Quality in Early Care and Education

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California Childcare Health Program
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California Childcare Health Program

The mission of the California Childcare Health Program is to improve the quality of child care by initiating and strengthening linkages between the health, safety and child care communities and the families they serve.

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LEARNING OBJECTIVES

To describe the critical components of quality in early care and education (ECE) programs.

To identify possible barriers to quality improvement.

To describe how to enhance quality through three commonly occuring routines in ECE programs.

To identify funding opportunities for quality improvement.

To utilize health and safety assessment tools in ECE programs.

WHY IS QUALITY IMPORTANT?

From 1975, the labor force participation rate of mothers with children under age 18 has grown from 47 to 72 percent. Mothers with children under the age of 3 years experienced the biggest increase in labor force participation. Fully 61 percent of this group was in the labor force in 2002, compared with only 34 percent about a quarter of a century earlier. Additionally, these proportions were higher for unmarried mothers than for married mothers (US Department of Labor, 2004). In California, it is estimated that 1.5 million of the 3 million children ages birth to 5 years have working parents (California Child Care Resource and Referral Network, 2001). Eighty-three percent of children with working parents in California spend an average of 35 hours per week in non-parental child care (Public Policy Institute of California, 2003). With these high numbers of children spending time in non-parental care, attention has been drawn to the quality of available ECE programs and the effects of quality care on children's health and well-being.

Because young children spend so much of their time in the care of people other than parents, ECE programs can have a significant impact on their lives (Fiene, 1992). High quality programs have a positive influence on the social, emotional, and cognitive development of children (National Institute of Child Health and Development (NICHD) Early Child Care Research Network, 1996). The positive effects of quality ECE programs on children's socio-emotional and cognitive development for children from different ethnic and cultural groups are very consistent findings in developmental science (Shonkoff & Phillips, 2000).

What are the Components of Quality Care in ECE programs?

The following are the five main components of quality in ECE programs: quality relationships; predictable routines; ECE provider qualifications; adult/child ratio and group size; and staff turnover.

Quality Relationships

Forming positive relationships between the ECE provider and the parent, and the ECE provider and the child, is essential to providing quality care. Parents need to feel free to visit the ECE program at all times, should be notified and made aware of any problems that arise, and should be able to discuss their concerns with the ECE provider. Equally important for parents is knowing what happens in the day-to-day occurrences in the life of their children, and having a sense that their children are important to the ECE provider (Fiene, 2002).

Children who receive warm and sensitive care are more likely to trust others, to enter school ready and eager to learn, and to get along well with other children (Carnegie Task Force on Meeting the Needs of Young Children, 1994). High-quality ECE programs produce environments that promote warm and positive relationships between children and staff. Children whose caregivers provide ample social and cognitive stimulation and individualized care perform better on a range of assessments measuring cognitive, language and social development (Howes, Hamilton, & Philipsen, 1998; Peisner-Feinberg et. al. 1999). Stability in caregiving is also essential for the development of positive relationships (Raikes, 1993; Whitebook, Howes & Phillips, 1990). Children who experience inconsistent care tend to be more aggressive, less socially competent with peers, and have smaller vocabularies (Howes et al., 1993; Whitebook, et al., 1990). Greenspan & Greenspan (1989) have delineated six basic stages in a child's healthy emotional development, and the types of early experiences necessary to nourish this growth. Caregivers can help provide these experiences.

Routines

Routines and predictable, structured activities are also important for quality care. Routines such as feeding, napping and toileting are opportunities for spending individualized and responsive one-on-one time with children. Infants, toddlers and young children feel safe and secure in familiar routines. Routines provide the base upon which to explore and develop the social, emotional, cognitive, language and physical skills they need. The absence of routines or poorly managed routines can be stressful and may have negative effects on children's development. However, there can also be multiple opportunities for injury, spread of infection, and power struggles during routines. For example, if young children are expected to wait in long lines to wash hands, keeping children occupied during these waiting periods could be difficult.

For ECE professionals to establish appropriate routines, foster positive relationships with and between children, and nurture early learning they must be educated and informed and must understand young children's developmental processes. Having sufficient education and understanding is essential, but for the ECE providers to have means to that education and the desire to use the skills learned requires important structural characteristics on the part of an ECE program (Phillipsen, Burchinal, Howes & Cryer, 1997; NICHD, 1996).

ECE Provider Qualifications

Whitebook (1995) found that centers rated as higher quality had teachers with more specialized training and education in early childhood. ECE providers with degrees and/or special training in ECE are better able to help young children learn, and educated and trained ECE providers are more likely to promote the physical and mental health, safety, and cognitive development of the children in their care (Fiene, 2002). In addition, gaining continuing education through workshops and courses is important to help ECE providers keep up-to-date on developments in the ECE field.

Adult to Child Ratio and Group Size

The fewer the children for each adult, the better the quality of the ECE program and the more attention each child will receive (Fiene, 2002). Child:staff ratios and group sizes are two of the best indicators for determining the quality of an ECE program and they significantly affect many other health and safety issues. Smaller group size is associated with a lower risk of infection in ECE programs (Fiene, 2002). States regulate the ratio that is acceptable for licensing. For younger children (under 1 year of age) the ratios are generally lower (i.e., one adult to three to four infants) than for older children. Cost, Quality and Child Outcomes in Child Care Centers (1995) found that centers with low child:staff ratios were seen as providing higher-quality care. Research suggests that children in groups of 12-14 with two caregivers are more cooperative, compliant, and exhibit more reflection and innovation than children in groups of 24-28 with four caregivers. Children in smaller groups also exhibit more social competence than children in larger groups (Clarke-Stewart, Gruber, & Fitzgerald, 1994). Children become securely attached to individuals whom they trust to care for them in a responsive and sensitive manner. ECE providers with small groups are more actively involved and spend more time interacting with children; they are more responsive, more socially stimulating, and less restrictive than caregivers in larger groups (NICHD Early Child Care Research Network, 1996).

Turnover

When choosing an ECE program, parents should inquire about how long ECE providers have been at the center or have provided care in their homes. It is best if children stay with the same ECE provider for at least one year. Staff turnover is an indication of how stable the ECE program is, how the staff are treated, and of overall quality. In ECE programs with high staff turnover, children may have a difficult time getting adjusted. Getting used to new ECE providers takes time and energy that could instead be spent on learning new things.

What the Research Tells Us

Research suggests that high-quality care, especially when provided in center-based programs, is particularly beneficial for low-income families (Burchinal, Landesman-Ramey, Reid, Jaccard, 1995). Children at risk of school failure benefit even more from quality ECE programs (Cost, Quality & Child Outcomes Study Team, 1995). Children in good to excellent ECE programs score higher than children in mediocre to poor programs in cooperation, relations with peers, and cognitive and language development (Cost, Quality & Child Outcomes Study Team, 1995).

A review of the ECE research literature shows that the quality of ECE programs in the United States is generally mediocre. The National Institute of Child Health and Human Development Study of Early Child Care (1999) reported that most ECE centers did not meet American Public Health Association and the American Academy of Pediatrics standards for quality. The Cost, Quality and Child Outcomes Study (1995) of more than 400 center-based ECE programs in four states found that 86 percent of these programs provided mediocre or poor-quality care. This lead to the conclusion that 80 percent of the nation's children spend their days—up to 50 hours per week—in poor or mediocre ECE programs (Cost, Quality & Child Outcomes Study Team, 1995). Infant and toddler care is particularly poor, with 40 percent of programs studied rated as low quality (Helburn & Howes, 1996). In a study of quality in family child care and "relative" care, only 9 percent of family child care homes and "relative" care in three states were rated as "good," 56 percent of the homes were rated as "adequate," and as many as 35 percent of the homes in the study were rated as "inadequate" (Galinsky, Howes, Kontos, & Shinn, 1994).

There are two studies that showed child care health consultation interventions in ECE programs improved the overall quality of the child care centers (Alkon, Sokal-Gutierrez, Wolff, 2002; Alkon, Ramler, MacLennan, 2003). Therefore, child care health consultation programs can impact not only health and safety standards, but also the overall quality of care provided in ECE programs.

WHAT THE CCHC NEEDS TO KNOW

Barriers to Quality in ECE Programs

Barriers to quality ECE programs can be linked to high staff turnover rates, due to low compensation, inadequate benefits, and limited growth opportunities. Turnover rates range from 25 percent to 50 percent of staff per year (Howes, Whitebook, & Phillips, 1992). New staff may not be as well trained or experienced as those that leave. High staff turnover rates require continuous training to provide necessary services to ensure the well-being of young children and the quality of the program. The high cost of ECE programs puts high quality programs out of financial reach for many families.

Children may change programs frequently, switch classrooms, or experience staff turnover. This can create an unfamiliar environment for the children and disrupt the close, caring relationships they have established with caregivers and other children.

Staff in programs may not match the language, class or culture of the children enrolled. This can make it difficult to provide the type of care children receive at home, and it creates a communication barrier between programs and families.

ECE providers attempt to meet regulations around feeding, napping and toileting/diapering but may find that they have not fully incorporated these procedures into their care giving philosophy or practices. What may result is a divergence between policy regulations and what the caregiver feels the child needs.

Children in programs are frequently at different chronological and developmental stages, and some may have exceptional health or behavior needs. Programs are often not equipped to meet the needs of all of these children.

The different components of quality that require continuous monitoring, professional training and continuing education for staff include health and safety regulations and standards, elements of accreditation, protection of children from harm, proper supervision of children, good communication between providers and parents, and providing nurturing, responsive and individualized care (Bredekamp, Copple & National Association for the Education of Young Children, 1997; NICHD, 1996).

Community Care Licensing Regulations and Applicable Laws

There are many situations in which Community Care Licensing regulations (State of California, 2002), *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, Second Edition* (CFOC) (American Academy of Pediatrics [AAP], American Public Health Association, & National Resource Center for Health and Safety in Child Care, 2002) and other applicable laws will set different levels of requirements. Bicycle helmets are a good example. A search for bicycle helmets in the Community Care Licensing regulations (State of California, Health and Human Services, Department of Social Services, 2002) may yield nothing, which means that there is no regulation specific to wearing bicycle helmets in ECE programs and that caregivers are not required by Community Care Licensing to use them for the children. However, CFOC (AAP et al., 2002; Standard 5.242), which advocates for best practices, has a standard for wearing helmets when riding any wheeled toy because of the high incidence of injuries that occur while engaged in those activities. And a state or local law might require that children riding bicycles on public streets must wear helmets. Therefore, a CCHC could explain that Community Care Licensing regulations don't require helmets, CFOC recommends them as best practice, and the law requires them on public streets.

CCHCs should be able to recognize program quality indicators as described and accepted by ECE professionals.

These indicators include (Harms, Clifford & Cryer, 2004):

- developmentally appropriate environment and activities

- responsive staff-child interactions
- accepted behavior guidance techniques
- learning opportunities ("teachable moments")
- ECE providers' education and staff development
- parent, staff and child education
- child-directed activities

Environmental Observation Tools

- CCHCs should become familiar with the environmental observation tools before using them in the program.
- Collect your observational and self-assessment tools for assessing the ECE program environment and understand their use for a particular program.
- Collect measuring tools and know how to use them, e.g. thermometer for measuring temperature of a refrigerator or hot water.
- Understand how to interpret observable or non-observable items. (See *Handout: CCHP Health and Safety Checklist-Revised User's Manual: Question-by-Question Specifications*).

Respect ECE Programs When Consulting

It is important that CCHCs respect ECE programs while visiting. Keep in mind the following:

- Use an indoor voice.
- If it is circle time, join in or quietly observe from the side rather than disturbing the group by talking to the caregiver.
- Find other things to do until a staff member is ready to talk. The ECE provider's main focus is on the children, and that should not be disrupted. Statistics show that most injuries to children happen when their ECE providers are distracted.
- Do not sit on their tables because they are low; these tables are for eating, playing and socializing.
- Adopt a respectful attitude that allows you to accept the program where it is at the moment.
- Keep personal possessions with you at all times.
- Do not look in personal spaces without asking.
- Limit talking to ECE providers and children, but acknowledge them if they approach.
- Respect confidentiality of what you hear and observe.

Health and Safety Practices for Three Routine Activities in ECE Programs

Across all types of ECE programs, whether in a center or family child care home, there are three commonly occuring routines that define how a significant part of the day is spent. These activities are: toileting/diapering, napping, and feeding. All children in ECE programs need attention in these areas. How the routines are handled, and how safety and health procedures are implemented during these routines are crucial in determining quality of care. ECE providers can enhance quality of care through these routine activities.

Toileting/Diapering

- Diapering that occurs on the floor increases opportunities for the spread of infectious disease. Diapering on the floor may be OK if it is done in a place that does not place the child at risk of being stepped on and if it is done on a disposable surface. Also, if the remaining, non-disposable surface can be cleaned with a sanitizing solution and the caregiver does not risk back injury by kneeling on the floor than it may be possible, but not preferable, to diaper children on the floor.
- Even with adequate diapering surfaces and areas, however, the diaper table may be injurious or lead to the spread of infection. Older children should climb up to the surface of the table so

the provider does not need to lift them. Supplies should be readily at hand but not within reach of the child. The height of the table should be comfortable for the provider and the sink should be close enough to prevent contamination of other surfaces. Children old enough to wash their own hands should be close enough to be supervised.

- If cloth diapers are used, soiled diapers should be removed in one piece along with the protective covering to minimize contact with stool. Although to the dismay of some parents, diapers should not be rinsed by providers, but emptied and tied securely in plastic bags and sent home. Diaper creams are considered medication and require parents to complete a medication form. Creams should be kept in children's personal containers, marked clearly with their name, and stored with their diapering supplies. Some diaper ointments contain lead, and parents need to be informed of this risk. Bloody diaper rashes will require the use of latex gloves (or the equivalent) by the caregiver. To avoid contamination of the ointment container, caregivers can dispense the amount of ointment needed for the diaper change onto a paper towel before beginning the procedure.

- Baby powder, while less widely used in ECE programs and not recommended (due to talc inhalation risk), is still in use. If programs honor parents' requests to use it, they should make sure it is cornstarch-based and does not contain talc. Some programs may continue using powder because the benefits to the caregiver-child relationship outweigh the risk to health and safety.

- Gloves are not required by either Community Care Licensing regulations (State of California, 2002) or CFOC (AAP et al., 2002) unless blood is present. Inappropriate gloving occurs in ECE programs. CCHCs should observe gloving procedures for multiple diaper changes with multiple caregivers to get a sense of compliance with the recommended procedure. If a program chooses to use gloves for diaper changes in the absence of blood, vinyl is fine. Vinyl is better than latex because vinyl gloves are more likely to be removed immediately upon completion of each diaper change because they are not as comfortable as latex gloves, thus reducing the transmission of germs. The California Childcare Health Program has produced a Health & Safety Note on latex allergies (see *Handout: Latex Allergy and Sensitivity in the Child Care Setting*) that could be used to persuade programs to switch to plastic or vinyl gloves. Observe when and how caregivers remove their gloves and encourage removal of gloves between each diaper change.

- Hand washing, while one of the most basic and frequently addressed training issues in ECE programs, is still rarely accomplished correctly or frequently enough. Caregivers and children must wash their hands after every diapering/toileting episode. Debates over liquid versus bar soap abound, and the use of antibacterial soap is almost universal in ECE programs. The use of waterless hand sanitizers has recently caught on in ECE programs. Observe when and how such products are used and encourage plain liquid soap and water unless it is absolutely not an option. You might observe that some caregivers skip hand washing when gloves are used and they need to be instructed that gloves do not preclude hand washing. CCHP has produced a wide range of materials on related topics, including mini-posters on hand washing, gloving and other procedures. Visit the CCHP Web site at www.ucsfchildcarehealth.org for free downloadable PDF copies.

- Some programs require children to be toilet trained to enroll or to move up to the next older age grouping. CFOC acknowledges that this is a developmental milestone that may not correspond to chronological age. It also conflicts with the Americans with Disabilities Act (ADA) in that some children may never be toilet trained or may progress at a much slower pace due to developmental delays. Programs that individualize care for each child can accommodate children in diapers at any age as long as they have the facilities to diaper appropriately (AAP et al., 2002).

- Supervision may be difficult when children are able to use the toilet unassisted. The goal is to staff and arrange the environment in such a way

that children can be supervised while they independently and privately use the toilet and wash their hands.

- Toilet training, or more appropriately "toilet learning," can be an area of conflict for ECE providers and parents. Culture, parenting styles and economics can impact the decision to embark on toilet learning before the child is ready. Generally, there are developmental guidelines that indicate when a child is ready to switch from diapers to pants. It is important to encourage communication between ECE providers and parents (see *Handout: Communicating with Your Child Care Provider*).

Sleeping/Napping

- Napping is one of the "sacred cows" of ECE programs. Many programs have a set time for napping and expect all children to participate. The amount of sleep each child needs and their sleeping schedule is individualized and does not lend itself easily to a set schedule. However, programs often rely on this time to schedule staff breaks, to complete paperwork and to prepare for the next activity. Community Care Licensing regulations (State of California, 2002, Section 101230) require that "all children shall be given the opportunity to nap or rest without distraction or disturbance from other activities at the center." Children who need to sleep longer or more frequently must be allowed to do so and this will require an environment and a schedule that makes this possible. For children who do not nap or who awake early, programs must find ways to prevent the disturbance of children who are sleeping or resting. Having space and activities for quiet play and development are essential.

- Adequate space for napping can pose a dilemma for programs, and cot storage and bedding must not provide an opportunity for the spread of infection.

- With sleeping recommendations by the American Academy of Pediatrics to reduce the risk of Sudden Infant Death Syndrome (SIDS), ECE programs are now expected to comply with these recommendations. While ECE providers are encouraged to respect parent preferences for the care of their child whenever possible, this is an area where safety must take precedence. Policies and procedures for sleep position, crib specifications, bedding and positioning of infants should be in place and communicated with parents upon enrollment. Recent research has determined that the incidence of SIDS is higher in ECE programs, particularly when infants are placed to sleep on their stomach and on their back at home (American Academy of Pediatrics Task Force on Infant Sleep Position and Sudden Infant Death Syndrome, 2000).

- Masturbation is common and typical for young children and nap time is the perfect opportunity for them to practice! Children may find rubbing themselves or rocking on their hands comforting. (For more information, see *Handout: Fact Sheet for Families: Children and Sexuality*). Providers can prepare for their response to such behaviors and to parent concerns by understanding the purpose of the behavior and not interpreting it as aberrant.

- To prevent baby bottle tooth decay and to reduce the risk of ear infections, children should not be placed to sleep with bottles. If a parent is adamant and the child will not rest without a bottle, programs may choose to agree to bottles containing a small amount of water for the child. (For more information, see *Handout: Tooth Decay in Young Children*).

- Children who require the use of apnea monitors need a special care plan and an exception from their local licensing analyst.

Feeding

General nutrition and food sanitation guidance will be addressed in a separate module. We will focus here on only the primary health and safety issues.

- The safe preparation of bottles for infant formula requires hygienic practices outlined in Community Care Licensing regulations (State of California, 2002, Section 101427) and CFOC. Staff and parents may disagree about disposal of unfinished bottles. Compromises can be reached by preparing more bottles with fewer ounces of formula to reduce waste. Bottles of formula can

rapidly grow bacteria and must not be refrigerated for feeding at a later time.

- Breastfeeding is encouraged whenever possible and appropriate for the child and the mother. With more young infants in ECE programs, it has proven a challenge for some programs to create "breastfeeding friendly" environments. Handling of breast milk is outlined in CFOC (AAP et al., 2002; Standard 4.015). Programs can assist parents in breastfeeding by timing bottle feedings so that the infant will nurse when the mother picks up the child at the end of the day or as arranged. Having a comfortable place in which to nurse will also encourage breastfeeding. Since breast milk is a body fluid, it is essential that bottles of breast milk not be shared with other children. This can be assured by holding all infants when they are fed and not allowing children to walk around with bottles. Holding infants during bottle feeding is also the best way to nurture and become attuned to the child's cues (see *Handout: Health and Safety Notes: Supporting Breastfeeding Families*).
- Infants should never be given honey until 1 year of age because of the risk of botulism.
- To prevent baby bottle tooth decay, it is recommended that infants be introduced to a cup by about six months of age, and weaned from the bottle at around one year of age. Parent preferences may require careful exploration and negotiation by ECE providers.
- Solid food is generally recommended at about 4 to 6 months of age, and the recommended sequence of introduction is listed in the Community Care Licensing regulations (State of California, 2002, Section 101427). Caregivers should not add solid food such as cereal to an infant's bottle even if the practice is common at home. Learning to feed oneself is messy business and can take an extraordinary amount of time. Reading children's cues and going at their pace helps caregivers be responsive and helps children acquire a sense of mastery. Parents and caregivers may need to discuss different options if they do not agree in order to meet the child's needs.
- Choking hazards exist in many ECE programs. Hot dogs and raw carrots cut into rounds and whole grapes are commonly served to young children. Never assume that caregivers are aware that these foods and many others should not be served to children less than 4 years of age. Foods do not need to be eliminated but must be modified by cooking or cutting differently to be served safely.
- Food allergies are very common in young children and must be treated as a serious health threat. Special care plans must be on file for all children with food allergies and updated at least every 6 months. Staff who serve snacks, meals, or who use food products in craft activities must be aware of allergies and emergency procedures in case of an exposure. Epinephrine (EpiPen Jr®) injecting devices should be obtained by parents from their health care provider and supplied to the ECE program. Staff should be trained in the use of the device and know when to use it. Research has shown that many parents do not know how to properly administer epinephrine, don't carry it with them at all times, or carry expired medication. By requiring parents to complete the special care plan with their medical provider, ECE programs may be saving a child's life by ensuring the parent is adequately trained and that medication is current.
- Children with a variety of special health and developmental needs may also have exceptional feeding needs. ECE programs can encourage parents to schedule occupational therapy services in the ECE setting to help caregivers better meet the feeding needs of the child.
- Programs will want to take into consideration the ethnic and cultural food preferences of families when planning menus for children.

Assessing Programs for Quality

The Early Childhood Environment Rating Scales are designed to assess quality in an early childhood or school age care setting. There are three environmental rating scales, each designed for different ECE programs.

Early Childhood Environment Rating Scale-Revised Edition (ECERS-R)

The ECERS-R may be used for periodic self-assessment, and outside reviewers (Harms, Clifford and Cryer, 2004). It can help to target interventions to improve the quality of the program and to measure change. The ECERS-R is a 43-item observational measure to assess ECE center-based programs serving children 2 ½ through 5 years of age. The ECERS-R includes the following seven subscales:

1. Space and Furnishings
2. Personal Care Routines
3. Language-Reasoning
4. Activities
5. Interaction
6. Program Structure
7. Parents and Staff

Each item on the ECERS- R is ranked on a scale from 1 to 7, with 1 being "inadequate" to 7 being "excellent." For a single item, scoring must start at 1, "inadequate," and progress upward until the correct score is reached.

Infant/Toddler Environment Rating Scale–Revised Edition (ITERS-R)

The ITERS-R is a 35-item observational measure used to assess the quality of center-based ECE programs serving children up to 30 months of age (Harms, Clifford, Cryer & Graham, 2002). The items are organized into seven subscales:

1. Furnishings and Display for Children
2. Personal Care Routines
3. Listening and Talking
4. Learning Activities
5. Interaction
6. Program Structure
7. Adult Needs

Family Day Care Rating Scale (FDCRS)

The Family Day Care Rating Scale (FDCRS) (Harms & Clifford, 1989) is designed to assess family child care homes conducted in a provider's home. The scale consists of 40 items, including eight supplementary items for programs enrolling children with disabilities. The items are organized into seven subscales:

1. Space and Furnishings for Care and Learning
2. Basic Care
3. Language and Reasoning
4. Learning Activities
5. Social Development
6. Adult Needs
7. Provisions for Exceptional Children

The ITERS-R and FDCRS use the same scoring method as the ECERS (Harms, et al., 1998).

Assessing Programs for Health and Safety

Health and safety is an essential component of quality ECE programs. Healthy and safe environments facilitate and support learning opportunities for young children.

- Research shows that children in ECE programs are at increased risk for infections including respiratory and gastrointestinal illnesses (Holmes, Morrow & Pickering, 1996). Hand washing can be an effective way to stop infectious diseases from spreading. Training information on proper hand washing and sanitation in ECE programs is available in CFOC (AAP et al., 2002; Standard 3.020).
- Immunizations are one of the most effective means of preventing childhood illnesses and outbreaks in ECE programs. Community Care Licensing regulations require that all children who attend ECE programs must be up-to-date on their immunizations upon entry. It is especially important for children in ECE programs to be immunized because they are exposed

to many different children. Awareness of and access to immunization services is a key element in raising immunization rates, which prevents certain diseases in children and contributes to a healthy environment for children in ECE programs.

- According to one study on SIDS in ECE programs, most ECE providers know that putting infants to sleep on their backs is the best practice to prevent SIDS, but only 14.3 percent of ECE programs were in compliance (Ford & Linker, 2002).
- Most injuries in ECE programs involve falls on playground equipment (U.S. Department of Health and Human Services, 2002; Kotch, Hussey & Carter, 2003). Serious injuries have also prompted states to develop new standards and regulations (Kotch, et al., 2003). Safe equipment and environments as well as adequate supervision are needed to prevent injuries.
- Studies have shown that health professionals can play an important role in ensuring that health and safety needs of children are met. They also support ECE programs' efforts to meet Community Care Licensing regulations and national standards (Alkon & Boyce, 1999; Crowley, 2000).

CCHP Health and Safety Checklist-Revised (CCHP H & S Checklist)

The original Health and Safety Checklist was based on the Child Care Evaluation Summary (Quality Enhancement Project for Infants and Toddlers, 2001) and a previous child care study's Health and Safety Checklist (Preschool Environment Project, 1997). An advisory group comprised of local ECE programs and health experts reviewed the Checklist for face and content validity. CCHP research staff developed a question-by-question instruction manual to standardize the administration of the Checklist. The Checklist was pilot-tested in four child care centers and the four research staff achieved 90 percent inter-rater reliability prior to data collection. Inter-rater reliability was established on a yearly basis. The CCHP research staff used the Checklist to evaluate change in health and safety practices in 128 ECE programs in five counties funded by the Child Care Health Linkages Project. Based on this data collection the Checklist was revised in 2005. The CCHP H & S Checklist (CCHP, 2005) is an 82-item assessment tool comprised of key CFOC standards and Community Care Licensing regulations.

The CCHP H & S Checklist includes the following subscales:

1. Emergency Prevention/Poisons
2. Staff and Children's Possessions
3. Special Needs
4. Hand Washing
5. Food Preparation/Eating/Sanitation
6. Oral Health
7. Outdoor/Indoor Equipment
8. Infant/Toddler (General, Diapering, Food Preparation/Eating and Sleeping/Napping)

Scoring is based on a two-point scale: (1) Completely Meets Standard and (2) Does Not Completely Meet Standard or NA (not applicable). In addition, there is a column for the CCHP H & S Checklist user to make comments for each item.

The CCHP H & S Checklist was developed to be used by ECE program providers, CCHCs, researchers, and others interested in health and safety assessment. The CCHP H & S Checklist User's Manual: Question-by-Question Specifications includes item-by item explanations on how to complete the CCHP H & S Checklist.

CCHP Health and Safety Policies Checklist (CCHP H & S Policies Checklist)

Written health and safety policies are important for quality ECE programs. Having written policies formalize health and safety practices. Improvements in health and safety practices can begin by assisting ECE providers to develop useful policies for their programs. The policies evaluated on the CCHP H & S Policies Checklist are:

1. Exclusion of Ill Children
2. Care of Mildly Ill Children

3. Administration of Medications
4. Daily Health Check
4. Hand Washing
5. Sanitation
6. Emergency Preparedness
7. Transportation Safety
8. Staff Health
9. Inclusion of Children with Special Needs

Each of the 10 policies are comprised of several components. Scoring is based on a two-point scale for each of the components: (1) Completely Meets Standard and (2) Does Not Completely Meet Standard. The components of each of the 10 policies are added-up. A total score from each policy can be computed.

Child Health Record Review: Early Care and Education Program Health Assessment

The Child Health Record Review is a standardized instrument formerly called the "Child Care Evaluation Worksheet" (Quality Enhancement Project for Infants and Toddlers, 2000). It is used to track children's health by reviewing information documented in the children's health records filed on-site at ECE programs. The form is used to review records in the following areas:

1. Emergency contact information
2. Well child physical
3. Well child physical in last year
4. Special health care needs as defined by the Federal Maternal and Child Health Bureau1
5. Whether the child with a special need has a special care plan
6. Immunization status
7. Health insurance
8. Medical home
9. Number of days absent in previous two months
10. Number of medically attended injuries in previous two months
11. Health screenings: height and weight, hematocrit and hemoglobin, lead, vision, hearing, speech and language, oral health, and general development

The rating of items 1 through 8 are "yes" when the information is present and complete or "no" when the information is not present or incomplete. The scoring for item 9, the screenings, are N for "Not Recorded," I for "Recorded but Incomplete," Y for "Recorded, Not Positive," P for "Positive, No Referral," R for "Positive, Referred, Pending," and C for "Positive, Referred, Complete." The Assessment is accompanied by two forms, the Child Health Record Review: Guidelines for Completion of Form and the Spreadsheet for Determining Child's Age in Months. These forms help the reviewer accurately complete the Assessment. *See Handouts: Child Health Record Review* and *Guidelines for Completion of Forms.*

What Resources Are Available for Improving Quality?

Various federal, state and local programs exist both to facilitate the dissemination of information important for quality improvement as well as funding opportunities for quality improvement.

Support Available from Regulatory Agencies

Compliance with Community Care Licensing regulations is required by law. However, even when appropriate regulations exist, they are not always enforced. In addition, compliance with CFOC standards is both more difficult and sometimes costly. Studies show that better monitoring of ECE programs increases compliance with health and safety standards (Koch, 1994). For this reason, better support and education about quality and compliance with national standards is needed in ECE.

Community Care Licensing Regulations

California's center-based regulations and ratio regulations are above the national median. However, more stringent educational and training requirements,

higher health and safety standards, and more comprehensive enforcement and adequate monitoring of compliance could improve quality.

California Department of Education, Child Development Division (CDE/CDD)

The Desired Results for Children and Families system includes Program Performance Standards that are the requirements for funding center-based programs and family child care home networks that contract with CDD. These standards support the achievement of "desired results" for children from birth to 14 years and their families. Key dimensions of "desired results" include: developmental and programmatic assessments, accountability, teaching and learning opportunities, staffing and professional growth, parent and community involvement, and governance and administration. Exemplary practices have been defined for child care centers, family child care homes, and resource and referral agencies. All programs supported by CDD are required to complete developmental profiles on each child based on observations including cognitive, social-emotional, language and physical domains. All subsidized programs are accountable for complying with the program performance standards through annual self-study. A coordinated compliance review is conducted by CDD every four years, which includes targeted technical assistance.

Local First 5 California Commissions

There are multiple resources for quality improvement, including grants for facility improvement, training opportunities, and ECE professional incentives to increase knowledge, skills and retention in the field.

Local Child Care Planning Councils

These are based in every California county and act as a coordinating body to ECE programs. Additionally, they assist with accessing and distributing resources for quality improvement.

Training Opportunities

Community Care LIcensing

California Department of Social Services, Community Care Licensing Division, provides training for new and prospective family child care providers.

California Department of Education

CDD funds a number of training activities including:

- The Child Care Initiative Project, which directs grants to local child care resource and referral agencies to train family ECE providers and to improve the quality and supply of ECE programs in California.
- The Program for Infant/Toddler Caregivers, a systematic, integrated system for providing training and technical assistance to early childhood professionals working with children ages 0 to 3 years old.
- The Child Development Training Consortium and Early Childhood Mentor Program address the critical shortage of qualified staff in ECE programs by supporting the professional growth and development of those already working in the field.

Comprehensive Approaches to Raising Education Standards (CARES)

CARES is a program designed to promote, reward, and encourage educational attainment among ECE professionals in California. For more information on your county program, contact the local Child Care Planning Council. CARES applicants may qualify for stipends based on their level of education in early childhood education.

Accreditation Opportunities

Fewer than 15 percent of ECE centers and family child care homes are accredited. Financial support to increase accreditation is available through many local child care resource and referral agencies and First 5 programs. Professional organizations such as the National Association for the Education of Young Children and the National Association of Family Child Care Providers provide accreditation criteria, training and support for ECE programs. Technical assistance can be obtained from the following sources:

- Child Development Training Consortium
- California Childcare Health Program
- Health and safety training

- Training for staff working with children with limited English proficiency
- Regional resource centers in underserved areas

Funding Opportunities

Programs that seek external sources of funding tend to be of higher quality than unsubsidized programs (Howes & Brown, 2000).

Federal funding guidelines from the *Child Care and Development Block Grant* require that at least 4 percent of funding be used for quality improvement activities in each state. Information about the Block grant is available at www.acf.hhs.gov/programs/ccb/policy1/current/finalrul. In California, an estimated $101 million is spent on quality improvement activities annually, including the Family Child Care Training Project and playground safety grants as well as the following infant and toddler care programs:

- The Program for Infant/Toddler Caregivers
- Infant/toddler specialist for CCHP's Healthline
- Inclusion of infants and toddlers with disabilities and other special needs
- Infant and toddler early development and learning guidelines

Other federal funding from the U.S. Department of Health and Human Services, the Administration for Children and Families, includes Head Start and Early Head Start.

Resource and referral agencies are located in every California county, address local and statewide ECE program needs, support recruitment and training efforts of ECE professionals, and advocate for quality, accessible and affordable ECE programs.

Local grants or loans can also assist in improving quality. These can come from local child care and development planning councils and can include facilities renovation and repair grants and instructional materials grants.

Early Childhood Mentor Programs and child care salary and retention incentive programs provide funding to compensate ECE providers.

WHAT THE CCHC NEEDS TO DO

Be Aware of Standards and Regulations

Become familiar with Community Care Licensing requirements, program performance standards, accreditation standards and the tools used to measure quality in ECE programs.

Recognize Indicators of Quality

Learn to recognize the indicators of quality of care, including health and safety, interactions between children and adults, and learning opportunities.

Provide Resources

Know about the community's ECE needs, programs and resources. Visit a variety of ECE programs to learn about local programs and the diverse settings. Visit model programs for first-hand knowledge of how a high-quality program works.

Empower Programs

Empower programs to meet their own health and safety needs. Provide consultation that is responsive to a program's needs and that is individualized for their particular mix of staff, children and families.

Advocate for Quality ECE Programs

Learn to advocate effectively for a quality ECE system. Be involved in discussions of how to define and achieve quality care at a programmatic, local and regional level. Identify and help develop high-quality programs in the area to serve as models, and be aware of county School Readiness Initiatives and Preschool for All measures.

Advocate for Health and Safety Issues

Advocate that health and safety be included in discussions of quality ECE programs. Attend or conduct workshops at local or regional child care/ECE meetings and conferences. Work collaboratively with other advocates for high-quality ECE programs such as child care resource and referral, Community Care Licensing, local planning councils or the local First 5 California commission and School Readiness Initiatives.

Develop Clear and Professional Expectations with ECE Providers

When a program requests an assessment, CCHCs should ascertain exactly what is being requested of them in order to prepare for the consultation, set aside adequate time, and obtain appropriate written materials. Assessments could be of the program itself, or may be just the policies, a particular facility, a child, or a play yard. CCHCs should develop a contract or agreement either verbal (documented by the CCHC at the moment the decisions are being made) or written and signed by both parties. CCHCs should be very clear as to what services they can and cannot provide the ECE program. Many things will influence this: the CCHC's scope of practice, job description, available time and the ECE program's goal.

Consider Whether the Requested Service is the Best Way to Approach the Issue

Just because a program has requested a service does not mean that is the best way to approach the issue at hand. For example, a program may contact a CCHC with a request for her to visit the facility and examine a child with a rash. This might require a long trip and a lengthy visit, when the child really should be referred to a health care provider. The CCHC might instead choose to tell the program staff this over the phone and offer them instead a list of three clinics in the area. The CCHC could also email or fax information sheets to be given to the child's family.

Provide the Right Amount of Material

CCHCs are most effective when they provide adequate information but do not overload harried program staff with more information than they can use.

Clarify What the Program Wants

Does the program want a consultation related to a specific problem, or an on-site comprehensive program assessment? An on-site comprehensive assessment would include reviewing policies and records, reviewing their food service, and curriculum, observing the environment, furnishings, safety policies and practices, and cleaning and sanitizing practices. Interview staff to determine knowledge, OSHA compliance and job satisfaction, observe the play times, routines times, staff child interactions, procedures, children's demeanor and behavior. Determining if the program carries liability insurance and provides the employees with required supplies and equipment to carry out their jobs safely. The comprehensive assessment is very time-consuming and can be very satisfying for both parties.

Use the Following Strategies When Making a Visit

- Take something to the program that staff members will find useful, such as a poster on hand washing.
- Be respectful of the program's security measures by checking in with the person who requested the assessment upon arriving at the program.
- Take directions from the contact person as to which areas of the program are acceptable for visiting, and how to enter rooms. In family child care programs especially, not every part of the home is part of the program. In child care centers, some rooms may be for napping and others may have children that need preparation before a stranger enters. However, CCHCs should note if staff asks that a room not be observed if no reason is given, especially if it happens more than once.

- Become familiar with the culture and personality of the program and then respect it.

When Deficits or Concerns Are Found, Assist the Program in Finding Remedies

- Follow the steps in *Handouts: Eight Steps in Assessment and Resolution of Health Concerns* or the *Child Care Health and Safety Action Plan*.
- Assist the program to find corrective advice in Community Care Licensing regulations, CFOC, and other recognized resources, keeping in mind that the CCHC is not a Licensing Evaluator.
- Assist programs in locating resources—for example, the Local Planning Council may have facility improvement funds.
- CCHCs should provide training or health education related to findings as they come into contact with caregivers in their environment. If cribs have corner posts that are higher than the railings, this is an important finding and a definite safety hazard. It is an observation that should be recorded and commented on later, but it should also be mentioned to staff who are nearby so they can avoid injury to the children until a remedy can be found. CCHCs can follow-up with written materials.
- Point out strengths of the program and how they enhance the health and safety for the children. For example, if a CCHC finds a First Aid Kit with all the right components and no hazards in it, he or she can leave a sticker of praise on the box or nearby and mention it in the follow-up report as well. This strategy provides positive feedback without interrupting the important work going on in the room.

Model Healthy Behavior

CCHCs should model the behavior they expect from ECE providers. This includes:

- Being on time for appointments.
- Washing hands when entering the program.
- Wearing protective shoe coverings when entering the infant room.
- Washing hands after toileting, diapering or administering first aid for a child.
- Avoiding using the diaper table as a work surface.

Make Use of the Environmental Health and Safety Checklists

- The Child Care Health Linkages Evaluation Project's *Handouts: CCHP Health and Safety Checklist-Revised* and *Health and Safety Checklist-Revised User's Manual: Question-by-Question Specifications* (available at www.ucsfchildcarehealth.org) are tools that provide excellent guidance for structuring your observations and for indicating levels of compliance. Guidance for remediating deficits can be found in the Community Care Licensing regulations and in CFOC. Healthline staff can provide assistance in locating remedial suggestions.
- CCHP's training curriculum *Health and Safety in the Child Care Setting: Prevention of Injuries, A Curriculum for the Training of Child Care Providers*, has a comprehensive observational tool for indoor and outdoor safety and for toy safety.
- *Model Child Care Health Policies, 4th edition,* (American Academy of Pediatrics, Pennsylvania Chapter, 1997), has a Health and Safety Checklist.
- The Community Care Licensing Web site, www.ccld.gov, in addition to providing the child care regulations also provides an Evaluator Manual, with additional guidance in implementing the regulations.

WAYS TO WORK WITH CCHAs

- Provide consultation to Child Care Health Advocates (CCHAs) on common health and safety issues in daily routines, environments and activities.
- Help providers and staff understand how health and safety issues relate to overall program quality. Point out the health and safety issues for fine and gross motor activities, social, emotional, intellectual and language development, and parental involvement.
- Review policies, procedures and practices to increase health, safety and quality of care.
- Offer to lead parent and/or staff education meetings on issues of healthy, safe care.
- Support program administrators and staff by providing resources and information on health, safety and quality.
- Provide resources on topics of special interest in your community, such as environmental health and pesticides, air quality, disaster preparedness, etc.

ACTIVITY 1: USING THE CCHP HEALTH AND SAFETY CHECKLIST

Familiarize yourself with the CCHP Health and Safety Checklist-Revised and the CCHP H & S Checklist-Revised User's Manual: Question-by-Question Specifications. Break up into nine groups and designate one reporter for each group. Each group will be assigned one subscale of the CCHP H & S Checklist for discussion. Review subscale items and refer to the CCHP H & S User's Manual for item completion. Be prepared to report back to the larger groups what you would need to do in an ECE setting to observe all the items and rate them accurately.

ACTIVITY 2: HEALTH AND SAFETY ACTION PLAN

- Break into small groups.
- Observe and list concerns in column 1 below.
- Brainstorm and record actions you can take to address your concerns about program quality. Refer to *Handout: Eight Steps in Assessment and Resolution of Health Concerns*.
- Write three possible actions for one of your concerns.
- Report back to the large group to share actions.

Health and Safety Action Plan

Observation	Quality Improvement Activity or Action	Resources
1.	1.	A.
		B.
		C.
	2.	A.
		B.
		C.
	3.	A.
		B.
		C.

NATIONAL STANDARDS

From *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, Second Edition*

Routines

2.028	Methods of Supervision
3.008	Scheduled Rest Periods and Sleep Arrangements
3.012	Type of Diapers
3.013	Checking for the Need to Change Diapers
3.014	Diaper Change Procedure
3.015	Use of a Diaper Changing Area
3.016	Access to Diaper Changing Area
3.017	Use of Diaper Changing Surface
3.018	Handling Cloth Diapers
3.019	Maintenance of Changing Tables
4.001	Written Nutrition Plan
4.007	Dietary Modifications
4.009	Feeding Plans
4.013	Feeding Infants on Demand with Feeding by a Consistent Caregiver
4.014	Techniques for Bottle Feeding
4.024	Encouraging Self-Feeding by Toddlers
4.025	Meal and Snack Patterns for School-Age Children
4.026	Food Service Staff by Type of Facility and Food Service
4.027	Child Care Nutrition Specialist
4.028	Developmentally Appropriate Seating and Utensils for Meals
4.029	Tableware and Feeding Utensils
4.030	Activities Incompatible with Eating
4.031	Socialization During Meals
4.032	Participation of Older Children and Staff in Mealtime Activities
4.033	Experience with Familiar and New Foods
4.034	Hot Liquids and Foods
4.035	Numbers of Children Fed Simultaneously by One Adult
4.036	Location of the Adult Supervising Children Feeding Themselves
4.037	Food that Are Choking Hazards
4.038	Progression of Experiences with Food Textures
4.039	Prohibited Uses of Food
5.142	Multiple Use of Rooms
5.143	Space for Infant Sleeping Rooms
5.144	Sleeping Equipment and Supplies
5.145	Cribs
5.146	Infant Sleeping Position Equipment and Supplies
5.147	Futons
5.065	Removal of Garbage
5.066	Containment of Garbage
5.067	Containment of Soiled Diapers
5.068	Labeling, Cleaning and Disposal of Waste and Diaper Containers
5.069	Storage and Disposal of Infectious and Toxic Wastes
5.070	Control of Animal Waste and Pests

Assessments

3.004	Assessment and Planning of Nutrition for Individual Children
7.003	Initial Assessment
Appendix E	Child Care Health Assessment
Appendix Z	Child Health Assessment

CALIFORNIA REGULATIONS

From *Manual of Policies and Procedures for Community Care Licensing Division*

Routines

101428	Diapering /Toileting
101230	Sleeping/Napping
101239.1	Sleeping/Napping
101227	Feeding
101427	Feeding

Assessments

101220	Child's Medical Assessments
101220.1	Immunizations
101221	Child's Records

RESOURCES

Organizations and Resources

Organization and Contact Information	Description of Resources
California Association for the Education of Young Children (CAEYC) www.caeyc.org	CAEYC offers opportunities for professional growth and training for early care professionals around the state.
California Childcare Health Program 1333 Broadway, Suite 1010 Oakland, CA 94612-1926 (510) 839-1195 office (800) 333-3212 Healthline www.ucsfchildcarehealth.org	The Child Care Healthline provides health and safety information to ECE providers, the families they serve, and related California professionals. The Healthline team of specialists consults on issues such as infectious disease, health promotion, behavioral health, serving children with disabilities and special needs, nutrition, infant-toddler development, lead poisoning prevention and more.
California Childcare Resource and Referral Network www.rrnetwork.org	Child Care Resource and Referral (R&R) agencies are located in every county in California. Over the last two decades, R&R services have evolved from a grassroots effort to help parents find child care, to a well-developed system that supports parents, providers, and local communities in finding, planning for, and providing affordable, quality child care.
California Department of Education, Child Development Division www.cde.ca.gov/sp/cd	General child care and development programs are state and federally funded programs that use centers and family child care home networks operated or administered by either public or private agencies and local educational agencies. These agencies provide child development services for children from birth through 12 years of age and older children with exceptional needs.
California Department of Social Services, Community Care Licensing www.ccld.ca.gov	The Community Care Licensing Division promotes the health, safety, and quality of life of each person in community care through the administration of an effective collaborative regulatory enforcement system.
Center for Health Improvement 1330 21st Street, Suite 100 Sacramento, California 95814 916.930.9200 phone 916.930.9010 fax www.centerforhealthimprovement.org	The Center for Health Improvement (CHI) is a national, independent, nonprofit health policy center dedicated to improving population health and encouraging healthy behaviors. CHI uses evidenced-based research as the basis for policy innovation and implementation.

Organization and Contact Information	Description of Resources
Clearinghouse on Early Education and Parenting (CEEP) http://ceep.crc.vivc.edu	The Clearinghouse on Early Education and Parenting (CEEP) is part of the Early Childhood and Parenting (ECAP) Collaborative within the College of Education at the University of Illinois at Urbana-Champaign. CEEP (a content provider) and the ECAP Information Technology Group (ECAP/ITG) work closely to build print and online resources for the worldwide early childhood and parenting communities.
Education Resources Information Center (ERIC) www.eric.ed.gov	Sponsored by the Institute of Education Sciences (IES) of the U.S. Department of Education, ERIC produces the world's premier database of journal and non-journal education literature. The ERIC online system provides the public with a centralized ERIC Web site for searching the ERIC bibliographic database of more than 1.1 million citations going back to 1966.
First 5 California California Children and Families Commission www.ccfc.ca.gov	The California Children and Families Act of 1998 is designed to provide, on a community-by-community basis, all children prenatal to five years of age with a comprehensive, integrated system of early childhood development services. Through the integration of health care, quality child care, parent education and effective intervention programs for families at risk, children and their parents and caregivers will be provided with the tools necessary to foster secure, healthy and loving attachments.
Head Start Bureau www.acf.dhhs.gov/programs/hsb	Head Start and Early Head Start are comprehensive child development programs that serve children from birth to age 5, pregnant women, and their families. They are child-focused programs and have the overall goal of increasing the school readiness of young children in low-income families.
National Association for the Education of Young Children www.naeyc.org	The National Association for the Education of Young Children (NAEYC) is dedicated to improving the well-being of all young children, with particular focus on the quality of educational and developmental services for all children from birth through age 8. NAEYC is committed to becoming an increasingly high performing and inclusive organization.
National Association for Family Child Care www.nafcc.org	NAFCC provides technical assistance to family child care associations. This assistance is provided through developing leadership and professionalism, addressing issues of diversity, and by promoting quality and professionalism through NAFCC's Family Child Care Accreditation.
National Association of Child Care Resource and Referral Agencies www.naccrra.net	NACCRRA is the national network of more than 850 child care resource and referral centers (CCR&Rs) located in every state and most communities across the US. CCR&R centers help families, child care providers, and communities find, provide, and plan for affordable, quality child care.

National Center for Early Development and Learning (NCEDL) Frank Porter Graham (FPG) Child Development Institute University of North Carolina Chapel Hill, NC www.fpg.unc.edu/~ncedl/	NCEDL is a national early childhood research project supported by the US Department of Education's Institute for Educational Sciences (IES), formerly the Office of Educational Research and Improvement (OERI). Administratively based at the FPG Child Development Institute, NCEDL is a collaboration with the University of Virginia & UCLA. NCEDL focuses on enhancing the cognitive, social, and emotional development of children from birth through age eight.
National Child Care Information Center www.nccic.org	The National Child Care Information Center (NCCIC), a service of the Child Care Bureau, is a national clearinghouse and technical assistance center that links parents, providers, policy-makers, researchers, and the public to early care and education information.
The Program for Infant/Toddler Caregivers www.pitc.org	The Program for Infant Toddler Caregivers (PITC) seeks to ensure that America's infants get a safe, healthy, emotionally secure and intellectually rich start in life. The PITC approach equates good care with trained caregivers who are preparing themselves and the environment so that infants can learn. PITC offers training and education to ECE professionals.
Trustline (800) 822-8490 www.trustline.org	Trustline is a database of nannies and baby-sitters that have cleared criminal background checks in California. It is the only authorized screening program of in-home caregivers in the sate with access to fingerprint records at the California Department of Justice and the FBI.
Zero to Three: National Center for Infants, Toddlers and Families www.zerotothree.org	Zero to Three's mission is to promote the healthy development of our nation's infants and toddlers by supporting and strengthening families, communities, and those who work on their behalf.

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Audio-Visual Resources

In Our Hands: This video is designed to promote quality care for infants and toddlers • www.pitc.org

It's Not Just Routine: Feeding/Diapering and Napping for Infants and Toddlers (2nd edition) • www.pitc.org

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HANDOUTS FOR QUALITY IN EARLY CARE AND EDUCATION MODULE

Handouts from California Childcare Health Program (CCHP), Oakland, CA

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Latex Allergy and Sensitivity in the Child Care Setting

With more child care providers and health professionals following universal precautions to protect themselves from infections such as viral hepatitis and HIV, we are seeing an increase in latex allergies and sensitivities. Universal precautions require that child care providers wear protective gloves for any procedures that put them into contact with blood. The most effective, inexpensive and comfortable protective gloves are made from latex.

What is latex?

Latex is a milky liquid produced by rubber trees. It is used to make a wide variety of common household products such as protective gloves, balloons, disposable diapers, bandage tapes, pacifiers, rubber bands, bottle nipples, tires, toys and elastic in clothing, to name a few.

What is latex allergy?

Latex allergy or hypersensitivity is a reaction of the body's immune system to proteins found in natural rubber latex. Some people also react to chemicals in the gloves besides the latex itself. Sensitivity to latex can range from a mild skin irritation to a severe allergic reaction.

Reactions can occur from direct contact with products containing latex or from breathing latex particles in the air. Most latex gloves are treated with cornstarch powder to make them easier to put on and take off, and this powder binds with the latex proteins. When gloves are removed or snapped, they release the powder—along with the latex proteins—into the air.

What are the symptoms?

If someone becomes sensitive to latex, symptoms usually begin within minutes of exposure, but they can occur hours later and be quite varied.

- Mild reactions may cause skin redness, hives or itching.
- More severe reactions may cause respiratory symptoms such as itchy eyes, sneezing, coughing and asthma.
- Rarely, life-threatening shock may occur (but this seldom occurs as the first episode).

Who is at risk?

Anyone can develop a latex allergy, but the following groups of people are at increased risk:

- people who wear latex gloves regularly, such as child care providers and health care workers
- children with spina bifida (a birth defect involving the spinal cord or backbone)
- people with other allergies or asthma
- people who have had multiple surgical procedures
- people who have allergies to certain foods, especially avocado, potato, banana, tomato, chestnuts, kiwi and papaya.

Latex allergy should be suspected in anyone who develops symptoms after exposure, and he or she should be evaluated by a medical provider to determine if the reaction was caused by exposure to latex.

What should I do if I am allergic?

If diagnosed with a latex allergy by a medical provider, you should:

- Tell your employer, clients and all health care providers that you are allergic. Do not rely on doctors, nurses or dentists to know this from your chart.
- Wear a medical alert bracelet and carry non-latex gloves for convenience.
- Know which products might contain latex and avoid them.
- If you have staff or children in your program who are allergic, post a list of products containing latex and try to replace as many of them as possible with safer alternatives.

- Consult your child care health consultant or health provider regarding preparation for and responding to emergencies (e.g., having auto-injectable epinephrine such as EpiPen and EpiPen Jr.) ready and knowing how to use it.

How can you avoid latex allergy?

- Reduce your exposure to latex by only using latex gloves when you really need to. Protective gloves of any kind are only one part of universal precautions, and handwashing with soap is the most important infection control practice. Wear vinyl gloves instead of latex for routine diaper changes, food preparation and procedures that do not expose you to blood (such as applying cream to a rash or cleaning up vomit). Remember that vinyl gloves are a less effective barrier after about 15 minutes of wear. Medical-grade vinyl gloves are also available for procedures involving blood.
- Use latex gloves without powder. This will reduce the amount of airborne latex.
- Do not use oil-based hand lotions because they can break down and release the latex in gloves.
- Always wash your hands after removing gloves.
- When you use latex gloves, try a larger size than you would normally wear so that you perspire less and trap less moisture under the glove.

Choosing Gloves

There are several kinds of gloves for you to choose from, and each has advantages and disadvantages. You will need to choose the right glove for the right situation.

- Latex gloves provide the most protection at the lowest cost and are the most comfortable for the majority of people.
- Single-use vinyl and polyvinyl chloride gloves do not contain latex and are appropriate for use in the child care setting when blood is not involved.
- Medical grade non-latex gloves provide maximum protection but are are generally more expensive. Consider a bulk purchasing arrangement through your Family Child Care Association.

Any disposable glove is acceptable for food preparation or routine diapering as long as you practice effective handwashing.

The most important point to consider is that not all disposable gloves will protect you from viruses like hepatitis B or C, or HIV. Be sure you are using a medical exam glove that meets EPA guidelines. Talk to a medical supply store or your pharmacist if you're not sure.

If you are searching for non-latex gloves, keep in mind that the term "hypoallergenic" is not regulated, and does not mean latex-free—it usually means there are fewer chemicals used to make them. Read the label or ask your pharmacist.

Also remember that gloves deteriorate over time, so no matter what kind of gloves you purhase, be sure to check the expiration date on the box and store extra boxes in a cool, dry, dark place.

Resources

American Academy of Allergy, Asthma & Immunology
800-222-2762 or www.aaaai.org

American Latex Allergy Association
888-97-ALERT or www.latexallergyresources.org

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CALIFORNIA CHILDCARE HEALTH PROGRAM

Health & Safety Notes

Supporting Breastfeeding Families

CHILDCARE HEALTHLINE

Human breastmilk is the best food for infants and contains ingredients that formula could never duplicate. Scientists and nutritionists describe it as a "living biological fluid" with over 80 identified ingredients that include antiviral, antiparasitic, antibacterial, and many other protective factors, most of which cannot be replicated by formula companies. The American Academy of Pediatrics (AAP) strongly recommends that breastfeeding be the preferred feeding for all infants, including premature newborns. The World Health Organization recommends human milk as the exclusive nutrient source for feeding full term infants during the first six months after birth. And, regardless of when complementary foods are introduced, breastfeeding should be continued at least through the first 12 months.

However, many new mothers return to work before their baby is 6 months old. Returning to work means making choices regarding child care for their infant. For mothers who breastfeed there is an additional concern that returning to work or school means weaning before mother and baby are ready. Many women continue to successfully breastfeed, and provide breastmilk for bottle-feeding in child care. The success of this choice depends on the mother and child care provider communicating well and supporting one another. Together, parents and child care providers can make breastfeeding a healthy priority.

What are the benefits of breastmilk?

For Infants. Breastfeeding facilitates optimal infant growth and development and offers lifelong health advantages. Breastfed infants have less colic and fewer illnesses the first year of life. They have a reduced risk for allergies and lower incidence of gastrointestinal and respiratory diseases and ear infections. They have a lower incidence of obesity by age 4 years. Breastfed infants have been shown to have higher IQ in later life, and lower rates of diabetes, obesity and other serious health problems.

For mothers. According to the La Leche League, breastfeeding is as healthy for mothers as it is for infants. There is a decreased incidence of breast cancer among women who nurse. Breastfeeding causes an increase in the maternal hormones prolactin and oxytocin, which act to enhance the let-down of milk and to inhibit post-partum bleeding. Mothers who breastfeed report less depression following childbirth. Breastfeeding burns calories, helping a mother get back to her pre-pregnancy weight more quickly. It also delays the return of a menstrual period (although breastfeeding alone is not a reliable method to prevent additional pregnancies). Breastfeeding appears to help build bone strength, protecting against fractures in older age. And importantly, breastfeeding helps mother and baby to bond.

For child care providers. Child care providers benefit, too. Breastfed infants are sick less often which means they are contagious less often. They have less colic, less spitting up, and their diapers don't smell as strong. Parents will feel good about their choice of child care when they feel supported in their choice to breastfeed.

Support for breastfeeding mothers

The child care provider plays an essential role in supporting and facilitating the breastfeeding relationship by understanding the parent's plan for infant feeding. This may include allowing space for mothers to feed their babies, if necessary, at drop off and pick up, timing infant feedings, when possible, to a mother's schedule for pick up, and providing safe storage and handling of breastmilk.

The feeding care plan for an infant should respect

the parent's wishes. Some infants will have breastmilk only, while others may receive supplemental formula. When infants are fed according to parents' instructions, parents will feel supported and confident in the care their child receives.

Support for child care providers

Parents can support their child care provider by making sure their breastfed baby is ready to feed from a bottle. Parents should introduce their baby to the bottle well before the first day of child care. Getting an infant used to a bottle may take several tries and some persistence on the part of the parents.

Develop feeding policies

Develop your policies around breastfeeding in consultation with your Child Care Health Consultant. Support each family's choice in a non-judgmental manner.

- Allow flexibility in programs and schedules so that infants' needs are met.
- Provide opportunities for communication and education of parents and staff.
- Offer staff professional development opportunities on breastfeeding and nutrition.
- Promote your setting as breastfeeding friendly.

Handling and storing human milk

Mothers should pump and store milk in unbreakable bottles in the freezer. The bottle should be labeled with a label that won't rub off and include the baby's name, date milk collected, and date of use for child care. The amount of milk in each bottle should equal the amount the baby usually takes at one feeding. Leftover milk should be disposed of if left out for more than one hour at room temperature. A few bottles can be frozen with one to two ounces for times when the baby may want extra nourishment.

Important points for handling and storing:

- Always wash your hands before preparing any bottle for feeding.
- Double check that each bottle is clearly labeled with child's name, date, time of collection, and that the milk is in an unbreakable, ready to feed bottle.
- Bottles of breastmilk should be refrigerated immediately on arrival to program (at 40 degrees or below).
- Use breastmilk on the day it is brought into the program.
- Thaw a bottle of frozen breastmilk under cool water and swirl to mix. *Never microwave or shake breastmilk.*
- Do not refreeze breastmilk that was previously frozen.
- Use breastmilk only for the infant for whom it was intended. In cases where an infant is given another infant's breastmilk refer to *Caring for Our Children* or call the California Child Care Healthline at (800) 333-3212.

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La Leche League. www.lalecheleague.org.

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Fact Sheets for Families

Communicating with Your Child Care Provider

Child care has become a necessary part of life in our society. More and more working parents depend on child care programs to provide a safe place for their children while they are at work or attending school.

Quality child care is more than baby sitting

Child care can make a major difference in children's development. A quality child care program can provide a warm, caring, age-appropriate, stimulating and safe environment, and help children to learn social skills and get the early childhood education they need to be ready for kindergarten and school.

The National Association for the Education of Young Children (NAEYC) suggests that a "high quality early childhood program provides a safe, nurturing environment that promotes the physical, social, emotional, and cognitive development of young children while responding to the needs of families."

Good communication is a key component

A positive relationship between you and your child care provider and the provider and your child is essential to providing quality care.

Just as child care providers have an obligation to report when children in their care are exposed to a contagious disease, you as a parent have the same obligation to report diseases to the child care program, even if you keep your child at home. That way, the child care provider can alert other parents in care to watch for signs of that illness in their child and seek medical advice when necessary. Several childhood diseases such as chickenpox, cytomegalovirus (CMV) and Fifth Disease can also harm an unborn child, if a pregnant woman is exposed to these diseases for the first time.

Your child care provider is your partner

Your child is continuously learning new skills both at home and child care. And your child care provider is your partner in your child's happy and healthy development. Personal contact on a daily basis is essential to ensure the transfer of information required to meet the child's needs. Talk with your provider about your child's development and behavior, and any concerns either of you have.

Some of the areas you may discuss with your provider

- When enrolling your child, ask about the physical structure, policies and procedures of the child care facility, and discuss your expectations and what they can expect from you.
- Review your child's current health records and health history with the child care provider to ensure correct information. This will help meet your child's health and social-emotional needs and assist him or her in progressing in the child care setting. The health history ensures that all information needed to care for the child is available.
- When your child has a contagious illness, you may need to take special measures so that the sickness does not spread to others. Some diseases or conditions must be reported to the local health department, child care licensing and others. Other parents also need to be informed that their child was exposed. Ask which conditions may cause your child to be excluded from child care.
- Talk about taking care of sick children and medication administration during child care hours.
- Share any behavior changes you notice and any concerns or questions you have. Keep providers informed about unusual things in your child's life such as sleep problems or family illness.
- If you need community resources, ask your child care program if they can provide information on topics such as low-cost health insurance for children.

You and your child care provider need to be aware and respectful of each other's beliefs, values and knowledge about how to deal with children. You both want what is best for your child. If you are in disagreement about what's best, take a step back and evaluate what it's really about. Call the Child Care Healthline at (800) 333-3212 for information.

by A. Rahman Zamani, MD, MPH (03/03)

CALIFORNIA CHILDCARE HEALTH PROGRAM

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03/03

Fact Sheets for Families

Children and Sexuality

Young children learn, grow and develop at an amazing rate in all areas. Parents and teachers are delighted in their growth with few exceptions—and sexual awareness seems to be one of them. Even though we know that children between the ages of 2 and 6 will become aware of genital differences between the sexes, develop curiosity about how babies are made, and explore their own and their friends' bodies, many of us become very uncomfortable about it anyway.

Laying the foundation

During the early years, we are laying the foundation for future development. Parents need to clarify in their own minds what they want for their child in the area of sexuality. With these values clearly in mind, it is easier to respond to specific incidents in a way that promotes growth in those values. Values might include sexual enjoyment, freedom to express oneself sexually, health issues, responsibility for sexual behavior, respect for one's body, respect for other people's bodies, exploitation of sex and procreation.

Age-Appropriate Behavior and Responses

In addition, adults must consider the age of the child. Children will exhibit certain behavior and be able to understand information based on their age.

For example, children discover their genitals in much the same way they discover the rest of their body—with a great deal of touching. This will occur between one and two years of age and, because the touching is pleasurable, will likely continue or expand into masturbation. Touching of the genitals may also become a response to nervousness or boredom.

In most cases, touching or self-exploration in the first 2 or 3 years should be considered part of the process of learning about the body. The older child should be responded to in a way consistent with the family's values. Developmentally appropriate responses range from ignoring the behavior to setting limits as to when and where the behavior is allowed, such as "I know that feels good, but playing with your penis is private. You need to do that in your room."

Children's natural curiosity will next lead to exploration of other children's bodies. This "sex play" may be exploitive with an older child of 4 or 5 undressing and handling the genitals of a younger child or it may be mutual with children taking turns looking and touching. Either way, many adults are offended or upset when confronted with this behavior. It is important to remember that this behavior is normal and that the situation can be used to teach your values.

Redirecting a child's focus

Redirection and addressing a child's natural curiosity may be the most appropriate response. Adults may also establish rules for appropriate behavior, such as "Johnny, I can't let you touch the private parts of Susan's body. I have a book you can look at to see what a girl's body looks like. Let's look at the book together."

Children may attempt to insert objects in genital openings. This behavior can be labeled as unsafe and compared to putting objects in the nose or ears, such as "I can't let you put that in your vagina. That could hurt your body just like it could hurt your ear or nose to put something into it."

Children may imitate what they have seen

Children exploring on their own will not usually link kissing and hugging with body exploration, but if they have observed these events in combination through television, observing adults or other children, or looking at pornographic literature, they may simulate intercourse or other sexual behavior. Immediate redirection is appropriate. Parents observing or receiving reports of this type of behavior from their child care providers should try to learn where their child was exposed to this material and protect their child from additional exposure to it. Young children are not ready to deal with sexually explicit material! Remember, you are teaching your child a value system and it is acquired during daily living and activities. Be sure you are providing experiences to reinforce your values and avoiding experiences that detract from them.

by Diane Hinds, Citrus College Child Development Center

04/02

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Fact Sheets for Families

Tooth Decay in Young Children

Dental caries (cavities or holes in teeth caused by decay) are the most common chronic childhood disease and occurs five times more often than the next most widespread disease, asthma (CDC, 2000). Early Childhood Caries, also called baby bottle tooth decay, is the term used for dental disease in infants, toddlers and preschool-age children, and may happen in children as young as 6 to 12 months.

What causes tooth decay?

Dental caries are contagious. They are caused by Streptococcus mutans and Lactobacillus species that are able to produce lactic acid. Children are not born with these bacteria, but are infected some time in their early life. Usually the bacteria is passed from the mother or caregiver to the child via saliva through shared toothbrushes, utensils, cups, or pacifiers that have been "cleaned" with saliva.

How do dental caries develop?

Four factors play roles in the development of caries: a vulnerable tooth; acid-producing bacteria; fermentable carbohydrates (sweet liquids, juice, milk, formula); and time (how long or how often teeth are exposed to sugar). Together these factors create an environment for the bacteria to multiply rapidly, and produce acids that slowly melt the calcium in teeth, causing tooth decay. Young children are especially at risk because they depend on adults to provide adequate oral care.

How can you recognize dental caries?

The appearance depends on how advanced the dental caries are.

- A dull white band along the gumline is the first sign of demineralization (reduced calcium in the tooth.)
- A yellow, brown or black collar around the neck of the teeth indicates that the demineralization has progressed to cavities.
- Teeth that look like brownish black stumps indicate that the child has advanced cavities.

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For more information, please contact:
Healthline 1-800-333-3212

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Why be concerned about baby teeth?

Healthy baby teeth guide permanent teeth into place. For many children, tooth decay can be severe and painful, can interfere with eating, sleeping, speaking, learning and playing, and may cause low self-esteem. Treatment can be expensive and require general anesthesia.

How can tooth decay be prevented?

As a bacterial infection caused by specific bacteria, caries are preventable. You and your child care provider can play an important role in reducing the risk of early childhood caries, protecting your child's smile and health.

Reduce bacterial transmission to children

- Minimize the bacteria in your mouth by brushing and flossing your teeth and visiting your dentist regularly, especially when pregnant.
- Avoid saliva-to-saliva contact with your child by not sharing spoons, chewing food for your baby, or putting pacifiers in your mouth.

Start cleaning teeth early

- As soon as your infant's first tooth erupts, wipe it daily with a clean damp cloth. Switch to a small soft toothbrush as more teeth come in.
- Brush children's teeth twice a day until they can brush alone (around age 4 or 5), then closely supervise to ensure proper brushing and use of toothpaste.
- Encourage swishing the mouth with water after meals to dislodge food particles from teeth.
- Take infants for a dental exam by the age of 1 year or as the first teeth emerge.

Use care if bottle feeding

- Breastfeed your baby—it is the healthiest option and breastfed babies have a reduced risk of dental caries. If bottle feeding is necessary, take the bottle away when the child has had enough.
- Never allow the child to fall asleep with a bottle of milk, formula, fruit juice, or sweetened liquids.
- Introduce a feeding cup between age 6 to 8 months. Wean from the bottle by the first birthday.
- Encourage children to drink water rather than fruit juices or sweet drinks when thirsty.

by A. Rahman Zamani, MD, MPH

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09/04

EIGHT STEPS IN ASSESSMENT AND RESOLUTION OF HEALTH CONCERNS

The following steps may assist Child Care Health Consultants in the assessment and resolution of health and safety concerns.

1. Check Community Care Licensing and other regulations that might apply (Title 5, Title 22, OSHA, ADA, etc.).

2. Check the *Caring for Our Children (CFOC): National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs* standards that might apply. Consult the Model Policies as well.

3. Does the program have a written policy on the issue? Is it enforced? Does it agree with CFOC standards and regulations?

4. Determine what the program has done so far. What action, discussion or research has taken place?

5. Assess the program's interpretation of the situation. Has the family been involved in the process? The health care provider? Anyone else?

6. Can the existing policy be individualized or is a new one needed?

7. Is there supportive documentation available? Is there a need for staff or parent training on the issue/policy?

8. Document the consultation and provide a report to the program.

Child Health Record Review:
Early Care and Education Program Health Assessment

Date: __ __ / __ __ / __ __ __ __ Program ID: __ __ __ - __ - __ __ __ __ Reviewer ID #: __ __ - __ __ -

Total Number of Children

	Enrolled	Reviewed
Infant/ Toddler		
Pre-school		
School Age		

		Y= Yes, N= No								**Record of Screenings (Previous 12 months)**							
										N = Not Recorded I = Recorded, but Record is Incomplete Y = Recorded, not Positive P = Positive, no Referral R = Positive, Referred, Pending C = Positive, Referred, Complete							
Child	Age in Months	Complete Emergency Contact Information on file	Well Child physical on file	Well Child physical in last year	Child with Special Needs (CSN)	Medical Care Plan on file	Immunizations Up-to-Date	Medical Home on file	Health Insurance on file	Height and Weight	Hct or Hgb	Lead	Vision	Hearing	Speech or Language	Oral	Development
1																	
2																	
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Child Health Record Review:
Early Care and Education Program Health Assessment

Date: __ __ / __ __ / __ __ __ __ Program ID: __ __ __ - __ - __ __ __ __ Reviewer ID #: __ __ - __ __ __ __

		Y= Yes, N= No										Record of Screenings (Previous 6 months)							
												N = Not Recorded I = Recorded, but Record is Incomplete Y = Recorded, not Positive P = Positive, no Referral R = Positive, Referred, Pending C = Positive, Referred, Complete							
Child	Age in Months	Complete Emergency Contact Information on file	Well Child physical on file	Well Child physical in last year	Child with Special Needs (CSN)	Medical Care Plan on file	Immunizations Up-to-Date	Medical Home on file	Health Insurance on file	Number of Days Absent (Previous 2 months)	Number Medically Attended Injury Incidents (Previous 2 months)	Height and Weight	Hct or Hgb	Lead	Vision	Hearing	Speech or Language	Oral	Development
26																			
27																			
28																			
29																			
30																			
31																			
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Child Health Record Review:
Early Care and Education Program Health Assessment:
Guidelines for Completion of Form

The information you use to complete a Child Health Record Review should come from and be completed for a one early care and education program.

Item	Instructions
Date	Record the date you are completing this form in the space provided. Record 2 digits for the month, 2 digits for the day, and 4 digits for the year, using the format mm/dd/yyyy. For example, August 11, 2005, would be coded 08/11/2005.
Program ID #	Record the name or ID number of the program. Please indicate whether you are serving a center or a family child care home by using "C" or "F" after the program name/number.
Reviewer's ID #	Record the ID number assigned to you.
Total # of Children	Use the following criteria for determining a child's age group: 0 - <36 months = Infant/Toddler 36 - <72 months = Pre-school (if not yet in Kindergarten) 72+ months = School Age (do not review charts for school age children)
Enrolled	Count the total number of children in each age group enrolled in the program, and record each number separately on the row labeled Infant/Toddler, Pre-school, and School Age, respectively.
Reviewed	Count the number of children in each age group you recorded on the Child Health Record Review, and record each number on the row labeled Infant/Toddler, Pre-school, and School Age, respectively.
Age in Months	Record the child's age in months. * *See the Spreadsheet for Determining Child's Age Group.*

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Child Health Record Review:
Early Care and Education Program Health Assessment:
Guidelines for Completion of Form

Y= Yes, N= No *For each child, all cells should be completed.*	
Complete Emergency Contact Information on file	Place a "Y" in this column if the child's file has complete emergency contact information. This information should include the name, address, and telephone number of the parent or other person to be contacted in case of an emergency, the responsible party's choice of health care provider and preferred hospital; any chronic illness the child has and any medication taken for that illness; and any other information that has a direct bearing on assuring safe medical treatment for the child. If information is not present *or* incomplete, place an "N" in this column.
Well Child Physical on file	Place a "Y" in this column if there is a complete record of a well child physical, otherwise place an "N" in this column.
Well Child Physical in last year	If there is a Well Child Physical on File, *and* the date of that physical is not more than a year prior to the date this form is completed, place a "Y" in this column. Place an "N" in this column if there is no record of a well child physical, or if it was done more than one year ago. Prior to the chart review ask the ECE provider for the most up-to-date records and also for emergency information cards to verify and augment the information in the chart. [1]
Children with Special Health Care Needs (CSHCN)	Defined as children who "have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally" (Maternal and Child Health Bureau, 1995)[2]. Place a "Y" in this column if the child has special needs. Place an "N" in this column if the child does not have special needs.
Medical Care Plan on file	If the child has special needs, *and* there is a record in the child's file of a medical care plan, place a "Y" in this column. If a child has no special needs or if a child with special needs has no medical care plan on file, place an "N" in this column. A complete medical care plan includes the name of the child and the date that the plan was written, a description of the condition, known triggers and typical signs and symptoms, evidence of an information exchange form completed by a health care provider, persons responsible for the child's care, other professionals involved in the child's care, specific medical information such as medication administration forms and use of medical equipment, staff training needs, nutritional and feeding needs, support programs for the child, emergency procedures and situations that might require medical attention right away. For detailed information refer to: Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, 2002.
Immunizations Up-to-Date	Place a "Y" in this column if there is a record of immunizations, and the child is up-to-date, according to state regulations, with such immunizations. If there is no record, or the record is incomplete, or child is not up-to-date, place an "N" in this column.
Medical Home on file	A medical home is not a building, house, or hospital, but rather an approach to providing comprehensive primary care. A medical home is defined as primary care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective. In a medical home, a pediatric clinician works in partnership with the family/patient to assure that all of the medical and non-medical needs of the patient are met. Through this partnership, the pediatric clinician can help the family/patient access and coordinate specialty care, educational services, out-of-home care, family support, and other public and private community services that are important to the overall health of the child/youth and family (American Academy of Pediatrics, 2003)[3]. Place a "Y" in this column if there is a record in the child's file that s/he has a medical home (i.e., first point of contact for continuous, comprehensive preventive and primary health services, available 24 hours a day, 7 days a week), otherwise place an "N" in this column. If the reviewer is unable to identify a medical home, but the name of a primary care provider is documented, the reviewer may consider this evidence of a medical home and place a "Y" in this column.

[1] Although some states (e.g., California) do not require yearly, updated Well-Child physicals on file, the National Health and Safety Standards advocate updates on a yearly basis.
[2] Maternal and Child Health Bureau (1995). Definition of Children with Special Health Care Needs. Rockville, MD. Division of Services for Children with Special Health Care Needs.
[3] American Academy of Pediatrics (2003). The National Center for Medical Home Initiative for Children with Special Needs. Retrieved July 15, 2005 from www.medicalhomeinfo.org.

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Child Health Record Review:
Early Care and Education Program Health Assessment:
Guidelines for Completion of Form

Health Insurance on file	Place a "Y" in this column if there is a record that the child has health insurance (i.e., private health insurance, Medicaid, CHIP, CHAMPUS, etc.), otherwise place an "N" in this column.

Record of Screenings (Previous 12 months): For each screening listed on the table, record one of the appropriate codes listed below for each child. Record only one code for each child screening. *For each child, all cells should be completed.*

N = No record of screening is evident in child's file.
I = Screening was recorded in child's file, but there is no record of its outcome, so it is incomplete.
Y = Screening was recorded in child's file, and was not positive.
P = Screening was recorded in child's file, was positive, but there is no record of a referral.
R = Screening was recorded in child's file, was positive, there was a referral, but referral is pending.
C = Screening was recorded in child's file, was positive, there was a referral, and referral is complete.

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Child Health Record REVIEW

Spreadsheet for Determining Child's Age in Months

The numbers in the cells indicate age in months.
A child's age is the number in the cell where the column of the current month and year intersects with the row of the child's birth month and year.

Current Month and Year

Birth Month and Year		Jan 2005	Feb 2005	Mar 2005	Apr 2005	May 2005	Jun 2005	Jul 2005	Aug 2005	Sep 2005	Oct 2005	Nov 2005	Dec 2005
JAN	2000	60	61	62	63	64	65	66	67	68	69	70	71
	2001	48	49	50	51	52	53	54	55	56	57	58	59
	2002	36	37	38	39	40	41	42	43	44	45	46	47
	2003	24	25	26	27	28	29	30	31	32	33	34	35
	2004	12	13	14	15	16	17	18	19	20	21	22	23
FEB	2000	59	60	61	62	63	64	65	66	67	68	69	70
	2001	47	48	49	50	51	52	53	54	55	56	57	58
	2002	35	36	37	38	39	40	41	42	43	44	45	46
	2003	23	24	25	26	27	28	29	30	31	32	33	34
	2004	11	12	13	14	15	16	17	18	19	20	21	22
MAR	2000	58	59	60	61	62	63	64	65	66	67	68	69
	2001	46	47	48	49	50	51	52	53	54	55	56	57
	2002	34	35	36	37	38	39	40	41	42	43	44	45
	2003	22	23	24	25	26	27	28	29	30	31	32	33
	2004	10	11	12	13	14	15	16	17	18	19	20	21
APR	2000	57	58	59	60	61	62	63	64	65	66	67	68
	2001	45	46	47	48	49	50	51	52	53	54	55	56
	2002	33	34	35	36	37	38	39	40	41	42	43	44
	2003	21	22	23	24	25	26	27	28	29	30	31	32
	2004	9	10	11	12	13	14	15	16	17	18	19	20
MAY	2000	56	57	58	59	60	61	62	63	64	65	66	67
	2001	44	45	46	47	48	49	50	51	52	53	54	55
	2002	32	33	34	35	36	37	38	39	40	41	42	43
	2003	20	21	22	23	24	25	26	27	28	29	30	31
	2004	8	9	10	11	12	13	14	15	16	17	18	19
JUN	2000	55	56	57	58	59	60	61	62	63	64	65	66
	2001	43	44	45	46	47	48	49	50	51	52	53	54
	2002	31	32	33	34	35	36	37	38	39	40	41	42
	2003	19	20	21	22	23	24	25	26	27	28	29	30
	2004	7	8	9	10	11	12	13	14	15	16	17	18

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Child Health Record REVIEW

Spreadsheet for Determining Child's Age in Months

The numbers in the cells indicate age in months.
A child's age is the number in the cell where the column of the current month and year intersects with the row of the child's birth month and year.

Current Month and Year

Birth Month and Year		Jan 2005	Feb 2005	Mar 2005	Apr 2005	May 2005	Jun 2005	Jul 2005	Aug 2005	Sep 2005	Oct 2005	Nov 2005	Dec 2005
JUL	2000	54	55	56	57	58	59	60	61	62	63	64	65
	2001	42	43	44	45	46	47	48	49	50	51	52	53
	2002	30	31	32	33	34	35	36	37	38	39	40	41
	2003	18	19	20	21	22	23	24	25	26	27	28	29
	2004	6	7	8	9	10	11	12	13	14	15	16	17
AUG	2000	53	54	55	56	57	58	59	60	61	62	63	64
	2001	41	42	43	44	45	46	47	48	49	50	51	52
	2002	29	30	31	32	33	34	35	36	37	38	39	40
	2003	17	18	19	20	21	22	23	24	25	26	27	28
	2004	5	6	7	8	9	10	11	12	13	14	15	16
SEP	2000	52	53	54	55	56	57	58	59	60	61	62	63
	2001	40	41	42	43	44	45	46	47	48	49	50	51
	2002	28	29	30	31	32	33	34	35	36	37	38	39
	2003	16	17	18	19	20	21	22	23	24	25	26	27
	2004	4	5	6	7	8	9	10	11	12	13	14	15
OCT	2000	51	52	53	54	55	56	57	58	59	60	61	62
	2001	39	40	41	42	43	44	45	46	47	48	49	50
	2002	27	28	29	30	31	32	33	34	35	36	37	38
	2003	15	16	17	18	19	20	21	22	23	24	25	26
	2004	3	4	5	6	7	8	9	10	11	12	13	14
NOV	2000	50	51	52	53	54	55	56	57	58	59	60	61
	2001	38	39	40	41	42	43	44	45	46	47	48	49
	2002	26	27	28	29	30	31	32	33	34	35	36	37
	2003	14	15	16	17	18	19	20	21	22	23	24	25
	2004	2	3	4	5	6	7	8	9	10	11	12	13
DEC	2000	49	50	51	52	53	54	55	56	57	58	59	60
	2001	37	38	39	40	41	42	43	44	45	46	47	48
	2002	25	26	27	28	29	30	31	32	33	34	35	36
	2003	13	14	15	16	17	18	19	20	21	22	23	24
	2004	1	2	3	4	5	6	7	8	9	10	11	12

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