**KyMel, Inc.**

**Camp Hope**

**HEALTH CARE PLAN**

**REVISED 2024**

The following Health Care Plan for Camp Hope

has been reviewed and revised as of

January 1, 2024

(date)

Andy Bukaty, DO- Camp Medical Director

(signature)

Lorraine Davis, RN – Camp Head Nurse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Mandy Graul-Conroy, MD –Pediatric Oncologist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Bryan Wohlwend, MD—Committee Chairman \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(signature)

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**Health Care Staff**

### Camp Medical Director

**Qualifications:**

1. Licensed in Kansas as a Doctor of Medicine or Doctor of Osteopathy.
2. Current CPR certification.
3. Must have three or more years of experience in field of practice.
4. Experience with children and young adults is desirable.
5. Ability to originate, update, and/or monitor health care, maintains records, and implements the healthcare plan.
6. Must have prior or current leadership experience in the healthcare setting.
7. Must be 28 years or older.
8. Must have at least 2 years experience at Camp Hope.
9. A member of the Camp Hope committee.
10. Must be available 24 hours a day via phone or on site.

**Responsible to:**

Committee Chair

**General Responsibilities:**

1. Be the health manager for all individuals in the camp.
2. Supervise the health and cleanliness standards and help provide adequate physical health conditions in the camp.

**Specific Responsibilities:**

1. Ensure that each volunteer and camper has on file a health history and examination form as required, and review all such forms prior to the camp session.
2. Supervise the health screening systems for arriving campers and volunteers.
3. Conduct and maintain inventory of supplies including placing orders and receiving supplies as necessary.
4. Establish appropriate medical routines including record keeping, disposal of medical waste, managing and safeguarding medications and utilizing approved standing orders.
5. Lead, along with other administrators and pertinent volunteer leaders where appropriate, specific areas of volunteer training pertaining to camp health and safety, psychosocial issues faced by campers, confidentiality of personal and medical camper information, sensitivity to personal care of privacy for many campers, proper lifting technique, issues related to coping with illness/death, appropriate post-camp communication/relationships with campers, use of universal precautions, behavior management, accommodating campers by modifying certain activities for the inclusion of campers with special needs, and infection control.
6. Keep incident reports that may be used for risk management assessment.
7. Prepare summary and evaluation of camp including inventories, camper reports on health problems, and make recommendations for the following year.
8. Ensure the supervision of medical staff.
9. Monitor and evaluate camp procedures, facilities, and conditions and modify accordingly to create more healthful conditions.

**Camp Physicians**

**Qualifications:**

1. Licensed in Kansas.
2. Special Interest and expertise in the care of children with cancer.
3. Current CPR certification.
4. Ability to originate, update, and monitor healthcare, maintain records, and implement the health care plan.

**Responsible to:**

Medical Director

**General Responsibilities:**

1. Be an active member of the medical staff.
2. Implement medical protocols.
3. Work with Medical Director to supervise and orient members of medical staff to Camp Hope medical protocols.

**Specific Responsibilities:**

1. The camp physician may perform any of the duties listed under the Medical Director.
2. Oversee daily medical care, directs first aid care and provides emergency medical care.
3. Direct responsibility of health care of the campers and volunteers while attending camp.
4. Responsible for medical management decisions while on duty as needed.
5. Attend camp medical staff meetings as indicated.
6. Review and help revise annually the Health Care Plan including standing orders for routine and emergency medical care.
7. Follow Camp Hope medical protocols.
8. Attend orientation sessions and be familiar with Camp Hope policies and procedures.
9. Actively participate in camp activities and participate in all activities with assigned campers.

**Camp Head Nurse**

**Qualifications:**

1. Licensed in Kansas either as a Registered Nurse or a Licensed Practical Nurse.
2. Current CPR certification.
3. Experience with children and young adults is desirable.
4. Ability to originate, update, and monitor healthcare, maintain records, and implement the health care plan.
5. Previous experience at Camp Hope as a camp nurse.

**Responsible to:**

Medical Director

**General Responsibility:**

1. Be an active member of the medical staff.
2. Implement medical protocols.
3. Work with Medical Director to supervise and orient members of medical staff to Camp Hope medical protocols.

**Specific Responsibilities:**

1. Work with Medical Director to annually review medical protocols.
2. Work with Medical Director to review medical protocols with all members of the medical staff.
3. Set up a system for health screening for arriving campers and volunteers.
4. Assist Medical Director in conducting and maintaining inventory of supplies.
5. Check and issue medical packs and walkie-talkies.
6. Assist Medical Director in training pertaining to camp health and safety, universal precautions, and infection control.
7. Establish and follow appropriate medical routines including record keeping in the daily medical log, disposal of medical waste, managing and safeguarding medications, and utilizing approved standing orders.
8. Function as a Camp Nurse

**Camp Nurses**

**Qualifications:**

1. Licensed in Kansas either as a Registered Nurse or a Licensed Practical Nurse.
2. Current CPR certification.
3. Experience with children and young adults is desirable.
4. Ability to originate, update, and monitor healthcare, maintain records, and implement the health care plan.

**Responsible to:**

Head Nurse

**General Responsibility:**

* + 1. Work with Medical Director and Head Nurse to maintain the individual healthcare regimens as previously prescribed by camper’s personal physician.

**Specific Responsibilities:**

1. Be aware of any known medical problems the campers might have and be ready to deal with them.
2. Know his/her limitations and be ready to request help, in any form, when necessary.
3. Be equipped with a first-aid backpack and walkie-talkie.
4. Will *not* be responsible for giving chemotherapy but may be asked to give other medications as directed by the Medical Director.
5. Participate in all activities.
6. Notify house parents and activities volunteers of any medical problems, as information is available.
7. Follow Camp Hope medical protocols

**Camp Pharmacist**

**Qualifications:**

1. Licensed in Kansas as a pharmacist
2. Experience with children and young adults is desirable
3. Ability to originate, update and monitor healthcare and maintain records as it pertains to medications

**Responsible to:**

Medical Director

**General Responsibility:**

1. Active member of medical staff.
2. Work with the medical director to supervise health care plan as prescribed by camper’s personal physician.

**Specific Responsibilities:**

1. Be aware of any medications the campers are taking and be available as a reference for the medical staff regarding potential side effects, interactions, allergic reactions or other adverse reactions of the medications.
2. Know his/her limitations and be ready to request help, in any form, when necessary.
3. Will not be responsible for dispensing medications to campers unless directed to do so by the medical director. Should not dispense any prn medications without approval of medical director.
4. Participate in all activities. During times when no pharmacist is needed, may assist the activities volunteers.
5. Help collect and discuss medications at check-in of the campers at the beginning of camp.
6. Assist with the organizing and preparation of medications on a daily/nightly basis.

### Camp Mental Health Director

**Qualifications:**

1. Hold a professional license in the State of Kansas in a mental health field such as social worker, professional counseling, psychiatrist, psychologist or marriage and family therapy.
2. Must have three or more years of experience in field of practice.
3. Experience with children and young adults is desirable.
4. Ability to originate, update, and/or monitor mental health needs, implements a mental health crisis plan and maintains documentation.
5. Must be 25 years or older.
6. Must have at least 2 years experience at Camp Hope, unless approved by the committee
7. Must be available 24 hours a day via pager or on site.

**Responsible to:**

Medical Director

**General Responsibilities:**

1. Be available to intervene in a mental health crisis for all individuals in the camp.
2. Supervise the mental health standards and help provide an appropriate camp environment that promotes health and wellness.

**Specific Responsibilities:**

1. Coordinate with the medical director regarding mental health concerns identified on camper and volunteer applications.
2. Monitor and intervene in any identified potential crisis situations.
3. Coordinate with the medical director in a crisis situation to ensure proper care of the camper or volunteer.
4. Make necessary reports of suspected abuse, harm to self or harm to others to the appropriate authorities.
5. Complete documentation of any crisis situation or intervention to be kept in the camper or volunteer confidential file.
6. Keep incident reports that may be used for risk management assessment.
7. Follow-up with camper parent as needed during and after a crisis situation.
8. Prepare summary and evaluation of how mental health crisis were handled and make recommendations for the following year.
9. Attend orientation sessions and be familiar with Camp Hope policies and procedures.

**Camp Mental/Social Health Provider**

**Qualifications:**

1. Hold a professional license in the state of Kansas in a mental health field such as psychiatrist, psychologist, social worker, child life specialist, professional counselor, etc.
2. Experience with children and young adults is desirable.
3. Ability to originate, update, and/or monitor mental health needs, implement a mental health crisis plan, and maintain documentation.

**Responsible to:**

Mental Health Director, Houseparent Coordinator (when applicable)

**General Responsibilities:**

1. Be available to help identify campers in need of mental and/or social support, develop plans specific for those campers, and/or provide extended support to those campers when needed.
2. Be available to intervene in a mental health crisis for selected individuals in the camp.

**Specific Responsibilities:**

1. Communicate with the Medical Director, Mental Health Director, and Houseparent Coordinator regarding campers in need of special mental and/or social health support.
2. Help identify, coordinate, and carry out plans of action regarding specific campers who need extra mental and/or social health support.
3. If assigned to a specific camper with mental and/or social health needs, provide close support to him/her throughout the week while maintaining clear communication with the appropriate supervisory personnel, such as Medical Director, Mental Health Director, and Houseparent Coordinator.
4. Monitor and intervene in any identified potential crisis situation involving a camper.
5. Coordinate with Medical Director and Mental Health Director in a crisis situation to ensure proper care of the camper.
6. Make necessary reports of suspected abuse, harm to self, or harm to others to the appropriate authorities.
7. Complete documentation of any crisis situation or intervention to be kept in the camper or volunteer confidential file.
8. Follow-up with camper parent as needed during and after a crisis situation.
9. No provider will be expected to do anything outside of his/her scope of practice.

**Child Life Specialist**

**Qualifications:**

1. Must be a Certified Child Life Specialist (CCLS), through the Child Life Certification Commission, a subsidiary of the Association of Child Life Professionals.
2. Experience with children and young adults is desirable.
3. Ability to originate, update, and/or monitor social and emotional needs of campers and maintain documentation.

**Responsible to:**

Mental Health Director, Houseparent Coordinator (when applicable)

**General Responsibilities:**

1. Be available to help identify campers in need of emotional/or social support, develop plans specific for those campers, and/or provide extended support to those campers when needed.
2. Be available to support mental health specialist in mental health crisis.

**Specific Responsibilities:**

1. Communicate with the Medical Director, Mental Health Director, and Houseparent Coordinator regarding campers in need of special mental and/or social health support.
2. Help identify, coordinate, and carry out plans of action regarding specific campers who need extramental and/or social health support.
3. If assigned to a specific camper with mental and/or social health needs, provide close support to him/her throughout the week while maintaining clear communication with the appropriate supervisory personnel, such as Medical Director, Mental Health Director, and Houseparent Coordinator.
4. Coordinate with Medical Director and Mental Health Director in a crisis situation to ensure proper care of the camper.
5. Make necessary reports of suspected abuse, harm to self, or harm to others to the appropriate authorities.
6. Complete documentation of any crisis situation or intervention to be kept in the camper or volunteer confidential file.
7. Follow-up with camper parent as needed during and after a crisis situation.
8. No provider will be expected to do anything outside of his/her scope of practice.

**Health Care Facility and Supplies**

**Medical Staffing**

Camp Hope will always have at least one physician present for the duration of camp, including any off-site travel. In addition, a medical team of other physicians, nurse practitioners and nurses will be present on-site at all times with a goal of at least one medical provider for 10 campers. The team will also have at least one pharmacist on-site. If not on-site, there is always an oncologist available by phone at the major medical centers. Additionally, a mental health team will be present that includes licensed clinic social workers, therapists, and psychologists.

**Location/Accommodations**

Access to medical personnel is available either by direct contact or by radio contact 24 hours a day. At least one member of the medical staff is immediately available at all camp activities, including the camp’s designated medical station. All members of the medical staff will carry a backpack of medical and first aid supplies and a walkie-talkie (as assigned).

A designated medical station is located on camp grounds. Access to this station is available to members of the medical staff 24 hours a day during the camp session. Specific areas within the medical station are set up for particular health care functions, for example, first aid/IV line care and dispensing of medications. Restrooms and water for drinking or cleaning are available. It will maintain a private and quiet space for isolation of sick campers. There will be enough isolation beds to maintain ratio of one bed per 50 campers and staff. Any person staying in the healthcare center will be under the continual supervision of a member of the medical staff. Camp ratios will be maintained as well with a minimum of 2 volunteers to 1 camper.

Cots are available within the same building. Space is available for isolation as necessary. If further isolation is necessary for the camper’s condition, he/she will be dismissed home (per protocols) for further care.

**Supplies**

The Camp Medical Director reviews the supplies list at least annually. The medical director, or designated staff, also completes an end-of-camp inventory. This supply list and inventory is used to order any necessary medical supplies for camp the following year.

All medications will be kept in a locked cabinet or box within the refrigeration unit. The primary emergency medication case is kept at the main medical station. Certain first aid supplies and emergency medications (i.e., inhalers, EpiPens) are carried by members of the medical staff or the camper as necessary for personal safety.

**Hospital/Emergency Facility**

**Access to Emergency Health Care**

Camp Hope is located approximately 20 minutes from the University of Kansas Hospital-Great Bend, a regional trauma center, at 514 Cleveland St., Great Bend, Kansas. That hospital is always available to the campers/volunteers from Camp Hope for emergency medical and psychiatric health care. Camp verbally notifies this facility that camp is in session to make them aware in case we need to use their services.  The phone number is 620-792-8833.

If emergency transport should be necessary from the camp location or in-town activity, the appropriate Emergency Medical Service (EMS) will be notified and utilized by calling 911. EMS should arrive within 20 minutes regardless of location.  Local EMS in Claflin and Great Bend will be notified verbally the dates of camp prior to camp starting.

In the case of an emergency, the camper’s individual physician and/or oncologist will be notified via phone as well.

At least one member of the medical team will carry a cell phone in order to call for emergency services if needed.

In addition, emergency dental care will be provided by the camp medical staff or by the emergency department for stabilization until subsequent referral to a dentist for definitive care can be arranged accordingly.    

**Access to Routine Health Care**

The medical director and/or mental health director may use their professional judgment to recommend evaluation at Great Bend for non-emergent conditions as well. In addition to the University of Kansas Hospital-Great Bend, St. Rose has an urgent care available for non-emergent needs.

Camp Hope will also maintain a medical and mental health staff at camp that will be on-site 24 hour/day while camp is in session.  This team will consist at minimum of one physician, one mental health therapist and one pediatric nurse. Camp Hope will strive for additional team members throughout the week as well.  The medical members of this team will all have be BLS certified at minimum and will always have access to basic first aid supplies.  There will always also be an easily accessible AED available.  All health team members will have active licenses to practice in the state of Kansas.

**Medical Records**

**Medical Forms**

Medical histories, including immunizations, medications/treatments and allergies, are obtained on all campers and volunteers before camp. Medical information pertaining to campers is provided by parents/guardians (part I) and physicians (part II). Medical information about volunteers is submitted in the volunteer application form. The Medical Director and members of the medical staff will review the medical history of each camper and volunteer upon arrival to the camp for clarification and for any changes in the obtained medical information.

Medical staff will have immediate access to medical records at all time, on or off site, via the electronic record.

**Consent Forms**

All campers must have an Authorization for Treatment Form that is signed by a parent or guardian on file.

**Medical Recordkeeping Systems**

The medical care received by each camper/volunteer is recorded as follows:

1. Computerized Medication Administration and Treatment Program

* A computer program is used to record all scheduled and PRN medications and treatments given to each camper/volunteer. Recorded information includes the medication, dosage, route, frequency and signature of the member of the medical staff. The program allows the entry of additional notes or comments regarding the health status of the camper/volunteer. The computer program can sort information by name, group and time. The record will be kept in two forms: hard copy and electronic copy. All entries are made by one camp physician and verified at least daily and as necessary by at least one other member of the medical staff.
  + 1. Camp Hope Medical Documentation Record
* The Camp Hope Documentation Record is used to document (a) any calls to lab, hospitals or physicians; (b) procedures done on campers/volunteers; and (c) calls made to any physician, parent or hospital regarding concerns about psychosocial status of the camper or volunteer. The completed documentation record is reviewed by the Medical Director and is then considered part of the permanent health record for that camper or volunteer from that year’s camp
  + - * 1. Camp Hope Accident/Incident Report
* The Camp Hope Accident/Incident Report is completed on a camper/volunteer who has had an accident, injury or illness that required professional medical treatment. The form documents circumstances, witnesses and actions in serious situations that result in, or nearly result in injury or danger to individuals.

Medical Follow-up Form for Camp Hope

* The Medical Follow-up Form for Camp Hope is used to inform parents/guardians of follow-up recommendation associated with any medical attention provided during Camp Hope. This form is given to the parent/guardian at the completion of camp.

**Record Retention Policy**

All medical records are retained by KyMel, Inc for the period that covers 7 years post age of majority per camper or volunteer participant. These records may be on the computer database.

**Health Screening and Eligibility**

The medical director will review the health records for campers and volunteers prior to camp. The Committee Chairman and/or the Medical Director will contact the parents/guardians or volunteer to clarify any health information prior to camp as necessary and determine if the individual is appropriate to attend camp.

Campers will be deemed appropriate to attend camp if they can enjoy at least some of the activities provided at the camp and they will not overwhelm the staffing abilities of the volunteers. This is determined on a case-by-case basis after review of the health records and discussion (if needed) with the child’s physician. Camp Hope attempts to accommodate all campers provided they are healthy enough to safely enjoy the camp experience.

Consult with campers’ physicians will also be used to help determine eligibility to attend camp when appropriate. Any camper who is currently on treatment, or has been within 6 months, will require clearance by their oncologist to attend.

All campers and volunteers will be asked to update their medical information during on-site registration. Any changes will be noted on the check-in form.

All members of the medical staff and other volunteers, including kitchen staff, houseparents and activities volunteers, are informed of medical information that is essential for the health and safety of the campers and volunteers. This information generally is shared during the orientation session prior to the beginning of camp and throughout the camp session as necessary. In addition, at least two members of the medical staff are assigned to each age group and thus have more in-depth information about the members of their specific age group.

As part of the camp registration/check-in, the Medical Director and members of the medical staff review all health-related information with arriving volunteers and campers, and update online forms as needed. All volunteers and campers are screened for any communicable diseases or illnesses. Campers must turn in all medications to a member of the medical staff at that time. A member of the medical staff reviews the administration routine for all camper medications. Any volunteer who will be residing in a camper-accessible area must also turn in all medications to the medical staff so these can be stored in a locked bin, which will inaccessible to campers, but will be accessible at all times to the volunteer who can self-administer them whenever appropriate.

**Immediate Response and Communication Related to Injury or Acute Illness**

1. Stabilize camper/volunteer as per camp medical protocols.
2. Have someone notify the Medical Director or a member of the medical staff and the Committee Chairman
3. Obtain the medical file for the camper/volunteer.
4. If unstable or critical, call 911 for transport to higher level of treatment.
5. The Medical Director (or a medical camp physician) and the committee chairman contact the family of the camper/volunteer with the information on the status and plan of the camper/volunteer.
6. The Committee Chairman will notify the Camp Hope Heartland president
7. If follow-up or continuing care is necessary, the Medical Director (or designated camp physician) will call the primary care physician of the camper/volunteer.

**Guardian Notification**

Guardians will be notified in writing of any illness or injury to their camper while at camp. Minor illness and injuries will be documented on the Parent Follow-Up Form. The medical director will call about any major illness or injury as well as any ED visit. This communication will be documented on the health care log for that event.

**Non-Medical Volunteer Role in Routine Health Care**

The camp director and members of the medical team are charged with the overall supervision of routine health care of the campers. However, all volunteers have an integral role in the supervision of campers’ health care needs. Volunteers are charged with managing cabin and activity groups to support activities of daily life (e.g., adequate rest, water, nutrition, hygiene). Volunteers are responsible for observing for and reporting to the designated member of the medical team or medical director any signs and symptoms of illnesses or injuries that may be present among the campers. Volunteers also participate in routine preventive duties such as applying sunblock and tick checks.

Medical volunteers are immediately available if called upon for help when needed. Medical volunteers should be called for ***any*** medical need. Any volunteer who will potentially come in contact with bodily fluids (vomit, blood, etc.) will be expected to wear gloves and a mask if needed. In addition, Camp Hope has mental health staff available should there be any need for help with behavior problems, homesickness, or more severe concerns. (Additional policies on abuse and suicide can be found later in the manual).

Non-medical volunteers are not permitted to distribute any medications, including over-the counter (i.e. Tylenol). Violation of this policy is grounds for immediate dismissal from camp.

**Relationship with Oncology**

Camp Hope receives referrals from a wide geographic range including several tertiary care centers.  When registering for camp families will report the name, hospital affiliation and contact information of their oncologist. The Camp Hope medical director reviews all medical records prior to camp and will call the camper's oncologist to discuss pre-camp concerns if necessary.  If an emergency or question arises during camp then Camp Hope will call the involved camper's oncologist, or whoever is covering them if they are unavailable, at the appropriate tertiary care center.

If general questions arise throughout the year regarding oncology then an oncologist will either be called or emailed.  In addition Camp Hope has an oncologist review oncology-specific medical protocols yearly.

Camp Hope will mail brochures to each tertiary center at least yearly when applications for camp are available.  In addition Camp Hope will reach out to each oncology center at least yearly via email or phone to discuss questions or concerns regarding camp.

**Camp Medical Protocols and Policies**

The following medical care protocols and policies are intended to assist in the delivery of medical care to the campers and volunteers (as needed). Always contact the camp Medical Director or camp physician if any question should arise regarding the health of a camper or volunteer.

The professional judgment of the Medical Director or camp physician always takes precedent over the Camp Hope Protocols and Policies. The Medical Director can dismiss a camper or volunteer to a hospital or to the care of the camper’s parents/guardian if, based on the Medical Director’s professional judgment, a camper’s or volunteer’s health will be jeopardized or will jeopardize the health of others by remaining at the camp.

Only designated members of the medical staff administer medications on campsite. Campers and volunteers are responsible for supplying their own prescribed medications and health care supplies.

These policies are reviewed annually by the medical director and an oncologist.

**Medical Protocols**

**Abrasions**

1. Cleanse area with soap and water, rinse and dry.
2. Cover with Band-Aid or dressing.
3. May use antibiotic ointment prn or bactine spray prn
4. Monitor for signs and symptoms of infection and notify physician if infection suspected.
5. Check for tetanus immunization.
6. Document care

**Allergies**

1. Assess cause
2. Assess pattern
3. Physical assessment by camp medical personnel
4. May contact parents or family physician to see what has been used in the past
5. May give an antihistamine such as Benadryl, Claritin, Allegra, Sudafed or Zyrtec if approved by the medical director. Dose according to weight and age guidelines.

6. Document indication and use of medication for situation

**Anaphylactic Reaction**

1. Any camper having a potential anaphylaxis reaction needs immediate treatment. Symptoms include:
   * Skin reactions, including hives and itching and flushed or pale skin
   * Low blood pressure (hypotension)
   * Constriction of your airways and a swollen tongue or throat, which can cause wheezing and trouble breathing
   * A weak and rapid pulse
   * Nausea, vomiting or diarrhea
   * Dizziness or fainting
2. Immediately alert medical director and/or head nurse, both of whom carry an Epipen and Epipen, Jr. with them at all times.
3. If neither is immediately accessible, there is an Epipen located in the locked off-site bin.
4. Administer age-appropriate dose of Epipen to thigh, in standard fashion.
5. Medical director or another camp physician will need to examine and continue to monitor patient to determine if there is a need to take camper to the emergency department.
6. Parents will be notified of anaphylactic reaction and subsequent follow-up response and care.

**Antibiotic-Resistant Organisms**

1. Antibiotic-resistant organisms are bacteria and other microorganisms that have developed the ability to resist the effects of an antibiotic to which they were once sensitive.

2. Any camper with a known antibiotic-resistant organism will be dealt with on a case-by-case basis in consultation with their primary healthcare team and/or oncologist. Determination of appropriateness for that camper to attend camp, as well as the approach to that camper and the other campers based on this decision, will be made as part of that consultation.

3. Any antibiotics prescribed during camp will follow consensus guidelines for treating the given infectious disease and will take into account known local resistance patterns.

**Blood Drawing**

1. Central Venus Catheter
   * 1. Wash hands thoroughly.
     2. Apply gloves.
     3. Use alcohol preparation swabs to cleanse injection cap or catheter hub.
     4. Prepare two syringes—each with 3ml normal saline solution.
     5. If cap will be removed, clamp catheter.
     6. If cap is in place, insert needle of syringe containing 3ml normal saline and flush. If cap is removed, connect syringe tip to catheter hub, release clamp, flush, and reclamp.
     7. Connect syringe for blood sampling and release clamp. Aspirate 3ml fluid, reclamp, and discard aspirate.
     8. Attach or insert syringe of size equal to volume of blood sample to withdraw to catheter. Release clamp. Withdraw necessary blood for samples and reclamp.
     9. Attach or insert syringe filled with 3ml normal saline to catheter. If clamp is present, release, flush vigorously, and reclamp.
     10. If no continuous infusion is indicated, heparinize catheter. Connect syringe containing 1ml (10u/ml) heparin flush solution. If clamp is present, release, flush and reclamp.
     11. Replace new cap to end of catheter and remove clamp.
     12. Secure all tubing connections
     13. Dispose of soiled equipment and used supplies. Wash hands.
2. Implanted Infusion Port
   * + - 1. Wash hands thoroughly. Mask self and client, if indicated.
         2. Prepare sterile field and open sterile supplies.
         3. Using chlorhexidine, prepare camper’s skin overlying port septum, moving in concentric circles from the inside out. If the camper is allergic to chlorhexidine, alcohol followed by povidone-iodine swabs may be used instead. Camper individual protocol takes precedent.
         4. In the same manner, use povidone-iodine swabs to cleanse skin overlying port septum.
         5. Apply sterile gloves.
         6. As another nurse holds vial of saline, fill sterile syringe with 2ml saline solution.
         7. Attach one end of sterile extension tubing to syringe and attach special Huber needle to other end. Fill tubing with saline solution.
         8. Apply sterile drape to port site.
         9. Palpate port septum, observing strict aseptic technique.
         10. Insert 90-degree Huber needle through skin and push firmly down until needle penetrates silicone septum and rests firmly against needle stop.
         11. Fill another syringe, as in step 6, and flush port with 10ml normal saline. Do not irrigate forcefully if resistance is felt.
         12. To draw blood samples, first aspirate and discard 5ml of fluid.
         13. Withdraw necessary blood for each sample, using syringe size equal to total volume withdrawn.
         14. Refill saline syringe and flush port with 5-10ml normal saline after sample is obtained.
         15. Heparinize port by flushing with 2ml (100u/ml) heparin flush solution.
         16. Secure Huber needle with sterile gauze or transparent dressing.
         17. Dispose of all soiled supplies and used equipment. Send specimens to laboratory. Wash hands.

**Burns**

1. Heat burns
2. Critical
   * 1. Call 911
     2. Provide oxygen
     3. Flush with cool water or saline until burn area feels cool. Do not use ice or freezing water.
     4. Remove bunt clothes and jewelry IF ABLE
     5. Apply dry, loose sterile dressing
     6. Care for potential shock and monitor airway closely
     7. Complete incident report
3. Not critical
   1. Flush with cool water until burn area feels cool. Do not use ice or freezing water.
   2. Apply aloe vera or antibiotic cream if indicated as needed.
   3. Medicate with Tylenol or Advil as needed for comfort. Dosage according to weight and age guidelines.
   4. Apply dry, loose sterile dressing.
   5. Care for potential shock.
   6. Check for signs of infection. If present, notify Camp medical director and follow the sick camper protocol.
   7. Complete incident report.
4. Chemical burns
   * 1. Flush immediately w/large amounts of water
     2. Remove any affected clothing/jewelry
     3. Care for potential shock
     4. Obtain emergency medical care if indicated
     5. Complete incident report.
5. Electrical burns
6. Make sure environment is safe and power is off
7. Have someone obtain the AED
8. Check for multiple burn sites
9. Apply dry, loose sterile dressing
10. Care for potential shock
11. Obtain emergency medical care
12. Complete incident report

**Central Venous Catheter Care**

1. Dressing change per home care routine. If no standard routine, use the following:
2. Wash hands and apply clean gloves.
3. Mask self and client, if indicated.
4. Carefully remove old dressing, noting drainage and appearance of catheter or needle insertion site.
5. Inspect placement or exit site for signs of redness, swelling, inflammation, tenderness, and exudate.
6. If catheter is tunneled, palpate Dacron cuff in subcutaneous tunnel.
7. Inspect catheter and hub for intactness and remove clean gloves.
8. Apply sterile gloves.
9. Clean placement or exit site with chloraprep or betadine by starting from inside moving out in circular fashion, maintaining strict asepsis. Clean about a 3 cm area.
10. Redress site using sterile gauze and tape or transparent dressing as indicated.
11. Secure tubing or needle.
12. Label date and time of dressing change.
13. Dispose of soiled supplies; remove gloves and wash hands.
14. Flush per home care routine. If no standard routine, see Standard Flush Protocols.
15. Central lines are inspected at least daily in the evening. If line is of concern – immediately inform camp medical director for further instructions for care.
16. Campers with central lines may participate in all activities unless restricted by their oncologist. Activities may be adapted for that camper in order to protect the central line.
17. If a central line is damaged, a member of the medical team will immediately assess the damage. The line will be clamped if needed. At that point the camper’s oncologist will be notified to determine next steps which likely is transfer to their cancer facility.

**Chemotherapy Administration**

1.  Chemotherapy will be administered by a non-pregnant chemotherapy-certified nurse. Camp Hope will administer any treatment protocol if cleared by the camper’s oncologist that it is safe and okay to administer in a camp setting. The camper is responsible for bringing any necessary medications and supplies.

2.  Oral chemotherapy doses and times will be ordered and provided by the camper’s oncologist.  Doses and times will be confirmed at check-in by a Camp physician.

3.  IV chemotherapy doses and times will be ordered and provided by the camper’s oncologist.  At the scheduled time the Camp Medical Director will call the oncologist and review the orders for verification. A chemotherapy-certified nurse will witness.  IV chemotherapy will be administered in the medical facility.

4.  Following administration disposal of all related products will follow the above waste disposal protocol in the appropriate yellow chemotherapy container. Spill kits are located in the medical facility.

**Chest Pain/Myocardial Infarction**

1. Initiate CPR at anytime if indicated
2. Make sure the victim is resting and discontinue all exertion
3. Notify Medical Director or camp physician
4. Call 911 if indicated
5. Administer oxygen
6. Administer aspirin (325mg) if not contraindicated (allergy or history of bleeding) and with approval of camp physician
7. If the volunteer has nitroglycerin, administer it under the tongue *(this information is on the volunteer medical record)*
8. Check blood pressure and monitor vitals
9. Monitor and support ABCs until EMS arrives
10. Have someone obtain the volunteer health record

**Chicken Pox/Shingles**

If there is a confirmed or suspected case of varicella at camp:

1)       If the suspected or confirmed case is in a volunteer, the volunteer will be sent home immediately.

2)     If the suspected or confirmed case is in a camper, isolate the sick camper immediately and notify a camp physician

a.       If the camper is febrile and neutropenic, go to ED immediately

b.       If afebrile but immunocompromised (on chemo currently or within last 6 months), call oncologist

3)      Camp physician will determine which develop a list of which campers are immunocompromised and/or unimmunized and potential exposure risk.

a.       How close was the contact (same cabin, etc)?

b.       If shingles, were the lesions covered at all times?

4)      If an exposed camper is immunocompromised then place them in isolation and a camp physician will contact the oncologist to determine next steps in management.  Parents will then be notified to discuss recommendations.

5)      If an exposed camper is unimmunized place the camper in isolation immediately and notify parents.  They will need to go home unless parents consent to giving a dose of varicella vaccine.  If they consent then obtain written consent and call health department to see if vaccine is available.

6)      For campers who are fully immunized (2 doses) then parents will be notified of the exposure, but they can continue routine camp activities.

7)      For campers who have only one dose of varicella vaccine then parents will be notified. If a second dose can be obtained then the camper may resume routine camp activities.

8)      Notify the health department of a potential varicella outbreak

**Communicable Diseases**

1.      If a camper or volunteer has a suspected or confirmed communicable disease they will be immediately placed into isolation to prevent spread.

2.      The medical director will assess the situation to determine next steps (sending home, continued isolation, etc) based on the type of communicable disease.

3.      Camp will make every effort to prevent the spread of communicable disease by ensuring surfaces are cleaned with antiseptic products regularly, encouraging handwashing, requiring infection-control protocols are followed (handwashing, food preparation, etc) and requiring the use of hand sanitizer prior to meals.

4. All campers and staff undergo communicable disease screening upon arrival at camp. This is performed by a member of the medical team (physician or nurse).

5. All campers and staff are instructed not to come to camp if they have any illness within 72 hours of camp starting. They may call and discuss with the Camp Hope medical director if any concerns.

6. The Medical Director monitors throughout the year for any disease outbreaks and may change any policy if needed to prevent illness at camp. This could include requiring different immunizations (when medical able).

7. Families and staff are notified immediately if there is concern of a communicable disease exposure.

8. Camp Hope does require all campers and volunteers to be up to date (if medically able) on state and ACA-required vaccines, including tetanus, varicella, and MMR. Camp Hope follows all state-applicable laws regarding immunization requirements.

**Conjunctivitis**

1. Assess eye: vision/pain
2. Assess potential cause
3. Allergic
   1. Wash eye with sterile water (affected eye - from inner canthus to outer canthus)
   2. Check daily until subsides and document initial incident and subsequent care given.
4. Infectious
   1. Use warm compresses if eyes are painful or the eyelids are stuck together. Do not cross contaminate.
   2. Notify camp medical director for further care needed.
   3. Document incident and follow up care provided.

**Constipation**

1. Assess pattern
2. Assess diet
3. Assess activity
4. Assess current medications
5. Assess current disease
6. Assess abdomen
7. Increase fluids if no contradictions
8. Increase roughage foods if no contradictions
9. Increase exercise if no contradictions
10. If no temperature, may give Milk of Magnesia or Miralax as indicated for weight and age guidelines.
11. If no bowel movement, notify Camp Medical Director.

**Contact Poisons**

1. Contact Medical Director
2. Remove contaminated clothing.
3. Wash all contaminated skin with soap and water at least 5 minutes
4. Chemical poison: contact poison control center and follow their instructions - 800-362-0101
5. Ingestion of poison if unconscious:
6. Place on side
7. Determine what was ingested
8. Call poison control center and follow their instructions
9. Monitor airway, breathing and circulation frequently.
10. Transport to emergency facility or call 911
11. Complete incident report form
    * 1. Ingestion of poison if conscious:
12. Place on side
13. Determine what was ingested.
14. Call poison control center and follow their instructions.
15. Monitor airway, breathing and circulation frequently.
16. Transport to emergency facility if so indicated.
17. Complete incident report form
    1. Inhaled Poisons
18. Check to make sure the area is safe for you to enter.
19. Remove child from area to fresh air.
20. Call 911 (if unsure of poison name).
21. Call poison control and get directions
22. Complete incident report form
23. Poison Leaves (e.g., ivy, oak,)
24. Remove clothing and have it washed.
25. Wash the affected area with soap and water.
26. If poison ivy kit is available, use ivy block lotion on contacted area.
27. If no kit is available, apply Hydrocortisone at 1% two times a day to contact area.
28. Give antihistamine orally as per camp physician.
29. Push fluids and avoid repeated exposure
30. If edema/swelling or respiratory distress is present, immediately contact camp physician or medical director for further therapy and assess need for oral/IV steroids.
31. Complete incident report form.

**Cough**

1. Take temperature
2. Assess pattern and production of sputum.
3. Check ears, nose, throat, sinuses, lungs, lymph nodes
4. If persistent and if not allergic or asthmatic, assess with sick camper protocol and then follow with:
5. Cough syrup (dose based on age)
6. Throat lozenges
7. Decrease mucus-producing foods/activities
8. Notify Camp Medical Director if persistent
9. Complete incident report form

**Diarrhea**

* 1. Assess pattern and symptoms (i.e. bloody)
  2. Assess potential etiology i.e. diet, nervousness, infection, disease, or treatment related
  3. Take temperature – follow sick camper protocol
  4. If over 3X (non-formed stool in 8 hours) reassess etiology and hydration.
  5. Tylenol or Motrin for associated headache, fever and muscle aches. Dosage according to weight and age guidelines.
  6. Rest
  7. Low roughage diet
  8. If diarrhea persists for 24 hours, dismiss home for further evaluation.
  9. Document incident and treatment
  10. Consider isolation if there is a reasonable level of suspicion of infectious etiology

**Earache**

1. Assess pattern/hearing
2. Check ears, nose, throat, lungs, lymph nodes, and sinuses for infection or foreign objects.
3. If infection or foreign object is suspected, notify Camp Medical Director.
4. Medicate with Tylenol or Advil as needed for comfort according to weight and age guidelines.
5. Document incident and treatment

**External Bleeding**

1. If serious, call 911 and contact Medical Director
2. Stop bleeding by applying direct pressure
3. If fracture is not suspected, elevate extremity
4. If bleeding continues, apply pressure on closest arterial pressure point and transfer to medical center.

**Eye Injury, Penetrating**

1. Do not apply pressure to the wound
2. Notify medical director and 911
3. Position the victim on their back
4. If the object is still present, stabilize it if possible
5. Apply an eye shield to the wounded eye if available. If not, use gauze or the bottom of a paper cup.
6. Wrap both eyes. Do not put pressure on the wounded eye.
7. Reassure victim and notify their family of situation

**Eye Injury, Non-Penetrating** (foreign body or chemical injury)

1. Assess eye and vision
2. Obtain history
3. Wash eye with copious amount of water. For chemical injuries this may require up to 30 minutes.
4. If a chemical injury, seek medical attention.
5. Recheck frequently
6. Notify Medical Director

**Fever-see Sick Camper Protocol**

**Fish Hook Incident Protocol**

1. Medical Fishing Tackle box should be kept at fishing site with attending medical personnel
2. Medical personnel should have:
3. Medical backpack with emergency supplies
4. Walkie talkie for contact with campsite
   * 1. Check puncture site for bleeding
5. Do not remove hook from camper
6. Keep area clean. Cleanse area with saline or water
7. Transfer camper back to Camp Medical station or to Great Bend Hospital for further care
8. Keep camper calm
9. Inform Camp Medical Director of situation in progress via walkie talkie/radio
   * + - 1. Check camper’s medical status in regards to immunizations, bleeding tendency, and risk for infection.
         2. If hook may be removed on campsite, then care of a puncture wound will follow with twice a day evaluation of the site and documentation of the care.

Call campers family and inform them of the situation and treatment in progress as well as the plans

Documentation of the incident, calls and therapy should be documented

**Flush – Standard Protocols** (Pediatric to 18 years of age)

*The following protocols do not apply to hemodialysis catheters.*

Per physician discretion, normal saline or low dose heparin (e.g., 10u/ml is indicated for a flush when intermittent medications are administered more than qid and a continuous infusion is not maintaining the patency.)

1. Peripheral IV Lock
   * + 2 ml normal saline followed by 1 ml heparin 10u/ml after each use or at least every 12 hours. (8am-8pm)
2. Peripheral Inserted Central Catheter (single lumen or duel lumen)
   * + - * 2 ml normal saline (5 ml syringe or larger) followed by 1 ml heparin 10u/ml in each lumen after each use or at least q 12 hours. (8am-8pm)
3. Central Venous Catheter (Subclavian)

2 ml normal saline followed by 1 ml heparin 10u/ml in each lumen after each use or at least q 12 hours. (8am-8pm)

1. Hickman/Broviac Catheter

2 ml normal saline followed by 1 ml heparin 10u/ml in each lumen after each use or at least once daily. (8am)

1. Implanted Vascular Access
   * + - 5 ml normal saline followed by 2 ml 100u/ml heparin in each port after each use or at least once per month if not in use. When port is accessed for intermittent therapy, flush port daily.

**Fractures**

1. Check circulation
2. Provide splint to affected area
3. Notify Camp Medical Director or nurse
4. Apply a cold pack to area; on for 15 minutes, off for 45 minutes - use cloth between ice and skin
5. Elevate if possible and place blankets or pillows for stabilization.
6. Recheck circulation
7. Transport to nearest emergency room or call 911
8. Document incident and treatment

**General Health Guidelines (Sunscreen/Insect Repellent/Hydration)**

1)      Sunscreen:  Camp Hope will provide sunscreen for all participants.  Sunscreen will be applied to campers every 4 hours when outside.  If swimming sunscreen will be applied every hour.  Camp volunteers will also encourage appropriate clothing such as hats to prevent sunburn when indicated.

2)      Insect Repellent: Camp Hope will provide insect repellent. All participants will apply repellent before outdoor activity and will reapply every 4 hours.

3)      Hydration:  Camp Hope will provide water at all events. Volunteers will monitor camper water intake and take scheduled water breaks hourly.

**Headache**

1. Take temperature.
2. If febrile (101.5° or greater), follow SICK CAMPER PROTOCOL.
3. If afebrile (less that 101.5°)
   1. Give acetaminophen as ordered for camper.
   2. Evaluate for dehydration or heat exposure.
      1. Fluid intake; provide fluid, if needed.
      2. Heat exposure; removed from heat. Facilitate cooling down.
         1. Conduct follow-up check in 30 minutes.
         2. If headache persists:
            1. Conduct another follow-up in 30 minutes.
            2. If headache still persists, contact camp physician

Document assessment and follow-up check.

**Head Trauma, no LOC**

* 1. Is camper conscious? If no, see instructions for Head Injury with LOC
     + 1. Is there a scrape or wound?
          1. If yes, wash with soap and water. Apply pressure with sterile gauze and apply ice for 20 minutes if there is swelling.
       2. Observe the camper closely for 2 hours after injury.
          1. Camper should rest in a quiet environment
          2. The victim may sleep during this time but should be observed
          3. Awaken the victim after 2 hours to perform assessment
       3. If after 2 hours the patient is acting normal, they may return to activity as tolerated.
       4. If at anytime the victim develops symptoms such as vomiting, confusion, lethargy or seizure then notify the medical director and seek medical attention. Notify houseparents on symptoms to watch for over the next several days.
       5. Avoid pain medications initially. If the victim has a headache, he/she should be evaluated by a camp physician. If the headache is acutely worsening, notify medical staff immediately.
       6. Document the incident providing instructions for parents upon the end of camp.

**Head Trauma with LOC (concussion)**

1. If the patient is unconscious, manage airway and stabilize c-spine.
2. If the patient has not awakened within 2-3 minutes, call 911
3. Have a camp physician examine the patient. A full neurologic exam should be performed.
4. Observe the camper closely for 2 hours after injury
   * + - 1. Camper should rest in a quiet environment
         2. The victim may sleep during this time but should be observed.
         3. Awaken the victim after 2 hours to perform assessment
5. Victim should be monitored closely for the next 24 hours.
   * + 1. He/she should sleep in the medical cabin or in a cabin with medical staff present to monitor closely.
       2. Medical staff should check the patient every 4 hours for any neurologic changes.
       3. Avoid pain medications initially. If the victim has a headache, he/she should be evaluated by a camp physician. If the headache is actually worsening, notify medical staff immediately.
6. If at anytime the victim develops symptoms such as vomiting, confusion, lethargy or seizure, then notify the medical director and seek medical attention. Notify houseparents on symptoms to watch for over the next several days.
7. Camp is restricted from participating in any contact sports or high-impact activity (i.e. inflatables) unless cleared by the medical director. The camper should be completely symptom free (no headache, dizziness, tinnitus, etc.) before any vigorous activity is resumed.

**Heat Exhaustion/Heat Stroke**

* 1. Symptoms of heat exhaustion/stroke include: nausea, vomiting, dizziness, muscle cramps, diarrhea, chills, weakness, fatigue or mental status changes. If these develop:
  2. Take the victim’s temperature. If elevated (greater than 38C or 100.4F), notify a camp physician.
  3. If the temperature is >104 degrees, camper is hypotensive or if the victim has severe symptoms, this is **HEAT STROKE**.

1. Move the victim to a cool environment and cool body with ice, towels, & fans. Place ice pack in the armpits behind the neck and in the groin. Consider drenching the victim in water. Monitor the temperature every 5 minutes during this process. Do not cool below 98.6F (37C)
2. Call 911
3. Obtain IV access and start IV fluids. Do not give oral fluids if there are mental status changes.
4. Administer oxygen.
   1. If the temperature is <104 and the victim has minor symptoms, this is **HEAT EXHAUSTION**.
5. Move the victim to a cool environment and cool the body with ice packs, towels, fans and removal of clothing.
6. Initiate rehydration with oral fluids (water or electrolyte solution) if the camper does not have mental status changes or vomiting. Start an IV if these symptoms are present. Camper should receive at least 1 liter of fluid.
7. Monitor vital signs every 15 minutes for at least 1 hour then hourly for 3 hours.
8. If the symptoms do not resolve rapidly, transfer to the emergency room.

**Hickman Removal after accidental dislodge**

1. Hold pressure for 3-5 minutes over insertion site.
2. Observe
   1. If bleeding repeat #1.
   2. If dry after 5 minutes, proceed to #3
      1. Apply antibiotic and 2x2 gauze; proceed to tape.
      2. Wait 24 hours to get wet.
      3. Bandage for several days over area.

**Hickman Removal (intentional)**

* 1. Clean area with Betadine
  2. Apply Emla to site.
  3. Wait 10 minutes.
  4. Use forceps to open skin and pull Hickman.
  5. Clip sutures to skin.
  6. Hold tension at neck when pulling line.
  7. Proceed with instructions on accidental dislodge of line.

**Hickman - Sterile Dressing Change**

* + 1. Wash hands thoroughly with soap and warm water.
    2. Carefully remove all tape and gauze from area around Hickman Catheter. Open one package of the Povidone-Iodine Swabsticks and clean the area directly around the catheter entry site working from the inside out away from the entry site. Do this with two of the three swabsticks.
    3. Using the third swabstick, clean the tube from the entry site down the tube about three to four inches.
    4. Using an Alcohol Prep Pad, wipe off some of the iodine around the outer edges where tape will stick to skin.
    5. Open a new Gauze Drain Sponge and place it around entry site of catheter. Using paper tape, tape gauze sponge to skin around the outer edges. Tape a loop in the tubing so it will curl up underneath clothes.
    6. Prepare Heparin Lock Flush Solution (10 USP Heparin Units/mL) in pre-measured syringes. Press air out of Heparin vial. Clean end of Hickman Catheter with an Alcohol Prep Pad. Screw Heparin syringe on to catheter end and gently push Heparin Solution into catheter. Unscrew syringe and discard.

**Huber Needle Insertion**

Equipment

* 1. Latex hub
  2. Chlorhexidine

If camper is allergic to Chlorhexidine, will also need:

Alcohol swabsticks

Betadine swabsticks (3)

Betadine swabs (2)

* 1. No. 19 gauge, ¾ to 1 ½ -inch right-angled Huber needle
  2. 6-inch double port extension tubing and slide clamp
  3. 5-ml syringe
  4. No. 25-gauge, 5/8-inch needles (2)
  5. Sterile normal saline
  6. Medium-sized transparent dressing
  7. 2 x 2-inch gauze pads (2)
  8. Sterile gloves (2 pairs)

1. Obtain physician’s order.
2. Gather equipment on clean surface.
3. Place patient in a comfortable position in a well-lighted area.
4. Wash hands thoroughly.
5. Open all supply packages to be used and prepare on sterile field in order of their use.
6. Apply one sterile glove and draw up 5ml of sterile normal saline, using No. 25-gauge 5/8-inch needle, making sure syringe and glove remain sterile.
7. Apply second sterile glove.
8. Using aseptic technique connect extension tubing, latex hub and Huber needle.
9. Fill extension tubing and Huber needle with sterile normal saline (approx. 1ml) making sure Huber needle remains sterile. Note: Remaining saline to be used later in procedures.
10. Change needle on 5ml syringe discarding used needle in appropriate receptacle.
11. Remove old dressing and Huber needle/extension tubing, stabilizing infusion port. **Note:** Remove needle at a right angle with hub perpendicular to skin. This requires moderate pulling strength.
12. Palpate portal site with index and middle finger to locate portal septum.
13. Remove old gloves and apply new sterile gloves.
14. Cleanse area over portal septum with Chlorhexidine, beginning at center of septum and cleaning in a circular motion, never returning to the middle. If the patient is allergic to Chlorhexidine, alcohol followed by Betadine may be used instead. **Note:** If swabsticks are not available, use six cotton-tipped applicators soaked in alcohol.
15. Insert Huber needle into portal septum, using moderate to great pressure until needle hits bottom of portal chamber. **Note:** Pressure should be applied to the needle at the junction where the right angle is.
16. Cleanse latex hub of extension tubing with Chlorhexidine for 1 minute. If camper is allergic to Chlorhexidine, use two Betadine swabs for 1 minute each.
17. Insert sterile needle of 5ml syringe with sterile normal saline into the latex hub. Check for placement by aspirating blood.
18. If a good blood return is present, blush tubing with the remaining sterile normal saline.
19. Observe for swelling. If swelling occurs around site, stop procedure and notify physician.
20. Place a folded 2 x 2-inch gauze pad underneath the hub of the needle. **Note:** Huber needle position is maintained by the pad.
21. Place medium-sized transparent dressing over Huber needle and exit site. Reinforce dressing with tape if needed.
22. Discard gloves.
23. Heparinize per procedure if site will not be used immediately for infusion. (See standard flush protocols)
24. Document the following:
    * + 1. Procedure
        2. Equipment used
        3. Heparin dose
        4. Appearance of site
        5. Patient’s tolerance
           1. Notify physician of significant findings.

**Hypoglycemia in Diabetic Camper**

* 1. If camper is dizzy, confused, fatigued, weak, has tremors, the chills, is sweaty and or at camper’s request - CHECK BLOOD SUGAR and stop/remove camper from activity
     1. Hypoglycemia will be treated if BS is equal to or less than 60mg/dl. (Unless otherwise instructed by camper’s PCP)
        1. Have the camper take a rapid acting carbohydrate (3-4 glucose tablets (4 grams each) or a half cup of apple or orange juice)
        2. Recheck blood sugar 15 minutes after snack, if greater than 60mg/dl
           1. Have the camper eat one starch exchange before resuming participation in previous activity (ex: 2 tsp peanut butter or 1oz cheese and crackers) or approximately 15 grams of complex carbohydrate with protein
           2. Have camper rest at least 15 minutes to allow carbohydrate snack absorption prior to allowing the camper to return to his/her activity
           3. Recheck BS 15 minutes later

If still 60 or below – hypoglycemia is severe:

Administer intramuscular glucagon – 1.0 mg/kg to a maximum of 10 mg/kg

After 15 minutes if BS is still 80-60 repeat treatment

If hypoglycemia occurs during the late evening or night:

Treat with 30 grams of carbohydrate, 15 grams simple carbohydrate, 15 grams complex carbohydrate with protein

Recheck BS and it must be above or equal to 100 before returning to bed

1. Treatment may be initiated by any of the camp medical staff however, the medical director should be notified of the situation and the appropriate documentation should be completed as well. The group houseparent should be made aware of the situation so they may be alert to changes.
2. Some other hypoglycemia busters: (fast-acting carbohydrates)
   1. ½ - ¾ cup of orange or grape juice
   2. 2 glucose tablets
   3. 2 doses of glucose gel
   4. 2-4 pieces hard candy
   5. 5 gumdrops
   6. 1-2 tablespoons of honey
   7. 6 ounces regular non diet soda (about ½ can)
   8. 2 tablespoons of cake icing

**Insect Bite**

1. Inspect for insect bites. If tick bite, follow tick protocol.
2. Note any area that is inflamed or infected.
3. Inspect for spider bites. If spider bite, follow spider bite protocol.
4. Inspect for multiple sites.
   * 1. When site is found:
5. Determine if camper is on or off chemotherapy
6. Follow sick camper protocol
7. Make sure area is cleaned appropriately.
8. Apply antibacterial or antipruritic medication.
   * + - 1. Inform medical staff of situation
9. Medical staff will determine if bite should be reported or follow up done.
10. Medical staff assigned to group will be responsible for informing house parent of situation and what follow up is necessary.

**Insect (bee/wasp) Stings**

1. Scrape off stinger or insect with tweezers or remove insect
2. Wash with soap and water.
3. Patient must be brought to medical station for further evaluation and observation for at least 30 minutes.
4. Cover affected area with a paste of Adolph’s meat tenderizer and water and apply cold pack. Then wait 5-10 minutes and wash off paste. Then apply hydrocortisone cream.
5. If itching occurs may give oral Benadryl if approved by Camp Medical Director
6. Notify physician if a severe reaction occurs or if there is a know history of previous sensitivity
7. Complete incident report

**Lightning Strike**

Stabilize c-spine

Initiate CPR if needed. Obtain the AED if unconscious or unstable

Make sure you and the victim are in a safe location

Call 911

Examine for other injuries and treat accordingly if able

**Menstrual Cramps**

1. Assess pattern
2. Assess abdomen
3. Check previous history/pattern and previous treatment usually used by camper
4. May give Tylenol or Advil
   * Tylenol 325 mg. P.O. ages 7-12

650 mg. P.O. ages 12-18

* Ibuprofen 200 mg. P.O. ages 7-12

400 mg. P.O. ages 12-18

* May give every 8 hours, not to exceed 3 doses (take with food)
  1. Heating pad PRN (on low-medium setting)
  2. Rest as needed
  3. Complete incident report

**Nausea**

1. Take temperature
2. Determine cause - food, illness, exposure to chemical, homesickness, motion sickness, nervousness or treatment/disease related
   1. For physiological nausea or upset stomach not related to cancer or treatment of cancer
3. Utilize Zofran or Zofran ODT tablets or liquid (ages 7-12 1 tab/1 tsp., ages 12-18 2 tabs/2 tsp.)
4. Rest in quiet environment
5. Limit food intake
6. Encourage clear liquid intake
7. For physiological nausea
8. Provide support
9. Provide a quiet safe environment
   * 1. For motion sickness
10. Dramamine as indicated for weight and age guidelines.
    * + - 1. Check records for most recent chemotherapy received
          2. If persistent, notify Camp Medical Director
          3. Complete incident report

**Neutropenia with Fever**

Fever in a neutropenic child is a medical emergency.  Fever is defined as a single oral temperature of 101ºF or an oral temperature of 100.4 ºF sustained over a 1-hour period or reported from 2 consecutive readings in a 12-hour period.

If a camper has an oral temperature of 100.4 ºF or greater immediately notify a camp physician and the medical director.

If the camper meets criteria for febrile neutropenia:

1)      Camper will be taken immediately to the emergency department for evaluation

2)      Camp physician will contact the camper’s oncologist

3)      Camp physician will contact the camper’s family after discussing with oncologist

4)      Camper disposition will be determined by the oncologist and ED physician

**Nosebleed**

1. Keep camper in sitting position with head slightly forward. DO NOT tilt head back
2. Instruct camper to breathe through mouth
3. Apply gentle but firm pressure to pinch nostrils together
4. Pressure should be done from bridge of nose to nostril opening using your thumb and index finger. May use an ice pack as an adjunct to pressure
5. Hold for 10 minutes
   * 1. Inform the Camp Medical Director
     2. Document incident and resolution

**Restraining a Camper**

1. Physically restraining a camper by a volunteer will only be done in extreme situations when it is deemed that the camper is a physical threat to him/herself or to someone else.
2. No physical restraints will be used on a camper.
3. The camper will be restrained for the least amount of time necessary to de-escalate a situation.
4. If a situation cannot be de-escalated quickly and there is a concern for an ongoing need of restraint, the camper will be taken to the emergency department, or EMS or police will be contacted immediately.
5. The camper’s parent/guardian will be notified of the need for and use of physical restraint.

**Seizures**

1. Check for any medical information
2. Protect from nearby hazards/remove from any immediate danger
3. Place on side to keep airway clear
4. Check airway patency
5. Loosen shirt or any article around neck
6. Stay with camper and monitor status of seizure. Note the time/length of the seizure
7. Notify medical staff/assigned nurse as soon as possible
8. If multiple seizures occur, immediately call the medical staff for assistance
9. If short convulsive episode, call the medical staff once the camper is stable or the seizure is resolved
10. Assess need for anticonvulsant or adjustment of medications
11. Reassure camper when consciousness returns, have camper reassessed within one hour of incident
12. Make sure his/her houseparent is aware of situation and reports to medical staff on status before campfire, sooner if any questions or concerns. Medical staff in camper’s cabin is to report status from evening to Camp Medical Director (this will determine following day’s restrictions)
13. Complete incident report

**Sick Camper Protocol/Fever (temperature at least 101 degrees or 100.4 degrees measured in consecutive readings 1-12 hours apart)**

1. Verify temperature and document all rechecks and follow-up care
2. Check status of chemotherapy
3. If OFF chemotherapy:
   * 1. Give acetaminophen as ordered
     2. Recheck temperature in 30 minutes
     3. Follow-up check in one hour
4. If **febrile**, contact Camp Medical Director
5. If **afebrile**, contact houseparent. Monitor camper for return of signs/symptoms
   * + - 1. If ON chemotherapy:
         2. Have camper examined by Camp Medical Director. DO NOT give any medications until the physician examines camper.
         3. Physician will obtain counts (CBC, blood culture, platelet count) as appropriate
         4. If counts are normal:
6. Give acetaminophen as ordered
7. Recheck temperature in 30 minutes
8. Follow-up check in one hour
9. If febrile, contact Camp Medical Director
10. If afebrile, contact houseparent. Monitor camper for return of signs/symptoms.

If counts are **abnormal but nonneutropenic**:

1. Contact Camp Medical Director
2. Camp Medical Director contacts camper’s primary physician and family as needed.

If counts are **abnormal and neutropenic**

1. See Neutropenia with Fever protocol
2. Document any situation and resolution in medical log.

**Snake Bite**

In Kansas, the primary venomous snakes are pit vipers (copperheads, cottonmouth and rattlesnake). Common symptoms can include (if venom was released): local burning pain, weakness, nausea/vomiting, paresthesias, swelling and edema. These symptoms normally begin within 5 minutes of the bite. Fang marks may also be visible. If a camper or volunteer is bitten by a snake,

1. Make sure the victim is safe and out of reach of the snake (approximately the length of the snake).
2. Do not try and catch nor kill the snake. If the snake is dead, do not touch it.
3. Notify a medical director or camp physician.
4. Immobilize the bitten extremity with a splint.
5. Keep the limb at heart level.
6. Measure the limb circumference every 15 minutes while waiting for transport.
7. Encourage the victim to drink liquids while awaiting transport.
8. Do **NOT** apply a tourniquet.
9. Do **NOT** incise and attempt to suck out the venom.
10. Transport the victim to the ER via EMS

**Sore Throat**

1. Take temperature
2. Check records for most recent WBC and/or treatment
3. Check oral cavity, nasal passage, ears, lymph nodes, sinuses, and respiratory status
4. Check history of events, i.e. screaming, allergies, etc.
5. If no infection suspected, utilize
6. Cool fluids/soft foods PRN
7. Limit conversation PRN
8. Throat lozenges PRN
9. Salt-water rinses (¼ tsp. salt to 8 oz. warm water PRN)
   * 1. If temperature over 101 degrees, notify a camp physician. May give Tylenol or Ibuprofen per weight and age guidelines if there are no contraindications such as neutropenia.
     2. If infection suspected, notify Camp Medical Director and follow sick camper protocol
     3. Complete incident report

**Spider Bite**

The common venomous spiders in Kansas include the brown recluse and the black widow.

1. Clean the wound site.
2. Apply cold compresses to the wound intermittently.
3. Notify medical director or camp physician if suspected venomous bite.
4. Confirm tetanus status.

**Splinters**

1. Cleanse area with soap and water or hydrogen peroxide.
2. Remove splinters with tweezers
3. Cleanse area with soap and water or hydrogen peroxide again.
4. Check for signs and symptoms of infection - if found, notify Camp Medical Director
5. Verify recent date of Tetanus shot

**Sprains/Strains**

1. If the camper’s ankle or knee is affected, elevate and ice for at least 20-30 minutes. Do not allow him/her to walk, splint or wrap as indicated.
2. If fracture not suspected and platelet count is normal then:
3. Use Tylenol or Advil as needed for discomfort according to weight and age. May continue for 1-3 days until pain-free.
   * 1. If fracture suspected
   1. Immobilize and use bleeding protocol then transfer to Great Bend Emergency room or call 911
      * + 1. Inform Camp Medical Director and complete incident report

**Stroke**

1. Initiate CPR at anytime if indicated
2. Notify medical director or camp physician
3. Call 911 if indicated
4. Maintain airway.
5. Provide oxygen
6. Elevate victim’s head and body to approximately 30 degrees.
7. Check blood sugar
8. Attempt to start IV.
9. Continue to monitor breathing, airway and circulation pending EMS arrival

**Thrombocytopenia/Platelet Disorders**

If count is less than 100,000

1. Notify houseparent of precautions
2. Watch for:
3. Increased bruising
4. Petechiae
5. Nosebleed that is difficult to stop (refer to nosebleed protocol)
6. Gums that bleed easily
7. Avoid sharp foods or sharp objects in mouth
8. Bleeding from small cuts or scrapes that is hard to stop
9. Apply pressure if site is accessible
10. Notify camp medical director
11. Blood in urine, bowel movements or vomitus
12. Notify any camp physician and or camp medical director

Monitor Activities

1. Close monitoring of play activities to avoid injuries and bleeding
2. If house parent, activity supervisor and or medical personnel of your group deems it dangerous
   1. Stop participation until discussed either with medical director and if deemed necessary with the child’s oncologist or PCP for advice about participation
   2. Signs and symptoms of constipation
      1. Address this with the medical staff assigned to your group for resolution
   3. If count is equal to or less than 50,000
      1. Watch and monitor for all of the above
      2. NO diving allowed into the pool
      3. NO CONTACT SPORTS such as football, tackle sports, wrestling, and go carts
      4. NO horseback riding
      5. Further restrictions may be necessary based off the activity schedule
      6. Adolescents should use an electric shaver rather than a razor
      7. Female campers should inform medical staff of increased bleeding during menses
         1. If any of the above signs, symptoms or concerns is observed, notify your group’s medical staff. Then they will proceed with the documentation and notification of appropriate staff.
3. Always document the incident and its resolution. Immediately report the incident to the camp medical director. The camper’s PCP or parent will be notified as necessary.

**Tick Check and Removal**

* + - * 1. Tick checks are done every night on every camper (required).
        2. The nurse/physician is responsible for facilitating tick checks for all campers in the nurse’s/physician’s assignment group. House parents or another medical staff member can assist with the checks; however, the assigned nurse/physician is responsible for knowing the results of the checks.
        3. If NO tick is found:

Continue to monitor the camper for ticks

Continue with camp activities

If a tick is FOUND:

Contact the camper’s house parent

If tick is found by the houseparent, contact the assigned nurse/physician to have the tick removed.

Remove the tick according to the tick removal guidelines.

A follow-up check will be conducted within 24 hours by the assigned nurse/physician.

Check for redness, induration and/or rash.

If NO signs, have house parent continue to monitor site.

If signs are NOTED, contact camp physician.

1. Document incident and follow-up check.

**Tick Removal Guidelines**

1. Avoid handling ticks with uncovered fingers; use tweezers. If index finger and thumb must be used, protect them with rubber gloves, plastic, or even a paper towel.
2. Place the tips of tweezers around the area where the mouthparts of the tick enter the skin.
3. With steady slow motion, pull the tick away from the skin. Do not twist, jerk, crush, squeeze, or puncture the tick.
4. After removal, place the tick directly into a container that seals. Dispose of the tick in an appropriate receptacle.
   * 1. Cleanse the area around the bite site with an antiseptic such as Betadine. If camper is allergic to iodine, use alcohol to cleanse the area.

**Tooth Avulsion**

* + - 1. Gently rinse the tooth with either saline solution or milk. Only handle the tooth by the crown.
      2. Notify the medical director or camp physician.
      3. Irrigate the wound with saline to remove blood and clots.
      4. Attempt to replace the tooth with gentle pressure.
      5. If unable to replace the tooth, place the tooth in normal saline solution, milk or the victim’s saliva.
      6. Arrange for transport to and/or follow-up with a dentist.

**Transfusion**

Lab draws during camp are done by the local hospital. They with send a staff person to camp to draw the blood or they do it at the hospital. Results are then obtained in a the normal-hospital time frame. If the lab results show that the camper may need a transfusion, the oncologist will be notified. Camp Hope does not provide transfusions at camp itself.  Should a camper need a transfusion, then medical director will discuss the need with the oncologist first.  The medical director will then call the local hospital ED to discuss the possibility of doing the transfusion in the ED.  If the hospital agrees to do the transfusion, then the oncologist will provide written orders and the medical director will get approval from the camper’s family to proceed.  The hospital provider will then take over management.  Once the transfusion is complete, disposition of the camper will be determined by the family and oncologist.   If the local hospital is unable to do the transfusion then the camper will be transferred to a tertiary care center.

**Volunteer Illness or Injury**

***Clinically stable***

1. Assess volunteer
2. If the volunteer is coherent and stable, escort them to the medical facilities or notify a camp physician immediately.
3. The medical director or his/her designee will initiate care as indicated.

***Clinically unstable***

1. If the volunteer is unconscious, critically injured, incapacitated or is deemed unable to make an informed medical decision, yell for help and notify the medical director immediately. If the medical director is unavailable, notify a camp physician.
2. Initiate Basic Life Support (BLS) as indicated.
3. Call 911.
4. The medical director or his/her designee will initiate any treatment deemed necessary prior to EMS arrival.

**Medical Policies**

**Universal Precautions**

Universal precautions shall be consistently used for all campers and volunteers to protect all campers/volunteers from exposure to potentially or unknown infection contacts and to prevent contact with blood, body fluids, secretions, excretions or tissues. Universal precautions are designated to prevent infections that are transmitted by direct or indirect contact with infected blood or body fluids. While the use of universal precautions should be used in the care of all campers and volunteers, it is especially important in emergency care settings in which the infection status of the camper/volunteer is usually unknown.

* 1. Hands must be washed immediately if they are contaminated with blood or body fluids, before and after taking care of camper/volunteer and after removing gloves.
  2. Persons who are in contact with or anticipate contact with blood, specimens, tissue and body fluids or excretions, or contaminated surfaces or articles must wear gloves. Gloves should be changed after contact with each camper/volunteer.
  3. Protective eyewear (glasses or goggles) must be worn in situations where splattering of blood or body fluids is possible.
  4. Semi-impervious gowns or aprons are recommended for those likely to have direct contact with large quantities of camper/volunteer secretions, excretions or blood.
  5. Masks should be worn when splattering of blood or body fluids is possible. Campers/volunteers who may have microorganisms in respiratory secretions may be asked to wear a mask to protect campers/volunteers.
  6. Sharps should NOT be bent, broken reinserted into the original sheath, or unnecessarily handled. They shall be discarded intact immediately after use into an impervious needle disposal box. When recapping is unavoidable, the scoop technique of recapping shall be used.
  7. All needle stick incidents, mucous splashes or contamination or open wounds with blood or body fluids shall be reported to the Camp Medical Director.
  8. Specimens from camper/volunteers are obtained and transported by a representative from the laboratory department of a hospital in Great Bend
  9. All blood and body fluids spills should be cleaned up promptly with an approved hospital strength disinfectant and/or a body fluid spill kit.
  10. CPR masks should be used anytime CPR is performed unless a delay in treatment will be caused.

**Waste Separation**

1. Clear or Black Bags: Clear or black bags are used for all foodstuffs, paper items and miscellaneous trash. Any items with names or personal information must be shredded. Clear or black bags will be placed in the general use trash receptacles.
2. Red Bags: Red bags are used with all regulated waste and potentially infectious materials, specifically all items saturated or caked with blood or potentially infectious materials. Red bags will be placed in trash receptacles in areas that generate large quantities of infectious waste.
3. All sharps much be discarded in an impervious needle disposal box and will be sent to an appropriate medical facility at the end of camp for definitive disposal.
4. All chemo-contaminated disposable items must be discarded in an impervious needle disposal box or yellow bag and sent to an appropriate medical facility for definitive disposal.
5. Proper Trash Disposal:
6. All bags are to be tied at the top.
7. No bags are to be filled greater than 2/3 (two thirds) full.
8. No red or yellow bags or red or yellow bag items are to be placed in clear bags.
9. If items disposed of are particularly heavy, bags should be tied off, filled only minimally and double bagged to prevent breakage or leaking.

**Policy For Exposure To Blood Or Other Potentially Infectious Material**

Any exposure to blood or other potentially infectious material (OPIM) to eyes, skin, mucous membranes or through parental contact (i.e., piercing of skin barrier) that may result from the performance of any member of the medical staff/volunteer must be reported immediately to the Camp Medial Director and the Camp Hope Heartland liaison.

1. All exposures to a patient’s blood or OPIM should be reported to the Camp Medical Director immediately.
2. Document incident as per the Camp Hope Medical Documentation Protocol, as well as document on the Medical Follow-up Form for Camp Hope.
3. First-Aid Measures Recommended after exposure:
4. Percutaneous (needle sticks/sharp object) injury: wash with soap and water immediately
5. Splashes to mucous membranes, flush with water for inside of nose/mouth; irrigate eyes with clean water, saline, or sterile irrigants.
6. Splashes to non-intact skin, wash with soap and water.
   * 1. Source Patient Testing:
7. HBsAg, HCV antibody and HIV testing will be done on the source patient/camper when there is an occupational exposure. Consent will be obtained from the parents by phone. If the parents or source patient refuses to sign the consent form, or to have the blood drawn the source should be handled as an “unknown source”.
8. If the source patient/camper tests positive for HCV antibody, a qualitative PCR will be run to verify results if possible.
9. If the source patient/camper is already known to be positive for HBV, HCV, or HIV, testing does not need to be repeated for that particular virus.
10. The Camp Medical Director will share the results on the source patient/camper’s testing with the individual’s primary physician.
    * + - 1. Medical staff testing:
11. Baseline lab to be drawn on the med staff, after written consent is obtained. This lab will include HbsAg, HCV antibody, and HIV. In addition, an HbsAb will be drawn on employees immunized with Hepatitis B vaccine. If employee consents to start HIV postexposure prophylaxis, a baseline CBC should also be drawn. If the medical staff declines the testing but consents to collection, blood can be kept in the lab for 90 days in case the medical staff later decides to be tested.
12. The medical staff should report any illness or rash occurring within six weeks after exposure.

Recommended Prophylactic and Follow-up Treatment:

1. Prophylactic treatment should be based upon test results of the source patient/camper and the medical staff’s type of exposure. Treatment protocol will be based on the recommendations of the United States Public Health Service and CDC Guidelines.

Source patient/camper is HIV negative:

* 1. No follow up on the medical staff is required unless so desired. If it is requested then an HIV may be drawn at 3 and 6 months.
  2. If antiviral drugs were started, drug therapy will be discontinued.

1. Source patient/camper is HIV Positive:
2. Two-drug prophylaxis should be initiated promptly and consists of: Comivir (combination of Zidovudine 300 mg and Lamivudine 150 mgs) 1 tablet by mouth 2 times a day. Prophylaxis is given for 4 weeks.
3. Medical staff should have retesting for HIV at 6 weeks, 3 months, and 6 months post exposure.
4. In addition to baseline testing, follow-up CBCs are to be done at 2 weeks, 4 weeks, and 6 weeks if taking drug prophylaxis.
5. If the exposure deals with a large volume of blood (e.g., involving an injection of source patient/camper’s blood), start the two-drug therapy for exposure and consult with the Camp Medical Director or their personal physician to see if a three-drug prophylaxis consisting of Combivir (combination of Zidovudine 300 mg and Lamivudine 150 mg) 1 tablet by mouth 2 times a day, and Indinavir 800 mg, 3 times a day. Prophylaxis is given for 4 weeks.
   * 1. Recommendation for post exposure prophylaxis for percutaneous or permucosal exposure to hepatitis B virus:

|  |  |  |  |
| --- | --- | --- | --- |
| **Vaccination and antibody status of exposed person** | **Treatment when source is HbsAg**  **Positive** | **Treatment when source is HbsAg**  **Negative** | **Treatment when source is not tested or status is unknown** |
| Unvaccinated | HBIG\* X 1 and initiate HB vaccine series | Initiate HB vaccine series | Initiate HB vaccine series |
| Previously vaccinated | No treatment | No treatment | If know high-risk source, treat as if source were HBsAg positive |
| Known responder † | HBIG\* x 2 or HBIG\* x 1 and initiate revaccinations | No treatment |  |
| Known nonresponder |  |  |  |
| Antibody response | Test exposed person for anti-HBs | No treatment | Test exposed person for anti-HBs |
| Unknown | 1. If adequate, † no treatment 2. If inadequate, † HBIG x 1 and vaccine booster |  | 1. If adequate, † no treatment 2. If inadequate, † initiate revaccination |

HBsAg, Hepatitis B surface antigen, HBIG, hepatitis B immune globulin, HB, hepatitis vaccines, anti-HBs antibody to hepatitis B surface antigen

\* Dose 0.06 mg/kg IM

† Responder is defined as a person with adequate serum levels of anti HBs (210 mlU/ml), inadequate vaccination defined as serum anti-HBs < 10 mIU/ml

1. There is no recommended postexposure prophylaxis for an exposure to Hepatitis C virus. Baseline testing for HCV antibody will be done on the meds staff. Follow-up HCV antibody will be done at 3 months and 5 months.
2. Postexposure prophylaxis and follow-up treatment for an exposure to an unknown source patient/camper should include:
3. Hepatitis B vaccination series should be recommended if meds staff has not been previously immunized.
4. If employee has had Hepatitis B vaccination series, an HBsAb will be drawn. A positive antibody requires no treatment. Revaccination with Hepatitis B series is recommended if antibody is negative.

**Proper Lifting Technique**

The following is promoted and encouraged among all campers and volunteers.

Keep a wide base of support. Your feet should be shoulder-width apart, with one foot slightly ahead of the other.

Squat down, bending at the hips and knees only. If needed, put one knee to the floor and your other knee in front of you, bent at a right angle.

Keep good posture. Look straight ahead, and keep your back straight, your chest out, and your shoulders back. This helps keep your upper back straight while having a slight arch in your lower back.

Slowly lift by straightening your hips and knees (not your back). Keep your back straight, and don't twist as you lift.

Hold the load as close to your body as possible, at the level of your belly button.

Use your feet to change direction, taking small steps.

Lead with your hips as you change direction. Keep your shoulders in line with your hips as you move.

Set down your load carefully, squatting with the knees and hips only.

***Keep in mind:***

Do not attempt to lift by bending forward. Bend your hips and knees to squat down to your load, keep it close to your body, and straighten your legs to lift.

Never lift a heavy object above shoulder level.

Avoid turning or twisting your body while lifting or holding a heavy object.

**High Intensity/Impact Sports Policy**

Participation in high intensity/impact sports as recommended by the American College of Sports Medicine. These are sports such as: wall climbing, ropes courses, and tackle sports.

* 1. Liability Waiver must be signed by camper’s parent/guardian if given activity participation requires such a release.
  2. Contraindications to participate in these sports are:
     1. Hemoglobin LESS than 8
     2. Platelet count LESS 50,000
     3. Fever greater than 38
     4. Bone pain
        1. If the activity/sport requires significant balance and coordination the camper should avoid participation if:
           1. Has ataxia or dizziness
           2. Has peripheral sensory neuropathy
           3. Has loss of peripheral vision

Camper with seizures should proceed with caution or avoid participation in these activities. To be able to participate the camper should:

Be seizure free for minimum of 4 weeks prior to participation

Be on seizure medication

Camper with nephrostomy tubes, urinary bladder catheters, colostomies must be 8 weeks past surgery and should not have an open-ended pouch appliance to enter pool with other campers.

The asthmatic camper:

If the camper has exercise induced bronchospasm:

Must have his/her rescue inhaler available to medical staff assigned to the camper’s group.

During any activity the medical staff in that group should be notified immediately of any complaint of respiratory distress.

**Handling Emergencies on Camp-Sponsored Transportation**

1. There will be medical personnel present on all camp-sponsored transportation or a designated medical vehicle following in close proximity to any vehicle that does not have medical personnel directly on it.
2. In the event of an emergency on the vehicle, the medical personnel present will respond and act according to all protocols in the Health Care Manual.
3. The medical personnel have the authority to direct the driver to stop or divert to a different destination based on the needs of the emergency.
4. If there are not medical personnel on the vehicle, another volunteer is to command the driver to stop and will radio or call the driver of the medical vehicle so that they can board the vehicle immediately to assess the situation.

**Palliative Care/DNR**

1. Campers on palliative care will be accepted to camp after the medical director has discussed with parents/guardians and the camper’s oncologist so there is a full understanding of the desires and expectations of all parties.
2. Those desires will be clearly communicated to all medical personnel as well as all volunteers who need to know.
3. A copy of any DNR order, if pertinent, will be obtained and will be kept with medical records.
4. All pertinent staff will be trained to know when to communicate concerns about a camper’s health status to the medical team.
5. Regular communications will be made between medical staff and parents/guardians if there is any change in the camper’s health status.

**Death of a Camper/Volunteer Protocol**

1. Follow Immediate Response and Communication Related to Injury Protocol.

2. Crisis Response Team will be activated.

3. Immediately move all campers and volunteers from the scene to a safe location (i.e. dining hall or cabins). Offer distraction activities and make all mental health specialists available to campers and volunteers immediately.

4. Medical Director/Mental Health Director/Camp Physician will notify deceased emergency contacts within 30 minutes. Emergency contact will approve transportation of body to local funeral home (Bryant Funeral Home, Great Bend, KS).

5. Camp Director and Committee Chair (other committee members as delegated) will meet to discuss if Camp Hope will continue for the week or shut down. If determined to shut down Camp, committee will arrange transportation.

6. Mental Health Specialist and/or any volunteer designated by Medical Director or Mental Health Coordinator will call emergency contacts for all campers and use pre-scripted dialog to inform parents of death. Script includes follow-up for parents. Parents will also be notified at this time as to the status of Camp Hope for the week. If Camp Hope is to continue, parents will be given the option, as always, to pick up their campers early. Clergy will be made available to campers and/or volunteers if desired.

7. If deceased is camper, Medical Director or camp physician will contact camper’s clinician.

8. Camp activities shall continue as scheduled if possible, to continue help with coping for children. Campers will have access to quiet activities and mental health specialists.

9. All media will be directed to Media Liaison. Media Liaison will work with Committee Chairman and Camp Hope Board President to develop a media release that would not violate HIPPA/Privacy.

10. Mental Health Specialist will continue to be available to all campers and volunteers throughout the week. Mental Health Specialists will document all interactions with campers and notify parents of specific camper needs.

11. One week after Camp Hope, parents and volunteers will be sent a follow-up email with grief information and contact information for the Mental Health Director.

12. At one month, and six months after Camp Hope, parents and volunteers will be sent a follow-up email with grief information and contact information for the Mental Health Director.

**Mental Health Crisis Response Plan**

**Purpose**:

* To identify steps camp volunteers are to take to manage a camper’s aggressive behavior, verbal and/or physical, that is directed at self or others.
* To provide safety for the campers and the volunteers.

**Rationale:**

Prevention and early detection are the best interventions to diffuse any aggressive behavior. Reducing the camper’s anxiety and agitation to promote positive coping is the goal of all de-escalation interventions implemented. Being vigilant about a camper’s changing emotional, biological, and interpersonal factors and changing environmental factors is crucial to prevention of aggression.

Camp volunteers must be aware of their own internal reactions to a camper’s escalating behavior(s). Volunteers also must be aware of their own fears and boundaries. Knowing the appropriate procedure to implement will allow volunteers to have better control of the situation.

**Assessment:**

If on camp and if physical aggression has already taken place or there is imminent danger of physical harm to a camper or volunteer, notify the Camp Director immediately. In addition, notify the camper’s houseparent, the committee chairman and a member of the medical staff.

If off camp, contact 911 immediately and request emergency help from law enforcement. Notify the Camp Director.

Administer first aid as necessary.

Separate other campers from the aggressive camper by either removing the aggressive camper to another location or removing the campers from the vicinity of the aggressive camper.

The Camp Director or committee chairman will be responsible for contacting the camper’s parents or guardians.

**Assess the situation:**

* Is the camper threatening to harm himself/herself or someone else?
* What harm has already been done, if any?
* What is the camper’s level of anxiety/agitation?
* What immediate stressor could be contributing to the situation?
* What is the pressing concern?
* Is there a history of psychiatric disorders, head injury or other physical disorders that may contribute to the camper’s increased agitation?
* What is the developmental level of the camper in regard to selecting an appropriate intervention?
* What are the camper’s previous experiences with the camp?

**Management of an Escalating Situation:**

1. The Camp Director, the camper’s houseparent, the committee chairman, a member of the medical team will go to the setting of the situation. Additional volunteers will be notified by the Camp Director or committee chairperson as necessary.
2. The Activities Committee chair will be responsible for managing the other campers during the crisis, making certain that the campers are safe and are involved in activities as appropriate.
3. The camper displaying aggressive behavior needs to be approached in a caring and supportive manner. Do not threaten, intimidate or lecture. Maintain a calm, gentle, matter-of-fact approach.
4. Avoid power struggles. Do not argue, yell or make accusations.
5. Take cues from the camper. Respond, rather than react.
6. No single intervention is appropriate for every camper. It must be individualized and parallel the level of anxiety and camper responses to the intervention.
7. Use physical distance and touch cautiously. Be vigilant about the camper’s responses.
8. As much as possible, keep the environment quiet with minimal distractions. Make the environment as safe as possible by removing anything that could be used as a weapon to harm self or others, including sharps, chairs, etc.
9. Begin conversations with orienting information.
10. Do not make sudden abrupt moves.
11. Maintain confidence.
12. Be at eye level or below to convey “mutuality” rather than “hierarchy.”
13. Speak slowly and clearly.
14. Use short simple sentences.
15. Give the camper choices when possible so that they feel they have some control over what is happening to himself/herself. Limit the choices to no more than two.
16. One volunteer should be communicating with the camper. If the camper is continuing to escalate in behavior and the volunteer would like another volunteer present to take over, this needs to be communicated to the volunteers present.
17. Once the situation begins to de-escalate, stay with the camper to provide support and maintain safety.
18. Parent/guardian should be contacted by the Camp Director or committee chairman if this has not already been done and advised of the situation.
19. The Camp Director will determine if the camper is to be sent home.
20. If the camper seems to be escalating further or unable to de-escalate, it is the decision of the Camp Director or the committee chairman to call 911 and request assistance from law enforcement.
21. If the camper elopes from the established camp area:
    * If at all possible, keep the camper in sight.
    * It is the decision of the Camp Director or the committee chairman to contact 911 or to attempt to de-escalate the situation.
    * If the camper elopes from the established camp area and cannot be seen, the procedure for **Missing Persons/Kidnapping should be followed**. **See volunteer handbook.**

**De-escalation Techniques:**

* Empathic Listening: Genuine acknowledgment of the camper’s psychological state or point of view.

Empathic listening involves the volunteers frame of reference reflected through facial expression and body posture that is non-threatening.

* One-to-One: Giving the camper one-to-one time with a volunteer at the earliest signs of increased anxiety will allow the camper to verbalize unmet needs in a calm manner. Unmet needs often manifest into agitation or aggression. The desired outcome of the one-to-one de-escalation technique is to diffuse any potential for the camper to escalate into aggressive behavior.
* Limit Setting: One of the last de-escalation options is to give camper two choices. Limit setting does not mean saying “no” to all options. It is setting a priority as to “when” a camper can act on his/her choices. Volunteers must follow through with the choices and commitments made to the camper. Do not make false promises.
* Time Out: A time-out may be useful for the younger campers. It gives time for the disruptive behavior to be ignored and decrease potential for negative peer reinforcement. This should be done consistently for behaviors that the volunteer has previously agreed upon. It is essential to let the camper know what behaviors led to the time-out and what the expected behavior is for the camper after the time-out period.

**It is the Camp Director who determines if the crisis situation results in the implementation of the Camp’s Three Strikes Policy. See volunteer handbook.**

**Camp Hope Medical Forms**

The medical forms are housed in an electronic fashion on the Camp Hope UltraCamp account. They can be found at https://www.ultracamp.com/admin.

UltraCamp will hold all camper and volunteer medical histories and camper/volunteer medical check-in forms.

Additional paper forms that may be used can be found below.

Camper Information Sheet

This information is CONFIDENTIAL and should only be seen by the appropriate staff.

Camper: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Anemia (low hemoglobin)

This camper MAY be restricted to certain activities. Notify medical staff if the camper has excessive fatigue or is not acting right.

*Restricted activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 Diabetes

This camper has diabetes. Medical staff needs to be notified immediately if the camper experiences: dizziness, confusion, weakness, tremors, chills or if the camper appears excessively sweaty or fatigued. This camper should be allowed to check their blood sugar/see medical staff at their request. If the above symptoms occur, remove the camper from activity.

*Restricted activities: None*

 Neutropenia (low white blood cells)

This camper is at higher risk of infection. Notify medical staff immediately if the camper has a fever or if they are “just not acting right”. Also notify medical staff if any injury/cut/abrasion appears infected. This camper may NOT have any Tylenol or Motrin without discussing with the camp physician.

*Restricted activities: None*

 Seizures

This camper has a history of seizures. If he/she has a seizure, make sure they are not in any immediate danger by removing any nearby hazards or moving them to safety. Turn the camper onto their side in case they vomit. Make sure nothing is in the mouth/airway (and do NOT place anything in the mouth). Make note of the time and length of seizure. Notify medical staff. This camper may be limited to certain activities at the discretion of the medical staff.

*Restricted activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 Thrombocytopenia (low platelets) of less than 100,000

This camper has increased risk of bleeding. Notify medical staff if the camper has increased bruising, rash, nosebleed, or bleeding gums. The camper should avoid sharp food/objects in the mouth. Notify medical staff if the camper has any blood in his/her urine, vomit or bowel movements. Monitor activities closely to avoid injuries.

*Restricted activities: None*

 Thrombocytopenia (low platelets) of less than 50,000

This camper is at increased risk for bleeding. Follow all advice listed above. In addition, this camper may NOT participate in contact sports (football, tackling, wrestling). They may NOT participate in Go-Carts, horseback riding, bike riding and slip-n-slide either. They may NOT dive into the pool. Make sure adolescents utilize an electric razor for shaving. Female campers should be monitored for increased bleeding during her period as well. Report any rash, nosebleed, injury, bleeding gums or other bleeding to the medical staff immediately.

*Restricted activities: Go-Cart, Slip-N-Slide, contact sports, \_\_\_\_\_\_\_\_\_\_\_*

 Other concerns:

**Camp Hope**

**Parent Follow-Up Form**

Camper: Date:

Your camper required medical attention during his/her stay at Camp Hope due to the following

concern:

The following treatments were performed at camp:

1. No further follow-up is required
2. We recommend you call your physician upon returning home
3. We recommend you follow up with your physician in \_\_\_\_\_\_\_ days

For further information, please contact Camp Hope at camphopeks@gmail.com

Dr. Andy Bukaty

Dr. Pam Harrison

Medical Directors

**Camp Hope**

**Tick Bite Parental Notification**

Camper: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your child was noted to have a tick bite during camp. The tick was removed in proper fashion by appropriate camp staff without difficulty. There is nothing that needs to be done on your part, as the vast majority of tick bites do not lead to any problems. We are sharing this information with you in case your child develops a rash or other concerning symptoms in the coming weeks. You can then share this information with the medical provider who evaluates your child.

|  |  |
| --- | --- |
| Camp Aldrich  620-587-3349 | Camp Hope |

Fax

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| To: |  | From: |  |
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**Medication Organizing and Dispensing Protocol**

***Camper check-in:***

1. Review the medication sheet. Confirm the accuracy with the family. Make sure doses and times are legible. Confirm that the medication sheet and the prescription bottle have the same instructions. Note and discuss any discrepancies with the family.
2. Any camper who will require medications that evening will have his file placed in a separate bin for quick retrieval during medication set-up.
3. All other medications are filed alphabetically in the medication bins.
4. Campers with no medications will have their paperwork filed alphabetically in a separate filling bin.
5. Controlled substances are kept in locked containers at all times. These containers are stored in the medical facility, which is locked any time it is not staffed.

***Initial medication set-up (Sunday):***

1. The medical director, head nurse and two experienced members of the medical team will set up the medications after camper check-in.
2. Any medications that need to be dispensed Sunday at dinner or Sunday evening will be the first to be set up immediately following check-in.
3. Envelopes will be labeled as follows:

Camper Name (last, first)

Medication

Dose

Dispensing time (9A, 12, 6P, 9P)

1. Envelopes will be color coded as follows:

Blue = Scheduled procedure

Pink = High Risk (medications with increased potential for error)

Yellow = PRN medication

White = Routine

1. One person will take the medication bag and remove the medication form. Confirm doses and times with the prescription bottles and the medication sheet. This person will create an envelope as described above.
2. A second person will then take the envelopes and medications. After confirming the accuracy, they will fill the envelopes with the medication.
3. A third person then confirms that each envelope is filled, confirms the day/time and files the envelope in the appropriate bin.
4. The medication sheet is then passed to the fourth person to enter the medication into the computer file.

***Subsequent Medication Set-Up:***

1. Medication set-up is performed by 3-4 experienced members of the medical team.
2. Empty envelopes are alphabetized and given to the computer entry person. That person enters the medications into the computer. This confirms that the dose was provided and that no medications were missed. Once entered, the envelopes are passed on to the second person.
3. The next person removes the medications from the file, confirms the dose on the envelope and fills the envelope. A second person may assist.
4. A third person then confirms that the envelope is filled and confirms the time. They then place it into the appropriate delivery bin.
5. In the evening, a fourth person reviews all of the PRN medications and procedures that were documented. They confirm that the PRN envelopes have been refilled. They then pass this information on to the computer-entry person. Once completed with the PRNs, they review the delivery bins for one final check that medications are in the appropriate times.

***Medication Delivery:***

1. If able, a medication dispensing table will be set up where campers will stop to receive medications. This medication table will be staffed by 2-3 experienced members of the medical team. Water will be available so that the camper takes their medication prior to leaving.
2. If no medication table is available (i.e. meal is offsite, campfire medications), 2-3 experienced members of the medical team will dispense camper medications. The medication dispensers will confirm the camper identity by double-checking the camper ID badge prior to dispensing the medication. The empty envelopes will then be returned to the completed medication bin.
3. Any scheduled procedures (flushes, dressing changes, injections, etc) will be completed by their assigned medical staff at the appropriate times.
4. Chemotherapy will be administered by a chemotherapy-certified nurse or a physician with chemotherapy training or at least 2 years of camp experience.
5. Chemotherapy will be administered by a chemotherapy-certified nurse or a physician with chemotherapy training or at least 2 years of camp experience.  IV chemotherapy will be administered following written orders from the camper’s oncologist. Oral chemotherapy is administered per documentation on prescription bottles, unless otherwise confirmed to be different by both a camper guardian and the oncologist. Chemotherapy regimens are confirmed verbally by the medical director prior to camp by way of phone discussion with oncologists.

***PRN Medication Delivery:***

1. Camper PRN medications will be kept in the PRN medication file. A list of allergies will be kept with this file and should be double checked prior to administering any medication.
2. If a camper PRN medication is provided, the envelope will be placed in the completed medication bin and a note made on the PRN medication log.
3. If a PRN medication has been given and not restocked yet the camper is due for a dose, the medical director will be notified to obtain another dose.
4. Each camper’s family fills out a form prior to camp stating what common OTC medications they are allowed or not allowed to be given during camp. This list is reviewed prior to camp by the medical director and then confirmed at check-in with family. Any restrictions are listed on a database that each member of the medical team receives at the beginning of camp. This is also provided to the appropriate houseparents. The information on this database is reviewed by any member of the medical team and appropriate houseparents prior to administration of any OTC medications.
5. Over-the-counter PRN medications (Tylenol, Motrin) will be kept in a locked PRN medication bin in the dining hall at the first aid table. If a dose is given, it will be documented on the medication log at that table. This medication log should be checked prior to giving any PRN medication to confirm that a previous dose has not been administered.
6. Each cabin will have a locked over-the-counter PRN medication bin in order to dispense these medications at night. Prior to returning to the cabin, medical staff should check the medication log to see if any of their campers have received a PRN already that evening. If a PRN is given at night, it will be logged on the “Medical Report” page and turned in at the medication table in the morning. It will then be documented in the computer.
7. No camper on chemotherapy should be administered a PRN without first discussing it with the medical director.

**Suicidal Ideation/Self-Harm Protocol**

1. If a camper describes thoughts of suicide or self-harm, listen to the camper’s story and support them. Try to keep track of details but do not feel obligated to ask questions. Once the conversation is over, inform the camper that you will notify the medical director. Notify the medical director. If the camper asks that the information not be disclosed, inform them that you want to help him/her and to do so means you must inform the medical director. Do not leave the camper alone at any time.
2. The medical director will then notify the committee chairperson who will then notify the camp director and chair of the Camp Hope Committee. The medical director, committee chair, camp director and committee chairperson will determine the appropriate committee members to be involved in addressing the situation. They will also identify any other camp volunteer (such as a social worker) who could contribute to addressing the situation. All information will be kept confidential among committee members unless there is a person the committee identifies as appropriate to involve.
3. The medical director or the people he/she designates will meet with the camper to complete an assessment of the camper’s safety. This assessment may include, but is not limited to, the following:
   1. Determination if the camper intends to harm him/herself currently
   2. Determination if the camper has a plan of suicide
4. The camper will be taken into the Central Kansas Medical Center emergency room in Great Bend for an emergent psychiatric assessment.
5. The camper’s parents or guardians will be notified by the medical director.
6. If the ER assessment determines that the camper is not currently at risk for suicide/harm, arrangements will be made for the guardians to pick the camper up. At no time will the camper be left unattended. The camper’s house parent will be notified of the concern.
7. If the ER assessment determines that the camper is at acute risk, then the recommendations of the mental health provider will be followed.
8. The camper’s primary care physician and/or oncologist will be notified.
9. All of the above findings, procedure, discussions and outcomes will be documented and kept in the confidential camper personal file. The file will be kept by KyMel, Inc.

Suspected Abuse Protocol

**(physical, sexual, emotional, etc)**

1. If a camper describes abuse, listen to the camper’s story and support them. Try to keep track of details but do not feel obligated to ask questions. Once the conversation is over, inform the camper that you will notify the medical director. Notify the medical director. If the camper asks that the information not be disclosed, inform them that you want to help him/her and to do so means you must inform the medical director. If this seems to upset the camper and there is a concern about flight risk/injury risk, do not leave the camper alone and notify the medical director immediately.
2. The medical director will then notify the committee chairperson who will then notify the camp director. The medical director, camp director and committee chairperson will determine the appropriate committee members to be involved in addressing the situation. They will also identify any other camp volunteer (such as a social worker) who could contribute to addressing the situation. All information will be kept confidential among committee members unless there is a person the committee identifies as appropriate to involve.
3. The medical director or the people he/she designates will meet with the camper to complete an assessment of the camper’s safety. This assessment may include, but is not limited to, the following:
   1. Identification of the alleged perpetrator(s)
   2. Identification of the type of abuse
   3. Identification of the longevity and frequency of abuse
   4. Examination of the camper for any physical symptoms of abuse (either by a trained staff member at camp or via the local emergency room)
   5. Assessment of the camper’s safety to return home upon the completion of the camp,
4. An abuse report will be filed with child protective services at the State of Kansas intake number (1-800-922-5330). An additional report may also be filed with the Social and Rehabilitative Services (SRS) Office in the county the camper resides in.
5. If the parents (or legal guardians) are not identified as the perpetrator(s) of abuse, they will be notified of the allegations.
6. If one parent (or legal guardian) is identified as the perpetrator of abuse, all effort will be made to contact the other parent regarding the allegations.
7. If both parents (or legal guardians) are identified as the perpetrator(s) of abuse, neither will be contacted.
8. The camper’s primary care physician and/or oncologist will be notified of the allegations.
9. If the committee chairperson, camp director, and other camp volunteers or individuals involved in addressing the problem determine that the camper IS in immediate danger upon returning home and SRS has not made a recommendation, the police department will be notified.
10. All of the above findings, procedure, discussions and outcomes will be documented and kept in the confidential camper personal file. The file will be kept by Camp Hope Heartland
11. If the committee chairperson, camp director, and other camp volunteers or individuals involved in addressing the problem determine that the camper is NOT in immediate danger upon returning home, then no further action is needed.

**Bat Protocol**

Bats are common at Camp Aldrich and are very helpful in keeping the mosquito population controlled. It should be noted that one cannot contract rabies by simply being in close contact with a bat nor by being in contact with bat guano (feces). The following situations would necessitate implementing the bat exposure protocol (see below):

* **If a person awakens to find a bat in the room**
* **If you find a bat in a room with an unattended child who is unable to tell you if they were bitten**
* **If you see a bat near a person with a disability who may not know if they were bitten**
* **A confirmed bat bite**

**Bat Exposure Protocol**

1. If there is a suspected bat exposure, notify the Camp Director and Medical Director
2. Take note of all campers or volunteers that have been exposed.
3. If there is a known bite/wound, cleanse the wound with soap and water.
4. Contact the Barton County Health Department (BCHD) at 620-793-1902 to notify of exposure as soon as possible and within 48 hours. The state Epi hotline is also available at 877-427-7317 with any questions. The Camp Director has emergency contact information for the health department staff if needed. Camp Hope will work with BCHD in implementing rabies post-exposure prophylaxis if needed.
5. Close the cabin(s) where the exposure occurred for the duration of camp. Camp Hope chairperson will arrange new sleeping arrangements.
6. The camp will work with the Barton County Health Department (BCHD) in arranging for a professional animal control person to catch the bat(s), if needed. If such person is unavailable, the camp director will ask the camp ranger, or another designated person, to attempt to catch the bat(s). If this person is Camp Hope personnel, they will follow the bat-capture protocol (see below). Camp Hope will work with the BCHD in arranging for rabies testing as necessary.
7. Inspect all other cabins to insure there is no evidence of bats.
8. Notify all affected families.
9. If post-exposure rabies prophylaxis was initiated, Camp Hope will work with BCHD to insure appropriate follow-up is arranged for Camp Hope campers and volunteers upon the end of camp.

**Bat Prevention Protocol**

1. Camp Aldrich should insure that all cabins have been sealed between September and April.
2. Camp Aldrich should insure that all cabins have been appropriately bat-proofed prior to Camp Hope. This includes repairing/sealing any holes, screening all vents, replacing any damaged or poor quality window screens, and replacing damaged boards.
3. Each cabin should be inspected for evidence of bats in the spring and again one week prior to Camp Hope. This inspection can be done by the camp ranger or someone appointed by the Camp Hope committee.
4. The inspector should notify the CH Chairperson immediately of any evidence of bats
5. Campers and staff will be educated about the presence of bats during orientation. They will be instructed to notify the camp director immediately if any bats are seen in the sleeping cabins.

**Bat Capture Protocol (adapted from the CDC)**

1. The camp will maintain a bat-capture kit. This kit will include:

* **Leather or suitable work gloves**
* **Box, coffee can, or plastic container with a lid**
* **Piece of flat cardboard**
* **Net on a long pole**

1. Put on leather or other suitable work gloves.
2. Take the box, coffee can, or plastic container and the flat piece of cardboard.
3. Wait for the bat to roost on a wall or floor.
4. Slowly approach the bat and cover it with the container.
5. Keep the container flat against the wall, slide the lid or cardboard between the wall and bat.
6. Once the cardboard is covering all sides of the container, lift the container and cardboard away from the wall.
7. Secure the lid or cardboard to the container so the bat cannot escape.
8. Capture a bat in hard-to-reach areas with a net on a long pole. Then bring net down to a container, and drop/push (wearing gloves) the bat into the container.

COVID-19 Policies

The COVID-19 situation in the United States is constantly evolving. Camp Hope will make decisions regarding prevention and mitigation strategies on an ongoing basis leading up to and during each camp. These decisions will be made in a coordinated effort by the medical team, camp committee, and KyMel board, and will consider current local and federal laws as well as guidance from resources such as the CDC and the American Camp Association, especially their regularly updated Field Guide for Summer Camps. All decisions regarding COVID-19 will be made with the health and safety of the campers being the primary focus.

Prevention and mitigation strategies could include, but will not be limited to, encouraging COVID-19 vaccines and boosters when appropriate, social distancing, masking, focus on outdoor activities, use of cohorts, contact tracing, and isolation as needed. As noted above, specific utilization of these and other prevention/mitigation strategies will be adjusted on an ongoing basis to respond to the current state of the COVID-19 situation locally and throughout the country.