



# EARLY CHILDHOOD HEALTH LINK



Uniting Children, Parents, Caregivers and Health Professionals

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## Announcing...

### New National Standards for Health and Safety in Child Care

After years of review and revision, the 2nd edition of *Caring for Our Children, the National Health and Safety Performance Standards for Out of Home Child Care*, is ready for copy editing and publication. An early fall 2001 print date is expected. The most significant changes include a more user-friendly format, updated scientific rationale and references, and a few new or modified standards that are important for child care providers, state agency staff and health professionals to know about.

Many of the requirements described by the standards address the real constraints of child care operation at this time. The rationale defines the risk being avoided by the standard so that users can decide how stringently they might wish to observe or exceed the standard. The use of health consultants by every child care facility is an example of a reality-based compromise.

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## HEALTH AND SAFETY CALENDAR

Use the calendar to plan ahead.

### June

**National Dairy Month:** Read about calcium in the “Kids Need Calcium” article on page 5. For more information on dairy products, visit [www.whymilk.com](http://www.whymilk.com) For a “Get Up and Grow” growth chart and nutrition information, use the ECELS order form on page 7.

**Sun Safety:** Teach preschool children how to prevent over-exposure to sunlight and earn 2 hours of child care training credit at the same time! Use the ECELS order form on page 7 to order the Sun Safety self-learning module.

**Plan for training:** See the insert that describes the 17 self-learning modules that ECELS offers for training credit, including some that are new. Two involve valuable curriculum kits to use with the children. Also see the training request form insert that offers new health and safety workshops.

### July

**4th of July:** According to Prevent Blindness America®, sparklers are the second highest cause of fireworks injuries requiring trips to the emergency room. Post this edition’s sparkler insert. For a policy statement on “Children and Fireworks”, or the self-learning module, “Teaching Preschoolers Injury Prevention”, use the ECELS order form on page 7.

**Summer Food Safety:** Keep cold foods cold (40° Fahrenheit) and hot foods hot (140° Fahrenheit) until they are eaten. For a copy of the Centers for Disease Control’s (CDC) fact sheet “Foodborne Illnesses in the Child Care Setting,” use the ECELS order form on page 7. To access all the CDC fact sheets, visit their website at [www.cdc.gov](http://www.cdc.gov)

### August

**World Breastfeeding Week:** August 1-7, 2001. Support breastfeeding mothers with a place to feed their babies at drop-off and pick-up times, or on breaks from work. Store and feed expressed breastmilk. Check out the article on page 4 on nutrition. Use the order form on page 7 for the flier, “Good Nutrition Today for a Healthier Tomorrow.”

**Child Health Records:** Use the new DPW form (sample enclosed) and order what you need from DPW Regional offices.

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While more frequent visits to centers and family child care homes would be beneficial, the standard specifies a requirement for visits at least:

- ◆ Monthly to centers where children under two years of age are in care.
- ◆ Quarterly to centers that serve only children who are over two years of age.
- ◆ Annually to each family child care home.

¶ One change that is likely to please child care workers is that routine periodic tuberculosis screening is required as a one-time assessment by Mantoux skin-test at the time an adult enters the child care workforce, with follow-up as medically indicated. Adults who reside in family child care homes and who are considered to be at high risk for tuberculosis must have an initial Mantoux skin test also. Adults who are considered at high risk of tuberculosis include those who are foreign-born, have a history of homelessness, are HIV-infected, have contact with a prison population, or have contact with someone who has active tuberculosis. The old requirement for routine skin-testing every two years was a burden and has been found to be of little value in detecting active tuberculosis among adults who are not known to be in contact with individuals with infectious TB. This revision in the recommended use of skin-testing brings the standards in line with the CDC's most recent advisory on this matter. It will take time for state regulations to be changed to match this newly relaxed standard.



¶ Another change in the standards is dropping any mention of fever alone as reason for exclusion from child care. In an attempt to further reduce fever phobia, the standards are now very clear that behavior change in association with fever is the issue, not the fever itself. The rationale for the new standard mentions exclusion of very young infants from care for fever alone when children are under 2 months of age. (In the 1<sup>st</sup> edition, the recommendation for exclusion included babies with fever up to 4 months of age.) Fever is simply not useful as a criterion for exclusion. The issues to consider are whether the child can participate, whether the staff can accommodate the ill child without jeopardizing the care of the other children, and whether the child has a contagious condition that poses a risk to the group.



The 2<sup>nd</sup> edition of *Caring For Our Children* also features some nice format changes that make the standards easier to read and understand. Instead of the 3-column format that led to much white space, more pages and a heavy book, the standards are being printed with the text for a given standard flowing continuously in two columns. The references remain footnoted and listed at the end of each chapter since many references apply to multiple standards.

Many of the appendices have been revised or moved into the text of a standard. This streamlines the appendix section and makes the information more accessible. The "Advisory to the User" in the beginning of the standards explains clearly that the standards define acceptable desired performance, neither optimum nor minimum practice.

The staff of the National Resource Center for Health and Safety in Child Care at the University of Colorado (NRC) has carried the day-to-day burden of incorporating all the recommended changes, matching all the citations in the literature and bringing the 2<sup>nd</sup> edition from review through the copy-editing stages. They have created a summary of the significant changes in the standards to help those who were familiar with the 1<sup>st</sup> edition to focus on what is new. This summary will be published with the 2<sup>nd</sup> edition to help those who know the first edition well to focus on significant changes.

The 2<sup>nd</sup> edition of *Caring for Our Children* will be available for sale in print from the American Academy

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## PLAY AND DEVELOPMENT - Part II - Six to 12 months

(Part I appeared in the Spring 2001 edition of HEALTH LINK)

From six to twelve months of age, toys become much more goal driven. Children become fascinated by stacking nesting cups and “pop-up” toys (turn the knob, up pops a figure). Busy ball toys and simple one-piece puzzles are also good choices.

By one year of age children are on the move. Crawling and walking are the primary means of locomotion and toys that accommodate these new skills work best. Parents and caregivers should not be concerned that children in this age group do not show the same interest they once had in toys that require sitting and focusing. Children who are new to moving on their own seem to be only interested in moving and very little else. Pull toys including toy trucks and cars that can be pushed or pulled are fun for children this age. Children new to walking also like toys that support their limited standing and walking skills like toy shopping carts or the stand-behind walkers sometimes referred to as “easy walkers” or “activity walkers.” Baby doll strollers may not be good at this age because they are often very light and may not support a child.



Many young children have begun to sort before they turn one year of age. It is not uncommon for children of this age to move objects back and forth between containers. Also at this age, children take greater interest in stacking their toys to new heights. Some children will stack toys that one might not expect to be stackable. Nesting toys are designed to make the stacking of the toys easier for the child.

Another favorite toy for children at this age is an activity table. It's best to introduce an activity table around the time that a child first stands. The table will support the child's weight and will capture a child's interest because of the varied activities and bright colors.

One year of age is also a good time to introduce children to scribbling with washable crayons or markers. A grown-up should guide the child through this activity. Children should have access to scribbling at least twice a day. It will take less than a minute each time for the child to feel great satisfaction seeing the colors on the paper. Developing the skills of coloring early may have great impact on a child's ability to focus. This strengthening of a child's focus will carry over into other areas of learning.

Don't think that one special toy will hold a child's interest for hours. Young children need to switch activities frequently and will only stay on task for short periods of time. Children will stay on a task longer, however, if a grown-up sits next to the child, participates, and tells the child what is happening. Demonstrate to the child new ways to manipulate the toy without interfering with the child's opportunity to explore and experiment. Play responsively with the child, following the child's lead and interest. Of course, the fun should include giving plenty of laughs, kisses and hugs.

Chas Barrett, MEd  
ECELS Health Consultant

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of Pediatrics and the American Public Health Association. In addition, the text will be available on-line on the NRC website at <[www.nrc.uchsc.edu](http://www.nrc.uchsc.edu)> as soon as the copy editing step is completed. The on-line version is particularly useful if you are looking up a single topic such as hand washing or ill children and want to use an electronic search to pull up all the standards related to that topic. This new edition is much improved. The next step is for all of us to work together to implement the standards!

## WIC Still Works Wonders!

**The Department of Health, Division of Women, Infants and Children (WIC) has been helping families in Pennsylvania for more than 26 years.** WIC is a health and nutrition program for:

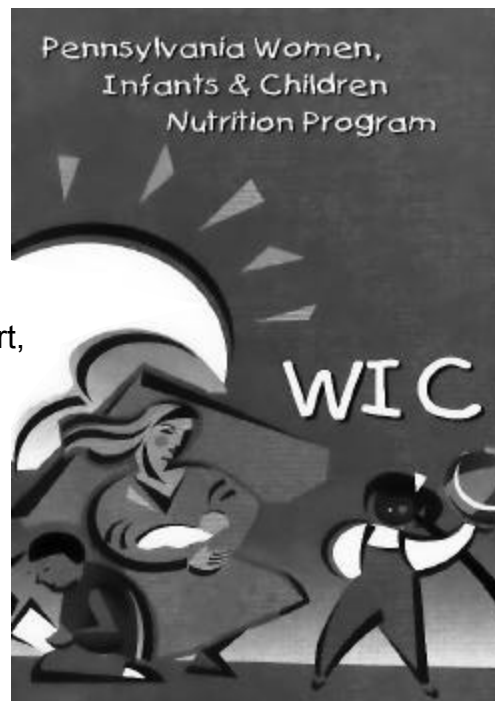
- ◆ pregnant women
- ◆ breastfeeding women up to twelve months postpartum
- ◆ non-breastfeeding women up to six months postpartum, and
- ◆ children up to five years of age who are determined by a health professional to have a medical or nutritional risk.

The Program is funded by the United States Department of Agriculture and is administered by the Pennsylvania Department of Health.

WIC provides women and children with specific foods (milk, iron-rich formula, cereal, eggs, etc.) that are needed by our participants during critical stages of growth and development in order to prevent health and nutrition problems. Other services include nutrition information, breastfeeding support, and referrals to community services.

To qualify for WIC an individual must reside in Pennsylvania; have a medical or nutritional risk (pregnancy, low blood iron, poor eating habits, etc.); and meet income guidelines (at or below 185% of the federal poverty level). Many working families qualify, and enrollment will not affect benefits received from other programs.

WIC is available in all 67 counties. Currently, there are 380 clinics where eligible women and children can receive benefits. WIC is a healthy choice mothers can make for their families now - that will last a lifetime! Encourage mothers of the children in your care to call **800/WIC-WINS** to locate the closest WIC clinic.



*In accordance with Federal law and U.S. Department of Agriculture policy, WIC is prohibited from discriminating on the basis of race, color, national origin, sex, age or disability.*

## **EyeCare America<sup>SM</sup>** **Children's Project**

Some children have serious eye disease, but show no signs of this problem. A short, simple screening in early childhood can save vision for later in life. Children should have a vision screening as part of routine health care. If the child's clinician does not do vision screening, lay vision screening is available in Pennsylvania. To find out about how to arrange for vision screenings call 800/272-EYES.

In a collaborative effort to boost vision screenings in young children, a national project called EyeCare America is being launched by the Foundation of the American Academy of Ophthalmology and the Knights Templar Eye Foundation. In addition to the Pennsylvania Academy of Ophthalmology and the Pennsylvania chapter of the American Academy of Pediatrics, EyeCare America leaders will be working with the Pennsylvania Association of the Blind, the Special Kids Network and the Philadelphia Block Captains.



EyeCare America<sup>SM</sup> Children's Project is a public service program designed to teach parents how to work with their child's pediatrician or primary care physician to seek appropriate and timely vision screening and medical care for any eye problems.

The Children's Project was piloted in Indiana in June 1998. Pennsylvania is the second state to introduce the project.

The goal of the Children's Project is to ensure infants and young children with significant eye disease are brought into the eye care delivery system at an early age. Early recognition of disease results in more effective treatment, which can be sight saving or even life saving. According to the standards of the American Academy of Pediatrics, every child in America should have an objective vision screening before four years of age.



### **Kids Need Calcium**

Sodas and juice drinks have pushed aside nutrient-rich milk for many kids, but these drinks don't provide the calcium children need for growth and development. The American Academy of Pediatrics says that adequate calcium intake during childhood is necessary for the development of healthy bones - and that the easiest way for kids to get calcium is through food such as milk and milk products.

One solution may be to offer kids chocolate milk! Did you know that chocolate milk has the same nine essential nutrients as regular milk? And that the amount of caffeine in a cup of chocolate milk is similar to the amount found in decaffeinated drinks? The American Academy of Pediatric Dentistry has even said that foods containing milk casein, calcium phosphorus and cocoa, all of which are found in chocolate milk, may be less likely to contribute to dental caries (cavities) than sugar alone or other snack foods.

For more information on calcium, chocolate milk, and dairy products, visit <[www.whymilk.com](http://www.whymilk.com)> For a fact sheet, use the ECELS order form on page 7.



**Asking about....****Pediatric Gastroesophageal Reflux**

Gastroesophageal Reflux or GER is the backflow of food, liquids, and acids from the stomach into the esophagus (tube that leads from the back of the throat to the stomach.) More often than in the past, caregivers are hearing from parents that a child has reflux. Reflux is not a new disease, but the diagnosis is more common because improved medical tests for the condition make it easier to detect. Also, more is known today about the potential consequences of untreated reflux in babies. At the lower end of the esophagus, a muscular area called the lower esophageal sphincter (LES) or cardiac sphincter functions as a valve between the esophagus and the stomach. Normally the LES opens to allow swallowing, belching and vomiting and then closes immediately. Reflux may occur because this valve relaxes when it shouldn't or closes inadequately.

**Symptoms of Pediatric GER:**

- ◆ pain, irritability, constant crying, "colic"
- ◆ frequent spitting-up or vomiting
- ◆ not outgrowing the spitting-up stage
- ◆ poor sleep habits, frequent waking
- ◆ "wet-burp" or "wet-hiccup" sounds
- ◆ "Sandifer's Syndrome", an odd arching of the neck

**Less common symptoms of pediatric GER include:**

- ◆ constant eating and drinking
- ◆ intolerance of certain foods
- ◆ poor weight gain; weight loss
- ◆ swallowing problems, gagging, choking
- ◆ hoarse voice
- ◆ excessive salivation, drooling, ear infections

**Possible complications of reflux:**

Most infants outgrow reflux between 12 to 18 months. The symptoms may be mild – just spitting up more than is typical for babies. Some of these infants have more severe symptoms that are hard on the babies and on their caregivers. The backflow of stomach acids and contents into the esophagus causes a burning sensation, commonly called "heart burn." The reddening or swelling of the esophagus that can be caused by this backflow is called esophagitis. In turn, the irritation of the esophagus can cause pain and a

lack of appetite. Poor growth due to lack of adequate nutrition may result. In severe cases, malnutrition or "failure to thrive" occurs from losing too much food, from frequent vomiting, or from lack of appetite due to pain.

Babies with reflux can also develop respiratory problems when the stomach contents enter the nose, windpipe and lungs. When stomach contents enter the lungs, this is called aspiration. Aspiration can be life-threatening if unnoticed and untreated.

**How if reflux diagnosed?**

Usually, reflux is diagnosed from the child's symptoms. If the symptoms are typical of reflux, a doctor may start treatment without further testing. If the baby responds well, tests may be unnecessary unless the doctor has a reason to believe there might be other medical conditions present.

Four tests are typically used for diagnosing GER. The first is a Barium Swallow x-ray that can show narrow areas of the esophagus and other abnormalities of the upper digestive tract. The second is a 24-hour pH-Probe Study, the most accurate way to diagnose reflux. This test monitors the acid levels in the esophagus. The third test is the Milk Scan that shows how food moves out of the stomach. Doctors use the Milk Scan when they suspect slow stomach emptying is a problem. The last test is the use of the endoscope, a tool that is a long thin tube with a tiny camera and light that the doctor inserts through the child's mouth to see inside the upper digestive tract and airway. During this procedure the doctor can watch the esophageal sphincter open and close.

**How is GER treated?**

Many treatment methods are available at this time. Remember that most children will outgrow reflux by 12 to 18 months of age. Only a few babies continue to have reflux after two years of age, but it happens occasionally.

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Simple and careful positioning during and after feedings helps many infants. Babies with reflux need to be positioned so gravity helps keep the food from coming back up. Unlike most babies who should always be put to sleep on their backs, doctors may recommend a prone (face or stomach-down), or side lying sleep position for some babies with medically significant reflux. Often the head of the bed is raised to help keep the food in the stomach. Infants should be held in an upright position while feeding and put to bed or held to avoid movement after a feeding. An active play period right after feeding increases the likelihood that the babies with reflux will bring up their food. Formula or breast milk may need to be thickened. Infants with reflux need frequent burping. As they grow older, they may need to avoid spicy, fatty and acidic foods.

Medications used to treat reflux include antacids and motility medications. Commonly, doctors try different drugs to find the best drug for each child. Not all children will react in the same way. Surgery to tighten the lower esophageal sphincter is a last resort after all other means have failed to help a child to thrive. This type of surgery is called fundoplication, and is required in only a small number of infants and children — those who are not growing normally.

Cheri Barber, BSN, RN, ECELS Health Consultant

**Editor's note: make sure all babies in your care are put to sleep on their backs UNLESS you are instructed to do otherwise by the baby's PHYSICIAN. Directions or requests from parents alone will not protect you or the baby. The physician's directions must be in writing. Use the ECELS Order Form below for a copy of the Special Care Plan.**

## ECELS ORDER FORM FOR PRINT MATERIAL

(Pennsylvania Child Care Providers & Pennsylvania Health Consultants Only)

Please use this form to order any brochure listed below. Check the box beside the items you would like and return the form to PA AAP, ECELS, Rosemont Business Campus, 919 Conestoga Road, Bldg. 2, Suite 307, Rosemont, PA 19010-1353.

### Brochures/Handouts:

One copy per organization

- "Get Up and Grow" nutrition materials
- "Children and Fireworks"
- "Good Nutrition for a Healthier Tomorrow"
- "Foodborne Illnesses in the Child Care Setting"
- Chocolate milk fact sheet
- Special Care Plan

### Highlighted ECELS' Self-Learning Modules:

- Sun Safety
  - Teaching Preschoolers Injury Prevention
  - Child Care & Children w/Special Needs
- (New:** Learn key strategies to inclusion - to earn 2 hrs. of credit, staff must view video, read print material & complete case studies. Keep video for ongoing training.)

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Area Code and Telephone #: \_\_\_\_\_

E-mail address (if you have one): \_\_\_\_\_

**Meet ECELS Staff!**

Amy Requa is a pediatric nurse practitioner who arrived at ECELS in August, 2000. Amy came to ECELS from Iowa where she was a state-wide health consultant for Iowa Head Start and Healthy Child Care Iowa. Amy is thrilled to be back in Pennsylvania where she grew up. She works closely with ECELS' staffer Heather Rivers on the "Pennsylvania Safe Child Care Project" as well as other tasks in her role as Training and Technical Assistance Coordinator.

Anita Somplasky came to ECELS with over 18 years of pediatric experience. She began her nursing career at the Children's Hospital of Philadelphia, and has worked in inpatient and outpatient pediatric units. Before joining ECELS, Anita was responsible for overseeing the quality assurance and management of Pediatric, Family Practice, Internal Medicine and Ob-Gyn practices for a health care system in Philadelphia. Anita lives in Collegetown with her husband and 3 sons.

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**Amy Requa and Anita Somplasky**

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