Emergency Medical Standards
For the Care of the Injured N.H.L. Player

2013-2014 Season (revised 8/26/13)

GOAL: To provide a consistent level of medical care for potential catastrophic injury at all NHL practices and games for both home and visiting teams.

The Emergency Care Task Group of the Medical Standards Subcommittee with the NHL Team Physicians Society (NHLTPS), the Team Athletic Trainers (PHATS), and the NHLPA (in connection with Collective Bargaining) have developed the following standards regarding the medical care of NHL Players, which are required to be implemented in each NHL Club's game and practice facilities for the 2013-14 season, including practices. Except for what is mandated by the CBA, it is recognized that a "one size fits all" solution may not be practical in all situations. If you believe you can meet the goals and functions outlined below in a different manner, you can contact Julie Grand at the League, who will consider if an exception to a specific item below, and approval of an alternative, is appropriate or permitted under the CBA.

Please note that the Medical Standards are intended to be consistent with the central philosophy of emergency care: stabilization and transport. It is not the intent that definitive care be provided at the arena but, rather, that Club facilities shall be staffed and equipped to stabilize and transport the injured player to a tertiary care center (e.g. hospital emergency department).

1. MEDICAL STAFF

1.1 MEDICAL DOCTORS:

- Each team shall have a minimum of two (2) team physicians in attendance at all home games.
- At least one of the team physicians shall have successfully completed hockey specific trauma management training (such as that offered by the NHLTPS) or Advanced Trauma Life Support (A.T.L.S.) training in the previous 3 (three) years.
- Each team shall have consultant specialists at each home game (the selection of whom shall be at the discretion of the Head Team Physician) to complement the skill set of the two (2) team physicians.
- Each Club's team physicians in attendance at home games shall include, either as part of the two (2) main team physicians or as consultants, (i) an orthopaedist and (ii) an internal medicine, emergency medicine or primary care sports physician.
- At least one of the team physicians shall have familiarity with the NHL Modified SCAT3 or other comprehensive standardized acute concussion assessment tool as recommended by the NHL/NHLPA Concussion Subcommittee.
- Team physicians shall be seated in close proximity to (within 50 feet of) the Players' bench with immediate access to the bench and ice surface in order to facilitate swift and easy access to the Players in the event of medical emergencies.
- During game play, one team physician must be in attendance at rink-side or in the medical room observing the game on reliable live television feed, provided rapid access to the bench and ice surface is not compromised.
- Each medical doctor hired or otherwise retained by the Club after the start date of the new CBA to treat its Players as part of the Club's primary medical team shall, in the United States be board certified in their respective field(s) of medical expertise, and in Canada be board certified by either the Royal College of Physicians and Surgeons (for specialists) or the College of Family Practice of Canada (for family physicians). Each Club medical doctor who is part of the primary medical team hired or retained after the start date of the new CBA, and any Head Team Physician hired or promoted to such position after the start date of the new CBA, shall have successfully completed a fellowship in Sports Medicine or have other "sports medicine" qualifications as the NHL and NHLPA may agree.

- Home team physicians should treat visiting players with the same philosophies and standards of care that they would use for their own players, including but not limited to working with the visiting player's training staff and possibly calls to the visiting player's appropriate medical staff.

1.2 DENTIST:

- It is preferable to have a Dentist in attendance at each home game.

1.3 ATHLETIC TRAINER/THERAPIST:

- Each Club shall employ at least two (2) Athletic Trainers/Therapists on a full-time basis.
- In the event both Athletic Trainers/Therapists do not travel with the Club on the road, and to the extent reasonably necessary in the Club's reasonable discretion to provide adequate services and treatment, the Club shall arrange for alternative means to provide athletic training services by providing at least one Athletic Trainer/Therapist, and either an additional Athletic Trainer/Therapist or other person of equal or greater medical training, or a massage therapist.
- Athletic Trainers/Therapists employed or retained by a Club to provide services to Players must be certified by either the National Athletic Trainers Association (NATA) or the Canadian Athletic Therapists Association (CATA), or shall be physical therapists licensed by an appropriate state or provincial authority and/or certified as a specialist in physical therapy, and shall hold current certification in Basic Cardiac Life Support (BCLS) or Basic Trauma Life Support (BTLS).
- At least one of the Athletic Trainers/Therapists shall have familiarity with the NHL Modified SCAT3 or other comprehensive standardized acute concussion assessment tool, as recommended by the NHL/NHLPA Concussion Subcommittee.
- An Athletic Trainer/Therapist shall be available on the bench at all times during games and practices.
- If the Athletic Trainer/Therapist must leave the bench for any reason (e.g., with an injured player), either (1) another Athletic Trainer/Therapist must be available to immediately replace such Athletic Trainer/Therapist on the bench or (2) another person with equal or greater medical training must be available to immediately replace the Athletic Trainer/Therapist on the bench. NOTE: This requirement can be satisfied through coverage by the opposing team's Athletic Trainer/Therapist or doctor if there is a prior agreement to such effect and the time frame for replacement coverage is of short duration.

2. EMERGENCY EQUIPMENT & FACILITIES at GAME ARENA

2.1 MEDICAL ROOM ACCESSIBLE TO BOTH HOME AND VISITING TEAMS:

- A medical room that can function as triage area shall be in close proximity to the benches of both teams, with good access from the ice surface and to a dedicated ambulance.
- The design of the room shall be large enough to accommodate Athletic Trainers/Therapists, medical staff, emergency ambulance personnel and a gurney or stretcher.
- The room shall have a table, stretcher(s) and adequate lighting to facilitate medical treatment.
- NOTE: The home team medical room can satisfy this requirement for a triage area, provided it is accessible to the visiting team in an emergency situation.

2.2 EQUIPMENT

- The medical room shall have equipment sufficient to provide the A.B.C.'s of trauma resuscitation:
    - **Airway**: equipment as outlined in A.T.L.S. provider manual or as suggested in related publications (Liberman & Mulder: Clinical Journal of Sports Medicine, Volume 17, Number 1, January 2007 pages 61-67), including capability for visor removal. The role of and procedure for rapid sequence intubation and surgical airway control in the clinic shall be determined by each Club's medical staff.

- **Breathing**: a method to supply supplemental oxygen with a (1) bag mask system (eg. Ambubag), (2) nasal and oral airways and (3) effective suctioning capability.

- **Circulation**: Ability to provide intravenous (I.V.) access for initial fluid replacement and IV medication administration.

- There shall be an Automatic External Defibrillator (A.E.D.) at the home team bench and on the player ambulance.
- There shall be an x-ray machine in every arena available to both home and visiting teams. Maintenance and use of this equipment shall be conducted in compliance with applicable laws regarding the use of x-ray equipment in patient care.
- Equipment for stabilization of cervical, thoraco-lumbar spine and fractures shall be available in the medical room at the discretion of the Head Team Physician and his consultant colleagues.
- Equipment shall be reviewed by the Head Team Physician, Athletic Trainer/Therapist and local ambulance authorities. The use of exchangeable standard back boards, collars, stretchers, etc. shall be encouraged.

2.3 VISITING TEAM TREATMENT ROOM

- The visiting team shall be provided a medical/treatment room separate from the home team at the game arena.

3. PRACTICE FACILITIES

- Home Team: The home team shall equip their practice facility to provide the same ABCs of trauma resuscitation as outlined above, including the provision of an AED.
- Visiting Team: A standardized set of emergency equipment, the “PHATS Visiting Team Emergency Kit”, shall be provided by the home team to the visiting team prior to practices. This equipment shall be used by the visiting team at its practice location (whether at practice or game facilities).
- The visiting team shall be responsible to report usage of any equipment or expendables to the home team. The home team shall be responsible to order replacement items and ensure the kit is up to date with a full set of supplies before next use.

4. AMBULANCE SERVICE

4.1 GAMES:

- Clubs are required to have at the arena an ambulance solely dedicated to Players, positioned at ice level, staffed by emergency personnel certified in airway management including intubation and IV access at the scene.
- In the event the player's ambulance is used to transport a player to a hospital, a replacement ambulance (with the same capabilities) dedicated to Players shall be available. If the replacement ambulance is not on site when the first ambulance departs, the home club should alert the NHL Video Room (416-359-7947) who will determine when resumption of play is appropriate.

4.2 PRACTICE:

- A protocol for obtaining prompt ambulance service must be in place to ensure availability during home and visiting team practice times.

5. EMERGENCY PLANS

5.1 ACCESS OF MEDICAL STAFF / EGRESS WITH PLAYER:

- Clear egress shall be available to the medical room from the bench and ice surface.

- Arena / security staff shall control access to the triage area and/or team medical room in the event of an emergency to ensure the medical staff have no distractions.

5.2 EMERGENCY ACTION PLAN (E.A.P.)

- A well posted Emergency Action Plan (E.A.P.) shall be produced by the home team medical staff prior to the start of training camp each year. It must be posted in both home and visiting team areas in both game and practice facilities. It must include:
    - List of medical and training staff with game responsibilities, contact information and arena seat location.
    - The supporting hospital for transfer of the injured player with E.R. contacts.
    - Location of ambulance service in the building and the contact mechanism.
    - List of preferred team consultants in related medical specialties with their contact information.
    - Common signal if the visiting Athletic Trainer/Therapist needs on-ice assistance of any kind (Physician, home Athletic Trainer/Therapist, stretcher, etc).
    - Plan for dealing with major injury including (but not limited to) airway, bleeding and cardiac emergencies, including treatment, stabilization and evacuation.
    - Mandatory trainer-to-trainer review of E.A.P before the visiting club's first practice or game of the season in such arena.
- The facility / security staff shall be involved in planning of evacuation routes from the building. Clubs need to explore police escort of the ambulance, depending on local circumstances.

5.3 REHEARSAL

- Emergency scenarios including evacuation of a spine-injured player from the ice surface shall be practiced on site, this season within the first month of the start of the regular season. These "dry runs" must include all medical staff (Athletic Trainers/Therapists, doctors, ambulance service) who might be in attendance at games.
- These procedures shall be reviewed periodically as needed during each season.

Emergency Care Task Group of the Medical Standards Subcommittee

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