

Caring for Our Children (CFOC): Basics^{1 2}

Legend

Stepping Stones: Stepping Stones 3, S. 1086: Senate Bill 1086, NPRM: Notice for Proposed Rule Making to Amend CCDF Regulations, HS 40: 40 Indicators from Head Start Program Standards, SS3 KI: 15 Key Indicators from Stepping Stones 3 (Rick Fiene), Pilot: 77 Observable Health and Safety Standards for Early Care and Education Providers from Caring for Our Children (Abbie Alkon)

Please note: CFOC Basics includes ALL relevant health and safety items from S.1086, HS 40, and NPRM. It is not inclusive of the complete Stepping Stones, SS3 KI, or Pilot.

This review represents minimum, basic health and safety standards that can be used to create a baseline across all early care and education settings.

Staffing

1) 1.2.0.2 Background Screening (**Stepping Stones, S. 1086, NPRM, HS 40**)

Directors of early care and education centers and caregivers/teachers in large and small family child care homes should conduct a complete background screening before employing any staff member (including volunteers, family members over age ten, substitutes, cooks, clerical staff, transportation staff, bus drivers, or custodians who will be on the premises or in vehicles when children are present). The background screening should include:

- a. Name and address verification;
- b. Social Security number verification;
- c. Education verification;
- d. Employment history;
- e. Alias search;
- f. Driving history through state Department of Motor Vehicles records;
- g. Licensing history with any other state agencies (i.e., foster care, mental health, nursing homes, etc.);
- h. References;

¹ CFOC: Basics are based on *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, Third Edition*. We would like to acknowledge the extensive work of the American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education, and Maternal and Child Health Bureau, Department of Health and Human Services. Please use *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs* for reference and more detailed recommendations (<http://nrckids.org/index.cfm/products/stepping-stones-to-caring-for-our-children-3rd-edition-ss3/>; <http://cfoc.nrckids.org/index.cfm>).

² Please note: Standards are not listed in order of importance.

- i. Comprehensive background checks that include:
 - a. The use of fingerprints for State checks of criminal history records;
 - b. The use of fingerprints for checks of Federal Bureau of Investigation (FBI) criminal; history records;
 - c. Clearance through the child abuse and neglect registry (if available); and
 - d. Clearance through sex offender registries (if available).

Drug tests may also be incorporated into the background screening. Written permission to obtain the background screening should be obtained from the prospective employee. Consent to the background investigation should be required for employment consideration.

When checking references and conducting employee or volunteer interviews, prospective employers should specifically ask about previous convictions and arrests, investigation findings, or court cases with child abuse/neglect or child sexual abuse. Failure of the prospective employee to disclose previous history of child abuse/neglect or child sexual abuse is grounds for immediate dismissal. Persons should not be hired or allowed to work or volunteer in the child care facility if they acknowledge being sexually attracted to children or having physically or sexually abused children, or are known to have committed such acts. Background screenings should be repeated periodically taking into consideration state and tribal laws and/or requirements.

2) 1.4.1.1/1.4.2.3 Pre-service Training/Orientation Topics (Stepping Stones, S. 1086, NPRM (not all are listed))

Before or during the first three months of employment, training/orientation should include health and safety issues for early care and education settings. All directors or program administrators and caregivers/teachers should document receipt of training that includes the following:

- a. Typical and atypical child development as well as best practice for a range of developmental and mental health needs including knowledge about the developmental stages for the ages of enrolled children;
- b. Positive ways to support language, cognitive, social, physical, and emotional development including appropriate guidance and discipline;
- c. Developing and maintaining relationships with families of children enrolled, including the resources to obtain supportive services for children's unique developmental needs;
- d. Procedures for preventing the spread of infectious disease;
- e. Infection control and injury prevention through role modeling;
- f. Safe sleep practices including reducing the risk of Sudden Infant Death Syndrome (SIDS) (infant sleep position and crib safety);
- g. Shaken baby syndrome/abusive head trauma prevention and identification;
- h. Poison prevention and poison safety;
- i. Immunization requirements for children and staff;
- j. Common childhood illnesses and their management, including exclusion policies and recognizing signs and symptoms of serious illness;

- k. Reduction of injury and illness through environmental design and maintenance;
 - l. Knowledge of U.S. Consumer Product Safety Commission product recall reports;
 - m. Staff occupational health and safety practices in accordance with Occupational Safety and Health Administration blood borne pathogens regulations;
 - n. Emergency procedures and preparedness for disasters, emergencies, other threatening situations (including weather-related, natural disasters), and injury to infants and children in care;
 - o. Promotion of health and safety in early care and education settings, including staff health and pregnancy;
 - p. First aid including CPR for infants and children;
 - q. Recognition and reporting of child abuse and neglect in compliance with state laws and knowledge of protective factors to prevent child maltreatment;
 - r. Nutrition and age-appropriate child-feeding;
 - s. Age-appropriate physical activity and limiting sedentary behaviors;
 - t. Prevention of childhood obesity and related chronic diseases;
 - u. Environmental health issues for both children and staff;
 - v. Medication administration policies and practices;
 - w. Caring for children with special health care needs, mental health needs, and developmental disabilities in compliance with the Americans with Disabilities Act;
 - x. Cleaning, sanitation, and disinfection procedures and policies;
 - y. Procedures for notifying parents/guardians of an infectious disease within the facility;
 - z. Procedures and policies for notifying public health officials about an outbreak of disease or the occurrence of a reportable disease;
 - aa. Injury prevention strategies and hazard identification procedures specific to the facility, equipment, etc.
- 3) 1.4.2.2 Orientation for Care of Children with Special Health Care Needs (Stepping Stones, S. 1086)**
- When an early care and education facility or family child care enrolls a child with special health care needs, the facility should ensure that all staff members have been oriented in understanding that child's special health care needs and have the skills to work with that child. For detail, please see CFOC 1.4.2.2.
- 4) 1.4.3.1 First Aid and CPR Training for Staff (Stepping Stones, S. 1086, NPRM, SS3 KI)**
- All staff members involved in providing direct care to children should have documentation of satisfactory completion of training in pediatric first aid and pediatric CPR skills as defined by the American Red Cross and the American Heart Association. At least one staff person who has successfully completed training in pediatric first aid that includes CPR should be in attendance at all times. Records of successful completion of training in pediatric first aid should be maintained in the personnel files of the facility.

5) 1.4.5.2 Child Abuse and Neglect Education (Stepping Stones, S. 1086, SS3 KI)

Caregivers/teachers should use child abuse and neglect prevention education to educate and establish child abuse and neglect prevention and recognition measures for the children, caregivers/teachers, and parents/guardians. The education should address physical, sexual, and psychological or emotional abuse and neglect. Caregivers/teachers are mandatory reporters of child abuse or neglect. Caregivers/teachers should be trained in compliance with their state's child abuse reporting laws.

Program Activities for Healthy Development**6) 2.1.1.4 Monitoring Children's Development/Obtaining Consent for Screening (Stepping Stones, S. 1086, HS 40)**

Programs should have a formalized system of developmental screening with all children that can be used near the beginning of a child's placement in the program, at least yearly thereafter, and as developmental concerns become apparent to staff and/or parents/guardians. The facility's formalized system should include a process for determining when a health or developmental screening or evaluation for a child is necessary. This process should include parental/guardian consent and participation. If the screening or any observation of the child results in any concern about the child's development, after consultation with the parents/guardians, the child should be referred to his or her primary care provider (medical home), or to an appropriate specialist or clinic for further evaluation. In some situations, a direct referral to the Early Intervention System in the respective state may also be required. For detail, please see CFOC 2.1.1.4.

7) 2.1.2.1 Personal Caregiver/Teacher Relationships for Infants and Toddlers (Stepping Stones, S. 1086, Pilot)

Facilities should practice relationship-based philosophies that promote consistency and continuity of caregivers/teachers for infants and toddlers. Facilities should limit the number of caregivers/teachers who interact with any one infant to no more than five caregivers/teachers across the period that the child is an infant in the early care and education program. The caregiver/teacher should:

- a. Hold and comfort children who are upset;
- b. Engage in frequent, multiple, and rich social interchanges such as smiling, talking, touching, singing, and eating;
- c. Be play partners as well as protectors;
- d. Be attuned to children's feelings and reflect them back;
- e. Communicate consistently with parents/guardians;
- f. Interact with children and develop a relationship in the context of everyday routines (diapering, feeding, etc.)

Opportunities should be provided for each child to develop a personal and affectionate relationship with, and attachment to, that child's parents/guardians and one or a small number of caregivers/teachers whose care for and responsiveness to the child ensure relief of distress, experiences of comfort and stimulation, and satisfaction of the need for a personal relationship.

8) 2.1.3.1 Personal Caregiver/Teacher Relationships for Three- to Five-Year-Olds (S. 1086)

Facilities should provide opportunities for each child to build long-term, trusting relationships with a few caring caregivers/teachers by limiting the number of adults the facility permits to care for any one child in an early care and education setting to a maximum of eight adults in a given year and no more than three primary caregivers/teachers in a day. Children with special health care needs may require additional specialists to promote health and safety and to support learning; however, relationships with primary caregivers/teachers should be supported.

9) 2.2.0.1 Methods of Supervision of Children (Stepping Stones, S. 1086, HS 40, SS3 KI, Pilot)

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

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

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

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

10) 2.2.0.4 Supervision Near Bodies of Water (Stepping Stones, S. 1086, Pilot)

Constant supervision should be maintained when any child is in or around water. During any swimming/wading/water play activities where either an infant or a toddler is present, the ratio should always be one adult to one infant/toddler. Children ages 13 months to five years of age should not be permitted to play in areas where there is any body of water, including swimming pools, ponds and irrigation ditches, built-in wading pools, tubs, pails, sinks, or toilets unless the supervising adult is within an arm's length providing "touch

supervision". Caregivers/teachers should ensure that all pools meet the Virginia Graeme Baker Pool and Spa Safety Act, requiring the retrofitting of safe suction-type devices for pools and spas to prevent underwater entrapment of children in locations with strong suction devices that have led to deaths of children of varying ages.

11) 2.2.0.6 Discipline Measures (Stepping Stones, S. 1086, Pilot)

Caregivers/teachers should guide children to develop self-control and appropriate behaviors in the context of relationships with peers and adults. Caregivers/teachers may never use physical punishment or abusive language. When a child needs assistance to resolve a conflict, manage a transition, engage in a challenging situation, or express feelings, needs, and wants, the adult should help the child learn strategies for dealing with the situation. Expectations for children's behavior and the facility's policies regarding their response to behaviors should be written and shared with families and children of appropriate age. Further, the policies should address proactive as well as reactive strategies. Programs should work with families to support their children's appropriate behaviors before it becomes a problem. For detail, please see CFOC 2.2.0.6.

12) 2.2.0.8 Preventing Expulsions, Suspensions, and Other Limitations in Services (Stepping Stones, S. 1086)

Early care and education programs should have a comprehensive discipline policy that includes an explicit description of alternatives to expulsion for children exhibiting extreme levels of challenging behaviors, and should include the program's protocol for preventing challenging behaviors. These policies should be in writing and clearly articulated and communicated to parents/guardians, staff and others. These policies should also explicitly state how the program plans to use any available internal mental health and other support staff during behavioral crises to eliminate to the degree possible any need for external supports (e.g., local police departments) during crises.

Staff should have access to in-service training on both a proactive and as-needed basis on how to reduce the likelihood of problem behaviors escalating to the level of risk for expulsion and how to more effectively manage behaviors throughout the entire class/group. Staff should also have access to in-service training, resources, and child care health consultation to manage children's health conditions in collaboration with parents/guardians and the child's primary care provider. Programs should attempt to obtain access to behavioral or mental health consultation to help establish and maintain environments that will support children's mental well-being and social-emotional health, and have access to such a consultant when more targeted child-specific interventions are needed. For detail, please see CFOC 2.2.0.8.

13) 2.2.0.9 Prohibited Caregiver/Teacher Behaviors (Stepping Stones, Pilot)

The following behaviors should be prohibited in all early care and education settings and by all caregivers/teachers:

- a. The use of corporal punishment. Corporal punishment means punishment inflicted directly on the body including, but not limited to:

- i. Hitting, spanking (refers to striking a child with an open hand on the buttocks or extremities with the intention of modifying behavior without causing physical injury), shaking, slapping, twisting, pulling, squeezing, or biting;
 - ii. Demanding excessive physical exercise, excessive rest, or strenuous or bizarre postures;
 - iii. Compelling a child to eat or have in his/her mouth soap, food, spices, or foreign substances;
 - iv. Exposing a child to extremes of temperature.
- b. Isolating a child in an adjacent room, hallway, closet, darkened area, play area, or any other area where a child cannot be seen or supervised;
 - c. Binding or tying to restrict movement, such as in a car seat (except when travelling) or taping the mouth;
 - d. Using or withholding food as a punishment or reward;
 - e. Toilet learning/training methods that punish, demean, or humiliate a child;
 - f. Any form of emotional abuse, including rejecting, terrorizing, extended ignoring, isolating, or corrupting a child;
 - g. Any abuse or maltreatment of a child, either as an incident of discipline or otherwise. Any early care and education program must not tolerate, or in any manner condone, an act of abuse or neglect of a child by an older child, employee, volunteer, or any person employed by the facility or child's family;
 - h. Abusive, profane, or sarcastic language or verbal abuse, threats, or derogatory remarks about the child or child's family;
 - i. Any form of public or private humiliation, including threats of physical punishment;
 - j. Physical activity/outdoor time should not be taken away as punishment.

14) 2.2.0.10 Using Physical Restraint (Stepping Stones, Pilot)

When a child with special behavioral or mental health issues is enrolled who may frequently need the cautious use of restraint in the event of behavior that endangers his or her safety or the safety of others, a behavioral care plan should be developed with input from the child's primary care provider, mental health provider, parents/guardians, center director/family child care home caregiver/teacher, child care health consultant, and possibly early childhood mental health consultant in order to address underlying issues and reduce the need for physical restraint. It should never be necessary to physically restrain a typically developing child unless his/her safety and/or that of others are at risk. For detail, please see CFOC 2.2.0.10.

Health Promotion and Protection

15) 3.1.1.1 Conduct of Daily Health Check

Every day, a trained staff member should conduct a health check of each child. This health check should be conducted as soon as possible after the child enters the early care and

education facility and whenever a change in the child's behavior or appearance is noted while that child is in care. The health check should address:

- a. Reported or observed illness or injury affecting the child or family members since the last date of attendance;
- b. Reported or observed changes in behavior of the child (such as lethargy or irritability) or in the appearance (e.g., sad) of the child from the previous day at home or the previous day's attendance at an early care and education program;
- c. Skin rashes, impetigo, itching or scratching of the skin, itching or scratching of the scalp, or the presence of one or more live crawling lice;
- d. A temperature check if the child appears ill (a daily screening temperature check is not recommended);
- e. Other signs or symptoms of illness and injury (such as drainage from eyes, vomiting, diarrhea, cuts/lacerations, pain, or feeling ill).

The caregiver/teacher should gain information necessary to complete the daily health check by direct observation of the child, by querying the parent/guardian, and, where applicable, by conversation with the child.

16) 3.1.3.1 Active Opportunities for Physical Activity (S. 1086, Pilot)

The facility should promote children's active play every day. Children should have ample opportunity to do moderate to vigorous activities such as running, climbing, dancing, skipping, and jumping. Infants should have supervised tummy time every day when they are awake. Beginning on the first day at the early care and education program, caregivers/teachers should interact with an awake infant on their tummy for short periods of time (three to five minutes), increasing the amount of time as the infant shows s/he enjoys the activity. For detail, please see CFOC 3.1.3.1.

17) 3.1.4.1 Safe Sleep Practices and SIDS Risk Reduction (Stepping Stones, S. 1086, Pilot)

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

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

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

- a. Infants up to 12 months of age should be placed for sleep in a supine position (wholly on their back) for every nap or sleep time unless the infant's primary care provider has completed a signed waiver indicating that the child requires an alternate sleep position;
- b. Infants should be placed for sleep in safe sleep environments; which includes: a firm crib mattress covered by a tight-fitting sheet in a safety-approved crib (the crib should meet the standards and guidelines reviewed/approved by the U.S. Consumer Product Safety Commission [CPSC] and ASTM International), no monitors or positioning devices should be used unless required by the child's primary care provider, and no other items should be in a crib occupied by an infant except for a pacifier;
- c. Infants should not nap or sleep in a car safety seat, bean bag chair, bouncy seat, infant seat, swing, jumping chair, play pen or play yard, highchair, chair, futon, or any other type of furniture/equipment that is not a safety-approved crib (that is in compliance with the CPSC and ASTM safety standards);
- d. If an infant arrives at the facility asleep in a car safety seat, the parent/guardian or caregiver/teacher should immediately remove the sleeping infant from this seat and place them in the supine position in a safe sleep environment (i.e., the infant's assigned crib);
- e. If an infant falls asleep in any place that is not a safe sleep environment, staff should immediately move the infant and place them in the supine position in their crib;
- f. Only one infant should be placed in each crib (stackable cribs are not recommended);
- g. Soft or loose bedding should be kept away from sleeping infants and out of safe sleep environments. These include, but are not limited to: bumper pads, pillows, quilts, comforters, sleep positioning devices, sheepskins, blankets, flat sheets, cloth diapers, bibs, etc. Also, blankets/items should not be hung on the sides of cribs. Swaddling infants when they are in a crib is not necessary or recommended, but rather one-piece sleepers should be used;
- h. Toys, including mobiles and other types of play equipment that are designed to be attached to any part of the crib should be kept away from sleeping infants and out of safe sleep environments;
- i. When caregivers/teachers place infants in their crib for sleep, they should check to ensure that the temperature in the room is comfortable for a lightly clothed adult, check the infants to ensure that they are comfortably clothed (not overheated or sweaty), and that bibs, necklaces, and garments with ties or hoods are removed (clothing sacks or other clothing designed for sleep can be used in lieu of blankets);
- j. Infants should be directly observed by sight and sound at all times, including when they are going to sleep, are sleeping, or are in the process of waking up;
- k. Bedding should be changed between children, and if mats are used, they should be cleaned between uses.

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

A caregiver/teacher trained in safe sleep practices and approved to care for infants should be present in each room at all times where there is an infant. This caregiver/teacher should remain alert and should actively supervise sleeping infants in an ongoing manner. Also, the caregiver/teacher should check to ensure that the infant's head remains uncovered and re-adjust clothing as needed. The construction and use of sleeping rooms for infants separate from the infant group room is not recommended due to the need for direct supervision. In situations where there are existing facilities with separate sleeping rooms, facilities should develop a plan to modify room assignments and/or practices to eliminate placing infants to sleep in separate rooms.

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

18) 3.1.5.1 Routine Oral Hygiene Activities (Stepping Stones, Pilot)

Caregivers/teachers should promote the habit of regular tooth brushing. All children with teeth should brush or have their teeth brushed at least once during the hours the child is in an early care and education program. For detail, please see CFOC 3.1.5.1.

19) 3.2.1.4 Diaper Changing Procedure (Stepping Stones, S. 1086, SS3 KI, Pilot)

The following diaper changing procedure should be posted in the changing area, should be followed for all diaper changes, and should be used as part of staff evaluation of caregivers/teachers who diaper. The signage should be simple and should be in multiple languages if caregivers/teachers who speak multiple languages are involved in diapering. All employees who will diaper should undergo training and periodic assessment of diapering practices. Caregivers/teachers should never leave a child unattended on a table or countertop, even for an instant. A safety strap or harness should not be used on the diaper changing table. If an emergency arises, caregivers/teachers should bring any child on an elevated surface to the floor or take the child with them.

An EPA-registered disinfectant suitable for the surface material that is being disinfected should be used. If an EPA-registered product is not available, then household bleach diluted with water is a practical alternative. All cleaning and disinfecting solutions should be stored to be accessible to the caregiver/teacher but out of reach of any child.

Step 1: Get organized. Before bringing the child to the diaper changing area, perform hand hygiene, gather and bring supplies to the diaper changing area.

Step 2: Carry the child to the changing table, keeping soiled clothing away from you and any surfaces you cannot easily clean and sanitize after the change. Always keep a hand on the child.

Step 3: Clean the child's diaper area.

Step 4: Remove the soiled diaper and clothing without contaminating any surface not already in contact with stool or urine.

Step 5: Put on a clean diaper and dress the child.

Step 6: Wash the child's hands and return the child to a supervised area.

Step 7: Clean and disinfect the diaper-changing surface

Dispose of the disposable paper liner used on the diaper changing surface in a plastic-lined, hands-free covered can. If clothing was soiled, securely tie the plastic bag used to store the clothing and send home.

Step 8: Perform hand hygiene and record the diaper change in the child's daily log.

In the daily log, record what was in the diaper and any problems (such as a loose stool, an unusual odor, blood in the stool, or any skin irritation), and report as necessary.

20) 3.2.2.1 Situations that Require Hand Hygiene (Stepping Stones, S. 1086, HS 40, SS3 KI, Pilot)

All staff, volunteers, and children should follow procedures for hand washing as necessary throughout the day including: Upon arrival for the day, after breaks, or when moving from one group to another;

Before and after:

1. Preparing food or beverages;
2. Eating, handling food, or feeding a child;
3. Giving medication or applying a medical ointment or cream in which a break in the skin (e.g., sores, cuts, or scrapes) may be encountered;
4. Playing in water (including swimming) that is used by more than one person;
5. Diapering;

After:

6. Using the toilet or helping a child use a toilet;
7. Handling bodily fluid (mucus, blood, vomit), from sneezing, wiping and blowing noses, from mouths, or from sores;
8. Handling animals or cleaning up animal waste;
9. Playing in sand, on wooden play sets, and outdoors;
10. Cleaning or handling the garbage.

Situations or times that children and staff should perform hand hygiene should be posted in all food preparation, hand hygiene, diapering, and toileting areas.

21) 3.2.2.2 Hand Washing Procedure (Stepping Stones, S. 1086, HS 40, SS3 KI, Pilot)

Children and staff members should wash their hands using the following method:

- a. Check to be sure a clean, disposable towel is available;
- b. Turn on water to a comfortable temperature;
- c. Moisten hands with water and apply soap to hands;

- d. Rub hands together vigorously until a soapy lather appears, hands are out of the water stream, and continue for at least twenty seconds (sing Happy Birthday silently twice).
- e. Rinse hands under running water until they are free of soap and dirt. Leave the water running while drying hands;
- f. Dry hands with the clean, disposable paper or single use cloth towel;
- g. If taps do not shut off automatically, turn taps off with a disposable towel.

The use of alcohol based hand sanitizers is an alternative to traditional hand washing with soap and water by children over twenty-four months of age and adults on hands that are not visibly soiled. A single pump of an alcohol-based sanitizer should be dispensed. Hands should be rubbed together, distributing sanitizer to all hand and finger surfaces and hands should be permitted to air dry.

Situations/times that children and staff should wash their hands should be posted in all hand washing areas.

Children and staff who need to open a door to leave a bathroom or diaper changing area should open the door with a disposable towel to avoid re-contaminating clean hands. If a child can not open the door or turn off the faucet, they should be assisted by an adult.

22) 3.2.3.4 Prevention of Exposure to Blood and Body Fluids (Stepping Stones, S. 1086, Pilot)

Early care and education facilities should adopt the use of Standard Precautions developed for use in hospitals by The Centers for Disease Control and Prevention. Standard Precautions should be used to handle potential exposure to blood, including blood-containing body fluids and tissue discharges, and to handle other potentially infectious fluids. In early care and education settings:

- a. Use of disposable gloves is optional unless blood or blood containing body fluids may contact hands. Gloves are not required for feeding human milk, cleaning up of spills of human milk, or for diapering;
 - b. Gowns and masks are not required;
 - c. Barriers to prevent contact with body fluids include moisture-resistant disposable diaper table paper, disposable gloves, and eye protection.
- Caregivers/teachers are required to be educated regarding Standard Precautions to prevent transmission of blood borne pathogens before beginning to work in the facility and at least annually thereafter. Training must comply with requirements of the Occupational Safety and Health Administration. For details, please see CFOC 3.2.3.4.

23) 3.3.0.1 Routine Cleaning, Sanitizing, and Disinfecting (Stepping Stones, S. 1086, Pilot)

Keeping objects and surfaces in a early care and education setting as clean and free of pathogens as possible requires a combination of frequent cleaning and, when necessary, an application of a sanitizer or disinfectant. Facilities should follow a routine schedule of cleaning, sanitizing, and disinfecting as outlined in Appendix K. Cleaning, sanitizing and

disinfecting products should not be used in close proximity to children, and adequate ventilation should be maintained during any cleaning, sanitizing or disinfecting procedure to prevent children and caregivers/teachers from inhaling potentially toxic fumes.

24) 3.4.1.1 Use of Tobacco, Alcohol, and Illegal Drugs (Stepping Stones, Pilot)

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

25) 3.4.3.1 Emergency Procedures (Stepping Stones, S. 1086, HS 40, SS3 KI)

When an immediate emergency medical response is required, the following emergency procedures should be utilized:

- a. First aid should be employed and an emergency medical response team should be called such as 9-1-1 and/or the poison center if a poison emergency (1-800-222-1222);
- b. The program should implement a plan for emergency transportation to a local emergency medical facility;
- c. The parent/guardian or parent/guardian's emergency contact person should be called as soon as practical;
- d. A staff member should accompany the child to the hospital and will stay with the child until the parent/guardian or emergency contact person arrives. Child to staff ratio must be maintained, so staff may need to be called in to maintain the required ratio.

Programs should develop contingency plans for emergencies or disaster situations when it may not be possible or feasible to follow standard or previously agreed upon emergency procedures. Children with known medical conditions that might involve emergent care require a Care Plan created by the child's primary care provider. All staff should be trained to manage an emergency until emergency medical care becomes available.

26) 3.4.4.1 Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation

Each facility should have a written policy for reporting child abuse and neglect. Caregivers/teachers are mandated reporters of child abuse and neglect. The facility should report to the child abuse reporting hotline, department of social services, child protective services, or police as required by state and local laws, in any instance where there is reasonable cause to believe that child abuse and neglect has occurred. Every staff person should be oriented to what and how to report. Phone numbers and reporting system as required by state or local agencies should be clearly posted by every phone.

Caregivers/teachers should receive initial and ongoing training to assist them in preventing child abuse and neglect and in recognizing signs of child abuse and neglect. Programs are encouraged to partner with primary care providers, child care health consultants and/or child protection advocates to provide training and to be available for consultation. Employees and volunteers in centers and large family child care homes should receive an

instruction sheet about child abuse and neglect reporting that contains a summary of the state child abuse reporting statute and a statement that they will not be discharged/disciplined solely because they have made a child abuse and neglect report. Some states have specific forms that are required to be completed when abuse and neglect is reported. Some states have forms that are not required but assist mandated reporters in documenting accurate and thorough reports.

In those states, facilities should have such forms on hand and all staff should be trained in the appropriate use of those forms. Parents/guardians should be notified upon enrollment of the facility's child abuse and neglect reporting requirement and procedures.

27) 3.4.4.3 Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma (Stepping Stones)

All early care and education facilities should have a policy and procedure to identify and prevent shaken baby syndrome/abusive head trauma. All caregivers/teachers who are in direct contact with children including substitute caregivers/teachers and volunteers, should receive training on preventing shaken baby syndrome/abusive head trauma, recognition of potential signs and symptoms of shaken baby syndrome/abusive head trauma, strategies for coping with a crying, fussing or distraught child, and the development and vulnerabilities of the brain in infancy and early childhood.

28) 3.4.4.5 Facility Layout to Reduce Risk of Child Abuse and Neglect (Pilot)

The physical layout of facilities should be arranged so that there is a high level of visibility in the inside and outside areas as well as diaper changing areas and toileting areas used by children. All areas should be viewed by at least one other adult in addition to the caregiver/teacher at all times when children are in care. For center-based programs, rooms should be designed so that there are windows to the hallways to keep classroom activities from being too private. Ideally each area of the facility should have two adults at all times. Such an arrangement reduces the risk of child abuse and neglect and the likelihood of extended periods of time in isolation for individual caregivers/teachers with children, especially in areas where children may be partially undressed or in the nude.

Caregivers/teachers should have increased awareness of risk of abuse and neglect when a caregiver/teacher is alone with a child. Other caregivers/teachers should periodically walk into a room with one caregiver/teacher to ensure there is no abuse and neglect.

29) 3.4.6.1 Strangulation Hazards (Stepping Stones, S. 1086, HS 40, Pilot)

Strings and cords (such as those that are parts of toys and those found on window coverings) long enough to encircle a child's neck should not be accessible to children in early care and education programs. Mini-blinds and venetian blinds should not have looped cords. Vertical blinds, continuous looped blinds, and drapery cords should have tension or tie-down devices to hold the cords tight. Inner cord stops should be installed. Shoulder straps on guitars and chin straps on hats should be removed.

Straps/handles on purses/bags used for dramatic play should be removed or shortened. Ties, scarves, necklaces, and boas used for dramatic play should not be used for children under three years. If used by children three years and over, children should be supervised.

Pacifiers attached to strings or ribbons should not be placed around infants' necks or attached to infants' clothing.

Hood and neck strings from all children's outerwear, including jackets and sweatshirts, should be removed. Drawstrings on the waist or bottom of garments should not extend more than three inches outside the garment when it is fully expanded. These strings should have no knots or toggles on the free ends. The drawstring should be sewn to the garment at its midpoint so the string cannot be pulled out through one side.

30) 3.5.0.1 Care Plan for Children with Special Health Care Needs (Stepping Stones, S. 1086, HS 40)

Reader's Note: Children with special health care needs are defined as "...those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally".

Any child who meets these criteria should have a Routine and Emergent Care Plan completed by their primary care provider in their medical home and included in their on-site health record. The Care Plan should be updated after every hospitalization or significant change in health status of the child. The Care Plan is completed by the primary care provider in the medical home with input from parents/guardians, and it is implemented in the early care and education setting. The child care health consultant should be involved to assure adequate information, training, and monitoring is available for early care and education staff. For detail, please see CFOC 3.5.0.1.

31) 3.6.1.1 Inclusion/Exclusion/Dismissal of Children (Stepping Stones)

Daily health checks as described in Standard 3.1.1.1 should be performed upon arrival of each child each day. Staff should objectively determine children are ill or well and which children with mild illnesses can remain in care and which need to be excluded.

Staff should notify the parent/guardian when children develop new signs or symptoms of illness. Parent/guardian notification should be immediate for emergency or urgent issues. Staff should notify parents/guardians of children who have symptoms that require exclusion and parents/guardians should remove children from the early care and education setting as soon as possible. For children whose symptoms do not require exclusion, verbal or written notification of the parent/guardian at the end of the day is acceptable. Most conditions that require exclusion do not require a primary care provider visit before re-entering care.

Conditions/symptoms that do not require exclusion:

- a. Common colds, runny noses;
- b. A cough not associated with a infectious disease or a fever;
- c. Watery, yellow or white discharge or crusting eye discharge without fever, eye pain, or eyelid redness;
- d. Yellow or white eye drainage that is not associated with pink or red conjunctiva (i.e., the whites of the eyes);
- e. Pink eye (bacterial conjunctivitis) indicated by pink or red conjunctiva with white or yellow eye mucous drainage and matted eyelids after sleep. Parents/guardians should discuss care with child's primary care provider. If two unrelated children in the same program have conjunctivitis, there may be a higher risk of transmission and a health care professional should be consulted;
- f. Fever without any signs or symptoms of illness in children who are older than six months regardless of whether acetaminophen or ibuprofen was given. Fever (temperature above 101°F [38.3°C] orally or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method) is an indication of the body's response to something, but is neither a disease nor a serious problem by itself. Body temperature can be elevated by overheating caused by overdressing or a hot environment, reactions to medications, and response to infection.
- g. Rash without fever and behavioral changes;
- h. Lice or nits (exclusion for treatment of an active lice infestation may be delayed until the end of the day);
- i. Ringworm (exclusion for treatment may be delayed until the end of the day);
- j. Molluscum contagiosum (do not require exclusion or covering of lesions);
- k. Thrush (i.e., white spots or patches in the mouth or on the cheeks or gums);
- l. Fifth disease (slapped cheek disease, parvovirus B19) once the rash has appeared;
- m. Methicillin-resistant *Staphylococcus aureus*, or MRSA, without an infection or illness that would otherwise require exclusion. Known MRSA carriers or colonized individuals should not be excluded;
- n. Cytomegalovirus infection;
- o. Chronic hepatitis B infection;
- p. Human immunodeficiency virus (HIV) infection;
- q. Asymptomatic children who have been previously evaluated and found to be shedding potentially infectious organisms in the stool. Children who are continent of stool or who are diapered with formed stools that can be contained in the diaper may return to care. For some infectious organisms, exclusion is required until certain guidelines have been met. Note: These agents are not common and caregivers/teachers will usually not know the cause of most cases of diarrhea;
- r. Children with chronic infectious conditions that can be accommodated according to the Americans with Disabilities Act.

Key criteria for exclusion of children who are ill:

When a child becomes ill but does not require immediate medical help, a determination must be made regarding whether the child should be sent home (i.e., should be

temporarily “excluded” from early care and education). Most illnesses do not require exclusion. The caregiver/teacher should determine if the illness:

- a. Prevents the child from participating comfortably in activities;
- b. Results in a need for care that is greater than the staff can provide without compromising the health and safety of other children;
- c. Poses a risk of spread of harmful diseases to others.

If any of the above criteria are met, the child should be excluded, regardless of the type of illness. The child should be removed from direct contact with other children and should be monitored and supervised by a single staff member known to the child until dismissed from care to the care of a parent/guardian or a primary care provider. The area should be where the toys, equipment, and surfaces will not be used by other children or adults until after the ill child leaves and after the surfaces and toys have been cleaned and disinfected.

Temporary exclusion is recommended when the child has any of the following conditions:

- a. The illness prevents the child from participating comfortably in activities;
- b. The illness results in a need for care that is greater than the staff can provide without compromising the health and safety of other children;
- c. An acute change in behavior this could include lethargy/lack of responsiveness, irritability, persistent crying, difficult breathing, or having a quickly spreading rash;
- d. Fever (temperature above 101°F [38.3°C] orally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method) and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, diarrhea). An unexplained temperature above 100°F (37.8°C) axillary (armpit) in a child younger than six months should be medically evaluated. Any infant younger than two months of age with fever should get urgent medical attention.

Diarrhea is defined by watery stools or decreased form of stool that is not associated with changes of diet. Exclusion is required for all diapered children whose stool is not contained in the diaper and toilet-trained children if the diarrhea is causing soiled pants or clothing. In addition, diapered children with diarrhea should be excluded if the stool frequency exceeds two or more stools above normal for that child. Re-admission after diarrhea can occur when diapered children have their stool contained by the diaper (even if the stools remain loose) and when toilet-trained children are continent. Special circumstances that require specific exclusion criteria include the following:

- a. Toxin-producing *E. coli* or *Shigella* infection, until stools are formed and the test results of two stool cultures obtained from stools produced 24 hours apart do not detect these organisms;
- b. *Salmonella* serotype Typhi infection, until diarrhea resolves. In children younger than five years with *Salmonella* serotype Typhi, three negative stool cultures obtained with 24-hour intervals are required; people five years of age or older

- may return after a 24-hour period without a diarrheal stool. Stool cultures should be collected from other attendees and staff members, and all infected people should be excluded;
- c. Blood or mucus in the stools not explained by dietary change, medication, or hard stools;
 - d. Vomiting more than two times in the previous 24 hours, unless the vomiting is determined to be caused by a non-infectious condition and the child remains adequately hydrated;
 - e. Abdominal pain that continues for more than two hours or intermittent pain associated with fever or other signs or symptoms of illness;
 - f. Mouth sores with drooling unless the child's primary care provider or local health department authority states that the child is non-infectious;
 - g. Rash with fever or behavioral changes, until the primary care provider has determined that the illness is not a infectious disease;
 - h. Active tuberculosis, until the child's primary care provider or local health department states child is on appropriate treatment and can return;
 - i. Impetigo, until treatment has been started;
 - j. Streptococcal pharyngitis (i.e., strep throat or other streptococcal infection), until 24 hours after treatment has been started;
 - k. Head lice until after the first treatment (note: exclusion is not necessary before the end of the program day);
 - l. Scabies, until after treatment has been given;
 - m. Chickenpox (varicella), until all lesions have dried or crusted (usually six days after onset of rash);
 - n. Rubella, until six days after the rash appears;
 - o. Pertussis, until five days of appropriate antibiotic treatment;
 - p. Mumps, until five days after onset of parotid gland swelling;
 - q. Measles, until four days after onset of rash;
 - r. Hepatitis A virus infection, until one week after onset of illness or jaundice if the child's symptoms are mild or as directed by the health department. (Note: Immunization status of early care and education contacts should be confirmed; within a 14 day period of exposure, incompletely immunized or unimmunized contacts 40 years of age and younger should receive the hepatitis A vaccine as post exposure prophylaxis, unless contraindicated. Consult with a primary care provider for recommendations);
 - s. Any child determined by the local health department to be contributing to the transmission of illness during an outbreak.

Procedures for a child who requires exclusion:

The caregiver/teacher will:

- a. Provide care for the child in a place where the child will be comfortable and supervised by someone who knows the child well and who will observe the child for new or worsening symptoms. A potentially contagious child should be

- separated from other children by at least three feet. Each facility should have a predetermined physical location(s) where an ill child(ren) could be placed until care can be transferred to a parent/guardian or primary care provider;
- b. Ask the family to pick up the child as soon as possible;
 - c. Discuss the signs and symptoms of illness with the parent/guardian who is assuming care. Review guidelines for return to the early care and education program. If necessary, provide the family with a written communication that may be given to the primary care provider. The communication should include onset time of symptoms, observations about the child, vital signs and times (e.g., temperature 101.5°F at 10:30 AM) and any actions taken and the time actions were taken (e.g., one children's acetaminophen given at 11:00 AM). The nature and severity of symptoms and or requirements of the local or state health department will determine the necessity of medical consultation. Telephone and electronic transmissions of instructions are acceptable without an office visit;
 - d. Follow the advice of the child's primary care provider;
 - e. Contact the local health department if there is a question of a reportable (harmful) infectious disease in a child or staff member in the facility. If there are conflicting opinions from different primary care providers about the management of a child with a reportable infectious disease, the health department has the legal authority to make a final determination;
 - f. Document actions in the child's file with date, time, symptoms, and actions taken (and by whom); sign and date the document;
 - g. In collaboration with the local health department, notify the parents of contacts to the child or staff member with presumed or confirmed reportable infectious infection.

The caregiver/teacher should make the decision about whether a child meets or does not meet the exclusion criteria for participation and the child's need for care relative to the staff's ability to provide care. If parents/guardians and staff disagree, and the reason for exclusion relates to the child's ability to participate or the caregiver's/teacher's ability to provide care for the other children, the caregiver/teacher should not be required to accept responsibility for the care of the child.

Reportable conditions:

The [current list of infectious diseases](#) is designated as notifiable by the Centers for Disease Control and Prevention.

The caregiver/teacher should contact the local health department:

- a. When a child or staff member who is in contact with others has a reportable disease;
- b. If a reportable illness occurs among the staff, children, or families involved with the program;
- c. For assistance in managing a suspected outbreak. Generally, an outbreak can be considered to be two or more unrelated children with the same diagnosis or

symptoms in the same group within one week. Clusters of mild respiratory illness, ear infections, and certain dermatological conditions are common and generally do not need to be reported.

32) 3.6.1.2 Staff Exclusion for Illness (Stepping Stones)

Please note that if a staff member has no contact with the children, or with anything with which the children come into contact, this standard may not apply to that staff member.

A program should not deny admission to or send home a staff member or substitute with illness unless one or more of the following conditions exists:

- a. Chickenpox, until all lesions have dried and crusted, which usually occurs by six days;
- b. Shingles, only if the lesions cannot be covered by clothing or a dressing until the lesions have crusted;
- c. Rash with fever or joint pain, until diagnosed not to be measles or rubella;
- d. Measles, until four days after onset of the rash (if the staff member or substitute is immunocompetent);
- e. Rubella, until six days after onset of rash;
- f. Diarrheal illness, stool frequency exceeds two or more stools above normal for that individual or blood in stools, until diarrhea resolves; if *E. coli* 0157:H7 or *Shigella* is isolated, until diarrhea resolves and two stool cultures are negative, for *Salmonella* serotype Typhi, three stool cultures collected at 24 hour intervals and resolution of diarrhea is required;
- g. Vomiting illness, two or more episodes of vomiting during the previous twenty-four hours, until vomiting resolves or is determined to result from non-infectious conditions;
- h. Hepatitis A virus, until one week after symptom onset or as directed by the health department;
- i. Pertussis, until after five days of appropriate antibiotic therapy;
- j. Skin infection (such as impetigo), until treatment has been initiated; exclusion should continue if lesion is draining AND cannot be covered;
- k. Tuberculosis, until noninfectious and cleared by a health department official or a primary care provider;
- l. Strep throat or other streptococcal infection until 24 hours after initial antibiotic treatment and end of fever;
- m. Head lice, from the end of the day of discovery until after the first treatment;
- n. Scabies, until after treatment has been completed;
- o. *Haemophilus influenzae* type b, prophylaxis, until antibiotic treatment has been initiated;
- p. Meningococcal infection, until appropriate therapy has been administered for 24 hours;
- q. Respiratory illness, if the illness limits the staff member's ability to provide an acceptable level of care and compromises the health and safety of the children.

Caregivers/teachers who have herpes cold sores should not be excluded from the early care and education facility, but should:

1. Cover and not touch their lesions;
2. Carefully observe hand hygiene policies.

33) 3.6.1.4 Infectious Disease Outbreak Control (Stepping Stones, S. 1086)

During the course of an identified outbreak of any reportable illness at the facility, a child or staff member should be excluded if the health department official or primary care provider suspects that the child or staff member is contributing to transmission of the illness at the facility, is not adequately immunized when there is an outbreak of a vaccine preventable disease, or the circulating pathogen poses an increased risk to the individual. The child or staff member should be readmitted when the health department official or primary care provider who made the initial determination decides that the risk of transmission is no longer present.

34) 3.6.3.1/3.6.3.2 Medication Administration and Storage (Stepping Stones, S. 1086, HS 40, SS3 KI, Pilot)

The administration of medicines at the facility should be limited to:

- a. Prescription or non-prescription medication (over-the-counter) ordered by the prescribing health professional for a specific child with written permission of the parent/guardian. Written orders from the prescribing health professional should specify medical need, medication, dosage, and length of time to give medication;
- b. Labeled medications brought to the early care and education facility by the parent/guardian in the original container (with a label that includes the child's name, date filled, prescribing clinician's name, pharmacy name and phone number, dosage/instructions, relevant warnings as well as specific, legible instructions for administration, storage, and disposal).

Programs should not administer folk or homemade remedies or treatment. Programs should not administer a medication that is prescribed for one child in the family to another child in the family.

Non-prescription sunscreen and insect repellent require parental consent but do not require instructions from each child's prescribing health professional. Documentation that the medicine/agent is administered to the child as prescribed is required. Over-the-counter medications should be kept in the original container as sold by the manufacturer, labeled by the parent/guardian, with the child's name and specific instructions given by the child's prescribing health professional for administration. All medications, refrigerated or unrefrigerated, should:

- a. Have child-resistant caps;
- b. Be kept in an organized fashion;
- c. Be stored away from food;
- d. Be stored at the proper temperature;
- e. Be completely inaccessible to children.

Medication should not be used beyond the date of expiration. Unused medications should be returned to the parent/guardian for disposal. In the event medication cannot be returned to the parent or guardian, it should be disposed of according to the recommendations of the US Food and Drug Administration. Documentation of all disposed medications should be kept in the early care and education setting.

35) 3.6.3.3 Training of Caregivers/Teachers to Administer Medication (Stepping Stones, S. 1086)

Any caregiver/teacher who administers medication should complete a standardized training course that includes skill and competency assessment in medication administration. The trainer in medication administration should be a licensed health professional. The course should be repeated according to state and/or local regulation. At a minimum, skill and competency should be monitored annually or whenever medication administration error occurs. In facilities with large numbers of children with special health care needs involving daily medication, best practice would indicate strong consideration to the hiring of a licensed health care professional. The trainer in medication administration should be a licensed health professional: Registered Nurse, Advanced Practice Registered Nurse, Physician, Physician's Assistant, or Pharmacist.

Nutrition and Food Service

36) 4.2.0.3 Use of U.S. Department of Agriculture (USDA) , Child and Adult Care Food Program (CACFP) Guidelines (Stepping Stones, S. 1086, Pilot)

All meals and snacks and their preparation, service, and storage should meet the requirements for meals of the child care component of the USDA, CACFP, and the 7 Code of Federal Regulations Part 226.20.

37) 4.2.0.6 Availability of Drinking Water (Stepping Stones, S. 1086, Pilot)

Clean, sanitary drinking water should be readily available, in indoor and outdoor areas, throughout the day. Water should not be a substitute for milk at meals or snacks where milk is a required food component unless it is recommended by the child's primary care provider.

On hot days, infants receiving human milk in a bottle can be given additional human milk in a bottle but should not be given water, especially in the first six months of life. Infants receiving formula and water can be given additional formula in a bottle. Toddlers and older children will need additional water as physical activity and/or hot temperatures cause their needs to increase. Children should learn to drink water from a cup or drinking fountain without mouthing the fixture. They should not be allowed to have water continuously in hand in a "sippy cup" or bottle. Permitting toddlers to suck continuously on a bottle or sippy cup filled with water, in order to soothe themselves, may cause nutritional or in rare instances, electrolyte imbalances. When tooth brushing is not done after a feeding, children should be offered water to drink to rinse food from their teeth.

38) 4.2.0.10 Care for Children with Food Allergies (Stepping Stones, S. 1086, HS 40, Pilot)

When children with food allergies attend the early care and education facility, the following should occur:

1. Each child with a food allergy should have a care plan prepared for the facility by the child's primary care provider, to include:
 - a. Written instructions regarding the food(s) to which the child is allergic and steps to be taken to avoid that food;
 - b. A detailed treatment plan to be implemented in the event of an allergic reaction, including the names, doses, and methods of administration of any medications that the child should receive in the event of a reaction. The plan should include specific symptoms that would indicate the need to administer one or more medications.
2. Based on the child's care plan, the child's caregivers/teachers should receive training, demonstrate competence in, and implement measures for:
 - a. Preventing exposure to the specific food(s) to which the child is allergic;
 - b. Recognizing the symptoms of an allergic reaction;
 - c. Treating allergic reactions;
3. Parents/guardians and staff should arrange for the program to have necessary medications, proper storage of such medications, and the equipment and training to manage the child's food allergy while the child is present;
4. Caregivers/teachers should promptly and properly administer prescribed medications in the event of an allergic reaction according to the instructions in the care plan;
5. The program should notify the parents/guardians immediately of any suspected allergic reactions, the ingestion of the problem food, or contact with the problem food, even if a reaction did not occur;
6. The program should recommend to the family that the child's primary care provider be notified if the child has required treatment for a food allergic reaction;
7. The program should contact the emergency medical services system immediately whenever epinephrine has been administered;
8. Parents/guardians of all children in the child's class should be advised to avoid any known allergens in class treats or special foods brought into the early care and education setting;
9. Individual child's food allergies should be posted prominently in the classroom where staff can view and/or wherever food is served;
10. The written child care plan, a mobile phone, and the proper medications for appropriate treatment if the child develops an acute allergic reaction should be routinely carried on field trips or transport out of the early care and education setting.

39) 4.3.1.3 Preparing, Feeding, and Storing Human Milk (Stepping Stones, S. 1086, Pilot)

Expressed human milk should be placed in a clean and sanitary bottle with a nipple that fits tightly or into an equivalent clean and sanitary sealed container to prevent spilling during transport to home or to the facility. Only cleaned and sanitized bottles, or their equivalent, and nipples should be used. The bottle or container should be properly labeled with the

infant's full name and the date and time the milk was expressed. The bottle or container should immediately be stored in the refrigerator on arrival.

The mother's own expressed milk should only be used for her own infant. Likewise, infant formula should not be used for a breastfed infant without the mother's written permission.

Bottles made of plastics containing BPA or phthalates should be avoided (labeled with #3, #6, or #7). Glass bottles or plastic bottles labeled BPA-free or with #1, #2, #4, or #5 are acceptable.

Non-frozen human milk should be transported and stored in the containers to be used to feed the infant, identified with a label which will not come off in water or handling, bearing the date of collection and child's full name. The filled, labeled containers of human milk should be kept refrigerated. Human milk containers with remaining contents greater than one ounce may be returned to the mother at the end of the day as long as the child has not fed directly from the bottle.

Frozen human milk may be transported and stored in single use plastic bags and placed in a freezer with a separate door or a standalone freezer. Human milk should be defrosted in the refrigerator if frozen, and then heated briefly in bottle warmers or under warm running water so that the temperature does not exceed 98.6°F. If there is insufficient time to defrost the milk in the refrigerator before warming it, then it may be defrosted in a container of running cool tap water, very gently swirling the bottle periodically to evenly distribute the temperature in the milk. Some infants will not take their mother's milk unless it is warmed to body temperature, around 98.6°F. The caregiver/teacher should check for the infant's full name and the date on the bottle so that the oldest milk is used first. After warming, bottles should be mixed gently (not shaken) and the temperature of the milk tested before feeding.

Expressed human milk that presents a threat to an infant, such as human milk that is in an unsanitary bottle, is curdled, smells rotten, and/or has not been stored following the [storage guidelines of the Academy of Breastfeeding Medicine](#), should be returned to the mother. For detail, please see CFOC 4.3.1.3.

40) 4.3.1.5 Preparing, Feeding, and Storing Infant Formula (Stepping Stones, S. 1086, Pilot)

Formula provided by parents/guardians or by the facility should come in a factory-sealed container. The formula should be of the same brand that is served at home and should be of ready-to-feed strength or liquid concentrate to be diluted using water from a source approved by the health department. Powdered infant formula, though it is the least expensive formula, requires special handling in mixing because it cannot be sterilized. The primary source for proper and safe handling and mixing is the manufacturer's instructions that appear on the can of powdered formula. Before opening the can, hands should be washed. The can and plastic lid should be thoroughly rinsed and dried. Caregivers/teachers should read and follow the manufacturer's directions. If instructions are not readily available, caregivers/teachers should obtain information from the [World Health](#)

[Organization's Safe Preparation, Storage and Handling of Powdered Infant Formula Guidelines](#). The local WIC program can also provide instructions.

Formula mixed with cereal, fruit juice, or any other foods should not be served unless the child's primary care provider provides written documentation that the child has a medical reason for this type of feeding.

Iron-fortified formula should be refrigerated until immediately before feeding. For bottles containing formula, any contents remaining after a feeding should be discarded.

Bottles of prepared or ready-to-feed formula should be labeled with the child's full name and time and date of preparation. Any prepared formula must be discarded within one hour after serving to an infant. Prepared powdered formula that has not been given to an infant should be covered, labeled with date and time of preparation and child's full name, and may be stored in the refrigerator for up to 24 hours. An open container of ready-to-feed, concentrated formula, or formula prepared from concentrated formula, should be covered, refrigerated, labeled with date of opening and child's full name, and discarded at 48 hours if not used. The caregiver/teacher should always follow manufacturer's instructions for mixing and storing of any formula preparation.

Some infants will require specialized formula because of allergy, inability to digest certain formulas, or need for extra calories. The appropriate formula should always be available and should be fed as directed. For those infants getting supplemental calories, the formula may be prepared in a different way from the directions on the container. In those circumstances, either the family should provide the prepared formula or the caregiver/teacher should receive special training, as noted in the infant's care plan, on how to prepare the formula.

41) 4.5.0.10 Foods that Are Choking Hazards (Stepping Stones, HS 40, Pilot)

Caregivers/teachers should not offer foods that are associated with young children's choking incidents to children under four years of age (round, hard, small, thick and sticky, smooth, compressible or dense, or slippery). Examples of these foods are hot dogs and other meat sticks (whole or sliced into rounds), raw carrot rounds, whole grapes, hard candy, nuts, seeds, raw peas, hard pretzels, chips, peanuts, popcorn, rice cakes, marshmallows, spoonfuls of peanut butter, and chunks of meat larger than can be swallowed whole. Food for infants should be cut into pieces one-quarter inch or smaller, food for toddlers should be cut into pieces one-half inch or smaller to prevent choking. In addition to the food monitoring, children should always be seated when eating to reduce choking hazards. Children should be supervised while eating, to monitor the size of food and that they are eating appropriately (for example, not stuffing their mouths full).

42) 4.8.0.1 Food Preparation Area Access (Stepping Stones, S. 1086, Pilot)

Infants and toddlers should not have access to the kitchen in early care and education centers. Access by older children to the kitchen of centers should be permitted only when

supervised by staff members who have been certified by the nutritionist/registered dietitian or the center director as qualified to follow the facility's sanitation and safety procedures. In all types of early care and education facilities, children should never be in the kitchen unless they are directly supervised by a caregiver/teacher. Children of preschool-age and older should be restricted from access to areas where hot food is being prepared. School-age children may engage in food preparation activities with adult supervision in the kitchen or the classroom.

Parents/guardians and other adults should be permitted to use the kitchen only if they know and follow the food safety rules of the facility. The facility should check with local health authorities about any additional regulations that apply.

43) 4.9.0.1 Compliance with U.S. Food and Drug Administration Food Code and State and Local Rules (aspects in [Stepping Stones, S. 1086, Pilot](#))

The facility should conform to applicable portions of the U.S. Food and Drug Administration [Food Code](#) and all applicable state and local food service rules and regulations for centers and large and small family child care homes regarding safe food protection and sanitation practices. If the federal code and local regulations are in conflict, the health authority with jurisdiction should determine which requirement the facility must meet.

Facilities, Supplies, Equipment, Environmental Health

44) 5.1.1.2 Inspection of Buildings ([Stepping Stones, S. 1086, NPRM, HS 40](#))

Existing and/or newly constructed, renovated, remodeled, or altered buildings should be inspected by a public inspector to assure compliance with applicable building and fire codes before the building can be made accessible to children.

45) 5.1.1.3 Compliance with Fire Prevention Code ([Stepping Stones, S. 1086, NPRM, Pilot](#))

Every twelve months, the early care and education facility should obtain written documentation to submit to the regulatory licensing authority that the facility complies with a state-approved or nationally recognized Fire Prevention Code. If available, this documentation should be obtained from a fire prevention official with jurisdiction where the facility is located. Where fire safety inspections or a Fire Prevention Code applicable to early care and education centers is not available from local authorities, the facility should arrange for a fire safety inspection by an inspector who is qualified to conduct such inspections using the National Fire Protection Association (NFPA) 101: Life Safety Code.

46) 5.1.1.5 Environmental Audit of Site Location ([Stepping Stones, S. 1086](#))

An environmental audit should be conducted before construction of a new building; renovation or occupation of an older building; or after a natural disaster, to properly evaluate and, where necessary, remediate or avoid sites where children's health could be compromised. The environmental audit should include assessments of:

- a. Potential air, soil, and water contamination on early care and education facility sites and outdoor play spaces;

- b. Potential toxic or hazardous materials in building construction; and
- c. Potential safety hazards in the community surrounding the site.

A written environmental audit report that includes any remedial action taken should be kept on file.

47) 5.1.4.1 Alternate Exits and Emergency Shelter (Stepping Stones, S. 1086, NPRM, Pilot)

Each building or structure, new or old, should be provided with a minimum of two exits, at different sides of the building or home, leading to an open space at ground level. If the basement in a small family child care home is being used, one exit must lead directly to the outside. Exits should be unobstructed, allowing occupants to escape to an outside door or exit stair enclosure in case of fire or other emergency. Each floor above or below ground level used for early care and education should have at least two unobstructed exits that lead to an open area at ground level and thereafter to an area that meets safety requirements for an early care and education indoor or outdoor area. Children should remain there until their parents/guardians can pick them up, if reentry into the facility is not possible.

Entrance and exit routes should be reviewed and approved by the applicable fire inspector. Exiting should meet all the requirements of the current edition of the National Fire Protection Association (NFPA) 101: Life Safety Code.

48) 5.2.1.10 Gas, Oil or Kerosene Heaters, Generators, Portable Gas Stoves, and Charcoal and Gas Grills (Stepping Stones, HS 40, Pilot)

Unvented gas or oil heaters and portable open-flame kerosene space heaters should be prohibited. Gas cooking appliances, including portable gas stoves, should not be used for heating purposes. Charcoal grills should not be used for space heating or any other indoor purposes.

Heat in units that involve flame should be vented properly to the outside and should be supplied with a source of combustion air that meets the manufacturer's installation requirements.

49) 5.2.1.11 Portable Electric Space Heaters (Stepping Stones, HS 40, Pilot)

Portable electric space heaters should:

- a. Be attended while in use and be off when unattended;
- b. Be inaccessible to children;
- c. Have protective covering to keep hands and objects away from the electric heating element;
- d. Bear the safety certification mark of a nationally recognized testing laboratory;
- e. Be placed on the floor only and at least three feet from curtains, papers, furniture, and any flammable object;
- f. Be properly vented, as required for proper functioning;
- g. Be used in accordance with the manufacturer's instructions;
- h. Not be used with an extension cord.

The heater cord should be inaccessible to children as well.

50) 5.2.4.2 Safety Covers and Shock Protection Devices for Electrical Outlets (Stepping Stones, S. 1086, HS 40, Pilot)

All electrical outlets accessible to children who are not yet developmentally at a kindergarten grade level of learning should be a type called “tamper-resistant electrical outlets.” These types of outlets look like standard wall outlets but contain an internal shutter mechanism that prevents children from sticking objects like hairpins, keys, and paperclips into the receptacle. This spring-loaded shutter mechanism only opens when equal pressure is applied to both shutters such as when an electrical plug is inserted.

In existing early care and education facilities that do not have “tamper-resistant electrical outlets,” outlets should have “safety covers” that are attached to the electrical outlet by a screw or other means to prevent easy removal by a child. “Safety plugs” should not be used since they can be removed from an electrical outlet by children.

All newly installed or replaced electrical outlets that are accessible to children should use “tamper-resistant electrical outlets.”

In areas where electrical products might come into contact with water, a special type of outlet called Ground Fault Circuit Interrupters (GFCIs) should be installed. A GFCI is designed to trip before a deadly electrical shock can occur. To ensure that GFCIs are functioning correctly, they should be tested at least monthly. GFCIs are also available in a tamper-resistant design.

51) 5.2.4.4 Location of Electrical Devices Near Water (Stepping Stones, S. 1086, HS 40, Pilot)

No electrical device or apparatus accessible to children should be located so it could be plugged into an electrical outlet while a person is in contact with a water source, such as a sink, tub, shower area, water table, or swimming pool.

52) 5.2.5.1 Smoke Detection Systems and Smoke Alarms (Stepping Stones, S. 1086, Pilot)

In centers with new installations, a smoke detection system (such as hard-wired system detectors with battery back-up system and control panel) or monitored wireless battery operated detectors that automatically signal an alarm through a central control panel when the battery is low or when the detector is triggered by a hazardous condition should be installed with placement of the smoke detectors in the following areas:

- a. Each story in front of doors to the stairway;
- b. Corridors of all floors;
- c. Lounges and recreation areas;
- d. Sleeping rooms.

In large and small family child care homes, smoke alarms that receive their operating power from the building electrical system or are of the wireless signal-monitored-alarm system

type should be installed. Battery-operated smoke alarms should be permitted provided that the facility demonstrates to the fire inspector that testing, maintenance, and battery replacement programs ensure reliability of power to the smoke alarms and signaling of a monitored alarm when the battery is low and that retrofitting the facility to connect the smoke alarms to the electrical system would be costly and difficult to achieve.

Facilities with smoke alarms that operate using power from the building electrical system should keep a supply of batteries and battery-operated detectors for use during power outages.

53) 5.2.8.1 Integrated Pest Management (Stepping Stones, Pilot)

Facilities should adopt an integrated pest management program (IPM) to ensure long-term, environmentally sound pest suppression through a range of practices including pest exclusion, sanitation and clutter control, and elimination of conditions that are conducive to pest infestations. IPM is a simple, common-sense approach to pest management that eliminates the root causes of pest problems, providing safe and effective control of insects, weeds, rodents, and other pests while minimizing risks to human health and the environment.

Pest Prevention: Facilities should prevent pest infestations by ensuring sanitary conditions. This can be done by eliminating pest breeding areas, filling in cracks and crevices; holes in walls, floors, ceilings and water leads; repairing water damage; and removing clutter and rubbish on the premises.

Pest Monitoring: Facilities should establish a program for regular pest population monitoring and should keep records of pest sightings and sightings of indicators of the presence of pests (e.g., gnaw marks, frass, rub marks). **Pesticide Use:** If physical intervention fails to prevent pest infestations, facility managers should ensure that targeted, rather than broadcast applications of pesticides are made, beginning with the products that pose least exposure hazard first, and always using a pesticide applicator that has the licenses or certifications required by state and local laws. Facilities should ensure that pesticides are never applied when children are present and that re-entry periods are adhered to.

Records of all pesticides applications (including type and amount of pesticide used), timing and location of treatment, and results should be maintained either on-line or in a manner that permits access by facility managers and staff, state inspectors and regulatory personnel, parents/guardians, and others who may inquire about pesticide usage at the facility.

Facilities should avoid the use of sprays and other volatilizing pesticide formulations. Pesticides should be applied in a manner that prevents skin contact and any other exposure to children or staff members and minimizes odors in occupied areas. Care should be taken to ensure that pesticide applications do not result in pesticide residues accumulating on

tables, toys, and items mouthed or handled by children, or on soft surfaces such as carpets, upholstered furniture, or stuffed animals with which children may come in direct contact.

Following the use of pesticides, herbicides, fungicides, or other potentially toxic chemicals, the treated area should be ventilated for the period recommended on the product label.

Notification: Notification should be given to parents/guardians and staff before using pesticides to determine if any child or staff member is sensitive to the product. Staff should directly observe the application to be sure that toxic chemicals are not applied on surfaces with which children or staff may come in contact. For detail, please see CFOC 5.2.8.1.

54) 5.2.9.1 Use and Storage of Toxic Substances (Stepping Stones, S. 1086, Pilot)

The following items should be used as recommended by the manufacturer and should be stored in the original labeled containers:

- a. Cleaning materials;
- b. Detergents;
- c. Automatic dishwasher detergents;
- d. Aerosol cans;
- e. Pesticides;
- f. Health and beauty aids;
- g. Medications;
- h. Lawn care chemicals;
- i. Other toxic materials.

Material Safety Data Sheets (MSDS) must be available onsite for each hazardous chemical that is on the premises. These substances should be used only in a manner that will not contaminate play surfaces, food, or food preparation areas, and that will not constitute a hazard to the children or staff. When not in active use, all chemicals used inside or outside should be stored in a safe and secure manner in a locked room or cabinet, fitted with a child-resistant opening device, inaccessible to children, and separate from stored medications and food.

Chemicals used in lawn care treatments should be limited to those listed for use in areas that can be occupied by children. Medications can be toxic if taken by the wrong person or in the wrong dose. Medications should be stored safely and disposed of properly (see Standard 3.6.3.1/3.6.3.2).

The telephone number for the poison center should be posted in a location where it is readily available in emergency situations (e.g., next to the telephone). Poison centers are open 24 hours a day, seven days a week, and can be reached at 1-800-222-1222.

55) 5.2.9.4 Radon Concentrations (Stepping Stones)

Radon concentrations inside a home or building used for early care and education programs must be less than four picocuries per liter of air. All facilities must be tested for the

presence of radon, according to U.S. Environmental Protection Agency testing protocols for long-term testing (i.e., greater than ninety days in duration using alpha-track or electret test devices).

56) 5.2.9.5 Carbon Monoxide Detectors (Stepping Stones, Pilot)

Carbon monoxide detector(s) should be installed in early care and education settings if one of the following guidelines is met:

- a. The early care and education program uses any sources of coal, wood, charcoal, oil, kerosene, propane, natural gas, or any other product that can produce carbon monoxide indoors or in an attached garage;
- b. If detectors are required by state/local law or state licensing agency.

Facilities must meet state or local laws regarding carbon monoxide detectors. Detectors should be tested monthly. Batteries should be changed at least yearly. Detectors should be replaced at least every five years.

57) 5.2.9.13 Testing for Lead (Stepping Stones)

In all early care and education settings, both exterior and interior surfaces covered by paint with lead levels of 0.06% and above, or equal to or greater than 1.0 milligram per square centimeter and accessible to children, should be removed by a safe chemical or physical means or made inaccessible to children, regardless of the condition of the surface.

In large and small family child care homes, flaking or deteriorating lead-based paint on any surface accessible to children should be removed or abated according to health department regulations. Where lead paint is removed, the surface should be refinished with lead-free paint or nontoxic material. Sanding, scraping, or burning of lead-based paint surfaces should be prohibited. Children and pregnant women should not be present during lead renovation or lead abatement activities.

Any surface and the grounds around and under surfaces that children use at an early care and education setting, including dirt and grassy areas should be tested for excessive lead in a location designated by the health department. Caregivers/teachers should check the [U.S. Consumer Product Safety Commission's website](#) for warnings of potential lead exposure to children and recalls of play equipment, toys, jewelry used for play, imported vinyl mini-blinds and food contact products. If they are found to have toxic levels, corrective action should be taken to prevent exposure to lead at the facility. Only non-toxic paints should be used.

58) 5.3.1.1 Safety of Equipment, Materials, and Furnishings (Stepping Stones, S. 1086, HS 40, Pilot)

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

- a. Openings that could entrap a child's head or limbs;

- b. Elevated surfaces that are inadequately guarded;
- c. Lack of specified surfacing and fall zones under and around climbable equipment;
- d. Mismatched size and design of equipment for the intended users;
- e. Insufficient spacing between equipment;
- f. Tripping hazards;
- g. Components that can pinch, shear, or crush body tissues;
- h. Equipment that is known to be of a hazardous type;
- i. Sharp points or corners;
- j. Splinters;
- k. Protruding nails, bolts, or other components that could entangle clothing or snag skin;
- l. Loose, rusty parts;
- m. Hazardous small parts that may become detached during normal use or reasonably foreseeable abuse of the equipment and that present a choking, aspiration, or ingestion hazard to a child;
- n. Strangulation hazards (e.g., straps, strings, etc.);
- o. Flaking paint;
- p. Paint that contains lead or other hazardous materials;
- q. Tip-over hazards, such as chests, bookshelves, and televisions.

59) 5.4.5.2 Cribs (Stepping Stones, S. 1086, Pilot)

Facilities should check each crib before its purchase and use to ensure that it is in compliance with the current U.S. Consumer Product Safety Commission (CPSC) and ASTM safety standards. All cribs should meet the ASTM F1169-10a Standard Consumer Safety Specification for Full-Size Baby Cribs, F406-10b Standard Consumer Safety Specification for Non-Full-Size Baby Cribs/Play Yards, or the CPSC 16 CFR 1219, 1220, and 1500 – Safety Standards for Full-Size Baby Cribs and Non-Full-Size Baby Cribs; Final Rule.

Cribs should be placed away from window blinds or draperies.

As soon as a child can stand up, the mattress should be adjusted to its lowest position. Once a child can climb out of his/her crib, the child should be moved to a bed. Children should never be kept in their crib by placing, tying, or wedging various fabrics, mesh, or other strong coverings over the top of the crib. Cribs intended for evacuation purpose should be of a design and have wheels that are suitable for carrying up to five non-ambulatory children less than two years of age to a designated evacuation area. This crib should be used for evacuation in the event of fire or other emergency. The crib should be easily moveable and should be able to fit through the designated fire exit.

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

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

60) 5.5.0.6 Inaccessibility to Matches, Candles and Lighters (Stepping Stones, S. 1086, Pilot)

Matches, candles, and lighters should not be accessible to children.

61) 5.5.0.7 Storage of Plastic Bags (Stepping Stones, Pilot)

Plastic bags, whether intended for storage, trash, diaper disposal, or any other purpose, should be stored out of reach of children.

62) 5.5.0.8 Firearms (Stepping Stones, Pilot)

Centers should not have any firearms, pellet or BB guns (loaded or unloaded), darts, bows and arrows, cap pistols, stun guns, paint ball guns, or objects manufactured for play as toy guns within the premises at any time. If present in a small or large family child care home, these items must be unloaded, equipped with child protective devices, and kept under lock and key with the ammunition locked separately in areas inaccessible to the children. Parents/guardians should be informed about this policy.

Play Areas/Playgrounds and Transportation

63) 6.1.0.6 Location of Play Areas Near Bodies of Water (Stepping Stones, S. 1086, Pilot)

Outside play areas should be free from the following bodies of water:

- a. Unfenced swimming and wading pools;
- b. Ditches;
- c. Quarries;
- d. Canals;
- e. Excavations;
- f. Fish ponds;
- g. Water retention or detention basins;
- h. Other bodies of water.

64) 6.1.0.8 Enclosures for Outdoor Play Areas (Stepping Stones, S. 1086, Pilot)

The outdoor play area should be enclosed with a fence or natural barriers. Fences and barriers should not prevent the observation of children by caregivers/teachers. If a fence is used, it should conform to applicable local building codes in height and construction. Fence posts should be outside the fence where allowed by local building codes. These areas should have at least two exits, with at least one being remote from the buildings.

Gates should be equipped with self-closing and positive self-latching closure mechanisms. The latch or securing device should be high enough or of a type such that children cannot open it. The openings in the fence and gates should be no larger than three and one-half

inches. The fence and gates should be constructed to discourage climbing. Play areas should be secured against inappropriate use when the facility is closed.

Wooden fences and playground structures created out of wood should be tested for chromated copper arsenate (CCA). Wooden fences and playground structures created out of wood that is found to contain CCA should be sealed with an oil-based outdoor sealant annually.

65) 6.2.3.1 Prohibited Surfaces for Placing Climbing Equipment (Stepping Stones, S. 1086, SS3 KI, Pilot)

Equipment used for climbing should not be placed over, or immediately next to, hard surfaces such as asphalt, concrete, dirt, grass, or flooring covered by carpet or gym mats not intended for use as surfacing for climbing equipment.

All pieces of playground equipment should be placed over and surrounded by a shock-absorbing surface. This material may be either the unitary or the loose-fill type, as defined by the U.S. Consumer Product Safety Commission guidelines and ASTM International standards, extending at least six feet beyond the perimeter of the stationary equipment. These shock-absorbing surfaces must conform to the standard stating that the impact of falling from the height of the structure will be less than or equal to peak deceleration of 200G and a Head Injury Criterion of 1000 and should be maintained at all times. Organic materials that support colonization of molds and bacteria should not be used. All loose fill materials must be raked to retain their proper distribution, shock-absorbing properties and to remove foreign material. This standard applies whether the equipment is installed outdoors or indoors.

66) 6.2.5.1 Inspection of Indoor and Outdoor Play Areas and Equipment (Stepping Stones, S. 1086, HS 40)

The indoor and outdoor play areas and equipment should be inspected daily for basic health and safety including but not limited to:

- a. Missing or broken parts;
- b. Protrusion of nuts and bolts;
- c. Rust and chipping or peeling paint;
- d. Sharp edges, splinters, and rough surfaces; e. Stability of handholds;
- e. Visible cracks;
- f. Stability of non-anchored large play equipment (e.g., playhouses);
- g. Wear and deterioration.

Observations should be documented and filed, and the problems corrected before the playground is used by children.

67) 6.3.1.1 Enclosure of Bodies of Water (Stepping Stones, S. 1086, HS 40, Pilot)

All water hazards, such as pools, swimming pools, stationary wading pools, ditches, fish ponds, and water retention or detention basins should be enclosed with a fence that is four

to six feet high or higher and comes within three and one-half inches of the ground. Openings in the fence should be no greater than three and one-half inches. The fence should be constructed to discourage climbing and kept in good repair. For detail, please see CFOC 6.3.1.1.

68) 6.3.1.6 Pool Drain Covers (Stepping Stones, S. 1086, Pilot)

All covers for the main drain and other suction ports of swimming and wading pools should be listed by a nationally recognized testing laboratory in accordance with ASME/ANSI standard "A112.19.8: Standard for Suction Fittings for Use in Swimming Pools, Wading Pools, Spas and Hot Tubs," and should be used under conditions that do not exceed the approved maximum flow rate, be securely anchored using manufacturer-supplied parts installed per manufacturer's specifications, be in good repair, and be replaced at intervals specified by manufacturer. Facilities with one outlet per pump, or multiple outlets per pump with less than thirty-six inches center-to-center distance for two outlets, must be equipped with a Safety Vacuum Release System (SVRS) meeting the ASME/ANSI standard "A112.19.17: Manufactured Safety Vacuum Release Systems for Residential and Commercial Swimming Pool, Spas, Hot Tub and Wading Pool Suction Systems" or ASTM International standard "F2387-04: Standard Specification for Manufactured SVRS for Swimming Pools, Spas, and Hot Tubs" standards, as required by the Virginia Graeme Baker Pool and Spa Safety Act, Section 1404(c)(1)(A)(I).

69) 6.3.2.1 Lifesaving Equipment (S. 1086, Pilot)

Each swimming pool more than six feet in width, length, or diameter should be provided with a ring buoy and rope, a rescue tube, or a throwing line and a shepherd's hook that will not conduct electricity. This equipment should be long enough to reach the center of the pool from the edge of the pool, should be kept in good repair, and should be stored safely and conveniently for immediate access. Caregivers/teachers should be trained on the proper use of this equipment so that in emergencies, caregivers/teachers will use equipment appropriately. Children should be familiarized with the use of the equipment based on their developmental level.

70) 6.3.5.2 Water in Containers (Stepping Stones, S. 1086, Pilot)

Bathtubs, buckets, diaper pails, and other open containers of water should be emptied immediately after use.

71) 6.4.1.2 Inaccessibility of Toys or Objects to Children Under Three Years of Age (Stepping Stones, Pilot)

Small objects, toys, and toy parts available to children under the age of three years should meet the federal small parts standards for toys. For detail, please see CFOC 6.4.1.2.

72) 6.5.2.2 Child Passenger Safety (Stepping Stones, S. 1086, HS 40)

When children are driven in a motor vehicle other than a bus, school bus, or a bus operated by a common carrier, the following should apply:

- a. A child should be transported only if the child is restrained in developmentally appropriate car safety seat, booster seat, seat belt, or harness that is suited to the child's weight, age, and/or psychological development in accordance with state and federal laws and regulations and the child is securely fastened, according to the manufacturer's instructions, in a developmentally appropriate child restraint system.
- b. Age and size-appropriate vehicle child restraint systems should be used for children under eighty pounds and under four-feet-nine-inches tall and for all children considered too small, in accordance with state and federal laws and regulations, to fit properly in a vehicle safety belt. The child passenger restraint system must meet the federal motor vehicle safety standards contained in the Code of Federal Regulations, Title 49, Section 571.213 (especially Federal Motor Vehicle Safety Standard 213), and carry notice of such compliance.
- c. For children who are obese or overweight, it is important to find a car safety seat that fits the child properly. Caregivers/teachers should not use a car safety seat if the child weighs more than the seat's weight limit or is taller than the height limit. Caregivers/teachers should check the labels on the seat or manufacturer's instructions if they are unsure of the limits. Manufacturer's instructions that include these specifications can also be found on the manufacturer's Website.
- d. Child passenger restraint systems should be installed and used in accordance with the manufacturer's instructions and should be secured in back seats only.

All children under the age of 13 should be transported in the back seat of a car and each child not riding in an appropriate child restraint system (i.e., a child seat, vest, or booster seat), should have an individual lap-and-shoulder seat belt.

For maximum safety, infants and toddlers should ride in a rear-facing orientation (i.e., facing the back of the car) until they are two years of age or until they have reached the upper limits for weight or height for the rear-facing seat, according to the manufacturer's instructions. Once their seat is adjusted to face forward, the child passenger must ride in a forward-facing child safety seat (either a convertible seat or a combination seat) until reaching the upper height or weight limit of the seat, in accordance with the manufacturer's instructions. Plans should include limiting transportation times for young infants to minimize the time that infants are sedentary in one place.

A booster seat should be used when, according to the manufacturer's instructions, the child has outgrown a forward-facing child safety seat, but is still too small to safely use the vehicle seat belts (for most children this will be between four feet nine inches tall and between eight and 12 years of age).

Car safety seats, whether provided by the child's parents/guardians or the early care and education program, should be labeled with the child passenger's name and emergency contact information. Car safety seats should be replaced if they have been recalled, are past the manufacturer's "date of use" expiration date, or have been involved in a crash that

meets the U.S. Department of Transportation crash severity criteria or the manufacturer's criteria for replacement of seats after a crash.

The temperature of all metal parts of vehicle child restraint systems should be checked before use to prevent burns to child passengers.

For children with special health care needs and greater detail on this standard, in general, please see CFOC 6.5.2.2.

73) 6.5.2.4 Interior Temperature of Vehicles (Stepping Stones, S. 1086)

The interior of vehicles used to transport children should be maintained at a temperature comfortable to children. When the vehicle's interior temperature exceeds 82°F and providing fresh air through open windows cannot reduce the temperature, the vehicle should be air-conditioned. When the interior temperature drops below 65°F and when children are feeling uncomfortably cold, the interior should be heated. To prevent hyperthermia, all vehicles should be locked when not in use, head counts of children should be taken after transporting to prevent a child from being left unintentionally in a vehicle, and children should never be intentionally left in a vehicle unattended.

74) 6.5.3.1 Passenger Vans (Stepping Stones, S. 1086)

Early care and education facilities that provide transportation to children, parents/guardians, staff, and others should avoid the use of 15-passenger vans whenever possible. Other vehicles, such as vehicles meeting the definition of a "school bus," should be used to fulfill transportation of child passengers in particular. Conventional 12 to 15-passenger vans cannot be certified as school buses by the National Highway Traffic Safety Administration standards, and thus cannot be sold or leased, as new vehicles, to carry students on a regular basis. Caregivers/teachers should be knowledgeable about the laws of the state(s) in which their vehicles, including passenger vans, will be registered and used.

Infectious Disease

75) 7.2.0.1 Immunization Documentation (HS 40)

Early care and education facilities should require that all parents/guardians of children enrolled in early care and education provide written documentation of receipt of immunizations appropriate for each child's age. Infants, children, and adolescents should be immunized as specified in the "Recommended Immunization Schedules for Persons Aged 0 Through 18 Years – United States, 2011" developed by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians . Children whose immunizations are not up-to-date or have not been administered according to the recommended schedule should receive the required immunizations, unless contraindicated or for legal exemptions.

An updated immunization schedule is published annually in the AAP's Pediatrics and in the CDC's MMWR and should be consulted for current information. In addition to print versions of the recommended immunization schedules, the current child, adolescent, and catch-up schedules are posted on the websites of the [CDC](#) and the [AAP](#).

76) 7.2.0.2 Unimmunized Children (Stepping Stones, SS3 KI)

If immunizations have not been or are not to be administered because of a medical condition (contraindication), a statement from the child's primary care provider documenting the reason why the child is temporarily or permanently medically exempt from the immunization requirements should be on file. If immunizations are not to be administered because of the parents/guardians' religious or philosophical beliefs, a legal exemption with notarization, waiver or other state-specific required documentation signed by the parent/guardian should be on file.

The parent/guardian of a child who has not received the age-appropriate immunizations prior to enrollment and who does not have documented medical, religious, or philosophical exemptions from routine childhood immunizations should provide documentation of a scheduled appointment or arrangement to receive immunizations. This could be a scheduled appointment with the primary care provider or an upcoming immunization clinic sponsored by a local health department or health care organization. An immunization plan and catch-up immunizations should be initiated upon enrollment and completed as soon as possible according to the "Recommended Immunization Schedules for Persons Aged 0 Through 18 Years – United States, 2011" from the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Academy of Family Physicians. Parents/guardians of children who attend an unlicensed early care and education facility should be encouraged to comply with the "Recommended Immunization Schedules".

If a vaccine-preventable disease to which children are susceptible occurs in the facility and potentially exposes the unimmunized children who are susceptible to that disease, the health department should be consulted to determine whether these children should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements. For detail, please see CFOC 7.2.0.2.

77) 7.2.0.3 Immunization of Caregivers/Teachers (Stepping Stones, HS 40)

Caregivers/teachers should be current with all immunizations routinely recommended for adults by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention as shown in the "[Recommended Adult Immunization Schedule](#)".

Caregivers/teachers should have received the recommended vaccines in the following categories:

- a. Vaccines recommended for all adults who meet the age requirements and who lack evidence of immunity (i.e., lack documentation of vaccination or have no evidence of prior infection)
- b. Recommended if a specific risk factor is present

If a staff member is not appropriately immunized for medical, religious or philosophical reasons, the early care and education facility should require written documentation of the reason.

If a vaccine-preventable disease to which adults are susceptible occurs in the facility and potentially exposes the unimmunized adults who are susceptible to that disease, the health department should be consulted to determine whether these adults should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements.

78) 7.3.3.1 Influenza Immunizations for Children and Caregivers (Stepping Stones, HS 40)

The parent/guardian of each child six months of age and older should provide written documentation of current annual vaccination against influenza unless there is a medical contraindication or philosophical or religious objection. Children who are too young to receive influenza vaccine before the start of influenza season should be immunized annually beginning when they reach six months of age.

Staff caring for all children should receive annual vaccination against influenza. Ideally people should be vaccinated before the start of the influenza season (as early as August or September) and immunization should continue through March or April.

79) 7.3.3.2 Influenza Control (Stepping Stones)

When influenza is circulating in the community, facilities should encourage parents/guardians to keep children with symptoms of acute respiratory tract illness with fever at home until their fever has subsided for at least 24 hours without use of fever reducing medication. Caregivers/teachers with symptoms of acute respiratory tract illness with fever also should remain at home until their fever subsides for at least 24 hours.

80) 7.4.0.1 Control of Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections (Stepping Stones)

Early care and education programs should use the following procedures, as well as those stated in Child and Staff Inclusion/Exclusion/Dismissal Standards 3.6.1.1-3.6.1.4, to prevent and control gastrointestinal tract infections (including diarrhea) or hepatitis A (HAV):

- a. Toilet trained children who cannot use a toilet for all bowel movements while attending the facility and who develop diarrhea should be removed from the facility by their parent/guardian. Exclude diapered children if stool is not contained in the diaper, stool frequency exceeds two or more stools above

normal for that child, blood or mucus in the stool, abnormal color of stool, no urine output in eight hours, jaundice, fever with behavior change, or looks or acts ill. Pending arrival of the parent/guardian, the child should not be permitted to have contact with other children or be placed in areas used by adults who have contact with children. This should be accomplished by removing the child who is ill to a separate area of the early care and education program or, if not possible, to a separate area of the child's room. The area should be one where the child is supervised by an adult known to the child, and where the toys, equipment, and surfaces will not be used by other children or adults until after the child who is ill leaves and after the surfaces and toys have been disinfected. When moving a child to a separate area of the facility creates problems with supervision of the other children, the child who is ill should be kept as comfortable as possible, with minimal contact between children who are ill and well children, until the parent/guardian arrives. Caregivers/teachers with diarrhea should be excluded. Separation and exclusion of children or caregivers/teachers should not be deferred pending health assessment or laboratory testing to identify an enteric pathogen.

- b. A child who develops jaundice (when skin and white parts of the eye are yellow) while attending early care and education programs should be separated from other children and the child's parent/guardian should be contacted to remove the child. The child should remain separated from other children as described above until the parent/guardian arrives and removes the child.
- c. Exclusion for diarrhea should continue until either the diarrhea stops or the continued loose stools are deemed not to be infectious by a licensed health care professional. Exclusion for HAV should continue for one week after onset of jaundice.
- d. Alternate care for children with diarrhea or HAV in special facilities for children who are ill should be provided in facilities that can provide separate care for children with infections of the gastrointestinal tract (including diarrhea) or HAV.
- e. Children and caregivers/teachers who excrete intestinal pathogens but no longer have diarrhea generally may be allowed to return to the early care and education program once the diarrhea resolves, except for the case of infections with *Shigella*, Shiga toxin-producing *E. coli* (STEC), or *Salmonella enterica* serotype Typhi. For *Shigella* and STEC, resolution of symptoms and two negative stool cultures are required for readmission, unless state requirements differ. For *Salmonella* serotype Typhi, resolution of symptoms and three negative stool cultures are required for readmission. For *Salmonella* species other than serotype Typhi, documentation of negative stool cultures are not required from asymptomatic people for readmission to the early care and education program.
- f. The local health department should be informed immediately of HAV infection or an increased frequency of diarrheal illness in children or staff.
- g. Recommended post-exposure prophylaxis for HAV includes administration of HAV vaccine or immune globulin to all previously unimmunized staff members

and attendees of an early care and education facility in which a person with HAV is identified.

- h. If there has been an exposure to a person with HAV or diarrhea in the early care and education facility, caregivers/teachers should inform parents/guardians, in cooperation with the health department, that their children may have been exposed to children with HAV or to another person with a diarrheal illness.

Policies

81) 9.2.4.1 Written Plan and Training for Handling Urgent Medical Care or Threatening Incidents (**Stepping Stones, S. 1086, HS 40**)

The facility should have a written plan for reporting and managing what they assess to be an incident or unusual occurrence that is threatening to the health, safety, or welfare of the children, staff, or volunteers. The facility should also include procedures of staff training on this plan. The management, documentation, and reporting of the following types of incidents, at a minimum, that occur at the early care and education facility should be addressed in the plan:

- a. Lost or missing child;
- b. Suspected maltreatment of a child (also see state's mandates for reporting);
- c. Suspected sexual, physical, or emotional abuse of staff, volunteers, or family members occurring while they are on the premises of the early care and education facility;
- d. Injuries to children requiring medical or dental care;
- e. Illness or injuries requiring hospitalization or emergency treatment;
- f. Mental health emergencies;
- g. Health and safety emergencies involving parents/guardians and visitors to the program;
- h. Death of a child or staff member, including a death that was the result of serious illness or injury that occurred on the premises of the early care and education facility, even if the death occurred outside of early care and education hours;
- i. The presence of a threatening individual who attempts or succeeds in gaining entrance to the facility.

The following procedures, at a minimum, should be addressed in the plan for urgent care:

- a. Provision for a caregiver/teacher to accompany a child to a source of urgent care and remain with the child until the parent/guardian assumes responsibility for the child;
- b. Provision for the caregiver/teacher to provide the medical care personnel with an authorization form signed by the parent/guardian for emergency medical care and a written informed consent form signed by the parent/guardian allowing the facility to share the child's health records with other service providers;
- c. Provision for a backup caregiver/teacher or substitute for large and small family child care homes to make the arrangement for urgent care feasible (child:staff ratios must be maintained at the facility during the emergency);
- d. Notification of parent/guardian(s);

- e. Pre-planning for the source of urgent medical and dental care (such as a hospital emergency room, medical or dental clinic, or other constantly staffed facility known to caregivers/teachers and acceptable to parents/guardians);
- f. Completion of a written incident/injury report and the program's response; g. Assurance that the first aid kits are resupplied following each first aid incident, and that required contents are maintained in a serviceable condition, by a monthly review of the contents;
- g. Policy for scheduled reviews of staff members' ability to perform first aid for averting the need for emergency medical services;
- h. Policy for staff supervision following an incident when a child is lost, missing, or seriously injured.

82) 9.2.4.3/9.2.4.6 Disaster Planning, Training and Communication/Use of Daily Roster During Evacuation Drills (Stepping Stones, S. 1086, NPRM, HS 40)

Facilities should consider how to prepare for and respond to emergency or natural disaster situations and develop written plans accordingly. All programs should have procedures in place to address natural disasters that are relevant to their location (such as earthquakes, tornados, tsunamis or flash floods, storms, and volcanoes) and all hazards/disasters that could occur in any location including acts of violence, bioterrorism/terrorism, exposure to hazardous agents, facility damage, fire, missing child, power outage, and other situations that may require evacuation, lock-down, or shelter-in-place. Procedure for notifying and updating parents must be included. For detail, please see CFOC 9.2.4.3.

The center director, or his/her designees, and family child care home caregivers should use the daily class roster(s) in checking the evacuation and return to a safe space for ongoing care of all children and staff members in attendance during an evacuation drill.

83) 9.2.4.7 Sign-in/Sign-out System (Stepping Stones and Pilot)

The facility should have a sign-in/sign-out system to track who enters and exits the facility. The system should include name, contact number, relationship to facility (e.g., parent/guardian, vendor, guest, etc.) and recorded time in and out.

84) 9.2.4.8 Authorized Persons to Pick Up Child (Stepping Stones)

Names, addresses, and telephone numbers of persons authorized to take a child under care out of the facility should be obtained during the enrollment process and regularly reviewed, along with clarification/documentation of any custody issues/court orders. The legal guardian(s) of the child should be established and documented at this time.

85) 9.4.1.12 Record of Valid License, Certificate or Registration of Facility (Stepping Stones)

Every facility should hold a valid license or certificate, or documentation of, registration prior to operation as required by the local and/or state statute.

86) 9.4.2.1 Contents of Child Records (HS 40)

The facility should maintain a file for each child in one central location within the facility. This file should be kept in a confidential manner but should be immediately available to the child's caregivers/teachers (who should have parental/guardian consent for access to records), the child's parents/guardians, and the licensing authority upon request. The file for each child should include the following:

- Pre-admission enrollment information;
- Admission agreement signed by the parent/guardian at enrollment;
- Initial health care professional assessment, completed and signed by the child's primary care provider and based on the child's most recent well care visit and containing a complete [immunization record](#) and a statement of any special needs with a care plan for how the program should accommodate these special needs (this should be on file preferably at enrollment or a two week written plan should be provided upon admission);
- Updated health care professional assessments should be completed from the initial assessment filed except that such assessments should be at the recommended intervals by the American Academy of Pediatrics until the age of two years and annually thereafter;
- Health history to be completed by the parent/guardian at admission, preferably with staff involvement;
- Medication record, maintained on an ongoing basis by designated staff;
- Authorization form for emergency medical care;
- Any written informed consent forms signed by the parent/guardian allowing the facility to share the child's health records with other service providers.

87) 10.4.2.1 Frequency of Inspections for Child Care Centers, Large Family Child Care Homes, and Small Family Child Care Homes (Stepping Stones, S. 1086)

The licensing inspector should make an onsite inspection to measure compliance with licensing rules prior to issuing an initial license and at least two inspections each year to each center and large and small family child care home thereafter. At least one of the inspections should be unannounced and more if needed for the facility to achieve satisfactory compliance or is closed at any time. Sufficient numbers of licensing inspectors should be hired to provide adequate time visiting and inspecting facilities to insure compliance with regulations

The number of inspections should not include those inspections conducted for the purpose of investigating complaints. Complaints should be investigated promptly, based on severity of the complaint. States are encouraged to post the results of licensing inspections, including complaints, on the Internet for parent and public review. Parents/guardians should be provided easy access to the licensing rules and made aware of how to report complaints to the licensing agency.

Appendix J**SELECTING AN APPROPRIATE SANITIZER OR DISINFECTANT**

One of the most important steps in reducing the spread of infectious diseases in child care settings is cleaning, sanitizing or disinfecting surfaces that could possibly pose a risk to children or staff. Routine cleaning with detergent and water is the most common method for removing some germs from surfaces in the child care setting. However, most items and surfaces in a child care setting require sanitizing or disinfecting after cleaning to further reduce the number of germs on a surface to a level that is unlikely to transmit disease.

What is the difference between sanitizing and disinfecting?

Sometimes these terms are used as if they mean the same thing, but they are not the same.

Sanitizer is a product that reduces but does not eliminate germs on inanimate surfaces to levels considered safe by public health codes or regulations. A sanitizer may be appropriate to use on food contact surfaces (dishes, utensils, cutting boards, high chair trays), toys that children may place in their mouths, and pacifiers. See Appendix K, Routine Schedule for Cleaning, Sanitizing and Disinfecting for guidance on use of sanitizer vs. disinfectant.

Disinfectant is a product that destroys or inactivates germs (but not spores) on an inanimate object. A disinfectant may be appropriate to use on hard, non-porous surfaces such as diaper change tables, counter tops, door & cabinet handles, and toilets and other bathroom surfaces. See Appendix K, Routine Schedule for Cleaning, Sanitizing and Disinfecting for guidance on use of sanitizer vs. disinfectant.

The U.S. Environmental Protection Agency (EPA) recommends that only EPA-registered products be used. Only a sanitizer or disinfectant product with an EPA registration number on the label can make public health claims that they are effective in reducing or inactivating germs. Many bleach and hydrogen peroxide products are EPA-registered and can be used to sanitize or disinfect.

Please see the “How to Find EPA Registration Information” section below to learn more specific information on the products. Always follow the manufacturers’ instructions when using EPA-registered products described as sanitizers or disinfectants. This includes pre-cleaning, how long the product needs to remain wet on the surface or item, whether or not the product should be diluted or used as is, and if rinsing is needed. Also check to see if that product can be used on a food contact surface or is safe for use on items that may go into a child’s mouth. Please note that the label instructions on most sanitizers and disinfectants indicate that the surface must be pre-cleaned before applying the sanitizer or disinfectant.

Are there alternatives to chlorine bleach?

A product that is not chlorine bleach can be used in child care settings IF:

- It is registered with the EPA;
- It is also described as a sanitizer or as a disinfectant;
- It is used according to the manufacturer's instructions.

Check the label to see how long you need to leave the sanitizer or disinfectant in contact with the surface you are treating, whether you need to rinse it off before contact by children, for any precautions when handling, and whether it can be used on a surface that may come in contact with child's mouth.

Some child care settings are using products with hydrogen peroxide as the active ingredient instead of chlorine bleach. Check to see if the product has an EPA registration number and follow the manufacturer's instructions for use and safe handling. (Please see the "How to Find EPA Registration Information" section below for more information.) Remember that EPA-registered products will also have available a Material Safety Data Sheet (MSDS) that will provide instructions for the safe use of the product and guidance for first aid response to an accidental exposure to the chemical.

In addition, some manufacturers of sanitizer and disinfectant products have developed "green cleaning products" that have EPA registration. As new environmentally-friendly cleaning products appear in the market, check to see if they are EPA-registered.

Household Bleach & Water

Many household bleach products are now EPA-registered. When purchasing EPA-registered chlorine bleach, make sure that the bleach concentration is for household use, and not for industrial applications. Household chlorine bleach is typically sold in retail stores as an 8.25% sodium hypochlorite solution. EPA-registered bleach products are described as sanitizers and disinfectants. Check the label to see if the product has an EPA registration number and follow the manufacturer's safety and use instructions. (Please see the "How to Find EPA Registration Information" section below for more information.) Pay particular attention to the mixing "recipe" and the required contact time (i.e., the time the solution must remain on a surface to be effective) for each use. Remember, the recipe and contact time are most likely different for sanitizing and disinfecting.

If you are not using an EPA-registered product for sanitizing and disinfecting, please be sure you are following state or local recommendations and/or manufacturer's instructions for creating safe dilutions necessary to sanitize and/or disinfect surfaces in your early care and education environment. Using too little (a weak concentration) bleach may make the mixture ineffective; however, using too much (a strong concentration) bleach may create a potential health hazard.

To safely prepare bleach solutions:

- Dilute bleach with cool water and do not use more than the recommended amount of bleach.
- Select a bottle made of opaque material.

- Make a fresh bleach dilution daily; label the bottle with contents and the date mixed.
- Wear gloves and eye protection when diluting bleach.
- Use a funnel.
- Add bleach to the water rather than the water to bleach to reduce fumes.
- Make sure the room is well ventilated.
- Never mix or store ammonia with bleach or products that contain bleach.

To safely use bleach solutions:³

- Apply the bleach dilution after cleaning the surface with soap or detergent and rinsing with water if visible soil is present.
- If using a spray bottle, adjust the setting to produce a heavy spray instead of a fine mist.
- Allow for the contact time specified on the label of the bleach product.
- Apply when children are not present in the area.
- Ventilate the area by allowing fresh air to circulate and allow the surfaces to completely air dry or wipe dry after the required contact time before allowing children back into the area.
- Store all chemicals securely, out of reach of children and in a way that they will not tip and spill.

To Review:

- Determine if the surface requires sanitizing or disinfecting;
- Check the labels of all products to see if they are EPA-registered; there are alternatives to chlorine bleach;
- Many chlorine bleach products (8.25% sodium hypochlorite) are now EPA-registered
 - If EPA-registered, you must follow the label instructions for “recipes” and contact times;
- If using non-EPA-registered products, follow state or local recommendations for “recipes” and contact times;
- Prepare and use the solutions safely;
- Use products that are safe for oral contact when used on food contact surfaces or on items that may be mouthed by children.

How to Find EPA Registration Information

The following information is intended to serve as a visual guide to locating EPA registration numbers and product label information. Any products featured in the examples below are used for illustrative purpose only, and do not represent an endorsement by the National Resource

³ Adapted from: California Childcare Health Program. 2013. Safe and Effective Cleaning sanitizing and Disinfecting. Health and Safety Notes (March).

Center for Health and Safety in Child Care and Early Education (NRC). The NRC does not endorse specific products.

1. Locate the EPA Registration number on the product label
2. Go to <http://iaspub.epa.gov/apex/pesticides/f?p=PPLS:1>. Enter this number into the box titled "EPA Registration Number" and click the Search button
3. You should see the details about the product, and beneath that, a portable document file (PDF) bearing the date that this product was registered by the EPA (if there is a list, the PDF at the top of the list should show the most recent approval). Click on that most recently-approved PDF. You will need a PDF file reader to access this file. There are a variety of readers available and most are free.
4. The PDF should come up on your screen. Scroll down to the section that shows the directions for using the product as a sanitizer or disinfectant. Follow the directions listed for your intended use.

A Final Note

Remember that any cleaning, sanitizing or disinfecting product must always be safely stored out of reach of children. Always follow the manufacturer's instruction for safe handling to protect yourselves and those in your care.

Appendix K

Routine Schedule for Cleaning, Sanitizing, and Disinfecting

Areas	Before Each Use	After Each Use	Daily (At the End of the Day)	Weekly	Monthly	Comments
Food Areas						
• Food preparation surfaces	Clean, Sanitize	Clean, Sanitize				Use a sanitizer safe for food contact
• Eating utensils & dishes		Clean, Sanitize				If washing the dishes and utensils by hand, use a sanitizer safe for food contact as the final step in the process; Use of an automated dishwasher will sanitize
• Tables & highchair trays	Clean, Sanitize	Clean, Sanitize				
• Countertops		Clean	Clean, Sanitize			Use a sanitizer safe for food contact
• Food preparation appliances		Clean	Clean, Sanitize			
• Mixed use tables	Clean, Sanitize					Before serving food
• Refrigerator					Clean	
Child Care Areas						
• Plastic mouthed toys		Clean	Clean, Sanitize			
• Pacifiers		Clean	Clean, Sanitize			Reserve for use by only one child; Use dishwasher or boil for one minute
• Hats			Clean			Clean after each use if head lice present
• Door & cabinet handles			Clean, Disinfect			
• Floors			Clean			Sweep or vacuum, then damp mop
• Machine washable cloth toys				Clean		Launder
• Dress-up clothes				Clean		Launder
• Play activity centers				Clean		

• Drinking Fountains			Clean, Disinfect			
• Computer keyboards		Clean, Sanitize				Use sanitizing wipes, do not use spray
• Phone receivers			Clean			
Toilet & Diapering Areas						
• Changing tables		Clean, Disinfect				Clean with detergent, rinse, disinfect
• Potty chairs		Clean, Disinfect				
• Hand-washing sinks & faucets			Clean, Disinfect			
• Countertops			Clean, Disinfect			
• Toilets			Clean, Disinfect			
• Diaper pails			Clean, Disinfect			
• Floors			Clean, Disinfect			Damp mop with a floor cleaner/ disinfectant
Sleeping Areas						
• Bed sheets & pillow cases				Clean		Clean before use by another child
• Cribs, cots, & mats				Clean		Clean before use by another child
• Blankets					Clean	