2015

Caring for Our Children Basics
Health and Safety Foundations for Early Care and Education

Administration for Children and Families
U.S. Department of Health and Human Services

6/25/2015

Contents

Acknowledgements

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; American Public Health Association; National Resource Center for Health and Safety in Child Care and Early Education; and Maternal and Child Health Bureau, Department of Health and Human Services in developing these standards. We would also like to especially thank the following experts for their help in this effort:

Abbey Alkon, RN, Ph.D.
School of Nursing
University of California, San Francisco

Judy Collins
Consultant

Richard Fiene, Ph.D.
Research Institute for Key Indicators

Walter Gilliam, Ph.D.
Edward Zigler Center in Child Development and Social Policy
Yale University Child Study Center

Danette Swanson Glassy, MD, FAAP
American Academy of Pediatrics

Barbara Hamilton, MA
Maternal and Child Health Bureau
Health Resources and Services Administration
U.S. Department of Health and Human Services

Pauline D. Koch
Koch Consulting

Marilyn Krajicek, Ed.D., RN, FAAN
National Resource Center for Health and Safety in Child Care and Early Education
College of Nursing
University of Colorado Denver

Beverly Schmalzreid, Ph.D.
Department of Child Development
South Texas College

Nancy Von Bargen, MS
Office of Child Care National Center for Child Care Quality Improvement

Jeanne VanOrsdal, M. Ed.
Early Education and Child Care Initiatives
American Academy of Pediatrics

Marcus Williams
National Association for Regulatory Administration

Introduction

Evidence continues to mount that demonstrates the profound influence children's earliest experiences have on later success. Nurturing and stimulating care given in the early years builds optimal brain architecture that allows children to maximize their potential for learning. Interventions in the first years of life are capable of altering the course of development and shift the odds for those at risk of poor outcomes toward more adaptive ones.

To meet the needs of our nation's most vulnerable children and families, the early care and education programs administered by the Administration for Children and Families (ACF) are designed to both provide enriching early childhood experiences that promote the long-term success of children and assist low-income working parents with the cost of child care. In partnership with families, all early care and education programs should support children's needs and age-appropriate progress across domains of language and literacy development; cognition and general knowledge; approaches to learning; physical health and well-being and motor development, and social and emotional development that will improve readiness for kindergarten. Head Start, Early Head Start, pre-Kindergarten, and child care programs aim to support the ability of parents, teachers, child care providers and other community members to interact positively with children in stable and stimulating environments to help create a sturdy foundation for later school achievement, economic productivity, and responsible citizenship.

ACF strives to achieve the following goals in all early childhood programs:

- Build successful Early Learning and Development Systems across Early Head Start, Head Start, child care, and pre-Kindergarten.
- Promote high quality and accountable early learning and development programs for all children.
- Ensure an effective early childhood workforce.
- Improve the physical, developmental, mental health, and social well-being of children in early learning and development settings.
- Promote family engagement and support in a child's development with the recognition that parents are their children's primary teachers and advocates.
- Build on the strengths and address the needs of culturally and linguistically diverse children and families.
- Improve the health and safety of early learning and development settings

While 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 settings can result in unsafe environments that disregard children's basic physical and emotional needs leading to neglect, toxic stress, injury, or even death. As a result, it is not surprising that health and safety has been identified in multiple parent surveys as one of the most important factors to consider when evaluating child care options (Shlay, 2010). Health and

safety practices provide the foundation on which states and communities build quality early care and education settings.

Licensing of center-based care and family child care homes is a process that establishes the minimum requirements necessary to protect the health and safety of children in care. State licensing requirements are regulatory requirements, including registration or certification requirements, established under State law necessary for a provider to legally operate and provide child care services.

From 2009 to 2011, more than half of states made changes to licensing regulations for center-based care and family child care homes. For example, states increased the pre-service training requirements for center directors, and increased the number of ongoing training hours for all center staff roles, as well as family child care providers. Specifically, 47 States require center staff and 37 States require family child care providers to complete first aid training. With respect to CPR, 46 States require training of center staff and 36 require it of family child care providers. More than half of States require center staff to complete training on child abuse and neglect (27 States) or the prevention of communicable diseases (25 States). The number of States requiring fingerprint checks of federal records and checks of sex offender registries has increased since 2007. All States that license centers and more than 85% that license family child care homes have requirements about the nutritional content of meals and snacks served to children. States have added requirements about fences for outdoor space, transportation, and emergency preparedness, and more States prohibit firearms in child care centers (Office of Child Care National Center on Child Care Quality Improvement and National Association for Regulatory Administration, 2013).

Great progress has been made in States to safeguard children in out of home care, yet more work must be done to ensure children can learn, play, and grow in settings that are safe and secure. States vary widely in the number and content of health and safety standards as well as the means by which they monitor compliance. Some early care and education programs may receive no monitoring while others receive multiple visits. Further, some programs who receive funding from multiple sources may receive repeated monitoring visits that evaluate programs against complicated, and sometimes conflicting, standards. While there are differences in health and safety requirements by funding stream (e.g. Head Start, Child Care Development Fund, Individuals with Disabilities Education Act, and Title I), early childhood program type (e.g. center-based, family child care homes) and length of time in care, there are basic standards that must be in place to protect children no matter what type of variation in program. Until now, there has been no federal guidance that supports States in creating basic, consistent health and safety standards across early care and education settings.

ACF is pleased to announce *Caring for Our Children Basics: Health and Safety Foundations for Early Care and Education*. *Caring for our Children Basics* represents the **minimum** health and safety standards experts believe should be in place where children are cared for outside of their homes. *Caring for our Children Basics* seeks to reduce the conflicts and redundancy found in program standards linked to multiple funding streams. Caring *for our Children Basics* should not

be construed to represent all standards that should 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.

Caring for our Children Basics is the result of work from both federal and non-federal experts and is founded on *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, Third Edition,* created by the American Academy of Pediatrics; American Public Health Association; and National Resource Center for Health and Safety in Child Care and Early Education with funding from the Maternal and Child Health Bureau. The Office of Child Care, Office of Head Start, Office of the Deputy Assistant Secretary for Early Childhood, and the Maternal and Child Health Bureau were instrumental in this effort. Although use of *Caring for our Children Basics* is not federally required, the set of standards was posted for public comment in the Federal Register to provide ACF with practical guidance to aid in refinement and application. The standards, regulations, and guidance with which *Caring for our Children Basics* was produced are located at the end of this document.

Quality care can be achieved with consistent, basic health and safety practices in place. Though **voluntary**, ACF hopes *Caring for Our Children Basics* will be a helpful resource for states and other entities as they work to improve health and safety standards in both licensing and quality rating improvement systems (QRIS). As more states build their QRIS, it is hoped that *Caring for Our Children Basics* will support continuous quality improvement in programs as they move to higher levels of quality and improve the overall health and well-being of **all** children in out-of-home settings. In addition, ACF anticipates *Caring for Our Children Basics* will support efficiency and effectiveness of monitoring systems for early care and education settings. A common framework will assist the Nation in working towards and achieving a more consistent foundation for quality upon which families can rely.

Staffing

1.1.1.1-1.1.1.5 Ratios for Centers and Family Child Care Homes

Appropriate ratios should be kept during all hours of program operation. Children with special health care needs or who require more attention due to certain disabilities may require additional staff on-site, depending on their needs and the extent of their disabilities.

In center-based care, child-provider ratios should be determined by the age of the majority of children and the needs of children present.

	Child Care Centers
Age	Maximum Child: Provider Ratio
≤ 12 months	4:1
13-23 months	4:1
24-35 months	4:1-6:1
3-year-olds	9:1
4- to 5-year-olds	10:1

In family child care homes, the provider's own children under the age of 6, as well as any other children in the home temporarily requiring supervision, should be included in the child: provider ratio. In family child care settings where there are mixed age groups that include infants and toddlers, a maximum ratio of 6:1 should be maintained and no more than two of these children should be 24 months or younger. If all children in care are under 36 months, a maximum ratio of 4:1 should be maintained and no more than two of these children should be 18 months or younger. If all children in care are 3 years old, a maximum ratio of 7:1 should be preserved. If all children in care are 4 to 5 years of age, a maximum ratio of 8:1 should be maintained.

1.2.0.2 Background Screening

All caregivers/teachers and staff in early care and education settings (in addition to any individual age 18 and older, or a minor over age 12 if allowed under State law and if a registry/database includes minors, residing in a family child care home) should undergo a complete background screening upon employment and once at least every five years thereafter. Screening should be conducted as expeditiously as possible and should be completed within 45 days after hiring. Caregivers/teachers and staff should not have unsupervised access to children until screening has been completed. Consent to the background investigation should be required for employment consideration. The comprehensive background screening should include the following:

a) A search of the State criminal and sex offender registry or repository in the State where the child care staff member resides, and each State where such staff member resided during the preceding 5 years;

b) A search of State-based child abuse and neglect registries and databases in the State where the child care staff member resides, and each State where such staff member resided during the preceding 5 years; and
c) A Federal Bureau of Investigation fingerprint check using Next Generation Identification.

Directors/programs should review each employment application to assess the relevancy of any issue uncovered by the complete background screening, including any arrest, pending criminal charge, or conviction, and should use this information in employment decisions in accordance with state laws.

1.4.1.1/1.4.2.3 Pre-service Training/Orientation

Before or during the first three 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; pediatric first aid and CPR; safe sleep practices, including risk reduction of Sudden Infant Death Syndrome/Sudden Unexplained Infant Death (SIDS/SUID); poison prevention; shaken baby syndrome and abusive head trauma; standard precautions; emergency preparedness; nutrition and age-appropriate feeding; medication administration; and care plan implementation for children with special health care needs. Caregivers/teachers should complete training before administering medication to children. See Standard 3.6.3.3 for more information. All directors or program administrators and caregivers/teachers should document receipt of training.

Providers should not care for children unsupervised until they have completed training in pediatric first aid and CPR; safe sleep practices, including risk reduction of Sudden Infant Death Syndrome/Sudden Unexplained Infant Death (SIDS/SUID); standard precautions for the prevention of communicable disease; poison prevention; and shaken baby syndrome/abusive head trauma.

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 current certification in pediatric CPR. Records of successful completion of training in pediatric first aid and CPR should be maintained in the personnel files of the facility.

1.4.4.1/1.4.4.2 Continuing Education for Directors, Caregivers/Teachers in Centers, and Family Child Care Homes

Directors and caregivers/teachers should successfully complete intentional and sequential education/professional development in child development programming and child health, safety, and staff health based on individual competency and any special needs of the children in their care.

1.4.5.2 Child Abuse and Neglect Education

Caregivers/teachers should be educated on child abuse and neglect to establish child abuse and neglect prevention and recognition strategies for 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

2.1.1.4 Monitoring Children's Development/Obtaining Consent for Screening

Programs should have a process in place for age-appropriate developmental and behavioral screenings for all children at the beginning of a child's enrollment in the program, at least yearly thereafter, and as developmental concerns become apparent to staff and/or parents/guardians. Providers may choose to conduct screenings, themselves; partner with a local agency/health care provider/specialist who would conduct the screening; or work with parents in connecting them to resources to ensure that screening occurs. This process should consist of parental/guardian education, consent, and participation as well as connection to resources and support, including the primary health care provider, as needed. Results of screenings should be documented in child records.

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

Programs should implement relationship-based policies and program practices 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

In center-based programs, caregivers/teachers should directly supervise children under age 6 by sight and sound at all times. In family child care settings, caregivers should directly supervise children by sight or sound. When children are sleeping, caregivers may supervise by sound with frequent visual checks.

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. Children under the age of 6 should never be inside or outside by themselves.

2.2.0.4 Supervision near Water

Constant and active supervision should be maintained when any child is in or around water. During swimming and/or bathing where an infant or toddler is present, the ratio should always be one adult to one infant/toddler. During wading and/or water play activities, the supervising adult should be within an arm's length providing "touch supervision." Programs should ensure that all pools have drain covers that are used in compliance with the Virginia Graeme Baker Pool and Spa Safety Act.

2.2.0.8 Preventing Expulsions, Suspensions, and Other Limitations in Services

Programs should have a comprehensive discipline policy that includes developmentally appropriate social-emotional and behavioral health promotion practices as well as discipline and intervention procedures that provide specific guidance on what caregivers/teachers and programs should do to prevent and respond to challenging behaviors. Programs should ensure all caregivers/teachers have access to pre- and in-service training on such practices and procedures. Practices and procedures should be clearly communicated to all staff, families, and community partners, and implemented consistently and without bias or discrimination. Preventive and discipline practices should be used as learning opportunities to guide children's appropriate behavioral development.

Programs should establish policies that eliminate or severely limit expulsion, suspension, or other exclusionary discipline (including limiting services); these exclusionary measures should be used only in extraordinary circumstances where there are serious safety concerns[1] that cannot otherwise be reduced or eliminated by the provision of reasonable modifications.

2.2.0.9 Prohibited Caregiver/Teacher Behaviors

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

a) The use of corporal punishment\ including, but not limited to:
   i. Hitting, spanking, 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, tying to restrict movement, or taping the mouth;
d) Using or withholding food or beverages as a punishment;
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;;
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 (1);
j) Physical activity/outdoor time taken away as punishment;
k) Placing a child in a crib for a time-out or for disciplinary reasons.

[1] Determinations of safety concerns must be based on actual risks, best available objective evidence, and cannot be based on stereotypes or generalizations.

Health Promotion and Protection

3.1.3.1 Active Opportunities for Physical Activity

Programs should promote developmentally appropriate active play for all children, including infants and toddlers, every day. Children should have opportunities to engage in moderate to vigorous activities indoors and outdoors, weather permitting.

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 American Academy of Pediatrics (AAP). Cribs must be in compliance with current U.S. Consumer Product Safety Commission (CPSC) and ASTM International safety standards. See Standard 5.4.5.2 for more information.

3.1.5.1 Routine Oral Hygiene Activities

Caregivers/teachers should promote good oral hygiene through learning activities including the habit of regular tooth brushing.

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/bring the child to the changing table/surface, 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 if 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/surface.