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The Nurse Practitioner at Camp: Streamlining the Crossover between Nursing and Medical Care

Ellen A. Reynolds, RN, MSN, CPNP and Carol A. Williams, RN, MSN, CRNP

Abstract: *Nurse Practitioners (NPs) are advanced-practice nurses who incorporate both nursing care and the medical model of diagnosis and treatment into their practice. Functions of this master's prepared nurse vary somewhat state to state although all states have a mechanism for prescriptive authority. Nurse practitioners can be a valuable member of the health care team in camp Health Centers. Their ability to assess and prescribe as well as to order definitive testing such as x-rays or lab work assist in decreasing off-site trips. The role can be implemented in a variety of ways.*

Key Words: *Nurse Practitioner, camp health, health center, Advanced Practice Nurses*

Linda falls and hurts her ankle. You are quite certain it's sprained, but because of tenderness behind the malleolus, you sure would like to have an x-ray to rule out a fibula fracture. Eric's mother sends you a beautiful contingency plan for his asthma, written up by his Primary Care Provider (PCP). The only problem is that he specified medications, but didn't send the prescriptions for the meds. Issues like these take up time for the camp nurse, campers, and staff. To get the x-ray that would verify your assessment probably requires sending the camper to a local emergency room (ER), which in turn entails phone calls home, negotiating staffing for the trip, time spent waiting, and an insurance expense for an ER visit that may not be needed. Following through on the asthma plan would involve calls to the mother and/or physician, requesting that prescriptions be sent—often a more complicated and time consuming event than one would think. Perhaps having a nurse practitioner on staff would provide an efficient bridge.

What is a Nurse Practitioner?

Nurse practitioners (NPs) are advanced-practice nurses who incorporate both nursing care and the medical model of diagnosis and treatment into their practice. The role began in 1965 in Colorado as collaboration between an MD and a nurse, in response to the rural need for cost-efficient, easily accessible primary care providers with public health knowledge. NP preparation begins with education as an RN. Currently, entry level for NP practice requires a Master's degree, although NPs who were educated prior to the mid-1980s in certificate programs may have been "grandfathered" into the role. NP graduate school curricula focus on preparation as either generalist (family practice), or in one of a wide range of specialty areas (pediatrics, gerontology, emergency care, women's health, for example), with emphasis on diagnosis and treatment. There is a great deal of literature supporting the successful care of patients by NPs, which generally includes more focus on health promotion, disease prevention, and health education than care given by MDs (AANP, 2007). National certification, requiring examination and evidence of continuing education, is available through various professional organizations (ANCC, PNCB).

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In This Issue...

The Economy Hits the Health Center

We are quick to acknowledge our country's economic mess. The realities of the situation are all around us and no one I know thinks that camps will escape the fallout. Early signs of change are registration trends. Camps are experiencing a much slower camper registration than usual. Returning campers may be signing up for shorter stays. New camper registrations are not coming in at the usual rate. Some families are taking a "wait and see" approach before making summer camp decisions. Others may have to forego a family trip or vacation rental and instead plan a camp experience. For others, day camp may replace overnight camp.

Camp administrators are also making tough decisions about facilities and programming. Planned renovations or new buildings are frequently being put on hold as are new equipment purchases. New program ideas requiring big investments in equipment or training such as a new sailing program may be replaced this season by others requiring lower expenditures. An upturn is that summer staff may be easier to recruit as many college-age students will have fewer job choices.

As camp nurses, it is prudent to begin to think about ways we can contribute to running a sound and safe operation without undue expenditures. Practice Sharing in this issue provides some ideas your colleagues are sharing. We will need to be very creative about how to make do with less. Wendy Burton in her Practice Sharing ideas says she thinks nurses have always done a pretty good job here. I agree. But this year our imaginations may be further challenged.

Can camp nurses be more creative in staffing the Health Center? If your camp uses a mix of providers, is the best possible use being made regularly of each person's skills? Even camps with just one nurse might explore how an untrained staff member could be utilized to advantage. Changing beds, doing laundry, getting food for sick campers, cleaning, and restocking first aid kits are just the beginnings of doable tasks. One summer I was given two hours of a junior staff member's time each morning and was amazed at what a huge difference that made in my day. An interested staff member with basic first aid can do a lot of valuable work under your direction. Let me be clear--I am not saying less nursing time but I am saying make better use of the time we have. Be creative. You could unknowingly influence a future nurse!

Be prepared for underlying stress and fear that uncertain times can engender. Keep your fingers on the pulse here and be ready to pitch in with the right attitude, helping hands, and listening ears. Directors are under immense pressures to offer the best ever season with fewer resources. Programs they and their senior staff members had really wanted to implement and maybe even promised to campers are not happening. Staff may be coming with more than the usual pressures about money, continuing school or finding jobs. Camp parents may be under more stress than usual and will need our patience and support when, because of unusual circumstances, they are not able to get what we need when we need it. It may take some reviewing of the rules to see which can be bent or modified in unusual circumstances without sacrificing the intent.

Campers may bring their own fears and worries about their families, whether their parent has lost a job or gotten a new one yet. We know that these kinds of worries can show up in campers in unusual ways. Campers frequently may not even know they are scared. How to recognize and address some of these issues is an important topic to address with your director. Determine together how this whole issue will be addressed in staff training and set expectations with staff about how to be helpful without undue doom and gloom that will help no one.

Preplanning will have its own payoffs. Camp is still the wonderful fun experience it has always been, full of adventure and lore. Friendship, laughter, and builing good memories are still doable—even in tough times.

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Defining Scope of Practice

The scope of practice for nurse practitioners is determined on a state-by-state basis. All states now provide for NPs to write prescriptions, although the specifics (ability to prescribe narcotics, relationship with a physician collaborator) vary greatly. Many states provide for a "collaborative agreement" between NPs and MDs, which allow an NP to practice independently as long as there is provision for the MD to oversee or give input into NP practice. This is easily achieved in many camps in the relationship with the camp physician.

NPs work in a wide range of practice settings, from clinics and private practices to hospital inpatient units and emergency departments. Generally, NPs may perform procedures for which they have been trained and in which the collaborating physician agrees the NP has competence. This may include suturing, gynecological examination, central line insertion, and others, depending on the setting. Again, NP preparation varies greatly depending on the field of specialty and the individual NP's breadth of experience.

At Camp

Nurse practitioners are uniquely qualified for working in the camp setting. They have extensive education in well child issues (think camp check-in), treating acute illness and injury (the many sore throats and sprained ankles that occur), and managing chronic conditions (the asthma flare that isn't responding to albuterol MDI). Because of this background, it is second nature for an NP to consider if a child with a blow to the head needs further evaluation, or to place a call to a camper's PCP to discuss the need for bumping up daily asthma therapy. A camp NP can streamline situations that often require hours out of the camp nurse's or counselor's day – such as ordering an x-ray to differentiate between a fracture and a sprain, or calling in a refill prescription to replace the medication that got wet on a canoe trip. In a large camp, or one with several sites, an NP could function as a consultant, educator, and supervisor for RNs/LPNs/aides.

The variations in role and scope of practice definitions among states provide the basis for ongoing practice issues, which camps must consider when hiring an NP. While NPs are desirable employees because of their consistent high-level and cost-effective care, physician organizations traditionally have sought to limit NP independence, presumably in an effort to protect their patient markets from competition by NPs. When moving across state lines, NPs must follow guidelines of the new state for both NP practice and RN licensure. Some states (i.e., Pennsylvania) require NPs to maintain both RN and NP licensure, as well as a separate license for NP prescriptive authority. In addition, NPs functioning in that role (rather than as an RN) at camp presents a new set of liability issues, which must be discussed with the camp's insurance underwriter.

Collaboration

Collaboration between a camp NP and a camp physician could provide an ideal partnership for assessing and planning for the unique needs of a particular camp. The local physician knows the available resources and referral networks, and the NP has a pulse on the day-to-day reality of camp life. In such a partnership, planning for care services, fine-tuning of the camp health care manual and ideas for research could thrive. Consider the possibilities!

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Sharing our Camp Nurse Practitioner Experiences

NP Services go to Camp

My interest in going onsite to camps began once I became a PNP and was working in a NH area with many camps. An opportunity arose to provide on-site services to a local camp that had previously had a set in-office time to see ill campers. We negotiated the service between the camp and the practice and thus the beginning of my journey. I did this for four years as well as visiting two others camps before I left that practice.

Visiting NP: In my new job (now eight years ago) in the Lakes Region of NH, there were many camps that used our pediatric office for seeing their campers. One of these was the brother camp of one of my former camps. I broached the subject of visiting the camps instead of having the campers come to the office. The camp nurses loved the idea and over the years it has worked well. I also picked up two more camps, one that I continue to go to and one that I refused to return to because of serious safety issues with the rotating health care staff.

I began my camping career 45 years ago as a young camper. For many summers we had a pediatrician who made camp visits. Once he retired, I was in place to pick up and run developing the NP model of visiting the camp where I had grown up. Now I see campers two days a week at my camp and at our brother camp during the first month of the summer. During the second month, I work at the girls' camp and see campers from our brother camp usually two days a week or more as needed. Two other camps see me once a week and the pediatrician once a week during the month I

am a camp nurse. During that month I work at the girls' camp, I work a busy schedule with five days at camp and two days in the office.

From the financial perspective, the practice has had a retainer fee agreement with camps for many years. When our practice took over my camp and the brother camp, we kept the retainer fee basis for a year. The following year, our practice attempted to institute this fee for all camps whose campers we see either in the office or at the camp. This fee is based on a per camper, per day basis. To date, however, not all camps support this fee but we hope this fee will be reinstituted in the near future. We are on call for the camps 24/7 during the camping season.

In addition to seeing campers, I also order prescriptions and x-rays when needed (saving an emergency room visit). I have also done lab ordering on rare occasions. We have done blood draws on and off for many years at my camp—again saving the camper a trip out of camp. I have only encountered one reimbursement roadblock. This occurred when one insurance company would not pay me if the camper who had had an x-ray without an ER visit needed to be referred to a specialist.

NP at Camp: For the second month of summer camp season, I am hired as the Health Center Manager. I use my NP skills when the situation arises, otherwise I see myself in an RN role. The campers are only charged for my services when I see them as an NP. Otherwise, when I am seeing them as the nurse, I am following standing orders for many non-complex problems--orders I wrote for the camps I visit and approved by the physician practice where I work. Role delineation is often a very fine line for me and is sometimes challenging. Nokomis uses the campers' insurance to cover my services and sometimes it is a hassle to obtain the insurance referral.

My Take: I have had a unique opportunity and feel fortunate to be so supported by my office to continue this each summer. The camps truly appreciate what I do. I have made many friends over the years and truly believe camp friends are my best and forever friends.

Deborah Stone, MS, ARNP
Pediatric Nurse Practitioner
YMCA Camp Nokomis
Meredith, NH

Nurse Practitioner Part time and On Call

I work part time at camp during the summer season. In working collaboratively with the camp's nursing staff, I found that my Family Nurse Practitioner diagnostic skills in pediatrics, orthopedics, GI, GU, Gyn, neurology, ER, dermatology, psych, public health, ENT and nutrition were regularly utilized in seeing the campers. These skills were also well utilized and appreciated by the staff. In addition to working regular hours at camp, I was on call so the staff could call me when they had a question. I was able to stop by at camp on my way to or from our practice to see campers as requested by the nursing staff. I live close to camp so it was easy to stop by to see campers as requested by the nursing staff This facilitated timely assessment and treatment of camper health issues and was far easier for all than arranging care in town, a busy summer resort.

As in most camps, the Heath Center has standing orders signed by a group of pediatricians in the area that guide the nurses in their actions. My NP skills add a further dimension of care. There is an urgent care clinic in the area that we use when necessary and of course the hospital's emergency department.

My license to prescribe was a major help to everyone. Campers and staff received treatment much quicker and with better follow up with me right there in the Health Center part time. I think parents were pleased too as I kept them in the loop. I basically made my assessment of the camper and then handed the camper the phone to call their parent or guardian. For minor problems most parents didn't even ask to talk to me.

Camp Wingate Kirkland is self insured so most off site medical consultations and prescriptions were billed through either the camp insurance or the camper's insurance. I am paid hourly. Camp does not bill parents for campers' NP visits but I should tell them to find out if they can!

My Take: My part time camp nurse experience has been such a surprise. I should have realized that all nurses are practitioners and multitaskers!

Sheila Kane APRN, BC
Family Nurse Practitioner
Camp Wingate Kirkland
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Nurse Practitioner Students

Camp AmeriKids is for children infected with or affected by HIV/Aids. The medication load is very heavy with many given in liquid form, more than once during the day and either on an empty stomach or with food. Some campers require their medications be given through gastric tubes. The challenge of finding enough nurses to meet the medical and nursing needs of these campers has been met by having a partnership with the Family Nurse Practitioner Program at Columbia University.

Each summer the Administrative Staff of the camp, including the Nurse Facilitator and the Medical Director, visit a class session to explain the camp and recruit the FNP students to spend a week at camp. The student receives clinical hours for the time spent at camp where each student spends shifts in the Health Center to see and evaluate campers and staff presenting with complaints. The student develops a plan of care for the individual and presents the individual to the resident emergency room physicians who review the plan. The NP student then carries out the plan.

In addition, each student is assigned to a cabin to administer medications. A second nurse is sometimes assigned to cabins with the heaviest medication load. Pre-packed medications do not fit the needs of this population.

The NP students benefit from daily two-hour classes given by the volunteer physicians, who are board certified emergency physicians volunteering their time at the camp. Topics are relevant to care of the camper such as evaluation of injuries, diagnosis

of abdominal pain, etc. As the nurse facilitator I am responsible for the administrative functions of the camp and orientation of the NP students and with the physicians, the orientation of the counselors.

My Take: This is a challenging and rewarding experience for me. The camp administration has been very supportive of my efforts. Each summer brings new challenges.

Ann Bello, RN, BSN, MA
Nurse Facilitator
Camp AmeriKids
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Nurse Practitioner/Nurse Manager

My summers as the Nurse Practitioner/Nurse Manager at Cape Cod Sea Camps (CCSC) are the busiest, craziest and most wonderful times of my life! CCSC is a co-ed recreational camp located in Brewster, MA with a day program of close to 300 campers and a residential program with 400 campers. As the Director of Health Services, my job is multidimensional. I answer to the executive director of CCSC and work closely with both the day and resident camp directors. My responsibilities include a blend of administration, clinical care, 24 hour on-call coverage, crisis management, and education. At CCSC we have a Health Station at the day camp staffed by a full time RN and a Health Center at the resident camp which operates around the clock and is staffed by five RNs. My position involves overseeing both health facilities, the staffing, the supplies, the written policies and procedures and providing clinical consultation for campers and staff requiring provider level care.

Nurse Manager: From the Nurse Manager aspect of my position, I work six days each week from 7 a.m. until I am "done." Some days I may be done by 10 a.m. and other days I am there until 10 p.m. My position is residential, so the coming and going is relatively easy. I start the day with report from the RNs and then head to breakfast and CCSC's morning council ring. Here I am able to follow up or report on any campers with health concerns. I have developed a daily communication log and bring it to the meeting to document for the nurses any special events, trips or campers in need of extra attention. Facilitating communication is a huge component of my role. After morning assembly, I head back to the Health Center to evaluate any campers who have been referred to me in the clinical capacity of my role.

Experience has taught me that if I am always in the Health Center, it interferes with the nurses' ability to effectively do their job. My role is to establish systems and support the RNs as they implement them. I am also a trouble-shooter and at times "the enforcer." I listen to their feedback and am constantly striving to create positive change.

Nurse Practitioner: We have protocols for referrals and the campers/staff that see me have "appointments." I try to consolidate my appointments to either a morning or rest hour time slot, with the exception of emergencies. I am available to consult verbally when it is not appointment time and if I determine that the individual needs to be examined prior to the next clinic, we will arrange an appointment. Rest hour is reserved for appointments of a more confidential nature. I often talk with both kids and counselors who are struggling with personal issues. In fact, I often have five to six "standing appointments" each week for those individuals who need a regular "check-in."

At CCSC we do not charge for camper or staff NP appointments. The cost of any health services provided in the Health Center is borne by the camp. I am a salaried employee. This arrangement has worked very well for our organization. There is tremendous flexibility regarding the timing of appointments and the campers/staff are examined by someone they know and trust. I am also able to make treatment recommendations based on not only the individual but also an in-depth knowledge of what it is truly like to live at camp. Services I prescribe which must be obtained off-site such as x-rays, lab/diagnostic work, prescriptions and referrals to specialists are handled in a slightly different manner. Before I phone in a prescription or arrange for a diagnostic test, I always discuss options with staff members and speak with the parents of campers to obtain their informed consent. CCSC has chosen to pay any expenses at the time/point of service and then bill the parents for the service/medication. Parents then have the option of submitting the bill to their insurance company for reimbursement. We use the same process when referring to specialists. This has allowed the camp to develop close relationships with the local pharmacy, lab and radiology center. CCSC also has many associations with many area pediatric specialists and they are always extremely responsive to our request for evaluation. Our consulting pediatrician, who covers when I am off and serves as a clinical consultant when I need a second set of eyes and ears, will come to camp to examine those in need. He is also salaried and does not charge for his time.

My Take: I absolutely love my time at camp! The position allows me to utilize all of the skills I learned in my education as a nurse practitioner and not simply the clinical component of the role. I feel extremely fortunate to work for an organization that is so well organized and values wellness of the "whole" person.

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Camp Nurse? Disaster Nurse? What We Have In Common

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Abstract: *Camp nursing brings to mind beautiful outdoor settings of woods and lakes, of sunny skies and starlit nights, of fun adventures and spirited singing. Disaster nursing, on the other hand, brings to mind the natural and weather-induced emergencies of floods, hurricanes, earthquakes and of fear, survival, and loss. Based on the experiences of a nurse who has done both, she proposes there are many common elements. These include: critical thinking, assessment skills, technical skills, illness and disease management, information and healthcare technologies, ethical behavior, confidentiality, and team orientation.*

Key Words: *camp nursing, disaster nursing, critical thinking, assessment skills, technical skills, ethical behavior, disease management, team orientation*

Several years ago, quite by accident, I became a camp nurse. About that same time, through another serendipitous set of circumstances, I joined the local chapter of the American Red Cross and began to work in their disaster services. Over the course of these years, as experience and promotions have unfolded, I have found that these two types of work are amazingly similar. Undoubtedly, there are some days at camp when the nurse feels like a disaster nurse, days of bad weather evacuations, multiple "stomach flu" cases, or a bad accident. Conversely, there are times in a disaster response setting where it feels a lot like camp. The skill set that we bring to camp nursing is quite similar to the skill set that a disaster response demands from the health services department.

Critical Thinking

At the top of the list, even above assessment for both settings, lies the most important skill, that of critical thinking. Both of these settings are essentially public health settings. A nurse needs to be able to not only assess the child with diarrhea in a camp or in an evacuation shelter, but be able to go beyond that to consider contacts, where is he/she sleeping, what is he/she eating, is there adequate hand washing, who is going to be able to care for them??? And those are only the initial questions to consider. From my perspective, both settings are like a three-dimensional chess game, needing to look always past the single layer to a multiplicity of levels of possibilities.

Assessment Skills

Assessment skills are certainly critical in these settings. In camp you are likely to be the only health care practitioner and often in a remote area. You need to be able to sort through various signs and symptoms, take a history, look at the whole picture, and make a decision about treatment in camp, or perhaps advanced care elsewhere. You often have some protocols for guidance, routine first aid supplies and a handful of basic medications.

In a disaster scenario, in a shelter, often there has already been some compromise of the infrastructure of the health care delivery system, and it can be as if you are as isolated as if you were in the north woods of Minnesota in terms of the difficulties in obtaining out-of-shelter health care. You need to assess, consider your working protocols, look at your formulary, and help that client make a decision about OTC (over the counter) treatments on site, or seeking care elsewhere.

Technical Skills

Technical skills are a bedrock part of the skill set we carry in our eyes and ears and hands. Take a pulse, determine a blood pressure, help with a glucometer reading, or look into that swimmer's ear. Consider what is the skin turgor or is there diaphoresis? We are always gathering pieces and building a picture to complement our assessment skills and these skills are very portable. Wherever we are working we are doing some "lying on of hands" which contributes to stress reduction in our population. Checking blood pressures in a shelter full of evacuees, all worried about whether they will have a home to return to, can be a reassuring and soothing opportunity for a conversation, an opportunity for kind reassurance and a cue to the nurse about the stress levels of the clients. Being able to check the blood pressure of the camp director might well provide the same information!

Illness and disease management

Both camp and a disaster setting are public health and individual health settings. Having both the 1:1 skill set of sorting an upper respiratory infection presentation from a risk for strep throat, and the much broader view of the health of the community you are serving is a bonus in both places. In a camp setting, a youngster who presents with chicken pox will need a particular understanding on the nurse's part of "what next?"' And in a shelter, the nurse is faced with exactly the same puzzle. How do we isolate this individual? Who do we need to tell about it? Can this person be sent home from camp? What about in a shelter where there may be no other place to go? Or what if the parents can't come get the camper? Can the active case of Chicken Pox stay in your health center? Is this breakthrough disease, or did the child never have the vaccination? What if I have newborns in the shelter?

Information and healthcare technologies

There is no setting of nursing care delivery that can get by without an understanding of these principles and some type of access to information. Access to the Internet as a resource for information varies quite a bit across the country. Just as many camps are in remote places—locations likely to have fewer cell towers and less Internet, many disaster sites are at least for a period of time also quite compromised by loss of the communications infrastructure. This reality of practice has led both of these settings to be prepared for lower level information resources. A current drug book and a pediatric text or resource manual can be the staple resources at camp, and the portable set of protocols and policies travel in the luggage of the disaster nurse. The beauty of the ARC disaster nursing model is that our policies are portable across the country, whereas with camp nursing, the nurse is accountable in each setting to particular local and state expectations.

Want to Know More about Disaster Nursing? Start with these Resources

American Red Cross--For information about finding your local chapter and disaster training. All Red Cross chapters need nurse expertise. www.redcross.org

Sigma Theta Tau—This nursing site offers disaster preparedness for nurses site with CEU's. http://www.nursingknowledge.org/stti_ce/SP0004/sp0004_index.html.

FEMA--For on-line training in disaster preparedness, www.fema.gov is a rich site of possibility.

Contact the author, Janice Springer, directly at dogmushr@cloudnet.com.

Ethical behavior

When studies are done about "who do you trust" nurses come out as being at or near the top of every other profession listed (Gallup, 2006). We have a reputation in any setting for being safe, neutral, caring, and professional. There are ethical dilemmas that arise in all health care delivery settings, and it is imperative we bring that sense of clarity to the circumstances we face in both camp and disasters. The good news in camp settings is that there are many fewer ambiguous situations. Any camp that has been around for very long has created some form of policy manual that speaks to almost anything than can (or has) happened. Those policies or procedures provide guidance about the type of intervention and the connection to the parents, or in the case of staff, the consequences that might unfold given various scenarios. In a disaster setting there is more room for ambiguity and we can find ourselves working with clients who have lost everything, who really are faced with choosing to eat or buy medications, whether to protect their property or their life, to ask for help, or to go without.

There are always going to be situations where there have to be choices made, the ethical compass of the nurse can often be a resource for clarity.

Confidentiality

Confidentiality is something we are accustomed to in all our work settings, but both camp and disaster can beg for us to consider different options. In the camp setting we are functioning *in loco parentis* which means essentially we are the eyes and the ears for the parents. This may mean that we need to be in the room with the doctor when they make a diagnosis as if we were the parent. It may mean we need to share information about a camper's health with our camp director or a counselor. The 'need to know' may expand beyond the boundaries that we are used to in other settings. This may also be true for your adult staff in camp. If their injury is going to pull them away from their job, we have to include their supervisor in the discussion. The tight community of a camp setting can be a hotbed of gossip, and it can be a challenge to keep information confidential. It is a difficult line to maintain.

In disaster settings, nurses also face confidentiality challenges. The biggest challenges have to do with finding people. Displacement is a huge difficulty in disasters where evacuation is a primary event. People get lost and have to be found. Families get separated and need to be re-united. In a hospital emergency room I may not be able to tell you who is or is not there, but my ability to share that same information in a shelter may result in family reunification. Still, there needs to be some discretion, as we sometimes find people who don't want to be "found." It is important in all settings to be familiar with the HIPAA regulations and other guidelines that support your practice around handling confidential information (HIPPA, 2009).

Team oriented

There are few settings where we work in isolation, and neither camp nor disaster response can function without a strong sense of teamwork. When you are in the camp setting, you fully need the eyes and ears of the counselors to notice a child who seems ill, who may not be eating, who hasn't been to the bathroom for a few days, or any number of other observations. The counselors are your team.

In Disaster settings, there is scarcely a single thing that health services can do that does not require the support of another team member on the job. We need others to purchase medications to back fill our shelter kits, we need to work with the kitchen team to make sure we have good meal choices for diabetics, and we work very closely with the mental health team for the holistic care of our clients.

What I've learned

I've found that these two very different appearing settings for health care delivery have emerged to be extremely complementary. When I returned from a disaster such as Hurricane Ike, where I was a manager for the job, I brought home new ideas for information management. I also came home with several new nurse contacts, experienced professionals who might like to come to work at camp. Each summer at camp I routinely see practice ideas and protocols that can enrich the disaster response world. The transferable skill sets, the rich work environment and the wonderful team spirit of both of these worlds enrich my professional life every year. Come on down!

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Managing Seizure Disorders at Camp

Barbara Hill, RN, MSN, CNE, CMSRN

Abstract: *Managing seizure disorders at camp requires careful information gathering at check-in to clarify the medication regimen, compliance issues (if any), and the camper's seizure history. Safety measures need to be addressed in activities where a person experiencing a seizure would be at greater risk for injury. The nurse should assure that involved staff members know about the camper's seizure experience and how to handle a seizure should one occur. With adequate planning and sensitivity, a camp experience can be a wonderful opportunity for the camper with a seizure disorder.*

Key Words: *Seizures, camp nursing, nursing assessment, seizure medications, ketogenic diet*

When a camper or staff member with a seizure disorder is coming to camp, camp nurses will want to take the necessary steps to help assure a safe and rewarding experience. Check-in time is a good opportunity to make sure adequate planning occurs if this has not occurred pre-camp. Camp nurses may see a noticeable change in the medications campers bring to camp in recent years. Intake is a time to review the medications with parents and campers. When seizure medications are brought to camp, what questions can be asked and what information should be documented by the nurse? Parents and campers want to be through with the health check-in process and off to camp on that busy arrival day, but the wise nurse will take a few extra minutes to ask some key questions. Keep in mind seizures are a chronic condition and the camper wants to be a "regular" kid and play at camp.

Intake Assessment

A nursing assessment is essential at the time of camper intake since this might be the only time for parent, camper and nurse to develop a personal plan of care prior to an event. In this scenario, provisions for a private discussion despite the hectic nature of check-in need to be made to ensure complete information for safety of the camper. For situations when the health history is obtained prior to the camper's arrival, it is appropriate to have a phone discussion with the parent to get further information in a less hurried, private manner. In the second situation, the pertinent information can be communicated to the counselor in advance of the camper's arrival. The following questions are key assessment items to be investigated and documented during this interaction:

- About medications
  - What medications is the camper taking?
  - How long has the camper been on this medication and this dose?
  - Does the dose and instruction on each medication bottle match what the parent tells you?
  - Have there been any medication compliance issues?
  - What has happened when the camper missed a dose in the past?
- About seizure experiences
  - Can you describe the last seizure and any problems before, during, or after the seizure?
  - What factors precipitate a seizure? (i.e. lack of sleep)
  - Does the camper have an aura with seizures?
  - How long do seizures last?
  - Has there been any injury with seizures?
  - Does the camper experience a loss of continence or loss of consciousness with seizure activity?
- About seizure-related safety
  - Does the camper wear a medic alert bracelet? (teaching point)
  - Are there any activities the camper should not participate in or any special precautions to be taken?

Seizure Classification

The camper's parent and Health History Form will probably tell you the type of seizure disorder the camper has. If the term "seizure disorder" is used without any further clarification, you will want to ask the parent a few more questions so you have a picture of where within the current seizure nomenclature this camper's experience falls. Currently the nomenclature is standardized to include the following definitions:

Partial or Focal Seizures: One level may progress to the next level of partial seizure.

- Simple: No loss of consciousness. Characterized by behavioral and/or sensory, experiential phenomena, clonic jerking of a body part, or localized pain.
- Complex: Impaired consciousness or altered awareness. Automatic or repetitive behaviors may appear such as: picking at clothing, smacking lips, or fluttering of eyes followed by confusion or amnesia.
- Partial with secondary generalization: Either of the former two types may spread and become a general clonic tonic or grand mal seizure.

Generalized Seizure: Involves both sides of the brain

- Absence: (Petit mal) Brief loss of awareness without postictal period. May be mistaken for "daydreaming."
- Myclonic: Quick abrupt jerks of the upper extremities that occur most frequently on awakening. Tasks such as eating, brushing teeth, and morning care are challenging.
- Atonic:(drop attacks) Sudden loss of postural tone and the person drops to the floor. Children with this type of seizure wear helmets for protection.
- Generalized clonic-tonic seizure (grand mal): There may be a warning or aura for the patient and then it develops into alternating stiffening (tonic) and shaking (clonic) movements. Included in the episode maybe the following: tongue biting, clenched jaw, incontinence, dyspnea, apnea, or cyanosis. Post seizure observations include, confusion, amnesia, or difficulty speaking along with drowsiness (Marthaler 2004, Reis 2009).

A seizure lasting longer than 5-10 minutes needs further medical evaluation and in many camps such a situation would require a 911 call. Careful documentation of the past history

of seizure activity can assist in decision making should the camper experience a seizure at camp.

Seizure Triggers

In a camp setting, campers are in different living conditions than at home. The nurse might identify these triggers on the parent-camper interview to avoid problems at camp. If any are identified, the precipitating events need to be communicated to the camper's counselor as well. Some commonly encountered triggers are:

- Lack of sleep
- Noncompliance with medications
- Increased body temperature
- Stress
- Recreational drugs and alcohol

Non-compliance with medication regimen is the primary reason for seizures to occur and thus nurses need to be vigilant in checking camp Medical Administration Records (MAR) for daily compliance. Hydration is an important key to keeping the body temperature stable during summertime activities—obviously important for all campers. Fatigue is also an issue that can affect all campers and cabin staff must plan for assuring adequate rest especially if this is a seizure trigger for one of the campers.

Staff Training

If staff or campers with seizure disorders are anticipated, the topic should be addressed in staff training. In addition to information that follows about safety and assisting the person experiencing a seizure, it may be useful to review crowd control and how to summon the nurse in an emergency. If the camp uses a bracelet system for swimming level or allergies, a colored wristband for campers with a seizure history may be a valuable addition especially if the person does not use a Medic Alert bracelet. Many campers find these bracelets "cool" and not a stigma. If alerting staff to the possible signs of suicidal thoughts, expressions or behaviors is not covered elsewhere in staff orientation, this is a good time to include this information.

Activity Safety

Safety is a camp-wide issue and affects all participants but some activities can pose even greater hazards for the camper with a seizure disorder should a seizure occur during the activity. Table 1. gives some examples of such activities and preventative actions that can be taken. It is important that camp staff know activities in which the campers should not participate, which require special safety precautions, or require one-on-one observation during participation. Discuss any activities with the camper and parent that are in question given the history of seizure activity. A well implemented universal safety program at camp is designed to offer enough protection and offset the risk of participating in activities. The goal is to keep the camper involved appropriately in activities of their choice. Everyone wants camp to be a positive camp experience.

Interventions Related to a Seizure

The camp needs to have a well-developed plan should a camper or staff member have a seizure. Adapting from the Epilepsy Foundation's (2009) first aid guidelines, safety measures might include being close enough to other staff to call for help and other staff being aware of the history to avoid frightening campers and offer adequate supervision. Key points to teach in staff training are highlighted in Table 2.

Table 2. Key points in attending to a person experience a seizure

- Assist patient to floor and clear the area
- Loosen clothing around the neck
- Place a folded garment under the patient's head
- Do not hold the patient down or restrain them
- Time the seizure
- Do Not attempt to insert anything into the patient's mouth as it may injure the mouth or teeth.
- Turn patient to the side to keep the airway clear
- Reorient the person as the seizure subsides
- Contact a parent or appropriate emergency contact person
- Observe the patient until fully recovered according to the camp's protocol

It is imperative that all camp staff understand two key items: crowd control and not attempting to insert anything into the patient's mouth as it may cause injury. One-on-one observation is advisable until both the individual and the observer agree that full recovery appears to have happened. Continued observation by a staff member is advisable as the camper returns to activities. Educating and having a plan ahead of time can avoid unsafe practices. Document the following:

- Medication regimen and last dose
- Whether or not the person had an aura
- How long the seizure lasted
- Whether or not any injury occurred with the seizure
- Whether or not there was incontinence with seizure

Table 1. Activity safety actions for campers with seizure disorders

Potentially hazardous activity	Preventive Actions
Swimming	• Swim with a buddy capable of life saving skills • People with epilepsy have 15-19 times higher risk of drowning
Bathing	• Showers rather than tub baths
Activities with potential hazards--rock climbing, climbing wall, bicycling	• Helmets during high risk activities to prevent head injury, i.e. bike riding, rock climbing, etc. • The best method of preventing injury is to prevent the seizure from occurring.

(Epilepsy Foundation)

Occasionally a camper with acute or cluster seizures may have an order for the administration of rectal diazepam gel for seizure control. Its use has been observed as a recent change in practice seen by school nurses and camp nurses may see this practice as well. If a camper comes with this order, the camp nurse should consider in advance how to implement guidelines noted by O'Dell and O'Hara (2007) and Schafer (1999):

- Privacy for the patient maybe offered with some staff holding a blanket as a screen and Implementing crowd control measures.
- Availability of the nurse and the medication
- Timely control and avoiding a visit to the emergency room are the reason the gel is administered in school settings.
- Following administration, monitoring of respirations and further seizure activity for at least four hours should occur.

Seizure Medications

The most common treatment for seizure disorders is medication. Camp nurses will see a variety of medications for seizure control with many campers being on more than one. There are newer and older antiepileptic medications (See Table 3) and campers may have already tried several before the current choice was prescribed. Side effects and dosing are individual to the patient and it is likely the nurse will encounter some unfamiliar medications at check-in. Having an updated drug reference book on hand at check-in time can be very helpful.

It is important to clarify at check-in exactly what is expected of the camper in terms of coming to the Health Center for medications. The parent has provided information about the child's compliance and that will help the nurse to underscore the camp routine so that all parties are clear about when and where medication will be given. The child's counselor needs to know that these medications are not optional. Careful documentation of medication administration for these children is essential.

Other Seizure Treatments

Although medications are the most common approach to seizure management, surgery is occasionally used in a small number of persistent types of disorders not responsive to medication. Another approach occasionally seen today is the use of the ketogenic diet sometimes used with refractory complex seizures. It is mentioned here only because the nurse may be asked if the camp could manage this diet. It is not a decision to be made lightly. This is not a simple avoidance or elimination diet but rather a calculated diet high in fat and low in carbohydrates and protein that aims to have the child burning fats instead of carbohydrates resulting in ketosis. There is also a fluid intake restriction. Managing this diet at camp would be difficult because of the calculations needed and because of the risks inherent with increased activity and warm temperatures on the camper's state of ketosis (Epilepsy Foundation, 2009).

Food and Drug Administration Suicide Alert for anti-epileptic Drugs

Patients taking one or a combination of anti-epileptic drugs had nearly twice the risk of suicidal thoughts compared to patients without the drug therapy. Suicidal thought risk for patients taking antidepressants and anti-epileptic medications was increased significantly over those on anticonvulsant therapy alone.

This is a serious alert and pharmacies are obligated to provide medication guides with written information about this risk available each time a prescription is filled. These guides rarely accompany a child to camp so it is imperative that camp nurses beware of the risk and assess for signs and symptoms of suicidal thoughts, actions or changes in behavior by asking the related questions at the check-in assessment:

- Talking or thinking about harming oneself
- Preoccupation with death and dying
- Depression or worsening depression
- Giving away prized possessions

(Epilepsy Foundation, 2009)

Supporting the Camper with Seizures

Most campers with seizure disorders are well controlled on their medications and may well have no seizure experiences during their camp stay. For the camper or staff member who does experience a seizure, they need the opportunity after the seizure to do those things they have found helpful at other times. Some will want to sleep or have a quiet rest time. They should have the opportunity to talk with their parent and collectively you can agree on what would be helpful now. Assistance with reintegrating with their group as soon as possible is usually recommended. They need assurance that the group understands what has happened and is eager to have the person back in their group and to continue having fun.

Table 3. Newer and Older Antiepileptic Drugs

Newer (since 1993)	Older
• Felbamate (Felbatol) • Fosphenytoin (Cerebyx) • Gabapentin (Neurontin) • Lamotrigine (Lamictal) • Levetiracetam (Keppra) • Oxcarbazepine (Trileptal) • Tiagabine (Gabatril) • Topiramate (Topamax) • Zonisamide (Zonegran)	• Carbamazapine (Tegretol, Carbatrol) • Chlorazepam (Klonipin) • Ethosuximide (Zarontin) • Phenobarbital (Luminal) • Phenytoin (Dilantin) • Primidone (Mysoline) • Valproic acid (Depakote, Depakene, Depacon)

(Reis and Keil, 2009)

Most campers with seizure disorders will not be coming to camp unless their seizure disorder is generally well controlled. The camp experience can build self care skills, is fun, and motivates positive attitudes about a chronic condition. It is important for campers to interact as kids and play without unnecessary restrictions (Sawin, Lannon, and Austin, 2001). Efforts to integrate students with chronic conditions into the school system have been successful; the same is being seen in camp settings. Camper safety is best first addressed at the camp registration by the nurse interacting with the parent and the camper. The nurse's attitude and the information imparted during staff training can be positive factors in managing seizure disorders at camp.

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Epilepsy Foundation. www.epilepsyfoundation.org

Epilepsy Health Center: Web MD medical reference in collaboration with the Cleveland Clinic: Epilepsy: medications to treat seizures. Retrieved January 19, 2009 from http://www.webmd.com/epilepsy/medications-treat-seizures?print=true

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Evaluating Ankle Injuries—Don't Let It Trip You Up!

Doris Nerderman, RN, BSN

Abstract: *Ankle injuries are a common occurrence in camp settings given the uneven terrain, the wide range of activities undertaken, and the footwear commonly worn. Camp nurses are frequently faced with the decision of whether or not to send an injured camper or staff member for an x-ray. Thorough evaluation includes gathering information about the accident and then performing a careful assessment. Providing for camper comfort and reviewing other information about the camper, the situation, and what influences the pain threshold are important components of the assessment.*

Key Words: *ankle injuries, physical assessment, pain assessment, camp nursing*

It can be frustrating to determine whether an ankle injury needs additional medical evaluation and treatment. When x-rays are negative, we wonder if we might have evaluated better and saved the time and expense. On the other hand, when we initially assess and opt not to get an x-ray, only to learn later that there is indeed a fracture, we spend a good amount of time reviewing what we could have done better and how we could improve in the future.

Recently in a conversation with some veteran camp nurses, we agreed that if we could be granted one superpower, it would be to have x-ray vision! Occasionally, like in the next scenario, we may even feel like we do.

Common Scenarios at Camp

As the camp nurse, you are called to the baseball diamond because a camper was injured sliding into second base. On your arrival you see that the camper is writhing in pain and you can tell from a distance that the ankle has an obvious deformity. You know immediately that this is not a question of whether advanced medical care is indicated but instead a question of how the camper will be transported. Fortunately, injuries this severe don't happen very often.

These next scenarios occur much more frequently. You are busy in the Health Center when:

- You are called to the field where campers have been playing Capture the Flag. You find a camper sitting on the grass complaining of ankle pain.
- A camper turns his ankle on the trail going from the cabin to an activity. Another camper comes to the Health Center to get you to help.
- A camper jumps from a rock in the grove and is carried to the Health Center.

Just about now is when it would be terrific for that x-ray vision to activate! But, functioning without it, there are some steps to take in considering the injury.

Initial Response

The initial assessment of a closed ankle injury includes determining that the camper has no obvious deformities, no circulatory compromise and no other injuries. The nurse would then probably proceed with making the camper comfortable and treating with RICE (rest, ice, compression, and elevation) while continuing the assessment.

Ask Questions

The mechanism of injury can tell you a lot so it is important to take the time and get the full story. Ask, 'How did this happen?"

- Were they running?
- Did they slip?
- Did they jump and then fall?
- Did they twist their ankle on uneven terrain?
- What type of footwear were they wearing?
- Did their body land on their foot when they fell?
- Did anyone else land on their foot/leg?
- Was there any torque during the incident, especially if others landed on the camper?

Severity of the injury is increased the faster the camper was traveling, the farther the fall, the worse the terrain and the increased weight and/or torque on the leg.

Ask, "Did you hear any unusual noises with the fall?"

- Any snaps or pops during incident?

A pop or snap reported by the injured party or those present is significant.

Ask, "What happened immediately after?"

- Did the camper bear weight on the leg?
- Any numbness or tingling?
- Have the camper rate and describe the initial pain.

The inability to bear weight and the more severe the pain indicates increased severity. Once the RICE regimen has been instituted, have the camper rate and describe their pain.

Ask, "Can you tell me about your pain?"

- Is the pain constant or reactionary?
- If the pain is reactionary only, what causes the pain?

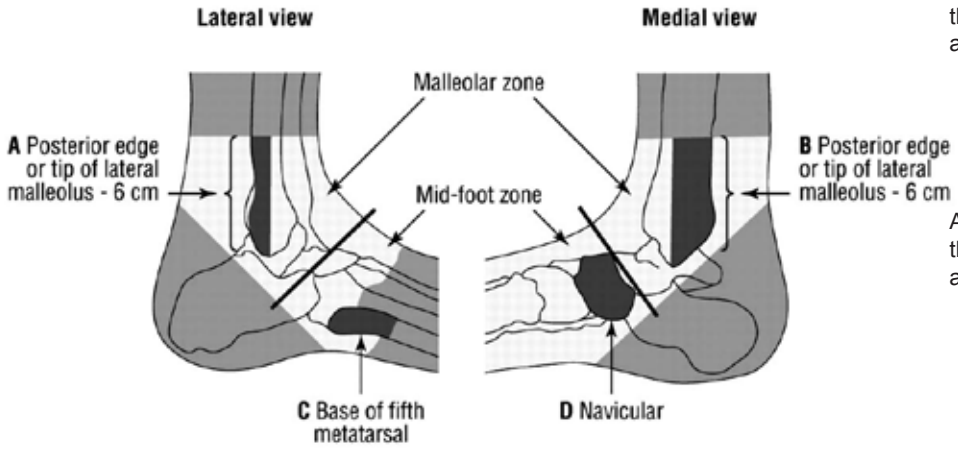
Constant pain could indicate a worse injury.

Physical Assessment

Take the time needed to perform a careful physical assessment of the injured ankle. Remember too that time is on your side in making a decision. You can use RICE and consider pain medication administration while continuing to assess the situation. The following aspects should be considered in assessment:

- Any bruising, swelling, numbness? Is the foot warm? Can they wiggle toes?
- Compare the foot to the uninjured side. Sometimes unusual bumps are just that and appear on both.
- Palpate, attempting to differentiate between bone and tissue injuries. Palpate the medial and lateral malleoli for point tenderness and a 6-cm zone indicated as A) and B) on Figure 1.
- Continue by examining the foot as well. Squeeze the navicular bone and cuboid together and then the 1st and 5th metatarsals.
- Have the camper attempt to bear weight on the affected foot.

Figure 1. Ottawa Foot and Ankle Rules for Ankle Injury X-ray Decision-making.



An ankle x-ray series is only required if there is any pain in malleolar zone and any of these findings:

1. bone tenderness at A OR
2. bone tenderness at B OR.
3. inability to bear weight both immediately and in the emergency department

A foot x-ray series is only required if there is any pain in midfoot zone and any of these findings:

1. bone tenderness at C OR
2. bone tenderness at D OR
3. inability to bear weight both immediately and in the emergency department

(Source: Stiell and McKnight, 1994).

The Ottawa Ankle/Foot Rules (Figure 1) may assist in your decision of whether or not an x-ray is indicated. Research on individuals three years old and over has shown that using these criteria can reduce the need for x-ray. These are the "technical" procedures that can help you make the decision "to x-ray or not to x-ray", but I have learned over the years that there are other components to consider as well.

Additional Camper Considerations

When initially injured, campers can be scared, agitated, and/or nervous. These reactions can skew an assessment. That is why it is beneficial to calm the camper and let them catch their breath and realize they are in no imminent danger.

If reactions to pain seem uncharacteristically exaggerated, continue to monitor and use your RICE procedures. Observing closely the reactions to an assessment when the camper is otherwise occupied can also give you a clue to extent of injury. Pain thresholds vary. If this is a camper that you are familiar with (AKA frequent flier), waiting a period of time can also provide additional information. If it is a camper you are not familiar with, talking to the leader could prove to be useful to learn the demeanor of this camper.

Be aware if the injured camper has behavioral disabilities. You will need to change your assessment and how you question this camper to get as accurate a picture as possible. The camper needs to understand what you are asking them in order to answer appropriately. Disabilities can also change pain thresholds.

It may also be a good idea to speak to the parents for helpful information. They will be able to tell you whether their child cries at the drop of the hat or are usually stoic when injured.

The pain threshold in a homesick camper may be decreased. The child who isn't having a good time and is already campaigning to go home may find their injury much more severe. They may even look at this injury as "a ticket out of Dodge" If the conversation frequently returns to "If I can't do anything, I might as well go home" it is probably time to be having the "how is camp going otherwise?" discussion.

Blood also may decrease the pain threshold. If the camper has an abrasion as well, they tend to be more fearful and react more strongly to the injury.

If there have been recent similar injuries in a cabin or a group, particularly in younger age groups, don't rule out that this injury is the result of a "contagion." Attention seekers could be looking for just that.

If the injury is the result of a tussle with other campers and the injured camper is identified as one of the instigators, they may fear what "trouble they might be in" and focus on injury to postpone the implications of their undesirable actions.

Finally, listen to those who have had a history of ankle injuries. Older campers and leaders especially can tell you if the present situation is similar to or different from previous sprains/fractures.

In Summary

Each injury and each camper is unique and it is important to assess each injury individually in the context of the camper, the setting, and the event. Hopefully these guidelines will be helpful to and make you feel more often that you truly do have that longed for x-ray vision.

Resources

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Where Are You From? A Global Perspective for Camp Health Centers

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Abstract: *Care, the focus of nursing practice, is valued by an individual when they feel "cared for." The nurse in the camp Health Center needs to understand the concept of care, assess an individual's beliefs about care and adapt interventions to complement care whenever possible. Differences in care beliefs are influenced strongly by background and culture. Cultures have definite differences in care. The goal of the nurse is to identify those beliefs in individuals and be responsive by bridging differences through awareness, learning, and negotiation. Global competence in providing care at camp is a vital skill to be developed and implemented.*

Key Words: *camp nursing, health center, nursing care, caring, health beliefs, global health*

The heart of nursing is the ability to care for people. Care is what people value from nurses. They go to physicians for a diagnosis of their illness/injury; they turn to nurses for the care they need. Care is the focus of nursing practice. But care is valued by an individual only when they feel "cared for." A nurse can do many things for someone; but if the person does not perceive those as caring behaviors, the feeling of being "cared for" does not exist.

The concept of care has particular importance for camp nursing practice. Care is valued and expected. When campers and staff come to the Health Center, they should leave feeling "cared for." Putting a band-aid on a bleeding wound elicits that feeling for some. Others want their suffering/pain acknowledged; still others expect a "kiss-and-make-it-better" approach. It is the responsibility of the nurse to assess the person's need for care and to meet that need.

Madeleine Leininger and other nurse researchers have examined care. Leininger, in particular, states that the perception of being "cared for" is a function of health care beliefs that are culture-bound (Leininger, 1984, 1990). In other words, each camper and staff member arrives with a preconceived idea of what constitutes good care; that idea has been learned from their culture. It is nursing's responsibility to assess those beliefs and adapt nursing interventions in a way that complements expected care whenever possible. For example, a person from the United States who has the flu may want chicken broth and soda crackers whereas a person from Germany might prefer a grated apple which has been allowed to turn brown. Determining what a person considers "sick food" is easily addressed by simply asking what the person wants to eat. That's fairly straightforward. But other culture bound differences are more subtle. A person from Germany might take two Tylenol for a headache and considers him/herself cared for and cured, while a Spanish-speaking person takes Tylenol for the same reason but does not feel cured (yet) nor cared for. Cultures have different definitions of care.

Exploring U.S. Healthcare Beliefs

To understand what is important to others, it is helpful to recognize what is valued in one's own culture. People in the United States, for example, generally believe that everything possible should be done for a sick/injured person – particularly if the person is considered vulnerable (like kids). In addition, the quicker the attention is obtained, the better. U.S. health care speaks of "aggressively pursuing" a problem and "beating cancer." Over-the-counter medications are marketed on how quickly they enter the bloodstream rather than how effective they are once they get there. Beliefs such as these mean that the camp nurse should consider telling U.S. clients how long it will take before they notice an improvement, should remember to ask about improvement, and should assess the scope of care to determine if it was thorough enough from the client's perspective.

Another U.S. healthcare belief is that caretakers are aware of the health needs of the children with whom they have contact. The typical U.S. parent assumes that a cabin counselor will note these needs and attend to them without the child requesting such care. Parents expect that counselors will notice a change in behavior (e.g. not eating), affect (e.g. listlessness), or physical status (e.g. outbreak of poison ivy). In addition, the expectation is not only to note the change but also to act on that observation. For many counselors, most of whom have only begun looking after themselves let alone someone else, this is new information. This expectation is even more challenging if the counselor is from a culture that relies on children to self-report. In this case, the notion of being observant may feel intrusive. Counselors – both internationals and U.S. – need education about this U.S. belief so they are able to respond appropriately.

Sometimes nurses need education too. For example, a child hurts his/her ankle. A physician examines it and diagnoses a sprain. An ace wrap is put on and the child returns to camp with instructions to elevate, use Tylenol as needed, and cool the area. The nurse, by virtue of delegation, completes the medical care as defined by the physician. But nursing care is also needed. The child has a locomotion problem – how will s/he get around camp? The child sleeps on the top bunk – who advocates for a change? The schedule emphasizes Olympic Events that afternoon and evening – how does this child participate? The camper will write home about the ankle – who anticipates parental concern? These are the domains of nursing care.

Another U.S. value is the expectation that something will be done when one accesses the healthcare system. A child who has itchy mosquito bites comes to the Health Center. This problem might be minimized by providers and no care given to the client. However, itching can be treated and deserves to be if it is identified as a problem by the client (Erickson, Tomlin, & Swain, 1983). With thorough nursing care, it may even be prevented by encouraging the use of insect repellents.

Sometimes nursing care means bridge-building between two different health values. For example, a well-known U.S. adage states that "cleanliness is next to Godliness." While cleanliness has a prominent role in health care, it is interesting to note how strong values of cleanliness can have negative health effects. Minerals are removed from food under the guise of cleaning, and natural immunities are decreased in a concern for overly clean environments. Cleanliness may even predispose people to certain problems; consider the person who develops an outer ear infection because, in an effort to have "clean ears," s/he has decreased the protection offered by cerumen. Also consider the counselor who complains because "my kids never take showers!" Yet, upon questioning, the kids do not smell nor do they look dirty nor do they have any symptoms of illness. The counselor's health belief system may mandate a shower every day, but not the kids' value!

Discovering the Health Beliefs of Others

Even if people share a culture – rural Minnesota and downtown Chicago are part of U.S. culture – their expectations about health care may be very different. Difference in healthcare beliefs is even more apparent when the client and nurse are from different cultures. Consequently, it is important to assess beliefs both of one's self as well as the client (Galani, 1991).

Assume that the camp's medical protocols and Health Center policies represent one culture. According to Leininger (George, 2002), it is possible to determine if behaviors from that culture match the expectations of the client's culture by asking. For example, when a counselor from Finland is admitted because s/he has a cold, it would be important to ask what s/he wanted to eat and drink rather than assume their preferences matched expected ones. It is then a simple matter to determine if the client's expectations complement, mismatch, or are in partial agreement with the nurse's expectations.

If at all possible, preserve (meet) the client's care expectations (Muzoz and Luckmann, 2005). A camper who feels homesick may need daily attention from the nurse just to maintain him/herself. Provide that attention. Sometimes, however, it is not possible to meet a person's expectations or to allow a particular behavior to continue. The person with diabetes, for instance, who eats indiscriminately, is not helping themself. In these situations, the focus becomes one of repatterning, changing the client's behavior to a more meaningful pattern. This requires a tactful approach and time to provide it. When some aspects of expected care are not in agreement – for example, the counselor with a cold who wants medicine for symptoms but refuses to increase fluids or get more rest – it is important to negotiate a change with the client (and maybe the supervisor!).

The goal is to match the client's care expectations and culture-bound health beliefs with those of the camp nurse. This matching of client needs and provided care preserves and complements culture-bound health beliefs. The result is what U.S. culture calls a "compliant person." If recommended care does not meet client expectation and the nurse ignores or doesn't recognize this, the client is likely to feel neglected, spiteful, angry, disgruntled, and/or a host of other alienating emotions. Health status can be compromised as a result.

Sometimes a negative response occurs even when the nurse has attempted to meet expectations. Consider the situation in which a girl sees the nurse because of poison ivy on her face, neck and arms. The girl would like relief from the itching so, after carefully washing the area, the nurse applies calamine lotion and gives 25 mg of Benadryl. That afternoon the nurse overhears the girl complaining to other campers. The girl expected the medication to "cure" the rash but it has gotten worse; it is now blistering and has begun to weep serous fluid. The problem is that the girl was not told what to expect; there is a discrepancy between what she assumed and what actually happened. The expectation may well be a function of the U.S. belief that effective medication is medication that cures. What the nurse thought to be a request for relief from itching was something quite different.

In this situation, follow-up care would occur. Here is the opportunity to reassess what type of care is valued. Perhaps the camper is concerned about her image; poison ivy on the face can be hard to take at 13 years old. Perhaps the client needs education about the expected course of poison ivy. Perhaps the camper really did expect the medication to cure it. These expectations reflect culturally-influenced beliefs. Some responses – like teaching the expected course of PI – result in repatterning the client's expectations. Others – like adapting the treatment to preserve the client's body image – require accommodation from the nurse.

The most difficult situations are typically those that require negotiation. A difference exists between what the client expects and what the nurse would like to do. Resolution of that difference requires the camp nurse to focus on true client-centered care, a concept thoroughly explored by Erickson's now classic Modeling-Role Modeling theory (1983). There are times when it is necessary to do (or not do) something because of the client's wishes. Effective negotiation results in the client feeling "cared for." For example, a young man who is a camper takes tetracycline for acne, a medication given on an empty stomach. The nurse and boy arrange their schedules to comply with that. If the boy consistently neglects to come for the medication, it means the camp nurse must look for him. This can get tiresome very quickly. For whatever reason, the camper has put a higher priority on something else. The nurse probably needs to talk with the client to discover why the disconnect exists. Perhaps the scheduled time was in the middle of soccer and this boy is an avid player; perhaps the boy could care less about the medication and the perceived need for medication is really a parent issue. Whatever the reason, the nurse needs to discover it and then adapt using negotiation skills.

Negotiation does not work all the time. Sometimes the client wants or is doing something that is not appropriate. Then repatterning is important. Take the example of a camper with diabetes. This person has been a self-manager at home. The ability to self-manage is important but often needs to be adapted in the camp setting. For example, it is camp practice to keep all medication

in the Health Center. To someone used to being self-sufficient at home, it may feel like an imposition to keep supplies in the Health Center. It means getting up, getting dressed, and going to the Health Center for pre-breakfast glucose monitoring and an injection. Everything was on the bedside table at home. The perception of convenience is now very different. This must be recognized by the camp nurse and an explanation provided so the camper does not feel powerless. Situations like these can be minimized by reviewing health forms and calling people before arrival to discuss potential problem areas in a supportive and tactful manner. The key is to first establish a supportive relationship and then address the issue.

Globalizing the Health Center

Dreher, Shapiro, and Asselin (2006) discuss the relationship between healthy people and healthy places. Their premise is that a health promoting environment requires culturally competent nursing practice. The camp Health Center can be such an environment. People from a variety of cultural backgrounds will access the camp Health Center so create a space that has some cultural flexibility. This can be done with visual cues such as posting a chart – or a giant thermometer – that compares Fahrenheit to Celsius. It can be done by including care modalities that improve the perception of care such making chamomile tea. And it can be done with words, words such as "What else would help you feel better?" If the camp enjoys staff and campers from other countries, draw a person on tag board and label body parts in the languages spoken by the internationals. Learn how to say common things – like band-aid, medicine, cough, headache, sore throat, mosquito or tick – in those languages.

Globalizing the Health Center is also accomplished by improving the nurse's cultural competence. Talking with clients about their culture-bound health beliefs provides opportunity for a growing understanding of their world view, a view that influences and impacts health status. Questions like these are recommended by Pedersen and Ivey (1993) and Muzoz and Luckmann (2005):

- What do you do each day to keep yourself healthy?
- What do you like to drink when you are sick? What do you like to eat?
- What foods are considered healthy? Unhealthy?
- What do you do to help yourself recover from a cold or the flu?
- Who do you generally tell when you're not feeling well? What if that person isn't available?
- How do people from your culture express pain? Is it done differently when at home as opposed to in public areas?
- Who is the primary care-giver at home? What if help beyond the skills of that person is needed – who decides this and to whom do you go?
- Tell me what it's like to see a doctor in your country.
- Tell me what nurses do in your country.
- Do people pay for healthcare in your country? Does it make a difference in the care if someone pays extra?

Working with International Medications

Nurses who have worked with people from other countries know what it's like when a camper or staff member plops their medicine down and the nurse can't even pronounce the name of the substance let alone determine active ingredients, untoward effects, normal dose, or even how or when the medicine is administered. It can be a real challenge to work with international medications. It's also challenging when U.S. campers and staff bring herbal, homeopathic and other remedies to camp. These substances do not fall under FDA guidelines and most nursing education only prepares the nurse to work with medications common to western medical modalities.

So what's the camp nurse to do? Begin by having access to reputable references such as Mosby's *Handbook of Herbs and Natural Supplements* (Skidmore-Roth, 2006; a new edition is scheduled for release in April 2009) and/or *The PDR for Nonprescription Drugs, Dietary Supplements, and Herbs* (2009). Also consider accessing online resources – but take care to access those without a commercial interest in the product being researched. And talk with a pharmacist or pharmacy school (ask about and pre-arrange this consultative resource).

Since client safety is a primary concern, ask international staff and campers to have their medication and information on the label translated into English before leaving their home country. If translated information is still unclear to the nurse, remember that adult staff can "self medicate" and use the substance per their own judgment. Document this action and, since the substance is unfamiliar, do not concurrently give other U.S. medications. If the individual with an unclear medication/substance is a camper, talk with the camp director about policy. Sometimes a call to parents will clear things up but this is definitely something with which the camp director should be involved, especially when parent calls do not help.

For some nurses, working with U.S. herbal and homeopathic remedies and food supplements is also troublesome because the nurse lacks education about these items. In addition, production of the substance may not be standardized, resulting in inconsistent levels of the active ingredient(s) in a given tablet/tea bag (hint: look for "standardized dose" on the substance's label). In these situations, explain the concern to the camp administration and jointly determine how these substances will be handled. It may be determined that adult staff self-medicate while a more limited action – including not giving the substance – may be the action with campers, especially those for whom a parent contact is not possible. Decisions such as these should be collaborative determined between camp administration and the nurse and, in all instances, prudent – safe – action taken with regard to the client. Sometimes, especially while waiting for an answer, non-pharmacologic strategies can be used to alleviate symptoms.

Enjoy the World of Camp!

Readers familiar with the International Camping Fellowship (ICF; http://www.campingfellowship.org/ICF-Web/DesktopDefault.aspx) know that there's a global network of camp professionals who stand ready to help one another. The Association of Camp Nurses is a member of ICF and currently working to establish a knowledge network about culture-bound health beliefs. Until this initiative is formalized, informal contact between ICF members

has been helpful when sorting out questions about culture-bound health practices. ACN members are encouraged to call ACN's office and request such a referral if needed.

Meanwhile, take time to talk with people you meet from various walks of life. Ask about some of the things presented in this article. Consider affiliating with the Transcultural Nursing Society (http://www.tcns.org/). If you find your interest level piqued take advantage of books and workshops that explore the impact of culture upon health. It's a fascinating world, one that our campers and staff – the leaders of tomorrow – are already enjoying!

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Linda Erceg, RN, MS, PHN, has worked year-round as a camp nurse at Concordia Language Villages, Bemidji, MN, for almost 30 years. The program attracts staff from around the world – over 300 of them a year – as well as international campers. Her nursing practice continually focuses on helping individuals bridge their culture-bound health beliefs from home with those found at the Language Villages. Linda is also ACN's Executive Director.

Using Camp RN
A computer listerv for camp nurses

CampRN links camp nurses across the country via computer, providing a way for nurses for ask a question, seek or share information, and communicate with others. It is free and easy to use. All you need to do to be part of the listserv is subscribe—that gets you in touch with the list. You can post questions or answer the questions of others or just enjoy the communication that comes to you. ACN member Kris Miller manages the list from Washington State University.

Subscribing to the CampRN mailing list

- To subscribe to the mailing list, send an e-mail (using your own computer's e-mail program) to the e-mail address of the mailing list server: campRN@lists.wsu.edu.
- The subject line must be blank
- The body of the message should only contain the following information: sub CampRN your name. Use your real name, not your e-mail address. Use only plain text here, not HTML.

Posting or Responding to a Question

- Write your question in the form of an e-mail message. The subject line of your e-mail should say what the question is about. Be sure it is what you want to say to several hundred people.
- Sign your message with your name and affiliation.
- Send the question in the form of an e-mail message to CampRN@lists.wsu.edu.
- Your question is then automatically posted to the list.
- To reply to a question, you simply do "reply" and type your response. Your response goes to the whole list.
- You may also respond "off-list" by sending a new message to the individual who sent the question. Their e-mail is listed in the original posting "…on behalf of…"

Our Camp RN listserv has been a little quiet lately. Share your questions for the coming season with your colleagues and benefit from their experience.

Excerpted from Buckner, E. What's New at CampRN? *CompassPoint* 17(3). September 2007.

– People in Practice – Meet Frost Valley's Patty Conklin

Susan B. Baird, RN, MPH, MA

Abstract: *Meeting the health and safety needs of campers and staff at Frost Valley YMCA presents lots of challenges. A new Wellness Center opened this past year to house both the general health facilities and a dedicated camper dialysis program. The Health Administrator oversees a busy staff that fluctuates in number by season. Policies are in place for summer camp programs and additional school year programs. A unit-dose medication distribution policy was developed and implemented this past year and wellness initiatives continue to be an important focus.*

Key Words: *camp nursing, wellness center, health center, unit-dose medications, wellness programs, environmental education*

There's lots of snow in the Catskill Mountains of New York this time of year but there's no lack of activity at Frost Valley where Patty Conklin is Health Care Administrator. Most camps we know are closed and shuttered for the winter, but Frost Valley provides four seasons of outdoor and educational opportunities each year for more than 30,000 people of all ages, backgrounds and abilities. Frost Valley is one of the country's largest YMCA camp facilities and plenty of challenge for Patty and her team.

Taking the Leap to Frost Valley

Patty Conklin brings a rich and varied background to camp nursing, one she feels has prepared her well for its challenges. She graduated and became a Registered Nurse in 1997 and went into the mental health and psychiatric field. She chose this field based on her desire to focus on the whole person, an underlying force for her in nursing. She moved on to school nursing for a good fit with her children's schedules and learned a lot about diabetes, asthma, and common childhood health issues. This experience was followed by several years working in long term drug rehabilitation and in an acute mental health unit. After a colleague was attacked and killed in this setting and Patty was later attacked by a patient, she decided she needed a break from mental health and accepted a dialysis unit position. She became a preceptor there and was not really looking for a change when the Frost Valley Position opened. Patty says, "I just couldn't refuse this opportunity."

Patty and her girls moved to Frost Valley in November, 2007, a move of about 45 minutes and a change in schools for her girls now 19, 18, and 11. Moving and living on site was a transition for them all. Her older daughter is now in college and the younger two well settled—a good fit all around. Patty had never been to camp as a child but had some camping background as a scout leader and a town program day camp director for one summer. A friend who had worked at the summer camp told her about the position. Patty's past experiences and her energy were a good fit for the position.

Frost Valley's Rich History

In 2008, Frost Valley celebrated its 50th anniversary in its current location, transformed from the Forstmann's family estate, Contentment Corner. Frost Valley's roots go back to 1885 with camp being at a few different locations in NJ before its final move and the formation of the Frost Valley Association to run the Frost Valley Camp and Conference Center. In 1968, Frost Valley was incorporated as an independent YMCA. Ten of the original buildings from the Forstmann's estate still stand and additional land acquisitions increased the site size to 6000 acres of forest, field, meadow and streams.

Frost Valley boasts an amazing array of programs. The main summer camps are Camp Wawayanda for younger campers and Camp Henry Hird challenges older campers. A residential environmental education program serves schools in NY and NJ throughout the school season. Other programs include Farm Summer Camp, Day Camp, After School Program, Elderhostel, and Adult Education. Additional programs include family and group retreats, cross country skiing, three season horseback riding and programs with the Tokyo YMCA. It may help to grasp the size of this operation by a few user numbers:

- 15,000 students yearly in the environmental education program,
- 14,000 overnight guests from such groups as scout troops, individual families, YMCA, and church groups
- 2000+ children per summer.

These numbers alone give you some idea of the demands on the healthcare services at Frost Valley. In addition to users, staff can obviously present needs. Frost Valley has more than 100 year-round employees and an additional 200 seasonal employees. In addition, two program partnerships have a direct impact on the health facilities and staff:

- Mainstreaming at Camp Program, a partnership with the Young Adult Institute/National Institute for People with Developmental Disabilities
- Dialysis Center at Frost Valley, a partnership with the Ruth Carol Gottscho Kidney Foundation and Montefiore Children's Hospital (This program and Maureen Eissele, its nurse director, will be highlighted in the next issue of *CompassPoint*).

Frost Valley's fishing dock is the perfect spot to enjoy the area's scenic vista.

This circa 1913 farmhouse served as Frost Valley's Health Center for many years.

Guenther Family Wellness Center

Many camp nurses dream about a new Health Center but few get one—not so at Frost Valley. The Guenther Family Wellness Center opened its doors in time for summer camp of 2008, Patty's first season there. The two storied building has 16,000 sq. ft. of space. The upper floor of this two story building serves as a traditional Health Center and the Kidney Dialysis Center. Paid for through a generous lead donation and from Frost Valley Alumni contributions, the center adds another year-round building.

Its first floor has an alumni reception area dedicated to the beloved Joy White who served as the Frost's camp nurse for more than a decade. Joy was a pioneer in Wellness and TLC in the mid- to late 70's at Frost Valley. The lower area also contains indoor program space, including a toddler room, arts and crafts center, and a 150-seat theatre. This space is a tremendous addition for year round programming in a geographic area well known for its cold and snow

Wondering how it works to have health services in a second floor location? Patty says, "The health services are on the same level and near the dining hall intentionally to make medication administration times convenient for the campers and guests. The building is centrally located on the property making access convenient. The lower level, which is built into a hill, houses the program space. You have to go down stairs to utilize that part of the building.

It was really time for new health facilities. The old center was in a circa 1913 farmhouse. The facilities for dialysis were insufficient for this population and in order for that program to continue, an upgrade was definitely needed. A center designed and built for health care delivery was needed instead of refurbishing an older building and "making do." Input from many sources was used in working with the architects—the local health department, camp physician, the dialysis team, and other nurses all had a voice. Nurses were involved in frequent planning sessions and this carefully preparation has really paid off.

The new Wellness Center opened a couple of days before the 2008 summer season. There is a waiting area, two exam rooms and a trauma room. There are four rooms each with three beds and two isolation rooms—each bedroom has its own bathroom. Rooms are handicapped accessible. There is a conference room and a staff bathroom. The trauma room is designed with nearby direct access for ambulance so that ambulance personnel when needed do not go through other areas. Unlike many Health Centers, the nurses do not "live" in the building for the summer but there is an on call room for a staff person when there is a camper in the Center overnight. Frost Valley's CEO felt very strongly about not wanting someone to be actually living in the Health Center all summer, believing that staff should have living space away from their direct work setting.

Patty says the new facility functioned very well in its first season. The staff found the new space unbelievable wonderful. The sleeping areas for campers are really quite comfortable and kids can actually get rest. The only function that did not work out as well as hoped is medication distribution. There is good space for preparation but it was quickly seen that a "pass through" approach would be preferable than having campers come through the building. Frost Valley had a Norwalk Virus outbreak last summer and during that time they temporarily used an existing window for medication delivery to keep well campers out of the center. Based on this experience, Patty suggests to those planning a new facility that they incorporate a pass through system for medication administration to keep healthy children out of the building where sick children reside.

Frost Valley's Wellness Initiative

The preference for the term Health Center over Infirmary has occurred in many camps to reflect more fully the intent and function of such buildings. Patty finds the term Wellness Center at Frost Valley very fitting going back to a big wellness initiative that has been going on for many years and is an inherent part of the camp program. It seemed natural to make the change with the new building. Nurses are involved monthly promoting a wellness-related issue and do some kind of outreach to staff as well as to guests or to the community. For example, the Center has participated in the "Healthy Heart--Go Red" campaign. They are involved in such staff and community outreach efforts as CPR and First Aid instruction, creating a Nordic ski patrol, becoming outdoor emergency instructors, and providing wellness in-service programs throughout year. Currently the nurses are working in collaboration with a dietitian to develop nutrition counseling.

Wellness is a part of the camp values and curriculum and has been since the late 1960s. Today wellness is more important than ever at camp. A fun example of the wellness activities is the

The new Guenther Family Wellness Center is built into a hill allowing ground level access to the health facilities (left) and programming space in the lower level (right).

Incredible Edible House where campers learn to cook healthy foods that are fun for kids to make and good for them as well. The YMCA has launched a national program called Activate America and Frost Valley has launched a variety of initiatives and integrated them into its programs. The Frost Valley and YMCA websites are good resources for those wanting to plan initiatives for their camp.

Staffing

Year-round Wellness Center staff consists of Patti and another RN, an LPN, an EMT and an EMS coordinator. The nursing services are primarily for the school environmental education program. There are two eight hour shifts on school days, from before breakfast to 2:00 p.m. and from 2-9 p.m. Patty fills in as needed. The EMT is on call overnight and a nurse will respond if requested by the EMT. The EMT is also responsible for the needs of conference guests.

Additional staffing for the summer includes three RNs and an EMT. The EMTs work 24 hours on and 24 hours off. The nurse's aide stays in the "on call" room if there are children staying overnight in the Center. A change planned for this summer is the addition of nursing aides. The intent is for the aides to help campers staying in the Center continue to get some camp experiences. They will be taking on the responsibility for nutrition, hydration, and appropriate activities, even taking recovering campers out for a walk.

For some programs, such as the After-School program, the nursing role is less direct. For these programs Patty reviews policies, assures access to emergency supplies and provides CPR instruction. She also addresses incident reports.

New Medication Planning

Along with the new Wellness Center, the 2008 camping season initiated a new prescriptive drug system for campers—an interesting plan. The plan called for parents to submit new prescriptions along with their health history forms and insurance information. The prescriptions were then filled in unit-dose packaging by one local pharmacy for the number of days campers would be attending. The main reason for this system was to improve safety in the receipt of camper medications and to facilitate dispensing. The new system worked quite well for its first year. The camp had an excellent longstanding relationship with the pharmacy but unit-dosing was a new joint venture to which the pharmacy was very committed. With reminders and encouragement, Patty's team realized about 75% parent compliance. One-on-one contacts were used to answer questions and facilitate the process.

Medications not in pill form, such as eye drops or inhalers, were sent to camp ahead of time by the parent or brought to camp with the camper. Originally the plan was to get these medications by prescription from the local pharmacy as well but for some parents this meant an unnecessary refill of an only occasional use drug so Patty decided to accept these items from the parent.

An issue arose for out-of-state campers as NY State regulations affected the prescription filling for out-of-state prescriptions. The process had to be modified. The parents were asked to have their pharmacy provide unit-dose packaging. Alternatively, we forward these prescriptions to our pharmacy for packaging. Frost Valley's programs are big and having already received the majority of medications prior to check-in day, having checked them against the camper's history and orders, and having them in unit-dose packaging facilitated both check-in and subsequent medication distribution. The pharmacist actually came to camp on check-in day with his packaging equipment to be able to facilitate late-arrival orders or packaging.

The pharmacist was also able to answer questions from parents or campers about the delivery system. For next year, Patty and her team plan to improve the parent education process to facilitate compliance. She is also quick to say she is well aware of what parents can and cannot get done before camp and therefore her preferred system has to be open to individual modifications.

School Program Health Services

The Wellness Center offers an interesting option to schools bringing their students for environmental education. This plan may be of interest to camp nurses whose camps have different user groups for short periods of time. Schools can elect to purchase the services of the Wellness Center while they are on site or they can elect to bring their own nurse to perform those functions. There are pros and cons to both systems.

There are well developed protocols and instructions in place to guide the schools in preparing to come and also for parents. There is a timetable to help schools plan their experience without leaving everything to the last minute. One particularly helpful handout for parents defines what constitutes a "sick child" and Frost Valley's policy on "sick children."

Patty's Experience

Patty has been at Frost Valley through one full year and then some. She has worked through the building stages of a new Wellness Center and its first season of operation. She says her greatest satisfactions come from being comfortable with what she does and with being able to introduce new ideas and services. She really likes being able to facilitate growth and change in a positive way. Like most of us, Patty's frustrations come sometimes with juggling home and work. Being able to "roll with the punches" helps through trying times! During this next year she would like to work on communications. She said it had been a major emphasis during her first year but that there is always room for improvement in working with campers and with staff. She has spent time trying to make forms clearer and easier to use hoping that will improve compliance.

Patty's hard pressed to find much at camp she doesn't like. But, when pressed, she'll tell you it's Ultimate Sicko ball—lots of twisted ankle and other minor injuries.

A fun place for her to visit at camp is the Farm Program. She likes the animals, collecting eggs, and interacting with the 46 kids who call this program home. Located about 20 minutes from the main camp, she finds this program great for kids who would not be as happy in a big multi-faceted program. Patty acknowledged she did not get out and about at camp this first summer as much as she would have liked. But, there's always next year!

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http://www.frostvalley.org

Susan B. Baird,, RN, MPH, MA is the editor of CompassPoint, official publication of the ACN. She is grateful to Patty Conklin for making time in her busy schedule to chat and to Karen Rauter, Marketing Director, for providing background and photographs.

Industry-Relevant Research for Camp Professionals from ACA
2009
Healthy Camp Update

Fatigue, MRSA, and the Use of Protective Equipment: New Insights From Year Three of the Healthy Camp Study

With continuing support from ACA Mission Partner, the Markel Insurance Company, the third year of the American Camp Association's five year national study of camp injuries and illness was completed in 2008 with 177 camps providing data. In this issue of the Healthy Camp Update, we explore three topics that have emerged as important in the injury and illness experience of campers and staff: fatigue, MRSA, and protective equipment.

When Get-Up-and-Go Has Got-Up-and-Went: Fatigue at Camp

Linda E. Erceg, R.N., M.S., P.H.N.

Although fatigue is rarely identified as the cause of an injury or illness, it can be a contributing factor. It shares this fame with elements such as hydration and nutritional status. In combination, this triad — the absence of fatigue plus good hydration and nutrition status — can make a difference in both a person's resistance to as well as recovery from injury-illness events.

Nutrition and hydration have enjoyed attention in the camp community. We take pride in nutritious meals and the ubiquitous water bottle appears everywhere. But fatigue has remained an enigma. Camp professionals anecdotally speak of tired staff and campers but no strategic plan to address fatigue has been developed. It's time to change that.

If one subscribes to the belief that being tired makes it more likely for injury-illness to occur, then one would expect that, as the day wears on and a person tires, one would tend to get ill or injured. Interestingly, summative data from the *2008 Healthy Camp Study* indicated this was the case for resident camp participants. Only 32 percent of resident camper injuries occurred between 8:00 a.m. – 1:00 p.m. as opposed to 61 percent occurring from 1:00 – 10:00 p.m., with a spike for both campers and staff between 4:00 – 5:00 p.m. It appears that fatigue may be a factor in the resident camp setting, with illness increasing as week one progressed. This was not the case for day camps. Injury events for day campers and staff were fairly balanced between a.m. and p.m. times. The "hot zone" for injuries in day camps was 10:00 a.m. – 12:00 p.m. (approximately 28 percent for campers and 36 percent for staff).

These data suggest that fatigue may be a factor in the expression of illness in camp. Beginning in 2009, new questions about fatigue will be added to the *Healthy Camp Study*. Once we have a better understanding of fatigue's role, we'll be in a better position to intentionally address its impact. Interestingly, fatigue tends to show up in a given person's demeanor quicker than in any injury or illness event. Campers and staff become short-tempered, and we speak of someone being "more of a beast than a beauty." Perhaps if we'd attend to these early signals and appropriately intervene when they occur, we could change the impact of fatigue much in the same way that we've improved nutrition and hydration states.

Protective Equipment: What's Really Happening in Camps?

Mary Marugg, R.N.

From goggles and sunscreen to shin guards and helmets, the use of protective gear is a routine part of the camp experience. But the results of the *Healthy Camp Study* paint a different picture. For example, in resident camps, applicable protective equipment wasn't being used in approximately 18 percent of camper injuries and 28 percent of staff injuries. Increasing compliance and consistency in the use of protective gear continues to be an important strategy for injury prevention.

Protective equipment includes gear for both recreation and the workplace. State law regulates safety equipment for campers and staff, and ACA standards address protective gear as well, so the framework is already established. Our challenge is to increase compliance with protective equipment guidelines. Increasing compliance

Continued on page 2 of the Healthy Camp Update

Methicillin Resistant Staphylococcus Aureus (MRSA): Dispelling the Myths

Edward A. Walton, M.D., F.A.A.P., F.A.C.E.P.

You've seen the headlines about school closings and cancelled athletic events. The media has had a field day reporting on the newest "Super Bug," Methicillin Resistant Staphylococcus Aureus, also known as MRSA. While MRSA can cause serious infections, and has certainly occurred at camp, with a little planning and common sense your camp staff can learn to prevent MRSA infections and recognize and prevent the spread of a MRSA infection if one does occur at camp.

The Emergence of MRSA

The emergence of MRSA is the result of antibiotic overuse since the development of penicillin in the 1920's. Antibiotics were requested by patients and prescribed frequently by doctors for infections for which they had no effect, including the common cold and the flu. The old saying is still true; there is no cure for the common cold. As a result of this overuse, common bacteria that live on our bodies all the time no longer respond to routine antibiotic treatment. One of these organisms is Staphylococcus Aureus. Staph lives on our skin and in our noses all the time. However, as a result of inappropriate antibiotic use, this common bug has become resistant to methicillin, an antibiotic that it was killed by in the past. Hence the emergence of Methicillin Resistant Staphylococcus Aureus, or MRSA.

Recognition of Infection

The classic description of a MRSA infection as a "spider bite" is inaccurate. Most parts of the country don't have spiders that bite. The infection starts as a small red bump that is swollen, red, and painful and may fill with pus or drain. The infection may start in a hair follicle on as the back of the neck, groin, buttock, armpit, or inner thighs, or in the area of a scrape or cut. In most cases the infection stays localized. Despite being resistant to some kinds of antibiotics, MRSA, if recognized early, is easily treated by other classes of antibiotics. It isn't as scary an infection as you may believe.

Prevention of MRSA Outbreaks

MRSA is spread by direct human-to-human contact in contact sports such as wrestling and football. MRSA can linger on surfaces for hours to days depending on the surface and environmental conditions. Common athletic equipment which allows the spread of MRSA, including helmets, athletic pads, exercise machines, and gymnastic mats, need to be treated frequently with disinfectants that kill MRSA and other types of Staph. An easy disinfection recipe is ¼ cup of regular household bleach in 1 gallon of water. Disinfection efforts should be concentrated on surfaces that come in frequent contact with skin. You don't need to "fog" entire buildings to kill MRSA, in fact these efforts are just silly. As soon as humans return to the space that has been disinfected, MRSA has returned as well.

Control of Infection

Despite good hand washing and infection control measures, MRSA may still appear as it lives naturally on many people. If a MRSA infection occurs the infected person should:

1. Be treated with antibiotics that treat MRSA.
2. Keep the infection covered.
3. Refrain from contact sports or activities which require close contact until the infection is healed.
4. Wash all laundry at regular temperatures with detergent, do not share towels.
5. Wash hands frequently with soap and water or alcohol-based hand sanitizer.

In many areas of the country MRSA has become the most common cause of skin infection. However, with good hand washing and thoughtful infection control and disinfection practices, you can keep your camp from becoming a "MRSA mess."

Continued from page 1

involves staff awareness of the equipment available, how to use it correctly, how to store and care for it properly, and the importance of consistent use.

Structured camper activities should include routines involving helmets, shin guards, and other protective gear written as policy. Monitoring the use of protective gear by campers should be part of the routine as well. When areas of noncompliance are identified, staff training can be targeted to those areas where protective equipment is not routinely used. Consistency in using the gear is the hallmark to preventing injury.

Staff work areas such as maintenance and the kitchen should be a high priority for training staff in the availability and use of safety equipment and monitoring the use of that gear. Train staff to understand that a quick job requires the same safety routines as a lengthy project. Although it's easy for staff to downplay the importance of eye protection, gloves, boots, and other gear when the task is "just" a short five-minute job, establishing protocols for the use of protective equipment and monitoring these protocols will help reduce injuries.

– Practice Sharing -
Let's Save Money!

Saving on Supplies

I usually get some supplies donated from my hospital. I save for camp things that the package says expired and are usually thrown out.

Camp directors could save more money if they planned ahead and bought supplies on sale. For my camp, we have to deal with the logistics of bringing the supplies to the camp's location and usually by plane. The directors usually depend on me to tell them what to buy when we arrive. This is not cost effective!

Robin in Florida

Focus on Basic Areas for Savings

I think we do a pretty good job of avoiding waste but I have thoughts about two areas we might work on.

First, the primary thing a nurse can do to save money for a camp is to help reduce staff absenteeism due to illness/exhaustion. Although most camps don't need to "hire a substitute" when staff are down with illness, it's harder to cover the campers. Either administrative or program staff have to fill in (and in the meantime, their jobs don't get done), or the group works short-staffed, which means an increased likelihood of accidents. Nurses can help to reduce staff illness/exhaustion by encouraging staff to come in as soon as there's a problem – before they're so sick or tired that they can't work. Nurses can help to ensure that staff members are getting adequate sleep and enough to eat (that's nourishing food, not a handful of Cheetos in the staff lounge).

Second, like many camps we spend quite a bit of money on gas and staff time as well – trips to the grocery store, taking the kids canoeing, picking up the mail, and so on. Nurses can be aware of when trips to town take place, and try to organize their needs around these trips. If you know you're almost out of ginger ale or elastic bandages, mention that to whoever does the purchasing and specify that there's no need for a special trip. If you do need something immediately, check in with the administrative staff and the kitchen to see if there are any other needs that can be taken care of at the same time.

Wendy Burton, RN BSN
Camp Menzies
Arnold, CA

Cheapskate Chap Stick

Frequent requests for chap stick? I put some petroleum jelly in a small plastic bag and stick a few short cotton-tipped applicators in the petroleum jelly. Campers can keep the bag in their pockets and use it when they need it—no mess and fewer visits to the Health Center.

Jane McEldowney, BS, RN, NCSN
Camp Sandy River
Corbett, OR

If you know someone who works in surgery, ask them to save the plastic containers from the 4x4 gauze. They can be used as individual containers for camper's medications. Put a label on the outside to identify and keep each camper's meds together.

Doris Nerderman, RN, BSN
Camp Belknap, NH

Great Free Communicable Disease Reference

Not sure the budget will stretch for a new text this year? A quick and reliable reference for communicable diseases may be found at http://www.hennepin.us/childcaremanual. This is the web address for the Hennepin County Health Department Communicable Disease Manual. This whole manual is available online with lots of professional as well as parent information and additional info from disinfecting to concerns for pregnant staff. The manual may be viewed by clicking under Related Links. This is a reference that is used daily within our school district, but would also be valuable for camp nurses to have as a reference or to access parent information sheets for communicable diseases.

Lynda Lankford, RN, BSN
Deerfoot Lodge
Adirondack Mountains, NY

Start with a Single Sock

Do you keep a sock drawer in the Health Center? Dry clean socks are just the answer in so many situations. You've treated a cut and cleaned up the dirty foot but can't bear to put the damp dirty sock back on. The camper is not wearing socks inside his sneaker but you want to keep the dressing clean and dry. You've redressed that knee, palm or elbow so many times and know a clean white sock could be cut to provide a protective bandage over the dressing. Most commonly, the camper can't find any clean socks and you really want a sock over the blister you've treated as well as wanting to prevent blistering on the other foot.

Make a colorful poster and put it in a visible place during Health Center check-in. A catchy slogan such as "Single Socks Needed" or "We Need Socks Without Partners!" will catch the attention of parents as they wait in line. Let them know that those single socks that end up in the bottom of the clean laundry basket each week would be perfect at camp. Many moms use camp as a good time to clean out kids' rooms and outgrown or unworn clothes. You can let moms know other items you could use such as outgrown rainwear. On pick-up day you'll get lots of socks, singles and pairs, to refill your drawer. You can also let the staff know of your need and they will bring you dirty ones left in cabins after campers leave. A good washing is all they need.

Susan B. Baird, RN, MPH
Editor, *CompassPoint*

Share from Your Practice !! Do you have ideas to share with your colleagues? Of Course you do!!

Practice Sharing is a regular feature of *CompassPoint* designed to share ideas. Tips for sharing need not be research-based but are just ideas you have tried and that others might find useful. Think about new uses for usual products, Health Center uses for household products, time-saving tips, handling difficult situations, or ideas you have tried for improving medication dispensing, documentation or paper-handling ideas. Camp nurses have the best ideas! When I ask colleagues why they have not thought about sharing their ideas through *CompassPoint*, they commonly reply either. "I thought everybody knew that." or "I really can't write." Well, put those ideas aside. I'll help you with both. Chances are your idea will be new to many and if you just send me an e-mail at nursusan2@aol.com, I'll do whatever is needed to put your idea into print.

Next Issue: Let's hear from you about any ideas for the 2009 season! Staff training? Check-in day? New Health Center Staff? Share your ideas with your colleagues.

– Keeper of the Kits -
Tips for Sore Throats at Camp

Mary Marugg, RN

Dry throats, red throats or white patches—we are all familiar with sore throats at camp. Sore throats may be an annoyance, caused by the dryness from exertion, and mouth breathing, especially in hot dry climates, or cold climates at high altitude. Or they may be the result of a viral infection, easily spread in the camp community. Usually viral sore throats resolve in 3 to 6 days without any therapy. They are a discomfort but are not a serious health concern. Streptococci bacteria also may cause sore throats. It is not the most common cause, but is potentially dangerous as it can lead to rheumatic fever which may damage heart valves or glomerulonephritis, a kidney disease. With all this in mind, how do you evaluate and treat a sore throat at camp?

A firm diagnosis of strep throat can only be made with lab tests, but there are assessments that a camp nurse can make that help the decision making process of whether or not to pursue testing.

Physical Assessment

Solid physical assessment is key to starting decision making. Strep often causes distinctive white patches on the throat and tonsils, and frequently tonsils are swollen and red with a strep infection. Temperature, skin appearance, and all the usual assessment parameters should be completed as well. Low grade fever of 101f or less often indicates a cold. A fever over 101f raises the likelihood of strep, although strep may be present with little or no fever. Coughing and sneezing will contribute to discomfort, but often point to a cold virus, and not strep. Lymph nodes in the neck should be assessed, as swollen lymph nodes point towards strep.

As a strep infection progresses untreated, a fine, red rough-textured rash may appear on the neck and chest, and then spread to the rest of the body. It appears 12 to 48 hours after the fever begins. When this rash appears, the infection is known as scarlet fever. The rash itself is not dangerous, and may be treated with antibiotics.

Indicators of Strep Infections

- Fever
- Exudates
- Enlarged lymph nodes
- General malaise

Rapid Strep Tests

Definitive diagnosis of strep requires lab tests. Rapid strep tests are available, and could be stocked at camp. A CLIA (Clinical Laboratory Improvement Amendments) waived test must be used. Results are available in 5 to 10 minutes. The tests do not pick up every case of strep, and a throat culture sent to a lab is much more accurate. Some considerations for stocking Rapid Strep Tests at camp include:

- To use the tests, guidelines from your medical advisor should be in place.
- Not all strep tests are created equally. In some regions of the country, a rapid strep test should be backed up with a 24 hour test. For most camps this means a visit to definitive health care in addition to the rapid strep test, so the expense of the a rapid test may be an extra expense not needed.
- Camp health insurance may weigh in on the decision, especially if the insurance company provides professional malpractice for the healthcare provider and/or is interested in the scope of care provided at camp.
- Parent opinion makes a difference at some camps. If this is a factor, making sure parents understand the limits of a quick strep may also be important.

Treatment

If strep is diagnosed, a course of antibiotics will be necessary. The camper or staff will feel much better within 24-48 hours. To relieve sore throat pain, there are several treatments that can be used based on your camp's treatment guidelines. Salt water gargle is very effective. One teaspoon of salt dissolved in a cup of warm water and then gargled will be very soothing. You may find that many campers do not know how to gargle and will have to be shown. Oral Ibuprofen or acetaminophen will also be helpful. Throat lozenges may be used, but results are usually are not very satisfying.

Camp nurses are great at the basics, and relying on basic assessments is how to approach care and treatment of a sore throat.

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New Products, New Ideas

Doris Nerderman, RN, BSN

■ **Community Acquired MRSA**

Community Acquired MRSA is becoming more common and is frequently seen in high schools and associated with sports activities and equipment. Certainly this is a possibility at camp as well and one to be avoided. VisualDxHealth is a very informative website. At this site you can also print out some great posters to use for education purposes. One poster that would be great for locker/shower areas is a poster "Rules for preventing infections in athletes." Go to www.visualdxhealth.com for information on MRSA and access to these posters.

■ **Effects of Meditation on AHDH**

The December 2008 issue of *Current Issues in Education* reports recent promising study findings regarding meditation as ADHD therapy. This study involved children ages11 to14 with ADHD. The children were able to learn to do the transcendental meditation and showed improvements in attention, working memory, organization and behavior control. Ongoing studies will continue. To learn more about the study go to the journal cited above or http://nlm.nih.gov.

■ **Itraconazole for Hard to Treat Asthma**

The January issue of the American Journal of Respiratory and Critical Care Medicine reports that the antifungal drug itraconazole has shown a positive effect in people with hard to treat asthma. Research continues but this raises questions regarding the relationship of fungal allergy and asthma. More information can be found at http://nlm.nih.gov.

■ **Second Hand Smoke and Behavior Problems in Children with Asthma**

The Cincinnati Children's Hospital Medical recently reported its study on the relationship between second hand tobacco smoke and behavioral problems in children with asthma. The 220 boys and girls participating were tested for cotinine, a nicotine byproduct. There was no link between the cotinine level and behaviors in the girls. Interestingly though, the greater exposure in boys showed external behavior problems such as hyperactivity, aggression and conduct disorders along with internal behavior problems like anxiety and depression. To read more go to http://www.nlm.nih.gov or Journal of Development and Behavioral Pediatrics, online December 4, 2008.

■ **A Clue to Colds at Camp?**

The Archives of Internal Medicine (January 12, 2009) reports recent study findings that you are three times more likely to catch a cold if you get less than seven hours of sleep a night. Additionally, it states that sleeping poorly makes you five times more susceptible. Does this explain the many cases of colds at camp each summer? Over the years, I've treated lots of colds at camp and have attributed this mostly to communal living and decreased cleanliness. I have also noticed that campers suffering with homesickness often develop colds during their camp stays. This seemed to happen so frequently that I would often comment that just when the camper seemed to be settling in and getting past homesickness they became physically ill. Frequently, homesick campers complain of not being able to sleep at night. This is often true of the first time camper and the younger campers as well. For specifics of the study go to http://www.nlm.nih.gov.

■ **Update on Peanut Allergy Research**

Chicago researchers have developed a mouse model for food allergy that imitates symptoms that appear during a human reaction to peanuts. The Director of the National Institutes of Allergy and Infectious Diseases will allow for better understanding of the allergy and allow for better treatment.

■ **Are You Ready for the New Inhalers?**

The familiar albuteral inhalers propelled by the chlorofluorocarbon are no longer being manufactured (as of December 31, 2008). They have been replaced by hydrofluoroalkane propelled inhalers. The old inhalers were bad for the ozone layer. These new inhalers have some differences that camp nurses need to be aware of:

- The fine mist results in not hearing or feeling the force of the spray so you might think the inhaler is not working.
- The new inhalers give better drug distribution but the user must inhale slowly and hold their breath.
- The user who uses a spacer will not notice any difference.
- To prime the canister, follows the directions on the package insert. *Be aware* that instructions are different for each brand and should be followed carefully.
- The fine mist from these inhalers tends to clog the canisters so manufacturers suggest cleaning once a week. *Be aware* that Instructions for cleaning differ by brand so consult individual inserts. *Suggestions:* Familiarize yourself with cleaning before an emergency occurs and the canister does not work properly.
- There is not yet a generic HFA inhaler. There are three brands of this inhaler: Proventil, Ventolin, and ProAir. Without a generic inhaler, the brand name inhalers are more expensive than the generic albuteral inhalers. You may want to take this into consideration when expecting parents to send a spare inhaler or when budgeting for back-up inhalers for the Health Center.

Each of the new inhalers has a web site where you are able to download coupons to help in the purchase of these inhalers: http://www.proairhfa.com, http://www.ventolin.com and http://www.hfa.com.

- Addendum: While researching this I learned that Walmart is carrying an HFA inhaler starting at $9--ReliOn Ventolin inhaler. This inhaler also has a dose counter on it (something that not all of the inhalers have). It contains 60 doses, not as many as some of the inhalers hold, but sufficient. Go to: http://www.walmart.com/pharmacy.

■ New Drugs that May Come to Camp

Several drugs approved by the FDA in 2008 may be seen this summer at camp. These include:

• Moxatag – An extended release amoxicillin tablet for adults and children over 12 years to treat strep throat. This is to be taken daily for 10 days.

• Alvesco – An inhaler of manmade corticosteroid used for the prevention of asthma attacks in adults and children over 12.

• Stavzor (Depakane) – A sustained-release tablet used for the treatment of seizures.

For a complete list of 2008 approved drugs, go to http://www.fda.gov. For complete information of the drugs listed above go to http://www.drugs.com.

■ Plastic Water Bottles

A *Connecticut Nursing News* article talks about breaking the bottled water habit noting bottled water is expensive and bottles are frequently not recycled. For those who thought you were recycling by refilling disposable water bottles, this article warns against this practice. Many commonly use plastics leach chemicals (those that are shown to be hormone disrupters and carcinogens) into the water. Plastics with these numbers on the bottom are leachers:

• #3 (PVC)

• #6 (polystyrene)

• #7 (includes polycarbonate hard plastic camping bottles)

Plastics #2, #4, and #5 are better but should be limited in use as well. Our efforts at camp have been on making sure there is adequate water intake with less emphasis on the actual water containers. Perhaps we could be the agents of change by using non-plastic containers when out and about at camp and consider talking to the director about types of water bottles sold in the camp store.

■ FDA Warning on Two Asthma Drugs

The risks of two widely used asthma drugs outweigh their benefits for both children and adults according to a December 2008 FDA warning: Serevent (salmeterol) and Foradil (formoterol). The FDA did not require they be taken off the market but warned that these drugs should not be used alone but rather in conjunction with inhaled corticosteroids. This means that you will probably see more Advair (salmeterol) or Symbicort (foradil) discus at camp. Both of these inhalers already contain corticosteroids. Find additional information at http://fda.gov.

■ Searching out Mercury Sources

The U. S. continues to phase out thermometers and blood pressure sphygmomanometers containing mercury. Mercury is a potent neurotoxin. Are any of these items still in your Health Center? If not knowing proper disposal is keeping them around, call your local disposal company to learn how. To read more about this subject go to http://www.noharm.org/details.cfm?type=document&id=2030.

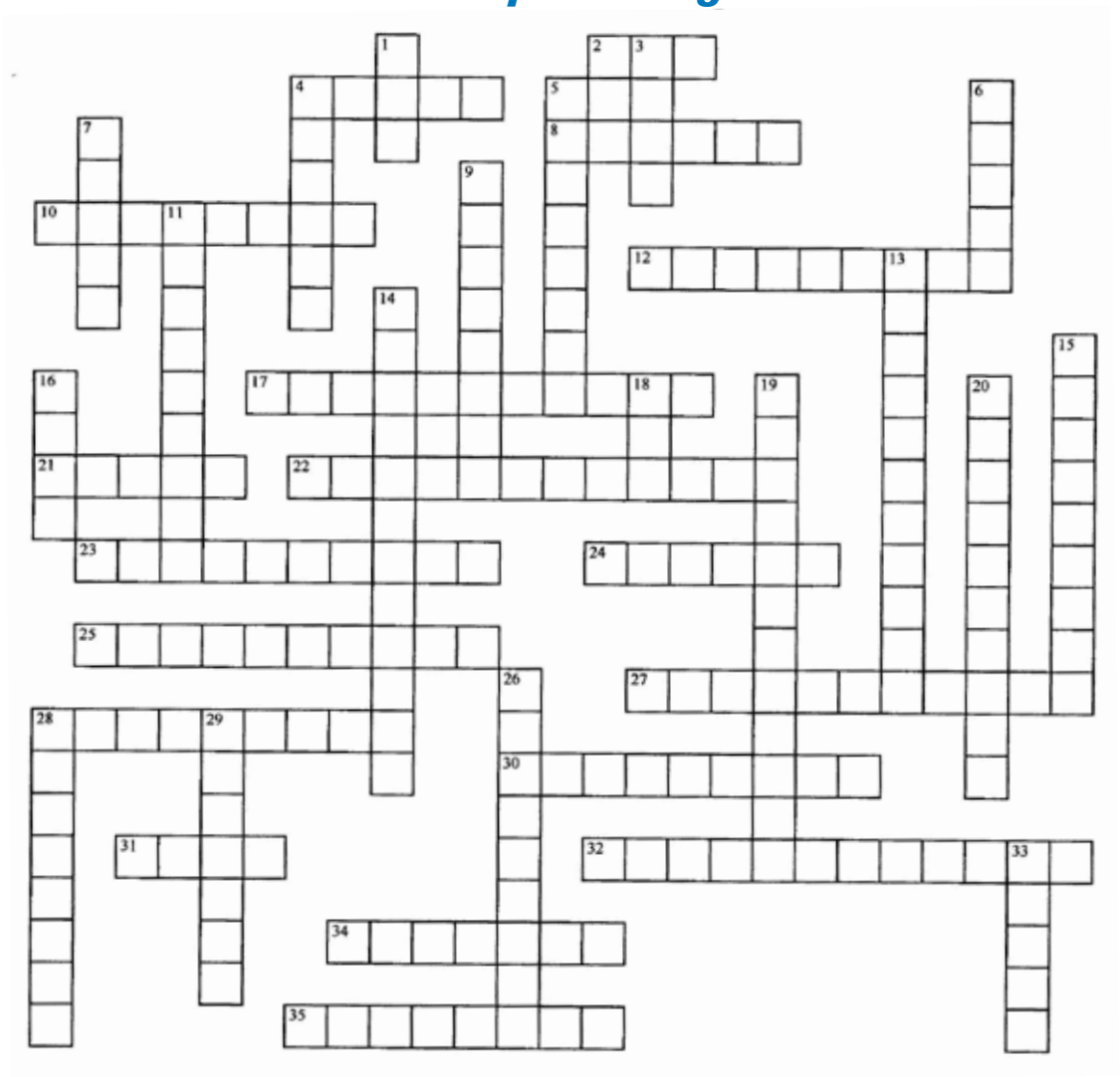
■ Two New Ideas for Staff Training

• Use the BeeGee's 70's hit song, "Stayin Alive" to practice the rhythm of CPR. The Annals of Emergency Medicine reports a recent study showing the song is useful in teaching CPR. The song's rhythm is 103 beats per minute which the American Heart Association says it is close to the optimal pace for compressions. Using this song could make learning more upbeat, fun and easy. How much more appropriate than the song "Stayin Alive?"

• EPA's Sunwise will be releasing a new online certification program for outdoor recreation staff to learn about sun safe behaviors and how to teach these to others. If you would like to be notified when this is available, email sunwise@epa.gov.

CALL FOR ASSISTANCE — IF ANYONE IS AWARE OF INTERESTING INFORMATION THAT THEY WOULD LIKE TO SHARE, PLEASE EMAIL ME AT dmn53@adelphia.net Your expertise needs to be shared. I am particularly interested in information regarding special populations.

Camp Nursing



ACROSS

2 Document of health care visits
4 Executive Director of ACN
8 Chronic respiratory disease
10 Used in ear exams
12 Camp physician's orders
17 Also called otitis externa
21 Where campers live
22 Where campers come for care
23 Members of ACN
24 Afternoon rest time
25 Document of camper's health information
27 #1 way to break chain of infection
28 Measured by SPF
30 Spreads urushiol
31 Signals it is time for bed
32 When campers with they were home
34 Camp where kids go home every evening
35 In charge of the camp

DOWN

1 ACN collaborates with the assn.
3 Founder of ACN
4 Used for anaphylaxis
5 We use them to cover wounds
6 Where campers sleep
7 #1 way to prevent dehydration
9 Camp where kids spent the night
11 Happens every spring in Chicago
13 Used for bacterial infections
14 ACN newsletter
15 Required within 24 hours of campers' arrival
16 Acronym for treatment of sprains
18 This assn
19 They go on hikes
20 Cabin cleanliness check
26 Keeps mosquitos away
28 Common pool/lake camp activity
29 Who we serve
33 Injured arm support

(D. Nerderman)

Association of Camp Nurses
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Association News

❖ Final Symposium Preparations Underway

Want to know what's happening? See the schedule for ACN's Camp Nurse Symposium, 28-29 March, by going to www.ACN.org and following the schedule's link. Speakers include well-know favorites like Patsy Gehring, Doris Nerderman, VJ Gibbins, Susan Baird, Rebecca Mitchell and Linda Erceg as well as several new presenters.

- Contact hours will be available to Symposium participants – earn up to 10 by attending Saturday and Sunday!
- This year's focus on legal and ethical implications of camp nursing practice will be underscored by the participation of Reb Gregg. Reb is a lawyer who has specialized in the recreational field. He's a regular speaker at the annual Wilderness Risk Management Conference and several ACA conferences. His articles have been published in *CompassPoint* as well as other journals. Join your camp nursing colleagues for what promises to be an exceptional Symposium experience!
- Lucy Pryor is gathering items for the Goodie Bags and Melissa Swank is working with the MidStates Exhibit Hall Committee so there's "value added" to your investment in this year's Symposium!

❖ It's Available!

The second edition of The Basics of Camp Nursing has been published and is available online from ACN's Camp Nurse Store. Go to www.ACN.org and follow the link today!

❖ ACN Members at Other Conferences

In an effort to increase awareness of health-promoting efforts, President VJ Gibbons celebrated a return to his Canadian roots with a January trip to join the camp nurses of the Ontario Camping Association's Healthcare Committee. VJ spoke at the event.

Executive director Linda Erceg helped present a pre-conference seminar on mental, emotional and social health at ACA's national conference in Orlando. Linda also collaborated with ACA staff member Barry Garth to deliver a session about the Healthy Camps research, partnered with ACN member Skip Walton for the Skier Insurance Ben Applebaum Forum, and hosted a "Bleeding, Breathing & Barf" break-out session about emerging health issues.

The Healthy Camps message will be delivered by Susan Baird at ACA's TriStates Camping Conference and at CampWest by Mary Marugg and Linda Erceg. Erceg will also present other topics at CampWest.

❖ Board Elections Scheduled for Late Spring

While ACN's current Board continues to work on its initiatives, the Association is also preparing a slate of candidates for member election this spring. The next edition of *CompassPoint* will include bio statements from the candidates. That will be closely followed by a mailed ballot. Be ready to return your ballot; your voice is important!