



**EA NATIONAL EVENTING RULES
UPDATE
EFFECTIVE IMMEDIATELY
February 2022**



Rule	Heading	Justification	Revised Rule
Annex D.1	Medical Services	Safety	<u>Effective immediately</u> The updates shown below were recommended by the Medical Consultative Group for immediate implementation and unanimously supported by the EA Eventing Committee at their meeting on Tuesday 8 th February 2022.

EA D1 Attachment A**Medical Service Provider Pre-Event Form 07**

This document is to be completed by ~~any~~ **all** Medical Service Providers engaged for **all** ~~any~~ EA endorsed EA **Eventing** Events. Part A: Accompanies Form 06

Part A: to be completed PRIOR to the day of the **Event**

Item	1. Medical Personnel Requirements	Yes	No	If No provide further comments
1.1	Personnel are representatives of the organisation and covered by their relevant scope of practice insurances.			
1.2a	Personnel are registered with AHPRA, or the MSP must have a designated supervising person with an AHPRA registration (accessible) with no relevant conditions and/or limitations or restrictions to practice. Must be either Medical Practitioner (Doctor) or person with the skills to perform (1.4) or assist			
1.2b	Optional: Other Additional Medical Support are registered with AHPRA with have no relevant conditions and/or limitations or restrictions to practice. E.g., Registered or Enrolled Nurse			
1.3	Personnel (1.2.a) are NOT performing any other role associated with the event e.g., organiser, participant or competing			
1.4	Personnel (1.2a) have received current trauma training having performed the following procedures and assessed as being competent in: <ul style="list-style-type: none"> • Chest Needle Decompression (Thoracostomy) • Advanced Airway Management (minimum LMA/i-Gel) • Pelvic Immobilisation (SAM splint, T-pod) & C-collar • Intra-venous Cannulation • Fluid Replacement • Splinting & management of orthopaedic fractures Inc. traction splint for fractured femur. 			

1.5	Personnel (1.2a) have received the mandated list of equipment prior to the event.			
2.Event Configuration Requirements:				
2.1	<u>General:</u> Minimum 2 x personnel configured as 1 Medical Team, with 1 x personnel having the skill set listed in (1.2a)			
2.2	<u>Dressage:</u> A first aid service must be always present			
2.3	<u>Jumping Test:</u> A Registered Paramedic or Doctor (plus a first aider to make a team of 2) is sufficient when the jumping phase is standalone			
2.4	<u>Concurrent XC and Jumping Tests:</u> a) 2 teams are recommended when XC and SJ are running concurrently unless co-located and OC's event schedule allows time for the XC to halt when there is an SJ incident. b) If there are 2 teams the SJ team may be comprised of a single Paramedic c) XC must STOP if the response team is unable to respond to an incident on XC due to attendance at an SJ incident or for any other reason.			

Part A: to be completed PRIOR to the day of the event

Other Notes / Comments:

Medical Provider Representative Name: _____ Signature: _____ Date: ___/___/___

-----Office Use Only-----

Item	Completed	Further Actions (Yes / No)
EA-HSMS-MED-Form 07 Part A: Date Received	/ /	
Received by OC or Representative:	Yes / No	Name: _____ Signature: _____ Date: / /

Part B. To be completed on or prior to the day of the event relevant to the listed requirements.

Item	3. Medical Personnel Requirements	Yes	No	If NO provide further comments
3.1a	Minimal of 1 x Personnel has attended (Inc. virtual or by phone) any pre-briefing discussion where the event on the 'Serious Incident Management Plan' is discussed.			
3.1b	All other Personnel have been advised of the event 'Serious Incident Management Plan', know and understand critical response procedures.			
3.2	Personnel have checked <u>all</u> equipment a minimum of 90 minutes prior to the commencement of the event			
3.3	Personnel as advised by OC are positioned are located in a position to respond to a patient <u>within 3 minutes</u> or less during a Jumping test or during a Cross Country test.			
Item	4. Capabilities Audit	Yes	No	If NO provide further comments
4.1	Copy of 'Event Serious Incident Management Plan' Medical personnel have received and reviewed a copy of 'Event Serious Incident Management Plan' and are aware of traffic management, access, and egress locations			
4.2	All Personnel reviewed copy of Event Serious Incident Management Plan', traffic management, access and egress locations			
4.2	Vehicle/s capable of accessing all areas of event venue <u>within three minutes</u> .			
4.3	When a 4-wheel drive vehicle is used, the driver is to have the skills to operate this vehicle			
4.4	When a 4-wheel drive vehicle is used, the driver is to have the required licencing to operate this vehicle			
4.5	Sufficient vehicles to access in optimum time of 3 minutes and vehicles appropriately located			
4.6	Have local external emergency services been advised as per event protocol of access/egress points, GPS co-ordinates and nearest cross-streets.			
Item	5. Capabilities Equipment Audit (All equipment present, calibrated/certified as required & in full working order Pre-Event)			
	5.1 General Equipment	Yes	No	If NO provide further comments
5.1.1	Stretcher (Scoop with straps)			

Annex D Medical Services

5.1.2	Torch (Including spare batteries)			
5.1.3	Oxygen cylinder/s			
5.1.4	Defibrillator			
5.1.5	Trauma shears			
5.1.6	Disposable Gloves			
5.1.7	Vomit Bags			
5.1.8	Space Blanket			
5.1.9	Scissors			
	5.2 Monitoring Equipment	Yes	No	If NO provide further comments
5.2.1	Stethoscope			
5.2.2	Blood pressure cuff			
5.2.3	Pulse Oximeter			
	5.3 Airway Management	Yes	No	If NO provide further comments
5.3.1	Laryngoscopes (adult and children sizes) MAC 1-4			
5.3.2	NPA: Naso Pharyngeal airway (Paediatric 2, 2.5) and (adult 5,6,7)			
5.3.3	OPA: Oropharyngeal airway (Paediatric and Adult)			
5.3.4	LMA: Laryngeal mask / lgel (Paediatric and Adult)			
5.3.5	ETT: Endotracheal tubes cuffed (available if skilled person present)			
5.3.6	Bag valve mask: Adult and Paediatric			
5.3.7	Portable Suction Kit			
5.3.8	Nasal cannula			
5.3.9	Oxygen tubing			
	5.4 Surgical Intervention	Yes	No	If NO provide further comments
5.4.1	Surgical airway kit or large bore IV cannulas			
5.4.2	Thoracostomy kit or large bore IV cannulas			
	5.5 Circulation	Yes	No	If NO provide further comments
5.5.1	Soft t-wide tourniquet or equivalent			
5.5.2	Trauma dressing large and small (compressible)			
5.5.3	Non-stick dressing			
5.5.4	Various bandages			
5.5.5	IV access (14g, 16g, 18g, 20g)			
5.5.6	IV adhesive dressing			

5.5.7	Adhesive tape, micropore and coban			
	5.6 Immobilisation	Yes	No	If NO provide further comments
5.6.1	Pelvic splint			
5.6.2	Cardboard, mouldable or inflatable splints			
5.6.3	Traction splint			
	5.7 Fluids (within expiry periods)	Yes	No	If NO provide further comments
5.7.1	2 Litres IV Crystalloid Fluids			

Other Notes / Comments:

Medical Provider Representative Name: _____ Signature: _____ Date: ___/___/___

-----Office Use Only-----

Item	Completed	Further Actions (Yes / No)		
EA-HSMS-MED-Form 07 Part B: Date Received	/ /			
Received by OC or Representative:	Yes / No	Name:	Signature:	Date: / /

EA-HSMS-MED-Medical Provider Pre-Event Checklist & Service Agreement

EA-HSMS-MED-Form 6

EA-HSMS-MED-Medical Provider Pre-Event Checklist & Service Agreement

EA-HSMS-MED-Form 6

Medical Service Provider Checklist & Service Agreement Form 06

This document outlines the agreed services to be provided by a Medical Service Provider (MSP) and is to be agreed and approved by the Event Organising Committee (OC). All sections of this agreement are to be completed prior to the commencement of any endorsed Equestrian Australia Eventing event.

Service Provider:	Contact person:
Address:	Contact No:
Event Name:	Event Dates:

Part A. To be completed by Medical Service Provider (Checklist)
Medical Service Provider Documents (copies to be provided to OC)

- Signed Copy of Service Agreement — copy provided to event OC
- Professional Indemnity Insurance Certificate of Currency (Service Provider name, Policy Number, Period of Cover, Liability 20 Million)
- Workers Compensation Certificate of Currency (current)
- List of medical staff attending the event, including the relevant skills as outlined in the EA-HSMS-MED-Medical Service Provider Pre-event Audit Form 07 and mobile contact details

Other Current Documents (copies available on request)

- AHPRA Registration and/or Skills Certifications of all attending Medical Personnel
- Medical response vehicle registration (current)
- Medical staff motor vehicle licenced to operate a four-wheel-drive vehicle (if applicable)
- Equipment certifications/calibrations (current)

Event Operations (to be provided to the OC prior to the event)

- Quotation of Medical Service provision for the equestrian event (attached to ~~this service agreement~~)
- Pre-event ~~Before the event~~ complete EA-HSMS-MED-Medical Service Provider Pre-event Audit Eventing Form 07
- Agree to work collaboratively with the designated Event Medical Co-ordinator (or relevant person ~~when available~~)

- ~~Agree to attend Serious Incident Management Plan (SIMP) Pre-event meeting~~
- Agree to participate in a Serious Incident Management Plan (SIMP) briefing provided by the CMO or Head of SIMP **prior** to the start of the Cross-Country test
- Agree to liaise with external response teams (e.g., state ambulance, retrieval teams etc)
- Agree to complete EA-HSMS-MED-Incident-Referral Report Form 08 and Concussion Protocols
- Agree to participate in post incident-accident debrief activities (as required)
- ~~Agree to complete in conjunction with the nominated Event Medical Co-ordinator, an Event Medical Services Summary Report within 24 hours following the completion of the equestrian event~~
- ~~A medical event action plan (e.g. SIMP) is to be forwarded to the nearest Ambulance or external medical provider prior to the commencement of the event.~~
- ~~The medical event action plan (e.g. SIMP) is to include event (location) GPS co-ordinates, address and nearest cross streets and access locations, to be discussed with OC prior to commencement of event.~~

Medical **Service** Provider Representative Name:

_____ Date: ____/____/____

Title: _____ Signature: _____

Part B. To be completed by Medical Service Provider (Service Agreement)

The following is a service agreement including the terms and conditions for a **MSP Medical Provider** to be engaged by an OC.

I/We, _____ (MSP
Medical Provider Name),

warrant and declare the Medical Service Provider will:

- a) Complete Part A of this Service Agreement and provide or have available for inspection on request all relevant documents, plans and processes if/as requested by the OC.
- b) Complete all pre-event and post-event documentation and summary report within the required timeframe
- c) Agrees to indemnify _____ (OC and Equestrian Australia) from and against all claims, demands, actions, losses and costs arising from or in relation to (i) any breach of any representation or warranty contained in this service agreement and (ii) any breach of any other obligation or duty this service agreement or under applicable law.
- d) Where equivalent items are supplied in place of a listed Item (EA-HSMS-MED-Medical Service Provider Pre-event Audit Eventing Form 07) these items are to have the same purpose and effect as the named and listed item.

A quotation for the provision of Medical Services is attached including service rates of payment, a list of suitably skilled and qualified service providers as outlined in (EA-HSMS-

EA-HSMS-MED-Medical Provider Pre-Event Checklist & Service Agreement

EA-HSMS-MED-Form 6

MED-Medical Service Provider Pre-Event Audit Eventing Form 07), and any foreseen alterations or variances that may be applicable to this service agreement.

MSP ~~Medical Provider~~ Representative Name: _____
Date: ____/____/____

Title: _____ Signature: _____

-----Office Use Only-----

Item	Completed	Further Actions
EA-HSMS-MED-Form 06 Date Received		
Part A Documents Reviewed:	Yes / No	
Part B Completed and Signed:	Yes / No	
Quotation Received:	Yes / No	
EA-HSMS-MED-Form 07 Date Received		

OC/Other Representative: _____(Name) Date: ____/____/____

Signature: _____



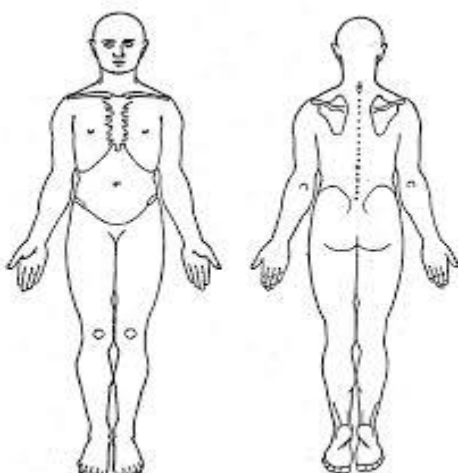
EA D1 Attachment C

Event Name:	_____	Date:	____/____/____ Time: _____ am/pm
Athlete Name:	State:	DOB:	Age: _____ Gender: M / F / NB
Athlete No:	_____	Discipline:	

Injury/Illness Severity: **NO** Apparent Inj/Ill **YES** > Minor Inj/Ill Serious Inj/Ill Critical
 Concussion Fatality

Brief description of incident:

a) Mounted > b) Speed: Stationary Walk Trot Canter Gallop _____ c) Un-mounted
 d) Helmet: Yes No N/A e) Helmet Damaged: Yes No N/A f) Body Protector: Yes No N/A g) Air Vest Activated: Yes No N/A

Medical History:	Medications:	Allergies:																																								
Observations /Examination: <div style="text-align: center;">  </div>	Treatment Provided:																																									
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T																																										
Medical Clearance Return to Ride <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If <input type="checkbox"/> No requires > Treatment Plan/Discharge Advice:	<input type="checkbox"/> Observation or <input type="checkbox"/> Hospital T/F > <input type="checkbox"/> Amb <input type="checkbox"/> Car																																									
Concussion card issued <input type="checkbox"/> Yes <input type="checkbox"/> No Athlete Mob: _____ Email: _____	Concussion protocols advised <input type="checkbox"/> Yes <input type="checkbox"/> No Athlete/Support Personnel Signature: _____ _____																																									



Other documents provided/attached:	
Name: Qualification (if applicable):	Signature: Mob: _____ Email: _____
Copy to a) OC/TD/Coach & b) reporting@equestrian.org.au c) Medical Provider Email:	Received by _____ Date: ___/___/___ /

~~EA Athlete Concussion Advice~~ REMOVE

EA-HSMS-MED-Athlete Concussion Advice
EA-HSMS-MED-Form 09

This document is to be issued to the person monitoring the suspected or concussed athlete

Venue/Event:			
Athlete:	Name:	Contact Details:	
Injury Details:	Date:	Time:	am/pm
Medical Review	Date:	Time:	am/pm
Medical Officer:	Name:	Contact Details:	
EA Official	Name:	Title:	
Transfer Information (Hospital/Clinic)	Medical Facility: Contact Details (if known):		

This athlete (patient) has recovered from an injury to the head. A careful medical examination / assessment has been completed and no signs of serious complications have been identified.

Recovery time is variable for individuals and the athlete (patient) will require further monitoring for an additional period by a responsible adult. Your treating medical practitioner will provide you with guidance as to this required time frame.

Requires Immediate Action:

If you notice any change in athletes (patient) behaviour, e.g. vomiting, dizziness, worsening headache, double vision or excessive drowsiness or any other unusual symptoms:

Immediately contact the nearest hospital emergency department or call 000.

Other Important Points:

- Rest both physically and mentally
- Do not consume alcohol
- Do not take sleeping tablets
- Do not use aspirin, anti-inflammatory medication, sedatives or analgesic (pain) medication
- Do not use any prescription or non-prescription medication without medical supervision or clearance
- Do not drive a motor vehicle or any other form of transportation until medically cleared to do so
- Do not participate in training or playing sports until all symptoms have resolved and you have a full-medical clearance from a medical practitioner.

EA strongly recommends you seek medical advice and follow a graduated return to sport requirements as outlined in <https://www.concussioninsport.gov.au/>

If you have any further questions regarding this suspension (EA concussion protocol), please contact me (or your parents/guardians) either via return email, or on mobile _____.

Yours sincerely, _____ (Officials Signature)

<https://www.equestrian.org.au/content/health-and-safety-training>