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ABSTRACT

This manual on health and safety considerations in caring for young children with exceptional health care needs is a product of Project EXCEPTIONAL (EXceptional Children: Education in Preschool Techniques for Inclusion, Opportunity-building, Nurturing And Learning), which has the goal of increasing the quality and quantity of inclusive child care and development options for California's young children (birth to age 5) with disabilities through development of a training model and materials to support the training of interagency community teams. The manual's text focuses on 10 key points: (1) the increasing need by children with disabilities for child care services; (2) the moral and legal responsibility of child care providers to include children with exceptional needs; (3) the rewards, risks, and responsibility of servicing these children; (4) the vast diversity in health-related conditions and need for individualized accommodations; (5) inclusion as a national, state, and local priority; (6) barriers to inclusion; (7) critical elements of quality child care; (8) best practices; (9) characteristics of a health supportive environment; and (10) the need to ensure the health and safety of every child. Much of the document consists of 13 appendices, including a listing of national parent organizations; a recommended training curriculum; authorization forms; discussion of safety issues, emergency contact information, and incident reports; recommended procedures for nutrition and feeding, diapering, and hand washing; universal precautions; information on childhood diseases; health condition fact sheets and record forms; medication records; and training activities. (DB)

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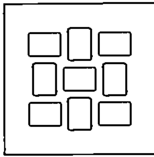

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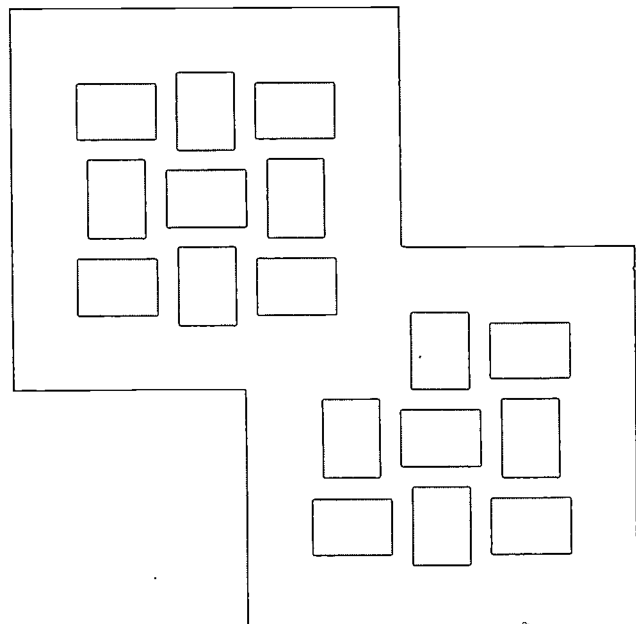
EXceptional Children: Education in Preschool Techniques for Inclusion, Opportunity-building, Nurturing And Learning

Health and Safety Considerations:

Caring for Young Children With Exceptional Health Care Needs

Betty Presler, R.N., Ph.D.

Edited by:
Linda Swenson Cranor
Anne Kuschner, M.A.



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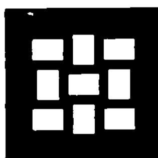

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Project EXCEPTIONAL Materials

Basic documents:

- ☐ *A Guide for Training and Recruiting Child Care Providers to Serve Young Children with Disabilities, Vol. 1* (Topic chapters)
- ☐ *A Guide for Training and Recruiting Child Care Providers to Serve Young Children with Disabilities, Vol. 2* (Training activities)

Supplemental documents:

- ☒ *Health and Safety Considerations*
- ☐ *College Instructor's Guide*
- ☐ *Dimensions of Diversity*
- ☐ *Chinese Translations*
- ☐ *Spanish Translations*
- ☐ *Supplemental Training Activities*

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KEY POINTS

1. An increasing number of children with disabilities or serious health conditions need quality, affordable child care services.

2. Child care providers have a moral as well as a legal responsibility to respond to the needs of families by opening their doors and their hearts to children with exceptional needs.

3. The rewards of serving children with exceptional needs are enormous; the risks are real and the responsibility must be taken seriously.

4. There is vast diversity in health related conditions. It is critical to remember that these children's needs are not all alike. Accommodations required to meet a child's exceptional needs may range from simple to complex. Determinations of care must be made on a child-by-child and program-by-program basis.

5. Inclusion of children with exceptional health care needs in typical child care settings must become a national, state, and local priority. The child care system must be strengthened at both the state and community level.

6. Barriers to inclusion include:
   - Negative attitudes and fears of child care providers
   - Lack of training, support, and technical assistance
   - Restrictions in legislation or regulation
   - Lack of statewide coordinated system to ensure safe, quality care for children with special health care needs

7. Critical elements supporting quality child care giving include:
   - A knowledgeable, capable administrator
   - Staff who are sensitive to the needs of children
   - Adequate facilities
   - Adequate staffing
   - Adequate training
   - Accessible health consultation
   - Available resources
   - Supportive policies and procedures

8. Best practices for quality child care giving include being:
   - Family-centered
   - Linked and coordinated at the community level
   - Supportive of safety
   - Supportive of health
   - Developmentally supportive

9. A health supportive environment must encompass health promotion activities such as hygiene, nutrition, sleep/rest, activity/play, toileting, and communication. Additionally, it must include disease prevention activities such as immunizations, morning health check, good hand washing, universal precautions, protection of high risk, vulnerable children, and protection of pregnant child care workers.

10. The current child care system is not totally prepared to ensure the health and safety of every child. It is our job to make it so.

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SUMMARY

Inclusion of children with special health care needs or disabilities in child care must become a national, state, and local priority. The needs of children and families for affordable, accessible, quality child are real and urgent. The Americans with Disabilities Act mandates equal access. Unfortunately, our system of child care is not totally prepared for this challenge. It is our job to make it so. In the interim child care providers need to open their doors and hearts to these children and families and the possibilities for quality care. When a family calls and requests enrollment, the first response must be, "Let's get together and try to make it work out." However, "working it out" one-on-one with the family is often not enough, unfortunately, to ensure the safety and well-being of the child or to reduce liability for the child care provider.

A very thoughtful assessment of the child's needs and the capacity of the program to make the necessary accommodations must occur. Families, child care providers, and health professionals must work together to be sure that every decision is in the best interest of each child. We must also consider the resources and capabilities of individual child care providers and the communities which support them. No one wins if enrollment of children with special health care needs closes the doors of good child care facilities or causes harm to a child. We must remember that the moral mandate to "do good" (i.e. to support inclusion) is secondary to the moral mandate to " do no harm". Child care providers should not allow irrational fears to dictate decisions, nor should they accept children they are not prepared to safely care for.

The *rewards* of serving children with exceptional needs are enormous. Everyone involved can grow in understanding, acceptance, and respect for those who are "different." The *risks* are real. Unsafe, unmonitored care can lead to disastrous outcomes. The *responsibilities* are daunting. Families, health care professionals, and child care providers must find ways to institute best practices in family-centered, community-based, inclusive child care that is safe and promotes health and development of *all* children. We can and must create opportunity and success child by child; and, in the process, build a safe, effective child care system that meets the needs of all families throughout this country .

> *"The need for change bulldozed a road down the center of my mind."*
>
> Maya Angelou

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PREFACE

The goal of Project EXCEPTIONAL is to increase the quality and quantity of inclusive child care and development options in local communities for young children (birth to five) with disabilities. The primary focus of the project has been to enhance community capacity building by developing a replicable training model and materials designed to support the training of interagency community teams, which include family members of children with disabilities.

Everyone benefits when young children with disabilities are included in family and community child care and development settings staffed by trained and sensitive caregivers. A basic premise of Project EXCEPTIONAL is that there are individuals within all communities who, given support and training, have the desire and capacity to provide quality services to young children with exceptional needs. It is our responsibility to ensure that these individuals are supported in developing the confidence and competence needed to be successful. Identifying and utilizing local and regional resources with state, jurisdiction, and federal level assistance helps to provide the support that is critically needed.

It has been our experience that the greatest influence on creating quality inclusive family and community child care and development settings comes about when people join together to achieve a common goal. It is our hope that the use of the Project EXCEPTIONAL materials will help make this goal a reality for *all* children and their families.

Linda Cranor
Anne Kuschner

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Health and Safety Considerations: Caring for Young Children With Exceptional Health Care Needs

Betty Presler

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"Whatever trials you suffer, the world goes on, often oblivious to your needs or pain. The world of child care can be a similar experience for families of children with disabilities or chronic health concerns. It can be a reality in which those around you may have no sense of the struggles you face as a parent and the level of your need for help."

Parent

INTRODUCTION

Currently in the United States we have a new generation of infants and young children with disabilities and serious health conditions living at home, surviving on the love and care of their families, and in need of the support of their communities. Estimates of the prevalence of children with disabilities or special health care needs generally fall between ten and twenty percent of all children (Butler, Rosenbaum, & Palfrey, 1987). Thirty years ago many of these children died. Those who did not were often institutionalized. Today, modern medicine and technology have increased both the survival rate and longevity of children with disabilities or exceptional health needs.

Health care is a concern for every American. For families who have members with disabilities, there may be no greater need or pressing issue than that of accessing consistent, quality health care for their family. Hand in hand with the need for accessing health care, these families often have an equally pressing need to access affordable, quality child care.

Families of children with disabilities or health care concerns have the same needs for child care as other families. In fact, often the need to work is accentuated due to the financial demands associated with their child's health care. For example, families may need to work to maintain existing health benefits or to generate income to cover deductibles and co-payments. If the parent of a child with exceptional needs changes jobs, the child may be excluded from insurance benefits because of the pre-existing condition exclusions of many insurance companies.

Although government assistance for health care is available through Medicaid and state Title V programs for Children with Special Health Care Needs (CSHCN), assistance is often contingent on reaching a certain percentage of the "official" federal poverty level. *The road to poverty that grants access to government assistance can be a nightmare for many families.*

In some situations, children are placed in residential care homes or facilities by their families because the family does not meet income eligibility for government assistance programs for children with disabilities. Unfortunately, children of these families are eligible for Supplemental Security Income (SSI) benefits, including Medicaid coverage, only if they are living in an out of home placement. Because of lack of in home support and community-based services, parents may also have no other alternative than to place their children in order to ensure the on-going availability of trained care givers or to provide an avenue by which the family is able to maintain their overall ability to function and care for the needs of other family members. Even more devastating is the fact that in many states when a child has a severe disability compounded with health impairments, licensed residential care homes with nursing support are frequently unavailable within the child's community or region of the state.

In light of these experiences often encountered by families, advocates must begin to support systems which are responsive to family needs on all levels—federal, state, and local. Agencies and providers that offer services within our communities have a moral, as well as a legal responsibility to respond to the needs of families by opening their doors and their hearts to

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children with exceptional needs. The rewards of community inclusion are enormous. In the fields of health care, early intervention, child care, and education, administrators and staff can experience the positive benefits of providing services to families in need of community-based support. Additionally, in the field of child care, staff can grow and benefit from additional training in the care of children with a range of exceptional health care needs. The increased awareness and sensitivity gained in understanding the individual needs of this population can be translated into increased sensitivity to the needs of all children. Finally, all children and their families can benefit from inclusion. Exposure to children who are "differently abled" can enhance appreciation for diversity at an early age.

Throughout the nation, and in California, child care providers are successfully serving children with a range of special needs in their programs everyday. By collaborating with families and other professionals, providers are increasingly enhancing their knowledge, learning new skills, and developing confidence in their abilities. These successful experiences are a catalyst for increased community child care inclusion. Additionally, through these experiences concerns relating to the critical need to provide support and prepare child care providers who care for children with significant health conditions have been identified. *While the rewards of serving these children are enormous, the risks are real and the responsibility must be taken very seriously.*

Inclusion of children with exceptional health care needs in typical child care settings must become a national, state, and local priority. Collaboration and advocacy at every level of policy making must become a focus of attention as the numbers of children and families entering our service delivery systems continue to increase. Families, health care professionals, and child care providers must find ways to institute best practices in family-centered, community-based, inclusive care that are safe and promote the health and development of *all* children. At the same time we must work together to evaluate our current capabilities to care for children with chronic health conditions and move towards best practices on many levels.

The purpose of this document is to provide for Project EXCEPTIONAL trainers, and other advocates, a foundation for understanding the broad scope of issues which must be addressed when training child care providers on the topic of caring for young children with exceptional health care needs. The material will present an overview of systems level factors affecting the movement toward inclusive child care settings. Additionally, it will highlight elements that are in place that support the movement and review barriers that currently still exist. A primary focus of the content is identification of critical elements for assessing and preparing an individual child care program's or a local or statewide child care system's capacity to provide safe and effective care for children with exceptional health care needs. The material highlights key components of best practices in a family-centered, appropriately linked and coordinated service delivery system.

While this document is neither a comprehensive nor a complete resource, it represents a level of content that extends beyond an introductory presentation designed solely for newly recruited or trained child care providers. The rational for presenting material of this scope is related to the important nature of this subject. The desire of the author and editors is to offer a resource which will assist individuals in increasing their own understanding of the complicated nature of this training topic. It is hoped that this material will be useful to trainers, instructors, families, and policy makers of varying degrees of experience and expertise.

CHILDREN WITH EXCEPTIONAL HEALTH CARE NEEDS

Children with exceptional health care needs represent a wide population of children commonly cared for in community child care settings, as well as an increasing number of children historically excluded from typical child care programs. This population includes children with disabilities and children with health conditions that are not typically thought of within the context of disability. Children with exceptional health care needs may have conditions that are mild, moderate or severe. Additionally, children may have short-term, temporary health

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conditions; chronic, on-going conditions; or permanent health impairments. Examples of health conditions which illustrate this diverse range include:

- Children who experience the residual effects of prematurity
- Children born with congenital disorders such as heart defects, Spina Bifida, or cleft lip and palate
- Children with genetic disorders such as sickle cell disease, hemophilia, cystic fibrosis, or brittle bones disease
- Children with acquired infections such as hepatitis or HIV
- Children with chronic health problems such as cancer, allergies, asthma, diabetes, or seizures
- Children with environmentally caused problems such as accidents, lead poisoning, or abuse

Because of the range and shear number of health related conditions that exist, it is critical to remember that these children's needs are not all alike. Just as children are uniquely diverse individuals, so are the numerous types and severities of health conditions. Additionally, when accommodating these needs, a range of modifications and adaptations may need to be considered. These accommodations may extend from simple to complex. An example of a simple modification is the daily monitoring of a child with a well-controlled seizure disorder. A more complex adaptation would need to be made for a child who ingested a corrosive poison and must be fed with a gastrostomy tube (a tube placed directly into the stomach and held in place with a suture). Given this understanding, it is very important that each child's health status and assessment of their exceptional care giving needs be individually addressed on a child by child basis. It is equally critical to individually assess a provider's capability and the adequacy of the program to appropriately meet the unique needs of the children entering their care.

GOOD HEALTH: THE MIND-BODY CONNECTION

Health is a reflection of one's physical, mental, and emotional status. Good health is often thought of as being of sound body, mind, and spirit. Bad health is often though of in the context of disease, pain, hospitalizations, long-term treatments, and disability. A health condition, however, in and of itself does not necessarily make one feel unhealthy per se. With proper care and monitoring of their health condition, most people (including those with significant health impairments or disabilities) adapt very well and live normal, active lives. It is often one's own response to their health status and the response of others around them, that results in the feeling of "well-being" (Calder, 1995).

Just as most adults learn to successfully adapt to their unique health conditions, young children show incredible resilience and ability to overcome problems related to their health. Young children, however, are unique in that their health care is both managed and provided for by adults. They are, therefore, more vulnerable to and affected by the attitudes of the adults providing their care. For this reason, a child with a significant health challenge who is provided quality care from an adult with an accepting positive attitude may often feel and act in ways more typical of a "healthy" child. On the other hand, a child with a very mild health condition who is treated differently by adults or other children because of his/her condition may feel or be perceived as "unhealthy." *The mental and physical health status of every young child is*

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dependent upon the commitment of the adults in their lives to assure the delivery of quality health care giving and to provide encouragement and support to live a full and productive life.

A goal for all care givers serving young children with exceptional health care needs must be to become accepting of these children and their conditions. At the same time, thoughtful consideration must be given to the assessment of our own capabilities and program capacities to provide safe, quality care to children requiring exceptional care giving.

ASSESSING THE ADEQUACY OF OUR SYSTEM: WHAT IS IN PLACE TO SUPPORT OUR EFFORTS

Fortunately, while many challenges remain before all children with special health care needs will be able to access child care in their communities, many factors are currently in place which support inclusion. These factors include enabling federal and state legislation, California's mandated health training for child care and development staff, the establishment of local level interagency coordinating councils and family resource centers throughout California and the United States, quality child development training, and course work offered through community college and state university systems as well as local, state and federally funded training projects.

Legal responsibility for the inclusion of children with physical or mental impairments in child care is clearly established in the Americans with Disabilities Act of 1990 (ADA). The most sweeping piece of federal civil rights legislation to affect the private sector ever passed by congress, the ADA states that all public accommodations, including child care settings, *must make reasonable modifications* in practices and procedures in order to accommodate children and adults with disabilities. As a result of passage of the ADA, we now have a window of opportunity to inform parents, train care givers, and promote systems changes that support inclusion of exceptional children and quality child care for children with exceptional care giving needs. For a review of the ADA and guidelines for thinking through what is a reasonable accommodation and/or an undue burden, refer to the Project EXCEPTIONAL text and training activities in "Nuts and Bolts: Administrative Issues in Serving Children with Exceptional Care Needs and Their Families." For further information about laws, regulations, and community services affecting the child care system, refer to the Project EXCEPTIONAL materials titled "Who Will Care for Our Children: A Historical Perspective of Services for Young Children with Disabilities."

ASSESSING THE ADEQUACY OF OUR SYSTEM: WHAT IS NOT IN PLACE TO SUPPORT OUR EFFORTS

The Americans with Disabilities Act is a landmark piece of federal legislation passed to ensure non-discriminatory access to public services for children and adults with disabilities. However, significant challenges must be addressed before equal access will become a reality for all children and families needing quality child care. Many barriers currently stand in the way of full implementation of this goal. The following discussion identifies key challenges facing families, providers, and advocates alike across this country.

Attitudes and Fears of Child Care Providers

While the ADA has increased the awareness of many child care providers about the legalities of discriminatory practices, negative attitudes and prejudice are still prevailing barriers faced by families of children with disabilities. Child care providers are also often afraid to care for children with special health care needs or disabilities. Some of these fears may include:

- Fear of not knowing how to provide safe care
- Fear of the child becoming seriously ill or getting injured
- Fear of an unexpected, life-threatening emergency
- Fear of increased liability
- Fear of increased cost
- Fear of driving away families who are afraid that their child may be placed at risk or not receive the same level of care previously provided

Lack of Training, Support, and Technical Assistance

While there is a great need for training and support to assist providers in learning new techniques to care for children with disabilities there is little training available at the state or local level or financial resources to support training or technical assistance. Information and open discussion can reduce or eliminate the barriers of fear and bias. On-site technical assistance can ensure that child care facilities make appropriate accommodations for individual children. Lack of resources is especially disheartening when we know that most providers are willing to care for children with disabilities given support, training, and on-site technical assistance.

Barriers in Child Care Regulations/State Licensing Systems

In California, and other states as well, barriers exist in the state licensing system which place providers in the position of being out of compliance with either state licensing regulations or the mandates of the ADA. Child care regulations vary greatly from state to state. Some states have few or no restrictions relating to health and safety issues; others, such as California, restrict the definition of a child care center to a "facility which provides *non-medical care* to children in need of personal services, supervision or assistance essential to sustaining activities of daily living or the protection of an individual on less than a twenty-four-hour basis." (California Health and Safety Code, Section 1596.750). Clearly, both extremes should be avoided. Minimal health and safety regulations and standards place all children (including those with special health care needs or disabilities) at risk for injuries, infections, and complications resulting from poorly managed health problems, inadequate treatment protocols, or un-monitored health-related procedures. On the other hand, restrictive regulations exclude many children who could safely participate in, and benefit from, out-of-home child care.

Joint advocacy efforts on the part of families and professionals are crucial to eliminating regulatory barriers while maintaining standards that promote and protect the health and safety of all children. The most effective agents of change are families. National parent or family organizations with a strong commitment to children with special health care needs include Family Voices, The Federation for Children with Special Health Care Needs and The Association for the Care of Children's Health (ACCH), among others. (See Appendix A for a listing of selected national parent organizations.)

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Restrictive Licensing Statues

In some states, Nurse Practice Acts restrict the performance of nursing care by unlicensed personnel other than family members. Performance of certain "invasive procedures" can result in felony charges. The intent of these restrictions is to protect "the public" from unsafe nursing practices. California's Nurse Practice Act defines nursing as "those functions, including basic health care, which help people cope with difficulties in daily living which are associated with their actual or potential health or illness problems or the treatment there of which require a substantial amount of scientific knowledge of technical skill (Chapter six, Article two, Section 2725 of California Business and Professions Code)."

Nurses cannot delegate 1) performance of a comprehensive assessment, 2) formulation of a nursing diagnosis and a nursing plan of care, 3) evaluation of the effectiveness of the nursing care provided, 4) care of a patient who is "medically fragile," or 5) performance of a task which requires a substantial amount of knowledge and skill, such as handling invasive lines, parenteral medications, and sterile technique (California Board of Nursing, 1994). The bottom line for child care providers is to be aware that children with special health care needs or disabilities often need nursing care while in the child care environment. Therefore, nursing consultants are essential to ensure safe, legal practice. Nurses (including representatives from state boards of nursing), child care providers and families of children with special needs should join together in examining nurse practice acts and developing policies that both support inclusion and protect the health and safety of children in child care environments.

Lack of Medical and Nursing Resources

Additionally, there is a lack of readily achievable on-site health consultation for many providers throughout California and in other states. Lack of medical and nursing resources, as well as affordable reimbursement systems for consultation expenses make it impossible for many providers to care for children who require professional monitoring and supervision. All child care providers need access to medical and nursing consultation. These consultants can assist child care providers in developing appropriate health practices and procedures, conducting staff training, providing emergency support, and assessing and evaluating the appropriateness of a child's placement in a child care facility. This consultation may be available through the local health department, the state's program for Children with Special Health Care needs, or the state's child care system. If it is not, those responsible for systems development in health and child care should work together to ensure that child care providers have access to appropriate medical and nursing resources. Currently, this model of collaboration is being successfully implemented in the state of Colorado.

Lack of a Statewide Coordinated Structure to Ensure Safe, Quality Care for Children with Special Health Care Needs

Lastly, and perhaps most importantly, is the lack of a statewide, coordinated system which ensures safe, quality care for children. Currently many of the basic elements that are needed to ensure quality child care for children with special health care needs are missing. These missing pieces may include lack of state regulations which support inclusion, lack of a statewide system to provide health-related training and consultation, and lack of a statewide system for data collection that could facilitate monitoring and evaluating critical health and safety indicators for children with special health care needs in child care environments.

The goal is to create a response at all levels which will move us toward the assurance of safe, quality care for all children inclusive of those children who bring more significant health care needs.

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ENSURING QUALITY CARE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Critical elements that support quality in a state or community system of child care for children with special health care needs or disabilities include:

1. Utilization of national or state standards and processes for accreditation such as those proposed by the National Academy of Early Childhood Programs

2. State regulations which promote and protect the health and safety of each child and do not categorically exclude any child

3. A structure such as an interagency council which promotes formal interagency collaboration and communication. This council should include parents, child care providers, representatives from state programs (such as Early Intervention, Public Health, Maternal and Child Health, and Children with Special Health Care Needs) and health care providers (physicians, nurses, therapists, social workers, and nutritionists) who have expertise in the general care of children as well as children with special health care needs or disabilities.

4. A Nurse Practice Act which protects children from harm and supports delegation within a framework of assessment, planning, training, monitoring, and evaluation

5. Statewide or local systems of health consultation from expert clinicians knowledgeable about health and developmental needs of children with special health care needs or disabilities, state or local child care regulations, the National Health and Safety Performance Standards (APHA and AAP, 1992), nurse practice acts, and resources for children with special health care needs or disabilities

6. A statewide or local system of emergency medical back-up and support

7. A statewide or local system for training and technical assistance for child care providers to care for children with special health care needs which includes qualified trainers, accessible resources, and materials. (See the partial list of training resources at the end of this document.)

8. A statewide or local system for monitoring and evaluation to ensure that child care facilities providing services to children with special health care needs or disabilities are meeting standards and providing safe care to this population of children

Just as there are critical elements that must be a part of a quality statewide or community child care system, there are equally critical elements that must be present to support quality care giving in family child care homes and child care and developmental programs. These elements include:

1. A knowledgeable, capable administrator who is supportive of including children with diverse needs

2. Staff who are sensitive to the needs of children and open to learning about how to care for children with special health care needs or disabilities

3. Adequate facilities which are free of safety hazards or architectural barriers

4. Adequate staffing

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5. Adequate staff orientation and training (See Appendix B for recommended core content of health and safety training in California.)

6. Accessible, available health consultation and supervision

7. Available resources (financial or other) to secure necessary adaptations/modifications for accommodations of individual children's needs

8. Adequate community-based resources for emergency care and ongoing support of children with special health care needs or disabilities in the child care environment

9. Memoranda of Agreement with supportive agencies such as the health department, home health agencies, or early intervention providers/programs

10. A representative family advisory group which provides formal input into the development of a philosophy which supports diversity and inclusion and contributes to the evaluation of the child care programs' overall operation

11. Policies and procedures which address the health and safety needs of all children. These policies and procedures must reflect best practices and be in compliance with regulations from the Occupational Safety and Health Administration (OSHA), Center for Disease Control (CDC), relevant state statutes, and other national standards or guidelines. Examples include policy and procedures related to:

    - Immunizations (children and staff)
    - Infection Control (hand washing, universal precautions)
    - Diapering/toileting
    - Feeding
    - Cleaning toys and equipment
    - Management of disasters such as fire, floods, earthquakes, tornado
    - Management of minor illness, major illness, and emergencies (children and staff)
    - Management of children with ongoing health problems
    - Safety of pregnant workers
    - Management of minor accidents, major accidents, and emergencies (children and staff)
    - Accident prevention
    - Informed consent for release of or request for information

12. Written policies and procedures relating specifically to children with special health care needs

13. A written training plan which addresses what training is provided, to whom, and how the competency of child care providers is evaluated

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14. A written quality assurance plan which identifies how the quality of child care is evaluated and by whom

15. References which describe community resources for children and families

WHAT WE CAN DO TO MAKE A DIFFERENCE

Collaborating to Impact Change at the Programmatic, Community, and State Levels

Many issues must be simultaneously addressed. The system that is needed will take time to develop. However, key stake holders in communities and at the federal and state levels must continue working to build a child care system that is safe for all children. These stake holders include 1) families of children with special health care needs or disabilities, 2) those responsible for developing and monitoring state child care regulations, 3) child care providers in public and private sectors, 4) public health care providers (to include representatives from local, state, or federal Maternal & Child Health, and Children with Special Health Care Needs Programs), 5) the American Academy of Pediatrics through their state or local affiliates, 6) the American Nurses Association through their state affiliates, 7) representatives from the State Board of Nursing, 8) representatives from University Affiliated Programs, 9) representatives from state Department Disabilities Councils, and 10) representatives from children's advocacy groups.

These individuals and organizations must band together joining forces in their advocacy efforts to support change. The critical task is to strengthen the child care system so that inclusive child care options will become a reality for all children and families seeking child care in typical community settings.

In the meantime, our efforts must be to do what we can *safely* do to include children with exceptional health care needs in child care NOW, realizing the system is far from perfect and we may not be able to safely accommodate every child immediately. By closely following the guidelines set forth in the ADA for determination of service on a case by case basis, families and providers will be able to assess both the needs of individual children and the capacities of a program to meet a child's exceptional health care needs.

IMPLEMENTING BEST PRACTICES

Quality child care for all children, including those with special health care needs, should be family-centered, appropriately linked and coordinated at the community level (with state and local resources and providers), and supportive of the safety, health and development of all children. Best practices for each of these components follow:

Family-Centered Child Care

Developing a partnership with the child's family is the first step in providing child care to any child including those with special health care needs. We need to "come to know" the child and family through their eyes. What are their priorities, needs, concerns, and resources? What have they experienced in the past? What do they hope to experience in the future? What are their expectations for child care?

Families of children with special health care needs or disabilities want to be treated like any other family—with respect, understanding, and honesty. They want the opportunity to make an informed choice about what is best for their child and family. It is important to acknowledge that families are the experts about their child's needs and care, and that they are an invaluable resource and source of information.

Maintaining the confidentially of children and families served in child care settings is an important component of family-centered care and a legal obligation. A written authorization (release of information) is required to release or obtain information. Usually the release is time-limited, specifies what information can be shared or requested, and states to whom the information may be released. This release of information must be signed by a child's parent (with legal custody) or legal guardian (California Civil Code Section 56.11). Care givers should never disclose or discuss personal information regarding children or their families with any unauthorized personnel. Only staff to whom parents have authorized release of information because they have a "need to know" in order to provide care should have access to specific information about a child's health and developmental needs. It is important to note that sharing medical information including information about AIDS or HIV infection is prohibited by law unless an explicit release is first obtained. (See Appendix C for an example of a release of information form.)

Family-centered care also includes providing culturally competent services. Care providers must develop sensitivity to the values, beliefs, behaviors, customs, styles of parenting, communicating, and coping of individuals and families from various cultures. Recognizing one's own cultural values and beliefs is an important first step in developing cultural sensitivity.

Best Practices in Family-Centered Care for Child Care Providers

- Recognize the family is the expert about their child.
- Obtain a view of the whole child in the context of his or her family, culture, language, strengths, and weaknesses. Discuss with the family any exceptional care giving needs their child may have.
- Obtain the family's vision of what they are looking for in a child care setting and what they believe their child needs in this environment.
- Discuss honestly and realistically the strengths and limitations of the program in relationship to what the family is looking for and the individual needs of their child.
- Brainstorm together any accommodations that may be necessary in order to make the enrollment a success for the child.
- Identify with the family any other individuals or agencies who may be of assistance in coordinating services or accessing resources.
- Collaborate with the family, other community resources, and staff members to coordinate any necessary accommodations. Work together seeking solutions to challenges and barriers. Work towards a mutual determination of whether or not the child care home or program is prepared to safely and appropriately meet the child's exceptional care giving needs.
- Upon determination of enrollment, develop an action plan together to prepare for the child's entry. At a minimum the action plan should include:
  - Obtaining an appropriate and properly signed release of information form (see Appendix C)
  - Obtaining needed health or developmental information (to include immunization status) from other providers such as the child's physician or therapist

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- Obtaining any needed health consultation from the child's physician, other health professionals providing services to the child and family, and/or the facility's nurse
- Identifying any needed adaptations or modifications to the physical environment
- Identifying any needed auxiliary aids and services to ensure effective communication with children who have disabilities affecting hearing, vision or speech
- Developing a plan, with the family and other helpful service providers who are working with the child and family, that addresses health and developmental needs, activities of daily living, family support, and emergency actions
- Providing staff training as needed
- Discussing with the family the preparation and transition of their child into the new child care setting
- Discussing with the family (and child if appropriate) their specific preferences in regards to what and how information is shared about their child's exceptional needs with other children and their families. Parents or legal guardians should also be asked what information they do or do not wish to be shared about their child with other family members, staff, volunteers, and/or outside agency personnel who may come into contact with their child.
- Developing a mutual agreement for the process of on-going communication and problem solving, continued coordination of services with outside agency personnel, and the evaluation of how well the accommodations are successfully meeting the child's needs

Child Care Linked and Coordinated at the Community Level

Children with special health and developmental needs and their families may often need additional services and resources beyond what the child care facility can provide. During the initial assessment it is essential to determine who is involved in the child's care and what community resources and services the family is currently using. Remember, child care providers are very important members of the child's interdisciplinary team!

Many young children with special health and developmental needs may be receiving or be eligible to receive services through their statewide early intervention system. Every child care director and teacher must become knowledgeable about the services and resources available through Part H and Part B of the Individuals with Disabilities Education Act (IDEA). Evaluation, assessment, therapy, nursing care, care coordination, adaptive equipment to include technology, and transportation, are only a few of the services available to eligible children. Children with certain disabilities, such as Cerebral Palsy and Down Syndrome are often automatically eligible for services. If the child (birth to 3) is eligible for services under IDEA, an Individualized Family Services Plan (IFSP) will be developed in collaboration with the child's health and education providers, and should include their child care provider. Services that are identified on the IFSP must be provided and a funding source found. Children, age three through five, who are eligible for public support through the Department of Education will have an Individual Education Plan (IEP) developed. Children who are eligible for public services through the Department of Developmental Disabilities will have their services provided through the development of an Individual Program Plan (IPP). In any case, it may be possible that a child could receive services or resources in the child care environment that are publicly supported.

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If the child is not eligible for early intervention services, it is even more important to assess if the family has access to and is using community resources. Who is the child's primary physician? Are there medical specialists involved? Does the child receive therapy or need therapy? Does the child and family have needed adaptive equipment or supplies? Do they have the needed financial resources to obtain medical care, food, housing, transportation? If not, is the child and/or family eligible for financial assistance through such programs as Medicaid, SSI (Supplemental Security Income Program), the state's Children with Special Health Care Needs Program (in California this program is known as Children's Medical Services, which includes California Children's Services (CCS) and Child Health and Disability Prevention (CHDP)), subsidized child care, housing, food stamps or WIC (Women's, Infant's, and Children's Supplemental Nutrition Program)?

Child care centers should display brochures and other information about the services and resources available in their community and state. These brochures may be available through child care resource and referral services. Every county in California and most others states has resource and referral services. These brochures or printed information should also be available in the primary languages of the families served. In addition, it is important for child care providers to know that every state has a Central Directory of Services maintained by the state's Early Intervention Program. Child care providers should have access to an up-to-date copy of the Central Directory or access to information about statewide resources and services stored in a centralized data bank.

Best Practices Supportive of Coordinated, Community-Based Care

- Participate actively in community efforts designed to coordinate and link with children's services, resources, and providers such as interagency councils and local child care planning councils required by federal child care and development block grant funding.

- Collaborate with agencies and providers involved in providing services to children with special health care needs or disabilities.

- Become knowledgeable about the services and resources available through Part H and Part B of IDEA, Head Start, Public Health, state Children with Special Health Care Needs (CSHCN) programs, and other state and local services and resources.

- Distribute information about resources that can be helpful to all families including families of children with disabilities.

- Develop a plan of care in collaboration with the other significant individuals in the child's life. This plan should identify the child's needs, the parent's priorities, and the services and resources needed as well as how, when and where they will be provided. Expectations of the child care center and child care providers should be included. If the child is receiving services through their CSHCN (Children with Special Health Care Needs) program or the state's Early Intervention system, a plan of care will have been initiated.

Child Care Supportive of Safety

Accidents are the leading cause of death in children at all ages. Child care providers should develop a general safety program based on recommendations from *Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs* (APHA, AAP, 1992), and expert knowledge of growth and development.

This publication outlines safety standards for all child care facilities and key elements of a safety plan for all children. They recommend that child care staff providing direct care become certified in pediatric first aid to include rescue breathing and first aid for choking. Those

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providing care to children with special health care needs should also be certified in infant and child CPR. (Recommended core content of health and safety training mandated in California's Assembly Bill 243 is included in Appendix B.)

Some children with special health care needs should have additional safety measures instituted. The child's medical diagnosis, adaptive equipment needs, strength, balance, coordination, and developmental age, as well as the general environment of the child care center must be carefully assessed. For example, children with tracheostomies should be protected from all substances which can be inhaled directly into the lungs. Glitter is particularly harmful. Children with diabetes need protection from sweets that may accompany other children to school for birthday parties or other celebrations. Children who are allergic to certain foods, pets, or environmental agents, will need to have their environment carefully monitored. For example, children with asthma, cystic fibrosis, or other chronic respiratory problems must be protected from secondary smoke. In addition, children with uncontrolled seizure disorders may need protection from falls. Playground equipment may be particularly hazardous. (Selected safety-related information can be found in Appendix D.)

Unfortunately children with special health care needs or disabilities are not immune to child abuse and neglect. In fact, because of their increased demands and needs as well as increased levels of family stress, their risk status is increased. Medical neglect can occur when a family denies the seriousness of their child's health problems or lacks the resources to obtain or pay for health care. Child care providers should be alert for signs and symptoms of abuse or neglect.

There are many excellent training resources for child care providers that provide information about common causes of accidents, developmental considerations, preventive measures, care of children needing emergency first aid, and detecting and reporting child abuse. (See "resources" section at the end of this document.) It is highly recommended that child care facilities utilize available training and information resources to enhance staff awareness and reduce the risk of accidents.

Safety issues should be discussed during the pre-enrollment conference with parents of children with special health care needs or disabilities. Request that the parents tour the facility, including the outside play area, to identify potential hazards and recommend approaches to reduce risks. In addition, consultation from the child's physician or therapist and the facility's nurse or consulting nurse may be essential. A safety plan for the individual child must be developed and all staff providing care for the child with special health care needs should be familiar with the child's safety plan. This plan should also address safety issues while on outings and field trips and should be periodically reviewed to ensure that it is appropriately updated in response to developmental and health status changes.

Best Practices Supportive of Safety

Each child care facility will comply with their state licensing regulations pertaining to health and safety and those outlined in the *National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs* (APHA, AAP, 1992). Each child care facility should have in place:

- An emergency plan and policies, procedures and training to cover emergencies such as fire, earthquake, or other natural disasters. This plan and training should address how children with special health care needs or disabilities will be safely managed in the event of an emergency.

- Written policies and procedures relating to accident prevention. Examples include equipment standards, maintenance and inspection; environmental safety; safe, appropriate toys for children based on developmental and health status; and emergency procedures.

- Periodic training for child care workers relating to safety issues and accident prevention.

- A general transportation plan and an emergency transportation plan. Some children with special health care needs may require special adaptive car seats or appropriate space and equipment to secure their wheelchairs.

- An emergency care plan for each child. This plan, at a minimum, would include emergency telephone numbers of parents and physician. The emergency plan for children with special health care needs should include immediate management and treatment of potential emergencies related to the child's health condition, as well as when, how, and where to transport the child to a medical treatment facility. Collaboration with the Emergency Medical System (EMS) is essential. (See Appendix E for a sample.)

- Staff competent to assess an injury, provide basic first aid and CPR, and to know when to activate the Emergency Medical System (EMS).

- Consultants who can recommend environmental adaptations that will enhance the safety of all children to include children with special health care needs or disabilities. Rating scales such as the Infant/Toddler Environment Rating Scale (Harms, Cryer & Clifford, 1990) should be used to ensure a through environmental assessment.

- Periodic training regarding signs and symptoms of child abuse and neglect as well as reporting procedures.

- An incident accident and injury report form. Three copies should be made; one for the parent, one for the child's folder, and one for the facility's central injury report file. (An example can be found in Appendix E.)

- An injury log maintained with specific information about the date and time of each accident, who was involved, what happened, first aid provided, who was notified, follow-up care, and measures that should be taken to prevent a similar accident from occurring in the future.

Health Supportive Child Care

Every child care facility should provide a health supportive environment to all children. Careful attention should be given to health, hygiene, oral care, nutrition, sleep/rest, toileting, activity, play, and communication. These activities of daily living which support health may need to be adapted for children with special health care needs. Families, physicians, and knowledgeable health consultants can provide child care staff with needed information. A very brief overview of the components of a health supportive environment with selected examples are provided here.

Health Promotion. Promoting and maintaining health is important for all children. It is essential that all children have a health record which includes their health and developmental history, screening and assessment results, immunization status, health and safety care plan, emergency care plan, and relevant injury, illness, and medication reports. In addition, health promotion is an important component of the child care curriculum and milieu. Health promotion activities can include learning the value of eating healthy foods, exercise, and play, and good hygiene practices to include hand washing and oral care.

Best Practices for Health Promotion

- Develop a system for maintaining complete, up-to-date information.

- Use posters, books, games, and audiovisuals creatively.

- Incorporate health promotion into the child care curriculum in a developmentally appropriate manner.

- Encourage staff to be "perfect" role models.

Hygiene. Young children must be taught good hygiene practices and developmentally appropriate self-care skills. Important components of a health-supportive child care milieu include teaching young children to practice keeping dirty hands out of the mouth, nose, eyes, and ears; wash hands after toileting, after playing outside, and before eating; brush, floss, and rinse; prevent the spread of germs by covering the mouth when coughing; use and properly dispose of tissues; care for their own bumps, scrapes, and blood; and, not touch blood from others. The local health department, public library, or child care resource and referral service often have excellent developmentally appropriate posters, pamphlets, books, and audiovisuals that can introduce and reinforce these concepts. Of course, there is no substitute for good role models, continuous reminders, and positive reinforcement from child care providers.

Some children with special health care needs or disabilities may need adaptations to customary hygiene practices. For example, children with some physical disabilities may need assistance with hand washing. Others may have problems with managing secretions. Oral care can be a special challenge. For example, a frequently prescribed medication for seizure disorders often causes the development of excessive gum tissue which makes good oral hygiene even more important. Some children may have an over-reactive biting reflex which makes brushing the teeth more difficult.

Best Practices for Good Hygiene

- Ask families how hygiene is managed at home, what special assistance the child may need, and what is helpful for a particular child.

- Encourage self-care to the greatest extent possible. Try never to do for a child what he or she can do for him or herself, even if more time is required to complete the task.

- Monitor the effectiveness of each child's hygiene practices.

- Provide positive reinforcement for self-care and self-sufficiency.

- Make hygiene practices a scheduled activity in planning your day.

- Be a positive role model.

Nutrition and Feeding. Good nutrition is important for all children. It is true—you are what you eat! Appropriate amounts of food and fluids are essential to good health and growth. During the first year of life, infants need 90 to 120 calories per kilogram (Kcal) of body weight. Between 12 and 36 months of age toddlers need approximately 90 calories per kilogram, while pre-schoolers and school-aged children need between 1800 and 2100 Kcal per day. Children who have feeding problems often do not ingest adequate calories and food nutrients. Every bite must count! Child care providers should not sacrifice quality nutrition for the developmental goal of self-feeding. Some children with special needs will require assistance with feeding for a much longer period of time than children who are not nutritionally compromised.

Children with special health care needs or disabilities may have nutritional deficits, feeding problems, or require special dietary modifications. For example, children with cystic fibrosis must have special enzymes with their meals to promote digestion. Children with cerebral palsy may have problems with sucking, chewing, or swallowing, and they may be at risk for choking or aspirating. Other children with severe feeding problems may need to be fed through a gastrostomy tube. California's Nurse Practice Act supports delegation of gastrostomy tube

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feedings by non-medical professionals after the site (where the tube is inserted) has healed. Child care providers will need specific training by the child's parents and a nurse to ensure proper technique and to learn what to do if the gastrostomy tube becomes dislodged. Children who need nasogastric tube feedings or have problems with reflux and aspiration from their feedings will require a registered nurse to assist with feeding and ongoing evaluation for serious or life-threatening complications resulting from feeding.

It is important to note that young children with special health care needs can be more vulnerable to dehydration resulting from vomiting and diarrhea. Signs of dehydration that should be referred for immediate medical evaluation include:

- Decreased urine output along with dark color and strong odor
- Absence of tears
- Sunken eyes
- Sunken fontannel
- Changes in behavior such as becoming listless, drowsy, and confused

Best Practices for Nutrition and Feeding

- Obtain a written nutrition and feeding history from the child's family and physician and develop a specific feeding and nutrition plan. (Examples can be found in Appendix F.)
- Consult a nutritionist, occupational therapist, or nurse to develop the plan and train child care staff to feed a particular child if needed.
- Maintain an intake and output record on all children who are at risk for food or fluid deficits including those with vomiting, diarrhea, and constipation. (See Appendix F.)
- Ask family members who are responsible for feeding the child to demonstrate any special techniques and/or tips they use.
- Keep in close communication with the family and other professionals. Discuss immediately any concerns that may arise.

Sleep and Rest. All children need adequate sleep and rest to promote health and maintain energy for playing and learning. Young infants require frequent naps with increasing periods of awake time. By one year of age many infants take only one afternoon nap per day. All children have problems sleeping if they are overly tired or overly stimulated prior to nap time or bedtime.

Some children with special health care needs will require adaptation of their sleep/rest schedule or sleep/rest environment. For example, infants who were born prematurely may need to be monitored for apnea (not breathing) while asleep. Infants at risk for sleep apnea often sleep with an apnea monitor which alerts their caretaker if the child's breathing slows down or stops. Some children, such as those with a generalized seizure disorder, may need to sleep or rest following a seizure. Other children may have problems getting enough sleep or rest. Children with asthma sometimes have disrupted sleep patterns related to their medication regime. Children who have attention deficit disorder with hyperactivity may have problems settling down for a nap in a group situation.

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Best Practices for Sleep and Rest

- Obtain a thorough sleep/rest history from the families of children with special health care needs or disabilities.
  - How much sleep or rest does this child need?
  - Are there special adaptations that should be made that are related to the child's health or individual needs?
  - What helps the child go to sleep?
  - Are there times when the child might require more or less sleep?
  - Is the child receiving medications that have side effects which may interrupt normal sleep patterns?
- Maintain the flexibility to adapt space and staff to accommodate the needs of a child for additional sleep/rest.

Toileting. Diapering, toileting, and toilet training are needs of all infants and young children. It is essential that child care providers maintain the very highest standards for these activities to promote health, prevent disease, and maintain the self-esteem of all children. Recommendations from *Caring For Our Children, the National Health and Safety Standards* (APHA and AAP, 1992) can be found in Appendix G.

Some children with special health care needs or disabilities may need adaptations to customary diapering, toileting, or toilet training procedures. For example, most children with Spina Bifida do not completely empty their bladder when they urinate, which makes them susceptible to urinary tract infections and even kidney damage. Because of this health problem, they may need to be routinely catheterized. Catheterization is considered an invasive procedure, therefore, child care providers must always consult with the child's parents, physician, *and a nurse* to ensure that this procedure is safely performed and in compliance with the state's child care regulations and Nurse Practice Act. Also, it is essential to know that children with Spina Bifida are often allergic to latex and can have fatal allergic reactions. Therefore, latex gloves should not be used for this procedure. Latex-free gloves can be obtained from a medical supply store. Child care providers should know that children who have difficulty in emptying their bladder often develop urinary tract infections. Symptoms include foul-smelling, thick, cloudy urine, crying when urinating, loss of appetite, irritability, and distended abdomen. These symptoms should be reported to parents who must follow-up with their child's health care provider.

Other children may have problems with bowel elimination requiring a colostomy or ileostomy. Child care staff will need to learn how to change bags and provide special stoma and skin care. To acquire these skills, consultation, and training from family members and a nurse is essential.

Certain medications or health problems can cause either diarrhea or constipation. Diarrhea is an increase in the frequency, volume, and fluid content of bowel movements. Frequent watery stools can lead to severe dehydration. Constipation is described as infrequent or difficult bowel movements which usually produce hard, dry stool. Mild constipation can usually be treated with dietary modification such as increased fiber and fluids. Severe constipation should be followed by the child's pediatrician. It can be a symptom of underlying disease which should be identified and treated. If no underlying cause is identified, medically prescribed stool softeners, suppositories, bulking agents, or enemas may be prescribed. If constipation or diarrhea is a concern, child care providers should monitor intake and output with a written intake and output record (see Appendix F).

Many children with special health or developmental needs may need to have adaptations to toilet training schedules due to physiological or developmental alterations. The book, *Handling the Young Cerebral Palsied Child at Home* (Finnie, 1975) has excellent information related to adaptive toileting equipment. Toilet training should not be initiated until the child and parents are ready to begin and a plan is established which promotes consistency between what is done at home and in the child care center.

Best Practices Relating to Toileting

- Obtain a complete history which identifies special needs and concerns relating to elimination. Examples of questions to ask include:
  - What is the child's "normal" elimination pattern? How often? How much? What is the usual color, consistency, odor?
  - Are there changes that should be reported to the child's parents and how urgent is the reporting need?
  - Does the child need to have intake and output recorded?
  - Are any special adaptations needed? (Examples include more frequent toileting, special skin care, catheterization, colostomy or ileostomy care, or special adaptive equipment to maintain sitting balance while on the toilet.)
- Obtain consultation from the child's physician and a registered nurse if the child requires catheterization or has an "ostomy" to promote bowel or urinary elimination.
- Monitor all children for signs and symptoms of vomiting, diarrhea, constipation, urinary tract infections, and dehydration and discuss with parents.
- Develop a plan of care, institute appropriate staff training, and ensure ongoing supervision and evaluation by appropriate health professionals.
- Always use appropriate hand washing techniques and universal precautions. (See Appendix G and Appendix J.)

Activity and Play. Children with special health care needs or disabilities have the same needs for activity and play as other children. Some children may need special adaptive equipment to enhance their mobility. Child care workers may need to learn how to apply and remove braces (orthoses), observe for and prevent skin breakdown, or adapt the environment for children who use crutches, walkers, or wheelchairs (see Project EXCEPTIONAL text, "Caring for Young Children Who Have Physical Disabilities" for more specific recommendations). Many children with casts can be safely cared for in the child care environment. If the child's physician recommends that the child with a cast return to child care, the staff must learn how to safely move and position the child, assist with toileting to prevent soiling, and be able to recognize signs and symptoms associated with a cast that is too tight. Consultation from the child's family and the facility's nurse or nurse consultant is essential.

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Best Practices for Activity/Play

- Obtain information of a child's play and activity levels from the family Questions could include:
    - What does the child enjoy doing most?
    - What is most difficult or frustrating for the child?
    - Is special adaptive equipment needed to promote mobility?
    - Are environmental adaptations needed to promote activity, play, and peer acceptance? For example, does cold weather trigger asthma?
- Obtain appropriate consultation from a nurse, physical or occupational therapist, or special education staff member.
- Plan activities and adapt the environment to promote participation and peer acceptance.
- Provide staff training as needed.

Communication. Communication is essential for all children and is necessary for learning and interactions with others (family members, playmates, and staff). Some special health care needs or disabilities can interfere with the development of communication. For example, children who have a hearing loss may have delayed development of speech. Children who are born with profound congenital deafness may not develop speech but rely on sign language or "total" communication approaches. Some children with cerebral palsy may be unable to coordinate movements of the throat, mouth, and tongue and, thus, be unable to produce intelligible speech. These children often have adequate hearing and receptive language skills. A simple communication board or sophisticated computers with voice synthesizers can open the world of communication. Child care staff must accommodate the curriculum, environment, and themselves to support communication of children with speech or hearing problems.

Best Practices for Communication

- Obtain information from parents about any communication, speech or hearing problems the child may have.
- Observe all children to identify children who may have speech and language delays.
- Provide periodic speech and hearing screening to identify children who have problems.
- Include strategies in a plan of care which support each child's communication strengths and needs.
- Obtain consultation from a speech and hearing consultant as needed.
- Provide staff training as needed.

Disease Prevention

Young children are vulnerable to an array of illnesses. Their immune system is immature and their hygiene practices less than optimal. Children with disabilities and/or exceptional health care needs are often more vulnerable to disease than their peers. Therefore, child care providers must

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be vigilant in their approach to disease prevention. When a child becomes ill, often parents must miss work and other children or caregivers may also become infected. The following general practices and guidelines will reduce the risks of contacting and spreading serious illness among children, child care staff, and families.

Immunizations. Immunizations are a critical requirement for all children prior to entering child care. Written documentation should be placed in the child's health record. Immunization records must be kept updated. Vaccines are routinely given for diphtheria, pertussis, and tetanus (DPT), polio, measles, mumps and rubella, and Haemophillus influenzae. Protection against Hepatitis B is also recommended. In addition, children should be skin tested to determine if they have been exposed to tuberculosis. Consult with your local health department, consulting physician or nurse to obtain the most recent recommendations from the Center for Disease Control or American Academy of Pediatrics. Some children with special health care needs may need to have their immunization schedules adapted. A written explanation should be provided by the physician and the appropriate immunizations given as soon as possible.

Just as it is important for children to be immunized, child care staff should also have up-to-date immunizations. Adult immunizations can be provided by the health department or a private physician. Recommended immunizations include diptheria, polio, measles, mumps and rebella, tetanus, Hepatitis B, and yearly TB skin testing. Women of childbearing age who have a negative rubella or chicken pox titer should be immunized against these diseases unless they are pregnant or may become pregnant within three months.

Morning Health Check. To identify children who may be ill and/or contagious to others a morning health check should be conducted on every child daily. This should occur when the child first comes in for the day and before the parent leaves. Signs and symptoms to observe for include:

- Activity level
- Skin color
- Unusual spots or rashes
- Swelling or bruises
- Sores
- Severe coughing, sneezing
- Discharge from the nose, eyes, ears
- Problems breathing
- General mood
- Unusual behavior such as lethargy, extreme sleepiness
- Complaints of pain, nausea, vomiting

(Appendix H provides guidelines to identify acutely ill or potentially ill children who should be excluded from child care, as well as guidelines for exclusion of staff who are ill.)

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Some children with special health care needs are at risk for serious complications from common childhood diseases or illnesses. Examples of vulnerable children include:

- Children whose immune systems are suppressed by disease or drugs.
- Children whose lungs have been damaged as a result of prematurity.
- Some children who were born with a genetic syndrome such as Down Syndrome.
- Children with severe asthma.

Prior to entry into the child care program, the child's physician and parents should alert staff to potential problems. For example, chicken pox can be life-threatening for a child whose immune system is suppressed. Procedures should be developed to notify the parents of possible exposure to any infectious diseases. (See Appendix I for guidelines for notification of parents.)

In addition children with special health care needs may need to be observed for more specific signs, symptoms or behaviors and/or need a focused observational check more than once a day. The child's parents, physician, and the child care health consultant can identify what should be checked and how often. For example, children who have seizures may exhibit pre-seizure behaviors that could help identify the potential onset of a seizure. Children who are diabetic often exhibit certain behaviors when their blood sugar is too low. A glass of orange juice could prevent a serious episode of hypoglycemia.

Hand washing. *The single most important measure that care takers can take to prevent illness in child care centers is to wash their hands and children's hands often!* Hands should be washed:

- Before and after eating or handling food
- Before and after feeding a child
- After diapering and toileting
- After handling body secretions
- Before and after giving medications
- Before and after any health procedure
- After handling pets or being outdoors
- After removing and disposing of gloves

Universal Precautions. Universal precautions are designed to prevent exposure to blood and blood-containing body fluids. Staff should wear gloves if there is contact or potential contact with blood or blood-containing body fluids or tissue discharges. Spills of body fluids (urine, feces, blood, saliva, nasal discharge, eye discharge, injury or tissue discharges) must be cleaned up immediately with a solution of chlorine bleach and water (1/4 cup of bleach to 1 gallon of water or 1 tablespoon of chlorine bleach to 1 quart of water).

If blood is present or the caretaker has cuts or open sores on his or her hands, gloves should be worn to protect the child care provider. Gloves should be worn for the following procedures: (Remember, children with Spina Bifida are often allergic to latex gloves.)

- Caring for bloody injuries (scraped knees or bloody nose)
- Changing diapers if there is blood in the stool or a diaper rash that oozes blood (Some child care centers recommend gloving for all diaper changes.)
- Providing mouth or eye care
- When instituting certain medical procedures
- Cleaning surfaces or any object contaminated with blood
- Cleaning up large spills of other body fluids such as urine, stool or vomit

(See Appendix J for more specific recommendations regarding universal precautions.)

Sanitation, Disinfection, and Maintenance of Toys or Objects. Toys that are placed in children's mouths or contaminated by other body secretions should be immediately taken out of use, cleaned with soap and water, disinfected (1/4 cup of bleach to 1 gallon of water or 1 tablespoon of chlorine bleach to 1 quart of water), rinsed, and air dried. Other toys and surfaces should be cleaned daily with soap and water and disinfected. Soft cloth toys are generally not recommended because they are difficult to disinfect unless they are fully washable and can be machine dried (Early childhood educators feel strongly about having softness in young children's environments.).

Protection of Pregnant Child Care Workers. Child care staff are at increased risk of exposure to infectious diseases during pregnancy. Rubella, cytomegalovirus, fifth disease, and varicella (chicken pox) present the greatest risk. However, Herpes Type II, Toxoplasmosis, Hepatitis B, and Human Immunodeficiency Virus can also infect pregnant women and damage the fetus. Pregnant child care workers should take protective measures to prevent exposure. Of greatest concern is the high incidence of cytomegalovirus in young children. The rate of congenital infection for exposed susceptible women is high (40%), and 10 to 15% of these exposures result in vision, hearing, or intellectual deficits in their live-born infants (APHA/AAP, 1992). (See Appendix K.)

Best Practices for Disease Prevention

- Ensure that all children and staff are appropriately immunized.
- Identify and protect children who are at high risk if exposed to infectious diseases.
- Conduct a systematic morning health check of children and staff. Exclude any individual who has an acute, contagious disease.
- Institute strict hand washing policies, procedures, and training.
- Institute routine environmental cleaning and sanitizing practices.
- Institute strict universal precautions policies, procedures, and training.
- Protect pregnant child care workers.

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Management of Specific Health Conditions

Many health conditions or disabilities are so mild that the child care provider would not know they were present unless the child's parents or physician told them. No modifications in the activities of daily living or treatments are required. Others require adaptations to activities of daily living as were described in the previous sections. Still other children will have temporary or long-term health problems which will require direct intervention while in the child care setting. If health fragile children are included in the child care setting, a registered nurse should be available on a part-time or full-time basis to provide assessment, develop a plan of care, provide intervention or delegate intervention to an appropriately trained and supervised child care worker (in accordance with the state's Nurse Practice Act) and evaluate the effect of care on the child's health.

Appendix L (fact sheets on specific health conditions/diseases) identifies the responsibilities of child care providers in caring for children with common chronic health problems such as asthma, epilepsy, Spina Bifida, diabetes, and sickle cell disease. This appendix also provides a sample of a Chronic Illness Health Record. Appendix M provides specific information about administration of medications.

Developmentally Supportive Child Care

Children with special health care needs or disabilities grow and develop much like other children and their basic developmental needs parallel those of other children. However, achievement of selected developmental tasks may be more difficult because of their health or developmental challenges. For example, children with health conditions which cause chronic oxygen deficit, nutritional problems or decreased liver or kidney function often do not have the same level of energy as other children to invest in achievement of their developmental tasks. In addition, tiring treatment regimes can rob a child of the energy needed to support development.

Child care workers should focus on the strengths and abilities of all children and consciously plan how to use these strengths and abilities to promote learning and development. They must also be vigilant to identify children who need formal developmental assessment, and make referrals as needed to local resources.

Infants. The major developmental tasks of infants is to develop a strong sense of trust in their care givers and to learn about their environment through sensorimotor exploration (Vessey and Caserza, 1992). Infants who have health problems may have already experienced separation, pain, intrusive procedures, bright lights, and noise. Some may be irritable, fussy, and difficult to console. These infants, as will all infants, need patient care givers who know the importance of fostering the development of trust and sensorimotor development. Creativity may be needed as well as consultation from a therapist. Adaptive equipment can be used to help the infant play while lying prone, sitting, or standing. Every effort should be made to foster the infant's development of cognitive, gross motor, fine motor, speech and language, and social skills.

Toddlers. The major developmental tasks of toddlerhood are to develop autonomy, self-control, and the capacity for symbolic representation. Prolonged dependency, immobility, lack of neurological maturity or physiological capability for toilet training can thwart achievement of these critical developmental tasks (Vessey and Caserza, 1992). Care givers should focus on promoting independence, self-care, and autonomy to the greatest extent possible. Never do for a child what he or she can learn to do for him or herself! Encourage and reward effort! Create opportunities for small victories! Celebrate every success! Children who are not able to be toilet trained at the same age as their peers could benefit from pull-ups which resemble underwear. Every effort should be made to protect the child's self-esteem and minimize feelings of embarrassment.

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Toddlers who have problems with movement or mobility might be assisted with equipment such as scooter boards, wheelchairs, or parapodiums. A toddler needs to be able to direct his or her mobility to move away from or move towards other people and the environment. The appropriateness of any piece of adaptive equipment should be determined by a child's therapist. Any health care problem that affects the development of speech and language should be identified and corrected if possible. Hearing problems from chronic ear infections can delay the development of speech and language significantly.

Pre-schoolers. Acquiring a sense of initiative to explore and understand the expanding world around them is the primary developmental task of pre-schoolers. Children with chronic illnesses or disabilities may lack the physical energy or mobility to keep up with their peers as they begin to play interactively, perfect gross motor and fine motor skills, and attempt to satisfy their never-ending curiosity. Preschoolers also engage in "magical thinking." As a result they may believe that they are being punished when they become ill or require hospitalization. Lack of energy and feelings of guilt can interfere with the development of a positive self-concept. Child care providers can adapt the environment and curriculum to support emerging initiative and reduce feelings of guilt and misunderstanding resulting from pre-operational thinking.

Best Practices for Developmentally Supportive Child Care

- Support growth and development of each child.
- Adapt the environment and/or child care practices to support achievement of core developmental tasks.
- Embrace the concept of partial participation; understanding that although not all children will be able to fully participate in developmentally age appropriate activities, they will benefit from the opportunity of being involved.
- Periodically evaluate each child's development. Are they progressing? Are delays emerging? Are previously acquired skills being lost?
- Remember there is often a direct relationship between health and development. Note and report to families small changes in behavior which may be the only early warning symptoms of deteriorating health status.
- Refer children (with parental consent) for developmental assessment and/or a thorough evaluation by their managing physician or early intervention system, if delays are suspected or manifested.

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Videotape/Manual, 30 minutes—$198, Rental—$50

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to the developmental and emotional needs of the child. Based on standards set by the Centers for Disease Control and Prevention and the American Academy of Pediatrics, the program is geared to Child Development Associate competencies and National Association for the Education of Young Children's accreditation criteria. Available from National Association for the Education of Young Children, Attn: Customer Service, 1509 16th Street, N.W., Washington, D.C. 20036-1426, (202) 328-2604, (202) 328-1846 FAX. Videotape (28 minutes)—$39

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The University of Colorado Health Sciences Center School of Nursing. (1995). *Classmates with Asthma.* Explains importance and use of nebulizers, peak flow meters and metered dose inhalers. Illustrates asthma episodes and suggests how students can help their classmates with asthma. Available from Learner Managed Designs, Inc., 647 Massachusetts Street, Suite 209, P.O. Box 747, Lawrence, KS 66044, (913) 842-9088, (913) 842-6881 FAX. Videotape (12 minutes)/Manual—$99, Rental—$50

The University of Colorado Health Sciences Center School of Nursing. (1995). *Classmates with Diabetes.* Explains what diabetes is and describes what students can do to help make their school a safe and friendly place for their classmates with diabetes. Available from Learner Managed Designs, Inc., 647 Massachusetts Street, Suite 209, P.O. Box 747, Lawrence, KS 66044, (913) 842-9088, (913) 842-6881 FAX. Videotape(12 minutes)/Manual—$99, Rental—$50

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647 Massachusetts Street, Suite 209, P.O. Box 747, Lawrence, KS 66044, (913) 842-9088, (913) 842-6881 FAX. Skill Videotape (37 minutes)/Manual/Test Packet,—$198, Skill and Evaluation Tape/Manual/Test Packet—$279, Rental—$50

The University of Colorado School of Nursing. (1995). *Care of Children with Diabetes in Child Care and School Settings.* Describes how to make a school or child care setting a safe and "friendly" place for children with diabetes. Instruction on ways to help prevent problems by monitoring the child's blood sugar level, food intake, exercise and what to do in case of a low blood sugar reaction. Available from Learner Managed Designs, Inc., 647 Massachusetts Street, Suite 209, P.O. Box 747, Lawrence, KS 66044, (913) 842-9088, (913) 842-6881 FAX. Skill Videotape (40 minutes)/Manual/Test Packet—$198, Skill and Evaluation Tape/Manual/Test Packet—$279, Rental—$50

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The University of Colorado School of Nursing. (1995). *Home Oxygen for Infants and Young Children.* Available from Learner Managed Designs, Inc., 647 Massachusetts Street, Suite 209, P.O. Box 747, Lawrence, KS 66044, (913) 842-9088, (913) 842-6881 FAX. Videotape (30 minutes)—$198 (Spanish available)

The University of Colorado School of Nursing. (1995). *Infection Control in Child Care Settings.* Available from Learner Managed Designs, Inc., 647 Massachusetts Street, Suite 209, P.O. Box 747, Lawrence, KS 66044, (913) 842-9088, (913) 842-6881 FAX. Videotape (26 minutes)—$198 (Spanish available)

The University of Colorado School of Nursing. (1995). *Nutrition for Infants and Toddlers with Special Needs.* Available from Learner Managed Designs, Inc., 647 Massachusetts Street, Suite 209, P.O. Box 747, Lawrence, KS 66044, (913) 842-9088, (913) 842-6881 FAX. Videotape (24 minutes)—$199

The University of Colorado School of Nursing. (1995). *Positioning for Infants and Young Children with Motor Problems.* Available from Learner Managed Designs, Inc., 647 Massachusetts Street, Suite 209, P.O. Box 747, Lawrence, KS 66044, (913) 842-9088, (913) 842-6881 FAX. Videotape (37 minutes)—$198

The University of Colorado School of Nursing. (1995). *Rolling Along: Children in Wheelchairs at School.* Information on caring for and assisting children in wheelchairs throughout the day in educational settings. Addresses proper positioning, including prevention of pressure sores and transferring techniques. Accessibility and psycho social issues also discussed. Available from Learner Managed Designs, Inc., 647 Massachusetts Street, Suite 209, P.O. Box 747, Lawrence, KS 66044, (913) 842-9088, (913) 842-6881 FAX. Skill Videotape (40 minutes)/Manual/Test Packet—$198, Skill and Evaluation Tapes/Manual/Test Packet—$279, Rental—$50

APPENDIX A

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SELECTED NATIONAL PARENT ORGANIZATIONS

Family Voices
Polly Arango
P.O. Box 769
Algodones, NM 87001
Phone: (505) 867-2368
FAX: (505) 867-6517

New England Serve
101 Tremont Street, Suite 812
Boston, MA 02108
Phone: (617) 574-9493
Contact: Susan Edstine
Alexa Halberg

Federation for Children with Special Needs
312 Stuart Street, 2nd Floor
Boston, MA 02116
Phone: (617) 482-2915
Contact: Betsy Anderson
(Has information about parent training and information centers through the TAPP Project.)

The Federation of Families for Children's Mental Health
1021 Prince Street
Alexandria, Virginia 22314-2971
Phone: (703) 684-7710

National MCH Clearinghouse
8201 Greensboro Drive 600
McLean, VA 22102-3810
Phone: (703) 821-8955
FAX: (703) 821-2098

United Cerebral Palsy of America
1522 K Street, NW
Washington, DC 20005
Phone: (800) 872-5827
Contact: Allan Bergman
(Prints *Washington Watch*, a weekly update on legislation, etc.)

Beach Center on Families and Disability
Betsy Santelli
3111 Haworth Hall
University of Kansas
Lawrence, KS 66045
Phone: (913) 864-7606
FAX: (913) 864-7605
(For further information about Parent to Parent groups or to find a local program in your area.)

National Parent Network on Disabilities
1600 Prince Street, Suite 115
Alexandria, VA 22314
Phone: (703) 684-6763
FAX: (703) 836-1232
Contact: Patty McGill Smith

Spina Bifida Association of America
4590 MacArthur Boulevard, NW, Suite 250
Washington, DC 20007-4226
Phone: (202) 944-3285
FAX: (202) 944-3295

APPENDIX B

ERIC

RECOMMENDED CORE CONTENT OF HEALTH AND SAFETY TRAINING FOR CHILD CARE PROVIDERS IN CALIFORNIA

Core Content that SHALL be included as part of the fifteen hours of Training:

Pediatric Cardio-Pulmonary Resuscitation (CPR) Technique (training must be by the American Heart Association, the American Red Cross or an EMSA* approved training organization):

- Emergency action principles
- Assessment
- Use of 911 emergency response system

Pediatric First Aid in Child Care (training must be by the American Red Cross or an EMSA* approved training organization)

- Patient examination and injury assessment
- Orientation and access to emergency systems
- Recognition and treatment of burns, environmental exposure, bleeding, bites and stings (insect, human, etc.), dental emergencies, diabetic emergencies, eye injuries and irritants, fainting and seizures, head and neck injuries, respiratory distress, fractures and sprains, exposure and response to toxic substances, shock management, wounds
- Assembly and use of first aid kits and supplies
- Universal precautions and personal safety
- Development of first aid action plans
- Injury reporting
- Reassuring parents and children
- Talking to children about emergencies
- Emergency action plan practice

Prevention of Infectious Disease

Preventive Health Practices

- Universal precautions
- Environmental sanitation (what, when & how) -- toys, equipment & facilities
- Hand-washing (who, when, how)
- Food handling, preparation, service, & storage
- Diapering/toileting procedures
- Air quality
- Role of the caregiver

Prevention Policies

- Staff health: policies, immunization review, OSHA requirements
- Exclusion/inclusion policies
- Exposure notice
- Reportable diseases (how, when & to whom)
- Signs of infectious disease -- mild & serious
- Immunizations: assessment for age & record keeping
- Medication administration & record keeping
- Referral for medical assistance or advise
- Community resources

Injury Prevention

- The relationship between stages of development, appropriate curriculum activities, and the risk of injury
- Enforcement of safety policies and behavior management
- Regular safety checks of indoor & outdoor environment & reporting and/or correction of problems
- Field trip & transportation safety
- Safety education for caregivers, children & parents in the following: prevention of choking, motor vehicle safety, prevention of falls, fire & burn prevention, poison prevention, water safety & weapons in the home
- Lead poisoning prevention

Core Content that MAY be offered to meet the Requirements:

Disaster Preparedness

- Overview of types of disaster -- earthquake, fire, floods, civil disobedience, etc.
- Importance of preparation -- equipment, environment, preparing children via evacuation, duck & cover drills, etc.
- Reducing potential hazards in the environment
- Community resources

Nutrition

- Age appropriate nutritional requirements & proportions
- Appropriate eating/feeding behaviors for caregivers & children
- Meal planning
- Sanitary food handling, preparation, service & storage
- Dental health

Child abuse Identification & Prevention

- Importance of early intervention
- Identifying families under stress
- Signs of abuse and neglect
- Reporting responsibilities
- Community resources
- Working with at-risk, abused or neglected children & families
- Caregiver stress & the relation to abuse issues

Children with Special Needs

- Identifying children who may have special needs
- Working with children who have special needs: adapting the environment, promoting peer acceptance & developing competence
- Working with parents
- Working with the intervention team
- Community resources
- Legislation -- American w/Disabilities Act, PL 99-457

Care of the Mildly Ill Child

(expanded information on infectious disease management)

- Differences between signs of common & serious
- Taking temperatures
- Guidelines for managing the following signs of illness: fever, nausea & vomiting, febrile convulsions, diarrhea, colds, & rashes
- Medication administration, record keeping & storage guidelines
- Separation/isolation guidelines

PREPARED BY THE CALIFORNIA CHILD CARE HEALTH PROJECT
Funded by the Maternal & Child Health Program, Federal Dept. of Health & Human Services Project #MCJ 063918-01-0

*EMSA (Emergency Medical Services Authority) has established guidelines and processes for the approval of training organizations, and can be reached at (916) 322-4336.

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APPENDIX C

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, ____ give my permission for
(parent or guardian)

____ to release to
(sending professional/agency)

____ the following information:
(receiving professional/agency)

____.
(screenings, tests, diagnoses and treatment, or recommendations)

This information will be used to plan and coordinate the care of:

Name of Child: ____

Address: ____

City: ______________________ State:_______ Zip Code: ______________

Date of Birth: ______________________

______________________________ ______________________
Parent/Guardian Signature Date

______________________________ ______________________
Witness Signature Date

This authorization is valid through: ______________________________
Date

____
Staff member to be contacted for additional information

PARENTS OR GUARDIANS SIGNING THIS DOCUMENT HAVE THE LEGAL RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION

This release conforms to the requirements of California Civil Code Section 56.11
Adapted from: Pennsylvania Chapter of the American Academy of Pediatrics (1993). *Model Child Health Care Policies.* Bryn Mawr, Penn.: Authors.

APPENDIX D

SAFETY ISSUES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS OR DISABILITIES

Accidents are the leading cause of death in children of all ages. The top five accidents which cause death in children include: auto collisions, falls, choking, suffocation, and smoke inhalation related to fires, and poisonings.

Recommended Procedures for Safe Practice

Auto Accidents

- Use appropriate restraints; i.e., seat belt or care seat.
- Ensure that children in casts have adapted restraints.
- Ensure that children in wheel chairs are properly secured with tie-downs for their chairs and safety restraints.
- Fence in outside play areas to keep children away from traffic.
- Supervise outside play.

Falls

- Never leave any young child unattended on a changing table or any other surface other than the floor, crib, or playpen.
- Keep crib rails raised.
- Use furniture and equipment with protective restraints (for example in a high chair or wagon).
- Keep windows or screens locked.
- Use gates at the top and bottom of stairs.
- Supervise children on playground equipment.
- Use adapted equipment, such as bucket swings, as needed, and monitor safety.
- "Fall-proof" the environment based on the age of the child and/or the child's disability. For example, children with orthopedic problems may slip on throw rugs or have difficulty negotiating steps safely. Children with generalized seizures may lose consciousness and fall unexpectedly. If this is a frequent event, head protection is sometimes provided by a helmet.
- Recognize children who are especially prone to an injury from a fall. These include children with "brittle bones disease", children who have recently had a cast removed, or children who are immobile.
- Know the signs and symptoms of a potential sprain, strain, or fracture, as well as first aid treatment.

Choking and Suffocation

- Avoid foods that can cause choking particularly for children under the age of three and children with disabilities who do not chew or swallow effectively. These include popcorn, peanuts, hot dogs or wieners, raw vegetables, grapes with skins, hard candy, cough drops, gum, lollipops, ice or chips.
- Avoid toys less than 1 1/2 inch in diameter. Examples include: marbles, balloons, buttons, beads, game tokens. Be cognizant of recall by toy manufacturers and recommended ages on toys.
- Do not feed an infant or a child with a disability when he/she is lying down.
- Never force food or medicine by holding the child's nose or mouth closed.
- Know how to administer emergency first aid for choking.
- Do not place an infant, or any child with lack of head control, on his or her abdomen or prop with large, soft pillows.

Fires, Smoke Inhalation, Burns

- Practice fire prevention and fire drills accommodating the special needs of children with disabilities.

- Use smoke detectors.
- Keep matches away from children.
- Do not allow the hot water temperature to exceed 110 to 120 degrees F.
- Check the temperature of food before serving or feeding.
- Cover all electrical outlets.
- Protect children from sunburn.
- Protect children who do not have sensation from extremes in heat or cold. They are vulnerable to burns from hot surfaces such as swing seats or park benches and to frostbite from lack of warm, protective clothing.

Poisoning

- Practice prevention—most poisonings involve medication (overdose), household products and plants. Keep medicines and cleaning products locked up. Keep medications in their original containers and never mix medications. Know which plants are poisonous and exclude from the child care facility (The San Diego County Consortium for the California Child Care Health Project, 1991).
- Always use products with child safety caps.
- Read labels carefully prior to using any product.
- Follow "best practices" for administration of medication. (See Appendix K.)
- Survey the environment frequently to identify and remove harmful insects, spiders, or snakes.
- Know emergency first aid for poisoning of all types to include when to induce vomiting and when vomiting is contraindicated.
- Post the telephone numbers of the poison control center.

Resources Relating to Child Abuse

National Child Safety Council	800-222-1464
Consumer Product Safety Commission	800-638-2772
ACES Association for Children for Enforcement of Support, Inc.	800-537-7072
American Humane Association, Children's Division	800-227-5242
Child Find of America, Inc.	800-426-5678
Childhelp, USA	800-422-4453
Children of the Night (hotline for runaways)	800-551-1300
Clearing House on Child Abuse and Neglect Information	800-394-3366
Committee For Children (publications and curriculum)	800-634-4449
False Memory Syndrome Foundation	800-568-8882
Family Service America	800-221-2681
KIDSRIGHTS (publications)	800-892-5437
Missing Children Help Center	800-872-5437
National Center for Missing And Exploited Children	800-843-5678
National Council On child Abuse And Family Violence	800-222-2000
National Victim's Resource Center	800-627-6872
NCCAN'S Clearinghouse on Child Abuse and Neglect Information	800-394-3366
Operation Lookout National Center for Missing Youth	800-782-7335
Vanished Children's Alliance	800-826-4743

Material adapted from:

First Start Curriculum, developed by the University of Colorado School of Nursing and published by Learner Managed Designs, Inc.

Starting Point . . . How to Open Your Program (and Your Heart) to Children With Special Needs, published by San Diego State University, Graduate School of Public Health, Maternal and Child Health Division.

Injury Prevention and Response: A Training Manual for Child Health Providers, San Diego State University, Graduate School of Public Health, Maternal and Child Health Division.

Listing of toll free numbers was compiled by Guideposts FIND (Family Information Network Database (1994),. *Toll Free Number Directory*, 39 Seminary Hill Road, Carmel, NY: Guideposts Associates, Inc.

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APPENDIX E

CHILD CARE EMERGENCY CONTACT INFORMATION

Child's Name: ______________________ Birth date: ______________

Legal Guardian #1 Name: ______________________

Telephone Numbers: Home: ______________ Work: ______________

Legal Guardian #2 Name: ______________________

Telephone Numbers: Home: ______________ Work: ______________

Emergency Contacts (to whom child may be released if guardian is unavailable):

Name #1: ______________________

Telephone Numbers: Home: ______________ Work: ______________

Name #2: ______________________

Telephone Numbers: Home: ______________ Work: ______________

Child's Usual Source of Medical Care:

Name: ______________________

Address: ______________________

Telephone Number: ______________________

Child's Health Insurance:

Name of Insurance Plan: ______________________ ID #______________

Subscriber's name (on insurance card): ______________________

Special Conditions, Disabilities, Allergies, or Medical Information for Emergency Situations:

____

Transport Arrangement in an Emergency Situation:

Ambulance service: ______________ Child will be taken to: ______________
(Parents/guardians are responsible for all emergency transportation charges)

Parent/Guardian Consent and Agreement for Emergencies:

As parent/guardian, I give consent to have my child receive first aid by facility staff, and, if necessary, be transported to receive emergency care. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed above **to act on my behalf** until I am available. I agree to review and update this information whenever a change occurs and at least every 6 months.

Date: ______________ Parent/Guardian Signature: ______________________

Date: ______________ Parent/Guardian Signature: ______________________

Pennsylvania Chapter of the American Academy of Pediatrics (1993). *Model Child Care Health Policies.* Bryn Mawr, PA: Authors.

CHILD CARE INCIDENT REPORT

Fill in all blanks and boxes that apply.

Name of Program: ______________________________ Phone: ______________

Address of Facility: ____

Child's Name: ____________________ Sex: M F Birthdate: ___/___/___ Incident Date: ___/___/___

Time of Incident: _____:_____ am/pm Witnesses: ______________________________

Parent(s) Notified By: ______________________________ Time Notified: _____:_____ am/pm

Location where incident occurred: ❑ playground ❑ classroom ❑ bathroom ❑ hall ❑ kitchen ❑ doorway
❑ large muscle room or gym ❑ office ❑ dining room ❑ stairway ❑ unknown
❑ other (specify): ______________

Equipment/product involved: ❑ climber ❑ slide ❑ swing ❑ playground surface ❑ sandbox ❑ trike/bike
❑ hand toy (specify): ______________ Other equipment (specify): ______________

Cause of injury (describe): ______________________________________
❑ fall to surface; estimated height of fall _____ feet; type of surface: ______________
❑ fall from running or tripping ❑ bitten by child ❑ motor vehicle ❑ hit or pushed by child
❑ injured by object ❑ eating or choking ❑ insect sting/bite ❑ animal bite ❑ injury from exposure to cold
❑ other (specify): ______________

Parts of body injured: ❑ eye ❑ ear ❑ nose ❑ mouth ❑ tooth ❑ other face ❑ other part of head ❑ neck
❑ arm/wrist/hand ❑ leg/ankle/foot ❑ trunk ❑ other (specify): ______________

Type of injury: ❑ cut ❑ bruise/swelling ❑ puncture ❑ scrape ❑ broken bone/dislocation ❑ sprain
❑ crushing injury ❑ burn ❑ loss of consciousness ❑ unknown ❑ other (specify): ______________

First aid given at the facility: (e.g., pressure, elevation, cold pack, washing, bandage): ______________

____

Treatment provided by: ______________________________________

❑ no doctor's or dentist's treatment required
❑ treated as an outpatient (e.g., office or emergency room)
❑ hospitalized (overnight) # of days: __________

Number of days of limited activity from this incident: _____ Follow-up plan for care of the child: ______________

____

Corrective action needed to prevent reoccurrence: ______________________________

Name of official/agency notified: ______________________________ Date: __________

______________________________ ______________
Signature of staff member Date

______________________________ ______________
Signature of parent Date

Copies: 1) child's folder, 2) parent, 3) injury log

Pennsylvania Chapter of the American Academy of Pediatrics (1993). *Model Child Care Health Policies*. Bryn Mawr, PA: Authors.

APPENDIX F

SAMPLE

NUTRITION AND FEEDING INFORMATION SHEET

Child's Name:______________________________ Date: __________________

1. Which types of foods does your child usually eat? Check all that apply:

   ___ Pureed/strained food ___ Mashed table food ___ Ground table food

   ___ Finger foods ___ Chopped table food ___ Regular table food

   ___ Thick liquids only (trouble swallowing thin liquids)

2. How often does your child need to be fed?______________________________

3. How much does your child usually eat or drink at each feeding?____________________

   ____

4. Can your child self-feed? ___ Yes ___ No

5. Is your child learning to self-feed? ___ Yes ___ No Comments: ____________

   ____

6. What "utensils" do you use to feed your child? Check all that apply:

   ___ Bottle ___ Cup ___ Spoon ___ Fork ___ Fingers

   ___ Other (explain): ____

7. Does your child have problems with chewing, swallowing, or choking? ___ Yes ___ No

8. Does your child need special assistance when eating? Please explain:______________

   ____

   Any special equipment? ____

   Special food textures?____

   Special positioning concerns when eating or drinking? ______________________

   ____

9. Is your child allergic to any foods? ___ Yes ___ No

If yes, what?____

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Please give detailed information on what the child cannot eat. (Ask for medical prescription from doctor and lists of foods.)

____

____

10. Is your child on a special diet? Please give detailed information, such as a medical prescription from a doctor.

    ____

    ____

11. Is there a dietitian who helped plan your child's diet (so you can talk to them for further information or with questions, if necessary)? ______________________________

12. Is there a feeding team specialist who works with your child (who can help with questions, training, etc.)?____

13. May I have permission to contact the doctor/dietitian/therapist to clarify any information?

    Yes___ No___ (If yes, get the consent form signed.)

Adapted from:
Project Chance, Arizona Department of Health Services, Office of Nutrition, 1740 West Adams, Phoenix, AZ 85007, (602) 542-1886.

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SAMPLE

INTAKE AND OUTPUT RECORD

Child's Name: ______________________________ Date: ______________

INTAKE			OUTPUT		
Time	Fluid	Solid	Urinary	Stool	Vomiting

Comments: ____

____

____

____

SAMPLE

GASTROSTOMY TUBE FEEDING INFORMATION SHEET

Child's Name: ______________________________ Date: ____________________

Type of Formula ____

____

Time of day ____

____

Volume (how much to feed) ____

____

Rate of flow ____

____

Special equipment needed ____

____

How long for feeding ____

____

Position of child ____

____

Who can provide specific training relating to tube feeding _______________

____

Who can provide monitoring and ongoing consultation ___________________

____

Who is trained to feed this child? _______________________________________

____

Other comments: ____

____

____

APPENDIX G

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BEST PRACTICES FOR DIAPERING

- ✦ Check all children in diapers at least hourly.
- ✦ Change immediately if soiled or wet.
- ✦ Change only in the diaper changing area which must be equipped with a sink and a waste receptacle with a foot operated lid.
- ✦ The diaper changing surface must be sturdy, adult height, and have rails and impervious, non-absorbent surfaces. (Safety straps should not be used.)
- ✦ Gloves need not be worn unless there is blood in the child's stool or urine. If gloves are worn because of center policy or personal preference, it is important to remember that gloves do not replace hand washing.
- ✦ The child's perineal area should be cleaned with disposable wipes.
- ✦ The soiled diaper should be placed in a plastic lined pedal operated trash container. (If cloth diapers are used or clothes are soiled, place in a plastic bag to go home with the child.)
- ✦ After removing a soiled diaper and before putting on a clean diaper, the child care worker should wipe their hands with a pre-moistened or damp paper towel.
- ✦ After fresh diaper has been applied, wash hands thoroughly.
- ✦ Wash the child's hands.
- ✦ Clean diaper surface with soap and water and then disinfect the diaper changing surface after every diaper change (1/4 cup of bleach to 1 gallon of water or 1 tablespoon of bleach to 1 quart of water.)

Note: For a list of general precautions for the prevention of infectious disease see "Prevention of Infectious Disease" activity handout in the "Hand to Hand" activity included in this document.

Adapted from:
American Public Health Association & American Academy of Pediatrics. (1992). *Caring For Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care.* (1992). Washington, DC: Authors, pp. 68-72.

Also recommended is the Center for Disease Control publication *What to Do to Stop Disease in Child Day Care Centers.*

HAND WASHING

The **4** most important concepts to remember about hand washing are:	**WHEN** HANDS SHOULD BE WASHED
1 You must use running water which drains out — not a stoppered sink or container. A common container of water spreads germs! **2** You must use soap, preferably liquid. **3** You must use friction (rubbing your hands together). This action removes germs. **4** You must turn off the faucet with a paper towel. The faucet is considered "dirty" at all times — if you touch it with clean hands, you will be recontaminated. (Ideally, then throw the paper towel into a lined covered trash container with a foot pedal).	**Always wash your hands upon arrival at the center, and:** • before eating or handling food • before feeding a child • after diapering and toileting • after handling body secretions (mucus, vomitus, etc.) • after cleaning • before and after giving medication (particularly eye drops/ointment, etc.) **Be sure the children's hands are washed too — especially:** • when they arrive at the center • before they eat or drink • after they use the toilet or have their diapers changed • after they've touched a child who may be sick

Adapted from:
The Mainstreaming Project, San Diego State University, Graduate School of Public Health, Maternal and Child Health Division

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APPENDIX H

GUIDELINES FOR EXCLUSION OF CHILD FROM CHILD CARE

The child with any of the following conditions should be excluded from child care:

1) **Elevated oral temperature**, 101 (degrees) or greater; rectal temperature 102 [degrees] or greater; axillary (armpit) temperature 100 (degrees) or greater; accompanied by behavior changes or other signs or symptoms of illness—until medical evaluation indicates inclusion in the facility. Oral temperature shall not be taken on children younger than 4 years (or younger than 3 years if a digital thermometer is used). Rectal temperature shall be taken only by persons with specific health training.

2) **Symptoms and signs of possible severe illness** such as unusual lethargy, uncontrolled coughing, irritability, persistent crying, difficult breathing, wheezing, skin color, or other unusual signs`—until medical evaluation allows inclusion.

3) **Uncontrolled diarrhea**, that is, increased number of stools, increased stool water, and/or decreased form that is not contained by the diaper—until diarrhea stops.

4) **Vomiting illness** (two or more episodes of vomiting in the previous 24 hours) until vomiting resolves or until a health care provider determines the illness to be non communicable, and the child is not in danger of dehydration.

5) **Mouth sores with drooling**, unless a health care provider or health official determines the condition is non-infectious.

6) **Rash with fever or behavior change**, until a health care provider determines that these symptoms do not indicate a communicable disease.

7) **Purulent conjunctivitis** (defined as "pink eye"), until 24 hours after treatment has been initiated.

8) **Scabies, head lice, or other infestation**, until 24 hours after treatment has been initiated.

9) **Tuberculosis**, until a health care provider or health official states that the child can attend child care.

10) **Impetigo**, until 24 hours after treatment has been initiated.

11) **Strep throat or other streptococcal infection**, until 24 hours after initial antibiotic treatment and cessation of fever.

12) **Chicken pox**, until six days after onset of rash or until all sores have dried and crusted.

13) **Exposure to pertussis**, until five days of appropriate antibiotic treatment (currently, erythromycin) to prevent an infection have been completed.

14) **Mumps**, until nine days after onset of parotid gland swelling.

15) **Hepatitis A virus**, until one week after onset of illness or as directed by the health department when passive immunoprophylaxis (currently, immune serum globulin) has been administered to appropriate children and staff.

16) **Measles**, until six days after onset of rash.

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17) **Rubella,** until six days after onset of rash.

18) **Unspecified respiratory illness** if the illness affects the child's participation and/or results in a need for greater care than can be provided by the staff without compromising the health and safety of other children.

19) **Shingles,** upon recommendation of the child's health care provider or if the skin lesions cannot be kept covered by clothing or a dressing, until they have crusted.

20) **Herpetic gingivostomatitis,** until the lesion has healed unless the child has very mild disease and good control of oral secretions and permission of their health care provider.

Adapted from:
The American Public Health Association and the American Academy of Pediatrics,, (1992). *Caring For Our Children, The National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*, Washington, D.C.: Authors. pp. 81-84, 212, 223.

GUIDELINES FOR EXCLUSION OF STAFF FROM CHILD CARE

(Please note that if a staff member has no contact with the children, or anything the children come into contact with, these standards do not apply to that member.)

A facility shall not deny admission to or send home a staff member or substitute with illness unless one or more of the following conditions exist. The staff member shall be excluded as follows:

1) **Chicken pox**, until six days after onset of rash or until all sores have dried and crusted over.

2) **Shingles**, only if the sores cannot be covered by clothing or a dressing until the sores have crusted.

3) **Rash with fever or joint pain**, until diagnosed not to be measles or rubella.

4) **Measles or rubella**, until five days after rash onset.

5) **Diarrheal illness**, three or more episodes of diarrhea during the previous 24 hours, until diarrhea resolves.

6) **Vomiting illness**, two or more episodes of vomiting during the previous 24 hours, until vomiting resolves or is determined to be due to such noncommunicable conditions as pregnancy or a digestive disorder.

7) **Hepatitis A virus**, for one week after onset or as directed by the health department when immunoglobulin has been given to appropriate children and staff in the facility.

8) **Pertussis**, until after five days of antibiotic therapy.

9) **Skin infection** (e.g., impetigo), until 24 hours after treatment has been initiated.

10) **Tuberculosis**, until noninfectious or as determined by a health care provider or health official.

11) **Strep throat or other streptococcal infection**, until 24 hours after initial antibiotic treatment and cessation of fever.

12) **Scabies, head lice, or other infestation**, until 24 hours after treatment has been initiated.

13) **Purulent conjunctivitis**, until 24 hours after treatment has been initiated.

14) **Haemophilus influenzae** type b (Hib), as determined by a health care provider or health official.

15) **Meningococcal infection**, as determined by a health care provider or health official.

16) **Respiratory illness**, as determined by a health care provider or health official.

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During the course of an identified outbreak of any communicable illness in the out-of-home child care setting, a staff member may be excluded if the health department or health consultant determines that he/she is contributing to the transmission of the illness at the facility. The staff member may be readmitted when the health department determines that the risk of transmission is no longer present.

Adapted from:
The American Public Health Association and the American Academy of Pediatrics (1992). *Caring For Our Children, The National Health and Safety Performance Standards: Guidelines for Out-of-home Child Care Programs*. Washington, D.C.: Authors, pp. 84-86.

ERIC

APPENDIX I

ERIC

NOTIFICATION TO PARENTS ABOUT EXPOSURE OF CHILDREN TO A COMMUNICABLE DISEASE

In order to effectively control and prevent the occurrence of communicable diseases in the child care setting, it is important to notify parents whenever their children have been exposed to a communicable disease which has been diagnosed by a physician.

The child care facility should consult with the facility's health consultant or the responsible local Public Health Department authority regarding notification of parents about exposure of their child to a communicable disease.

When notification is recommended, it should be oral or written and should include the following information:

1. The disease to which the child was exposed, and whether there is one case or an outbreak.
2. Signs and symptoms of the disease that the parent should watch for in the child.
3. Period of communicability.
4. Disease-prevention measures recommended by the Public Health Department, if needed.
5. Control measures implemented at the facility.
6. California child care regulations contain a list of diseases that should be reported to your local Health Department.

Please refer to the manuals and textbooks cited in this article under "references", for in-depth discussions of specific communicable diseases and exclusion criteria.

References:
American Public Health Association and American Academy of Pediatrics. (1992). *Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-home Child Care Programs.* Washington, D.C.: Authors.
Committee on Infectious Diseases, American Academy of Pediatrics. (1991). *Report of the Committee on Infectious Diseases* (2nd ed.), Elk Grove Village, IL: Author.
Kendrick, A.S., Kaufman, R., & Messenger, K.P., (Eds.) (1991). *Healthy Young Children, a Manual for Programs.* National Association for the Education of Young Children, Washington, D.C.: Author.
San Diego County Consortium for the California Child Care Health Project. (1991). *Control of Communicable & Infectious Disease, A Course for Child Care Providers.* Project Director: Betty Z. Bassoff, D.S.W., San Diego State University, Graduate School of Public health, Maternal and Child Health: Author.

By Generosa Soler Rader, R.N., M.P.H., Public Health Nurse Consultant, California Child Care Healthline

The California Child Care Health Project, 1212 Broadway, Ste. 830, Oakland, CA 94612.
(510) 839-1195, (510) 834-3741 FAX

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APPENDIX J

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UNIVERSAL PRECAUTIONS

"Bacteria and viruses carried in the blood such as Hepatitis B or Human Immunodeficiency Virus (HIV) can pose a small but finite hazard in the child care setting. Blood and direct blood-derived fluids pose the highest potential risk. However, other body fluids, such as saliva contaminated with blood or blood-associated fluids may contain live hepatitis B virus, but at lower concentrations than found in the blood itself. Other body fluids, including urine and feces, do not pose a risk unless they are visibly contaminated with blood. However, they can pose a risk in relationship to other infectious diseases" (APHA and AAP, 1992, p.74).

- Gloves must be worn if there is contact or potential contact with blood or blood-containing body fluids or tissue discharges.
- Spills of body fluids (i.e., urine, feces, blood, saliva, nasal discharge, eye discharge. and injury or tissue discharges) shall be cleaned up immediately as follows: *
  a) For spills of vomitus, urine, and feces, floors, walls, bathrooms, table tops, toys, kitchen countertops, and diaper-changing tables shall be cleaned and disinfected.
  b) For spills of blood or blood-containing body fluids and injury and tissue discharges, the area shall be cleaned and disinfected. Gloves shall be used in these situations unless the amount of blood or body fluid is so small that it can easily be contained by the material used for cleaning.
  c) Persons involved in cleaning contaminated surfaces shall avoid exposure of open skin sores or mucous membranes to blood or blood-containing body fluids and injury or tissue discharges by using gloves to protect hands when cleaning contaminated surfaces.
  d) Mops shall be cleaned, rinsed in sanitizing solution, and then wrung as dry as possible and hung to dry.
- Diapers shall be disposed of in a plastic bag with a secure tie. All blood-contaminated material should be double bagged, marked with a red tag or Hazardous waste label, and disposed of through proper procedures.
- Good hand washing practices must be observed following every exposure to blood or blood-containing body fluids and tissue discharges. (APHA and AAP, 1992, pp. 75, 76)

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* In the child care environment a solution of 1/4 cup of bleach to 1 gallon of tap water is an effective disinfectant for environmental surfaces and other inanimate objects that have been contaminated with body fluids. However, the surfaces must have been cleaned to remove organic material. To achieve maximum effectiveness, the surface should be left "glistening" wet and allowed to air dry.

Adapted from:
American Public Health Association and the American Academy of Pediatrics, (1992). *Caring For Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*, pp. 74 - 77.

Federal OSHA laws require that all employees at risk for blood borne diseases be trained in universal precautions. Additionally, they must be offered protection from Hepatitis B at the time of employee orientation. The Hepatitis B vaccine can be given at the time of employment or immediately after a blood exposure.

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APPENDIX K

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CHILDHOOD DISEASES WHICH CAN POSE A THREAT TO PREGNANT CHILD CARE WORKERS

Disease	Exclusion Status	Risks to Pregnant Child Care Workers	Comments
Herpes Simplex	Children with herpetic gingivostomatitis who do not have control of oral secretions should be excluded from child care.	Extremely low	Maternal herpes infections that are a threat to the fetus are caused by the Herpes type II virus. As a rule, these lesions are on the genitalia and the virus is sexually transmitted. Herpes type II can cause spontaneous abortions, prematurity, microcephaly, fetal infection.
Chicken Pox	Until six days after the onset of the rash OR until all sores have dried and crusted over.	High if not immune	Adults who acquire chicken pox often have a serious infection. Chicken Pox can cause miscarriage, central nervous system disease, cataracts, clubbed feet. The exposed child care worker without immunity should consult her health care provider within 24 hours after exposure is recognized.
Shingles	Exclusion is usually not necessary IF all sores can be covered. The child's health care provider should be consulted.	Lower than with chicken pox as chicken pox is also spread from respiratory secretions.	Risk status from shingles must be determined case by case. The pregnant child care worker should consult with their health care provider and be able to describe where the lesions are and the likelihood of exposure to them.
Cytomeg-alovirus (CMV)	Because of the very high rate of young children who shed CMV from child care, exclusion is NOT recommended.	High	CMV is the leading cause of congenital infection in the United States. It can cause hearing loss, visual problems, mental retardation or cerebral palsy. Maternal immunity does not provide absolute protection. Pregnant child care workers should consult their health care provider to discuss risks. It is recommended that non-immune pregnant women avoid contact with children less than 2 years of age and others who "shed" CMV during the first 24 weeks of pregnancy.
Hepatitis B	Exclusion is not recommended unless the child has open wounds, sores or is aggressive (bites and scratches)	Low IF universal precautions are strictly followed. Non-pregnant child care workers should be offered hepatitis B vaccination.	Hepatitis B can cause prematurity, psychomotor retardation and newborn disease.

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Disease	Exclusion Status	Risks to Pregnant Child Care Workers	Comments
HIV Positive	Exclusion is not recommended provided the child care environment does not pose risks to the child's health AND the child's health status or behavior does not pose a threat to others. Consultation from the child's health care provider is needed.	Low IF universal precautions are followed.	Can cause fetal infection.
Rubella	Until six days after the onset of the rash.	High if not immune.	Avoid contact if not immune and vaccinate if not pregnant. Can cause deafness, microcephaly CNS disease, heart defects, cataracts.

Adapted from:

Gratz, R.R., & Barlton, P. (1994). Health Considerations for Pregnant Child Care Staff. *Journal of Pediatric Health Care*, 8(1): 18-26.

American Public Health Association and American Academy of Pediatrics, (1992). *Caring For Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*. Washington, DC: Authors.

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APPENDIX L

HEALTH CONDITION FACT SHEET

ASTHMA

Definition: Asthma is a chronic disease which causes air passages to become temporarily narrowed or blocked. Many children have mile to moderate asthma that is well controlled with appropriate medical and family management. Five basic events have been identified which may trigger asthma attacks: colds or viral infections; allergens; exercise or over-exertion (especially in cold weather); irritation from air pollution such as cigarette smoke, perfumes, strong odors; and, rarely, very strong emotions. (Silkworth & Jones, 1988)

Incidence: Approximately 10% of all children in the United States have signs and symptoms suggestive of asthma (Goldenhersh & Rachelefsky, 1989). Approximately 80% have symptoms before age five (Blair, 1977). Most children with mild to moderate asthma do extremely well in child care settings. Some children with severe, uncontrolled asthma are high risk and will need to be enrolled in child care centers that have on-site support of a registered nurse. "Asthma causes more hospital admissions, visits to the emergency room, and school absences than any other chronic disease of childhood" (Silkworth & Jones, 1988, p. 75).

Responsibilities of Child Care Providers:

- Consult with the child's parents, physician and the facility's nurse. It is important to find out:
  - what triggers an attack
  - how to modify the environment or behavior to reduce the likelihood of an episode
  - medications taken routinely
  - medications that should be given when breathing problems begin
  - how to administer medications and their side effects
  - how to judge the severity of an episode
  - emergency management
- Provide staff training regarding administration or oral or inhaled medications, signs, symptoms, initial management of asthma, and recognition of a serious or life-threatening situation.
- Modify the environment as needed. For example, a child who is allergic to mold will probably not do well in a basement classroom.
- Encourage the child to drink additional fluids. (This helps thin respiratory mucus.)
- Observe for signs and symptoms such as wheezing, coughing, difficulty breathing, complaint of tightness in the chest, or bluish color in the lips or nail beds, retractions.

- Institute treatment as outlined by the parents, physician, and nurse:
  - help child sit up
  - keep child relaxed—stay calm
  - encourage fluids
  - administer medications
  - if child does not respond or symptoms worsen, notify the child's parents or physician
  - institute the child's emergency plan as needed
- Document the episode in the center's daily log and the child's health record. What seemed to trigger the event? How long did it last? What were the child's symptoms? What medications were given?
- Encourage the child with asthma to participate as fully as possible in the everyday activities of the child care center. Do not focus on the disease! Focus on the child!

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HEALTH CONDITION FACT SHEET

EPILEPSY

Definition: Epilepsy is a chronic disorder of the brain characterized by recurrent seizures. A child is usually said to have epilepsy if he or she has more than two seizures not related to a fever, illness, or accident. Infections, lack of oxygen, birth trauma, intra-cranial hemorrhage, and genetic factors are only some of the possible causes of epilepsy (Jones-Saete, 1989). The cause, age of onset, type of seizures, frequency of occurrence, and success of treatment influence the child's prognosis (Farley, 1992). There are many different types of seizures. Some cause loss of consciousness, others do not; some cause body movements, others do not. Often a child's seizure behavior is difficult to observe and evaluate because behavioral changes are so subtle. Some studies have found that up to 50% of children diagnosed with epilepsy will eventually be seizure free. Most children's seizures are well-controlled with medication. However, some children will have persistent seizures in spite of good medical management. Both groups of children can be safely cared for in the child care environment with appropriate staff training and support.

Incidence: The incidence of epilepsy varies with age, however, it is greatest in infants, averaging about 1 per 1000 infants in the United States (Farley, 1992).

Responsibilities of Child Care Providers:

- Consult with the child's parents, physician, the child care facility's nurse. It is important to find out:
  - type(s) of seizures the child has, to include frequency, duration, and behaviors before, during, and after a seizure
  - medications taken, to include name, color, amount, frequency, side effects, and what to do if a dose is accidentally missed or vomited.
  - when to contact parents or physician
  - treatment of prolonged seizures to include plan for emergency management and transportation
  - the capacity of the Emergency Medical Services Authority to respond in an emergency situation
  - special safety needs (for example, a child who falls frequently may benefit from wearing a helmet)
- Teach appropriate staff to properly administer medications and provide basic and emergency care to children with seizure disorders. (See Appendix M.)
- Learn to recognize and manage each child's seizures:
  - Determine if the child is having a seizure. Are there changes in consciousness or responsiveness? Is the child having any involuntary movement? Does the child seem to have a perceptual alteration such as changes in vision, hearing, taste, smell, or touch?
  - Remain calm, observe what happens to the child during the seizure.

- Protect the child from injury. Do not restrain or place anything in the child's mouth. Place in the side lying position if possible, and remove sharp, hard objects from the environment.

- Recognize if and when a seizure has become an emergency (usually a seizure that lasts longer than five minutes OR two seizures that occur back to back without the child regaining consciousness OR the child does not start breathing after the seizure.

- Institute the child's emergency plan as needed. (Administer mouth-to-mouth resuscitation if not breathing; call EMS; notify parents and physician; facilitate transportation to the nearest emergency room.) Remember, brain damage or death can occur as a result of prolonged, uncontrolled seizure activity or prolonged periods of no breathing.

- After the seizure is over, stay with the child. Do no offer any food or drink until the child is alert and wide-awake. Allow the child to rest. Check to see if the child needs diapers or clothing changed.

- Reassure other children as needed. They need to know that seizures are not "catching".

- Document the seizure in the daily log and the child's health record. How did it start? How long did it last? What did you observe during the seizure? Was the seizure typical for this child? How did the child respond/act after the seizure was over? Did the child injure himself or herself? Were the parents or physician contacted? Did the child require implementation of emergency measures?

- Discuss the seizure with the child's parent(s). Are seizures becoming more frequent or severe? Are there problems with getting the child to take their medication? The primary cause of status epilepticus (prolonged seizures) is either not taking medication or "outgrowing" the medication dosage. Parents need to know what is happening in the child care environment which could indicate that their child needs to be seen by his/her physician.

• Encourage full participation in child care activities to the greatest extent possible.

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HEALTH CONDITION FACT SHEET

SPINA BIFIDA

Definition: The term myelodysplasia refers to the defective formation and subsequent development and function of the spinal cord. It is one of several possible congenital problems classified as a neural tube defect (Farley & Dunleavy, 1992). This defect can occur at any level of the spinal cord and affects body functioning below the level of the defect. The lower the level of the defect, the less symptoms the child will usually have. Some children with Spina Bifida can walk unassisted, while others may need braces, crutches, walkers, or wheelchairs. Other problems that can be caused by this defect include total or partial loss of sensation, loss of bowel and bladder control, various musculoskeletal problems, hydrocephalus, visual and perceptual problems, and learning disabilities. Spina Bifida can be one of the most serious health conditions potentially compatible with full inclusion over the life span. However, most children with Spina Bifida adapt to their disabilities and participate in life with great enthusiasm.

Incidence: In the United States the incidence of neural tube defects is approximately 1 in 1000. However, in some geographic areas the rate is as high as 1 in 500.

Responsibilities of Child Care Providers:

- Consult with the child's parents, physician, and the facility's nurse to determine:
  - The child's health needs to include: mobility, need for adaptive equipment, positioning needs, bowel and bladder function, skin problems, feeding or nutritional concerns, special safety needs such as protection of skin from extreme heat or cold, monitoring for signs and symptoms of increased intra-cranial pressure.
  - If the child has symptomatic Arnold-Chiari malformation. These children are at increased risk for sleep apnea or sudden respiratory arrest. Special precautions, such as using an apnea monitor, having portable suction equipment, and having infant CPR certified staff are essential.
  - Develop a plan for staff training by parents, physician, the nurse, or therapists.
  - If the child requires catheterization, check with the Board of Nursing and child care regulations to determine if this procedure can be delegated or must be performed by a registered nurse. (Be aware that the Supreme Court has upheld the right of children who require catheterization to be mainstreamed into school settings.)
  - Encourage a high fiber diet and fluids to prevent constipation. Usually the child's bowel program will be managed at home. If the child has constipation or diarrhea, the parents should consult their child's physician.
  - Encourage adequate fluids to reduce urinary tract infections and constipation. Ask parents to determine if certain drinks such as "soda pop" should be avoided.
  - Ensure that catheterization is performed in a private place. Protect the child's modesty always. Some children begin to learn to self-catheterize by ages 4 to 5. Support and encourage independence as soon as developmentally and medically appropriate. The child's family and health care providers will determine when to begin a self-catheterization program.

- Never use latex products around children with Spina Bifida.
- Never scold, shame, or embarrass a child about bowel or bladder accidents.
- Inspect the child's skin every two to four hours for signs and symptoms of skin breakdown. An area of redness can progress to actual skin breakdown and "sore" formation rapidly. Complications from skin breakdown are the leading cause of death in persons with Spina Bifida!
- Encourage parents to utilize early intervention resources and services. Most children with Spina Bifida are automatically eligible.
- Encourage or provide periodic vision and hearing screening.
- Report to parents any subtle complaints such as headache, weakness, excessive fatigue, over-active gag reflex, vomiting, changes in bowel or bladder patterns, increased problems with mobility, fever. These symptoms all could indicate that the child has a serious health problem.
- Encourage maximum levels of independence, self-care, mobility, and participation in child care activities.
- Remember, in spite of numerous health problems, most children with Spina Bifida are very resilient and capable. Do not disable them by doing for them what they can do or learn to do for themselves.

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HEALTH CONDITION FACT SHEET

DIABETES MELLITUS

Definition: Type I diabetes is known as insulin dependent diabetes. It is believed that both genetics and auto immunity play a role in the development of this health problem. Lack of insulin production leads to disturbances in carbohydrate, protein, and fat metabolism which can be life-threatening if unrecognized and untreated. Treatment for Type I diabetes includes administration of insulin via injection, monitoring blood glucose levels, and preventing hyper- or hypoglycemia (high and low blood sugar levels). Most children with diabetes benefit from socialization in child care or pre-school programs and need little specialized care. Other children with diabetes may have difficulty maintaining an appropriate blood sugar level and need more frequent monitoring and treatment.

Incidence: Insulin-dependent diabetes mellitus is the most common metabolic disease of childhood affecting approximately 1 in 600 children (LaPorte & Cruickshanks, 1985).

Responsibilities of Child Care Providers:

- Consult with the child's parents, physician, dietitian, and the facility's nurse to determine:
  - the child's need for insulin injections while in child care,
  - the child's need for blood glucose monitoring while in child care,
  - dietary/nutritional needs to include what to do if the child does not eat their snack or meal,
  - the degree to which the child's diabetes is well-controlled. Children who have very uncontrolled diabetes may need to be enrolled in a child care center that offers continuous, on-site nursing care.
- Develop an emergency plan to treat hypoglycemia, to include: 1) early symptom recognition (shaking, sweating, hunger, paleness, dizziness, numbness or tingling of the lips or nose, irritability, poor coordination, confusion, headaches, blurred vision), 2) administration of suitable fast-acting glucose foods (such as 1/2 cup of regular pop or fruit juice, 1 small box of raisins), 3) when to notify parents or the child's health care provider, 4) plan for emergency treatment of life-threatening hypoglycemia (child loses consciousness).
- If the child's daily management includes the need for insulin injections and/or finger pricks to determine blood glucose levels, ensure nurse consultation regarding delegation issues.
- Develop a training plan for staff to ensure that staff involved in the child's care understand the relationship between food, exercise, stress, insulin, and blood sugar level.
- Encourage the child to participate actively in the child care setting.

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HEALTH CONDITION FACT SHEET

SICKLE CELL DISEASE

Definition: Sickle cell disease is a term used to describe a disorder which causes blood cells to develop an abnormal sickle or crescent shape. Fever, dehydration, lack of oxygen, and other factors can cause the red blood cell to sickle. This shortens the life span of the cell and leads to anemia, musculoskeletal pain, and multiple other problems. Many children with Sickle Cell Disease remain healthy most of the time. A key goal of treatment is to prevent "sickling" by preventing infections and dehydration, and maintaining a normal body temperature. Prompt treatment also can interrupt the sickling process. Approximately one-third of patients with Sickle Cell Disease have a crisis every few years, while one-third may have a crisis monthly or weekly. The remaining third represent the range between the two ends of this continuum.

Incidence: Sickle cell disease is one of the most common genetic diseases and is seen most often in individuals of African descent. It is estimated that 1 in 12 black Americans is a carrier while 1 in 500 actually has the disease (Lisak, 1992).

Consideration for Inclusion:

- Consult with the child's parents, physician, and the facility's nurse to determine:
  - The severity of the child's health problem
  - What triggers the sickling process
  - Preventive measures
  - Signs and symptoms
  - Medications
  - When to call the parents or physician
- Evaluate the extent to which the child is likely to be exposed to infections. A small child care center or home environment may be preferable.
- Ensure that the child stays well hydrated, especially during warm weather. Vomiting and diarrhea can also lead to dehydration and sickling.
- Ensure that an emergency plan is developed to respond to fever, vasocclusive crisis, respiratory distress or stroke.
- Encourage full participation in child care activities to the greatest extent possible.

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SAMPLE

CHRONIC ILLNESS HEALTH RECORD

Child's Name: ______________________________ Date: __________________

1. Which health problems (chronic illnesses) does the child have?

_____ allergies ____________________

____

_____ anemia

_____ asthma

_____ diabetes

_____ epilepsy

_____ heart trouble

_____ kidney trouble

_____ sickle-cell disease

_____ other ____________________

____

____

____

2. What happens to the child when she or he has a crisis related to the condition(s)?

3. What procedures would the staff follow to:

a. prevent these crises?

b. deal with them when they occur?

4. Does the staff need to be trained in any particular emergency procedures (e.g., CPR)? If so, which one(s)?

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Chronic Illness Health Record, continued

5. What medication(s) does the child take?

a. Are there any side effects (including behavioral)? From which medicines?

b. Does the child need to have medication during program hours? On what schedule?

6. Check all of the program areas that require any changes. Tell us what changes or special arrangements need to be made.

   a. _____ Diet. What?

   b. _____ Order of activities. Describe:

   c. _____ Types of activities. Describe:

   d. _____ Length of activities. Describe:

   e. _____ Nap time routine. Explain:

   f. _____ Toileting. Explain:

   g. _____ Other. Explain:

7. Name of person(s) other than yourself (selves) to contact for questions about this child's condition if your are unavailable

   Person: ____________________

   Relationship to child: ____________

   Phone: ____________________

   Person: ____________________

   Relationship to child: ____________

   Phone: ____________________

8. Any other information you feel we should have:

______________________________ ______________

Person completing form (please print) Date

Shapiro Kendrick, A., Kaufman, R., Messinger, K. (Eds.). (1991). *Healthy Young Children: A Manual for Programs*. NAEYC Permission to reprint given by NAEYC. Materials developed with MCH funds.

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SAMPLE

CHRONIC ILLNESS RECORD FORM

1. Does the child have an ongoing health problem or chronic illness? *Check those that apply:*
   _______Allergies — Which?_______________
   _______Anemia
   _______Asthma
   _______Diabetes
   _______Epilepsy/Seizures
   _______Heart trouble
   _______Kidney trouble
   _______Sickle cell disease
   _______Other — What?_______________

IF THE CHILD DOES HAVE A CHRONIC PROBLEM, ASK THE FOLLOWING ADDITIONAL QUESTIONS:

2. What happens to the child when s/he has a crisis related to the condition:? _______________

3. What procedures would the child care staff follow to:
   a. prevent these crises? _______________
   b. deal with them when they occur?_______________

4. Does the staff need to be trained in any particular emergency procedures (e.g., CPR)? If so, which?
   ____

5. Is the child taking any regular medications? Which? _______________
   a. Are there any side effects with this medication? Which?_______________
   b. Does the child need to have medication regularly? On what schedule?_______________

6. Does the child require any changes in the following program areas? Check all that apply.
   a. ______ Diet — What? _______________
   b. ______ Order of activities — Describe:_______________
   c. ______ Types of activities — Describe: _______________
   d. ______ Length of activities — Describe:_______________
   e. ______ Nap time routine — Explain: _______________
   f. ______ Toileting — Explain:_______________
   g. ______ Other — Explain: _______________

7. Name of person(s) other than yourself who should be contacted for questions about this child's condition if you are unavailable?_______________
   Phone: _______________

National Association for the Education of Young Children. (1991). *Healthy Young Children: A Manual for Child Care Programs.*

APPENDIX M

ERIC

ADMINISTRATION OF MEDICATION

Many children in child care environments must receive medications either on a "routine" or "as needed" basis. Most children take medications by mouth, however, some medications must be inhaled, applied topically, instilled into the eyes, ears, nose, or rectum, or taken intravenously or intramuscularly. In all situations administration of medications should be considered a serious responsibility and appropriate parental consent, education/training, and monitoring must occur. The following guidelines will assist child care providers in developing a method to ensure safe and appropriate administration of medications.

General Guidelines

1. Always obtain written consent from the child's parents to administer the medication.

2. Always obtain written instructions from the child's physician, pharmacist or the nurse. These instructions should include:

   - The medication to be administered (by name and color)
   - Why it is being given
   - The time it should be given
   - The amount to be given
   - How long it should be administered, e.g. number of days
   - How it is to be administered:

     - with meals or snacks, before meals or snacks, or after meals or snacks
     - in a nipple, teaspoon, oral administration syringe, medicine cup, food
     - via inhaler
     - topically (on the skin)
     - via nose drops, eye drops, ear drops, in the rectum
     - via injection

   - What to do if a dose is missed, refused, vomited.
   - Potential side effects to include serious complications.
   - Potential food interactions
   - What to do if certain side effects are noted.
   - What to do if the child has an allergic response to the medication.

3. Establish a plan of communication about who needs medication and who will administer it. Have a back-up plan for when staff are absent.

4. Ensure that staff are properly trained in developmentally appropriate methods of administration. For example:

   - Be positive in your approach to the child
   - Never give a child a choice whether or not to take the medication
   - Never add medication to formula or essential foods such as milk, juice, or cereal
   - Never tell a child medication is candy
   - Never force a medication in the mouth of a child who is crying
   - Never hold a child's nose to make him or her swallow

5. Follow infection control protocols.

   - Wash hands before and after administration of medications.
   - Keep all medications away from diapering and toileting areas.

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6. Ensure that proper safety procedures are followed:

   - Keep medications away from children (preferably under lock and key).
   - Follow the "five rights" in administration of all medications:

     1 — the *right* drug
     2 — the *right* child
     3 — the *right* time
     4 — the *right* amount
     5 — the *right* route (oral, topical, rectal, etc.)

7. Document administration of all medication in the child's medication log.

8. Report any errors in administration immediately to the child's parents or physician and/or the facility's nurse.

Oral Medications *

Infants

1. If using a dropper or syringe, hold the infant in the cradle position, stabilizing the head against your body. Press on the infant's chin to open the mouth, squirting the medication to the back and side of the mouth. Give the medication slowly in small squirts allowing the infant time to swallow.

2. If using a nipple, hold the infant in the cradle position, placing the medication from the syringe or medicine cup into the nipple. Allow the infant to suck the medication from the nipple. Follow the medication with 2 to 3 ml of water.

Toddlers and Older Children

1. When administering liquids, a medicine cup or teaspoon can be used. Younger children will need assistance in holding the medicine cup. Always stay with the child to be sure the entire dose is swallowed.

2. Tablets may be swallowed whole or crushed and given in applesauce. Do not crush tablets without first checking with the pharmacist to be sure that crushing does not affect drug absorption or action. Some tablets are chewable and will be labeled as such. Do not encourage a child to chew a non-chewable tablet as the taste may be extremely bitter.

3. Older children may actually enjoy the challenge of swallowing capsules. Place the capsule on the back of the tongue and provide several large swallows of fluid. Stay with the child until you are sure that the medication is gone. Some capsules may be opened and the contents sprinkled on food. Check with the pharmacist to see which capsules can be opened.

* Children with physical disabilities may need adaptations to methods of administering oral medications. Consultation from the child's family and a nurse is recommended.

Nose Drops

1. Hold an infant in the cradle position, tilting the head slightly back. Squeeze the drops into each nostril. Hold the infant in position for at least one minute following administration.

2. Toddlers should recline with head tilted back and supported with a pillow.

Ear Drops
Place the infant or child on the side opposite the ear that will receive the drops. For children under three, pull the pinna of the ear down and back; for children over three, pull the pinna up and back. Assist the child to remain in the side-lying position for 5 - 10 minutes. Then place a small cotton plaget into the ear canal to prevent leakage. Repeat the procedure on the opposite ear.

Eye Drops or Ointments
1. Place the infant or child on their back. Restrain the infant or child as necessary to safely instill the medication. Pull the lower eyelid down and out to form a cup for the medication. Instill the appropriate number of eye drops into the cup. Close the eye gently and keep it closed for a few minutes.

2. When using an ointment, pull the lower eyelid down and out. Apply the ointment along the lower eyelid margin starting with the inner margin. Do not touch the tip of the tube on the skin.

Rectal Medications
Find a quiet location where privacy can be maintained. Place the child in a side-lying or prone position. Lubricate the suppository with a water soluble gel. Using a finger cot or glove, insert the suppository approximately 1/2 inch into the rectum. Direct the suppository towards the wall of the rectum and away from stool (BM). The buttocks should be held tightly together for 10 minutes.

Inhaled Medications
Some children with asthma may use an inhaler to deliver medication directly into the lungs. This is particularly important when the bronchial tubes have begun to tighten or narrow. Child care workers should receive training prior to using an inhaler. In addition, these general guidelines should be followed:

Directions for Inhalation Tube:

- be calm and reassuring, demonstrating confidence and competence
- explain what you want the child to do
- demonstrate
- shake the inhaler
- hold in the upright position
- encourage the child to fully exhale
- place the tube in the child's mouth
- instruct the child to breath in
- as the child begins breathing in, spray the inhaler
- encourage the child to breath as deeply as possible for a period of 2-3 seconds
- remove the inhaler from the child's mouth and encourage the child to hold their breath while you count to ten
- if another puff is needed, wait for five minutes and repeat the process (Silkworth and Jones, 1985, pp. 90-94).

Injections
Administration of medications sub-cutaneously, intramuscularly, or intravenously is considered an invasive procedure. Injections should be administered by the child care facility's nurse or the child's parent. In an emergency caused by a severe allergic reaction, child care providers can administer a pre-measured dose of epinephrine delivered by auto-injection. The dosage must be individualized by the child's physician and given as directed in written instructions.

Adapted from: Skale, N. (1992). *Manual of Pediatric Nursing Procedures*, pp. 117-128

ERIC

SAMPLE

MEDICATION RECORD

For parent to complete:

I, ______________________________ (Name of parent),

give permission to ______________________________ (Name of caregiver)

to give my child ______________________________ (Name of child)

the following medicine ______________________________ (Name of medicine)

for ______________________________ (Problem or illness)

on ______________________________ (Date)

at ______________________________ (Time)

in the amount of ______________________________ (Amount)

by ______________________________ (Body location and method of use)

Side effects of the medicine to watch for: ______________________________

This medicine has been prescribed by: ______________________________

The telephone number of the doctor is: ______________________________

By: ______________________________ ______________________________

(Signature of parent) (Date)

For staff to complete:
Give medicine **only** if you can answer yes to all questions below:

Is the permission form above completed? ☐ yes ☐ no
Is the medication in a child-proof container? ☐ yes ☐ no
Is the original prescription label on the container? ☐ yes ☐ no
Is the name of the child on the container? ☐ yes ☐ no
Is the date on the prescription current? ☐ yes ☐ no

Name of medicine	Dose	Date	Time	Given by	Comments

Caregiver signature: ______________________________

Adapted from:
American Red Cross. (1990). *Child Care Health & Safety Units.*
Nat'l Assoc. for the Education of Young Children. (1991). *Healthy Young Children.*

TRAINING ACTIVITIES

Training Activity Format

Training Activities:

- Hand to Hand
- Infection Control in Child Care
- Hazards and Haphazards: Environmental Safety

ERIC

TRAINING ACTIVITY FORMAT

Project EXCEPTIONAL training activities have been developed to support information presented in this document. They are designed to provide the trainer detailed information to assist in the successful presentation of the interactive process and guide the trainer in the recommended use of the activities.

Purpose

The purpose states the aim of the activity and what is to be accomplished. Trainers should make sure the stated purpose matches the training objectives.

Outcomes

The anticipated learning experience is stated in the outcomes. Outcomes provide an easy means of evaluation for each activity, "Was the stated outcome met?"

Time

The time listed for an activity is the approximate time needed to complete the Experiential Learning Cycle. As trainers become familiar and use the activities, they will be able to better gauge time requirements based on training variables such as size of audience or time constraints.

Group Size

The appropriate group size is given. Often, adaptations for small or large groups are provided with the activity.

Training Method

Project EXCEPTIONAL activities include small and large group discussion, quiz, game, case study, demonstration and practice, individual exercise, brainstorming, paired exercise, role play, panel presentation, short lecture, puzzle, videotape, and cooperative learning activities. It is important to include activities utilizing different training methods during a training session. Each audience member has a preferred way of learning. A variety of training methods assures that the learning style of individual participants is accommodated. A variety of training methods also makes the training dynamic and keeps participants interested.

Supplies

Lists all materials required to complete the activity.

Source

Whenever possible the original source of the activity is provided. Activities originated or designed by Project staff and/or consultants are credited to the Project.

Preparation

Lists the steps to be taken in preparation for the activity.

Start the Activity

The suggested process to begin and carry out the activity is provided.

ERIC

Large/small Group Discussion
This section outlines how to lead participants through a discussion of their thoughts and reactions to each activity. Large group discussions assist participants to complete the Experiential Learning Cycle.

Key Points
Major points to highlight during the activity are identified. The key points help trainers in completing the Experiential Learning Cycle and in meeting the stated purpose and outcomes. Key points may be adjusted as necessary to correspond to changes the trainers may make in the activity.

Activity Work Sheets
Reproducible work sheets that are necessary to complete an activity are provided.

Activity Handouts
Supplemental material developed to enhance the learning experience.

Additional training activities have been developed to support the information presented in this document. They are presented in the Project EXCEPTIONAL *Supplemental Training Activities* available through California Institute on Human Services (see address at the front of this document).

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Activity:

Hand to Hand

Purpose	To provide participants with a heightened awareness of how disease is transmitted
Outcomes	Participants will understand the concept of disease transmission (spreading of germs).
Time	10 minutes
Group Size	Flexible, up to 50 participants
Training Methods	Interactive activity, large group discussion
Supplies	Handout
Source	Helen Brown, R.N., Retired School Nurse, Los Angeles County Office of Education

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Step-By-Step Procedures:

Hand to Hand

Preparation

Duplicate the activity handout for each participant.

Start the Activity

1. Ask participants to pretend that they are arriving at a party or sporting event where they are greeting old friends or meeting new people. Have them move around the room simulating their typical interactions in such a setting.
2. The trainer shakes hands with or physically greets (touches) several participants as they enter the room.
3. After all participants are seated, the trainer introduces herself or himself again and states, "Everyone who shook hands with me please stand up."
4. Then the trainer says, "Whoever has shaken hands with or physically greeted those who just stood up please stand up also."
5. The trainer repeats, "Whoever has shaken hands with or physically greeted those who just stood up please stand up also."
6. Continue until no more participants stand up.
7. The trainer asks participants to be seated.

Large Group Discussion

1. Begin the discussion about the transmission of disease and how easily such transmission occurs in everyday contact with people we know and do not know.
2. Pass out the handout and review it briefly, emphasizing cleanliness and proper hygiene.
3. Wrap up with the key points.

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Key Points:

Hand to Hand

1. Awareness of the way in which germs are transmitted is crucial in planning for the health and safety of all children and adults in child care settings.

2. Simple prevention techniques are easily overlooked and are often of significant importance to the health maintenance of children with exceptional-care needs.

3. Disease transmission through respiratory droplets, blood, semen, and other bodily fluids is a significant health issue in child care settings. Information and training about disease transmission and the use of universal precautions is a critical factor of quality caregiving for all children.

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Tips for Training:

Hand to Hand

1. Use this activity as an opener for instruction in the area of health and safety.
2. If possible, invite a school nurse or public health nurse to facilitate the session.

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Activity Handout:

Hand to Hand

PREVENTION OF INFECTIOUS DISEASE

Family child care providers should establish and routinely follow certain general precautions for the prevention of infectious disease. The value and usage of these precautions should be discussed and reviewed on an ongoing basis.

The following measures are recommended for the control of infectious disease:

1. Wash hands (the most effective means of preventing infectious disease):
   a. Before and after toileting a child
   b. Before and after personal use of the toilet
   c. Following contact with bodily fluids (e.g., wound drainage, blood, saliva, vomitus, feces, urine, menstrual flow, and nasal drainage)
   d. Before preparing or handling food
   e. After removal of disposable gloves
   f. After removal of a smock, apron, or other form of protective clothing
   g. Before and after assisting with dental care
   h. Before and after administering first aid or examining an ill child.
2. Wear disposable gloves (latex or vinyl) when dealing with the following situations:
   a. Changing diapers when feces or urine may contain blood
   b. Exposing yourself to blood and bodily fluids
   c. Administering oral care

   In addition, when an adult has open cuts, weeping lesions, burns, or eczema, he or she should wear disposable gloves.
3. Do not use gloves more than once. Wash hands after removing gloves.
4. Avoid rubbing or touching eyes.
5. Dispose of soiled tissues in a plastic-lined, covered receptacle immediately after use.
6. Wear smocks if there is a possibility that clothing will become soiled with blood or bodily fluids.

ERIC Full Text Provided by ERIC

7. Launder smocks and other linen separately (bleach added) when they have been soiled with blood or bodily fluids. *Note:* Hot water causes bleach to be less effective; bleach should be added to the wash during the rinse cycle. If sheets or other laundry will come in contact with an infant's face, rinse laundry again.
8. Store toothbrushes in separate containers.
9. Wash with a cleaning agent and rinse toys, furniture, floor mats, and other articles soiled with blood, saliva, and bodily excretions. Take the following precautions:
   a. Following removal of blood and bodily fluids, wash the item again with a solution of bleach and water—1/4 cup bleach to one gallon water, or 1 Tbsp. bleach to one quart water.
   b. Use disposable towels, if possible.
   c. Wash any nondisposable cleaning cloths in detergent and add bleach during the rinse cycle.
   d. Rinse mops in a bleach solution.
10. Wash the toilet seat between use by children if urine or feces are on the seat. After washing, spray the seat with a bleach solution and dry with a paper towel.
11. Do not store bleach solution longer than one day. Once mixed, bleach loses its potency quicker than it does at full strength.
12. Provide soap dispensers rather than bars of soap.
13. Bag all items soiled with blood and bodily fluids and place in a plastic-lined, covered receptacle. At the end of the day, tie the outer bag securely. Mark with a hazardous waste sticker or red tag.
14. Wash thermometers before placing them in a disinfectant solution.
15. Inform new employees and substitute workers before they begin work about necessary universal precautions for preventing infectious disease.
16. Take the following precautions to protect an immune-deficient child (e.g., the child with HIV or AIDS or children receiving radiation therapy or steroid therapy):
    a. Consult a physician about necessary precautions.
    b. Restrict the child from contact with a child who has herpes, chicken pox, or measles.
    c. Consider excluding the child if an outbreak of chicken pox or measles is present.

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HAND WASHING

The 4 most important concepts to remember about hand washing are:

1 You must use running water which drains out — not a stoppered sink or container. A common container of water spreads germs!

2 You must use soap, preferably liquid.

3 You must use friction (rubbing your hands together). This action removes germs.

4 You must turn off the faucet with a paper towel. The faucet is considered "dirty" at all times — if you touch it with clean hands, you will be recontaminated. (Ideally, then throw the paper towel into a lined covered trash container with a foot pedal).

WHEN HANDS SHOULD BE WASHED

Always wash your hands upon arrival at the center, and:

- before eating or handling food
- before feeding a child
- after diapering and toileting
- after handling body secretions (mucus, vomitus, etc.)
- after cleaning
- before and after giving medication (particularly eye drops/ointment, etc.)

Be sure the children's hands are washed too — especially:

- when they arrive at the center
- before they eat or drink
- after they use the toilet or have their diapers changed
- after they've touched a child who may be sick

STOP DISEASE

METHOD OF HAND WASHING

1 Use soap and running water

2 Rub your hands vigorously

3 Wash all surfaces including:

Backs of hands
Wrists
Between fingers
Under nails

4 Rinse well

5 Dry hands with a paper towel

6 Turn off the water using a paper towel instead of bare hands

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Activity:

Infection Control in Child Care

Purpose	To increase participants' knowledge of basic health and safety factors related to infection control in child care settings
Outcomes	Participants will review, through video and discussion, health and safety precautions to be used in child care settings
Time	One hour
Group Size	Flexible
Training Methods	Video (27-38 minutes), large group discussion
Supplies	VCR, television monitor, videotape *Healthy Child Care, Is It Really Magic?* or *Infection Control in Child Care Settings,* chart pads with markers, tape
Source	Project EXCEPTIONAL

Step-By-Step Procedures:
Infection Control in Child Care

Preparation

1. Preview the video. It covers:
   - Spread and prevention of infectious disease
   - Washing of hands, toileting, diapering
   - Food preparation and feeding
2. Determine from the number of participants whether to conduct the discussion in a large group or in small groups.
3. Questions may be recorded on a chart pad for a large group or copied as a handout for small groups.

Start the Activity

1. You may begin the session with the "Hand to Hand" activity as an icebreaker.
2. Review the purpose of the activity.
3. Introduce the video. Indicate that the group will be asked to respond to several questions following the presentation of the video.

Large Group Discussion

1. Display (or distribute) the activity work sheet questions and designate the time for the large (or small) group discussion. (Allow 15–20 minutes.)
2. Summarize with a review of the key points.

Key Points:

Infection Control in Child Care

1. Providing for the health and safety of young children is a significant task, even in the absence of a child with a disability or medical condition.
2. Ongoing monitoring of the health practices of staff members is necessary. Written reminders posted in key areas are helpful.
3. Washing hands is the single most important means of preventing illness and infectious disease.
4. Toileting areas should be clearly designated.
5. Toys and surfaces used for work and play should be cleaned daily with a solution of 1/4 cup bleach to 1 gallon water or 1 tbsp. bleach to 1 quart water.
6. Universal precautions should be used by all caregivers with all children.

Tips for Training:

Infection Control in Child Care

1. This activity can be varied by inviting a panel to discuss the issues raised by the video. Invite representatives who work in a variety of child care settings such as a large and a small child care center, family child care home, and parents who have played a role in implementing successful and sound health practices.

2. Determine whether participants would feel more comfortable discussing the health procedures in small or large groups.

3. If you use small group discussions, allow time for reporting back to the large group.

4. Order *Infection Control in Child Care Settings* (27 minutes) from:
   Agency for Instructional Technology
   Video Collection for Staff Development
   At-Risk Early Childhood, Health Special Needs #6
   Infection Control in Child Care Settings
   Box A
   Bloomington, IN 47402-0120
   (800) 457-4509 or (812) 339-2203

   Order *Healthy Child Care, Is It Really Magic?* (38 minutes) from:
   Bananas
   5232 Claremont Avenue
   Oakland, CA 94618
   (510) 658-7101
   (510) 658-8354 FAX

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Activity Work Sheet: Infection Control in Child Care

DISCUSSION QUESTIONS

1. Are the precautions and practices shown in the video consistent with those used in child care settings you are familiar with?

2. If not, what might be prohibiting the staff from using the techniques?

3. Do you feel that any of the recommended practices for infection control may interfere with you as a child care provider?

4. What additional strategies other than those in the video are you aware of that could be used to support and promote proper health and safety techniques?

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CLEANING AND DISINFECTING SANITIZING SOLUTION

- Mix 1/4 cup bleach in 1 gallon of water or mix 1 tablespoon bleach in 1 quart water
- Place in labeled spray bottle out of reach of children in the bathroom, the diapering area, and the kitchen
- Wash surfaces first with soap or detergent and water
- Spray on sanitizing solution and allow to air dry
- Replace solution daily

1/4 cup bleach to 1 gallon water	OR	1 tbsp. bleach to 1 quart water

The Mainstreaming Project, San Diego State University,
Graduate School of Public Health, Maternal and Child Health Division

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Activity Handout:

Infection Control in Child Care

CLEANING AND DISINFECTION GUIDELINES

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DEFINITION OF IMPORTANT WORDS AND CONCEPTS

CLEAN
To remove dirt and debris (e.g., blood, urine, vomit, stool) by scrubbing and washing with soap and water. All purpose liquid detergents and water are the best cleaning agents.

SANITIZE
To remove filth or soil and small amounts of certain bacteria. For an inanimate surface to be considered sanitary, the surface must be clean and the number of germs must be reduced to such a level that disease transmission by that surface is unlikely. This procedure is less rigorous than disinfection. Soap, detergent, or abrasive cleaners may be used to sanitize.

DISINFECT
To eliminate virtually all germs from inanimate surfaces through the use of chemicals (e.g., disinfectants) or physical agents (e.g., heat). In the child care setting, a solution of 1/4 cut household liquid chlorine bleach added to 1 gallon of cool tap water (or 1 tablespoon bleach to 1 quart water) prepared fresh daily is an effective disinfectant.

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PROCEDURES

Step 1:
CLEAN
Clean objects and surfaces with detergent and water. This procedure removes dirt so that disinfectant can be more effective in killing germs on the object or surface.

Step 2:
DISINFECT
Apply bleach solution by spraying from a spray bottle or by dipping the object in the bleach solution. Allow object or surface to air dry before using it again.

Note: Machine washable cloth toys can be machine-washed when contaminated, and machine heat dried.

CLEANIING AND DISINFECTING SANITIZING SOLUTION

- Mix 1/4 cup bleach in 1 gallon of water or mix 1 tablespoon bleach in 1 quart water.
- Place in labeled spray bottle out of reach of children in the bathroom, the diapering area, and the kitchen.
- Wash surfaces first with soap or detergent and water
- Spray on sanitizing solution and allow to air dry.
- Replace solution daily

CLEANING AND DISINFECTING SCHEDULE

Diaper changing area, toilets, potty chairs:
- Clean after every use with soap and water to remove visible soil
- Spray with sanitizing solution and air dry

Bathroom and kitchen area:
- Clean thorougly one or more times daily

Toys:
- Wash and sanitize all mouthed toys daily
- Maintain toys of ill children separately
- Stuffed toys should be machine washable
- Sanitize wading pools after each use

Cribs:
- Disinfect weekly
- Change linen

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The Mainstreaming Project, San Diego State University,
Graduate School of Public Health, Maternal and Child Health Division

Activity:

Hazards and Haphazards: Environmental Safety

Purpose	To increase participants' level of awareness of basic health and safety needs in child care settings
Outcomes	Participants will increase their awareness of safety precautions in child care environments by evaluating a setting from the child's perspective.
Time	Video, 10 minutes; activity, 30–40 minutes
Group Size	Up to 25 participants
Training Methods	Video with large group; small group exercise
Supplies	Videotape *Safe and Sound: Choosing Quality Child Care* (segments titled "Health and Safety" and "Physical Setting"), VCR, monitor, chalkboard or chart pads and markers, tape, activity work sheet
Source	Project EXCEPTIONAL

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Step-By-Step Procedures:

Hazards and Haphazards: Environmental Safety

Preparation

1. This activity will work most effectively if conducted within a child care setting.
2. Preview the entire video. The sections titled "Health and Safety" and "Physical Setting" will be used in this activity.
3. Record the directions for small groups on chart pads before conducting the activity.
4. Prepare enough copies of the activity work sheet for each small group.

Start the Activity

1. State the purpose and outcomes of the activity.
2. Introduce the activity by discussing the importance of the physical setting and safety considerations when caring for young children, particularly children with disabilities.
3. Show the video sections that deal with physical settings and health and safety.

Small Group Activity

1. Divide participants into small groups and assign each group to a particular area within the selected setting. Include outside play areas, if possible.
2. Instruct the groups to explore the environment, giving thought to the following questions:
   a. Is the area free of safety hazards?
   b. Is the area interesting?
   c. Are materials accessible?
   d. Is there enough room for children?

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Participants are to evaluate the space from the following perspectives:

- While lying on their stomachs (a child who cannot sit up)
- While sitting in a child-sized chair, such as a wheelchair
- While sitting on the floor (a nonwalker)
- While kneeling on the floor (a child who walks)

3. If time permits, direct groups to switch areas. Plan about five minutes for each area.
4. Allow small groups to discuss their experiences and observations, using questions from the activity work sheet.

Large Group Discussion If there is time, reconvene in a large group to allow participants an opportunity to comment on what they learned and to share suggestions that were generated.

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Key Points:

Hazards and Haphazards: Environmental Safety

1. Through careful planning and evaluation of a child care setting, providers take the first step toward prevention of unnecessary accidents.
2. Environments need to be evaluated from the perspective of the children in the home or center.
3. Both the inside and outside environment should be evaluated to ensure good safety practices. Additional modifications may need to be implemented for children with disabilities. Each child's strengths and needs must be considered.
4. Environmental hazards for all small children include unstable furniture, sharp corners, uneven surfaces, and inadequate space and storage.
5. Safe and appropriate physical settings invite children to explore their environment. The children's development is enhanced through the accessibility of play areas and opportunities for child-initiated play.

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Tips for Training:

Hazards and Haphazards: Environmental Safety

1. Instruct participants to go back to their own centers or homes and use this technique to evaluate the environment from a child's perspective.

2. Remind participants that all aspects of child care environments should be evaluated for safety considerations on a regular basis. Children's developmental needs change throughout the year as well as the composition of children in different settings.

3. Order videotape *Safe and Sound: Choosing Quality Child Care* (56 minutes) from:

   Baxly Media Group
   110 West Main Street
   Urbana, IL 61801
   (800) 421-6999
   (217) 384-8280 FAX

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Activity Work Sheet:

Hazards and Haphazards: Environmental Safety

DISCUSSION QUESTIONS

1. What were the safety issues?

2. Were the areas, including materials and work space, accessible to all children?

3. Were the spaces designed to accommodate children who are nonambulatory? For example, a child's stroller, a walker or a wheelchair?

4. Brainstorm suggestions for changing a space to meet the physical and safety needs of all children.

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Project EXCEPTIONAL

TRAINING MATERIALS DESCRIPTION

The goal of Project EXCEPTIONAL is to increase the quality and quantity of inclusive child care and education programs for young children (birth to five) with disabilities through local community capacity building. The project has developed training materials and conducts training of trainers workshops for community interagency teams (which include family representation) and college instructors on these materials and their use.

The focus of Project EXCEPTIONAL workshops is to provide information on quality practices of inclusive caregiving. Target audiences are state, jurisdiction, or systems level agencies with broad dissemination capacities. The goal of these services is to collaboratively develop a customized service delivery plan through training to interagency community teams or college instructors, and to provide consultation, technical assistance, and follow-up activities. For further information about scheduling a workshop, please contact George Triest, California Institute on Human Services (CIHS), (707) 664-3929. You can obtain more information about California Institute on Human Services on the World Wide Web at http://www.sonoma.edu/cihs/ or Email us at cihs@sonoma.edu.

Original funding for the development of Project EXCEPTIONAL materials was received by CIHS from the California State Department of Education, Child Development Division. With these funds the Project EXCEPTIONAL documents, *A Guide for Training and Recruiting Child Care Providers to Serve Young Children with Disabilities, Vols. 1 & 2*, were developed. These documents are available from the California Department of Education, Bureau of Publications, Sales Unit, P.O. Box 271, Sacramento, CA 95812-0271, (800) 995-4099. Be sure to call for current prices and shipping charges. See the order form that follows this description.

A GUIDE FOR TRAINING AND RECRUITING CHILD CARE PROVIDERS TO SERVE YOUNG CHILDREN WITH DISABILITIES, VOL. 1, 1996 (195 pgs)
Edited by Anne Kuschner, M.A., Linda Cranor, and Linda Brekken, Ph.D.

Authored by parents and professionals, these training materials have been designed to support the inclusion of young children (birth to five) with disabilities in community child care and development programs. This guide consists of nine topic-specific narratives covering content which relates to creating successful inclusive opportunities for young children. Intended audience: Early childhood special education teachers, child care providers, families, policy makers, administrators, trainers, specialized service providers, university and community college instructors, early childhood educators, and Head Start staff. Topics are:

Who Will Care for Our Children? A Historical Perspective of Services for Young Children With Disabilities *Bea Gold, M.A.*
Historical perspective of the disability rights movement, highlights significance of equal opportunities for individuals with disabilities and their families, critical need for child care options for children with exceptional care needs, how everyone benefits when children with disabilities are included in local child care settings.

More Alike Than Different *Gina Guarneri, M.A.*
Focus on ability awareness and respect for diversity; how myths affect one's perceptions, attitudes and actions; the importance of knowing one's feelings and values about disabilities; significance of children developing feelings of positive self-worth; role caregivers play in viewing children in the context of their "wholeness."

Living With Disability: The Family Perspective
Barbara Coccodrilli Carlson, Esq., Linda Cranor, Anne Kuschner, M.A.
Highlights issues that families of young children with disabilities face when looking for child care; similarity in needs of families with and without children who have disabilities; uniqueness of individual family members and diversity of families in general; normal emotional reactions parents may experience upon learning of their child's disability; caregiver role in providing service to families.

Inclusion: Developmentally Appropriate Care for All Young Children

Beth Hannaman, M.A., Kristen Zink, M.S., M.A.

Discusses concepts of developmentally appropriate integrated care; caregiver role in creating environment to enhance optimal development of all children; observation, play and social interaction; benefits and challenges of including children with disabilities in community care.

Family Caregiver Partnerships *Kate Warren*

Looks at importance of quality relationship building; key components of a successful parent-provider partnership; tips for keeping communication open and ongoing; how providers can assist families of children with exceptional care needs.

When Concerns Arise: Identifying and Referring Children with Exceptional Needs

Eleanor W. Lynch, Ph.D.

Focuses on the benefits of assisting parents in seeking help for a child who may be in need of specialized services; what an assessment is, when assessment is needed, how to approach parents about concerns, and how to make a referral.

Caregiving Strategies: Building Resilience in Children at Risk *Marie Kanne Poulsen, Ph.D.*

Includes practical suggestions for providers which support positive and nurturing care to young children who are demonstrating "at risk" behaviors; tips to better understand stresses young children must cope with, and how behaviors are influenced.

Caring for Young Children Who Have Physical Disabilities

Nora Snowden, O.T.R., Karla Snorf, R.P.T.

Focus is on optimal child participation in play and socializing for child care settings; physical development both typical and atypical; safe and appropriate positioning and handling, use of adaptive equipment, setting up the environment, and adult safety in lifting.

Nuts and Bolts: Administrative Issues in Serving Children With Exceptional Needs and Their Families

Barbara Coccodrilli Carlson, Esq., Abby J. Cohen, Esq., Kathy Heftman, Paralegal

Intended for child care center directors, staff and family day care providers, views administrative issues when deciding to care for a child with disabilities or exceptional care needs; issues in licensing, insurance, liability rates, contracts, discrimination, and confidentiality.

A GUIDE FOR TRAINING AND RECRUITING CHILD CARE PROVIDERS TO SERVE YOUNG CHILDREN WITH DISABILITIES, VOL. 2, 1996 (295 pgs)

Linda Cranor, and Anne Kuschner, M.A.

Designed to supplement *A Guide for Training and Recruiting Child Care Providers, Vol. 1*, this guide provides four to eight activities developed to highlight the key points in each of the nine topics presented in Vol. 1. These activities are for training and instructing child care and development staff in quality practices of inclusive care and each activity includes the purpose, outcomes, step-by-step procedures for conducting the activity and handouts. Intended audience: Trainers, university and community college instructors. Vol. 2 also contains *Successful Staff Development: Tips and Techniques for Training.*

Successful Staff Development: Tips and Techniques for Training

Ann B. Carr, M.S., and Gina Guarneri, M.A.

Offers practical information and suggestions for conducting successful trainings. Reviews essential elements which make up a quality training and gives twenty-three training tips for effectively communicating your point.

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SUPPLEMENTAL TRAINING MATERIALS DESCRIPTION

Supplemental materials to *A Guide for Training and Recruiting Child Care Providers to Serve Young Children with Disabilities, Vols. 1 & 2,* were developed under a grant from the Office of Special Education and Rehabilitation Services (OSERS), Washington, D.C. These materials are available from the California Institute on Human Services (CIHS), Sonoma State University, 1801 East Cotati Avenue, Rohnert Park, CA 94928-3609, (707) 664-2051 or 664-2416, (707) 664-2417 FAX. See the order form that follows the description below.

HEALTH AND SAFETY CONSIDERATIONS: CARING FOR YOUNG CHILDREN WITH EXCEPTIONAL HEALTH CARE NEEDS, 1996 (130 pgs) *Betty Presler, R.N., Ph.D.*

Provides a foundation for understanding of the broad scope of issues related to the topic. Presents an overview of system level factors affecting the movement to include children with exceptional health care needs in community child care and development programs and a framework for assessing and preparing an early childhood program's capacity to provide safe and effective care for children with exceptional health care needs. Key components of best practices in family-centered, appropriately linked and coordinated service delivery systems are highlighted and suggestions for implementation are recommended. Intended audience: Early childhood special education teachers, child care providers, families, policy makers, administrators, trainers, specialized service providers, health care providers, community service providers, university and community college instructors, early childhood educators, resource & referral staff, and Head Start staff.

SPANISH TRANSLATIONS, 1996 (185 pgs)
CHINESE TRANSLATIONS, 1996 (60 pgs)
Coordinated by Linda Cranor, Diana Jung, M.Ed., M.A., and Aura Zapata, M.A.

Selected materials from *A Guide for Training and Recruiting Child Care Providers, Vols. 1 & 2,* have been translated into Spanish and Chinese. Intended audience: Trainers, university and community college instructors.

COLLEGE INSTRUCTOR'S GUIDE: INFUSING INFORMATION ABOUT YOUNG CHILDREN WITH EXCEPTIONAL NEEDS INTO CHILD DEVELOPMENT AND EARLY CHILDHOOD COURSE WORK, 1996 (165 pgs) *Eleanor W. Lynch, Ph.D.*

Designed to accompany *A Guide for Training and Recruiting Child Care Providers, Vols. 1 & 2,* on inclusion in early childhood programs. It includes information for instructors on how each of the training topics fit into the college curriculum, key points, reproducible handouts, transparencies, and questions for college students that build on their experience in topic content. Intended audience: Trainers, university and community college instructors.

DIMENSIONS OF DIVERSITY, 1996 (75 pgs) *Eleanor W. Lynch, Ph.D.*

Designed to accompany *A Guide for Training and Recruiting Child Care Providers, Vols. 1 & 2,* and the *Instructor's Guide* on inclusion in early childhood. It identifies and discusses content that may be perceived differently across cultures, language groups, economic levels, and other dimensions of diversity and provides information on these differences. Intended audience: Early childhood special education teachers, child care providers, families, policy makers, administrators, trainers, specialized service providers, health care providers, community service providers, university and community college instructors, early childhood educators, resource & referral staff, and Head Start staff.

SUPPLEMENTAL ACTIVITIES, 1997 *Linda Cranor, and Anne Kuschner, M.A.*

Contains additional instructional training activities designed to compliment those developed in *A Guide for Training and Recruiting Child Care Providers, Vol 2.* These activities are for training and instructing child care and development staff in quality practices of inclusive care and each activity includes the purpose, outcomes, step-by-step procedures for conducting the activity and handouts. Intended audience: Trainers, university and community college instructors.

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