office via the sliding glass door.

Patient will be stabilized and loaded via EMS mobile gurney from the injured site and transported via ambulance to the Emergency Department.

SUN OAKS

TENNIS & FITNESS



S U N  A K S

TENNIS & FITNESS