

**- My View -**  
**COVID-19's Emotional Impact:**  
**Recognizing and Coping with Feelings**

Linda Erceg, RN, MS, PHN

COVID-19, a universal incident, has touched everyone. Some call it a shared trauma. It's a long-duration event. Nothing about it feels "normal" because we've not experienced it before (it's novel). Because information about COVID-19 continues to evolve, constant change is part of its profile. In addition, people who care for others, let alone oversee business matters, often feel a burdensome responsibility to make "right" decisions.

These disruptions are stress-inducing, some triggering more stress than others. How a person emotionally responds may feel like riding a roller-coaster. Sometimes things feel okay, sometimes it feels as though things are careening out-of-control, and other moments it's like bouncing from one emotional rail to another depending on the crisis at hand.

These emotional reactions are felt by capable-of-everyday-functioning people — in other words, everyone. Those who cope with a mental, emotional, social health (MESH) concern may have a different response. Their feelings may be more augmented or even blunted by COVID-19. These folks may feel less empowered because they perceive more limited options. Their resiliency may be limited, resulting in lower tolerance or quicker emotional outbursts. The list goes on.

The point is that EVERYONE has an emotional response — sometimes several emotions — to COVID-19. In addition, some experience their responses to a greater degree than others.

As a result, camp professionals are navigating an emotional mine field. While we seek to understand and cope with our personal feelings, we also have to make decisions that touch the lives and feelings of others, especially the campers and staff who have a strong affiliation with our camps. While emotional navigation may feel raw given the uncertainty amid this pandemic, such navigation will continue for the next 12–18 months as we adjust to a world in which COVID-19 exists.

Preparing for long-term COVID-19 impacts should be on every camp professional's mind. We need to identify and explore what people are feeling (including ourselves). We must understand what behaviors are used to communicate those feelings and then consider strategies that can be utilized, both prior to and at camp, to minimize the deleterious impact of associated emotions. Note the word "deleterious." Emotions aren't good or bad in themselves; it's how a person behaves as a result of that emotion that results in a positive or negative impact. For example, everyone feels afraid at some point. The ability to label that fear — of thunder, of death, of losing one's livelihood, etc. — ought to motivate the individual to take actions to minimize, if not eliminate, the fear. So, one learns about thunder, talks with trusted people about death, and actively tries to secure one's livelihood. Failure to do so means the fear is not addressed, thus setting the stage for continued fear and inadequate or inappropriate adaptation.

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## - Editorial - An Attitude of Gratitude

“It’s been a tough year.” Chances are you’ve heard this phrase uttered before, and perhaps it has even crossed your lips a time or two, which is completely understandable given the current state of the world. Yes, it’s as plain as the masks on our faces when we’re around other people — 2020 has packed a wallop in the challenges department. COVID-19, racial discord, natural disasters, the election (regardless of which way your politics lean) — it’s enough to make some of us want to head to a tropical island and bury our heads in the sand (if travel wasn’t frowned upon). And who could blame us for focusing on the negative in the face of such trying times?

Well, our bodies, for one.

According to the American Heart Association, “Some neuroscience experts think our brains focus on negative information as a way to remember pain so we can avoid it in the future. They call this the ‘negativity bias’” But taking a deep dive down the negativity rabbit hole can lead to depression, a weakened immune system, and poor heart health (American Heart Association, 2020).

So, what’s a pandemic-weary, socially starved, merriment-missing person to do? Well, I may have said it once or twice in past issues of *CompassPoint*, but either way it bears repeating:

practice gratitude.

In a time of physical distancing, “Gratitude is an emotion of connectedness, which reminds us we are part of a larger universe with all living things,” said *Psychology Today* contributor Melanie Greenberg, PhD.

“Regular practice of gratitude can change the way our brain neurons fire into more positive automatic patterns. The positive emotions we evoke can soothe distress and broaden our thinking patterns so we develop a larger and more expansive view of our lives” (Greenberg, 2011).

In other words, focusing on the things we are grateful for makes it easier to know in our guts that “this, too, shall pass.” We *will* get back to a place where we can freely hug our friends and belly laugh to our hearts’ content unfettered by face masks and plastic shields. While we may not have reached that nirvana just yet, hope is on the horizon.

In the meantime, the holidays are a great time for us each to take a pause and reflect on the people and lessons in our lives for which we are grateful. Greenberg said, “Gratitude can lead to feelings of love, appreciation, generosity, and compassion, which further open our hearts and help rewire our brains to fire

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## – My View –

### **COVID-19's Emotional Impact: Recognizing and Coping with Feelings**

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Applying this to our pandemic-driven emotions may be more challenging because COVID-19 impacts are long-standing. Consequently, people have learned to adjust and function while physically distanced, to wash hands more frequently, wear face masks, and exist with limited access to things like restaurants, sporting events, and large (more than 10 people) get-togethers. Indeed, some people may become so acclimated to COVID-19 protections that they'll have trouble readjusting when the protections are no longer needed. Consider, for example, the camper who has been physically distanced from others for the past 3–5 months and then comes to camp where being part of a group — even one as small as 10 people — is required. We can expect that child to be somewhat wary, standoffish, or even belligerent.

With this in mind, we need to consider how we'll reintegrate campers and staff to camp's group-based, high-touch, interactive experience where people work in close proximity to accomplish great things. How might we accomplish this given residual COVID-19 impacts? Help may lie in the grid "Assessing COVID's Emotional Impact & Responding to Those Feelings" (see Table 1 on pages 4–5). Consider your camp and first explore the emotions felt by camp leaders and the behaviors used to communicate those feelings to others (camp directors/leaders can fill the grid out themselves). Then explore ways to address each feeling both at home and when at camp. Then use the grid again in concert with your administrative team and your camp's mental health professional; explore the emotional landscape of your campers, staff, and the parents of campers. As you do so, keep in mind that some emotional responses will be adaptive; these tend to support the individual's sense of well-being, resiliency, and hopefulness. Capitalize on those responses. Other feelings may be maladaptive. These often have a negative impact in that they set the person up for problems once the threat of COVID-19 has been mitigated. As previously discussed, fear is a good example. For some, their fear is motivating; it makes them do things to address the fear. For others, fear causes them to freeze or withdraw; they will not cope with but bury or avoid their fear.

The point is to understand the scope of emotions felt by your camp community and develop strategies to help people navigate those emotions in a supportive, assuring, and blameless manner. Doing this builds your repertoire of MESH-responsive skills which, in turn, improves the camp experience for your campers and the staff working with them.

Exercises such as this must reflect the social determinants of the camp's community. For example, the skills of staff, experience of camp leaders, age range(s) of campers, home-

accrued COVID-19 history, and the group's innate resilience, as well as their self-confidence and competency (hopefulness), all contribute to how one navigates COVID-19's emotion potentials. Consequently, grids completed by one camp will often look different from those done by and for another camp.

Finally, be sure to access the knowledge of a MESH professional when doing this work. These folks are skilled at noting and interpreting behaviors. They're also adept with making a distinction between expected (normal) behaviors and pathology and linking behaviors with the person's developmental stage and individual needs. In addition, MESH professionals are used to identifying supportive interventions as well as recognizing practices that may backfire.

The bottom line is readiness to provide support for campers and staff. They need to be supported, not submerged, in caring concern and understanding — and coached when their own coping skills flag. This can only happen when camp professionals are prepared.

*Content for this article was informed by a 14 May 2020 webinar called "Support for Camp Directors" presented by Bob Ditter, Tommy Feldman, and Sheila Tollman. Their sensitive and inclusive acknowledgment of our "all over the board" feelings spurred my thinking. I am grateful to them for opening my eyes and getting me to consider the responses of campers and staff too. We'll eventually adjust to a new normal; let's support everyone in that process. Your comments are welcomed by emailing [erceg@campnurse.org](mailto:erceg@campnurse.org). May your today be better than yesterday and your tomorrows better yet!*

Table 1.  
**Assessing COVID's Emotional Impact & Responding to Those Feelings**  
 r/t = related to

This grid was completed for this group of people (check one):  
 Camp Leaders  Campers  Staff  Camper Parents  
 Date Completed \_\_\_\_\_

Emotion	Behavior(s) Person may Exhibit at Camp	At-Home Strategies to Address the Feeling	At Camp:	
			Strategies that Reduce the Potential for the Emotion	Strategies to Relieve, Reduce the Emotion when it Emerges
<b>EMOTIONS that tend to have NEGATIVE impacts for the individual</b>				
<b>FEAR</b> r/t being around others; passing COVID-19 to others; its impact on business/livelihood.				
<b>WORRY, ANXIETY</b> r/t sense of helplessness, hopelessness; no matter what, it won't make a difference.				
<b>*GRIEF, LOSS</b> r/t death(s) from COVID; loss of community, friends, anticipated experiences.				
<b>ANXIETY</b> r/t consuming thoughts of personal mortality.				
<b>HEIGHTENED SENSITIVITY</b> (vulnerability) r/t perceived threats.				
<b>NEED FOR REASSURANCE</b> r/t living in a constantly changing environment.				
<b>EXHAUSTION, POOR SLEEP</b> r/t constant coping, decision-making, & on-going threat no matter what one does/doesn't do.				

<b>INDECISIVENESS</b> r/t fatigue from prolonged stress exposures.					
<b>OVERWHELMED</b> r/t on-going perception of threat(s).					
<b>OTHER EMOTIONS:</b>					
<b>EMOTIONS that tend to have POSITIVE impacts for the individual</b>					
<b>FEAR</b> r/t motivating one to take appropriate risk-reduction & self-preservation actions.					
<b>HOPEFULNESS</b> r/t sense of “getting through this” using personal assets.					
<b>RESILIENCY</b> r/t use of personal coping skills to “bounce back” from perceived threats.					
<b>ENJOYING OTHERS</b> r/t seeking meaningful connection while physically distanced.					
<b>SELF-ASSURANCE, SELF-CONFIDENCE</b> r/t personal capacity to handle threatening situation.					
<b>OTHER EMOTIONS:</b>					

\***GRIEF, LOSS:** Varies based on stage of grief/loss the person is experiencing. This may include expression(s) of denial, anger, deal-making, sadness, and/or acceptance.

## Use of Non-Pharmacological Interventions and Personal Protective Equipment by Camps in the Summer of 2020: Selected Findings from ACN’s Study of Camp Health Care Practice Following the Onset of COVID-19

*Ali Dubin, Barry A. Garst, & Tracey Gaslin*

This fall, the Association of Camp Nursing surveyed members about camp health care practices in the summer of 2020 following the onset of the COVID-19 pandemic. The 181 survey respondents were asked a range of questions about

how COVID-19 impacted their camp health care practices. This research brief provides select findings from the study about camp use of non-pharmacological interventions (NPI) and personal protective equipment (PPE). These findings

Figure 1. Frequency of Camp Use of Non-Pharmacological Interventions (NPIs) in the Summer of 2020 (Scale of 1-5, where 1 = never, and 5 = always)

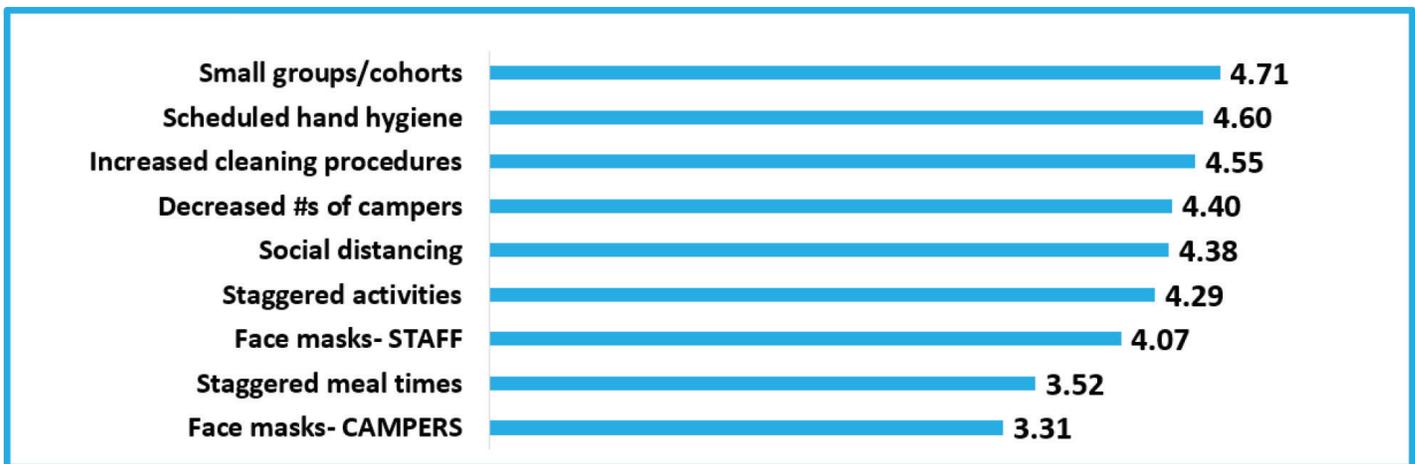
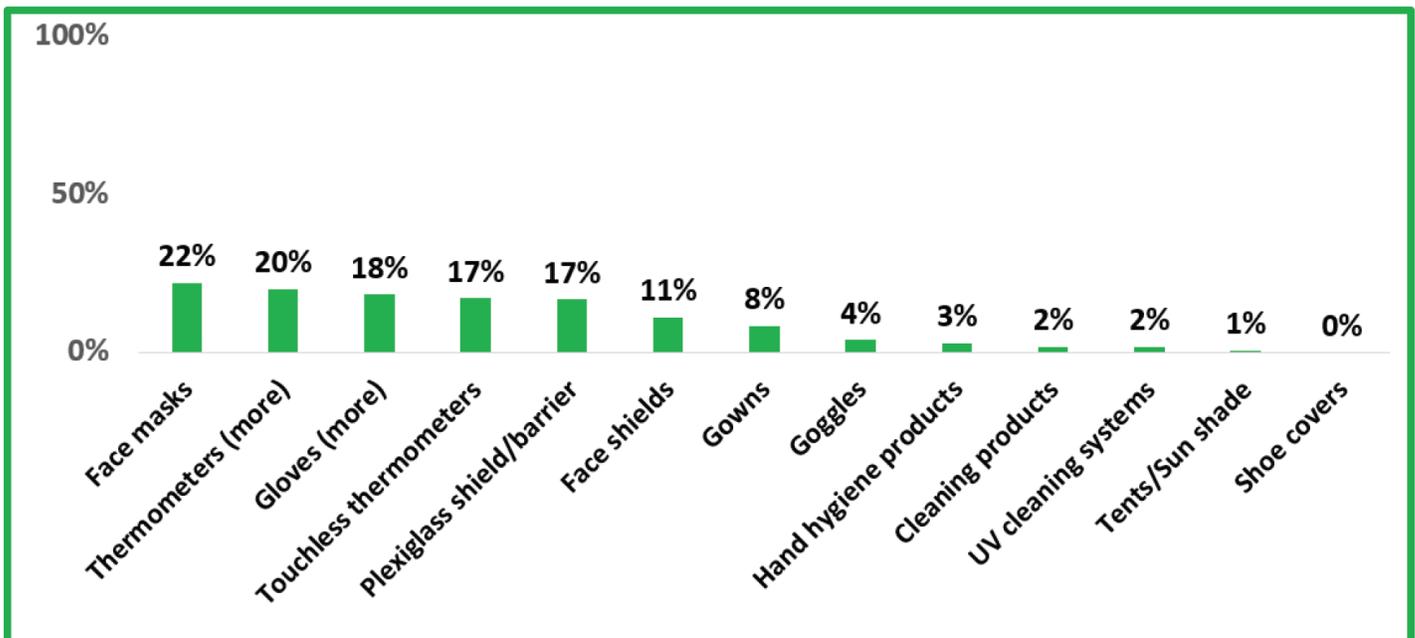


Figure 2. Camp Health Center Use of Personal Protective Equipment (PPE) in the Summer of 2020\*



indicate that many camps chose to alter their programming and operations, and to some extent their health care procedures, to safely run camp during COVID-19.

The use of small groups or cohorts (also known as pods, families, and villages) was the most frequently used NPI implemented to reduce the spread of COVID-19 among campers and staff (see Figure 1). This cohort strategy was frequently supplemented by a decreased number of campers and social distancing. Additionally, many camps scheduled times for hand hygiene and increased their regular cleaning procedures. Staggered activities and the use of face masks for staff were other common procedures, with staggered mealtimes and the use of face masks for campers happening less frequently. The lower rate of camper face mask usage may be tied to cohorting, which allows small numbers of campers and staff (usually 8–15 people) to navigate the camp experience together without having contact with other cohorts. Many camps decided to allow campers to remove their masks while in their cohorts. The camper face-masking rate may also be related to times where campers would not be required to wear masks, such as while eating, sleeping, or swimming.

Additionally, in camp health centers there was an increase

in personal protective equipment use, although it was not on the same scale as programmatic changes (see Figure 2). Roughly one-fifth of camps reported using face masks in the health center (22 percent), using more thermometers (20 percent), and using more gloves (18 percent) than in previous summers. Some camps chose to install plexiglass barriers (17 percent), while a few used face shields (11 percent) for physical barriers between health care providers and patients. The rates of use for additional hand hygiene products or additional cleaning products were extremely low, suggesting that hand hygiene and cleaning procedures in health centers are priorities every summer, and those procedures were adequate for COVID-19. Very few camps used UV cleaning systems to sanitize instruments or areas within the health center, suggesting that either these systems were cost prohibitive or not deemed necessary.

These early statistics begin to help us understand successful risk-mitigation techniques that allowed camps to operate during a global communicable disease event. Nursing has long reinforced preventative care measures, and these data lend insight to how we might move forward into summer camp 2021.

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in more positive ways” (2011). That’s a pretty amazing gift we can give ourselves and others.

Then let’s keep the positivity going after the holidays by taking deliberate steps to make being grateful a habit. Here are just a handful of ways to mindfully practice gratitude (Conlon, n.d.):

- Smile more often.
- Notice the beauty in nature each day.
- Avoid negative media and movies with destructive content.
- Include an act of kindness in your life each day.
- Commit to one day a week when you won’t complain about anything.
- Be thankful when you learn something new.
- See the growth opportunity in your mistakes.

It’s human to get down at times like these, and if we took every bad thing in stride, we might not recognize the peaks from the valleys. But in those moments when we’re not feeling so upbeat, we should focus on those we care about and those who have shown care for us.

“Nobel Peace Prize winning philosopher Albert Schweitzer said, “At times, our own light goes out and is rekindled by a

spark from another person. Each of us has cause to think with deep gratitude of those who have lighted the flame within us.”

I am grateful for my family, who offer no-strings support; for friends who laugh at my jokes and help me to laugh at myself; and I am grateful for you, who inspire me with your thoughtful care of others at camp and at home.

Marcia Ellett, MA  
Editor

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## Words and Concepts Used in Communicable Disease Management

Linda Erceg, RN, MS, PHN

*“Managing an outbreak at camp is a team sport.”*

**Abstract:** This article defines common words and concepts associated with communicable disease management in the camp setting.

Camp nurses and other camp professionals typically don't cope with a communicable disease outbreak on a day-to-day basis, even though recent experience with COVID-19 makes one think otherwise. As a result, some of the words and concepts associated with communicable disease management may become fuzzy and benefit from reclarifying. This content addresses that need. In some instances, examples germane to the camp experience are included.

### Outbreak, Endemic, Epidemic, Pandemic: What's the Difference?

These words refer to how widespread a communicable disease is within a given population.

- “Outbreak” refers to a sudden increase in the number of disease cases within a population or group and is usually associated with rapidly spreading contagion. The word can also be used more generically with any of the other three terms. Camp nurses might refer to several cases of infectious conjunctivitis or impetigo among campers/staff as an “outbreak.”
- “Endemic” refers to disease(s) that is found in a specific population or particular area of the world, and which maintains a constant (ongoing) baseline within that locale or group of people. Lyme disease and malaria, for example, are endemic to some geographic areas, while tuberculosis (TB) is endemic in some population groups.
- “Epidemic” is used to describe a disease outbreak that affects an exceptionally high percentage of people in a community or larger geographic area at one time. Seasonal flu sometimes reaches epidemic proportions. A norovirus outbreak that sickens many campers and staff might also be deemed epidemic in that camp.
- “Pandemic” is used when a disease is exceptionally widespread, even worldwide, and it affects a very high percentage of people. Some disease specialists believe a pandemic must also cause severe or life-threatening illness in addition to being widespread. COVID-19 is an example of a pandemic.

### The Epidemiologic Triangle: How Communicable Disease Factors Relate to One Another

Epidemiology is the study of disease distribution and determinants in a group or population. As illustrated in Figure 1, it is classically based on understanding the interaction among three factors:

- The **HOST**: who gets ill
- The **AGENT**: what causes the illness
- The **ENVIRONMENT**: where illness occurs

The interaction of these factors is what supports the transmission of a given disease to others. This has particular impact for managing camp outbreaks, because each factor provides opportunity to interrupt the cycle of outbreak. This opportunity is predicated by the resiliency and susceptibility of each factor. “Resilience” refers to the factor's ability to withstand or fight off the disease, while “susceptibility” refers to increased likelihood of getting the disease.

Classic epidemiology holds that well-nourished, hydrated, rested, and immunized campers and staff (hosts) are more resilient than counterparts who may be fatigued, under-nourished, inadequately hydrated, and/or inadequately immunized. Classic epidemiology also indicates that a camp (the environment) with strong risk-reduction practices — handwashing, sleeping with the greatest distance between heads, cough/sneeze etiquette, isolation of questionable cases, and so on — is more resistant to disease threats than camps without these practices. Finally, classic epidemiology indicates that potentially infectious organisms (agents) that are few in number (perhaps due to cleaning or maintenance precautions), or stressed in some way— (such as limited access to food or shelter support), results in a decrease in both the amount of

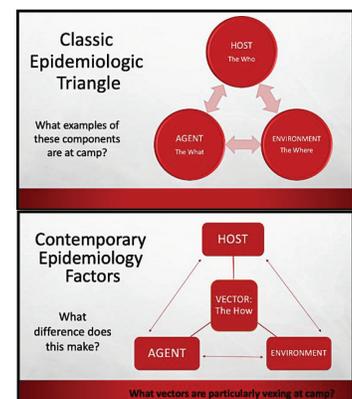


Figure 1 Comparison between the Classic (top) and Contemporary (lower) Epidemiologic Triangle.

### What Does “Vector” Mean?

“Vector” refers to an animal — including a person — who transmits disease but doesn’t actually get the disease. Examples include:

- Ducks hosting the microbe that triggers “swimmer’s itch” when the microbe connects with a human instead of a duck.
- Ticks that pick up the microbe for Lyme disease, harbor it, then pass the microbe to a person when feeding on that person’s blood.
- Asymptomatic carriers of disease like “Typhoid Mary” (read more about it at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3959940/>).

### What’s a “Fomite”?

A “fomite” is an inanimate object on which pathogen-causing microbes survive for a given amount of time until a human touches that object and, in so doing, transfers the microbe from the object to their self. Examples include:

- Towel used by a person with impetigo that is then used by a noninfected person.
- Hairbrush used by a lice-infested person that is then used by a noninfested person.
- Eyelash mascara wand used by a person with infectious conjunctivitis that is then used by a noninfected person.

### What Does “Zoonosis” Mean?

This noun describes an infection common in animal populations that occasionally infects humans. Several versions of “bird flu” originated this way.

pathogens and the pathogen’s viability.

There are two key messages here:

- Maintain practices that strengthen host and environment resilience.
- Implement practices that decrease agent resilience and/or reduce the amount of the agent.

Contemporary epidemiology, however, adds the concept of **how** disease is transmitted (see Figure 1’s bottom diagram). Some call this a “vector.” It acknowledges that disease transmission is often helped by behaviors or characteristics of the host, agent, and/or environment. For example, failure of campers or staff to apply insect repellent or do a daily tick check (behaviors) may result in more bug bites and resultant infections like Lyme disease. The point is that, in a camp setting, looking at how a communicable disease is transmitted and the frequency or strength of control measures may be as helpful as understanding factors associated with managing the host, agent, and environment.

Norovirus provides an excellent example of a communicable disease’s “how.” This illness triggers feelings of being sick, emesis (throwing-up), and diarrhea in a relatively healthy group. It quickly passes from person to person via droplet (e.g., breathing, coughing, yelling) and fecal shedding (e.g., infected person, especially food handlers, inadequately washing their hands after passing stool). A camp that enforces appropriate handwashing, cough/sneeze etiquette, and quickly isolates people with gastro-intestinal symptoms typically experiences fewer cases of a norovirus outbreak than a camp without those protective behaviors. Norovirus, because of its droplet transmission, can also be limited by physically distancing people from one another, something 2020’s COVID-19 experience has aptly demonstrated.

Using a combination of control strategies around each factor — host, agent, and environment — elicits the best outbreak control. Sometimes, however, one strategy is effective. That’s illustrated by using a DEET repellent to ward off ticks that cause Lyme disease. However, even that is bolstered by another behavior: daily tick checks.

### Infectious, Communicable, Contagious: What’s the Difference?

- “Infectious” refers to a disease that’s a) caused by a microorganism and b) is capable of being transmitted to others with or without contact. This term is all about spreading bad germs.
- “Communicable” refers to the capability of being transmitted or passed along to another: human to human, animal to animal, animal to human, and/or human to animal.
- “Contagious” means the illness is capable of being transmitted from one individual to another.

In the camp setting, infectious diseases such as conjunctivitis, the common cold, chicken pox, and strep throat are all caused by a microorganism and can be passed from person to person with or without contact. These same illnesses could also be called communicable or contagious. Lyme disease, however, is contracted by the bite of an infected tick. Consequently, it’s contagious and communicable, but some would say it isn’t infectious because it’s not passed human to human.

- All contagious diseases are infectious, but not all infectious diseases are contagious.
- Communicable only refers to the ability of an illness to be transmitted to another human or animal and is typically associated with a period of time during which the illness can be transmitted. The term doesn’t care about what causes the illness (e.g., germ; microorganism; tick, or family goldfish).

### Is Quarantine Different from Isolation? What's an Index Case?

In short, yes. Suppose a camper in a particular cabin with a total of 12 people (campers and staff) was diagnosed with whooping cough (pertussis), an infectious disease that's typically managed via immunization. That camper — the person diagnosed with the disease — would be separated from contact with others. That's called **ISOLATION**. Their period of isolation lasts until they can no longer pass the illness to others (that's a long time for pertussis).



The camper who first presented with pertussis is called the **INDEX CASE**. Granted, the person had to get pertussis from someone but, since that "someone" isn't at camp, this camper is considered the Index Case at camp. Interestingly, most State Departments of Health (DOH) mandate that one report pertussis; it's a "reportable illness." The DOH's super sleuthing team would backtrack to find the original Index Case.

A camp nurse might then review the immunization record of cabinmates to determine who is at risk for pertussis because a) they were never vaccinated or b) their vaccination schedule wasn't complete. (Staff may be the most at risk for inadequate pertussis immunization.) These people would go into **QUARANTINE**. Granted, they don't yet have the disease, but they're at risk of getting it so they, too, are separated from others. They are quarantined for the disease's **INCUBATION PERIOD** (amount of time between exposure and when the individual would break out with the disease if they did, indeed, contract it).

The COVID-19 experience demonstrated another aspect of quarantine: cohorting a group of people until they demonstrate no illness. Some camps used this strategy to minimize the risk of exposing large groups to COVID-19 by keeping campers and their counselors in small groups (10–12 people) — or **COHORTS** — for a period of time. Assuming no one in that small group came down with the illness, the small group was expanded to a larger cohort who enjoyed camp experiences as a larger group for an additional period of time. If everyone remained healthy, the larger cohort was then combined with other large cohorts, a strategy that felt more camp-like. Cohorting helps sort out suspected cases while minimizing exposure to an entire group.

### Immunity: Different Kinds of Immunity Confer Different Durations of Protection

A person who is protected from getting an infectious

disease is said to be **IMMUNE** from — or have **IMMUNITY** for — that illness. This status is typically conferred via immunization or is naturally acquired after the person recovers from the illness. Some interesting facts about immunity, especially as it impacts the camp community, include the following:

- Some immunizations **WANE** over time; their protective ability falls off or disappears. This is why people need a tetanus immunization (booster) every 10 years and immunization for shingles (herpes zoster) in later life.
- Some disease-causing **PATHOGENS CHANGE** over time; they're adept at mutation. This is why an annual flu shot is recommended and why we continue to get the common cold even when we've had it before.
- Some immunizations confer **LIFETIME IMMUNITY** (at least currently believed). Examples of these immunizations include measles, hepatitis B, and polio.
- Newborns who are nursed acquire **PASSIVE IMMUNITY** through the mother's breastmilk, an immunity that **WANES** as the child is weaned. A similar response occurs when immune globulin is given with the first rabies immunization; the immune globulin "wakes up" or "bridges" the body's immune response until the rabies vaccine kicks in, by which point its effect drops away.

**HERD IMMUNITY** describes a community's capacity to ward off an infectious pathogen. The term refers to the critical proportion of a community who must be immunized for that disease or had the illness. For example, if 97 percent of your campers and staff have been immunized for measles, a highly contagious illness, your camp's herd immunity (ability to ward

#### What's Your Herd's Immunity?

Disease	Transmission	HIT*
Measles	Airborne	92-95%
Pertussis	Airborne Droplet	92-95%
Diphtheria	Saliva	83-86%
COVID-19	Airborne Droplet	50-83%
Influenza	Airborne Droplet	33-44%

HIT\*: Herd Immunity Status

Information retrieved from [https://en.wikipedia.org/wiki/Herd\\_immunity](https://en.wikipedia.org/wiki/Herd_immunity) on 15 Sept 2020.

off measles) for that illness is 97 percent. Immune individuals act as a barrier in the spread of disease by slowing or preventing the disease's transmission to others. This percent is referred to as a "herd immunity threshold" (HIT) and may be important to parents whose child is immunocompromised.

*Camp nurses: determine your camp's herd immunity each season. If current records are incomplete, consider using last summer's records and identify the information as "based on last summer's records."*

## Transmission: How Are Communicable Diseases Passed Along?

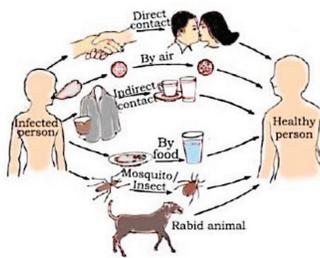


Figure 2. Common ways (routes) in which communicable diseases are transmitted.

"Transmission" refers to the passing of a disease from one person to another. There are several ways or routes in which this can happen. The more common ones include:

- **AIRBORNE** transmission means the infectious particle is distributed by aerosol, droplet, or dust particles. Varicella (chicken pox) and measles are spread via airborne particles.
- **DROPLET** transmission refers to airborne infectious particles. These larger, heavier particles typically drop to the ground about 3 feet from an infected person who is coughing, sneezing, shouting, and/or singing (like around the campfire).
- **AEROSOLIZED** transmission refers to smaller particles that remain suspended in air — thus capable of being inhaled — beyond 3 feet from the source. The concentration of these particles depends on factors such as air movement and humidity.
- **DIRECT** transmission occurs when an infected person touches or breathes on a noninfected person. Enough disease particles need to be transferred to cause the disease. Each disease has its own threshold for how many pathogens are needed to trigger the illness.
- **INDIRECT** transmission occurs through an intermediary agent (e.g., air, water, contaminated surface) or a living disease vector. This route makes handwashing important!
- **VECTOR** refers to a disease carrier capable of transmitting a disease-causing organism from infected to noninfected individuals. Examples include mosquitos carrying malaria protozoa, bats

with the rabies virus, and rodents infested by flea-carrying *Yersinia pestis* (plague-causing).

Each illness has a transmission route, sometimes more than one. Each illness also has its own window of time during which it can be passed along. Some windows of time are short; others are long. Some occur before the infected person shows symptoms (e.g., measles, COVID-19), some when the infected person is actually ill (e.g., common cold), others happen once the infected person feels well (e.g., viral shedding), and some communicable diseases bridge more than one timeframe for transmission (e.g., norovirus).

## Prevalence and Incidence: Related but Different Concepts

Assume that your camp nurse told you she admitted two campers and a staff member last night for an overnight stay because they were periodically throwing

up, had slightly elevated temperatures and no appetite, and just "didn't feel well." Then, late this afternoon, the nurse returned to your office to tell you that six more people with the same symptoms had been admitted; two came in before lunch and the others arrived in the afternoon. The original three are still sick too. This scenario illustrates the difference between:

$$\text{prevalence} = \frac{\text{ALL cases}}{\text{Population @ risk}}$$

$$\text{iNcidence} = \frac{\text{New cases}}{\text{Population @ risk}}$$

- **INCIDENCE:** the frequency of NEW cases of a disease or condition within a group or population and
- **PREVALENCE:** the TOTAL NUMBER of cases of a disease present in a specified group/population at a given time

In other words, there are now a total of nine sick people (prevalence) with similar symptoms; three presented yesterday and six presented today (incidence over each of two days). That's a big jump in cases (from three to six more) and should make someone ask what's going on. Indeed, one might suspect more cases to show up as the evening wears on.

Monitoring the prevalence of cases (total number) indicates how busy Health Center staff might be, the point at which Health Center capacity may get overwhelmed, and the need to implement the camp's communicable disease plan even if one hasn't quite figured out what's going on.

Monitoring the number of new cases that present day by day (incidence) allows one to determine if the outbreak is increasing, waning, or holding steady. Incidence also helps indicate the effectiveness of implemented risk-reduction strategies.

### Morbidity vs. Mortality: Words Often Used in Conjunction with Prevalence and Incidence

- **MORBIDITY** refers to the number of people sick with the disease of concern in relation to a specific population. Suppose, for example, there were 150 campers plus staff in camp (population) and 18 of them had strep throat (disease of concern). That means the day's morbidity for strep was 18 or, expressing the same information as a percent, 12 percent of the population (number with the illness divided by the total population; that number then multiplied by 100). Tracking morbidity over time (e.g., day to day) indicates if things are getting better or worse.
- **MORTALITY**, on the other hand, describes the number of deaths in the population. Let's assume the strep throat outbreak hasn't yet killed anyone. That means the camp's mortality is zero (0) or, expressing it as a percent, 0 percent.

### Regulation, Guideline, or Standard: What's the Difference?

- **REGULATION** refers to a directive that must be followed; in most cases, regulations are linked to laws. The source of a given regulation can vary from local or county-specific to state and/or federal level regulations. Some communicable diseases like measles and rabies are, by virtue of state law, reportable. Thus, a camp must inform the appropriate agency should that disease be diagnosed during the camp season. A list of reportable diseases is typically available on the state's Department of Health website.
- **GUIDELINE** refers to a recommended practice typically issued by an authoritative body and intended for use by professionals. The Association of Camp Nursing's "Communicable Disease Management in the Camp Setting" Practice Guideline (2020; available at <https://campnurse.org/education-and-resources/resources/>) is such an example. It guides nursing practice in the camp setting but is not nurse-specific; the guideline was written for camp professionals. Note that guidelines are meant to guide not define, practice; recognize that exercising professional judgement is an aspect of guideline use.
- **STANDARD** is used when an authoritative body, such the American Camp Association (ACA), issues statements that describe acceptable practices which are, in turn, based on evidence and often linked to obtaining a particular credential (e.g.,

accreditation for a camp). For example, ACA's FA.12 Healthcare Center standard (2019) directs that the Health Center's physical environment includes "isolation, quiet and privacy . . ." (pg 119). Standards are often quite broad and, thus, acknowledge variation among camps. Consequently, they often describe what should be done or provided but not necessarily how that should happen. In this case, camps are directed to make provision for isolation in the Health Center but not told how to accomplish that. ACA's Standards are, from a legal perspective, considered the standard of practice for camps.

### Personal Protective Equipment (PPE): Who Needs What? What Are the Characteristics of Effective PPE?

A camp outbreak quickly establishes the need for personal protective equipment (PPE), especially for those staffing the Health Center and/or caring for a person with a communicable disease. At minimum, these individuals need gloves, eye protection, and masks (and perhaps protective clothing/gowns). PPE is meant to minimize, if not protect, noninfected individuals from the illness of concern. The "line of defense" provided by PPE is strengthened when that protective equipment is fit to the person using it and quality-tested by a reputable source such as the Occupational Safety & Health Association (OSHA).

#### Personal Protective Equipment (PPE) Is Exactly That — Personal.

It's meant to be used by a given individual and not shared by or with others.

#### Also Consider the Setting's Need for Protection.

The camp environment might benefit from protective supplies like hand sanitizers, antimicrobial wipes, and adequate hand-washing stations, but that environment also needs adequate refuse containers/disposal.

Because there's no way to know what communicable disease(s) might occur at camp, it's good practice to provide appropriate PPE for each Health Center staff person and have additional PPE that others can use. Comments specific to some of this equipment include the following:

- **MASKS:** the goal is to prevent infectious droplets and aerosolized microbes from being inhaled by noninfected individuals.
  - N95 respirators are most effective when fit to the person (fit-tested).
  - Surgical-quality masks limit a person's breath

from leaking through while also providing a microbial barrier when inhaling room air.

- Cloth masks are somewhat effective, especially if the mask has a clip to bend around the bridge of the nose, is made of 2–3 layers of closely woven material, is large enough to drape over the nose and tuck below the chin, and is anchored to the face by double straps that loop around the ears or, better yet, uses two independent straps that are placed below the occiput and at the top of the head.
- “Neck Gator” masks tend to be least protective because of the material used to construct them — but they’re better than nothing!
- **GLOVES** are a day-to-day necessity for Health Center staff and should be in every first aid kit and offered to staff so they can carry their own pair (or two).
  - Provide various sizes: small, medium, large, X-large.
  - Nitrile, powder-free gloves are preferred by many professional providers.
  - All gloves should be latex-free.
- **SHIELDS** (protection), both eye and face, are also needed by Health Center staff. Indeed, if campers are at risk for spitting, face shields may provide better protection. NOTE: Like one’s mouth, the eyes are another opening (portal) to the rest of the body. Protect them too! (See Figure 3)
- **Disposable PROTECTIVE CLOTHING** is typically not needed and may be improvised by using large garbage bags in combination with bread bags to cover the arms. Ponchos or a raincoat might also suffice.



Figure 3. Using both mouth and face (eye) shields provides better protection than just one of these.

### The Future with Communicable Diseases

As long as humans exist, there *will* be communicable diseases to contend with. Some, like measles and flu, will ebb and flow over time. But others — like COVID-19 — will be novel. They’ll emerge and have impact until we figure out how to manage them. That management, whether for known or novel outbreaks, needs a camp community that routinely practices communicable disease risk-reduction strategies and quickly adds actions when infectious illness overwhelms

protective strategies and/or isn’t deterred by them.

Also recall that those who attend camp (campers and counselors) tend to travel. At minimum, that travel, whether short- or long-distance, often includes geographic changes with different pathogens. Consequently, camp Health Centers need to consider the impact of geographic change on presenting illnesses. It’s quite feasible that a camper or counselor presents with a set of symptoms that actually originated in their previous location. As Michael Osterholm and Mark Olshaker (2020) remind us: “. . . a dangerous microbe anywhere in the world today could be everywhere tomorrow” (pg xxiii). And we may need to “make adequate decisions based on inadequate information” (pg 48). Those are impactful statements.

The nature of the great camp experience — being physically close to others, interacting in ways that heighten emotional connectivity, and sharing with abandon — also increases the potential for camp to amplify communicable disease. Be ready. Recognize the signs and nature of communicability with equal abandon. Use the concepts included here to minimize, if not eliminate, that experience.

#### Reference

Osterholm, M. T., and Olshaker, M. (2020). *Deadliest enemy: Our war against killer germs*. New York: Little, Brown Spark.

#### Read More About It

Erceg’s expanded practice guideline, *Communicable Disease Management in the Camp Setting* (2020) is available on ACN’s website under the “Resources” tab (<https://campnurse.org/education-and-resources/resources>).

Osterholm & Olshaker’s book, *Deadliest Enemy* (2020), combines information about communicable diseases with policy practices and injects a global perspective to the discussion.

The American Public Health Association’s (APHA) *Control of Communicable Diseases Manual* is a gold star reference for all communicable diseases. It’s typically produced every five years, but now a digital subscription is available. Learn more at <https://www.apha.org/publications-and-periodicals/published-books/ccdm>.

The CDC’s website ([www.cdc.gov](http://www.cdc.gov)) can be searched for information about specific communicable diseases. The site often includes several downloadable PDFs for use at camp as well as images (JPGs) in the public domain.

Need or want greater detail about communicable diseases? Try Roger Webber’s *Communicable Diseases: A Global Perspective* (2020). The author not only discusses illnesses but also includes solid epidemiology about each one.

## Nursing Students Educate Children with ASD through Digital Posters

Constance E. McIntosh, EdD, MBA, RN; Pamela Brelage, MS, RN;  
Barbara Phelps, MS, RNC-MNN; & Janelle Wendel, MS, RN

**Abstract:** This article discusses Camp Achieve, a camp for children ages 6–12 with Autism Spectrum Disorder, including a partnership between camp Registered Nurses (RN) and a School of Nursing (SON) that allowed nursing students to provide education to the campers and their parents.

### Introduction

The prevalence of Autism Spectrum Disorder (ASD) in children is reaching 2 percent, with 1 in 54 diagnosed annually (CDC, 2020). ASD is a broad term that describes a developmental disorder characterized by deficits in communication (e.g., challenges to language) and social skills (e.g., challenges when making friends, difficulty reading social cues). It often includes repetitive behavior (e.g., ritualistic, stimming) and focus on particular interests. (American Psychiatric Association, 2013). Children with ASD also experience a plethora of unique challenges due to their hypersensitivity to light, sound, touch, smell, and taste. This discussion that follows details a specialty camp, Camp Achieve, for children ages 6–12 with ASD and a partnership between camp Registered Nurses (RN) and a School of Nursing (SON) that allowed nursing students to provide education to its campers and their parents.

### Camp Background

At the time of the partnership, the specialty camp had been in existence for 12 years. The camp's goal was to work with children with ASD on their social and communication skills. The camp's main focus was on improving social interaction and behavior in children with ASD. The camp employed multiple experts in ASD: a special educator and board-certified behavior analyst at the doctoral level (BCBA-D), camp counselors, and a psychologist. In consultation with parents and, at times, school nurses, the staff established a range of individual goals for the campers, such as sitting quietly in a classroom, acknowledging a friend by name, or completing a healthcare physical without fidgeting. Professionals (e.g., RNs, Psychologists, Nutritionists, and Behavior Analysts) worked collaboratively to meet camper goals. At the end of the camp, the professionals provided parents a detailed report on the child's progress toward all goals and behaviors, which was also often shared with the child's school (e.g., teacher, administrator, school nurse).

Before the start of camp, two RNs completed wellness checks (i.e., vital signs, height, weight, skin assessment) on each camper. RNs provided mini-educational sessions about a variety of requirements for campers. For example, campers were required to wear sunscreen and bug spray due to much

of the camp being held outside. Often, parents would report that children were hypersensitive to anything applied to their skin. Therefore, parents did not require their children to put sunscreen on, resulting in burns. Consistently, parents asked questions about how to improve compliance with their children. And in addition, to the preceding example, the RNs noted parents' similar questions, such as:

- "How can I improve the hygiene of my child?"
- "How can I break down the steps of brushing teeth?"
- "How do I keep my child safe?"

The nurses knew this would be an excellent opportunity for nursing students to teach parents and campers about these common topics. The RNs reached out to a local Midwestern SON, where they met with two baccalaureate nursing instructors. Together the four RNs discussed the educational gaps (e.g., hygiene, oral hygiene, use of sunscreen/bug spray, safety) that could be addressed with the campers and their parents. The nursing instructors identified that a collaboration would be beneficial to nursing students and the campers and their families. This opportunity would allow nursing students to apply theoretical knowledge of nursing, public health, and related disciplines to provide therapeutic nursing interventions in a community setting. Additionally, this partnership would allow students to apply research findings from public health science, nursing science, and epidemiology to the nursing process in primary prevention. The students would have the opportunity to use effective communication in collaboration with health professionals, peers, faculty, clients, and other community members while demonstrating professionalism in nursing practice.

### Camp and Nursing Student Collaboration

To begin, the nursing students needed education about ASD and the purpose of the camp. Faculty incorporated this education into campus laboratory clinical activities. The camp nurses, in partnership with the SON instructors, arranged for senior nursing students enrolled in a community health course to attend the camp as part of observation-only clinical experience. They were supervised by one of the camp nurses who focused on how these individuals' social and communication

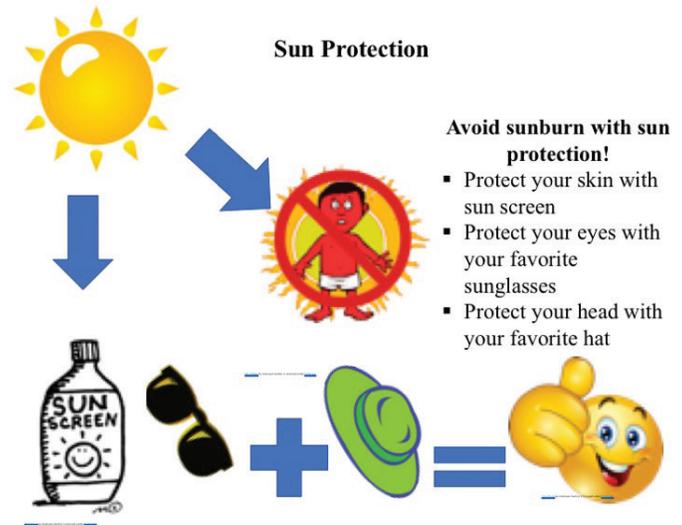
skills impacted care received in any healthcare environment. The camp director provided background information and explanations of all aspects of the camp, including overall purpose, typical behaviors, room designs, visual cues, and the reward system. Multiple opportunities were provided for observation of children as they interacted with each other and with staff. Questions of staff were encouraged, as they were well prepared to educate these nursing students. At the end of the day, the students attended a debriefing session with the camp director, camp nurse, and clinical instructor.

Upon completing the clinical observation at the day camp, nursing students completed a journal focused on noticing, interpreting, responding to, and reflecting on the experience. Student feedback was tremendously positive. Students expressed gratitude for the opportunity and were touched on a human level by the experience. On an academic level, the students not only reported an abundance of learning, but they also identified a need in the curriculum for nursing students to receive education related to persons and families affected by ASD. In response to this feedback, faculty and camp personnel continued this partnership between the SON and the specialty camp.

Subsequent sessions of the community health nursing course provided education to senior-level nursing students about ASD and the camp's purpose. The students were to identify one priority concern where there is a knowledge gap in education. Next, students were instructed to perform additional research to find evidence-based data on the topic. Students compiled their information into a poster presentation that could be used to educate the children attending the camp and their parents. The project's specific instructions included utilizing quality, evidence-based resources to effectively communicate informative and useful content to the target audience. Primary prevention interventions, such as health promotion and injury prevention, were presented using visually appealing pictures and concise statements, words, or commands. Educational posters created included:

- Handwashing
- Mealtime tips for better nutrition
- Communication tools
- Appropriate sunscreen use
- Water safety

Posters were on display during initial camp assessments and check-in for parents to view. Posters were also displayed by staff during specific lessons. The handwashing poster was used in the bathroom area to remind children of the essential hand hygiene steps. The nutrition poster was displayed at mealtime or made visible daily to remind parents of healthy food and snack choices. The water safety poster was displayed outside the pool area to reinforce essential swim and play safety



among the children.

Additionally, the nursing students presented these posters and made them available to local school nurses. These presentations helped to educate and provide the school nurses with resources for working with children and families. The school nurses were attentive during these presentations and provided positive verbal feedback, indicating the posters and presentations were useful to their practice.

This collaborative project provided multiple benefits:

- Nursing students were:
  - Provided with a firsthand experience to witness multiple children at varying autism spectrum degrees.
  - Instructed on best practices for communication with this population and observed the techniques being practiced.
  - Able to carry this information with them as they continue to work as healthcare providers to provide appropriate care to this population and educate and model appropriate practices for other health care providers.
  - Able to use this knowledge to create the necessary educational materials.
- The young campers:
  - Saw these adults present in their safe environment and were, therefore, less intimidated by their unfamiliarity.
  - Learned that these visitors were nursing students who wanted to learn more about them and the camp. They were part of the educational process for the nursing students.
  - Found comfort in knowing that these medical people were not there to poke, prod, or quickly look at them and walk away.
  - The camp counselors and staff realized the

value in the nursing students learning about the social and communication deficits of individuals on the spectrum and the need to utilize best practices in all health-care settings when interacting with this population.

- The autism community and their families realized the nursing student training occurring at camp would create more advocates on their behalf.
- Health education, provided in a simplistic and usable format, was provided for ASD campers and their caregivers.

### Conclusions

Feedback from nursing students was extremely positive. The overwhelming majority of students stated they never realized how uneducated they were regarding ASD. Students referred, many times, the necessity of learning how to communicate with the children, including the use of visual aids. A student who attended the camp stated, “I learned so much about what the spectrum is, how it manifests, what communication means, and how to communicate effectively. It scares me to think that people in the healthcare profession will encounter and communicate with this population without really knowing what they are saying.” Students discussed how informative the staff and director were and how passionate and caring they were in helping these ASD children. Another student stated, “The staff is amongst the most amazing people the world has to offer,

the camp is free for families, it promotes safety, independence, fun, and bettering yourself. It accommodates and advocates for a population who otherwise would not be able to do so themselves.” Another student stated, “I am confident in saying this experience completely transformed my outlook and will make me a better nurse and human being. It was beyond an educational and beautiful experience, and I will never be able to fully express how much it meant to me and how truly grateful I am.” In collaborating with *Camp Achieve*, one of the main goals was to educate students and help them realize the importance of education for fellow health care providers in the treatment of ASD patients in the hospital and/or health care setting.

### References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. (Fifth ed.). Washington, DC: American Psychiatric Association.

Center for Disease Control and Prevention. (2020, September). *Data & statistics on Autism Spectrum Disorder*. Retrieved from <https://www.cdc.gov/ncbddd/autism/data.html>

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### Top Tips

- Camp nurses should develop a partnership with their local School of Nursing.
- Nursing courses, such as community and pediatrics, could help students develop their clinical skills with specialized populations.
- Have a brief orientation to camp before the nursing students' first day.
- Have a brief meet and greet with camp professionals (e.g., psychologist) for the nursing students.
- Nursing students can be instrumental in assisting camp nurses in education.
- Nursing students can develop poster presentations (e.g., e-posters) for camp education.
- Posters should be colorful with steps to a learning activity.
- Posters can be shared with other healthcare professionals (e.g., school nurses) for easy transition and continuity of care.

## Fall Webworm Infestation — A Camp Nurse's Story

Matt Hecht, RN

Late in the 2019 camp season, my co-director and I started to see cocoons popping up on our camp's black walnut and oak trees. This was not completely new to us; we see a few about that time every year. Camp lore, if you will, was that these were "tent caterpillars" that would come every few years or so and be a mild annoyance. Well, we looked it up and determined they were, in fact, fall webworms. Eastern tent caterpillars are a spring phenomenon, whereas the latter are a late-summer phenomenon.

This small annoyance was actually about to become a camp-life-changing event that led to relocating half of the camp's population for the final three days of the season.

Fall webworms — if you don't know what I'm talking about, look them up. They're gross, and camp got hit very hard with them. They form web-like cocoons about the size of a football where hundreds of them grow until they pop out of the web and drop to the ground. Then these webworms climb up the tallest thing around them. Many of our 80-foot trees were covered in hundreds of cocoons, meaning there were thousands of these inch-long, actively moving worms in a space of about a football field (bunking 100 people in open-air, A-frame tents and pavilions). It was an infestation.

In about 36 hours, it went from a curiosity to the only thing people talked about. The infestation was deeply affecting camp. For the first time in memory we evacuated the affected bunks for the last three nights of camp — and we probably would have had to come up with a longer-term plan if our season hadn't been so close to its end.

So what did we do and what did we learn?

### Phrasing and Reframing Are important!

Most of the campers were more than up for the challenge of sleeping in the barn and an ancillary building for the last couple nights, as they were involved in the process. We increased buy-in by:

- 1. Gathering staff together first to recognize and name the problem.** Some of them were visibly affected, and we attended to their needs and made sure they felt heard. We asked them to continue to be the great people they were by being positive and helping out others who were stressed, and by being extra caring with each other and their campers. We asked them for their input, and answered their questions. The tone relayed was as follows:  
"We recognize this is affecting you and it is awful. You still have a job to care for kids (and yourselves). We are developing a plan that will involve all of us. You will hear about it shortly. Remember that the

heebie-jeebies are contagious, so don't freak out. Try not to let negativity rule the bunk."

- 2. We then gave all of camp mostly the same message.**

- 3. We gathered our senior staff together to come up with a plan.** This involved the program director (to modify the program), the Health Center (some kids had skin reactions to bugs that were attracted to the infestation), our maintenance director, and our counselors-in-training.

Things we had to consider: When a tent got rid of all the caterpillars at once, it was less than three hours before it looked like they hadn't been removed at all. They were covering entire 80-foot trees right by the bunks and didn't look like they were suddenly going to go away. They were most active during the day. Some kids had skin issues with some other look-alike caterpillar that had slightly longer antennae. There was no magic spray or dance that was going to get rid of them before the session ended. The fields around the tents were crawling with them, making a "sleep out," or anything similar, out of the question. No one was having serious reactions.

- 4. We modified the schedule but did not abandon it entirely.** This proved to be very important to keep a semblance of normalcy. It allowed everyone to fall back into something routine and familiar.

- 5. We maintained open communication with the Health Center, directors, and kitchen** (dinner was delayed for 30 minutes) to allocate and then reallocate resources (in this case, the tractor with flatbed to move bedding into the barn), indoor space near the Health Center for campers who had a reaction to a bite, and staff to supervise areas as needed.

- 6. We continued to dialogue with campers and staff to hear about their trials and tribulations.** Having the opportunity to tell their stories and be heard was a powerful reminder of the importance of active listening. It was tempting to hear their stories and try to correct/help, etc., but what we really accomplished was allowing children to describe how they overcame the obstacles they faced.

- 7. "Way-to-go's!" all around.** We praised campers and staff alike for their resourcefulness and resilience. Being acknowledged is important! At check-out, we praised the campers and staff to the parents who

were about to hear all about fall webworms. This allowed us to frame what happened before they heard tales from their children and gave them the opportunity to ask questions.

Camp ended and the webworms were bad for another few days, significantly tapering off over the next week. After that it was dealing with their remnants. Also gross.

*Matt Hecht, RN, is a camp director and an ACN Board member.*

## Super Sleuth

*Karen Dedominicis, RN, BSN*

I need to inform you of something important. Just so everyone is aware, *writing* the Super Sleuth column, and *being* a super sleuth are two totally separate things.

I'm sure I wasn't the only one this past summer wishing I had super sleuth powers to differentiate every sniffly nose, sore throat, and cough from the dreaded COVID-19 virus that has everyone looking twice, if not thrice, when someone sneezes. I know many of us already wished that our camp nursing expertise and assessment skills came with x-ray vision for all of those suspected but uncertain fractures. If only we could have "COVID-19-nasal-swab-results vision" too. I searched high and low for an old bottle at camp that I could rub lovingly with an alcohol wipe and hand sanitizer, hoping a genie would emerge to grant my nursing wish — a clinical assessment method for determining that dreaded coronavirus that kept those of us operating camp in 2020 on our toes and outright exhausted. But to no avail. All I found were countless handwashing and hand sanitizing stations all over camp. And all I heard was the frequent knocking on my health center door by another camper or staff member presenting with minor upper-respiratory symptoms and concerned about having *the* virus.

I wished I could tell them right away that they had one of the other common cold coronaviruses that are out there every day. Or a common histamine reaction brought on by allergies. But I didn't have the depth of vision to definitively make that diagnosis.

Having a relationship with a COVID-19 molecular testing site and proper protective protocols in place was the way to go this summer. But having to make that decision regarding who needed to be tested, who could and could not attend camp, and when to send people home, was enough to knock the fight out of many of us.

Fortunately, there are many conditions at camp that we can diagnose for the campers and staff in our care — and I am looking for some fresh ideas or topics for the Super Sleuth column. If you have an idea to share with me, please email me at [nurse@carolinacreek.org](mailto:nurse@carolinacreek.org). Perhaps you can help me stump our readers!



If you happened on a genie's bottle at camp, what would your summer camp nurse wish be? If one of your wishes is to see your name in print, submit your wish idea or other story to *CompassPoint* at [acn@campnurse.org](mailto:acn@campnurse.org). We might be able to grant that one.

*Karen DeDominicis, RN, BSN, is the health services coordinator at Carolina Creek Christian Camps*

## New Products, New Ideas

Marcia Ellett, MA

■ **Seizure Recognition and First Aid Certificate:** Seizure Recognition and First Aid Certification is a formal training offered by the Epilepsy Foundation that teaches people:



- How to recognize signs of a seizure
- How to respond with proper seizure first aid
- When to call for help

The certification lasts two years. <https://www.epilepsy.com/learn/seizure-first-aid-and-safety/first-aid-seizures-stay-safe-side#Upcoming%20Trainings>



■ **UniMed Massager:** Want to brighten your staff's morale? A deep tissue massager may be just the way. Deep tissue massage is a massage technique that's mainly used to treat musculoskeletal issues, such as strains and sports injuries. It involves applying sustained

pressure using slow, deep strokes to target the inner layers of your muscles and connective tissues. This helps to break up scar tissue that forms following an injury and reduce tension in muscle and tissue.

It may also promote faster healing by increasing blood flow and reducing inflammation.

As a bonus – the entire unit may be cleaned and disinfected between uses. <https://www.unimedmassager.com/>

■ **Mask Lanyards:** In the era of COVID-19, everyone is wearing a face mask. There is one issue — where do you set your mask down when it's time to take a drink or eat? Solution: mask lanyards. These adjustable mask lanyards are convenient and easy to use. Available on Amazon in a multitude of colors.



■ **Water Filter:** Is the camp water flavor not your favorite? Are you worried about junk in your water? Enter Berkey. It's a water filter that produces purified drinking water. The Berkey removes 99.999999 percent of pathogenic bacteria and reduces viruses by 99.999 percent. Berkey's black filters have been tested by several EPA-accredited laboratories, which confirmed the removal of pathogenic bacteria, viruses, heavy metals, micro-organisms, pharmaceutical drugs, pesticides, and volatile organic compounds. For more information, visit: <https://www.berkeyfilters.com/>

■ **Nasal Glucagon:** BAQSIMI is the first and only dry nasal spray that can treat severe hypoglycemia. It is a form of glucagon given as a puff in the nose. In a study, BAQSIMI raised blood sugar successfully in 100 percent of patients ages 4 through 16 within an average time of about 12 minutes.



Keep tube sealed until ready to use.

BAQSIMI should still be given in a low blood sugar emergency even if one is passed out, because BAQSIMI does not need to be inhaled. It should be given even if the patient's nose is congested or they have used decongestants.

When you need a medication others can use to help you in a low blood sugar emergency, that's where BAQSIMI comes in. [www.baqsimi.com](http://www.baqsimi.com)

ACN does not endorse or recommend specific products.

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## Association News

❖ **ACN Membership** - At an all-time high! Our membership has risen **27 percent** over the past several months! We welcome all our new members!

❖ **Say HELLO to ACN's New Administrative Assistant** - We welcome Kayla Waterhouse to our ACN team. Kayla is creative, energetic, and brings wonderful insight regarding new and different ways to serve and educate. We are thrilled to have Kayla on our team!



❖ **ACN Online Education Center - New courses** have been loaded in the ACN Online Education Center. The sessions are from the Fall Camp Nurse Conference. Nursing contact hours are available for those who watch the recorded presentations and complete the evaluation(s). Check us out at: <https://campnurse.org/education-and-resources/online-education-center/>

❖ **COVID-19 Updates**

<https://campnurse.org/education-and-resources/covid-19-considerations-for-camp/>

- Coronavirus Resources – Visit our COVID-19 Resource page and take advantage of the great information provided for you. We continue to update our webpage as the CDC posts new information.

❖ **Camp Nursing Symposium 2021 - Going Virtual!**

ACN has decided to move the Camp Nursing Symposium 2021 to a virtual event. A variety of factors have driven this decision and our hope is that we will be able to serve more folks than ever before. Registration for the Symposium opened on



**November 1, 2020**. Keep your eyes open for information on the website regarding speakers, topics, and confirmed dates. We look forward to being together — even virtually!

❖ **ACN's CompassPoint** – Did your camp open this summer? We would love to hear your story and experience in navigating camp during COVID-19 times. Consider jotting down your summer experiences and sending them to ACN. Submit your information to [acn@campnurse.org](mailto:acn@campnurse.org).

### Connect with Us!

