Camp Ho Mita Koda

Medical Manual

2023 Policies and Procedures

Approved May 2023

Mission Statement

Camp Ho Mita Koda Foundation's mission is to help children living with Type 1 Diabetes grow in mind, body, and spirit through an outdoor camping experience that strengthens their confidence and creates a community of peers.

Camp Ho Mita Koda Foundation
14040 Auburn Rd, Newbury Township, OH 44065
(440) 739-4095
Contact: *info@camphomitakoda.org*

Thank you for joining Camp Ho Mita Koda. We greatly appreciate your time and effort and are looking forward to having you on the Camp HMK 2023 team!

This manual has been developed to guide the medical staff in their tasks in managing diabetes and other health matters of campers during camp. Exceptions to these guidelines may be made at the discretion of the medical staff. The policies that follow may be helpful during other activities at Camp Ho Mita Koda, such as Teen Camp and Family Camp, but some of the information may not apply because the campers' parents are always present and solely responsible for the care of their children.

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Introductory Notes:

Open Communication

Throughout the campers' time at CHMK, clinic staff should stress that the campers must be engaged in their own diabetes care. Let them know we want them to be able to come forward at any time if they have questions or concerns about any changes made to their insulin dosage, rate, or schedule. This encouragement about open communication should be stressed whenever possible throughout the session and attempts to engage campers in dialogue should be ongoing. One goal of this engagement is to eliminate problems arising from campers independently and secretly giving themselves insulin boluses.

Camp for children with diabetes serves many purposes, which include:

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

Considerations

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

Healthcare Plan Review:

All Medical Staff shall review the Medical Manual prior to camp medical training. The review will focus particularly on the management of diabetes, but will also extend to all aspects of health maintenance and safety. Following the camp season each year, the Medical Committee will meet at least once with the Camp Healthcare Manager to review the policies and procedures in place and make recommendations for changes/improvements. The Attending Providers will take these recommendations under advisement when preparing the protocol for the subsequent year.

Healthcare Plan: Medical Aspects

- Camp Ho Mita Koda exists as a resource for children with diabetes who live in northeastern Ohio, surrounding regions, and across the United States.
- The medical care of diabetes and other direct healthcare matters is under the direction of the Camp Medical Director, who is a Pediatric Endocrinologist.
- The medical staff is comprised of physicians (MD/DO residents, fellows, and attendings), RNs, PharmDs, NPs, and PAs as well as medical assistants (students, EMTs, RDs, and

unlicensed certified diabetes care educators). The duties of the medical staff are included in the Koda Clinic team section of this manual.

- Each Camp session is assigned to a team of medical providers from a Northeast Ohio area healthcare system for the Ohio location and Michigan medical providers for the Michigan location, who provide medical supervision and overall management of the children's diabetes.
- Prior to arrival at Camp, each child's parent or guardian completes a medical history form. At intake, this information is reviewed, and the camper undergoes a targeted physical examination. At the conclusion of this intake evaluation, a diabetes care plan is created for each camper. In addition, a problem list is generated for any non-diabetes related problems that are necessary to treat or be aware of (examples: asthma, penicillin allergy, emotional problems). The medical provider gives guidance for the adjustment of insulin doses and other aspects of diabetes care, including emotional and behavioral disorders.
- Elective rotations are available for the following Healthcare professionals in training:
    - *Physicians in training (from certified residency/fellowship training programs in pediatrics, family practice, endocrinology, or internal medicine)*
    - *Student physicians, physician assistants, and nurse practitioners from CWRU School of Medicine or other institutions*
    - *Student dietitians (from RD training programs at Cleveland Clinic Foundation, University Hospitals, VA, Metro Health, and other area training programs)*
    - *Student nurses from CWRU or other institutions*
- Although there are many approaches to the management of type 1 diabetes, at Camp HMK we strive for safe blood glucose levels while minimizing the risks of serious hypoglycemic reactions.
- An electronic medical record is maintained for each camper through the camp season.
- At the conclusion of each camping session, parents will be provided with home-going instructions. They will be given the option to have details on any medical events and home going insulin doses emailed to them.
- Although we are capable of treating many minor illnesses and injuries, and even episodes of hypoglycemia at Camp HMK, hospital evaluation and treatment may be required. Children requiring a higher level of care will be transported to an appropriate medical facility. A camper's parent/guardian will be notified if a camper requires non-emergency medical transportation. The camper's parent/guardian is given the option of transporting the camper if they can arrive within a reasonable period of time. In the event of a serious injury or an illness precluding safe transport by the parent/guardian or camp staff, the Newbury Fire Rescue squad would be summoned to camp. We always attempt to have a member of the medical staff accompany the child to the medical facility.
- Because of the possibility of an abrupt, unexpected hypoglycemic reaction in any child with diabetes, many precautions are taken. Emergency kits are maintained and available for the detection and treatment of hypoglycemia at all camp activities. Regular

communications are maintained between the camping, dietary, and clinic staff, so that activities, meals, and insulin dosages can be coordinated.

- Training of camp and healthcare staff is arranged prior to the commencement of camp. Specific health-care topics are covered, and each staff member is signed off for each topic (e.g. recognition and treatment of hypoglycemia, prevention of blood-borne disease, use of blood glucose meters, insulin administration, and management of hyperglycemia/ketones).

Overview of Camp Ho Mita Koda

Founded in 1929 by Dr. Henry John and his wife Betty John, Camp Ho Mita Koda is the oldest operating summer camp in the world for kids with T1D!

Located outside of Cleveland, Camp Ho Mita Koda welcomes boys and girls in grades K-11 for one-week sessions during the summer. Additionally, CHMK serves as an asset to the community and hosts informational teen weekends, family programs, rentals, community events, and many more programs aimed at spreading awareness of T1D and providing support to countless families and campers.

In 2023, CHMK also opened a second location in Metamora Michigan.

For more information on the history of camp and our current program offerings, please visit our website: https://www.camphomitakoda.org/

Location

Camp Ho Mita Koda is located on 72 private acres 45 minutes outside of downtown Cleveland in the small town of Newbury Township.

14040 Auburn Road
Newbury, OH 44065

Contact Information

Main Phone: (440) 739-4095

Ian Roberts, Executive Director: ian@camphomitakoda.org

Alex, Operations Manager: alex@camphomitakoda.org

Jamie Wood, Medical Director: Jamie.wood@uhhospitals.org

What does a day at camp look like?
During camp, you will get to help with mealtime insulin dosing, carb calculations, treating high and low blood glucose, monitoring glucose at various activities, and reviewing glycemic data daily with endocrinologists. You will also have the opportunity to evaluate and manage lots of non-diabetes injuries and illnesses that can occur during camp.

You will be given a schedule each day to work alongside our campers and other medical staff. Most days your schedule will start before breakfast around 7:30 am. You will be with the campers at various activities and mealtimes throughout the day. You are encouraged to participate with the campers in their activities as much as feasible. After dinner you will help implement any dose changes recommended by the endocrine specialist, adjusting pump settings. Our days wrap up with an evening all-camp activity, during which much of the medical staff has a bit of a break. A few are needed for bedtime insulin administration, and the night team reports at 7pm. These long days are packed solid with fun!

SAMPLE CAMPER DAILY SCHEDULE (Monday-Friday)
Check-in Day (Sunday) and Check-out day (Saturday) follow a different schedule

7:15 a.m. First Bell

7:30 a.m. Rise & Shine!
Early rising campers kickoff the day with an optional camp activity. From yoga to fishing and other recreational activities, there's no better way to start the day.

7:30 a.m. Glucose monitoring and Insulin administration

8:15 a.m. Breakfast
The most important meal of the day, often served with sides of bacon – one of our campers' favorite foods – and dancing.

9:00 a.m. Prep for the Day

9:20 a.m. Flag Raising and Daily Kickoff

9:30 a.m. – 11:40 p.m. ACTIVITIES!!
Campers rotate through two activity blocks and enjoy art, the challenge course, drama, fishing, nature and discovery, canoeing, kayaking, and more!

11:30 a.m. Glucose monitoring and Insulin administration

12:00 p.m. Lunch
After a fun-filled morning of activities, it's time to groove for your food, refuel, and share stories. And then there's time for lots and lots of singing as a group.

1:10 p.m. – 3:40 p.m. ACTIVITIES!!
Because activities in the morning aren't enough, there are even more activities offered in the afternoon. From rotating to the activity areas or participating in an all-camp activity like Silly

Olympics, imagine lots of messy, silly, crazy, wacky, and paint-filled festivities. There is also a snack in the afternoon.

3:40 p.m. Cabin Time
Some of the best time is spent in the cabin sharing stories from the day, playing games, dancing, and enjoying new friends before dinner and evening activities.

4:00 p.m. Afternoon Rotation
Campers rotate between open swim, the trading post, and shower time.

5:30 p.m. Glucose monitoring and Insulin administration

6:00 p.m. Dinner
Can you say No-Hands Spaghetti Dinner? Utensils are sometimes optional at dinner as entire meals are eaten without your hands. And, of course, dinner is followed by dancing, dancing, and more dancing!

7:00 p.m. Evening Activity Prep

7:15 p.m. Flag Lowering

7:30 p.m. Evening Activity
From Cabin Night to the ever popular Stage Night, campfire, and more, evening activities provide yet another opportunity for camp fun either as a cabin or an entire camp.

8:40 p.m. Cabin Chat / Glucose monitoring and insulin administration
Following a day of busy activities, it's time for reflection in a safe, respectful environment. Cabin Chat provides a special opportunity to share and reflect, helping campers recognize their strength and the commonality they share with others.

9:15 p.m. Snack

9:30 – 11:00 p.m. Lights Out (depending on age)
Bedtime! Lots of rest is needed to prepare for another fun and exciting day at camp.

What to bring
Leave your scrubs and business casual clothes at home, and dress "camp casual". More information on the CHMK Dress Code can be found on the online portal as referenced above.

Activities at camp

- Waterfront: Canoeing, kayaking, stand-up paddleboarding and fishing
- Field: Kickball, baseball, tetherball, soccer, Gaga ball, team sports, etc.
- Courts: 9-square, basketball, wall ball, can jam, spikeball, etc.
- Adventure: High/Low ropes challenge course, teambuilding, and rock climbing
- Outdoor Education

- Paintball & Slingshot Range
- Archery and Tomahawk throwing range
- Swimming Pool and Volleyball Court
- Hammock Village and Treehouse
- Arts and Crafts
- Mountain biking
- Hiking, backcountry cooking, and hammock camping

Meals

During camp, you will be provided with 3 meals and 3 snacks per day. If you have any dietary restrictions, please let us know as soon as possible and we will do our best to accommodate you. Of note, there will be gluten-free options available at every meal and snack.

Expectations for Medical Staff

At Camp Ho Mita Koda, we are accredited by the American Camp Association and licensed as a State Child Care facility. There are many rules and regulations that we must follow to maintain our standing. Once you have committed to CHMK, you will be asked to complete the following prior to starting work at camp:

- Completion of the CHMK Specific Application: This allows you to get into our system where we store important information as required by the state.
- Completion of an online background check.
- Completion of an Online Child Abuse Awareness Training.
- Completion of pre-season staff training as required.
- Completion of all required volunteer onboarding paperwork.

Unless all pre-camp requirements are completed in full, you will not be able to work at camp this season.

***Prior to volunteering at camp*, you will be required to attend or complete medical staff training at Camp Ho Mita Koda. This is mandatory training as required by the American Camp Association and State of Ohio.**

By attending training in-person, you will get to meet other medical & field staff, play games, do hands-on training, learn the computerized charting system, and become familiar with camp. Of note, you may stay at camp overnight during training.

If you are unable to attend staff training, you can complete an alternate training assignment in the form of online modules. These modules must be completed in full and you must pass the

online quiz before the camp season begins. This must be cleared by the Education Coordinator. In short, no training = no camp.

FAQs

Can I camp for only some nights?
We prefer all staff to stay on site for the duration of their committed time at camp unless work/school obligations require them to leave. However, we are willing to work with our staff and provide accommodations as appropriate. You are invited and encouraged to join our campers and staff to sleep outside in hammocks 1-2 nights per session.

Are showers available at camp?
Yes! You can always take a dip in the pool or lake to rinse off too!

Can you accommodate my dietary restriction or allergy?
Our Dining Service team is able to meet a lot of needs, so please advise your director of any dietary needs/restrictions. While we can do a lot, we can't guarantee your requests so please check with us ahead of time!

What if the weather is cold/rainy/etc.?
The show must go on! We will continue to have an awesome time camping, eating, and training together, no matter the weather. Please practice Leave No Trace rule #1 by planning ahead and being prepared with proper gear, clothing, and plenty of extra layers.

Where can I learn about the programs?
Check out our website for more information on a specific location or program.
https://www.camphomitakoda.org/

Is CHMK Right For Me?

We fully understand that camp is not the right fit for everyone. In order to be successful here, you must love children and the outdoors. We expect you to interact with the campers and staff. You must be able to communicate effectively, work as part of a team, and be flexible!

Remember, this is not a hospital environment. We do things differently at camp. We want to meet your expectations, and vice versa.

If you have any other questions, reach out to our Healthcare Manager and we will gladly help you out.

General Responsibilities:

Koda Clinic Team

Camp Ho Mita Koda is a collaborative environment; this also applies to all medical staff. Our goal is to keep the campers out of the clinic and in their activities. In the event of an illness, evaluation will be performed at the clinic. Minor illnesses will be cared for at camp. Major illnesses and other problems, such as fractures and lacerations, will be cared for at a local hospital. Parents do not need to be notified of a minor illness, but will be called for major illnesses/problems, including any time a child has to be taken to any outside medical facility. The medical staff is available 24 hours a day for emergencies. All routine medications are dispensed by a licensed healthcare provider (registered nurse, nurse practitioner, physician or pharmacist).

Medical Director and Senior Medical Staff

Medical oversight, supervision, and policy for Camp HMK are carried out by medical providers who are experienced in all aspects of medical care of children with diabetes. A roster of the providers volunteering at camp will be maintained at the Koda Clinic during the camp season.

One or more medical providers who specialize in diabetes management from surrounding healthcare systems will supervise each camping session. If more than one provider is assigned, they will coordinate the responsibilities among them, so that all days and times of the session are covered. These tasks include participating with camper intake history and physicals (as needed/if not completed prior to check in) on the first day of the session and developing a diabetes management plan for each camper. Orders will also be written for the care of non-diabetes related medical problems, as indicated. A supervising provider will be available to the on-site medical staff for consultation at all times. This may be by phone, when required.

Medical providers will systematically review campers' glucose/insulin records and any other health issues daily or on alternate days, at the discretion of the supervising medical provider of each session. Rounds are typically in the afternoon and may be performed in-person or remotely via review of the Electronic Medical Record (EMR) system, as available. Adjustments to the campers' insulin doses will made as needed during the camp session. The supervising provider will assure that the healthcare staff has their current office, home, and cell phone numbers. The camp medical director, or his designee, will be available for backup to the attending throughout the summer sessions.

Scope of Practice: Delegation of Tasks to Unlicensed Personnel (Koda Clinic assistants):

Koda Clinic assistants are an important part of the Camp HMK Clinic Team and collaborate with licensed staff. It is important that all team members understand the role and scope of clinic assistants to ensure camper needs are being safely met within all applicable laws and rules governing nursing and medical practice. The following policies have been derived utilizing both

the Ohio Revised Code and the Ohio Administrative Code after extensive review, collaboration, and discussion amongst Camp HMK Clinic Team members.

Insulin Dosage Calculation

1. Clinic assistants are trained by licensed healthcare staff how to calculate various types of insulin dosages per physician orders.
2. Clinic assistants utilize this knowledge to assist licensed personnel to confirm the correct insulin dosages specific to each camper. At least two trained staff must calculate each insulin dose prior to administration via injection.

Insulin Administration

1. Clinic assistants may supervise and assist in the administration of insulin to campers who have been deemed capable of safely self-directing his or her own insulin administration, including via subcutaneous injection and subcutaneous insulin pump infusion. The camper must show the dose (on the insulin pen/syringe or as calculated by the pump) to the assistant for verification prior to self-administering.
2. Clinic assistants may directly administer subcutaneous insulin injections or perform treatment/care for an insulin pump therapy site only AFTER being signed off as competent by the Healthcare Manager.

Insulin Pump Settings

1. Clinic assistants may supervise and assist campers to enter physician ordered data regarding insulin pump settings into their individual devices. All entered data must be verified by a licensed healthcare provider prior to implementation of any setting changes.
2. Clinic assistants may not make changes to insulin pump settings independently.

Emergency Medications

1. Clinic assistants are trained in proper preparation and administration technique of epinephrine via an Epi-Pen in the event of an anaphylactic reaction in a camper or staff member secondary to exposure to an allergen.
2. Clinic assistants are trained in proper preparation and administration technique of Glucagon via injection in the event of a severe hypoglycemic reaction in a camper or staff member.
3. In the event of either an anaphylactic or hypoglycemic reaction, clinic assistants are expected to properly implement provided training to provide necessary emergency care.

Oral Medications

1. See attached delegation laws.
2. Licensed medical staff dispense home prescription medications and over the counter medications to campers.

Topical Medications

1. Clinic assistants may apply OTC topical medications to intact skin only.

Documentation

1. Clinic assistants are expected to document in the medical record all clinic-related interventions (including supervision of insulin administration and assistance with pump setting changes) provided to campers.
2. All documentation performed by clinic assistants must be reviewed and cosigned by a licensed healthcare provider.
3. Any documentation discrepancies must be addressed immediately; failure to resolve any noted discrepancy needs to be reported to the Healthcare Manager.

Questions/Concerns

- All questions and concerns regarding an individual's scope of practice shall be addressed in a timely manner by appropriate clinic team staff.
- If an individual is in doubt regarding his/her legal ability to perform a specific action regarding medical or nursing care/treatment and the current situation is not emergent, then the individual is responsible for notifying the Healthcare Manager. If the concern cannot be addressed at that time, the duty to be performed should be completed by a licensed staff member legally capable of performing the task until scope of practice can be verified.

Policy written and effective June 2013. Updated April 2023.
Sources: *Ohio Revised Code Chapter 2305.23: Liability for emergency care. Ohio Administrative Code Chapter 4723-13: Delegation of Nursing Tasks*

<u>Koda Clinic Staff Responsibilities:</u>

Guidelines for opening/preparing the clinic during staff week

1. Clean the clinic including all rooms and cabinets/counters.
2. Wash bed linens and make beds. Change after each use and session.
3. Check all cabinets for expired medications and supplies. Discard any expired and update inventory on Sortly (our electronic inventory system).
4. Unpack and stock all supplies.
5. Inventory all supplies in the clinic. Document inventory log in Medical OneDrive.
6. Take insulin pen/vial inventory after each session and at the end of the season.
7. Check all red bags/emergency kits. Remove any expired items and restock.
8. Ensure scale (electronic and weighted) is working properly.

Preparing camper-specific materials prior to first session

1. Healthcare Manager will update the EMR with new information and ensure all data has been entered completely and accurately for each camper.
2. Contact families as needed for missing information prior to session.

3. Make camper labels as necessary with the small label maker after receiving camper names and cabin assignments from the Camp Director.
    a. Labels for all camper glucometers
    b. Labels for camper pumps

Camper Check in Day Schedule (Subject to Change):

Campers arrive on Sunday of their scheduled session.

11:30 AM
Staff Arrival

12:00 PM
Brunch in Great Hall
Healthcare Manager to attend counseling staff meeting

1 PM- 3PM
Campers arrive (arrival times are staggered)

4 PM- 5PM
Clinic staff member at pool for counselor swim tests

5:30 PM
Glucose checking / insulin administration

6:00 PM
Dinner

7:15 PM
Flag lowering

7:30 PM
Opening Campfire

8:45 PM
Glucose checking/bedtime insulin/snack

10 PM
Lights out!

1 AM
Glucose checking in cabins by clinic staff

4 AM

Glucose checking in cabins by clinic staff, if needed

Check-In Day Guidelines - Check-In Passport

Prepare & staff each check-in station

1. Medical provider reviews current dosing/pump settings and recent data that was entered by parents and the Healthcare Manager (HCM) during camper registration.
2. Medical provider discusses changes briefly with family/camper and finalizes updated orders in EMR and with the clinic staff checking in the camper.
3. Get the final Camper List from the Operations Manager.

Final Checks

1. Once check in stations are complete, 2nd clinic staff/HCM will ensure all dosing changes are documented, all camp profiles and settings are updated and initiated.
2. Second staff will sign off in EMR that the final check was completed.

Camp Ho Mita Koda Check In Passport

NAME_____ CABIN_____Session_____

Red station first, Blue station last.

Exam Station - Counselor

- Photo of Camper
  - *In campviews> Check In tab > Blue "Take Picture" button*
- Lice Check
- Foot and Skin Check (list any findings here):
  _____
- Weight _____lb

Insulin Adjustment Station - Medical Provider

- Review home settings and calculate camp settings
- WRITE this info CLEARLY on Paper Form (separate forms for Injections vs. Pumps)
- Program pump with CAMP settings (if applicable)
- Providers immediately hand completed form to "Camp Setting Entry" Clinic Assistant so they can enter into EMR
- **Camp Settings Entry to Top Profile - Clinic Assistant**
  - Update Top Profile. Click on any cell in flowsheets and enter the following
    - CAMP Correction Factor (AKA Insulin Sensitivity Factor, ISF)
    - CAMP Carb Ratio
    - PUMP only: Pump Type
    - PUMP only: CAMP Basal Rates
    - Short Acting Insulin type
    - Injection ONLY: Long Acting Insulin type

- Injection ONLY: "Time Given" (Fill in dose and administration time of any long acting insulin, with time options of breakfast, lunch, dinner, or evening snack).
- Once info is entered, put Paper Insulin Order forms in each cabin's clear bins with pump supplies.

Medication Station – Licensed Staff +/- Clinic Assistant (for charting)

- Turn in all home meds (We do not need any over-the-counter meds to take "as needed" such as ibuprofen since we provide these)
- If not done already, label each medicine bottle with the camper's name. If more than one med, place medications in ziplock bag labeled with camper's name
- *Campviews: Enter each dose in "Medical Check In" tab of Campview*
- *Campviews: Write note at bottom of logsheets with what meds were left.*
- Any allergies to food or medicine? (Document allergen & reaction)

  _____
  - Give wristband with allergy written on it
- *Campviews:*
  - *Enter weight in Camper Tab (need laptop to see this)*
  - *Double check allergies (listed in Medical Check In Tab). If new allergies identified and camper does not yet have the symbol by their name, tell the Healthcare Manager to add the symbol to their name in CampViews (I.e. nut, milk, pork, gluten free, pills)*

Supplies & Site Change Station

- Supplies for Pump and CGM
  - Turn in all Pump and CGM supplies.
    - Parents do not need to provide any insulin, ketone strips, or meters.
  - Label supplies with camper's name & place in ziplock bag
  - *Campviews: Add note at bottom of logsheets with what supplies were left.*
- Site Change
  - When is next CGM change due? _____ or N/A
  - When is next pump site or omnipod change due? _____ or N/A
  - *Campviews: Site Change Tab (Pink) > Schedule Site Change > Enter date of change.*
    - *If pump/pod AND CGM need changed at some point enter each*
    - *If change is AFTER camp, no need to log this.*
    - *(ONLY on tablet and phone as the Campviews app has more capabilities than the web browser)*

Device Station

- For any CGM Receiver/Phone:
  - Label with Camper's name
  - TURN off passcode OR CHANGE passcodes to 1929 if 4 digits, 192900 if 6 digits (year camp was founded!)
  - **STOP SHARE** with each person individually (do not stop ALL sharing)
  - Set ALARMS – low alarm to 90, high alarm to 350.

    - Turn up Alarm volume
- For any PDM:
    - Label with Camper's name
    - TURN off passcode OR CHANGE passcodes to 1929 if 4 digits, 192900 if 6 digits (year camp was founded!)
    - Collect Onmipod PDMs (Except for Omnipod 5) and put in proper cabin's Meal Time Handle Baskets
        - (DIY Loop and Omnipod 5 remotes stay with camper in the "CGM" pencil pouch
- Keep a list of kids with tubed pumps (Tslim and Medtronic)

General Clinic Staff Responsibilities during Sessions:

1. Prepare for check-in and check-out days (see Camper Check-in and Check-out sections).
2. Making contact with campers when they come to the clinic, performing necessary exams, solving simple problems, keeping accurate records.
3. Hypoglycemia episodes must be recorded on the camper's glucose log chart. Any PRN glucose checks must be recorded in the camper's chart.
4. For more complex problems for which continuing care is required or are more detailed, complete note in EMR.
5. Documentation of the following (by specific types of staff):
    a. All glucose values (MD, NP, RN, PharmD, clinic assistant (CA), counselor).
    b. Ketone results (MD, NP, RN, PharmD, CA, counselor)
    c. Insulin doses (MD, NP, RN, PharmD, CA with licensed professional).
    d. Pump site changes (MD, NP, RN, PharmD; CA can document "witnessed by" if the camper is capable of their own site changes).
    e. Hypoglycemia and hyperglycemia treatment and follow up per protocols (MD, NP, RN, PharmD, CA, Counselor).
    f. Illnesses and treatment, to whom it was reported and at what time (MD, NP, PharmD, RN).
    g. Medications dispensed to campers from the clinic by a licensed healthcare provider.
6. Maintain a watch list that tracks campers with high/low glucose for assigned campers and ensure follow-up checks are done per protocols outlined in this manual.
    a. A watch list will be provided from each cabin's clinic staff to the night staff when they take over.
    b. Document in EMR: First Name, Last name, Cabin, time of latest check, latest glucose, latest ketones, and time of next check.
7. Maintain Watch Board (middle room) which lists Medical Issues/Allergies.
8. Maintain list of when infusion set changes are due on White Board in Koda Clinic.

In-clinic staff (licensed, by rotation)

- Medications will be logged in EMR before Check-in Day, and camper meds will be stored in locked cabinets in the clinic.
- Restock supplies, clean contaminated materials/surfaces, and prepare educational sessions and bulletin boards in the clinic.
- Remain in the clinic during assigned rotation.
- Have walkie-talkie and/or phone for contact at all times while assigned.
- Provide assessment and treatments as needed.
- Complete infusion set and CGM changes as needed.
- Administer OTC medications as needed per standing orders.
- Clean clinic as needed.
- Monitor campers that need to stay in the clinic related to illness, moderate-large ketones, hypoglycemia, etc.
- Retrieve staff medications/supplies as necessary.
- Communicate with HCM any needs, issues, or incidents in a timely manner.
- Document scheduled meds, pump site changes and PRN meds in EMR.
- *Other duties may be assigned.*

Appropriate handling of medical waste

- All used lancets and needles will be deposited in medical sharps containers.
- Filled sharps containers will be placed in large hazardous waste boxes and sealed.
- Under no circumstances will any staff member re-cap needles.
- Gloves must be worn when performing or assisting with blood checking.
- Blood spills will be cleaned with a 1:10 bleach solution (available in the clinic).

Check-Out Day:

Check-out occurs on Saturday morning of the session. The following are clinic staff responsibilities in preparing for and during check-out time:

1. Ensure all records are complete in EMR and ready to be emailed.
2. Home-going instructions with reminders for pump settings changes (completed by covering provider).
3. Release found in EMR, parent signature obtained on paper.
4. Put pump supplies and insulin pens in plastic bags labeled with camper names.
5. Details of supplies used during the session will be provided in the emailed report.
6. Check the med box for any medications that need to go home with the camper.
7. Put all camper supplies in bins for each cabin.

When parents arrive:

1. Provide home-going instructions. Direct all parent questions to the supervising provider or HCM as appropriate.
2. Ask if they want to be emailed a copy of their child's medical record while at camp.
    a. If yes, ask for their email and enter it into EMR system
3. One clinic staff member from each cabin will return supplies and meds to parents.

Night Shift Responsibilities:

- 7 pm: report to clinic for night shift meeting
- 7-10 pm: float to assist with whatever needed
    - Someone in clinic for evening activity
    - Assist with pump/CGM changes
    - Run supplies to cabins as needed
- 10 pm: receive report from day staff by cabin. Make note of any high/low glucoses at bedtime snack that need to be rechecked at 1am
- 10 pm-1 am: hypoglycemia management PRN
    - Campers' glucose will still sometimes drop after snack. Counselors will call in reports of lows. Run any needed hypoglycemia treatment supplies to cabins and ensure the follow up checks are happening.
- 1 am: glucose checks per protocol (see section below)
    - Take glucose check list and necessary supplies to the cabins. Find campers using the cabin's bed chart, check glucose, and follow camp's policy for treating hypoglycemia/hyperglycemia at night.
    - While in the cabin, observe other campers for signs of hypoglycemia such as thrashing, lip smacking, and profuse sweating. Check glucose on any camper you are not sure about. Campers with alarming CGMs must also be attended to. Call licensed staff/supervising provider with any questions or concerns.
- 4am: glucose checks per protocol (see section below)
    - Repeat the same procedure for glucose checks in cabins using a new list of campers with low or high glucose at 1 am.
- 7:15am: give report to day shift/HCM

Tasks to be completed anytime during night shift:

- Counselors may call in for help with CGM alarms or out-of-range glucoses at any time.
- *After midnight*: make mini glucs using 2 glucagons and label with expiration date (24 hours after mixed)
- Restock backpacks and tackle boxes
    - Alcohol swabs
    - Lancets
    - Glucose tabs
    - Mini glucs (REPLACE!)
    - Meters
    - Test strips
    - Ketone strips
    - Band-aids
    - Cotton balls/ gauze
    - Check that sharps containers are not full / replace if needed

    - Empty trash from backpack/ replace clear plastic bio-hazard bags that we use as trash bags
- Restock mealtime supplies
    - Alcohol swabs
    - Insulin pen needles
    - Glucose tabs
    - Meters
    - Strips
    - Lancets
- Charge PDMs in clinic
- Clean clinic: sweep, wipe down counters, & tidy up
- Document fridge temp
- Calibrate & clean all clinic meters (from boxes, backpacks, table) as needed per meter requirements
- Control testing as needed per meter requirements
- Prepare for the next day pump site changes.
    - Identify which pumpers need a site change by flagging in EMR.
    - On a white label, write the camper's name, cabin, type of insulin pump, and type of insulin. Place it on a plastic bag.
    - In individual bags, place following items from the camper's personal supplies: infusion kit, any needed insertion device, wipes, and cartridge/reservoir.
- Monitor any campers that need overnight stay in clinic
- Communicate with on call / supervising provider as necessary
- Communicate with HCM any issues, needs, or incidents in a timely manner
- Prep for discharge (Fridays): put all camper meds and supplies together in cabin bins to go home

Bedtime Insulin Protocol:

HCM: decide if the day was active or inactive and communicate to clinic staff

- AID systems at bedtime: always enter in all carbs (actual amount) and glucose level in bolus calculator and administer recommended dose
- If not on AID: Use chart
- Second helpings at bedtime snack should be avoided

GLUCOSE LEVEL →	**< 150**	**150-220**	**>220**
ACTIVE DAY or ACTIVITY after Bedtime Snack	NO carb coverage or correction	HALF carb coverage, NO correction	HALF carb coverage + FULL correction

INACTIVE DAY	NO carb coverage or correction	FULL carb coverage, NO correction	FULL carb coverage + FULL correction

Night Glucose Check Protocol

At any point after 10:00 PM

- Cabin counselor to alert staff when camper's glucose is below 100 (or less than 120 with down arrows) or above 300

1:00 AM

WHO:

- Any camper with glucose >300 at bedtime/ evening snack check
- Any camper with glucose <100 at bedtime/ evening snack check
- Any camper with glucose <100 between bedtime/evening snack and midnight check
- Any campers who participated in physical activity (e.g. night hikes) after bedtime/evening snack check
- Campers with a CGM alarming
- PRN based on Medical Staff concern
- ALL CAMPERS on the first night of camp and at the discretion of the HCM

ACTION:

- If glucose is still over 300, check for ketones and follow hyperglycemia protocol.
- If glucose <90, treat with glucose tabs until >90, then give PBG/Ensure.
- If glucose between 90 and 110, give PBG/Ensure.
- Add any camper that needed treatment to the 4 am check list.

4:00 AM

WHO:

- Campers with glucose <100 at 1AM to make sure glucose stays >100
- Campers with glucose >300 at 1AM
- Campers with a CGM alarming

ACTION:

- If glucose still over 300 or if elevated ketones previously, recheck for ketones.
- If glucose >300, provide correction per hyperglycemia protocol.
- If glucose <90, treat with glucose tabs until >90, then give PBG/Ensure.
- If glucose between 90 and 110, give PBG/Ensure

Emergency Kits / Supplies for Activities:

Activity Bag:

- Walkie talkie (One Per Activity Group)
- Blood glucose meters (2)
- Blood glucose meter strips (3 vials)
- Blood Ketone Strips (1 vial- Used During daytime to verify positive urine ketones and for all Nighttime Ketone Checks)
- Ketostix (1 bottle)
- Disposable lancets (1 bag)
- Alcohol pads (1 box)
- Epi-pen (Jr + Adult)
- Glucose tabs (2 bottles)
- Glucose gels (3)
- PBGs/ Celiac snacks/ Nut free snacks (Grab from Kitchen Daily)
- Mini-gluc (2)
- Glucagon (1)
- Band-Aids (1 box)
- 4x4" sterile pads (3)
- Tape 1" (1 roll)
- Disposable gloves (3 - 5 pairs)
- Ziploc bag for regular garbage
- Sharps container (1)
- Ink Pen
- Tissues
- Pad of Paper

Tackle Box:

- Blood glucose meters (8)
- Blood glucose meter strips (6 vials)
- Ketostix (1 bottle)
- Disposable lancets (2 bags)
- Alcohol pads (2 box)
- Epi-pen (Jr + Adult)
- Glucose Tabs (4 bottles)
- Glucose gels (5)
- Glucagon (2)
- Band-Aids (1 box)
- 4x4" sterile pads (3)
- Tape 1" (1 roll)
- Co-band (1 roll)
- Disposable gloves (3 - 5 pairs)
- Ziploc bag for regular garbage
- Ink Pen

- Pad of Paper

Koda Clinic Team: "A Day in the Life":

- **This schedule is intended as a general overview of the daily responsibilities and not an all-inclusive list.**
- Check daily assignments to see your specific responsibilities for the day.

Time:	Responsibility:
7:45 AM - 8:15 AM	**Brief clinic meeting, receive updates from night staff** **ALL CLINIC STAFF WILL EAT WITH CAMPERS**
Breakfast	**Pre-meal insulin** 1. Glucoses are obtained by clinic staff. 2. Insulin doses will be calculated and entered into the camper's chart in teams of two. 3. Doses will be delivered by pen or via pump prior to the meal, unless glucose is <100, per policy. Verify the dose to be given with the camper and sign off on the chart. **Front desk / medications:** • Non-insulin medications administered at meal time by licensed clinic staff assigned to each cabin. **Post-meal insulin:** • Any post-meal boluses/injections to be given by clinic staff assigned to each cabin. Assistance as needed from HCM. **After breakfast/before first period** Any tasks below that were unable to be completed overnight by night shift will be done at this time: • Prepare tackle box and green backpacks for the day's activities: clean out any trash, check supplies, and replenish. • Calibrate glucometers. Glucometers are to be delivered by the counseling staff at breakfast insulin time for all cabins. Clean the outside of meters. Return to bags for dispersal to cabins. If a camper or other staff member is available, ask them to return meters to cabins.

	• Stock supplies.
9:30 AM - 10:20 AM **Morning Activity 1**	**<u>Healthcare Manager:</u>** • Ensure all clinic staff are completing their jobs thoroughly by auditing the EMR. • Check bedtime snack calculations, pump insulin setting changes, appropriate high and low glucose checks with follow-up overnight, morning insulin doses, ketone correction procedures from overnight/morning. **<u>Clinic:</u>** • In-clinic staff as assigned by rotation. **<u>Activities:</u>** • Walk with assigned cabin to their activities. • Document all glucose levels with times and any treatments in EMR. • NOTE: camper does NOT need an additional complex carb snack (e.g. PBG) after treating a low if it is within 15 MINUTES OF MORNING SNACK. • Participate as able. **<u>Lake Activity</u>**: • Drive golf cart to the lake with supplies noted below. • In the boat house, set-up a clinic station. • Document all glucose levels with times and any treatments. • Connect T slims to chargers during activity. • After the activity, make sure all pumps have been retrieved and are reconnected. • Be the last to leave the lake area, making sure that other staff members do not need anything before leaving. • Back in the clinic, record all glucose/treatment data in EMR if connectivity was lost during activity. • Treat and record first aid treatment on a tablet in Campsite. **REQUIRED SUPPLIES** for when staff are away from the clinic at an activity:

	• A walkie-talkie and/or group chats/apps as set up • Stocked supplies kit (green backpack or tackle box) • Backpack with snacks/lunch box • First Aid Kit with First Aid forms and supplies
10:20 AM **Snack**	**<u>Mid-morning break at location of first activity:</u>** • All children with glucose >250 at breakfast are to be rechecked at 10:15am by clinic staff. • AM snack
10:30 AM- **11:20** **Morning Activity 2**	**<u>Clinic:</u>** • In-clinic staff as assigned by rotation **<u>Activities:</u>** • See activity responsibilities listed in first activity period
11:30 AM **LUNCH PREP**	• Clinic staff assigned to cabins will check their campers' glucoses, obtain their planned carbs, calculate and administer insulin. • Insulin dose calculations are performed in teams of two and entered into the camper's chart in EMR. • Cabin clinic staff prepare lunch time medications.
12:00 - 1:00 **PM LUNCH**	**ALL CLINIC STAFF WILL EAT WITH CAMPERS** **<u>Pre-meal & post-meal insulin:</u>** • See breakfast instructions; same protocols are followed. • Cabin clinic staff to remind campers if this is a shower/pump site change day.

1:10 - 2:10PM **&** **2:20 - 3:20 PM** **Third & Fourth Activity Periods**	**<u>Activities:</u>** • See activity responsibilities listed in first activity period. • Take enough snacks to last through pool time. • NOTE: camper does NOT need an additional complex carb snack (e.g. PBG) after treating a low if it is within 15 MINUTES OF AFTERNOON SNACK **<u>Clinic</u>**: In-clinic staff as assigned by rotation **<u>Healthcare Manager:</u>** • Ensure all clinic staff are completing their jobs thoroughly by auditing the EMR for morning activity glucose corrections and lunch insulin doses.
3:20 PM **Snack Time**	**<u>Afternoon snack</u>** • Clinic staff will check campers' glucose and record in EMR. • Treat out-of-target glucoses per protocols. Clinic staff are responsible for ensuring any treatments given are recorded in the EMR.
3:30-4:30 PM **Rest time cabin Group Choice**	**<u>Healthcare Manager</u>** • Complete EMR audits. • Check for trends and potential adverse health events.

Pool/Shower/ Trading Post	**<u>Pool:</u>** • Clinic staff will check glucose of each camper assigned to their group. Treat any low glucose per hypoglycemia protocol. • All Medtronic 670/770G and Tandem X2 insulin pumps need to be suspended when taken off. • Pumps will be removed at the pool area and placed in individual cabin boxes. • Document all glucose #s, time checked, and treatments given. (See "**Checking Glucose Before Water Time"** policy). **<u>Shower/Trading Post</u>** • All clinic staff assigned to groups that are showering must remind their campers to go to the clinic for insulin pump site change **<u>after</u>** their shower. • Activity-assigned clinic staff must turn in or ensure that all glucose values from the day have been entered and give report to the HCM. • After the above is done, clinic staff may take a break. **<u>Healthcare Manager/Licensed In-clinic assigned staff</u>** • Two licensed personnel will change pump sites in the clinic. • All site changes must be charted on the camper's insulin record in EMR.
5:30 PM **DINNER PREP**	• See previous meals; same protocols are followed. • Cabin clinic staff prepare dinner-time medications. • Make sure all glucoses from the day have been recorded for each camper for the covering provider to review during rounds.

6:00 PM DINNER	**ALL CLINIC STAFF WILL EAT WITH CAMPERS** **Pre-meal & post-meal insulin:** • See breakfast instructions; same protocols are followed. **Healthcare Manager:** • Dispense dinner-time medications to campers.

Diabetes Education:

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

- Campers will learn new skills and reinforce existing knowledge through planned participatory activities, observation, and individual and group instruction.
- Campers will learn how to properly prepare for diabetes management when participating in different activities, such as swimming, boating, hiking, archery, climbing, and team building.
- Hands-on carb counting will occur at all meals and snacks.
- Campers will develop a sense of environmental awareness through interaction with the natural environment.
- Campers will improve self-confidence, interpersonal skills, and conflict resolution skills through an environment that is intentionally built to support them in the management of type 1 diabetes.

AGE RELATED RESPONSIBILITIES AND TRAITS		
	Characteristics	**Diabetes Responsibilities**
Ages 2-7	Imaginative, concrete thinkers, cannot think abstractly, self-centered	• adult supervision for all activities, gradually learn to cooperate for glucose checks and insulin injections, learn to recognize hypoglycemia • inconsistent with food choices, not much concept of time

		• food choice is primarily the responsibility of adults • positive reinforcement for healthy choices; do not tie the admin of insulin to a negative consequence of eating sweets
Ages 7-12	Concrete thinkers, more objective and understanding, more curious, more social, more responsible	• adult supervision recommended, but can be loosened as autonomy is learned and safe practices are observed regularly • can learn to check own glucose • can begin to draw up and give injections • can make food choices; avoid using judgmental language when educating about food choices • can recognize and treat hypoglycemia • can be responsible for remembering snacks • start establishing trust in some aspects of management
Ages 12-18	More independent, behavior varies, body image important, away from home more, more responsible	• adult supervision recommended, but can do majority of preparing/administering insulin and components of pump and CGM changes • will start expecting more independence • know which foods to eat; body image and food relationship kept in mind when educating about food choice; do not tie the admin of insulin to a negative consequence of eating sweets • gradually recognize the importance of optimal glycemic outcomes to prevent complications, may make more independent self-management decisions

<u>Emergencies:</u>

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

General

Summon clinic staff and/or camp provider if the ill or injured person cannot safely be moved to the clinic. For severe emergencies, it is generally best not to move the individual unnecessarily

until they are medically stabilized. Immediate aid should be given on the scene until a trained and equipped emergency rescue transport team arrives. Examples of major emergencies include drowning, severe burns, major fracture, anaphylactic reaction, suspected neck/spine injury, and loss of consciousness or seizures. Medical personnel (MD, NP, RN, PharmD, or other clinic staff) will perform a rapid assessment within their scope of practice, starting with airway, breathing, bleeding and circulatory status. Appropriate stabilizing measures will be instituted; for example, the airway may need to be opened by means of a jaw-thrust maneuver, mouth-to-mouth resuscitation initiated, bleeding controlled by direct pressure, or the feet elevated and blankets applied if circulation is poor.

Hypoglycemic Emergency

If the emergency is diabetes-related, a glucose level should be measured as quickly as possible. For severe clinical symptoms which are very likely to be due to hypoglycemia in a child with diabetes (e.g. seizure, unconsciousness, confusion), immediate treatment may be instituted for presumed hypoglycemia, with blood glucose value checked after treatment has been initiated.

If hypoglycemia is present, glucose should be given rapidly by mouth if the person can swallow safely.

If safe swallowing cannot be assured (as with unconsciousness, near-unconsciousness, or convulsion), then Glucagon 1 mg SQ should be given to correct hypoglycemia. Camper should be turned to his or her side if consciousness is impaired, to protect airway from aspiration. Camp Ho Mita Koda clinic staff have been trained and are authorized in the use of Glucagon SQ (just as parents of our campers are often trained in its use at home). If there is no response to a single dose of SQ Glucagon, it may safely be repeated after 10 minutes. If available, Baqsimi (glucagon nasal powder) 3 mg is an appropriate alternative to subcutaneous glucagon, can be administered intranasally, and can also be repeated if needed.

If there is hypoglycemia, plus convulsions or loss of consciousness or near-unconsciousness, and if clinical alertness is not regained by 10 minutes after the first dose of Glucagon, the clinic staff should administer a second dose of SQ Glucagon, 1 mg and summon the emergency rescue squad.

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

Non-Diabetes Emergency

If the illness or injury is severe in nature, after rapid assessment and initiation of first aid measures, the **Newbury emergency rescue squad** will be called **(Phone 440-564-2261 or 911)**. Give clear directions as to location. If permitted by the squad, the camp physician or clinic staff may choose to accompany the person to the hospital (UH Geauga).

For minor, non-critical emergencies requiring hospital emergency room evaluation but not rescue squad transport (examples: minor sprain, minor laceration, mild wheezing), staff will follow procedures in the non-emergency Medical Transportation Policy. Before departing camp, the Camp Director should be notified, if readily available. Obtain and take the parental release for medical emergency care from the camp office.

Non-Emergency Medical Transportation Policy

If a camper requires non-emergency medical transportation, the covering provider **or Healthcare Manager** will contact the camper's parent/guardian. If the parent/guardian can transport the camper to the appropriate medical facility in a reasonable period of time, the camper will be released from camp into their care. If the parent/guardian is not available or chooses not to provide transportation, the covering provider or Healthcare Manager will arrange non-emergency medical transportation by a clinic staff member (over the age of 18) who will accompany the camper. The covering provider or Healthcare Manager will ensure that the camper has copies of all medical, insurance, treatment, and waiver forms.

Medical Phone Calls to Families

Camp policy is to have the covering provider or Healthcare Manager phone the family or the family physician before instituting any major and fundamental changes in insulin type, timing or frequency (see above). This refers to changes that would be apt to impact home management plans (e.g. three shots of insulin daily instead of two). The covering provider or Healthcare Manager will also call the family as soon as possible if there is any illness or injury significant enough to require emergency room or hospital evaluation or treatment, or the prescribing of a new medication (except OTC preparations). This includes, for example, sprains with negative x-ray, amoxicillin for strep, as well as problems of a more severe nature.

Incident Reporting (Event Findings):

An Incident Report form should be completed by a camp staff member if any of the following conditions have occurred (including but not limited to):

- Suspected physical, emotional, or sexual abuse/ reports of abuse
- Glucagon administration
- ER visit or hospitalization
- Seizure
- Any medical emergency call from cabin to clinic
- Medication error
- Any behavior/incident that resulted in physical or emotional harm to the person or others
- Removing a camper from an activity or the dismissal of a camper from an activity
- An emergency evacuation or sheltering due to fire or severe weather conditions
- A missing person (camper, staff, volunteer, or visitor)
- Intruder(s)

- Water rescue in lake or pool
- Termination of employment or dismissal of a volunteer
- Camper who is asked to leave for violation of rules
- Failure of safety equipment
- Any act that violates the law
- Damage to camp property
- Protocol deviation
- Exposure of a person with a known severe allergy to that allergen such as a food item or medication

Incident reports will be completed immediately following an incident. Witnesses to the incident will submit a written account and signed statement. Parents will be contacted by the Healthcare Manager, Covering Provider or Resident Physician as soon as possible but within 8 hours of the following incidents: Glucagon administration, ER visit or hospitalization, Seizure, Any medical emergency call from cabin to clinic, Medical Error.

Glucose Monitoring:

Glucose monitoring is the principal method by which diabetes is monitored and managed. For those not wearing CGMs or for those who need to calibrate or confirm CGM glucose values, fingerstick glucose checks are performed. This requires functional meters, reproducible and correct technique, and user safety regarding precautions against blood-borne disease. All glucose checking supplies are donated by various organizations. Campers do not need to bring their own meters, strips, or lancets and will only be allowed to use those provided by camp. Single-use lancets will be provided.

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

Glucose will be checked a minimum of 4-5 times daily by all campers at the following times:

- Before Breakfast
- Before Lunch
- Before Swimming
- Before Dinner
- Before Bedtime

Additional glucose monitoring will be done at the following times:

- When a camper complains of feeling low, is acting strangely/confused, is having symptoms of hypoglycemia, or is unable or unwilling to eat scheduled meals/snacks
- Overnight (1 am and/or 4 am) per "Night Glucose Check Protocol" above
- Per protocols for follow-up of hypoglycemia and hyperglycemia

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

Blood Glucose Meters:

- Each camper (even if using CGM) will have their own meter in the cabin and should only use their own meter in the cabin.
- Blood glucose meter strips must be kept in their original containers and be properly closed. Moisture, water, and humidity can affect the reagent surface.
- Meters will be cleaned according to the methods specified by the manufacturer. Meters should be cleaned daily – or more often as necessary.
- Some brands of meters require calibration against each vial or package of strips. This must be done faithfully to assure accuracy. If several meters are used in one location (e.g. the clinic), be sure that all strip vials/packages have the same calibration code; if this is not possible, then label the meters and the strip containers so they are easily matched up by the user.

Control testing procedure:

- Will be done daily by the clinic night staff or in-clinic day staff.
- Perform tests according to manufacturer's instructions.
- Make sure the result falls between suggested ranges on the strip bottle. Document on Control Testing Log sheet - Initial/date.

Most meters employ standard control solutions for testing accuracy. These should be on hand and can be re-ordered as needed from the manufacturer's representative who services Camp. Quality assurance determinations (done per manufacturer's instructions) will be run on each meter in use daily. These results will be written in the meter QA logbook. If the blood glucose meter results are outside the expected limits, as defined by the manufacturer, that meter will be removed from use until the problem is corrected.

Blood Glucose Checking Procedure:

- Assemble materials needed for checking: meter, strips, single-use lancets, alcohol pads, cotton balls, protective gloves when necessary
- Insert strip into meter
- Verify code on meter matches strips
- Clean finger with alcohol pad or soap/water and allow to dry
- Poke finger with single-use lance
- Obtain adequate blood sample
- Touch blood sample to strip to start blood glucose check (automatically starts counting down on meter)
- Read value when timing complete
    - LO is a value below the measurement threshold of the meter

    - HI is a value greater than 600 mg/dL on most meters
- Record result
- Clean up area properly following OSHA regulations

Checking Glucose Before Water Time:

All campers are required to check glucose before entering the water (lake or pool). Fingerstick or CGM may be used. If glucose is less than 100 at initial check or less than 120 on CGM **WITH** down arrows, they will be treated per hypoglycemia protocol (see section on treatment of **mild-to moderate hypoglycemia**) by the counselor and will report to the designated clinic area. Camper will wait 15 min and recheck. If glucose is **greater than 90** the camper is permitted to enter the pool. If glucose is less than 90, hypoglycemia treatment will be repeated; recheck will occur after another 15 minutes. If there are back-to-back water activities, glucose needs to be checked prior to each one. If glucose is elevated and it has been less than 2 hours from a meal, then a correction insulin dose is not necessary. If the glucose is over 300 or child feels ill, ketones should be checked.

Exercise:

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

It is our goal to avoid serious hypoglycemic reactions, while encouraging the full and vigorous physical activities normal to children. We want to maintain an educational emphasis that enables the camper to better learn the self-management skills that permit homeostasis during periods of fluctuating physical activity. Campers with higher levels of physical activity intensity may need more frequent BG monitoring and extra carbohydrates than campers who are not as intensive.

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

Examples:

A high-energy activity, such as roller skating or a long hike, is scheduled. The preceding meal or snack might be enriched, and/or the appropriate insulin doses prior to the activity scaled back.

Consideration should be given to extra checking before and at intervals during sustained high energy activities so campers can be monitored, and so that they can learn their own patterns of glucose response to vigorous exercise.

Snacks and/or glucose supplements should be immediately accessible during sustained high energy activities, so campers can be quickly treated if needed.

The possibility of delayed hypoglycemia should be considered, that is, hypoglycemia that occurs several hours after vigorous exercise. Hypoglycemia may develop, for example, during sleep the night after a day-long hike.

When sedentary activities such as skits or movies are planned, the meal plan might be reduced and/or insulin doses increased to avoid hyperglycemia.

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

Hypoglycemia At Camp:

Hypoglycemia (low blood glucose) is the most common acute complication of diabetes. It is also one of the most uncomfortable facets of learning to live with diabetes. Ideally, campers should be able to recognize hypoglycemia early and seek appropriate treatment. However, hypoglycemia can be confused with symptoms of home sickness, anxiety, and stress. Occasionally, some children will use their diabetes as an excuse to not participate in camp activities or deal with a difficult or stressful situation, such as being away from home for the first time or difficulty getting along with other children.

Special consideration is needed for those with a history of severe or frequent hypoglycemia.

Causes of Hypoglycemia:

Hypoglycemia may be caused by any one or a combination of the following factors:

- Increased exercise. Muscles use more glucose during the increased physical activities at camp, leading to hypoglycemia. This is probably the most important factor contributing to hypoglycemia in the camp setting. When children increase their physical activities continuously for several days, their bodies become more insulin sensitive (insulin works more efficiently in their bodies). Medical staff anticipate this and reduce insulin doses of most campers at check-in.
- Too much insulin. This may result from an over-calculation of meal insulin boluses, or due to inadequate reduction in the insulin doses of campers. Rarely, consider

intentional overdosing by a camper who has access to self-administer insulin outside of the clinic.
- Too little carbohydrate intake. This might result from missing a snack or eating less than the calculated amount of carbohydrates at a meal.

ALWAYS rule out hypoglycemia first!

Campers who may be experiencing hypoglycemia should have their glucose checked immediately, wherever they are. If the glucose is low, they will receive treatment wherever they are, such as the cabin, activity area, or dining hall.

All clinic staff will carry bags or tackle boxes that contain supplies to check blood glucose and treat hypoglycemia. These bags are checked and stocked daily by the clinic staff and remain with the clinic staff at all times, including water activities. They include blood glucose meters, lancets, and strips, sharps containers, gloves, and cotton balls.

Symptoms of Hypoglycemia
Each person's reaction to low blood glucose is different. Below are possible signs and symptoms of hypoglycemia, from mild to severe:

- Feeling shaky
- Being nervous or anxious
- Sweating and clamminess
- Irritability or impatience
- Confusion
- Racing heartbeat
- Feeling lightheaded or dizzy
- Hunger
- Nausea
- Pale appearance
- Feeling sleepy
- Feeling weak or having no energy
- Blurry vision
- Tingling or numbness in the lips, tongue, or cheeks
- Headaches
- Coordination problems, clumsiness
- Confusion
- Seizures
- Passing out / losing consciousness

Levels of Hypoglycemia:

1. **Mild**: a low blood glucose that is 54 mg/dL or higher, and the camper is alert.
2. **Moderate**: glucose is less than 54 mg/dL, but the camper is still alert and able to follow directions to treat the low.

3. **Severe**: any low blood glucose that the camper cannot treat without significant assistance from others, due to an alteration in mental status such that they may not recognize their symptoms and/or be able to follow commands.
4. **Severe with loss of consciousness**: any low blood glucose associated with complete loss of consciousness, with or without seizure.

Hypoglycemia Treatment:

- If sending a camper with hypoglycemia to the clinic for monitoring/treatment, someone with normal blood glucose should accompany them.

Mild-to-moderate hypoglycemia:

- Assuming the individual is awake and alert, the *initial* treatment for a low glucose is always rapid-acting carbohydrates (such as glucose tabs or juice), according to the treatment chart below:

Age	**Glucose level (mg/dL)**		
	Under 70 (meter or CGM)	**70-100 (meter or CGM)**	**101-120 with DOUBLE DOWN ARROWS (CGM only)**
≤ 8 yr	8g carbs (2 glucose tabs)	4g carbs (1 glucose tab)	4g carbs (1 glucose tab)
≥ 9 yr	15g carbs (4 glucose tabs)	8g carbs (2 glucose tabs)	8g carbs (2 glucose tabs)

- After treating a low glucose, wait 15 minutes, then recheck glucose **on a meter.** *(Do not use a CGM to recheck glucose after treating a low.)*
    - If repeat glucose is still <90, re-treat per table above.
    - Once glucose ≥90, *if the next scheduled meal or snack is more than 30 min away*, give a complex carbohydrate snack that also contains fat/protein (e.g. PBG).
        - Campers 8 years old and younger receive a 8g carb snack
        - Campers 9 years old and older receive a 15g carb snack
- If hypoglycemia symptoms do not improve, recheck glucose in another 15 minutes.
- Also see the section on **mini dose glucagon** for treating moderate hypoglycemia.

Severe hypoglycemia *without* loss of consciousness or seizure:

- Ensure that the camper is sitting with support, for example, in front of a seated counselor with the camper resting against the counselor's chest. Send someone for clinic staff.

- Attempt to give glucose gel between cheek and gums, while in a firm soothing voice encouraging camper to swallow.
- Continue to squeeze glucose gel as above until the camper is able to follow commands. When the camper is able to respond to commands, give additional oral glucose followed by a complex carbohydrate snack with fat/protein.
- If the camper loses consciousness, proceed with treatment as outlined below, performed by the medical team.

Severe hypoglycemic event with loss of consciousness:

1. In the event of unresponsiveness, convulsion, or life-threatening emergency, staff/counselor will call the clinic via the red phone or walkie-talkie to report the event and provide current location.
2. Protect campers from injury and clear the area of campers and other staff.
3. A licensed clinic staff member will go to the reported location with an emergency box/kit to administer glucagon as soon as possible.
4. The Healthcare Manager or delegate will notify the on call/covering provider.

Glucagon:

Glucagon is a pancreatic hormone that counteracts insulin and elevates blood glucose. Standard glucagon is injected and has to be mixed (as a freeze-dried pellet with aqueous diluent) at the time of use. There are now other forms of glucagon (premixed syringe, nasal) that may also be available. Standard dose for all ages is 1 mg (1 vial) SQ or IM, although children under 20kg (44lb) can receive a half dose (0.5mg). Glucagon is used when the camper is unconscious, convulsing, or so lethargic or combative that oral methods of treating hypoglycemia are unsafe or impractical. Glucagon takes about 5-10 minutes to work. If there is no response, prompt administration of IV glucose should be considered, if available. Alternatively, a 2nd full dose of glucagon may be given. To avoid recurrent hypoglycemia, follow the successful use of glucagon with food as soon as possible (when the camper regains consciousness).

Preparing & Administering Standard Glucagon:

1. Remove the flip-off seal from the bottle of powdered glucagon. Wipe rubber stopper on the bottle with an alcohol swab.
2. Remove the needle protector from the syringe, and inject the entire liquid contents of the syringe into the bottle of powdered glucagon. DO NOT REMOVE THE PLASTIC CLIP FROM THE SYRINGE. Remove the syringe from the bottle.
3. Swirl bottle gently until glucagon dissolves completely in the diluent. Glucagon should NOT be used unless the solution is clear (appears water-like).
4. Using the same syringe, hold the bottle upside down and, making sure the needle tip remains in solution, gently withdraw all of the solution from the bottle (to the 1mg mark on the syringe). The plastic clip on the syringe will prevent the rubber stopper from being pulled out of the syringe; however, if the plastic plunger rod separates from the rubber stopper, simply reinsert the rod by turning it clockwise.

a. The standard dose is 1 mg (the entire vial).
b. For children weighing less than 44 lb (20 kg), 0.5 mg (half of the solution from the bottle) can be given. Any unused portion should be discarded.

5. Inject glucagon under the skin immediately after mixing, as follows:
   a. Cleanse injection site on buttock, arm, or thigh with an alcohol swab.
   b. Insert the needle into the loose tissue under the cleansed injection site, and inject the glucagon solution.
   c. Apply light pressure at the injection site, and withdraw the needle.
   d. Press an alcohol swab against the injection site.
6. Turn the patient on his/her side in case of vomiting (a common side effect of glucagon) to prevent him/her from choking. There is no danger of overdose.
7. Give a snack to the camper as soon as awake, alert, and able to safely swallow. Give both a fast-acting source of glucose (such as juice or tabs) followed by a complex carbohydrate (e.g. PBG).
8. If the camper does not awaken within 10 minutes of a glucagon dose, administer another dose of glucagon and **inform the on-call provider or emergency services immediately**.
9. After the camper has been successfully treated, promptly notify the on-call provider to alert them that a severe hypoglycemic reaction has occurred.

BAQSIMI (Nasal Glucagon):

BAQSIMI is an alternative, nasal form of glucagon that works as well as injected glucagon and is much easier to use. It will work even in the setting of an upper respiratory infection or nasal congestion. Do not remove the shrink wrap or open the tube until you are ready to use it. If the tube has been opened, BAQSIMI could be exposed to moisture, and it may not work as expected.

Administering BAQSIMI:

1. Remove the shrink wrap by pulling on the red stripe.
2. Open the lid and remove the device from the tube.
3. Hold the device between fingers and thumb. (Do NOT push the plunger until you are ready to give the dose.)
4. Insert the tip gently into one nostril until fingers touch the outside of the nose.
5. Push the plunger firmly all the way in.
6. Dose is complete when the green line disappears.
7. Discard the used device and tube.
8. After giving the dose, if the person is unconscious, turn them on their side.

GVOKE (premixed glucagon injection or autoinjector):

GVOKE is a recently approved premixed formulation of glucagon for injection in a prefilled syringe (PFS) that can be used just like standard glucagon. The adult PFS contains a 1 mg dose of glucagon, while the pediatric PFS contains a 0.5 mg dose. It should remain packaged in its foil pouch until time of use, and stored at room temperature (do not freeze or refrigerate).

Administering GVOKE (autoinjector):

1. Remove the red cap.
2. Press the yellow end to bare skin.
3. Hold for 5 seconds.
4. The window will turn red.
5. If the person is unconscious, turn them on their side.

Administering GVOKE (prefilled syringe):

1. Tear open the pouch at the dotted line and carefully remove the GVOKE PFS.
2. Look at the liquid medicine through the viewing window. It must be clear and colorless or a pale yellow. Air bubbles are normal. Do not use it if the liquid contains lumps, flakes, or particles.
3. Remove any clothing covering the injection site (lower abdomen, outer thigh, or outer upper arm). The injection must be performed straight into the skin.
4. Pull the needle cap straight off the syringe.
5. Pinch the skin directly around the injection site and keep pinching for the entire injection to prevent injection into the muscle.
6. Without touching the plunger, insert the needle into the skin at the injection site at a 90-degree angle.
7. Push the plunger down as far as it will go to inject all of the liquid medicine into the skin. Inject the medicine very fast to help decrease any pain.
8. After the injection is complete, lift the syringe straight up from the injection site. Do not recap the syringe.
9. Dispose of the used syringe into a sharps container immediately after use.
10. If a person is unconscious, turn them to their side.

Mini-Dose Glucagon:

- Mini-dose glucagon is a safe and effective way to treat moderate hypoglycemia in the diabetes camp setting. It can quickly raise blood glucose without nausea or vomiting.

Mini-dose glucagon can be used in the following situations:

- Initial treatment of glucose < 50 mg/dL, as long as the person is awake and alert.
    - Initial treatment of severe hypoglycemia *with loss of consciousness or seizure* is FULL DOSE glucagon as described in the previous section.
    - Initial treatment of hypoglycemia when *glucose >50* mg/dL should still be rapid acting oral glucose, per the treatment table provided previously.
- Follow-up treatment for hypoglycemia when blood glucose is still < 70 mg/dL despite being treated with rapid acting glucose 15 minutes prior.
    - Give campers the option of treating again with rapid acting glucose (per hypoglycemia treatment chart) OR receiving mini-dose glucagon.
- To prevent or treat hypoglycemia during sick-day management when the camper is too nauseated or vomiting and is unable or unwilling to take carbohydrate to treat

hypoglycemia or impending hypoglycemia.

How to prepare and administer mini-dose glucagon:

1. Add diluent to glucagon vial according to package insert instruction (and described in the section above).
2. Once glucagon has been reconstituted, it can be used within the next 24 hours and then needs to be discarded.
    a. The date and time should be written on the side of any reconstituted vial with a black sharpie pen.
3. Draw the appropriate dose of mini-dose glucagon into a U-100 insulin syringe.
    a. Dosing is 1 unit on an insulin syringe per year of the child's age (up to max dose of 15 units).
    b. Examples: A 6-year-old receives 6 units on an insulin syringe, a 15-year-old receives 15 units on an insulin syringe, and a 19-year-old receives 15 units on an insulin syringe.
    c. Inject the dose SQ (under the skin), in any of the same locations that insulin can be injected.

Other notes:

- Mini-dose glucagon can be repeated again after 1 hour.
- Use of mini-dose glucagon should be charted in the camper's medical record, and if using 2 or more doses in a 24-hour period, the attending physician in charge should be notified so that insulin doses can be modified.
- If mini-dose glucagon is being used as part of sick day management, then the covering provider in charge should be notified.
- Once a day, clinic staff will draw up 15 units of mini-dose glucagon in insulin syringes and store them in red glucagon containers for use over the next 24 hours. If the camper is younger than 15 years, then the clinic staff should squirt out the unneeded portion of the dose, so that the correct amount is left in the syringe and can be administered to the camper.

<u>Hyperglycemia At Camp:</u>

Elevated blood glucose levels may occur from any combination of the following factors:

1. **Too little insulin.**
    1. This is the most frequent cause of hyperglycemia. Possible scenarios include missed insulin doses, miscalculation of the insulin dose at meal times, or excessive reduction of doses at check-in or daily rounds. In campers using insulin pumps, consider mechanical malfunction of the pump itself or kinking of the infusion set at the skin insertion site.
2. **Less physical activity.**
    1. This will typically happen when it starts raining for extended periods and campers' physical activity levels decrease substantially.

3. **More carbohydrate intake.**
    1. This may result from under-counting of carbohydrates consumed at meals or snacks.
4. **Intercurrent illnesses.**
    1. These include infections (such as ear infections, sore throat, pneumonia, or urinary tract infections) and moderate-to-major trauma (such as fractures). Both physiological stress and medications such as prednisone lead to insulin resistance (insulin does not work as efficiently).

Whenever there is significant hyperglycemia, it is important to CHECK KETONES!

Rising blood glucose levels indicate that there is insufficient insulin available to the body (relative insulin deficiency), meaning the body is unable to use blood glucose as the sole source of energy. Breakdown of fat stores begins, leading to the generation of ketones. If this process is not reversed quickly, the child may develop diabetic ketoacidosis (DKA), a dangerous condition that requires transfer to a healthcare facility.

General Principles of Managing Hyperglycemia:

1. **Frequent monitoring.**
    1. Glucose levels and ketones (checked in the urine or blood) will need to be monitored frequently, at least every 2 hours. Campers may require observation and treatment at the clinic.
2. **Hydration.**
    1. This will help flush out ketones in the urine and replace fluid losses from increased urination caused by hyperglycemia. It is preferable to give electrolyte-containing, sugar-free fluids.
3. **Additional insulin.**
    1. This will stop the production of ketones. Usually, insulin doses will need to be administered every 2 hours, by injection or pump. In campers using an insulin pump, troubleshooting the pump insulin delivery is also an important step.
4. **Treatment of any underlying illness**, when applicable.

<u>Ketone Checking:</u>

Checking for ketones will be done by all campers:

- Any time glucose is greater than 300 mg/dL (or if >250 at the first AM check)
- Any time a camper is feeling ill or vomiting
- At the request of medical staff
- In order to conserve blood ketone strips, during daytime hours ketones should be checked in urine and confirmed with blood ketones if moderate/large. Blood ketone strips can be used first overnight or when a restroom is not near (pool/lake).

Checking Urine Ketones with KETOSTIX:

1. Dip 1 Ketostix into urine.

2. Wait 15 seconds.
3. Immediately compare with the color chart to determine the amount of ketones. A delay in reading past 15 seconds can alter the validity.
4. Record results in the camper's medical record.

Checking Urine Ketones with CHEMSTRIP K:

1. Dip 1 Chemstrip K into urine.
2. Wait 1 minute.
3. Compare with a color chart to determine the amount of ketones. Results will be accurate for an additional minute.
4. Record results in the camper's medical record.

Checking ketones with the blood ketone meter:

1. Wash and dry hands.
2. Insert the strip into the ketone meter.
3. Use the lancet device to prick a finger for a blood sample.
4. Place blood sample into the ketone strip.
5. Interpret results:
    - < 0.6 mmol/L: Negative
    - 0.6-0.9 mmol/L: Small
    - 1-1.5 mmol/L: Moderate
    - >1.5 mmol/L: Large

Actions based on ketone results:

The specific treatment of hyperglycemia will vary depending on whether or not there are elevated ketone levels (also see the detailed protocols below).

Negative to small:

- Give insulin, if needed per protocols below.
- Resume camp activities.

Moderate or large:

- **Limit activity.** Campers with moderate/large ketones should be held from rigorous activity, but may attend activities passively, change activities, or stay in the clinic.
- **Give additional insulin** as directed per protocols below.
- **Increase fluid intake.**
- **Notify the covering provider** who will provide guidance on how much extra insulin to give.

HYPERGLYCEMIA PROTOCOL FOR INSULIN PUMPS:

If glucose is greater than 300 mg/dL (or >250 upon awakening in the morning), check ketones and troubleshoot the pump and infusion set.

In the event the pump is malfunctioning, call the Pump Helpline. If the problem cannot be resolved, notify parents.

If Ketones are <u>Negative to Small:</u>

- Give a correction bolus as calculated by the insulin pump.
- If glucose has been persistently >300 for over 2 hours, change out both the pump infusion set and insulin in the reservoir before bolusing.
- Automated insulin delivery mode can be resumed, if it's been at least 2 hours since the last injection insulin dose (if applicable).
- Camp activities can be resumed until time for their glucose recheck.
- Recheck glucose in 2 hours:
    - If <300: protocol is complete.
    - If still >300: recheck ketones and follow appropriate protocol based on the result.**

If Ketones are <u>Moderate or Large</u>:

- Give a correction with booster insulin dose:
    - Calculated dose = (Current glucose – Target glucose) / ISF
    - Multiply this calculated dose by 1.2 to 1.5 (to provide 20-50% extra insulin, at the discretion of the covering provider).
    - Do NOT bolus through their pump; give the dose via injection.
- If the pump is currently in an automated insulin delivery mode, switch the pump to manual mode for two hours after any insulin dose given via injection.
- Change out the pump infusion set and insulin in the pump reservoir.
- Hydrate: encourage camper to drink a cup of water every 30 minutes.
- Recheck glucose and ketones in 2 hours:
    - If glucose <300 and ketones neg/trace: protocol is complete.
    - If glucose <300 but ketones still elevated: continue hydration, discuss with the covering provider whether more insulin is needed, and recheck ketones every 2 hrs until trace.
    - If glucose still >300, recheck ketones and follow the appropriate protocol based on the result.**

****If ketones remain moderate or large 2 hours after a correction dose of insulin, or if at any point the camper becomes lethargic or unable to tolerate drinking fluids, contact the covering provider.**

<u>HYPERGLYCEMIA PROTOCOL FOR INSULIN INJECTIONS:</u>

If glucose is greater than 300 mg/dL (or >250 upon awakening in the morning), check ketones.

If Ketones are <u>Negative to Small:</u>

- Give a correction bolus only if it has been **more than 2 hours since the last dose of insulin.**
    - Calculated dose = (Current glucose – Target glucose) / ISF

    - Round to the nearest whole number and administer dose via injection.
- Camp activities can be resumed until time for their glucose recheck.
- Recheck glucose in 2 hours:
    - If <300: protocol is complete
    - If still >300: recheck ketones and follow appropriate protocol based on the result.**

If Ketones are <u>Moderate or Large</u>:

- Give a correction insulin dose if it has been **more than 2 hours since the last dose of insulin.**
    - Calculated dose = (Current glucose – Target glucose) / ISF
    - Multiply this calculated dose by 1.2 to 1.5 (to provide 20-50% extra insulin, at the discretion of the covering provider).
    - Round to the nearest whole number and administer dose via injection.
- *If an insulin dose has been given in the past 2 hours, discuss the appropriate dose with the covering provider.*
- Hydrate: encourage camper to drink a cup of water every 30 minutes.
- Recheck glucose and ketones in 2 hours:
    - If glucose <300 and ketones neg/trace: protocol is complete.
    - If glucose <300 but ketones still elevated: continue hydration, discuss with the covering provider whether more insulin is needed, and recheck ketones every 2 hrs until trace.
    - If glucose still >300, recheck ketones and follow the appropriate protocol based on the result.**

****If ketones remain moderate or large 2 hours after a correction dose of insulin, or if at any point the camper becomes lethargic or unable to tolerate drinking fluids, contact the covering provider.**

<u>Insulin Administration at Camp:</u>

General:

- Insulin is donated by Eli Lilly, Novo Nordisk, and Sanofi. Most Insulin (Humalog, Novolog, Apidra, Lantus, Basaglar and Tresiba)
- If your camper requires a different insulin (Fiasp, Admelog, Levemir or Lyumjev) please bring your own and label it with camper's name

Note: We do NOT use premixed insulins at camp (e.g. 70/30, 75/25, 50/50).

Insulin Administration:
Pre-meal, bedtime, and any PRN insulin doses are administered by clinic staff (see following section).

Documentation:

At camp, all of the campers' glucoses, insulin doses, ketone checks, and treatments for hypoglycemia are logged on either electronic or paper log sheets. At intake, the medical staff fill in the starting pump settings or multiple daily injection insulin doses for each camper.

Insulin Adjustments:

During the session, a provider will periodically review the log sheets and adjust insulin regimens accordingly. Often, insulin doses need to be decreased at camp to prevent frequent hypoglycemia because of increased activity levels. Sometimes, doses remain the same or are increased because of higher glucose levels. If parents have any questions about these procedures, they should be discussed with the medical staff at Check-In Day. "Perfect" glucose is not the goal at diabetes camp, but every effort will be made to provide safe diabetes care, preventing severe low glucose, ketones in the blood/urine, and symptoms of high glucose. At times, the medical staff may use rapid-acting insulin to correct an elevated glucose level, per hyperglycemia protocols. Any pump setting changes ordered by the physician will be entered (typically in the evening) under the direct supervision of licensed clinic staff.
The ultimate decision for an insulin dose will be at the discretion of the medical staff.

Insulin Administration Procedures:

- Prior to insulin administration, each camper's glucose will be checked under the supervision of the cabin clinic staff and/or counselor.
- Low glucose will be treated immediately per protocol.
- Ketones will be monitored for elevated glucose per protocol.

Any camper with glucose over 400 OR with moderate/large ketones needs to go to the clinic immediately.

- Glucose will be recorded by clinic staff and used to determine the appropriate insulin doses for each camper.
- Insulin injection doses are always calculated by a minimum of two clinic staff.
- Any doses via syringe will be drawn up by the clinic staff.
- A licensed provider will check the dose, verifying the camper’s **name**, insulin **type**, and insulin **dose** prior to administration.
- If appropriate, a camper may administer the dose/bolus themselves AFTER it is verified by clinic staff.
- Campers should NOT be forced to administer their own insulin until they are ready to do so.
- Clinic staff will record the actual insulin dose given.
- Injection / pump site rotation should be taught and implemented by the clinic staff. Do not use sites which have lipohypertrophy. (Record hypertrophied areas in EMR based on intake physical form and camper health forms.)

Insulin Injection via Syringe Protocol:

Used for correction dosing in above range levels which require pump site change per policy, or as otherwise ordered by a provider.

Equipment: Insulin syringe, alcohol swab, insulin, gloves

- **Double check** to ensure that you have the correct insulin type.
- **NO mixing of insulins!**

Procedure:

- Wash hands.
- Cleanse rubber stopper of insulin vial with alcohol.
- Remove the cap from the syringe.
- Withdraw plunger of the syringe to desired amount of insulin plus 2-3 extra units and inject the air into the vial.
- Invert the vial and draw the desired amount of insulin plus an additional 2-3 units.
- Remove the syringe from the vial keeping the cap off.
- With the syringe pointing upward, lightly tap the sides to get the bubbles to rise to the top and then push the plunger slightly to get the air out of the syringe and keep pushing until all of the bubbles are out of the needle.
- Keep pushing to ensure the appropriate amount of insulin was drawn. If desired amount is low, redraw to the correct dose.
- Replace the cap on the syringe.
- Put on protective gloves if assisting with injection.
- Choose a site for injection and prepare it with alcohol, if used.
- Remove the cap from the needle.
- Insert the needle into the skin at a 90-degree angle.
- Press plunger down, injecting all insulin. Count to 5 prior to removing the needle.
- Remove the needle from the skin.
- Place the UNCAPPED syringe into a medical waste container. DO NOT recap the needle.

Insulin Pen Protocols:

General Information:

- Unused pens should be kept refrigerated until opened.
- Open pens should be stored at room temperature and must be kept at less than 86°F. Refrigeration increases the risk of bubbles developing.
- Do not store pens with needles attached. If a needle is attached, insulin may leak from the pen or dry in the needle causing it to clog, or air bubbles may form inside the cartridge.
- Each U100 insulin pen contains 3mL = 300 units of insulin.

- Doses of insulin can be dialed in 1 or 2 unit increments depending on the type of pen.
- Each Camper will have his/her own pen assigned. PENS MAY NOT BE SHARED EVEN IF THE NEEDLES ARE CHANGED.

Pen needle sizes:

- 5mm (3/16”) x 31 G
- 8mm (5/16”) x 31 G or 30 G
- 4mm x 32 G (ultra fine nano)
- 6mm x 32 G

Administering a Dose from Insulin Pen:

Procedure:

- Pull off cap and wipe rubber stopper with alcohol pad.
- Attach a new pen needle by screwing it on.
- Remove the outer needle cap.
- Prime the insulin pen: dial up 2 units, hold the pen with the needle pointing upward, and tap the reservoir gently so any air bubbles rise up to the needle.
- Press the injection button at the bottom of the pen all the way in. Check that at least a drop of insulin comes out of the needle. If not, repeat this step or try a new needle.
- Dial up the desired number of units.
- Inject needle into skin at a 90 degree angle.
- Press the injection button all the way in.
- Holding the button in the depressed position, slowly count to 10, then withdraw the needle.
- Unscrew the needle from the pen and dispose of it safely in a sharps container.
- Replace the cap on the pen for storage.

Rounding Calculated Insulin Dose to Whole Units:

- If the calculated dose is within 3 decimal points of a whole unit, round up or down appropriately. Example: 2.7 rounds up to 3 units Example: calculation of 2.3 rounds down to 2 units
- If calculated dose is approximately halfway between whole units (~0.4-0.6):
  - Round up if glucose > 150
  - Round down if glucose < 150

Insulin Pump Policy:
See Technology addendum for most current updates.

At Check in: Basal rate, ISF and carb ratio reduction is standard for all pumps. Insulin pumps may be used at Camp Ho Mita Koda for campers, counselors, and staff who use these devices at home. All manufacturer recommendations should be followed regarding pump functioning, care, etc. The Medical Committee has developed these guidelines for all campers while at Camp Ho Mita Koda. Pump manuals are available in the clinic and online as resource materials. Several clinic staff and providers have experience with pumps and may be available to answer questions. Additionally, representatives from the individual companies are available at any time for technical assistance/advice by contacting the following phone numbers:

Pump Company Phone Numbers:

- Medtronic Minimed (800) 646-4633
- Omnipod (800) 591-3455
- Tandem (877) 801-6901

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

- Infusion sets/ pods (double the anticipated amount needed while at camp)
- Insulin cartridges/reservoirs including syringe (double the anticipated amount needed while at camp)
- An injector (if used)
- IV prep and extra tape or any other adhesives used to keep pump site in place
- Backup pump (if available)

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

Note: insulin is not needed and if brought should be returned to the camper's family.

General Guidelines for the Use of Insulin Pumps:

- As with all medical supplies, individual pump supplies will be stored in the clinic.
- Campers are required to attend all meal and snack times. Campers not required to take a snack will still check glucose at this time. The clinic staff can require a snack if glucose seems too low.
- The pump will be labeled with the camper's name.
- Campers are permitted to set the pump to give a bolus but can only give the bolus under the supervision of a member of the medical staff. They are similarly only allowed to change a basal rate or otherwise administer insulin under supervision. Any violation of this rule must be reported to the clinic immediately.
- While at camp, pumps must be set on the highest sound level for alarms. The vibrate mode cannot be used by campers.

- Infusion sets/catheters including the reservoirs/cartridges will be changed at least every 48-72 hours routinely or at the discretion of the medical staff. Set changes must be done at the clinic and recorded in the electronic medical record. A list with camper's name and date of next infusion set change is typically kept on White Board in Koda Clinic.
- If the pump malfunctions at camp, the camper is to be brought to the clinic immediately, day or night.
- Omnipod pumps present a special case because the insulin delivery unit with insulin is affixed to the skin, but the control unit is separate. To avoid loss of or damage to the control unit, it will be kept in the clinic in the appropriate cabin box so that it is always available when needed (Exception, Omnipod5 PDM is kept with camper)
- Omnipod PDMs (DASH system) and Controllers (Omnipod 5 System) will also be charged in the clinic.
- Campers who use the Dexcom G6/G7 can provide their sensor glucose reading to be recorded at the meal time. Campers will have access to the menu to select their carbohydrate serving choices.
- Campers may remove their pump before showering without taking a bolus. Pumps should be suspended prior to removing. It will be the responsibility of the cabin counselors to ensure that all campers are reconnected and insulin resumed.
- The clinic staff will periodically check the pump history to support the campers safe dosing and delivery of insulin.
    - In the event it is discovered a camper is administering additional insulin or altering insulin dosage, the incident should immediately be reported to the health care manager and the camp director.

Pumps and swimming:

- All campers will check glucose prior to swimming (please see protocol for BG monitoring near water)
- It is the responsibility of the clinic to ensure all tubed pumps are suspended. Pumps should be plugged in to charge while swimming wherever possible.
- It will be the responsibility of the cabin counselors and clinic staff to ensure that all campers are reconnected to their pump and pumps resumed after swimming.

Insulin Pump Troubleshooting:

- Is the battery dead?
- Is the pump suspended?
- Does the reservoir/cartridge have insulin?
- Do you smell insulin?
- Is the infusion site painful to the touch? Red? Swollen?
- Are there any leaks between the reservoir and the tubing? Do you see wetness?
- Is the tubing kinked or damaged?
- Are there any leaks at the skin site?
- Is the site secure?
- Is there blood in the tubing?

- Do you see air bubbles in the tubing that may be causing high glucose?
- Has the insulin become damaged (excessive heat, expired, etc.)? Is the time of day set correctly on the pump?
- Is the camper in the correct Basal Program for Camp?
- Check the history menu for time/delivery of the last bolus. Was it completed?
- Does the pump have insulin in it?
- If using an AID system, which delivery mode is activated?

When in doubt, change the site out!

Links to pump guides

Medtronic 770: https://www.medtronicdiabetes.com/sites/default/files/library/download-library/user-guides/MiniMed_770G_System_User_Guide.pdf

Medtronic 670: https://www.medtronicdiabetes.com/sites/default/files/library/download-library/user-guides/MiniMed-670G-System-User-Guide.pdf

Tandem T slim: https://www.tandemdiabetes.com/docs/default-source/product-documents/tslim-insulin-pump/tslim-user-guide-(4-3-2).pdf?sfvrsn=da6e39d7_10

Omnipod: https://www.omnipod.com/sites/default/files/2021-04/Omnipod-System_User-Guide_English.pdf

Omnipod 5: https://www.omnipod.com/sites/default/files/Omnipod-5_User-guide.pdf

Policy for Medtronic 670/770G/780GAutomated Insulin Delivery System:

The Medtronic 670/770G/780G is a hybrid closed loop system using a both a Medtronic insulin pump and Medtronic Guardian CGM. The 670G and 770G use the Guardian 3 CGM; the 780G uses the Guardian 4 CGM. The Guardian 3 requires fingersticks glucose calibrations 2-4 times per day, but the Guardian 4 only requires a fingerstick glucose at the time of entry into Smartguard (automated mode).
The algorithm is the same for the 670g and 770G and the basal rate is increased or decreased based on CGM values. The 780G algorithm is different; it adjust basal rate but also gives automated corrections if the automated basal rate has reached maximum delivery. It has adjustable glucose targets of 100, 110 or 120 mg/dL. A temporary target of 150 mg/dL can be used on all 3 Medtronic systems; the 780G will not deliver automated corrections if the temporary target is on. 770G and 780G have bluetooth capabilities and a mobile app which shows CGM readings in addition to viewing CGM readings on the pump.

While in auto mode, the 670/770G/780G will automatically adjust basal rates, and will also automatically calculate insulin sensitivity factors. The insulin on board feature and the

carbohydrate ratios are the only adjustable settings while in auto mode. Insulin on board should be adjusted if there is a concern about over-or under-correcting hyperglycemia. Every night at midnight, the pump will re-calculate the total daily dose based on the average total daily dose for the past six days. There are also minimum and maximum auto basal delivery limits, based on the total daily dose.

The goal is to keep campers in automated mode as much as possible during camp. When campers are very active, they typically do not need as much insulin. However, as the total daily dose on the 670/770/780G is an average over the past six days, the basal rates and insulin sensitivity factor may not change as quickly as needed if there is a sudden increase in activity. We recommend that campers are as active as possible during the week prior to camp. This will allow the total daily dose to reset and be more accurate for the increased activity level at camp. Temporary target should be set to 150 mg/dL at all times. The temporary target can be set for 12 hours at a time, so it needs to be verified, and reset if needed, at each meal and before bed. It should be documented each time a calibration is completed and each time the temp target is reset.

The 670/770/780G must be suspended any time it is removed, including the swimming pool and shower. This is very important because the pump needs to know how much insulin the patient is actually receiving to appropriately adjust the insulin doses.

A correction bolus (for hyperglycemia) should not be given when the 670/770 shows down arrows. Only deliver a correction dose when the system shows up or steady arrows. The 780G algorithm will account for changes in glucose trends so a correction can be given at any time.

A carbohydrate bolus can be given at any time regardless of the arrows. The auto basal on the system will always be working to bring the glucose to 100-120 mg/dL (150 with the temp target).

If the camper has an alert that the pump is exiting auto mode, or if there is an alert that the pump requires a fingerstick glucose confirmation, the camper should see a clinic member within the next 60 minutes for assistance. The clinic staff will assist the camper in entering a fingerstick glucose into the system, or if needed further troubleshoot to try to re-enter auto mode. Clinic staff should refer to the Medtronic School Nurse guide for further information. It is our goal to keep the camper in auto mode as much as possible during camp, but there may be situations where this is not possible and manual mode will be used.

Considerations and Adjustments prior to starting camp

- At Check In: Reduce carb ratio and ISF
- **At check-in, manual basal rates and other manual settings must be adjusted by the physician as would be done for any other pump, in the case that auto mode is turned off and the pump reverts to manual mode.**
- Campers must bring all pump and CGM supplies with them, including several extra sensors in case one falls off early, batteries and a CGM transmitter charger

- Camp is not responsible for lost or damaged 670/770/780G systems.

Policy for Tandem Automated Insulin Delivery System:

The TandemX2 insulin pump is integrated with Dexcom G6 CGM. It is small, touch-screen and has a rechargeable lithium battery. The pump charges just like a cell phone does. Pumps should be charged daily at camp. The TandemX2 insulin pump has two softwares (algorithms) available, Basal IQ and Control IQ.

Basal IQ uses CGM data to make 30 minute glucose predictions. If predicted to be under 80 mg/dL or if glucose is under 70 mg/dL, basal insulin delivery automatically suspends. The algorithm reassess every 5 minutes to see if glucose is trending up, and will make the decision to stay suspended or resume.

Tandem basal IQ low glucose suspend:
● Low glucose suspend feature will be kept ON during camp.

Control IQ is a hybrid closed loop insulin pump software/algorithm using a t-slimX2 pump with a Dexcom G6 CGM. It uses the programmed basal rates as a starting place, and automatically adjusts the set basal rates up and down to reach the target glucose using 30 minute predictions. When in automated mode, the target is automatically set to 110 mg/dL (basal will decrease if glucose predicted to drop below 112.5 mg/dL, and increase if glucose predicted to go over 160 mg/dL). Targets can also be set for correction doses, but only for manual mode. The pump also uses the programmed carbohydrate ratios and insulin sensitivity factors. It has a factory set insulin on board of 5 hours. It gives automatic correction boluses up to every hour if the glucose is predicted to be over 180 mg/dL; the bolus is 60% of what the usual bolus would be, and is only given if it has been one hour after the previous bolus.

Exercise mode is an option under the “activity” menu. Exercise mode will be turned on for all campers, for the duration of camp. When exercise mode is turned on, the target glucose is increased to 140-160. This means that it will decrease basal delivery if the glucose is predicted to drop below 140, and increase basal delivery if glucose is predicted to increase over 160 mg/dL. An automatic correction bolus will be given every hour as needed, if the predicted glucose is over 180 mg/dL. You can tell that exercise mode is on because a small running person icon will show up in the upper right corner of the pump screen.

There is also an option for **“sleep mode”** on controlIQ. Sleep mode should **never be on during camp**. In sleep mode, the basal will decrease if glucose is predicted to drop below 110 mg/dL, but will increase if glucose is predicted to go above 120 mg/dL (rather than 160 as in normal or exercise mode). Automatic corrections are not given in sleep mode. You can tell that sleep mode is on because a cloud icon with “zzz” will show up in the upper right corner of the pump screen.

Control IQ will remain in "automated" mode as long as it is receiving CGM data without signal loss for more than 20 minutes. The goal is to keep campers in automated mode all of the time.

Considerations and Dose Adjustments at the Start of Camp:

- **Tandem Control IQ hybrid closed loop system at Check In:**
    1. **Reduce correction**
    2. **Reduce carb ratio**
    3. **Put in exercise mode**
- The camper should create a second basal profile with settings appropriate for camp, usually at least a 10% reduction. This basal profile should be the active profile during the duration of camp. Campers may also need less insulin for carbohydrates and correction doses (ISF); this should be an individual consideration at check-in.
- Exercise mode should be turned on for the duration of camp. Once it is turned on, it will stay on until it is manually turned off. There will be a small icon of a person "running" in the upper right corner of the screen.
- Camp clinic staff should double check the icon is there at least once a day.
- Sleep mode should never be on during camp. At check-in, clinic staff should cancel any pre-set sleep mode settings (in addition, sleep mode and exercise mode cannot be active at the same time).
- The Control IQ system must be suspended any time it is removed, including the swimming pool and shower. This is very important because the pump needs to know how much insulin the patient is actually receiving to appropriately adjust the insulin doses.
- Campers must bring all pump and CGM supplies with them, including several extra sensors in case one falls off early.
- Camp is not responsible for lost or damaged Control IQ systems.

Policy for Omnipod 5 Automated Insulin Delivery System:

Omnipod 5 Automated Insulin Delivery System:

The Omnipod 5 System is a hybrid closed loop system that consists of the Omnipod 5 app (using either an Insulet-provided Controller or compatible smartphone), Omnipod 5 application, Omnipod 5 pod, and the Dexcom G6 CGM system with Dexcom G6 Mobile phone application. Compatible smartphones have a mobile app for controlling the pods, which also displays Dexcom data, as well as a separate Dexcom app. Either the Insulet-provided Controller OR the mobile app is used. If the Insulet provided controller is used, a separate smart device is needed for the Dexcom.

At system initiation, the Omnipod 5 System uses the programmed basal rates as a starting point for automated insulin delivery. It then adapts with each pod change over time by tracking insulin delivered by the system. Insulin history and adaptation is stored in the Omnipod 5

controller or Omnipod 5 app. As each pod is deactivated and a new one is activated, the system adapts insulin delivery based on physiological needs and total daily insulin (TDI) delivered. The system increases insulin delivery for predicted hyperglycemia and decreases or pauses insulin delivery for predicted hypoglycemia based on one hour predictions. The basal rate changes are called “adaptive basal rate”. The adaptive basal rate can by up to 4 times as much as the standard basal rate. THE BASAL RATES THAT ARE PROGRAMMED ONLY MATTER IN MANUAL MODE. THEY HAVE NO IMPACT AT ALL ON AUTOMATED MODE; AUTOMATED MODE BASAL RATES ARE CALCULATED BY THE ALGORITHM BASED ON THE TOTAL DAILY INSULIN, AS DESCRIBED ABOVE.

Target glucose is customizable and can be set between 110-150 mg/dL, in 10 mg/dL increments and up to 8 segments can be added per day. The system uses user-set bolus calculator settings (insulin to carbohydrate ratios, correction factor, and target glucose), current glucose, CGM trend arrow, and entered carbohydrates to calculate boluses with the SmartBolus Calculator in Automated and Manual Modes. The Duration of Insulin Action parameter is used to calculate IOB from recent bolus delivery, is customizable, and impacts user-initiated bolus delivery.

The only setting that directly impacts insulin delivery by the algorithm is the target glucose. The system will stay in Automated Mode as long as it is receiving CGM data. If CGM data is lost, the system will enter “Automated Mode: Limited ” and it will use the lower basal rate (programmed vs. most recent automated basal rate) during “Automated Mode: Limited”. If the automated basal rate was zero, a zero basal rate will be delivered for up to one hour, at which time the programmed basal rate will resume. To troubleshoot “Automated Mode: Limited” outside of the CGM warm-up period or water activities, ensure there is a CGM signal and open up the Dexcom G6 mobile app. If maximum basal delivery is reached, the system will alert and revert to manual mode. To go back in automated mode, the alert must be acknowledged, and after waiting for 1 CGM cycle, the user must re-enter automated mode.

Considerations and Adjustments prior to starting camp:

1. The camper should create a second basal profile with settings appropriate for camp, usually at least a 10% reduction. This basal profile should be the active profile during the duration of camp in case of utilizing manual mode (programmed basal rates do not matter while in automated mode). Also consider reduction of carb coverage and correction doses (ISF). This should be an individual decision at check-in.
2. The target should be set to 150 for the duration of camp for all campers.
3. Activity feature can be used as needed on an individual basis and should be discussed at check in with the camper and family. If it is turned on, activity feature has to be reset every 24 hours. Using activity feature increases the target to 150 but also limits the adaptive basal rate by half (adaptive basal rate will be up to 2x the standard basal rate, rather than the usual 4x.)
4. The Omnipod 5 pods can be worn in the pool and are waterproof. This is different from other HCL systems and must be kept in mind, because these campers will continue to receive their insulin the entire time during swimming and water sports, while Control IQ and Medtronic users will not be receiving insulin. They may require even lower insulin

settings during swimming. Water often interferes with the signal between the CGM and the pod, so the system may enter "Automated Mode: Limited" frequently during swim time.

5. Campers must bring all pods and CGM supplies with them, including several extra sensors and pods in case any fall off early.
6. Camp is not responsible for lost or damaged Omnipod 5 systems.

See Pre-Pivotal Publication for System Functionality information provided
https://www.liebertpub.com/doi/pdf/10.1089/dia.2020.0546

DIY Closed Loop Systems:

- Campers are able to use DIY systems at camp, but must have the ability to manage and troubleshoot on their own.
- Campers must bring a Nightscout/Tidepool report at check-in, or other similar report that shows current pump settings.
- We recommend setting up a "camp profile" ahead of time; this may be adjusted at check-in after discussion with a physician.
- If having too many hypos with the auto-bolus branch, camper will be switched to "open loop".
- We will do our best to assist campers, but if we are unable to troubleshoot, or if there is too much hypoglycemia or hyperglycemia, the camper will need to use the system in "open loop". Families should be prepared with an alternative system and "open loop" settings if needed.

Policy for the Use of Real Time Continuous Glucose Monitors (CGM) at Camp Ho Mita Koda:

1. With FDA approval of CGM use in children, many campers are using these devices. Some devices are now approved to be used without confirmatory blood glucose monitoring, and several do not require calibration.
2. At Camp Ho Mita Koda, we want to encourage campers to grow in their diabetes care and we will support those who choose to wear CGM devices. However, the camping environment is different from home and we are implementing the following policy around CGM use to make sure camp remains a fun and safe experience for all of our campers.
3. There are now several different brands and versions of CGMs available. The table below summarizes each CGM system. They have different calibration needs and different situations where they can be used without additional blood glucose meter monitoring. In addition, consideration must be given to the delay that CGMs may have compared to blood glucose meter values. This policy is intended to allow for maximum benefit to campers utilizing CGMs in the camp setting.

CGM Device	Dexcom G6	Dexcom G7	Libre* and Libre 2	Libre 3	Medtronic Guardian 3	Medtronic Guardian 4 and Synergy
Display Devices	Receiver Smartphone T-slim pump Omnipod 5 pump	Receiver Smartphone (does not work with pumps yet)	Scanner Smartphone	Smartphone	Pumps: 670G 770G 780G (can be used with guardian 3 or 4)	Guardian 4 works with 780G pump Synergy investigational only
Sensor and Transmitter	Sensor and transmitter are separate pieces. A new sensor is used with each CGM change. Transmitter must be saved and re-used for up to 3 months.	Sensor and transmitter integrated in one unit. Both are disposed of after 10 days of use.	Sensor and transmitter are integrated in one unit. Both are disposed of after 14 days of use.	Sensor and transmitter are integrated in one unit. Both are disposed of after 14 days of use.	Sensor and transmitter are separate pieces. A new sensor is used with each CGM change. Transmitter must be saved and re-used for up to 12 months.	Guardian 4: Sensor and transmitter are separate pieces. Transmitter must be saved and re-used. Synergy: Sensor and Transmitter integrated in one unit, disposed of together
Glucose data frequency	Glucose automatically displayed every 5 minutes.	Glucose automatically displayed every 5 minutes.	Glucose displayed with scanning only. Not continuously displayed.	Glucose automatically displayed every 1 minute.	Glucose automatically displayed every 5 minutes.	Glucose automatically displayed every 5 minutes.
Data share capabilities?	Yes	Yes	No	Yes	Yes	Yes
How many days does it last?	10	10	14	14	7	7
Does it require calibration?	No	No	No	No	Yes, at least every 12 hours	No (guardian 4 requires blood glucose only

						to enter smartguard (auto mode)

***Libre does not have glucose alerts for hyperglycemia or hypoglycemia. All other CGMs have alerts.**

General:

- Camp Ho Mita Koda is not responsible for the loss, damage, or theft of the camper's transmitters, sensors or receiver devices.
- It is preferred for campers to use non-mobile device CGM receivers. However, if necessary, campers are permitted to use mobile devices as CGM receivers at camp **with removal of the SIM card**. If the pump functions as the receiver for the CGM being used, mobile device receivers are prohibited.
- **There will be no CGM data sharing at camp**. CGM data sharing must be turned OFF for all followers while at camp.

Setting Alerts:

- The **high** glucose alert will be set at 350. If the alert sounds and the reading is HIGH, a confirmatory blood glucose meter reading should be done, and the blood glucose reading will be used to determine the required insulin dose. If there are multiple false alarms, the clinic staff in discussion with the camp physician may change alert thresholds.
- The **low** glucose alert will be set at 90 mg/dL based on discussion with parents and physician at check-in. If there are multiple false alarms, the clinic staff in discussion with the camp physician may change alert thresholds. If the low glucose alert sounds, the CGM glucose can be used WITHOUT A CONFIRMATORY METER GLUCOSE CHECK and the hypoglycemia protocol should be used. Recheck after treatment of a low glucose must be done on the blood glucose meter. If a child feels hypoglycemic but the CGM does not have a low reading, a blood glucose meter check should be done, and that number should be used to decide if treatment is needed. If available, the repeat/snooze alarm interval will be set at 30 minutes for a "LOW glucose."
- All rate of change alerts will be turned off.
- The CGM alerts will be set at the **loudest audio volume and repeat alerts will be turned on.**

Using CGM Data for Treatment Decisions:

- Glucose values from devices approved for non adjunctive use in pediatrics (see table above, currently Dexcom G6/G7, Libre 2/3) can be used for treating hypoglycemia and insulin management, without blood glucose meter results. The Medtronic disposable sensor 5 is can also be used non-adjunctively but is currently an investigational device and will only be used by campers in a research study.
- Changes in insulin management and camp activity clearance will be based on both meter blood glucose results and available CGM results (such as arrows), although there will be no download of CGM data.

- Although CGM data can be used for insulin dosing and low treatment with most CGMs, confirmatory fingerstick checks will be performed 15 minutes after treatment of lows for all CGMs including Dexcom G6
- Counselors and medical staff will be routinely checking the real-time CGM results at the appropriate scheduled glucose check times (pre-meal, bedtime, etc.), but will not be looking at CGM results in between unless the CGM alarms or the camper is symptomatic.

CGM maintenance, including storage, insertion, and calibration:

- Clinic staff will assist campers with insertion of new sensors when needed. We ask that all campers come to camp with a CGM placed **12-24 hours prior** to the start of camp, with the goal that it will last until the end of the camp session.
- Clinic staff will assist campers in calibrating CGMs in the morning and before bed. Calibration glucoses **must be within 5 minutes** of entering the value into the CGM.
- Calibrations will be done on all Medtronic CGMs and the Dexcom G5. Dexcom G6 will **not** be calibrated **unless** showing discrepancy. Freestyle Libre **does not** require calibration (see table).
- Sensors will be stored in the clinic, documented with the camper name. Counselors will work with campers to ensure CGM receivers/display devices are charged. **Charging will be done in the cabins.**

<u>Psychosocial Care and Support:</u>

Attending Camp Ho Mita Koda is intended to be a supportive, enjoyable experience. It can encourage independence both of and for the child. Camp is intended to foster personal growth and to promote the process of adaptation to living with a chronic disease. There are several principles that will foster the achievement of these goals.
Campers require encouragement. Inappropriate counter-motivating methods like coercion, sarcasm, humiliation and intimidation **have no place at camp.** Some campers are lacking in self-care skills, which should be taught and promoted – but only in ways that are positive and sustaining, not in ways that may be perceived as hurtful and hostile.

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

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

Children, like adults, respond to respect and recoil from sarcasm and belittling. Good humor, warmth, and an ability to listen carefully are personal skills that help to bridge gaps and build trust between campers and staff. It would be wise to remain continually aware that campers tend to look up to staff, emulate them, and view them both as older, wiser adults and as friends. Occasionally, a child is beset with serious emotional problems or an overwhelming home environment. **Camp Ho Mita Koda is not a therapeutic milieu**. When serious emotional or psychosocial problems surface, however, they should be brought promptly to the attention of the Camp Director and the Senior attending physician, who will help arrange for a reasonable working plan for the duration of the child's stay at Camp and for a follow-up program at home, with the cooperation of the family, the child's physicians, and/or community agencies.

Non-Diabetes Health Issues:

*For this document: As directed = Follow Over the Counter (OTC) package instructions
*If there is a medication, product, or treatment referenced in below guidelines that is not available at camp, an alternative treatment option can be used or this can be obtained from a local drug store. Some problems are too rare to keep all treatments on hand at camp but suggestions are provided here as guidance.

PROBLEMS	PREPARATIONS OR TREATMENT

Abdominal Pain; gastric (upper abdomen)	• Check blood glucose and rule out ketoacidosis.
	• Burning sensation after eating or with prone position:
	  • Antacids (Tums) as directed
	  • Pepcid (not on formulary) as directed for campers >12 yrs. with parental consent for recurrent symptoms of GERD or gastritis

Abdominal Pain; non-gastric (lower abdomen)	• Check blood glucose and rule out ketoacidosis. • Consult the covering provider with fever, nausea and psoas muscle pain (r/o appendicitis). • Infectious: liquid/bland diet, rest, Bismuth Subsalicylate 263 mg as directed. Do not give this if there is any concern for chicken pox or influenza (as it contains salicylate and can put at risk for Reye's syndrome). • Gyn mid menstrual cycle: Ibuprofen as directed prn, rest, heating pad to abdomen. • Irritated bowel: Tylenol or Ibuprofen as directed prn and/or Bismuth Subsalicylate as directed prn; increase water-soluble fiber as tolerated. • Ginger tea (not on formulary) • See treatment for nausea and/or diarrhea • With urinary frequency or urinary pain: Consider urinalysis to rule out urinary tract infection
Abrasions, small lacerations (check tetanus for a dirty wound--must be < 5 years ago)	• Cleanse with Hibiclens and water. • Cover with Band-aid or non-adherent dressing until scabbed. • Second Skin (not on formulary) is an excellent option to retain moisture. • Mupirocin/bacitracin ointment for minor s/s of infection; consult covering provider if worsens. • Instruct camper on s/s of infection (induration, exudate, pain, expanding erythema) • If there is a significant area of surrounding redness, outline in pen/marker with time and date to monitor if expanding or improving
Allergic rhinitis	• Loratadine as directed or Cetirizine as directed. May add Pseudoephedrine (not on formulary) as directed prn
Allergic Reaction, systemic hives	• Cetirizine (10mg) given orally • With shortness of breath AND/OR vomiting/diarrhea AND/OR fainting/lightheadedness/hypotension, EpiPen immediately and call 911 (see Anaphylaxis Protocol) • If a severe reaction, consider oral prednisone, if available, 1 mg/kg to max of 60 mg (not on formulary and must weigh the risk/benefits of elevated glucose secondary to prednisone).

Aphthous Ulcer	• Swish and spit salt solution • Swish and spit Maalox as directed for pain and protective coating • Throat Coat Tea (not on formulary) swish and swallow
Asthma exacerbation	• Consult covering provider for inadequately controlled asthma esp. in the context of a URI • Give up to 6 puffs back to back with albuterol inhaler and spacer
Bee Stings or other insect bite	• With history of bee sting allergy, administer Epi-Pen immediately and call 911 (see Anaphylaxis Protocol) • Ice locally • Hydrocortisone 1% • Calamine lotion • Cetirizine 10 mg now and daily as needed for itching. • Gauze pad saturated with Diphenhydramine 2% with Benzethonium Chloride 0.15% and Zinc (Calagel) (not on formulary)
Blisters	• Reduce friction to area by eliminating surface contact or with Vaseline or ointment as directed. • Protect any blisters from tearing. • Treat an open/torn blister as an abrasion.
Bug bites (esp. mosquitos)	• Topical calamine lotion. • Topical hydrocortisone cream. • Topical Diphenhydramine 2% with Benzethonium Chloride 0.15% and zinc (Calagel) (not on formulary) • Cetirizine 10 mg daily as needed for itching • Encourage prevention (bed netting, repellants)

Burns: (first and second degree; superficial and partial thickness) **A third degree burn or burns affecting more than 10% of the body require immediate medical care.**	• Cold water (running or chilled) to area for 20 minutes at time of burn. • Salicylate solution topically (use aspirin in water or Willow Bark tincture). • Ibuprofen as directed prn pain • Use Aloe for regeneration of intact skin • If superficially blistered and relatively small, treat as blister. • Cover burn with bandage to help with pain. • For burns over sensitive areas like joints, face, head, neck, genitals or hands, or where joint function or cosmetic outcome could be compromised, consult the covering provider as needed. • For a larger or open partial thickness burn, consult the covering provider. • Elevate any extremity with a partial thickness burn.
Cerumen impaction (ear)	• To soften hardened cerumen, allow hydrogen peroxide to sit in the ear canal for a few minutes, repeat as often as needed. • Encourage chewing gum when appropriate to promote natural wax removal. • If softening is unsuccessful, consult a covering provider.
Conjunctivitis, allergic	• Cool compress for immediate relief • Ketotifen fumarate (Zaditor) eye drops as directed • Cetirizine as directed
Conjunctivitis, bacterial	• Consult covering provider • Antibiotic drops (per formulary) • Emphasize anti-contagion measures
Conjunctivitis, viral	• Consult covering provider • Cleanse eyes with gentle soap like baby shampoo • Application of damp gauze pad with a spot of tearless soap x 10 min QID • Emphasize anti-contagion measures

Constipation, acute	• MiraLAX as directed • Dietary teaching and assistance (e.g. provide fruit for snack)
Cough	• Cough drops • Steam inhalation; apply Vicks vapor rub (not on formulary) • Guaifenesin (not on formulary) as directed for >12 yr. with a productive, tight cough PP. See Asthma esp. for nighttime cough if hx of asthma • If no prior dx asthma, consult a covering provider for SOB, Wheezing or for worsening cough, esp. with fever or >2 weeks • Consider COVID test
Dermatitis, atopic	• Hypoallergenic moisturizing cream applied immediately once done drying off after showering. • Hydrocortisone Cream 1% as directed
Dermatitis, contact	• For blistered dermatitis e.g. poison ivy. Apply to the affected area 3-4 times a day: calamine lotion. Also consider Topical Diphenhydramine 2% with Benzethonium Chloride .15% and zinc (Calagel - not on formulary) • Hydrocortisone cream 1% as directed • Blister fluid does not spread poison ivy, but if oils remain on skin or clothing it can - clean with poison ivy soap (this is available in clinic).
Dermatitis, sun rash	• Aloe Vera • Cool baking soda paste
Diarrhea, acute	• Replace fluids, liquid diet advanced to bland as tolerated until resolved. • Avoid dairy products. • Dietary teaching
Dysmenorrhea (menstrual cramps)	• Ibuprofen as directed • Heating pad to abdomen

Eye irritation; foreign body, dry eye etc.	• Flush (with isotonic buffered eye wash) or remove foreign body if present • Can pull out upper eyelid and invert with qtip to evaluate for remaining foreign body  • Eye Wash as directed • Single dose eye lubricant - can use allergy eye drops if no other eye drops available
Fever (Temperature over 100.4F)	• Hydrate • Acetaminophen as directed • Consult covering provider for any fever • Consider COVID test • Evaluate for source of fever
Folliculitis	• Wash with antibacterial soap. • Apply Mupirocin/Bacitracin cream to affected area and keep covered • Consider oral antibiotics if there is a significant lesion or large involved area, consult the covering provider. • Emphasize anti-contagion measures if MRSA/Impetigo diff dx (see protocol below)

Head lice	• Nix (not on formulary) as directed for live lice or nits with no history of treatment followed by nit removal as much as possible • Monitor only for nits less than 1” from scalp with hx of treatment • Malathion (Ovide) for Permethrin (Nix) resistant lice per consult with the covering provider. • Heat treat (hot water or dryer) all bedding and recently worn shirts hats jackets combs brushes etc. (anything near the head) or bag these items x 7 days.
Headache	• Hydrate child. • Rest in a dark room. • Acetaminophen as directed or • Ibuprofen as directed.
Head Injury	• See Head Injury Protocol (Appendix A)
Herpes - orolabial	• Docosanol (Abreva)(not on formulary) as directed at first tingle • Contact parent for history and treatment preference. • Consult covering provider for antiviral treatment within 48 hours if prior history and per parent authorization
Impetigo and infected excoriated insect bites	• Shower with antibacterial soap • Apply Mupirocin/Bacitracin cream and cover if lesion is open • Consider oral Keflex, consult covering provider
Musculoskeletal injury	• Assess for fracture and consult covering provider as needed • Rest, Ice, Compression, Elevation • Ibuprofen as directed

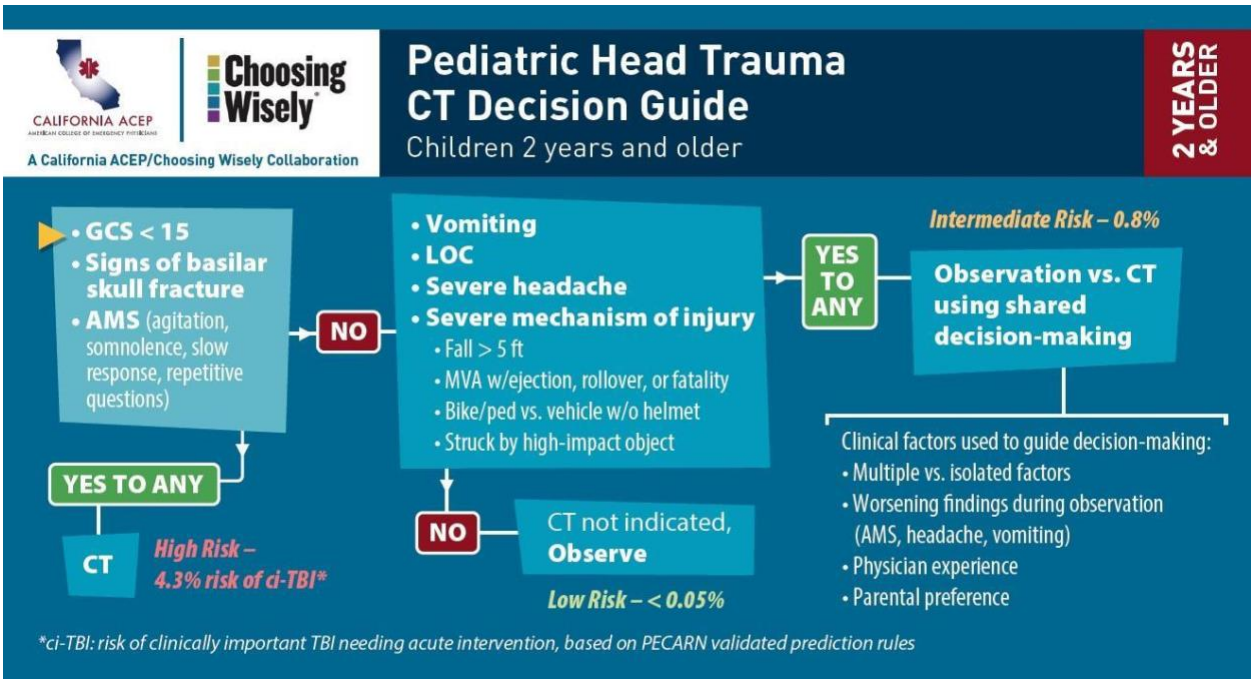
Nausea/vomiting	• Check blood glucose and rule out ketoacidosis. • Encourage small sips of clear liquids every 15 minutes, rest • Ondansetron as directed in consultation with covering provider for emesis with dehydration (max 2 doses) • Advance diet slowly • Follow Oral Rehydration Solution recipe. Take small sips frequently
Otitis Externa	• Mix 1:1 rubbing alcohol with white vinegar immediately after swimming for mild pain or slight redness • Ofloxacin ear drops per consult with covering provider for worsening pain, redness • Okay to swim, but camper should not put head under water until treatment complete
Otitis Media	• Ibuprofen as directed, prn pain • Consult covering provider for antibiotic with bulging red tympanic membrane or severe worsening pain
Pharyngitis, strep	• Refer to urgent care high probability (fever, cervical adenopathy, abnormal exam pharynx)
Pharyngitis, viral	• Hydrate vigorously. • Salt water gargle • Ibuprofen as directed • Comfort measures (Cepacol lozenge/spray, tea w/honey) • Consult covering provider for r/o Mono w/symptoms: fatigue, rash, swollen glands
Sinusitis, sinus pain	• Pseudoephedrine if congested as directed. • Ibuprofen as directed. • Saline nasal rinse BID (not on formulary) • Vigorous hydration • Consult covering provider for prolonged symptoms

Tick bite	• Remove tick and identify • Use fine-tipped tweezers to grasp the tick as close to the skin's surface as possible. • Pull upward with steady, even pressure. Don't twist or jerk the tick; this can cause the mouth-parts to break off and remain in the skin. If this happens, remove the mouth-parts with tweezers. If you are unable to remove the mouth easily with clean tweezers, leave it alone and let the skin heal. • After removing the tick, thoroughly clean the bite area and your hands with rubbing alcohol or soap and water. • Never crush a tick with your fingers. Dispose of a live tick by putting it in alcohol, placing it in a sealed bag/container, wrapping it tightly in tape, or flushing it down the toilet. • If it is a deer tick and has been attached at least 36 hours (by history or fully engorged), consult the covering provider for prophylactic antibiotics.

UTI	• Check LMP/sexual activity in appropriate population • Evaluate for s/s of pyelonephritis (CVA tenderness, fever, abd/pelvic pain); Obtain clean catch urinalysis. • Consult covering provider for positive leukocytes and/or positive nitrites on clean catch dipstick, with symptoms. • Encourage fluids. • Use Keflex as first line antibiotic if UTI, consult covering provider • Consult covering provider for persistent and/or severe symptoms with negative dipstick • Educate campers on completely emptying the bladder, not holding urine, and proper wiping technique for female campers.

Head Injury Protocol:

- All incidents of head injury are to be evaluated using the Traumatic Brain Injury (TBI) assessment tool (see below). If using a TBI tool, Healthcare Manager needs to inform parents of the event, findings (even if negative), and plan.
- A positive finding is defined as any deficit/change in level of consciousness (AVPU) and or any degree of amnesia.
- Any camper who has a positive finding on the TBI assessment tool will be monitored closely and depending on the severity of the symptoms or deterioration of symptoms, will result in an ER referral or 911 call. Any + TBI finding needs to have a call to the covering provider.
- After any ER visit, the camper will be closely monitored for at least 2-4 hours. The development of any neurological deficit or alteration in consciousness, a progressively severe headache, blurred vision, photophobia or repeated bouts of vomiting would result in a return to the ER/Urgent Care/HCP. It is understood that a significant period of uninterrupted rest during the night is essential for healing to occur.
- Any camper who develops signs and symptoms of post concussive syndrome (normal mental status (A&Ox4) with – mild to moderate headache, disrupted sleep pattern, nausea, loss of appetite, dizziness) will be monitored and treated with rest and restricted activity as determined by the severity of the symptoms. It is understood that a significant period of uninterrupted rest during the night is essential for healing to occur.
- If symptoms deteriorate, the patient will be referred to the ER. Otherwise, consider consulting a covering provider based on findings and plan s/p initial ER evaluation.
- A graduated plan for participation in camp activity will be developed by the nurse in conjunction with the covering provider for any camper who has sustained a head injury with positive findings on the TBI assessment tool or post concussive syndrome.



Source: https://californiaacep.org/resource/resmgr/files/images/pecarn_over_2.jpg

MRSA Protocol:

Pre Camp:
Screen for a history of MRSA (the first episode in a camp is usually a recurrence) and recent skin infection
Train staff to watch for, recognize, and refer lesions that might be MRSA/impetigo

Clinical:
Symptoms:

1. Any skin lesion such as a sore (may look like a spider bite) or boil that presents with significant redness, warmth, swelling, and tenderness should be considered a potential site of MRSA. For girls that shave, common sites are armpits and legs.
2. A sore that seems minor but does not heal and/or recurs should be considered suspicious.
3. See http://www.webmd.com/skin-problems-and-treatments/ss/slideshow-closer-look-at-mrsa for pictures

Treatment of Suspected Lesions:

- Skin lesions (usually folliculitis) that are suspicious of MRSA, but present with intact skin and no exudate that could be obtained (i.e. no white 'head') can be treated with BID washing with antibacterial soap and the application of neomycin cream (ointment can be used, but is less well absorbed) or mupirocin (Bactroban) on consultation with covering provider

- Any lesion suspicious of MRSA that is draining or could be drained should be referred for culture. Instruct campers/staff to never ever drain or pop a skin lesion.

Treatment of diagnosed MRSA:

- Administer antibiotics and perform skin care per covering provider. Maintain an occlusive dressing.
- Ensure that camper/staff will responsibly maintain an intact and occlusive dressing and will be compliant with dressing changes.
- Clinician is to review lesions and decide if camper/staff can swim and should shower/bathe separately so that the area can be disinfected after use and the dressing changed.
- Consider switching out disposable personal items (razor, bar soap etc.) and clothing, towels, sheets etc. must be washed in hot water after treatment is initiated.
- Campers/staff will be instructed on hand washing and provided with alcohol-based cleansers.

Public Health Measures:

Standard (to be in place while camp is in session and when there is no more than one active case of diagnosed or suspected MRSA).

- Mantra of don't share towels or washcloths from day one.
- Clean showers and outhouses daily with bleach (1 tablespoon to 1 quart)
- Keep all open cuts or sores covered. Educate campers/staff.
- Monitor excoriation (esp. Mosquito bites) and refer with signs of infection (see impetigo).

Heightened Alert (if more than one camper has an active case of diagnosed MRSA):

- Institute some form of head to toe inspection (respecting privacy) without inducing paranoia or panic.
- Consider antibacterial soap showers for close contacts (would need consulting provider approval and parental consent)
- Ensure frequent washing in hot water for towels and sheets of close contacts.
- Rigorous follow through on standard measures

<u>Homesickness at Camp Ho Mita Koda:</u>

Homesickness is most often of short duration and may occur in any age child. The best treatment for helping a child through homesickness is to provide a "friend". This "friend" becomes someone the camper can rely upon but, more importantly, is someone who is firm in reinforcing camp as a fun rewarding place.

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

Staff Guidelines:

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

Standing Orders for OTC & PRN Medications:

Pain Medications:

- Ibuprofen – 10 mg/kg/dose (Max 600 mg) q6h PRN
- Acetaminophen – 15 mg/kg/dose (Max 1000 mg) q6h PRN

Anti-histamines:

- Cetirizine – 10mg daily or PRN allergic reaction
- Loratadine – 10mg daily (if available)

GI Meds:

- Throat lozenges – >5 yrs – 1 every 2 hours PRN
- TUMS:
    - < 5 yrs 1 every 2-4 hours (Max 3 tabs in 24 hours)
    - 6-11 yrs 2 every 2-4 hours (Max 6 tabs in 24 hours)
    - > 12 yrs 2 every 2-4 hours (Max is 15 tabs in 24 hours)
- Miralax – 1 capful twice daily PRN. Mix with 8 oz of water.
- Bismuth subsalicylate: Max 8 doses in 24 hours.
    - 6-9 yrs: 175 mg q1h PRN
    - 9-12 yrs: 262 mg q1h PRN
    - >12yrs: 524 mg q1h PRN

Topicals:

- Bacitracin – Application to cuts and abrasions. 1 application twice daily
- Calamine Lotion – Insect bites, poison ivy
- Hydrocortisone 1% - insect bites, dermatitis
- Technu – Poison Ivy Wash (Wear gloves, wrap clothes, in shower)
- Aloe Vera – Cooling lotion for sunburn. PRN.
- Sunscreen/Zinc Oxide – Prevention of sunburn on exposed areas. Apply every 2 hours as needed.
- Lotrimin/Tolnaftate powder – Athlete's foot/ jock itch. Apply twice daily as needed.
- Vasoline
- Eye Flush – Keep the injured eye lower and flush for 15 minutes.
- ALL OTHER MEDICATIONS PER MD ORDER

Per MD Order:
Antibiotics, Prednisone, Zofran, Eye/ Ear Drops
All other medications, including those on formulary.

Sexual and Physical Abuse and Neglect:

Warning Signs of Child Sexual Abuse and Exploitation:

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

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

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

Symptoms of Child Abuse and Neglect:

- Possible indications may be when the child:
    - Repeatedly shows evidence of overall poor care
    - Malnourished
    - Dirty
    - Inadequately and inappropriately dressed for weather
    - Lack of medical attention
    - Has obvious injuries: welts, bruises, untreated sores or other skin injuries
    - Appears different in physical or emotional make-up
    - Displays withdrawn, fearful, apprehensive or extremely aggressive behavior
    - Exhibits learning problems that cannot be diagnosed
    - Attention wanders a substantial portion of the time
    - Easily self-absorbed
    - Often appears tired and frequently sleeps
    - Demonstrates adult-like behavior, especially towards parents
    - Exhibits sudden change in behavior

Staff: Health and Medications:

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

Staff medications, including insulin, syringes and other diabetes supplies, will be kept in the inner room clinic under lock, unless such medications can be securely maintained, away from the children. The purpose of this is to prevent children playing or tampering with these materials. Camp staff are Not Allowed to enter the inner room of the clinic to obtain medication, therefore clinic personnel must retrieve and present camp staff member's medication.

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

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

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

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

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

Universal Precautions:

As part of an overall exposure control plan, mandated by the OSHA Bloodborne Pathogens Standard, "universal precautions" are part of infection-control practices.

They are specific guidelines which must be followed by all CHMK staff and volunteers to provide every person adequate protection from diseases which may be present in blood. Since blood can carry all types of infectious diseases, even when a person does not look or feel ill, knowledge of universal precautions is essential for anyone who might encounter blood or other

body fluids.

The following guidelines apply to all employees and healthcare providers of the Camp Ho Mita Koda Foundation:

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

- Healthcare providers who have draining lesions or weeping dermatitis should refrain from all direct care and from handling equipment until the condition resolves.
- All procedures should be specific to the staff and clientele served.
- All persons who might encounter blood or other body fluids must be trained to follow appropriate procedures.

Exposure Control Plan:

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

JOB CLASSIFICATIONS WHICH, BY VIRTUE OF JOB DESCRIPTION, INCUR THE RISK OF EXPOSURE TO BLOOD AND OTHER BODY FLUIDS: nurse, physician, resident physician, clinic staff, counseling staff and all onsite staff and volunteers during an active camp session.

JOB CLASSIFICATIONS WHICH, BY VIRTUE OF JOB DESCRIPTION, PROVIDE FIRST-AID CARE AS AN ANCILLARY TASK RATHER THAN A PRIMARY TASK: lifeguarding staff when on-duty at the waterfront and all onsite staff and volunteers during an active camp session.

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

Koda Clinic staff and healthcare providers can reasonably expect to encounter blood and other body fluids. The potential for exposure to transmitted diseases is greatest for these staff members. Consequently, the recommended exposure control plan involves the following practices:

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

1. Identification of risk areas: contact with bloodborne pathogens (e.g., hepatitis, HIV), contact with airborne pathogens (e.g., common cold, TB), contact with surface- borne pathogens (e.g., staph infections).
2. Education about the nature of the risk: the method of transmission, virulence of pathogens, resistance factors related to potential host, symptoms, and information sources which provide clues to potential risk areas.
3. Work practices designed to minimize exposure:

a. Availability of personal protective equipment (PPE) – gloves, CPR mask, antimicrobial soap, (eye, nose, and mouth) shield, body fluid spill clean-up kits.
b. Double-bagging via red bag and disposal procedure for hazardous waste.
c. Screening individuals who come to the program.
d. Requiring participants to provide health information.
e. Use of universal precautions by staff.
f. Education for people working in risk areas: health-care team members, lifeguards, housekeeping, kitchen staff.
g. Hepatitis B vaccination for nurses: camp pays for vaccinations done by the local provider during the nurse's contracted time. Camp encourages unvaccinated nurses to get vaccinated.
h. Video which teaches effective use of the CPR mask.
i. Sharps container provided which has biohazard label affixed.
j. Resource personnel to answer questions: camp health-care administrator, camp supervising physician, and State Dept. of Health epidemiologist.

Behavior expected from employees to minimize risk:

Use of PPE:

- Gloves are used when in contact with body fluids or providing skin treatment (e.g., applying medication to poison ivy, washing a rash).
- A CPR mask or faceshield is used to provide CPR/artificial respiration.
- Minimum 15-second hand washing with antimicrobial soap after: removing gloves, contact with potential risk, unprotected contact with any body fluid.
- Minimum 60-second hand washing with antimicrobial soap after blood splash. Use of body fluid spill clean-up kit.
- Vaccination to protect from hepatitis B.
- Sharps disposed of properly: no recapping of needles, all sharps (lancets, needles) placed in a sharps container immediately after use, full sharps container given to Administrator for disposal through local hospital.
- Participation in education about disease control.
- Immediate reporting suspected exposure (e.g., needle stick) to supervisor and Administrator.
- Performing job tasks in a manner which minimizes/eliminates exposure potential.
- Evaluation of compliance with the camp exposure control plan as part of the camp personnel-management system.

Camp Counseling Staff:

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

In keeping with accepted practices, the camp Healthcare Manager educates camp staff during orientation about appropriate response practices:

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

Needle stick Injuries:

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

Post-Exposure Plan:

Camp employees who have a blood exposure incident are eligible for follow-up treatment. Follow-up is initiated by the employee who must immediately (within fifteen minutes) notify the camp nurse when a blood exposure incident occurs. The following plan is initiated. Records

of the incident are maintained for the duration of employment plus thirty (30) years by the Camp Director and according to OSHA requirements (i.e., separate from personnel records). Camp administration debriefs each incident in an effort to identify ways to improve the camp's exposure risk.

Timeline	Employee's Actions	Healthcare Manager's	CHMK Leadership
Timeline: Within 24 hours	Employee's Actions: Exposure incident occurs. Report the incident to the camp nurse within 15 minutes of happening. Begin prophylactic treatment. Complete Workers' comp form & incident report with camp director.	Healthcare Manager's: Notify the Camp Director. Begin 15- second scrub of area with bacteriostatic soap, followed by application of disinfectant. Contact supervising MD and refer client for assessment. Begin psychosocial support process.	CHMK Leadership: Determine source of contamination; initiate request to have source screened for infectious diseases. Notify insurance. Create incident report files with supporting documentation. Contact mental health professionals for employees. Complete Workers' comp & incident report form with employee.

Within next 48 hours	Continue medical follow-up, per MD orders. Begin counseling support.	Monitor client adjustment to situation; answer questions, as needed. Provide needed care.	Follow testing of source individuals as warranted. Consult with mental health professional to arrange post-camp therapy, per need.
Beyond first three days	Continue post-exposure prophylaxis, as directed by MD. Participate in a review of incident.	Participate in a review of incident.	Maintain contact with employees to follow incidents. Lead review of incident. Review incidents; adapt camp practices as needed to manage risk, and to minimize chance for repeat of situations. Maintain records for duration of employment, plus 30 years.

Guidelines for Closing the Clinic at the End of the Season:

1. Inventory all supplies and meds.
2. Put open meds in plastic bags and place them in a box to be given to the Camp Ho Mita Koda Foundation.
3. Check all cabinets for medications and supplies that will expire prior to next camp season. Place in box for the Camp Ho Mita Koda Foundation; label as meds to expire.
4. For all remaining insulin, ensure expiration dates are beyond the dates for camp next year. If insulin will expire prior to next season, please place it in plastic bags and give it to the Healthcare Manager. Insulin that can be used the following camp year will be stored until next season.
5. Estimate needs for next year. Send inventory and list of needs for next year to the Healthcare Manager.
6. Seal all pump supply boxes.
7. Clean all counter tops.
8. Check with the Operations Manager and Medical Committee to see if anything else needs to be done.

Links to External Documents:

Link to Communicable Disease Plan

CDP.docx

Link to Pump Guides

ADA Pump guides.docx

Non-Camp Programing and Rental Camps:

- Camp Ho Mita Koda sponsored camps or weekends may have medical staff on site, medical staff on call or non-licensed medical staff present depending on the event.
- It is suggested that campers follow camp protocols for diabetes and non-diabetes related medical concerns as applicable.
- If it is a family camp and a concern arises, the camper's parent/guardian should be involved in care if present.
- Non-Emergency
    - If non-emergency medical support is needed, camper may contact medical staff on site or on call. If there is no one on call for the event, camper and or staff/family should contact their personal provider /nurse line as they would do if experiencing a situation while at home.
- Emergency
    - If an emergency happens at camp
        - If medical staff is on site they should be contacted first.
        - If medical staff is not on site, camper or staff should be taken to the urgent care, emergency room or call 911 as indicated. If medical staff is on call, they should be notified of this event and advice solicited if there is time to do so.
- Rental Camps
    - Rental Camps (camps using Camp Ho Mita Koda property but not sponsored directly) are responsible for their own medical coverage staff member for medical needs. This includes managing and dispensing of home medication, treating basic first aid and other complaints that arise during camp. Rental camp staff may have access to basic first aid l supplies IF a Camp Ho Mita Koda staff member (preferably the Healthcare Manager) is present when these items are obtained. The Healthcare Manager may choose to make a limited amount of basic supplies available (bandages, etc) for that week and keep other supplies locked away. Items that will expire before the next sponsored Camp Ho Mita Koda event may be shared liberally. Items that could be saved for future Camp Ho Mita Koda events should be shared cautiously. If a significant amount of items are used a week, an inventory should be taken at the end of the week to adjust numbers and determine if this policy should be adjusted.

CHMK Koda Clinic Supply Inventory Protocols:

UNPACKING PROTOCOL:

This should ideally be conducted by 2 members of the medical committee or medical staff.

1. All deliveries should be received in person by the Executive Director, Camp Director, Healthcare manager or another designated individual.
2. All supplies should be checked against the packing slip/delivery form, if available.
3. All items should be labeled immediately with expiration date in clear view. Example: 06/2021. If there is no expiration date, the date the item was received should be labeled. Example: R: 06/2021. (This allows quick, and clear ability to recognize expiring materials and to be sure to use all supplies in a first-in-first-out method.)
    a. If any items have already expired, please set aside and immediately notify the inventory team for next steps.
    b. Please label each individual item package within reason. For example, label each box of blood glucose strips, not the entire cardboard box, but also not each strip.
4. All items should be added to Sortly appropriately.
5. Then, place the item in its appropriate location within the clinic, ensuring that the new items are always placed in the bottom and back of any existing supplies to allow a first-in-first-out method. (Oldest items up front and top and newest items in the back and bottom)
    a. If the designated location is unknown, please consult with Healthcare Manager or a member of the inventory committee to determine its proper location.
    b. All supplies should be kept up and off the floor. All medications should be kept in a locked area.
6. Any packing slips or delivery forms should be forwarded on to the healthcare manager and inventory committee to allow for checking if all ordered items were able to be received or if alternate options need to be identified.
7. Be sure to double check no items were overlooked in the packaging and dispose of it properly.

INVENTORY PROTOCOL:

This should be completed at the end of EACH camp session; ideally be conducted by 2 members of the medical committee or medical staff.

1. Work in a meaningful manner throughout the clinic to ensure no items are overlooked. (moving in a circle through the space starting top to bottom)
2. Check all expiration dates. If any items are expired, please set them aside, and mark them as wasted in the notes section of sortly.
3. Update inventory system with current item count. If the current count has fallen below the critical level, be sure to immediately notify the healthcare manager.
4. Ensure all items are in the correct location and organized in a first-in-first-out method. (Oldest items up front and top and newest items in the back and bottom)

    a. All supplies should be kept up and off the floor. All medications should be kept in a locked area.
5. Continue until all medications and supplies have been inventoried.
6. Throw away any medications that expired when finished. MAKE NOTE OF WHAT HAD TO BE THROWN AWAY using “wasted” in the notes section of Sortly. so this can be accounted for in future ordering. Be sure to notify the healthcare director of any critical supply issues.

END OF SEASON PROTOCOL:

This should be completed immediately following the last camp session; ideally be conducted by 2 members of the medical committee or medical staff.

1. NO medications should be removed from the clinic prior to final inventory.
2. Work in a meaningful manner throughout the clinic to ensure no items are overlooked. (moving in a circle through the space starting top to bottom)
3. Check all expiration dates. If any items will expire prior to July of the following year, please set them aside, and mark them as wasted in the notes section of Sortly.
4. Update inventory system with leftover item count.
5. Ensure all items are in the correct location and organized in a first-in-first-out method. (Oldest items up front and top and newest items in the back and bottom)
    a. All supplies should be kept up and off the floor. All medications should be kept in a locked area.
6. Continue until all medications and supplies have been inventoried.
7. Notify the healthcare director of the medications that have been pulled due to expiration dates so that they can be distributed appropriately.

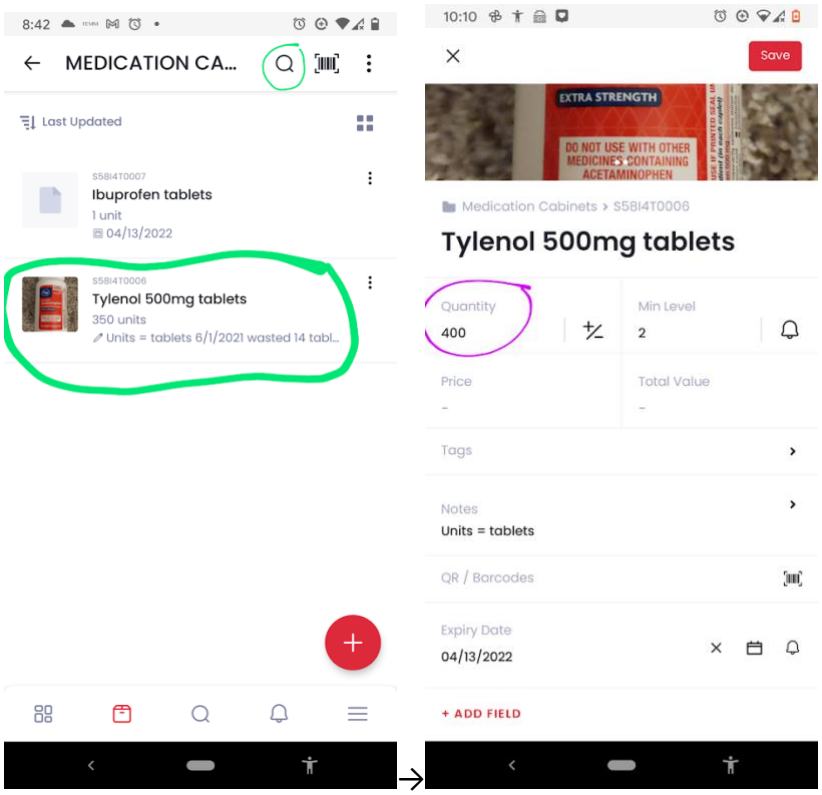
User Guide to Sortly App

Steps To Update the Quantity of Each Item

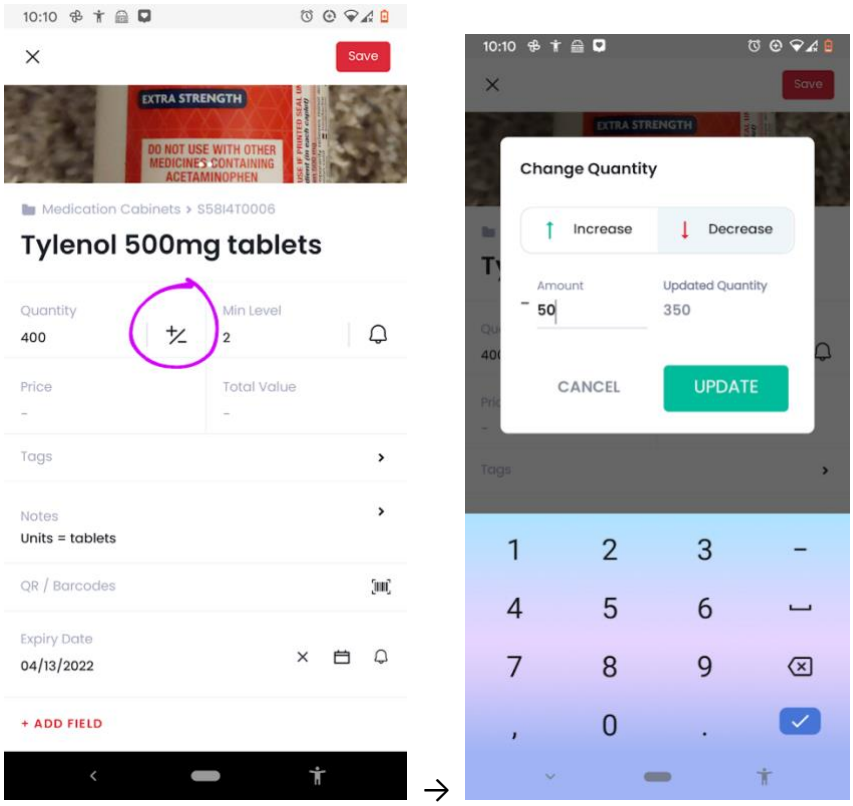
1. Open Sortly App -
    1. Email medical@camphomitakoda.org Password: banting1

2. Find item by clicking on name of the item OR searching for it

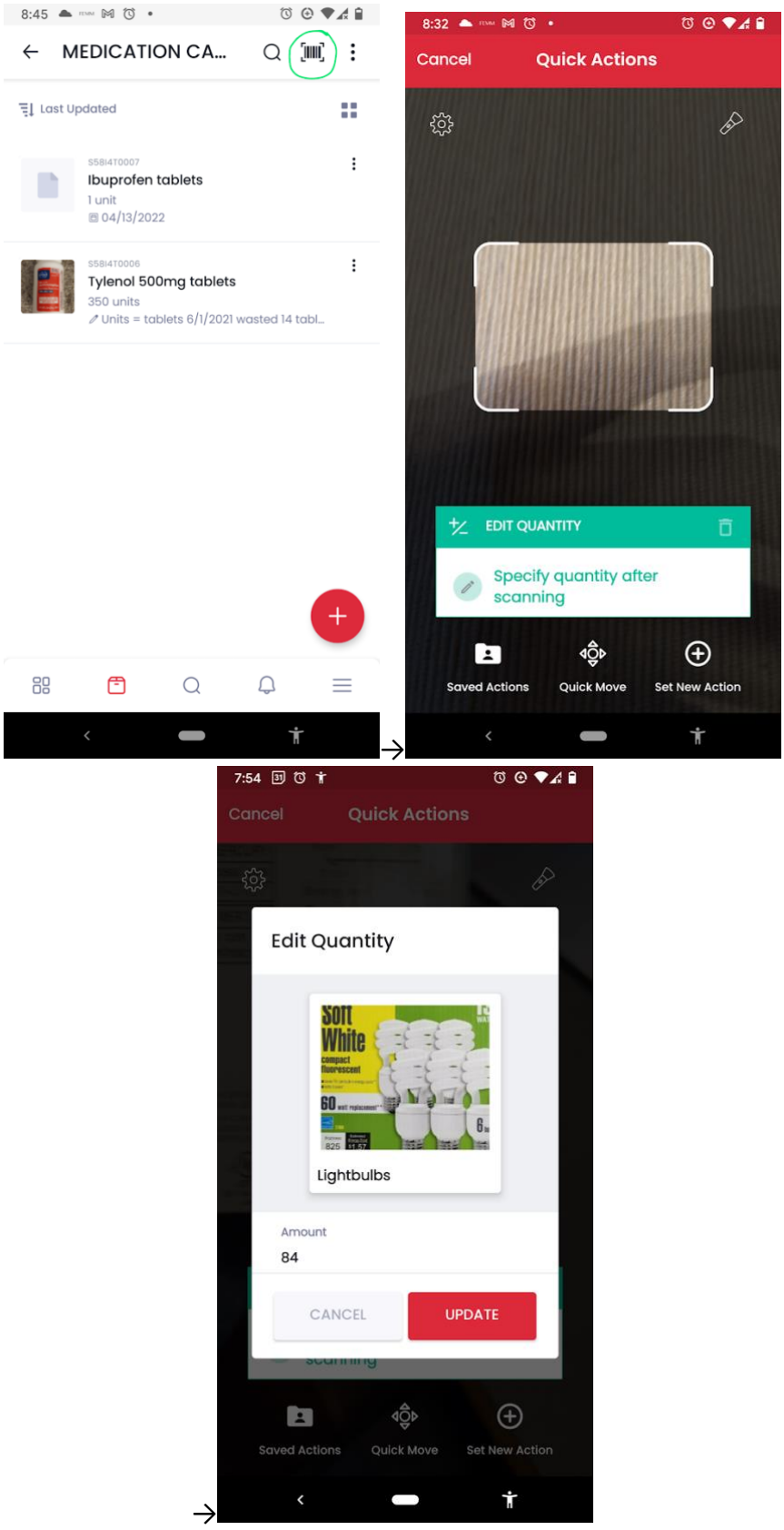
   Either directly edit the total amount by clicking on the number OR…



3. ...select the +/- button and increase or decrease the total amount

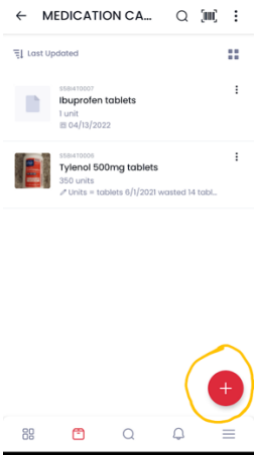


4. You can also search by barcode which pulls up a different screen where you can just edit total quantity

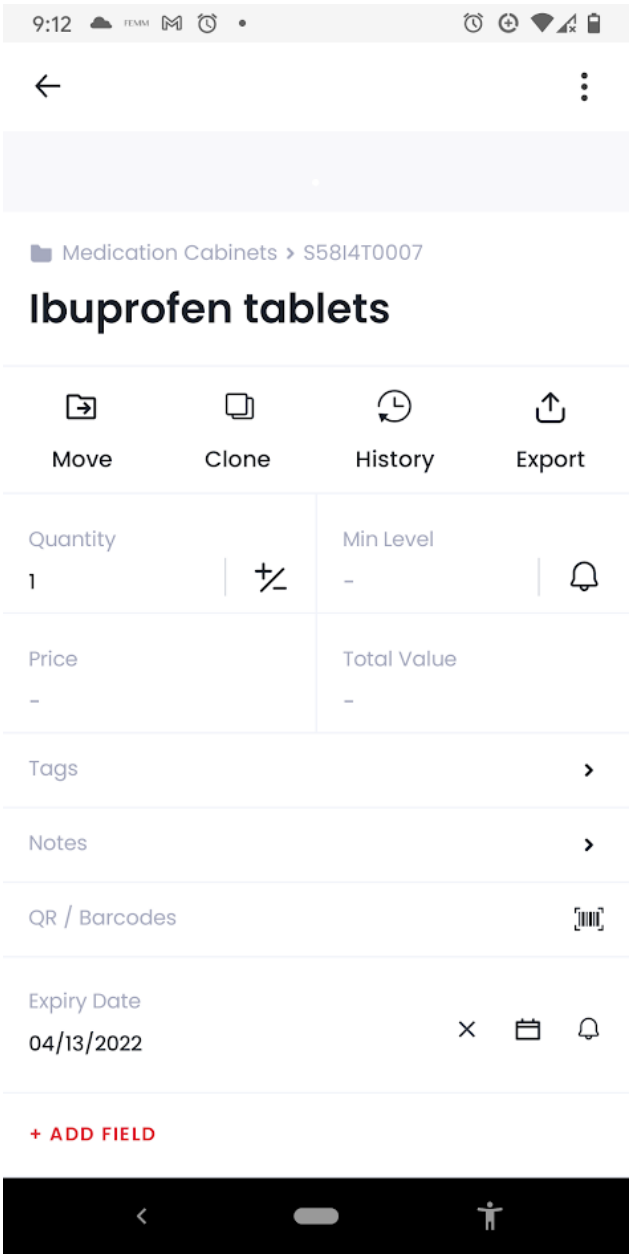


Steps To Add A New Item

1. Make sure you are in the correct account (medications vs. non-medications)
2. Select the add (+) icon



3. Select Add Item
4. Enter Name (Use generics vs brand name. Make sure to include size if applicable eg 4mm x 32G)
5. Enter Quantity
6. Enter Min level
7. In the Notes section, define units (i.e Units = tablets, Units = bottles, Units = strips, units = vials)
8. Add Barcode if available
9. Add Expiration date. If multiple expiry dates, enter the earliest one.
10. Add Photo



Steps to Entering Items Wasted due to Expiration Date

1. Find item by clicking on name of the item OR searching for it
2. In the Notes sections, write date and number wasted (i.e. 6/1/2021 41 strips wasted)

EMR Documentation (Work in Progress):

Sections :

- Campers:
  - "Quick entry BG"
  - Can jump to check in, logsheet, and check out

- Check in - general
  - Parent name/info, **pick up information**
  - Dexcom login
  - Pictures (: makes verifying right camper easier in the chaos

- Check in - medical
  - Where insulin doses will go (home settings)
  - Verify allergies and other medical info
  - Lice/sore check
  - Add daily meds
  - Record next site change *it only lets you do one, do soonest. Add any others in log sheet notes (see below)
  - *SEE LOG SHEETS

- Log sheets *CHECK IN:
  - Camper general info and insulin dosage info listed. Scroll all the way to the bottom of this page for misc notes space. Do NOT put misc notes in logsheet entry grid.
  - Click "Add Note," list the type, brand, and quantity of all non-insulin, non-glucose checking supplies
  - "Add Note," **TURN OFF SHARE - must be documented** ☑
  - "Add Note," Additional site changes if applicable

- Log sheets - Notes
  - Camper general info and insulin dosage info listed. Scroll all the way to the bottom of this page for misc notes space. Do NOT put misc notes in logsheet entry grid.
  - Under Camper general info and insulin dosage info is where camper will be flagged for dose/ratio changes as "medical change" and "staff attention needed" (more info: see log sheets - medical change**)
  - May be flagged here for a note for the cabin nurse as "staff attention needed"
  - "First aid," plus treatment
  - "PRN Meds:" list symptoms, med/dose/time. *whoever is documenting is GIVING IT - licensed individuals
  - ANY OTHER MISC. when in doubt, put a note
  - Notes in this section are not able to be edited
  - **Are we putting long acting admin here or in logsheet?**

- Log sheets - glucose entry
    - Logsheet grid is for GLUCOSE ENTRIES AND DOSAGE CHANGES ONLY, do NOT use this space for misc notes
    - Click on logsheet grid on correct date and time.
    - Choose applicable mealtime for breakfast/lunch/dinner/snack dosing. Enter camper glucose, carbs eaten, and insulin dose administered. Before meal admin is entered under “pre-bolus.” After meal admin is entered under “post-bolus.”
    - **Do we need any post meal glucose documented if a camper was low before eating?**
    - This section is able to be edited.
    - If a camper has additional carbs, edit the entry and add in the carbs and added coverage.
    - **Are we putting long-acting admin here under the block labeled “notes”?**
    - **Non mealtime log sheet entries** should go in “notes” section appropriate for time of day (ie glucose taken during the first activity of the day will go in the block labeled AM1) *these labels can and should be changed if things need to be added or stripped*

- Log sheets - medical change**
    - Clock on log sheet entry grid at date and time of day change is being performed.
    - Scroll down under glucose recording section. CURRENT Dosages/ratios will be listed here. This is where changes made must be updated. Be sure to compare order to what is programmed into any pumps AND this section or camper will be incorrectly dosed. (Dual sign??)
    - Make sure to save!
    - Unflag the camper once changes are finished and verified

- Daily meds
    - Check off each child for med admin, sorted by mealtime or cabin
    - Additional meds can be added in under “Medical Check in”
    - Licensed?

- Site Change
    - Campers are flagged ✕ when site changes are due and checked ☑ when up to date
    - When a site change is complete, schedule the next change based on device protocol

- Check out
    - Per check in, verify if correct person is picking up the child
    - Check yes or no if guardian wants copies of medical forms for the week

<u>MORE TO BE ADDED SOON!! – IN PROGRESS -</u>