Special Collection

Caring for Our Children: Environmental Health in Early Care and Education

Applicable Standards from:

Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 3rd Edition

A Joint Collaborative Project of

American Academy of Pediatrics
141 Northwest Point Boulevard
Elk Grove Village, IL 60007-1019

American Public Health Association
800 I Street, NW
Washington, DC 20001-3710

National Resource Center for Health and Safety in Child Care and Early Education
University of Colorado, College of Nursing
13120 E 19th Avenue
Aurora, CO 80045

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APHA American Public Health Association

National Resource Center for Health and Safety in Child Care and Early Education

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Document Design & Layout: Betty Geer & Linda Satkowiak

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(Editor's Note: All other appendices are located in *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*, Third Edition. http://www.cfoc.nrckids.org/).

INTRODUCTION

Caring for Our Children: Environmental Health in Early Care and Education (*EH*) is a collection of 123 nationally recognized health and safety standards that have the greatest impact on environmental health in early care and education settings. These standards and the associated 9 Appendices are a subset of materials available in *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*, 3rd Edition (*CFOC3*). *CFOC3*† is a collection of nationally recognized best practice health and safety standards for the early care and education environment.

Another important subset of *CFOC3* is *Stepping Stones*, 3rd Edition (*SS3*), which presents the 138 essential *CFOC3* standards that, when put into practice, are most likely to prevent various adverse outcomes in early care and education settings. The *SS3* standards included in this collection are designated with an asterisk (*). These noted standards represent the most critical environmental health standards.

The purpose of this collection is to serve as a compilation of best practices for environmentally-healthy early care and education programs. In some cases, additional resources may be needed in order to meet the standard.

The Importance of Children's Environmental Health

Environmental health is the field that studies how substances or other environmental factors have an impact on human health. The presence of naturally occurring and man-made chemicals in the air, water, food, pesticides, cleaning products, furniture, and buildings/homes is relevant to early care and education settings. Other important factors include pests, weather, allergens such as mold and fungi, and noise and lighting. All of these factors can impact human health.

Children live in an environment vastly different from previous generations. One of these changes is that every day, they are exposed to dozens, perhaps hundreds, of chemicals that did not exist 50 or 100 years ago. The extent of such exposures is relatively new. Currently, more than 80,000 chemicals are in use in the United States (1). For the majority of the thousands of new chemicals produced, little is known about their health effects on humans, especially their effects on children's developing systems (2).

These chemical exposures mean that traces of synthetic compounds are found in all humans and animals around the world (3). For example, a recent report from the Centers for Disease Control and Prevention (CDC) found Bisphenol A (or BPA, a compound found in some plastics, the lining of food cans, children's bottles and cups, and many other items) in more than 90 percent of the U.S. population (4). Other research has found that BPA interferes with hormones and has been linked to a variety of harmful health effects (5).

We now know that what is safe for an adult may not be safe for a child (6). Children are vulnerable to harm from environmental toxins because of their developing systems and unique behaviors, for example their proximity to the floor, mouthing behaviors, and respiratory rate. The primary task of a developing fetus, infancy and childhood is growth and development. If growth and development are hampered at any of these stages, the chances of a healthy adulthood dramatically decrease (7,8). For some chemicals, such as lead and mercury, we now know that exposure levels can interfere with growth and development, which can result in life-long harm to the child (9).

Because of this, children's vulnerability and emerging knowledge, science- and health-based organizations are increasingly recommending best practices to protect children from unnecessary chemical exposures. For example, in 2012 the American Academy of Pediatrics (AAP) issued a policy statement and technical report that urged minimizing children's exposures to pesticides (10). In spring 2014, AAP, the American Lung Association, and other health groups went on record recommending avoiding exposure to fragrances and other unnecessary chemicals as a best practice (11,12).

Every day, approximately 11 million children under the age of 5 in the U.S. attend early care and education programs (13). An average of 36 hours per week is spent in these programs (14). It is important for children to be in healthy and safe environments with caregivers/teachers who understand and follow basic environmental health and safety best practices.

Also, pregnant women and women who may become pregnant, a population represented in the ECE provider community, require specific consideration of their exposures to have confidence that their health is adequately protected.

This resource can be used by a variety of stakeholders to learn about and recognize potential environmental hazards in the early care and education setting, and take action to remove or minimize these hazards. Taking these steps will help reduce health risks from environmental hazards in an early care and education settings.

Overview and Organization of Content

- The EH collection presents the *CFOC3* Standard and Type of Facility only, whereas the comprehensive *CFOC3* also includes the Rationale for why the standard is important to implement, Comments relevant to implementing the standard, Related Standards, and References. It is essential to review and understand the rationale and comments that support these EH standards within the general collection of *CFOC3*.
- Users can click directly on the hyperlinked standard number and title in this collection to review these additional sections in the *CFOC3* database. Users can also find these additional sections in the *CFOC3* book and the PDF version of *CFOC3*. PLEASE NOTE: Since *CFOC3* publication (2011), several standards have been updated. The standards in this collection reflect the most current standard language.

- Standards and appendices are organized according to the chapters in *CFOC3*. Section 5: Facility, Supplies, and Equipment has been divided into three subsections based on topic area.
- The standards included in this collection are relevant to *all* children, including those with special health care needs.

The intended audiences for this document are:

- **Early care and education caregivers/teachers** (family child care providers as well as center-based providers) who can implement these strategies to provide a safe and healthy environment in early care and education settings, while simultaneously supporting and partnering with families;
- **Facility owners, managers, and administrators** who develop and implement policies and who make decisions regarding building construction, furnishing, maintenance, heating/cooling, foods, toys, cleaning products, and other purchasing decisions.
- **State and local regulators and policy makers** who can promote the adoption of these standards in their state and local licensing regulations in an effort to promote best practices within early care and education programs;
- **Health, mental health and education consultants, infant/toddler specialists, trainers and other health/public health professionals** who can promote these standards to early care and education programs and caregivers/teachers;
- **Parents/guardians** who can recommend and advocate for the use of these standards in their child's early care and education setting; and
- **Early care and education academic degree program administrators** who can enhance their curriculum.

Standard Determination

'Environmental health' is a term with multiple definitions. One could identify the vast majority of *CFOC3* standards as having the potential to influence the environment and environmental health of an early care and education setting. For the purposes of this compilation, it was determined to focus on those standards that addressed naturally occurring and man-made chemicals in the air, water, food, pesticides, cleaning products, furniture, buildings/homes, and other factors, including pests, weather, allergens such as mold and fungi, and noise and lighting.

Thus, one factor used in reviewing the standards for inclusion was to ask: 'If this standard was not followed, would the resulting harm be considered the result of an environmental health incident (e.g. a chemical or allergen exposure, noise level); a physical injury (e.g., a fall); or an infectious agent (bacteria, virus)?' Only those standards for which the answer would be 'an environmental health incident' are included.

There were numerous steps that determined the standards and material to be included in *EH*.

1. The NRC staff searched the *CFOC3* database (http://cfoc.nrckids.org/) for standards that included key terms such as *chemical* and *environmental* in all chapters of *CFOC3* except Chapter 5.
2. The Children's Environmental Health Network (CEHN) (http://www.cehn.org) staff searched the *CFOC3* database (http://cfoc.nrckids.org/) and selected Chapter 5 standards for the collection and also added to the list provided by the NRC of applicable standards from other chapters.
3. The NRC staff then reviewed *Stepping Stones*, 3rd Edition (*SS3*) to determine if any of those standards not already included should be a part of *EH*.
4. The list of standards was shared with the *CFOC3* Chair of the Environmental Quality Technical Panel and the *CFOC3* Steering Committee and they provided feedback.
5. This feedback was incorporated into a draft document that included all introductory material and then shared with a group of reviewers, which included parents/guardians, early care and education providers, health care professionals, early childhood researchers, licensors and regulators, and representatives from national organizations for their feedback and recommendations.
6. This feedback was then compiled by the NRC staff into a draft document sent to the *CFOC3* Steering Committee for their final review and approval.

† The full edition is available on the National Resource Center for Health and Safety in Child Care and Early Education (NRC) website at http://cfoc.nrckids.org/. Since publication (2011), several standards have been updated. Please consult the NRC website for the most current standard language. Print copies can be purchased from the American Academy of Pediatrics (http://www.aap.org) and the American Public Health Association (http://www.apha.org/publications/bookstore/).

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Resources

As with all areas in health, new research comes forth and we recommend that users continue to visit the following web sites for the most up-to-date information on environmental health:

Air Quality Index

American Academy of Pediatrics (AAP)
- Council on Environmental Health

American Public Health Association (APHA)
- Environmental and Occupational Health

Art & Creative Materials Institute

Center for Environmental Research & Children's Health (CERCH)
- Child Care Providers

Children's Environmental Health Network (CEHN)
- Eco-Healthy Child Care®

Centers for Disease Control and Prevention
- Agency for Toxic Substances and Disease Registry
- Styrene
- Children's Health and the Built Environment

Environmental Working Group (EWG)

Green Cleaning, Sanitizing, and Disinfecting: A Toolkit for Early Care and Education (University of California, San Francisco School of Nursing's Institute for Health & Aging, University of California, Berkeley's Center for Environmental Research and Children's Health, and Informed Green Solutions, with support from the California Department of Pesticide Regulation)

Leadership in Energy and Environmental Design (LEED)

Making Child Care Centers SAFER: A Non-Regulatory Approach to Improving Child Care Center Siting (Somers TS, Harvey ML, Rusnak SM, Public Health Rep. 2011; 126(Suppl 1): 34–40)

Midwest Pesticide Action Center
- Resource Guide for Integrated Pest Management in Schools/Childcares

Pediatric Environmental Health Specialty Units (PEHSU) (Association of Occupational and Environmental Clinics)

U.S. Consumer Product Safety Commission (CPSC)

U.S. Department of Agriculture
- Farm to Child Care

U.S. Environmental Protection Agency (EPA)
- Air Cleaners
- America's Children and the Environment, 3rd Edition (ACE3)
- Arsenic in your Drinking Water Fact Sheet
- Art Supplies: Teacher's Classroom Checklist
- Asbestos
- Chromated Copper Arsenate (CCA)
- Fish Consumption Advisories
- What You Need to Know about Mercury in Fish and Shellfish
- Formaldehyde
- Healthy Child Care
- Lead
- Mercury
- Plastics
- Polybrominated diphenylethers (PBDEs)
- Radon
- Reduce, Reuse, and Recycle
- Water: Consumer Information

For questions or assistance on these standards or CFOC3, please contact:

National Resource Center for Health and Safety in Child Care and Early Education (NRC)

Toll-free Hotline: 1-800-598-KIDS (5437)
Email: info@nrckids.org
Website: http://nrckids.org

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This collection was inspired by *CFOC3*'s comprehensive approach to environmental health, which includes new and expanded standards addressing this vital topic. The development of *EH* was supported in part by technical assistance from the Children's Environmental Health Network (CEHN).

Twenty individuals, representing seventeen organizations, reviewed and validated the chosen standards. This broad collaboration and review from the best minds in the field has led to a comprehensive and useful tool. We would like to acknowledge those individuals and those whose names may have been omitted. Our sincere appreciation goes to all of our colleagues who willingly gave their time and expertise to the development of this resource.

CFOC3 Steering Committee

Danette Swanson Glassy, MD, FAAP
Co-Chair, American Academy of Pediatrics
Mercer Island, WA

Brian Johnston, MD, MPH
Co-Chair, American Public Health Association
Seattle, WA

Marilyn J. Krajicek, EdD, RN, FAAN
Director, National Resource Center for Health and Safety in Child Care and Early Education
Aurora, CO

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

*National Resource Center for Health and Safety in Child Care and Early Education Project Team^*

Marilyn Krajicek, EdD, RN, FAAN – Director

Jean M. Cimino, MPH – *CFOC3* Content Manager

Betty Geer, MSN, RN, CPNP – Healthcare Professional

Doug Chapman, BS – Information Technologist

Sue Purcell, MA – Project Specialist

Linda Satkowiak, ND, RN, CNS, NCSN – Child Care Health and Safety Nurse Consultant

Gerri Steinke, PhD – Evaluator

Lorina Washington, BA – Administrative Assistant

^ Based at the University of Colorado Anschutz Medical Campus College of Nursing

Children's Environmental Health Network Project Team

Carol Stroebel - Director of Training and Policy

Hester Paul, MS - Director of Eco-Healthy Child Care®

Organizational and Stakeholder Reviewers

Nancy Alleman, BSN, RN, CPNP, CSN; American Academy of Pediatrics ECELS - Healthy Child Care PA; Media, PA

Ally Beasley, MPH; United States Environmental Protection Agency Office of Children's Health Protection, Washington, DC.

Asa Bradman, PhD, MS; Center for Environmental Research and Children's Health (CERCH), School of Public Health; UC Berkeley; Berkeley, CA

Steven B. Eng, MPH, CIPHI(C); Fraser Health; Port Moody, British Columbia, Canada

Jennifer Grauer, parent, Denver, Colorado

Gwendolyn N. Hudson, PhD, MPH, CPH; U.S. Public Health Service FDA, Center for Food Safety and Applied Nutrition Office of Compliance; College Park, MD

Sara Sroka Kihn, MS, RN, NCSN; Children's Hospital Colorado; Aurora, Colorado

Mira Killmeyer, MBA; Great Heights Preschool; Denver, CO

Vickie Leonard, RN, NP, PhD; Pediatric Environmental Health Specialty Unit, University of California; San Francisco, CA

Ada Otter, DNP, ARNP, FNP-BC; Northwest Pediatric Environmental Health Specialty Unit; Seattle, Washington

Jeannie Reardon, MPH Leadership, BS; NC Child Care Health and Safety Resource Center, UNC Gillings School of Global Public Health; Raleigh, North Carolina

Karen Riley, RN BSN; Caring 4 Kids Nurse Consulting, LLC; Thornton, CO

Carley Schneider, BS; Family Star Montessori School; Denver, CO

Tarah S. Somers, RN, MSN/MPH; Agency for Toxic Substances and Disease Registry, Region 1 (New England) Office; Boston, MA

Libby Ungvary, Med; American Academy of Pediatrics ECELS - Healthy Child Care PA; Media, PA

I. Staffing and Training

STANDARD 1.3.2.7: Qualifications and Responsibilities of Health Advocates

Each facility should designate at least one administrator or staff person as the health advocate to be responsible for policies and day-to-day issues related to health, development, and safety of individual children, children as a group, staff, and parents/guardians. In large centers it may be important to designate health advocates at both the center and classroom level. The health advocate should be the primary contact for parents/guardians when they have health concerns, including health-related parent/guardian/staff observations, health-related information, and the provision of resources. The health advocate ensures that health and safety is addressed, even when this person does not directly perform all necessary health and safety tasks.

The health advocate should also identify children who have no regular source of health care, health insurance, or positive screening tests with no referral documented in the child's health record. The health advocate should assist the child's parent/guardian in locating a Medical Home by referring them to a primary care provider who offers routine child health services.

For centers, the health advocate should be licensed/certified/credentialed as a director or lead teacher or should be a health professional, health educator, or social worker who works at the facility on a regular basis (at least weekly).

The health advocate should have documented training in the following:

a. Control of infectious diseases, including Standard Precautions, hand hygiene, cough and sneeze etiquette, and reporting requirements;
b. Childhood immunization requirements, record-keeping, and at least quarterly review and follow-up for children who need to have updated immunizations;
c. Child health assessment form review and follow-up of children who need further medical assessment or updating of their information;
d. How to plan for, recognize, and handle an emergency;
e. Poison awareness and poison safety;
f. Recognition of safety, hazards, and injury prevention interventions;
g. Safe sleep practices and the reduction of the risk of Sudden Infant Death Syndrome (SIDS);
h. How to help parents/guardians, caregivers/teachers, and children cope with death, severe injury, and natural or man-made catastrophes;
i. Recognition of child abuse, neglect/child maltreatment, shaken baby syndrome/abusive head trauma (for facilities caring for infants), and knowledge of when to report and to whom suspected abuse/neglect;
j. Facilitate collaboration with families, primary care providers, and other health service providers to create a health, developmental, or behavioral care plan;
k. Implementing care plans;
l. Recognition and handling of acute health related situations such as seizures, respiratory distress, allergic reactions, as well as other conditions as dictated by the special health care needs of children;
m. Medication administration;
n. Recognizing and understanding the needs of children with serious behavior and mental health problems;
o. Maintaining confidentiality;
p. Healthy nutritional choices;
q. The promotion of developmentally appropriate types and amounts of physical activity;
r. How to work collaboratively with parents/guardians and family members;
s. How to effectively seek, consult, utilize, and collaborate with child care health consultants, and in partnership with a child care health consultant, how to obtain information and support from other education, mental health, nutrition, physical activity, oral health, and social service consultants and resources;
t. Knowledge of community resources to refer children and families who need health services including access to State Children's Health Insurance (SCHIP), importance of a primary care provider and medical home, and provision of immunizations and Early Periodic Screening, Diagnosis, and Treatment (EPSDT).

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 1.4.1.1: Pre-service Training

In addition to the credentials listed in Standard 1.3.1.1, upon employment, a director or administrator of a center or the lead caregiver/teacher in a family child care home should provide documentation of at least thirty clock-hours of pre-service training. This training should cover health, psychosocial, and safety issues for out-of-home child care facilities. Small family child care home caregivers/teachers may have up to ninety days to secure training after opening except for training on basic health and safety procedures and regulatory requirements.

All directors or program administrators and caregivers/teachers should document receipt of pre-service training prior to working with children that includes the following content on basic program operations:

a. Typical and atypical child development and appropriate best practice for a range of developmental and mental health needs including

knowledge about the developmental stages for the ages of children enrolled in the facility;

b. Positive ways to support language, cognitive, social, and emotional development including appropriate guidance and discipline;
c. Developing and maintaining relationships with families of children enrolled, including the resources to obtain supportive services for children's unique developmental needs;
d. Procedures for preventing the spread of infectious disease, including hand hygiene, cough and sneeze etiquette, cleaning and disinfection of toys and equipment, diaper changing, food handling, health department notification of reportable diseases, and health issues related to having animals in the facility;
e. Teaching child care staff and children about infection control and injury prevention through role modeling;
f. Safe sleep practices including reducing the risk of Sudden Infant Death Syndrome (SIDS) (infant sleep position and crib safety);
g. Shaken baby syndrome/abusive head trauma prevention and identification, including how to cope with a crying/fussy infant;
h. Poison prevention and poison safety;
i. Immunization requirements for children and staff;
j. Common childhood illnesses and their management, including child care 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 (CPSC) product recall reports;
m. Staff occupational health and safety practices, such as proper procedures, in accordance with Occupational Safety and Health Administration (OSHA) bloodborne 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 the child care setting, including staff health and pregnant workers;
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 including food preparation, choking prevention, menu planning, and breastfeeding supportive practices;
s. Physical activity, including age-appropriate activities and limiting sedentary behaviors;
t. Prevention of childhood obesity and related chronic diseases;
u. Knowledge of environmental health issues for both children and staff;
v. Knowledge of 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 (ADA);
x. Strategies for implementing care plans for children with special health care needs and inclusion of all children in activities;
y. Positive approaches to support diversity;
z. Positive ways to promote physical and intellectual development.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 1.4.2.3: Orientation Topics

During the first three months of employment, the director of a center or the caregiver/teacher in a large family home should document, for all full-time and part-time staff members, additional orientation in, and the employees' satisfactory knowledge of, the following topics:

a. Recognition of symptoms of illness and correct documentation procedures for recording symptoms of illness. This should include the ability to perform a daily health check of children to determine whether any children are ill or injured and, if so, whether a child who is ill should be excluded from the facility;
b. Exclusion and readmission procedures and policies;
c. Cleaning, sanitation, and disinfection procedures and policies;
d. Procedures for administering medication to children and for documenting medication administered to children;
e. Procedures for notifying parents/guardians of an infectious disease occurring in children or staff within the facility;
f. Procedures and policies for notifying public health officials about an outbreak of disease or the occurrence of a reportable disease;
g. Emergency procedures and policies related to unintentional injury, medical emergency, and natural disasters;
h. Procedure for accessing the child care health consultant for assistance;
i. Injury prevention strategies and hazard identification procedures specific to the facility, equipment, etc.;
j. Proper hand hygiene.

Before being assigned to tasks that involve identifying and responding to illness, staff members should receive orientation training on these topics. Small family child care home caregivers/teachers should not commence operation before receiving orientation on these topics in pre-service training (1).

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 1.4.4.1: Continuing Education for Directors and Caregivers/Teachers in Centers and Large Family Child Care Homes

All directors and caregivers/teachers of centers and large family child care homes should successfully complete at least thirty clock-hours per year of continuing education/professional development in the first year of employment, sixteen clock-hours of which should be in child development programming and fourteen of which should be in child health, safety, and staff health. In the second and each of the following years of employment at a facility, all directors and caregivers/teachers should successfully complete at least twenty-four clock-hours of continuing education based on individual competency needs and any special needs of the children in their care, sixteen hours of which should be in child development programming and eight hours of which should be in child health, safety, and staff health.

Programs should conduct a needs assessment to identify areas of focus, trainer qualifications, adult learning strategies, and create an annual professional development plan for staff based on the needs assessment. The effectiveness of training should be evident by the change in performance as measured by accreditation standards or other quality assurance systems.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center, Large Family Child Care Home

STANDARD 1.4.4.2: Continuing Education for Small Family Child Care Home Caregivers/Teachers

Small family child care home caregivers/teachers should have at least thirty clock-hours per year (2) of continuing education in areas determined by self-assessment and, where possible, by a performance review of a skilled mentor or peer reviewer.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Small Family Child Care Home

STANDARD 1.4.5.3: Training on Occupational Risk Related to Handling Body Fluids

All caregivers/teachers who are at risk of occupational exposure to blood or other blood-containing body fluids should be offered hepatitis B immunizations and should receive annual training in Standard Precautions and exposure control planning. Training should be consistent with applicable standards of the Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030, "Occupational Exposure to Bloodborne Pathogens" and local occupational health requirements and should include, but not be limited to:

a. Modes of transmission of bloodborne pathogens;
b. Standard Precautions;
c. Hepatitis B vaccine use according to OSHA requirements;
d. Program policies and procedures regarding exposure to blood/body fluid;
e. Reporting procedures under the exposure control plan to ensure that all first-aid incidents involving exposure are reported to the employer before the end of the work shift during which the incident occurs (1).

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center, Large Family Child Care Home

*STANDARD 1.5.0.2: Orientation of Substitutes

The director of any center or large family child care home and the small family child care home caregiver/teacher should provide orientation training to newly hired substitutes to include a review of ALL the program's policies and procedures (listed below is a sample). This training should include the opportunity for an evaluation and a repeat demonstration of the training lesson. In all child care settings the orientation should be documented. Substitutes should have background screenings.

All substitutes should be oriented to, and demonstrate competence in, the tasks for which they will be responsible. On the first day a substitute caregiver/teacher should be oriented on the following topics:

a. Safe infant sleep practices if an infant is enrolled in the program;
b. Any emergency medical procedure/medication needs of the children;
c. Any nutrition needs of the children.

All substitute caregivers/teachers, during the first week of employment, should be oriented to, and should demonstrate competence in at least the following items:

a. The names of the children for whom the caregiver/teacher will be responsible, and their specific developmental needs;

b. The planned program of activities at the facility;
c. Routines and transitions;
d. Acceptable methods of discipline;
e. Meal patterns and safe food handling policies of the facility (special attention should be given to life-threatening food allergies);
f. Emergency health and safety procedures;
g. General health policies and procedures as appropriate for the ages of the children cared for, including but not limited to the following:
    1. Hand hygiene techniques, including indications for hand hygiene;
    2. Diapering technique, if care is provided to children in diapers, including appropriate diaper disposal and diaper changing techniques, use and wearing of gloves;
    3. The practice of putting infants down to sleep positioned on their backs and on a firm surface along with all safe infant sleep practices to reduce the risk of Sudden Infant Death Syndrome (SIDS), as well as general nap time routines for all ages;
    4. Correct food preparation and storage techniques, if employee prepares food;
    5. Proper handling and storage of human milk when applicable and formula preparation if formula is handled;
    6. Bottle preparation including guidelines for human milk and formula if care is provided to children with bottles;
    7. Proper use of gloves in compliance with Occupational Safety and Health Administration (OSHA) bloodborne pathogens regulations;
    8. Injury prevention and safety including the role of mandatory child abuse reporter to report any suspected abuse/neglect.
h. Emergency plans and practices;
i. Access to list of authorized individuals for releasing children.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 1.6.0.1: Child Care Health Consultants

A facility should identify and engage/partner with a child care health consultant (CCHC) who is a licensed health professional with education and experience in child and community health and child care and preferably specialized training in child care health consultation.

CCHCs have knowledge of resources and regulations and are comfortable linking health resources with child care facilities.

The child care health consultant should be knowledgeable in the following areas:

a. Consultation skills both as a child care health consultant as well as a member of an interdisciplinary team of consultants;
b. National health and safety standards for out-of-home child care;
c. Indicators of quality early care and education;
d. Day-to-day operations of child care facilities;
e. State child care licensing and public health requirements;
f. State health laws, Federal and State education laws (e.g., ADA, IDEA), and state professional practice acts for licensed professionals (e.g., State Nurse Practice Acts);
g. Infancy and early childhood development, social and emotional health, and developmentally appropriate practice;
h. Recognition and reporting requirements for infectious diseases;
i. American Academy of Pediatrics (AAP) and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening recommendations and immunizations schedules for children;
j. Importance of medical home and local and state resources to facilitate access to a medical home as well as child health insurance programs including Medicaid and State Children's Health Insurance Program (SCHIP);
k. Injury prevention for children;
l. Oral health for children;
m. Nutrition and age-appropriate physical activity recommendations for children including feeding of infants and children, the importance of breastfeeding and the prevention of obesity;
n. Inclusion of children with special health care needs, and developmental disabilities in child care;
o. Safe medication administration practices;
p. Health education of children;
q. Recognition and reporting requirements for child abuse and neglect/child maltreatment;
r. Safe sleep practices and policies (including reducing the risk of SIDS);
s. Development and implementation of health and safety policies and practices including poison awareness and poison prevention;
t. Staff health, including adult health screening, occupational health risks, and immunizations;
u. Disaster planning resources and collaborations within child care community;
v. Community health and mental health resources for child, parent/guardian and staff health;
w. Importance of serving as a healthy role model for children and staff.

The child care health consultant should be able to perform or arrange for performance of the following activities:

a. Assessing caregivers'/teachers' knowledge of health, development, and safety and offering training as indicated;
b. Assessing parents'/guardians' health, development, and safety knowledge, and offering training as indicated;
c. Assessing children's knowledge about health and safety and offering training as indicated;
d. Conducting a comprehensive indoor and outdoor health and safety assessment and on-going observations of the child care facility;
e. Consulting collaboratively on-site and/or by telephone or electronic media;
f. Providing community resources and referral for health, mental health and social needs, including accessing medical homes, children's health insurance programs (e.g., CHIP), and services for special health care needs;
g. Developing or updating policies and procedures for child care facilities (see comment section below);
h. Reviewing health records of children;
i. Reviewing health records of caregivers/teachers;
j. Assisting caregivers/teachers and parents/guardians in the management of children with behavioral, social and emotional problems and those with special health care needs;
k. Consulting a child's primary care provider about the child's individualized health care plan and coordinating services in collaboration with parents/guardians, the primary care provider, and other health care professionals (the CCHC shows commitment to communicating with and helping coordinate the child's care with the child's medical home, and may assist with the coordination of skilled nursing care services at the child care facility);
l. Consulting with a child's primary care provider about medications as needed, in collaboration with parents/guardians;
m. Teaching staff safe medication administration practices;
n. Monitoring safe medication administration practices;
o. Observing children's behavior, development and health status and making recommendations if needed to staff and parents/guardians for further assessment by a child's primary care provider;
p. Interpreting standards, regulations and accreditation requirements related to health and safety, as well as providing technical advice, separate and apart from an enforcement role of a regulation inspector or determining the status of the facility for recognition;
q. Understanding and observing confidentiality requirements;
r. Assisting in the development of disaster/emergency medical plans (especially for those children with special health care needs) in collaboration with community resources;
s. Developing an obesity prevention program in consultation with a nutritionist/registered dietitian (RD) and physical education specialist;
t. Working with other consultants such as nutritionists/RDs, kinesiologists (physical activity specialists), oral health consultants, social service workers, early childhood mental health consultants, and education consultants.

The role of the CCHC is to promote the health and development of children, families, and staff and to ensure a healthy and safe child care environment (11).

The CCHC is not acting as a primary care provider at the facility but offers critical services to the program and families by sharing health and developmental expertise, assessments of child, staff, and family health needs and community resources. The CCHC assists families in care coordination with the medical home and other health and developmental specialists. In addition, the CCHC should collaborate with an interdisciplinary team of early childhood consultants, such as, early childhood education, mental health, and nutrition consultants.

In order to provide effective consultation and support to programs, the CCHC should avoid conflict of interest related to other roles such as serving as a caregiver/teacher or regulator or a parent/guardian at the site to which child care health consultation is being provided.

The CCHC should have regular contact with the facility's administrative authority, the staff, and the parents/guardians in the facility. The administrative authority should review, and collaborate with the CCHC in implementing recommended changes in policies and practices. In the case of consulting about children with special health care needs, the CCHC should have contact with the child's medical home with permission from the child's parent/guardian.

Programs with a significant number of non-English-speaking families should seek a CCHC who is culturally sensitive and knowledgeable about community health resources for the parents'/guardians' native culture and languages.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 1.7.0.4: Occupational Hazards

Written personnel policies of centers and large family child care homes should address the major occupational health hazards for workers in child care settings. Special health concerns of pregnant caregivers/teachers should be carefully evaluated, and up-to-date information regarding occupational hazards for pregnant caregivers/teachers should be made available to them and other workers. The occupational hazards including those regarding pregnant

workers listed in Appendix B, Major Occupational Health Hazards, should be referenced and used in evaluations by caregivers/teachers and supervisors.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

II. Program Activities for Healthy Development

STANDARD 2.1.1.3: Coordinated Child Care Health Program Model

Caregivers/teachers should follow these guidelines for implementing coordinated health programs in all early care and education settings. These coordinated health programs should consist of health and safety education, physical activity and education, health services and child care health consultation, nutrition services, mental health services, healthy and safe indoor and outdoor learning environment, health and safety promotion for the staff, and family and community involvement. The guidelines consist of the following eight interactive components:

1. Health Education: A planned, sequential, curriculum that addresses the physical, mental, emotional, and social dimensions of health. The curriculum is designed to motivate and assist children in maintaining and improving their health, preventing disease and injury, and reducing health-related risk behaviors (1,2).

2. Physical Activity and Education: A planned, sequential curriculum that provides learning experiences in a variety of activity areas such as basic movement skills, physical fitness, rhythms and dance, games, sports, tumbling, outdoor learning and gymnastics. Quality physical activity and education should promote, through a variety of planned physical activities indoors and outdoors, each child's optimum physical, mental, emotional, and social development, and should promote activities and sports that all children enjoy and can pursue throughout their lives (1,2,6).

3. Health Services and Child Care Health Consultants: Services provided for child care settings to assess, protect, and promote health. These services are designed to ensure access or referral to primary health care services or both, foster appropriate use of primary health care services, prevent and control communicable disease and other health problems, provide emergency care for illness or injury, promote and provide optimum sanitary conditions for a safe child care facility and child care environment, and provide educational opportunities for promoting and maintaining individual, family, and community health. Qualified professionals such as child care health consultants may provide these services (1,2,4,5).

4. Nutrition Services: Access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all children. School nutrition programs reflect the U.S. Dietary Guidelines for Americans and other criteria to achieve nutrition integrity. The school nutrition services offer children a learning laboratory for nutrition and health education and serve as a resource for linkages with nutrition-related community services (1,2).

5. Mental Health Services: Services provided to improve children's mental, emotional, and social health. These services include individual and group assessments, interventions, and referrals. Organizational assessment and consultation skills of mental health professionals contribute not only to the health of students but also to the health of the staff and child care environment (1,2).

6. Healthy Child Care Environment: The physical and aesthetic surroundings and the psychosocial climate and culture of the child care setting. Factors that influence the physical environment include the building and the area surrounding it, natural spaces for outdoor learning, any biological or chemical agents that are detrimental to health, indoor and outdoor air quality, and physical conditions such as temperature, noise, and lighting. Unsafe physical environments include those such as where bookcases are not attached to walls and doors that could pinch children's fingers. The psychological environment includes the physical, emotional, and social conditions that affect the well-being of children and staff (1,2).

7. Health Promotion for the Staff: Opportunities for caregivers/teachers to improve their own health status through activities such as health assessments, health education, help in accessing immunizations, health-related fitness activities, and time for staff to be outdoors. These opportunities encourage caregivers/teachers to pursue a healthy lifestyle that contributes to their improved health status, improved morale, and a greater personal commitment to the child care's overall coordinated health program. This personal commitment often transfers into greater commitment to the health of children and creates positive role modeling. Health promotion activities have improved productivity, decreased absenteeism, and reduced health insurance costs (1,2).

8. Family and Community Involvement: An integrated child care, parent/guardian, and community approach for enhancing the health and safety, and well-being of children. Parent/guardian-teacher health advisory councils, coalitions, and broadly based constituencies for child care health can build support for child care health program efforts. Early care and education settings should actively solicit parent/guardian involvement and engage community resources and services to respond more effectively to the health-related needs of children (1,2).

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 2.4.2.1: Health and Safety Education Topics for Staff

Health and safety education for staff should include physical, oral, mental, emotional, nutritional, physical activity, and social health of children. In addition to the health and safety topics for children in Standard 2.4.1.1, health education topics for staff should include:

a. Promoting healthy mind and brain development through child care;
b. Healthy indoor and outdoor learning/play environments;
c. Behavior/discipline;
d. Managing emergency situations;
e. Monitoring developmental abilities, including indicators of potential delays;

f. Nutrition (i.e., healthy eating to prevent obesity);
g. Food safety;
h. Water safety;
i. Safety/injury prevention;
j. Safe use, storage, and clean-up of chemicals;
k. Hearing, vision, and language problems;
l. Physical activity and outdoor play and learning;
m. Appropriate antibiotic use;
n. Immunizations;
o. Gaining access to community resources;
p. Maternal or parental/guardian depression;
q. Exclusion policies;
r. Tobacco use/smoking;
s. Safe sleep environments and SIDS prevention;
t. Breastfeeding support (1);
u. Environmental health and reducing exposures to environmental toxins;
v. Children with special needs;
w. Shaken baby syndrome and abusive head trauma;
x. Safe use, storage of firearms;
y. Safe medication administration.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 2.4.3.2: Parent/Guardian Education Plan

The content of a parent/guardian education plan should be individualized to meet each family's needs and should be sensitive to cultural values and beliefs. Written material, at a minimum, should address the most important health and safety issues for all age groups served, should be in a language understood by families, and may include the topics listed in Standard 2.4.1.1, with special emphasis on the following:

a. Safety (such as home, community, playground, firearm, seat belts, safe medication administration procedures, poison awareness, vehicular, or bicycle, and awareness of environmental toxins and healthy choices to reduce exposure);
b. Value of developing healthy and safe lifestyle choices early in life and parental/guardian health (such as exercise and routine physical activity, nutrition, weight control, breastfeeding, avoidance of substance abuse and tobacco use, stress management, maternal depression, HIV/AIDS prevention);
c. Importance of outdoor play and learning;
d. Importance of role modeling;
e. Importance of well-child care (such as immunizations, hearing/vision screening, monitoring growth and development);
f. Child development and behavior including bonding and attachment;
g. Domestic and relational violence;
h. Conflict management and violence prevention;
i. Oral health promotion and disease prevention;
j. Effective toothbrushing, handwashing, diapering, and sanitation;
k. Positive discipline, effective communication, and behavior management;
l. Handling emergencies/first aid;
m. Child advocacy skills;
n. Special health care needs;
o. Information on how to access services such as the supplemental food and nutrition program (i.e., The Women, Infants and Children [WIC] Supplemental Food Program), Food Stamps (SNAP), food pantries, as well as access to medical/health care and services for developmental disabilities for children;
p. Handling loss, deployment, and divorce;
q. The importance of routines and traditions (including reading and early literacy) with a child.

Health and safety education for parents/guardians should utilize principles of adult learning to maximize the potential for parents/guardians to learn about key concepts. Facilities should utilize opportunities for learning, such as the case of an illness present in the facility, to inform parents/guardians about illness and prevention strategies.

The staff should introduce seasonal topics when they are relevant to the health and safety of parents/guardians and children.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Large Family Child Care Home; Small Family Child Care Home

III. Health Promotion and Protection

*STANDARD 3.1.3.2: Playing Outdoors

Children should play outdoors when the conditions do not pose a safety risk, individual child health risk, or significant health risk of frostbite or of heat related illness. Caregivers/teachers must protect children from harm caused by adverse weather, ensuring that children wear appropriate clothing and/or appropriate shelter is provided for the weather conditions. Outdoor play for infants may include riding in a carriage or stroller; however, infants should be offered opportunities for gross motor play outdoors, as well.

Weather that poses a significant health risk should include wind chill factor at or below minus 15°F and heat index at or above 90°F, as identified by the National Weather Service (NWS).

Sunny weather:

a. Children should be protected from the sun by using shade, sun-protective clothing, and sunscreen with UVB-ray and UVA-ray protection of SPF 15 or higher, with permission from parents/guardians;
b. Children should wear sun-protective clothing, such as hats, when playing outdoors between the hours of 10 AM and 4 PM.

Warm weather:

a. Children should be well hydrated before engaging in prolonged periods of physical activity and encouraged to drink water during periods of prolonged physical activity;
b. Caregivers/teachers should encourage parents/guardians to have children dress in clothing that is light-colored, lightweight, and limited to one layer of absorbent material that will maximize the evaporation of sweat;
c. 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.

Cold weather:

a. Children should wear layers of loose-fitting, lightweight clothing. Outer garments such as coats should be tightly woven, and be at least water repellent when precipitation is present, such as rain or snow;
b. Children should wear a hat, coat, and gloves/mittens kept snug at the wrist;
c. Caregivers/teachers should check children's extremities for maintenance of normal color and warmth at least every fifteen minutes.

Caregivers/teachers should also be aware of environmental hazards such as contaminated water, loud noises, and lead in soil when selecting an area to play outdoors. Children should be observed closely when playing in dirt/soil, so that no soil is ingested. Play areas should be secure and away from heavy traffic areas.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 3.1.3.3: Protection from Air Pollution While Children Are Outside

Supervising adults should check the air quality index (AQI) each day and use the information to determine whether all or only certain children should be allowed to play outdoors.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Large Family Child Care Home; Small Family Child Care Home

*STANDARD 3.2.1.4: Diaper Changing Procedure

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. Please refer to Appendix J, Selecting an Appropriate Sanitizer or Disinfectant.

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:

a. Non-absorbent paper liner large enough to cover the changing surface from the child's shoulders to beyond the child's feet;
b. Unused diaper, clean clothes (if you need them);
c. Wipes, dampened cloths or wet paper towels for cleaning the child's genitalia and buttocks readily available;
d. A plastic bag for any soiled clothes or cloth diapers;
e. Disposable gloves, if you plan to use them (put gloves on before handling soiled clothing or diapers) and remove them before handling clean diapers and clothing;

f. A thick application of any diaper cream (e.g., zinc oxide ointment), when appropriate, removed from the container to a piece of disposable material such as facial or toilet tissue.

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.

a. Always keep a hand on the child;
b. If the child's feet cannot be kept out of the diaper or from contact with soiled skin during the changing process, remove the child's shoes and socks so the child does not contaminate these surfaces with stool or urine during the diaper changing.

Step 3: Clean the child's diaper area.

a. Place the child on the diaper change surface and unfasten the diaper, but leave the soiled diaper under the child;
b. If safety pins are used, close each pin immediately once it is removed and keep pins out of the child's reach (never hold pins in your mouth);
c. Lift the child's legs as needed to use disposable wipes, or a dampened cloth or wet paper towel to clean the skin on the child's genitalia and buttocks and prevent recontamination from a soiled diaper. Remove stool and urine from front to back and use a fresh wipe, or a dampened cloth or wet paper towel each time you swipe. Put the soiled wipes or paper towels into the soiled diaper or directly into a plastic-lined, hands-free covered can. Reusable cloths should be stored in a washable, plastic-lined, tightly covered receptacle (within arm's reach of diaper changing tables) until they can be laundered. The cover should not require touching with contaminated hands or objects.

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

a. Fold the soiled surface of the diaper inward;
b. Put soiled disposable diapers in a covered, plastic-lined, hands-free covered can. If reusable cloth diapers are used, put the soiled cloth diaper and its contents (without emptying or rinsing) in a plastic bag or into a plastic-lined, hands-free covered can to give to parents/guardians or laundry service;
c. Put soiled clothes in a plastic-lined, hands-free plastic bag;
d. Check for spills under the child. If there are any, use the corner of the paper to fold the paper that extends under the child's feet over the soiled area so a fresh, unsoiled paper surface is now under the child's buttocks;
e. If gloves were used, remove them using the proper technique (see Appendix D) and put them into a plastic-lined, hands-free covered can;
f. Whether or not gloves were used, use a fresh wipe to wipe the hands of the caregiver/teacher and another fresh wipe to wipe the child's hands. Put the wipes into the plastic-lined, hands-free covered can.

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

a. Slide a fresh diaper under the child;
b. Use a facial or toilet tissue or wear clean disposable glove to apply any necessary diaper creams, discarding the tissue or glove in a covered, plastic-lined, hands-free covered can;
c. Note and plan to report any skin problems such as redness, skin cracks, or bleeding;
d. Fasten the diaper; if pins are used, place your hand between the child and the diaper when inserting the pin.

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

a. Use soap and warm water, between 60°F and 120°F, at a sink to wash the child's hands, if you can.

Step 7: Clean and disinfect the diaper-changing surface.

a. Dispose of the disposable paper liner used on the diaper changing surface in a plastic-lined, hands-free covered can;
b. If clothing was soiled, securely tie the plastic bag used to store the clothing and send home;
c. Remove any visible soil from the changing surface with a disposable paper towel saturated with water and detergent, rinse;
d. Wet the entire changing surface with a disinfectant that is appropriate for the surface material you are treating. Follow the manufacturer's instructions for use;
e. Put away the disinfectant. Some types of disinfectants may require rinsing the change table surface with fresh water afterwards.

Step 8: Perform hand hygiene according to the procedure in Standard 3.2.2.2 and record the diaper change in the child's daily log.

a. 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 (2).

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 3.2.1.5: Procedure for Changing Children's Soiled Underwear/Pull-Ups and Clothing

The following changing procedure for soiled pull-ups or underwear and clothing should be posted in the changing area, should be followed for all changes, and should be used as part of staff evaluation of caregivers/teachers who change pull-ups or underwear and clothing. The signage should be simple and should be in multiple languages if

caregivers/teachers who speak multiple languages are involved in changing pull-ups or underwear. All employees who will change pull-ups or underwear and clothing should undergo training and periodic assessment of these practices.

Changing a child from the floor level or on a chair puts the adult in an awkward position and increases the risk of contamination of the environment. Using a toddler changing table helps establish a well-organized changing area for both the child and the caregiver/teacher. Changing tables with steps that allow the child to climb with the caregiver/teacher's help and supervision are a good idea. This would help reduce the risk of back injury for the adults that may occur from lifting the child onto the table (1).

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 changing surface. 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. Please refer to Appendix J, Selecting an Appropriate Sanitizer or Disinfectant.

Step 1: Get organized and determine whether to change the child lying down or standing up. Before bringing the child to the changing area, perform hand hygiene, and gather and bring supplies to the changing area.

a. Non-absorbent paper liner large enough to cover the changing surface;
b. Unused pull-up or underwear, clean clothes (if you need them);
c. Wipes, dampened cloths or wet paper towels for cleaning the child's genitalia and buttocks readily available;
d. A plastic bag for any soiled clothes, including underwear, or pull-ups;
e. Disposable gloves, if you plan to use them (put gloves on before handling soiled clothing or pull-ups) and remove them before handling clean pull-ups or underwear and clothing.

Step 2: Avoid contact with soiled items.

a. If the child is standing, it may cause the clothing, shoes and socks to become soiled. The caregiver/teacher must remove these items before the change begins;
b. To avoid contaminating the child's clothes, have the child hold their shirt, sweater, etc. up above their waist during the change. This keeps the child's hands busy and the caregiver/teacher knows where the child's hands are during the changing process. Caregivers/teachers can also use plastic clothes pins that can be washed and sanitized to keep the clothing out of the way;
c. If disposable pull-ups were used, pull the sides apart, rather than sliding the garment down the child's legs. If underwear is being changed, remove the soiled underwear and any soiled clothing, doing your best to avoid contamination of surfaces;
d. To avoid contamination of the environment and/or the increased risk of spreading germs to the other children in the room, do not rinse the soiled clothing in the toilet or elsewhere. Place all soiled garments in a plastic-lined, hands-free plastic bag to be cleaned at the child's home;
e. If the child's shoes are soiled, the caregiver/teacher must wash and sanitize them before putting them back on the child. It is a good idea for the child care facility to request a few extra pair of socks and shoes from the parent/caregiver to be kept at the facility in case these items become soiled (1).

Step 3: Clean the child's skin and check for spills.

a. Lift the child's legs as needed to use disposable wipes, or a dampened cloth or wet paper towel to clean the skin on the child's genitalia and buttocks. Remove stool and urine from front to back and use a fresh wipe, dampened cloth or wet paper towel each time you swipe. Put the soiled wipes or paper towels into the soiled pull-up or directly into a plastic-lined, hands-free covered can. Reusable cloths should be stored in a washable, plastic-lined, tightly covered receptacle (within arm's reach of diaper changing tables) until they can be laundered. The cover should not require touching with contaminated hands or objects;
b. Check for spills under the child. If there are any, use the paper that extends beyond or under the child's feet to fold over the soiled area so a fresh, unsoiled paper surface is now under the child;
c. If gloves were used, remove them using the proper technique (see Appendix D) and put them into a plastic-lined, hands-free covered can;
d. Whether or not gloves were used, use a fresh wipe to wipe the hands of the caregiver/teacher and another fresh wipe to wipe the child's hands. Put the wipes into the plastic-lined, hands-free covered can;

Step 4: Put on a clean pull-up or underwear and clothing, if necessary.

a. Assist the child, as needed, in putting on a clean disposable pull-up or underwear, then in re-dressing (1);
b. Note and plan to report any skin problems such as redness, skin cracks, or bleeding;
c. Put the child's socks and shoes back on if they were removed during the changing procedure (1).

Step 5: Wash the child's hands and return the child to a supervised area.

a. Use soap and warm water, between 60°F and 120°F, at a sink to wash the child's hands, if you can.

Step 6: Clean and disinfect the changing surface.

a. Dispose of the disposable paper liner used on the changing surface in a plastic-lined, hands-free covered can;
b. If clothing was soiled, securely tie the plastic bag used to store the clothing and send home;
c. Remove any visible soil from the changing surface with a disposable paper towel saturated with water and detergent, rinse;
d. Wet the entire changing surface with a disinfectant that is appropriate for the surface material you are treating. Follow the manufacturer's instructions for use;
e. Put away the disinfectant. Some types of disinfectants may require rinsing the change table surface with fresh water afterwards.

Step 7: Perform hand hygiene according to the procedure in Standard 3.2.2.2 and record the change in the child's daily log.

a. In the daily log, record what was in the pull-up or underwear and any problems (such as a loose stool, an unusual odor, blood in the stool, or any skin irritation), and report as necessary (3).

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 3.2.2.2: Handwashing Procedure

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

a. Check to be sure a clean, disposable paper (or single-use cloth) towel is available;
b. Turn on warm water, between 60°F and 120°F, to a comfortable temperature;
c. Moisten hands with water and apply soap (not antibacterial) 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) (2). Rub areas between fingers, around nail beds, under fingernails, jewelry, and back of hands. Nails should be kept short; acrylic nails should not worn (3);
e. Rinse hands under running water, between 60°F and 120°F, 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 paper or single use cloth towel;
h. Throw the disposable paper towel into a lined trash container; or place single-use cloth towels in the laundry hamper; or hang individually labeled cloth towels to dry. Use hand lotion to prevent chapping of hands, if desired.

The use of alcohol based hand sanitizers is an alternative to traditional handwashing 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 handwashing areas.

Use of antimicrobial soap is not recommended in child care settings. There are no data to support use of antibacterial soaps over other liquid soaps.

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 possibly re-contaminating clean hands. If a child can not open the door or turn off the faucet, they should be assisted by an adult.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 3.2.2.5: Hand Sanitizers

The use of hand sanitizers by children over twenty-four months of age and adults in child care programs is an appropriate alternative to the use of traditional handwashing with soap and water. For visibly dirty hands, rinsing under running water or wiping with a water-saturated towel should be used to remove as much dirt as possible before using a hand sanitizer.

Hand sanitizers using an alcohol-based active ingredient must contain 60% to 95% alcohol in order to be effective to kill germs, including multi-drug resistant pathogens. Child care programs should follow the manufacturer's instructions for use, check instructions to determine how long the hand sanitizer needs to remain on the skin surface to be effective.

Supervision of children is required to monitor effective use and to avoid potential ingestion or inadvertent contact of hand sanitizers with eyes and mucous membranes.

When alcohol based hand sanitizers are offered in a child care facility, the facility should encourage parents/guardians to teach their children about their use at home.

Where alcohol-based hand sanitizer dispensers are used:

a. The maximum individual dispenser fluid capacity should be as follows:
b. 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors;
c. 0.53 gal (2.0 L) for dispensers in suites of rooms;

d. Where aerosol containers are used, the maximum capacity of the aerosol dispenser should be 18 oz. (0.51 kg) and should be limited to Level 1 aerosols as defined in NFPA 30B: Code for the Manufacture and Storage of Aerosol Products;

e. Wall mounted dispensers should be separated from each other by horizontal spacing of not less than 48 in. (1,220 mm);

f. Wall mounted dispensers should not be installed above or adjacent to ignition sources such as electrical outlets;

g. Wall mounted dispensers installed directly over carpeted floors should be permitted only in child care facilities protected by automatic sprinklers (1).

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 3.2.3.4: Prevention of Exposure to Blood and Body Fluids

Child care facilities should adopt the use of Standard Precautions developed for use in hospitals by The Centers for Disease Control and Prevention (CDC). 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 child care 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 bloodborne 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 (OSHA).

Procedures for Standard Precautions should include:

a. Surfaces that may come in contact with potentially infectious body fluids must be disposable or of a material that can be disinfected. Use of materials that can be sterilized is not required.

b. The staff should use barriers and techniques that:

1. Minimize potential contact of mucous membranes or openings in skin to blood or other potentially infectious body fluids and tissue discharges; and

2. Reduce the spread of infectious material within the child care facility. Such techniques include avoiding touching surfaces with potentially contaminated materials unless those surfaces are disinfected before further contact occurs with them by other objects or individuals.

c. When spills of body fluids, urine, feces, blood, saliva, nasal discharge, eye discharge, injury or tissue discharges occur, these spills should be cleaned up immediately, and further managed as follows:

1. For spills of vomit, urine, and feces, all floors, walls, bathrooms, tabletops, toys, furnishings and play equipment, kitchen counter tops, and diaper-changing tables in contact should be cleaned and disinfected as for the procedure for diaper changing tables in Standard 3.2.1.4, Step 7;

2. For spills of blood or other potentially infectious body fluids, including injury and tissue discharges, the area should be cleaned and disinfected. Care should be taken and eye protection used to avoid splashing any contaminated materials onto any mucus membrane (eyes, nose, mouth);

3. Blood-contaminated material and diapers should be disposed of in a plastic bag with a secure tie;

4. Floors, rugs, and carpeting that have been contaminated by body fluids should be cleaned by blotting to remove the fluid as quickly as possible, then disinfected by spot-cleaning with a detergent-disinfectant. Additional cleaning by shampooing or steam cleaning the contaminated surface may be necessary. Caregivers/teachers should consult with local health departments for additional guidance on cleaning contaminated floors, rugs, and carpeting.

Prior to using a disinfectant, clean the surface with a detergent and rinse well with water. Facilities should follow the manufacturer's instruction for preparation and use of disinfectant (3,4). For guidance on disinfectants, refer to Appendix J, Selecting an Appropriate Sanitizer or Disinfectant.

If blood or bodily fluids enter a mucous membrane (eyes, nose, mouth) the following procedure should occur. Flush the exposed area thoroughly with water. The goal of washing or flushing is to reduce the amount of the pathogen to which an exposed individual has contact. The optimal length of time for washing or flushing an exposed area is not known. Standard practice for managing mucous membrane(s) exposures to toxic substances is to flush the affected area for at least fifteen to twenty minutes. In the absence of data to support the effectiveness of shorter periods of flushing it seems prudent to use the same fifteen to twenty minute standard following exposure to bloodborne pathogens (5).

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 3.3.0.1: Routine Cleaning, Sanitizing, and Disinfecting

Keeping objects and surfaces in a child care setting as clean and free of pathogens as possible requires a combination of:

a. Frequent cleaning; and
b. 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: Routine Schedule for 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 any cleaning, sanitizing or disinfecting procedure to prevent children and caregivers/teachers from inhaling potentially toxic fumes.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 3.4.1.1 Use of Tobacco, Alcohol, and Illegal Drugs

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 child care program's paid time including break time.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 3.4.5.1: Sun Safety Including Sunscreen

Caregivers/teachers should implement the following procedures to ensure sun safety for themselves and the children under their supervision:

a. Keep infants younger than six months out of direct sunlight. Find shade under a tree, umbrella, or the stroller canopy;
b. Wear a hat or cap with a brim that faces forward to shield the face;
c. Limit sun exposure between 10 AM and 4 PM, when UV rays are strongest;
d. Wear child safe shatter resistant sunglasses with at least 99% UV protection;
e. Apply sunscreen (1).

Over-the-counter ointments and creams, such as sunscreen that are used for preventive purposes do not require a written authorization from a primary care provider with prescriptive authority. However, parent/guardian written permission is required, and all label instructions must be followed. If the skin is broken or an allergic reaction is observed, caregivers/teachers should discontinue use and notify the parent/guardian.

If parents/guardians give permission, sunscreen should be applied on all exposed areas, especially the face (avoiding the eye area), nose, ears, feet, and hands and rubbed in well especially from May through September. Sunscreen is needed on cloudy days and in the winter at high altitudes. Sun reflects off water, snow, sand, and concrete. "Broad spectrum" sunscreen will screen out both UVB and UVA rays. Use sunscreen with an SPF of 15 or higher, the higher the SPF the more UVB protection offered. UVA protection is designated by a star rating system, with four stars the highest allowed in an over-the-counter product.

Sunscreen should be applied thirty minutes before going outdoors as it needs time to absorb into the skin. If the children will be out for more than one hour, sunscreen will need to be reapplied every two hours as it can wear off. If children are playing in water, reapplication will be needed more frequently. Children should also be protected from the sun by using shade and sun protective clothing. Sun exposure should be limited between the hours of 10 AM and 4 PM when the sun's rays are the strongest.

Sunscreen should be applied to the child at least once by the parents/guardians and the child observed for a reaction to the sunscreen prior to its use in child care.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 3.4.5.2: Insect Repellent and Protection from Vector-Borne Diseases

Insect repellents offer varying levels of protection from insect bites. Most insects do not carry human disease and most bites only cause mild irritation. Insect repellents may be used with children in child care in areas of the country due to specific disease outbreaks and alerts. Parents/guardians and caregivers/teachers should decide about the use of repellents depending upon the likelihood that local insects are carrying diseases (e.g., local cases of meningitis from mosquito bites). Caregivers/teachers should consult with a child care health consultant, the primary care provider, or the local health department about the appropriateness of use.

Insect repellent used for preventive purposes does not require a written authorization from a primary care provider. Parent/guardian written permission is required, and all label instructions must be followed. If the skin is broken or an allergic reaction is observed, discontinue use and notify the parent/guardian.

Repellents with 10%-30% DEET offer the broadest protection against mosquitoes, ticks, flies, chiggers, and fleas. The concentration of DEET that is used should be dependent upon how much time the child will be exposed. Products with 10% DEET are effective for approximately

two hours whereas products with 24% DEET offers protection for approximately five hours. Caregivers/teachers should read the product label and confirm that the product is safe for children and contains a concentration of 30% DEET or less. Some repellents may contain up to 100% DEET and could be very dangerous if applied to a child. DEET is not approved for infants less than two months of age.

Application of this product for children older than two months is acceptable using the following guidelines:

a. Apply insect repellent to the caregiver/teacher's hands first and then put it on the child;
b. Use just enough repellent to cover exposed skin;
c. Do not apply under clothing;
d. Do not use DEET on the hands of young children;
e. Avoid applying to areas around the eyes and mouth;
f. Do not use over cuts or irritated skin;
g. Do not use near food;
h. Do not use products that combine insect repellent and sunscreen. If sunscreen is used, apply sunscreen first;
i. Do not apply a second application to the skin (1);
j. DEET concentration should not exceed 30% for use with children (1);
k. After returning indoors, wash treated skin immediately with soap and water;
l. If the child gets a rash or other bad reaction from an insect repellent, stop using the repellent, wash the repellent off with mild soap and water, and call a local poison center (1-800-222-1222) for further guidance. (1,3,4)

Oil of lemon and eucalyptus products should NOT be used on CHILDREN UNDER THREE YEARS OF AGE (1). Most product labels for registrations containing DEET recommend consultation with a physician if applying to a child less than six months of age.

Picaridin and IR3535 are other products registered at the Environmental Protection Agency (EPA) identified as providing repellent activity sufficient to help people avoid the bites of disease carrying mosquitoes (3).

Caregivers/teachers should practice hand hygiene after applying insect repellent to the children in the group.

Written parent/guardian permission is required before applying any insect repellent to children.

In places where ticks are likely to be found, caregivers/teachers should take the following steps to protect children in their care from ticks:

a. Wear light colored clothing, long sleeves and pants, tuck pants into socks;
b. Conduct tick checks when returning indoors (2).
c. Caregivers/teachers should also take the following protective measures against ticks and mosquitoes with children's play areas:
d. Remove stagnant water sources to prevent breeding grounds for mosquito larvae;
e. Remove leaf litter and clear tall grasses and brush around homes and buildings and at the edges of lawns;
f. Place wood chips or gravel between lawns and wooded areas to restrict tick migration to recreational areas;
g. Mow the lawn and clear brush and leaf litter frequently;
h. Keep playground equipment, decks, and patios away from yard edges and trees.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 3.5.0.1 Care Plan for Children with Special Health Care Needs

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" (1).

Any child who meets these criteria should have a Routine and Emergent Care Plan completed by their primary care provider in their medical home. In addition to the information specified in Standard 9.4.2.4 for the Health Report, there should be:

a. A list of the child's diagnosis/diagnoses;
b. Contact information for the primary care provider and any relevant sub-specialists (i.e., endocrinologists, oncologists, etc.);
c. Medications to be administered on a scheduled basis;
d. Medications to be administered on an emergent basis with clearly stated parameters, signs, and symptoms that warrant giving the medication written in lay language;
e. Procedures to be performed;
f. Allergies;
g. Dietary modifications required for the health of the child;
h. Activity modifications;
i. Environmental modifications;
j. Stimulus that initiates or precipitates a reaction or series of reactions (triggers) to avoid;
k. Symptoms for caregiver/teachers to observe;
l. Behavioral modifications;
m. Emergency response plans – both if the child has a medical emergency and special factors to consider in programmatic emergency, like a fire;
n. Suggested special skills training and education for staff.

A template for a Care Plan for children with special health care needs is provided in Appendix O.

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 child care setting. The child care health consultant should be involved to assure adequate information, training, and monitoring is available for child care staff.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 3.6.1.3: Thermometers for Taking Human Temperatures

Digital thermometers should be used with infants and young children when there is a concern for fever. Tympanic (ear) thermometers may be used with children four months and older. However, while a tympanic thermometer gives quick results, it needs to be placed correctly in the child's ear to be accurate.

Glass or mercury thermometers should not be used. Mercury containing thermometers and any waste created from the cleanup of a broken thermometer should be disposed of at a household hazardous waste collection facility.

Rectal temperatures should be taken only by persons with specific health training in performing this procedure. Oral (under the tongue) temperatures can be used for children over age four. Individual plastic covers should be used on oral or rectal thermometers with each use or thermometers should be cleaned and sanitized after each use according to the manufacturer's instructions. Axillary (under the arm) temperatures are less accurate, but are a good option for infants and young children when the caregiver/teacher has not been trained to take a rectal temperature.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 3.6.3.2: Labeling, Storage, and Disposal of Medications

Any prescription medication should be dated and kept in the original container. The container should be labeled by a pharmacist with:

- The child's first and last names;
- The date the prescription was filled;
- The name of the prescribing health professional who wrote the prescription, the medication's expiration date;
- The manufacturer's instructions or prescription label with specific, legible instructions for administration, storage, and disposal;
- The name and strength of the medication.

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:

- Have child-resistant caps;
- Be kept in an organized fashion;
- Be stored away from food;
- Be stored at the proper temperature;
- 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 (FDA) (1). Documentation should be kept with the child care facility of all disposed medications. The current guidelines are as follows:

a. If a medication lists any specific instructions on how to dispose of it, follow those directions.
b. If there are community drug take back programs, participate in those.
c. Remove medications from their original containers and put them in a sealable bag. Mix medications with an undesirable substance such as used coffee grounds or kitty litter. Throw the mixture into the regular trash. Make sure children do not have access to the trash (1).

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

IV. Nutrition and Food Service

STANDARD 4.2.0.11: Ingestion of Substances that Do Not Provide Nutrition

All children should be monitored to prevent them from eating substances that do not provide nutrition (often referred to as Pica). The parents/guardians of children who repeatedly place non-nutritive substances in their mouths should be notified and informed of the importance of their child visiting their primary care provider.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 4.3.1.3: Preparing, Feeding and Storing Human Milk

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 in feeding. 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 significant amount of contents remaining (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 (not a compartment within a refrigerator but either 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 as shown later in this standard, should be returned to the mother.

Some children around six months to a year of age may be developmentally ready to feed themselves and may want to drink from a cup. The transition from bottle to cup can come at a time when a child's fine motor skills allow use of a cup. The caregiver/teacher should use a clean small cup without cracks or chips and should help the child to lift and tilt the cup to avoid spillage and leftover fluid. The caregiver/teacher and mother should work together on cup feeding of human milk to ensure the child is receiving adequate nourishment and to avoid having a large amount of human milk remaining at the end of feeding. Two to three ounces of human milk can be placed in a clean cup and additional milk can be offered as needed. Small amounts of human milk (about an ounce) can be discarded.

Human milk can be stored using the following guidelines from the Academy of Breastfeeding Medicine: Guidelines for Storage of Human Milk http://www.cdc.gov/breastfeeding/recommendations/handling_breastmilk.htm

Location	Temperature	Duration	Comments
Countertop, table	Room temperature (up to 77°F or 25°C)	6-8 hours	Containers should be covered and kept as cool as possible; covering the container with a cool towel may keep milk cooler.
Insulated cooler bag	5°F – 39°F or -15°C – 4°C	24 hours	Keep ice packs in contact with milk containers at all times, limit opening cooler bag.
Refrigerator	39°F or 4°C	5 days	Store milk in the back of the main body of the refrigerator.
Freezer compartment of a refrigerator	5°F or -15°C	2 weeks	Store milk toward the back of the freezer, where temperature is most constant. Milk stored for longer durations in the ranges listed is safe, but some of the lipids in the milk undergo degradation resulting in lower quality.
Freezer compartment of refrigerator with separate doors	0°F or -18°C	3-6 months	
Chest or upright deep freezer	-4°F or -20°C	6-12 months	

Source: Academy of Breastfeeding Medicine Protocol Committee. 2010. Clinical protocol #8: Human milk storage information for home use for healthy full term infants, revised. Breastfeeding Med 5:127-30. http://www.bfmed.org/Media/Files/Protocols/Protocol%208%20-%20English%20revised%202010.pdf
From the Centers for Disease Control and Prevention Website: Proper handling and storage of human milk – Storage duration of fresh human milk for use with healthy full term infants. http://www.cdc.gov/breastfeeding/recommendations/handling_breastmilk.htm.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 4.3.1.5: Preparing, Feeding and Storing Infant Formula

Formula provided by parents/guardians or by the facility should come in a factory-sealed container. The formula should be of the same brand that is served at home and should be of ready-to-feed strength or liquid concentrate to be diluted using water from a source approved by the health department. Powdered infant formula, though it is the least expensive formula, requires special handling in mixing because it cannot be sterilized. The primary source for proper and safe handling and mixing is the manufacturer's instructions that appear on the can of powdered formula. Before opening the can, hands should be washed. The can and plastic lid should be thoroughly rinsed and dried. Caregivers/teachers should read and follow the manufacturer's directions. If instructions are not readily available, caregivers/teachers should obtain information from the World Health Organization's Safe Preparation, Storage and Handling of Powdered Infant Formula Guidelines at http://www.who.int/foodsafety/publications/micro/pif2007/en/index.html (8). The local WIC program can also provide instructions.

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

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

Bottles of formula prepared from powder or concentrate 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 twenty-four 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 forty-eight hours if not used (7,9). The caregiver/teacher should always follow manufacturer's instructions for mixing and storing of any formula preparation.

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.

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.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 4.3.1.9: Warming Bottles and Infant Foods

Bottles and infant foods can be served cold from the refrigerator and do not have to be warmed. If a caregiver/teacher chooses to warm them, bottles should be warmed under running, warm tap water or by placing them in a container of water that is no warmer than 120°F. Bottles should not be left in a pot of water to warm for more than five minutes. Bottles and infant foods should never be warmed in a microwave oven.

Infant foods should be stirred carefully to distribute the heat evenly. A caregiver/teacher should not hold an infant while removing a bottle or infant food from the container of warm water or while preparing a bottle or stirring infant food that has been warmed in some other way. Only BPA-free plastic, plastic labeled #1, #2, #4 or #5, or glass bottles should be used.

If a slow-cooking device, such as a crock pot, is used for warming infant formula, human milk, or infant food, this slow-cooking device should be out of children's reach, should contain water at a temperature that does not exceed 120°F, and should be emptied, cleaned, sanitized, and refilled with fresh water daily.

If a bottle warmer is used for warming infant formula, human milk, or infant food, it should be out of children's reach and used according to manufacturer's instructions.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 4.5.0.2: Tableware and Feeding Utensils

Tableware and feeding utensils should meet the following requirements:

a. Dishes should have smooth, hard, glazed surfaces and should be free from cracks or chips. Sharp-edged plastic utensils (intended for use in the mouth) or dishes that have sharp or jagged edges should not be used;
b. Imported dishes and imported ceramic dishware or pottery should be certified by the regulatory health authority to meet U.S. standards and to be safe from lead or other heavy metals before they can be used;
c. Disposable tableware (such as plates, cups, utensils made of heavy weight paper, food-grade medium- weight or BPA- or phthalates-free plastic) should be permitted for single service if they are discarded after use. The facility should not use foam tableware for children under four years of age;
d. Single-service articles (such as napkins, paper placemats, paper tablecloths, and paper towels) should be discarded after one use;
e. Washable bibs, placemats, napkins, and tablecloths, if used, should be laundered or washed, rinsed, and sanitized after each meal. Fabric articles should be sanitized by being machine-washed and dried after each use;
f. Highchair trays, plates, and all items used in food service that are not disposable should be washed, rinsed, and sanitized. Highchair trays that are used for eating should be washed, rinsed, and sanitized just before and immediately after they are used for eating. Children who eat at tables should have disposable or washed and sanitized plates for their food;
g. All surfaces in contact with food should be lead-free;
h. Tableware and feeding utensils should be child-sized and developmentally appropriate.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 4.8.0.7: Ventilation Over Cooking Surfaces

In centers using commercial cooking equipment to prepare meals, ventilation should be equipped with an exhaust system in compliance with the applicable building, mechanical, and fire codes. These codes may vary slightly with each locale, and centers are responsible to ensure their facilities meet the requirements of these codes (1-2).

All gas ranges in centers should be mechanically vented and fumes filtered prior to discharge to the outside. All vents and filters should be maintained free of grease build-up and food spatters, and in good repair.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center

STANDARD 4.8.0.8: Microwave Ovens

Microwave ovens should be inaccessible to all children, with the exception of school-age children under close adult supervision. Any microwave oven in use in a child care facility should be manufactured after October 1971 and should be in good condition. While the microwave is being used, it should not be left unattended.

If foods need to be heated in a microwave:

a. Avoid heating foods in plastic containers;
b. Avoid transferring hot foods/drinks into plastic containers;
c. Do not use plastic wrap or aluminum foil in the microwave;
d. Avoid plastics for food and beverages labeled "3" (PVC), "6" (PS), and "7" (polycarbonate);
e. Stir food before serving to prevent burns from hot spots.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 4.9.0.13: Method for Washing Dishes by Hand

If the facility does not use a dishwasher, reusable food service equipment and eating utensils should be first scraped to remove any leftover food, washed thoroughly in hot water containing a detergent solution, rinsed, and then sanitized by one of the following methods:

a. Immersion for at least two minutes in a lukewarm (not less than 75°F) chemical sanitizing solution. Bleach may be used as a sanitizing solution when diluted according to manufacturer's instructions. The sanitized items should be air-dried; or
b. Immersed in an EPA-registered sanitizer following the manufacturer's instructions for preparation and use; or
c. Complete immersion in hot water and maintenance at a temperature of 170 °F for not less than thirty seconds. The items should be air-dried (1);
d. Or, other methods if approved by the health department.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

V. Facilities, Supplies and Equipment

A. Location, Layout and Construction

*STANDARD 5.1.1.2: Inspection of Buildings

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.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center

*STANDARD 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 (1,3).

The environmental audit should include assessments of:

a. Potential air, soil, and water contamination on child care 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.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.1.1.6: Structurally Sound Facility

Every exterior wall, roof, and foundation should be structurally sound, weather-tight, and water-tight to ensure protection from weather and natural disasters.

Every interior floor, wall, and ceiling should be structurally sound and should be finished in accordance with local building codes to control exposure of the occupants to levels of toxic fumes, dust, and mold.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.1.1.7: Use of Basements and Below Grade Areas

Finished basements or areas that are partially below grade may be used for children who independently ambulate and who are two years of age or older, if the space is in compliance with applicable building and fire codes. Environmental health factors may be reviewed with county or city public health departments.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.1.1.9: Unrelated Business in a Child Care Area

Child care areas should not be used for any business or purpose unrelated to providing child care when children are present in these areas.

If unrelated business is conducted in child care areas when the child care facility is not in operation, activities associated with such business should not leave any residue in the air or on the surfaces, or leave behind materials or equipment, that could be harmful to children.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.1.1.11: Separation of Operations from Child Care Areas

Rooms or spaces that are used for the following activities or operations should be separated from the child care areas and the egress route should not pass through such spaces:

a. Commercial-type kitchen;
b. Boiler, maintenance shop;
c. Janitor closet and storage areas for cleaning products, pesticides, and other chemicals;
d. Laundry and laundering supplies;
e. Woodworking shop;
f. Flammable or combustible storage;
g. Painting operation;
h. Rooms that are used for any purpose involving the presence of toxic substances;
i. Area for medication storage.

Areas that have combustibles should be protected by fire-resistant barriers. The egress route and the fire-resistant separation should be approved by the appropriate regulatory agencies responsible for building and fire inspections. In small and large family child care homes, a fire-resistant separation should not be required where the food preparation kitchen contains only a domestic cooking range and the preparation of food does not result in smoke or grease-laden vapors escaping into indoor areas. Where separation is provided between the egress route and the hazardous area, it should be safe to use such route, but egress should not require passage through the hazardous area.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.1.3.1: Weather-Tightness and Water-Tightness of Openings

Each window, exterior door, and basement or cellar hatchway should be weather-tight and water-tight when closed.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

B. Quality of Outdoor and Indoor Environment

STANDARD 5.1.3.3: Screens for Ventilation Openings

All openings used for ventilation should be screened against insect entry.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 5.2.1.1: Fresh Air

As much fresh outdoor air as possible should be provided in rooms occupied by children. Windows should be opened whenever weather and the outdoor air quality permits or when children are out of the room (1). When windows are not kept open, rooms should be ventilated, as specified in Standards 5.2.1.1-5.2.1.6. The specified rates at which outdoor air must be supplied to each room within the facility range from fifteen to sixty cubic feet per minute per person (cfm/p). The rate depends on the activities that normally occur in that room.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.1.2: Indoor Temperature

A draft-free temperature of 68°F to 75°F should be maintained at thirty to fifty percent relative humidity during the winter months. A draft-free temperature of 74°F to 82°F should be maintained at thirty to fifty percent relative humidity during the summer months (1,3). All rooms that children use should be heated and cooled to maintain the required temperatures and humidity.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.1.3: Heating and Ventilation Equipment Inspection and Maintenance

All heating and ventilating equipment, including heaters, stoves used for heating (or furnaces), stovepipes, boilers, and chimneys, should be inspected and cleaned before each cooling and heating season by a qualified heating/air conditioning contractor, who should verify in writing that the equipment is properly installed, cleaned, and maintained to operate efficiently and effectively. The system should be operated in accordance with operating instructions and be certified that it meets the local building code by a representative of the agency that administers the building code. Documentation of these inspections and certification of safety should be kept on file in the facility.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.1.4: Ventilation When Using Art Materials

Areas where arts and crafts activities are conducted should be well-ventilated. Materials that create toxic fumes or gases such as spray adhesives and paints should not be used when children are present. Material Safety Data Sheets (MSDS) should be obtained and kept for all chemicals used.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.1.5: Ventilation of Recently Carpeted or Paneled Areas

Doors and windows should be opened in areas that have been recently carpeted or paneled using adhesives until the odors are no longer present. Window fans, room air conditioners, or other means to exhaust emission to the outdoors should be used.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.1.6: Ventilation to Control Odors

Odors in toilets, bathrooms, diaper changing, and other inhabited areas of the facility should be controlled by ventilation and appropriate cleaning and disinfecting. Toilets and bathrooms, janitorial closets, and rooms with utility sinks or where wet mops and chemicals are stored should be mechanically ventilated to the outdoors with local exhaust mechanical ventilation to control and remove odors in accordance with local building codes. Chemical air fresheners or air sanitizers should not be used. Adequate ventilation should be maintained during any cleaning, sanitizing or disinfecting procedure to prevent

children and caregivers/teachers from inhaling potentially toxic fumes.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.1.8: Maintenance of Air Filters

Filters in forced-air heating and cooling system equipment should be checked and cleaned or replaced according to the manufacturer's instructions on a regular basis, at least every three months (and more often if necessary) (1).

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.1.9: Type and Placement of Room Thermometers

Thermometers that will not easily break and that do not contain mercury should be placed on interior walls in every indoor activity area at children's height.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 5.2.1.10: Gas, Oil, or Kerosene Heaters, Generators, Portable Gas Stoves, and Charcoal and Gas Grills

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.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.1.12: Fireplaces, Fireplace Inserts, and Wood/Corn Pellet Stoves

Fireplaces, fireplace inserts, and wood/corn pellet stoves should be inaccessible to children. Fireplaces, fireplace inserts, and wood/corn pellet stoves should be certified to recognized national performance standards such as Underwriters Laboratories (UL) or the American National Standards Institute (ANSI) and Environmental Protection Agency (EPA) standards for air emissions. The front opening should be equipped with a secure and stable protective safety screen. Fireplaces, fireplace inserts, and wood/corn pellet stoves should be installed in accordance with the local or regional building code and the manufacturer's installation instructions. The facility should clean the chimney as necessary to prevent excessive build-up of burn residues or smoke products in the chimney.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.1.15: Maintenance of Humidifiers and Dehumidifiers

If humidifiers or dehumidifiers are used to maintain humidity, as specified in Standard 5.2.1.2, the facility should follow the manufacturer's cleaning, drainage, and maintenance instructions to avoid growth of bacteria and mold and subsequent discharge into the air.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.2.1: Levels of Illumination

Natural lighting should be provided in rooms where children work and play for more than two hours at a time. Wherever possible, windows installed at child's eye level should be provided to introduce natural lighting. All areas of the facility should have glare-free natural and/or artificial lighting that provides adequate illumination and comfort for facility activities. The following guidelines should be used for levels of illumination:

a. Reading, painting, and other close work areas: fifty to 100 foot-candles on the work surface;
b. Work and play areas: thirty to fifty foot-candles on the surface;
c. Stairs, walkways, landings, driveways, entrances: at least twenty foot-candles on the surface;
d. Sleeping and napping areas: no more than five foot-candles during sleeping or napping except for infants and children who are resting in the same room that other children are involved with activities.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

Standard 5.2.2.3: High Intensity Discharge Lamps, Multi-Vapor, and Mercury Lamps

High intensity discharge lamps, multi-vapor, and mercury lamps should not be used for lighting the interior of buildings unless provided with special bulbs that self-extinguish if the outer glass envelope is broken.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.3.1: Noise Levels

Measures should be taken in all rooms or areas accommodating children to maintain the decibel (db) level at or below thirty-five decibels for at least 80% of the time as measured by an acoustical engineer or, more practically, by the ability to be clearly heard and understood in a normal conversation without raising one's voice. These measures include noncombustible acoustical ceiling, rugs, wall covering, partitions, or draperies, or a combination thereof.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 5.2.5.1: Smoke Detection Systems and Smoke Alarms

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.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.6.1: Water Supply

Every facility should be supplied with piped running water under pressure, from a source approved by the Environmental Protection Agency (EPA) and/or the regulatory health authority, to provide an adequate water supply to every fixture connected to the water supply and drainage system. The water should be sufficient in quantity and pressure to supply water for cooking, cleaning, drinking, toilets, and outside uses.

Water supplied by a well or other private source should meet all applicable health and safety federal, state, and local public health standards and should be approved by the local regulatory health authority. Well water should be tested annually for bacterial and chemical content (nitrates or other run-off chemicals) or according to local regulatory health authority (2). Any facility not served by a public water supply should keep on file documentation of approval, from the local regulatory health authority, of the water supply.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.6.2: Testing of Drinking Water Not From Public System

If the facility's drinking water does not come from a public water system, or the facility gets the drinking water from a household well, programs should test the water every year or as required by the local health department, for bacteriological quality, nitrates, total dissolved solids, pH levels, and other water quality indicators as required by the local health department. Testing for nitrate is especially important if there are infants under six months of age in care.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 5.2.6.3: Testing for Lead and Copper Levels in Drinking Water

Drinking water, including water in drinking fountains, should be tested and evaluated in accordance with the assistance of the local health authority or state drinking water program to determine whether lead and copper levels are safe.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.6.4: Water Test Results

All water test results should be in written form and kept with other required reports and documents in one central location in the facility, ready for immediate viewing by consumers and regulatory personnel. Early care and education programs should maintain photocopies of all water-testing results if the business is required to submit reports to the regulatory authority.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.6.5: Emergency Safe Drinking Water and Bottled Water

Emergency safe drinking water should be supplied during interruption of the regular approved water supply. Bottled water should be certified as chemically and bacteriologically potable by the Food and Drug Administration (FDA), local health department or its designee.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.6.6: Water Handling and Treatment Equipment

Newly installed water handling, treatment, filtering, or softening equipment should meet applicable National Sanitation Foundation (NSF) standards and should be approved by the local regulatory health authority.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.6.7: Cross-Connections

The facility should have no cross-connections that could permit contamination of the potable water supply:

a. Backflow preventers, vacuum breakers, or strategic air gaps should be provided for all boiler units in which chemicals are used. Backflow preventers should be tested annually;
b. Vacuum breakers should be installed on all threaded janitorial sink faucets and outdoor/indoor hose bibs;
c. Non-submersible, antisiphon ballcocks should be provided on all flush tank-type toilets.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.7.1: On-Site Sewage Systems

A sewage system should be provided and inspected in accordance with state and local regulations. Whenever a public sewer is available, the facility should be connected to it. Where public sewers are not available, an on-site sewage system or other method approved by the local public health department should be installed. Raw or treated wastes should not be discharged on the surface of the ground.

The wastewater or septic system drainage field should not be located within the outdoor play area of a child care program, unless the drainage field has been designed by a sanitation engineer with the presence of an outdoor play area in mind and meets the approval of the local health authority.

The exhaust vent from a wastewater or septic system and drainage field should not be located within the children's outdoor play area.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.7.2: Removal of Garbage

Garbage and rubbish should be removed from rooms occupied by children, staff, parents/guardians, or volunteers on a daily basis and removed from the premises at least twice weekly or at other frequencies required by the regulatory health authority.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 5.2.7.3: Containment of Garbage

Garbage should be kept in containers approved by the regulatory health authority. Such containers should be constructed of durable metal or other types of material, designed and used so wild and domesticated animals and pests do not have access to the contents, and so they do not leak or absorb liquids. Waste containers should be kept covered with tight-fitting lids or covers when stored.

The facility should have a sufficient number of waste and diaper containers to hold all of the garbage and diapers that accumulate between periods of removal from the premises. Plastic garbage bag liners should be used in such containers. Exterior garbage containers should be stored on an easily cleanable surface. Garbage areas should be free of litter and waste that is not contained. Children should not be allowed access to garbage, waste, and refuse storage areas.

If a compactor is used, the surface should be graded to a suitable drain, as approved by the regulatory health authority.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 5.2.7.6: Storage and Disposal of Infectious and Toxic Wastes

Infectious and toxic wastes should be stored separately from other wastes, and should be disposed of in a manner approved by the regulatory health authority.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 5.2.8.1: Integrated Pest Management

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 (2,4).

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 (5).

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 who has the licenses or certifications required by state and local laws.

Facility managers should follow all instructions on pesticide product labels and should not apply any pesticide in a manner inconsistent with label instructions. Material Safety Data Sheets (MSDS) are available from the product manufacturer or a licensed exterminator and should be on file at the facility 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 (3).

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. A member of the child care 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.

Registry: Child care facilities should provide the opportunity for interested staff and parents/guardians to register with the facility if they want to be notified about individual pesticide applications before they occur.

Warning Signs: Child care facilities must post warning signs at each area where pesticides will be applied. These signs must be posted forty-eight hours before and seventy-two hours after applications and should be sufficient to restrict uninformed access to treated areas.

Record Keeping: Child care facilities should keep records of pesticide use at the facility and make the records available to anyone who asks. Record retention requirements vary by state, but federal law requires records to be kept for two years (7). It is a good idea to retain records for a minimum of three years.

Pesticide Storage: Pesticides should be stored in their original containers and in a locked room or cabinet accessible only to authorized staff. No restricted-use pesticides should be stored or used on the premises except by properly licensed persons. Banned, illegal, and unregistered pesticides should not be used.

To view the Rationale and Comments for this standard, click here.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.8.2: Insect Breeding Hazard

No facility should maintain or permit to be maintained any receptacle or pool, whether natural or artificial, containing water in such condition that insects breeding therein may become a public health issue.

To view the Rationale and Comments for this standard, click here.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 5.2.9.1: Use and Storage of Toxic Substances

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-resistive 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 (see Standard 3.6.3.1) and disposed of properly (see Standard 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 twenty-four hours a day, seven days a week, and can be reached at 1-800-222-1222.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 5.2.9.2: Use of a Poison Center

The poison center should be called for advice about any exposure to toxic substances, or any potential poisoning emergency. The national help line for the poison center is 1-800-222-1222, and specialists will link the caregiver/teacher with their local poison center. The advice should be followed and documented in the facility's files. The caregiver/teacher should be prepared for the call by having the following information for the poison center specialist:

a. The child's age and sex;
b. The substance involved;
c. The estimated amount;
d. The child's condition;
e. The time elapsed since ingestion or exposure.

The caregiver/teacher should not induce vomiting unless instructed by the poison center.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 5.2.9.3: Informing Staff Regarding Presence of Toxic Substances

Employers should provide staff with hazard information, including access to and review of the Material Safety Data Sheets (MSDS) as required by the Occupational Safety and Health Administration (OSHA), about the presence of toxic substances such as formaldehyde, cleaning and sanitizing supplies, insecticides, herbicides, and other hazardous chemicals in use in the facility. Staff should always read the label prior to use to determine safety in use. For example, toxic products regulated by the Environmental Protection Agency (EPA) will have an EPA signal word of CAUTION, WARNING, or DANGER. Where nontoxic substitutes are available, these nontoxic substitutes should be used instead of toxic chemicals. If a nontoxic product is not available, caregivers/teachers should use the least toxic product for the job. A CAUTION label is safer than a WARNING label, which is safer than a DANGER label.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 5.2.9.4: Radon Concentrations

Radon concentrations inside a home or building used for child care 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 (EPA) testing protocols for long-term testing (i.e., greater than ninety days in duration using alpha-track or electret test devices).

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 5.2.9.5: Carbon Monoxide Detectors

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

a. The child care 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.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.9.6: Preventing Exposure to Asbestos or Other Friable Materials

Any asbestos, fiberglass, or other friable material or any material that is in a dangerous condition found within a facility or on the grounds of the facility should be repaired or removed. Repair usually involves either sealing (encapsulating) or covering asbestos material. Any repair or removal of asbestos should be done by a contractor certified to do in accordance with existing regulations of the U.S. Environmental Protection Agency (EPA). No children or staff should be present until the removal and cleanup of the hazardous condition have been completed.

Pipe and boiler insulation should be sampled and examined in an accredited laboratory for the presence of asbestos in a friable or potentially dangerous condition.

Non-friable asbestos should be identified to prevent disturbance and/or exposure during remodeling or future activities.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.9.7: Proper Use of Art and Craft Materials

Only art and craft materials that are approved by the Art and Creative Materials Institute (ACMI) should be used in the child care facility. Art and craft materials should conform to all applicable ACMI safety standards. Materials should be labeled in accordance with the chronic hazard labeling standard, ASTM D4236.

The facility should prohibit use of unlabeled, improperly labeled old, or donated materials with potentially harmful ingredients.

Caregivers/teachers should closely supervise all children using art and craft materials and should make sure art and craft materials are properly used, cleaned up, and stored in original containers that are fully labeled. Materials should be age-appropriate. Children should not eat or drink while using art and craft materials.

Caregivers/teachers should have emergency protocols in place in the event of an injury, poisoning, or allergic reaction. If caregivers/teachers suspect a poisoning may have occurred they should call their poison center at 1-800-222-1222. Rooms should be well ventilated while using art and craft materials.

Only ACMI-approved unscented water-based markers should be used for children's art projects and work.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.9.8: Use of Play Dough and Other Manipulative Art or Sensory Materials

The child care program should have the following procedures on the use and life span of manipulative art or sensory materials such as clay, play dough, etc:

a. If handmade, these materials should be made fresh each week, labeled, dated and stored in airtight containers;
b. If purchased, these products should be stored in their original packaging;
c. Products that are labeled as toxic are prohibited;
d. The surface upon which they are used and the tools used with these materials should be cleaned and sanitized before and after use;
e. Children should practice hand hygiene before and after each use;
f. Material should be discarded if it is sneezed upon, put into a child's mouth, or in any other way possibly contaminated;
g. Children with latex or gluten allergies should be given their own portion of the material and that individual portion should be stored separately if for repeat use.
h. Children with cuts, sores, scratches and colds with sneezing and runny noses should be given their own portion of the material and that individual portion should be stored separately if for repeat use.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.9.9: Plastic Containers and Toys

The facility should use infant bottles, plastic containers, and toys that do not contain Polyvinyl chloride (PVC), Bisphenol A (BPA), or phthalates. When possible, caregivers/teachers should substitute materials such as paper, ceramic, glass, and stainless steel for plastics.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.9.10: Prohibition of Poisonous Plants

Poisonous or potentially harmful plants are prohibited in any part of a child care facility that is accessible to children. All plants not known to be nontoxic should be identified and checked by name with the local poison center (1-800-222-1222) to determine safe use.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.9.11: Chemicals Used to Control Odors

The use of the following should be prohibited:

a. Incense;
b. Moth crystals or moth balls;
c. Chemical air fresheners; and
d. Toilet/urinal deodorizer blocks.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.9.12: Treatment of CCA Pressure-Treated Wood

A penetrating coating (e.g., oil-based, semi-transparent stain) should be applied every six months to all chromated copper arsenate (CCA)-treated surfaces to which a child may have access.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 5.2.9.13: Testing for Lead

In all centers, both exterior and interior surfaces covered by paint with lead levels of 0.009% or 90 ppm and above, and accessible to children, should be removed by a safe chemical or physical means or made inaccessible to children, regardless of the condition of the surface.

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

Any surface and the grounds around and under surfaces that children use at a child care facility, 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, http://www.cpsc.gov, 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 nontoxic paints should be used.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.9.14: Shoes in Infant Play Areas

Adults and children should remove or cover shoes before entering a play area used by a specific group of infants. These individuals, as well as the infants playing in that area, may wear shoes, shoe covers, or socks that are used only in the play area for that group of infants.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.2.9.15: Construction and Remodeling During Hours of Operation

Construction, remodeling, painting, or alterations of structures during child care operations should be isolated from areas where children are present and done in a manner that will prevent hazards or unsafe conditions (such as fumes, dust, safety, and fire hazards).

Low volatile organic compounds (VOC) paints should be used in child care areas. Painted areas should be ventilated until they are fully dry and odor-free before children are permitted to occupy them.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

C. General Furnishings/Equipment and Maintenance

*STANDARD 5.3.1.1: Safety of Equipment, Materials, and Furnishings

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 (CPSC) 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.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.3.1.4: Surfaces of Equipment, Furniture, Toys, and Play Materials

Equipment, furnishings, toys, and play materials should have smooth, nonporous surfaces or washable fabric surfaces that are easy to clean and sanitize, or be disposable.

Walls, ceilings, floors, furnishings, equipment, and other surfaces should be suitable to the location and the users. They should be maintained in good repair, free from visible soil and in a clean condition. Programs should choose materials with the least probability of containing materials that off-gas toxic elements such as volatile organic compounds (VOCs), formaldehyde, or toxic flame retardants (polybrominated diphenylethers [PBDE]). Carpets, porous fabrics, and other surfaces that trap soil and potentially contaminated materials should not be used in toilet rooms, diaper change areas, and areas where food handling occurs (1).

Areas used by staff or children who have allergies to dust mites or components of furnishings or supplies should be maintained according to the recommendations of primary care providers.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.3.1.6: Floors, Walls, and Ceilings

Floors, walls, and ceilings should be in good repair, and easy to clean when soiled. Only smooth, nonporous surfaces should be permitted in areas that are likely to be contaminated by body fluids or in areas used for activities involving food. The hand contact and splash areas of doors and walls should be covered with a finish that is at least as cleanable as an epoxy finish or enamel paint.

Floors should be free from cracks, bare concrete, dampness, splinters, sliding rugs, and uncovered telephone jacks or electrical outlets.

Carpeting should be clean, in good repair, nonflammable, and nontoxic.

Each bathroom, toilet room, and shower room floor and wall should be impervious to water up to a height of five feet and capable of being kept in a clean and sanitary condition.

All public bathrooms should be constructed of materials that are impervious to moisture, bacteria, mold, or fungus growth. The floor-to-wall joints should be constructed to provide a sanitary cove with a minimum radius of three-eighths inch. Flooring material should be appropriate for bathroom use (e.g., vinyl sheet, ceramic tile, fiber-reinforced plastic, epoxy products). All wall surfaces within twenty-four inches of a water closet or urinal should be ceramic tile to a height of forty-eight inches (1).

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.4.1.5: Chemical Toilets

Chemical toilets should not be used in child care facilities unless they are provided as a temporary measure in the event that the facility's normal plumbed toilets are not functioning. Constant supervision should be required for young children using a chemical toilet. In the event that chemical toilets may be required on a temporary basis, the caregiver/teacher should seek approval for use from the regulatory health agency.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.4.2.6: Maintenance of Changing Tables

Changing tables should be nonporous, kept in good repair, and cleaned and disinfected after each use to remove visible soil and germs.

***To view the Rationale and** Comments for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.5.0.5: Storage of Flammable Materials

Gasoline, hand sanitizers in volume, and other flammable materials should be stored in a separate building, in a locked area, away from high temperatures and ignition sources, and inaccessible to children.

***To view the Rationale and** Comments for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.6.0.4: Microfiber Cloths, Rags, and Disposable Towels and Mops Used for Cleaning

Microfiber cloths should be preferred for cleaning. They should be laundered between each use. If microfiber cloths are not appropriate for use, disposable towels should be preferred for cleaning. If clean reusable rags are used, they should be laundered separately between each one-time use for cleaning. Disposable towels should be sealed in a plastic bag and removed to outside garbage. Cloth rags should be placed in a closed, foot-operated, plastic-lined receptacle until laundering. When a mop is needed, microfiber mops should be considered as a preferred cleaning method over conventional loop mops. Use of sponges in child care facilities for cleaning purposes is not recommended.

***To view the Rationale and** Comments for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.7.0.1: Maintenance of Exterior Surfaces

Porches, steps, stairs, and walkways should:

a. Be maintained free from accumulations of water, ice, or snow;
b. Have a non-slip surface;
c. Be kept free of loose objects;
d. Be in good repair;
e. Be free of flaking paint.

To view the Rationale and Comments for this standard, click here.

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.7.0.2: Removal of Hazards From Outdoor Areas

All outdoor activity areas should be maintained in a clean and safe condition by removing:

a. Debris;
b. Dilapidated structures;
c. Broken or worn play equipment;
d. Building supplies and equipment;
e. Glass;
f. Sharp rocks;
g. Stumps and roots;
h. Branches;
i. Animal excrement;
j. Tobacco waste (cigarette butts);
k. Garbage;
l. Toxic plants;
m. Anthills;
n. Beehives and wasp nests;
o. Unprotected ditches;
p. Wells;
q. Holes;
r. Grease traps;
s. Cisterns;
t. Cesspools;
u. Unprotected utility equipment;
v. Other injurious material.

Holes or abandoned wells within the site should be properly filled or sealed. The area should be well-drained, with no standing water.

A maintenance policy for playgrounds and outdoor areas should be established and followed.

***To view the Rationale and** Comments for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.7.0.3: Removal of Allergen Triggering Materials From Outdoor Areas

Outdoor areas should be kept free of excessive dust, weeds, brush, high grass, and standing water.

***To view the Rationale and** Comments for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.7.0.5: Cleaning Schedule for Exterior Areas

A cleaning schedule for exterior areas should be developed and assigned to appropriate staff members. Delegated staff members should actively look for flaking or peeling paint while cleaning the exterior areas. If flaking/peeling paint is found, it should be tested for lead. If the paint is found to contain lead, the area should be covered by latex-based paint to create a barrier between the lead-based paint and the children in care.

***To view the Rationale and** Comments for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.7.0.6: Storage Area Maintenance and Ventilation

Storage areas should have appropriate lighting and be kept clean. If the area is a storage room, the area should be mechanically ventilated to the outdoors when chemicals or a janitorial sink are present.

***To view the Rationale and** Comments for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.7.0.7: STRUCTURE MAINTENANCE

The structure should be kept in good repair and safe condition.

Each window, exterior door, and basement or cellar hatchway should be kept in sound condition and in good repair.

***To view the Rationale and** Comments for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 5.7.0.10: CLEANING OF HUMIDIFIERS AND RELATED EQUIPMENT

Humidifiers, dehumidifiers, and air-handling equipment that involve water should be cleaned and disinfected according to manufacturers' instructions.

***To view the Rationale and** Comments for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

VI. Play Areas/Playgrounds

STANDARD 6.1.0.1: Size and Location of Outdoor Play Area

The facility or home should be equipped with an outdoor play area that directly adjoins the indoor facilities or that can be reached by a route that is free of hazards and is no farther than one-eighth mile from the facility. The playground should comprise a minimum of seventy-five square feet for each child using the playground at any one time.

The following exceptions to the space requirements should apply:

a. A minimum of thirty-three square feet of accessible outdoor play space is required for each infant;
b. A minimum of fifty square feet of accessible outdoor play space is required for each child from eighteen to twenty-four months of age.

There should be separated areas for play for the following ages of children:

a. Ages six through twenty-three months
b. Ages two to five years*
c. Ages five to twelve years**

*These areas may be further sub-divided into ages two to three years and four to five years.

** These areas may be further sub-divided into grades K-1, 2-3, and 4-6.

The outdoor playground should include an open space for running that is free of other equipment (4).

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 6.1.0.2: Size and Requirements of Indoor Play Area

If a facility has less than seventy-five square feet of accessible outdoor space per child or provides active play space indoors for other reasons, a large indoor activity room that meets the requirement for seventy-five square feet per child may be used if it meets the following requirements:

a. It provides for types of activities equivalent to those performed in an outdoor play space;
b. The area is ventilated with fresh, temperate air at a minimum of five cubic feet per minute per occupant when open windows are not possible;
c. The surfaces and finishes are shock-absorbing, as required for outdoor installations in Standard 6.2.3.1;
d. The play equipment meets the requirements for outdoor installation as stated in Standards 6.2.1.3-6.2.1.6 and Standards 6.2.2.3-6.2.2.4.

There should be separated areas for play for the following ages of children:

a. Ages six through twenty-three months
b. Ages two to five years*
c. Ages five to twelve years**

*These areas may be further sub-divided into ages two to three years and four to five years.

** These areas may be further sub-divided into grades K-1, 2-3, and 4-6.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center

STANDARD 6.1.0.7: Shading of Play Area

Children should be provided shade in play areas (not just playgrounds). Shading may be provided by trees, buildings, or shade structures. Metal equipment (especially slides) should be placed in the shade (1,2). Sun exposure should be reduced by timing children's outdoor play to take place before ten o'clock in the morning or after four o'clock in the afternoon standard time (3).

***To view the Rationale and** Comments for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 6.1.0.8: Enclosures for Outdoor Play Areas

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.

***To view the Rationale and** Comments for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 6.2.1.1: Play Equipment Requirements

Play equipment and materials in the facility should meet the recommendations of the U.S. Consumer Product Safety Commission (CPSC) and the ASTM International (ASTM) for public playground equipment. Equipment and materials intended for gross-motor (active) play should conform to the recommendations in the CPSC Public Playground Safety Handbook and the provisions in the ASTM "Standard F1487-07ae1: Consumer Safety Performance Specifications for Playground Equipment for Public Use."

All play equipment should be constructed, installed, and made available to the intended users in such a manner that meets CPSC guidelines and ASTM standards, as warranted by the manufacturers' recommendations. A Certified Playground Safety Inspector (CPSI) who has been certified by the National Recreation and Park Association (NRPA) should conduct an inspection of playground plans for new installations. Previously installed playgrounds should be inspected at least once each year, by a CPSI or local regulatory agency, and whenever changes are made to the equipment or intended users.

Inspectors should specifically test wooden play equipment structures for chromated copper arsenate (CCA). The wood in many playground sets can contain potentially hazardous levels of arsenic due to the use of CCA as a wood preservative.

Play equipment and materials should be deemed appropriate to the developmental needs, individual interests, abilities, and ages of the children, by a person with at least a master's degree in early childhood education or psychology, or identified as age-appropriate by a manufacturer's label on the product package. Enough play equipment and materials should be available to avoid excessive competition and long waits.

The facility should offer a wide variety of age-appropriate portable play equipment (e.g., balls, jump ropes, hoops, ribbons, scarves, push/pull toys, riding toys, rocking and twisting toys, sand and water play toys) in sufficient quantities that multiple children can play at the same time (1-5).

Children should always be supervised when playing on playground equipment.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 6.2.1.8: Material Defects and Edges on Play Equipment

All pieces of play equipment should be free of sharp edges, protruding parts, weaknesses, and flaws in material construction. Sharp edges in wood, metal, or concrete should be rounded on all edges. All corners and edges on rigid materials should have a minimum radius of one-quarter inch unless the material thickness is less than one-half inch, in which case the radius should be half the thickness of the material. This requirement does not apply to swing seats, straps, ropes, chains, connectors, and other flexible components. Wood materials should be free of chromated copper arsenate (CCA), sanded smooth, and should be inspected regularly for splintering.

***To view the Rationale and** Comments for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 6.2.4.1: Sandboxes

The facility should adhere to the following requirements for sand play areas:

a. Sandboxes should be constructed to permit drainage;
b. Sandboxes should be covered with a lid or other covering when they are not in use;
c. Sandboxes should be kept free from cat and other animal excrement;
d. Sandboxes should be regularly cleaned of foreign matter;
e. Sandboxes should be located away from prevailing winds, if this is not possible, windbreaks using bushes, trees, or fences should be provided;
f. Sand used in the box should be washed, free of organic, toxic, or harmful materials, and fine enough to be shaped easily;
g. Sand should be replaced as often as necessary to keep the sand visibly clean and free of extraneous materials;
h. Sand play areas should be distinct from landing areas for slides or other equipment;
i. Sand play area covers should be adequately secured when they are lifted or moved to allow children to play in the sandbox.

***To view the Rationale and** Comments for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 6.2.4.2: Water Play Tables

Communal, unsupervised water play tables should be prohibited. Communal water tables should be permitted if children are supervised and the following conditions apply:

a. The water tables should be filled with fresh potable water immediately before designated children begin a water play activity at the table, and changed when a new group begins a water play activity at the table even if all the child-users are from a single group in the space where the water table is located; or, the table should be supplied with freely flowing fresh potable water during the play activity;
b. The basin and toys should be washed and sanitized at the end of the day;

c. If the basin and toys are used by another classroom, the basin and toys should be washed and sanitized prior to use;
d. Only children without cuts, scratches, and sores on their hands should be permitted to use a communal water play table;
e. Children should wash their hands before and after they use a communal water play table;
f. Caregivers/teachers should ensure that no child drinks water from the water table;
g. Floor/surface under and around the water table should be dried during and after play;
h. Avoid use of bottles, cups, and glasses in water play, as these items encourage children to drink from them.

As an alternative to a communal water table, separate basins with fresh potable water for each child to engage in water play should be permitted. If separate basins of water are used and placed on the floor, close supervision is crucial to prevent drowning.

***To view the Rationale and** Comments for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 6.2.4.3: Sensory Table Materials

All materials used in a sensory table should be nontoxic and should not be of a size or material that could cause choking. Sensory table activities should not be used with children under eighteen months of age. For toddlers, materials should be limited to water, sand and fixed plastic objects. All sensory table activities should be supervised for toddlers and preschool children. When water is used in a sensory table, the requirements of Standard 6.2.4.2, Water Play Tables should be met.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 6.3.2.3: Pool Equipment and Chemical Storage Rooms

Pool equipment and chemical storage rooms should be locked, ventilated, and used only for pool equipment and pool chemicals.

***To view the Rationale and** Comments for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 6.3.4.1: Pool Water Quality

Water in swimming pools and built-in wading pools that children use should be maintained between pH 7.2 and pH 7.8. The water should be disinfected by available free chlorine between 1.0 ppm and 3.0 ppm, or bromine between 1.0 ppm and 6.0 ppm, or by an equivalent agent approved by the health department. The pool should be cleaned, and the chlorine or equivalent disinfectant level and pH level should be tested every two hours during periods of use.

Equipment should be available to test for and maintain a measurable residual disinfectant content in the water and to check the pH of the water. Water should be sampled and a bacteriological analysis conducted to determine absence of fecal coliforms (e.g., Escherichia coli, Pseudomonas aeruginosa, and Giardia intestinalis) at least monthly or at intervals required by the local health authority.

***To view the Rationale and** Comments for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 6.3.4.2: Chlorine Pucks

"Chlorine Pucks" must not be placed in skimmer baskets or placed anywhere in pools when children are present. If pucks are used, they must be dissolved before children enter the pool.

***To view the Rationale and** Comments for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 6.4.1.2: Inaccessibility of Toys or Objects to Children Under Three Years of Age

Small objects, toys, and toy parts available to children under the age of three years should meet the federal small parts standards for toys. The following toys or objects should not be accessible to children under three years of age:

a. Toys or objects with removable parts with a diameter less than one and one-quarter inches and a length between one inch and two and one-quarter inches;
b. Balls and toys with spherical, ovoid (egg shaped), or elliptical parts that are smaller than one and three-quarters inches in diameter;
c. Toys with sharp points and edges;
d. Plastic bags;
e. Styrofoam objects;
f. Coins;
g. Rubber or latex balloons;
h. Safety pins;
i. Marbles;
j. Magnets;
k. Foam blocks, books, or objects;
l. Other small objects;
m. Latex gloves;
n. Bulletin board tacks;
o. Glitter.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

VII. Administration

STANDARD 9.2.1.1: Content of Policies

The facility should have policies to specify how the caregiver/teacher addresses the developmental functioning and individual or special health care needs of children of different ages and abilities who can be served by the facility, as well as other services and procedures. These policies should include, but not be limited to, the following:

a. Admissions criteria, enrollment procedures, and daily sign-in/sign-out policies, including authorized individuals for pick-up and allowing parent/guardian access whenever their child is in care;
b. Inclusion of children with special health care needs;
c. Nondiscrimination;
d. Payment of fees, deposits, and refunds;
e. Termination of enrollment and parent/guardian notification of termination;
f. Supervision;
g. Staffing, including caregivers/teachers, the use of volunteers, helpers, or substitute caregivers/teachers, and deployment of staff for different activities;
h. A written comprehensive and coordinated planned program based on a statement of principles;
i. Discipline;
j. Methods and schedules for conferences or other methods of communication between parents/guardians and staff;
k. Care of children and staff who are ill;
l. Temporary exclusion for children and staff who are ill and alternative care for children who are ill;
m. Health assessments and immunizations;
n. Handling urgent medical care or threatening incidents;
o. Medication administration;
p. Use of child care health consultants and education and mental health consultants;
q. Plan for health promotion and prevention (e.g., tracking routine child health care, health consultation, health education for children/staff/families, oral health, sun safety, safety surveillance, preventing obesity, etc.);
r. Disasters, emergency plan and drills, evacuation plan, and alternative shelter arrangements;
s. Security;
t. Confidentiality of records;
u. Transportation and field trips;
v. Physical activity (both outdoors and when children are kept indoors), play areas, screen time, and outdoor play policy;
w. Sleeping, safe sleep policy, areas used for sleeping/napping, sleep equipment, and bed linen;
x. Sanitation and hygiene;
y. Presence and care of any animals on the premises;
z. Food and nutrition including food handling, human milk, feeding and food brought from home, as well as a daily schedule of meals and snacks;
aa. Evening and night care plan;
bb. Smoking, tobacco use, alcohol, prohibited substances, and firearms;
cc. Human resource management;
dd. Staff health;
ee. Maintenance of the facility and equipment;
ff. Preventing and reporting child abuse and neglect;
gg. Use of pesticides and other potentially toxic substances in or around the facility;
hh. Review and revision of policies, plans, and procedures.

The facility should have specific strategies for implementing each policy. For centers, all of these items should be written. Facility policies should vary according to the ages and abilities of the children enrolled to accommodate individual or special health care needs. Program planning should precede, not follow the enrollment and care of children at different developmental levels and abilities and with different health care needs. Policies, plans, and procedures should generally be reviewed annually or when any changes are made. A child care health consultant can be very helpful in developing and implementing model policies.

*To view the **Rationale** and **Comment**s for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 9.2.3.10: Sanitation Policies and Procedures

The child care facility should have written sanitation policies and procedures for the following items:

a. Maintaining equipment used for hand hygiene, toilet use, and toilet learning/training in a sanitary condition;
b. Maintaining diaper changing areas and equipment in a sanitary condition;
c. Maintaining toys in a sanitary condition;
d. Managing animals in a safe and sanitary manner;
e. Practicing proper handwashing and diapering procedures (the facility should display proper handwashing instruction signs conspicuously);
f. Practicing proper personal hygiene of caregivers/teachers and children;
g. Practicing environmental sanitation policies and procedures, such as sanitary disposal of soiled diapers;
h. Maintaining sanitation for food preparation and food service.

*To view the **Rationale** and **Comment**s for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 9.2.3.15: Policies Prohibiting Smoking, Tobacco, Alcohol, Illegal Drugs, and Toxic Substances

Facilities should have written policies addressing the use and possession of tobacco products, alcohol, illegal drugs, prescription medications that have not been prescribed for the user, and unauthorized potentially toxic substances. Policies should include that all of these substances are prohibited inside the facility, on facility grounds, and in any vehicles that transport children at all times. Policies should specify that smoking is prohibited at all times and in all areas used by the children in the program. Smoking is also prohibited in any vehicles that transport children.

Policies must also specify that use and possession of all substances referred to above is prohibited during all times when caregivers/teachers are responsible for the supervision of children, including times when children are transported, when playing in outdoor play areas not attached to the facility, and during field trips.

Child care centers and large family child care homes should provide information to employees about available drug, alcohol, and tobacco counseling and rehabilitation, and any available employee assistance programs.

*To view the **Rationale** and **Comment**s for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 9.2.4.3: Disaster Planning, Training, and Communication

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.

Written Emergency/Disaster Plan:

Facilities should develop and implement a written plan that describes the practices and procedures they use to prepare for and respond to emergency or disaster situations. This Emergency/Disaster Plan should include:

a. Information on disasters likely to occur in or near the facility, county, state, or region that require advance preparation and/or contingency planning;
b. Plans (and a schedule) to conduct regularly scheduled practice drills within the facility and in collaboration with community or other exercises;
c. Mechanisms for notifying and communicating with parents/guardians in various situations (e.g., Website postings; email notification; central telephone number, answering machine, or answering service messaging; telephone calls, use of telephone tree, or cellular phone texts; and/or posting of flyers at the facility and other community locations);
d. Mechanisms for notifying and communicating with emergency management public officials;
e. Information on crisis management (decision-making and practices) related to sheltering in place, relocating to another facility, evacuation procedures including how non-mobile children and adults will be evacuated, safe transportation of children including children with special health care needs, transporting necessary medical equipment obtaining emergency medical care, responding to an intruder, etc.;
f. Identification of primary and secondary meeting places and plans for reunification of parents/guardians with their children;
g. Details on collaborative planning with other groups and representatives (such as emergency management agencies, other child care facilities, schools, emergency personnel and first responders, pediatricians/health professionals, public health agencies, clinics, hospitals, and volunteer agencies including Red Cross and other known groups likely to provide shelter and related services);
h. Continuity of operations planning, including backing up or retrieving health and other key records/files and managing financial issues such as paying employees and bills during the aftermath of the disaster;
i. Contingency plans for various situations that address:
    1. Emergency contact information and procedures;
    2. How the facility will care for children and account for them, until the parent/guardian has accepted responsibility for their care;
    3. Acquiring, stockpiling, storing, and cycling to keep updated emergency food/water and supplies that might be needed to care for children and staff for up to one week if shelter-in-place is required and when removal to an alternate location is required;
    4. Administering medicine and implementing other instructions as described in individual special care plans;
    5. Procedures that might be implemented in the event of an outbreak, epidemic, or other infectious disease emergency (e.g., reviewing relevant immunization records, keeping symptom records, implementing tracking procedures and corrective actions, modifying exclusion and isolation guidelines, coordinating with schools, reporting or responding to notices about public health emergencies);

6. Procedures for staff to follow in the event that they are on a field trip or are in the midst of transporting children when an emergency or disaster situation arises;
7. Staff responsibilities and assignment of tasks (facilities should recognize that staff can and should be utilized to assist in facility preparedness and response efforts, however, they should not be hindered in addressing their own personal or family preparedness efforts, including evacuation).

Details in the Emergency/Disaster Plan should be reviewed and updated bi-annually and immediately after any relevant event to incorporate any best practices or lessons learned into the document.

Facilities should identify in advance which agency or agencies would be the primary contact for them regarding child care regulations, evacuation instructions, and other directives that might be communicated in various emergency or disaster situations.

Training:

Staff should receive training on emergency/disaster planning and response. Training should be provided by emergency management agencies, educators, child care health consultants, health professionals, or emergency personnel qualified and experienced in disaster preparedness and response. The training should address:

a. Why it is important for child care facilities to prepare for disasters and to have an Emergency/Disaster Plan;
b. Different types of emergency and disaster situations and when and how they may occur;
    1. Natural Disasters;
    2. Terrorism (i.e., biological, chemical, radiological, nuclear);
    3. Outbreaks, epidemics, or other infectious disease emergencies;
c. The special and unique needs of children, appropriate response to children's physical and emotional needs during and after the disaster, including information on consulting with pediatric disaster experts;
d. Providing first aid, medications, and accessing emergency health care in situations where there are not enough available resources;
e. Contingency planning including the ability to be flexible, to improvise, and to adapt to ever-changing situations;
f. Developing personal and family preparedness plans;
g. Supporting and communicating with families;
h. Floor plan safety and layout;
i. Location of emergency documents, supplies, medications, and equipment needed by children and staff with special health care needs;
j. Typical community, county, and state emergency procedures (including information on state disaster and pandemic influenza plans, emergency operation centers, and incident command structure);
k. Community resources for post-event support such as mental health consultants, safety consultants;
l. Which individuals or agency representatives have the authority to close child care programs and schools and when and why this might occur;
m. Insurance and liability issues;
n. New advances in technology, communication efforts, and disaster preparedness strategies customized to meet children's needs.

Communicating with Parents/Guardians:

Facilities should share detailed information about facility disaster planning and preparedness with parents/guardians when they enroll their children in the program, including:

a. Portions of the Emergency/Disaster Plan relevant to parents/guardians or the public;
b. Procedures and instructions for what parents/guardians can expect if something happens at the facility;
c. Description of how parents/guardians will receive information and updates during or after a potential emergency or disaster situation;
d. Situations that might require parents/guardians to have a contingency plan regarding how their children will be cared for in the unlikely event of a facility closure.

Facilities should conduct an annual drill, test, or "practice use" of the communication options/mechanisms that are selected.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

*STANDARD 9.2.4.5: Emergency and Evacuation Drills/Exercises Policy

The facility should have a policy documenting that emergency drills/exercises should be regularly practiced for geographically appropriate natural disasters and human generated events such as:

a. Fire, monthly;
b. Tornadoes, on a monthly basis in tornado season;
c. Floods, before the flood season;
d. Earthquakes, every six months;
e. Hurricanes, annually;
f. Threatening person outside or inside the facility;
g. Rabid animal;
h. Toxic chemical spill;
i. Nuclear event.

All drills/exercises should be recorded. Please see Standard 9.4.1.16: Evacuation and Shelter-in-Place Drill Record for more information.

A fire evacuation procedure should be approved and certified in writing by a fire inspector for centers, and by a local fire department representative for large and small family child care homes, during an annual on-site visit when an evacuation drill is observed and the facility is inspected for fire safety hazards.

Depending on the type of disaster, the emergency drill may be within the existing facility such as in the case of earthquakes or tornadoes where the drill might be moving to a certain location within the building (basements, away from windows, etc.) Evacuation drills/exercises should be practiced at various times of the day, including nap time, during varied activities and from all exits. Children should be accounted for during the practice.

The facility should time evacuation procedures. They should aim to evacuate all persons in the specific number of minutes recommended by the local fire department for the fire evacuation, or recommended by emergency response personnel.

Cribs designed to be used as evacuation cribs, can be used to evacuate infants, if rolling is possible on the evacuation route(s).

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 9.4.1.2: Maintenance of Records

The facility should maintain the following records:

a. A copy of the facility's license, insurance coverage, child care regulations or registration, all inspection reports, correction plans for deficiencies, and any legal actions;
b. Physical health records for any adult who has direct contact with children;
c. Training records of the caregiver/teacher and any assistants;
d. Criminal history records and child abuse and neglect records, as required by state licensing regulations;
e. Results of well-water tests where applicable;
f. Results of lead tests;
g. Insurance records;
h. Child health records;
i. Attendance records and sign-in/sign-out records, as well as authorization for pick-up;
j. List of reportable diseases;
k. Incident reports;
l. Fire extinguisher records and smoke detector and carbon monoxide detector battery checks;
m. Evacuation, emergency, and shelter-in-place drill records;
n. Play area and equipment warranty, maintenance, and inspection records;
o. Consultation records;
p. Medication administration logs; and
q. Nutrition and food service records.

The length of time to maintain records should follow state regulation requirements. A sample of a state regulation is below.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 9.4.1.6: Availability of Documents to Parents/Guardians

In an easily available space that parents/guardians are made aware of and able to access, facilities should make available the following items:

a. The facility's license, child care regulations, or registration, which also includes information on how to file a complaint and the telephone number for filing complaints with the regulatory agency;
b. A statement informing parents/guardians about how they may obtain a copy of the licensing or registration requirements from the regulatory agency;
c. Inspection certificates;
d. Reports of any legal sanctions and documentation that all required corrections have been completed;
e. A notice that inspection reports/certificates, legal actions, and compliance letters are available for inspection in the facility;
f. Accreditation certificates;
g. Quality rating score, if applicable;
h. Evacuation route;
i. Emergency evacuation procedures, including fire evacuation and weather related evacuation procedures, to be posted in each room of the center;
j. Procedures for the reporting of child abuse and neglect consistent with state law and local law enforcement and child protective service contacts;
k. Notice announcing the "open-door policy" (parents/guardians may visit at any time and will be admitted without delay);
l. The action the facility will take to handle a visitor's request for access if the caregiver/teacher is concerned about the safety of the children;
m. A current weekly menu of any food or beverage served in the facility to the children for parents/guardians and caregivers/teachers including changes in the menus as they are served; the facility should provide copies of menus to parents/guardians, if requested, and copies of menus served should be kept on file for six months;
n. A statement of nondiscrimination for programs participating in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP) and for programs who receive Child Care

Assistance Child Care Development Block Grant (CCDBG) funds;

o. Policy manual (health and safety policies, nutrition and oral health policies, etc.);

p. A copy of the policy and procedures for discipline, including the prohibition of corporal punishment;

q. Legible safety rules for the use of swimming and built-in wading pools if the facility has such pools (safety rules should be posted conspicuously on the pool enclosure);

r. Phone numbers and instructions for contacting the fire department, police, emergency medical services, physicians, dentists, rescue and ambulance services, and the poison center, child abuse reporting hotline; the address of the facility; and directions to the facility from major routes north, south, east, and west (this information should be conspicuously posted adjacent to the telephone);

s. A list of reportable infectious diseases as required by the state and local health authorities;

t. Employee rights and safety standards as required by the Occupational Safety and Health Administration (OSHA) and/or state agencies;

u. Breastfeeding policy that includes information and guidance for mothers on how to store and transport human milk;

v. A notice of what, where and when pesticides have been applied within or around the program's property (this notice should be put up forty-eight hours in advance of any pesticide use);

w. Reports of lead concentration and water quality.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

VIII. Licensing and Community Action

STANDARD 10.3.5.1: Education, Experience and Training of Licensing Inspectors

Licensing inspectors, and others in licensing positions, should be pre-qualified by education and experience to be knowledgeable about the form of child care they are assigned to inspect. Prior to employment or within the first six months of employment, licensing inspectors should receive training in regulatory administration based on the concepts and principles found in the National Association for Regulatory Administration (NARA) Licensing Curriculum through onsite platform training or online coursework (1). In addition, they should receive no less than forty clock hours of orientation training upon employment (1). In addition, they should receive no less than twenty-four clock hours of continuing education each year (1), covering the following topics and other such topics as necessary based on competency needs:

a. The licensing statutes and rules for child care;
b. Other applicable state and federal statutes and regulations;
c. The historical, conceptual, and theoretical basis for licensing, investigation, and enforcement;
d. Technical skills related to the person's duties and responsibilities, such as investigative techniques, interviewing, rule-writing, due process, and data management;
e. Child development, early childhood education principles, child care programming, scheduling, and design of space;
f. Law enforcement and the rights of licensees;
g. Center and large or small family child care home management;
h. Child and staff health in child care;
i. Detection, prevention, and management of child abuse;
j. Practical techniques and ADA requirements for inclusion of children with special needs;
k. Exclusion/inclusion of children who are ill;
l. Health, safety, physical activity, and nutrition;
m. Recognition of hazards.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 10.5.0.1: State and Local Health Department Role

State and local health departments should play an important role in the identification, prevention and control of injuries, injury risk, and infectious disease in child care settings as well as in using the child care setting to promote health and safety. This role includes the following activities to be conducted in collaboration with the child care licensing agency:

a. Assisting in the planning of a comprehensive health and safety program for children and child care providers, including promoting and ensuring maintenance of a system of child care health consultation;
b. Monitoring the occurrence of serious injury events and outbreaks involving children or providers;
c. Alerting the responsible child care administrators about identified or potential injury hazards and infectious disease risks in the child care setting;
d. Controlling outbreaks, identifying and reporting infectious diseases in child care settings including:
    1. Methods for notifying parents/guardians, caregivers/teachers, and health care providers of the problem;
    2. Providing appropriate actions for the child care provider to take;
    3. Providing policies for exclusion or isolation of infected children;
    4. Arranging a source and method for the administration of needed medication;
    5. Providing a list of reportable diseases, including descriptions of these diseases. The list should specify where diseases are to be reported and what information is to be provided by the child care provider to the health department and to parents/guardians;
    6. Requiring that all facilities, regardless of licensure status, and all health care providers report certain infectious diseases to the responsible local or state public health authority. The child care licensing authority should require such reporting under its regulatory jurisdiction and should collaborate fully with the health department when the latter is engaged in an enforcement action with a licensed facility;
    7. Determining whether a disease represents a potential health risk to children in out-of-home child care;
    8. Conducting the epidemiological investigation necessary to initiate public health and safety interventions;
    9. Recommending a disease prevention or control strategy that is based on sound public health and clinical practices (such as the use of vaccine, immunoglobulin, or antibiotics taken to prevent an infection);
    10. Verifying reports of infectious diseases received from facilities with the assessment and diagnosis of the disease made by a health care provider and, or the local or state health department;
e. Designing systems and forms for use by facilities for the care of children who are ill to document the surveillance of cared for illnesses and problems that arise in the care of children in such child care settings;

f. Assisting in the development of orientation and annual training programs for caregivers/teachers. Such training should include specialized education for staff of facilities that include child who are ill, as well as those in special facilities that serve only children who are ill. Specialized training for staff who care for children who are ill should focus on the recognition and management of childhood illnesses, as well as the care of children with infectious diseases;

g. Assisting the licensing authority in the periodic review of facility performance related to caring for children who are ill by:
    1. Reviewing written policies developed by facilities regarding inclusion, exclusion, dismissal criteria and plans for health care, urgent and emergency care, and reporting and managing children with infectious disease;
    2. Assisting with periodic compliance reviews for those rules relating to inclusion, exclusion, dismissal, daily health care, urgent and emergency care, and reporting and management of children with infectious disease;

h. Collaborating in the planning and implementation of appropriate training and educational programs related to health and safety in child care facilities. Such training should include education of parents/guardians, primary care providers, public health and safety workers, licensing inspectors, and employers about how to prevent injury and disease as well as promote health and safety of children and their caregivers/teachers;

i. Promoting that health care personnel, such as qualified public health nurses, pediatric and family nurse practitioners, and pediatricians serve as child care health consultants;

j. Ensuring child care programs are included and represented in local and state disaster preparedness and pandemic flu planning.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 10.6.1.1: Regulatory Agency Provision of Caregiver/Teacher and Consumer Training and Support Services

The licensing agency should promote participation in a variety of caregiver/teacher and consumer training and support services as an integral component of its mission to reduce risks to children in out-of-home child care. Such training should emphasize the importance of conducting regular safety checks and providing direct supervision of children at all times. Training plans should include mechanisms for training of prospective child care staff prior to their assuming responsibility for the care of children and for ongoing/continuing education. The higher education institutions providing early education degree programs should be coordinated with training provided at the community level to encourage continuing education and availability of appropriate content in the coursework provide by these institutions of higher education.

Persons wanting to enter the child care field should be able to learn from the regulatory agency about training opportunities offered by public and private agencies. Discussions of these trainings can emphasize critical child care health and safety messages. Some training can be provided online to reinforce classroom education.

Training programs should address the following:

a. Child growth and development including social-emotional, cognitive, language, and physical development;
b. Child care programming and activities;
c. Discipline and behavior management;
d. Mandated child abuse and neglect reporting;
e. Health and safety practices including injury prevention, basic first aid and CPR, reporting, preventing and controlling infectious diseases, children's environmental health and health promotion, and reducing the risk of SIDS and use of safe sleep practices;
f. Cultural diversity;
g. Nutrition and eating habits including the importance of breastfeeding and the prevention of obesity and related chronic diseases;
h. Parent/guardian education;
i. Design, use and safe cleaning of physical space;
j. Care and education of children with special health care needs;
k. Oral health care;
l. Reporting requirements for infectious disease outbreaks;
m. Caregiver/teacher health;
n. Age-appropriate physical activity.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 10.6.1.2: Provision of Training to Facilities by Health Agencies

Public health departments, other state departments charged with professional development for out of home child care providers, and Emergency Medical Services (EMS) agencies should provide training, written information, consultation in at least the following subject areas or referral to other community resources (e.g., child care health consultants, licensing personnel, health care professionals, including school nurses) who can provide such training in:

a. Immunization;
b. Reporting, preventing, and managing of infectious diseases;

c. Techniques for the prevention and control of infectious diseases;
d. Exclusion and inclusion guidelines and care of children who are acutely ill;
e. General hygiene and sanitation;
f. Food service, nutrition, and infant and child-feeding;
g. Care of children with special health care needs (chronic illnesses, physical and developmental disabilities, and behavior problems);
h. Prevention and management of injury;
i. Managing emergencies;
j. Oral health;
k. Environmental health;
l. Health promotion, including routine health supervision and the importance of a medical or health home for children and adults;
m. Health insurance, including Medicaid and the Children's Health Insurance Program (CHIP);
n. Strategies for preparing for and responding to infectious disease outbreaks, such as a pandemic influenza;
o. Age-appropriate physical activity;
p. Sudden Infant Death Syndrome (SIDS) and Shaken Baby Syndrome/Abusive Head Trauma.

*To view the **Rationale** and **Comments** for this standard, click here.*

TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

Appendices