

child care health connections

A HEALTH AND SAFETY NEWSLETTER FOR CALIFORNIA CHILD CARE PROFESSIONALS

Published by the California Childcare Health Program (CCHP), a program of the University of California, San Francisco School of Nursing (UCSF)



Naps in Child Care

Sleep is an important part of healthy growth and development. When children sleep their brains develop, they heal and they grow. Regular naps provide predictable routines and help children cope with the stimulating activities in child care settings. In California, licensing regulations require that “all children shall be given the opportunity to nap or rest without distraction or disturbance from other activities at the center”.

Naptime routines

Naptime can be a warm and relaxing time of the day for children and caregivers. Providing a calm environment, comforting practices and allowing for the individual needs of young children will help make naptime peaceful. Since children have different needs for rest, some may not sleep. You can't force a child to sleep but you can insist upon a quiet rest time. It may take several weeks to establish a routine but it is worth the effort since both staff and children enjoy the benefits.

Naptime tips for caregivers:

- Put young children in a crib or on a cot while sleepy but not yet asleep. This teaches children how to wind down and self-soothe.
- Play soft music and dim the lights.
- Read a quiet story or rhyme.
- Quietly remind children of naptime rules such as “stay on your cot” or “speak only in whispers.”
- Allow children to bring comforting objects from home, such as a small blanket or stuffed animal.
- Place cots three feet apart and head to toe to avoid spreading germs.
- Remember that infants must be placed on their backs for sleep.
- Do not place children to sleep with bottles. This will prevent baby bottle tooth decay and reduce the risk of ear infections.

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California Child Care

Healthline



Call **800.333.3212**
for free consultations
on health and safety
in child care

health + safety tips

Magnet Ingestion Injuries

The U.S. Consumer Product Safety Commission (CPSC) reports that children have been injured by swallowing magnets from toys. To help prevent serious magnet ingestion injuries, the CPSC recommends:

- Seek prompt medical attention if you suspect your child may have swallowed a magnet.
- Look for non-specific abdominal symptoms: abdominal pains, nausea, vomiting and diarrhea.
- Keep small magnets and small pieces containing magnets away from young children who might mistakenly or intentionally swallow them.
- Regularly inspect toys and children's play areas for missing or dislodged magnets.
- Check www.cpsc.gov to make sure your children's magnetic toys are not recalled products.

Adapted from the U.S. Consumer Product Safety Commission

Child Care Health Connections is a bimonthly newsletter published by the California Childcare Health Program (CCHP), a community-based program of the University of California, San Francisco School of Nursing, Department of Family Health Care Nursing. The goals of the newsletter are to promote and support a healthy and safe environment for all children in child care reflecting the state's diversity; to recreate linkages and promote collaboration among health and safety and child care professionals; and to be guided by the most up-to-date knowledge of the best practices and concepts of health, wellness and safety. Information provided in *Child Care Health Connections* is intended to supplement, not replace, medical advice.

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Subscriptions, Renewals, Inquiries

Contact CCHP at (800) 333-3212 or cchp@ucsfchildcarehealth.org.

CCHP Program Office

1950 Addison St., Suite 107
Berkeley, CA 94704
T (510) 204-0930 (new number)
F (510) 204-0931 (new number)

California Child Care Healthline

(800) 333-3212
healthline@ucsfchildcarehealth.org

www.ucsfchildcarehealth.org

Newsletter Editors

A. Rahman Zamani, MD, MPH
Judy Calder, RN, MS
Bobbie Rose, RN
Victoria Leonard, RN, FNP, PHD
Mara Gendell



ask the nurse

Safely Surrendered Baby Law

Q I direct a teen pregnancy and parenting program and the young women in class were interested in more information on the Safely Surrendered Baby Law. Where can I find the information?

A The Safely Surrendered Baby (SSB) Law, established in 2001, provides a safe way for a parent who feels unable or unwilling to care for a baby to surrender the baby within three days of birth and be protected from prosecution for child abandonment. It does require that the baby be given to an on-duty employee of a hospital or safe haven site designated by each county (for example, fire station) that displays the Safe Surrender logo. No information is required of the person surrendering the baby although a voluntary medical questionnaire can be completed. The babies are given medical attention and are placed in foster or pre-adoptive care. Under the law, a parent or surrendering person has at least 14 days to reclaim the baby that has been given a coded bracelet.

California and other states have enacted this law to ensure the continued safety and protection of babies. Formerly, desperate mothers who may not have known about or considered other options such as adoption may have abandoned these babies in unsafe or dangerous locations. Since the law has been enacted there have been 182 babies safely surrendered as of January 2007. In 2006, 60 babies were surrendered, the largest number since the program began. The number of babies left illegally has also dropped from 33 in 2002 to 16 in 2006.

Child care programs and other community organizations and services such as high schools, social services agencies, churches, or local stores can play a key role in spreading information on this very important life-saving legislation. SSB posters and brochures are available, free of charge, to requesting individuals and organizations through the web site at www.babysafe.ca.gov. If you do not have access to an internet source you may call your local social services agency or Healthline (800) 333-3212.

by Judy Calder, RN, MS



We have new numbers:

Office (510) 204-0930

Fax (510) 204-0931

The following contact information remains the same:

California Childcare Health Program
1950 Addison Street, Suite 107, Berkeley, CA 94704
Healthline (800) 333-3212 • cchp@ucsfchildcarehealth.org • www.ucsfchildcarehealth.org

Autism: When to Refer a Child for Evaluation

Autism is a diagnosis that should be made as early as possible because early intervention can make an enormous difference in a child's ability to communicate with others and participate in the human community.

Autism is a severe, life-long disorder, marked by delayed social development, and problems with communication and play that often become evident soon after birth, but always by age three. Autism is not a specific disease but rather a disorder of brain development. The causes are not known but it is known that there is a strong genetic basis. Once considered rare, today autism is estimated to affect as many as one in every 150 children. Milder forms of autism are more common than the severe form. It is difficult to diagnose early, particularly in its milder forms, because there is no sign or laboratory test to detect it. However, a significant number of symptoms of autism are present by 18 months of age or even earlier. Unfortunately, children are typically not diagnosed until 3 to 4 years of age, or later.

ECE professionals are familiar with the range of "normal" behavior; they also know when a child's behavior seems out of the range of normal. They may be better able to identify a child who needs evaluation than parents who usually have more limited experiences with young children and are not as familiar with normal developmental milestones. It is very important for ECE professionals to talk with parents about evaluation if they have concerns about a child's development. Here are some behavioral signs that a child should be evaluated by a health care provider.

When an infant or toddler:

- Has limited eye contact with and diminished overall awareness of and responsiveness to others.
- Does not babble, point, or make meaningful gestures by 1 year of age.
- Does not combine two words by 2 years of age.
- Has loss of language and/or social skills during the second year.
- Does not play "pretend" games (for example, pretend feeding a doll).
- Does not respond to his/her name at one year.
- Doesn't smile socially.

- Becomes attached to unusual objects.
- Seems to be hearing impaired at times, although no evidence of a hearing problem is present.
- Exhibits unusual repetitive behaviors like hand flapping, humming, or rocking.
- Does not use eye contact and/or finger pointing for the social purpose of sharing experiences with others.

When a preschooler:

- Has difficulty with change.
- Is unable to imitate the behaviors of others.
- Has difficulty with expressing emotion and responding to the emotions of others.
- Repeats or echoes words or phrases.
- Has trouble grasping the meaning of idioms, sayings, humor and sarcasm.
- Has difficulty with initiating and maintaining a conversation with another child.
- Laughs, cries, or shows distress for no apparent reason.
- Has an unapproachable manner, prefers to be alone.
- Has uncontrollable tantrums.
- May not want to cuddle or be cuddled.
- Has uneven gross and fine motor skills.
- Plays oddly with toys or objects.
- Is over-sensitive or under-sensitive to pain.
- Has no real fear of danger.

Resources

CCHP Health and Safety Note: *Autism*, http://ucsfchildcarehealth.org/pdfs/healthandsafety/AutismEN092506_adr.pdf.

American Academy of Neurology (AAN) Guideline Summary for Parents and Caregivers: Screening and Diagnosing Children with Autism. St. Paul (MN): American Academy of Neurology (AAN); 2000, http://aan.com/professionals/practice/guidelines/guideline_summaries/autism_Guideline_for_Patients.pdf.

American Academy of Pediatrics, *Understanding Autism Spectrum Disorders (ASD)*.

CDC Autism Information Center, <http://www.cdc.gov/ncbddd/autism/>.

Wiseman, N. *Could it be autism?* 2006.

by Vickie Leonard, RN, FNP, PHD

Rest and Sleep for Caregivers

A good night's sleep can have a big impact on how well you function the next day. We need sleep to heal, refresh and restore. Along with a healthy diet and plenty of exercise, sleep is an important part of your overall health.

Sleep and brain function

The areas of the brain that help us learn, remember and solve problems are very active during sleep. People who regularly lack sleep are prone to being irritable and are more likely to become depressed. We need sleep to think clearly, react quickly and for memory.

Sleep and physical health

While asleep the body repairs tissues and cells and fights infections. Inadequate sleep increases the risk for high blood pressure, heart disease and diabetes. Sleep also has an effect on how the body uses energy. People who sleep less are more often obese or overweight and tend to prefer foods high in calories and carbohydrates.

How much sleep do adults need?

The amount of sleep needed varies between individuals, but most adults need about 8 hours of sleep each night. And the quality of sleep matters. Healthy sleep is divided into stages. Deep sleep is most restful. When deep sleep stages are interrupted you may wake feeling groggy. A full night's sleep with few interruptions is best.

Job performance and sleep

Studies show that when people don't sleep enough they use poor judgment, take more risks and have more accidents and injuries. Lack of sleep can lead to problems with mood, behavior and relationships. As a result, poor sleep can effect how well ECE professionals do their jobs. Young children need adults to be patient and respond in a predictable manner. They depend on

caregivers who are aware and alert to keep them safe and help them learn. Do yourself and the children in your program a favor by making healthy sleep a priority!

Tips for improving sleep

- Stick to a regular sleep schedule—even on the weekends.
- Get regular exercise, but not too close to bedtime.
- Limit drinks with caffeine and have them early in the day.
- Quit smoking.
- Avoid alcohol before bed. A “night cap” may make it easier to fall asleep but alcohol interferes with substances in the brain that allow for continuous sleep and can cause repeated waking (or partial waking) through the night.
- Avoid large meals late at night.
- Keep naps under one hour and take them before 3:00 p.m.
- Unwind and relax before bed by reading, listening to music or taking a hot bath.
- Create a sleeping environment that is cool, quiet and without distractions.



When to see a health professional

If you feel tired even though you sleep at night, are unable to sleep at night or experience loud snoring followed by periods of silence and gasps, talk to your doctor or a sleep specialist.

Resources and References

National Institute of Health, Your Guide to Healthy Sleep, 2006 at http://www.nhlbi.nih.gov/health/public/sleep/healthy_sleepfs.pdf.

CCHP Fact Sheet for Families, *Good Sleep*, <http://www.ucsfchildcarehealth.org/pdfs/factsheets/goodsleepen011804.pdf>.

by Bobbie Rose, RN



Oral Health can Affect General Health

You may have heard of the mouth-body connection. What goes on in your mouth can affect the rest of your body and what goes on in the rest of your body can have an effect on your mouth. In other words, *oral health* is important and connected to *general health* and well-being.

Links between oral and general health

The mouth is filled with numerous bacteria, including those linked to dental caries (tooth decay), periodontal (gum) disease, and systemic disease that affect general health. These bacteria are usually kept under control with good oral hygiene such as daily brushing and flossing. When harmful bacteria grow out of control, they can cause serious gum infections and provide a port of entry into the bloodstream.

The mouth is a window to your body's health

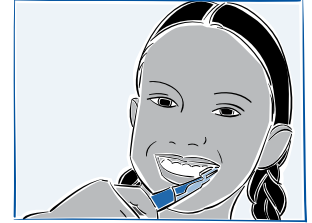
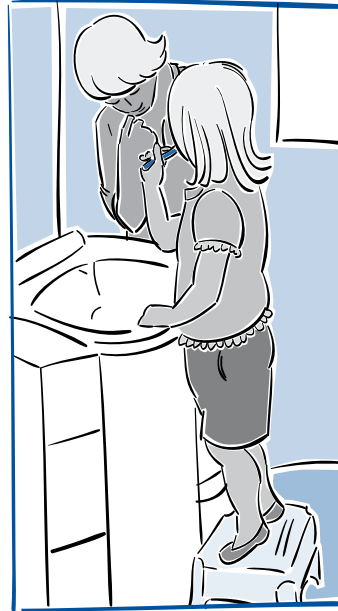
The mouth reflects signs and symptoms of health and disease. It can show signs of illnesses, general infections and nutritional deficiencies. The former Surgeon General, in a 2000 report on U.S. oral health, noted that “[a] physical examination of the mouth and face can reveal signs of disease, drug use, domestic physical abuse, harmful habits or addictions such as smoking and general health status.”

Oral health can affect other diseases and conditions

- Different studies have indicated an association between serious gum disease and certain diseases that affect the body, including diabetes and heart disease.
- The mouth may serve as a direct reservoir for bacterial contamination of the lungs with subsequent development of bacterial pneumonia.
- Pregnant women with gum disease are at an increased risk for pre-term births and low birth weight babies.
- Infection in the mouth can disrupt blood-sugar levels and make diabetes harder to control.

Diseases and conditions can affect your oral health

- People with weakened immune systems are more likely to get fungal and viral infections in the mouth.
- Some blood disorders, gastrointestinal disorders such as GERD (Gastro Esophageal Reflux Disease), respiratory



- diseases and conditions can affect your oral health.
- Cardiovascular conditions, diabetes and pregnancy can affect your dental care and oral health.
- Medicine taken for other conditions may cause dry mouth, which can increase your risk of dental decay, oral yeast infections and other oral infections.
- Vitamin deficiencies can have serious effects on your mouth and teeth.
- Tobacco use and poor dietary practices can affect mouth and face.

Good health may start with your mouth

While oral diseases are important themselves, their relationship to overall general health is often overlooked by parents, health care and child care providers. Promotion of oral health and what you can do about oral health problems is an important step in maintaining overall health.

Resources

Oral Health in America: A Report of the Surgeon General available online at www.surgeongeneral.gov/library/oralhealth/.

Systemic Diseases Caused by oral Infection. Clinical Microbiology review, Oct 2000.

by A. Rahman Zamani, MD, MPH



Transitioning of Young Children with Disabilities



Every year thousands of children with special needs move from one type of early childhood program to another. Although transition is a normal and anticipated part of every child's life, it is a stressful and worrisome period for parents of children with disabilities.

What is transition?

Transition is the process of moving a child from one location or program to another. For children with disabilities, transition is a coordinated set of activities designed to promote a smooth transfer of a child from one service setting or delivery system to another without an interruption in their services. Transitions for young children with "special needs" can occur at a number of points; for instance, when the child moves:

- from the hospital to the family's home
- from care in the home to infant/toddler early intervention services
- from infant/toddler services to preschool
- from preschool to kindergarten and elementary school

The law and transition

Under the Individuals with Disabilities Education Improvement Act of 2004, all states must develop a transition policy for all children with special needs. The law requires that a transition plan be developed for any child with an Individualized Family Services Plan (IFSP) when the child is between 30 and 33 months of age. The Service Coordinator, designated in the IFSP, from the "sending" agency is responsible for planning and coordinating the transition plan.

It is important to know that you should obtain written consent from the child's parents before sharing any information about a child with any person outside of the child care program.

There are four stages in implementing a Transition Plan

1. Stage one: The initial plan occurs when the family and the service provider get together and discuss the transition plan.
2. Stage two: The child will be re-assessed to figure out his /her progress according to the goals in the child's IFSP or Individual Education Plan (IEP).
3. Stage three: The child's family and the child care provider from the current (sending) program get familiar with the new (receiving) program. Open communication between the family and the new program's administrator and teacher begins.
4. Stage four: The transition plan is evaluated for its efficiency.

At what age must young children have a Transition Plan?

When children reach the age of three, they are no longer eligible for services from the "Birth to Three" system (provided for in Part C of IDEA), and begin receiving services from the local school district (provided for in Part B of IDEA).

Federal and state regulations require that the first transition plan be developed by the time the child is two years six months of age. The transition plan should specify when the child's IEP meeting will take place. This will give parents sufficient time to advocate and discuss placement for the child in a preschool program. The child must have an individualized education program (IEP) in place by his/her third birthday.

The second important transition happens when a child is approximately six years old and about to transition to kindergarten. Again, as occurred at age three, all children with special needs should be re-evaluated for appropriate placement prior to transitioning to a new program. If the results of the re-evaluation indicate

that the child is no longer eligible for special needs services, his/her transition will be followed like that of a typically developing child. But, if the results show that the child is still qualified to receive special education services then the service provider should plan for the child's transition to inclusive kindergarten. It is important at this point that the parent and service provider meet and plan these transition events. This also serves as continuous monitoring process.

Transitioning children with special needs from a preschool program to kindergarten

The end of the preschool program occurs with the beginning of kindergarten, which is the first step to formal education. The transition to kindergarten marks a milestone in the lives of children and their families. Transitioning a child with "special needs" to kindergarten should also be a collaborative process with the parent and service provider in order to make the process as smooth as possible. Similar to the transition from early intervention programs, the transition into kindergarten can be stressful and worrisome but it can also be an exciting and happy period of time for children and their families. An appropriate re-evaluation must be conducted before the child enters kindergarten to determine whether the child needs further special education and should have an updated IEP in place. Transition planning should be included as part of the child's annual IEP.

What is a child care provider's role and responsibility?

Child care providers are important members of the child's transition team. They can assist families by providing support, and preparing the child and family for the new program and change of services. Plan visits to the new program and accompany the family and child to the receiving program. Communicate with the new service providers regarding the child's strengths and needs.

Who attends a transition planning conference?

It is up to the parent to invite and include any individual in the transition meeting. This might include the child's IEP team, members of multidisciplinary team, and/or caregivers the appropriate educational and re-

lated services professionals are the individuals who will be involved in developing the transition plan.

The place for the conference meeting should be central and based on parent's wish.

Who coordinates the transition conference?

The term Service Coordinator or Transition Coordinator was first used in IDEA-1997 and introduced in early intervention laws. He or she is the primary contact person for service providers, parents, administrators, teachers, and other related services personnel for the program details, eligibility requirements, services, and resources.

What are the components of a smooth transition?

- Parents are involved at every level of the decision making and planning process.
- The transition plan is developed in a timely manner with input from parents.
- Responsibilities are well defined and every member including parents are informed.
- The team is well informed about the new program.
- An agreement between the agencies has been developed and signed by appropriate administrators.
- The transition plan was developed with respect to family's culture and their home language
- A visit to the new setting is included in the plan.
- Transportation issues are explained clearly in the plan.

Although transition is a stressful time for both parents and children, with good planning this event could be a positive learning process for their advocacy.

Resources and References

K. Eileen Allen and Glynnis E. Cowdery, *The Exceptional Child Inclusion in Early Childhood Education*, 5th Edition, 2004, pages 386-399

Janet W. Lerner, Barbara Lowenthal, and Rosemary W. Egan, *Preschool Children with Special Needs*, Second Edition, 2005, pages 272-286

National Dissemination Center for Children with Disabilities www.nichcy.org

Tahereh Garakani, MA Ed

3/07

California Childcare Health Program • 1950 Addison Street, Suite 107 • Berkeley, CA 94704-1182
Telephone 510-204-0930 • Fax 510-204-0931 • Healthline 1-800-333-3212 • www.ucsfchildcarehealth.org

Children with Spina Bifida in Child Care Setting: Part I

Spina Bifida (SB) is a Neural Tube Defect (NTD). This abnormal development defect involves an incomplete closure in the spinal column, which takes place in the first four weeks of pregnancy. Any abnormal development of the nerves, muscles, and the fluid-filled sac that surrounds the spinal cord can cause permanent mild to severe birth defects.

What causes SB?

During the first month of pregnancy the human brain and spine begin as a flat plate of cells that rolls into a tube. Any opening or lesions during this process will cause an NTD. The size and location of the lesion determines the disability: the closer the lesion is to the neck, the more severe the disability.

The following factors affect the normal development of the neural tube:

- lack of proper vitamins and nutrients in the diet
- genetic problems
- infection
- exposure to hazardous chemicals or substances
- prescription drugs and alcohol consumption during pregnancy
- maternal age—more common in teenage mothers

Is SB preventable?

The cause of spina bifida is thought to be a combination of genetic and environmental factors. Research shows that consumption of folic acid or Vitamin B9 can help reduce the risk of NTD (The B vitamins are eight water-soluble vitamins. Supplements containing all eight B vitamins are generally referred to as a vitamin B complex). Folic acid is found in most green leafy veg-

etables, nuts, beans, citrus fruits, and fortified breakfast cereals.

Recent research has shown that there is a specific gene that causes spina bifida, allowing parents to identify embryos that may develop the condition (Science Daily (05/04/2007)).

How SB is diagnosed?

Neural tube defects including SB can usually be diagnosed by testing mother's blood and having an ultrasound during pregnancy. Genetic counseling and testing, such as amniocentesis or an amniotic fluid test, may also be offered.

What are the symptoms of SB after the baby is born?

Each baby may experience symptoms differently, but the following are the most common symptoms:

- hydrocephalus, which is increased fluid in the brain; 90% of children with SB have this problem
- bowel and bladder problems
- abnormal appearance on the back: hairy patch, dimple or birthmark
- paralysis below the lesion area
- children with spina bifida commonly have learning disabilities and ADHD

(Part II of this article will continue in Nov/Dec issue).

Resources and References

Spina Bifida Association of America, 800-621-3141, www.sbaa.org.

National Dissemination Center for Children with Disabilities, 800-695-0285, www.nichcy.org, nichcy@aed.org.

by Tahereh Garakani, MA, ED

Naps in Child Care, continued from page 1

Work with parents

Signs that a child may need more sleep include yawning and dozing during the day, crankiness, trouble waking in the morning, uncooperative behavior, trouble focusing, impatience, and aggressive behavior or hyperactivity. Encourage families to establish regular sleep routines and bedtimes rituals at home. Communicate about behaviors that may signal a need for more sleep. Bed times may need to be adjusted before giving up a nap. When discussing nap times with families, always put the child's needs first while respecting family time and cultural differences.

Be sensitive to different cultural beliefs and practices. Discuss your program policy and negotiate and solve any conflicts due to cultural differences.

Resources and References

Naps, Namours Foundation, at www.kidshealth.org.

Saifer, Steffen, Practical Solutions to Practically Every Problem, 2003, Redleaf Press.

Protecting Infants in Our Care From SIDS, CCHP at <http://www.ucsfchildcarehealth.org/pdfs/healthandsafety/sidsen112805.pdf>.

by Bobbie Rose, RN

Diapering Stations: Design Strategies to Prevent the Spread of Infectious Diseases

Infectious diseases are a fact of life in child care and many infectious diseases are difficult or even impossible to prevent. There is one area, though, where changing policies and practices can really prevent the spread of disease: diaperchanging. Changing diapers in ECE settings serving infants and toddlers is an everyday occurrence; so everyday, in fact, that many ECE providers don't think much about it. But many research studies have found that training ECE providers in hygiene practices (see *Recommendations for Cleaning, Sanitizing and Disinfecting* in **Resources**, below), and periodically reviewing those practices, does help reduce illnesses. A recent study published in the journal, *Pediatrics*, found that using Child Care Health Consultants to train ECE caregivers in proper hygiene practices decreased the frequency of diarrheal diseases in children and staff absences due to illness. In addition, the study found that the installation of separate diaper-changing, hand-washing, and food-preparation equipment that was specifically designed to reduce the transmission of infectious disease resulted in even fewer diarrheal diseases among children and staff absences due to illness. Equipment included tables with a seamless, smooth surface that did not absorb liquid or retain soil, touchless faucets and cabinets, and foot-activated waste bins for diaper disposal.

Diaper changing facilities should be designed with three things in mind: hygiene, safety and supervision. When

you are designing or remodeling your facilities, consider the following:

- Keep changing tables and sinks completely separate from food preparation areas and hand-washing sinks. Hand-washing sinks should not be used for



rinsing soiled clothing or for cleaning equipment that is used for toileting.

- A diaper changing station should only be used by one classroom of children.
- Use hands-free equipment wherever possible (invest in commercial-grade step cans large enough to hold the number of soiled diapers the station collects before someone can remove the contents to an outside trash receptacle).
- Keep the sink in the diaper changing area within an arm's length from the diapering table (one sink per two diaper changing tables). For large and small family child care homes, hand-washing sinks should be within 10 feet

of changing tables if they cannot be located with an arm's length for space reasons.

- Provide liquid soap dispensers for hand-washing.
- Keep changing tables at a comfortable counter height (between 28 and 32 inches high) to prevent staff back injuries. Consider designs that incorporate steps that allow toddlers to climb onto the table with supervision.
 - Equip changing tables with railings or barriers that extend at least 6 inches above the changing surface (diaper changing tables should not have safety straps; they can't be relied upon to hold a squirming child and are difficult to clean and sanitize).
 - Provide a disposable towel dispenser that dispenses towels without having to touch the container or the fresh towel supply.

Resources:

American Academy Of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care and Early Education (2002). *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, 2nd edition.*

CCHP *Recommendations for Cleaning, Sanitizing and Disinfecting*, http://ucsfchildcarehealth.org/pdfs/healthandsafety/recommenEN_adr.pdf.

Kotch, J. et al (2007) Hand-washing and diapering equipment reduces disease among children in out-of-home child care centers. *Pediatrics*, 120, e29-e36.

by Vickie Leonard, RN, FNP, PHD



Divorce and Young Children

One out of every two marriages today ends in divorce and many divorcing families include children. Parents who are getting a divorce are frequently worried about the effect the divorce will have on their children. Divorce can be an extremely painful experience for children.

What emotional reactions are common in children?

While emotional reactions can vary, the most common are anger, fear, shame, denial, grief, unresponsiveness and relief (if there has been much fighting in the home).

Separation and divorce have an emotional impact on children of all ages. In this article we'll look at the effects of divorce on children between 0–5 years.

Ages 0–8 months

While infants do not understand divorce, they are aware of adults' feelings and emotions and respond accordingly. So, if a parent acts depressed, worried or sad around an infant, the infant is most likely to feel the same.

Ages 8 months–18 months

While separation anxiety is normal for infants in this age range, older infants experiencing divorce may experience more profound separation distress (see the CCHP Health And Safety Note, *Separation Anxiety*, for more information). They may cry, scream and become too dependent on the company or emotional support of other people.

Ages 18 months to 3 years

Toddlers start to use language to express thoughts and feelings but there are still many things they do not understand. They may notice that one parent is not living at home, but they do not understand why, so toddlers' questions must be answered simply and patiently.

Children from 3 to 5 years

These children may be:

- Frightened and choose immature or aggressive behavior.
- Experiencing temporary developmental regression. They may return to security blankets or lapse in toilet training.
- Confused over why Mom or Dad has left.
- In denial that anything has changed.
- Hopeful for a return to life with both parents in the home.
- Attempting to bring some order to their world.

In time, most children will understand the situation and adjust to it. With the help of caring adults these children can be expected to do as well in school as they did before the divorce.

What can child-care providers do to help children go through divorce?

- Maintain confidentiality at all times and inform parents of the confidential policy.
- Communicate with parents.
- Treat the child's confusion or misunderstandings with patience.
- Reassure the child that both parents will continue to love him or her.
- Remind children that they are not responsible for the divorce.
- Gently clarify any misunderstandings about custody arrangements and transition.
- Observe them and wait until they're ready to talk.
- Children books are great tools for talking about their feelings.
- Encourage divorcing parents to consider the child's needs first; avoid arguing in front of the child and learn to calmly make joint decisions about the child.

The following books are appropriate for infants and toddlers:

Baby Faces, by Margaret Miller

How are You Peeling? Foods with Moods, by Saxton Freymann and Joost Elffers

I Love You All the Time, by Jessica Hirschman, Jennifer Cole, & Bonnie Bright

Guess How Much I Love You, by Sam McBratney and Anita Jeram

Owl Babies, by Martin Waddell and Patrick Benson

Resources and References

National Association for the Education of Young Children, www.naeyc.org/ece/1999/12.asp.

National Council on Family Relations, <http://www.ncfr.org>.

www.parentsasteachers.org/site/apps/s/content.asp?c=ekIRLcMZJxE&cb=289389&ct=1705147.

Divorce and Children: An Interview with Robert Hughes, Jr, PhD.

ZERO TO THREE: National Center for Infants, Toddlers and Families, www.zerotothree.org/site/DocServer/Hill_Solchany_Infant_Mental_Health_Assessments_for_court.pdf?docID=1851.

by Tahereh Garakani, MA, ED

Neighborhood Walks

Teach the children in your program new skills, show them new sights and increase the amount of time they are active by taking walks in your neighborhood. Here are some ideas to make your walks safe and enjoyable:

- Use a “walking rope” with handles or loops for children to grasp. This keeps the children orderly and together. Walking ropes can be homemade or purchased at early education supply companies.
- Dress children in matching t-shirts for walking trips. Provide matching adult-sized shirts for teachers so the children can easily recognize them.

- Assign each child a buddy.
- Assign each teacher or assistant a few children to supervise.
- Visit interesting places in your neighborhood like the fire station, post office or library.
- Avoid walking at rush hour and take routes with fewer cars.
- Work to improve pedestrian safety in your community.

For information on creating walkable communities:

Safe routes to School California, CDHS, EPIC at <http://www.dhs.ca.gov/routes2school/>.

Kids walk to School, CDC, at <http://www.cdc.gov/nccd/php/dnpa/kidswalk/>.

Free Multilingual Health and Safety Training for ECE Professionals in Alameda County

The California Childcare Health Program (CCHP) is pleased to announce a new training opportunity for Early Care and Education (ECE) professionals in Alameda County. The three-day training is supported by Every Child Counts—First Five Alameda County, and will be provided in three separate languages—English, Farsi and Spanish.

In addition to complimentary training registration, participants will also receive:

1. Training Curriculum (18 modules, 800 pages).

2. Resource binder of Health & Safety materials to share.
3. Resource CD of California Childcare Health Program's Health & Safety materials.
4. One year free subscription to the Child Care Health Connection's newsletter.
5. Gift package of eco-friendly environmental cleaning products.
6. Certificate of Child Care Health Advocate (CCHA) training.

CARES credit may also be available through the local First 5 commission.

For more information please call Tahereh Garakani at 510-204-0939.



health + safety calendar

October 2–3

Child Development Policy Institute Fall Forum

Sacramento, California

Current and Emerging Policy Trends: What's on the Horizon for Early Education in 2008?

A registration form can be downloaded from the Events section on the CDPI website at www.cdpi.net.

October 3–5

30th Annual R&R Network Conference

*Asilomar Conference Grounds,
Pacific Grove, California*

www.rnetwork.org/news-and-events/events/index.html



Breastfeeding Trends and Updated National Health Objectives for Exclusive Breastfeeding 2000–2004. The findings in this report indicate that although progress is being made toward achieving the Healthy People 2010 objectives for breastfeeding initiation and duration, rates of exclusive breastfeeding are below desired levels, especially among black infants and those born to women who are young, unmarried, have lower incomes, are less educated, or who live in rural areas. Online at www.cdc.gov/mmwr/preview/mmwrhtml/mm5630a2.htm?s_cid=mm5630a2_e.

Kids Count. The Annie E. Casey Foundation released the 18th annual KIDS COUNT Data Book, a national and state-by-state effort to track the status of children in the U.S. By providing policymakers and citizens with benchmarks of child well-being, KIDS COUNT seeks to enrich local, state, and national discussions concerning ways to secure better futures for all children. California slipped one spot to No. 19 in an annual state-by-state analysis of child well-being—a report that some advocates said raises concerns about the state’s education system and the availability of health care for children.

The report shows that California improved in half of the 10 key categories, such as the child death rate, teen birth rate and percentage of children living below the poverty line. Online at www.kidscount.org/sld/databook.jsp.

America’s Children: Key National Indicators of Well-Being, 2007. Focuses on seven domains of child well-being, including: (1) Family and social environment, (2) Economic circumstances,

(3) Health care, (4) Physical environment and safety, (5) Behavior, (6) Education, and (7) Health. Online at www.childstats.gov/americaschildren/index.asp.

Dramatic Increase in Food Allergies in Children. The National Institutes of Health released the Report of the NIH Expert Panel on Food Allergy Research, declaring that food allergy “HAS EMERGED AS AN IMPORTANT PUBLIC HEALTH PROBLEM” and calling for additional NIH-funded research to uncover the causes of food allergy, and to develop treatments for the life-threatening disease. Available online at www3.niaid.nih.gov:80/healthscience/healthtopics/foodAllergy/ReportFoodAllergy.htm.

Important New Data on Sunscreens. The Environmental Working Group has released a new database that lists sunscreens that offer the best combination of safety and effectiveness. In their analysis of 785 sunscreen products they found that 84 percent of those with an SPF rating of 15 or higher offer inadequate protection from the sun’s harmful rays, or contain ingredients with safety concerns. Their lists of the best and worst sunscreens are available on their website at www.ewg.org/sunscreen/.

Summer 2007 Child Indicator Newsletter. The summer 2007 Child Indicator Newsletter, a periodic newsletter about the major developments within the child and youth social indicators fields, is now available from Child Trends at www.childtrends.org/Files//Child_Trends-2007_06_21_CISummer.pdf.

University of California, San Francisco
Child Care Health Connections
School of Nursing
Department of Family Health Care Nursing
San Francisco, CA 94143-0606

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