

# Safe Sleep Practices and SIDS/ Suffocation Risk Reduction



Applicable Standards from:

## **Caring for Our Children:**

National Health and Safety Performance Standards;  
Guidelines for Early Care and Education Programs  
Third Edition

A Joint Collaborative Project of

American Academy of Pediatrics  
141 Northwest Point Boulevard  
Elk Grove Village, IL 60007-1019

American Public Health Association  
800 I Street, NW  
Washington, DC 20001-3710

National Resource Center for Health and Safety in Child Care and Early Education  
University of Colorado, College of Nursing  
13120 E 19th Avenue  
Aurora, CO 80045

Support for this project was provided by the  
Maternal and Child Health Bureau,  
Health Resources and Services Administration,  
U.S. Department of Health and Human Services  
(Cooperative Agreement #U46MC09810)

Adapted from *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*, 3rd Edition.

Copyright © 2012

American Academy of Pediatrics

American Public Health Association

National Resource Center for Health and Safety in Child Care and Early Education

All rights reserved. This publication is protected by copyright. No part of this publication may be reproduced in any form or by any means, including photocopying, or utilized by any information storage and retrieval system without prior written permission from the publisher.

To request permission to reproduce materials from this publication, please contact the Permissions Editor at the American Academy of Pediatrics by fax (847/434-8780), mail (PO Box 927, Elk Grove Village, IL 60007-1019), or email ([marketing@aap.org](mailto:marketing@aap.org)).

Suggested Citation:

American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. 2012. Safe sleep practices and SIDS risk reduction: Applicable standards from: *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs*. 3rd Edition. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association.

Available at <http://nrckids.org>.

The National Standards are for reference purposes only and shall not be used as a substitute for medical or legal consultation, nor be used to authorize actions beyond a person's licensing, training, or ability.

Design & Typesetting: Betty Geer, Diane Malk, Lorina Washington

## Table of Contents

<b>Introduction &amp; Acknowledgements .....</b>	<b>v</b>
<b>Safe Sleep Practices</b>	
Standard 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction.....	1
Standard 3.1.4.2: Swaddling .....	4
Standard 3.1.4.3: Pacifier Use.....	4
Standard 3.1.4.4: Scheduled Rest Periods and Sleep Arrangements .....	5
Standard 2.2.0.1: Methods of Supervision of Children .....	6
<b>Safe Sleep Environment</b>	
Standard 5.4.5.1: Sleeping Equipment and Supplies.....	7
Standard 5.4.5.2: Cribs .....	9
Standard 5.4.5.3: Stackable Cribs .....	10
Standard 6.4.1.3: Crib Toys.....	11
Standard 2.2.0.2: Limiting Infant/Toddler Time in Crib, High Chair, Car Seat, Etc.....	11
Standard 5.3.1.10: Restrictive Infant Equipment Requirements .....	11
Standard 5.3.1.1: Safety of Equipment, Materials and Furnishings.....	12
Standard 5.3.1.2: Product Recall Monitoring .....	13
Standard 3.4.1.1: Use of Tobacco, Alcohol, and Illegal Drugs.....	13
<b>Education on Safe Sleep and Reducing the Risk of SIDS</b>	
<b>Knowledge Base</b>	
Standard 1.3.1.1: General Qualifications of Directors .....	14
Standard 1.3.2.4: Additional Qualifications for Caregivers/Teachers Serving Children Three to Thirty-five Months of Age .....	15
Standard 1.3.3.1: General Qualifications of Family Child Care Caregivers/Teachers to Operate a Family Child Care Home .....	16
Standard 1.3.2.7: Qualifications and Responsibilities for Health Advocates .....	17
Standard 1.6.0.1: Child Care Health Consultants .....	19
<b>Orientation, Training and Continuing Education</b>	
Standard 1.4.1.1: Pre-service Training .....	22
Standard 1.4.2.1: Initial Orientation of All Staff .....	24
Standard 1.5.0.1: Employment of Substitutes .....	24
Standard 1.5.0.2: Orientation of Substitutes .....	25
Standard 1.4.4.1: Continuing Education for Directors and Caregivers/Teachers in Centers and Large Family Child Care Homes.....	26
Standard 1.4.4.2 Continuing Education for Small Family Child Care Home Caregivers/Teachers..	28
Standard 2.4.2.1: Health and Safety Education Topics for Staff.....	29
Standard 9.4.3.3: Training Record.....	30
Standard 10.6.1.1: Regulatory Agency Provision of Caregiver/Teacher and Consumer Training and Support Services .....	30
Standard 10.6.1.2: Provision of Training to Facilities by Health Agencies .....	31

**Safe Sleep Policies and Information**

Standard 9.2.1.1: Contents of Policies ..... 31  
Standard 1.8.2.1: Staff Familiarity with Facility Policies, Plans and Procedures..... 32  
Standard 9.2.1.3: Enrollment Information to Parents/Guardians and Caregivers/Teachers..... 32  
Standard 9.4.2.3: Contents of Admissions Agreement between Child Care Program and Parent/  
Guardian ..... 34  
Standard 9.2.3.13: Plans for Evening and Nighttime Care ..... 34  
Standard 9.2.3.15: Policies Prohibiting Smoking, Tobacco, Alcohol, Illegal Drugs, and Toxic Sub-  
stances ..... 35

**Related Issues**

Standard 4.3.1.1: General Plan for Feeding Infants ..... 35  
Standard 3.6.4.5: Death ..... 37

**Index ..... 39**

## INTRODUCTION

### **Why Safe Sleep Practices are Important**

Early care and education caregivers/teachers touch the lives of young children and their families in many important ways. One of the most important ways to reduce infant deaths in child care settings is for caregivers/teachers to implement (and model for parents/guardians and families) safe sleep practices in their programs. Safe sleep practices include placing infants on their backs to sleep; using safe cribs and equipment for sleeping, prohibiting smoking, and training caregivers/teachers on appropriate safe sleep practices.

The rate of Sudden Infant Death Syndrome (SIDS) in the U.S. has dropped by more than 50 percent since the issuance of the American Academy of Pediatrics (AAP) statement advising side/back sleep positions for infants in order to reduce the risk of SIDS in 1992 and the launch of the even safer Back to Sleep Campaign (side sleeping was found to still contribute to SIDS deaths) in 1994 (1). More safe sleep actions have been identified such as the use of pacifiers, not using strollers or car safety seats as a sleep setting, and the use of no blankets, bumpers, and extraneous bedding in the sleeping area. For child care programs, swaddling is not recommended.

These recent recommendations are supported by the American Academy of Pediatrics (AAP) and can be found in *SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment (AAP, 2011)*. Caregivers and teachers need to continue this educational and implementation effort because there are still approximately 2,250 SIDS-related deaths per year in the U.S. (3). Putting into practice the standards outlined in this document can help to lower these numbers and reduce the risk to infants in care.

### **Overview of Content**

This document is a compilation of 27 nationally recognized health and safety standards from *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 3<sup>rd</sup> Edition, 2011 (CFOC3)\** on safe sleep and reducing the risk of Sudden Infant Death Syndrome (SIDS)/suffocation in child care and early education settings. Standards are listed in order of relevance to the topic. For this reason, the 27 standards are not necessarily in numerical order as they are presented in CFOC3. Throughout the document there are references to other standards contained in the full edition of CFOC3. For example, in Standard 5.3.1.1: Safety of Equipment, Materials, and Furnishing, the Related Standards section refers to Standard 3.4.6.1: Strangulation Hazards (which is not provided in this document, but can be found in the full edition at <http://nrckids.org/CFOC3>).

The intended audiences for this document are:

**child care and early education caregivers/teachers** who can implement these strategies, many of which are cost free, to provide safe sleep environments and reduce the number of SIDS/suffocation related deaths in child care and early education settings;

**state regulators and policy makers** who can promote the adoption of safe sleep practices and SIDS/suffocation risk reduction methods in their state licensing standards;

**health consultants, trainers and other health professionals** who can promote and teach these strategies to child care and early education caregivers/teachers; and

**parents/guardians** who can demand the use of these strategies and practices in their child's child care and early education setting.

As with all areas in health, new research comes forth and we recommend that users continue to visit the following web sites for the most up-to-date information on Safe sleep practices and policies and SIDS/suffocation risk reduction measures:

American Academy of Pediatrics  
<http://www.aap.org> and <http://www.healthychildcare.org>

American Public Health Association  
<http://www.apha.org>

American SIDS Institute  
<http://www.sids.org>

Association of SIDS and Infant Mortality Programs <http://www.asip1.org/>

Consumer Product Safety Commission  
<http://www.cpsc.gov>

First Candle  
<http://www.firstcandle.org>

National Institute of Child Health and Human Development  
<http://www.nichd.nih.gov/sids/>

National SUID/SIDS Resource Center  
<http://www.sidscenter.org/>

For questions or assistance on these standards or CFOC3, please contact:  
National Resource Center for Health and Safety in Child Care and Early Education (NRC)  
Toll-free Hotline: 1-800-598-KIDS (5437)  
Email: [info@nrckids.org](mailto:info@nrckids.org)  
Website: <http://nrckids.org>

## REFERENCES

1. National Institutes of Health, Eunice Kennedy Shriver National Institute of Child Health and Human Development. Back to Sleep Public Education Campaign. <http://www.nichd.nih.gov/sids/>
2. American Academy of Pediatrics, Task Force on Sudden Infant Death Syndrome. 2011. SIDS and other sleep-related infant deaths: Expansion of recommendations for a safe infant sleeping environment. *Pediatrics* 128:1030-1039.
3. Centers for Disease Control and Prevention. Sudden Unexpected Infant Death and Sudden Infant Death Syndrome. <http://www.cdc.gov/sids/>.

## ACKNOWLEDGEMENTS

Thanks to the **CFOC3 Standards Review Council**: Danette Swanson Glassy, MD, FAAP; Barbara U. Hamilton, MA; and Marilyn Krajicek, Ed.D., RN, FAAN for reviewing this compilation of Safe Sleep Practices and Reducing the Risk of SIDS/Suffocation standards. We would also like to thank all those individuals who contributed to CFOC3. A listing can be viewed at: [http://nrckids.org/CFOC3/PDFVersion/PDF\\_Color/CFOC3\\_acknowledgments.pdf](http://nrckids.org/CFOC3/PDFVersion/PDF_Color/CFOC3_acknowledgments.pdf).

Also, a special thanks to Rachel Moon, MD, FAAP, of the American Academy of Pediatrics, Task Force on Infant Positioning and SIDS, for reviewing the standards to ensure alignment with the 2011 AAP Policy, and to Erin Reiney, MPH, CHES, Public Health Analyst at the Maternal and Child Health Bureau, for reviewing the Introduction.

\* The full edition is available on the National Resource Center for Health and Safety in Child Care and Early Education (NRC) web site at <http://nrckids.org/CFOC3>. Print copies can be purchased from the American Academy of Pediatrics ([www.aap.org](http://www.aap.org)) and the American Public Health Association (<http://www.apha.org/publications/bookstore/>).

## Safe Sleep Practices

### STANDARD 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction

Facilities should develop a written policy that describes the practices to be used to promote safe sleep when infants are napping or sleeping. The policy should explain that these practices aim to reduce the risk of sudden infant death syndrome (SIDS) or suffocation death and other infant deaths that could occur when an infant is in a crib or asleep.

All staff, parents/guardians, volunteers and others approved to enter rooms where infants are cared for should receive a copy of the Safe Sleep Policy and additional educational information and training on the importance of consistent use of safe sleep policies and practices before they are allowed to care for infants (i.e., first day of employment/volunteering/subbing). Documentation that training has occurred and that these individuals have received and reviewed the written policy should be kept on file.

All staff, parents/guardians, volunteers and others who care for infants in the child care setting should follow these required safe sleep practices as recommended by the American Academy of Pediatrics (AAP) (1):

- a) Infants up to twelve months of age should be placed for sleep in a supine position (wholly on their back) for every nap or sleep time unless the infant's primary care provider has completed a signed waiver indicating that the child requires an alternate sleep position;
- b) Infants should be placed for sleep in safe sleep environments; which includes: a firm crib mattress covered by a tight-fitting sheet in a safety-approved crib (the crib should meet the standards and guidelines reviewed/approved by the U.S. Consumer Product Safety Commission [CPSC] and ASTM International [ASTM]), no monitors or positioning devices should be used unless required by the child's primary care provider, and no other items should be in a crib occupied by an infant except for a pacifier;
- c) Infants should not nap or sleep in a car safety seat, bean bag chair, bouncy seat, infant seat, swing, jumping chair, play pen or play yard, highchair, chair, futon, or any other type of furniture/equipment that is not a safety-approved crib (that is in compliance with the CPSC and ASTM safety standards) (4);
- d) If an infant arrives at the facility asleep in a car safety seat, the parent/guardian or caregiver/teacher should immediately remove the sleeping infant from this seat and place them in the supine position in a safe sleep environment (i.e., the infant's assigned crib);
- e) If an infant falls asleep in any place that is not a safe sleep environment, staff should immediately move the infant and place them in the supine position in their crib;
- f) Only one infant should be placed in each crib (stackable cribs are not recommended);
- g) Soft or loose bedding should be kept away from sleeping infants and out of safe sleep environments. These include, but are not limited to: bumper pads, pillows, quilts, comforters, sleep positioning devices, sheepskins, blankets, flat sheets, cloth diapers, bibs, etc. Also, blankets/items should not be hung on the sides of cribs. Swaddling infants when they are in a crib is not necessary or recommended, but rather one-piece sleepers should be used (see Standard 3.1.4.2 for more detail information on swaddling);
- h) Toys, including mobiles and other types of play equipment that are designed to be attached to any part of the crib should be kept away from sleeping infants and out of safe sleep environments;
- i) When caregivers/teachers place infants in their crib for sleep, they should check to ensure that the temperature in the room is comfortable for a lightly clothed adult, check the infants to ensure that they are comfortably clothed (not overheated or sweaty), and that bibs, necklaces, and garments with ties or hoods are removed (clothing sacks or other clothing designed for sleep can be used in lieu of blankets);
- j) Infants should be directly observed by sight and sound at all times, including when they are going to sleep, are sleeping, or are in the process of waking up;
- k) Bedding should be changed between children, and if mats are used, they should be cleaned between uses.

The lighting in the room must allow the caregiver/teacher to see each infant's face, to view the color of the infant's skin, and to check on the infant's breathing and placement of the pacifier (if used).

A caregiver/teacher trained in safe sleep practices and approved to care for infants should be present in each room at all times where there is an infant. This caregiver/teacher should remain alert and should actively supervise sleeping infants in an ongoing manner. Also, the caregiver/teacher should check to ensure that the infant's head remains uncovered and re-adjust clothing as needed.

The construction and use of sleeping rooms for infants separate from the infant group room is not recommended due to the need for direct supervision. In situations where there are existing facilities with separate sleeping rooms, facilities should develop a plan to modify room assignments and/or practices to eliminate placing infants to sleep in separate rooms.

Facilities should be aware of the current recommendation of the AAP about pacifier use (1). If pacifiers are allowed, facilities should have a written policy that describes relevant procedures and guidelines. Pacifier use outside of a crib in rooms and programs where there are mobile infants or toddlers is not recommended.

**RATIONALE:** Despite the decrease in deaths attributed to SIDS and the decreased frequency of prone (tummy) infant sleep positioning over the past two decades, many caregivers/teachers continue to place infants to sleep in positions

or environments that are not safe. Deaths in child care facilities attributable to SIDS continue to occur at an alarming rate, with a majority occurring in the first day or first week that an infant starts attending a child care program (2,3). Many of these deaths appear to be associated with prone positioning, especially when the infant is unaccustomed to being placed in that position (2,4).

Infants who are cared for by adults other than their parent/guardian or primary caregiver/teacher are at increased risk for dying from SIDS. Recent research and demonstration projects (2) have revealed that:

- a) Caregivers/teachers are unaware of the dangers or risks associated with prone or side infant sleep positioning, and many believe that they are using the safest practices possible, even when they are not;
- b) Although training programs are effective in improving the knowledge of caregivers/teachers, these programs alone do not always lead to changes in caregiver/teacher practices, beliefs, or attitudes;
- c) Caregivers/teachers report the following major barriers to implementing safe sleep practices:
  - 1) They have been misinformed about methods shown to reduce the risk of SIDS;
  - 2) Facilities do not have or use written “safe sleep” policies or guidelines;
  - 3) State child care regulations do not mandate the use of supine (wholly on their back) sleep position for infants in child care and/or training for infant caregivers/teachers;
  - 4) Other caregivers/teachers or parents/guardians have objections to use of safe sleep practices, either because of their concern for choking or aspiration, and/or their concern that some infants do not sleep well in the supine position;
  - 5) Parents/guardians model their practices after what happens in the hospital or what others recommend. Infants who were placed to sleep in other positions in the hospital or home environments may have difficulty transitioning to supine positioning at home and later in child care.

Training that includes observations and addresses barriers to changing caregiver/teacher practices would be most effective. Use of safe sleep policies, continued education of parents/guardians, expanded training efforts for child care professionals, statewide regulations and mandates, and increased monitoring and observation are critical to reduce the risk of SIDS and other infant deaths in child care (3).

Loose or ill-fitting sheets have caused infants to be strangled or suffocated (8).

**COMMENTS:** Background: Deaths of infants who are asleep in child care (whether attributable to SIDS, suffocation, or other causes) may be under-reported because of the lack of consistency in training and regulating death scene investigations and determining and reporting cause of death. Not all states require documentation that clarifies that an infant died while being cared for by someone other than their parents/guardians.

Although the cause of SIDS is not known, researchers believe that some infants develop in a manner that makes it challenging for them to be aroused or to breathe when they experience a life-threatening challenge during sleep. Although some state regulations require that caregivers/teachers “check on” sleeping infants every ten, fifteen, or thirty minutes, an infant can suffocate or die in only a few minutes. It is for this reason that the standards above discourage toys or mobiles in cribs and recommend direct, active, and ongoing supervision when infants are falling to sleep, are sleeping, or are becoming awake. This is also why *Caring for Our Children* describes a safe sleep environment as one that includes a safety-approved crib, firm mattress, firmly fitted sheet, and the infant placed on their back at all times, in comfortable, safe garments, but nothing else – not even a blanket.

When infants are being dropped off, staff may be busy. Requiring parents/guardians to remove the infant from the car seat and re-position them in the supine position in their crib (if they are sleeping), will reinforce safe sleep practices and reassure parents/guardians that their child is in a safe position before they leave the facility.

Challenges: National recommendations for reducing the risk of SIDS or suffocation and other infant deaths are provided for use in the general population. Most research reviewed to guide the development of these recommendations was not conducted on children in child care. Because infants are at increased risk for dying from SIDS in child care (5) and because caregivers/teachers are liable for their actions, they must err on the side of caution and must provide the safest sleep environment for the infants in their care for liability and other reasons.

When hospital staff or parents/guardians of infants who may attend child care place the infant in a position other than supine for sleep, the infant becomes accustomed to this and can have a more difficult time adjusting to child care, especially when they are placed for sleep in a new unfamiliar position.

Parents/guardians and caregivers/teachers want infants to transition to child care facilities in a comfortable and easy manner. It can be challenging for infants to fall asleep in a new environment because there are different people, equipment, lighting, noises, etc. When infants sleep well in child care, adults feel better. Placing personal items in cribs with infants and covering or wrapping infants with blankets may help the adults to believe that the child is more comfortable or feels comforted. However, this may or may not be true. These practices are not the safest practices for infants in child care, and they should not be allowed. Efforts to educate the public about reducing the risk of SIDS and suffocation and promoting the use of consistent safe sleep practices need to continue.

Special Care Plans: Some facilities require staff to place infants in a supine position for sleep unless there is documentation in a child’s special care plan indicating a medical need for a different position. This can provide the caregiver/

teacher with more confidence in implementing the safe sleep policy and refusing parental demands that are not consistent with safe sleep practices. It is likely that an infant will be unaccustomed to sleeping supine if his or her parents/guardians object to the supine position (and are therefore placing the infant prone to sleep at home). By providing educational information on the importance of consistent use of safe sleep policies and practices to expectant parents, facilities will help raise awareness of these issues, promote infant safety, and increase support for proper implementation of safe sleep policies and practices in the future.

**Use of Blankets:** AAP recommendations state that blankets may be hazardous, and use of blankets is not advisable.\*

**Use of Pacifiers:** Caregivers/teachers should be aware of the current recommendation of the AAP about pacifier use to reduce the risk of SIDS. While using pacifiers to reduce the risk of SIDS seems prudent (especially if the infant is already sleeping with a pacifier at home), pacifier use has also been shown to be associated with an increased risk of ear infections. Keeping pacifiers clean and limiting their use to sleep time is best. Using pacifiers in a sanitary and safe fashion in group care settings requires special diligence.

Pacifiers should be inspected for tears before use. Pacifiers should not be clipped to an infant's clothing or tied around an infant's neck.

For children in the general population, the AAP recommends:

- a) Consider offering a pacifier when placing the infant down for nap and sleep time;
- b) If the infant refuses the pacifier, s/he should not be forced to take it;
- c) If the infant falls asleep and the pacifier falls out of the infant's mouth, it should be removed from the crib and does not need to be reinserted. A pacifier has been shown to reduce the risk of SIDS, even if the pacifier falls out during sleep (1);
- d) Pacifiers should not be coated in any sweet solution, and they should be cleaned and replaced regularly;
- e) For breastfed infants, delay pacifier introduction until fifteen days of age to ensure that breastfeeding is well-established (7);
- f) Written permission from the child's parent/guardian is required for pacifier use in the facility.

**Swaddling:** Hospital personnel or physicians, particularly those who work in neonatal intensive care units or infant nurseries in hospitals may recommend that newborns be swaddled in the hospital setting. Although parents/guardians may choose to continue this practice at home, swaddling infants when they are being placed to sleep or are sleeping in a child care facility is not necessary or recom-

mended. See Standard 3.1.4.2 for more detailed information.

**Concern about Plagiocephaly:** If parents/guardians or caregivers/teachers are concerned about positional plagiocephaly (flat head or flat spot on head), they can continue to use safe sleep practices but also do the following:

- a) Offer infants opportunities to be held upright and participate in supervised "tummy time" when they are awake;
- b) Alter the position of the infant, and thereby alter the supine position of the infant's head and face. This can easily be accomplished by alternating the placement of the infant in the crib – place the infant to sleep with their head facing to one side for a week and then turning the infant so that their head and face are placed the other way. Infants typically turn their head to one side toward the room or door, so if they are placed with their head toward one side of the bed for one sleep time and then placed with their head toward the other side of the bed the next time, this changes the area of the head that is in contact with the mattress.

A common question among caregivers/teachers and parents/guardians is whether they should return the infant to the supine position if they roll onto their side or their tummies. Infants up to twelve months of age should be placed wholly supine for sleep every time. In fact, all children should be placed (or encouraged to lie down) on their backs to sleep. When infants are developmentally capable of rolling comfortably from their backs to their fronts and back again, there is no evidence to suggest that they should be re-positioned into the supine position.

The California Childcare Health Program has available a Safe Sleep Policy for infants in child care programs at [http://ucsfchildcarehealth.org/pdfs/forms/SafeSleep\\_policy1108.pdf](http://ucsfchildcarehealth.org/pdfs/forms/SafeSleep_policy1108.pdf) (6). AAP provides a free online course on safe sleep practices at <http://www.healthychildcare.org/sids.html>.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standard 3.1.4.2: Swaddling  
Standard 3.1.4.3: Pacifier Use  
Standard 3.1.4.4: Scheduled Rest Periods and Sleep Arrangements  
Standard 3.6.4.5: Death  
Standard 4.3.1.1: General Plan for Feeding Infants  
Standard 4.5.0.3: Activities That are Incompatible With Eating  
Standard 5.4.5.1: Sleeping Equipment and Supplies  
Standard 5.4.5.2: Cribs  
Standard 6.4.1.3: Crib Toys

**REFERENCES:**

1. American Academy of Pediatrics, Task Force on Sudden Infant Death Syndrome. 2009. Policy statement: The changing concept of SIDS: Diagnostic coding shifts, controversies regarding the sleeping environment, and new variables to consider in reducing risk. *Pediatrics* 123:188.
2. Moon R. Y., T. Calabrese, L. Aird. 2008. Reducing the risk of sudden infant death syndrome in child care and changing provider practices: Lessons learned from a demonstration project. *Pediatrics* 122:788-79.

\*This represents a change from the printed version of CFOC3 based on the AAP's new policy statement on SIDS and other sleep-related infant deaths (<http://pediatrics.aapublications.org/content/early/2011/10/12/peds.2011-2284>). This change is also noted in the html and PDF formats of CFOC3 (<http://nrckids.org/CFOC3>).

3. American Academy of Pediatrics, Back to Sleep, Healthy Child Care America, First Candle. 2008. *Reducing the risk of SIDS in child care*. <http://www.healthychildcare.org/pdf/SIDSfinal.pdf>.
4. ECELS, Healthy Child Care Pennsylvania. 2007. Car seats and swings are not safe for sleeping. *Health Link Online* 18:1-2. [http://www.ecels-healthychildcarepa.org/content/3-27-07 April-May 2007 HL Online.pdf](http://www.ecels-healthychildcarepa.org/content/3-27-07%20April-May%202007%20HL%20Online.pdf).
5. Leonard, V. 2009. *Health and safety notes: Reducing the risk of SIDS for infants in our care*. Berkeley, CA: California Childcare Health Program. [http://www.ucsfchildcarehealth.org/pdfs/healthandsafety/SIDS\\_en1009.pdf](http://www.ucsfchildcarehealth.org/pdfs/healthandsafety/SIDS_en1009.pdf).
6. California Childcare Health Program (CCHP). 2008. *Safe sleep policy for infants in child care*. Berkeley, CA: CCHP. [http://ucsfchildcarehealth.org/pdfs/forms/SafeSleep\\_policy1108.pdf](http://ucsfchildcarehealth.org/pdfs/forms/SafeSleep_policy1108.pdf).
7. Jenik, A. G., N. E. Vain, A. N. Gorenstein, N. E. Jacobi, Pacifier and Breastfeeding Trial Group. 2009. Does the recommendation to use a pacifier influence the prevalence of breastfeeding? *J Pediatrics* 155:350-54.
8. National MCH Center for Child Death Review. Sudden infant death syndrome (SIDS)/Sudden unexplained infant death (SUID): Fact sheet. <http://www.childdeathreview.org/causesSI.htm>.

### STANDARD 3.1.4.2: Swaddling

In child care settings, swaddling is not necessary or recommended.

**RATIONALE:** There is evidence that swaddling can increase the risk of serious health outcomes, especially in certain situations. The risk of sudden infant death is increased if an infant is swaddled and placed on his/her stomach to sleep (4) or if the infant can roll over from back to stomach. Loose blankets around the head can be a risk factor for sudden infant death syndrome (SIDS) (3). With swaddling, there is an increased risk of developmental dysplasia of the hip, a hip condition that can result in long-term disability (1,5). Hip dysplasia is felt to be more common with swaddling because infants' legs can be forcibly extended. With excessive swaddling, infants may overheat (i.e., hyperthermia) (2).

**COMMENTS:** Most infants in child care centers are at least six-weeks-old. Even with newborns, research does not provide conclusive data about whether swaddling should or should not be used. Benefits of swaddling may include decreased crying, increased sleep periods, and improved temperature control. However, temperature can be maintained with appropriate infant clothing and/or an infant sleeping bag. Although swaddling may decrease crying, there are other, more serious health concerns to consider, including SIDS and hip disease. If swaddling is used, it should be used less and less over the course of the first few weeks and months of an infant's life.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

#### RELATED STANDARDS:

Standard 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction

#### REFERENCES:

1. Van Sleuwen, B. E., A. C. Engelberts, M. M. Boere-Boonekamp, W. Kuis, T. W. J. Schulpen, M. P. L'Hoir. 2007. Swaddling: A systematic review. *Pediatrics* 120:e1097-e1106.
2. Franco, P., N. Seret, J. N. Van Hees, S. Scaillet, J. Groswasser,

- A. Kahn. 2005. Influence of swaddling on sleep and arousal characteristics of healthy infants. *Pediatrics* 115:1307-11.
3. Contemporary Pediatrics. 2004. *Guide for parents: Swaddling 101*. [http://www.aap.org/sections/scan/practicingsafety/Toolkit\\_Resources/Module1/swaddling.pdf](http://www.aap.org/sections/scan/practicingsafety/Toolkit_Resources/Module1/swaddling.pdf).
4. Richardson, H. L., A. M. Walker, R. S. Horne. 2010. Influence of swaddling experience on spontaneous arousal patterns and autonomic control in sleeping infants. *J Pediatrics* 157:85-91.
5. Mahan, S. T., Kasser J. R. 2008. Does Swaddling Influence Developmental Dysplasia of the Hip? *Pediatrics* 121:177-78.

### STANDARD 3.1.4.3: Pacifier Use

Facilities should be informed and follow current recommendations of the American Academy of Pediatrics (AAP) about pacifier use (1-3).

If pacifiers are allowed, facilities should have a written policy that indicates:

- a) Rationale and protocols for use of pacifiers;
- b) Written permission and any instructions or preferences from the child's parent/guardian;
- c) If desired, parent/guardian should provide at least two new pacifiers (labeled with their child's name using a waterproof label or non-toxic permanent marker) on a regular basis for their child to use. The extra pacifier should be available in case a replacement is needed;
- d) Staff should inspect each pacifier for tears or cracks (and to see if there is unknown fluid in the nipple) before each use;
- e) Staff should clean each pacifier with soap and water before each use;
- f) Pacifiers with attachments should not be allowed; pacifiers should not be clipped, pinned, or tied to an infant's clothing, and they should not be tied around an infant's neck, wrist, or other body part;
- g) If an infant refuses the pacifier, s/he should not be forced to take it;
- h) If the pacifier falls out of the infant's mouth, it does not need to be reinserted;
  - i) Pacifiers should not be coated in any sweet solution;
  - j) Pacifiers should be cleaned and stored open to air; separate from the diapering area, diapering items, or other children's personal items.

Infants should be directly observed by sight and sound at all times, including when they are going to sleep, are sleeping, or are in the process of waking up. The lighting in the room must allow the caregiver/teacher to see each infant's face, to view the color of the infant's skin, and to check on the infant's breathing and placement of the pacifier.

Pacifier use outside of a crib in rooms and programs where there are mobile infants or toddlers is not recommended.

Caregivers/teachers should work with parents/guardians to wean infants from pacifiers as the suck reflex diminishes between three and twelve months of age. Objects which provide comfort should be substituted for pacifiers (6).

**RATIONALE:** Mobile infants or toddlers may try to remove a pacifier from an infant's mouth, put it in their own mouth,

or try to reinsert it in another child's mouth. These behaviors can increase risks for choking and/or transmission of infectious diseases.

Cleaning pacifiers before and after each use is recommended to ensure that each pacifier is clean before it is inserted into an infant's mouth (5). This protects against unknown contamination or sharing. Cleaning a pacifier before each use allows the caregiver/teacher to worry less about whether the pacifier was cleaned by another adult who may have cared for the infant before they did. This may be of concern when there are staffing changes or when parents/guardians take the pacifiers home with them and bring them back to the facility.

If a caregiver/teacher observes or suspects that a pacifier has been shared, the pacifier should be cleaned. Caregivers/teachers should make sure the nipple is free of fluid after cleaning to ensure the infant does not ingest it. For this reason, submerging a pacifier is not recommended. If the pacifier nipple contains any unknown fluid, or if a caregiver/teacher questions the safety or ownership, the pacifier should be discarded (4).

While using pacifiers to reduce the risk of sudden infant death syndrome (SIDS) seems prudent (especially if the infant is already sleeping with a pacifier at home), pacifier use has been associated with an increased risk of ear infections and oral health issues (7).

**COMMENTS:** To keep current with the AAP's recommendations on the use of pacifiers, go to <http://www.aap.org>.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**REFERENCES:**

1. American Academy of Pediatrics, Task Force on Sudden Infant Death Syndrome. 2009. Policy statement: The changing concept of SIDS: Diagnostic coding shifts, controversies regarding the sleeping environment, and new variables to consider in reducing risk. *Pediatrics* 123:188.
2. Hauck, F. R. 2006. Pacifiers and sudden infant death syndrome: What should we recommend? *Pediatrics* 117:1811-12.
3. Mitchell, E. A., P. S. Blair, M. P. L'Hoir. 2006. Should pacifiers be recommended to prevent sudden infant death syndrome? *Pediatrics* 117:1755-58.
4. Reeves, D. L. 2006. Pacifier use in childcare settings. *Healthy Child Care* 9:12-13.
5. Cornelius, A. N., J. P. D'Auria, L. M. Wise. 2008. Pacifier use: A systematic review of selected parenting web sites. *J Pediatric Health Care* 22:159-65.
6. American Academy of Pediatrics, Back to Sleep, Healthy Child Care America, First Candle. 2008. *Reducing the risk of SIDS in child care*. <http://www.healthychildcare.org/pdf/SIDSfinal.pdf>.
7. Mayo Clinic. 2009. Infant and toddler health. Pacifiers: Are they good for your baby? <http://www.mayoclinic.com/health/pacifiers/PR00067/>.

### **STANDARD 3.1.4.4: Scheduled Rest Periods and Sleep Arrangements**

The facility should provide an opportunity for, but should not require, sleep and rest. The facility should make available a regular rest period for preschool and school-aged children,

if the child desires. For children who are unable to sleep, the facility should provide time and space for quiet play.

Facilities that offer infant care should use a written Safe Sleep Policy that describes the practices to be used to reduce the risk of sudden infant death syndrome (SIDS) and other infant deaths.

**RATIONALE:** Conditions conducive to sleep and rest for younger children include a consistent caregiver, a routine quiet place, regular times for rest (1), and use of similar routines and safe practices. Most preschool children in all-day care benefit from scheduled periods of rest. This rest may take the form of actual napping, a quiet time, or a change of pace between activities. The times of naps will affect behavior at home (1).

Studies suggest that sleep is essential for optimal health and growth for young children. There are studies that show the amount of time young children sleep in a twenty-four-hour period is related to obesity later in life (2). Preschool children who sleep less than other children are at higher risk of being obese adults. In a meta-analysis of the association between sleep duration and childhood obesity, children with shorter sleep durations had a 58% higher risk of developing obesity compared to children with longer sleep durations (3). Children with ten hours or less of sleep ages six to seven years of age are more likely to be obese adults than children who sleep more than ten hours.

In a nationally representative sample, three-year-olds slept an average of ten and one-half hours and five-year-olds slept an average of ten hours on weekdays (2). Daytime naps supplement the nighttime sleep period to meet the total sleep requirement. Daily sleep duration of less than twelve hours during infancy also appears to be a risk factor for overweight and adiposity in preschool-aged children (4).

**COMMENTS:** In the young infant, favorable conditions for sleep and rest include being dry, well-fed, and comfortable. Infants may need one or two (or sometimes more naps during the time they are in child care). As infants age, they typically transition to one nap per day, and having one nap per day is consistent with the schedule that most facilities follow. A facility that includes preschool and school-age children should make available books, board games and other forms of quiet play. Different practices such as rocking, holding a child while swaying, singing, reading, patting an arm or back, etc. could be included. Lighting does not need to be turned off during nap time.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

- Standard 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction
- Standard 5.2.2.1: Levels of Illumination
- Standard 5.4.5.1: Sleeping Equipment and Supplies
- Standard 5.4.5.2: Cribs

**REFERENCES:**

1. Murph, J. R., S. D. Palmer, D. Glassy, eds. 2005. *Health in child care: A manual for health professionals*. Elk Grove Village, IL: American Academy of Pediatrics.

2. Snell, E. K., E. K. Adam, G. J. Duncan. 2007. Sleep and body mass index and overweight status of children and adolescents. *Child Development*. 78:309-23.
3. Chen, Z., M. A. Beydoun, Y. Wang. 2008. Is sleep duration associated with childhood obesity? A systematic review and meta-analysis. *Obesity*. 16:265-74.
4. Taveras, E. M., S. L. Rifas-Shiman, E. Oken, E. P. Gunderson, M. W. Gillman. 2008. Short sleep duration in infancy and risk of childhood overweight. *Arch Pediatr Adolesc Med* 162:305-11.

### **STANDARD 2.2.0.1: Methods of Supervision of Children**

Caregivers/teachers should directly supervise infants, toddlers, and preschoolers by sight and hearing at all times, even when the children are going to sleep, napping or sleeping, are beginning to wake up, or are indoors or outdoors. School-age children should be within sight or hearing at all times. Caregivers/teachers should not be on one floor level of the building, while children are on another floor or room. Ratios should remain the same whether inside or outside.

School-age children should be permitted to participate in activities off the premises with appropriate adult supervision and with written approval by a parent/guardian and by the caregiver. If parents/guardians give written permission for the school-age child to participate in off-premises activities, the facility would no longer be responsible for the child during the off-premises activity and not need to provide staff for the off-premises activity.

Caregivers/teachers should regularly count children (name to face on a scheduled basis, at every transition, and whenever leaving one area and arriving at another), going indoors or outdoors, to confirm the safe whereabouts of every child at all times. Additionally, they must be able to state how many children are in their care at all times.

Developmentally appropriate child:staff ratios should be met during all hours of operation, including indoor and outdoor play and field trips, and safety precautions for specific areas and equipment should be followed. No center-based facility or large family child care home should operate with fewer than two staff members if more than six children are in care, even if the group otherwise meets the child:staff ratio. Although centers often downsize the number of staff for the early arrival and late departure times, another adult must be present to help in the event of an emergency. The supervision policies of centers and large family child care homes should be written policies.

**RATIONALE:** Supervision is basic to safety and the prevention of injury and maintaining quality child care. Parents/guardians have a contract with caregivers/teachers to supervise their children. To be available for supervision or rescue in an emergency, an adult must be able to hear and see the children. In case of fire, a supervising adult should not need to climb stairs or use a ramp or an elevator to reach the children. Stairs, ramps, and elevators may become unstable because they can be pathways for fire and smoke.

Children who are presumed to be sleeping might be awake and in need of adult attention. A child's risk-taking behavior

must be detected and illness, fear, or other stressful behaviors must be noticed and managed.

The importance of supervision is not only to protect children from physical injury, but from harm that can occur from topics discussed by children or by teasing/bullying/inappropriate behavior. It is the responsibility of caregivers/teachers to monitor what children are talking about and intervene when necessary.

Children like to test their skills and abilities. This is particularly noticeable around playground equipment. Even if the highest safety standards for playground layout, design and surfacing are met, serious injuries can happen if children are left unsupervised. Adults who are involved, aware, and appreciative of young children's behaviors are in the best position to safeguard their well-being. Active and positive supervision involves:

- a) Knowing each child's abilities;
- b) Establishing clear and simple safety rules;
- c) Being aware of and scanning for potential safety hazards;
- d) Standing in a strategic position;
- e) Scanning play activities and circulating around the area;
- f) Focusing on the positive rather than the negative to teach a child what is safe for the child and other children;
- g) Teaching children the appropriate and safe use of each piece of equipment (e.g., using a slide correctly – feet first only – and teaching why climbing up a slide can cause injury, possibly a head injury).

Children are going to be more active in the outdoor learning/play environment and need more supervision rather than less outside. Playground supervisors need to be designated and trained to supervise children in play areas (1). Supervision of the playground is a strategy of watching all the children within a specific territory and not engaging in prolonged dialog with any one child or group of children (or other staff). Other adults not designated to supervise may facilitate outdoor learning/play activities and engage in conversations with children about their exploration and discoveries. Facilitated play is where the adult is engaged in helping children learn a skill or achieve specific outcome of an activity. Facilitated play is not supervision (2).

Children need spaces, indoors and out, in which they can withdraw for alone-time or quiet play in small groups. However, program spaces should be designed with visibility that allows constant unobtrusive adult supervision. To protect children from maltreatment, including sexual abuse, the environment layout should limit situations in which an adult or older child is left alone with a child without another adult present (3,4).

Many instances have been reported where a child has hidden when the group was moving to another location, or where the child wandered off when a door was opened for another purpose. Regular counting of children (name to face) will alert the staff to begin a search before the child

gets too far, into trouble, or slips into an unobserved location.

Caregivers/teachers should record the count on an attendance sheet or on a pocket card, along with notations of any children joining or leaving the group. Caregivers/teachers should do the counts before the group leaves an area and when the group enters a new area. The facility should assign and reassign counting responsibility as needed to maintain a counting routine. Facilities might consider counting systems such as using a reminder tone on a watch or musical clock that sounds at timed intervals (about every fifteen minutes) to help the staff remember to count.

Caregivers/teachers should be ready to provide help and guidance when children are ready to use the toilet correctly and independently. Caregivers/teachers should make sure children correctly wash their hands after every use of the toilet, as well as monitor the bathroom to make sure that the toilet is flushed, the toilet seat and floor are free from stool or urine, and supplies (toilet paper, soap, and paper towels) are available.

Older preschool children and school-age children may use toilet facilities without direct visual observation but must remain within hearing range in case children need assistance and to prevent inappropriate behavior. If toilets are not on the same floor as the child care area or within sight or hearing of a caregiver/teacher, an adult should accompany children younger than five years of age to and from the toilet area. Younger children who request privacy and have shown capability to use toilet facilities properly should be given permission to use separate and private toilet facilities.

Planning must include advance assignments, monitoring, and contingency plans to maintain appropriate staffing. During times when children are typically being dropped off and picked up, the number of children present can vary. There should be a plan in place to monitor and address unanticipated changes, allowing for caregivers/teachers to receive additional help when needed. Sufficient staff must be maintained to evacuate the children safely in case of emergency. Compliance with proper child:staff ratios should be measured by structured observation, by counting caregivers/teachers and children in each group at varied times of the day, and by reviewing written policies.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

- Standards 1.1.1.1-1.1.1.5: Child:Staff Ratios
- Standard 3.4.4.5: Facility Layout to Reduce Risk of Child Abuse and Neglect
- Standard 5.4.1.2: Location of Toilets and Privacy Issues

**REFERENCES:**

1. National Program for Playground Safety. 2006. Playground supervision training for childcare providers. University of Northern Iowa. [http://www.playgroundsafety.org/training/online/childcare/course\\_supervision.htm](http://www.playgroundsafety.org/training/online/childcare/course_supervision.htm).
2. National Program for Playground Safety. 2006. NPPS Website. <http://www.playgroundsafety.org>.
3. National Association for the Education of Young Children. 1996.

Position Statement. Prevention of child abuse in early childhood programs and the responsibilities of early childhood professionals to prevent child abuse.

4. Fiene, R. 2002. *13 indicators of quality child care: Research update*. Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. <http://aspe.hhs.gov/hsp/ccquality-ind02/>.

**ADDITIONAL READINGS:**

- Harms, T., R. M. Clifford, D. Cryer. 2005. Early childhood environment rating scale, revised ed. Frank Porter Graham Child Development Institute, University of North Carolina. <http://ers.fpg.unc.edu/node/82/>.
- Harms, T., D. Cryer, R. M. Clifford. 2005. Infant/toddler environment rating scale, revised ed. Frank Porter Graham Child Development Institute, University of North Carolina. <http://ers.fpg.unc.edu/node/84/>.
- Chen, X., M. Beran, R. Altkorn, S. Milkovich, K. Gruaz, G. Rider, A. Kanti, J. Ochsenhirt. 2006. Frequency of caregiver supervision of young children during play. *Intl J Injury Control and Safety Promotion* 14:122-24.
- Schwebel, D. C., A. L. Summerlin, M. L. Bounds, B. A. Morrongiello. 2006. The stamp-in-safety program: A behavioral intervention to reduce behaviors that can lead to unintentional playground injury in a preschool setting. *J Pediatric Psychology* 31:152-62.
- U.S. Consumer Product Safety Commission (CPSC). 2010. Public playground safety handbook. <http://www.cpsc.gov/cpscpub/pubs/325.pdf>.

## Safe Sleep Environments

### STANDARD 5.4.5.1: Sleeping Equipment and Supplies

Facilities should have an individual crib, cot, sleeping bag, bed, mat, or pad that has not been recalled for each child who spends more than four hours a day at the facility. No child should simultaneously share a crib, bed, or bedding with another child. Facilities should ensure that toddler beds are in compliance with the current U.S. Consumer Product Safety Commission (CPSC) and ASTM safety standards (1). Clean linens should be provided for each child. Beds and bedding should be washed between uses if used by different children. Regardless of age group, bed linens should not be used as rest equipment in place of cots, beds, pads, or similar approved equipment. Bed linens used under children on cots, cribs, futons, and playpens should be tight-fitting. Sheets for an adult bed should not be used on a crib mattress. See Standard 5.4.5.2 for crib specifications.

When pads are used, they should be enclosed in washable covers and should be long enough so the child's head or feet do not rest off the pad. Mats and cots should be made with a waterproof material that can be easily washed and sanitized. Plastic bags or loose plastic material should never be used as a covering.

No child should sleep on a bare, uncovered surface. Seasonally appropriate covering, such as sheets, sleep garments, or blankets that are sufficient to maintain adequate warmth, should be available and should be used by each child below school-age. Pillows, blankets, and sleep positioners should not be used with infants. If pillows are used

by toddlers and older children, pillows should have removable cases that can be laundered, be assigned to a child, and used by that child only while s/he is enrolled in the facility. Each child's pillow, blanket, sheet, and any special sleep item should be stored separately from those of other children.

Pads and sleeping bags should not be placed directly on any floor that is cooler than 65°F when children are resting. Cribs, cots, sleeping bags, beds, mats, or pads in/on which children are sleeping should be placed at least three feet apart. If the room used for sleeping cannot accommodate three feet of spacing between children, it is recommended for caregivers/teachers to space children as far as possible from one another and/or alternate children head to feet. Screens used to separate sleeping children are not recommended because screens can affect supervision, interfere with immediate access to a child, and could potentially injure a child if pushed over on a child. If unoccupied sleep equipment is used to separate sleeping children, the arrangement of such equipment should permit the staff to observe and have immediate access to each child. The ends of cribs do not suffice as screens to separate sleeping children.

The sleeping surfaces of one child's rest equipment should not come in contact with the sleeping surfaces of another child's rest equipment during storage.

Caregivers/teachers should never use strings to hang any object, such as a mobile, or a toy or a diaper bag, on or near the crib where a child could become caught in it and strangle.

Infant monitors and their cords and other electrical cords should never be placed in the crib or sleeping equipment.

Crib mattresses should fit snugly and be made specifically for the size crib in which they are placed. Infants should not be placed on an inflatable mattress due to potential of entrapment or suffocation.

**RATIONALE:** Separate sleeping and resting, even for siblings, reduces the spread of disease from one child to another.

Droplet transmission occurs when droplets containing microorganisms generated from an infected person, primarily during coughing, sneezing, or talking are propelled a short distance (three feet) and deposited on the conjunctivae, nasal mucosa, or mouth (2).

Because respiratory infections are transmitted by large droplets of respiratory secretions, a minimum distance of three feet should be maintained between cots, cribs, sleeping bags, beds, mats, or pads used for resting or sleeping (2). A space of three feet between cribs, cots, sleeping bags, beds, mats, or pads will also provide access by the staff to a child in case of emergency. If the facility uses screens to separate the children, their use must not hinder observation of children by staff or access to children in an emergency.

Lice infestation, scabies, and ringworm are among the most common infectious diseases in child care. These diseases

are transmitted by direct person-to-person contact. Ringworm is transmitted by the sharing of personal articles such as combs, brushes, towels, clothing, and bedding. Prohibiting the sharing of personal articles helps prevent the spread of these diseases.

The use of tight-fitting bed linens prevents suffocation and strangling. Adult bed sheets can become loose and entangle an infant (3).

From time to time, children drool, spit up, or spread other body fluids on their sleeping surfaces. Using cleanable, waterproof, nonabsorbent rest equipment enables the staff to wash and sanitize the sleeping surfaces. Plastic bags may not be used to cover rest and sleep surfaces/equipment because they contribute to suffocation if the material clings to the child's face.

Canvas cots are not recommended for infants and toddlers. The end caps require constant replacement and the cots are a cutting/pinching hazard when end caps are not in place. A variety of cots are made with washable sleeping surfaces that are designed to be safe for children.

**COMMENTS:** Although children freely interact and can contaminate each other while awake, reducing the transmission of infectious disease agents on large airborne droplets during sleep periods will reduce the dose of such agents to which the child is exposed overall. In small family child care homes, the caregiver/teacher should consider the home to be a business during child care hours and is expected to abide by regulatory expectations that may not apply outside of child care hours. Therefore, child siblings related to the caregiver/teacher may not sleep in the same bed during the hours of operation.

Caregivers/teachers may ask parents/guardians to provide bedding that will be sent home for washing at least weekly or sooner if soiled.

Pillows are not required for older children.

Many caregivers/teachers find that placing children in alternate positions so that one child's head is across from the other's feet reduces interaction and promotes settling during rest periods. This positioning may be beneficial in reducing transmission of infectious agents as well.

The use of solid crib ends as barriers between sleeping children can serve as a barrier if they are three feet away from each other (2).

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standard 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction

Standard 3.4.6.1: Strangulation Hazards

Standard 5.4.5.2: Cribs

Standard 9.2.4.5: Emergency and Evacuation Drills/Exercises Policy

**REFERENCES:**

1. U.S. Consumer Product Safety Commission (CPSC). 2011. CPSC approves new mandatory standard for toddler beds. <http://www.cpsc.gov/cpscpub/prerel/prhtml11/11199.html>.

2. Pickering, L. K., C. J. Baker, D. W. Kimberlin, S. S. Long, eds. 2009. *Red book: 2009 report of the Committee on Infectious Diseases*, 153. Elk Grove Village, IL: American Academy of Pediatrics.

3. American Academy of Pediatrics. 2010. Ages and stages: A parent's guide to safe sleep. Healthy Children. <http://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx>.

### **STANDARD 5.4.5.2: Cribs**

Facilities should check each crib before its purchase and use to ensure that it is in compliance with the current U.S. Consumer Product Safety Commission (CPSC) and ASTM safety standards.

Recalled or “second-hand” cribs should not be used or stored in the facility. When it is determined that a crib is no longer safe for use in the facility, it should be dismantled and disposed of appropriately.

Staff should only use cribs for sleep purposes and should ensure that each crib is a safe sleep environment. No child of any age should be placed in a crib for a time-out or for disciplinary reasons. When an infant becomes large enough or mobile enough to reach crib latches or potentially climb out of a crib, they should be transitioned to a different sleeping environment (such as a cot or sleeping mat).

Each crib should be identified by brand, type, and/or product number and relevant product information should be kept on file (with the same identification information) as long as the crib is used or stored in the facility.

Staff should inspect each crib before each use to ensure that hardware is tightened and that there are not any safety hazards. If a screw or bolt cannot be tightened securely, or there are missing or broken screws, bolts, or mattress support hangers, the crib should not be used.

Safety standards document that cribs used in facilities should be made of wood, metal, or plastic. Crib slats should be spaced no more than two and three-eighths inches apart, with a firm mattress that is fitted so that no more than two fingers can fit between the mattress and the crib side in the lowest position. The minimum height from the top of the mattress to the top of the crib rail should be twenty inches in the highest position. Cribs with drop sides should not be used. The crib should not have corner post extensions (over one-sixteenth inch). The crib should have no cutout openings in the head board or footboard structure in which a child's head could become entrapped. The mattress support system should not be easily dislodged from any point of the crib by an upward force from underneath the crib. All cribs should meet the ASTM F1169-10a Standard Consumer Safety Specification for Full-Size Baby Cribs, F406-10b Standard Consumer Safety Specification for Non-Full-Size Baby Cribs/Play Yards, or the CPSC 16 CFR 1219, 1220, and 1500 – Safety Standards for Full-Size Baby Cribs and Non-Full-Size Baby Cribs; Final Rule.

Cribs should be placed away from window blinds or draperies.

As soon as a child can stand up, the mattress should be adjusted to its lowest position. Once a child can climb out of his/her crib, the child should be moved to a bed. Children should never be kept in their crib by placing, tying, or wedging various fabric, mesh, or other strong coverings over the top of the crib.

Cribs intended for evacuation purpose should be of a design and have wheels that are suitable for carrying up to five non-ambulatory children less than two years of age to a designated evacuation area. This crib should be used for evacuation in the event of fire or other emergency. The crib should be easily moveable and should be able to fit through the designated fire exit.

**RATIONALE:** Standards have been developed to define crib safety, and staff should make sure that cribs used in the facility meet these standards to protect children and prevent injuries or death (1-3). Significant changes to the ATSM and CPSC standards for cribs were published in December 2010. As of June 28, 2011 all cribs being manufactured, sold or leased must meet the new stringent requirements. Effective December 28, 2012 all cribs being used in early care and education facilities including family child care homes must also meet these standards. For the most current information about these new standards please go to <http://www.cpsc.gov/info/cribs/index.html>.

More infants die every year in incidents involving cribs than with any other nursery product (4). Children have become trapped or have strangled because their head or neck became caught in a gap between slats that was too wide or between the mattress and crib side.

An infant can suffocate if its head or body becomes wedged between the mattress and the crib sides (6).

Corner posts present a potential for clothing entanglement and strangulation (5). Asphyxial crib deaths from wedging the head or neck in parts of the crib and hanging by a necklace or clothing over a corner post have been well-documented (6).

Children who are thirty-five inches or taller in height have outgrown a crib and should not use a crib for sleeping (4). Turning a crib into a cage (covering over the crib) is not a safe solution for the problems caused by children climbing out. Children have died trying to escape their modified cribs by getting caught in the covering in various ways and firefighters trying to rescue children from burning homes have been slowed down by the crib covering (6).

CPSC has received numerous reports of strangulation deaths on window blind cords over the years (7).

**COMMENTS:** For more information on articles in cribs, see Standard 5.4.5.1: Sleeping Equipment and Supplies and Standard 6.4.1.3: Crib Toys.

A “safety-approved crib” is one that has been certified by the Juvenile Product Manufacturers Association (JPMA).

If portable cribs and those that are not full-size are substituted for regular full-sized cribs, they must be maintained in the condition that meets the ASTM F406-10b Standard

Consumer Safety Specification for Non-Full-Size Baby Cribs/Play Yards. Portable cribs are designed so they may be folded or collapsed, with or without disassembly. Although portable cribs are not designed to withstand the wear and tear of normal full-sized cribs, they may provide more flexibility for programs that vary the number of infants in care from time to time.

Cribs designed to be used as evacuation cribs, can be used to evacuate infants, if rolling is possible on the evacuation route(s).

To keep window blind cords out of the reach of children, staff can use tie-down devices or take the cord loop and cut it in half to make two separate cords. Consumers can call 1-800-506-4636 or visit the Window Covering Safety Council Website at <http://windowcoverings.org> to receive a free repair kit for each set of blinds.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standard 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction

Standard 5.4.5.1: Sleeping Equipment and Supplies

Standard 5.4.5.3: Stackable Cribs

Standard 6.4.1.3: Crib Toys

**REFERENCES:**

1. ASTM International. 2010. ASTM F1169-10a: *Standard consumer safety specification for full-size baby cribs*. West Conshohocken, PA: ASTM.
2. ASTM International. 2010. ASTM F406-10b: *Standard consumer safety specification for non-full-size baby cribs/play yards*. West Conshohocken, PA: ASTM.
3. U.S. Consumer Product Safety Commission (CPSC). 2010. Safety standards for full-size baby cribs and non-full-size baby cribs; final rule. 16 CFR 1219, 1220, and 1500. <http://www.cpsc.gov/businfo/frnotices/fr11/cribfinal.pdf>.
4. U.S. Consumer Product Safety Commission (CPSC). 1997. *The safe nursery*. Washington, DC: CPSC. <http://www.cpsc.gov/cpscpub/pubs/202.pdf>.
5. Juvenile Products Manufacturers Association. 2007. *Safe and sound for baby: A guide to juvenile product safety, use, and selection*. 9th ed. Moorestown, NJ: JPMA. <http://www.jpma.org/content/retailers/safe-and-sound/>.
6. U.S. Consumer Product Safety Commission (CPSC). 1996. CPSC warns parents about infant strangulations caused by failure of crib hardware. Document #5025. <http://www.cpsc.gov/cpscpub/pubs/5025.html>.
7. U.S. Consumer Product Safety Commission (CPSC). *Are your window coverings safe?* <http://www.cpsc.gov/cpscpub/pubs/5009a.pdf>.

**STANDARD 5.4.5.3: Stackable Cribs**

Use of stackable cribs (i.e., cribs that are built in a manner that there are two or three cribs above each other that do not touch the ground floor) in facilities is not advised. In older facilities, where these cribs are already built into the structure of the facility, staff should develop a plan for phasing out the use of these cribs.

If stackable cribs are used, they must meet the current Consumer Product Safety Commission's (CPSC) federal

standard for non-full-size cribs, 16 CFR 1220. In addition they should be three feet apart and staff placing or removing a child from a crib that cannot reach from standing on the floor, should use a stable climbing device such as a permanent ladder rather than climbing on a stool or chair. Infants who are able to sit, pull themselves up, etc. should not be placed in stackable cribs.

**RATIONALE:** Stackable cribs are designed to save space by having one crib built on top of another. Although they may be practical from the standpoint of saving space, infants on the top level of stackable cribs will be positioned at a height that will be several feet from the floor. Infants who fall from several feet or more can have an intracranial hemorrhage (i.e., serious bleed inside of the skull). While no injury reports have been filed, there is a potential for injury as a result of either latch malfunction or a caregiver/teacher who slips or falls while placing or removing a child from a crib. It is best practice to place an infant to sleep in a safe sleep environment (safety-approved crib with a firm mattress and a tight-fitting sheet) at a level that is close to the floor.

A minimum distance of three feet between cribs is required because respiratory infections are transmitted by large droplets of respiratory secretions, which usually are limited to a range of less than three feet from the infected person. (1).

Young children placed to sleep in stackable cribs may have difficulties falling asleep because they may not be used to sleeping in this type of equipment. In addition, requiring staff to use stackable cribs may cause them concern and fear regarding their liability if an injury occurs.

**COMMENTS:** Many state child care licensing regulations prohibit the use of stackable cribs (2). If stackable cribs are not prohibited in the caregiver's/teacher's state and they are used, parents/guardians should be informed and extreme care should be taken to ensure that no infant falls from the higher level cribs due to the potential for injury. Any injury that is suspected to be related to the use of stackable cribs should be reported to the U.S. Consumer Product Safety Commission (CPSC) at 1-800-638-2772 or <http://www.cpsc.gov>.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standard 5.4.5.1: Sleeping Equipment and Supplies

Standard 5.4.5.2: Cribs

**REFERENCES:**

1. Pickering, L. K., C. J. Baker, D. W. Kimberlin, S. S. Long, eds. 2009. *Red book: 2009 report of the Committee on Infectious Diseases*, 153. Elk Grove Village, IL: American Academy of Pediatrics.
2. National Resource Center for Health and Safety in Child Care and Early Education (NRC). 2010. NRC Website. Individual states' child care licensure regulations. <http://nrckids.org/STATES/states.htm>.

### **STANDARD 6.4.1.3: Crib Toys**

Crib gyms, crib toys, mobiles, mirrors, and all objects/toys are prohibited in or attached to an infant's crib. Items or toys should not be hung from the ceiling over an infant's crib.

**RATIONALE:** Falling objects could cause injury to an infant lying in a crib.

The presence of crib gyms presents a potential strangulation hazard for infants who are able to lift their head above the crib surface. These children can fall across the crib gym and not be able to remove themselves from that position (1).

The presence of mobiles, crib toys, mirrors, etc. present a potential hazard if the objects can be reached and/or pulled down by an infant (1). Some stuffed animals and other objects that dangle from strings can wrap around a child's neck (2).

Soft objects/toys can cause suffocation.

**COMMENTS:** Ornamental or small toys are often hung over an infant to provide stimulation; however, the crib should be used for sleep only. The crib is not recommended as a place to entertain an infant or to "contain" an infant. If an infant is not content in a crib, the infant should be removed.

Even though this is best practice for infants in any environment, the recommendation for prohibiting all crib gyms, mobiles, and all toys/objects in or attached to cribs may differ from what is done at an infant's home. Caregivers/teachers have a professional responsibility to ensure a safe environment for children; therefore, child care settings are held at a higher standard, warranting the removal of these potential hazards.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standard 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction

**REFERENCES:**

1. U.S. Consumer Product Safety Commission (CPSC). CPSC warns of strangulation with crib toys. Consumer Product Safety Alert. <http://www.cpsc.gov/cpscpub/pubs/5024.pdf>.
2. American Academy of Pediatrics, Task Force on Sudden Infant Death Syndrome. 2005. Policy statement: The changing concept of sudden infant death syndrome: Diagnostic coding shifts, controversies regarding the sleeping environment, and new variables to consider in reducing risk. *Pediatrics* 116:1245-55.

### **STANDARD 2.2.0.2: Limiting Infant/Toddler Time in Crib, High Chair, Car Seat, Etc.**

A child should not sit in a high chair or other equipment that constrains his/her movement (1,2) indoors or outdoors for longer than fifteen minutes, other than at meals or snack time. Children should never be left out of the view and attention of adult caregivers/teachers while in these types of equipment/furniture. A least restrictive environment should be encouraged at all times. Children should not be left to sleep in equipment, such as car seats, swings, or infant

seats that does not meet ASTM International (ASTM) product safety standards for sleep equipment.

**RATIONALE:** Children are continually developing their physical skills. They need opportunities to use and build on their physical abilities. This is especially true for infants and toddlers who are eagerly using their bodies to explore their environment. Extended periods of time in the crib, high chair, car seat, or other confined space limits their physical growth and also affects their social interactions. Injuries and Sudden Infant Death Syndrome (SIDS) have occurred when children have been left to sleep in car seats or infant seats when the straps have entrapped body parts, or the children have turned the seats over while in them. Sleeping in a seated position can restrict breathing and cause oxygen desaturation in young infants (3). Sleeping should occur in equipment manufactured for this activity. When children are awake, restricting them to a seat may limit social interactions. These social interactions are essential for children to gain language skills, develop self-esteem, and build relationships (4).

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

- Standard 3.1.3.1: Active Opportunities for Physical Activity
- Standard 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction
- Standard 5.3.1.10: Restrictive Infant Equipment Requirements
- Standard 5.4.5.1: Sleeping Equipment and Supplies
- Standard 5.4.5.2: Cribs

**REFERENCES:**

1. Kornhauser Cerar, L., C.V. Scirica, I. Stucin Gantar, D. Osredkar, D. Neubauer, T.B. Kinane. 2009. A comparison of respiratory patterns in healthy term infants placed in care safety seats and beds. *Pediatrics* 124:e396-e402.
2. Benjamin, S.E., S.L. Rifas-Shiman, E.M. Taveras, J. Haines, J. Finkelstein, K. Kleinman, M.W. Gillman. 2009. Early child care and adiposity at ages 1 and 3 years. *Pediatrics* 124:555-62.
3. Bass, J. L., M. Bull. 2008. Oxygen desaturation in term infants in car safety seats. *Pediatrics* 110:401-2.
4. New York State Office of Children and Family Services. Website. <http://www.ocfs.state.ny.us/main/>.

### **STANDARD 5.3.1.10: Restrictive Infant Equipment Requirements**

Restrictive infant equipment such as swings, stationary activity centers (e.g., exersaucers), infant seats (e.g., bouncers), molded seats, etc., if used, should only be used for short periods of time (a maximum of fifteen minutes twice a day) (1). Infants should not be placed in equipment until they are developmentally ready. Infants should be supervised when using equipment. Safety straps should be used if provided by the manufacturer of the equipment. Equipment should not be placed on elevated surfaces, uneven surfaces, near the top of stairs, or within reach of safety hazards. Stationary activity centers should be used with the stabilizing legs down in a locked position. Infants should not be allowed to sleep in equipment that was not manufactured as infant rest/sleep equipment. The use of jumpers (attached to a door frame or ceiling) and infant walkers is prohibited.

**RATIONALE:** Keeping an infant confined in a piece of infant equipment prevents an infant from active movement. Infants need the opportunity to play on the floor in a safe open area to develop their gross motor skills. If infants are not given the opportunity for floor time, their development can be hindered or delayed (2). The shape of an infant's head can be affected if pressure is applied often and for long periods of time. This molding of the skull is called plagiocephaly. Due to the recommendation for back sleeping, an infant's skull already experiences a great amount of time with pressure on the back of the head. When an infant is kept in a piece of infant equipment such as an infant seat or a swing, the pressure again is applied to the back of an infant's head; thus, increasing the likelihood of plagiocephaly. To prevent plagiocephaly and to promote normal development, infants should spend time on their tummies when awake and supervised (3).

Infants are not well-protected in restrictive infant equipment and can be injured by animals or other children. Other children or animals can hang, climb, or jump on or into the equipment; therefore, supervision is required during use. Safety straps must be used to prevent injuries and deaths of infants; infants have fallen out of equipment or have been strangled when safety straps have not been used (10).

Equipment must always be placed on the floor and away from the top of stairs to prevent falls; infants have been injured when equipment has been pushed or pulled off an elevated surface or the top of stairs. The surface or floor under the equipment needs to be level to prevent the risk of the equipment tipping over. It is imperative for equipment to be placed out of the reach of potential safety hazards such as furniture, dangling appliance cords, curtain pulls, blind cords, hot surfaces, etc., so infants cannot reach them. The guideline of twenty minutes twice a day was designated so that use could be clearly measured and monitored (1).

Infants should not be placed in equipment, such as stationary activity centers, that require them to support their heads on their own unless they have mastered this skill. Allowing infants to sleep in infant equipment is not recommended due to the documented decrease in an infant's oxygen saturation caused by the downward flexion of an infant's head and neck due to an infant's underdeveloped head and neck muscles (8,9). If an infant falls asleep in a piece of equipment, the infant should be promptly removed and placed flat on the infant's back in a safety approved crib.

If the stabilizing legs on stationary activity centers are not down and locked in place, this puts an infant at risk of tipping over in the equipment as well as creates an unstable piece of equipment for a mobile infant to use to pull himself up.

Infant walkers are dangerous because they move children around too fast and to hazardous areas, such as stairs. The upright position also can cause children in walkers to "tip over" or can bring children close to objects that they can pull down onto themselves. In addition, walkers can run over or run into others, causing pain or injury. Many injuries, some fatal, have been associated with infant walkers (4-7).

There have been several reports of spring/clamp breaking on various models of jumpers (jump-up seats) according to the CPSC (7).

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standard 3.1.3.4: Caregivers'/Teachers' Encouragement of Physical Activity

**REFERENCES:**

1. National Association for Family Child Care, The Family Child Care Accreditation Project, Wheelock College. 2005. *Quality standards for NAFCC accreditation*, standard 4.5. 4th ed. Salt Lake City, UT: NAFCC. <http://www.nafcc.org/documents/QualStd.pdf>.
2. American Physical Therapy Association (APTA). 2008. Lack of time on tummy shown to hinder achievement of developmental milestones, say physical therapists. Press release.
3. American Academy of Pediatrics (AAP), Healthy Child Care America. 2008. *Back to sleep, tummy to play*. Elk Grove Village, IL: AAP. <http://www.healthychildcare.org/pdf/SIDStummytime.pdf>.
4. American Academy of Pediatrics, Committee on Injury and Poison Prevention. 2008. Policy statement: Injuries associated with infant walkers. *Pediatrics* 122:450.
5. DiLillo, D., A. Damashek, L. Peterson. 2001. Maternal use of baby walkers with young children: Recent trends and possible alternatives. *Injury Prevention* 7:223-27.
6. Shields, B. J., G. A. Smith. 2006. Success in the prevention of infant walker-related injuries: An analysis of national data, 1990-2001. *Pediatrics* 117: e452-59.
7. Chowdhury, R. T. 2009. *Nursery product-related injuries and deaths among children under age five*. Washington, DC: U.S. Consumer Product Safety Commission. <http://www.cpsc.gov/library/nursery07.pdf>.
8. Kinane, T. B., J. Murphy, J. L. Bass, M. J. Corwin. 2006. Comparison of respiratory physiologic features when infants are placed in car safety seats or car beds. *Pediatrics* 118:522-27.
9. Kornhauser, C. L., C. V. Scirica, I. S. Gantar, D. Osredkar, D. Neubauer, T. B. Kinane. 2009. A comparison of respiratory patterns in healthy term infants placed in car safety seats and beds. *Pediatrics* 124: e396-e402.
10. Warda, L., G. Griggs. 2006. *Childhood Falls in Manitoba: CHIRPP Report: An assessment of injury severity and fall events by age group*. Winnipeg: The Injury Prevention Centre of Children's Hospital. <http://www.mpeta.ca/documents/IOI/Falls.pdf>.

**STANDARD 5.3.1.1: Safety of Equipment, Materials, and Furnishings**

Equipment, materials, furnishings, and play areas should be sturdy, safe, and in good repair and should meet the recommendations of the U.S. Consumer Product Safety Commission (CPSC) for control of the following safety hazards:

- a) Openings that could entrap a child's head or limbs;
- b) Elevated surfaces that are inadequately guarded;
- c) Lack of specified surfacing and fall zones under and around climbable equipment;
- d) Mismatched size and design of equipment for the intended users;
- e) Insufficient spacing between equipment;
- f) Tripping hazards;
- g) Components that can pinch, shear, or crush body tissues;

- h) Equipment that is known to be of a hazardous type;
- i) Sharp points or corners;
- j) Splinters;
- k) Protruding nails, bolts, or other components that could entangle clothing or snag skin;
- l) Loose, rusty parts;
- m) Hazardous small parts that may become detached during normal use or reasonably foreseeable abuse of the equipment and that present a choking, aspiration, or ingestion hazard to a child;
- n) Strangulation hazards (e.g., straps, strings, etc.);
- o) Flaking paint;
- p) Paint that contains lead or other hazardous materials;
- q) Tip-over hazards, such as chests, bookshelves, and televisions.

**RATIONALE:** The hazards listed in this standard are those found by CPSC to be most commonly associated with injury (1).

A study conducted by the Center for Injury Research and Policy of The Research Institute at Nationwide Children's Hospital found that from 1990-2007 an average of nearly 15,000 children younger than eighteen years of age visited emergency departments annually for injuries received from furniture tip-overs (2).

**COMMENTS:** Equipment and furnishings that are not sturdy, safe, or in good repair, may cause falls, entrap a child's head or limbs, or contribute to other injuries. Disrepair may expose objects that are hazardous to children. Freedom from sharp points, corners, or edges should be judged according to the Code of Federal Regulations, Title 16, Section 1500.48, and Section 1500.49. Freedom from small parts should be judged according to the Code of Federal Regulations, Title 16, Part 1501. To obtain these publications, contact the Superintendent of Documents of the U.S. Government Printing Office. For assistance in interpreting the federal regulations, contact the CPSC; the CPSC also has regional offices.

Used equipment and furnishings should be closely inspected to determine whether they meet this standard before allowing them to be placed in a child care facility. If equipment and furnishings have deteriorated to a state of disrepair, where they are no longer sturdy or safe, they should be removed from all areas of a child care facility to which children have access. Staff should check on a regular basis to ensure that toys and equipment used by children have not been recalled. A list of recalls can be accessed at <http://www.cpsc.gov>, or facilities can subscribe to an email notification list from the CPSC (see also, RELATED STANDARDS).

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

- Standard 3.4.6.1: Strangulation Hazards
- Standard 5.1.3.5: Finger-Pinch Protection Devices
- Standard 5.1.6.6: Guardrails and Protective Barriers
- Standard 5.4.5.2: Cribs

Standard 5.3.1.2: Product Recall Monitoring  
Chapter 6: Play Areas/Playgrounds and Transportation

**REFERENCES:**

1. U.S. Consumer Product Safety Commission (CPSC). 2008. *Public playground safety handbook*. Bethesda, MD: CPSC. <http://www.cpsc.gov/cpscpub/pubs/325.pdf>.
2. Gottesman, B. L., L. B. McKenzie, K. A. Conner, G. A. Smith. 2009. Injuries from furniture tip-overs among children and adolescents in the United States, 1990-2007. *Clin Pediatrics* 48:851.

**STANDARD 5.3.1.2: Product Recall Monitoring**

Staff should, on a monthly basis, seek information on recalls of juvenile products that may be in use at the facility. Of particular importance are recalls related to cribs, bassinets, and portable play yards that may be used for infant sleep. Additionally, caregivers/teachers should be aware of recalls of toys, playground equipment, strollers, and any other product routinely used by children in the child care facility.

**RATIONALE:** Product recalls are often ineffective at removing hazardous products from use because the owners/users are not aware of the recall. Children have died in child care settings from injury related to sleep equipment that had been recalled.

**COMMENTS:** The U.S. Consumer Product Safety Commission (CPSC) offers a free subscription email service for product recall notices at <http://www.cpsc.gov/cpsclist.aspx>. Subscribers can note that they only want to receive recalls related to juvenile products.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

- Standard 5.3.1.1: Safety of Equipment, Materials, and Furnishings
- Standard 5.4.5.2: Cribs
- Standard 6.4.1.2: Inaccessibility of Toys or Objects to Children Under Three Years of Age

**STANDARD 3.4.1.1: Use of Tobacco, Alcohol, and Illegal Drugs**

Tobacco use, alcohol, and illegal drugs should be prohibited on the premises of the program (both indoor and outdoor environments) and in any vehicles used by the program at all times. Caregivers/teachers should not use tobacco, alcohol, or illegal drugs off the premises during the child care program's paid time including break time.

**RATIONALE:** Scientific evidence has linked respiratory health risks to secondhand smoke. No children, especially those with respiratory problems, should be exposed to additional risk from the air they breathe. Infants and young children exposed to secondhand smoke are at risk of developing bronchitis, pneumonia, and middle ear infections when they experience common respiratory infections (1-5). Separation of smokers and nonsmokers within the same air space does not eliminate or minimize exposure of nonsmokers to secondhand smoke. Tobacco smoke contamination lingers after a cigarette is extinguished and children come in

contact with the toxins (6). Thirdhand smoke exposure also presents hazards. Thirdhand smoke refers to gases and particles clinging to smokers' hair and clothing, cushions and carpeting, and outdoor equipment, after tobacco smoke has dissipated (1). The residue includes heavy metals, carcinogens and radioactive materials that young children can get on their hands and ingest, especially if they're crawling or playing on the floor. Residual toxins from smoking at times when the children are not using the space can trigger asthma and allergies when the children do use the space (1,2).

Cigarettes used by adults are the leading cause of ignition of fatal house fires (7-9).

Adults under the influence of alcohol and other drugs cannot take care of young children and keep them safe. Alcohol use, illegal drug use and misuse of prescription or over the counter (OTC) drugs prevent caregivers/teachers from providing appropriate care to infants and children by impairing motor coordination, judgment, and response time. Safe child care necessitates alert, unimpaired caregivers/teachers.

The use of alcoholic beverages in family child care homes after children are not in care is not prohibited.

**COMMENTS:** The age, defenselessness, and dependence upon the judgment of caregivers/teachers of the children under care make this prohibition an absolute requirement.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standard 9.2.3.15: Policy on Prohibiting Tobacco, Alcohol, Illegal Drugs, and Toxic Substances

**REFERENCES:**

1. U.S. Department of Health and Human Services. 2007. *Children and secondhand smoke exposure*. Excerpts from the health consequences of involuntary exposure to tobacco smoke: A report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Coordinating Center for Health Promotion, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health.
2. Schwartz, J., K. L. Timonen, J. Pekkanen. 2000. Respiratory effects of environmental tobacco smoke in a panel study of asthmatic and symptomatic children. *Am J Resp Crit Care Med* 161:802-6.
3. Stenstrom, R., P. A. Bernard, H. Ben-Simhon. 1993. Exposure to environmental tobacco smoke as a risk factor for recurrent acute otitis media in children under the age of five years. *Inter J Pediatr Otorhinolaryngol* 27:127-36.
4. Pershagen, G. 1999. Accumulating evidence on health hazards of passive smoking. *Acta Paediatr* 88:490-92.
5. Gergen, P. J., J. A. Fowler, K. R. Maurer, et al. 1998. The burden of environmental tobacco smoke exposure on the respiratory health of children 2 months through 5 years of age in the United States: Third national health and nutritional examination survey, 1988 to 1994. *Pediatrics* 101: e8.
6. Winickoff, J. P., J. Friebely, S. E. Tanski, C. Sherrod, G. E. Matt, M. F. Hovell, R. C. McMillen. 2009. Beliefs about the health effects of "thirdhand" smoke and home smoking bans. *Pediatrics* 123: e74-e79.

7. Runyan, C. W., S. I. Bangdiwala, M. A. Linzer, et al. 1992. Risk factors for fatal residential fires. *N Eng J Med* 327:856-63.

8. Brigham, P. A., A. McGuire. 1995. Progress towards a fire-safe cigarette. *J Public Health Policy* 16:433-39.

9. Ballard, J. E., T. D. Koepsell, F. Rivara. 1992. Association of smoking and alcohol drinking with residential fire injuries. *Am J Epidemiol* 135:26-34.

## Education on Safe Sleep and Reducing the Risk of SIDS

### Knowledge Base

#### STANDARD 1.3.1.1: General Qualifications of Directors

The director of a center enrolling fewer than sixty children should be at least twenty-one-years-old and should have all the following qualifications:

- a) Have a minimum of a Baccalaureate degree with at least nine credit-bearing hours of specialized college-level course work in administration, leadership, or management, and at least twenty-four credit-bearing hours of specialized college-level course work in early childhood education, child development, elementary education, or early childhood special education that addresses child development, learning from birth through kindergarten, health and safety, and collaboration with consultants OR documents meeting an appropriate combination of relevant education and work experiences (6);
- b) A valid certificate of successful completion of pediatric first aid that includes CPR;
- c) Knowledge of health and safety resources and access to education, health, and mental health consultants;
- d) Knowledge of community resources available to children with special health care needs and the ability to use these resources to make referrals or achieve interagency coordination;
- e) Administrative and management skills in facility operations;
- f) Capability in curriculum design and implementation, ensuring that an effective curriculum is in place;
- g) Oral and written communication skills;
- h) Certificate of satisfactory completion of instruction in medication administration;
  - i) Demonstrated life experience skills in working with children in more than one setting;
  - j) Interpersonal skills;
  - k) Clean background screening.

Knowledge about parenting training/counseling and ability to communicate effectively with parents/guardians about developmental-behavioral issues, child progress, and in creating an intervention plan beginning with how the center will address challenges and how it will help if those efforts are not effective.

The director of a center enrolling more than sixty children should have the above and at least three years experience as a teacher of children in the age group(s) enrolled in the center where the individual will act as the director, plus at least six months experience in administration.

**RATIONALE:** The director of the facility is the team leader of a small business. Both administrative and child development skills are essential for this individual to manage the facility and set appropriate expectations. College-level coursework has been shown to have a measurable, positive effect on quality child care, whereas experience per se has not (1-3,5).

The director of a center plays a pivotal role in ensuring the day-to-day smooth functioning of the facility within the framework of appropriate child development principles and knowledge of family relationships (6).

The well-being of the children, the confidence of the parents/guardians of children in the facility's care, and the high morale and consistent professional growth of the staff depend largely upon the knowledge, skills, and dependable presence of a director who is able to respond to long-range and immediate needs and able to engage staff in decision-making that affects their day-to-day practice (5,6). Management skills are important and should be viewed primarily as a means of support for the key role of educational leadership that a director provides (6). A skilled director should know how to use early care and education consultants, such as health, education, mental health, and community resources and to identify specialized personnel to enrich the staff's understanding of health, development, behavior, and curriculum content. Past experience working in an early childhood setting is essential to running a facility.

Life experience may include experience rearing one's own children or previous personal experience acquired in any child care setting. Work as a hospital aide or at a camp for children with special health care needs would qualify, as would experience in school settings. This experience, however, must be supplemented by competency-based training to determine and provide whatever new skills are needed to care for children in child care settings.

**COMMENTS:** The profession of early childhood education is being informed by research on the association of developmental outcomes with specific practices. The exact combination of college coursework and supervised experience is still being developed. For example, the National Association for the Education of Young Children (NAEYC) has published the *Standards for Early Childhood Professional Preparation Programs* (4). The National Child Care Association (NCCA) has developed a curriculum based on administrator competencies; more information on the NCCA is available at <http://www.nccanet.org>.

**TYPE OF FACILITY:** Center

**RELATED STANDARDS:**

Standards 1.3.1.2-1.3.2.3: General Qualifications for all Caregivers/Teachers, Including Directors, of All Types of Facilities  
Standards 1.4.2.1-1.4.2.3: Orientation Training

Standards 1.4.3.1-1.4.3.3: First Aid and CPR Training  
Standards 1.4.4.1-1.4.6.2: Continuing Education/Professional Development

**REFERENCES:**

1. Roupp, R., J. Travers, F. M., Glantz, C. Coelen. 1979. *Children at the center: Summary findings and their implications*. Vol. 1 of *Final report of the National day care study*. Cambridge, MA: Abt Associates.
2. Howes, C. 1997. Children's experiences in center-based child care as a function of teacher background and adult:child ratio. *Merrill-Palmer Q* 43:404-24.
3. Helburn, S., ed. 1995. *Cost, quality and child outcomes in child care centers*. Denver, CO: University of Colorado at Denver.
4. National Association for the Education of Young Children (NAEYC). 2009. *Standards for early childhood professional preparation programs*. Washington, DC: NAEYC. <http://www.naeyc.org/files/naeyc/file/positions/ProfPrepStandards09.pdf>.
5. Fiene, R. 2002. *13 indicators of quality child care: Research update*. Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. <http://aspe.hhs.gov/hsp/ccquality-ind02/>.
6. National Association for the Education of Young Children (NAEYC). 2007. *NAEYC early childhood program standards and accreditation criteria: The mark of quality in early childhood education*. Washington, DC: NAEYC.

**STANDARD 1.3.2.4: Additional Qualifications for Caregivers/Teachers Serving Children Three to Thirty-Five Months of Age**

Caregivers/teachers should be prepared to work with infants and toddlers and, when asked, should be knowledgeable and demonstrate competency in tasks associated with caring for infants and toddlers:

- a) Diapering and toileting;
- b) Bathing;
- c) Feeding, including support for continuation of breastfeeding;
- d) Holding;
- e) Comforting;
- f) Practicing safe sleep practices to reduce the risk of Sudden Infant Death Syndrome (SIDS) (3);
- g) Providing warm, consistent, responsive caregiving and opportunities for child-initiated activities;
- h) Stimulating communication and language development and pre-literacy skills through play, shared reading, song, rhyme, and lots of talking;
- i) Promoting cognitive, physical, and social emotional development;
- j) Preventing shaken baby syndrome/abusive head trauma;
- k) Promoting infant mental health;
- l) Promoting positive behaviors;
- m) Setting age-appropriate limits with respect to safety, health, and mutual respect;
- n) Using routines to teach children what to expect from caregivers/teachers and what caregivers/teachers expect from them.

Caregivers/teachers should demonstrate knowledge of development of infants and toddlers as well as knowledge of

indicators that a child is not developing typically; knowledge of the importance of attachment for infants and toddlers, the importance of communication and language development, and the importance of nurturing consistent relationships on fostering positive self-efficacy development.

To help manage atypical or undesirable behaviors of children, caregivers/teachers, in collaboration with parents/guardians, should seek professional consultation from the child's primary care provider, an early childhood mental health professional, or an early childhood mental health consultant.

**RATIONALE:** The brain development of infants is particularly sensitive to the quality and consistency of interpersonal relationships. Much of the stimulation for brain development comes from the responsive interactions of caregivers/teachers and children during daily routines. Children need to be allowed to pursue their interests within safe limits and to be encouraged to reach for new skills (1-7).

**COMMENTS:** Since early childhood mental health professionals are not always available to help with the management of challenging behaviors in the early care and education setting early childhood mental health consultants may be able to help. The consultant should be viewed as an important part of the program's support staff and should collaborate with all regular classroom staff, consultants, and other staff. Qualified potential consultants may be identified by contacting mental health and behavioral providers in the local area, as well as accessing the National Mental Health Information Center (NMHIC) at <http://store.samhsa.gov/mhlocator/> and Healthy Child Care America (HCCA) at <http://www.healthychildcare.org/Contacts.html>.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standards 1.3.1.1-1.3.2.3: General Qualifications for all Caregivers/Teachers, Including Directors, of All Types of Facilities

Standards 1.4.2.1-1.4.2.3: Orientation Training

Standards 1.4.3.1-1.4.3.3: First Aid and CPR Training

Standards 1.4.4.1-1.4.6.2: Continuing Education/Professional Development

Standard 1.6.0.3: Early Childhood Mental Health Consultants

Standard 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction

Standards 4.3.1.1-4.3.1.12: Nutrition for Infants

**REFERENCES:**

1. Shore, R. 1997. *Rethinking the brain: New insights into early development*. New York: Families and Work Inst.
2. National Forum on Early Childhood Policy and Programs, National Scientific Council on the Developing Child. 2007. *A science-based framework for early childhood policy: Using evidence to improve outcomes in learning, behavior, and health for vulnerable children*. [http://developingchild.harvard.edu/index.php/library/reports\\_and\\_working\\_papers/policy\\_framework/](http://developingchild.harvard.edu/index.php/library/reports_and_working_papers/policy_framework/).
3. Moon, R. Y., T. Calabrese, L. Aird. 2008. Reducing the risk of sudden infant death syndrome in child care and changing provider practices: Lessons learned from a demonstration project. *Pediatrics* 122:788-98.
4. Fiene, R. 2002. *13 indicators of quality child care: Research update*. Washington, DC: U.S. Department of Health and Human

Services, Office of the Assistant Secretary for Planning and Evaluation. <http://aspe.hhs.gov/hsp/ccquality-ind02/>.

5. Centers for Disease Control and Prevention. Learn the signs. Act early. <http://www.cdc.gov/ncbddd/actearly/>.

6. Shonkoff, J. P., D. A. Phillips, eds. 2000. *From neurons to neighborhoods: The science of early childhood development*. Washington, DC: National Academy Press.

7. Cohen, J., N. Onunaku, S. Clothier, J. Poppe. 2005. *Helping young children succeed: Strategies to promote early childhood social and emotional development*. Washington, DC: National Conference of State Legislatures; Zero to Three. [http://main.zerotothree.org/site/DocServer/help\\_yng\\_child\\_succeed.pdf](http://main.zerotothree.org/site/DocServer/help_yng_child_succeed.pdf).

### STANDARD 1.3.3.1: General Qualifications of Family Child Care Caregivers/Teachers to Operate a Family Child Care Home

All caregivers/teachers in large and small family child care homes should be at least twenty-one years of age, hold an official credential as granted by the authorized state agency, meet the general requirements specified in Standard 1.3.2.4 through Standard 1.3.2.6, based on ages of the children served, and those in Section 1.3.3, and should have the following education, experience, and skills:

- a) Current accreditation by the National Association for Family Child Care (NAFCC) (including entry-level qualifications and participation in required training) and a college certificate representing a minimum of three credit hours of early childhood education leadership or master caregiver/teacher training or hold an Associate's degree in early childhood education or child development;
- b) A provider who has been in the field less than twelve months should be in the self-study phase of NAFCC accreditation;
- c) A valid certificate in pediatric first aid, including CPR;
- d) Pre-service training in health management in child care, including the ability to recognize signs of illness, knowledge of infectious disease prevention and safety injury hazards;
- e) If caring for infants, knowledge on safe sleep practices including reducing the risk of sudden infant death syndrome (SIDS) and prevention of shaken baby syndrome/abusive head trauma (including how to cope with a crying infant);
- f) Knowledge of normal child development, as well as knowledge of indicators that a child is not developing typically;
- g) The ability to respond appropriately to children's needs;
- h) Good oral and written communication skills;
- i) Willingness to receive ongoing mentoring from other teachers;
- j) Pre-service training in business practices;
- k) Knowledge of the importance of nurturing adult-child relationships on self-efficacy development;
- l) Medication administration training (6).

Additionally, large family child care home caregivers/teachers should have at least one year of experience serving the

ages and developmental abilities of the children in their large family child care home.

Assistants, aides, and volunteers employed by a large family child care home should meet the qualifications specified in Standard 1.3.2.3.

**RATIONALE:** In both large and small family child care homes, staff members must have the education and experience to meet the needs of the children in care (7). Small family child care home caregivers/teachers often work alone and are solely responsible for the health and safety of small numbers of children in their care.

Most SIDS deaths in child care occur on the first day of care or within the first week; unaccustomed prone (tummy) sleeping increases the risk of SIDS eighteen times (3). Shaken baby syndrome/abusive head trauma is completely preventable. Pre-service training and frequent refresher training can prevent deaths (4).

Caregivers/teachers are more likely to administer medications than to perform CPR. Seven thousand children per year require emergency department visits for problems related to cough and cold medications (5).

Age eighteen is the earliest age of legal consent. Mature leadership is clearly preferable. Age twenty-one is more likely to be associated with the level of maturity necessary to independently care for a group of children who are not one's own.

The NAFCC has established an accreditation process to enhance the level of quality and professionalism in small and large family child care (2).

**COMMENTS:** A large family child care home caregiver/teacher, caring for more than six children and employing one or more assistants, functions as the primary caregiver as well as the facility director. An operator of a large family-child-care home should be offered training relevant to the management of a small child care center, including training on providing a quality work environment for employees.

For more information on assessing the work environment of family child care employees, see *Creating Better Family Child Care Jobs: Model Work Standards*, a publication by the Center for the Child Care Workforce (CCW) (1).

**TYPE OF FACILITY:** Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standards 1.3.1.1-1.3.2.6: Qualifications for all Caregivers/Teachers, Including Directors, of All Types of Facilities  
Section 1.3.3: Family Child Care Home Caregiver/Teacher Qualifications

Standards 1.4.3.1-1.4.3.3: First Aid and CPR Training  
Standard 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction

**REFERENCES:**

1. Center for Child Care Workforce. 1999. *Creating better family child care jobs: Model work standards*. Washington, DC: Center for Child Care Workforce.
2. National Association for Family Child Care. NAFCC official Website. <http://nafcc.net>.

3. Moon, R. Y., T. Calabrese, L. Aird. 2008. Reducing the risk of sudden infant death syndrome in child care and changing provider practices: Lessons learned from a demonstration project. *Pediatrics* 122:788-98.

4. Centers for Disease Control and Prevention. Learn the signs. Act early. <http://www.cdc.gov/ncbddd/actearly/>.

5. U.S. Department of Health and Human Services. 2008. CDC study estimates 7,000 pediatric emergency department visits linked to cough and cold medication: Unsupervised ingestion accounts for 66 percent of incidents. Centers for Disease Control and Prevention (CDC). <http://www.cdc.gov/media/pressrel/2008/r080128.htm>.

6. American Academy of Pediatrics, Council on School Health. 2009. Policy statement: Guidance for the administration of medication in school. *Pediatrics* 124:1244-51.

7. National Association for Family Child Care (NAFCC). 2005. *Quality standards for NAFCC accreditation*. 4th ed. Salt Lake City, UT: NAFCC.

### STANDARD 1.3.2.7: Qualifications and Responsibilities for Health Advocates

Each facility should designate at least one administrator or staff person as the health advocate to be responsible for policies and day-to-day issues related to health, development, and safety of individual children, children as a group, staff, and parents/guardians. In large centers it may be important to designate health advocates at both the center and classroom level. The health advocate should be the primary contact for parents/guardians when they have health concerns, including health-related parent/guardian/staff observations, health-related information, and the provision of resources. The health advocate ensures that health and safety is addressed, even when this person does not directly perform all necessary health and safety tasks.

The health advocate should also identify children who have no regular source of health care, health insurance, or positive screening tests with no referral documented in the child's health record. The health advocate should assist the child's parent/guardian in locating a Medical Home by referring them to a primary care provider who offers routine child health services.

For centers, the health advocate should be licensed/certified/credentialed as a director or lead teacher or should be a health professional, health educator, or social worker who works at the facility on a regular basis (at least weekly).

The health advocate should have documented training in the following:

- a) Control of infectious diseases, including Standard Precautions, hand hygiene, cough and sneeze etiquette, and reporting requirements;
- b) Childhood immunization requirements, record-keeping, and at least quarterly review and follow-up for children who need to have updated immunizations;
- c) Child health assessment form review and follow-up of children who need further medical assessment or updating of their information;
- d) How to plan for, recognize, and handle an emergency;

- e) Poison awareness and poison safety;
- f) Recognition of safety, hazards, and injury prevention interventions;
- g) Safe sleep practices and the reduction of the risk of Sudden Infant Death Syndrome (SIDS);
- h) How to help parents/guardians, caregivers/teachers, and children cope with death, severe injury, and natural or man-made catastrophes;
- i) Recognition of child abuse, neglect/child maltreatment, shaken baby syndrome/abusive head trauma (for facilities caring for infants), and knowledge of when to report and to whom suspected abuse/neglect;
- j) Facilitate collaboration with families, primary care providers, and other health service providers to create a health, developmental, or behavioral care plan;
- k) Implementing care plans;
- l) Recognition and handling of acute health related situations such as seizures, respiratory distress, allergic reactions, as well as other conditions as dictated by the special health care needs of children;
- m) Medication administration;
- n) Recognizing and understanding the needs of children with serious behavior and mental health problems;
- o) Maintaining confidentiality;
- p) Healthy nutritional choices;
- q) The promotion of developmentally appropriate types and amounts of physical activity;
- r) How to work collaboratively with parents/guardians and family members;
- s) How to effectively seek, consult, utilize, and collaborate with child care health consultants, and in partnership with a child care health consultant, how to obtain information and support from other education, mental health, nutrition, physical activity, oral health, and social service consultants and resources;
- t) Knowledge of community resources to refer children and families who need health services including access to State Children's Health Insurance (SCHIP), importance of a primary care provider and medical home, and provision of immunizations and Early Periodic Screening, Diagnosis, and Treatment (EPSDT).

**RATIONALE:** The effectiveness of an intentionally designated health advocate in improving the quality of performance in a facility has been demonstrated in all types of early childhood settings (1). A designated caregiver/teacher with health training is effective in developing an ongoing relationship with the parents/guardians and a personal interest in the child (2,3). Caregivers/teachers who are better trained are more able to prevent, recognize, and correct health and safety problems. An internal advocate for issues related to health and safety can help integrate these concerns with other factors involved in formulating facility plans.

Children may be current with required immunizations when they enroll, but they sometimes miss scheduled immuniza-

tions thereafter. Because the risk of vaccine-preventable disease increases in group settings, assuring appropriate immunizations is an essential responsibility in child care. Caregivers/teachers should contact their child care health consultant or the health department if they have a question regarding immunization updates/schedules. They can also provide information to share with parents/guardians about the importance of vaccines.

Child health records are intended to provide information that indicates that the child has received preventive health services to stay well, and to identify conditions that might interfere with learning or require special care. Review of the information on these records should be performed by someone who can use the information to plan for the care of the child, and recognize when updating of the information by the child's primary care provider is needed. Children must be healthy to be ready to learn. Those who need accommodation for health problems or are susceptible to vaccine-preventable diseases will suffer if the staff of the child care program is unable to use information provided in child health records to ensure that the child's needs are met (5,6).

**COMMENTS:** The director should assign the health advocate role to a staff member who seems to have an interest, aptitude, and training in this area. This person need not perform all the health and safety tasks in the facility but should serve as the person who raises health and safety concerns. This staff person has designated responsibility for seeing that plans are implemented to ensure a safe and healthful facility (1).

A health advocate is a regular member of the staff of a center or large or small family child care home, and is not the same as the child care health consultant recommended in Child Care Health Consultants, Standard 1.6.0.1. The health advocate works with a child care health consultant on health and safety issues that arise in daily interactions (4). For small family child care homes, the health advocate will usually be the caregiver/teacher. If the health advocate is not the child's caregiver/teacher, the health advocate should work with the child's caregiver/teacher. The person who is most familiar with the child and the child's family will recognize atypical behavior in the child and support effective communication with parents/guardians.

A plan for personal contact with parents/guardians should be developed, even though this contact will not be possible daily. A plan for personal contact and documentation of a designated caregiver/teacher as health advocate will ensure specific attempts to have the health advocate communicate directly with caregivers/teachers and families on health-related matters.

The immunization record/compliance review may be accomplished by manual review of child health records or by use of software programs that use algorithms with the currently recommended vaccine schedules and service intervals to test the dates when a child received recommended services and the child's date of birth to identify any gaps for which referrals should be made. On the Website of the Centers for Disease Control and Prevention (CDC), individual vaccine

recommendations for children six years of age and younger can be checked at <http://www.cdc.gov/vaccines/recs/scheduler/catchup.htm>.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standards 1.3.1.1-1.3.2.3: General Qualifications for all Caregivers/Teachers, Including Directors, of All Types of Facilities

Standards 1.4.2.1-1.4.2.3: Orientation Training

Standards 1.4.3.1-1.4.3.3: First Aid and CPR Training

Standards 1.4.4.1-1.4.6.2: Continuing Education/Professional Development

Standard 1.6.0.1: Child Care Health Consultants

Standard 3.1.2.1: Routine Health Supervision and Growth Monitoring

Standards 3.1.3.1-3.1.3.4: Physical Activity and Limiting Screen Time

Standard 7.2.0.1: Immunization Documentation

Standard 7.2.0.2: Unimmunized Children

Standards 8.7.0.3: Review of Plan for Serving Children With Disabilities or Children With Special Health Care Needs

Appendices G and H: Immunization Schedules for Children and Adults

**REFERENCES:**

1. Uline, M. S. 1997. Health promotion and injury prevention in a child development center. *J Pediatr Nurs* 12:148-54.
2. Kendrick, A. S., R. Kaufmann, K. P. Messenger, eds. 1991. *Healthy young children: A manual for programs*. Washington, DC: National Association for the Education of Young Children.
3. Murph, J. R., S. D. Palmer, D. Glassy, eds. 2005. *Health in child care: A manual for health professionals*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics.
4. Alkon, A., J. Bernzweig, K. To, J. K. Mackie, M. Wolff, J. Elman. 2008. Child care health consultation programs in California: Models, services, and facilitators. *Public Health Nurs* 25:126-39.
5. Centers for Disease Control and Prevention (CDC). 2011. Immunization schedules. <http://www.cdc.gov/vaccines/recs/schedules/>.
6. Hagan, J. F., J. S. Shaw, P. M. Duncan, eds. 2008. *Bright futures: Guidelines for health supervision of infants, children, and adolescents*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics.

**STANDARD 1.6.0.1: Child Care Health Consultants**

A facility should identify and engage/partner with a child care health consultant (CCHC) who is a licensed health professional with education and experience in child and community health and child care and preferably specialized training in child care health consultation.

CCHCs have knowledge of resources and regulations and are comfortable linking health resources with child care facilities.

The child care health consultant should be knowledgeable in the following areas:

- a) Consultation skills both as a child care health consultant as well as a member of an interdisciplinary team of consultants;
- b) National health and safety standards for out-of-home child care;

- c) Indicators of quality early care and education;
- d) Day-to-day operations of child care facilities;
- e) State child care licensing and public health requirements;
- f) State health laws, Federal and State education laws (e.g., ADA, IDEA), and state professional practice acts for licensed professionals (e.g., State Nurse Practice Acts);
- g) Infancy and early childhood development, social and emotional health, and developmentally appropriate practice;
- h) Recognition and reporting requirements for infectious diseases;
- i) American Academy of Pediatrics (AAP) and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening recommendations and immunizations schedules for children;
- j) Importance of medical home and local and state resources to facilitate access to a medical home as well as child health insurance programs including Medicaid and State Children's Health Insurance Program (SCHIP);
- k) Injury prevention for children;
- l) Oral health for children;
- m) Nutrition and age-appropriate physical activity recommendations for children including feeding of infants and children, the importance of breastfeeding and the prevention of obesity;
- n) Inclusion of children with special health care needs, and developmental disabilities in child care;
- o) Safe medication administration practices;
- p) Health education of children;
- q) Recognition and reporting requirements for child abuse and neglect/child maltreatment;
- r) Safe sleep practices and policies (including reducing the risk of SIDS);
- s) Development and implementation of health and safety policies and practices including poison awareness and poison prevention;
- t) Staff health, including adult health screening, occupational health risks, and immunizations;
- u) Disaster planning resources and collaborations within child care community;
- v) Community health and mental health resources for child, parent and staff health;
- w) Importance of serving as a healthy role model for children and staff.

The child care health consultant should be able to perform or arrange for performance of the following activities:

- a) Assessing caregivers'/teachers' knowledge of health, development, and safety and offering training as indicated;
- b) Assessing parents'/guardians' health, development, and safety knowledge, and offering training as indicated;
- c) Assessing children's knowledge about health and safety and offering training as indicated;

- d) Conducting a comprehensive indoor and outdoor health and safety assessment and on-going observations of the child care facility;
- e) Consulting collaboratively on-site and/or by telephone or electronic media;
- f) Providing community resources and referral for health, mental health and social needs, including accessing medical homes, children's health insurance programs (e.g., CHIP), and services for special health care needs;
- g) Developing or updating policies and procedures for child care facilities (see comment section below);
- h) Reviewing health records of children;
- i) Reviewing health records of caregivers/teachers;
- j) Assisting caregivers/teachers and parents/guardians in the management of children with behavioral, social and emotional problems and those with special health care needs;
- k) Consulting a child's primary care provider about the child's individualized health care plan and coordinating services in collaboration with parents/guardians, the primary care provider, and other health care professionals (the CCHC shows commitment to communicating with and helping coordinate the child's care with the child's medical home, and may assist with the coordination of skilled nursing care services at the child care facility);
- l) Consulting with a child's primary care provider about medications as needed, in collaboration with parents/guardians;
- m) Teaching staff safe medication administration practices;
- n) Monitoring safe medication administration practices;
- o) Observing children's behavior, development and health status and making recommendations if needed to staff and parents/guardians for further assessment by a child's primary care provider;
- p) Interpreting standards, regulations and accreditation requirements related to health and safety, as well as providing technical advice, separate and apart from an enforcement role of a regulation inspector or determining the status of the facility for recognition;
- q) Understanding and observing confidentiality requirements;
- r) Assisting in the development of disaster/emergency medical plans (especially for those children with special health care needs) in collaboration with community resources;
- s) Developing an obesity prevention program in consultation with a nutritionist/registered dietitian (RD) and physical education specialist;
- t) Working with other consultants such as nutritionists/RDs, kinesiologists (physical activity specialists), oral health consultants, social service workers, early childhood mental health consultants, and education consultants.

The role of the CCHC is to promote the health and development of children, families, and staff and to ensure a healthy and safe child care environment (11).

The CCHC is not acting as a primary care provider at the facility but offers critical services to the program and families by sharing health and developmental expertise, assessments of child, staff, and family health needs and community resources. The CCHC assists families in care coordination with the medical home and other health and developmental specialists. In addition, the CCHC should collaborate with an interdisciplinary team of early childhood consultants, such as, early childhood education, mental health, and nutrition consultants.

In order to provide effective consultation and support to programs, the CCHC should avoid conflict of interest related to other roles such as serving as a caregiver/teacher or regulator or a parent/guardian at the site to which child care health consultation is being provided.

The CCHC should have regular contact with the facility's administrative authority, the staff, and the parents/guardians in the facility. The administrative authority should review, and collaborate with the CCHC in implementing recommended changes in policies and practices. In the case of consulting about children with special health care needs, the CCHC should have contact with the child's medical home with permission from the child's parent/guardian.

Programs with a significant number of non-English-speaking families should seek a CCHC who is culturally sensitive and knowledgeable about community health resources for the parents'/guardians' native culture and languages.

**RATIONALE:** CCHCs provide consultation, training, information and referral, and technical assistance to caregivers/teachers (10). Growing evidence suggests that CCHCs support healthy and safe early care and education settings and protect and promote the healthy growth and development of children and their families (1-10). Setting health and safety policies in cooperation with the staff, parents/guardians, health professionals, and public health authorities will help ensure successful implementation of a quality program (3). The specific health and safety consultation needs for an individual facility depend on the characteristics of that facility (1-2). All facilities should have an overall child care health consultation plan (1,2,10).

The special circumstances of group care may not be part of the health care professional's usual education. Therefore, caregivers/teachers should seek child care health consultants who have the necessary specialized training or experience (10). Such training is available from instructors who are graduates of the National Training Institute for Child Care Health Consultants (NTI) and in some states from state-level mentoring of seasoned child care health consultants known to chapter child care contacts networked through the Healthy Child Care America (HCCA) initiatives of the AAP.

Some professionals may not have the full range of knowledge and expertise to serve as a child care health consultant but can provide valuable, specialized expertise. For

example, a sanitarian may provide consultation on hygiene and infectious disease control and a Certified Playground Safety Inspector would be able to provide consultation about gross motor play hazards.

**COMMENTS:** The U.S. Department of Health and Human Services Maternal and Child Health Bureau (MCHB) has supported the development of state systems of child care health consultants through HCCA and State Early Childhood Comprehensive Systems grants and continues to support the NTI. Child care health consultants provide services to centers as well as family child care homes through on-site visits as well as phone or email consultation. Approximately twenty states are funding child care health consultant initiatives through a variety of funding sources, including Child Care Development Block Grants, TANF, and Title V. In some states a wide variety of health consultants, e.g., nutrition, kinesiology (physical activity), mental health, oral health, environmental health, may be available to programs and those consultants may operate through a team approach. Connecticut is an example of one state that has developed interdisciplinary training for early care and education consultants (health, education, mental health, social service, nutrition, and special education) in order to develop a multi-disciplinary approach to consultation (8).

Certificates are provided for graduates of the NTI upon completion of the course and continuing education units are awarded. Some states offer CCHC training. Not all states implement CCHC training as modeled by the NTI. Some states offer continuing education units, college credit, and/or certificate of completion. Credentialing is an umbrella term referring to the various means employed to designate that individuals or organizations have met or exceeded established standards. These may include accreditation of *programs or organizations* and certification, registration, or licensure of *individuals*. Accreditation refers to a legitimate state or national organization verifying that an educational program or organization meets standards. Certification is the process by which a non-governmental agency or association grants recognition to an individual who has met predetermined qualifications specified by the agency or association. Certification is applied for by individuals on a voluntary basis and represents a professional status when achieved. Typical qualifications include 1) graduation from an accredited or approved program and 2) acceptable performance on a qualifying examination. While there is no national accreditation of CCHC training programs or individual CCHCs at this time, this is a future goal. Contact NTI at [nti@unc.edu](mailto:nti@unc.edu) for additional information.

CCHC services may be provided through the public health system, resource and referral agency, private source, local community action program, health professional organizations, other non-profit organizations, and/or universities. Some professional organizations include child care health consultants in their special interest groups, such as the AAP's Section on Early Education and Child Care and the National Association of Pediatric Nurse Practitioners (NAP-NAP).

CCHCs who are not employees of health, education, family service or child care agencies may be self-employed. Compensating them for their services via fee-for-service, an hourly rate, or a retainer fosters access and accountability.

Listed below is a sample of the policies and procedures child care health consultants should review and approve:

- a) Admission and readmission after illness, including inclusion/exclusion criteria;
- b) Health evaluation and observation procedures on intake, including physical assessment of the child and other criteria used to determine the appropriateness of a child's attendance;
- c) Plans for care and management of children with communicable diseases;
- d) Plans for prevention, surveillance and management of illnesses, injuries, and behavioral and emotional problems that arise in the care of children;
- e) Plans for caregiver/teacher training and for communication with parents/guardians and primary care providers;
- f) Policies regarding nutrition, nutrition education, age-appropriate infant and child feeding, oral health, and physical activity requirements;
- g) Plans for the inclusion of children with special health or mental health care needs as well as oversight of their care and needs;
- h) Emergency/disaster plans;
- i) Safety assessment of facility playground and indoor play equipment;
- j) Policies regarding staff health and safety;
- k) Policy for safe sleep practices and reducing the risk of SIDS;
- l) Policies for preventing shaken baby syndrome/abusive head trauma;
- m) Policies for administration of medication;
- n) Policies for safely transporting children;
- o) Policies on environmental health – handwashing, sanitizing, pest management, lead, etc.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standard 1.6.0.3: Early Childhood Mental Health Consultants

Standard 1.6.0.4: Early Childhood Education Consultants

**REFERENCES:**

1. Alkon, A., J. Bernzweig, K. To, J. K. Mackie, M. Wolff, J. Elman. 2008. Child care health consultation programs in California: Models, services, and facilitators. *Public Health Nurs* 25:126-39.
2. Alkon, A., J. Farrer, J. Bernzweig. 2004. Roles and responsibilities of child care health consultants: Focus group findings. *Pediatric Nurs* 30:315-21.
3. Crowley, A. A. 2000. Child care health consultation: The Connecticut experience. *Maternal Child Health J* 4:67-75.
4. Gupta, R. S., S. Shuman, E. M. Taveras, M. Kulldorff, J. A. Finkelstein. 2005. Opportunities for health promotion education in child care. *Pediatrics* 116:499-505.
5. Farrer, J., A. Alkon, K. To. 2007. Child care health consultation programs: Barriers and opportunities. *Maternal Child Health J* 11:111-18.

6. Heath, J. M., et al. 2005. *Creating a statewide system of multi-disciplinary consultation system for early care and education in Connecticut*. Farmington, CT: Child Health and Development Institute of Connecticut. [http://nitcci.nccic.acf.hhs.gov/resources/10262005\\_93815\\_901828.pdf](http://nitcci.nccic.acf.hhs.gov/resources/10262005_93815_901828.pdf).
7. Crowley, A. A., J. M Kulikowich. 2009. Impact of training on child care health consultant knowledge and practice. *Pediatric Nurs* 35:93-100.
8. Crowley, A. A., R. M. Sabatelli. 2008. Collaborative child care health consultation: A conceptual model. *J for Specialists in Pediatric Nurs* 13:74-88.
9. Dellert, J. C., D. Gasalberti, K. Sternas, P. Lucarelli, J. Hall. 2006. Outcomes of child care health consultation services for child care providers in New Jersey: A pilot study. *Pediatric Nurs* 32:530-37.
10. Alkon, A., J. Bernzweig, K. To, M. Wolff, J. F. Mackie. 2009. Child care health consultation improves health and safety policies and practices. *Academic Pediatrics* 9:366-70.
11. Crowley, A. A. 2001. Child care health consultation: An ecological model. *J Society Pediat Nurs* 6:170-81.

## Orientation, Training and Continuing Education

### STANDARD 1.4.1.1: Pre-service Training

In addition to the credentials listed in Standard 1.3.1.1, upon employment, a director or administrator of a center or the lead caregiver/teacher in a family child care home should provide documentation of at least thirty clock-hours of pre-service training. This training should cover health, psychosocial, and safety issues for out-of-home child care facilities. Small family child care home caregivers/teachers may have up to ninety days to secure training after opening except for training on basic health and safety procedures and regulatory requirements.

All directors or program administrators and caregivers/teachers should document receipt of pre-service training prior to working with children that includes the following content on basic program operations:

- a) Typical and atypical child development and appropriate best practice for a range of developmental and mental health needs including knowledge about the developmental stages for the ages of children enrolled in the facility;
- b) Positive ways to support language, cognitive, social, and emotional development including appropriate guidance and discipline;
- c) Developing and maintaining relationships with families of children enrolled, including the resources to obtain supportive services for children's unique developmental needs;
- d) Procedures for preventing the spread of infectious disease, including hand hygiene, cough and sneeze etiquette, cleaning and disinfection of toys and equipment, diaper changing, food handling, health department notification of reportable diseases, and health issues related to having animals in the facility;
- e) Teaching child care staff and children about infection control and injury prevention through role modeling;
- f) Safe sleep practices including reducing the risk of Sudden Infant Death Syndrome (SIDS) (infant sleep position and crib safety);
- g) Shaken baby syndrome/abusive head trauma prevention and identification, including how to cope with a crying/fussy infant;
- h) Poison prevention and poison safety;
- i) Immunization requirements for children and staff;
- j) Common childhood illnesses and their management, including child care exclusion policies and recognizing signs and symptoms of serious illness;
- k) Reduction of injury and illness through environmental design and maintenance;
- l) Knowledge of U.S. Consumer Product Safety Commission (CPSC) product recall reports;
- m) Staff occupational health and safety practices, such as proper procedures, in accordance with Occupational Safety and Health Administration (OSHA) bloodborne pathogens regulations;
- n) Emergency procedures and preparedness for disasters, emergencies, other threatening situations (including weather-related, natural disasters), and injury to infants and children in care;
- o) Promotion of health and safety in the child care setting, including staff health and pregnant workers;
- p) First aid including CPR for infants and children;
- q) Recognition and reporting of child abuse and neglect in compliance with state laws and knowledge of protective factors to prevent child maltreatment;
- r) Nutrition and age-appropriate child-feeding including food preparation, choking prevention, menu planning, and breastfeeding supportive practices;
- s) Physical activity, including age-appropriate activities and limiting sedentary behaviors;
- t) Prevention of childhood obesity and related chronic diseases;
- u) Knowledge of environmental health issues for both children and staff;
- v) Knowledge of medication administration policies and practices;
- w) Caring for children with special health care needs, mental health needs, and developmental disabilities in compliance with the Americans with Disabilities Act (ADA);
- x) Strategies for implementing care plans for children with special health care needs and inclusion of all children in activities;
- y) Positive approaches to support diversity;
- z) Positive ways to promote physical and intellectual development.

**RATIONALE:** The director or program administrator of a center or large family child care home or the small family child care home caregiver/teacher is the person accountable for all policies. Basic entry-level knowledge of health and safety and social and emotional needs is essential to administer the facility. Caregivers/teachers should be knowledgeable about infectious disease and immunizations because properly implemented health policies can reduce the spread

of disease, not only among the children but also among staff members, family members, and in the greater community (1). Knowledge of injury prevention measures in child care is essential to control known risks. Pediatric first aid training that includes CPR is important because the director or small family child care home caregiver/teacher is fully responsible for all aspects of the health of the children in care. Medication administration and knowledge about caring for children with special health care needs is essential to maintaining the health and safety of children with special health care needs. Most SIDS deaths in child care occur on the first day of child care or within the first week due to unaccustomed prone (on the stomach) sleeping; the risk of SIDS increases eighteen times when an infant who sleeps supine (on the back) at home is placed in the prone position in child care (2). Shaken baby syndrome/abusive head trauma is completely preventable. It is crucial for caregivers/teachers to be knowledgeable of both syndromes and how to prevent them before they care for infants. Early childhood expertise is necessary to guide the curriculum and opportunities for children in programs (3). The minimum of a Child Development Associate credential with a system of required contact hours, specific content areas, and a set renewal cycle in addition to an assessment requirement would add significantly to the level of care and education for children.

The National Association for the Education of Young Children (NAEYC), a leading organization in child care and early childhood education, recommends annual training based on the needs of the program and the pre-service qualifications of staff (4). Training should address the following areas:

- a) Health and safety (specifically reducing the risk of SIDS, infant safe sleep practices, shaken baby syndrome/abusive head trauma), and poison prevention and poison safety;
- b) Child growth and development, including motor development and appropriate physical activity;
- c) Nutrition and feeding of children;
- d) Planning learning activities for all children;
- e) Guidance and discipline techniques;
- f) Linkages with community services;
- g) Communication and relations with families;
- h) Detection and reporting of child abuse and neglect;
- i) Advocacy for early childhood programs;
- j) Professional issues (5).

In the early childhood field there is often “crossover” regarding professional preparation (pre-service programs) and ongoing professional development (in-service programs). This field is one in which entry-level requirements differ across various sectors within the field (e.g., nursing, family support, and bookkeeping are also fields with varying entry-level requirements). In early childhood, the requirements differ across center, home, and school based settings. An individual could receive professional preparation (pre-service) to be a teaching staff member in a community-based organization and receive subsequent education and training as part of an ongoing professional development system (in-service). The same individual could also be pursuing a degree for a role as a teacher in a program for which licensure is required—

this in-service program would be considered pre-service education for the certified teaching position. Therefore, the labels *pre-service* and *in-service* must be seen as related to a position in the field, and not based on the individual’s professional development program (5).

**COMMENTS:** Training in infectious disease control and injury prevention may be obtained from a child care health consultant, pediatricians, or other qualified personnel of children’s and community hospitals, managed care companies, health agencies, public health departments, EMS and fire professionals, pediatric emergency room physicians, or other health and safety professionals in the community.

For more information about training opportunities, contact the local Child Care Resource and Referral Agency (CCRRA), the local chapter of the American Academy of Pediatrics (AAP) (AAP provides online SIDS and medication administration training), the Healthy Child Care America Project, the National Resource Center for Health and Safety in Child Care and Early Education (NRC), or the National Training Institute for Child Care Health Consultants (NTI) at the University of North Carolina at Chapel Hill. California Childcare Health Program (CCHP) has free curricula for health and safety for caregivers/teachers to become child care health advocates. The curriculum (English and Spanish) is free to download on the Web at <http://www.ucsfchildcarehealth.org/html/pandr/trainingcurrmain.htm>, and is based on NTI’s curriculum for child care health consultants. Online training for caregivers/teachers is also available through some state agencies.

For more information on social-emotional training, contact the Center on the Social and Emotional Foundations for Early Learning (CSEFEL) at <http://csefel.vanderbilt.edu>.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standard 1.3.1.1: General Qualifications of Directors  
Standard 1.4.1.1: Pre-service Training  
Standard 1.4.3.1: First Aid and CPR Training for Staff  
Standard 1.7.0.1: Pre-Employment and Ongoing Adult Health Appraisals, Including Immunization  
Chapter 3: Health Promotion and Protection  
Standard 9.2.4.5: Emergency and Evacuation Drills/Exercises Policy  
Standard 9.4.3.3: Training Record  
Standards 10.6.1.1-10.6.1.2: Caregiver/Teacher Training

**REFERENCES:**

1. Hayney M. S., J. C. Bartell. 2005. An immunization education program for childcare providers. *J of School Health* 75:147-49.
2. Moon R. Y., R. P. Oden. 2003. Back to sleep: Can we influence child care providers? *Pediatrics* 112:878-82.
3. Fiene, R. 2002. *13 indicators of quality child care: Research update*. Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. <http://aspe.hhs.gov/hsp/ccquality-ind02/>.
4. Ritchie, S., B. Willer. 2008. *Teachers: A guide to the NAEYC early childhood program standard and related accreditation criteria*. Washington, DC: National Association for the Education of Young Children (NAEYC).
5. National Association for the Education of Young Children. 2010. *Definition of early childhood professional development*, 12. Eds.

M. S. Donovan, J. D. Bransford, J. W. Pellegrino. Washington, DC: National Academy Press.

### STANDARD 1.4.2.1: Initial Orientation of All Staff

All new full-time staff, part-time staff and substitutes should be oriented to the policies listed in Standard 9.2.1.1 and any other aspects of their role. The topics covered and the dates of orientation training should be documented. Caregivers/teachers should also receive continuing education each year, as specified in Continuing Education, Standard 1.4.4.1 through Standard 1.4.6.2.

**RATIONALE:** Orientation ensures that all staff members receive specific and basic training for the work they will be doing and are informed about their new responsibilities. Because of frequent staff turnover, directors should institute orientation programs on a regular basis (3).

Orientation and ongoing training are especially important for aides and assistant teachers, for whom pre-service educational requirements are limited. Entry into the field at the level of aide or assistant teacher should be attractive and facilitated so that capable members of the families and cultural groups of the children in care can enter the field. Training ensures that staff members are challenged and stimulated, have access to current knowledge (2), and have access to education that will qualify them for new roles.

Use of videos and other passive methods of training should be supplemented by interactive training approaches that help verify content of training has been learned (4).

Health training for child care staff protects the children in care, staff, and the families of the children enrolled. Infectious disease control in child care helps prevent spread of infectious disease in the community. Outbreaks of infectious diseases and intestinal parasites in young children in child care have been shown to be associated with community outbreaks (1).

Child care health consultants can be an excellent resource for providing health and safety orientation or referrals to resources for such training.

**COMMENTS:** Many states have pre-service education and experience qualifications for caregivers/teachers by role and function. Offering a career ladder and utilizing employee incentives such as Teacher Education and Compensation Helps (TEACH) will attract individuals into the child care field, where labor is in short supply. Colleges, accrediting bodies, and state licensing agencies should examine teacher preparation guidelines and substantially increase the health content of early childhood professional preparation.

Child care staff members are important figures in the lives of the young children in their care and in the well-being of families and the community. Child care staff training should include new developments in children's health. For example; a new training program could discuss up-to-date information on the prevention of obesity and its impact on early onset of chronic diseases.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

#### RELATED STANDARDS:

Standards 1.4.4.1-1.4.6.2: Continuing Education/Professional Development  
Standard 1.6.0.1: Child Care Health Consultants  
Standard 9.2.1.1: Content of Policies  
Standard 9.4.3.3: Training Record

#### REFERENCES:

1. Crowley, A. A. 1990. Health services in child care day care centers: A survey. *J Pediatr Health Care* 4:252-59.
2. Moon R. Y., R. P. Oden. 2003. Back to sleep: Can we influence child care providers? *Pediatrics* 112:878-82.
3. Fiene, R. 2002. *13 indicators of quality child care: Research update*. Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. <http://aspe.hhs.gov/hsp/ccquality-ind02/>.
4. National Association for the Education of Young Children (NAEYC). 2008. *Leadership and management: A guide to the NAEYC early childhood program standards and related accreditation criteria*. Washington, DC: NAEYC.

### STANDARD 1.5.0.1: Employment of Substitutes

Substitutes should be employed to ensure that child:staff ratios and requirements for direct supervision are maintained at all times. Substitutes and volunteers should be at least eighteen years of age and must meet the requirements specified throughout Standards 1.3.2.1-1.3.2.6. Those without licenses/certificates should work under direct supervision and should not be alone with a group of children.

A substitute should complete the same background screening processes as the caregiver/teacher. Obtaining substitutes to provide medical care for children with special health care needs is particularly challenging. A substitute nurse should be experienced in delivering the expected medical services. Decisions should be made on whether a parent/guardian will be allowed to provide needed on-site medical services. Substitutes should be aware of the care plans (including emergency procedures) for children with special health care needs.

**RATIONALE:** The risk to children from care by unqualified caregivers/teachers is the same whether the caregiver/teacher is a paid substitute or a volunteer (1).

**COMMENTS:** Substitutes are difficult to find, especially at the last minute. Planning for a competent substitute pool is essential for child care operation. Requiring substitutes for small family child care homes to obtain first aid and CPR certification forces small family child care home caregivers/teachers to close when they cannot be covered by a competent substitute. Since closing a child care home has a negative impact on the families and children they serve, systems should be developed to provide qualified alternative homes or substitutes for family child care home caregivers/teachers.

The lack of back-up for family child care home caregivers/teachers is an inherent liability in this type of care. Parents/

guardians who use family child care must be sure they have suitable alternative care, such as family or friends, for situations in which the child's usual caregiver/teacher cannot provide the service.

Substitutes should have orientation and training on basic health and safety topics. Substitutes should not have an infectious disease when providing care.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standards 1.1.1.1-1.1.1.5: Child:Staff Ratio and Group Size  
Standards 1.3.2.1-1.3.2.6: General Qualifications for All Caregivers/Teachers  
Standard 1.3.3.1: General Qualifications of Family Child Care Caregivers/Teachers to Operate a Family Child Care Home  
Standard 1.3.3.2: Support Networks for Family Child Care  
Standard 1.5.0.2: Orientation of Substitutes  
Standard 1.7.0.1: Pre-Employment and Ongoing Adult Health Appraisals, Including Immunization

**REFERENCES:**

1. National Association for Family Child Care (NAFCC). NAFCC official Website. <http://nafcc.net>.

**STANDARD 1.5.0.2: Orientation of Substitutes**

The director of any center or large family child care home and the small family child care home caregiver/teacher should provide orientation training to newly hired substitutes to include a review of ALL the program's policies and procedures (listed below is a sample). This training should include the opportunity for an evaluation and a repeat demonstration of the training lesson. In all child care settings the orientation should be documented. Substitutes should have background screenings.

All substitutes should be oriented to, and demonstrate competence in, the tasks for which they will be responsible. On the first day a substitute caregiver/teacher should be oriented on the following topics:

- a) Safe infant sleep practices if an infant is enrolled in the program;
- b) Any emergency medical procedure/medication needs of the children;
- c) Any nutrition needs of the children.

All substitute caregivers/teachers, during the first week of employment, should be oriented to, and should demonstrate competence in at least the following items:

- a) The names of the children for whom the caregiver/teacher will be responsible, and their specific developmental needs;
- b) The planned program of activities at the facility;
- c) Routines and transitions;
- d) Acceptable methods of discipline;
- e) Meal patterns and safe food handling policies of the facility (special attention should be given to life-threatening food allergies);
- f) Emergency health and safety procedures;
- g) General health policies and procedures as appropriate for the ages of the children cared for, including but not limited to the following:

- 1) Hand hygiene techniques, including indications for hand hygiene;
- 2) Diapering technique, if care is provided to children in diapers, including appropriate diaper disposal and diaper changing techniques, use and wearing of gloves;
- 3) The practice of putting infants down to sleep positioned on their backs and on a firm surface along with all safe infant sleep practices to reduce the risk of Sudden Infant Death Syndrome (SIDS), as well as general nap time routines for all ages;
- 4) Correct food preparation and storage techniques, if employee prepares food;
- 5) Proper handling and storage of human milk when applicable and formula preparation if formula is handled;
- 6) Bottle preparation including guidelines for human milk and formula if care is provided to children with bottles;
- 7) Proper use of gloves in compliance with Occupational Safety and Health Administration (OSHA) bloodborne pathogens regulations;
- 8) Injury prevention and safety including the role of mandatory child abuse reporter to report any suspected abuse/neglect.
- h) Emergency plans and practices;
- i) Access to list of authorized individuals for releasing children.

**RATIONALE:** Upon employment, substitutes should be able to carry out the duties assigned to them. Because facilities and the children enrolled in them vary, orientation programs for new substitutes can be most productive. Because of frequent staff turnover, child care programs must institute orientation programs as needed that protect the health and safety of children and new staff (1-3).

Most SIDS deaths in child care occur on the first day of care or within the first week due to unaccustomed prone (on stomach) sleeping. Unaccustomed prone sleeping increases the risk of SIDS eighteen times (4).

**COMMENTS:** Anyone who substitutes regularly should be up to date on all basic training as specified in this standard.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standard 1.2.0.2: Background Screening  
Section 2.1: Program of Developmental Activities  
Standards 2.2.0.6-2.2.0.9: Discipline  
Standard 3.1.4.4: Scheduled Rest Periods and Sleep Arrangements  
Standard 3.2.1.1: Type of Diapers Worn  
Standards 3.2.2.1-3.2.2.5: Hand Hygiene  
Standard 3.2.3.4: Prevention of Exposure to Blood and Bodily Fluids  
Standards 3.4.3.1-3.4.3.3: Emergency Procedures  
Chapter 4: Nutrition and Food Service  
Standards 5.4.1.1-5.4.1.9: Sanitation, Disinfection, and Maintenance of Toilet Learning/Training Equipment, Toilets, and Bathrooms  
Standards 5.4.5.1-5.4.5.5: Sleep and Rest Areas  
Standard 9.2.2.3: Exchange of Information at Transitions

Standard 9.2.3.11: Food and Nutrition Service Policies and Plans  
 Standard 9.2.3.12: Infant Feeding Policy  
 Standard 9.2.4.1: Written Plan and Training for Handling Urgent Medical Care or Threatening Incidents  
 Standard 9.2.4.2: Review of Written Plan for Urgent Care  
 Standard 9.4.1.18: Records of Nutrition Service  
 Appendix D: Gloving

#### REFERENCES:

1. Gore, J. S. 1997. Does school-age child care staff training make a difference? *School-Age Connections*, vol. 6. <http://www.canr.uconn.edu/ces/child/newsarticles/SAC643.html>.
2. Crosland, K. A., G. Dunlap, W. Sager, et al. 2008. The effects of staff training on the types of interactions observed at two group homes for foster care children. *Research Soc Work* 18:410-20.
3. Cain, D. W., L. C. Rudd, T. F. Saxon. 2007. Effects of professional development training on joint attention engagement in low-quality childcare centers. *Early Child Devel Care* 177:159-85.
4. Moon, R. Y., T. Calabrese, L. Aird. 2008. Reducing the risk of sudden infant death syndrome in child care and changing provider practices: Lessons learned from a demonstration project. *Pediatrics* 122:788-98.

### STANDARD 1.4.4.1: Continuing Education for Directors and Caregivers/Teachers in Centers and Large Family Child Care Homes

All directors and caregivers/teachers of centers and large family child care homes should successfully complete at least thirty clock-hours per year of continuing education/professional development in the first year of employment, sixteen clock-hours of which should be in child development programming and fourteen of which should be in child health, safety, and staff health. In the second and each of the following years of employment at a facility, all directors and caregivers/teachers should successfully complete at least twenty-four clock-hours of continuing education based on individual competency needs and any special needs of the children in their care, sixteen hours of which should be in child development programming and eight hours of which should be in child health, safety, and staff health.

Programs should conduct a needs assessment to identify areas of focus, trainer qualifications, adult learning strategies, and create an annual professional development plan for staff based on the needs assessment. The effectiveness of training should be evident by the change in performance as measured by accreditation standards or other quality assurance systems.

**RATIONALE:** Because of the nature of their caregiving/teaching tasks, caregivers/teachers must attain multifaceted knowledge and skills. Child health and employee health are integral to any education/training curriculum and program management plan. Planning and evaluation of training should be based on performance of the staff member(s) involved. Too often, staff members make training choices based on what they like to learn about (their “wants”) and not the areas in which their performance should be improved (their “needs”). Participation in training does not ensure that the participant will master the information and skills offered in the training experience. Therefore, caregiver/teacher change in behavior or the continuation of appropri-

ate practice resulting from the training, not just participation in training, should be assessed by supervisors and directors (4).

In addition to low child:staff ratio, group size, age mix of children, and stability of caregiver/teacher, the training/education of caregivers/teachers is a specific indicator of child care quality (2). Most skilled roles require training related to the functions and responsibilities the role requires. Staff members who are better trained are better able to prevent, recognize, and correct health and safety problems. The number of training hours recommended in this standard reflects the central focus of caregivers/teachers on child development, health, and safety.

Children may come to child care with identified special health care needs or special needs may be identified while attending child care, so staff should be trained in recognizing health problems as well as in implementing care plans for previously identified needs. Medications are often required either on an emergent or scheduled basis for a child to safely attend child care. Caregivers/teachers should be well trained on medication administration and appropriate policies should be in place.

The National Association for the Education of Young Children (NAEYC), a leading organization in child care and early childhood education, recommends annual training/professional development based on the needs of the program and the pre-service qualifications of staff (1). Training should address the following areas:

- a) Promoting child growth and development correlated with developmentally appropriate activities;
- b) Infant care;
- c) Recognizing and managing minor illness and injury;
- d) Managing the care of children who require the special procedures listed in Standard 3.5.0.2;
- e) Medication administration;
- f) Business aspects of the small family child care home;
- g) Planning developmentally appropriate activities in mixed age groupings;
- h) Nutrition for children in the context of preparing nutritious meals for the family;
  - i) Age-appropriate size servings of food and child feeding practices;
  - j) Acceptable methods of discipline/setting limits;
  - k) Organizing the home for child care;
  - l) Preventing unintentional injuries in the home (e.g., falls, poisoning, burns, drowning);
- m) Available community services;
- n) Detecting, preventing, and reporting child abuse and neglect;
- o) Advocacy skills;
- p) Pediatric first aid, including pediatric CPR;
- q) Methods of effective communication with children and parents/guardians;
- r) Socio-emotional and mental health (positive approaches with consistent and nurturing relationships);
- s) Evacuation and shelter-in-place drill procedures;
- t) Occupational health hazards;

- u) Infant safe sleep environments and practices;
- v) Standard Precautions;
- w) Shaken baby syndrome/abusive head trauma;
- x) Dental issues;
- y) Age-appropriate nutrition and physical activity.

There are few illnesses for which children should be excluded from child care. Decisions about management of ill children are facilitated by skill in assessing the extent to which the behavior suggesting illness requires special management (3). Continuing education on managing infectious diseases helps prepare caregivers/teachers to make these decisions devoid of personal biases (5). Recommendations regarding responses to illnesses may change (e.g., H1N1), so caregivers/teachers need to know where they can find the most current information. All caregivers/teachers should be trained to prevent, assess, and treat injuries common in child care settings and to comfort an injured child and children witnessing an injury.

**COMMENTS:** Tools for assessment of training needs are part of the accreditation self-study tools available from the NAEYC, the National Association for Family Child Care (NAFCC), National Early Childhood Professional Accreditation (NECPA), Association for Christian Education International (ACEI), National AfterSchool Association (NAA), and the National Child Care Association (NCCA). Successful completion of training can be measured by a performance test at the end of training and by ongoing evaluation of performance on the job.

Resources for training on health and safety issues include:

- a) State and local health departments (health education, environmental health and sanitation, nutrition, public health nursing departments, fire and EMS, etc.);
- b) Networks of child care health consultants;
- c) Graduates of the National Training Institute for Child Care Health Consultants (NTI);
- d) Child care resource and referral agencies;
- e) University Centers for Excellence on Disabilities;
- f) Local children's hospitals;
- g) State and local chapters of:
  - 1) American Academy of Pediatrics (AAP), including AAP Chapter Child Care Contacts;
  - 2) American Academy of Family Physicians (AAFP);
  - 3) American Nurses' Association (ANA);
  - 4) American Public Health Association (APHA);
  - 5) Visiting Nurse Association (VNA);
  - 6) National Association of Pediatric Nurse Practitioners (NAPNAP);
  - 7) National Association for the Education of Young Children (NAEYC);
  - 8) National Association for Family Child Care (NAFCC);
  - 9) National Association of School Nurses (NASN);
  - 10) National Training Institute for Child Care Health Consultants (NTI);
  - 11) Emergency Medical Services for Children (EMSC) National Resource Center;
  - 12) National Association for Sport and Physical Education (NASPE);

- 13) American Dietetic Association (ADA);
- 14) American Association of Poison Control Centers (AAPCC).

For nutrition training, facilities should check that the nutritionist/registered dietician (RD), who provides advice, has experience with, and knowledge of, child development, infant and early childhood nutrition, school-age child nutrition, prescribed nutrition therapies, food service and food safety issues in the child care setting. Most state Maternal and Child Health (MCH) programs, Child and Adult Care Food Programs (CACFP), and Special Supplemental Nutrition Programs for Women, Infants, and Children (WIC) have a nutrition specialist on staff or access to a local consultant. If this nutrition specialist has knowledge and experience in early childhood and child care, facilities might negotiate for this individual to serve or identify someone to serve as a consultant and trainer for the facility.

Many resources are available for nutritionists/RDs who provide training in food service and nutrition. Some resources to contact include:

- a) Local, county, and state health departments to locate MCH, CACFP, or WIC programs;
- b) State university and college nutrition departments;
- c) Home economists at utility companies;
- d) State affiliates of the American Dietetic Association;
- e) State and regional affiliates of the American Public Health Association;
- f) The American Association of Family and Consumer Services;
- g) National Resource Center for Health and Safety in Child Care and Early Education;
- h) Nutritionist/RD at a hospital;
- i) High school home economics teachers;
- j) The Dairy Council;
- k) The local American Heart Association affiliate;
- l) The local Cancer Society;
- m) The Society for Nutrition Education;
- n) The local Cooperative Extension office;
- o) Local community colleges and trade schools.

Nutrition education resources may be obtained from the Food and Nutrition Information Center at <http://fnic.nal.usda.gov>. The staff's continuing education in nutrition may be supplemented by periodic newsletters and/or literature (frequently bilingual) or audiovisual materials prepared or recommended by the Nutrition Specialist.

Caregivers/teachers should have a basic knowledge of special health care needs, supplemented by specialized training for children with special health care needs. The type of special health care needs of the children in care should influence the selection of the training topics. The number of hours offered in any in-service training program should be determined by the experience and professional background of the staff, which is best achieved through a regular staff conference mechanism.

Financial support and accessibility to training programs requires attention to facilitate compliance with this standard. Many states are using federal funds from the Child Care and

Development Block Grant to improve access, quality, and affordability of training for early care and education professionals. College courses, either online or face to face, and training workshops can be used to meet the training hours requirement. These training opportunities can also be conducted on site at the child care facility. Completion of training should be documented by a college transcript or a training certificate that includes title/content of training, contact hours, name and credentials of trainer or course instructor and date of training. Whenever possible the submission of documentation that shows how the learner implemented the concepts taught in the training in the child care program should be documented. Although on-site training can be costly, it may be a more effective approach than participation in training at a remote location.

Projects and Outreach: Early Childhood Research and Evaluation Projects, Midwest Child Care Research Consortium at [http://ccfl.unl.edu/projects\\_outreach/projects/current/ecp/mwrcr.php](http://ccfl.unl.edu/projects_outreach/projects/current/ecp/mwrcr.php), identifies the number of hours for education of staff and fourteen indicators of quality from a study conducted in four Midwestern states.

**TYPE OF FACILITY:** Center; Large Family Child Care Home

**RELATED STANDARDS:**

Standard 1.8.2.2: Annual Staff Competency Evaluation  
 Standard 3.5.0.2: Caring for Children Who Require Medical Procedures  
 Standard 3.6.3.1: Medication Administration  
 Standard 9.4.3.3: Training Record  
 Standard 10.3.3.4: Licensing Agency Provision of Child Abuse Prevention Materials  
 Standard 10.3.4.6: Compensation for Participation in Multidisciplinary Assessments for Children with Special Health Care or Education Needs  
 Standards 10.6.1.1-10.6.1.2: Caregiver/Teacher Training  
 Appendix C: Nutrition Specialist, Registered Dietician, Licensed Nutritionist, Consultant, and Food Service Staff Qualifications

**REFERENCES:**

1. National Association for the Education of Young Children (NAEYC). 2009. *Standards for early childhood professional preparation programs*. Washington, DC: NAEYC. <http://www.naeyc.org/files/naeyc/file/positions/ProfPrepStandards09.pdf>.
2. Whitebook, M., C. Howes, D. Phillips. 1998. *Worthy work, unlivable wages: The National child care staffing study, 1988-1997*. Washington, DC: Center for the Child Care Workforce.
3. Crowley, A. A. 1990. Health services in child care day care centers: A survey. *J Pediatr Health Care* 4:252-59.
4. Fiene, R. 2002. *13 indicators of quality child care: Research update*. Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. <http://aspe.hhs.gov/hsp/ccquality-ind02/>.
5. Aronson, S. S., T. R. Shope, eds. 2009. *Managing infectious diseases in child care and schools: A quick reference guide*. 2nd ed. Elk Grove Village, IL: American Academy of Pediatrics.

**STANDARD 1.4.4.2: Continuing Education for Small Family Child Care Home Caregivers/Teachers**

Small family child care home caregivers/teachers should have at least thirty clock-hours per year (2) of continuing

education in areas determined by self-assessment and, where possible, by a performance review of a skilled mentor or peer reviewer.

**RATIONALE:** In addition to low child:staff ratio, group size, age mix of children, and continuity of caregiver/teacher, the training/education of caregivers/teachers is a specific indicator of child care quality (1). Most skilled roles require training related to the functions and responsibilities the role requires. Caregivers/teachers who engage in on-going training are more likely to decrease morbidity and mortality in their setting (3) and are better able to prevent, recognize, and correct health and safety problems.

Children may come to child care with identified special health care needs or may develop them while attending child care, so staff must be trained in recognizing health problems as well as in implementing care plans for previously identified needs.

Because of the nature of their caregiving/teaching tasks, caregivers/teachers must attain multifaceted knowledge and skills. Child health and employee health are integral to any education/training curriculum and program management plan. Planning and evaluation of training should be based on performance of the caregiver/teacher. Provision of workshops and courses on all facets of a small family child care business may be difficult to access and may lead to caregivers/teachers enrolling in training opportunities in curriculum related areas only. Too often, caregivers/teachers make training choices based on what they like to learn about (their “wants”) and not the areas in which their performance should be improved (their “needs”).

Small family child care home caregivers/teachers often work alone and are solely responsible for the health and safety of small numbers of children in care. Peer review is part of the process for accreditation of family child care and can be valuable in assisting the caregiver/teacher in the identification of areas of need for training. Self-evaluation may not identify training needs or focus on areas in which the caregiver/teacher is particularly interested and may be skilled already.

**COMMENTS:** The content of continuing education for small family child care home caregivers/teachers should include the following topics:

- a) Promoting child growth and development correlated with developmentally appropriate activities;
- b) Infant care;
- c) Recognizing and managing minor illness and injury;
- d) Managing the care of children who require the special procedures listed in Standard 3.5.0.2;
- e) Medication administration;
- f) Business aspects of the small family child care home;
- g) Planning developmentally appropriate activities in mixed age groupings;
- h) Nutrition for children in the context of preparing nutritious meals for the family;
- i) Age-appropriate size servings of food and child feeding practices;
- j) Acceptable methods of discipline/setting limits;

- k) Organizing the home for child care;
- l) Preventing unintentional injuries in the home (falls, poisoning, burns, drowning);
- m) Available community services;
- n) Detecting, preventing, and reporting child abuse and neglect;
- o) Advocacy skills;
- p) Pediatric first aid, including pediatric CPR;
- q) Methods of effective communication with children and parents/guardians;
- r) Socio-emotional and mental health (positive approaches with consistent and nurturing relationships);
- s) Evacuation and shelter-in-place drill procedures;
- t) Occupational health hazards;
- u) Infant-safe sleep environments and practices;
- v) Standard Precautions;
- w) Shaken baby syndrome/abusive head trauma;
- x) Dental issues;
- y) Age-appropriate nutrition and physical activity.

Small family child care home caregivers/teachers should maintain current contact lists of community pediatric primary care providers, specialists for health issues of individual children in their care and child care health consultants who could provide training when needed.

In-home training alternatives to group training for small family child care home caregivers/teachers are available, such as distance courses on the Internet, listening to audiotapes or viewing media (e.g., DVDs) with self-checklists. These training alternatives provide more flexibility for caregivers/teachers who are remote from central training locations or have difficulty arranging coverage for their child care duties to attend training. Nevertheless, gathering family child care home caregivers/teachers for training when possible provides a break from the isolation of their work and promotes networking and support. Satellite training via down links at local extension service sites, high schools, and community colleges scheduled at convenient evening or weekend times is another way to mix quality training with local availability and some networking.

**TYPE OF FACILITY:** Small Family Child Care Home

**RELATED STANDARDS:**

Standard 1.4.4.1: Continuing Education for Directors and Caregivers/Teachers in Centers and Large Family Child Care Homes

Standard 1.7.0.4: Occupational Hazards

Standard 3.5.0.2: Caring for Children Who Require Medical Procedures

Standards 9.2.4.3-9.2.4.5: Emergency and Evacuation Plans, Training, and Communication

Standard 9.4.3.3: Training Record

Appendix B: Major Occupational Health Hazards

**REFERENCES:**

1. Whitebook, M., C. Howes, D. Phillips. 1998. *Worthy work, unlivable wages: The national child care staffing study, 1988-1997*. Washington, DC: Center for the Child Care Workforce.
2. The National Association of Family Child Care (NAFCC). 2005. *Quality standards for NAFCC accreditation*. 4th ed. Salt Lake City, UT: NAFCC. <http://www.nafcc.org/documents/QualStd.pdf>.
3. Fiene, R. 2002. *13 indicators of quality child care: Research update*. Washington, DC: U.S. Department of Health and Human

Services, Office of the Assistant Secretary for Planning and Evaluation. <http://aspe.hhs.gov/hsp/ccquality-ind02/>.

**STANDARD 2.4.2.1: Health and Safety Education Topics for Staff**

Health and safety education for staff should include physical, oral, mental, emotional, nutritional, physical activity, and social health of children. In addition to the health and safety topics for children in Standard 2.4.1.1, health education topics for staff should include:

- a) Promoting healthy mind and brain development through child care;
- b) Healthy indoor and outdoor learning/play environments;
- c) Behavior/discipline;
- d) Managing emergency situations;
- e) Monitoring developmental abilities, including indicators of potential delays;
- f) Nutrition (i.e., healthy eating to prevent obesity);
- g) Food safety;
- h) Water safety;
- i) Safety/injury prevention;
- j) Safe use, storage, and clean-up of chemicals;
- k) Hearing, vision, and language problems;
- l) Physical activity and outdoor play and learning;
- m) Appropriate antibiotic use;
- n) Immunizations;
- o) Gaining access to community resources;
- p) Maternal or parental/guardian depression;
- q) Exclusion policies;
- r) Tobacco use/smoking;
- s) Safe sleep environments and SIDS prevention;
- t) Breastfeeding support (1);
- u) Environmental health and reducing exposures to environmental toxins;
- v) Children with special needs;
- w) Shaken baby syndrome and abusive head trauma;
- x) Safe use, storage of firearms;
- y) Safe medication administration.

**RATIONALE:** When child care staff are knowledgeable in health and safety practices, programs are more likely to be healthy and safe (2). Compliance with twenty hours per year of staff continuing education in the areas of health, safety, child development, and abuse identification was the most significant predictor for compliance with state child care health and safety regulations (3). Child care staff often receive their health and safety education from a child care health consultant. Data support the relationship between child care health consultation and the increased health and safety of a center (4,5).

**COMMENTS:** Community resources can provide written health- and safety-related materials. Consultation or training can be sought from a child care health consultant (CCHC) or certified health education specialist (CHES).

Child care programs should consider offering “credit” for health education classes or encourage staff members to at-

tend accredited education programs that can give education credits.

The American Association for Health Education (AAHE), the National Commission for Health Education Credentialing (NCHEC), and the National Training Institute for Child Care Health Consultants (NTI) provide information on certified health education specialists.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standards 1.4.2.1-1.4.6.2: Professional Training, Education, and Compensation

Standard 2.4.1.1: Health Education Topics for Children

**REFERENCES:**

1. Gupta, R. S., S. Shuman, E. M. Taveras, M. Kuldorff, J. A. Finkelstein. 2005. Opportunities for health promotion education in child care. *Pediatrics* 116: e499-e505.
2. Alkon, A., J. Bernzweig, K. To, M. Wolff, J. F. Mackie. 2009. Child care health consultation improves health and safety policies and practices. *Academic Pediatrics* 9:366-70.
3. Crowley, A. A., M. S. Rosenthal. 2009. Ensuring the health and safety of Connecticut's early care and education programs. Farmington, CT: The Child Health and Development Institute of Connecticut. <http://www.chdi.org/admin/uploads/3074013304b154ef428c1a.pdf>.
4. Snohomish Health District: Child Care Health Program. Child care health consultation: Evidence based effectiveness. [http://www.napnap.org/docs/CCS\\_SIG\\_Evidence\\_Based\\_CCHP.pdf](http://www.napnap.org/docs/CCS_SIG_Evidence_Based_CCHP.pdf).
5. Rosenthal, M. S., A. A. Crowley, L. Curry. 2009. Promoting child development and behavioral health: Family child care providers' perspectives. *J Pediatric Health Care* 23:289-97.

### STANDARD 9.4.3.3: Training Record

The director of a center or a large or small family child care home should provide and maintain documentation or participate in the state's training/professional development registry of training/professional development received by, or provided for, staff. For centers, the date of the training, the number of hours, the names of staff participants, the name(s) and qualification(s) of the trainer(s), and the content of the training (both orientation and continuing education) should be recorded in each staff person's file or in a separate training file. If the state has a training/professional development registry, the director should provide training documentation to the registry.

Small family child care home caregivers/teachers should keep a written record of training acquired and certificates containing the same information as the documentation recommended for centers and large homes.

**RATIONALE:** The training record should be used to assess each employee's need for additional training and to provide regulators with a tool to monitor compliance. Continuing education with course credit should be recorded and the records made available to staff members to document their applications for licenses/certificates or for license upgrading. All accrediting bodies for child care facilities, homes and centers, require documentation of training.

In many states, small family child care home caregivers/teachers are required to keep records of training.

**COMMENTS:** Colleges issue transcripts, workshops can issue certificates, and facility administrators can maintain individual training logs.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standard 9.4.3.1: Maintenance and Content of Staff and Volunteer Records

### STANDARD 10.6.1.1: Regulatory Agency Provision of Caregiver/Teacher and Consumer Training and Support Services

The licensing agency should promote participation in a variety of caregiver/teacher and consumer training and support services as an integral component of its mission to reduce risks to children in out-of-home child care. Such training should emphasize the importance of conducting regular safety checks and providing direct supervision of children at all times. Training plans should include mechanisms for training of prospective child care staff prior to their assuming responsibility for the care of children and for ongoing/continuing education. The higher education institutions providing early education degree programs should be coordinated with training provided at the community level to encourage continuing education and availability of appropriate content in the coursework provide by these institutions of higher education.

Persons wanting to enter the child care field should be able to learn from the regulatory agency about training opportunities offered by public and private agencies. Discussions of these trainings can emphasize critical child care health and safety messages. Some training can be provided online to reinforce classroom education.

Training programs should address the following:

- a) Child growth and development including social-emotional, cognitive, language, and physical development;
- b) Child care programming and activities;
- c) Discipline and behavior management;
- d) Mandated child abuse and neglect reporting;
- e) Health and safety practices including injury prevention, basic first aid and CPR, reporting, preventing and controlling infectious diseases, children's environmental health and health promotion, and reducing the risk of SIDS and use of safe sleep practices;
- f) Cultural diversity;
- g) Nutrition and eating habits including the importance of breastfeeding and the prevention of obesity and related chronic diseases;
- h) Parent/guardian education;
- i) Design, use and safe cleaning of physical space;
- j) Care and education of children with special health care needs;

- k) Oral health care;
- l) Reporting requirements for infectious disease outbreaks;
- m) Caregiver/teacher health;
- n) Age-appropriate physical activity.

**RATIONALE:** Training enhances staff competence (1,2,4). In addition to low child:staff ratio, group size, age mix of children, and continuity of caregiver/teacher, the training/education of caregivers/teachers is a specific indicator of child care quality (1,2). Most states require limited training for child care staff depending on their functions and responsibilities. Some states do not require completion of a high school degree or GED for various levels of teacher positions (5). Staff members who are better trained are more able to prevent, recognize, and correct health and safety problems. Decisions about management of illness are facilitated by the caregiver's/teacher's increased skill in assessing a child's behavior that suggests illness (2,3). Training should promote increased opportunity in the field and openings to advance through further degree-credentialed education.

**RELATED STANDARDS:**

Standards 1.4.2.1-1.4.2.3: Orientation Training  
Standard 10.6.2.1: Development of Child Care Provider Organizations and Networks

**REFERENCES:**

1. U.S. General Accounting Office (USGAO); Health, Education, and Human Services Division. 1994. Child care: Promoting quality in family child care. Report to the chairman, subcommittee on regulation, business opportunities, and technology, committee on small business, House of Representatives. Publication no. GAO-HEHS-95-36. Washington, DC: USGAO.
2. Galinsky, E., C. Howes, S. Kontos, M. Shinn. 1994. *The study of children in family child care and relative care*. New York: Families and Work Institute.
19. Aronson, S. S., L. S. Aiken. 1980. Compliance of child care programs with health and safety standards: Impact of program evaluation and advocate training. *Pediatrics* 65:318-25.
3. Kendrick, A. S. 1994. Training to ensure healthy child day-care programs. *Pediatrics* 94:1108-10.
4. Moon, R. Y., R. P. Oden. 2003. Back to sleep: Can we influence child care providers? *Pediatrics* 112:878-82.
5. National Child Care Information and Technical Assistance Center, National Association for Regulatory Administration (NARA). 2010. *The 2008 child care licensing study: Final report*. Lexington, KY: NARA. [http://www.naralicensing.org/associations/4734/files/1005\\_2008\\_Child\\_Care\\_Licensing\\_Study\\_Full\\_Report.pdf](http://www.naralicensing.org/associations/4734/files/1005_2008_Child_Care_Licensing_Study_Full_Report.pdf).

**STANDARD 10.6.1.2: Provision of Training to Facilities by Health Agencies**

Public health departments, other state departments charged with professional development for out of home child care providers, and Emergency Medical Services (EMS) agencies should provide training, written information, consultation in at least the following subject areas or referral to other community resources (e.g., child care health consultants, licensing personnel, health care professionals, including school nurses) who can provide such training in:

- a) Immunization;

- b) Reporting, preventing, and managing of infectious diseases;
- c) Techniques for the prevention and control of infectious diseases;
- d) Exclusion and inclusion guidelines and care of children who are acutely ill;
- e) General hygiene and sanitation;
- f) Food service, nutrition, and infant and child-feeding;
- g) Care of children with special health care needs (chronic illnesses, physical and developmental disabilities, and behavior problems);
- h) Prevention and management of injury;
- i) Managing emergencies;
- j) Oral health;
- k) Environmental health;
- l) Health promotion, including routine health supervision and the importance of a medical or health home for children and adults;
- m) Health insurance, including Medicaid and the Children's Health Insurance Program (CHIP);
- n) Strategies for preparing for and responding to infectious disease outbreaks, such as a pandemic influenza;
- o) Age-appropriate physical activity;
- p) Sudden Infant Death Syndrome (SIDS) and Shaken Baby Syndrome/Abusive Head Trauma.

**RATIONALE:** Training of child care staff has improved the quality of their health related behaviors and practices. Training should be available to all parties involved, including caregivers/teachers, public health workers, health care providers, parents/guardians, and children. Good quality training, with imaginative and accessible methods of presentation supported by well-designed materials, will facilitate learning.

**RELATED STANDARDS:**

Standards 1.4.4.1-1.4.6.2: Continuing Education  
Standard 10.5.0.1: State and Local Health Department Role

**Safe Sleep Policies and Information**

**STANDARD 9.2.1.1: Content of Policies**

The facility should have policies to specify how the caregiver/teacher addresses the developmental functioning and individual or special health care needs of children of different ages and abilities who can be served by the facility, as well as other services and procedures. These policies should include, but not be limited to, the following:

- a) Admissions criteria, enrollment procedures, and daily sign-in/sign-out policies, including authorized individuals for pick-up and allowing parent/guardian access whenever their child is in care;
- b) Inclusion of children with special health care needs;
- c) Nondiscrimination;
- d) Payment of fees, deposits, and refunds;
- e) Termination of enrollment and parent/guardian notification of termination;

- f) Supervision;
- g) Staffing, including caregivers/teachers, the use of volunteers, helpers, or substitute caregivers/teachers, and deployment of staff for different activities;
- h) A written comprehensive and coordinated planned program based on a statement of principles;
- i) Discipline;
- j) Methods and schedules for conferences or other methods of communication between parents/guardians and staff;
- k) Care of children and staff who are ill;
- l) Temporary exclusion for children and staff who are ill and alternative care for children who are ill;
- m) Health assessments and immunizations;
- n) Handling urgent medical care or threatening incidents;
- o) Medication administration;
- p) Use of child care health consultants and education and mental health consultants;
- q) Plan for health promotion and prevention (e.g., tracking routine child health care, health consultation, health education for children/staff/families, oral health, sun safety, safety surveillance, preventing obesity, etc.);
- r) Disasters, emergency plan and drills, evacuation plan, and alternative shelter arrangements;
- s) Security;
- t) Confidentiality of records;
- u) Transportation and field trips;
- v) Physical activity (both outdoors and when children are kept indoors), play areas, screen time, and outdoor play policy;
- w) Sleeping, safe sleep policy, areas used for sleeping/napping, sleep equipment, and bed linen;
- x) Sanitation and hygiene;
- y) Presence and care of any animals on the premises;
- z) Food and nutrition including food handling, human milk, feeding and food brought from home, as well as a daily schedule of meals and snacks;
- aa) Evening and night care plan;
- ab) Smoking, tobacco use, alcohol, prohibited substances, and firearms;
- ac) Human resource management;
- ad) Staff health;
- ae) Maintenance of the facility and equipment;
- af) Preventing and reporting child abuse and neglect;
- ag) Use of pesticides and other potentially toxic substances in or around the facility;
- ah) Review and revision of policies, plans, and procedures.

The facility should have specific strategies for implementing each policy. For centers, all of these items should be written. Facility policies should vary according to the ages and abilities of the children enrolled to accommodate individual or special health care needs. Program planning should precede, not follow the enrollment and care of children at different developmental levels and abilities and with different health care needs. Policies, plans, and procedures should

generally be reviewed annually or when any changes are made. A child care health consultant can be very helpful in developing and implementing model policies.

**RATIONALE:** Neither plans nor policies affect quality unless the program has devised a way to implement the plan or policy. Children develop special health care needs and have developmental differences recognized while they are enrolled in child care (2). Effort should be made to facilitate accommodation as quickly as possible to minimize delay or interruption of care (1). For examples of policies see *Model Child Care Health Policies* at [http://www.ecels-healthychildcarepa.org/content/MHP4thEd Total.pdf](http://www.ecels-healthychildcarepa.org/content/MHP4thEd%20Total.pdf) and the California Childcare Health Program at <http://www.ucsfchildcarehealth.org>. Nutrition and physical activity policies for child care developed by the NAP SACC Program, Center for Health Promotion and Disease Prevention, University of North Carolina are available at <http://www.center-trt.org>.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

1.8.2.1: Staff Familiarity with Facility Policies, Plans, and Procedures

*Reader's note: Chapter 9 includes many standards containing additional information on specific policies noted above.*

**REFERENCES:**

1. Aronson, S. S., ed. 2002. *Model child care health policies*. 4th ed. Elk Grove Village, IL: American Academy of Pediatrics.
2. Child Care Law Center. 2009. *Questions and answers about the Americans with Disabilities Act: A quick reference for child care providers*. Updated Version. [http://www.childcarelaw.org/docs/ADA Q and A 2009 Final 3 09.pdf](http://www.childcarelaw.org/docs/ADA%20Q%20and%20A%202009%20Final%203%2009.pdf).

**STANDARD 1.8.2.1: Staff Familiarity with Facility Policies, Plans and Procedures**

All caregivers/teachers should be familiar with the provisions of the facility's policies, plans, and procedures, as described in Chapter 9, Administration. The compliance with these policies, plans, and procedures should be used in staff performance evaluations and documented in the personnel file.

**RATIONALE:** Written policies, plans and procedures provide a means of staff orientation and evaluation essential to the operation of any organization (1).

**TYPE OF FACILITY:** Center; Large Family Child Care Home

**RELATED STANDARDS:**

Chapter 9: Administration

**REFERENCES:**

1. Boone, L. E., D. L. Kurtz. 2010. *Contemporary business*. Hoboken, NJ: John Wiley and Sons.

**STANDARD 9.2.1.3: Enrollment Information to Parents/Guardians and Caregivers/Teachers**

At enrollment, and before assumption of supervision of children by caregivers/teachers at the facility, the facility should provide parents/guardians and caregivers/teachers with a

statement of services, policies, and procedures, including, but not limited, to the following:

- a) The licensed capacity, child:staff ratios, ages and number of children in care. If names of children and parents/guardians are made available, parental/guardian permission for any release to others should be obtained;
- b) Services offered to children including a written daily activity plan, sleep positioning policies and arrangements, napping routines, guidance and discipline policies, diaper changing and toilet learning/training methods, child handwashing, medication administration policies, oral health, physical activity, health education, and willingness for special health or therapy services delivered at the program (special requirements for a child should be clearly defined in writing before enrollment);
- c) Hours and days of operation;
- d) Admissions criteria, enrollment procedures, and daily sign-in/sign-out policies, including authorized individuals for pick-up and allowing parent/guardian access whenever their child is in care;
- e) Payment of fees, deposits, and refunds;
- f) Methods and schedules for conferences or other methods of communication between parents/guardians and staff.

Policies on:

- a) Staffing, including caregivers/teachers, the use of volunteers, helpers, or substitute caregivers/teachers, and deployment of staff for different activities;
- b) Inclusion of children with special health care needs;
- c) Nondiscrimination;
- d) Termination and parent/guardian notification of termination;
- e) Supervision;
- f) Discipline;
- g) Care of children and caregivers/teachers who are ill;
- h) Temporary exclusion and alternative care for children who are ill;
- i) Health assessments and immunizations;
- j) Handling urgent medical care or threatening incidents;
- k) Medication administration;
- l) Use of child care health consultants, education and mental health consultants;
- m) Plan for health promotion and prevention (tracking routine child health care, health consultation, health education for children/staff/families, oral health, sun safety, safety surveillance, etc.);
- n) Disasters, emergency plan and drills, evacuation plan, and alternative shelter arrangements;
- o) Security;
- p) Confidentiality of records;
- q) Transportation and field trips;
- r) Physical activity (both outdoors and when children are kept indoors), play areas, screen time, and outdoor play policy;

- s) Sleeping, safe sleep policy, areas used for sleeping/napping, sleep equipment, and bed linen;
- t) Sanitation and hygiene;
- u) Presence and care of any animals on the premises;
- v) Food and nutrition including food handling, human milk, feeding and food brought from home, as well as a daily schedule of meals and snacks;
- w) Evening and night care plan;
- x) Smoking, tobacco use, alcohol, prohibited substances, and firearms;
- y) Preventing and reporting child abuse and neglect;
- z) Use of pesticides and other potentially toxic substances in or around the facility.

Parents/guardians and caregivers/teachers should sign that they have reviewed and accepted this statement of services, policies, and procedures. Policies, plans and procedures should generally be reviewed annually or when any changes are made.

**RATIONALE:** *Model Child Care Health Policies*, available at <http://www.ecels-healthychildcarepa.org/content/MHP4thEdTotal.pdf>, has text to comply with many of the topics covered in this standard. Each policy has a place for the facility to fill in blanks to customize the policies for a specific site. The text of the policies can be edited to match individual program operations. Starting with a template such as the one in *Model Child Care Health Policies* can be helpful.

**COMMENTS:** For large and small family child care homes, a written statement of services, policies, and procedures is strongly recommended and should be added to the “Parent Handbook.” Conflict over policies can lead to termination of services and inconsistency in the child’s care arrangements. If the statement is provided orally, parents/guardians should sign a statement attesting to their acceptance of the statement of services, policies and procedures presented to them. *Model Child Care Health Policies* can be adapted to these smaller settings.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standards 1.1.1.1-1.1.1.5: Child:Staff Ratio and Group Size  
Standard 1.6.0.1: Child Care Health Consultants  
Standards 2.1.1.1-2.1.4.6: Program of Developmental Activities  
Standards 2.2.0.1-2.2.0.10: Supervision and Discipline  
Standards 2.4.1.2-2.4.3.2: Health Education  
Standards 3.1.1.1-3.1.1.2: Daily Health Check  
Standard 3.1.2.1: Routine Health Supervision and Growth Monitoring  
Standard 3.1.3.1: Active Opportunities for Physical Activity  
Standard 3.1.3.2: Playing Outdoors  
Standard 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction  
Standards 3.1.5.1-3.1.5.3: Oral Health  
Standards 3.2.1.1-3.2.1.5: Diapering and Changing Soiled Clothing  
Standards 3.2.2.1-3.2.2.5: Handwashing  
Standards 3.3.0.1-3.3.0.5: Cleaning, Sanitizing, and Disinfecting  
Standard 3.4.1.1: Use of Tobacco, Alcohol, and Illegal Drugs  
Standards 3.4.2.1-3.4.2.3: Animals  
Standards 3.4.3.1-3.4.3.3: Emergency Procedures  
Standard 3.6.1.1: Inclusion/Exclusion/Dismissal of Children

Standards 3.6.2.1-3.6.2.10: Caring for Children Who are Ill  
 Standards 3.6.3.1-3.6.3.3: Medications  
 Standards 4.2.0.1-4.2.0.12: General Requirements for Nutrition  
 Standards 4.3.1.1-4.3.3.1: Requirements for Special Groups or Ages of Children  
 Standards 4.6.0.1-4.6.0.2: Food Brought From Home  
 Standards 6.5.1.1-6.4.2.2: Transportation  
 Standards 7.2.0.1-7.2.0.3: Immunizations  
 Standard 9.2.1.1: Content of Policies  
 Standard 9.2.3.2: Content and Development of the Plan for Care of Children and Staff Who Are Ill  
 Standard 9.2.3.9: Written Policy on Use of Medications  
 Standard 9.2.3.11: Food and Nutrition Service Policies and Plans  
 Standard 9.2.3.12: Infant Feeding Policy  
 Standard 9.2.3.13: Plans for Evening and Nighttime Child Care  
 Standards 9.2.3.15-9.2.3.16: Policies Prohibiting Smoking, Tobacco, Alcohol, Illegal Drugs, Toxic Substances, and Firearms  
 Standards 9.2.4.1-9.2.4.10: Emergency/Security Policies and Plans  
 Standard 9.4.1.3: Written Policy on Confidentiality of Records

### **STANDARD 9.4.2.3: Contents of Admission Agreement Between Child Care Program and Parent/Guardian**

The file for each child should include an admission agreement signed by the parent/guardian at enrollment. The admission agreement should contain the following topics and documentation of consent:

- a) General topics:
  - 1) Operating days and hours;
  - 2) Holiday closure dates;
  - 3) Payment for services;
  - 4) Drop-off and pick-up procedures;
  - 5) Family access (visiting site at any time when their child is there and admitted immediately under normal circumstances) and involvement in child care activities;
  - 6) Name and contact information of any primary staff person designation, especially primary caregivers/teachers designated for infants and toddlers, to make parent/guardian contact of a caregiver/teacher more comfortable.
- b) Health topics:
  - 1) Immunization record;
  - 2) Breast feeding policy;
  - 3) For infants, statement that parent/guardian(s) has received and discussed a copy of the program's infant safe sleep policy;
  - 4) Documentation of written consent signed and dated by the parent/guardian for:
    - i) Any health service obtained for the child by the facility on behalf of the parent/guardian. Such consent should be specific for the type of care provided to meet the tests for "informed consent" to cover on-site screenings or other services provided;
    - ii) Administration of medication for prescriptions and non-prescription medications (over-the-counter [OTC]) including records and special care plans (if needed).
- c) Safety topics:

- 1) Prohibition of corporal punishment in the child care facility;
- 2) Statement that parent/guardian has received and discussed a copy of the state child abuse and neglect reporting requirements;
- 3) Documentation of written consent signed and dated by the parent/guardian for:
  - i) Emergency transportation;
  - ii) All other transportation provided by the facility;
  - iii) Planned or unplanned activities off-premises (such consent should give specific information about where, when, and how such activities should take place, including specific information about walking to and from activities away from the facility);
  - iv) Swimming, if the child will be participating;
  - v) Release of any information to agencies, schools, or providers of services;
  - vi) Written authorization to release the child to designated individuals other than the parent/guardian.

**RATIONALE:** These records and reports are necessary to protect the health and safety of children in care.

These consents are needed by the person delivering the medical care. Advance consent for emergency medical or surgical service is not legally valid, since the nature and extent of injury, proposed medical treatment, risks, and benefits cannot be known until after the injury occurs, but it does allow the parent/guardian to guide the caregiver/teacher in emergency situations when the parent/guardian cannot be reached (1). See Appendix KK: Authorization for Emergency Medical/Dental Care for an example.

The parent/guardian/child care partnership is vital.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Appendix KK: Authorization for Emergency Medical/Dental Care

**REFERENCES:**

1. American Academy of Pediatrics, Committee on Pediatric Emergency Medicine. 2007. Policy statement: Consent for emergency medical services for children and adolescents. *Pediatrics* 120:683-84.

### **STANDARD 9.2.3.13: Plans for Evening and Nighttime Child Care**

Facilities that provide evening and nighttime care should have plans for such care that include the supervision of sleeping children and the management and maintenance of sleep equipment including their sanitation and disinfection. Evacuation drills should occur during hours children are in care. Centers should have these plans in writing.

**RATIONALE:** Evening child care routines are similar to those required for daytime child care with the exception of sleep routines. Evening and nighttime child care requires special attention to sleep routines, safe sleep environment, supervision of sleeping children, and personal care routines,

including bathing and tooth brushing. Nighttime child care must meet the nutritional needs of the children and address morning personal care routines such as toileting/diapering, hygiene, and dressing for the day. Children and staff must be familiar with evacuation procedures in case a natural or human generated disaster occurs during evening child care and nighttime child care hours.

**COMMENTS:** Sleeping time is a very sensitive time for infants and young children. Attention should be paid to individual needs, transitional objects, lighting preferences, and bedtime routines.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standard 2.2.0.1: Methods of Supervision of Children

Standards 3.3.0.4-3.3.0.5: Cleaning Individual Bedding and Crib Surfaces

Standards 5.4.5.1-5.4.5.5: Sleep and Rest Areas

Standards 9.2.4.3-9.2.4.5: Evacuation and Emergency Plans, Drills, and Communication

### **STANDARD 9.2.3.15: Policies Prohibiting Smoking, Tobacco, Alcohol, Illegal Drugs, and Toxic Substances**

Facilities should have written policies addressing the use and possession of tobacco products, alcohol, illegal drugs, prescription medications that have not been prescribed for the user, and unauthorized potentially toxic substances. Policies should include that all of these substances are prohibited inside the facility, on facility grounds, and in any vehicles that transport children at all times. Policies should specify that smoking is prohibited at all times and in all areas used by the children in the program. Smoking is also prohibited in any vehicles that transport children.

Policies must also specify that use and possession of all substances referred to above is prohibited during all times when caregivers/teachers are responsible for the supervision of children, including times when children are transported, when playing in outdoor play areas not attached to the facility, and during field trips.

Child care centers and large family child care homes should provide information to employees about available drug, alcohol, and tobacco counseling and rehabilitation, and any available employee assistance programs.

**RATIONALE:** The age, defenselessness, and lack of discretion of the child under care make this prohibition an absolute requirement.

The hazards of second-hand and third-hand smoke exposure warrant the prohibition of smoking in proximity of child care areas at any time. Third-hand smoke refers to gases and particles clinging to smokers' hair and clothing, cushions, carpeting and outdoor equipment after visible tobacco smoke has dissipated (1). The residue includes heavy metals, carcinogens, and even radioactive materials that young children can get on their hands and ingest, especially if they're crawling or playing on the floor. Residual toxins from

smoking at times when the children are not using the space can trigger asthma and allergies when the children do use the space (1,2).

Safe child care necessitates sober caregivers/teachers. Alcohol and illegal drug use and misuse of prescription or over-the-counter (OTC) drugs prevent caregivers/teachers from providing appropriate care to infants and children by impairing motor coordination, judgment, and response time. Off-site use prior to or during work, of alcohol, illegal drugs, OTC medications, or prescription medications that have not been prescribed for the user, is prohibited.

The use of alcoholic beverages in family child care homes after children are not in care is permissible.

**COMMENTS:** The policies related to smoking and use of prohibited substances should be discussed with staff and parents/guardians. Educational material such as handouts could include information on the health risks and dangers of these prohibited substances and referrals to services for counseling or rehabilitation programs.

For family child care home, it is strongly urged that, whenever possible, the caregivers/teachers be non-tobacco users because of the role model effect of tobacco users on children. The entire home should be kept smoke-free at all times to prevent exposure of the children who are cared for in these spaces.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standard 3.4.1.1: Use of Tobacco, Alcohol, and Illegal Drugs

**REFERENCES:**

1. Winickoff, J. P., J. Friebely, S. E. Tanski, C. Sherrod, G. E. Matt, M. F. Hovell, R. C. McMillen. 2009. Beliefs about the health effects of "thirdhand" smoke and home smoking bans. *Pediatrics* 123: e74-79.
2. U.S. Environmental Protection Agency. Smoke-free homes and cars program. <http://www.epa.gov/smokefree/>.

## **Related Issues**

### **STANDARD 4.3.1.1: General Plan for Feeding Infants**

*Reader's Note: This standard is included because it encourages, provides arrangements for, and supports breastfeeding. According to the AAP's new policy statement on SIDS and other sleep-related infant deaths, breastfeeding is associated with a reduced risk of SIDS.*

At a minimum, meals and snacks the facility provides for infants should contain the food in the meal and snack patterns of the Child and Adult Care Food Program (CACFP). Food should be appropriate for the infant's individual nutrition requirements and developmental stages as determined by written instructions obtained from the child's parent/guardian or primary care provider.

The facility should encourage, provide arrangements for, and support breastfeeding. The facility staff, with appro-

appropriate training, should be the mother's cheerleader and enthusiastic supporter for the mother's plan to provide her milk. Facilities should have a designated place set aside for breastfeeding mothers who want to come during work to breastfeed, as well as a private area with an outlet (not a bathroom) for mothers to pump their breast milk (2-8). A place that mothers feel they are welcome to breastfeed, pump, or bottle feed can create a positive environment when offered in a supportive way.

Infants may need a variety of special formulas such as soy-based formula or elemental formulas which are easier to digest and less allergenic. Elemental or special non-allergic formulas should be specified in the infant's care plan.

Age-appropriate solid foods (complementary foods) may be introduced no sooner than when the child has reached the age of four months, but preferably six months and as indicated by the individual child's nutritional and developmental needs. For breastfed infants, gradual introduction of iron-fortified foods may occur no sooner than around four months, but preferably six months to complement the human milk.

**RATIONALE:** Human milk, as an exclusive food, is best suited to meet the entire nutritional needs of an infant from birth until six months of age, with the exception of recommended vitamin D supplementation. In addition to nutrition, breastfeeding supports optimal health and development. Human milk is also the best source of milk for infants for at least the first twelve months of age and, thereafter, for as long as mutually desired by mother and child. Breastfeeding protects infants from many acute and chronic diseases and has advantages for the mother, as well (4).

Research overwhelmingly shows that exclusive breastfeeding for six months, and continued breastfeeding for at least a year or longer, dramatically improves health outcomes for children and their mothers. *Healthy People 2010* Objective 16 includes increasing the proportion of mothers who breastfeed their infants, and increasing the duration of breastfeeding and of exclusively breastfeeding (1).

Importance of breastfeeding to the infant includes reduction of some of the risks that are greater for infants in group care. Many advantages of breastfeeding are documented by research, including reduction in the incidence of diarrhea, respiratory disease, otitis media, bacteremia, bacterial meningitis, botulism, urinary tract infections, necrotizing enterocolitis, SIDS, insulin-dependent diabetes, lymphoma, allergic disease, ulcerative colitis, ear infections, and other chronic digestive diseases (4,13,15). Evidence suggests that breastfeeding is associated with enhanced cognitive development (6,10). Additionally, some evidence suggests that breastfeeding reduces the risk of childhood obesity (9,11). Breastfeeding also lowers the mother's risk of diabetes, breast cancer, and heart disease (17).

Except in the presence of rare medical conditions, the clear advantage of human milk over any formula should lead to vigorous efforts by caregivers/teachers to promote and sustain breastfeeding for mothers who are willing to nurse

their infants whenever they can, and to pump and supply their milk to the early care and education facility when direct feeding from the breast is not possible. Even if infants receive formula during the child care day, some breastfeeding or expressed human milk from their mothers is beneficial (8).

Iron-fortified infant formula is an acceptable alternative to human milk as a food for infant feeding even though it lacks any anti-infective or immunological components. An adequately nourished infant is more likely to achieve normal physical and mental development, which will have long-term positive consequences on health (12,13).

**COMMENTS:** Some ways to help a mother to breastfeed successfully in the early care and education facility (3):

- z) If she wishes to breastfeed her infant or child when she comes to the facility, offer or provide her a:
  - 15) Quiet, comfortable, and private place to breastfeed (this helps her milk to letdown);
  - 16) Place to wash her hands;
  - 17) Pillow to support her infant on her lap while nursing if requested;
  - 18) Nursing stool or stepstool if requested for her feet so she doesn't have to strain her back while nursing; and
  - 19) Glass of water or other liquid to help her stay hydrated;

- aa) Encourage her to get the infant used to being fed her expressed human milk by another person before the infant starts in early care and education, while continuing to breastfeed directly herself;
- ab) Discuss with her the infant's usual feeding pattern and whether she wants the caregiver/teacher to feed the infant by cue or on a schedule, also ask her if she wishes to time the infant's last feeding so that the infant is hungry and ready to breastfeed when she arrives, also, ask her to leave her availability schedule with the early care and education program and ask her to call if she is planning to miss a feeding or is going to be late;
- ac) Encourage her to provide a back-up supply of frozen or refrigerated expressed human milk with the infant's full name on the bottle or other clean storage container in case the infant needs to eat more often than usual or the mother's visit is delayed;
- ad) Share with her information about other places in the community that can answer her questions and concerns about breastfeeding, for example, local lactation consultants (14,16);
- ae) Ensure that all staff receive training in breastfeeding support and promotion;
- af) Ensure that all staff are trained in the proper handling and feeding of each milk product, including human milk or infant formula;
- ag) Provide culturally appropriate breastfeeding materials including community resources for parents/guardians that include appropriate language and pictures of multicultural families to assist families to identify with them.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standard 4.2.0.9: Written Menus and Introduction of New Foods  
Standard 4.3.1.3: Preparing, Feeding, and Storing Human Milk  
Standard 4.3.1.5: Preparing, Feeding, and Storing Infant Formula  
Standard 4.3.1.11: Introduction of Age-Appropriate Solid Foods to Infants  
Standard 4.3.1.12: Feeding Age-Appropriate Solid Foods to Infants  
Appendix JJ: Our Child Care Center Supports Breastfeeding

**REFERENCES:**

1. U.S. Department of Health and Human Services. 2000. *Healthy people 2010: Understanding and improving health*. 2nd ed. Washington, DC: U.S. Government Printing Office.
2. Dietitians of Canada, American Dietetic Association. 2000. *Manual of clinical dietetics*. 6th ed. Chicago: ADA.
3. U.S. Department of Agriculture, Food and Nutrition Service (FNS). 1993. *Breastfed babies welcome here!* Alexandria, VA: FNS.
4. American Academy of Pediatrics, Section on Breastfeeding. 2005. Policy statement: Breastfeeding and the use of human milk. *Pediatrics* 115:496-506.
5. Uauy, R., I. DeAndrea. 1995. Human milk and breast feeding for optimal brain development. *J Nutr* 125:2278-80.
6. Wang, Y. S., S. Y. Wu. 1996. The effect of exclusive breast feeding on development and incidence of infection in infants. *J Hum Lactation* 12:27-30.
7. Quasdt, S. 1998. Ecology of breast feeding in the US: An applied perspective. *Am J Hum Biol* 10:221-28.
8. Hammosh, M. 1996. Breast feeding and the working mother. *Pediatrics* 97:492-98.
9. Kramer M. S., L. Matush, I. Vanilovich, et al. 2007. Effects of prolonged and exclusive breastfeeding on child height, weight, adiposity, and blood pressure at age 6.5 y: Evidence from a large randomized trial. *Am J Clin Nutr* 86:1717-21.
10. Lawrence, R. A., R. Lawrence. 2005. *Breast feeding: A guide for the medical profession*. 6th ed. St. Louis: Mosby.
11. Birch, L., W. Dietz, eds. 2008. *Eating behaviors of the young child: Prenatal and postnatal influences on healthy eating*. Elk Grove Village, IL: American Academy of Pediatrics.
12. Dietz, W. H., L. Stern, eds. 1998. *American Academy of Pediatrics guide to your child's nutrition*. New York: Villard.
13. Kleinman, R. E., ed. 2009. *Pediatric nutrition handbook*. 6th ed. Elk Grove Village, IL: American Academy of Pediatrics.
14. U.S. Department of Agriculture, Food and Nutrition Service (FNS). 2002. *Feeding infants: A guide for use in the child nutrition programs*. Rev ed. Alexandria, VA: FNS. [http://www.fns.usda.gov/tn/resources/feeding\\_infants.pdf](http://www.fns.usda.gov/tn/resources/feeding_infants.pdf).
15. Ip, S., M. Chung, G. Raman, P. Chew, N. Magula, D. DeVine, T. Trikalinos, J. Lau. 2007. *Breastfeeding and maternal and infant health outcomes in developed countries*. Rockville, MD: Agency for Healthcare Research and Quality.
16. U.S. Department of Agriculture, Food and Nutrition Service. Benefits and services: Breastfeeding promotion and support in WIC. <http://www.fns.usda.gov/wic/breastfeeding/mainpage.HTM>.
17. Stuebe, A. M., E. B. Schwarz. 2009. The risks and benefits of infant feeding practices for women and their children. *J Perinatology* (July 16).

**STANDARD 3.6.4.5: Death**

*Reader's Note: This standard is included because it describes procedures for handling a suspected SIDS or other unexplained death of a child.*

Each facility should have a plan in place for responding to any death relevant to children enrolled in the facility and their families. The plan should describe protocols the program will follow and resources available for children, families, and staff.

If a facility experiences the death of a child or adult, the following should be done:

- a) If a child or adult dies while at the facility:
  - 1) The caregiver/teacher(s) responsible for any children who observed or were in the same room where the death occurred, should take the children to a different room, while other staff tend to appropriate response/follow-up. Minimal explanations should be provided until direction is received from the proper authorities. Supportive and reassuring comments should be provided to children directly affected;
  - 2) Designated staff should:
    - i) Immediately notify emergency medical personnel;
    - ii) Immediately notify the child's parents/guardians or adult's emergency contact;
    - iii) Notify the Licensing agency and law enforcement the same day the death occurs;
    - iv) Follow all law enforcement protocols regarding the scene of the death:
      - a. Do not disturb the scene;
      - b. Do not show the scene to others;
      - c. Reserve conversation about the event until having completed all interviews with law enforcement.
    - v) Provide age-appropriate information for children, parents/guardians and staff;
    - vi) Make resources for support available to staff, parents and children;
  - b) For a suspected Sudden Infant Death Syndrome (SIDS) death or other unexplained deaths:
    - 1) Seek support and information from local, state, or national SIDS resources;
    - 2) Provide SIDS information to the parents/guardians of the other children in the facility;
    - 3) Provide age-appropriate information to the other children in the facility;
    - 4) Provide appropriate information for staff at the facility;
  - c) If a child or adult known to the children enrolled in the facility dies while not at the facility:
    - 1) Provide age-appropriate information for children, parents/guardians and staff;
    - 2) Make resources for support available to staff, parents and children.

Facilities may release specific information about the circumstances of the child or adult's death that the authorities and the deceased member's family agrees the facility may share.

If the death is due to suspected child maltreatment, the caregiver/teacher is mandated to report this to child protective services.

Depending on the cause of death (SIDS, suffocation or other infant death, injury, maltreatment etc.), there may be a need for updated education on the subject for caregivers/teachers and/or children as well as implementation of improved health and safety practices.

**RATIONALE:** Following the steps described in this standard would constitute prudent action (1-3). Accurate information given to parents/guardians and children will help them understand the event and facilitate their support of the caregiver/teacher (4-7).

**COMMENTS:** It is important that caregivers/teachers are knowledgeable about SIDS and that they take proper steps so that they are not falsely accused of child abuse and neglect. The licensing agency and/or a SIDS agency support group (e.g., CJ Foundation for SIDS at <http://www.cjsids.org>, the National Sudden and Unexpected Infant/Child Death and Pregnancy Loss Resource Center at <http://www.sidscenter.org>, and First Candle at <http://www.firstcandle.org>) can offer support and counseling to caregivers/teachers.

**TYPE OF FACILITY:** Center; Large Family Child Care Home; Small Family Child Care Home

**RELATED STANDARDS:**

Standard 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction

Standards 3.4.4.1-3.4.4.5: Child Abuse and Neglect

**REFERENCES:**

1. Moon, R. Y., K. M. Patel, S. J. M. Shaefer. 2000. Sudden infant death syndrome in child care settings. *Pediatrics* 106:295-300.
2. Moon, R. Y., T. Calabrese, L. Aird. 2008. Reducing the risk of sudden infant death syndrome in child care and changing provider practices: Lessons learned from a demonstration project. *Pediatrics* 122:788-98.
3. Moon, R. Y., L. Kotch, L. Aird. 2006. State child care regulations regarding infant sleep environment since the Healthy Child Care America – Back to Sleep Campaign. *Pediatrics* 118:73-83.
4. Boston Medical Center. Good grief program. <http://www.bmc.org/pediatrics-goodgrief.htm>.
5. Rivlin, D. The good grief program of Boston Medical Center: What do children need? Boston Medical Center. [http://www.wayland.k12.ma.us/claypit\\_hill/GoodGriefHandout.pdf](http://www.wayland.k12.ma.us/claypit_hill/GoodGriefHandout.pdf).
6. Trozzi, M. 1999. Talking with children about Loss: Words, strategies, and wisdom to help children cope with death, divorce, and other difficult times. New York: Berkley Publishing Group.
7. Knapp, J., D. Mulligan-Smith, Committee on Pediatric Emergency Medicine. 2005. Death of a child in the emergency department. *Pediatrics* 115:1432-37.

## Index

### A

AAP. *See* American Academy of Pediatrics (AAP)  
 Abusive head trauma. *See* Shaken baby syndrome/abusive head trauma  
 Accreditation, 16-17, 21, 27  
 Allergies, 14, 25, 35  
 American Academy of Pediatrics (AAP), 19-21, 23, 27  
     recommendations by, 1, 3-5, 35  
 ASTM International, 1, 11

### B

Back to sleep. *See* Sleep  
 Bedding  
     concerning safety, 1, 7-8  
     prohibiting sharing of, 1, 7  
 Bibs, 1  
 Blankets, 1-4, 7-8  
 Brain development, 16  
 Breastfeeding. *See also* Feeding, 3, 35-37  
 Burns, 26, 29

### C

Cardiopulmonary resuscitation (CPR). *See also*  
     First aid  
     training for caregivers/teachers, 16, 22-24, 26, 29-30  
 Caregivers/teachers  
     continuing education, 26-30  
     occupational hazards and, 26, 29  
     orientation, 22-24  
     performance evaluations, 28, 32  
     policies, 32  
     qualifications, 15-17, 24  
     training, 17, 22-24, 29-31  
     turnover, 24-25  
 Child care centers  
     qualifications, 16-17  
     substitutes, 24-26  
     training of caregivers/teachers, 17, 22-24, 29-31  
 Certification  
     caregivers/teachers, 16  
 Child abuse and neglect  
     recognizing signs and symptoms, 18-19, 22-23, 25-26, 29, 30, 32-34  
     reporting, 18-19, 22-23, 25-26, 29-30, 32-34  
 Child care health consultants (CCHC), 19-22  
     policies, 21, 33  
     when to contact, 29, 31-32  
 Children who are ill  
     immunizations, 17-19, 22, 29, 31-34  
     policies, 16, 27, 31-33  
 Children with special health care needs, 14, 20, 26, 31-32  
     pre-service training, 22-23  
 Child-staff ratios, 6, 24  
 Cleaning, 1, 3-5, 22, 30  
 Comforters, 1  
 Comforting, 2, 15, 27  
 Confidentiality of records, 18, 20, 32-33

Continuing education  
     for directors and caregivers/teachers in centers and large family child care homes, 26-28  
     for small family child care home providers, 28-29  
     records of, 30  
 Cots, 7-9  
 CPR. *See* Cardiopulmonary resuscitation  
 Cribs  
     evacuation, 9-10  
     stackable, 1, 10  
 Cultural diversity, 22, 30  
 Cultural groups, 24  
 Curriculum, 14-15, 23, 26, 28

### D

Death. *See also* Sudden Infant Death Syndrome (SIDS)  
     reporting, 37-38  
 Developmentally appropriate, 6, 15, 18, 19, 22, 23, 26, 28  
 Diapers  
     cloth, 1  
 Directors  
     responsibilities, 18, 22-26, 30  
     qualifications, 14-15  
 Disabilities, 4, 19, 22, 27, 31  
 Disasters  
     evacuation, 7, 9-10, 26, 29, 32-35

### E

Ear infections, 3, 5, 13, 36  
 Emergency Medical Services (EMS), 23, 27, 31  
 Emergency medical personnel, 27, 37  
 Emergency plans, 25, 32-33  
     for children with special health care needs, 20, 24  
 Emergency procedures, 22, 24-25, procedures, 32-34  
     termination of, 31, 33  
 Enrollment information, 32-34  
 Entrapment risks  
     in cribs, 8-9, 12-13  
 Evacuation of children. *See also* Shelter-in-place  
     cribs for evacuation, 26, 29, 32-33  
     plan, 7  
     procedures, 35  
 Evaluation  
     of caregiver/teacher performance, 27, 32  
     of training, 25-26, 28  
 Evening and nighttime child care, plans for, 34-35  
 Extension services sites, 29

### F

Falls, 10-13, 26, 29  
 Feeding. *See also* Breastfeeding  
     employee qualifications regarding, 15, 19  
 Infants, 35-37  
     plans, 35-37  
     policies, 21, 32-34, 36  
     training on, 22-23, 26, 28, 30-31  
 First aid. *See also* Cardiopulmonary resuscitation (CPR)

    training, 14, 16, 22-24, 26, 29-30  
 Formula, 35-37  
 Furniture  
     safety of, 1, 11-13

### H

Hand hygiene, 7, 17, 22, 25  
 Handwashing. *See* Hand hygiene  
 Hazards  
     awareness of, 6  
     safety, 3, 8, 9, 11-13, 16, 18, 21  
     second-hand smoke, 13, 35  
     third-hand smoke, 14, 35  
 Health advocates, qualifications and responsibilities for, 17-19  
 Health departments  
     resource for materials, 18, 23, 27, 31  
 Health education  
     for caregivers/teachers, 27, 29-30  
     for children, 19  
     for families, 2-3  
     policies, 21, 32-33  
 Holding, 5, 15  
 Human milk, 36

### I

Infants  
     nutrition, 27  
     feeding, 35-37  
     meal plans, 35-37  
     sleeping areas, 1, 9-10  
 Infection control, 22-24  
 Injuries  
     preventing  
         methods of, 6, 9, 12  
         training on, 23, 26-27, 29  
     records and reports of, 34  
 Isolation of staff, 29

### L

Large family child care homes  
     policies, 6, 35  
     substitutes, 24-26  
     training of caregivers/teachers, 26-28  
 Licensing agencies  
     notified of death, 37-38

### M

Mattresses, 1-3, 7-10

### N

Napping, 1, 3, 5-6, 25, 32-33  
 Neglect. *See* Child abuse and neglect

### O

Occupational Safety and Health Administration (OSHA), 22, 25  
 Orientation of caregivers/teachers, 24  
     of substitutes, 25-26  
 OSHA. *See* Occupational Safety and Health Administration (OSHA)

**P**

- Pacifiers
  - cleaning of, 4-5
  - sudden infant death syndrome and, 3
  - use of, 1, 3-5
- Parent/guardian education, 2, 30
- Pillows, 1, 7-8, 36
- Policies
  - child care health consultants, 19-21, 33
  - children who are ill, 22, 33
  - confidentiality, 33
  - content of, 31-32
  - feeding, 21
  - food handling, 25, 33
  - health education, 29-30, 33
  - immunizations, 33
  - medication administration, 21-22, 26, 33
  - safe sleep practices, 1-3, 19, 31-32, 33
  - safety, 21, 25, 33
  - sanitation, 21, 33
  - sleep position, 25, 33
  - smoking and prohibited substances, 33, 35
  - transportation, 21, 33-35
- Prohibited substances
  - policies, 35
- Prone position. *See* Sleep

**Q**

- Qualifications
  - of caregivers/teachers, 15-17, 24
  - of directors, 14-15
  - of health advocates, 17-19
  - of substitutes, 24
- Quilts, 1

**R**

- Records
  - child health, 17-18, 34
  - confidentiality, 33
  - training, 30
- Regulations, 2, 10, 13
  - training on, 2, 19, 22, 25, 29
- Resource and referral agencies, 20-21, 23
- Rest periods, 5-6

**S**

- Safe sleep. *See* Sleep
- Sanitation, 7, 21, 27, 31, 34
- Seizures, 18
- Sheepskins, 1
- Shaken baby syndrome/abusive head trauma
  - preventing and identifying, 23
  - prevention of, 16-17
- Shelter-in-place
  - drill procedures, 26, 29
- SIDS. *See* Sudden infant death syndrome (SIDS)
- Sleep
  - sleep position, 1, 3, 25
  - sleep positioning devices, 1
  - sleeping areas, 7-10
- Small family child care homes
  - training of caregivers/teachers, 28-30
- Smoking, 13-14

- policies prohibiting, 35
- Social workers, 17
- Staff. *See* Caregivers/teachers
- Substitutes, 24-26
- Sudden infant death syndrome (SIDS), 37
  - accusation of child abuse and neglect and, 37-38
  - in child care, 17, 23
  - deaths in child care facilities attributable to, 2
  - pacifier use and, 3
  - reducing risk of, 1-4, 15, 35
  - risk of, 2, 4, 11, 17, 23
- Suffocation, 1-2, 8-9, 11, 38
- Supervision
  - methods, 6-7
  - policies, 6-7, 11, 35
- Swaddling, 1, 3-4

**T**

- Teachers. *See* Caregivers/teachers
- Tobacco
  - policies prohibiting, 35
- Toddlers
  - caregiver/teacher qualifications for, 15-16
- Toilet learning/training, 7
- Toys
  - crib, 11
- Training
  - by health agencies, 31
  - by regulatory agencies, 30-31
  - of health advocates, 17-18, 23
  - orientation, 24-25, 32
  - pre-service, 22-24
  - record, 30
  - resources, 23, 27-28, 30-31
  - satellite, 29
- Transportation
  - policies, 34-35
- Turnover, 24-25

**V**

- Volunteers. *See also* Caregivers/teachers
  - qualifications for, 24