



serving children with diabetes since 1929

2013 Dispensary and Medical Manual

Mission Statement

Camp Ho Mita Koda's mission is to enable children to live well with diabetes through an enjoyable camp experience.

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About this Medical Manual: This manual has been developed to guide the medical staff in their activities during the six weeks of camp during the summer. Exceptions to these guidelines may be made at the discretion of the medical staff. The guidelines may be helpful during other activities at Camp Ho Mita Koda, such as Mini Camps, but some of the information does not apply to them because the campers' parents are always present and solely responsible for the care of their children.

Special thanks to Nicole Schmidt, RN, BSN, CDE and Jami Klein, RN, BSN, CDE for their compassionate care of our campers and for sharing their expertise in revising this manual!

Need to add to Manual

Communications:

Walkie Talkie

- use and expectations
- always on in dispensary

Phone

- Intercom
- Outgoing
- When to answer

Emergency Procedures:

- Missing children
- Evacuation plan/fire procedures
- Weather emergencies

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INTRODUCTION

History of Camp Ho Mita Koda

Camp Ho Mita Koda was founded in 1929 by Dr. Henry John, a physician from the Cleveland Clinic, and his wife, Betty.

Dr. John joined the staff of the Cleveland Clinic in 1921, the year insulin was discovered. Much work was being done in the field of diabetes at this time. As insulin was perfected and released to physicians throughout the country, Dr. John was chosen to carry out clinical experiments and report his findings to Eli Lilly Company, which produced the insulin product.

At about that same time, young Betty Beaman was growing up in Cincinnati, Ohio. Her little sister developed diabetes and her father, a physician, was heart-sick that he was unable to help his baby, knowing that she would likely die of this disease. Dr. Beaman heard about clinical research underway utilizing a promising new treatment. He contacted the Cleveland Clinic, was put in touch with Dr. John and, through him, acquired a supply of insulin. As Betty John told this story many years later, she stood by her sister's bedside while the emaciated child was injected with insulin. In a very short time the child began to feel better and almost miraculously, over time, regained her health.

Several years later, now grown, Betty found herself at the Cleveland Clinic working as a lab technician and there she met Henry John, the very same physician who had saved her sister's life. Though many years his junior, she fell in love and, in 1928, Betty and Henry married at his summer cottage in Newbury, Ohio; her then 13 year old sister was among the wedding guests.

As Dr. John continued to work with families of children with diabetes, he recognized two problems. Though insulin was keeping the children alive, their rigid diet and regimented daily routine was a heavy load on families, especially the mothers of these children. Dr. John also realized that it was not enough to just keep these children alive.

Dr. and Mrs. John envisioned a summer camp where children with diabetes could learn how to deal with and manage their diabetes and have fun with other children at the same time. So, in 1929, Dr. and Mrs. John decided to take six children with diabetes to their summer cottage in Newbury (also their wedding site). Their purpose was to provide as many normal activities as possible for the children and also to give some relief to the families. Dr. John provided medical care and Betty John, with extensive camping and scouting experience, provided activities and daily care. Two weeks at camp gave these six children, who ranged in age from 14 years old to an infant, their first vacation since developing diabetes.

After the success of this first summer, Dr. John recognized that the opportunity should be available to larger groups of children. Therefore, Camp Ho Mita Koda, the first organized camp of its kind in the world, was founded. The basic purpose and standards that guided the camp's first year continue to prevail to this day, but the program and property expanded significantly. The camp grew from 6 to 300 campers and from 10 to 75 woodland acres. Hand carved totem poles and animals - Dr. John's work, augmented by that of nationally known artisans - were added to give the camp, whose name means "Welcome, my friend" in the Sioux language, its distinctive charm. A "Great Hall" was built along with 6 camper cabins, a bathhouse, a pool, and a number of staff and service buildings.

In 1958, Dr. John retired and the camp continued under management of its Board of Trustees, with George E. Willis as President and Treasurer. From 1958-2006, Camp Ho Mita Koda was led by the dedicated volunteers of the camp executive committee and Board. During those years the camp has continued in the tradition of excellence established by Dr. and Mrs. John. Both have since passed away, but Mrs. John retained an active interest in the well-being of the camp and its children until her death in 1997.

In more recent years, the facility has been further developed by the addition of the beautiful Molly Blossom pool built in 1986 on the site of the old pool, the George E. Willis Team Challenge Course, dedicated in 1991, the Reinberger Bathhouse, dedicated in 1993, and a new addition to the old Great Hall which includes a modern new dispensary (The Diabetes Association of Greater Cleveland Dispensary) and dining hall (Humphrey Hall). These additions, along with 2 new camper cabins, were dedicated in 2001. In 2003, the Swain Family Climbing Wall was constructed, and the low and high ropes courses were renovated in 2004 and 2005.

In 2006, Camp Ho Mita Koda merged with the Diabetes Association of Greater Cleveland (DAGC), now called Diabetes Partnership of Cleveland, under the leadership of Jacquie Dickinson, who had served as the camp's Executive Director since 1991, and was President & CEO of the Diabetes Association of Greater Cleveland from 2005-2008. DAGC had been the major financial supporter of the camp for many years and professionally managed the camp since 1991. Camp Ho Mita Koda now operates as a subsidiary of Diabetes Partnership of Cleveland, enabling both organizations to increase services in northeast Ohio for children and teenagers with type 1 and type 2 diabetes. Kyle Chones, Camp and Youth Programs Manager, and Christina Milano President & CEO, have year round responsibility for the camp today.

Camp Ho Mita Koda has given 83 years of service to the Greater Cleveland community, to children with diabetes and their families, and to diabetes professionals throughout Northeast Ohio. Camp Ho Mita Koda has given thousands of children the opportunity to enjoy a normal summer camping experience while developing skills in diabetes self-management that will serve them throughout their lives.

NOTE: As mentioned above, effective June 2011, Diabetes Association of Greater Cleveland (DAGC) is now Diabetes Partnership of Cleveland.

Did you know Geauga is Native American name for raccoon?

Philosophy of Camping and Diabetes

The American Camping Association defines camping “as a sustained experience which provides a creative, recreational and educational opportunity in group living in the out-of-doors. It utilizes trained leadership and the resource of natural surroundings to contribute to each camper's mental, physical, social and spiritual growth.” We endorse this concept and definition. We wholeheartedly endorse the concept that our program is a **CAMP** for **CHILDREN** who have **DIABETES MELLITUS**.

Timeless Goals

Throughout time, we have helped boys and girls gain a better understanding of the world around them, while developing the personal confidence that makes all the difference in growing up with diabetes. Encouragement, education and a safe, happy environment will help make our camp an important part of our campers' summer.

Camp Objectives

Camp for children with diabetes serves many purposes. The following objectives are those established for our diabetes camping program.

1. To provide an enjoyable, recreational experience for children with diabetes.
2. To promote diabetes education.
3. To provide a safe and healthy setting away from home.
4. To enable children with diabetes to meet and live with other children with the same condition.
5. To promote independence.

Many parents are interested in the goals of diabetes care at camp. Because the camp experience involves different meal plan and exercise levels than at home, it is usually more difficult to judge insulin requirements. Some campers will need their insulin doses reduced to prevent hypoglycemia. Sometimes a camper's blood sugar will be higher than at home.

Camper Check-in Day

Campers arrive on Sunday of their scheduled session. The following is a schedule of activities on check-in day:

11am:	Staff Arrival
12pm:	Lunch with all Staff
1pm-3pm:	Campers arrive
4:30-4:45:	Blood glucose testing in Cabins
5:00pm:	Insulin administration
5:30pm:	Dinner
6:50pm:	Flag Lowering
7-8:15pm:	Evening Activity
8:30pm:	Blood glucose testing/Snack
8:45pm:	Bedtime insulin in Cabins
10:00pm:	Lights out!
12:00am:	Blood glucose testing in cabins by dispensary staff
2:00am:	Blood glucose testing in cabins by dispensary staff, if needed.

Dispensary Staff Responsibilities

During staff training week:

1. Have camper's previous year folder ready for each camper in session.
2. Have forms ready for each camper: Appendix B-if on shots/C-if on pump, D-if on pump/E-if on shots, Appendix L.
3. Punch 3-hole on sheets.
4. Label with Camper name and dates for camp session.
5. Make copies of med station checklists/forms needed.
6. Ensure Scale is working properly.
7. Have extra pens at each station

On check-in day:

1. Get final Camper List from Asst. Camp Director.
2. Set out Boxes/supplies for each check-in station
 - Pump Station: need pump supply boxes, label maker, pump site/pump setting log sheets (appendix R). Record when last pump site change was done. Ask how much insulin is needed to fill cannula used for pump site.
 - Camp Settings for Pumps:
 - Medtronic – set to Pattern B for Camp
 - Animus – set to Exercise for Camp
 - OmniPod – set to Basal 2 for Camp
 - Med station: bags/box for med storage, med book with blank sheets. Collect all medication from parents and ask when last dose was given. Make sure medications are labeled with campers name and place in cabin box until they can be reviewed/setup by nurses before dinner shots.
 - Height and Weight Station: Fill in Camper name/date/height and weight and send sheet with camper in folder.
3. Once camper goes through all check-in stations, send down to Dispensary to check-in with doctor. If line gets too backed up, take folder from Camper and place in pile in order they came in. Send parents/camper to cabin and ask that they return within 15-20 minutes.
4. When finished with checking in camper, give folder to charge nurse/doctor. Double check order sheets are complete, legible, and signed by physician. If you do not understand the orders, ASK FOR CLARIFICATION BEFORE THE DOCTOR LEAVES.
5. If Camper has allergies/Celiac/or any other concerns that should be noted by all dispensary staff, write it on WATCH BOARD and review at dinnertime shots.

Check-out Day

Check-out occurs on Thursday of the session. The following are dispensary staff responsibilities in preparing for check-out and during the actual check-out time:

1. Put all camper supplies/manila envelopes in bins for each Cabin.
2. Counselors will pick up Cabin Boxes from Dispensary and bring to cabins.
3. Contents of manila envelopes for parents:
 - Provide duplicate copy of BG log/medication log sheets for each camper with their name written on it.
 - Complete Home- Going instructions.
 - Put pump supplies and insulin pens in Ziploc bags with camper name; leave in cabin bin.
 - Check med box for any medications that need to go home with camper.
 - Direct all parent questions to the physician.
 - Remain in dispensary until all campers have left.
4. Leave list of "FIRSTS" for compilation at end of Camp.

Health Care Plan Review

The Senior Medical Staff shall, at its first meeting of the calendar year, review the camp **Dispensary and Medical Manual**.

The review will focus particularly on the management of diabetes, but shall extend to all aspects of health maintenance and safety.

Health Care Plan: Medical Aspects

1. Camp Ho Mita Koda exists as a resource for children with diabetes who live in north-central Ohio. The medical direction of diabetes and other direct health-care matters is under the direction of Camp's Medical Director, who is a physician licensed in the State of Ohio. She/he is assisted by a senior medical staff, made up of licensed physicians who also have a special interest in the treatment of children with diabetes.
2. Each Camp session is assigned to one or more members of the senior medical staff, who provide medical supervision, including overall management of the children's diabetes. On arrival at Camp, each child's parent(s) or guardian completes a medical history form (attachment), and undergoes a physical examination performed by a physician. Pertinent measurements of height, weight and blood pressure are also made. At the conclusion of this intake evaluation, a diabetic care plan is written for each camper. In addition, a problem list is made up for such non-diabetic problems as it is necessary to treat or to be aware of (examples: asthma, penicillin allergy, emotional problems). The senior medical staff provides guidance for the adjustment of insulin doses, and other aspects of diabetic (and non-diabetic) health care, including emotional and behavioral disorders. A written protocol details the responsibilities of the senior medical staff.
3. Dispensary staff consists of five licensed RN and/ LPN and three graduate or student nurses, dietetic students, and other health sciences students. The duties of the dispensary staff are included in the Dispensary Team section of this manual.
4. Elective rotations are available for the following health care professionals in training:
 - Physicians in training (from certified training programs in pediatrics, family practice, endocrinology, or internal medicine)
 - Student physicians from CWRU School of Medicine or other institutions);
 - Student dietitians (from RD training programs at Cleveland Clinic Foundation, University Hospitals, VA, Metro Health, and other area training programs)
5. Although there are many approaches to the management of juvenile diabetes, the philosophy at Camp HMK is to strive for safe levels of blood glucose control while minimizing the risks of serious hypoglycemic reactions. The philosophy is presented to the parents/guardians of camper in the form of a written statement.
6. Written medical histories, examinations, and log sheets are maintained indefinitely for each camper. At the conclusion of each camping session, a letter is mailed to each child's personal physician, summarizing that camper's stay at Camp, giving the last insulin doses, etc.
7. Although we are capable of treating many minor illnesses and injuries, and even substantial episodes of hypoglycemia, at Camp HMK, hospital evaluation and treatment may be required. Children requiring this level of care are transported to Geauga Community Hospital emergency room which is 5-10 minutes by car. A camper's parent will be notified if a camper requires non-emergency medical transportation. The camper's parent/guardian is given the option of transporting the camper if he/she can arrive in a reasonable period of time. Otherwise, the Resident Physician will contact a non-emergency medical transportation company to transport the camper. A member of the camp dispensary staff will accompany the camper. In the event of a serious injury or an illness precluding safe

transport by the parent/guardian or non-emergency medical transport company, the Newbury Fire Rescue squad would be summoned to Camp.

8. Because of the possibility of abrupt, unexpected hypoglycemic reaction in any child with diabetes, certain precautions are taken:
 - Regular communications are maintained between the camping, dietary, and dispensary staffs, so that activities, meals, and insulin dosages can be coordinated.
 - A dispensary staff member accompanies all children traveling off site except during the horseback riding activity at Blue Lakes Farm.
 - Emergency kits are maintained and available for the detection and treatment of hypoglycemia.

9. Training of camp and dispensary staff is arranged prior to the commencement of Camp. Specific health-care topics are covered, and each staff member is signed off for each topic (e.g. recognition and treatment of hypoglycemia; prevention of blood-borne disease, use of blood glucose meters).

Dispensary Team

Our goal is to keep the campers out of the Dispensary and in their activities. There are few problems, which require a camper to stay in the Dispensary. Minor illnesses will be cared for at camp. Major illnesses/and other problems, such as fractures and lacerations, will be cared for at a local hospital. Parents do not need to be notified of a minor illness, but will be called for major illnesses/problems, including any time a child has to be brought to any outside medical facility. The medical staff is available 24 hours a day for emergencies. All routine medications are dispensed by a nurse.

Dispensary is staffed 24 hours per day. Staff shifts include:

- 7am to 1st period
- 2nd period to Lunch
- After lunch to Dinner
- After dinner to 11pm
- 11pm to 7am, 1 nurse and 1 Dispensary assistant

Responsibilities:

1. During staff training week, set up dispensary.
2. Prepare for check-in and check-out days: see Camper Check-in and Check-out section
3. Making contact with campers when they come to the Dispensary, performing the necessary exam, solving simple problems, keeping accurate records. Hypoglycemia episodes must also be recorded on the camper's BG log chart. Any PRN BG checks must be recorded in camper's chart.
4. For more complex problems, i.e., those which might require "admission" or continuing care or are more detailed, a progress report using the problem-oriented format (S .O.A.P.) MUST BE used.
5. Documentation includes:
 - All blood glucose values: completed by MD, RN, DA, counselor
 - Urine tests for ketones: completed by MD, RN, DA, counselor
 - Insulin doses: MD, RN, DA with licensed professional
 - Pump site changes: MD, RN
 - Hypoglycemia and hyperglycemia treatment: MD, RN, DA
 - Illnesses and treatment: MD, RN

Note abbreviations:

- MD = medical doctor
- RN = registered nurse
- DA = dispensary assistant

6. Camper medications are dispensed from the dispensary, at meals by a nurse/dispensary assistant/qualified, trained staff.

7. Monitor dispensary watch list:

“Watch List” on a dry erase board is maintained in the Dispensary in the “Inner Circle” throughout the camp sessions to be sure that we do not lose track of campers whose diabetes is temporarily out of control. A camper is kept on the list whenever the glucose is over 300 and/or the ketones are moderate or large. When putting campers name on Watch List, be sure to use First Initial, Last name to help with privacy of camper. This information is also captured in the PsychoSocial Medical History.
Allergies?

The list includes the camper name, time of latest check, latest glucose, latest ketones and time of next check. If the time for the next check has passed for any camper, the counselor or activity leader should be called to get the camper into the dispensary. It is important to keep an eye on the Watch List and update the information (or erase the name) when a camper retests and is OK.

8. Medication sheets will be made out on Intake Day, and camper meds will be stored in locked cabinets in the dispensary.

9. Restocking supplies, cleaning contaminated materials/surfaces, preparing educational sessions and bulletin boards in the dispensary.

10. Appropriate handling of medical waste:

- ALL used lancets and syringes will be deposited in medical waste containers in cabins or dispensary. Filled containers will be placed in large hazardous waste boxes and sealed. Filled boxes are stored in the garage by the camp janitor or caretaker.
- Under no circumstances will any staff member re-cap syringes.
- Gloves must be worn when performing or assisting with blood testing.
- Blood spills will be cleaned with a 1: 10 bleach solution (available in Dispensary).

11. Other duties as assigned.

Guidelines for opening the dispensary during staff week:

I. Preparing the Dispensary

- a. Clean the Dispensary and all rooms and cabinets/counters.
- b. Wash bed linens and make beds. Change after each session and prn.

- c. Check all cabinets for expired medications and supplies. Discard if expired.
 - d. Unpack and stock all supplies.
 - e. Check all red bags/emergency kits. Remove any expired items and restock.
 - f. Take insulin pen/vial inventory after each session and end of season.
2. Staff Records
 - a. Have staff meet with Attending Physician for physical.
 - b. Store records in Staff folders.
 3. Copy all forms needed for camp session.

Guidelines for closing the dispensary at the end of the season:

1. Store all Camper/Staff folders in filing cabinet
2. Inventory all supplies and meds.
3. Put open meds in Ziploc bags and put in box to be given to Diabetes Partnership.
4. Seal all pump supply boxes.
5. Clean all counter tops.
6. If there is left over insulin at the end of camp season, ask counselors with diabetes to write type of insulin used on sheet of paper. Also, ask if counselor has insurance. Distribute insulin/pens to counselors in a fair manner.
7. Check with Camp and Youth Program Manager if anything else needs to be done.

Dispensary Team – “A Day in the Life”

This schedule is intended as a general over-view of the daily responsibilities and not an all-inclusive list.

Time	Responsibilities
7:00 A.M.	<p><u>Mealtime Calculators</u> = licensed and unlicensed staff take one cabin, calculate and draw-up breakfast insulin doses using blood sugars and carb counts sent in from cabins. Charts are checked by 3 people independently.</p> <ul style="list-style-type: none"> • Each pair checks and double checks their calculations and drawn-up insulin doses. • **Calculate doses for all campers whether injections or pumps. An inaccurate number for a pump should trigger the settings to be checked. • Insulin pens/syringes are labeled with camper name and and enters DOSE on appropriate line. • Staff member writing on log sheets writes initials in box. • If using syringe, place syringe in cabin’s tray. • *If blood sugar is LESS THEN 100 ~ DO NOT draw up insulin. Camper will return after meal for injection/bolus • Once morning insulin doses for all cabins have been drawn up ... Two or 3 cabins are called at a time to come to the dispensary (in the order that their BS/Carb count sheets were received). • As campers come into dispensary, the staff member calls the individual camper, rechecks the syringe against the log sheet, and then gives the camper their correct syringe. Some campers may ask the staff member to give the injection. After SC dose is administered (either by camper or staff), the camper’s log sheet is initialed by the staff member after giving. Sign the bottom of the page with full signature. • A staff member works with each pumper as the camper inputs the BS and Carb amount. The insulin pump calculates the bolus dose.... and then delivers it. The delivered bolus dose must be recorded on the daily log sheet and the staff member initials the appropriate box. <p><u>Licensed staff:</u></p> <ul style="list-style-type: none"> • Get medication book and 8:00 A.M. medication container ready. Administer meds as campers come to dispensary for insulin doses. • Remind the camper if this is a site change day (4-5pm in the dispensary).
8:00 A.M. BREAKFAST	<p>ALL DISPENSARY STAFF WILL EAT WITH CAMPERS</p> <p><u>After meal boluses/shots:</u></p> <ul style="list-style-type: none"> • One/two predetermined (by daily schedule) staff members will return to dispensary after meal to administer post meal boluses/shots • Draw-up held insulin doses and double check calculations and dose in pen/syringe with another staff member or the camper for a second check. Call the camper 10 min, before the meal. <p><u>After breakfast/before first period</u></p> <ul style="list-style-type: none"> • Prepare “red bags”/ activity bags for the day’s activities: clean out trash, check supplies in kits and replenish, have sharps containers ready with kits. • Don’t forget the walkie-talkies! • Be helpful See what needs to be done.

Time	Responsibilities
	<p>NOTE: When staff are away from the dispensary at an activity they MUST HAVE AT ALL TIMES:</p> <ul style="list-style-type: none"> • A walkie-talkie • Stocked Kit • Sharps container • Garbage bag • Writing tablet & pen
<p>9:00 A.M.</p>	<p><u>General Responsibilities:</u></p> <ul style="list-style-type: none"> • Glucose meters must be calibrated and logged daily. Glucometers are to be delivered by the counseling staff at breakfast shot time for all cabins. • Once meters are collected and in dispensary ... complete calibrations, record in log book and clean up the outside of meters. Return to bags for dispersal to cabins. If a camper or other staff member is available ask them to please return meters to cabins. • Prepare list of pumpers for snack time (10:15 A.M.) • Assist with pump site changes (try to keep this at a minimum as we want campers at activities. Have them come back at cabin time if they have enough insulin or set is OK) • Make pbgs as needed • Stock supplies. • **All children who are >300 at breakfast are to be retested at 10:15am.
<p>9:15 A.M.</p>	<p>First activity of the day begins. (There are 2 morning activities.)</p> <p><u>Ropes/Archery Responsibilities:</u></p> <ul style="list-style-type: none"> • Gather kit, walkie-talkie, juice, pbgs/ celiac alternative, sharps container. • Walk with group to ropes area • Treat low blood sugars and record on tablet • Be the last to leave after campers and check with staff to see if they need anything before leaving • Back in clinic record blood sugars on camper's log sheets <p><u>Lake/Drama Responsibilities:</u></p> <ul style="list-style-type: none"> • Prepare by gathering equipment (listed above), juice, pbgs, and a communication device. • Drive golf cart to lake • In boat house set-up dispensary station and get cabin boxes ready for pumpers to place their pumps in. Be sure campers put their pumps in the correct boxes. • Treat low blood sugars and record on tablet. • KEEP WALKIE-TALKIE ON A LOUD ENOUGH SETTING so you are ABLE TO HEAR IF ASSISTANCE is NEEDED in the ROPES or ARCHERY areas. • After activity ... make sure all pumps have been retrieved by their owner and are re-connected. • Be the last to leave the lake area... making sure that other staff members do not need anything before leaving. • Back in dispensary record all blood sugars on appropriate camper's long sheets. <p><u>Licensed Staff:</u></p> <ul style="list-style-type: none"> ▪ One licensed staff member always remains in the dispensary
<p>10:30 A.M.</p>	<p><u>Snack Time:</u></p> <ul style="list-style-type: none"> ▪ **All children who are >300 at breakfast are to be retested at 10:15am. ▪ Mid-morning snack is taken in the dining hall. All pumpers come into the dispensary and check their blood sugar.

	<ul style="list-style-type: none"> ▪ Glucose meters need to be back in cabins before 11:00 A.M. ▪ 2012: Not covering for carbs at any of the 3 snacks. Not correcting at this time.
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Time	Responsibilities
11:30 A.M.	<p><u>Mealtime:</u></p> <ul style="list-style-type: none"> • Report to dispensary for lunch blood sugars and insulin dose preparation. *See <i>Breakfast instructions</i>. • Cabin insulin preparations will be done in the order in which each cabin brings their Blood sugar/Carb count Sheet to the dispensary. Cabins will be called to the dispensary for their injections and boluses in that same order. <ul style="list-style-type: none"> ▪ Ready lunch time medications & med binder to administer meds to campers as they come in for insulin. ▪ Remind camper if this is a pump site change day. <p><u>General Responsibilities:</u></p> <ul style="list-style-type: none"> • Provide coverage for the front desk area – 1st aid, band-aids, pumps, etc.
Lunch	<p>ALL DISPENSARY STAFF WILL EAT WITH CAMPERS</p> <p><u>After meal boluses/shots:</u></p> <ul style="list-style-type: none"> • One/two predetermined (by daily schedule) staff members will return to dispensary after meal to administer post meal boluses/shots • Draw-up held insulin doses and double check calculations and dose in pen/syringe with another staff member <p><u>General Responsibilities:</u></p> <ul style="list-style-type: none"> ▪ Once a week (Sundays) check AED batteries are okay, supplies in place, and pads not expired. This should be done by a consistently assigned person/persons. ▪ Right after lunch Assist with pump site changes
1:00 P.M.	<p>Afternoon Activities: there are 2 sessions</p> <p><u>Lake Responsibilities:</u> *See <i>morning Lake Responsibilities</i></p> <ul style="list-style-type: none"> • On the way to the lake drop off at pool: <ul style="list-style-type: none"> - 3PM pool snacks - “red cabin bags” for pumper blood sugar checks • Take enough juice, pbgs and celiac alternatives to last through pool time
	<p><u>Pool Responsibilities:</u></p> <ul style="list-style-type: none"> • Set up pool dispensary station in pool house area. • Pumps must be removed at the pool area and placed in individual cabin boxes (there are a few exceptions) • Treat low blood sugars and record on tablets. Minimum 100 to go in pool. • 2 staff members (sometimes 3) are required for free swim time
3:00 P.M.	<p><u>Snack Time: 15 gm</u></p> <ul style="list-style-type: none"> • At the pool, cabin counselors are responsible for obtaining blood sugars • The blood sugar results are written on a pumper snack sheet found in each cabin’s red bag. • If pumper blood sugar is above 200: pumper may re-attach pump and treat • Check sheets in red bags to make sure all the pumpers have a blood sugar recorded
4:00 P.M.	<p><u>Rest Period</u> for campers Site change</p>

	General Responsibilities: Try to do PUMP SET CHANGES AT THIS TIME if at all possible
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Time	Responsibilities
4:30 P.M.	<p>Mealtime: report to dispensary to start calculations for dinner insulin doses. ALL DISPENSARY STAFF WILL EAT WITH CAMPERS</p> <p>After meal boluses/shots:</p> <ul style="list-style-type: none"> • One/two predetermined (by daily schedule) staff members will return to dispensary after meal to administer post meal boluses/shots • Draw-up held insulin doses and double check calculations and dose in pen/syringe with another staff member • Call cabins 10 min. before meal. <p>Licensed:</p> <ul style="list-style-type: none"> • Ready dinner medications/ medication book to dispense when campers come in for insulin.
5:30 P.M.	<p>Dinner:</p> <p>General Responsibilities:</p> <ul style="list-style-type: none"> • Make sure all blood sugars from the day have been recorded on camper's log sheets for physicians to review after dinner.
6:00 P.M.	<p>Physicians: review binders in the dispensary</p> <p>General Responsibilities:</p> <ul style="list-style-type: none"> ▪ After dinner campers have organized activities either with their cabins or as a whole group. Depending on the activity scheduled dispensary staff usually needs to be wherever the campers are. Check with Camp director/Assistant Director
8:30 P.M.	<p>Bedtime Snack: SHOTS/BOLUSES WILL BE DONE IN THE CABINS</p> <ul style="list-style-type: none"> • Snack is 30 gm. If blood glucose is <100, 45 gm. • Doses will be predetermined. Most bedtime injections are Lantus/Levemir • Take caddy with pens/syringes with you to cabin • Take binder with you to record doses given and changes made to settings on pump if needed • Bring a few extra pump sets/insulin vials with you just in case set change is needed at that time • This is your opportunity to talk with the campers. See how their day went, any questions/concerns that may need to be reported. TALK with them. EDUCATE them. ENJOY them. • HS meds <p>General Responsibilities:</p> <ul style="list-style-type: none"> • Physicians may order new pump settings in the evening. When pump changes are completed, initial and indicate time on camper's Pump Order Form. **Initial and date
10:00 P.M.	<p>General Responsibilities:</p> <ul style="list-style-type: none"> • Prepare a list of campers whose snack time blood sugar were less than 100 mg/dl or over 300 mg/dl and will need to be checked at 12 midnight. Communicate with DA/Student who will be doing BG checks any information they may need

	<p>Overnight Nurse:</p> <ul style="list-style-type: none"> • On days when there is a very rigorous evening activity, an all-camp 12am check may be needed. • Prepare for the next day pump site changes- <ol style="list-style-type: none"> 1. Identify which pumpers need a site change by checking medication book 2. On a white label write: camper's name, cabin, type of insulin pump, and type of insulin. Fix the label to a sandwich bag. 3. In individual bags place following items from camper's personal supplies: infusion kit, any needed insertion device, wipes, and cartridge/reservoir • Add new SC and Pump Log Forms to binders. Accurately fill out required information and correctly place in binder • Fill medication box for the following day – accurately placing 8AM, noon, 5PM and HS 2030 meds • Put labels on syringes and store in appropriate boxes if needed (rare if using pens) • Make pbg's (1 tbsp peanut butter between 2 graham crackers), stock apple juice, glucose tabs • Restock bags/kits from the day with supplies • Calibrate meters from bags/kits/dispensary. Please record
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Time	Responsibilities
12:00 A.M.	<p><u>Licensed:</u></p> <ul style="list-style-type: none"> ▪ Remains in dispensary and continues above work and responds to calls. ▪ Clean up the two camper rooms in the dispensary: fill canisters, check around beds for trash. <p><u>Unlicensed:</u></p> <ul style="list-style-type: none"> ▪ Blood sugar checks for campers identified on "Below 100 at HS List": With list and necessary supplies go to the necessary cabins and following cabin's bed chart find camper and check blood sugar. Follow camp's policy for treating hypoglycemia at night. Treat and recheck BS in 15 minutes. Call staff member in dispensary with any questions or concerns. ▪ While in cabin observe other campers for signs of hypoglycemia such as thrashing, lip smacking, and profuse sweating. Check BS on any camper you are not sure about.
2:00 A.M.	<p><u>General Responsibilities:</u></p> <ul style="list-style-type: none"> ▪ Make a list of all campers who were less than 100 mg/dl at 12 mid-night. <p><u>Unlicensed:</u></p> <ul style="list-style-type: none"> ▪ Repeat same procedure for blood sugar checks in cabins using new list of low campers at 12 AM. <p><u>Licensed:</u></p> <ul style="list-style-type: none"> ▪ Complete tasks remaining from 10 PM list ▪ Record all 12 AM blood sugars on camper log sheets
Sometime after 2 AM?	<p><u>After night blood sugar checks are completed:</u></p> <ul style="list-style-type: none"> ▪ Staff members may go to sleep. ▪ Leave light on above the dispensary desk only. ▪ Lock medication room and take key into nurse's quarters with you. ▪ Leave the outside light on until 7:00 A.M. ▪ Answer and respond to "Red Phone" calls.

Medical Director and Senior Medical Staff

Medical oversight, supervision and policy for Camp HMK are carried out by the Senior Medical Staff. A roster of the current Senior Medical Staff is attached. Members are experienced in the various aspects of diabetic care of children.

One or more Senior Medical Staff physicians will supervise each camping session. If more than one is assigned, they will agree between them how the tasks and days will be shared.

These tasks include participating with camper intake history and physicals on the first day of the session and developing for each camper a workable diabetic management plan. Orders will also be written for the care of non-diabetic medical problems, as indicated.

The physician(s) supervising a session will be available to the camp physician and dispensary staff for consultation. This may be by phone, when required. It is expected that in-person, evening rounds will be made at camp; the frequency of these will depend on the experience of the camp physician and dispensary staff. Typically, personal rounds at camp have been made on most days for the first week of a session and on alternate days for subsequent weeks of that session.

The attending senior staff will assure that the dispensary staff has their current office, home and cell phone numbers.

The camp medical director, or his designee, will be available for backup to the senior attending(s) throughout the summer sessions.

When the camp is off-premises (campouts, canoe trips, amusement parks, ball games, etc.) it is not expected that the senior staff will make in-person rounds.

Physician in Residence

The Camp Physician supervises and is responsible for the general health and safety of campers and staff. He/she will work under the direct supervision of the Camp Medical Director to provide daily management of summer camp dispensary operations, including management and supervision of nursing staff. The Camp Physician will live on-site (overnight residence required) at Camp Ho Mita Koda for the duration of each the residence camp session. He/she will abide by Camp Ho Mita Koda Medical Policies and American Camp Association guidelines. The Camp Physician will interface daily with the Camp Medical Director, Senior Medical Staff attending physicians, resident physicians and fellows, and the Camp Director.

Required Qualifications:

- Physician with current licensure in the State of Ohio
- Experience in managing routine out-patient medical conditions in children and adolescents, including common infections, minor injuries and insect bites.
- Possess working knowledge of current principles and techniques and procedures related to diabetes management and care, including blood glucose monitoring, insulin algorithms, management of hyper and hypoglycemia, and CPR and first aid.
- Applicants must, as a condition of employment, pass the following pre-offer and post-offer/hire processes: reference checks, state and FBI background screening including fingerprint checks, and sex-offender registry check. Drug screening is at the discretion of Camp administration.

Required Certification & Training:

- Must possess current licensure in the State of Ohio and CPR certification that remain valid through August 2013.
- Must attend one week of pre-camp training with the Camp Medical Director. This may require clinic and office time at Rainbow Babies and Children's Hospital. Additional training during this time includes familiarization with the use of insulin pumps.

Essential Functions, Knowledge, Skills and Abilities:

- Supervise the daily operations and staffing of the Camp Dispensary.
- Maintain daily communication with the Medical Director and/or Attending Physician.
- Health and Safety of campers and camp staff.
- Must participate in resident orientation and training
- Assist/carry out medical orders of physicians, including medication administration.
- Be responsible for setting daily, and interim, insulin doses;
- Take charge of any diabetes or medical emergencies, and initiate appropriate treatment. Perform first aid or CPR, in an emergency or in any other situation when found necessary.
- It is expected that the resident physician will collaborate in non-medical decisions with the Camp Director (on site) and the Director of Camp and Youth Programs (off-site).
- Become familiar with each camper and his/her chart.
- Documentation for medical evaluations and treatments given
- Provide coverage in Camp Dispensary. Coverage will include some camper activity sites and overnight on-call rotation.
- Assist with all dispensary related written documentation and recordkeeping including, but not limited to, requirements of the American Camp Association, Camp Medical Director, and the Diabetes Association of Greater Cleveland.
- Communicate with parents on telephone and at check-outs about camper health.
- Daily review of medical records with attending physician:

- Attending physician and Resident Doctor, in conjunction with nurses when possible, will review binders each evening.
- Each camper's BG log is reviewed daily to help each camper achieve the best diabetes control possible without hypoglycemia. Changes in the camper's protocol/insulin regimen can only be made by the attending or resident.
 - For pumpers and glargine/detemir/nph, the changes are made in the appropriate places on the order sheet; a "Change Order" is written on a row in the boxes provided and will be initialed by MD making change. MD should sign the bottom of sheet with name/date so we will know who made the change
 - For basal rate changes, a note is stuck onto the page to alert the nurse(s) that a basal rate change has been ordered. The note should say "change" and include the **date and camper first initial and last name number** in case it falls off the page and will be done at bedtime in the cabins.
 - For Conventional insulin management (NPH), changes will be written on order sheet and initial/dated by physician making changes. Change will be made the next appropriate time for insulin injection.
 - Physicians should sign and initial bottom of order sheet to identify who is making changes.
 - If nurses need to discuss any information about a camper, please see Attending at this time. If suggestions can be made from conversations held with camper, this is the appropriate time to discuss. Changes will be made at the Attending physicians discretion.

Diabetes Education

The camp setting is an optimal environment for campers to gain valuable knowledge and skills to improve their diabetes management. Diabetes education is integrated in all camp programming and takes advantage of many “teachable moments.” The primary educational goals of Camp Ho Mita Koda result in the development of lifelong wellness habits. Camp Ho Mita Koda strives to support, encourage and teach diabetes management skills in a fun, interactive and age-appropriate manner. Our diabetes education goals at camp are as follows:

- Campers will learn new skills and reinforce existing knowledge through planned participatory activities, observation, and individual and group instruction. Such activities may include swimming, boating, hiking, archery, climbing, and team building.
- Diabetes education will be offered as an elective activity at least one activity period each day. A variety of topics will be offered, including nutrition education.
- Carb counting will be taught and reinforced at all meals and snacks. Grams of carbs will be used to determine overall carb servings.
- Campers will develop a sense of environmental awareness through interaction with the natural environment.
- Campers will improve self confidence, interpersonal skills, and conflict resolution skills through the camp experience.

AGE RELATED RESPONSIBILITIES AND TRAITS		
	Non-Diabetes Related	Diabetes Related
Ages 2-7	Imaginative, Concrete thinkers, cannot think abstractly, Self-centered	Parent supervision for all activities, gradually learn to cooperate for BG testing and insulin injections, learn to recognize hypoglycemia, inconsistent with food choices, not much concept of time
Ages 7-12	Concrete thinkers, more objective and understanding, more curious, more social, more responsible	Adult supervision recommended, can learn to test BG, can draw up and give shots, can make food choices, can recognize and treat hypoglycemia, can be responsible for remembering snacks
Ages 12-18	More independent, behavior varies, body image important, away from home more, more responsible	Adult supervision recommended, can do majority of shots & blood tests, know which foods to eat, gradually recognize the importance of good sugar control to prevent complications, more willing to inject multiple shots per day

Emergencies

Medical emergencies (illness or injury) may arise at Camp. The following procedures should be followed:

GENERAL:

1. Summon dispensary staff and/or camp (resident) physician if the ill or injured person cannot safely be moved to the dispensary. For severe emergencies, it is generally best not to move the individual unnecessarily until they are medically stabilized. Immediate aid should be given on the scene until a trained and equipped emergency rescue transport team arrives. Examples of major emergencies include drowning, severe burns, major fracture, anaphylactic reaction, suspected neck/spine injury, and loss of consciousness or seizures.
2. Medical personnel (MD, RN, or other dispensary staff) will perform a rapid assessment within their scope of practice, starting with airway, breathing, bleeding and circulatory status. Appropriate stabilizing measures will be instituted; for example, the airway may need to be opened by means of a jaw-thrust maneuver, mouth-to-mouth resuscitation initiated, bleeding controlled by direct pressure, or the feet elevated and blankets applied if circulation is poor.

HYPOGLYCEMIC EMERGENCY

If the emergency is diabetic in nature, a blood glucose level should be measured as quickly as possible. For severe clinical symptoms very apt to be due to hypoglycemia in a diabetic child (e.g. seizure, unconsciousness, confusion), you may elect to initiate immediate treatment for hypoglycemia without delay and measure the blood glucose after treatment has been initiated. If hypoglycemia is present, glucose should be given rapidly by mouth **if** the person can swallow safely. **If safe swallowing cannot be assured (as with unconsciousness, near-unconsciousness, or convulsion)** then Glucagon, 1 mg. SQ should be given to correct hypoglycemia. Camp Ho Mita Koda dispensary staff has been trained and are authorized in the use of Glucagon SQ (just as parents of our campers are often trained in its use at home). If there is no response to a single dose of SQ Glucagon, it may safely be repeated after 5 minutes.

If there is hypoglycemia, plus convulsion or loss of consciousness or near-unconsciousness, and if clinical alertness is not regained by 5 minutes after the first dose of Glucagon, a push of 25% dextrose, 2-4 ml/kg should be given IV by a physician. This bolus dose of IV Glucose may be repeated if not restorative of normal blood glucose concentration and of clinical alertness within 3 - 5 minutes. If a physician is not present, the dispensary staff should administer a second dose of SQ Glucagon, 1 mg. and summon the emergency rescue squad.

Even in the case of a severe hypoglycemic event, treatment with SQ Glucagon and/or IV Glucose may be rapidly successful, and eliminate the need for local emergency squad transport and hospital emergency room evaluation or treatment. Follow-up oral intake is necessary to prevent recurrence of hypoglycemia.

NON-DIABETES EMERGENCY

If the illness or injury is not hypoglycemic and severe in nature, after rapid assessment and initiation of first aid measures, the **Newbury emergency rescue squad** should be called (**phone 440-564-5411**). Give clear directions as to location. If permitted by the squad, the

camp physician may choose to accompany the person to the hospital (Geauga Community). Dispensary staff is not required to accompany the patient via squad.

For minor, non-critical emergencies requiring hospital emergency room evaluation but not rescue squad transport (examples: minor sprain, minor laceration, mild wheezing), the injured or ill individual may be driven to Geauga Community Hospital accompanied by a member of the dispensary staff. Before departing camp, the Camp Director should be notified, if readily available. Obtain and take the parental release for medical emergency care from the camp office.

Medical Phone Calls to Families

Camp policy is to have the physician phone the family or the family physician before instituting any major and fundamental changes in insulin type, timing or frequency (see above). This refers to changes that would be apt to impact home management plans (e.g. three shots of insulin daily instead of two)

The physician will also call the family as soon as possible if there is any illness or injury significant enough to require emergency room or hospital evaluation or treatment, or the prescribing of a medication (except OTC preparations). This includes, for example, sprains with negative x-ray, penicillin for strep or URI, as well as problems of a more major nature.

Emergency Kits

Tackle boxes, Backpacks, Bags

Top Shelf

- Glucagon (3)
- Ketostix (1 vial)
- Disposable lancets
- Cotton balls
- Epinephrine 1 mg (2 vials injectables)
- Smelling salts.

Middle Shelf

- Tylenol
- Bacitracin
- Band-Aids

Bottom Shelf

- 1 sharps container
- 2 Blood glucose meters
- Blood Glucose test strips (3 vials)
- Glucose tablets (100)
- Instant Glucose (6)
- 4x4" sterile pads
- Tape 1" (1 roll)
- Disposable gloves (3 -5 pairs.)
- Ziploc bag for regular garbage

NOTE: A separate IV box is stocked and stored in the dispensary.

I.V. Supply Box

- Hypoallergenic tape 1" (1 roll)
- Cloth tape 1" (1 roll)
- Angiocaths
22 gauge (6)
20 gauge (3)
- 30 unit (low-dose) insulin syringes (3)
- Heparin flush adapters/heparin locks (5)
- 5 cc syringes (4)
- 20 – 30 cc syringes (3)
- Sterile saline for injection 10 ml (1)
- Heparinized saline sterile 100 units/ml; or Heparin flushes 100 units per vial (3)
- Pediatric mini-drip IV tubing 60 drops/cc (2)
- Dextrose 10% (1 bag)
- Lidocaine 1% (10mg/ml) 50 cc bottle (1)
- Chux (1)
- Alcohol wipes (10)
- Betadine wipes (10) or swabs (3)
- Nonsterile gauze pads (6)
- Venous tourniquet (2)
- Disposable gloves (3 pairs)

Incident Reporting

An Incident Report form should be completed by a camp staff member if any of the following conditions have occurred:

- Any injury of camper, staff, volunteer or visitor
- Any illness of camper, staff, volunteer or visitor
- Suspected physical, emotional, or sexual abuse/ Reports of abuse
- Glucagon administration
- ER visit or hospitalization
- Seizure
- Any 'red phone' medical call from cabin to dispensary
- Medical error
- Any behavior/incident that resulted in physical or emotional harm to the person or others
- Removing a camper from an activity or the dismissal of a camper from an activity
- An emergency evacuation or sheltering due to fire or severe weather conditions
- A missing person (camper, staff, volunteer, or visitor)
- Intruder(s)
- Water rescue in lake or pool
- Termination of employment or dismissal of a volunteer
- Camper who doesn't show up for session, leaves early, or is asked to leave for violation of rules
- Failure of safety equipment
- Any act that violates the law
- Damage to camp property

Incident reports will be completed immediately following an incident. Witnesses to incident will submit a written account and signed statement.

Parents will be contacted by the Nurse Manager, Attending Physician or Resident Physician as soon as possible but within 8 hours of the following incidents: Glucagon administration, ER visit or hospitalization, Seizure, Any 'red phone' medical call from cabin to dispensary, Medical Error.

Parents and appropriate authorities will be contacted by the Camp Director in the event of abuse or allegations of abuse within 8 hours.

Completed Incident Report Form (**Appendix H**) and attached witness statements will be faxed to the Attending Physician, Camp Medical Director, and Director of Camp and Youth Services within 2 hours of the incident. Original forms will be kept on file at the Administrative Office, 3601 S. Green Rd. Suite 100, Cleveland, OH 44122.

Blood Glucose Monitoring

Blood glucose monitoring is the principal method by which diabetes control is monitored and maintained. This requires functional meters, reproducible and correct technique, and user safety regarding precautions against blood-borne disease.

All blood testing supplies are donated by the. Campers do not need to bring their own meters, strips or lancets and will only be allowed to use those provided by camp. Single-use lancets will be provided.

Campers are required to check their own blood sugar with supervision by counselors or medical staff. If it is necessary for a counselor or medical staff to test a camper's blood sugar, **GLOVES MUST BE WORN.**

Campers will test a minimum of 4 times daily by all campers at the following times:

- Before breakfast
- Before Lunch
- Before Dinner
- Before Bedtime

Additional blood sugars will be done at the following times when a camper:

- Complains of feeling low
- Is acting strangely or confused
- Is having symptoms of low blood sugar such as irritable, sweating, shaking, etc.
- Is unable or unwilling to eat scheduled meals/snacks

- At Midnight, any camper who
 - Had an evening snack blood sugar less than 100 mg/dL or >300 mg/dL
 - Has received an injection of fast acting insulin at evening snack that is not part of camper's usual regimen
 - Has been having issues with overnight hypoglycemia or are considered at risk for overnight lows

NOTE: Blood glucose monitoring may be done at any other time at the discretion of the counselor and/or medical staff.

Blood Glucose Meters:

1. Each camper will have their own meter in the cabin and should only use their own meter in the cabin.
2. Meters used in the dispensary and at activities will be cleaned daily.
3. Test strips must be kept in their original containers and be properly closed. Moisture and humidity can affect the reagent surface.

4. Meters will be cleaned according to the methods specified by the manufacturer. Meters should be cleaned daily – or more often as necessary.
5. Some brands of meters require calibration against each vial or package of test strips. This must be done faithfully to assure accuracy. If several meters are used in one location (e.g. the dispensary, be sure that all test strip vials/packages have the same calibration code; if this is not possible, then label the meters and the test strip containers so they are easily matched up by the user.

Control testing procedure:

- Will be done daily by the dispensary staff
 - Are delivered to the dispensary by counselors
 - 9am-10am all cabins
 - Perform test according to manufacturer's instructions.
 - Make sure result falls between suggested ranges on test strip bottle. Document on Control Testing Log sheet—Initial/date
6. Most meters employ standard control solutions for testing accuracy. These should be on hand and can be re-ordered as needed from the manufacturer's representative who services Camp.
 7. Each meter used at camp shall be labeled with an ID number or child's name, and each meter shall be listed in a **meter AQ logbook**. Quality assurance determinations (done per manufacturer's instructions) will be run on each meter in use daily and each time a new vial of test strips is opened. These results will be written in the meter QA logbook. If the test results are outside the expected limits, as defined by the manufacturer, that meter will be removed from use until the problem is corrected.
 8. Fresh batteries will be obtained for each meter at the start of each summer season. Rechargeable batteries will not be used, unless that is recommended by the manufacturer; rechargeable battery voltages may be subtly different resulting in erroneous readings.

Blood Glucose Testing Procedure:

Assemble materials needed for testing: meter, strips, single-use lancets, alcohol pads, cotton balls, protective gloves when necessary.

1. Insert test strip into meter
2. Verify code on meter matches test strips
3. Clean finger with alcohol pad or soap/water and allow to dry
4. Poke finger with single-use lance
5. Obtain adequate blood sample
6. Touch blood sample to test strip to start test (automatically starts counting down on meter)
7. Read value when timing complete
8. LO is less than 20 mg/dL

9. HI is greater than 600 mg/dL
10. Record test result
11. Clean up area properly following OSHA regulations

Exercise

It is recognized that exercise has a direct effect on the blood glucose. When a program activity is expected to be either very vigorous or sustained, the dispensary, dietary and program staffs should work closely to coordinate insulin dosages, meals and snacks, and the specific activity in order to optimize the blood glucose control. It is especially important to avoid serious hypoglycemic reactions. In this way, the positive learning experience for campers will be enhanced.

It is our goal to avoid serious hypoglycemic reactions, while encouraging the full and vigorous physical activities normal to children. We want to maintain an educational emphasis that enables the camper to better learn the self-management skills that permit homeostasis during periods of fluctuating physical activity. Gender and age may be special factors to consider (e.g. if teen males are expected to be more vigorous in a particular activity).

Early communication between the program staff and the dispensary about scheduled activities is the key to permitting planning of dosages and meal plans.

Examples

- A. A high-energy activity, such as roller skating or a long hike, is scheduled. The preceding meal or snack might be enriched, and/or the appropriate insulin doses prior to the activity scaled back.
- B. Consideration should be given to extra testing before and at intervals *during* sustained high-energy activities so campers can be monitored, and so that they can learn their own patterns of glucose response to vigorous exercise.
- C. Snacks and/or glucose supplements should be immediately accessible during sustained high-energy activities, so campers can be monitored, and so that they can learn their own patterns of glucose.
- D. The possibility of *delayed* hypoglycemia should be considered, that is, hypoglycemia that occurs several hours after vigorous exercise. Hypoglycemia may develop, for example, during the sleep the night after a day-long hike.
- E. When *sedentary activities*, such as skits or movies, are planned, the meal plan might be reduced and/or insulin doses increased to avoid hyperglycemia.

Staff should use judgment about balancing self-testing during exercise against the value of full participation free of fear. It helps to make these judgments based upon familiarity with the child's personality; his or her fears of hypoglycemia, attention-seeking tendencies, recent blood glucose patterns, and observed or reported patterns of hypoglycemia. The examples above are only illustrative, and actual decisions need to be based on individual circumstances.

Hypoglycemia

Hypoglycemia (“low blood sugar, “Insulin reaction”) is the most frequent acute complication of diabetes. It is also one of the most uncomfortable facets of learning to live with diabetes. Ideally, campers should be able to recognize hypoglycemia early and seek appropriate treatment.

Occasionally, some children will use their diabetes as an excuse for not participating in camp activities, or dealing with a difficult or stressful situation. Being away from home for the first time or difficulty getting along with other children are a few examples. Hypoglycemia can be confused with symptoms of home sickness, anxiety, and stress.

ALWAYS rule out hypoglycemia first!

Campers who are/may be experiencing hypoglycemia are to have their blood sugar checked immediately, wherever they are. If the blood sugar is low, they will be treated wherever they are, such as cabin, activity area, dining hall.

All dispensary staff will carry “red bags” or tackle boxes that contain supplies to test blood sugar and treat hypoglycemia. These bags are checked and stocked daily by the dispensary staff and remain with the dispensary staff at all times, including water activities. They also contain blood testing supplies, including blood glucose meters/strips, sharps containers, gloves, and cotton balls. Special consideration is needed for those with a history of seizure or severe/frequent hypoglycemia.

Degrees of Hypoglycemia

Mild: Camper suspect hypoglycemia seeks and accepts appropriate food.

Moderate: Camper demonstrates signs/symptoms of hypoglycemia. Accepts food when offered. Symptoms include shakiness, nervousness, dizziness or complaints of lightheadedness, weakness, sweating, confusion, rapid behavior change (irritability, agitation), rapid heart rate, pale skin, numbness of lips and/or tongue, hunger, headache, blurred vision, sleepiness.

Severe: Camper cannot treat hypoglycemia without assistance. He/She does not recognize symptoms of hypoglycemia or is not able to seek help. . May or may not accept food and follow simple instructions.

Severe with LOC: Camper experiences hypoglycemia associated with loss of consciousness, with or without seizure. Symptoms include unconsciousness, seizure, trouble swallowing.

Hypoglycemia Treatment

Check camper's blood glucose. Stay with camper; do not send camper to the Dispensary without a Counselor/or another camper whose BG is normal.

MILD TO MODERATE:

- Give 3-4 glucose tablets (15-16 grams carbohydrate)
- Wait 15 min.
- Retest
- Follow with 15 grams carbohydrate snack if next meal or snack is more than 30 minutes away.
- Re-check blood glucose in 15 minutes. If symptoms do not improve, repeat above

***Snack example:** PBG (peanut butter gram cracker or substitute for camper with celiac disease.

SEVERE WITHOUT LOSS OF CONSCIOUSNESS OR SEIZURE:

1. Ensure that the camper is sitting with support. Counselor may sit behind camper with the camper resting against the counselor's chest. Send someone for dispensary staff.
2. Attempt to give Insta-glucose gel between cheek and gum, while in a firm soothing voice encourage camper to swallow.
3. Continue to squeeze Insta-glucose as above until camper is able to follow commands. When the camper is able to respond to commands, give 15grams carbohydrate snack such as juice or tabs.
4. If the camper loses consciousness, proceed with treatment of **SEVERE LOW BG by the medical team**. Treatment of severe low BG is NOT done by counselors.

SEVERE HYPOGLYCEMIC EVENT WITH LOSS OF CONSCIOUSNESS:

In the event of unresponsiveness, convulsion, or life threatening emergency, the staff will call the Dispensary **USING THE RED PHONES OR WALKIE-TALKIES**, and report event giving the cabin/location.

1. **The Counselor** will: --CALL DISPENSARY BY RED PHONE OR WALKIE TALKIE. --
Protect camper from injury (pillows, etc.) and the clear area of campers and staff.
2. **The Dispensary Nurse** will notify doctor(s) and back up nurse. **REMAIN** in the Dispensary.
3. **The Backup Nurse/Doctor** will go to the cabin/area with emergency box. Have the counselor clear the area of campers and staff

Glucagon

Glucagon is a natural hormone that elevates the blood glucose. Its action is counter to insulin, It is mixed (special diluent + freeze dried pellet) at the time of use.

Standard dose for all ages is 1 mg (= 1 vial) SQ or IM. Action requires 5-10 minutes. Glucagon is used when the camper is unconscious, seizing, or so obtunded/combatative that oral methods of treating hypoglycemia are unsafe or not practical.

If there is no response, prompt administration of IV Glucose should be considered. While preparing the IV push, a 2nd dose of Glucagon 1 mg may be given. To avoid recurrent hypoglycemia, follow the successful use of Glucagon with food as soon as possible.

Glucagon Administration

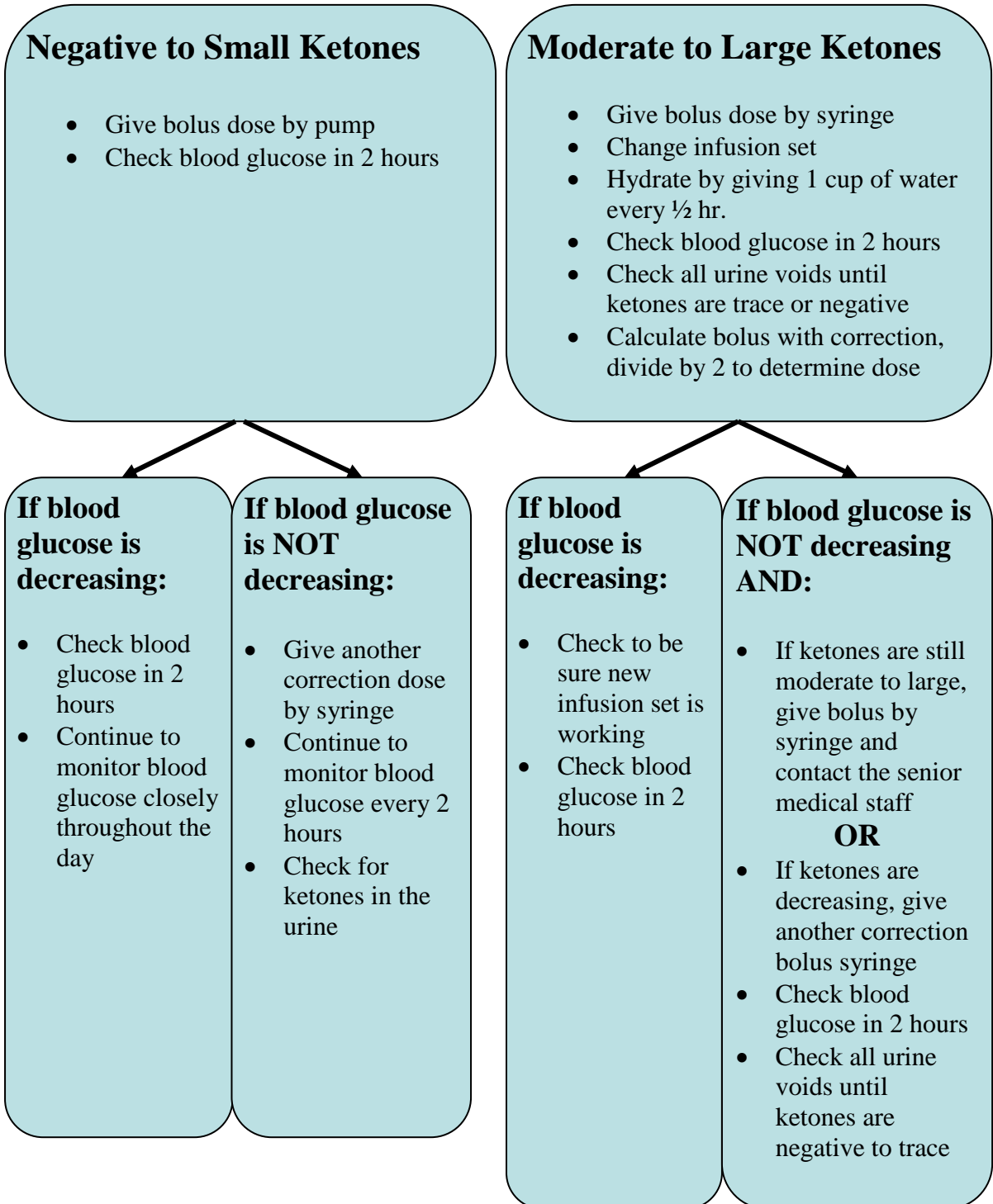
TO PREPARE GLUCAGON FOR INJECTION

1. Remove the flip-off seal from the bottle of glucagon. Wipe rubber stopper on bottle with alcohol swab.
2. Remove the needle protector from the syringe, and inject the entire contents of the syringe into the bottle of glucagon. **DO NOT REMOVE THE PLASTIC CLIP FROM THE SYRINGE.** Remove syringe from the bottle.
3. Swirl bottle gently until glucagon dissolves completely. **GLUCAGON SHOULD NOT BE USED UNLESS THE SOLUTION IS CLEAR AND OF A WATER-LIKE CONSISTENCY.**
4. **TO INJECT GLUCAGON.**
Using the same syringe, hold bottle upside down and, making sure the needle tip remains in solution, gently withdraw all of the solution (1 mg mark on syringe) from bottle. The plastic clip on the syringe will prevent the rubber stopper from being pulled out of the syringe; however, if the plastic plunger rod separates from the rubber stopper, simply reinsert the rod by turning it clockwise. The usual adult dose is 1 mg (1 unit). For children weighing less than 44 lb. (20 kg), give 1/2 adult dose (0.5 mg). For children, withdraw 1/2 of the solution from the bottle (0.5 mg mark on syringe). **DISCARD UNUSED PORTION.**
5. **INJECT GLUCAGON IMMEDIATELY AFTER MIXING.** Use same technique as for injecting insulin
6. Cleanse injection site on buttock, arm, or thigh with alcohol swab.
7. Insert the needle into the loose tissue under the cleansed injection site, and inject all (or 1/2 for children weighing less than 44 lb.) of the glucagon solution. **THERE IS NO DANGER OF OVERDOSE;** however, glucagon administration can be associated with nausea or vomiting. Apply light pressure at the injection site, and withdraw the needle. Press an alcohol swab against the injection site.
8. Turn the patient on his/her side. When an unconscious person awakens, he/she may vomit. Turning the patient on his/her side will prevent him/her from choking.
9. **FEED THE PATIENT AS SOON AS HE/SHE AWAKENS AND IS ABLE TO SWALLOW.** Give the patient a fast-acting source of sugar (such as a regular soft drink or fruit juice) and a long-acting source of sugar (such as crackers and cheese or a meat sandwich). If the patient does not awaken within 15 minutes, give another dose of glucagon and **INFORM A DOCTOR OR EMERGENCY SERVICES IMMEDIATELY.**
10. Even if the glucagon revives the patient, his/her doctor should be promptly notified. A doctor should be notified whenever severe hypoglycemic reactions occur.

HYPERGLYCEMIA FLOW SHEET?

Protocol for High BG Management

- If blood glucose is greater than 300mg/dL twice in a row, check urine ketones and troubleshoot pump and infusion set.
- In the event the pump is malfunctioning, the Pump Help Line will be called. If the problem cannot be resolved, parent(s) will be notified.



Intravenous Glucose

Use of IV glucose should be reserved for emergency situations due to hypoglycemia (loss of consciousness, seizures, and depressed respirations). Glucagon may be rapidly administered while preparing for the IV push (see above). IV glucose should not be used to treat hypoglycemic events of a milder nature or in situations where simpler methods would be likely safe and effective. The administration of IV glucose is a “medical intervention” that has a negative impact on a camper’s sense of self-control and security.

Dose: 25% Dextrose 2-4ml/kg should be given as an IV bolus push. Be certain the IV line is patent and not infiltrating. This dose may be repeated if not restorative of normal blood glucose concentration and of clinical awakesness after 3-5 minutes. Consideration should be given to following the bolus dose with D10% infusion if the child is not fully awake.

To avoid recurrent hypoglycemia, follow the successful use of IV glucose with food as soon as possible.

Ketone Testing

Testing urine for ketones will be done by all campers:

1. Anytime blood sugar is > 300 mg/dL
2. Anytime the camper complains of feeling ill or vomiting
3. At the request of medical staff

Campers who have positive ketones will be encouraged to increase PO fluids and will be required to retest ketones and blood sugar every 2 hours minimum until ketones are negative

Exercise will be restricted for campers who have positive ketones

NOTIFY PHYSICIAN anytime a camper has positive ketones. Physician may want to order supplemental insulin. Camper with moderate/large ketones should be held from doing rigorous activity. They may attend passively, change activities or stay in dispensary.

KETOSTIX

Equipment: Urine, Ketostix, Clock, WLPFU, Color chart (or Ketostix bottle)

Procedure:

1. Dip 1 Ketostix into urine.
2. Wait 15 seconds.
3. Compare and decide immediately with color chart the amount of ketones.
4. Record results on Campers Log sheet in Cabin binder Note: A delay in reading can alter the validity. Read in 15 seconds, if not, repeat the test.

CHEMSTRIP K

Equipment: Urine, Chemstrip - K, Clock/second hand, Color chart or Chemstrip bottle

Procedure:

1. Dip 1 Chemstrip K into urine.
2. Wait 1 minute.
3. Compare and decide with color chart the amount of ketones. Results will be accurate for an additional minute.
4. Record results on Campers Log sheet in Cabin binder

Insulin

General:

Insulin is donated by Eli Lilly, Novo Nordisk and Sanofi-Aventis. Campers will be provided with the brand (as above) and the type (Humalog/lispro, Novolog/aspart, Apidra/glulisine, regular, NPH, Lantus/glargine, Levemir/ detemir that they use at home.

Note: We **do not** use 70/30 or 75/25 insulin mixes at camp, since the amount of regular insulin needs to be adjusted daily.

Insulin Administration:

- Before and after breakfast, lunch and dinner insulin is given at the Dispensary.
- Bedtime insulin will be given **IN THE CABINS** by assigned RN/dispensary assistant.

Adjustments:

Occasionally, insulin doses need to be decreased at camp because of higher activity level. This is generally necessary to prevent frequent and/or severe low blood sugars. Sometimes, doses remain the same or are increased because of high blood sugars (200 mg/dl or higher). If parents have any questions about these procedures, they should be discussed with the medical staff at Check-In Day. "Perfect" blood sugar control is not a goal of diabetes camp. Every effort will be made to provide safe diabetes care at camp and more importantly, prevent severe low blood sugars, ketones in the urine, and symptoms of high blood sugars. At times, the medical staff may use Humalog/lispro or Novolog/aspart insulin to rapidly correct an elevated blood level.

The ultimate decision for an insulin dose will be at the discretion of the medical staff.

Guidelines for using the Log Sheets:

BG log sheets, in duplicate form, for managing insulin and tracking glucose are used at camp. Each camper (counselor in training with diabetes) has one. After intake day, the sheets are kept in cabin binders, one for each cabin, and color coded with dispensing trays if needed. At intake the doctors/RNs fill out the top sheet (pump, glargine/detemir or conventional insulin format) for each camper. The top sheet tells the nurses the insulin doses and pump settings. The bottom sheet is used by the nurses to record each camper's glucoses and insulin doses administered, as described below.

During the session the attending doctors/residents will review campers' glucoses and adjust insulin regimens accordingly each evening.

Insulin Administration

Prior to insulin administration, each camper's glucose will be checked in the cabin under the supervision of the counselor. Low blood glucose will be treated immediately as per protocol.

Any child with blood glucose over 400 needs to go to the Dispensary immediately. **Ketones will be checked and reported any time for blood sugars >300. Ketones that are moderate or large need to be reported to the Dispensary immediately.**

1. A counselor/camper will bring the glucose records to the Dispensary as soon as every child has tested so that the nurses have time to record the readings and determine the insulin doses.
2. The nurse will check the Cabin Binder assuring name, type and dose of insulin prior to administration of each insulin dose. The nurse will record the actual dose given on the log sheet.
3. For injected insulin, the nurse/dispensary assistant will draw insulin. For insulin pumps, the camper may set the bolus but cannot administer it until it is checked by the nurse. Similarly any change in a basal rate must be seen on the pump by the nurse before it is put into effect.

Campers **SHOULD NOT BE FORCED** to administer their own insulin until they are ready to do so.

4. Site rotation should be taught and implemented by the nurse. It should take into consideration what activities are planned (because of potential exercising of areas for injections). Do not use sites which have hypertrophy (record hypertrophied areas on log sheet based on intake physical form and camper health forms.)
5. Campers will be provided with the same type of pen/syringe used at home, i.e., short needle or regular length.

Note: Long-acting insulins, Lantus or Levemir, are administered using a separate syringe. These insulins may not be mixed in the same syringe with any other insulin.

Insulin Injection (no mixing of insulins)

Equipment: Insulin syringe, alcohol swab, insulin, gloves

Double check to ensure that you have the correct insulin.

Procedure:

1. Wash hands.
2. Cleanse rubber stopper of insulin bottle with alcohol.
3. Withdraw plunger of syringe to desired amount to have the air to inject in the bottle.
4. Remove cap over needle.
5. Insert needle into rubber stopper of insulin bottle and inject pre-drawn air into the bottle.
6. Invert bottle, pull back plunger of syringe to de-sired level of insulin.
7. Remove air (tap syringe gently).
8. Assure proper amount of insulin.
9. Withdraw syringe from bottle and replace cap on syringe.
10. Put on protective gloves if assisting with injection.
11. Choose site for injection and prepare site with alcohol, if used.
12. Remove cap from needle.
13. Insert needle into skin at a 90-degree angle to the area.
14. Press plunger down injecting all insulin. Count to 5 prior to removing needle.
15. Remove needle from skin.
16. Place **UNCAPPED** syringe in medical waste container. **DO NOT** recap needle.

Insulin Injection – Mixing Insulins

Note: Lantus, Levemir, and other 24 hour insulins may not be mixed.

Equipment: Insulin syringe, alcohol swab, insulin, gloves

Double check to ensure you have the correct insulin

Procedure:

1. Wash hands.
2. Cleanse rubber stopper with alcohol.
3. Retract plunger of syringe for desired amount of intermediate acting insulin (NPH).
4. Remove cap over needle.
5. Insert needle into rubber stopper of intermediate acting insulin and inject pre-drawn amount of air into the bottle.
6. Remove syringe.
7. Retract plunger of syringe for desired amount of short acting insulin.
8. Insert needle into rubber stopper of short acting insulin and inject pre-drawn amount of air into the bottle.
9. Invert bottle, pull back plunger of syringe to desired level of short acting insulin. Reg - clear
10. Remove air (gently tap syringe).
11. Assure proper amount of insulin.
12. Remove needle from rubber stopper.
13. Insert needle into rubber stopper of intermediate acting insulin. Be very careful; never allow the plunger to rise, injecting short acting insulin into the bottle of intermediate acting insulin.
14. Invert bottle and remove exact amount of insulin needed. NPH - cloudy
15. Remove needle and syringe.
16. Replace cap on needle. Put on gloves.
17. Choose site for injection and prepare site with alcohol, if used.
18. Remove cap from needle.
19. Inject needle into skin at a 90-degree angle to the area.
20. Press plunger down injecting insulin. Count to 5 prior to removing needle.
21. Remove needle from skin.
22. Place **UNCAPPED** syringe in medical waste container. **DO NOT** recap needle.

Insulin Adjustments

Insulin adjustment is a combination of art and science: basic precepts are modified by the patient's response, by his or her eating and exercise habits, and by common sense as regards general experience and safety.

Home doses:

Home insulin doses (amounts, times, types) are an important part of the intake medical history. The parents should have filled in this information, but it is important to double-check what they have written. **In addition**, the home doses are to be written by the physician on each child's insulin worksheet in the spaces provided.

Insulin worksheets:

"Guiding Comments" on the insulin worksheet include general advice to the dispensary staff in making later adjustments to doses (for example, the child is in the "honeymoon period" and doses have been dropping; or the child is exquisitely sensitive to Short Acting insulin, or the child typically needs much less insulin while at Camp). "Insulin_type(s)" refers to both the brand name and types of the insulin used (e.g. Novo-Nordisk human, etc.). Occasionally, a camper will be using a variety of brands and types of insulin.

During the intake history, the physician will determine – hopefully with the family's active participation – a reasonable *starting* insulin base dose of Intermediate or Long Acting insulin and an appropriate algorithm for Fast Acting insulin, which should be written, by the time of day, in the spaces provided on the insulin worksheet. Enter that day's date when initial schedules are developed, or as modifications are made to the base dose of Intermediate or Long Acting insulin and the algorithm for Fast Acting insulin. Remember: Base doses are to consist of only Intermediate and Long Acting forms of insulin; all Fast Acting insulin is to be built into the algorithm, and not included into the base dose, thereby creating a single, consistent system minimizing the chance of dosing errors.

It is important that the examining physician writes the base dose of Intermediate or Long Acting insulin and the starting algorithm for Fast Acting insulin when the child is seen at intake, while the individual circumstances are fresh, and with the parents or guardians available for feedback on the dosage plan.

Insulin adjustments:

I. "Stat" (one-time) adjustments

Consider reducing the dose of Fast Acting 10-20% if the concurrent blood glucose reading is <80 mg/dL. For glucose levels over 200, follow the correction algorithm, **especially** if accompanied by a positive ketone test. (When blood glucose is 300 mg/dL and the ketones are positive, retest in 2 hours, whether or not extra Fast Acting insulin has been administered.) If the patient does not have a correction algorithm the amount of "stat" change in Fast Acting insulin depends on the individual and his or her usual dose, usual response, and general sensitivity to Fast Acting insulin – but, in general, small changes are advisable. For example:

<80 mg/dL	deduct 1-2 units Fast Acting
<60 mg/dL	deduct 2-4 units Fast Acting

>300 mg/dL and + ketones, add 4-8 units of Fast Acting
Change site Cover with ½ sliding scale dose subcutaneously

2. Pattern adjustments

When reviewing the log sheet results, look for recent trends and patterns.

<u>Pattern observed</u>	<u>Action to consider</u>
High or low AM tests	change PM or HS NPH or Lantus
High or low PM tests	change AM NPH or Lantus
High or low noon tests	change AM Fast Acting
High or low HS tests	change PM Fast Acting
Low during night	change PM or HS NPH, or Lantus

Before changing the Base dose of NPH or Lantus consider the recent activity and eating patterns. If the tests were **fluctuations** attributable to transient changes in exercise or eating, then altering the dose may not be appropriate.

Changes in the base dose of NPH, or Lantus are generally made in increments or decrements of 1-2 units, and at intervals of 2-3 days. It may be necessary, however, to sometimes make daily adjustments in NPH or Lantus if control is very poor.

Changes in the base dose and algorithm are indicated on the insulin worksheet. Algorithm doses of Fast Acting are applied as called for by the blood glucose tests. Written comments stating the reasons for changes in base doses or algorithm will be helpful both at Camp and to the parents, who often need to understand our “moves” on dosage.

Algorithms

Some campers arrive with detailed algorithms. Others have none and one must be constructed for use at Camp. They might be very simple (e.g. >300 mg give 1 unit Fast Acting, or much more detailed. Algorithms from home generally need to be adapted for use at Camp, and the parents/guardians should be asked to help with this. Considerations include anticipated changes in diet and exercise and the camper’s pattern of tests and doses the previous year.

The base dose includes only intermediate and long-acting insulins; *all Fast Acting is incorporated into the algorithm*. At home, some campers have a standing amount of Fast Acting built into their base dose; in these cases, the algorithm should be recalculated to include the amounts of Fast Acting which are given as “base dose” at home.

Changes in algorithm should be justified by documentation on the log sheet. In general, changes are made gradually – even if they are made every few days. See the above suggestion re: the amount of increment or decrement to make in the base dose. Changes in the algorithm for Fast Acting are generally made in small increments or decrements (e.g. 0.5-2 units in either direction) at a time. The algorithm may be changed at one, or several, or all levels of blood glucose at one time, however.

The functions of algorithms for Fast Acting insulin are to teach the campers how to use insulin in relation to their actual blood glucose readings and to create a written rationale for dosing insulin safely and efficiently. With algorithms in place, selection of the dose of Fast Acting becomes standardized for each camper, medical judgments about dosage changes more logical, and documentation much clearer.

Insulin Pens

General Information for ALL Pens:

1. Unused Pens and Cartridges should be kept refrigerated.
2. Open Pens and Cartridges should NOT be refrigerated. Refrigeration increases the risk of bubbles developing.
3. They may be stored at room temperature but must be kept at less than 86°F.
4. Do not store pens with needle attached If needle pen, insulin may dry in the needle causing it to clog or air bubbles may form inside the cartridge
5. The pre-filled cartridges contain 3mL or 300 units of insulin.
6. Doses of insulin can be dialed in 1u or 1/2 unit increments depending on the type of pen.
7. Each Camper will have his/her own pen(s) and cartridges. **PENS MAY NOT BE SHARED EVEN IF NEEDLES ARE CHANGED**
8. Pen needles come in 2 different lengths:
 - 5mm (3/16") No pinch required 31 gauge
 - 8mm (5/16") Pinch up skin 31 gauge
 - BD Ultra Fine Nano = 4mm x 32 G
 - Novo Fine 6 = 6mm x 32 G
 - Novo Fine 8 = 8mm x 30 G

Novolog (Novo Nordisk) Insulin Pen Instructions

1. See General Information for All Pens
2. Pull off cap by gently twisting the cap and the barrel.
3. Unscrew the cartridge holder from the barrel.
4. Press the push button at the end of the barrel all the way to "0". "0" should be lined up with the white stripe.
5. Turn the reset mechanism clockwise until the piston rod is flat with the reset mechanism. NEVER press on the piston rod to get it flat.
6. Remove the appropriate insulin cartridge from the wrapper.
7. Drop the cartridge into the cartridge holder (rubber stopper/metal cap first.).
8. Screw the barrel into the cartridge holder completely.
9. Wipe the rubber stopper with alcohol.
10. Remove paper tab from disposable pen needle.
11. Screw disposable needle onto the cartridge holder.
12. Remove the outer plastic cap and the needle cap.
13. Holding the Pen with the needle pointing upward, tap the cartridge holder to raise any air bubbles to the top. Dial in **2 units** to prime.
14. Depress the push button at the bottom of the Pen. Insulin should appear at the needle tip; if not, repeat step 13 until it does. This **must** be done before each injection.

NOTE about NovoPen®Jr .

1. Full units are shown as numbers. Half units are shown as long lines between the numbers.
2. Select the dose by turning the dial-a-dose selector until the correct number of units appear in the window and is lined up with the white stripe.
3. As the dial-a-dose selector is being turned, the push button rises.
4. Check the dosage and follow Procedure for Injecting Insulin. If the wrong dose has been set, follow the instructions starting at # 13 above.
5. After injecting, the camper should replace the outer cap only, unscrew the needle and dispose of it properly.
6. Replace the cap.

NOTE: If the wrong dose has been set, follow these instructions:

1. DO NOT DIAL BACKWARD.
2. Grasp the cartridge holder firmly with your thumb and index finger.
3. Grasp the barrel firmly with the thumb and middle finger of the other hand.
4. Pull the cartridge holder down from the barrel as far as it will go.
5. Press the push button down with your index finger to reset the dose to "0".
6. Check that the "0" is lined up with the white strip.
7. Proceed from step 13 above.

Calculating Insulin Dose in Whole Units

Round Up if BG > 150

Round Down if BG < 150

(round at .5)

If within 3 decimal points from higher or lower number, round up/down appropriately, e.g., if calculation = 2.9 units, round to 3; if calculation = 2.1 units, round to 2.

SoloSTAR (Sanofi Aventis) Insulin Pens Instructions

Lantus SoloSTAR pen is gray and contains long acting insulin.

Lantus Apidra SoloSTAR pen is blue and contains rapid-acting insulin.

1. See general information for all pens.
2. Pull off cap and wipe rubber stopper with alcohol pad. Attach a new pen needle.
3. Keep the needle straight as you attach it.
4. Always perform this step before each injection. Select a dose of **2 units**. Take off the outer needle cap. Hold the pen with the needle pointing upward. Tap the reservoir gently so any air bubbles rise up to the needle.
5. Press the injection button all the way in. Check to see if insulin comes out of the needle. If not, check for air bubbles and repeat the test 2 more times to remove them. If no insulin comes out again, try a new needle.
6. Select your dose by dialing up to the desired number.
7. Inject needle into skin.
8. Press the injection button in all the way. Hold the button in that position, **slowly count to 10, then withdraw needle**.
9. Remove the needle and dispose safely in sharps container. Put the cap on the pen.

Humalog Kwik (Eli Lilly) Insulin Pen Instructions

1. See general information for all pens.
2. Pull cap off pen.
3. Wipe rubber stopper with alcohol.
4. Remove paper tab and attach Pen needle.
5. Turn the dose knob to 2 units.
6. Point pen up and tap to collect air bubbles at top.
7. Depress dose knob down to prime the needle. You will know it is primed when you see insulin coming out the end of needle.
8. Turn the dose knob to the desired dose by twisting the dose knob clockwise.
9. Once dose is dialed in, insert needle into skin and push dose knob until it stops.
10. Hold in place and count to 5 slowly.
11. Remove needle from skin.
12. Replace cap, unscrew needle and dispose in sharps container.
13. Put cap back on Pen for storage.

INSULIN PUMP POLICY

Insulin pumps may be used at Camp Ho Mita Koda for campers, counselors and staff who use these devices at home. All manufacturer recommendations should be followed regarding pump functioning, care, etc. The Senior Medical Staff Committee has developed these guidelines for all campers while at Camp Ho Mita Koda.

Pump manuals are available in the dispensary as resource material. Several medical staff members have experience with pumps and may be available to answer questions. Additionally, representatives from the individual companies are available at any time for technical assistance/advice by contacting the following phone numbers:

Pump Company Phone Numbers (or look for # on back of pump)

- Animas Corp. 877-937-7867 (877-YESPUMP)
- Medtronic Minimed 800-646-4633
- Omnipod 800-591-3455

Campers using an insulin pump are **required** to bring the following pump supplies:

- Infusion sets (bring double the amount you anticipate using while at camp)
- Extra batteries
- Insulin cartridges/ reservoirs (bring double the amount you anticipate using while at camp)
- An injector (if used)
- IV prep and extra tape
- Pump manual
- Backup pump (if available).

All pump supplies should be brought to camp in a bag or container labeled with Camper's name.

Guidelines:

1. As with all medical supplies, individual pump supplies will be stored in the Dispensary.
2. Campers are required to attend all meal and snack times. Campers not required to take snack will still test BG at this time. The dispensary staff can require a snack if BG seems too low
3. The pump will be labeled with the camper's name.
4. Campers are permitted to set the pump to give a bolus but can only give the bolus under the supervision of a member of the medical staff. They are similarly only allowed to change a basal rate or otherwise administer insulin under supervision. Any violation of this rule must be reported to the Dispensary immediately.

5. While at camp, pumps must be set on the highest sound level for alarms. The vibrate mode cannot be used by campers.
6. Infusion sets/catheters including the reservoirs/cartridges will be changed at least every 48-72 hours routinely or at the discretion of the medical staff. Set changes must be done at the Dispensary and recorded on the set change log.
7. If the pump malfunctions at camp, camper is to be brought to the Dispensary immediately, day or night.
8. Disconnecting/reconnecting a pump: When the pump needs to be disconnected, DO NOT SUSPEND for showers but can be SUSPENDED for swimming. It will be the responsibility of the cabin counselors to ensure that all campers are reconnected.
9. Omnipod pumps present a special case because the insulin delivery unit with insulin is affixed to the skin, but the control unit is separate. To avoid loss of or damage to the control unit, it will be kept in the Dispensary in the appropriate cabin box so that it is always available when needed.
10. All campers, including those on a pump will check their blood glucose prior to meals in their cabin. Campers will have access to the menu to select their carbohydrate serving choices.
 - Numbers of carbohydrate servings are recorded on the blood sugar result sheet.
 - The pump smart feature will be used to calculate the meal bolus.
 - Dispensary staff will calculate the meal bolus if pump smart features are not being used.
 - Campers on a pump are required to report to the dispensary for supervision of delivery of the bolus dose.
11. Campers may suspend their pump and remove it for showering without taking a bolus. It will be the responsibility of the cabin counselors to ensure that all campers are reconnected.
12. Pumps and swimming:
 - a. Prior to free swim, pumpers will test blood glucose and if needed will give correction bolus to target of 200. After this, campers can suspend pump.
 - b. Blood glucose will be checked every two hours when the pump is suspended.
 - c. All campers will test blood glucose and have a snack at 3:05 PM. Corrections will be made as needed.
 - d. It will be the responsibility of the cabin counselors to ensure that all campers are reconnected to their pump.

13. If a camper uses a pump with “smart features,” every effort will be made to maintain this plan. However, if the resident or attending physician decides that the camper needs more or less insulin, the pump’s calculation may be overridden.
14. The dispensary staff will periodically check the pump history to support the campers safe dosing and delivery of insulin.

Protocol for High Blood Glucose Management:

Treatment for campers with blood sugar level > 300md/dl **without** ketones:

1. Give a correction bolus dose via the pump.
2. Check BG and ketones again in 1 hour.
3. If BG has not improved and/or ketones become positive take corrective bolus via syringe FIRST and then change pump set up (reservoir, tubing, cannula, etc.) immediately.
4. Retest BG within 2 hours to assure BG is coming down.

Treatment for campers with blood sugar level >300mg/dl **with** ketones:

1. Give a correction bolus VIA SYRINGE immediately.

DO NOT GIVE A BOLUS DOSE VIA THE PUMP

2. Then change pump set up (reservoir, tubing, cannula, etc.).
3. Perform Troubleshooting check (See "Troubleshooting the Pump"). Encourage PO fluids, at least 8 oz. every 30 min. If camper is unable to take fluids, contact physician, who may want to give IV fluids.
4. Check BG and ketones again in 1 hour.
5. If BG is coming down, retest again in 1 hour and give correction bolus via pump if needed.

Insulin Pump Troubleshooting

1. Does the reservoir/cartridge have insulin?
2. Do you smell insulin?
3. Is the infusion site painful to the touch? Red? Swollen?
4. Is there any leak between the reservoir and the tubing? Do you see wetness?
5. Is the tubing kinked or damaged?
6. Is there any leak at the skin site?
7. Is the site secure?
8. Is there blood in the tubing?
9. Do you see air bubbles in the tubing that may be causing high BG?
10. Has the insulin become damaged (excessive heat, expired, etc.)?
11. Is the time of day set correctly on the pump?
12. Is the camper in the correct Basal Program for Camp?
13. Check the history menu for time/delivery of last bolus. Was it completed?
14. Does the pump have insulin in it?

When in doubt, change the site out!

Psychosocial Care and Support

Attending Camp Ho Mita Koda is intended to be a supportive, enjoyable experience. It can encourage independence both of and for the child. Camp is intended to foster personal growth and to promote the process of adaptation to living with a chronic disease. There are several principles that will foster the achievement of these goals.

Campers require encouragement. Inappropriate counter-motivating methods like coercion, sarcasm, humiliation and intimidation have no place at Camp. Some campers are lacking in self-care skills, which should be taught and promoted – but only in ways that are positive and sustaining, not in ways that may be perceived as hurtful and hostile.

Children learn best when their achievements are recognized and rewarded. There are a plenitude of opportunities to recognize and reward campers – for their accomplishments and achievements, large and small.

Children develop and learn at highly individualized rates. This range of variation must be accepted for what it is – normal. Children should not be forced into any preconceived model of what they “should have achieved” at a given age – this is particularly true for the self-care skills that characterize diabetes management. It is to be hoped that each camper **will** learn and progress while at Camp; this is most desirable. But failure should not be imprinted when patience and continued support will help better to win the day.

Children like adults respond to respect and recoil from sarcasm and belittling. Good humor, warmth, and an ability to listen carefully are personal skills that help to bridge gaps and build trust between campers and staff. It would be wise to remain continually aware that campers tend to look up to staff, emulate them, and view them both as older, wiser adults and as friends.

Occasionally, a child is beset with serious emotional problems or an overwhelming home environment. Camp Ho Mita Koda is not a therapeutic milieu. When serious emotional or psychosocial problems surface, however, they should be brought promptly to the attention of the Camp Director and/or the Senior attending physician, who will help arrange for a reasonable working plan for the duration of the child’s stay at Camp and for a follow-up program at home, with the cooperation of the family, the child’s physicians, and/or community agencies.

Medications: Camper Prescriptions from Home

Medications from home will be kept in the dispensary, not in the cabins. These medications will be maintained in the original containers and administered by the nursing staff according to the physician's order. Campers will not keep medications in their possession.

**Campers may check prescription med and home OTC meds unique to that camper, e.g., herbal/alternative meds, Generic pain/allergy meds are stocked in dispensary and it is not necessary to be left at check-in.

Non-Diabetes Health Issues

- I. Insect bites and stings:
 - A. Wash with soap and water
 - B. Apply ice pack at once to slow absorption from site
 - C. Apply calamine lotion
 - D. Check pulse, blood pressure, respirations
 - E. If symptoms of allergic reaction present, call MD.

2. Animal or snake bite:
 - A. Wash wound thoroughly to remove saliva. Use sterile gauze compress and solution of soap and water to scrub wound
 - B. Rinse with clear running water
 - C. Saturate wound with Betadine for 5 minutes, then blot dry
 - D. Apply a sterile dressing
 - E. Consult physician

NOTE: Poisonous snakes are not native at Camp Ho Mita Koda.

3. Sunburn:
 - A. Apply Solarcaine or Lubriderm lotion to area
 - B. Keep child out of sun
 - C. Urge intake of extra fluids

4. Heat Exhaustion:
 - A. Symptoms:
 1. Fatigue, headache, nausea during or just after exercise in hot environment. In severe cases: diaphoresis, weakness, pale and clammy skin.
 - B. Treatment:
 1. Check body temperature to rule out heat stroke (i.e. over heating). If temperature is more than 101 degrees, notify physician at once.
 2. Provide bed rest and salt-containing fluids such as Gatorade.

5. Blisters:

These are usually caused by pinching or chafing. Most often involve the palm, fingers, ankle or foot regions. Generally, no treatment is necessary – water or blood will gradually be absorbed by the body, once you remove the item causing the pressure. A dry sterile dressing may be applied for comfort. Betadine ointment should be applied to “open” blisters before dressing.

6. Boils:

Treatment – Do not squeeze -- this will drive germs into general circulation. Apply wet compresses of 1 tablespoon Epsom Salt in 1 pint warm water. If boil breaks, wipe puss away with a sterile wet pad and Betadine solution or scrub, then apply Neosporin or Bacitracin and dry sterile dressing.

7. Styes:

Styes along eyelids may be relieved by warm, wet compresses. The eye should not be red or sensitive to light. Consult physician when these occur.

8. Foreign object in eye:
 - A. Pull down lower lid and see if foreign body lies on surface of lid lining. If so, it can be lifted off gently with the corner of sterile 4 x 4 or moistened Q-tip.
 - B. Grasp lashes of upper lid gently between thumb and forefinger while child looks upward. Pull upper lid forward and down over lower eyelid. A foreign body on lining of upper lid can be dislodged and swept away with tears.
 - C. Flush eye with sterile saline or Dacryose solution
 - D. If on inspection, the object has lodged on cornea, make no attempt to remove it. Call physician. Cover with dry sterile dressing.
 - E. If bleeding or hemorrhage is noted in eye, application of cold pack will help halt bleeding. Call physician to examine patient.

9. Headache:

Rule out hypoglycemia, head trauma, fever, etc. Take vital signs. If negative history, may give Tylenol 325mg tablet. Urge rest until relief is obtained. If trauma/concussion/fever – have child lay down with head elevated on 2 pillows. Call physician. If it is hypoglycemia, treat per discussion below.

10. Nosebleed:

Pinch nostrils together for 10 minutes. Place child in upright position leaning forward. Keep head elevated.

11. Wounds:
 - A. Superficial scratches/abrasions – wash thoroughly but lightly with sterile 4 x 4 and Betadine for 5 minutes. Rinse with sterile water. Apply Neosporin ointment and then dry sterile dressing. Have child return the following day to be checked.
 - B. Puncture wounds – make sure child has had tetanus injection. Treat as above.
 - C. Bleeding – apply pressure directly over wound with dry sterile dressing until bleeding stops, then treat as above.
 - D. For more severe lacerations – attempt to stop bleeding with steady firm pressure over the wound (cover injury with 4 x 4 dressing). Consult physician.

12. Sprains, strains, skeletal injuries:

Immobilize part and elevate. Apply ice pack. Call physician to examine patient.

13. Stomach pain:

Get history of past 24 hour food intake, bowel activity or vomiting. Check TPR. Consult physician for abdominal inspection and palpation.

14. Diarrhea/Vomiting:

Take accurate history as above. Check blood glucose and urine ketones, and TPR. Consult physician. Kaopectate 15-30cc may be given following each loose stool up to 6 doses. Child should be confined to dispensary if vomiting. Check blood glucose and urine ketones. Give sips of fluid, caloric or non-caloric dependent on blood glucose as tolerated. Do not give solids until fluids tolerated well.

15. Sore Throat/Cough:

Check TPR. Consult physician for evaluation.

16. Splinters:
Cleanse area with soap and water. May extract with sterile needle. Cover with Bacitracin and dry sterile dressing.
17. Homesickness:
Homesickness is most often of short duration and may occur in any age child. The best treatment for helping a child through homesickness is to provide a “friend”. This “friend” becomes someone the camper can rely upon but, more importantly, is someone who is firm in reinforcing camp as a fun rewarding place.

Generally, this “friend” should be a member of the program staff. Experienced cabin counselors are able to set up interventions to help the camper. Medical staff must support the counselor’s program. Most often this support means **not** being overly protective, overly concerned, or overly helpful.

Staff Guidelines Include:

- A. Rule out hypoglycemia. The child’s behavior may be reflecting low blood glucose. Check blood sugar level.
- B. Refer the child to his program staff.
- C. The medical director and camp director are the only persons who may approve a call home.
- D. Homesickness is a stressor and may produce significant hyperglycemia and even ketonuria.

Standing Orders For Medications

Tylenol:	325mg. p.o. q 4 hours PRN for headache < 12 years of age; >12 years = 650 mg
Throat lozenges:	up to 3 per day for sore throat
Cough syrup:	per label instructions for OTC preparation being used
Kaopectate:	15-30cc for diarrhea up to 6 doses daily
Emetrol:	15cc q 5-15 minutes for vomiting. May repeat x 3 doses
Compazine suppositories:	per physician order only for intractable vomiting
Calamine Lotion:	for insect bites, poison ivy, PRN
Lubriderm:	(or similar skin lubricant lotion or Solarcaine ointment) for sunburn
Bacitracin/Neosporin Ointment:	for application to cuts and abrasions
Zinc Oxide ointment:	PRN for prevention of sunburn exposed parts (nose, ears, forehead)
Eye Drops/ointments:	apply as directed per physician
Maalox:	15-30cc p.o. for mild indigestion without severe abdominal pain, vomiting or fever
Cepacol gargle:	PRN for sore throat
Antihistamine	PRN per label instructions for preparation being used Drowsy (Benadryl) Non-drowsy (Claritin)
TUMS	2 p.o every 2-4 hours for indigestion

*May change based on supply.

Sexual and Physical Abuse and Neglect

Warning Signs of Child Sexual Abuse and Exploitation

In addition to being cognizant of staff activity that may create an opportunity for child sexual abuse or exploitation, staff should be aware of behavioral changes that indicate that sexual abuse or exploitation may be occurring. A checklist of specific signs pointing to possible child sexual exploitation follows:

1. Reluctance to be left alone with a particular person.
2. Graphic or age-inappropriate knowledge of sex.
3. Persistent and inappropriate sex play with toys or peers.
4. Wearing lots of clothing, especially to bed.
5. Genital discomfort.
6. Fear of touch.
7. Abuse of animals.
8. Nightmares or night terrors.

If abuse of a minor is ever suspected, you are required by law and by camp policy to contact the Camp Director, Head Nurse or Physician. Concerns must be shared confidentially with one of the previously mentioned camp leaders. They may ask you to document your information. Be positive and be certain that you report relevant information confidentially.

Symptoms of Child Abuse and Neglect

Possible indications may be when the child:

1. repeatedly shows evidence of overall poor care
2. malnourished
3. dirty
4. inadequately and inappropriately dressed for weather
5. lack of medical attention
6. has obvious injuries: welts, bruises, untreated sores or other skin injuries
7. appears different in physical or emotional make-up
8. displays withdrawn, fearful, apprehensive or extremely aggressive behavior
9. exhibits learning problems that cannot be diagnosed
10. attention wanders a substantial portion of the time
11. easily self-absorbed
12. often appears tired and frequently sleeps
13. demonstrates adult-like behavior, especially towards parents
14. exhibits sudden change in behavior

Staff: Health and Medications

Camp staff will be responsible for self-management of their diabetes and other medical conditions, unless they request assistance from the Camp physician(s) and dispensary staff.

Staff medications, including insulin, syringes and other diabetic supplies, will be **kept in the dispensary**, unless such medications can be securely maintained, away from the children. The purpose of this is to prevent children playing or tampering with these materials.

A staff health history form will be completed by each employee prior to the start of Camp. Immunization information will be based on historical recall, unless more exact information is required upon medical review of the history form. This medical history form will be individually reviewed with the employee by a Camp physician, at which time the employee will be generally inspected for gross signs of communicable illness or injury.

For employees <18 years of age, their medical history form will be signed both by them and by their parent or legal guardian.

Risk of tuberculosis will be assessed using questions based on the recommendations of the American Academy of Pediatrics, which allow the individual to be grouped into low and high risk categories (e.g. the household contact of a tubercular individual). Routine TB skin testing will not be performed, unless the reviewing physician concludes that a skin test (PPD) is medically indicated. Employees at low risk of TB will not have routine PPD test performed.

Each employee will also provide a medical report from their physician, based on an exam within the previous 12 months.

Employees whose duties might expose them to blood-borne infection will be given the opportunity to receive hepatitis B vaccination (if not already immunized), and will be provided with an educational program on the prevention of blood-borne infection (see separate Policy on Blood-borne Pathogens).

Universal Precautions

As part of an overall exposure control plan, mandated by the OSHA Bloodborne Pathogens Standard, "universal precautions" are part of infection-control practices. They are specific guidelines which must be followed to provide every person protection from diseases which are carried in the blood. Since blood can carry all types of infectious diseases, even when a person does not look or feel ill, knowledge of universal precautions is essential for anyone who might come into contact with blood or other body fluids.

The following guidelines apply to all employees, physicians and residents of Camp Ho Mita Koda:

1. Minimum 15 second handwashing with antimicrobial soap before and after contact with any camper or employee; after removing gloves, between interactions with camper or employee and before leaving the dispensary.
2. Dispensary staff training session to view a current video on the prevention of blood borne disease.
3. All health-care providers will use appropriate barrier precautions to prevent skin And mucous-membrane exposure when contact with blood or body fluid of any person is anticipated. Personal protective equipment such as latex or vinyl disposable gloves should be readily available in health-care, housekeeping and maintenance areas, in all first-aid kits, and in vehicles.
4. Any person giving first aid will **always** wear latex or vinyl disposable gloves if blood is visible on the skin, inside the mouth, or if there is an open cut on the victim. Gloves should be changed after contact with each person.
5. Gloves will **always** be worn when handling items or surfaces soiled with blood or bloody fluids. Such areas (floor, counter, etc.) should be flooded with bleach solution (1 part bleach to 10 parts water), alcohol, or a dry sanitary absorbent agent. However, routine cleaning practices are all that are needed if blood is not visible or likely to be present. Gloves will always be worn when cleaning up blood from a counter after a cut finger, but gloves do not usually need to be worn to handle urine-soaked bedding, unless blood is obvious. Disposable towels and tissues or other contaminated materials should be disposed of in a trash container lined with plastic. Biohazard bags ("red bags") are to be used for dressings or other materials used to soak up blood or other infectious waste.
6. Remove gloves properly – pulling inside out. Place gloves in bag with waste. Hands and other skin surfaces should be washed with soap and water immediately and thoroughly if contaminated with blood or other body fluids.
7. Masks, protective eye wear, gowns or aprons should be worn during procedures that are likely to generate droplets or splashes of blood or other body fluids.
8. Needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After use, disposable syringes and needles, scalpel blades and other sharp items should be placed in puncture-resistant "sharps" containers for disposal. Needle recapping will occur only when necessary and the single hand method of recapping will be used. Staff and campers should **never** hand an unsheathed needle to another person, but instead put it down and let the other person

pick it up. Needle must be placed directly into a “sharps” receptacle right after it has been used.

9. Mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which the need for resuscitation is predictable.
10. Health-care workers who have draining lesions or weeping dermatitis should refrain from all direct care and from handling equipment until the condition resolves.

All procedures should be specific to the staff and clientele served. All persons who might come into contact with blood or other body fluids must be trained to follow appropriate procedures.

Exposure Control Plan

This information is provided to camp employees in partial compliance with OSHA's Bloodborne Pathogen Standard. It is the intent of the camp to educate people about issues related to exposure to body fluids, to use management techniques and equipment to minimize exposure risks for employees, and to monitor individuals' use of these techniques. The camp program recognizes universal precautions as an effective control measure. This handout describes the application and monitoring of potential sources of risk in the camp program, the steps taken by camp to protect employees, and the actions taken by camp if blood or body fluid exposure occurs.

JOB CLASSIFICATIONS WHICH, BY VIRTUE OF JOB DESCRIPTION, INCUR THE RISK OF EXPOSURE TO BLOOD AND OTHER BODY FLUIDS: nurse, physician, resident physician, dispensary staff, counseling staff

JOB CLASSIFICATIONS WHICH, BY VIRTUE OF JOB DESCRIPTION, PROVIDE FIRST-AID CARE AS AN ANCILLARY TASK RATHER THAN A PRIMARY TASK: lifeguarding staff when on-duty at the waterfront.

(ALL OTHER JOB CLASSIFICATIONS ARE NOT EXPECTED TO PROVIDE FIRST AID BUT RATHER REFER PEOPLE IN NEED OF HEALTH CARE TO THE NURSE/PHYSICIAN.)

Camp nurses, physicians and dispensary staff can reasonably expect to come in contact with blood and other body fluids. The potential for exposure to transmitted diseases is greatest for these staff members. Consequently, the recommended exposure control plan involves the following practices:

Members of the camp health-care team are oriented to the potential for exposure by camp's health-care administrator. A record of who received the education and its content is kept for three years by the administrator. The orientation includes:

1. Identification of risk areas: contact with bloodborne pathogens (e.g., hepatitis, HIV), contact with airborne pathogens (e.g., common cold, TB), contact with surface-borne pathogens (e.g., staph infections).
2. Education about the nature of the risk: method of transmission, virulence of pathogens, resistance factors related to potential host, symptoms, and information sources which provide clues to potential risk areas.
3. Work practices designed to minimize exposure:
 - Availability of personal protective equipment (PPE) – gloves, CPR mask, antimicrobial soap, (eye, nose, and mouth) shield, body fluid spill clean-up kits.
 - Double-bagging via red bag and disposal procedure for hazardous waste.
 - Screening individuals who come to the program.
 - Requiring participants to provide health information.
 - Use of universal precautions by staff.
 - Education for people working in risk areas: health-care team members, lifeguards, housekeeping, kitchen staff.

- Hepatitis B vaccination for nurses: camp pays for vaccinations done by the local provider during the nurse's contracted time. Camp encourages nonvaccinated nurses to get vaccinated.
 - DVD/video which teaches effective use of the CPR mask.
 - Sharps container provided which has biohazard label affixed.
 - Resource personnel to answer questions: camp health-care administrator, camp supervising physician, and State Dept. of Health epidemiologist.
4. Behavior expected from employees to minimize risk:
- Use of PPE:
 - ✓ Gloves are used when in contact with body fluids or providing skin treatment (e.g., applying medication to poison ivy, washing a rash).
 - ✓ CPR mask is used to provide CPR/artificial respiration.
 - Minimum 15-second hand washing with antimicrobial soap after: removing gloves, contact with potential risk, unprotected contact with any body fluid.
 - Minimum 60-second hand washing with antimicrobial soap after blood splash.
 - Use of body fluid spill clean-up kit.
 - Vaccination to protect from hepatitis B.
 - Sharps disposed of properly: no recapping of needles, all sharps (lancets, needles) placed in sharps container immediately after use, full sharps container given to Administrator for disposal through local hospital.
 - Participation in education about disease control.
 - Immediate reporting suspected exposure (e.g., needle stick) to supervisor and Administrator.
 - Performing job tasks in a manner which minimizes/eliminates exposure potential.
 - Evaluation of compliance with the camp exposure control plan as part of the camp personnel-management system.

Camp Counseling Staff

While the potential for exposure to bloodborne pathogens is minimal for general counseling staff, it does exist. The camp health-care plan vests authority in general staff to respond to emergencies at the level of their training while initiating the camp emergency response system. Since camp emergency response occurs within minutes, the potential for exposure is limited and most likely confined to initiating CPR/artificial respiration and slowing severe bleeding.

In keeping with accepted practices, the camp health-care administrator educates camp staff during orientation about appropriate response practices:

- Staff are instructed to use a CPR mask for CPR and artificial respiration; masks are kept at the waterfront and health center.
- Staff are instructed to use gloves when potential for contact with blood or blood-tinged fluids exist. Gloves are in all first-aid kits. Staff members who want to carry a pair on their person may obtain them from the health center.
- Staff are instructed to respond in emergency situations to the level of their training per State Good Samaritan regulations.
- Staff are instructed to initiate the camp emergency response system immediately.
- Staff participate in a discussion of "emergency" to establish defining attributes of their response.
- Staff are educated to approach care of minor injuries from a coaching perspective and specifically directed to refer injured people to the camp health-care team if self-care is inappropriate or impossible.

Needlestick Injuries

1. Confer with the camp's medical director ASAP. If there is a significant risk of HIV transmission, prophylaxis should be begun within a matter of a few hours. For Hepatitis B prophylaxis the need for treatment is urgent. There is currently no available prophylaxis for Hepatitis C infection.
2. Obtain a specific medical history for hepatitis and HIV from the user of the needle (or his/her parents, in the case of a camper). Was this person immunized for Hepatitis B at birth or subsequently? Request and document their permission to obtain a blood test; written consent is best, but at a minimum document their verbal permission and understanding of the problem. Arrange for blood to be drawn and tested for Hepatitis B surface antigen, Hepatitis C antibody, and HIV antibody.
3. Recommend that the person injured obtain a baseline blood test as soon as possible for Hepatitis B surface Antigen, Hepatitis C antibody, and HIV antibody. In addition, recommend that they obtain a follow-up blood test for the same three infections 3 months later.
4. Facilitate the baseline blood collection and testing through a local medical facility or physician's office.
5. Obtain the test results when available and counsel the persons involved (or their parents if a camper or an employee who is <18 years old).
6. Using the Incident Report, document what is done, including conversations with involved campers and their parents or with employees and their parents.
7. Give Incident Report to the Camp Manager

Exposure Incident Report

CONFIDENTIAL

Exposure Incident: Should any staff member have a blood exposure incident, an Exposure Incident Report Form must be completed as soon as possible.

Date Completed _____ Employee Name _____
Date of Exposure _____ SS # _____ DOB _____
Time of Exposure _____ AM PM HomePhone (____) _____ Business Phone (____) _____

Vaccination Status _____ Job Title _____

Location of Exposure (be specific): _____

Describe what happened: _____

What task was the employee performing when the exposure occurred? _____

Was the employee wearing PPE? No Yes Type: _____

Did the PPE fail? No Yes In this way: _____

To what body fluid(s) was the employee exposed? _____

Estimate the size of the area covered by the fluid (consider taking a photo) _____

For how long was the fluid in contact with the employee's body? _____

Did a foreign body (needle, nail, dental wire, machine part, etc.) penetrate the employee's body?
 No Yes If yes, what was the object and where did it penetrate? _____

Was any fluid injected into the employee's body? No Yes
If yes, what fluid and how much? _____

Did the employee receive medical attention? No Yes
If yes, where? When? By whom? _____

Did the employee refuse medical attention? Yes Employee signature _____

Name, address & phone of the source individual(s)

Other pertinent Information _____

Signature of Person Completing this Report _____

Print Name of Person Completing this Report _____

Post-Exposure Plan

Camp employees who have a blood exposure incident are eligible for follow-up treatment. Follow-up is initiated by the employee who must immediately (within fifteen minutes) notify the camp nurse when a blood exposure incident occurs. The following plan is initiated. Records of the incident are maintained for the duration of employment plus thirty (30) years by the Camp Director and according to OSHA requirements (i.e., separate from personnel records). Camp administration debriefs each incident in an effort to identify ways to improve the camp's exposure risk.

Time Line	Employee's Actions	Camp Nurse's Actions	Camp Director's Actions
Within 24 hours	<p>Exposure incident occurs. Report incident to camp nurse within 15 minutes of happening.</p> <p>Begin prophylactic treatment.</p> <p>Complete Workers' comp form & incident report with camp director.</p>	<p>Notify camp director. Begin 15-second scrub of area with bacteriostatic soap, followed by application of disinfectant.</p> <p>Contact supervising MD and refer client for assessment.</p> <p>Begin psychosocial support process.</p>	<p>Determine source of contamination; initiate request to have source screened for infectious diseases.</p> <p>Notify insurance.</p> <p>Create incident report file with supporting documentation.</p> <p>Contact mental health professional for employee.</p> <p>Complete Workers' comp & incident report form with employee.</p>
Within next 48 hours	<p>Continue medical follow-up, per MD orders.</p> <p>Begin counseling support.</p>	<p>Monitor client adjustment to situation; answer questions, as needed. Provide needed cares.</p>	<p>Follow testing of source individual as warranted.</p> <p>Consult with mental health professional to arrange post-camp therapy, per need.</p>
Beyond first three days	<p>Continue post-exposure prophylaxis, as directed by MD.</p> <p>Participate in review of incident.</p>	<p>Participate in review of incident.</p>	<p>Maintain contact with employee to follow incident.</p> <p>Lead review of incident.</p> <p>Review incident; adapt camp practices as needed to manage risk, and to minimize chance for repeat of situation.</p> <p>Maintain records for duration of employment, plus 30 years.</p>