

Compass Point ... working for healthier camp communities by supporting the practice of camp nursing.

- My View -
Scope of Practice in Camp Health

Tracey Gaslin, PhD, CRNI, CPNP, FNP-BC

What type of individual do I need to provide health services at my camp? What skills should the person have to provide care? Can anyone with a license serve in our health center? These are questions that the ACN office receives frequently, especially as it heads into the summer season.

Many individuals are trained to provide healthcare services: physicians, nurse practitioners, nurses, EMTs, Wilderness First aiders, and others. Each of these individuals receives education with limitations. No healthcare provider has been trained to every aspect of healthcare. This means that each person, depending on their course of study, has received information to practice at a certain level and conduct certain skills. This is called the scope of practice.

Therefore, when seeking a healthcare provider, one needs to understand the training of that individual, the information they learned in their course of study, and the experience they bring to the camp. Each of these components give credence to an individual's ability to function in an autonomous role.

- If an individual has not had education around medication management, is that candidate a good fit for your camp?
• If the camp does tripping away from the main site, who is best prepared to manage health alterations with limited resources?
• If the camp serves special needs populations, what level of expertise (education and skills) is needed to serve safely?

There is not a specific answer to these questions; the response is different for each camp as they determine the healthcare needs of the populations being served. If you are hiring a healthcare provider, investigate the credentials, education, and experience they bring to camp. Do your best to make sure the individual is ready and prepared, with the right education and training, to serve your camp! You can find more information at www.campnurse.org.

In This Issue...

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- Editorial - Find Your Tree

I have a T-shirt that says, “Find your tree.” And I don’t think that wandering around a wooded area to find a tree that speaks to you is at all a wasted exercise. But I realized recently that that phrase is a much more profound statement than I originally thought. In fact, it might instead say, “Find your community,” because trees, like us, need each other to thrive.



According to forest ecologist Suzanne Simard, Douglas fir seedlings and paper birch trees take turns shuttling carbon (their food source) back and forth to one another. During the shady days of summer, the tall birch trees pass carbon to the sun-starved Douglas fir seedlings beneath. During the fall, when the birch trees have lost their leaves, the fir seedlings soak up the sun and return the favor (Cornell, 2017). That’s community!

I also learned from world-renowned naturalist Joseph Bharat Cornell what happens when a forest is planted with

trees intentionally far enough apart that each tree receives ample sunlight. The idea is that this will allow the trees to grow faster. It turns out, however, that the space prevents them from establishing a viable fungal network, which negatively affects their nutrient intake. This actually makes the trees less resilient (Cornell, 2017). They need the togetherness of community.

Now that summer is in full swing, many of you are back in your beloved camp environment looking after the wellbeing of campers and staff — and being uplifted in return by their gratitude and growth. It’s an amazing little ecosystem of caring, and a shining example of the positive impact of community. I hope it leaves you with the peaceful sense of having found your tree.

Marcia Ellett, MA
Editor

Reference

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Concussions at Camp

Sara Brown, MSN, DNP, CPNP

Abstract: Concussions are on the minds of many parents and providers today. The CDC and the NFL are becoming leaders in the push for the safety of our youth. New research about concussions is on the horizon as we strive to create a safer environment for our children at home and in the camp setting. As research continues, we hope to learn more about the long-term effects of and new strategies to prevent concussions. Until then, we must continue to look for ways to increase camper safety and provide the best care congruent with current recommendations.

The incidence of traumatic brain injury (TBI) and concussions (mTBI) in the youth population is difficult to pinpoint. The commonly accepted estimate of this type of injury is close to 3.8 million sports/recreational-related brain injuries happen each year (Bryan, Rowhani-Rahbar, Cornstock, & Rivera, 2016). The most concerning aspect of this estimate is the likelihood that the actual number of concussions each year is much greater, as the incidence of concussions is severely underreported. Also, because a concussion is not an outward injury that parents or children can see, the injury may not be taken as seriously as one that is visible. Awareness of TBI and concussions has been a popular topic in recent years as society is becoming increasingly aware of the potential dangers of this type of injury and the long-term effects. This new interest in concussions in communities may be a result of the National Football League (NFL) initiative to increase public awareness and conduct further research on concussions/TBI (Scutti, 2016). The Play Smart, Play Safe program is part of the NFL program geared toward the promotion of safety and prevention of injury in young athletes (playsmartplaysafe.com, 2017). The Centers for Disease Control (CDC) have followed suit by offering educational programs related to concussions in the pediatric population with the Heads Up program (CDC, 2017).

Many types of camps appeal to the diverse interests of millions of children each year. In addition to sports at camp, many popular camp activities pose a risk for concussions, such as horseback riding, ropes courses, and swimming. Camp nurses have a unique opportunity to help establish a culture of safety and prevention in the camp setting. Although the popular concussion initiatives and much of the research are geared toward organized school sports, camp nurses can utilize most of the information to meet the needs of campers. By integrating the available resources and evidence-based research, one can create concussion guidelines to promote a healthy camp community.

Long-term Effects of Concussions

Concussion guidelines are an important aspect of adolescent health. The brain continues to develop throughout adolescence until age 25 (Kerasidis, 2014). In the camp setting, campers and parents are not usually thinking about long-term consequences, like chronic traumatic encephalopathy (CTE),

found in retired NFL players. Camper and parents want to know how long this injury will impact their camping experience and potentially impact their sports participation during the regular school year. In the long term, children and adolescents who have had more than one concussion are at risk for developing post concussive syndrome (PCS). PCS occurs when symptoms of concussions linger for weeks to years after the brain injury and can interfere with many different aspects of life, including learning (Kerasidis, 2017). Recovery also depends on how many concussions a camper has already experienced; repeated head injury could influence the length of recovery time and future level of participation in activities (cdc.gov, 2016). Research in this area is continuing to pinpoint other possible long-term effects of repeated head injuries. Camp nurses should remember that a concussion is not just an acute event, but also potentially a chronic condition that has the likelihood of lifelong effects to the injured.

Camp Nursing

Close to 13 million children will have the opportunity to experience summer camp each year (American Camp Association, 2017). The camp nurse is an integral part of the experience for many campers, as illness and injuries can be a common occurrence at camp. Therefore, the camp nurse should be competent to handle any problem or concern that may occur (Parsh, 2014). The camp nurse should be able to recognize red flags and distinguish a medical emergency from one that needs consoling (Huey & McMullan, 2016). The lack of current evidence-based guidelines within the specialty area of camp nursing is concerning. There is a large gap in the information geared toward traditional nursing and the advancement of the camp nursing practice. Many times, camp nurses feel lost with the lack of current information created specifically to guide their practice safely in camps' unique healthcare setting. Quality, evidence-based guidelines are vital to promote and grow the camp nurse profession and provide consistent care for all campers.

Methods

For this study, *CompassPoint* was referenced for articles in previous publications that focused on the assessment and management of concussions at camp. A thorough review of

current recommendations related to concussions in literature was also performed using PubMed and the Cumulative Index of Nursing and Allied Health Literature. Furthermore, current facts from relevant, reputable websites specializing in information pertaining to this study were incorporated into the compiled data. In addition to research and immersion in the camp setting, extensive time was spent with the local athletic trainer performing assessments and putting evidence-based guidelines into action with adolescents participating in high school sports. The information and experience gathered in the review and immersion experience was combined to form the most current recommendations for camp nurses to use when assessing and managing a potential concussion while in the camp setting.

Changing Recommendations

Guidelines surrounding concussions and traumatic brain injuries have undergone a series of changes over the past few years. Although most of the applications of new guidelines center on participation in sports, one can easily modify them to be relevant to a variety of activities at camp. The acronym S.A.F.E. (symptoms, assessment, follow-up, execute return to activity) is an easy tool to guide the camp nurse through important decisions when faced with a camper who has a concussion (Provance, Engleman, Terhune, & Coel, 2016). This flow chart can serve as a quick reference at each stage of the concussion and recovery period (see Appendix A). The latest changes have moved past the quick pupil check and a slap on the back to return to the game after “getting your bell rung” (WPVI-TV Action News, 2016). Before 2002, it was common practice to allow a child to return to an activity if symptoms subsided within 15 minutes of impact, and professionals saw loss of consciousness as a marker of the severity of the concussion (Provance, et al, 2016). In fact, before 2009, there was no state legislation pertaining to the management of concussions among athletes. Although immediate return to play or activity once was a regular occurrence, research data suggests that the ten days following a concussion make up the period with the highest risk of sustaining another concussion (Bernhardt & Young, 2017). We also know that loss of consciousness may or may not occur at the time of injury, and the seriousness of the concussion is based on the mechanism of injury and the child’s symptoms (Gillooly, 2016).

The CDC created the Heads Up program to help raise awareness of concussions in youth (CDC, 2017). This program is designed to teach parents, children, coaches, and healthcare professionals how to recognize a concussion and strategies to keep safety first in any activity. In 2013, the American Academy of Neurology (AAN) recognized the importance of laypersons as first responders for suspected head injuries. The AAN encourages laypersons to be educated about concussion

assessment and be competent to administer an initial concussion assessment using a standardized checklist, such as the Standard Concussion Assessment Test (SCAT) or the Acute Concussion Evaluation (ACE) tools (Gaslin, 2013). Therefore, be sure to include all staff, counselors, and directors in concussion education guidelines. Although not medically trained, they can prove to be an asset to campers who sustain a head injury if they know how to utilize the selected standardized tool.

Initial Concussion Assessment

An initial assessment is critical for all head injuries and should be initiated immediately following the injury, preferably at the site where the injury occurred. Immediate removal from the activity is recommended whenever an injury occurs (Gillooly, 2016). Amnesia and confusion are very common symptoms and may be strong indicators that a concussion has occurred (Provance et al., 2016). An unconscious child is a definite sign that the brain has sustained a serious injury (Marugg, 1996). The priority for an unconscious child is to maintain the airway, breathing, and circulation until emergency personnel arrive. Loss of consciousness always warrants a medical evaluation to ensure there is not bleeding or more extensive injuries (Reynolds, 2010). In addition to loss of consciousness, the camp nurse should also be aware of other red flags that warrant immediate referral. Red flag symptoms include worsening headaches, nausea/vomiting, slurred speech, tingling in arms/legs, and increasing confusion (Provance et al., 2016). If the camper is conscious, the camp nurse should begin each initial concussion assessment remembering that not all concussions present with the same symptoms (Gillooly, 2016). An initial assessment should include watching for changes in behavior, thinking, or physical functioning (Gehring, 2011).

A detailed assessment should include evaluation of orientation, concentration, and memory. Orientation assessments could include questions about date, place, or details of injury (Gaslin, 2015). Concentration assessments can include giving a list of words and asking the camper to repeat them back. Memory can be tested by asking for the same words 10–15 minutes later. If the camper cannot pass tests in these areas, the camper should be referred promptly for an evaluation by a healthcare provider. An examination by a healthcare provider should be considered if physical symptoms such as balance problems, nausea/vomiting, or demonstrating other signs and symptoms of a concussion continue or worsen.

Evaluation of physical and cognitive symptoms is less subjective when a standardized tool is utilized. The Standard Concussion Assessment Test 5 (SCAT5) is the newest version of the SCAT test. SCAT5 is designed for use by trained medical professionals for children over age 13 (Davis, 2017). One of the sections of the SCAT5 that sets it apart from other forms of testing is the incorporation of the Glasgow Coma Scale (Gillooly,

2016). The Glasgow Coma Scale is a widely recognized tool to quantify the level of consciousness in individuals who may have an acute brain injury (glasgowcomascale.org, 2014). For the layperson at camp, the Concussion Recognition Tool 5 (CRT5) is designed for those who are not trained healthcare providers. These tests allow the signs and symptoms experienced by the injured camper to be quantified and have demonstrated the ability to identify close to 90 percent of suspected concussions and more accurately measure reaction times (Broglio, Guskiewicz, & Norwig, 2017). Both tests are easy to follow with instructions for each section. Although not always available to camp nurses, baseline screening using the available tests has proven to be beneficial to organized athletics by having a current measurement of the cognitive function prior to sustaining the concussion. In addition to baseline screening (if available), a complete health history should be on file in the health center that includes prior injuries, especially prior head injuries (Provance et al., 2016).

Management and Recovery Period

Early diagnosis and management for concussion is key to a complete recovery and prevention of complications (Gillooly, 2016). The current standard of care for children who have sustained a head injury is immediate removal from activity (Gaslin, 2015). The camper should not be allowed to return to play the same day as the suspected head injury occurred, as symptoms may take time to appear. Although rest is recommended to allow recovery and lessen symptoms, complete bed rest is not a best practice and may impede recovery times (Sufrinko, Kontos, Apps, McCreary, Hickey, Collins, & Thomas, 2017). Allowing the camper to resume normal, light activity, as tolerated, is the best approach to recovery (Provance et al., 2016). Light activities can include arts and crafts, cooking classes, and card games. Most importantly, campers should avoid any activity that has the potential of causing a second head injury (Meehan & O'Brein, 2017). Symptom management is equally important. The judicious use of Acetaminophen or Ibuprofen can be used for headaches. Zofran is also acceptable to use for nausea the first few days (Meehan & O'Brein, 2017). Care should be taken with use of Zofran because side effects can aggravate concussion symptoms. On the other hand, the nurse should not allow the camper to utilize medications to mask symptoms to begin return-to-activity steps (Meehan & O'Brein, 2017). The camp nurse should also be aware that campers often underreport symptoms to avoid having to sit out of a sport or camp activity (Gillooly, 2016). Therefore, use of standardized assessments and symptom checklists can help take the guesswork out of concussion recovery.

Safe Return to Play

Deciding when a camper can return to play is an important decision. Most campers will see a complete improvement of symptoms within seven to 10 days post injury (Provance et al., 2016). Keep in mind, a head injury that occurs before the brain has time to heal completely can have complications associated with Second Impact Syndrome (SIS). SIS is a rare, but potentially serious, medical condition that can cause cerebral edema and even death (Stovitz, Weseman, Hooks, Schmidt, Koffel, & Patricios, 2017). When the camper is free of symptoms, he or she can gradually return to play (Gaslin, 2015). Again, the nurse should be certain that medications are not masking concussion symptoms and the camper is truly symptom-free before the camper is permitted to return to activity (Meehan & O'Brein, 2017). Resuming full activities should be a slow progression over the course of several days (See Appendix B). Campers should be allowed to progress through each step of increasing levels of intensity if they continue to remain free of symptoms throughout the process (Brzycki, 2016). If a camper should experience signs and symptoms of a concussion at any point during the process, activity should be stopped and should not resume until symptoms are resolved. Remember, there is no rush to return to full activity, and the camper and parents should be educated about potential problems with resuming full activity too quickly.

Performing a Risk Assessment at Camp

Each camp nurse should perform a risk assessment of their camp's activities, staffing, and camper profiles to help in developing a concussion guideline for camp (Gaslin, 2015). A risk assessment is a methodological way to identify potential health risks and look for ways to minimize the impact (Kloosterman, 2014). The nurse can look for ways a camper may be at risk for concussions. Ropes courses, contact sports, swimming, and horseback riding are just a few areas that have potential risks. When creating a risk management plan, the nurse needs to address the likelihood of the injury and develop the plan to minimize the risk of concussions among campers. The plan should include guides to initial assessment, healthcare assessment, recovery period, and a process to return to activity (Gaslin, 2015). In addition, educational materials should be developed to help other camp staff become familiar with concussion guidelines. When it is time to put the plan into action, the nurse should pay close attention to what aspects of the plan are working and where improvement is needed. The process is cyclic; improvements can continue, and recognize that risks and management guidelines may change as research continues to expand. Camp nurses should continue to watch for the latest in research to keep their practice current.

Prevention

Although there is no way to eliminate the possibility of a concussion, we can reduce the likelihood of an occurrence. Preparation is the priority in creating a safe environment. Discussion with camp stakeholders to develop plans and update existing plans within the camp to promote safety among the staff and campers using the most current evidence is key. Education should be provided to staff and campers about safety equipment and risks to reduce injury. Helmets are an important start to reducing the amount of concussions. Properly maintained and age-appropriate helmets should be available for campers who participate in camp sports such as football, baseball, horseback riding, and ropes courses (CDC, 2015). In addition, routine maintenance should be performed on permanent camp equipment, such as basketball goals, ropes courses, fences, bleachers, and other frequently used areas, to keep a standard of safety in the camp area.

Synopsis of Current Guidelines

Current guidelines are in place for campers' safety. It begins with ensuring safe areas and proper equipment (CDC, 2015). Educate the staff about the correct guidelines in case of a head injury at camp and red flags that indicate immediate referral to the Emergency Department (Provance et al., 2016). Remember, your staff, director, and counselors are invaluable and can be trained to assess the situation and camper until the nurse arrives. If the camper loses consciousness, immediate referral to an Emergency Department is necessary (Meehan & O'Brein, 2017). Current recommendations state the camper should be removed from play when a suspected head injury occurs and immediately assessed for signs and symptoms of a concussion (Provance et al., 2016). Assessment of orientation, concentration, and memory are an important part of the evaluation process. The SCAT5 offers a step-by-step guide to help the nurse assess for and correctly identify a concussion (Davis, 2017). If a concussion is suspected, the camper should be monitored for any red flags that indicate an immediate referral to the Emergency Department (Provance et al., 2016). Rest should be encouraged, and play should not be resumed on the same day as the injury occurs. It is recommended that a camper not return to play until they are symptom-free without medications. Only then can activity be resumed slowly in a step-by-step process over a minimum of five days (Meehan & O'Brein, 2017). If symptoms return, it is recommended that progression through the return-to-activity steps stop and not begin again until symptoms are resolved (Provance et al., 2016). Provide encouragement to the camper to take the process slowly and not rush through the steps.

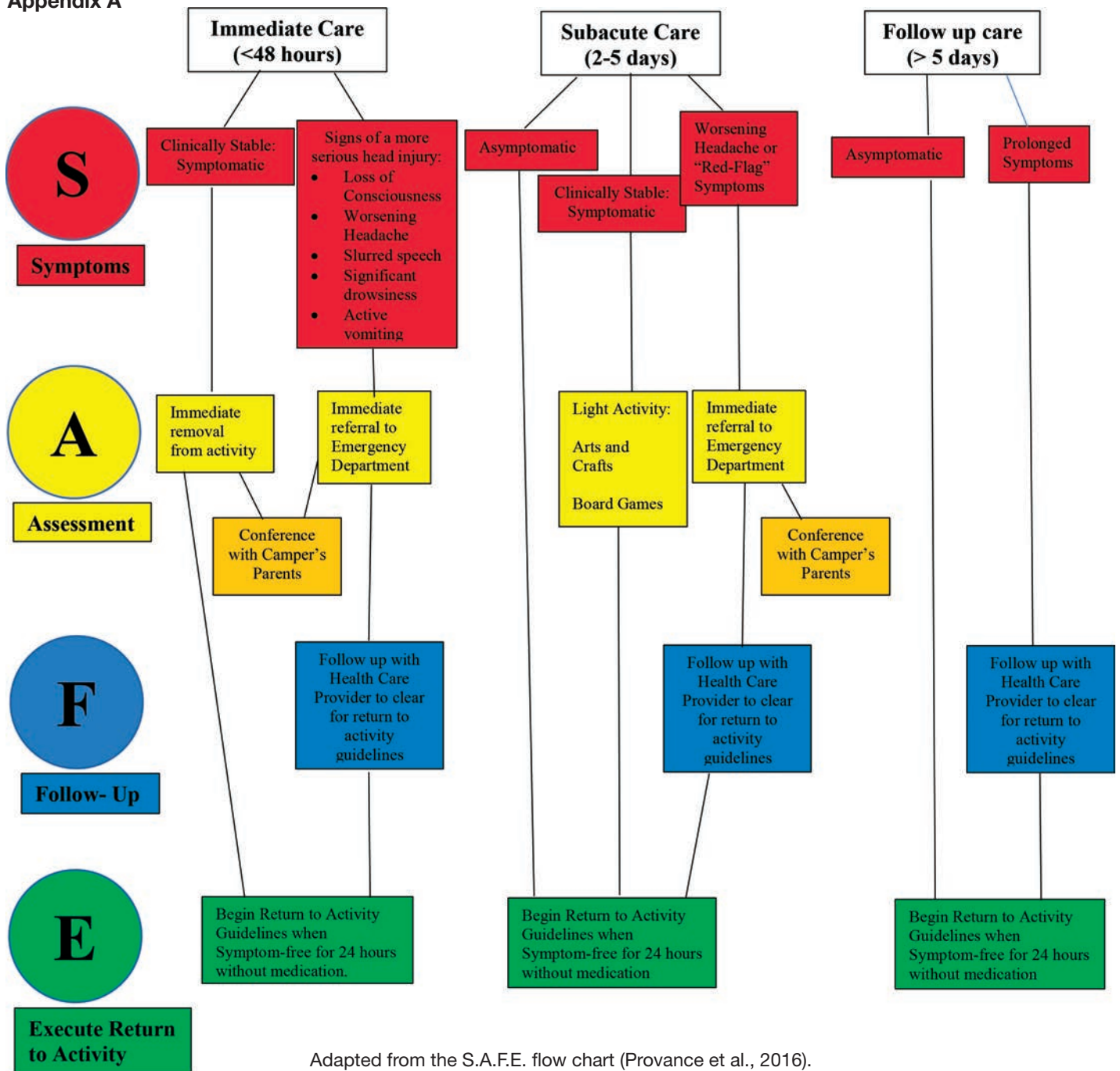
Conclusion

New research about concussions is on the horizon as we strive to create a safer environment for our children at home and in the camp setting. As research continues, we will continue to learn more about the long-term effects of and new strategies to prevent concussions. Until then, we must continue to look for ways to increase camper safety and provide the best pre- and post-concussion care congruent with current recommendations.

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Appendix A



Adapted from the S.A.F.E. flow chart (Provance et al., 2016).

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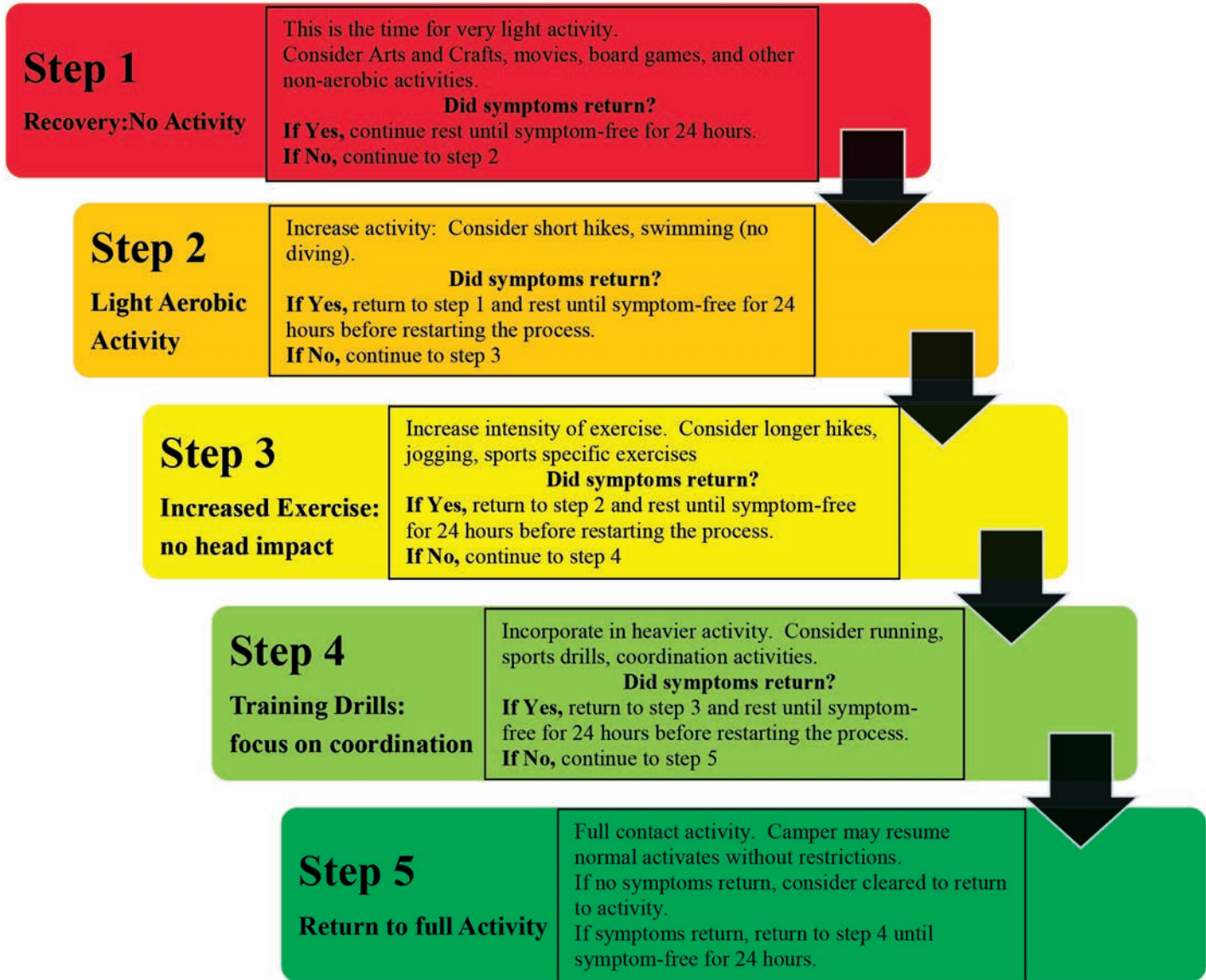
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Return to Camp Activity Steps



Remember: There is no rush to return to activities for the safety of the camper. When in doubt, return to previous step.

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Tips On Ticks

Ashley DeHudy, MD, MPH

Don't let ticks ruin your summer! Here are some tips for tick-borne illness identification and prevention.

Prevention

The goal is primary prevention. Make tick checks routine. Instruct campers and staff on important areas to check, including in or around the hairline or ears, under the arms, inside the belly button, around the waist, between the legs, and behind the knees. Some places are difficult to check independently and may require a buddy to help!

The goal is to find and remove ticks early. If ticks stay attached for less than 24 hours, the chance of passing on disease is very small. Ticks that have been attached for an extended period of time appear swollen and enlarged. This would be more worrisome.

Ensure campers and staff know what exactly they are looking for. Educate campers and staff on the appearance of ticks, most notably their tiny size. As a point of reference, an adult tick is about the size of a poppy seed.

Consider having campers conduct self-skin-checks at the start of camp to ensure that a tick does not get confused for a routine mole.

If ticks are a common problem in your camp, consider instructing families to pretreat camper clothes in permethrin. Treat-at-home sprays and kits provide effective repellency for up to six washings. Commercially treated clothing remains tick repellent through 70 wash cycles.

Additionally, encourage campers to bring insect repellent with 20- to 30-percent DEET to camp. Be aware that DEET concentrations of greater than 30 percent can be dangerous to children.

When exploring outdoors, encourage campers to:

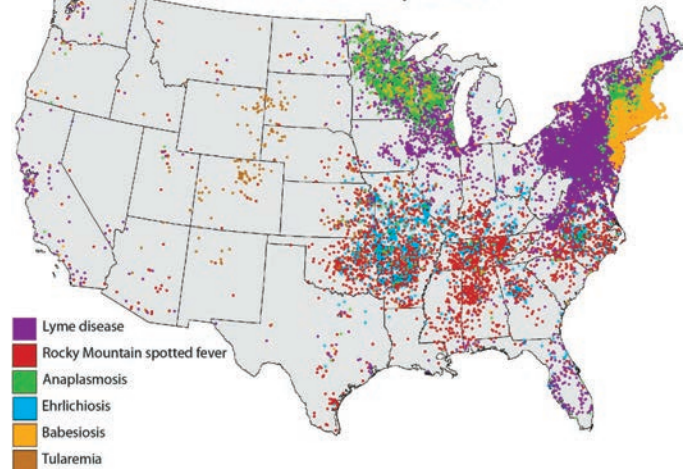
- Cover arms and legs by wearing a long-sleeved shirt and tucking pants into socks.
- Avoid wearing sandals in areas where ticks may live.
- Wear a hat to keep ticks away from the scalp. Keep long hair pulled back.
- Wear light-colored clothing to make it easier to spot ticks.

Remind campers and staff that ticks tend to live in brush and debris; whenever possible, stay on cleared trails. Ticks often wait in tall grasses for hosts to brush by and hitch a ride.

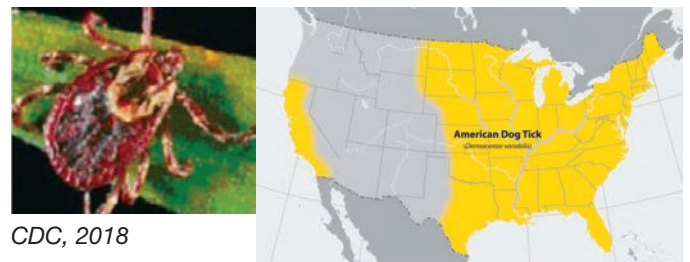
Tick Identification

Become familiar with the species of ticks that live in your area as well as the diseases they may carry. The Centers for Disease Control (CDC) has an excellent map: https://www.cdc.gov/ticks/geographic_distribution.html

Distribution of Key Tickborne Diseases, United States, 2015



CDC, 2018

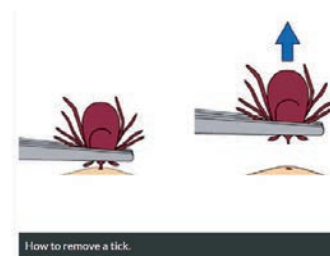


CDC, 2018

Tick Removal

Discourage campers or staff from removing ticks on their own. It is very important that removal is done appropriately. Do not use Vaseline, credit cards, or a match/flame to remove ticks.

To ensure removal of the whole tick, the CDC recommends the following approach:



CDC, 2018 (consider posting this graphic in the camp medical unit)

1. Use fine-tipped tweezers to grasp the tick as close to the skin's surface as possible.
2. Pull upward with steady, even pressure. Don't twist or jerk. Do not squeeze.
3. If mouthparts remain in the skin, remove them with tweezers or leave it alone and let the skin heal.

Post Tick Removal

After the tick is removed, wash the bite area with soap and water. Monitor the site of the tick bite. Mild redness or a small bump may develop at the site; it should go away within

Additional Resources

- Hikers Campers CDC Factsheet: https://www.cdc.gov/lyme/resources/toolkit/factsheets/10_508_Lyme-disease_HikersCampers_FACTSheet.pdf
- Project Lyme: <https://projectlyme.org/>
- Connecticut Tick Management Handbook: <http://www.ct.gov/caes/lib/caes/documents/publications/bulletins/b1010.pdf>
- Tick Bite Prophylaxis Info: <https://www.cdc.gov/ticks/tickbornediseases/tick-bites-prevention.html>



one or two days. This is not an indication of disease. At this time, the CDC does not recommend routine use of antibiotics to prevent Lyme disease after a recognized tick bite unless all the following criteria are met:

- Doxycycline is not contraindicated.
- The attached tick can be identified as an adult or nymphal I. scapularis tick (also known as Blacklegged or Deer Tick).
- The estimated time of attachment is 36 hours or more based on the degree of engorgement of the tick with blood or likely time of exposure to the tick.
- Prophylaxis can be started within 72 hours of tick removal.
- Lyme disease is common in the county or state where the patient lives or has recently traveled (i.e., CT, DE, MA, MD, ME, MN, NH, NJ, NY, PA, RI, VA, VT, WI).

Per the CDC, prophylactic antibiotic treatment following a tick bite is not recommended as a means to prevent Anaplasmosis, Babesiosis, Ehrlichiosis, or Rocky Mountain Spotted Fever.

Tick Disposal

The CDC does not recommend routine testing of ticks; however, many camps or health departments save ticks and have them tested.

Health Monitoring Post Tick Bite

After a tick bite, monitor closely for development of fever or chills, headache, fatigue, muscle aches, and rash. The rash most concerning for a tick-borne illness is referred to as erythema migraines. It looks like a bull's-eye.

The erythema migraines rash is the most common finding in patients diagnosed with Lyme disease; it is present in 70 to 80 percent of confirmed cases. The rash often begins at the site of the tick bite within three to 30 days. Given this extended window of time, it is important to educate families on what to

look out for after a child has returned home from camp. The rash may feel warm to the touch, but is rarely itchy or painful. It can expand rapidly, reaching up to 12 inches. If you notice any of these symptoms, consider treatment. Current treatment recommendations for treatment of early Lyme disease are as follows:

Age Category	Drug	Dosage	Maximum	Duration, Days
Adults	Doxycycline	100 mg, twice per day orally	N/A	10-21*
	Cefuroxime axetil	500 mg, twice per day orally	N/A	14-21
	Amoxicillin	500 mg, three times per day orally	N/A	14-21
Children	Amoxicillin	50 mg/kg per day orally, divided into 3 doses	500 mg per dose	14-21
	Doxycycline	4 mg/kg per day orally, divided into 2 doses	100 mg per dose	10-21*
	Cefuroxime axetil	30 mg/kg per day orally, divided into 2 doses	500 mg per dose	14-21

CDC, 2018

Raise Tick Awareness

Post informational posters in the bathrooms or cabins. The CDC has several publicly available materials aimed at hikers and campers.

Examples:

- Don't Let a Tick Make You Sick comic: https://www.cdc.gov/ticks/resources/DontletTicksbiteComicGenericFS_508.pdf
- Hikers Campers CDC Factsheet: https://www.cdc.gov/lyme/resources/toolkit/factsheets/10_508_Lyme-disease_HikersCampers_FACTSheet.pdf

Don't Let a Tick Make You Sick!



Don't Let a Tick Make You Sick Comic

Ticks and Lyme Disease



How to prevent tick bites when hiking and camping

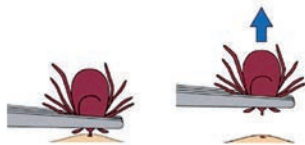
Ticks can spread disease, including Lyme disease. Protect yourself:

- Use insect repellent that contains 20 - 30% DEET.
- Wear clothing that has been treated with permethrin.
- Take a shower as soon as you can after coming indoors.
- Look for ticks on your body. Ticks can hide under the armpits, behind the knees, in the hair, and in the groin.
- Put your clothes in the dryer on high heat for 60 minutes to kill any remaining ticks.

How to remove a tick

1. If a tick is attached to you, use fine-tipped tweezers to grasp the tick at the surface of your skin.
2. Pull the tick straight up and out. Don't twist or jerk the tick—this can cause the mouth parts to break off and stay in the skin. If this happens, remove the mouth parts with tweezers if you can. If not, leave them alone and let your skin heal.
3. Clean the bite and your hands with rubbing alcohol, an iodine scrub, or soap and water.
4. You may get a small bump or redness that goes away in 1-2 days, like a mosquito bite. This is not a sign that you have Lyme disease.

Note: Do not put hot matches, nail polish, or petroleum jelly on the tick to try to make it pull away from your skin.



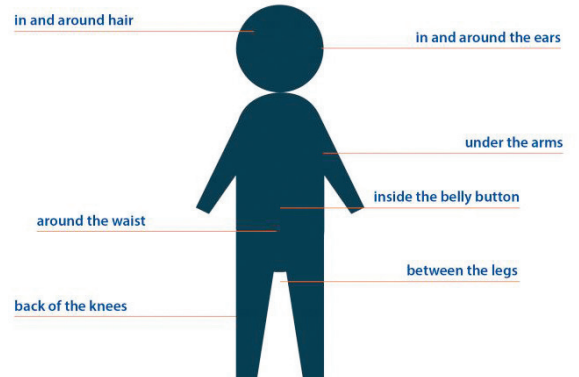
If you remove a tick quickly (within 24 hours) you can greatly reduce your chances of getting Lyme disease.

National Center for Emerging and Zoonotic Infectious Diseases
Division of Vector Borne Diseases | Bacterial Diseases Branch



University of New Hampshire, 2018.

Important areas to check for ticks



University of New Hampshire, 2018.

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Common Dermatological Concerns at Camp

Sara Brown, MSN, DNP, CPNP

Abstract: Dermatological problems can be tricky for even the most seasoned camp nurse. A systematic approach should be used to guide the nurse in identifying the cause and providing effective management. Staying up to date on the assessment and management of common rashes is invaluable for any nurse practicing in the camp setting.

Camp is a time for outdoor adventures for many children each year. Camp allows children a chance to escape their normal, everyday routine and participate in activities that may not be possible throughout the year. Hiking, swimming, and rock climbing are just a few of the many things that draw children to camp. Outside exploration in unfamiliar areas has risks such as potential for injury and skin alterations. Dermatological problems can be tricky for even the most seasoned camp nurse. A systematic approach should be used to guide the nurse in identifying the cause and providing effective management. Staying up to date on the assessment and management of common rashes is invaluable for any nurse practicing in the camp setting.

Rashes at Camp

Assessing and managing rashes at camp can be difficult because of the numerous potential causes. Some rashes encountered at camp are related to chronic conditions, such as eczema. Other rashes can be associated with acute illnesses or infections. Rashes can be directly linked to flora and fauna or other irritants. While the etiologies are varied, the camp nurse should be able to categorize the rash in a general group to more effectively manage the situation. Assessment is the most important component to management of rashes at camp (Reynolds, 2003). Gathering information is vital to the nurse when looking to identify the rash. What type of lesion is it and where did it first appear? Some rashes, like varicella, begin on the abdomen and move outward. Annular, or round, rashes can be fungal. Does the rash form a bulls-eye? What color is the rash, and does it blanch? Does the rash itch or hurt, and has this ever happened before? Is there bruising around the rash that appears trauma related? Is the only problem a rash, or are there other symptoms present such as fever? These questions with a pertinent health history can be invaluable to the identification of the concern.

The use of the mnemonic SCRIPTS has shown to be an organized approach to rash identification. Assessment of the characteristics will help the nurse identify the cause or the best strategy for successful management (See Appendix A). When the S (shape), C (color), R (region), I (itchy?), P (painful?), T (trauma-related?), and S (systematic symptoms) mnemonic is completed, the camp nurse can use this data to identify a rash he or she can treat, or refer the patient to a hospital emergency department if necessary (Olympia, 2017). If a camper has a high

fever, blisters, eruptions in the mucous membranes, excessive pain/tenderness, and/or unexplained bruising, consider referral to a higher level of care (Dinulos, 2015).

Atopic Dermatitis

Atopic dermatitis (AD) can be a common dermatological condition in the camp setting (Reynolds, 2003). This skin condition is dependent on variables such as environmental and immunological triggers, as well as dysfunctions in the camper's natural skin barrier. The AD rash often appears suddenly, and the affected skin is red, papular, dry, papulosquamous (scaly), with intense pruritus, and may appear to weep fluid. Common places for patches of AD to appear are in the flexural creases of the arms and legs, neck, wrists, and on the cheeks (aad.org, 2017). The etiology is usually an exposure to an allergen that triggers the outbreak. In the camp setting, a flare can occur from frequent swimming or an extended period of exposure to very dry air without proper moisturization (Reynolds, 2003). Food allergies are also a common cause of a flare and should be considered in identifying the etiology (Ahluwalia, Davis, Jacob, Waldman, Ong, Cohen, Friedman, & Lio, et al, 2017). It is important for the camp nurse to quickly differentiate AD from other rashes because this camper has a higher risk of the rash becoming an infection due to breakage of the skin from persistent scratching. Treatment goals are reducing inflammation, controlling pruritus, and restoring the natural skin barrier (Reynolds, 2003). Current treatment is application of topical steroids and aggressive use of emollients like Eucerin or Vaseline. Although the effectiveness of oral antihistamines for the management of AD is debated among professionals, current recommendations encourage the use of these drugs to relieve nighttime pruritus and restore sleeping patterns in the pediatric population (Nierengarten, 2017).

Contact Dermatitis

Contact dermatitis may be the most common medical complaint in the camp environment (Marugg, 1993). Even the most cautious camper can be easily exposed to allergens that can cause a skin eruption. Contact dermatitis is an inflammatory skin condition and can mimic symptoms of AD. Therefore, a good medical history is key to differentiating between the two. In general, a contact dermatitis rash is usually limited to the area of the body that was exposed to the irritant but has the potential to spread to other areas (Reynolds, 2003).

To help the camp nurse in her assessment, it is important to know that contact dermatitis can be further broken down into two subcategories according to etiology; Allergic contact dermatitis (ACD), which requires prior sensitization, and irritant contact dermatitis (ICD), which does not require a previous exposure (Jacob, Brankov, & Kerr, 2017). ICD is potentially the most commonly occurring type of rash in the camp setting. Exposure to chemicals, such as chlorine from swimming, bug sprays, and soaps, and other biological sources, like insects, saliva, and feces from poor hygiene, are the most common causes. ACD is the rash that occurs when contact with a previously sensitized allergen occurs.

One of the most common causes of ICD and ACD in the camp setting is exposure to a group of plants, genus *Toxicodendron* (Aksamit, 1999). This group of plants includes poison ivy, poison oak, and poison sumac, which all contain an oil irritant called urushiol. The urushiol does not have to come in direct contact with a camper for the camper to experience symptoms. Indirect exposure to urushiol can happen from animals, clothing, bed linens, sports equipment, and even exposure to airborne urushiol by burning plants (Hirschhoff, 2006). Avoidance of urushiol is optimal but unlikely in the camp setting. A variety of Federal Drug Administration (FDA) approved lotions are available to prevent exposure, including IvyBlock and Hydropel Moisture Barrier (Pekovic, 2016). However, education regarding prevention is vital for campers and staff to know how to recognize plants, how urushiol is spread, and strategies to avoid contact.

Exposure to urushiol at camp is almost certain to happen to someone, so it is essential to understand that urushiol is not destroyed by simply showering with soap and water; it is only broken down into smaller particles that can still be present despite washing (Erceg, 2003). Therefore, the exposed area should be rinsed well with cool water, and all soapy residue should be removed. Hot water should be avoided because it opens pores allowing the plant oil to enter the skin (Pekovic, 2016). All clothing, bed linens, and other objects that may have been exposed to the plant oil should be washed or cleaned properly. Zenfel is a product that removes urushiol from skin and other objects. Zenfel is safe for children and can be safely used post exposure (Boelman, 2013).

Despite preventative measures and decontamination of the camper, a rash may still occur. If a rash does develop, treatment goals are like that of atopic dermatitis; control inflammation and pruritis and prevent infection. Topical steroids can be helpful in the control of inflammation of a mild rash and can easily be kept in the camp health center for quick use (Marugg, 2004). For more extensive rashes, a referral to a physician may be necessary to get a prescription steroid (Hirschhoff, 2006). Although Benadryl is known for causing unwanted drowsiness, other oral

antihistamines, such as Zyrtec, are also considered useful in controlling pruritis without the unwanted effects (Erceg, 2003). Calamine lotions, zinc oxide, and oatmeal lotions like Aveeno may help ease the discomfort from the pruritis (Pekovic, 2016). When pruritis is present, the possibility for infection exists due to skin breakdown (Nerderman, 2009). Therefore, helping the camper keep the area clean is key to preventing unwanted infections.

Infections

Pyoderma is a localized, superficial bacterial infection of the skin that includes diagnoses such as impetigo and folliculitis. These infections of the skin occasionally begin as a rash but can be caused by other breaks in the skin like an insect bite or a minor wound. Commonly, *Staphylococcus aureus* and *Staphylococcus pyogenes* are the bacteria responsible for the infection (Anand & Dhyani, 2016). Summer heat and humidity, as well as lack of proper hygiene, play a role in the perpetuation of these skin infections (Yeoh, Bowen, & Carapetis, 2016). The nurse may begin to see an increase in secondary or satellite red bumps around the primary rash or original injury site. Many times, there is increased redness around the area and a yellow or honey-crust top layer to the rash or wound site (Reynolds, 2003). Topical antibiotics are usually adequate to treat small areas of less than five lesions of impetigo. However, if the area of infection is large or close to the eyes, oral antibiotics should be considered in addition to the topical treatment (Anand & Dhyani, 2016). Antibiotics should be carefully considered to cover any strain of *Staphylococcus*. Amoxicillin and Erythromycin have both proven to be effective courses of treatment with a success rate of 89 percent (Yeoh et al., 2016). The camp nurse should encourage good hygiene practices, such as hand washing and daily bathing, as impetigo is very contagious and could spread to other campers.

Folliculitis is also a common skin infection at camp. Folliculitis is another superficial eruption centered around a hair follicle. This has the potential to occur anywhere on the body. A camper is usually asymptomatic until the painful papule and pustules appear. As with impetigo, *Staphylococcus* is to blame. Treatment for small areas is usually with topical antibiotics like Bactroban. Oral antibiotics may be considered if the infection is not improving or covers a large area. Folliculitis has a tendency for reoccurrence. In cases of frequent outbreaks of folliculitis, the prophylactic use of antibacterial soaps may be helpful (Reich, Psomadakis, & Buka, 2017). The camp nurse should continue to monitor cases of impetigo and folliculitis in campers. Any development of a fever or red streaking from the primary infection site warrants a prompt referral to a higher level of care for evaluation (Reynolds, 2003).

Fungal Infections

Many opportunistic organisms are waiting to find their host at camp. Fungal infections in the camp setting can be miserable for campers. Fungal infections are occasionally mistaken for other common skin conditions, as they may present as red, itchy, scaly patches very similar to atopic dermatitis (Reynolds, 2003). A thorough, systematic assessment can be beneficial, as fungal infections usually follow a different distribution pattern than other camp rashes. A common fungal infection at camp is ringworm. Ringworm (*tinea corporis*) is a red, scaly, itchy, nummular patch on the body. Treatment is usually a topical antifungal, which may be complicated by the length of treatment. If necessary, parents should be educated about the treatment and how long to continue after the child returns home.

Candidiasis is another fungal problem in the camp setting. Also known as yeast infections, candidiasis loves a moist, warm, dark environment. Campers' sweaty feet and groin areas are ideal hosts for yeast. A camper may present with a beefy red, itchy, painful rash with satellite lesions surrounding the primary area in the groin or any other similar environment on the body (Reynolds, 2003). Treatment involves the application of topical antifungals, like nystatin, and keeping the area clean and dry.

Exanthems

Exanthems are usually rash-like symptoms of a viral or bacterial illness. A camper with a viral or bacterial rash may present to the camp nurse with additional symptoms. The nurse should complete a health history, including recent travel, immunization status, and current medications, to make decisions regarding etiology of the condition. Distribution patterns should also be considered. Varicella, a viral exanthem, usually starts on the trunk and spreads outward to the face and extremities (Anand & Dhyani, 2016). A measles rash generally starts on the face and spreads down (Anand & Dhyani, 2016). Accompanying symptoms may include a fever and mild flu-like symptoms (Reynolds, 2003). A common bacterial exanthem is scarletina, which presents with a rough rash to the upper trunk or neck accompanied with fever and sore throat (Reynolds, 2003). It is important to consider that exanthem rashes may need to be referred for medical examination and treatment if management is not possible in the camp setting.

Consideration for Camp Nurses

Rashes are common in the camp setting, and the nurse should be up to date on the current recommendations. Following evidence-based guidelines will help the nurse make better decisions for campers. Based on the current literature and previously published articles in *CompassPoint*, there are important points to consider when treating a child with a rash.

A thorough assessment is important to distinguish between a rash that should be referred to a higher level of care and one that can be managed on site at the camp health center. Consider a systematic approach to a physical assessment, such as using the mnemonic SCRIPTS, to ensure all characteristics of the presenting rash are considered. For contact dermatitis rashes, consider all circumstances under which the camper may have come in contact with an irritant or urushiol. Remember how important education can be in the prevention of rashes and their subsequent infections at camp. Think of ways to encourage good hygiene practices to prevent common camp rashes and keep current rashes free of infection. When dealing with fungal infections, the management goal is to keep the area dry and apply topical antifungal creams or powders to effectively manage symptoms. Lastly, consider referral to a physician for a medical examination when campers present with warm rashes with streaks or other constitutional symptoms accompanying the rash.

Conclusion

Rashes do not have to be daunting. The ability to be competent with assessment and management of any rash that may occur at camp is important. A systematic approach to the rash will allow one to manage rashes more efficiently and refer rashes that may require a higher level of care. When one is comfortable with the identification and management of common dermatological complaints, these rashes can be treated more effectively, and the camper can return to the fun and exciting time at summer camp.

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Appendix A

S.C.R.I.P.T.S. for Rashes at Camp

S	Shape (size and morphology)	<ul style="list-style-type: none"> • How big is the lesion? • Is the lesion raised or flat? • Has the shape changed?
C	Color	<ul style="list-style-type: none"> • What is the color (red, purple, black, brown, pink, white)? • Does the lesion blanch? • Hyperpigmented or hypopigmented?
R	Region	<ul style="list-style-type: none"> • Where is the rash located? • Where did it start? • Is the rash spreading? • Does the rash come and go?
I	Itchy?	<ul style="list-style-type: none"> • Hive-like? • Crusted over?
P	Painful?	<ul style="list-style-type: none"> • Is the rash red, warm?
T	Trauma-related?	<ul style="list-style-type: none"> • Bruising near or around the rash? • Take a good history of the concern. Is the story consistent?
S	Systematic symptoms?	<ul style="list-style-type: none"> • Fever? • Headache? • Neck pain? • Change in mental status? • Nausea/Vomiting/Diarrhea? • Mucous membrane changes?

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One Woman's Journey to Camp Nursing, Part II

Karen DeDominicis, BSN, RN

Note: Part I of this story appeared in the Spring 2018 issue of *CompassPoint*.

Should I accept this offer to be the director of three health centers for what appears to be a great summer camp? I hadn't worked in four years and I was somewhat rusty, and more importantly, I had never been a summer camp nurse. It looked like I had a lot of discussing to do with my husband and family, and some important decisions to make, and soon!

Of course, my kids were super excited at the thought of Mom working at a summer camp and them having full access to all the assumed pleasures of a "staff kid." My husband was also quick to jump on board, immediately realizing that this job offer for me would quickly result in an accumulation of extra income that could be used to *finally* buy that Ford Mustang GT he had been dreaming of for the last several years, and for which we had already been saving. So, with visions of fun-filled lake activities and Mustangs floating through my family's heads, the decision was quickly made.

The following week I met with both Lori, the executive director and Jason, the health and safety director, for the camps again to go over final details. I asked more questions to try and get a picture of what it was exactly I would be doing. I discovered the list of responsibilities was quite lengthy. Jason gave me a tour of the three health centers. That was a shock! A *lot* of work needed to be done in the next two weeks to get the health centers cleaned, stocked, and ready to receive campers and staff. One health center had just recently been renovated and remodeled, so it was bare-bones empty — as in no furniture, no equipment, and no supplies.

"We would love for you to purchase anything you think would be best to make this health center look amazing," Lori said. "I would like to leave it up to you to purchase the equipment, exam table, desk, and any other furniture and items necessary to have it ready. I trust you."

You trust me? You hardly know me! My shoulders were starting to feel quite heavy, almost as if three health centers were stacked on top of them.

It's okay, I thought. I love organizing, I love decorating, I love shopping. This will afford me the opportunity to do all three, and get paid for it! But, oh, where do I start?

I viewed the housekeeping that needed to be done as the "easy" part. But I was confounded by how to actually direct the health centers. Still, I took up the gauntlet and accepted the challenge. We agreed upon my pay, signed some paperwork, and it was final. I had only two weeks to prepare for the arrival of our 200 summer staff, and an additional two weeks after that before campers arrived. It was time to get busy!

I started with the first step — prayer. After all, it's what helped me make this decision in the first place. Then the most basic of basics, I searched the Internet for "how to be a summer camp nurse."

My prayers were answered in cyber-speed time! My search engine led me straight to what I now call the "Camp Nurse's Bible," and that is *The Basics of Camp Nursing*, by Linda Ebner Erceg. I ordered the book immediately and read it in a matter of days, making constant notes in the margins, going through highlighters, and creating my to-do list. Simultaneously, I worked on cleaning and organizing the health centers and created an inventory list and a probably-need-to-order list.

I also created a list of questions to ask my supervisor, Jason, who had the most creative of answers. I asked, "How do you store all the campers' medications after they arrive?"

He replied, "You will need to ask Karen."

"Oh, there is another Karen besides myself who works here?" I inquired.

"No, just you!" he chuckled. He reminded me that they didn't have any policies or rules. There was not a well-established system as far as the health centers and their operation were concerned. He reassured me that he wanted me to establish that, and that I could accomplish that task in whatever way I thought was best. He trusted my judgment and knew it would take time and some trial and error. He said he would do whatever I needed him to do to help me accomplish that goal, but that the decisions were mine to make. That is essentially why they had hired me. All of a sudden, my shoulders felt heavy again.

Based on what I had read and learned in *The Basics of Camp Nursing*, I trudged onward and looked up the *Texas Administrative Code for Medical and Nursing Care* for camps. Obviously, I knew to follow whatever laws may exist on the subject.

Next, I looked up the American Camp Association's *Health & Wellness Standards*. I knew I wanted to strive to meet all of their standards.

Then it was time to learn how to use the camp's computer software for the health centers. That was not something I could ask Karen, because I'm not very computer savvy, so Jason needed to have a better answer this time. Luckily, there was a wonderful woman that was able to give me the basics and guide me through learning the software.

Learning about our standing orders was next. I knew we had a camp physician whom I hadn't met yet. She lived three hours away and had been the camp physician since the camp

originated, 15 years ago. I connected with her via email only to find out we didn't have any standing orders at all. What? I had one week before campers arrived, and I had no standing orders or protocols.

My camp physician encouraged me to create some standing orders and protocols and said she would be happy to sign them for me after she reviewed and approved them. *Great!* Have I mentioned that I had never been a camp nurse before?

Next step: search the Internet for "summer camp health center protocols." Unfortunately, there wasn't much to be found, but I learned enough to give me a starting point, and with my experience as an ED nurse for so many years, I did know what standing orders and protocols looked like. I started my task of writing them out. A week later, they were sent to the editor (AKA my camp physician) and with just a few corrections, they were signed.

The weight on my shoulders grew lighter. I was now the proud director of organized, stocked, and clean health centers. I was following the Texas law. I was striving to meet ACA standards. And I now had protocols to follow too.

Summer was looking promising, but I was already completely exhausted, and the first influx of campers hadn't even arrived! Would my protocols suffice? Would my health aides, whom I just met, be helpful? What was I supposed to teach them? Would the state inspector show up at camp this summer? What was the worst thing I might see during camp, and was I really prepared? Why did I have a lump forming in my throat? How was I going to make it through the entire summer?

To be continued...

Karen DeDominicis, BSN, RN, is the health coordinator and nursing director at Carolina Creek Christian Camps.

The Rise of e-Cigarettes among Youth

Marcia Ellett, MA

E-cigarettes are apparently very enticing to youth. Between 2011 and 2015, the US Surgeon General (2016) found e-cigarette use among high school students increased by 900 percent, with more teens now using e-cigarettes than cigarettes.

In particular, JUUL, a newer e-cigarette product that closely resembles a USB drive rather than a traditional cigarette, is all the rage with high schoolers, according to *US News & World Report* (Oliver, 2018). While JUUL is marketed to smokers as an alternative nicotine delivery system, its discreet design and fruit flavors may be contributing to its popularity among youth.

Though e-cigarette research is still in its early stages, recent studies have reported that teenagers using e-cigarettes may be ingesting cancer-causing toxins and inhaling unsafe levels of toxic metals (Oliver, 2018).

Additionally, "Nicotine exposure during adolescence can cause addiction and can harm the developing adolescent brain," according to the Surgeon General (2016).

The Surgeon General (2016) further concluded that e-cigarette use among youth represents a significant public health concern and should be discouraged by parents, educators, and policymakers. That means the camp community should also be vigilant about detecting use of e-cigarettes among campers and young staff at camp. Camp health staff may want to suggest an amendment to any antismoking

policies to include e-cigarettes (as an additional means of ingesting nicotine — and marijuana in some cases) if that hasn't already been done.

Linda Erceg also suggested in her *CompassPoint* article, "Vaping: Are Camp Nurses Aware?" that broadening health assessment may be warranted when presenting symptoms of campers and staff feeling unwell "don't hold together." In those cases, she wrote, "it may be time to ask a question such as: 'Have you recently been exposed to nicotine or marijuana?'"

"The bottom line is that we have something else to consider. Get educated. Be aware of other potentials as your campers and staff seek your care" (Erceg, 2015).

With e-cigarette use so sharply on the rise among youth, it is very likely their presence will be felt and remain a concern at camp for the foreseeable future.

References

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- US Department of Health and Human Services (2016). *E-cigarette use among youth and young adults: A report of the Surgeon General*. Retrieved from https://e-cigarettes.surgeongeneral.gov/documents/2016_sgr_full_report_non-508.pdf

New Products, New Ideas

Paula Lauer, RN, BAN, and Susan B. Baird, RN, MPH, MA

■ **Test My Tick:** Your tick can be tested for over 20 different disease-causing organisms that ticks can carry (like Lyme disease, Rocky Mountain Spotted Fever, and newly discovered diseases like Powassan, Heartland, and Colorado Tick Fever Virus). We now share that data as part of Tick-Borne Disease Network passive surveillance, which we hope will provide unprecedented insights to who is being bitten by ticks, when they get bitten, and what pathogens those ticks are carrying. We encourage everyone to SAVE THE TICKS for testing! www.testmytick.com

■ **New ANA position statement on the Ethical Responsibility to Manage Pain:**

The national response to the opioid crisis affects pain management for nurses in every role and practice setting. For nurses at camp, the new position statement would make a valuable topic for team discussion and would serve these nurses well in their practice settings outside of camp. Print this 2018 position statement from: <http://bit.ly/ethicalpainmanagement>.



■ **Asthma in Children:** CDC's *MMWR* and Medscape have introduced a new FREE continuing education (CE) activity that describes trends and demographic differences in health outcomes and healthcare use for childhood asthma. This activity is intended for pediatricians, pulmonologists, public health officials, nurses, and other clinicians caring for patients with childhood asthma. Access this activity at: https://www.cdc.gov/mmwr/cme/medscape_cme.html. If you are not a registered user on Medscape, you may register for free or log in without a password and get unlimited access to all CE activities and other Medscape features.

■ **Emergency Preparedness for Weather Events:** Is this the year you participate in reviewing and updating your camp's weather emergency plans? Recent disasters in the news have alerted us to a variety of weather-related emergencies. Check out ways to prepare for these with CDC resources: <https://www.cdc.gov/other/index.html>.

■ **Updated Partner, Build, Grow Program:** The Center for Health and Health Care in Schools (CHHCS) has launched an updated Action Guide for its *Partner Build Grow* program. The guide outlines practical steps to build school and community efforts and resources that enable children to succeed and to sustain these through collaboration and system change. Camps may well be a logical connector. The program is divided into four sections: Build-

ing an Action Team, Mapping Assets, Connecting with the Policy Environment, and Communications. Each section will help participants engage with cross-sector partners, develop an action plan for their specific context, access viable financing and regulatory strategies, and create communications objectives. It can be used to maintain an effective initiative or to help schools and communities (and camps) determine new actions that will best benefit their children. The revisions include a new section for those just starting the process, and new and updated information in each prong, as well as within the corresponding worksheets: chhcs@gwu.edu.

■ **Curaplex Epi-Safe Kits by Bound Tree:**

Curaplex Epi-Safe Kits are a cost-effective alternative to using an epinephrine auto-injector. These kits specifically supply a unique syringe that



provides an easy-to-use visual indicator for dosing and contains ADRENALIN-epinephrine for emergency treatment of allergic reactions (Type 1), including anaphylaxis, which may result from allergic reactions to insect stings, biting insects, foods, drugs, sera, diagnostic testing substances and other allergens, as well as idiopathic anaphylaxis or exercise-induced anaphylaxis.

Common adverse reactions to systematically administered epinephrine include anxiety, apprehensiveness, restlessness, tremor, weakness, dizziness, sweating, palpitations, pallor, nausea and vomiting, headache, and respiratory difficulties. These symptoms occur in some individuals receiving therapeutic doses of epinephrine, but are more likely to occur in patients with heart disease, hypertension, or hyperthyroidism.

One- and two-dose kits are available. Find more information at <https://www.boundtree.com/curaplex-epi-safe-kits-group-39977-4222.aspx?search=epi>.

Is there a subject you would like to see *CompassPoint* cover?

If so, let ACN's Executive Director Tracey Gaslin know: gaslin@campnurse.org.



ACN Board for 2019-2021



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Association News

❖ *CompassPoint* – Request for Writers

ACN is looking for individuals who might be willing to write for *CompassPoint*. We are looking for new writers for regular columns as well as feature articles. If you are interested or have questions, please feel free to contact our editor, Marcia Ellett (marcia.ellett@gmail.com). She can assist you in finding great opportunities to share.

❖ Congratulations to the newly elected ACN Board for 2019-2021.

We are fortunate to have a strong, prosperous group of camp nurses and leaders willing to take a role in leading ACN into the future!

❖ Symposium 2019!

Dates: 18-20 February 2019

Location: Gaylord Opryland Hotel, Nashville, TN

Mark your calendars and make plans to attend a great event!

❖ Call for Presenters for 2019 ACN Symposium

The call for presentations for the ACN symposium will go out in a few weeks. Please keep your eyes posted if you are interested in possibly sharing your expertise with others.

❖ ACN - Now a 501(c)3 Organization

Just recently, ACN received its 501(c)3 status. This allows the organization to do several things:

- Write grants to support services
- Receive donations that are tax deductible
- Expand our educational reach

We are excited about the opportunities this designation affords us.

❖ Advertising in *CompassPoint*

To help our members, we will be introducing a limited number of advertisements to *CompassPoint*. Members do not always have access to resources and companies if they are not attending conference. We want to bridge that gap and help members find quality camp health resources.

❖ Camp Health Hotline - Summer 2018

Need information and support during a summer health event? Has lice appeared? Are you dealing with illness at your facility? Give us a call at **502-232-2945**. We are here to provide feedback, guidance, and helpful tips as you care for the many wonderful campers this year.

Connect with Us!



Association of Camp Nursing



CampNurses