

child care health connections

A HEALTH AND SAFETY NEWSLETTER FOR CALIFORNIA CHILD CARE PROFESSIONALS

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



Responding to Head Injuries in Child Care Programs

As young children learn to walk, run and climb, they are wobbly and often misjudge distance and danger. Their heads are large in relation to the rest of their bodies and it is often the head that breaks a fall. Head injuries can be minor bumps or can cause serious injury to the brain. A head injury can be internal, external or both. Any blow to the head can cause the brain to bang against the inside of the skull or cause bleeding within the skull that can harm the brain.

Superficial or minor head injuries

A scrape or a cut can cause minor injuries to bleed. Minor scalp injuries can also result in blood collecting under the skin of the scalp and bulging outward (sometimes called a "goose egg.") If a child is active, with normal behavior after a bump to the head, a serious injury is unlikely.

However, since any blow to the skull can cause injury to the brain, it is important to watch the child closely for the next 24 hours since the symptoms may not show up until later. This means that you must always let parents know if a child in your care has had a blow to the head so they can observe the child for signs of an internal injury after leaving your program and seek medical help if necessary.

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California Child Care Healthline



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

Happy New Year!
Our best wishes for a
happy, safe and healthy
new year for you and
all the children in
your care.

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Improving Fitness for Preschoolers

Q

I would like to offer some suggestions to parents in my child care program about improving fitness for their preschoolers.

A

Good nutrition and physical activity are the key elements to prevent childhood obesity and having a parent education program devoted to this health topic will support your efforts. Dedicating a bulletin board, parent newsletter column, parent handouts or participatory activities for parents are good ways to engage busy parents.

The most important thing parents need to understand is that preschoolers have a strong need for motor activity and can achieve a good level of fitness when allowed free play to actively explore their environment. To do that the environment must be safe with some materials to provide developmental challenges and a level of supervision to make sure play does not become dangerous. Young children are not ready for organized competitive sports but may benefit from developmentally appropriate activities like gymnastics and movement programs. You can help provide information on parks, family events and outdoor activities or sponsor a raffle for parents who submit their ideas of neighborhood activities.

Advice on indoor activities that you provide in the classroom may help parents with ideas for home. Simple games like hide and seek, animal charades (acting out animals that run, hop, fly or squirm), obstacle courses using old boxes or tunnels, balancing games using walking cans, balance boards or pathways for hopping, jumping, or skipping made with tape all promote activity. Nerf balls or balls made of crumpled paper can be used for tossing, indoor golfing with a cardboard tube, or basketball in a garbage can. And dancing to music can be good for kids and adults to just cut loose and have a little fun. Parents will appreciate whatever easy suggestions for home activities you can provide.

Lastly the best advice you can give parents is to reduce screen time from TV, video or computer games. Help parents understand their important role (and role model) in encouraging physical activity habits in the preschool years as a basis for lifelong well being and disease prevention.

Specific activities can be found at www.fitness.gov/funfit/kidsinaction



by Judy Calder, RN, MS

Leaving Sleeping Babies in Car Seats Can Be Dangerous

Infant car seats are essential for transporting infants and young children safely in motor vehicles. It is common for infants and young children to fall asleep while riding in their car seats and it is tempting for caregivers to leave those sleeping tots in their car seats when they arrive at their destination. A new study suggests, however, that leaving sleeping children in car seats that are placed on hard surfaces indoors can impair their breathing and be life threatening. This is especially true for infants whose mothers smoke. When car seats are sitting on firm surfaces babies' positions are slightly more upright than when the seat is installed in a car. This position, researchers found, caused babies' heads to fall forward and their jaws to rest on their chests, causing their airways to narrow. Caregivers of the studied babies thought they had stopped breathing. The study authors recommend that sleeping children are safer when they are placed on their backs in cribs. When children fall asleep in their car seats, they should be removed when they arrive home and placed in their cribs on their backs.

While back to sleep is the safest for infants from birth to one year of age, it is also very important to give those babies "tummy time" when they are awake. A recent study found that babies who are put to sleep on their backs and do not spend time on their tummies are temporarily delayed in their motor development. So, avoid placing infants in infant seats and other equipment that prevent "tummy time" exercise when they are awake. Provide infants with a rug or blanket that is at least 5 feet by 7 feet to encourage playing, rolling and other large muscle activities when they are awake.



References

Pin, T., B. Eldridge, et al. (2007). "A review of the effects of sleep position, play position, and equipment use on motor development in infants." *Developmental Medicine & Child Neurology* 49(11): 858-67.

Tonkin, S. L., S. A. Vogel, et al. (2006). "Apparently life threatening events in infant car safety seats." *British Medical Journal* 333(7580): 1205-1206.

Resources

Active Start: A Statement of Physical Activity Guidelines for Children Birth to Five Years. (2002) National Association for Sport and Physical Education

by Vickie Leonard, RN, FNP, PHD

Responding to Head Injuries, continued from page 1

What are the signs of an internal head injury?

Since internal head injuries can cause damage to the brain, call 911 for the following symptoms:

- Unconsciousness
- Abnormal breathing
- Bleeding or clear fluid from the nose, ear, or mouth
- Disturbance of speech or vision
- Pupils of unequal size
- Weakness or paralysis
- Dizziness
- Neck pain or stiffness

- Severe headache
- Seizures
- Repeated vomiting; three or more times

Resources and References

CCHP Injury Report Form

www.ucsfchildcarehealth.org/pdfs/forms/InjuryReportForm.pdf

KidsHealth, Nemours, Head Injuries, May, 2007

www.kidshealth.org/parent/firstaid_safe/emergencies/head_injury.html

National Safety Council, Pediatric First Aid and CPR, 2001

by Bobbie Rose RN

Caregivers and MRSA Infections

Recently, MRSA (Methicillin Resistant *Staphylococcus Aureus*) infections have become more common in community settings. These infections can spread to people of all ages who are otherwise healthy.

What is *Staphylococcus Aureus*?

Staphylococcus aureus (staph) is a kind of bacteria that is commonly found on the skin or in the noses of healthy people without causing infection. This is called colonization. When these bacteria get through the skin barrier, they can cause a skin or soft tissue infection.

What is MRSA?

MRSA is a strain of staph bacteria that has become resistant to some antibiotics. MRSA infections can be more difficult to treat since there are fewer antibiotic choices.

What do MRSA infections look like?

Symptoms can vary depending on the part of the body that is infected. Skin infections are most common. MRSA infections may look like boils, pimples, spider or insect bites or draining wounds. Infected people often complain of a sore that started as a spider bite.

How is MRSA spread?

MRSA is most commonly spread by:

- Skin-to-skin contact between individuals
- Sharing personal items and equipment
- Contact with dressings or other surfaces soiled with secretions from infected wounds

Individuals who have draining infections are shedding more bacteria and are therefore more infectious. And people with cuts, scrapes, rashes or other breaks in the skin barrier are at greater risk for becoming infected.

How do you limit the spread?

- *Hand washing is the best way to prevent the spread of MRSA.*
- Keep infected wounds covered with clean bandages.

- Sanitize surfaces that may be soiled with secretions.
- Wash towels or clothing that have been soiled with secretions in hot water and dry in a hot dryer.
- Don't share personal items such as towels and bedding.
- Keep all cuts and scrapes clean and covered until healed.
- Wear non-porous gloves when cleaning children's wounds or changing bandages.
- Wash hands before and after using gloves.
- Share information about handwashing, reducing the spread of infectious disease, and sanitizing procedures. (See CCHP posters: www.ucsfchildcarehealth.org/html/pandr/postersmain.htm)



Should caregivers with MRSA infections stay home from work?

- Those with MRSA who have draining wounds that cannot be covered or have dressings that cannot contain the drainage, and/or be kept dry and intact should not work in a child care setting.
- Seek medical attention for any symptoms of MRSA infection, especially if symptoms occur in more than one person in the family.

For more information about MRSA infections call the Healthline at 1-800-333-3212.

References and Resources

CDC, 2006, Strategies for Clinical Management of MRSA in the Community, www.cdc.gov/ncidod/dhqp/pdf/ar/CAMRSA_ExpMtgStrategies.pdf

Questions and Answers about MRSA in schools www.cdc.gov/Features/MRSAinSchools/

AAP, Hot Topic Community-Acquired MRSA 07 at www.pedialink.org, site visited 10/23/07

"Staph" or Community-Associated Methicillin-Resistant *Staphylococcus aureus* (CAMRSA) Information www.lapublichealth.org/acd/MRSA/MRSAguide.htm, site visited 10/24/07

by Bobbie Rose RN

Vaccine Safety

Childhood immunization has been called one of the most important public health achievements of the 20th century. Vaccination prevents three million deaths in children each year worldwide. Most parents believe in the benefits of immunization for their children; however, some still have concerns about vaccine safety or misconceptions about immunizations. By choosing not to immunize their children parents put their children at risk and increase the possibility of harming other people.

Common Parental Concerns

Parents may be concerned about vaccine side effects, their child's discomfort, too many vaccines given at one time or following a complex schedule. Others may wonder about the safety of vaccinating infants with minor illnesses, or the need for vaccines against diseases that do not seem to exist.

Mercury in vaccines and the relationship between vaccines and autism

The Immunization Safety Review Committee, an independent expert committee, put together by the Institute of Medicine (IOM) was asked by the Centers for Diseases Control and Prevention (CDC) and the National Institutes of Health (NIH) to review evidence about whether vaccines cause certain health problems. The committee looked at whether the MMR (measles-mumps-rubella) vaccine causes autism and whether vaccines with the preservative thimerosal cause neurodevelopment disorders, including autism, attention deficit hyperactivity disorder (ADHD) and speech or language delay. The committee concluded in 2004 that thimerosal-containing vaccines were not a cause of autism or other neurodevelopmental disorders.

The evidence from numerous studies indicates that vaccines are not associated with autism. There is also no proof that any material used to make or preserve the vaccine plays a role in causing autism. Several recent studies including a study published in January, 2008 by the California Department of Public Health also reaffirmed the vaccine safety. Thimerosal is no longer used as a preservative in any of the recommended childhood vaccines.

Recommended Immunization Schedule for Persons Aged 0–6 Years

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B ¹	HepB	HepB	HepB	<i>see footnote 1</i>			HepB					
Rotavirus ²				Rota	Rota	Rota						
Diphtheria, Tetanus, Pertussis ³				DTaP	DTaP	DTaP	<i>see footnote 3</i>	DTaP				DTaP
Haemophilus influenzae type b ⁴				Hib	Hib	Hib ⁴		Hib				
Pneumococcal ⁵				PCV	PCV	PCV		PCV				PPV
Inactivated Poliovirus				IPV	IPV			IPV				IPV
Influenza ⁶							Influenza (Yearly)					
Measles, Mumps, Rubella ⁷								MMR				MMR
Varicella ⁸								Varicella				Varicella
Hepatitis A ⁹								HepA (2 doses)				HepA Series
Meningococcal ¹⁰												MCV4

Since thimerosal was removed as a preservative in 1999, cases of autism have actually increased.

What this Means to You

Myths and misinformation about vaccine safety can confuse parents who are trying to make sound decisions about their children's health and wellbeing. Although some vaccines may cause mild reactions, such as temporary fever or discomfort around the shot site, serious reactions are very rare. Children can also usually get vaccinated even if they have a mild illness like a cold, earache, mild fever, or diarrhea. The benefits provided by most vaccines extend beyond benefit to the individual who is immunized. There is also a significant public health benefit, especially in child care settings. Vaccines work best when most members of the community are vaccinated. The American Academy of Pediatrics (AAP) strongly endorses universal immunization.

References and Resources for Further Information

The CDC's National Immunization Program website (www.cdc.gov/ncbddd/autism/) has many materials about vaccines and autism. You can also get information on vaccines and vaccine safety by calling 1-800-CDC-INFO.

The Institute for Vaccine Safety (www.vaccinesafety.edu) at the Johns Hopkins University School of Public Health provides an independent assessment of vaccines and vaccine safety.

National Institute of Child Health and Human Development (NICHD) has a website about autism and vaccines (www.nichd.nih.gov), which includes research being done by NIH.

by A. Rahman Zamani, MD, MPH



Emergency/Disaster Preparedness for the Child Care Setting



Please take a few minutes to think about how you would answer the following 3 questions:

1. Does your child care setting have emergency/disaster plans?
2. Are emergency/disaster drills practiced regularly at your child care setting?
3. As a child care provider, do you know your role in an emergency/disaster?

Whether you answered yes to all 3 questions or answered no to one or more, you are congratulated for taking the time to review some of the steps that should be taken for your child care setting to be fully prepared for an emergency/disaster.

Emergencies/disasters are typically unplanned and shocking. Therefore, being properly prepared ahead of time can guide you to respond appropriately and aid you to stay calm in an emergency/disaster. This can help save both time and lives. Remember, you are the one responsible for the safety of yourself and of the children in your care.

What is an emergency and a disaster?

Something that is important to understand is the difference between an emergency, such as an asthma attack, and a disaster, such as an earthquake. Even though this writing purposely uses emergency and disaster as if they are the same, according to Random House Webster's Dictionary (1998), there is a definite difference between an emergency and a disaster. An emergency is "a sudden, urgent, usually unexpected occurrence requiring immediate action". A disaster is "a calamitous (great misfortune) event, especially one occurring suddenly and causing great damage". Both emergencies and disasters can begin suddenly, but disasters usually result in a larger impact to the community when compared to emergencies.

Why have emergency/disaster plans?

Having a plan can help you be more prepared before an emergency/disaster. Your child care setting must have written plans that are updated, practiced, and/or trained for routinely. The more overall experience you have with your plans, the more effectively you will respond in an emergency/disaster. The Head

Start Disaster Preparedness Workbook says that disaster plans "define the policies, procedures, and resources put in place by your program to prepare for, respond to and recover from any type of disaster that may occur". You can also use the above definition to define an emergency plan by putting the word emergency in place of disaster.

Which emergency/disaster plans are needed?

The American Academy of Pediatrics recommends that your child care setting has emergency/disaster plans available in writing for the following:

- Handling urgent medical care or threatening incidents;
- Emergency evacuations;
- Medical emergencies;
- Children with seizures;
- Children with asthma;
- Children with food allergies.

What emergency/disaster training is needed?

Once the emergency/disaster plans are in place, you will need to be well trained in order to carry out the emergency/disaster plans when the time is necessary. The American Academy of Pediatrics recommends that you receive training for the following:

- Handling urgent medical care or threatening incidents;
- First aid;
- CPR;
- Emergency evacuations;
- Handling seizures;
- Handling asthma;
- Handling food allergies.

What emergency/disaster drills are needed?

In preparation for an emergency/disaster, the regular practice of emergency/disaster drills is important for both the adults and the children in your care. Moreover, the Title 22 Regulations for licensed child care programs require that all programs, including centers and family child care homes,

have a disaster plan in writing and perform and document a disaster drill at least every six months. A copy of the form (called Form 610 for child care centers and Form 610A for family child care homes) can be obtained by calling your local CCL office or can be downloaded from the CCL web site at http://ccl.dss.cahwnet.gov/LicensingF_1774.htm.

Evacuation drills help assist you, other staff, and the children with knowing what to do in an actual emergency/disaster. As earthquakes and fires are a high risk in California, earthquake and fire drills should definitely be practiced. The American Academy of Pediatrics recommends that earthquake drills are practiced at least every 6 months. Children and staff should practice how to duck, cover, and hold. The recommendation for fire drills is that children learn how to crawl on the floor under smoke and how to stop, drop, and roll. Your child care setting should keep the date and time of the evacuation drills on record. A good practice to have during the evacuation drills is to take roll of the children to make sure they have all safely evacuated.

What if an emergency/disaster happens?

Take a moment to think about yourself working at your child care setting. Imagine that a serious earthquake happens while you are working. The damage from the earthquake is so bad that you are left without running water and electricity in your child care setting. The structure you are in has been partly destroyed and is no longer safe. Everyone must evacuate. Some children and staff have been injured and need assistance right away. Ask yourself the following questions. What do you need to do at this moment and what did you need to do to be prepared? Is your child care setting prepared for this situation or for any emergency/disaster? Continue reading to find out what else you need to be ready.

What is your role in an emergency/disaster?

Before an emergency/disaster occurs, you need to know what your role will be in the event of an emergency/disaster. The staff at your child care setting should write down, discuss, and practice the positions that each person will take in an emergency/disaster. Some examples of role responsibilities include first aid, documentation, and child care. To limit confusion, usually there is only one person that is chosen to be in charge of everyone. Another person should be picked to take over for the leader position if the person in charge is unavailable at the time.

Communicating with families

Communication with the families of the children in

your care should be a high priority before, during, and after an emergency/disaster. Before an emergency/disaster takes place, families should be made aware of your emergency/disaster plans. Of most importance is making sure the families know how to contact you and that you know how to contact the families in case of an emergency/disaster.

An emergency card should be completed and kept on file at your child care setting for each child. Make sure the information on the emergency cards is updated regularly, at least every three months, and as needed so that the information will be accurate. The families should be told where you would go in the event of an evacuation, so they will know how to find their children. Have the families tell you who is allowed to pick up their children, and do not send children home with unauthorized people. Taking these steps ahead of time can help you maintain contact with families during an emergency/disaster. Once the emergency/disaster is over, update your emergency plan to bring things back to normal again in the child care setting.

What to remember in an emergency/disaster

When an emergency/disaster occurs, people will sometimes go into shock and panic. Panicking often results in difficulty thinking, which can lead to a response that is unsuccessful at ensuring safety quickly. Knowing what to do before a disaster/emergency happens can help prevent this dangerous situation. Here are a few important tips to remember.

- STAY CALM
- Be prepared
- Supervise the children; make sure the children are safe
- Follow your written plan
- Communicate your plan to parents and staff
- Assign specific roles to staff
- Listen to the person in charge
- Know when to get help
- Keep the families involved

*By Erica D. Hooper, RN, PHN, BSN
Child Care Health Consultant*

References and Resources

Caring for our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care (2nd ed.). Elk Grove Village, IL: American Academy of Pediatrics.

Head Start Disaster Preparedness Workbook. Los Angeles, CA: UCLA Center for Public Health and Disasters.

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Self-Assessment of Your Child Care Program

Every child needs and deserves to have a nurturing, caring and safe environment to grow and develop. Supporting high quality child care settings should be a priority for every community. Measuring your program against high standards can help you provide the very best for the children in your care. One way to take a good look at the quality of your program is to complete a self-assessment on a regular basis.

What is a self-assessment?

A self-assessment is a systematic way to monitor and detect areas that need improvement. In a child care program, it is an exercise to review facilities, practices, procedures, policies and staff development in a variety of areas. It is an objective way to identify strengths and weaknesses in the program. Once areas to improve have been identified, a plan can be developed to correct the weaknesses. The self-assessment can assist Early Care and Education (ECE) professionals to prepare for outside reviewers and can help assess change in quality over time.

Self-assessment tools for child care programs

There are a number of tools available to perform a self-assessment. You may use one or more depending upon your program needs and your priorities. Here are some to consider:

California Community Care Licensing Self-Assessment Guides

The Child Care Advocate Program developed these guides with input from the child care community as “user friendly” tools to help Child Care Centers and Family Child Care Homes comply with state licensing regulations. These guides are available on the Community Care Licensing website and are published in multiple languages:

- Self-Assessment Guides
- Safe Food Handling and Preparation
- How to Make Your Child Care Center Safe
- Waivers, Exceptions and Exemptions
- Disaster Guides for Homes and Centers
- Tenant Rights Guide



California Childcare Health Program Health and Safety Checklist

This checklist evaluates health and safety in child care programs with references to licensing regulations, national standards, NAEYC standards and Head Start Performance Standards. It evaluates indoor and outdoor environments and practices with a subsection for infant/toddler care. It covers emergency preparedness, handwashing, food preparation, oral health, diapering, injury prevention and special needs.

Early Childhood Environment Rating Scales (ECERS) by Harms, Clifford and Cryer

This widely used system of evaluation has four environment rating scales depending on the segment of the child care field: Early Childhood (ECERS), Infant Toddler (ITERS), Family Child Care (FDCRS) and School Age Care (SACERS). Each of the scales evaluates the physical environment, basic care, curriculum, interaction, schedule, program structure and parent and staff training.

For more information about high quality child care, call the Healthline at 1-800-333-3212.

References and Resources

Child Care Centers Self Assessment Guides www.cclcd.ca.gov/PG496.htm

Environment Rating Scales www.fpg.unc.edu/~ecers/

The CCHP Health and Safety Checklist-Revised ucsfchildcarehealth.org/pdfs/Checklists/UCSF_Checklist_rev2.0802.pdf

by Tahereh Garakani, MA.Ed. and Bobbie Rose RN

Responding to Life Threatening Allergic Reactions

More children are being diagnosed with life-threatening allergies and child care programs that care for these children must be prepared for allergic emergencies.

What is Anaphylaxis?

Anaphylaxis is a serious allergic reaction that happens quickly and may cause death. It is most commonly caused by allergies to foods, insect stings, medications and latex. The most common food allergies are peanuts, tree nuts (pecans, walnuts, almonds etc.), milk, eggs, fish, and shellfish. Food allergies are most common in children under five. Allergies tend to get worse with repeated exposure to the allergen (the allergy causing substance).

Anaphylaxis can develop within seconds of exposure to the allergen. When a child is exposed, the body releases chemicals to “protect” itself from the allergen. These chemicals can cause itching, hives, wheezing or difficult breathing, or swelling of the lips or face. Children may also faint, or vomit. Within moments, the throat may begin to close, choking off breathing and leading to death. Because death can occur within minutes, anaphylaxis requires immediate attention.

How is Anaphylaxis Treated?

The drug used to treat anaphylaxis is called epinephrine and it is given by needle injection (Epi-Pen or Twinject) and is prescribed by a health care provider. It must be available to the child at all times, and must be given promptly to prevent death. Fatal anaphylaxis in children can happen when epinephrine is not given promptly. Children with severe allergies

who also have asthma are at greater risk for anaphylaxis. Side effects of epinephrine are short term, and generally not serious, and it is always safer to administer epinephrine if you suspect anaphylaxis than to wait.

How do I use Epinephrine?

Epinephrine is provided for use outside of the hospital in a disposable, pre-filled auto-injection system. It should be kept at room temperature and out of direct sunlight. The solution should be clear and colorless. If it turns color, or is past its expiration date, it should be replaced. Sometimes, a child will need a second injection of epinephrine so it is best to keep two injectors on hand. Epinephrine is best given in the outside of the thigh. The needle is meant to be inserted through clothing into the thigh all the way until it clicks to get the fastest blood levels of the drug. Hold it there for 10 seconds. Remove the needle and massage the area for 10 seconds more. If a child has a life threatening allergic reaction, always call 911 immediately, in addition to giving epinephrine. Give the used auto-injector to paramedics to take to the hospital.

Planning Ahead

The most effective strategy for calming fears about enrolling a child with a life threatening allergy is advance planning.

- Meet with the child’s parents and develop a special health care plan and have it reviewed by the child’s health care provider.
- Include in the plan strategies for avoiding exposure of the child to the allergen

and a description of the child’s particular experience of anaphylaxis; for instance, what words does he use to describe it and what are his typical symptoms?

- Determine which staff will learn how to use the auto-inject epinephrine, and how the medication will be handled so that it is always available to the child, even on field trips away from the program site.
- Determine how to ensure there is a staff member available who is properly trained to administer medications during the school day regardless of time or location.
- Provide training for staff about how to manage the child’s allergy, including how to give the injection of epinephrine.
- Copy the Allergy Action Plan on brightly colored paper so it is easy to find and attach a copy of the child’s picture to it. Keep a copy of the plan with the child’s epinephrine auto-injector.

An Action Plan protects the child as well as the child care program. The Food Allergy and Anaphylaxis Network has a model Food Allergy Action Plan and is a great resource for information and training materials (see Resources).

References and Resources

Sicherer, S. H. and F. E. Simons (2007). “Self-injectable epinephrine for first-aid management of anaphylaxis.” *Pediatrics* 119(3): 638-46.

The Food Allergy & Anaphylaxis Network Child Care and Preschool Guide to Managing Food Allergies, available from: www.foodallergy.org

How to Use the Epi-Pen (Epinephrine) Auto Injector www.epipen.com/howtouse.aspx

by Vickie Leonard, RN, FNP, PhD

Best Practices

How to Prevent Children from Leaving a Child Care Facility Due to a Lack of Supervision

Below is a compilation of best practices for preventing children from leaving child care facilities as a result of a lack of supervision.

Family Child Care Home regulations require that licensees ensure that children are supervised at all times.ⁱ

Child Care Center regulations require that licensees shall provide care and supervision as necessary to meet the children's needs and that supervision shall be visual.ⁱⁱ

Caregivers should regularly count children on a scheduled basis, at every transition, and whenever leaving one area and arriving at another. This is necessary to confirm the whereabouts of every child at all times. Supervision is basic to the prevention of harm. Parents have a contract with caregivers to supervise their children. To be available for supervision or rescue in an emergency, an adult must be able to hear and see children at all times.

Many instances have been reported where a child has hidden when the group was moving to another location, or where the child wandered off when a door was opened for another purpose. Regular counting of children will alert the staff to begin a search before the child gets too far away or into trouble. Counting children routinely is without substitute in assuring a child has not slipped into an unobserved location. It is recommended that caregivers record the counting on a predetermined schedule per the Child Care facility's policies and procedures.ⁱⁱⁱ

Playground areas should be monitored by adults with knowledge of injury prevention and first aid. Adults should scan the areas to ensure gates are closed and the area is safe. Adults should set reasonable, appropriate rules for what children may do. Small groups of children and appropriate staffing ratios are just as important outdoors as it is indoors to make sure children get the attention and supervision they need.^{iv}

Plans for dealing with emergencies should include how to respond to injured, sick, or lost children. These plans should be reviewed regularly and shared with parents during enrollment interviews and conferences.^v



Missing children should be reported to parents/guardians and local law enforcement immediately. Law enforcement agencies recommend that 911 be called whenever an individual's safety is in danger.^{vi}

Resources and References

- i. Title 22, Division 12, Section 102417(a)
- ii. Title 22, Division 12, section 101229(a)(1)
- iii. American Academy of Pediatrics, American Heart Association
- iv. National Association for Education of Young Children
- v. National Resource Center for Health and Safety in Child Care Early Education-Healthy Kids, Healthy Care
- vi. National Center for Missing Children and Oakland Police Department

Source: CCPO

Pick a card, Take a step

Try this indoor physical activity on a rainy day. It will help children learn to follow directions, take turns and develop their understanding of numbers.

- From a deck of 52 playing cards, sort, and pick out numbers 2-10 (for younger children, limit to low numbers 2, 3 and 4)
- Set up a starting line and a finish line
- Ask each child to pick a card, look at the card, and take the number of steps that is on the card.
- Repeat until all of the children reach the finish line
- Substitute hopping or jumping for taking steps
- Once the children understand the game, let them take turns collecting and handing out the cards



health + safety calendar

February 2 & 9, 2008

Building Family Child Care Association

February 2, 2008, Davis February 9, 2008, Petaluma, CA

The Family Child Care Association Development Project, a Project of California Department of Education CDE, Child Development Division CDD and of the International Child Resource Institute is registering Family Child Care Providers and Association Leaders for building Family Child Care Association.

Pre-Register by calling Toll Free (800) 808 0283 or (800) 462 1315

February 26–28, 2008

Special Education Early Childhood Administrators Project (SEECAP) Symposium 2008

Radisson Hotel – Newport Beach

For more information contact kfinn@sdcoe.net

February 2, 22 & 29, 2008

Family Partnership Initiative Training-of-Trainer Institutes

WestEd, Center for Child and Family Studies will be conducting a series of Family Partnership Initiative Training-of-Trainer Institutes. Learn techniques to enhance family/staff partnerships.

Contact Dee Roeder at droeder@wested.org or (858) 530-1178

April 3–5, 2008

CAEYC's Leadership Day and Annual Conference & Expo

Long Beach, CA

For more information e-mail info@caeyc.org

February 9, 16 & 23, 2008

Health and Safety Training for Child Care Providers in Alameda County

Oakland, California

The California Childcare Health Program (CCHP) is conducting a three days training for Early Care and Education (ECE) professionals in Alameda County.

For more information Contact Tahereh Garakani at tgarakani@ucsfchildcarehealth.org or call (510) 204-0939.

www.ucsfchildcarehealth.org

CCHP/CTI calendar

Events in Early Education is now available at my.calendars.net/early_ed



California kids falling behind in health and education

The 2008 California Report Card: The State of the State's Children highlights the generally poor health and education status of the state's children by assigning letter grades to key individual determinants, such as a C in health insurance, a C- in K-12 education and a D+ in obesity.

- Only 47% of 3- and 4-year-olds attend preschool;
- One in three children is overweight or obese;
- Just 65% graduate from high school on time;
- 37% of children, ages 2-5, did not visit a dentist within the last year;
- Fewer than half of families can afford the basics of housing, child care, food, health insurance and transportation.

Available online at publications.childrennow.org/publications/invest/reportcard_2008.cfm

Study links preschool teachers' stress to student expulsions

Preschool teachers who are highly stressed because of classroom conditions, depression or other factors are far more likely than their colleagues to recommend expulsion for children with behavioral problems, according to a study released Thursday. Read this complete Los Angeles Times story online at www.latimes.com/news/local/la-me-expulsions11jan11,1,163452.story?coll=la-headlines-california

Cost of Care for Four Year Olds among Highest Household Expenditures

The National Association of Child Care Resource and Referral Agencies (NACCRRA) released new data on the cost of child care around the country. Surveying its network of state and local resource and referral agencies, NACCRRA compiled information on the cost of care for infants and four year olds and found that the price of child care is rising faster than inflation.

- Average Annual Price of Full-Time Infant Care \$10,745
- Child Care as a Percentage of Median Single Parent Family Income 42.1%
- Child Care as a Percentage of Median Two Parent Family Income 15.0%
- Rank (based on percentage of two-parent family income) 7

Available online at www.naccrra.org/docs/press/price_report.pdf

California Child Care Portfolio

There is one licensed child care slot for about every four children with working parents in California, according to a report to be released Wednesday, which says that San Francisco fares better than any other Bay Area county in terms of child care. In San Francisco County, licensed care is available for 43 percent of children with working parents.

This year's report, the sixth biennial edition, specifically focused on care for infants and young children. Available online at www.rnnetwork.org/our-research/2007-portfolio.html

California Childcare Health Program
Child Care Health Connections
1950 Addison Street, Suite 107
Berkeley, CA 94704-1182

CHANGE SERVICE REQUESTED