



Diabetes Youth New Zealand

National Diabetes Camping Guidelines

*The Organisation and Management of Camps
for Young People with Diabetes, and their Families*



Produced by Diabetes Youth New Zealand in association with
the Starship Paediatric Diabetes Team and
the Diabetes Nurse Specialist section of the New Zealand Nurses organisation, and
supported by the New Zealand Society for the Study of Diabetes

August 2010



PREFACE

These guidelines have been designed to ensure that the health and safety of young people with diabetes is maintained at all times during camp.

These guidelines replace the May 1992 version.

All Diabetes Youth New Zealand and Diabetes New Zealand Societies and Support Groups should follow these guidelines wherever possible and appropriate. It is strongly recommended that all other New Zealand groups organising camps for young people or families with diabetes also follow these guidelines.

The information contained within these guidelines is provided for reference purposes and is not intended to be a complete manual or handbook, nor is it intended to provide absolute forms, policies or procedures for diabetes camps. Every camp must develop its own materials that address the safe and effective provision of services to children with diabetes in its own unique camp setting - these services must meet the regulations of local and national government/accrediting bodies. The information provided here is intended to guide the reader through the process.

While every reasonable precaution has been taken in the preparation of these guidelines, the author and publisher assume no responsibility for errors or omissions, nor for the uses made of the materials contained herein and the decisions based on such use. This document does not contain all the information necessary for the total operation of a diabetes camp. As such no individual may solely rely on the information presented herein in forming a comprehensive diabetes camping program. Neither the author nor the publisher shall be liable for direct, indirect, special, incidental or consequential damages arising out of the use or inability to use the contents of these guidelines.

By necessity, as research evidence and new treatment approaches emerge, this document will be reviewed and updated by DYNZ on a continuing basis. Feedback from all stakeholders is encouraged.

Next Review Date: July 2012

©Diabetes Youth New Zealand

E-mail:

contact@diabetesyouth.org.nz

Website:

www.diabetesyouth.org.nz



CONTENTS

1. Introduction

- 1.1 Background
- 1.2 Purpose of these Guideline
- 1.3 Aims and Objectives of Diabetes Camping
 - 1.3.1 Primary Aim of a Camp
 - 1.3.2 Secondary Objectives of Camps
 - 1.3.3 Additional benefits of camps

2. Camp Organisation and Management

- 2.1 The Camp Committee
- 2.2 Roles of the Camp Committee: Planning the Camp
 - 2.2.1 Selection of camp site
 - 2.2.2 Raising funds and working to a budget
 - 2.2.3 Appointing Staff
 - 2.2.4 Selection of campers
 - 2.2.5 Defining specific objectives for the camp
 - 2.2.6 Programme Development
 - 2.2.7 Administration: Policies and Procedures
 - 2.2.8 Camp Report
- 2.3 Teen Events
 - 2.3.1 Objectives
 - 2.3.2 Staff
 - 2.3.3 Participants and their Selection
 - 2.3.4 Rules and Regulations
- 2.4 Family Camps
 - 2.4.1 General Objectives
 - 2.4.2 Educational Objectives
 - 2.4.3 Staff
 - 2.4.4 Campers
 - 2.4.5 General Rules for Family Camps
- 2.5 On Site Facilities
- 2.6 General Guidance and Camp Rules
- 2.7 Safety Requirements
- 2.8 Fire Safety
- 2.9 Insurance
- 2.10 Motor Vehicles Used During the Camp

3. Camp Staff

- 3.1 Selection of Staff
 - 3.1.1 Clinical Staff
 - 3.1.2 Non-clinical Staff
 - 3.1.3 Staff Ratios
- 3.2 Roles and Responsibilities of Staff
 - 3.2.1 Division of Responsibility
 - 3.2.2 Expectations of Staff
 - 3.2.3 Specific Responsibilities of the Camp Coordinator and Clinical Staff
 - 3.2.4 Specific Responsibilities of the Non-Clinical Staff



- 3.3 Training
 - 3.3.1. General requirements
 - 3.3.2. Pre-camp Briefing for Clinical Staff
 - 3.3.3. Pre-camp Workshops for Non-clinical Staff and Volunteers

4. Medical Care at Camp

- 4.1 Medical Facilities
 - 4.1.1. Off Site
 - 4.1.2. On Site – the Medical Health Unit
- 4.2 Medical Supplies
 - 4.2.1. Diabetes Supplies
 - 4.2.2. General First Aid Supplies
 - 4.2.3. Kits for Outings
 - 4.2.4. Other Supplies
- 4.3 Blood Glucose Monitoring
 - 4.3.1. Objectives of Monitoring
 - 4.3.2. Monitoring In Practice
- 4.4 Insulin Adjustment
 - 4.4.1. General Guidance
- 4.5 Management of Young People using Insulin Pumps
 - 4.5.1 Basal Insulin
 - 4.5.2 Bolus Insulin for Meals
 - 4.5.3 Bolus Insulin for Blood Glucose Correction
 - 4.5.4 Hypoglycaemia
 - 4.5.6 Disconnection
- 4.6 Management of Hypoglycaemia
 - 4.6.1. Standard First-Response Treatment for Hypoglycaemia
 - 4.6.2. Administration of Glucagon
 - 4.6.3. Administration of Intravenous Glucose
- 4.7 Management of Hyperglycaemia
 - 4.7.1. Hyperglycaemia in the Context of Camps
 - 4.7.2. Testing Ketone Levels
 - 4.7.3. Treatment of Hyperglycaemia with Ketonuria or Raised Blood Ketones
 - 4.7.4. Management of Hyperglycaemia and Sick Days
- 4.8 Medical Care for Illness or Conditions other than Diabetes

5. Campers

- 5.1 Applying for Camp
 - 5.1.1. Registration
 - 5.1.2. Legal Consent
- 5.2 Selection Criteria
 - 5.2.1. Inclusion Criteria
 - 5.2.2. Exclusion Criteria
- 5.3 On Arrival at Camp
- 5.4 Education at Camp
 - 5.4.1. General Objectives
 - 5.4.2. Detailed Objectives
- 5.5 What to Bring and WHAT NOT to Bring to Camp



6. Evaluation

- 6.1 Aims of Evaluation
- 6.2 Methods of Evaluation
 - 6.2.1 Collection of Data
 - 6.2.2 Interpretation of Evaluation Data
- 6.3 Implementation of Evaluation Data

7. References

8. Appendices

- Appendix 1 – Memorandum of Understanding for Group leaders, Camp assistants, Industry representatives
- Appendix 2 – Camp Registration Form: Youth/Teen camp
- Appendix 3 – Camp Registration Form: Family camp
- Appendix 4 – Sample Budget
- Appendix 5 – Guidelines for Hypoglycaemia for Campers using Insulin Pumps
- Appendix 6 – Photography Permission Form



1. Introduction

Camping provides young people with diabetes and their families with a unique opportunity to share with and learn from others with diabetes. Every family with a young person with diabetes in New Zealand should be given the opportunity to benefit from the diabetes camping experience.

1.1. Background

These guidelines have been prepared by Diabetes Youth New Zealand (DYNZ) in collaboration with various special interest groups within New Zealand. The guidelines are supported by New Zealand Society for the Study of Diabetes (NZSSD). The document is based on previous guidance published by the NZNO Diabetes Nurse Specialists Group (1992).

1.2. Purpose of these Guidelines

These guidelines have been produced for the attention of all persons involved with diabetes camping, and are intended to be used in the conduct of educational and recreational camps for young people with diabetes in New Zealand.

It is essential that all camps adhere to minimum standards of organisation and management, education, health and safety. These guidelines are intended to direct and advise, however it is acknowledged that local factors or preferences may lead to adaptations in practice.

1.3. Aims and Objectives of Diabetes Camping

1.3.1. Primary Aim of a Camp

The primary objective of holding a camp is to provide children and young people with diabetes with a fun but safe environment that allows them to learn about themselves and their diabetes, to reinforce current education, and to promote the further development of management and coping strategies.

1.3.2. Secondary Objectives of Camps

- To provide an enjoyable recreational camping experience for young people with diabetes and/or families;
- To provide a safe and healthy environment away from home, embodying the physical, social and emotional well-being of campers;
- To enable young people with diabetes to meet and share experiences with others with diabetes;
- To encourage young people with diabetes to learn more about their condition, and how to manage it;
- To promote emotional adjustment to having diabetes, increase confidence, and to overcome any sense of isolation, stigma or pessimism;
- To support young people in taking responsibility for their own wellbeing and mastering habits of resourcefulness, dependability, tolerance, originality and appropriate levels of independence.



NOTE: In addition, individual camps are expected to have specific aims and objectives that are prepared by the camp committee during the planning stage for the given camp (see sections 2.2.5 and 2.2.6; also see section 5.4 for educational objectives).

1.3.3. Additional benefits of camps

In addition to achieving the above objectives, camps bestow numerous additional benefits to children and young people with diabetes, their parents and families, and the health professionals who care for these young people at camp:

- Many camps provide the opportunity for campers to take part in vigorous or unusual activities, where diabetes management can be demonstrated and positively reinforced;
- Campers may gain confidence in dealing with diabetes away from the home setting – this benefit may also extend to an increase in confidence of the parents or caregivers;
- Increasing self-reliance in young people with diabetes will tend to support regular attendance of camps, and further the benefit;
- An increased confidence and ability to deal with diabetes away from the home setting may encourage participation in other independent activities, such as sleepovers and school camps;
- Health professionals participating in camps gain an increased understanding of the day-to-day challenges facing children and young people with diabetes – this is an invaluable experience;
- Camps provide a respite for parents and caregivers from the daily stresses of dealing with diabetes.

2. Camp Organisation and Management

The organisation of a camp should be initiated at least 9 – 12 months prior to the proposed camp.

2.1. The Camp Committee

Each camp should operate under the authority of a local or regional Camp Committee. This body should consist of at least the following members:

- Camp Coordinator – Person responsible for overall co-ordination of activities of camp committee, camp staff, site staff, campers, parents, and implementation of these guidelines;
- Clinical Advisors – Health professionals with expertise in diabetes who are able to advise on paediatric medical, nursing and dietetic aspects of the camp;
- Financial Officer – Responsible for the budget, coordination of fundraising, collection of receipts and upkeep of detailed accounts;
- Parent Representative.

Additional committee members might include adult volunteers with a special interest in, or experience of, diabetes in young people.



2.2. Roles of the Camp Committee: Planning the Camp

2.2.1. Selection of camp site

The chosen camp site is usually one that has been previously used for diabetes youth or family camps. See sections 2.5 – 2.9 for essential facilities and other requirements of a camp site.

2.2.2. Raising funds and working to a budget

Funding should be sourced at least 12 months prior to the camp. The Camp Committee should consider fundraising possibilities on an ongoing basis. Some funding may be available from:

- Lottery Grants
- Diabetes Youth New Zealand
- Local Diabetes Societies
- District Health Boards
- Charitable Trusts
- Income Support and other Government sources
- Company sponsorship and/or donations
- Service Clubs – e.g. Lions, Rotary

Early application to the appropriate District Health Board(s) is essential to secure funding and medical supplies.

A sample budget is included in Appendix 4.

2.2.3. Appointing Staff

The health and safety of staff and campers is dependent on adequate staff numbers – both overall, and within specific professional or skilled areas. The exact staff required will depend on the nature of the camp and the age range and number of campers.

Also see sections 2.3.2, 2.4.3 and 3.1.

- **Clinical Staff** – Medical director, Diabetes Nurse Specialist(s), Dietitian(s), Registered nurse(s), Night nurse
- **Non-clinical Staff** (*Group Leaders and Camp Assistants*) – Additional volunteers with experience of diabetes in young people

Early application to the appropriate District Health Board(s) is essential for the release of necessary medical, nursing and dietetic staff.

The appointment of all clinical staff should be confirmed at least 2 months prior to the start of camp.

The following roles may also need to be appointed by the Camp Committee; alternatively these roles may be covered by camp venue or 'site' staff:



- Recreation Officer
- Transport Officer
- Housekeeper
- Cook

The Camp Coordinator should clarify the roles assumed by Site Staff and appointed Camp Staff, and ensure that all Staff understand their responsibilities.

NOTE: Security police checks are mandatory for all staff

See section 3 for more detailed guidance on selection, training, and roles and responsibilities of Camp Staff.

2.2.4. Selection of campers

Advertising should be initiated at least 6 months prior to the camp, with the close date no later than one month before the camp. The Camp Committee should consider the following national and local advertising options:

- Diabetes Youth Times
- Diabetes Youth New Zealand Website
- Diabetes Youth New Zealand local or regional coordinator
- Local Diabetes Clinic
- Local Diabetes Society
- Local Magazines and Newspapers or Newsletters

The close off date for applications to be returned should be set at 6 weeks before the start of camp.

Participants should be appointed in liaison with clinical staff. Campers should belong to a Diabetes Society or be accountable to a Diabetes Youth Committee in order that they are covered by Diabetes New Zealand indemnity insurance.

More guidance on selection and approval of prospective camp participants can be found in sections 5.1 and 5.2.

2.2.5. Defining specific objectives for the camp

In addition to the general objectives of camp (see section 1.3) each camp must have a defined scope and specific objectives that it wishes to achieve. These objectives should be written and borne in mind by all people involved with the camp, including campers themselves (especially in the case of a teen event (see section 2.3) or family camp (see section 2.4)). Educational objectives are covered in section 5.4.

Evaluation of the objectives as the camp proceeds should occur in conjunction with evaluation of the programme and documented as appropriate (see section 6 for guidance on evaluation).



2.2.6. Programme Development

The programme must be designed to achieve the goals of the individual camp (see section 2.2.5). Ideally, a balanced mix of social, recreational and educational components will be sought.

Development of the programme will be the responsibility of the Camp Committee in consultation with the appropriate camp venue staff. Coordination with the Recreational Officer and Transport Officer will be necessary (NOTE: Some outings and transport will need to be booked well in advance).

Other pertinent points to consider include the following:

- Previous camp experience of staff members and camp participants
- Age of campers, their skills and abilities
- Specific skills or expertise of staff
- Duration of camp
- Time of year/season/weather
- Available adult or group leader/assistant to camper ratio
- Camp resources
- Safety factors

Coordination of staff skills is important in order to ensure an interesting and stimulating camp for the relevant age group.

Some activities may be finalised during pre-camp training workshops (see section 3.3), when staff get together and are able to coordinate their skills and ideas.

2.2.7. Administration: Policies and Procedures

A written statement of policies and procedures is required. These may include the following:

- Specific objectives of the camp
- Memorandum of Agreement for members of staff
- A description of channels of communication and responsibility
- Formal camper selection procedure
- Medical protocols and procedures
- The upkeep of camper records
- Fire and general safety policies
- Emergency procedures
- Search & rescue for persons lost or missing
- Reporting of incidents
- General rules for campers; behaviour management

2.2.8. Camp Report

On completion of each camp a written report should be compiled. This is essential for future reference and to inform planning of other camps. The report should include a formal evaluation of the camp (see section 6).



The report should be put together by the Camp Coordinator in collaboration with the Camp Committee and the Camp Staff. Input from **all participants** – clinical staff, group leaders and assistants, and campers themselves - ensures that a balanced report is produced.

A copy of the final report must be sent to Diabetes Youth New Zealand and may also be required or requested by other funding agencies or diabetes societies.

2.3. Teen Events

Teen events are usually both exhilarating and exhausting - for all of those involved. They provide specific challenges pertaining to the age group of the participants.

Education should occur in an informal environment as described in section 5.4, with topics/activities appropriate and relevant for the given camp participants (in line with camp objectives, the young people themselves may participate in the development of a specific education program).

NOTE: For teens it may be preferable to refer to campers as “camp participants”.

2.3.1. Objectives

- Essentially, the aims and objectives of Teen Camps are the same as those described for camps in general – see section 1.3.
- Whilst safety is always the primary concern, it is essential that a certain amount of ‘space’ is allowed for the development of the emerging adult, and all that that entails (i.e. acquiring confidence, independence, autonomy, and responsibility);
- Specific individual and group objectives for the camp are often best defined with the involvement of the camp participants themselves;
- The fostering of a team spirit is particularly important in teen camps – older camp participants, group leaders and camp assistants are encouraged to promote team spirit and to ensure that no one is left out or feeling isolated (the Camp Coordinator should be notified of any potential problems arising in this context).

2.3.2. Staff

The staff required for a teen event may depend on the location and nature of the planned camp.

When considering staffing a camp, the Camp Committee should consider the following:

- The type of event being held
- The age range of the young people invited to attend
- Additional related expertise of prospective staff
- Prior knowledge of the teens and their medical and social background (see box)
- Ability and sensibility of the young participants (see box)
- Possibility/likelihood of potential misadventure
- Accessibility of closest medical help/emergency services.

2.3.3. Participants and their Selection

See sections 2.2.4 and 5.2.



2.3.4. Rules and Regulations

- General rules for the camp should be agreed prior to, or at the beginning of the camp. See sections 2.6 – 2.10.
- If camp participants are under the age of 16 years, the Camp Coordinator is legally bound to have a consent form for that participant from their parent or legal guardian (see Appendix 2). This should provide the Camp Coordinator with ultimate responsibility for specific camp rules that are defined, and that should be adhered to during camp.

2.4. Family Camps

It is recognised that family camps often differ when it comes to local, regional and national aims /objectives and organisation. These guidelines are intended to ensure that safety - regarding food, physical activities, clinical decisions and accidents - remains a principle concern for all.

2.4.1. General Objectives

Family camps share the same aims and objectives as described in section 1.3.

Additionally, family camps aim to include close family in the educational experience that tends to evolve on getting to know and learning from other people and families coping with diabetes.

2.4.2. Educational Objectives

Whilst the objectives described in section 5.4 should be noted, it should also be observed that family camps are about sharing and learning from each other and creating an environment in which all members are equal – i.e. diabetes should not single one family member out as being “special” or to have “special needs” (over and above the essential monitoring and insulin administration, and ideally these management aspects should be shared with others, as opposed to being concealed from others).

Group/family sessions should not only be diabetes-focused; team-building events and activities that promote confidence-building should also be included.

2.4.3. Staff

Although not mandatory, clinical and/or leadership staff are advantageous at a Family Camp.

Clinical staff tend to have a more low-key role in Family Camps, since care of the individual with diabetes is usually assumed by the family. However, the “Clinical Staff” remain an integral part of the camp and usually have much to offer in terms of education from a more social/interactive perspective.

Essential clinical staff may provide back-up for medical emergencies, should they arise.



Family Camps provide an excellent learning experience for health professionals, and those in training. The opportunity to learn about the challenges faced by individuals and families with diabetes should not be turned down by any qualified or would-be health professional in almost any speciality, given the prevalence of diabetes today, and that forecast for the future.

The attendance of a Medical Director/Camp Physician at a Family Camp is not essential since medical care – in terms of day-to-day diabetes management - of the individual with diabetes is usually assumed by the family attending camp, or the person themselves. However the learning experience for the health professional may in fact be invaluable, so participation by physicians is still encouraged.

The Diabetes Nurse Specialist may assume an educational role during camp – formal and/or informal educational approaches may be discussed with the Camp Committee during the planning stages.

The dietitian may provide input during the planning stage in terms of providing a menu and liaising with cooking/kitchen staff to ensure that meal and snack times are appropriate. More formal educational sessions may be desired – this will depend upon the specific camp objectives (see section 2.2.5) and educational objectives (see section 5.4).

Other staffing requirements may be fulfilled as described in section 3. A roster system may need to be established to ensure that essential chores (such as cleaning toilets, setting tables, washing dishes etc.) are shared out and completed satisfactorily.

2.4.4. Campers

Selection of campers should essentially take place as described in section 5.2; however inclusion/exclusion criteria may be influenced by the prospective attendance of parents or guardians at camp.

2.4.5. General Rules for Family Camps

- The young person with diabetes should be supervised by their own caregiver at all times;
- Family members must be aware that physical contact with non-family members may be misconstrued; for this reason it is recommended that any physical contact be made only in public;
- Blood testing may be performed as per family expectations (although it is hoped that education may promote adequate testing – 4+ times daily - if this is deemed appropriate);
- Blood testing at supper time is mandatory;
- All medical supplies should be supplied by the family.

Also see sections 2.6 – 2.10.



NOTE: Whilst these guidelines are applicable for family camps, they may need to be adapted to suit local or individual camp requirements. Check with DYNZ if you have any queries (see inside front page for contact details).

2.5. On Site Facilities

The site should comprise a well-defined contained area. Essential facilities at the prospective camp site include the following:

- Water supply
- Toilets
- Washing facilities
- Sleeping units (cabins or tents)
- Kitchen
- Dining hall
- Area to be used as Medical Health Unit (see section 4.1.2)
- Recreation hall
- Outdoor recreational area
- Equipment for activities
- Fire protection and sanitation
- Civil Defence Kit
- Telephone

2.6. General Guidance and Camp Rules

- 2.6.1 No smoking, alcohol, or illegal drugs are permitted on the camp premises, or on camp outings.
- 2.6.2 It is desirable to keep age groups divided into developmental stages, e.g. 8-10, 11-12, 13-15, 15-18 years.
- 2.6.3 Lifting of bedwetters should be carried out according to guidance from the parent or guardian, with consideration to normal practice for the child.
- 2.6.4 Two adults must be present at all times when attending children during the night.
- 2.6.5 No persons other than those involved with the camp are permitted to stay on the camp premises overnight without prior arrangement through the Camp Coordinator.
- 2.6.6 If campers wish to drive themselves to camp then car keys must be surrendered on arrival. NOTE: it is preferable if parents or caregivers drop campers off and collect them at the end of camp.
- 2.6.7 Permission to take/use photographs of campers should be sought; see Appendix 6.

2.7. Safety Requirements

- 2.7.1 All activities must **at all times** be supervised by a responsible adult who has a good knowledge of diabetes and particularly hypoglycaemia, its signs, symptoms and management. Also see section 4.6.



- 2.7.2 **The whereabouts of all campers and staff must be known** - at least by the Camp Coordinator - **at all times**. Campers should leave the camp site only with the prior approval of the Camp Coordinator, and should preferably be accompanied by a responsible adult, or group leader.
- 2.7.3 Potentially hazardous camp activities (e.g. archery, horse-riding, swimming) must be under the direct supervision of a suitably qualified adult, capable of implementing safety standards and with training or experience in conducting the activity.
- 2.7.4 Staff must be aware that physical contact may be misconstrued and for this reason it is recommended that staff only touch camp participants in public. If a child is upset or troubled, refer to camp leadership or a camp parent.
- 2.7.5 Incidents must be fully documented - when a problem occurs (including bullying or alleged abuse) or a complaint of a serious nature is lodged by a camper, staff member, or visitor. A copy of the incident report should be retained on file for the Camp Committee, and a confidential copy should be sent to the Camp Coordinator, the National Youth Coordinator and the President of Diabetes Youth New Zealand (See inside front page for contact details).
- 2.7.6 Injury forms/reports are primarily the responsibility of the camp site, and will usually be designed around their own safety RAMS. If any child is injured at camp, the camp site staff must complete their own appropriate forms and should provide copies to the Camp Coordinator.

Health and Safety Legislation - mandatory requirements:

- Maintenance of a hazard register with known hazards;
- Reporting of incidents to the organisation, recorded on an incident register;
- Notification of Occupational Safety and Health (OSH) of serious harm as soon as possible and reporting within seven days. (You can send reports directly to OSH from the National Incident Database To notify serious harm, see www.osh.dol.govt.nz);
- Reporting of fatalities to the police.

2.8. Fire Safety

- 2.8.1 All camps must be equipped with fire-fighting equipment of the type and quantity approved by the local fire authority.
- 2.8.2 The staff of the camp must be familiar with the fire-fighting equipment and its use.
- 2.8.3 A plan of sleeping locations of both campers and staff should be on display.
- 2.8.4 There should be a written protocol for emergency evacuation.
- 2.8.5 It is mandatory that each camp have a fire drill including an evacuation brief and safety brief at the start of the camp.



2.9. Insurance

- 2.9.2 The Camp Committee should ensure that appropriate insurance will cover all aspects of the camp.
- 2.9.3 Some circumstances are potentially covered by Accident Compensation Corporation (ACC).
- 2.9.4 All camp attendees **must** be a financial member of Diabetes New Zealand, Diabetes Youth New Zealand, or local diabetes society to be covered by indemnity insurances held by Diabetes New Zealand. Subscription may be requested upon registration.
- 2.9.5 Insurance should cover any transportation vehicles used.

2.10. Motor Vehicles Used During the Camp

- 2.10.1 Any vehicle used for transporting staff and/or campers must be maintained in a safe condition; it must be registered, insured, and have a current warrant of fitness.
- 2.10.2 Every vehicle used for transporting staff and/or campers must be equipped with a first aid kit plus any other appropriate emergency equipment/medical supplies (also see sections 4.2.2 and 4.2.3).
- 2.10.3 Open bed trucks or trailers must not be used to transport campers and/or staff.
- 2.10.4 The seating capacity of the vehicle must not be exceeded and seat belts must be worn if fitted.
- 2.10.5 A back-up or support vehicle should be available in case of breakdown.
- 2.10.6 All drivers transporting campers and/or staff must hold a full driver's licence applicable to the type of vehicle being driven.
- 2.10.7 All drivers transporting campers and/or staff must obey the Road Code at all times.

3. Camp Staff

3.1. Selection of Staff

The Camp Committee is responsible for appointing staff.

The following staff members are essential for the safe and smooth running of the camp:

3.1.1 Clinical Staff - Medical Director/Physician, Diabetes Nurse Specialist(s), Dietitian(s), Registered Nurse(s), Night Nurse

All clinical staff should have clinical experience of - and a specific personal or professional interest in - diabetes in children and young people.

3.1.2 Non-clinical Staff - (Group Leaders and Camp Assistants) - Additional Volunteers with Experience of Diabetes in Young People

Ideal qualities sought in non-clinical staff and young adult leaders include the following:

- good role model
- show maturity and responsibility
- aged 16 years or over
- personal experience of diabetes



- holds a current First Aid certificate
- willing to attend at least one workshop or meeting prior to camp
- willing to have a police check conducted

3.1.3 Staff Ratios

General - there should be at least one diabetes nurse(or doctor) **and** one adult/leader/assistant per 10 campers.

Nursing staff - one Diabetes Nurse Specialist and one experienced Registered Nurse per 25 campers.

Night staff - there should be one night nurse and at least one night assistant.

If the number of campers is in excess of 25, staff numbers must be increased accordingly.

Staff ratios may be affected by age and experience of both campers and staff. These recommendations may be altered, should the Camp Committee deem this to be appropriate.

3.2. Roles and Responsibilities of Staff

3.2.1. Division of Responsibility

Responsibility should be divided as follows:

- **Medical** – activities carried out by clinical staff under supervision of the Medical Director and in liaison with the Camp Coordinator.
- **Recreational** – activities carried out by all camp staff under supervision of the Recreation Officer and/or in liaison with the Camp Coordinator.
- **Household** – activities carried out by Camp Staff and/or Site Staff under supervision of Housekeeper/Site Supervisor and/or Camp Coordinator.

3.2.2. Expectations of Staff

It is desirable for each camp to have a written statement of personnel policies and practices as they affect both the camp and staff member; these may be based upon a memorandum of agreement (see Appendix 1).

Staff members are expected to:

- have read and understood the current version of these guidelines;
- be fully aware of all specific camp policies and practices, rules and safety regulations (see section 2.2.7 and sections 2.6 - 2.10), and to comply with these at all times;
- appreciate the specific aims and objectives of the camp, as defined by the Camp Committee (see section 2.2.5);
- work creatively towards achieving educational objectives (see section 5.4).

It is desirable that all Camp Staff – including group leaders/camp assistants – arrive at camp at least two hours prior to the arrival of campers. This enables Camp Staff and Site Staff to become fully acquainted and to confirm roles and responsibilities.



All staff must be fully aware of the signs, symptoms and management of hypoglycaemia. All Camp Staff **and** Site Staff (especially those supervising specialised activities) should be provided with a Hypoglycaemia Management Protocol (see Section 4.6).

NOTE: It may be necessary to train Site Staff prior to camp, so that a basic understanding of hypoglycaemia, its causes and treatment, are understood in advance of the camp.

3.2.3. Specific Responsibilities of the Camp Coordinator and Clinical Staff

3.2.3.1. Camp Coordinator

The Camp Coordinator

- is responsible for the overall coordination of the camp –in the planning stages, and during the camp itself;
- must ensure there is clear communication between the staff;
- should know the whereabouts of all staff and campers at all times.

3.2.3.2. Medical Director/Physician

It is essential that the camp have a physician in residence, with up-to-date knowledge of diabetes management, and who is actively involved in the camp. The physician will usually assume the role of the Medical Director during the camp.

The Medical Director/Camp Physician

- is responsible for the overall health of the campers;
- will work closely with all members of the clinical team, with the camp coordinator, and with other staff, to ensure that optimum health is achieved for all campers during the camp;
- should ensure that the camp environment is conducive for the clinical staff to work together and communicate well with each other and the other members of staff;
- must agree the clinical guidelines, policies and procedures to be used in the medical management of campers;
- should be fully involved in the development of the educational program for the camp (see section 5.4), in line with the specific objectives for the camp (see section 2.2.5)
NOTE: this should be completed during the planning phase of the camp in conjunction with the Camp Committee;
- should be aware of the health status of all members of staff, as well as that of the campers.

In conjunction with the Diabetes Nurse Specialist, the Medical Director/Camp Physician is also responsible for:

- maintaining camp medical records;
- ordering and maintaining pharmaceutical supplies;
- altering insulin doses (except where older youths take responsibility for their own insulin adjustment, as agreed prior to camp);
- supervising the Registered Nurse(s);
- implementing the education program in line with the specific objectives for the camp.



3.2.3.3. Diabetes Specialist Nurse

The Diabetes Nurse Specialist will work closely with other members of clinical staff to oversee the following essential aspects of diabetes care for the campers:

- supervision of insulin injections;
- supervision of monitoring of blood glucose, and if appropriate, ketones;
- provision of appropriate care for diabetes-related health problems that may arise during camp.

In conjunction with the Medical Director/Camp Physician, the Diabetes Nurse Specialist, may also be responsible for further duties as described in section 3.2.3.2.

3.2.3.4. Registered Nurse

The Registered Nurse will work closely with the Medical Director/Camp Physician and Diabetes Specialist Nurse, and under their supervision.

Any general nurses that are not diabetes specialists, but have a special interest in diabetes, may require some pre-camp training.

The Registered Nurse will assist the Diabetes Nurse Specialist as required.

The Registered Nurse may be responsible for:

- maintaining first-aid equipment in a designated area;
- supervision of care for non-diabetes related conditions of campers, such as:
 - treatment of diarrhoea and/or vomiting;
 - dressings;
 - administration of non-diabetes related medications;
 - application of ointment/lotion.
- initiating first-aid treatment as and when appropriate.

3.2.3.5. Night Nurse

The Night Nurse should always be accompanied by a responsible adult when performing regular night rounds.

Campers should be checked at least every two hours.

The duties of the Night Nurse are under the direct authority of the Medical Director/Camp Physician, and should include:

- regular observation for hypoglycaemia;
- testing of any young person that may be at risk of (see box) or thought to be currently experiencing hypoglycaemia (see section 4.6).

Any episodes of hypoglycaemia should be treated and documented, as described in section 4.6.



The Night Nurse should be aware of individual potential problems that may arise as a result of hypoglycaemia, or independently of hypoglycaemia, such as:

- bedwetting
- sleepwalking
- nightmares

Risk Factors for Nocturnal Hypoglycaemia

- Known susceptibility to nocturnal hypoglycaemia;
- Bedtime blood glucose test < 8.0 mol/L;
- Previous nocturnal hypoglycaemia occurring at camp;
- Severe or repeated hypoglycaemia experienced during the previous day.

3.2.3.6. Dietitian

Each camp will ideally have an experienced dietitian fully involved with dietetic planning and ongoing supervision of meals and snacks.

Campers with special food requirements should be brought to the attention of the dietitian well in advance of the camp.

The dietitian may also be involved with educational aspects at camp (see section 5.4).

3.2.4. Specific Responsibilities of the Non-Clinical Staff

3.2.4.1. Group Leaders and Camp Assistants

The bulk of voluntary staff at camps will tend to fall into the category of group leaders and their 'assistants'. Group leaders and camp assistants may be youth leaders (peer group leaders), adults with diabetes or a special interest in diabetes, or medical/industry representatives.

Group leaders and camp assistants must be good role models, and have a good working knowledge and experience of diabetes.

Specific responsibilities of group leaders will usually include the following:

- To know the whereabouts of all of the group members at all times;
- To establish a good rapport with the campers in the group;
- To encourage a healthy team spirit within the group;
- To attend daily camp meetings as appropriate;
- To watch for the signs of hypoglycaemia in members of the group, and act accordingly (see section 4.6);
- To report anything untoward to the Camp Coordinator and/or Medical Director immediately.



Group leaders and camp assistants are encouraged to enjoy themselves and have fun – this rubs off on the campers and positively influences the success of a camp.

Group leaders should be able to take time out for their own socialisation as necessary (although this must be pre-organised with the Camp Coordinator and must be within certain guidelines i.e. no alcohol, illicit illegal drugs, or smoking).

NOTE: Industry Representatives

Industry reps are encouraged to participate in camps as group leaders/camp assistants; however they should be reminded that their role at camp is predominantly one of a supervisory nature. Direct promotion of any product(s) is not permitted, unless agreed beforehand with the camp director, and a specific time is set aside for this purpose.

3.2.4.2. Recreational Staff

The main role of the Recreational Staff is to organise appropriate development activities around set meal and snack times.

Potentially hazardous camp activities must be supervised by suitably qualified or experienced people, who are able to implement appropriate safety standards should the need arise.

NOTE: All activities should be supervised at all times by a responsible adult who can readily identify hypoglycaemia, and treat it confidently.

3.2.4.3. Housekeeper

The responsibilities of the housekeeper should include the following:

- coordination of day-to-day care of clothes and bedding;
- supervision of hygiene of toilet and shower facilities;
- ensuring camper's hygiene standards are maintained e.g. by supervising hand washing before meals;
- supervision of hygiene of washing-up area, ensuring frequent changing of washing-up water and tea towels as necessary.

NOTE: The kitchen should be staffed by an **experienced cook** who is capable of organising kitchen staff to prepare the required food for the said number of people at the required times. Liaison with the dietitian may also be required.

3.2.4.4. Camp Parents

Camp Parents assist in the general smooth running of camp by helping campers that may need individual attention, for example:

- at times when home sickness is experienced;
- if there is conflict with other campers;
- if the young person is feeling or experiencing social isolation.

An additional role of Camp Parents is the supervision of settling at bedtime, in coordination with the other staff.



Camp Parents are an integral part of the staff and should ideally participate in all consultative meetings with the organising Camp Committee and Clinical Staff both prior to and during the camp.

3.2.4.5. Transport Officer

The Transport Officer is responsible for the safe supervision of campers (by prior arrangement) to and from the camp, and during the camp. Also see section 2.10.

3.2.4.6. Financial Officer

The Financial Officer:

- should be part of the Camp Committee but does not necessarily need to be present at the camp itself;
- is responsible for the budget, coordination of fundraising, collection of receipts and the upkeep of detailed accounts relating to the camp;
- is required to contribute to the Camp Report (see section 2.2.8 and section 6).

3.3. Training

3.3.1. General requirements

The Camp Committee is responsible for ensuring that all of the Camp Staff undergo appropriate pre-camp training as necessary. Final agreement of the camp programme (see section 2.2.6) by Camp Staff and the Camp Committee may coincide with pre-camp training.

Each individual member of staff should be issued with an up-to-date copy of these guidelines, along with the specific aims and objectives of the camp, and the appropriate memorandum of agreement (see Appendix 1), prior to the start of the camp.

Any staff that will be attending camp for the first time must attend at least one pre-camp briefing or training session.

3.3.2. Pre-camp Briefing for Clinical Staff

It is desirable that the Clinical Staff meet in advance of the camp in order to establish roles and responsibilities under the direction of the Medical Director.

Education in pre-camp meetings should be supported with written information. This should include the following:

General

- A copy of these DYNZ Camp guidelines
- Aims and objectives of the camp
- Plan for routine diabetes care.

Education about diabetes

- Procedures for insulin administration under supervision
- Procedure for blood glucose/ketones testing including defined frequency of testing (at least four times daily – more often if unwell or hypoglycaemia suspected)
- If feeling “hypo” or unwell, management of “hypos” – prevention, detection and treatment
- Information regarding hyperglycaemia and ketones



- Procedure for documentation
- Hygiene
- Procedures for daily review of health and possible adjustments to regime.

3.3.3. Pre-camp Workshops for Non-clinical Staff and Volunteers

Basic training in the principles of diabetes management may be necessary for non-clinical staff and volunteers. Some coaching in leadership skills may also be valuable, depending on age and experience.

Roles and responsibilities of non-clinical staff, and general expectations of group leaders and camp assistants should be explained and clarified during pre-camp training workshops.

4. Medical Care at Camp

The Medical Director is responsible for coordinating and overseeing medical care at camp.

Medical management of campers should be sensitive and relevant to the needs of the young people. Any parental concerns should also be borne in mind.

In addition to registers held by members of the clinical staff, a central medical register should be maintained. All medically associated activities and occurrences must be fully documented.

4.1. Medical Facilities

4.1.1. Off Site

Prior to camp, the nearest hospital, medical centre, pharmacy, and out-of-hours emergency primary care provider must be identified. The distance from these facilities may have a bearing on the resources that will be required on site during camp.

Appropriate local medical personnel (paediatricians, primary care centres, and emergency departments) should receive prior notification of the camp – dates, venues, numbers of children, and medical staff in attendance.

4.1.2. On Site – the Medical Health Unit

There should be a separate area at the camp that is designated the Medical Health Unit. This facility should be suitably organised and equipped to handle diabetes related and non-diabetes related medical problems (the latter are likely to be primarily of a First Aid nature).

Blood testing equipment must be readily available in the Medical Health Unit.

Additional requirements of the designated Medical Health Unit:

- A sink, running water, and toilet facilities;
- At least one bed; a means of isolation for a child with an actual or suspected communicable disease while transport home is arranged (this should occur within 6 hrs);
- An area for medical records to be stored and updated;
- A storage area for medical supplies, to include a refrigerator;
- A private treatment area;



- There should be an *Emergency Plan* to hand;
- Key emergency telephone numbers must be displayed close by a telephone. *Money or a Telecom phone card must be immediately available if required to operate the telephone.* [NOTE: Do not rely on a cell phone; coverage for 021 and 027 phones differs, and it may be necessary to have both. It is suggested that coverage be checked before camp and all staff notified of signal strengths prior to camp];
- A list of local providers (see 4.1.1) and a map clearly defining their location should be displayed in the Medical Health Unit.

The medical director and camp coordinator should agree a plan to transport sick or injured individuals to the nearest appropriate medical care facility. Information clearly defining the location of the nearest facility should be readily available.

4.2. Medical Supplies

There should be adequate medical supplies available for the treatment of diabetic and non-diabetic health problems. The quantities of supplies will depend on the number of campers and the distance from local providers.

NOTE: All usual medication and supplies should be provided by the camper's family – this includes diabetes supplies plus anything required for any illness or condition other than diabetes. See section 5.5 for a checklist of medical supplies that would normally be brought to camp by the campers themselves.

4.2.1. Diabetes Supplies

Personal diabetes supplies may be the responsibility of the camper but always ensure that there are adequate "spares" available.

- Meters
- Meter batteries
- Test Strips
- Finger pricking devices plus lancets
- Record books or sheets
- Cotton wool
- Paper towels
- Glucagon kits (at least 1 per 5 people with diabetes)
- Ketone testing strips
- Insulin syringes
- Insulin pens & pen needles
- Insulins, including pen vials
- Insulin pump consumables
- Insulin pump batteries
- Glucose tablets (allow at least 30g per child)
- Glucose powder
- Emergency carbohydrate foods e.g. fruit juice, muesli bars
- Secure and rigid sharps container(s)
- 50% glucose vials and 10% dextrose bags for emergency plus appropriate tubing and needles for intravenous administration.



4.2.2. General First Aid Supplies

- Adrenaline (1:1000 solution)
- Hydrocortisone (1%)
- Salbutamol Inhaler
- Band Aids
- Bandages
- Dressing pads
- Scissors
- Adhesive Tape
- Insect repellent
- Antiseptic solution and cream
- Antihistamine tablets and cream
- Steri-strips
- Plastic spray dressing
- Laxative
- Paracetamol tablets and syrup
- Sun-block

4.2.3. Kits for Outings

- Blood glucose monitoring equipment
 - Strips and meter(s)
 - Finger pricking device & lancets
 - Cotton wool/tissues
- Wipes
- Insulin & syringes
- Container(s) for sharps
- Glucose – tablets and powder
- Glucagon kits
- Emergency carbohydrate foods e.g. fruit juice, muesli bars
- Whistle(s)
- Sun-block
- Insect repellent
- Fully stocked First Aid kit (see below)

Essentials for First Aid Kits

- Band aids
- Bandages
- Steri-strips
- Slings (component)
- Antiseptic solution
- Tourniquet
- Antihistamine tablets & cream
- Burn cream
- Dressings
- Scissors
- Adhesive tape



4.2.4. Other Supplies

- Phone cards or coins for phone box
- Torch
- Batteries
- Identity key rings or cards – for satchels
- Mobile/Cell Phone [NOTE: Coverage for 021 and 027 phones differs, and it may be necessary to have both. It is suggested that coverage be checked before camp and all staff notified of signal strengths prior to camp.]

4.3. Blood Glucose Monitoring

4.3.1. Objectives of Monitoring

The general aim is to avoid hypoglycaemia and symptomatic hyperglycaemia, particularly ketonuria.

Suggested **pre-prandial targets: 4.0 – 10.0 mmol/L**

Suggested **overnight range: 7.0 – 12.0 mmol/L**

*Individual targets may be determined by the clinical team
with consultation with parents*

NOTE: Tight blood glucose control is **not** the ultimate objective at camp, and it may result in recurrent hypoglycaemia.

4.3.2. Monitoring In Practice

Frequency of testing and the degree of supervision required will depend on the age, experience and abilities of each individual camper. Active involvement in monitoring should be encouraged in all young people with diabetes.

A minimum of 4 times per day - before meals and at nighttime – should form the basis of the testing routine for all campers.

Monitoring requirements for each camper should be assessed by the medical team prior to camp. Those using a basal/bolus or insulin/carb ratio approach to diabetes management may also need to perform post-prandial tests. Those on an insulin pump may also require additional testing (also see section 4.5).

An accurate meter must always be used for blood glucose measurements.

If the child or young person is unwell and/or ketotic, intensive blood glucose monitoring – at least hourly – may be necessary until the person is stable. Ketone testing should continue until ketonuria is absent or blood ketone levels return to normal. See section 4.7.

All test results should be recorded in the central medical register. Any action taken that is based on the test result must also be fully documented.



4.4. Insulin Adjustment

4.4.1. General Guidance

Insulin adjustment must be individualised, and carried out in conjunction with the camper. Dosage adjustments should be agreed by the Physician, Medical Director, or Diabetes Nurse Specialist, unless it has been agreed prior to camp that the camper will be responsible for his/her own insulin adjustments. See section 4.5 for guidance pertaining to young people using insulin pumps at camp.

Changes in activity levels and dietary intake will need to be taken into account. Other factors to bear in mind include previous level of fitness and metabolic control, the weather, emotional state of the camper (is the individual homesick or happy?), and the length of the camp.

Previous control should also be borne in mind when making adjustments to insulin dosage; a recent HbA1c level is useful in this context.

Insulin adjustment should always be made in order to try to achieve the individuals' agreed blood glucose targets whilst minimising the risk of hypoglycaemia. The camp environment usually requires a reduction in insulin in order to avoid recurrent hypoglycaemia, and a 'reduction protocol' may need to be agreed by the Medical Director in conjunction with the other clinical staff.

Dosage and time of insulin administration must be recorded in the central medical register, and in the supervising clinical staff member's register.

4.5. Management of Young People using Insulin Pumps

Detailed records of basal and bolus insulin must be kept, with changes to the normal routine being fully documented in the central medical register, and in the supervising clinical staff member's register.

4.5.1. Basal Insulin

- The usual formula for the proportional decrease to the insulin should be added as a 24 hour minus temporary basal at the start of camp. i.e. -30% .
- This decrease is to be adjusted each day in consultation with medical staff as per the usual reduction protocol for all children (see Section 4.4).
- The Diabetes Specialist Nurse should be the person responsible for setting the basal insulin each day.

4.5.2. Bolus Insulin for Meals

- The usual insulin/carbohydrate ratio at mealtimes should be used until patterns show that this needs to be changed.
- Note that children will be eating exercise snacks of 15 -30 grams of carbohydrate regularly throughout an active day WITHOUT a bolus being required; these are extra to normal meals that will be bolused for.



4.5.3. Bolus Insulin for Blood Glucose Correction

All blood glucose levels >13.5mmol/L should be followed by a blood ketone test - see Section 4.7.

- Children/young people on a pump should test before every meal and snack.
- A correction bolus need only be given if the blood sugar is over target (usually 7 mmol/L) and there has not been any other bolus in the last 3 hours.
- Any pump user with ketones should have correction done manually with an insulin pen or a syringe.
- Overnight, pumpers should be tested routinely at midnight and a correction given if outside the target. If a correction is required at midnight, the child should be tested again at 3 am.

4.5.4. Hypoglycaemia

See section 4.6 and Appendix 5.

NOTE: Some children may require a temporary decrease in basal insulin (i.e. -40%) for 1-2 hours after strenuous exercise.

4.5.5. Disconnection

- Children should disconnect their pump for all contact or water based activities.
- The pump should be given to the Diabetes Specialist Nurse, who is responsible for making sure it is reconnected at the end of the activity session.

4.6. Management of Hypoglycaemia

All staff must be confident and competent in treating a “hypo” without panic or hesitation. Some pre-camp training may be necessary to ensure that **all staff – including site staff** - understand the basics of hypoglycaemia, what causes it, what the signs and symptoms are, and how it should be managed.

For young people using insulin pumps, also see Appendix 5 for the management of hypoglycaemia.

Hypoglycaemia should be confirmed by a
**blood glucose test giving a result of
< 4.0 mmol/L.**

All episodes of hypoglycaemia must be documented with blood glucose test results accompanied by a full description of actions taken and/or treatment administered.



4.6.1. Standard First-Response Treatment for Hypoglycaemia

First-Response Treatment for a Hypo

- 1 Give 10g glucose (3 vita or Dextrosol glucose tablets)
OR
1 tablespoon glucose powder in 100ml fluid (e.g. water)
OR
125ml tetra pack of juice (13g CHO)
- 2 Wait 10 mins
- 3 Re-test blood glucose; if still < 4.0 mmol/L, repeat glucose administration as per step 1, and wait a further 10 – 15 mins.

NOTE: Do not give any food at this stage; giving food slows down the absorption of the glucose.

- 4 When blood glucose level is above 4.0 mmol/L a mixed carbohydrate and protein snack can be given if meal-time is more than 15 minutes away.
- 5 Monitor closely until stable.

4.6.2. Administration of Glucagon

During camp, glucagon may only be given by the Medical Director or Diabetes Nurse Specialist, ***unless other members of staff have been fully trained*** in glucagon administration, ***and the Medical Director has approved this responsibility prior to the start of camp.***

Glucagon needs to be administered to treat hypoglycaemia if:

- uncontrollable behaviour is exhibited
- the person is unable to swallow
- the person is fitting
- the person is unconscious.

For young children the dose may need to be calculated by weight – refer to protocol if necessary.

Contact medical personnel as per Medical Director's prior guidance.

NOTE: Be aware of the possibility of vomiting; lay the person in the recovery position if necessary.

Once conscious or sufficiently awake treat as described in 4.6.1 (if behaviour allows).

4.6.3. Administration of Intravenous Glucose

If necessary, glucose can be administered intravenously by a suitably qualified member of the clinical team. This responsibility must be previously agreed by the Medical Director/Camp Physician.



4.7. Management of Hyperglycaemia

4.7.1. Hyperglycaemia in the Context of Camps

In the context of camps, hyperglycaemia can be simply defined as a blood glucose level above the desirable range. A blood glucose level above 15mmol/L is generally recognised as indication to test for ketones and may require close monitoring. A level of 15mmol that falls by itself after a few hours is usually not cause for concern, however if blood glucose levels remain high (*persistent hyperglycaemia*) for a number of hours, the risk of diabetic ketoacidosis (DKA) is significantly high.

4.7.2. Testing Ketone Levels

Blood ketone testing is superior to urine ketone testing.

Blood ketone levels (β -hydroxybutyrate)

< 0.6 mmol/L *normal*

0.6 – 1.5 mmol/L *raised* ketone levels indicate potential problem

> 1.5 mmol/L *high* ketone levels indicate significant risk of DKA

4.7.3. Treatment of Hyperglycaemia with Ketonuria or Raised Blood Ketones

Treatment of Hyperglycaemia with Ketonuria or Raised Blood Ketone Level

Test urine for ketones – if ketones are present then the following guidance should be followed:

- Allow person to rest
- Give clear fluids to prevent dehydration (200 ml hourly)
- Increase fast-acting insulin (Novorapid or Humalog) - approx 10% of total daily dose given 2 hourly - as required
- Monitor blood glucose level hourly to identify the effect of treatment and monitor progress
- Continue to test for ketones until clear from urine or blood level <0.6 mmol/L

Follow the agreed Sick Day Plan (see section 4.7.4) if necessary.



4.7.4. Management of Hyperglycaemia and Sick Days

Prior to camp, the Medical Director/Camp Physician should work with the other Clinical Staff to agree a Sick Day Plan for campers. This should include guidance on:

- frequency of testing blood glucose and blood or urinary ketones
- insulin adjustment
- food and/or fluid intake
- when to request collection of young person by parents//guardians
- when to refer to emergency care.

Treatment of Hyperglycaemia and Sick Days

Take at least the usual insulin dose.

Test blood/urine for ketones – if ketones are present in the urine, or raised in the blood, then the guidance in section 4.7.3 should be followed.

If blood glucose levels > 12mmol/L give sugar free clear foods.

If blood glucose levels < 12mmol/L but the young person is unable to tolerate normal food intake, replace with fluids or soft foods to balance the effect of insulin 1 – 2 hourly:

- 1 glass (200 ml) ordinary lemonade (not sugar free or diet) or fruit juice
- 1 scoop ice-cream
- ½ cup ordinary jelly

Test blood glucose levels hourly.

If unable to tolerate even fluids by mouth, intravenous fluids will be necessary.

Observe for underlying cause – e.g. stress, infection.

When blood glucose levels stabilise at near-normal levels return to usual insulin dosage and routine management.

4.8. Medical Care for Illness or Conditions other than Diabetes

There must be an agreed plan for the administration of medications required for illness or conditions other than diabetes, including acute medical problems or emergencies.

All such medication should be given under supervision of the camp medical staff, and must be documented. Usual medical supplies should be provided by the camper's family; however some emergency and First Aid supplies should be made available on site (see section 4.2).



5. Campers

5.1. Applying for Camp

Communication with families is important to ensure that accurate information about the child's health is obtained. There should be ample opportunity for parents/carers to discuss their child's health before, during, and after camp.

5.1.1. Registration

All young people applying for camp will need to be reviewed by their health care team, before a place on camp can be confirmed.

The registration form must cover the following:

- Name, date of birth, residential address, and contact information for parents/carers
- Usual diabetes health care providers
- Up-to date insulin information
 - Type(s)
 - Usual timing and dosage
- Recent HbA1c test result
- Details of other medical conditions – e.g. asthma, epilepsy, allergies
 - Other medications
- Duration of diabetes
- Hypo information – usual signs & symptoms, any predisposition towards severe hypos that may include fitting
- Previous attendance at camps – include dates
- Family background/social history, including relevant information on domestic circumstances and/or situation at school
- Existing behavioural problems (NOTE: major problems may disrupt the camp experience for other campers)
- Other potential problems e.g. bedwetting
- Details of usual meal plan
- Immunisation status, plus details of any recent contact with infections such as chicken pox or vomiting and diarrhoea
- Emergency contacts.

See Appendices 2 and 3 for example registration forms, covering the essential aspects outlined above.

NOTE: It is essential that the clinical staff see all camp registration forms at least 2-3 weeks before the camp start date

5.1.2. Legal Consent

An appropriate legally binding consent form must be signed by the parent or guardian – this should include consent for any necessary medical, surgical or anaesthetic care in an emergency, should this be required during camp. (See Appendix 2)



5.2. Selection Criteria

The selection of campers should be made jointly by the Camp Committee and the Camp Staff.

5.2.1. Inclusion Criteria

The needs of the entire group of camp participants must be considered, as well as the personal needs of a given individual. Thus, if one individual has the potential to disrupt the entire event, the inclusion of that individual should be carefully reviewed.

Consider the following:

- This to be a first camp experience
- Newly diagnosed
- Social reasons
- Geographical (consideration to those in remote areas)
- Age (consider giving priority to those who may not be eligible next year)
- Exclusion from previous camps on account of numbers
- Recommendation from young person's health professional.

5.2.2. Exclusion Criteria

- Exceptional behavioural or medical grounds
- On account of age or gender ratio.

5.3. On Arrival at Camp

Parents/guardians must be encouraged to bring their children to camp if possible. This is important - parents/guardians are given the chance to meet members of the clinical staff to discuss their youth's health, diabetes care, and current diabetes knowledge and management abilities. This in turn provides the opportunity to assure the parents/guardians that their youth's individual needs will be met.

NOTE: Equally, at the conclusion of the camp, parents should be encouraged to collect young people and take the opportunity to discuss their camping experience with both clinical and non-clinical staff that have been spending time with the young person.

5.4. Education at Camp

Camps clearly illustrate the successful concept of diabetes education away from the formal setting. Much of the learning process occurs spontaneously in the environment created during general camp activities.

Each camp provides new opportunities for all participants (including the staff) to learn more about living with diabetes, and the challenges that this presents.

Camp staff may draw on creative methods of imparting and reinforcing diabetes knowledge – e.g. through the use of crosswords, quizzes, role plays.



Educational objectives should be aligned with both the general and specific aims and objectives of the camp (see sections 1.3 and 2.2.5).

5.4.1. General Objectives

- To provide and reinforce diabetes knowledge and management skills in a camp setting;
- To encourage independence and the development of self-reliance skills;
- To reinforce that diabetes is a condition that can be controlled with proper self-care;
- To foster a positive attitude towards having diabetes, promoting the fact that having diabetes does not limit the potential achievement of an individual.

5.4.2. Detailed Objectives

Specific educational objectives should include the following:

- The importance of blood glucose monitoring and control
- The relationships between food intake, exercise and insulin
- The factors relating to the development of hypo- and hyperglycaemia
- Signs, symptoms of hypo- and hyperglycaemia
- Management of hypo- and hyperglycaemia
- Management of food intake
- Blood glucose management during exercise/sports
- The whys and wherefores of:
 - Injecting insulin
 - Blood glucose monitoring
 - Ketone testing.

5.5. What to Bring and WHAT NOT to Bring to Camp

The Camp Committee should compile a list of what to bring and what not to bring to camp. This will be appropriate to the type of camp and the age group of the campers.

6. Evaluation

Evaluation of camps is an essential part of the process.

Evaluation informs future camps and promotes the advancement of diabetes camps for young people across New Zealand.

The Camp Committee should be able to use the results of a formal evaluation to make recommendations for future camps or events. The evaluation should be fully documented within the camp report (see section 2.2.8).



6.1. Aims of Evaluation

- To provide feedback to the Camp Committee on the overall success (or otherwise) of the camp;
- To assess whether the objectives of the camp were achieved;
- To inform future camp organisation.

Specific aims of the evaluation should be drafted at the time of defining the objectives for the camp (see section 2.2.5).

6.2. Methods of Evaluation

The precise methods and timing of data collection for evaluation purposes should be decided during the initial stages of planning (section 2.2).

6.2.1. Collection of Data

Evaluation of camps may include **subjective** and **objective** assessments, involving

- campers
- staff
- parents
- other caregivers

Information may be gathered through

- interviews
- questionnaires
- documented observation during camp
- written reports by camp staff
- written statements from campers

6.2.2. Interpretation of Evaluation Data

Evaluation data may be interpreted in the light of

- specific aims and objectives
- age range of the campers
- expectations of the campers
- previous camps, especially if any of the aims or objectives were based on recommendations from previous evaluations

6.3. Implementation of Evaluation Data

The evaluation of each camp should be implemented in connection with the results of previous or other concurrent evaluations in order to benefit all of those involved in the organisation, management and participation of camps for young people with diabetes in New Zealand.



7. References

- Outdoor Activities – Guidelines for Leaders. SPARC, 2005.
- Haddock, C., Outdoor safety – risk management for outdoor leaders, 2004.
- Safety and EOTC. A good practice guide for New Zealand schools. Ministry of Education, 2002.
- Health and Safety Code of Practice for State Primary, Composite, and Secondary Schools. Ministry of Education, 1998.
- Worksafe at School. Ministry of Education, 2002.
- Camping Standards – Guidelines for the conduct of camps for children and adolescents with diabetes. Diabetes Australia NSW / National Diabetes Camping Committee for Children and Adolescents, 2007.
- Maslo and Lobato. Diabetes summer camps: history, safety, and outcomes. Paediatric Diabetes, 2008. DOI 10.1111/j.1399-5448.2008.00467.x
- The Safe and Healthy Camp. Book User Friendly Resource Enterprises Ltd, 1998.
- APEG: Clinical Practice Guidelines. Type 1 Diabetes in Children and Adolescents. March 2005.
- American Diabetes Association. Diabetes Care at Camps. Diabetes Care Volume 27, Supplement 1. January 2004.



Appendix 1

MEMORANDUM OF UNDERSTANDING

Group leaders/Camp assistants/Industry representatives

Thank you for coming on the children’s diabetes camp. Without your valuable input, the children would not have this great experience. In order for everything to run smoothly and safely we have a few rules.

Whilst on camp, you will be allocated to a group of children
This group will consist of a nurse, team leaders and approximately 10 children.

The **nurse’s** main responsibility is to oversee all the blood glucose levels, drawing up and administration of insulin and treatment of hypoglycaemia and hyperglycaemia.

The **leader’s** responsibility is to assist the nurse in all these areas.

ONLY A NURSE MAY GIVE AN INJECTION TO ANOTHER PERSON.

Leaders’ main responsibility is to be with the children during the day, and overseeing and assisting them with the activities.

Please be prepared to help the children wash their hands, test and record their blood glucose levels, and observe the drawing up of insulin in children who are proficient. Each dose of short and then long acting insulin **must** be checked by nurse or leader.

ONLY nurses will **assist** children to do injections.

NO INSULIN INJECTIONS are to be given **UNTIL THE NURSE GIVES THE OK.**

The nurse will make the decision about the timing of injections prior to meals. Please make sure the children do not give insulin until the right time.

All these children are patients of medical teams on camp. They are on an individual regime that is tailored for them in their particular circumstances. Please do not take it upon yourself to make other treatment suggestions. You are not a health professional. Remember that everyone’s diabetes is different.

I accept and understand the responsibilities detailed above

SIGNATURE: _____

DATE: _____

NAME: _____



Appendix 2

CAMP REGISTRATION FORM: Youth/Teen camp

GENERAL INFORMATION:

Name of child _____ Age _____

Diabetes Clinic Doctor: _____ Hospital: _____ Phone: _____

Family Doctor/Practice: _____ Phone: _____ Allergies: _____

Date of diagnosis: _____ Hospital admissions in past 12 months - Yes / No (if yes supply details) _____

Any special needs / concerns: e.g. requires a caregiver, allergies, bedwetting, sleepwalking, asthma, other (please detail)

Has your child attended previous camps? Yes / No - if yes please supply details (relevant domestic or school details which will help the camp team) _____

List your child's usual sporting interests / physical activities: _____

Gauge of child's fitness level (1= very fit, 2 = moderately fit, 3 = moderately unfit, 4 = very unfit)

1.....23 4..... (please circle one)

Can your child swim? Yes / No

List any hobbies, crafts or activities your child enjoys / may enjoy: _____

Are there any special fears or dislikes? _____

Does your child get carsick? _____

Emergency contact name and contact details: _____



DECLARATION BY PARENT OR GUARDIAN:

I, would like to apply for

To attend theto be held at from

I understand that (name of society), all health professionals and members of the camp team will exercise all due care but will not be liable for any injury to them or damage to their property. As the (name of society) is liable for any damage caused by campers on camp, I further indemnify the (name of society) if my child is found to be responsible for that damage.

SIGNED..... Parent or guardian

Date.....



CURRENT INSULIN REGIMEN:

Young Person's Name: _____ Age: _____

	TYPE / NAME OF INSULIN(S)	NUMBER OF UNITS GIVEN	
Pre breakfast dose			Uses syringes (please tick)
Pre breakfast dose			
			30 unit syringes
			50 unit syringes
Pre lunch			100 unit syringes
			Insulin Pen/s
Pre tea / dinner			Yes / No
Pre tea / dinner			Type of pen
		
Evening / pre bed			Inject ease used
			Yes / No
Extra's/adjustments usually made. Give example/s			Insulin Pump
			Yes/No



Does your child give his / her own injections? Yes / No

Does your child draw up their own insulin/s? Yes / No

What injection site/s are used? _____

Frequency of home blood glucose testing: _____

Does your child require help with testing? Yes / No

Has your child had any episodes of Diabetic ketoacidosis / large amounts of ketones present within the last year? Yes / No

Has your child had any severe hypos requiring Glucagon within the last 12 months?

Yes / No - If yes - what were the circumstances?

Last HbA1c test result: _____

What are your child's hypo symptoms? _____

Does your child recognise hypo symptoms? Yes / No

What treatment does your young person prefer to use to treat hypos? _____

Do you usually adjust insulin and / or food for extra activity? If yes give examples _____

Duration of Diabetes? _____

Any comments relevant to management of his/her diabetes? _____



OTHER MEDICATIONS

Is your child on any other medication? Yes / No - (give details if yes) _____

Types/s: _____ Dose/s: _____ Times: _____

Please note: Sometimes it is necessary in a camp setting to change a child's insulin dose or food intake to compensate for the change in activity level he / she will experience. If you have any hesitation / concerns about this please contact your Diabetes Educator directly.



DIETARY INFORMATION:

Young Person's Name: _____ Age: _____

Usual Dietitian's Name: _____ Hospital Clinic: _____

Please write an outline of usual foods / fluids in boxes below:

If your child uses carbohydrate : insulin ratios please also write these below:

BREAKFAST:	LUNCH:	DINNER:
MID MORNING SNACK:	MID AFTERNOON SNACK:	EVENING SUPPER SNACK:

Does your child have coeliac disease? Yes / No

Does your child have any allergies to food / drinks? Yes / No - If yes please specify (include symptoms):

Please list favourite foods: _____

Please list food dislikes: _____

Any other comments: _____

We try to provide meals that all young people enjoy but we may be unable to accommodate all dislikes.

Please note that all information requested on these forms is essential in helping plan a safe camp. Thank you for completing in full, all aspects of the applications



Appendix 3

REGISTRATION FORM: Family camp

FAMILY NAME: _____

NAME OF PERSON WITH DIABETES: _____

NAME	RELATIONSHIP (e.g. mum, brother, aunt, etc)

Please note that families are responsible for their own health and welfare including the management of their diabetes.

All food will be available including snacks and extras, but please bring all your own personal insulin, testing equipment , ketone stix, glucagen etc.

SLEEPING

Cabins (you may have to share with another family)

FOOD

Other than diabetes-related food, does your family have any other food preferences, e.g. Vegetarian, coeliac?

If you have any queries regarding camp then please contact the Camp Coordinator.



Appendix 4

Sample Budget

This is a sample budget catering for young people between the ages of 8 and 13 with staff members (no paid staff).

The following items need to be considered when budgeting for a camp for young people.

- Accommodation & food (the cost here will vary considerably especially if using Health camps)
- Activities off site
- Night Nurse costs

Other costs (sample only)

• Name Tags	40.00
• Casual Meals	50.00
• Medical Supplies	400.00
• Hypo emergency foods e.g. Glucose Tablets	200.00
• Stationery	50.00
• Stamps	100.00
• Telephone Calls	100.00
• Photocopying	100.00
• Activities both on and off campus	? Obtain quotes

Optional costs (samples only)

- Certificates and Gifts (These costs and items to be decided by the camp committee)
- Photos and developing (consent to publish **MUST** be obtained from parents)
- T-shirts
- Satchels

Many of the above items may be donated or sponsored but should be budgeted for to get a true cost of the camp.

NOTE: If health professionals are brought in from outside your own area, you may need to pay them. It may also be necessary to pay for a night nurse or his/her expenses.



TIME FRAME

The following points should also be considered

- Check that any DHB funding is available.
 - Notify medical staff of proposed dates (try do this 12 months in advance)
 - Once the medical staff are confirmed book the venue and form a camp committee
 - Start to source funding as soon as possible. A letter may be needed to verify that the camp is taking place.
 - Initial expression of interest to camp; send out through DNS/Diabetes Youth NZ groups and Support groups four months before camp, to be received back 8-10 weeks before camp
 - After the selection of young people has been decided send out detailed applications to be received back six weeks before camp
 - This enables time for the medical staff to familiarise themselves with the young peoples' details.



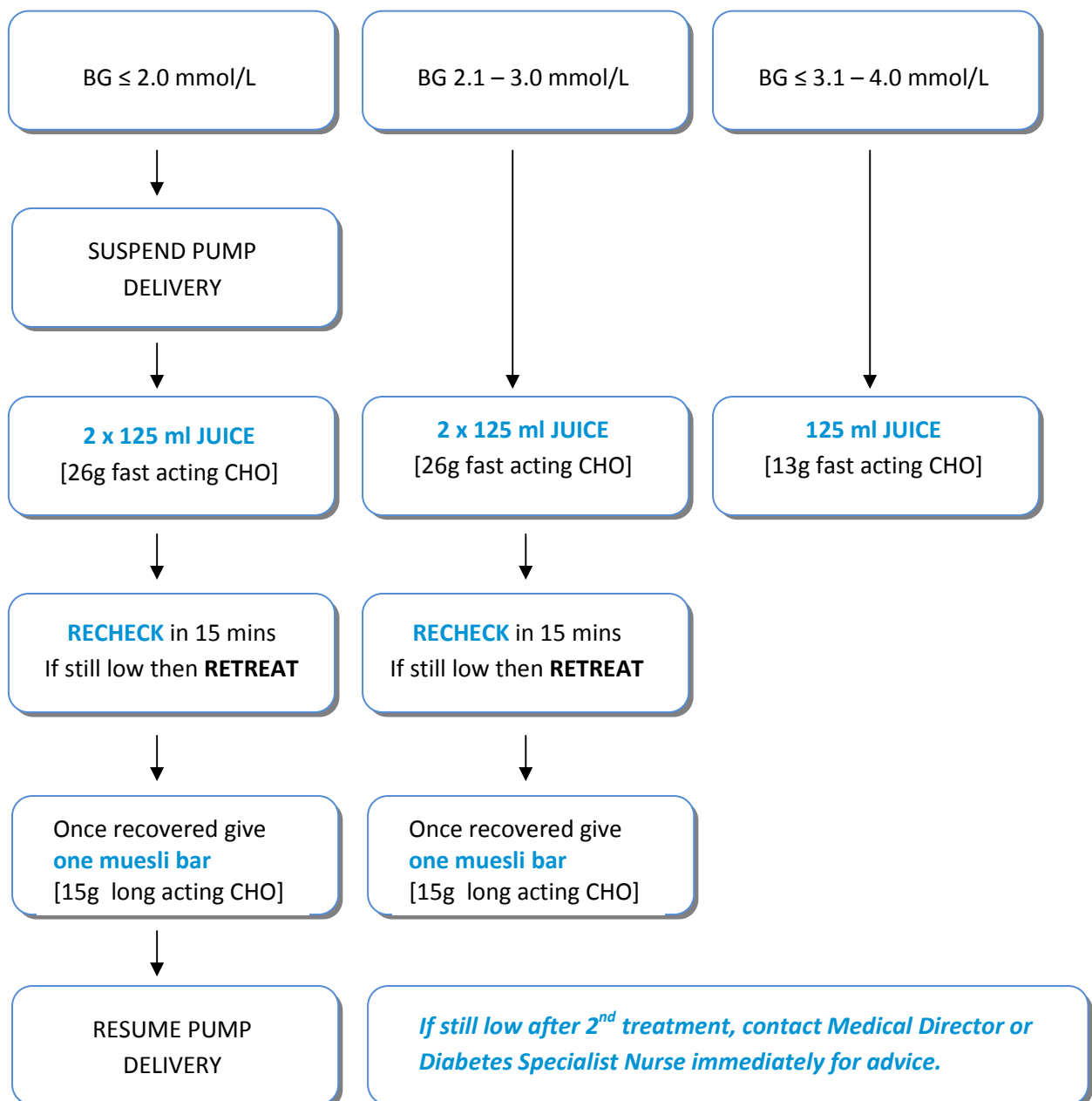
Appendix 5

Managing Hypoglycaemia in Young People on Insulin Pumps

Hypoglycaemia

DAYTIME PROTOCOL FOR PUMP USERS

For use when child conscious and able to swallow

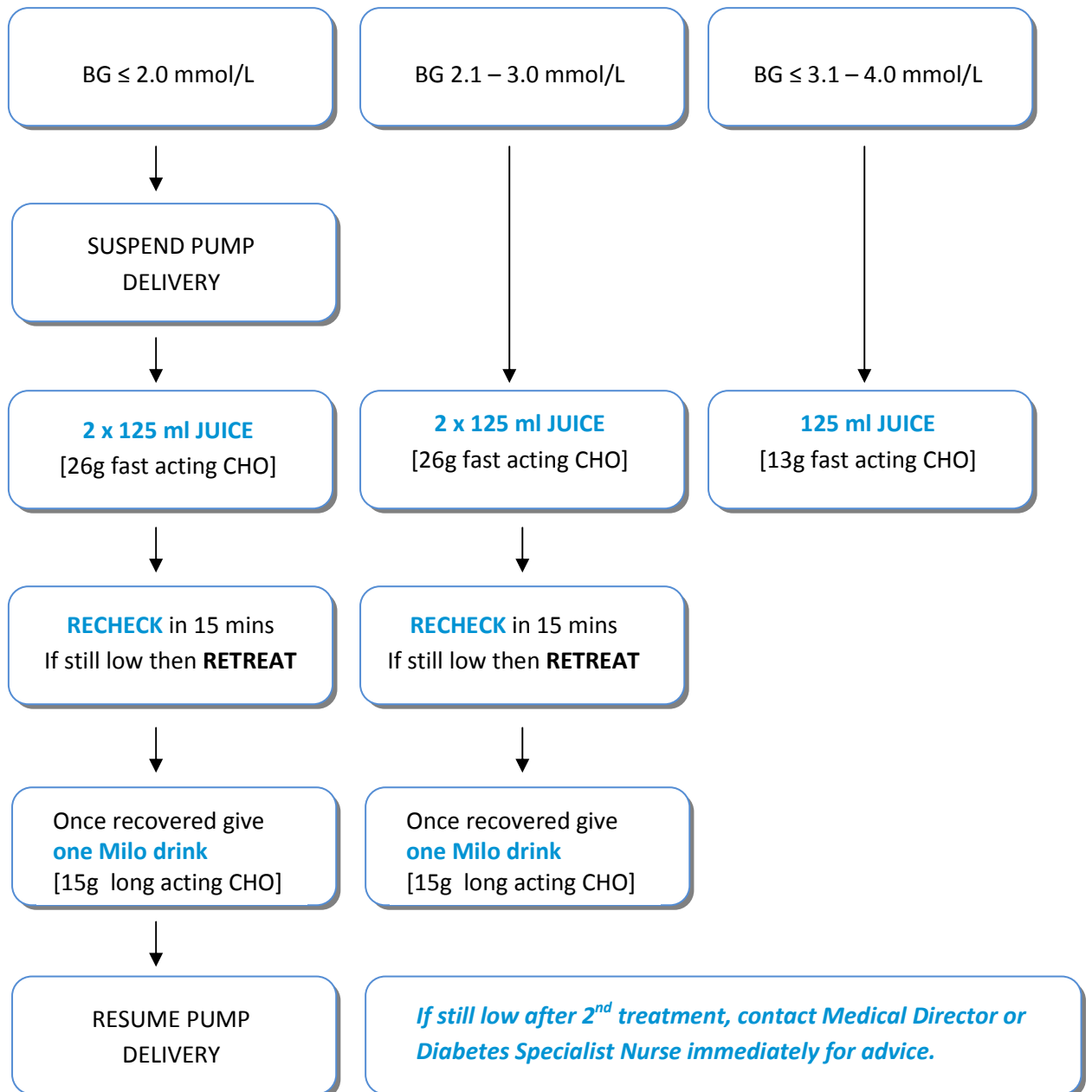




Hypoglycaemia

NIGHTTIME PROTOCOL FOR PUMP USERS

All children on pumps should have blood glucose levels tested at midnight.





Appendix 6

PHOTOGRAPHY PERMISSION FORM

Name of Camper: _____

Address: _____

Contact number: _____

E-mail address: _____

If the camper is under 16 years old, please give date of birth of individual and name and contact details for parent/guardian:

Date of birth: _____

Name of parent/guardian: _____

Contact number: _____

I permit Diabetes Youth New Zealand to take/use photographs of myself/my child in Diabetes Youth New Zealand or Diabetes New Zealand publications and/or publicity material.

SIGNATURE: _____

DATE: _____

NAME: _____

(must be signed by parent/guardian if individual is under 16 years old)



For DYNZ internal use:

Photographer: _____

Date: _____ Location: _____

Subject: _____

Copyright: _____



NOTES