Caring for Our Children Basics

February 10, 2015

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Purpose of Today’s Webinar

- Ensure that our State partners have information on Caring for Our Children Basics (COCB)
- Share background and development process of COCB
- Review proposed standards across domains
- Discuss ways to use COCB for alignment
- Answer questions
- Encourage submission of comments
ACF Early Childhood Goals

• Building successful early learning and development systems across Head Start, child care, home visiting, and pre-K

• Promoting high-quality and accountable early learning and development programs for all children

• Ensuring an effective early childhood workforce

• Promoting family support and engagement in children’s development

• Improving health and safety of early learning and development programs
Foundations of Care Quality

• High-quality early care and education settings can have significant developmental benefits and other positive long-term effects for children well into their adult years.

• Poor quality can result in unsafe environments that disregard children’s basic physical and emotional needs, leading to neglect, toxic stress, injury, or even death.

• Health and safety have been identified in multiple parent surveys as important factors when considering child care options.
Issue

• Healthy and safety standards vary widely across States and other jurisdictions in terms of number and content of health and safety standards as well as the monitoring of adherence to these regulations.

• Standards and requirements vary greatly by program type and funding stream.

• There is no Federal guidance that supports States in creating consistent health and safety standards across early care and education settings.
State Actions Taken to Strengthen Health and Safety Requirements

• 27 States made changes to licensing regulations for center-based care

• More than half have made changes to licensing requirements for family child care homes

• Largest increase was in the number of States that have requirements about safe-sleep practices
Caring for Our Children Basics

• ACF has developed a set of voluntary, baseline health and safety standards for use across child care programs, Head Start, and pre-K.

• We are working towards setting a consistent floor across early care and education programs from which programs would aspire/move to higher quality.

• Provides parents with assurances that children are safe.
Partners

- Office of the Deputy Assistant Secretary for Early Childhood Development
- Office of Child Care
- Office of Head Start
- Division of Home Visiting and Early Childhood Services, Maternal and Child Health Bureau, Health Resources and Services Administration
- Outside Expert Panel
Resources

- *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, Third Edition*

- *Stepping Stones to Caring for Our Children, Third Edition*

- Child Care and Development Block Grant (CCDBG) Act of 2014

- Key Indicators from Head Start Program Standards

- Key Indicators from Stepping Stones 3

- Observable Health and Safety Standards Checklist for Early Care and Education Providers from Caring for Our Children
Domains

- Staffing
- Program Activities for Healthy Development
- Health Promotion and Protection
- Nutrition and Food Service
- Facilities, Supplies, Equipment, Environmental Health
- Play Areas/Playgrounds and Transportation
- Infectious Disease
- Policies
Using Caring for Our Children Basics

• How do States use COCB as a basis for alignment?
  - Licensing
  - Head Start
  - CCDF
  - How else can you use this in your community?
Please look for *Caring for Our Children Basics* in the Federal Register!


Questions?
Caring for Our Children Basics Webinar
February 10, 2015

Tricia Haley: A few announcements and then we will get started. First of all, as you have likely seen, all of the lines are muted on this call. It’s so that we can avoid background noise and other kinds of disruptions. It is not because we don’t want to hear your questions, we absolutely do. Feel free to chat them to us throughout the course of the webinar. We’ll be watching them as they come in, but then Linda and Moniquin will be answering the ones that they can get to at the end of the webinar.

Finally, we always, always, always get the question of whether or not these slides are available; they are not yet, but they will be. We actually plan to archive this entire webinar, including the slides, and when we have that up, we will send it your way.

And with that, I will turn it over to Linda Smith, the deputy assistant secretary for early childhood development at the Administration for Children and Families (ACF).

Linda Smith: And thank you. Thank you every one for joining today. This is actually a nice day for us here. This is a project that we’ve been working on for a long time. We’re very excited to do the briefing for you and then take some questions on it, and hopefully can encourage you, if you haven’t already, to make comments to the standards in the Federal Register.

The purpose of the webinar today is to ensure that all of our State partners have information on what the Caring for Our Children Basics is really all about; how we developed them, look at the standards across the different domains, the way that we can use them to align programs across, and as those of you who heard me talk, talk about this horizontal alignment of our program from child care Head Start prekindergarten (HS preK) across the board; and then, obviously, answer some questions for you.

So the next slide just shows you the goals of the early childhood program here at ACF. I’m not going to spend a lot of time on them, but just quickly. Obviously, we’ve talked about building the early learning systems across these different domains, and this is, again, a point of these standards and the work we’re doing. How we are promoting high-quality accountable programs for all of our children, looking at the workforce, and there are references in the standards for some of the workforce requirements. Promoting family engagement, and then obviously the focus of this one is on improving health and safety in all of our early learning programs.

So these are sort of philosophical issues, but it is our belief here that, and obviously I think probably everyone on this call, that high quality does have significant benefits for our children; and that quite the opposite, poor-quality results and unsafe quality has a disregard for children’s physical and emotional safety and well-being, especially leading to some of the things that you show there.
So we basically feel that health and safety is a foundation for what we’re trying to do here. Survey after survey, the latest a couple years ago, shows that when parents are out looking for programs that they prioritize health and safety above all other quality features when selecting a child care arrangement, so it’s very important to parents. Sometimes I think parents have been fooled into thinking certain things are going on in programs that in fact are not when it comes to health and safety. And we’ll talk a little bit about why we think this answers some of those questions.

The next slide just gives you some of the issues that we think have been out there, that there’s great variability between health and safety standards among the States and across jurisdictions and across programs. We know that here between HS and child care, we’ll talk about that a little bit more later on. There is no Federal guidance that supports States in this.

We certainly have invested a lot in the *Caring for Our Children* book. We’ve done that work with our partners over at the Maternal and Child Health Bureau (MCHB) and throughout a number of agencies here in the government. But if you look at that book, and we do all the time; we go to it as a reference book for almost everything we do here, we also recognize that it can be a little overwhelming to a provider out there; that it’s more like a telephone book than it is a handy, dandy, little guide for some of the basic things.

So when we started this work, we wanted to recognize the fact that we wanted to put something out there that we thought would be the minimum that all programs could and should share, when it comes to the health and safety of children.

We’ve taken a look at these in a number of ways, and I want to just back up and say that States have taken many actions over the last several years to improve health and safety requirements in child care programs. In center-based programs in particular, you see 27 States have made changes to their licensing regulations, and more than half, have made changes to their family child care home standard.

So there has been an increase. Noteworthy is that the largest increase was in the number of States that are requiring safe sleep practices, but there sure are a number of things that we would like to see all States include in their basic standards.

So I think we’ve made a lot of progress. The States have worked really hard on this over the last several years, but there is more work that needs to be done.

So we decided here, and this has been in the works now for a couple of years, actually, here at ACF, to look at developing a set of voluntary, what we call “model” or “standards” that the States could look at and that would provide a baseline, a foundation, the minimum, if you will, or the floor for early care and education across all programs. And I think I need to keep stressing that, and we stress it in the preamble to the standards that were in the Federal Register; we view these standards as very basic.

What we wanted to make sure that we pass the sniff test on these things, or the laugh test, whichever one you want to call it, in terms of people saying, you’ve got to be kidding me, you’re
asking for, and there’s been over time many laughable things that don’t make sense to parents, that don’t make sense to legislators. So we tried to go for the minimum, and that there wouldn’t be anyone out there who could laugh at us for saying we want to require SIDS training, we want to require safe water practices when people have pools, those types of things, that no one would think they were unreasonable to ask for a child care program.

So again, keeping in mind that these are a basic, minimal, model standards that States and other programs can use to evaluate their own standards against to see that everything is covered.

So with all of that, I’m going to turn it over to Moniquin Huggins now, who is the director here at the Office of Child Care (OCC) for program operations and been the lead person in the OCC for the work we’ve been doing. So Moniquin, over to you.

**Moniquin Huggins:** So Linda talked a lot about the partners we’ve been working with, and I just wanted to reiterate, and just say we’ve spent a great deal of time working across ACF and the U.S. Department of Health and Human Services (HHS) to identify a set of standards that can serve as a baseline for early childhood programs. Within ACF, we’ve worked with Linda’s office, the OCC, the office of (HS), and our long-time partners at the MCHB, as well as the Division of Home Visiting.

We’ve also consulted with and gathered input from outside experts in the field of health, licensing, and resource referral agencies. And just to give you an example, we’ve engaged Rick Fiene, Walter Gilliam, Nancy vonBargen, Colleen Koch, Judy Collins. Those are names that are well-known in the field.

We’ve also been in contact and engaged the American Academy of Pediatrics, the American Public Health Association, and the National Resource Center for Health and Safety in early care and education in Colorado.

And before I go on, I would be remiss not to thank our own in-house lead here, and that’s Katie Beckmann. She would have been part of this webinar this afternoon, but as many of you know, or maybe you don’t know, she just recently gave birth to a beautiful baby boy. But she is the lead and has led our development in working across partners, both within HHS and outside of HS in developing these standards, so I just wanted to make a note of that in the webinar this afternoon.

And Linda mentioned this, we use existing resources, because we know there were resources and documents out there that Linda mentioned, *Care for Our Children* and *Stepping Stones for Care for Our Children*. And we just want to really take this time to acknowledge the extensive work of the American Academy of Pediatrics, and I mentioned just before the American Public Health Association, and the resource center, for their work in developing these resources that we use. We also, in developing the standards used for key indicators from the (HS) program, which Rick Fiene was a part of, and he’s with the Institute for Key Indicators. And also Abbey Alkon, who is with the University of San Francisco in California, with the 77 observable health and safety standards for early care and education providers.
We use those resources and really did a real in-depth look at those standards in identifying the
standards for Caring for Our Children Basics, as I said before. And then we reached out to our
partners, got input, and that has led us to the most recent Federal Register announcement for
Caring for Our Children Basics.

If you’ve had a chance, and hopefully you have had a chance, to look at Caring for Our Children
Basics, you will see that currently there are 66 proposed standards across 8 domains, and so 8
domains are listed there in the slide. And I just wanted to quickly go through the slide, through
the domains, and just say for staffing, when you look under that domain, you’ll see background
checks on a pre-service training for orientation. Then when you look at the program activities for
healthy development, you will see the status for monitoring children’s development.

Down further, you will see health promotion and protection. In that area, the domains are
opportunities for physical activity, the safe sleep practices, and the SIDS risk reduction. Those
are just highlights; there are many standards, but I didn’t want to take up too much [inaudible]
because our goal is to leave time this afternoon to hear questions from you.

When you look at the nutrition and food services, of course you have standards regarding
USDA-CACFP guidelines; caring for children with food allergies; and preparation areas for
access. Under the facilities, we have the inspection for buildings, the fire code, the use and
storage of processed substance, as well as the first aid and emergency supplies. And then, of
course, the play areas and playground and transportation, of course you’ll have standards related
to transportation and outdoor play areas.

Infectious disease, I would be remiss, we all know of the measles outbreak now. Immunization
documentation regarding unimmunized, standard regarding unimmunized children. And I would
just pause a moment, to just urge everyone that’s on the sound to please be in contact with your
local public health department and follow the Centers for Disease Control and Prevention (CDC)
rules and recommendations regarding immunizing young children, because we know this could
be a serious health problem for young children, especially in group settings such as child care.

And, of course, the last domain is in regards to policies. And, of course, in that area, you have
medication administration, disaster planning, and certificates of a number of policies that you
can develop as it relates to your program.

So the last slide here is using Caring for Our Children. And we really do believe that Caring for
Our Children Basics is a tool that States and agencies can use to align requirements across all
early child care programs regardless of funding. So if you’re in licensing, incorporating Caring
for Our Children Basics can serve as a baseline to ensure programs meet at least the minimum
basic requirements, as Linda stated earlier.

These Caring for Our Children Basics align with the HS standards. And as many of you know,
the recent reauthorization of the Child Care Development Block Grant (CCDBG) in late
November brought new specific health and safety requirements for the Child Care Development
Fund (CCDF) program, and the Caring for Our Children Basics aligns well with these new
requirements. The new requirements are background checks, monitoring, infections, and training requirements for providers.

And as you know, before the reauthorization, States had a great deal of flexibility in those three areas related to infectious disease training, and building and physical premises safety. But the new law put very specific requirements in four states, and we think that this will be a great tool the States could use in order to meet those requirements.

Caring for Our Children also provides an opportunity for coordination to maximize resources and avoid duplication of efforts.

And I just wanted to make this note before I turn it over to Linda again, that the new reauthorization did not stipulate who would carry out the law. Normally it’s the CCDF lead agency. But if you really look at the reauthorization, there are ‘many more entities that should and could be involved in administering the program, or actually implementing the program. For example, the licensing department. The licensing agency that’s working with the CCDF lead agency, or if there are ‘other agencies within the state that we can coordinate, that you can coordinate, and bring those entities together.

States have flexibility. We’re not taking away that flexibility. But States also have the flexibility to coordinate and collaborate across agencies, so it could be the licensing agency that does the implementation around the licensing. It could be working with the (USDA) in order to conduct the monitoring. But Caring for Our Children will provide you with the tool that you need to align programs across and provide the tool for whatever agencies that you’re working with to coordinate.

So with that, I’m going to turn it back over to Linda.

**Linda Smith:** Well, before we start to take questions, if you have them, go ahead and start to think about them now. One of the things I do want to add to what Moniquin said is that as a part of this being in the Federal Register, this is also being coordinated with other agencies in the Federal government, like the Department of Education (ED). And we’ve done a lot of work with the Department of Defense in other areas. We are really trying pretty hard to align, to use something, or, to create something here that everyone can sort of think about and use as a benchmark.

So as we move forward again, we do not -- these are not regulations, they are simply model standards that people can look at their own health and safety standards against those and hopefully fill some gaps if they need to. And as Moniquin said, the staff here has done a lot of work, coordinated with a lot of people on these things, and so I think it’s collectively the best thinking of a lot of very hard-working, smart people in this country.

So with that, I think we’ll open it up for questions that you might have. But again, just so you know, they are in the Federal Register right now for comments, and I think they close on the 20th.

**Moniquin Huggins:** 17th.
Linda Smith: The 17th will be the last day for comments on them. So if you haven’t commented already, please do so. While we’re waiting to see if we have any questions, one question that we have had here is, will we be transparent in these and let people see what comments we got? And we certainly can make any comments that we get from these available to the public. So far, the comments that we’ve got, we’ve been watching, and have been very helpful, making really substantive suggestions about the standards, but positive comments nonetheless. So we’re encouraged by this, and I guess we’ll see if we have any questions.

Tricia Haley: We do not have any questions chatted in yet. Folks, feel free to chat your questions through. I noticed that somebody does have their hand raised, and we don’t have our hand raise feature in use on this particular webinar. So, if you are the person with your hand raised, feel free to, oh. You already took it down. Well done.

Feel free to chat your question in, and we will try to answer it. I was going to say the old-fashioned way, but I don’t think that applies here. I think hand-raising, actually, probably would have been the old-fashioned way. So, do feel free to chat those questions in.

Linda Smith: As we wait, one of the other things that we had been doing, and part of our thinking on this has been, at the time we started the work on this is we were working on the child care Notice of Proposed Rulemaking (NPRM). Now we have a new law, and we’re working on that.

But obviously, we’re also thinking about revising the HS standards. So, we looked at all of these things across those 2 domains to try and make sure that we, if nothing else, are not contradicting each other in our own regulations that we put out, or standards, etc. So, we’ve done a fair amount of looking at that, and they are cross-referenced from both the HS and the child care side.

Tricia Haley: As always, the first question, and probably the last, and somewhere in the middle, is will we get sent a copy of the PowerPoint? As I mentioned early on, it is our intention to put not only the PowerPoint but this full webinar online, hopefully within the next couple of weeks. Once we have it up, we will send a note out to all participants and make sure that you can access that information.

You guys may have set a record for the clearest, most straightforward webinar, because we are not getting a lot of questions.

You will notice, folks who are on the call that the link that’s on your screen was also chatted out. We realize that the link that’s on your PowerPoint is not live. So, you feel free to check your chat box and access the link from there, if you’re interested in commenting.

Linda Smith: Well, if we don’t have any questions, then --

Tricia Haley: Oh, now they’re coming in. So we’ll start with, “What is the plan for those States that do not have strong, or for that matter, any licensing regulations in place for child care?”
Linda Smith: Well, I know where Deanna is from.

Really, they’re not regulatory from our perspective. And so one of the things that we would hope in a State that doesn’t have any standards at all, that they might look at these as a basis on which they would build something.

And, that perhaps, if you have legislative bodies that really don’t think basic regulations are worthwhile, that maybe they would take a look at these. Because they have been sort of thought from that common sense, what is the least we really need to do here, not the least, but what we need to do to cover children’s safety. So, there’s really not a lot of fluff in there, and I think they would make sense.

So I would encourage you, Deanna, to see and to talk with some of your legislative committees about these, in that they are just very basic, they’re not far overreaching as some people sometimes get concerned about.

The next one is what will be the frequency. We basically have in the standards, and you can look in them, the recommendations that were in the Caring for Our Children. Now, some of these things are now going to be, will defer to the regulations, for example, H S, or what’s in the new CCDBG law. So, the frequency is spelled out in those two laws, not in the standards, per se.

Tricia Haley: “When does the commentary period end?” Can you say that again, Moniquin?

[talking over each other]

Tricia Haley: For commenting on the --

Moniquin Huggins: For the [inaudible] -- 17th.

Tricia Haley: Thank you. “Are you guys sharing information with the ED?”

Linda Smith: Yes. We have. And they’ve already commented back to us on that. And I think, for the most part, we’re very happy with what they saw in them.

Tricia Haley: We got another question asking if there will be a report to see which States have voluntarily adopted these guidelines.

Moniquin Huggins: There could be, yes. We haven’t decided what mechanism we’ll use, but through our technical assistance (TA), there could be.

Linda Smith: And just to note, as part of the work in leading up to these being published, we did have our TA folks, Nancy vonBargen and her crew, look at the standards and compare them to existing State standards. So we have a sense of where the states are aligned, for
the most part, not on all standards, but on most of them. So, we will be sharing some of that, as we move forward as well.

**Tricia Haley:** Kind of tied to that, Linda, someone has asked if there are any recommendations about aligning these in Quality Rating and Improvement System (QRIS) programs in the various States.

**Linda Smith:** Well, I think that would be an excellent way to think about them. I think what we call the basics here as sort of the entry level for any program, and that as we’re building tiered systems and we’re striving for higher levels of quality, then we should look at some of the other things, in terms of after we have met all of these, and if you’re a State that wants to do more in terms of as you build a QRIS, you want to have improved and increased health and safety standards.

But you look at the next level up, which might be Stepping Stone. And then you go from that to the full document of Caring for Our Children, so that we build from the basics, a continuum on how states could move forward in looking at improved quality around health and safety.

**Tricia Haley:** I’m not sure I entirely have a handle on this one, but we’ll give it a try. “When can we expect the proposed basics to become finalized and need to review as an item to be contributed during the revision process of rules changing and writing?” What my thought is that this is kind of a question about whether or not folks are being held to this standard --

**Linda Smith:** Well, this is not a regulation. We just published these in the Federal Register for comment, to get the best before we did publish them, as final model standards for States. So, I would think that we would be looking to take the comments and have something this summer in final.

**Moniquin Huggins:** Right. And I think the commenter or the person asking the question may also be thinking if they’re going to make any proposals, they want to make sure they have the final document in place before they move forward to revise any of their regulations.

**Linda Smith:** Got it. Right. Oh, okay. And that’s a good question. And, thank you for that, because that actually does say that we do need to take a look at this quickly.

**Tricia Haley:** Oh, you already got it, Moniquin. Correctly interpreted the question; thank you for clarifying, Megan.

I guess with that, that’s our last question. With one final reminder that in your chat box, you will see the link to the Federal Register notice.

And yes. Someone has again asked about a recording of the webinar. We are recording the webinar. We will have it online hopefully within the next couple of weeks, and we will plan to send out an e-mail to all participants so that you can access it and share it among your colleagues, as you find helpful.
Linda Smith: Well, as we said when we started this, we are looking for you to make comments, and you have about another week or so to do that. So, please take a look at them and get us anything that you think does impact that common sense guarantee, because that’s what we’re really trying to do here. So, if there’s something that you think we need to look at, now is the time to let us know.

So, thank you all for joining us, and thanks for the great questions. We appreciate it.

Moniquin Huggins: Thank you.

Tricia Haley: All right. That concludes. Thanks very much, everyone. Have a great afternoon.

(END)
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Administration for Children and Families

Caring for Our Children Basics; Comment Request

AGENCY: Administration for Children and Families (ACF), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: As authorized by the 2014 Omnibus Act, ACF is requesting public comment on a voluntary set of minimum health and safety standards for early care and education settings titled, “Caring for Our Children Basics.”

DATES: The deadline for receipt of comments is midnight, February 17, 2015.

ADDRESSES: Submit comments to cfo/basics@acf.hhs.gov.

SUPPLEMENTARY INFORMATION: High quality early care and education settings can have significant developmental benefits and other positive long term effects for children well into their adult years. At the same time, poor quality can result in unsafe environments that disregard children’s basic physical and emotional needs leading to neglect, toxic stress, injury, or even death. It is not surprising that health and safety have been identified in multiple parent surveys as the most important factors to consider when evaluating child care options. For example, Shlay¹ found that, regardless of race/ethnicity, parents consistently prioritized health and safety over other quality features when selecting an early care arrangement.

From 2009 to 2011, 27 states made changes to licensing regulations for center-based care, and more than half made changes to licensing requirements for family child care homes. With respect to health and safety, the largest increase was in the number of states that have requirements regarding safe sleep practices (Office of Child Care’s National Center on Child Care Quality Improvement & National Association for Regulatory Administration, 2013). A number of states have taken action to strengthen health and safety requirements and their enforcement in reaction to tragedies where children have been injured or died in child care (e.g., Lexie’s Law (Kansas, 2010) and Joshua’s List (Oklahoma, 2010)).

However, more work must be done to ensure children can learn, play, and grow in settings that are safe and secure. Health and safety standards provide the foundation on which states and communities build a solid system of early care and education. Yet, states vary widely in the number and content of health and safety standards as well as how they monitor compliance with these standards. Some early care providers may receive no monitoring while others receive multiple visits. In addition, some early care and education providers who receive funding from multiple sources may receive repeated monitoring visits using conflicting standards. These sources can include Head Start, the Child Care and Development Fund, and the Child and Adult Care Food Program.

In testimony before the United States House Committee on Education and the Workforce, the Government Accountability Office (GAO) called attention to the multiple agencies that administer the federal investment in early learning and child care through multiple programs that sometimes have similar goals and are targeted to similar groups of children. They added that the existence of multiple programs can increase administrative costs associated with meeting varying requirements. We acknowledge that there are differences in health and safety requirements by funding stream (e.g., Head Start, Child Care Development Fund, pre-Kindergarten) and early childhood program type (e.g., center-based, home-based). While standards may vary depending on the length of the day and setting, there are some standards that must be in place to protect children no matter what type of variation in program.

The proposed model standards are called “Caring for our Children Basics.” They represent the minimum standards experts believe must be in place wherever children are regularly cared for in non-parental care settings. “Caring for our Children Basics” is the first attempt to reduce the conflicts and redundancy found in standards that are used to monitor early care and education settings. These are minimum standards and should not be construed to represent all standards that would need to be present to achieve the highest quality of care and early learning. For example, the caregiver training requirements outlined in these standards are designed only to prevent harm to children, not to ensure their optimal development and learning. This call for public comment is to obtain information to help HHS as we further develop the voluntary set of minimum health and safety standards for early care and education settings. Because quality care cannot be achieved without consistent, basic health and safety practices in place, ACF seeks to provide a helpful reference for states and other entities as they work to improve their health and safety standards across program type. Our hope is that a voluntary common framework will assist child care licensing agencies in working towards and achieving a more consistent foundation for quality across the country upon which families can rely. In addition, ACF plans to use “Caring for Our Children Basics” in aligning health and safety efforts in early care and education at the federal level. Public input will be helpful in providing HHS with practical guidance to aid in the refinement and application of “Caring for Our Children Basics.”

“Caring for Our Children Basics” is 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, the American Public Health Association, the National Resource Center for Health and Safety in Child Care and Early Education, and the Maternal and Child Health Bureau, Department of Health and Human Services in developing these standards.

Caring for Our Children Basics

Staffing

1.2.0.2 Background Screening

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 (in addition to any individuals residing in a family child care home over age 18). Consent to the background investigation should be required for employment consideration. The comprehensive background screening should 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 criminal history records;
(c) Clearance through the child abuse and neglect registry (if available); and
(d) Clearance through sex offender registries (if available).

1.4.1.1/1.4.2.3 Pre-service/Training/ Orientation

Before or during the first 3 months of employment, training and orientation should detail health and safety issues
for early care and education settings including, but not limited to, typical and atypical child development; first aid and CPR; safe sleep practices, including risk reduction of Sudden Infant Death Syndrome/Sudden Unexplained Infant Death (SIDS/SUId); infectious disease prevention; emergency preparedness; nutrition and age-appropriate feeding; medication administration; and care plan implementation for children with special health care needs. All directors or program administrators and caregivers/teachers should document receipt of training.

1.4.3.1 First Aid and CPR Training for Staff

All staff members involved in providing direct care to children should have up-to-date documentation of satisfactory completion of training in pediatric first aid and CPR skills as defined by the American Red Cross and American Heart Association. At least one staff person who has successfully completed this training should be in attendance at all times. Records of successful completion of training in pediatric first aid and CPR should be maintained in the personnel files of the facility.

1.4.5.2 Child Abuse and Neglect Education

Caregivers/teachers should be educated on child abuse and neglect prevention to 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

2.1.2.1/2.1.3.1 PersonalCaregiver/Teacher Relationships for Birth to Five-Year-Olds

Programs should practice relationship-based philosophies that promote consistency and continuity of care, especially for infants and toddlers. Early care and education programs should provide opportunities for each child to build emotionally secure relationships with a limited number of caregivers/teachers. Children with special health care needs may require additional specialists to promote health and safety and to support learning.

2.2.0.1 Methods of Supervision of Children

Caregivers/teachers should directly supervise infants, toddlers, and preschoolers by sight and hearing at all times, especially when children are going to sleep, napping, or sleeping; are beginning to wake up; or are indoors or outdoors. Developmentally appropriate child-to-staff ratios should be met during all hours of operation, and safety precautions for specific areas and equipment should be followed.

2.2.0.4 Supervision near Bodies of Water

Constant supervision should be maintained when any child is in or around water. During any swimming/wading activities where either an infant or a toddler is present, the ratio should always be one adult to one infant/toddler. Caregivers/teachers should ensure that all pools meet the Virginia Graeme Baker Pool and Spa Safety Act.

2.2.0.9 Prohibited Caregiver/Teacher Behaviors

The following behaviors should be prohibited in all early care and education settings:

(a) Use of corporal punishment;
(b) Isolating a child where a child cannot be supervised;
(c) Binding or tying to restrict movement 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, or corrupting a child;
(g) Any physical abuse or maltreatment of a child;
(h) Abusive, profane, sarcastic language or verbal abuse, threats, or derogatory remarks about the child or child’s family;
(i) Any form of public or private humiliation; and

(j) Exclusion of physical activity/ outdoor time as punishment.

Health Promotion and Protection

3.1.3.1 Active Opportunities for Physical Activity

Programs should demonstrate a commitment to active play for children, including infants and toddlers, indoors and outdoors every day.

3.1.4.1 Safe Sleep Practices and SIDS Risk Reduction

All staff, parents/guardians, volunteers, and others who care for infants in the early care and education setting should follow safe sleep practices as recommended by the Centers for Disease Control and Prevention (CDC) and the National Institute of Child Health and Human Development (NICHD). Cribs must be in compliance with current U.S. Consumer Product Safety Commission (CPSC) and ASTM International safety standards.

3.1.5.1 Routine Oral Hygiene Activities

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.

3.2.1.4 Diaper Changing Procedure

The following diaper changing procedure should be posted in the changing area and followed to protect the health and safety of children and staff:

Step 1: Before bringing the child to the diaper changing area, perform hand hygiene 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, diaper contents, and/or any problems.
Caregivers/teachers should never leave a child unattended on a table or countertop. A safety strap or harness should not be used on the diaper changing table.

3.2.2.1 Situations that Require Hand Hygiene
All staff, volunteers, and children should abide by the following procedures for hand washing, as defined by the CDC:
A. Upon arrival for the day, after breaks, or when moving from one group to another;
B. Before and after:
• Preparing food or beverages;
• Eating, handling food, or feeding a child;
• 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;
• Playing in water (including swimming) that is used by more than one person;
• Diapering.
C. After:
• Using the toilet or helping a child use a toilet;
• Handling bodily fluid (mucus, blood, vomit);
• Handling animals or cleaning up animal waste;
• Playing in sand, on wooden play sets, and outdoors;
• Cleaning or handling the garbage.

3.2.3.4 Prevention of Exposure to Blood and Body Fluids
Early care and education programs should adopt the use of Standard Precautions, developed by the CDC, to handle potential exposure to blood and other potentially infectious fluids. Caregivers and teachers are required to be educated regarding Standard Precautions and to begin to work in the program and annually thereafter. Training should comply with requirements of the Occupational Safety and Health Administration.

3.3.0.1 Routine Cleaning, Sanitizing, and Disinfecting
Programs should follow a routine schedule of cleaning, sanitizing, and disinfecting. Cleaning, sanitizing, and disinfecting products should not be used in close proximity to children, and adequate ventilation should be maintained during use.

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

3.4.3.1 Emergency Procedures
Programs should have a procedure for responding to situations when an immediate emergency medical response is required. Child-to-staff ratio should be maintained, and 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 to follow standard emergency procedures. All staff should be trained to manage an emergency until emergency medical care becomes available.

3.4.4.1 Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation
Because caregivers/teachers are mandated reporters of child abuse and neglect, each program should have a written policy for reporting child abuse and neglect. The program should report to the child abuse reporting hotline, the Department of Social Services, child protective services, or the 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.

3.4.4.3 Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma
All programs 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.

3.4.5.1 Sun Safety Including Sunscreen
Caregivers/teachers should ensure sun safety for themselves and children under their supervision by keeping infants younger than 6 months out of direct sunlight, limiting sun exposure when UV rays are strongest, wearing shatter resistant sunglasses with UV protection and hats, and applying sunscreen. Written permission from the parent/guardian for use of sunscreen should be required, and manufacturer instructions should be followed.

3.4.6.1 Strangulation Hazards
Strings and cords on toys and window coverings long enough to encircle a child’s neck should not be accessible to children in early care and education programs.

3.5.0.1 Care Plan for Children with Special Health Care Needs
Children with special health care needs are defined as:

1. 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 in an early care and education setting should have an up-to-date Routine and Emergent Care Plan, completed by their primary care provider with input from parents/guardians, included in their on-site health record. The child care health consultant should be involved to ensure adequate information, training, and monitoring is available for early care and education staff.

3.6.1.1 Inclusion/Exclusion/Dismissal of Children
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 to 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.

When a child becomes ill but does not require immediate medical help, a determination should be made regarding whether the child should be sent home. 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) Causes a fever (temperature above 101°F [38.3°C], or 100°F [37.8°C] or higher taken axillary [armpit]) and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, diarrhea). An unexplained temperature above 100°F (37.8°C) (armpit) in a child younger than 6 months should be medically evaluated. Any infant younger than 2 months of age with fever should get urgent medical attention.
If any of the above criteria are met, the child should be removed from direct contact with other children and monitored and supervised by a staff member known to the child until dismissed to the care of a parent/guardian or primary care provider. The local or state health department will be able to provide specific guidelines for exclusion.

3.6.1.4 Infectious Disease Outbreak Control

During the course of an identified outbreak of any reportable illness at the program, 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, 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 official or primary care provider who made the initial determination decides that the risk of transmission is no longer present.

3.6.3.1/3.6.3.2 Medication Administration and Storage

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 never administer a medication that is prescribed for one child to another child. Documentation that the medicine/agent is administered to the child as prescribed is required. Medication should not be used beyond the date of expiration. Unused medications should be returned to the parent/guardian for disposal.
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.

3.6.3.3 Training of Caregivers/Teachers to Administer Medication

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 an administration error occurs.

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

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 7 CFR 226.20.

4.2.0.6 Availability of Drinking Water

Clean, sanitary drinking water should be readily available in indoor and outdoor areas, throughout the day.

4.2.0.10 Care for Children with Food Allergies

Each child with a food allergy should have a care plan prepared for the facility by the child’s primary care provider and parents/guardians, 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 prompt administration of any medications. The plan should include specific symptoms that would indicate the need to administer one or more medications.

Based on the child’s care plan, the child’s caregivers/teachers should receive training for, 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.

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.

The program should notify the parents/guardians immediately of any suspected allergic reactions, as well as the ingestion of or contact with the problem food even if a reaction did not occur. The program should contact the emergency medical services system immediately whenever epinephrine has been administered.

Individual child’s food allergies should be posted prominently in the classroom and/or wherever food is served.

4.3.1.3 Preparing, Feeding, and Storing Human Milk

Programs should develop and follow procedures for the preparation and storage of expressed human milk that ensures the health and safety of all infants, as outlined by the CDC, and prohibits the use of infant formula for a breastfed infant without parental consent. The bottle or container should be properly labeled with the infant’s full name and date.

4.3.1.5 Preparing, Feeding, and Storing Infant Formula

Programs should develop and follow procedures for the preparation and storage of infant formula that ensures the health and safety of all infants. Formula provided by parents/guardians or programs should come in factory-sealed containers. The caregiver/teacher should always follow manufacturer’s instructions for mixing and storing of any formula preparation. 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. Bottles of prepared or ready-to-feed formula should be labeled with the child’s full name and time and date of preparation.
5.1.1.5 Environmental Audit of Site Location

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.

5.2.4.2 Safety Covers and Shock Protection Devices for Electrical Outlets

All accessible electrical outlets should be “tamper-resistant electrical outlets” that contain internal shutter mechanisms to prevent children from sticking objects into receptacles. In settings 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.

5.2.4.4 Location of Electrical Devices near Water

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.

5.2.5.8 Integrated Pest Management

Programs should adopt an integrated pest management program 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.

5.2.9.1 Use and Storage of Toxic Substances

All toxic substances should be used as recommended by the manufacturer and stored in the original labeled containers. All toxic substances should be inaccessible to children. The telephone number for the poison center should be posted in a location where it is readily available in emergency situations.

5.2.9.5 Carbon Monoxide Detectors

Programs should meet state or local laws regarding carbon monoxide detectors, including circumstances when detectors are necessary. Detectors should be tested monthly. Batteries should be changed at least yearly. Detectors should be replaced at least every 5 years.

5.3.1.1/5.5.0.6/5.5.0.7 Safety of Equipment, Materials, and Furnishings

Equipment, materials, furnishings, and play areas should be sturdy, safe, in good repair, and meet the recommendations of the CPSC.

Programs should attend to, including, but not limited to, 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 surfaced 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 parts 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; and
(q) Tip-over hazards, such as chests, bookshelves, and televisions.

Plastic bags, matches, candles, and lighters should not be accessible to children.

5.4.5.2 Cribs

Before purchase and use, cribs must be in compliance with current CPSC and ASTM International safety recommendations.
standards that include 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.

As soon as a child can stand up, the
mattress should be adjusted to its lowest
position. When an infant is able 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). 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 designed for carrying up to
five non-ambulatory children less than
2 years of age to a designated evacuation
area in the event of fire or other
emergency.

Staff should only use cribs for sleep
purposes and should ensure that each
crib is a safe sleep environment as
defined by the CDC and the NICHD. No
child of any age should be placed in a
crib for a time-out or for disciplinary
reasons. Cribs should be placed away
from window blinds or draperies.

5.5.0.8 Firearms

Early care and education programs
should not have firearms, pellet or BB
guns, darts, cap pistols, stun guns, paint
ball guns, or objects manufactured for
play as toy guns on the premises at any
time. If present in a family child care
home, parents should be notified and
these items should 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

6.1.0.6/6.1.0.8/6.3.1.1 Location of Play
Areas near Bodies of Water/Enclosures
for Outdoor Play Areas/Enclosure of
Bodies of Water

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.

Outside play areas should be free
from bodies of water. If present, all
water hazards should be enclosed with
a fence that is 4 to 6 feet high or higher
and comes within 3½ inches of the
ground. Gates should be equipped with
self-closing and positive self-latching
closure mechanisms that are high
enough or of a type such that children
cannot open it. The openings in the
fence and gates should be no larger than
3 inches. The fence and gates should
be constructed to discourage climbing.
Play areas should be secured against
inappropriate use when the facility is
closed.

6.2.3.1 Prohibited Surfaces for Placing
Climbing Equipment

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 a shock-absorbing
material that is either the unitary or the
loose-fill type, as defined by the CPSC
guidelines and ASTM International
Standards ASTM F1292–13 and ASTM
F2223–10, extending at least 6 feet
beyond the perimeter of the stationary
equipment. Organic materials that
support colonization of molds and
bacteria should not be used. This
standard applies whether the equipment
is installed outdoors or indoors.

6.2.5.1 Inspection of Indoor and
Outdoor Play Areas and Equipment

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;
(f) Visible cracks;
(g) Stability of non-anchored large
play equipment (e.g., playhouses);
(h) Wear and deterioration.
Observations should be documented
and filed, and the problems corrected
before the playground is used by
children.

6.3.2.1 Lifesaving Equipment

Each swimming pool more than 6 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. Children should be
familiarized with the use of the
equipment based on their
developmental level.

6.3.5.2 Water in Containers

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

6.5.1.2 Qualifications for Drivers

In addition to meeting the general
staff background check standards, any
driver or transportation staff member
who transports children for any purpose
should be at least 21 years of age and
have:
(a) A valid driver’s license that
authorizes the driver to operate the type
of vehicle being driven;
(b) A safe driving record for more than
5 years, with no crashes where a citation
was issued, as evidenced by the state
Department of Motor Vehicles records;
(c) No tobacco, alcohol, or drug use
before or while driving;
(d) No medical condition that would
compromise driving, supervision, or
evacuation capability;
(e) Valid pediatric CPR and first aid
certificate if transporting children alone.

The driver’s license number and date
of expiration, vehicle insurance
information, and verification of current
state vehicle inspection should be on
file in the facility.

6.5.2.2 Child Passenger Safety

When children are driven in a motor
vehicle other than a bus, all children
should be transported only if they are
restrained in a 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. The child should be
securely fastened, according to the
manufacturer’s instructions. The child
passenger restraint system must meet the
federal motor vehicle safety
standards contained in 49 CFR 571.213
and carry notice of compliance. Child
passenger restraint systems must be
installed and used in accordance with
the manufacturer’s instructions and
should be secured in back seats only.

Car safety seats should be replaced if
they have been recalled 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.

6.5.2.4 Interior Temperature of Vehicles

The interior of vehicles used to transport children for field trips and out-of-program activities should be maintained at a temperature comfortable to children. 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.

6.5.3.1 Passenger Vans

Early care and education programs that provide transportation for any purpose to children, parents/guardians, staff, and others should not use 15-passenger vans whenever possible. 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

7.2.0.1 Immunization Documentation

Programs should require that all parents/guardians of enrolled children 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,” developed by the Advisory Committee on Immunization Practices of the CDC, the American Academy of Pediatrics, 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.

7.2.0.2 Unimmunized Children

If immunizations have not been or are not to be administered because of a medical condition, 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. An immunization plan and catch-up immunizations should be initiated upon enrollment and completed as soon as possible.

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.

7.2.0.3 Immunization of Caregivers/Teachers

Caregivers/teachers should be current with all immunizations routinely recommended for adults by the Advisory Committee on Immunization Practices of the CDC as shown in the “Recommended Adult Immunization Schedule” 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); and

(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.

Policies

9.2.4.1 Written Plan and Training for Handling Urgent Medical Care or Threatening Incidents

The program should have a written plan for reporting and managing any incident or unusual occurrence that is threatening to the health, safety, or welfare of the children, staff, or volunteers. Staff training procedures should also be included. The management, documentation, and reporting of the following types of incidents should be addressed:

(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 program;

(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 program, 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.

9.2.4.3 Disaster Planning, Training and Communication

Early care and education programs should consider how to prepare for and respond to emergency or natural disaster situations that may require evacuation, lock-down, or shelter-in-place and have written plans, accordingly. The following topics should be addressed, including, but not limited to, regularly scheduled practice drills, procedures for notifying and updating parents, and the use of the daily class roster(s) to check attendance of children and staff during an evacuation or drill when gathered in a safe place after exit and upon return to the program.

9.2.4.7 Sign-In/Sign-Out System

Programs should have a sign-in/sign-out system to track those who enter and exit 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.
9.2.4.8 Authorized Persons To Pick Up Child

Children may only be released to adults authorized by parents or legal guardians and whose identity has been verified by photo identification. 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/course orders. The legal guardian(s) of the child should be established and documented at this time.

9.4.1.12 Record of Valid License, Certificate, or Registration of Facility

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

9.4.2.1 Contents of Child Records

Programs should maintain a confidential file for each child in one central location on-site and 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:

(a) Pre-admission enrollment information;
(b) Admission agreement signed by the parent/guardian at enrollment;
(c) Initial and updated health care assessments, completed and signed by the child’s primary care provider, based on the child’s most recent well care visit;
(d) Health history completed by the parent/guardian at admission;
(e) Medication record;
(f) Authorization form for emergency medical care;
(g) Written informed consent forms signed by the parent/guardian allowing the facility to share the child’s health records with other service providers.

10.4.2.1 Frequency of Inspections for Child Care Centers, Large Family Child Care Homes, and Small Family Child Care Homes

The licensing inspector or monitoring staff should make an onsite inspection to measure compliance with licensing/regulatory 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. As one of the inspections should be unannounced, and more if they are needed for the facility to achieve satisfactory compliance or if the facility is closed at any time. Sufficient numbers of licensing inspectors should be hired to provide adequate time visiting and inspecting programs to ensure 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.

Dated: December 12, 2014.

Linda K. Smith,

[FR Doc. 2014–29649 Filed 12–17–14; 8:45 am]

BILLING CODE 4184–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2014–N–0996]

Agency Information Collection Activities; Submission for Office of Management and Budget Review; Comment Request; Guidance for Industry: Fast Track Drug Development Programs: Designation, Development, and Application Review

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing that a proposed collection of information has been submitted to the Office of Management and Budget (OMB) for review and clearance under the Paperwork Reduction Act of 1995.

DATES: Fax written comments on the collection of information by January 20, 2015.

ADDRESSES: To ensure that comments on the information collection are received, OMB recommends that written comments be faxed to the Office of Information and Regulatory Affairs, OMB, Attn: FDA Desk Officer, FAX: 202–395–7285, or emailed to oira_submission@omb.eop.gov. All comments should be identified with the OMB control number 0910–0389. Also include the FDA docket number found in brackets in the heading of this document.

FOR FURTHER INFORMATION CONTACT: FDA PRA Staff, Office of Operations, Food and Drug Administration, 8455 Colesville Rd., COLE–14526, Silver Spring, MD 20993–0002, PRAStaff@fda.hhs.gov.

SUPPLEMENTARY INFORMATION: In compliance with 44 U.S.C. 3507, FDA has submitted the following proposed collection of information to OMB for review and clearance.

Guidance for Industry: Fast Track Drug Development Programs: Designation, Development, and Application Review—(OMB Control Number 0910–0389)—Extension

Section 112(a) of the Food and Drug Administration Modernization Act of 1997 (FDAMA) (Pub. L. 105–115) amended the Federal Food, Drug, and Cosmetic Act (the FD&C Act) by adding section 506 (21 U.S.C. 356). The section authorizes FDA to take appropriate action to facilitate the development and expedite the review of new drugs, including biological products, intended to treat a serious or life-threatening condition and that demonstrate a potential to address an unmet medical need. Under section 112(b) of FDAMA, FDA issued guidance to industry on fast track policies and procedures outlined in section 506 of the FD&C Act. The guidance discusses collections of information that are specified under section 506 of the FD&C Act, other sections of the Public Health Service Act (the PHS Act), or implementing regulations. The guidance describes three general areas involving the collection of information: (1) Fast track designation requests, (2) premeeting packages, and (3) requests to submit portions of an application. Of these, fast track designation requests and premeeting packages, in support of receiving a fast track program benefit, provide for additional collections of information not covered elsewhere in statute or regulation. Information in support of fast track designation or fast track program benefits that has previously been submitted to the Agency, may, in some cases, be incorporated into the request by referring to the information rather than resubmitting it.

Under section 506(a)(1) of the FD&C Act, an applicant who seeks fast track designation is required to submit a request to the Agency showing that the drug product (1) is intended for a serious or life-threatening condition and (2) has the potential to address an
Caring for Our Children (CFOC): Basics\textsuperscript{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;


\textsuperscript{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 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:

- 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;
- Positive ways to support language, cognitive, social, physical, and emotional development including appropriate guidance and discipline;
- Developing and maintaining relationships with families of children enrolled, including the resources to obtain supportive services for children’s unique developmental needs;
- Procedures for preventing the spread of infectious disease;
- Infection control and injury prevention through role modeling;
- Safe sleep practices including reducing the risk of Sudden Infant Death Syndrome (SIDS) (infant sleep position and crib safety);
- Shaken baby syndrome/abusive head trauma prevention and identification;
- Poison prevention and poison safety;
- Immunization requirements for children and staff;
- 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;
\\text{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) \textbf{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) \textbf{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 an 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.
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 refinshed 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, sheer, 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:
- Unfenced swimming and wading pools;
- Ditches;
- Quarries;
- Canals;
- Excavations;
- Fish ponds;
- Water retention or detention basins;
- 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;

h. 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.
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 manufactures’ 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 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.
### Routine Schedule for Cleaning, Sanitizing, and Disinfecting

<table>
<thead>
<tr>
<th>Areas</th>
<th>Before Each Use</th>
<th>After Each Use</th>
<th>Daily (At the End of the Day)</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Food Areas</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Food preparation surfaces</td>
<td>Clean, Sanitize</td>
<td>Clean, Sanitize</td>
<td></td>
<td></td>
<td></td>
<td>Use a sanitizer safe for food contact</td>
</tr>
<tr>
<td>• Eating utensils &amp; dishes</td>
<td></td>
<td>Clean, Sanitize</td>
<td></td>
<td></td>
<td></td>
<td>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</td>
</tr>
<tr>
<td>• Tables &amp; highchair trays</td>
<td>Clean, Sanitize</td>
<td>Clean, Sanitize</td>
<td></td>
<td></td>
<td></td>
<td>Use a sanitizer safe for food contact</td>
</tr>
<tr>
<td>• Countertops</td>
<td>Clean</td>
<td>Clean, Sanitize</td>
<td></td>
<td></td>
<td></td>
<td>Use a sanitizer safe for food contact</td>
</tr>
<tr>
<td>• Food preparation appliances</td>
<td>Clean</td>
<td>Clean, Sanitize</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mixed use tables</td>
<td>Clean, Sanitize</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Before serving food</td>
</tr>
<tr>
<td>• Refrigerator</td>
<td></td>
<td>Clean</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child Care Areas</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Plastic mouthed toys</td>
<td>Clean</td>
<td>Clean, Sanitize</td>
<td></td>
<td></td>
<td></td>
<td>Reserve for use by only one child; Use dishwasher or boil for one minute</td>
</tr>
<tr>
<td>• Pacifiers</td>
<td>Clean</td>
<td>Clean, Sanitize</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hats</td>
<td></td>
<td>Clean</td>
<td></td>
<td></td>
<td></td>
<td>Clean after each use if head lice present</td>
</tr>
<tr>
<td>• Door &amp; cabinet handles</td>
<td>Clean, Disinfect</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Floors</td>
<td>Clean</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sweep or vacuum, then damp mop</td>
</tr>
<tr>
<td>• Machine washable cloth toys</td>
<td>Clean</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Launder</td>
</tr>
<tr>
<td>• Dress-up clothes</td>
<td>Clean</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Launder</td>
</tr>
<tr>
<td>• Play activity centers</td>
<td></td>
<td>Clean</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Drinking Fountains | Clean, Disinfect
- Computer keyboards | Clean, Sanitize
- Phone receivers | Clean

**Toilet & Diapering Areas**
- Changing tables | Clean, Disinfect
- Potty chairs | Clean, Disinfect
- Hand-washing sinks & faucets | Clean, Disinfect
- Countertops | Clean, Disinfect
- Toilets | Clean, Disinfect
- Diaper pails | Clean, Disinfect
- Floors | Clean, Disinfect

**Sleeping Areas**
- Bed sheets & pillow cases | Clean
- Cribs, cots, & mats | Clean
- Blankets | Clean

Use sanitizing wipes, do not use spray

Clean with detergent, rinse, disinfect

Damp mop with a floor cleaner/disinfectant

Clean before use by another child

Clean before use by another child