Child Care Center HEALTH POLICY

Child Care Center Name: Early Learning Center at Crossroads

Director: Crystal Natland

Street: 351 Pease Road

City/State/Zip: Burlington, WA 98233

Telephone: 360-757-4200

Cross Street: Walnut

Email: elcatcrossroads@gmail.com Website: www.elccrossroads.com

Emergency telephone numbers:

Fire/Police/Ambulance: **911**

C.P.S.: **1-866-409-4649**
Mt. Vernon office (360) 416-7200

Poison Center: **1-800-222-1222**

Animal Control: **360-336-6201**

Other important telephone numbers:

Public Health Nurse Consultant: Jennifer Sass-Walton phone: (360) 416-1529

Public Health Nutrition Consultant: Susan Brown phone: (360) 336-9392

DEL Licensor: Sheau-Pyng Li phone: (360) 714-4134

DEL Health Specialist: LaLaine Diaz phone: (206) 760-2027

Infant Room Nurse Consultant: Jennifer Sass-Walton phone: (360) 416-1529

Communicable Disease Report Line at Skagit County Public Health Dept.
(360) 336-9477; ask for Communicable Disease Dept.
(360) 336-9380: main number for Skagit County Public Health Dept.

Out-of-Area Emergency Contact: Terry Baus 360-652-6562

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PURPOSE AND USE OF HEALTH POLICY

This health policy is a description of **our** health and safety practices.

Our policy was prepared by Trinh Nguyen.

Staff will be oriented to our health policy by director or co-director *(who),*

At date of hire and annually at staff meeting *(when)*.

Our policy is accessible to staff and parents and is located in a binder at the director's desk and with other policies in a binder for staff to read at home *(recommended for staff: copy in each classroom).*

Please note: Changes to health policy must be approved by a health professional (as per WAC).

This health policy does not replace these additional policies required by WAC:

1. *Pesticide Policy*
2. *Bloodborne Pathogen Policy*
3. *Behavioral Policy*
4. *Disaster Policy*
5. *Animal Policy and/or Fish Policy (if applicable)*

PROCEDURES FOR INJURIES AND MEDICAL EMERGENCIES

1. Child is assessed and appropriate supplies are obtained.

2. First aid is administered. Non-porous gloves (nitrile, vinyl or latex*) are used if blood is present. If injury/medical emergency is life-threatening, one staff person stays with the injured/ill child and administers appropriate first aid, while another staff person calls 911. If only one staff member is present, person assesses for breathing and circulation, administers CPR for one minute if necessary, and then calls 911.

3. If further information is needed, staff trained in first aid refer to the first aid guide *(name of guide)* located in every first aid kit_ *(where)*.

4. Staff call parent/guardian or designated emergency contact if necessary. For major injuries/medical emergencies, a staff person stays with the injured/ill child until a parent/guardian or emergency contact arrives, including during transport to a hospital.

5. Staff record the injury/medical emergency on Child Care Injury/Incident Report *(name of report form(s) for minor &/or major injuries)*,
   which is/are kept in every classroom and at the front desk *(where)*.
   The report includes:
   - date, time, place and cause of the injury/medical emergency (if known),
   - treatment provided,
   - name(s) of staff providing treatment, and
   - persons contacted.

   A copy is given to the parent/guardian the same day and a copy is placed in the child's file. For major injuries/medical emergencies, parent/guardian signs for receipt of the report and a copy is sent to the licensor no later than the day after the incident.

6. An injury is also recorded on the Injury Log, which is located in every classroom_ *(where)*. The entry will include the child's name, staff involved, and a brief description of incident. We maintain confidentiality of this log by keeping it in the teacher's binder which is only accessible to staff.

7. The child care licensor is called immediately for serious injuries/incidents which require medical attention.

**Please note: Use of latex gloves over time may lead to latex allergy. Latex-free gloves are preferred. If using latex gloves, consider selecting reduced-powder or powder-free low-protein/hypo-allergenic gloves. Hands should always be washed after gloves are removed.*

Please see Appendix I for Injury Log template.

FIRST AID

At least one staff person with current training in Cardio-Pulmonary Resuscitation (CPR) and First Aid is present with each group or classroom **at all times**. Training includes: instruction, demonstration of skills, and test or assessment. Documentation of staff training is kept in personnel files.

Our First Aid kits are inaccessible to children and located _
1. Busy bee classroom on counter
2. Red bin in a cubby under sign in book
3. Hanging on the wall in the upstairs hallway
4. On top of the refrigerator in the kitchen

First Aid kits are identified by a first aid sign.

Our First Aid Kits contain all of the following:

- First aid guide
- Sterile gauze pads (different sizes)
- Small scissors
- Adhesive tape
- Band-Aids (different sizes)
- Roller bandages
- Large triangular bandage
- Gloves (nitrile, vinyl, or latex)
- Tweezers for surface splinters
- CPR mouth barrier

Our first aid kits do not contain medications, medicated wipes, or medical treatments/equipment which would require written parental permission or special training to administer.

A fully stocked first aid kit is taken on all field trips and playground trips and is kept in each vehicle used to transport children. These travel first aid kits **also** contain:

- Liquid soap and paper towels
- Water
- Chemical ice (non-toxic) for injuries
- Cell phone, walkie-talkies, and/or change for phone calls.

All first aid kits are checked by director, co-director, or a teacher *(assigned person)* and restocked monthly *(how often; monthly recommended)* or sooner if necessary. The expiration date for Syrup of Ipecac is also checked at this time.

Please see Appendix II for First Aid Kit checklist.

BLOOD/BODY FLUID CONTACT OR EXPOSURE

Even healthy people can spread infection through direct contact with body fluids. Body fluids include blood, urine, stool (feces), drool (saliva), vomit, drainage from sores/rashes (pus), etc. All body fluids may be infected with contagious disease. **Non-porous gloves are always used when blood or wound drainage is present.** To limit risk associated with potentially infectious blood/body fluids, the following precautions are always taken:

1. Any open cuts or sores on children or staff are kept covered.
2. Whenever a child or staff comes into contact with any body fluids, the exposed area is washed immediately with soap and warm water, rinsed, and dried with paper towels.
3. All surfaces in contact with body fluids are cleaned immediately with soap and water, rinsed, and disinfected with an agent such as bleach in the concentration used for disinfecting body fluids (1/4 cup bleach per gallon of water or 1 Tablespoon/quart).
4. Gloves and paper towels or other material used to wipe up body fluids are put in a plastic bag, tied closed, and placed in a covered waste container. Any brushes, brooms, dustpans, mops, etc. used to clean-up body fluids are washed in soap and water or detergent, rinsed, and soaked in a disinfecting solution for at least 2 minutes and air dried. Machine washable items, such as mop heads, are washed with hot water and soap in the washing machine. All items are hung off the floor or ground to dry. Equipment used for cleaning is stored safely out of children's reach in an area ventilated to the outside.
5. A child's clothes soiled with body fluids are put into a closed plastic bag and sent home with the child's parent/guardian. A change of clothing is available for children in care, as well as for staff.
6. Hands are always washed after handling soiled laundry or equipment, and after removing gloves.

Blood Contact or Exposure

When a staff person or child comes into contact with blood (e.g. staff provides first aid for a child who is bleeding) or is exposed to blood (e.g. blood from one person enters the cut or mucous membrane of another person), the staff person informs director or codirector *(assigned person)* immediately.

When staff report blood contact or exposure, we follow current guidelines set by Washington Industrial Safety and Health Act (WISHA), as outlined in our Bloodborne Pathogen Exposure Control Plan *(separate document)*. We review the BBP Exposure Control Plan annually with our staff on our inservice training day in September *(when)* and document this review.

INJURY PREVENTION

1. Proper supervision is maintained at all times, both indoors and outdoors. Staff position themselves to observe the entire play area.

2. The site is inspected daily *(how often)* for safety hazards by all staff members *(assigned person)*. Staff review their rooms daily and remove any broken or damaged equipment.

   Hazards include, but are not limited to:
   - *Security issues (unsecured doors, inadequate supervision, etc.)*
   - *General safety hazards (broken toys & equipment, standing water, chokable & sharp objects, etc.)*
   - *Strangulation hazards*
   - *Trip/fall hazards (rugs, cords, etc.)*
   - *Poisoning hazards (plants, chemicals, etc.)*
   - *Burn hazards (hot coffee in child-accessible areas, unanchored or too-hot crock pots, etc.)*
   - *Other:* ____

3. The playground is inspected daily for broken equipment, environmental hazards, garbage, animal contamination, and required depth of cushion material under and around equipment by director or codirector *(assigned person)*. It is free from entrapments, entanglements, and protrusions.

4. Toys are age appropriate, safe, and in good repair. Broken toys are discarded. Mirrors are shatterproof.

5. Rooms with children under 3 years old are free of push pins, thumbtacks, and staples.

6. Cords from window blinds/treatments are inaccessible to children.
   (Many infants and young children have died from strangling in window cords. Consider cordless window treatments, or replace or retrofit corded models. See the Window Covering Safety Council's website, www.windowcoverings.org, for more information.)

7. Hazards are reported immediately to director or codirector *(assigned person)*. The assigned person will insure that they are removed, made inaccessible or repaired immediately to prevent injury.

8. The Injury Log is monitored by director or codirector *(assigned person)* monthly *(how often)* to identify accident trends and implement a plan of correction.

We routinely get updates on recalled items and other safety hazards on the Consumer Products Safety Commission Website: www.cpsc.gov

POLICY AND PROCEDURE FOR EXCLUDING ILL CHILDREN

Children with any of the following symptoms are not permitted to remain in care:

1. **Fever** of at least 100 º F as read under arm (axillary temp.) ***accompanied by*** one or more of the following:

    - diarrhea or vomiting
    - earache
    - headache
    - signs of irritability or confusion
    - sore throat
    - rash
    - fatigue that limits participation in daily activities

No rectal or ear temperatures are taken. Digital thermometers are used.

> ***(****Oral temperatures may be taken for preschool through school age children if single use covers are used over the thermometer. Glass thermometers contain mercury, a toxic substance, and are therefore should not be used. Temperature strips should not be used because they are frequently inaccurate.)*

2. **Vomiting:** 2 or more occasions within the past 24 hours.
3. **Diarrhea:** 3 or more watery stools within the past 24 hours, or any bloody stool.
4. **Rash,** especially with fever or itching.
5. **Eye discharge or conjunctivitis (pinkeye)** until clear or until 24 hours of antibiotic treatment.
6. **Sick appearance, not feeling well, and/or not able to keep up with program activities**.
7. **Open or oozing sores**, unless properly covered **and** 24 hours has passed since starting antibiotic treatment, if antibiotic treatment is necessary.
8. **Lice or scabies:**

    Head lice: until no nits are present.

    Scabies: until after treatment is begun.

Following exclusion, children are readmitted to the program when they no longer have any of the above symptoms and/or Public Health exclusion guidelines for child care are met.

Children with any of the above symptoms/conditions are separated from the group and cared for in the lobby near the director's desk *(location)*. Parent/guardian or emergency contact is notified to pick up child.

We notify parents and guardians when their children may have been exposed to a communicable disease or condition (other than the common cold) and provide them with information about that disease or condition. We notify parents and guardians of possible exposure by verbal and/or written notice *(letter, posted notice, or other means)*. Individual child confidentiality is maintained.

In order to keep track of contagious illnesses (other than the common cold), an Illness Log is kept. Each entry includes the child's name, classroom, and type of illness. This is located in each classroom *(where)*. We maintain confidentiality of this log by keeping it in the teacher's binder which is only accessed by staff.

Please see Appendix III for Illness Log template.

Fact sheets and sample letters are available from your public health nurse consultant.

Staff members follow the same exclusion criteria as children.

COMMUNICABLE DISEASE REPORTING

Communicable diseases can spread quickly in childcare settings. Because some of these diseases can be very serious in children, licensed childcare providers in Washington are required to notify Public Health when they learn that a child has been diagnosed with one of the communicable diseases listed below (WAC 246-101-415[1]). **In addition, providers should also notify Public Health when an unusual number of children and/or staff are ill (for example, >10% of children in a center, or most of the children in the toddler room), even if the disease is not on this list or has not yet been identified.**

To report any of the following conditions, call Public Health at (360) 336-9477

Acquired immunodeficiency syndrome (AIDS)
Animal bites
Arboviral disease (for example, West Nile virus)
Botulism (foodborne, wound, or infant)
Brucellosis
Campylobacteriosis
Cholera
Cryptosporidiosis
Cyclosporiasis
Diphtheria
Diseases of suspected bioterrorism origin (including anthrax and smallpox)
Diseases of suspected foodborne origin
Diseases of suspected waterborne origin
Enterohemorrhagic *E. coli*, (including *E. coli* O157:H7 infection)
Giardiasis
Haemophilus influenzae invasive disease
Hantavirus pulmonary syndrome
Hemolytic uremic syndrome
Hepatitis A, acute
Hepatitis B, acute
Hepatitis B, chronic
Hepatitis C, acute, or chronic
Hepatitis, unspecified
HIV infection
Immunization reactions, severe
Legionellosis
Leptospirosis
Listeriosis
Malaria
Measles
Meningococcal disease
Mumps
Paralytic shellfish poisoning
Pertussis
Plague
Poliomyelitis
Psittacosis
Q fever
Rabies and Rabies Exposures
Rare diseases of public health significance
Relapsing fever
Rubella
Salmonellosis
Sexually Transmitted Diseases (chancroid, gonorrhea, syphilis, genital herpes simplex, granuloma inguinale, lymphogranuloma venerium, *Chlamydia trachomatis*)
Shigellosis
Tetanus
Trichinosis
Tuberculosis
Tularemia
Typhus
Unexplained critical illness or death
Vibriosis
Yellow fever
Yersiniosis

Even though a disease may not require a report, you are encouraged to consult with a Public Health Nurse at (360) 336-9477 for information about childhood illness or disease prevention. More information about communicable diseases can be found at http://www.metrokc.gov/health/prevcont/.

[1] **WAC 246-101-415 Responsibilities of child day care facilities.** Child day care facilities shall: (1) Notify the local health department of cases or suspected cases, or outbreaks and suspected outbreaks of notifiable conditions that may be associated with the child day care facility. (2) Consult with a health care provider or the local health department for information about the control and prevention of infectious or communicable disease, as necessary. (3) Cooperate with public health authorities in the investigation of cases and suspected cases, or outbreaks and suspected outbreaks of disease that may be associated with the child day care facility. (4) Child day care facilities shall establish and implement policies and procedures to maintain confidentiality related to medical information in their possession.

IMMUNIZATIONS

To protect all children and staff, each child in our center has a completed and signed Certificate of Immunization Status (CIS) on site. The official CIS form or a copy of both sides of that form is used. Other forms/printouts are not accepted in place of the CIS form. The CIS form is returned to parent/guardian when the child leaves the program.

Immunization records are reviewed quarterly *(how often; quarterly recommended)* by the director or codirector *(whom).*

Children are required to be immunized for the following:

DTaP (Diphtheria, Tetanus, Pertussis)

IPV (Polio)

MMR (Measles, Mumps, Rubella)

Hepatitis B

HIB (Hemophilus Influenza Type B)

Varicella (Chicken Pox)

PCV (Pneumococcal bacteria) until age 5 yrs

Children may attend child care without an immunization:

- when the parent signs the back of the CIS form stating they have personal, religious or philosophical reasons for not obtaining the immunization(s)

OR

- the health care provider signs that the child is medically exempted.

A current list of exempted children is maintained at all times.

Children who are not immunized may not be accepted for care during an outbreak of a vaccine-preventable disease. This is for the protection of the unimmunized child and to reduce the spread of the disease. This determination will be made by Public Health's Communicable Disease and Epidemiology division.

MEDICATION MANAGEMENT

□ Medication is accepted only in its **original container**, labeled with **child's name**.
□ Medication is **not** accepted if it is **expired**.
□ Medication is given **only** with prior **written** consent of a child's parent/legal guardian. This consent on the medication authorization form includes **all of the following** (completed by parent/guardian):

- child's name,
- name of the medication,
- reason for the medication,
- dosage,
- method of administration,
- frequency (**cannot** be given "as needed"; consent must specify *time* at which and/or *symptoms* for which medication should be given),
- duration (start and stop dates),
- special storage requirements,
- any possible side effects (use package insert or pharmacist's written information), *and*
- any special instructions.

Parent /Guardian Consent

1. A parent/legal guardian may provide the sole consent for a medication, (without the consent of a health care provider), **if and only if** the medication meets all of the following criteria:

   - ❑ The medication is over-the-counter and is one of the following:
     - Antihistamine
     - Non-aspirin fever reducer/pain reliever
     - Non-narcotic cough suppressant
     - Decongestant
     - Ointment or lotion intended specifically to relieve itching or dry skin
     - Diaper ointment or non-talc powder intended for use in diaper area
     - Sunscreen for children over 6 months of age; ***and***
   - ❑ The medication has instructions and dosage recommendations for the child's age and weight; *and*
   - ❑ The medication duration, dosage, amount, and frequency specified on consent do not exceed label recommendations.

2. Written consent for medications covers only the course of illness or specific episode (of teething, etc.).

3. Written consent for sunscreen is valid up to 6 months.

4. Written consent for diaper ointment is valid up to 6 months.

   Please note: As with all medications, label directions must be followed. Most diaper ointment labels indicate that rashes that are not resolved, or reoccur, within 5-7 days should be evaluated by a health care provider

Health Care Provider Consent

1. The written consent of a health care provider with prescriptive authority is required for prescription medications and all over-the-counter medications that do not meet the above criteria (including vitamins, iron, supplements, oral re-hydration solutions, fluoride, herbal remedies, and teething gels and tablets).

2. Medication is added to a child's food or liquid only with the **written consent of health care provider.**

3. A licensed health care provider's consent is accepted in one of 3 ways:

   - ❑ The provider's name is on the original pharmacist's label (along with the child's name, name of the medication, dosage, frequency [cannot be given "as needed"], duration, and expiration date); *or*
   - ❑ The provider signs a note or prescription that includes the information required on the pharmacist's label; *or*
   - ❑ The provider signs a completed Medication Authorization Form.

   Parent/guardian instructions are required to be consistent with any prescription or instructions from health care provider.

Medication Storage

1. Medication is stored: <u>in the cupboard by the director's desk</u>
   ____ *(where)*.

   It is:
   - Inaccessible to children
   - Separate from staff medication
   - Protected from sources of contamination
   - Away from heat, light, and sources of moisture
   - At temperature specified on the label (i.e., at room temperature or refrigerated)
   - So that internal (oral) and external (topical) medications are separated
   - Separate from food
   - In a sanitary and orderly manner

2. Rescue medication (e.g., EpiPen® or inhaler) is stored: <u>in the child's classroom near the teacher's desk</u>

   (Location of rescue medications should be consistent in all classrooms.)

3. Controlled substances (e.g., ADHD medication) are stored in a locked container at the director's desk *(where)*. Controlled substances are counted and tracked with the Controlled Substance Form.

   Please see Appendix IV for Controlled Substance Form.

4. Medications no longer being used are promptly returned to parents/guardians, discarded in trash inaccessible to children, or in accordance with current hazardous waste recommendations. (Medications are not disposed of in sink or toilet.)

5. Staff medication is stored at the director's desk *(where)*, out of reach of children. Staff medication is clearly labeled as such.

Emergency supply of critical medications

For children's critical medications, including those taken at home, we ask for a 3-day supply to be stored on site with our disaster supplies. Staff are also encouraged to supply the same.

Staff Administration and Documentation

1. Medication is administered by staff trained in medication administration *(whom).*

2. Staff members who administer medication to children are trained in medication procedure and center policy by director or codirector (*director or designee*). A record of the training is kept in staff files.

3. The parent/guardian of each child requiring medication involving special procedures (e.g., nebulizer, inhaler, EpiPen®) trains staff on those procedures. A record of who has been trained is maintained on/with the medication authorization form.

4. Staff giving medication document the time, date, and dosage of the medication given on the child's Medication Authorization Form. Each staff member signs her/his initials each time a medication is given and her/his full signature once at the bottom of the page.

5. Any observed side effects are documented by staff on the child's medication authorization form and reported to parent/guardian. Notification is documented.

6. If a medication is not given, a written explanation is provided on authorization form.

7. Outdated Medication Authorization Forms are promptly removed from medication binder/clipboard and placed in child's file.

8. All information related to medication authorization and documentation is considered confidential and is stored out of general view.

Medication Administration Procedure

The following procedure is followed each time a medication is administered:

1. **Wash hands** before preparing medications.

2. Carefully read labels on medications, noting:
   - child's name,
   - name of the medication,
   - reason for the medication,
   - dosage,
   - method of administration,
   - frequency,
   - duration (start and stop dates),
   - any possible side effects (from experience, package insert, or pharmacist's written information), *and*
   - any special instructions

   Information on the label must be consistent with the individual medication form.

3. Prepare medication on a clean surface away from diapering or toileting areas.

   - Do not add medication to child's bottle/cup or food without health care provider's written consent.

   - For *liquid* medications, use clean medication spoons, syringes, droppers, or medicine cups with measurements provided by the parent/guardian (not table service spoons).

   - For *capsules/pills*, measure medication into a paper.

   - For *bulk medication, dispense in a sanitary manner.**

4. Administer medication.

5. **Wash hands** after administering medication.

6. Observe the child for side effects of medication and document on the child's Medication Authorization Form.

*We □X do not use *bulk medication*.
We □use the following *bulk medication*:
□ diaper ointment
□ sunscreen.

Medication authorization forms are maintained for each child receiving bulk medication.

Self-Administration by Child

A school-aged child is allowed to administer his/her own medication when the above requirements are met ***and***:

1. A written statement from the child's health care provider *and* parent/legal guardian is obtained, indicating the child is capable of self-medication without assistance.

2. The child's medications and supplies are inaccessible to other children.

3. Staff supervise and document each self-administration.

HEALTH RECORDS

Each child's health record will contain:

- health, developmental, nutrition, and dental histories
- date of last physical exam
- name and phone number of health care provider and dentist
- allergy information and food intolerances
- individualized care plan for child with special health care needs (medical, physical, developmental or behavioral)

  Note: In order to provide consistent, appropriate, and safe care, a copy of the plan should also available in child's classroom.

- list of current medications
- current immunization records (CIS form)
- consent for emergency care
- preferred hospital
- any assistive devices used (e.g., glasses, hearing aids, braces)

The above information will be updated annually *(how often; annually recommended)* or sooner for any changes.

CHILDREN WITH SPECIAL NEEDS

Our center is committed to meeting the needs of all children. This includes children with special health care needs such as asthma and allergies, as well as children with emotional or behavior issues or chronic illness and disability. Inclusion of children with special needs enriches the child care experience and all staff, families, and children benefit.

1. Confidentiality is assured with all families and staff in our program.

2. All families will be treated with dignity and with respect for their individual needs and/or differences.

3. Children with special needs will be accepted into our program under the guidelines of the Americans with Disabilities Act (ADA).

4. Children with special needs will be given the opportunity to participate in the program to the fullest extent possible. To accomplish this, we may consult with our public health nurse consultant and other agencies/organizations as needed.

5. An individual plan of care is developed for each child with a special health care need. The plan of care includes information and instructions for

   - daily care
   - potential emergency situations
   - care during and after a disaster

   Completed plans are requested from health care provider <u>annually_</u> *(how often; every 6 months – 1 year max. recommended)* or more often as needed for changes. Plans are reviewed, initialed, and dated <u>annually</u> *(how often; monthly recommended)* by parent/guardian. <u>Director</u> *(who)* is responsible for ensuring care plans are kept updated. Children with special needs are not present without plan on site.

6. All staff receive general training on working with children with special needs and updated training on specific special needs that are encountered in their classrooms.

7. Teachers, cooks, and other staff will be oriented to any special needs or diet restrictions by <u>_director or codirector</u> *(whom).*

   Please see Appendix V for Individual Plan tracking form. For individual plan templates or assistance with individual plans, please contact your Public Health Nurse Consultant.

HANDWASHING

Soap, warm water (between 85° and 120° F)**, and individual towels are available for staff and children at all sinks, at all times.**

All **staff** wash hands with soap and water:

(a) Upon arrival at the site and when leaving at the end of the day

(b) Before and after handling foods, cooking activities, eating or serving food

(c) After toileting self or children

(d) Before, during (with wet wipe - this step only), and after diaper changing

(e) After handling or coming in contact with body fluids such as mucus, blood, saliva, or urine

(f) Before and after giving medication

(g) After attending to an ill child

(h) After smoking

(i) After being outdoors

(j) After feeding, cleaning, or touching pets/animals

(k) After giving first aid

Children are assisted or supervised in handwashing:

(a) Upon arrival at the site and when leaving at the end of the day

(b) Before and after meals and snacks or cooking activities (in handwashing, not in food prep sink)

(c) After toileting or diapering

(d) After handling or coming in contact with body fluids such as mucus, blood, saliva or urine

(e) After outdoor play

(f) After touching animals

(g) Before and after water table play

Handwashing Procedure

The following handwashing procedure is followed:

1. Turn on water and adjust temperature.
2. Wet hands and apply a liberal amount of soap.
3. Rub hands in a wringing motion from wrists to fingertips for a period of not less than 10 seconds.
4. Rinse hands thoroughly.
5. Dry hands, using an individual paper towel.
6. Use hand-drying towel to turn off water faucet(s) and open any door knob/latch before discarding.
7. Apply lotion, if desired, to protect the integrity of skin.

Handwashing procedures are posted at each sink used for handwashing.

CLEANING, SANITIZING/DISINFECTING, AND LAUNDERING

Cleaning, rinsing, and sanitizing/disinfecting are required on most surfaces in child care facilities, including tables, counters, toys, diaper changing areas, etc. This 3-step method helps maintain a more sanitary child care environment and healthier children and staff.

1. ***Cleaning*** *removes a large portion of germs, along with organic materials - food, saliva, dirt, etc. – which decrease the effectiveness of sanitizers/disinfectants.*
2. ***Rinsing*** *further removes the above, along with any excess soap.*
3. ***Sanitizing/disinfecting*** *kills the vast majority of remaining germs.*

Storage

Our cleaning and sanitizing/disinfecting supplies are stored in a safe manner
In the staff bathroom *(where).*
All such chemicals are:

- inaccessible to children,
- in their original container,
- separate from food and food areas,
- in a place which is ventilated to the outside,
- kept apart from other incompatible chemicals
  (e.g., bleach and ammonia create a toxic gas when mixed), ***and***
- in a secured cabinet, to avoid a potential chemical spill in an earthquake

Cleaning

We use the following product for cleaning surfaces liquid dish detergent in a spray bottle of water
(recommended: a few drops of liquid dish detergent added to spray bottle of water), then wipe surface with a *paper towel (paper towel or single-use cloth).*

Rinsing

We use the following method for rinsing spray bottle of clear water and paper towel
(recommended: spray bottle of clear water, sprayed and wiped with paper towel or single-use cloth).

Sanitizing/Disinfecting

We use the following product for sanitizing/disinfecting surfaces sanitizer – Dish San, disinfectant - Oxivir
(recommended: bleach and water solution), then wipe surface with a *paper towel (paper towel or single-use cloth).*

Bleach solutions* are prepared and used as outlined below:

Body fluids (BF) solution for disinfecting:	**Amount of Bleach**	**Amount of Water**	**Contact Time**
Diapering areas, body fluids, bathrooms and bathroom equipment.	1 tablespoon ¼ cup	1 quart 1 gallon	2 minutes
General purpose (GP) solution for sanitizing:	**Amount of Bleach**	**Amount of Water**	**Contact Time**
Table tops, counters, toys, dishes, mats, etc.	¼ teaspoon 1 teaspoon	1 quart 1 gallon	2 minutes

- Bleach solution is applied to surfaces that have been cleaned and sanitized.
- Bleach solution is allowed to remain on surface for at least 2 minutes or air dry.
- Bleach solutions are made up daily by n/a (whom), using measuring equipment. For those handling full-strength bleach, we supply protective gear, including gloves and eye protection, as per manufacturer's instructions.

** Please see Appendix VI if other chemicals are used for cleaning/sanitizing/disinfecting.*

Cleaning and Sanitizing/Disinfecting Specific Areas and Items

□X We do all of our own cleaning.

□ We have a janitorial service for cleaning the following: ________________________
____
____.

["*BF*" and "*GP*" indicate which bleach solution is used.]

Bathrooms

- Sinks and counters are cleaned, rinsed, and sanitized *(BF)* daily or more often if necessary.
- Toilets are cleaned, rinsed, and disinfected *(BF)* daily or more often if necessary. Toilet seats are monitored and kept sanitary throughout the day.

Cribs, cots, and mats

- Cribs, cots, and mats are washed, rinsed, and sanitized *(GP)* weekly, before use by a different child, after a child has been ill, **and** as needed.

Door handles

- Door handles are cleaned, rinsed, and sanitized *(GP)* daily, or more often when children or staff members are ill.

Drinking Fountains

- Any drinking fountains are cleaned, rinsed, and sanitized *(GP)* daily or as needed.

Floors

- Solid-surface floors are swept, washed, rinsed, and sanitized *(GP)* daily. While children are napping on mats or cots, mopping is done with water or soap and water only.
- Carpets and rugs in all areas are vacuumed daily and professionally steam-cleaned every 3 months (every 1 month in infant room) or as necessary. Carpets are not vacuumed when children are present *(due to noise and dust)*.

Furniture

- Upholstered furniture is vacuumed daily. Removable cushions and covers are washed every month or as necessary. Non-removable upholstery is professionally steam-cleaned every six months or as necessary.
- Painted furniture is kept free of paint chips. No bare wood is exposed; paint is touched up as necessary. *(Bare wood cannot be adequately cleaned and sanitized.)*

Garbage

- Garbage cans are lined with disposable bags and are emptied when full.
- Diaper cans are additionally emptied when odor is present in classroom.
- Outside surfaces of garbage cans are cleaned, rinsed, and sanitized daily. Inside surfaces of garbage cans are cleaned, rinsed, and sanitized as needed.

  (*Diaper and food-waste cans must have tight-fitting lids and be hands-free. Garbage cans for paper towels must be hands-free; that is, lid-free or with a pedal-operated lid.)*

Infant equipment

- Infant saucers, seats, and swings are cleaned and sanitized *(GP)* and laundered (as appropriate) weekly and as needed.

Kitchen*

- Kitchen counters and sinks are cleaned, rinsed, and sanitized *(GP)* every day before and after preparing food.
- Equipment (such as blenders, can openers, and cutting boards) is washed, rinsed, and sanitized *(GP)* after each use.

  **For more details, please see the handbook "Food Safety and Sanitation" from the Child Care Health Program, Public Health - Seattle & King County.*

Laundry

- Cloths used for cleaning or rinsing are laundered after each use.
- Bibs and burp cloths are laundered when wet or soiled and between uses by different children.

□X Child care laundry is done on site.
Laundry is washed at a temperature of at least 140ºF or with bleach added during rinse cycle (measured amount as per manufacturer's instructions).
□ Child care laundry is done by a commercial service.
□ Child care laundry is done at a laundromat.

Mops

- Mops are cleaned, rinsed, and sanitized *(GP/BF)* in a utility sink, then air dried in an area with ventilation to the outside and inaccessible to children.

Tables and high chairs

- Tables and high chair trays are cleaned, rinsed, and sanitized *(GP)* before and after snacks or meals.
- High chairs are cleaned, rinsed, and sanitized *(GP)* daily and as necessary.

Toys

- **Only washable toys are used.**
- Mouthed toys are placed in a plastic "mouthed toy" container after use by each child. Mouthed toys are then cleaned, rinsed, and sanitized *(GP)* before use by a different child. Toys are washed, rinsed, and sanitized either in a full wash and dry cycle in the dishwasher or by the use of buckets, sinks, or spray bottles containing soap and water, rinse water, and bleach solution.
- Cloth toys and dress-up clothes are washed weekly (or as necessary) with 140ºF water. Dress-up clothes are laundered and stored during an outbreak of lice or scabies.
- Other toys are washed, rinsed, and sanitized *(GP)* weekly (or more often, as necessary) as described above for "mouthed toys."

Water Tables

- Water tables are emptied and cleaned, rinsed, and sanitized *(GP)* after each use, or more often as necessary.
- Children wash hands before and after water table play.

Other: ____ __________
____.

General cleaning of the entire facility is done as needed.

There are no strong odors of cleaning products in our facility.

Air fresheners and room deodorizers are not used.

SOCIAL-EMOTIONAL-DEVELOPMENTAL CARE

We have a developmentally-appropriate curriculum in each classroom. We consider the social-emotional needs of each age group. Our behavioral plan outlines our discipline practices and our plan for helping children who have behavioral difficulties.

INFANT CARE

Program and Environment

1. Infants are at least one month of age when enrolled.
2. The infant room is street-shoe-free to reduce infant exposure to dirt, germs, dangerous heavy metals, chemicals, and pesticides. All staff and other adults entering the room wear socks, slippers, inside-only shoes, or shoe covers over their street shoes.
3. The infant room has areas where all infants can be safely placed on the floor at any given time. *(Mats are recommended because they are easy to clean and disinfect when soiled. Blankets may be placed on the floor if they are used only for that purpose and are changed when soiled with vomit or other body fluids.)*
4. All infants spend time on the floor – including on their "tummies" – each day. *(Floor time – especially tummy time – encourages brain and muscle development.)*
5. Infants do not spend more than 20 minutes per day in swings, infant seats or saucers. Saucers are used only with infants who are developmentally ready and are adjusted so that infant's feet are in contact with the bottom surface of the equipment at all times.
6. A nurse consultant visits the infant room monthly. The nurse consultant is a Registered Nurse, currently licensed, with training and/or experience in Pediatric Nursing or Public Health.

Sleep/Napping

1. Each infant is allowed to follow his/her individual sleep pattern. Infant providers look for and respond to cues as to when an infant is sleepy.
2. Infants are visible to providers at all times while asleep. Rooms are kept light enough to allow easy observation of sleeping infants.
3. Infants are placed to sleep on their backs in a crib or on a cot or mat. *(Infants sleeping on their stomachs are at a higher risk of death from S.I.D.S. - Sudden Infant Death Syndrome.)*

4. Cribs meet current safety requirements, including:
   - Cribs are sturdy and in good repair (with no sharp edges, points, unsealed rough surfaces, splinters, peeling paint, cracks, or missing/broken parts).
   - Sides and end panels are constructed with vertical slats that are no more than 2 3/8 inches apart or solid Plexiglas.
   - Mattresses are firm, snug fitting, intact, and waterproof.

5. Crib sheets fit mattresses snugly, but do not cause mattresses to curl up at corners.

6. Cribs do not contain bumper pads, pillows, soft toys, cushions or thick blankets. If a blanket is used on a sleeping infant, it is:
   - a thin, “receiving”-type blanket,
   - placed no higher than infant’s chest, and
   - tucked in at sides and bottom of mattress.

   (Overheating during sleep is associated with an increased risk of SIDS – Sudden Infant Death Syndrome.)

7. Infants do not sleep in car seats, swings or infant seats. Any child who arrives at the center asleep in a car seat, or who falls asleep in a swing or infant seat, is immediately moved to a crib, cot, or mat. *(Sleeping in infant seats or swings makes it harder for infants to breathe fully and may lead to head and neck issues.)*

8. Any alternate sleep position must be specified in writing by the parent/guardian ***and*** the child’s health care provider.

9. Cribs are spaced at least 30 inches apart or separated by Plexiglas barrier.

10. Cribs are not located directly under windows unless windows are constructed of safety glass or Plexiglas, or have an applied polymer safety coating.

11. Nothing is stored above cribs unless securely attached to wall.

Evacuation Cribs

1. Evacuation cribs are available for all infants (max. 4 infants per crib).

2. Evacuation cribs have:

   - wheels - *preferably 4 inches or larger* - capable of crossing terrain on evacuation route
   - a reinforced bottom

3. A clear pathway is kept between evacuation cribs and emergency exits at all times.

4. Nothing is stored below or around evacuation cribs that would block immediate exit of cribs.

INFANT BOTTLE FEEDING

Bottle/Food Preparation Area

1. Before preparing bottles or food, staff wash hands in the handwashing sink. **The food preparation sink and area are not used for handwashing or general cleaning.**

2. A minimum of eight feet is maintained between the food preparation area and the diapering area. *(If this is not possible, a moisture-proof, transparent 24-inch barrier of ¼ inch Plexiglas or safety glass must be installed.)*

3. Preparation surfaces are cleaned, rinsed, and sanitized before bottles or food is prepared.

4. Bottles are prepared with cold water from the following clean source: pitcher of water brought from the kitchen daily.

   (Hot water can be contaminated with lead. Only cold water should be taken from the tap for cooking or drinking. Water for bottles should not be taken from a handwashing sink.)

5. Bottles are mixed or prepared as needed and capped if not immediately used.

6. We do **not** use microwave ovens to warm formula, breastmilk or baby food.

   □ We use a crock pot for warming infant bottles and food, and

   - Water temperature in crock pot is monitored and kept below 120°F.
   - Crock pot **contains no more than 1 1/2 inches** of water *(Crock pots pose a risk of scalding).*
   - Crock pot is secured to the counter or wall.
   - Crock pot is cleaned, rinsed, and sanitized daily.

   (Consider replacing crock pot with a bottle warmer or heat bottles by placing in warm water.)

   □X We use the following method for warming infant bottles and food: bottle warmer____.

7. Bottles are warmed no longer than 5 minutes.

8. Used bottles and dishes are not stored within eight feet of the diapering area or placed in the diapering sink.

9. All unused bottles and non-frozen breastmilk are returned to parent/guardian at the end of each day.

Bottle Labeling and Cleaning

1. Staff wash hands at the handwashing sink before handling bottles.

2. All bottles are labeled with the child's full name and date prepared.

3. □X Bottles are not washed and re-used at our center. Families provide a sufficient number of bottles to meet the daily needs of the infant.

   □ We re-use bottles during the day (or from day to day without sending them home).

   - Between uses, bottles are washed, rinsed, and sanitized, or placed in a dishwasher with a sanitizing cycle. Used bottles are not cleaned in a food sink, but are placed directly in the dishwasher or in a tub to be cleaned in the kitchen.

   - Nipples needing to be re-used are washed, rinsed and boiled for 1 minute, then allowed to air dry, or placed in a dishwasher with a sanitizing cycle.

4. All bottle nipples are covered at all times, except during feeding, to reduce the risk of contamination and exposure.

Refrigeration

1. Filled bottles are capped and refrigerated immediately upon arrival at the center or after mixing, unless being fed to an infant immediately.

2. Bottles that babies have drunk from are **not** placed back in the refrigerator or re-warmed. *(Bacteria from baby's mouth are introduced into milk and begin to multiply once bottles are taken from the refrigerator and warmed.)*

3. Bottles are stored in the coldest part of the refrigerator, not in the refrigerator door.

4. A thermometer is kept in the warmest part of the refrigerator (usually the door) and is at or below 41° F at all times. *(It is recommended that the refrigerator be adjusted between 30° and 35° to allow for a slight rise when opening and closing the door.)*

5. Frozen breastmilk is stored at 10° F or less and for no longer than 2 weeks.

Feeding Practice

1. Infants are fed on demand by a caregiver who holds and makes eye contact with the infant during feeding, and talks to and touches the infant in a nurturing way.

2. Bottles are labeled with time feeding begins. Unconsumed portions are discarded after 1 hour to prevent bacterial growth.

3. Infants are held when fed with a bottle. Bottles are not propped. **Infants are not allowed to walk around with food, bottles or cups.**

4. Infants are not given a bottle while lying down or in a crib. *(Lying down with a bottle puts a baby at risk for baby bottle tooth decay, ear infections, and choking.)*

5. Staff watch for and respond appropriately to cues such as:

   - Hunger Cues - fussiness/crying, opening mouth as if searching for a bottle/breast, hands to mouth and turning to caregiver, hands clenched

   - Fullness Cues - falling asleep, decreased sucking, arms and hands relaxed, pulling or pushing away.

6. Cups of water, formula or breastmilk are introduced around 6 months of age.

7. Infants and young children are closely supervised when eating.

Contents of Bottle

1. Infants are fed breastmilk or iron-fortified infant formula until they are one year of age.

2. Written permission from the child's licensed health care provider is required if an infant is to be fed an electrolyte solution *(e.g., Pedialyte®)* or a special diet formula.

3. No medication, cereal, supplements, or sweeteners are added to breastmilk or formula without written permission from the child's licensed health care provider.

4. Bottles contain formula or breastmilk. Juice, if offered, is served only in a cup.

Formula

1. Formula is not used past printed expiration date.

2. Formula is mixed **as directed on the can** with cold water from a clean water source. Water from the handwashing sink is **not** used for bottle preparation.

Breastmilk

1. Frozen breastmilk is stored at 10° F or less and for **no longer than 2 weeks**. Containers of breastmilk are labeled with the child's full name and date.

2. Frozen breastmilk is thawed in the refrigerator or in warm water (water under 120° F) and then warmed as needed before feeding. Thawed breastmilk is not refrozen.

3. Unused, thawed breastmilk is returned to the family at the end of the day.

INFANT AND TODDLER SOLID FOODS

1. When parents provide food from home, it is labeled with the child's name and the date. Perishable foods are stored at or below 41° F.

2. Food is introduced to infants when they are developmentally ready for pureed, semi-solid and solid foods. Food, other than formula or breastmilk, is not given to infants younger than 4 months of age, unless there is a written order by a health care provider.

3. No egg whites *(allergy risk)* or honey *(botulism risk)* is given to children less than 12 months of age. (This includes other foods containing these ingredients such as honey grahams.)

4. Children 12-23 months are given whole milk, unless the child's parent/guardian ***and*** health care provider have requested low-fat milk or a non-dairy milk substitute in writing. *(Low-fat diets for children under age 2 may affect brain development.)*

5. Chopped, soft table foods are encouraged after 10 months of age.

6. Cups and spoons are encouraged by 9 months of age.

7. Staff serve commercially packaged baby food from a dish, not from the container. Foods from opened containers are discarded or sent home at the end of the day.

8. Children eat from plates and utensils. Food is not placed directly on table.

For allergies or special diets, see the Nutrition section of this policy.

TODDLER NAPPING

Children 29 months of age or younger follow their individual sleep patterns. Alternate quiet activities are provided for a child who is not napping (while others are doing so).

Rooms are kept light enough to allow for easy observation of sleeping children.

DIAPERING

We use □ cloth diapers □X disposable diapers at our center.

Children are **never** left unattended on the diaper-changing table. Safety belts are not used on the diaper changing table. *(They are neither washable nor safe.)*

The diaper changing table is used only for diapering. Toys, pacifiers, papers, dishes, blankets, etc., are not placed on diapering surface.

Diaper changing pads are replaced when they become torn/ripped. No tape is present on diaper changing pad.

The following diapering procedure (also available on WA Department of Health poster) is posted and followed at our center:

1. Wash Hands.
2. Gather necessary materials. If using bulk diaper ointment, put a dab of ointment on paper towel.
3. Put on disposable gloves, if desired.
4. Place child gently on table and remove diaper. *Do not leave child unattended.*
5. Dispose of diaper in hands-free container with cover *(foot pedal type).*
6. Clean the child's diaper (peri-anal) area from front to back, using a clean, damp wipe for each stroke.
7. If a signed medication authorization indicates, apply topical cream/ointment/lotion. (Please refer to the Medication section.)
8. Wash hands. If wearing gloves, remove gloves and wash hands. Please note: A wet wipe or damp paper towel may be used for this handwashing only. *Do not leave child unattended.*
9. Put on clean diaper (and protective cover, if cloth diaper used). Dress child.

10. **Wash child's hands** with soap and running water **(**or with a wet wipe for young infants).

11. Place child in a safe place.

12. Clean diaper changing pad with soap and water, rinse, and then disinfect with bleach solution (1 tablespoon bleach in 1 quart water). Allow the bleach solution to air dry or to remain on the surface for at least 2 minutes before drying with a paper towel.

13. **Wash Hands.**

Please note: Even if gloves are used, all of the above handwashing must still be done.

Stand-Up Diapering for Older Children

When developmentally appropriate, diapers are changed standing up.

Stand-up diapering changing takes place: bathroom attached to the classroom (location; *recommended: bathroom floor).*

Diaper changing procedure is posted in stand-up diaper changing area. Stand-up diaper changing procedure is followed:

1. Wash hands.
2. Gather necessary materials (diaper/pull-up, wipes, cleaner and sanitizer, gloves, plastic bag).
3. Put on disposable gloves, if desired.
4. Have child pull down pants and remove soiled diaper/pull-up (with adult help as needed).
5. Dispose of soiled diaper in sealed plastic bag and then into covered foot pedal container lined with a plastic garbage bag.
6. Clean the child's diaper area (peri-anal) front to back using a clean, damp wipe for each stroke. (If developmentally appropriate encourage child to clean him/herself.)
7. Remove gloves, if worn, and wash hands (adult and child).
8. If a signed medication authorization indicates, apply topical cream/ointment/lotion using disposable gloves. (Remove gloves.)
9. Put on clean diaper/pull-up and clothing and have child step away from immediate area.
10. Clean floor (where diaper was changed) with soap and water, rinse, and then disinfect with bleach solution (1 tablespoon bleach in 1 quart water). Allow the bleach solution to air dry or to remain on the surface for at least 2 minutes before drying with a paper towel.
11. Wash hands.

FOOD SERVICE

□X We prepare meals and snacks at our center.

□ We prepare only snacks at our center.

1. **Food handler permits** are required for staff who prepare full meals and are encouraged for all staff. An "in charge" person with a food handler permit is onsite during all hours of operation, to assure that all food safety steps are followed.

2. **Orientation and training** in safe food handling is given to all staff. Documentation is posted in the binder of staff requirements (where; in the kitchen area and/or in staff files).

3. **Ill staff or children** do not prepare or handle food.

   Food workers may not work with food if they have:

   - diarrhea, vomiting or jaundice
   - diagnosed infections that can be spread through food such as Salmonella, Shigella, E. coli or hepatitis A
   - infected, uncovered wounds
   - continual sneezing, coughing or runny nose

4. **Child care cooks** do not change diapers or clean toilets**.**

5. **Staff wash hands** with soap and warm running water prior to food preparation and service in a designated hand-washing sink – never in a food preparation sink.

6. **Refrigerators and freezers** have thermometers placed in the warmest section (usually the door). Thermometers stay at or below 41º F in the refrigerator and 10°F in the freezer.

7. **Microwave ovens,** if used to reheat food, are used with special care. Food is heated to 165 degrees, stirred during heating, and allowed to cool at least 2 minutes before serving. *Due to the additional staff time required, and potential for burns from "hot spots," use of microwave ovens is not recommended.*

8. **Chemicals** and cleaning supplies are stored away from food and food preparation areas.

9. **Cleaning and sanitizing** of the kitchen is done according to the Cleaning, Disinfecting and Laundering section of this policy.

10. **Dishwashing** complies with safety practices:

    - Hand dishwashing is done with three sinks or wash basins (wash, rinse, sanitize).

    - Dishwashers have a high temperature sanitizing rinse (140º F residential or 160ºF commercial) or chemical disinfectant.

11. **Cutting boards** are washed, rinsed, and sanitized between each use. No wooden cutting boards are used.

12. **Food prep sink** is not used for general purposes or post-toilet/post-diapering handwashing.

13. **Kitchen counters, sinks, and faucets** are washed, rinsed, and sanitized before food production.

14. **Tabletops** where children eat are washed, rinsed, and sanitized before and after every meal and snack.

15. **Thawing frozen food:** frozen food is thawed in the refrigerator 1-2 days before the food is on the menu, or under cold running water. *Food may be thawed during the cooking process IF the item weighs less than 3 pounds. If cooking frozen foods, plan for the extra time needed to cook the food to the proper temperature. Microwave ovens cannot be used for cooking meats, but may be used to cook vegetables.*

16. **Food is cooked to the correct internal temperature:**

    Ground Beef 155º F

    Fish 145º F

    Pork 145º F

    Poultry 165º F

17. **Holding hot food:** hot food is held at a temperature of 140° F or above until served.

18. **Holding cold food:** food requiring refrigeration is held at a temperature of 41°F or less.

19. **A digital thermometer** is used to test the temperature of foods as indicated above, and to ensure foods are served to children at a safe temperature.

20. **Cooling foods** is done by one of the following methods:

    - Shallow Pan Method: Place food in shallow containers (metal pans are best) 2" deep or less, on the top shelf of the refrigerator. Leave uncovered and then either put the pan into the refrigerator immediately or into an ice bath or freezer (stirring occasionally).

- Size Reduction Method: Cut cooked meat into pieces no more than 4 inches thick.

Foods are covered once they have cooled to a temperature of 41° F or less.

21. **Leftover foods** *(foods that have been held lower than 41° F or above 140° F and have not been served*) are cooled, covered, dated, and stored in the refrigerator or freezer. Leftover food is refrigerated immediately and is not allowed to cool on the counter.

22. **Reheating foods:** foods to be reheated are heated to at least 165⁰ F in 30 minutes or less.

23. □**X** We do not use catered foods at our center.

    □ We use **catered foods** at our center, and

    - The temperature of catered food provided by a caterer or satellite kitchen is checked with a digital thermometer upon arrival. *Foods that need to be kept cool must arrive at a temperature less than or at 41⁰ F. Foods that need to be kept hot must arrive at a temperature of 140⁰ F or more.* **Foods that do not meet these criteria are deemed unsafe and are returned to the caterer.**

    - Documentation of daily temperatures of food is kept ______________________________ *(where)*. The initials or name of the person accepting the food are recorded __________________________ *(where)*.

    - A permanent copy of the menu (including any changes made or food returned) is kept for at least 6 months ____________________________ *(where)*.

    - A copy of the caterer's contract or operating permit is kept ____________________________________ *(where)*.

    Be sure to keep "back up" food available to serve, should the food arrive out of the proper temperature range. Good items to have on hand include tuna fish and baked beans.

24. **Food substitutions**, due to allergies or special diets and authorized by a licensed health care provider, are provided within reason by the center.

25. When children are involved in cooking projects our center assures safety by:

    - closely supervising children,

    - ensuring all children and staff involved wash hands thoroughly,

    - planning developmentally-appropriate cooking activities *(e.g., no sharp knives),*

- following all food safety guidelines.

26. Perishable items in sack lunches are refrigerated upon arrival at the center.

NUTRITION

1. Menus are posted at least one week in advance. Menus are dated and include portion sizes.

2. Food is offered at intervals not less than 2 hours and not more than 3 ½ hours apart.

3. □ Our site is open 9 hours or less; we provide
   - □ two snacks and one meal
   - □ one snack and two meals

   □X Our site is open over 9 hours; we provide
   - □X two snacks and two meals
   - □ three snacks and one meal

The following meals and snacks are served by the center:

Time	Meal/Snack
8:30	breakfast
10:00	am snack
12:00	lunch
3:00	pm snack

4. Each snack or meal includes a liquid to drink. This drink is water or one of the required components such as milk or 100% fruit juice.

5. Menus include hot and cold food and vary in colors, flavors and textures.

6. Ethnic and cultural foods are incorporated into the menu.

7. Menus list specific types of meats, fruits, vegetables, etc.

8. Menus include a variety of fruits, vegetables, and entrée items.

9. Foods served are generally moderate in fat, sugar, and salt content.

10. Children have free access to drinking water (individual disposable cups or single use glasses only).

11. Menu modifications are planned and written for children needing special diets.

12. Menus are followed. Necessary substitutions are noted on the permanent menu copy.

13. Permanent menu copies are kept on file for at least six months. *(USDA requires food menus to be kept for 3 years plus the current year.)*

14. Children with food allergies and medically-required special diets have diet prescriptions signed by a health care provider on file. Names of children and their specific food allergies are posted in the kitchen, the child's classroom, and the area where food is eaten by the child.

15. Children with severe and/or life threatening food allergies have a completed individual care plan signed by the parent and health care provider.

16. Diet modifications for food allergies, religious and/or cultural beliefs are accommodated and posted in the kitchen and classroom and eating area. All food substitutions are of equal nutrient value and are recorded on the menu or on an attached sheet of paper.

17. Mealtime and snack environments are developmentally appropriate and support children's development of positive eating and nutritional habits. We encourage staff to sit, eat and have casual conversations with children during mealtimes.

18. Coffee, tea, and other hot beverages are not consumed by staff while children are in their care, in order to prevent scalding injuries.

19. Staff do not consume pop and other non-nutritional beverages while children are in their care in order to provide healthy nutritional role modeling.

20. Families who provide sack lunches are notified in writing of the food requirements for mealtime.

TOOTHBRUSHING

Toothbrushing decreases the colonization of bacteria on teeth by disrupting the formation of plaque. The use of fluoridated toothpaste changes the environment of the mouth, making it more resistant to bacteria growth. Toothbrushing in the classroom improves the child's oral health, teaches the child basic hygiene and health promotion, and helps establish a lifelong prevention habit.

□X Toothbrushing is not done at our center.
□ Toothbrushing is done in the following rooms in our center:
____
____.

As recommended, **fluoridated toothpaste is not used by children under 2 years old** or who are unable to spit out toothpaste after brushing.

Toothbrushing is supervised to ensure:

- a routine which enhances learning
- proper toothpaste usage
- good toothbrushing technique
- toothbrushes are not shared and are handled properly
- children do not walk with toothbrushes in their mouths.

Toothbrushes:

- Each child has his/her own toothbrush with his/her name clearly marked on the handle with marker. No sharing or borrowing is allowed.
- Small toothbrushes with soft, rounded nylon bristles that are short and even are used.
- Toothbrushes are replaced every 3 months or sooner if the bristles become splayed or the toothbrush is contaminated.
- Toothbrushes are provided by ________________________________ *(whom)*.
- Toothbrushes are not disinfected or put in the dishwasher.
- Toothbrushes are stored to decrease cross-contamination:
  - open to air with the bristles up
  - unable to drip on one another
  - not in contact with each other or any other thing

We use the following procedure for toothbrushing at our center:

□ Toothbrushing at a Table (recommended)

- Teacher(s) assisting with toothbrushing wash hands.
- As children finish eating, they are given a small paper cup with a small amount of water in the bottom and their toothbrush.

- Teacher dispenses toothpaste in a manner which eliminates cross-contamination: ____
  (e.g., via pea-sized dots of toothpaste around the rim of a paper plate or top of cup).
- Child begins brushing on the biting surface, and then moves from area to area (left-to-right and top-to-bottom) around the mouth.
- Brushing continues for at least one minute. (Exposure to fluoridated toothpaste is beneficial even with unsatisfactory brushing technique).
- Child takes small sip of water and then spits water and toothpaste residue back into paper cup.
- If desired, child may then be given a cleansing drink of water from another cup.
- Child holds the toothbrush over the designated rinse container and the teacher pours water from a clean water source over the toothbrush to rinse it.
- The child hands the toothbrush to the teacher, who replaces it in the drying rack.
- Child throws the paper cup away.
- Table is cleaned with the 3-step process (clean, rinse, sanitize).

□ Toothbrushing at a Classroom Sink:

- Teacher(s) assisting with toothbrushing wash hands.
- Sink and faucet are cleaned, rinsed, and sanitized.
- Water from a clean water source is obtained.
- Teacher hands each child a small cup of water and his/her toothbrush.
- Teacher dispenses toothpaste in a manner which eliminates cross-contamination: ____
  (e.g., via pea-sized dots of toothpaste around the rim of a paper plate or at top of cup).
- Child begins brushing on the biting surface, and then moves from area to area (left-to-right and top-to-bottom) around the mouth.
- Brushing continues for at least one minute. (Exposure to fluoridated toothpaste is beneficial even with unsatisfactory brushing technique).
- When brushing is completed, child spits excess toothpaste into sink and rinses his/her mouth with a drink from the cup of water.
- Child holds the toothbrush over the sink and the teacher pours water from a clean water source over the toothbrush to rinse it.
- If desired, child may then use their paper cup and be given a cleansing drink of water from a clean water source.
- The child hands the toothbrush to the teacher, who replaces it in the drying rack.
- Child throws the paper cup away.
- Classroom handwashing sink is cleaned with 3-step process after all the children are finished.

(Teachers may want to brush their own teeth to model the desired behavior.)

DISASTER PREPAREDNESS

Plan and Training

Our Center has developed a disaster preparedness plan/policy. Our plan includes responses to the different disasters our site is vulnerable to, as well as procedures for on- and off-site evacuation and shelter-in-place. Evacuation routes are posted in each classroom. Our disaster preparedness plan/policy is located at the director's desk *(where).*

Staff are oriented to our disaster policy at the date of hire and annually at a staff meeting *(when/how often; at least annually)*. Parents/guardians are oriented to this plan at enrollment___________________________ *(when/how).*

Staff are trained in the use of fire extinguishers at the date of hire *(when, by whom)*. The following staff persons are trained in utility control (how to turn off gas, electric, water): director and codirector.

Disaster and earthquake preparation and training are documented.

Supplies

Our center has a supply of food and water for children and staff for at least 72 hours, in case parents/guardians are unable to pick up children at usual time. Director and codirector is responsible for stocking supplies. Expiration dates of food, water, and supplies are checked monthly *(how often)* and supplies are rotated accordingly. Essential medications and medical supplies are also kept on hand for individuals needing them.

Hazard Mitigation

We have taken action to make our center earthquake/disaster-safe. Bookshelves, tall furniture, refrigerators, crock pots, and other potential hazards are secured to wall studs. We continuously monitor all rooms and offices for anything that could fall and hurt someone or block an exit – and take action to correct these things. _Director is the primary person responsible for hazard mitigation, although all staff members are expected to be aware of their environment and make changes as necessary to increase safety.

Drills

Fire drills are conducted and documented each month. Disaster drills are conducted _quarterly_ *(how often; quarterly at a minimum – monthly recommended).*

Please see Appendix VII for 3-Day Emergency Medication form and Appendix VIII for Disaster Drill form. For more detailed information on disaster preparation, please contact your Public Health Nurse Consultant.

STAFF HEALTH

1. New staff and volunteers must document a tuberculin skin test (Mantoux method) within the past year, unless not recommended by a licensed health care provider.

2. Staff members who have had a positive tuberculin skin test in the past will always have a positive skin test, despite having undergone treatment. These employees do not need documentation of a skin test. Instead, by the first day of employment, documentation must be on record that the employee has had a negative (normal) chest x-ray and/or completion of treatment.

3. Staff members do not need to be retested for tuberculosis unless they have an exposure. If a staff member converts from a negative test to a positive test during employment, medical follow up will be required and a letter from the health care provider must be on record that indicates the employee has been treated or is undergoing treatment.

4. Our center complies with all recommendations from the local health jurisdiction. (TB is a reportable disease.).

5. Staff members who have a communicable disease are expected to remain at home until no longer contagious. Staff are required to follow the same guidelines outlined in EXCLUSION OF ILL CHILDREN in this policy.

6. Staff members are encouraged to consult with their health care provider regarding their susceptibility to vaccine-preventable diseases.

7. Staff who are pregnant or considering pregnancy should inform their health care provider that they work with young children. When working in child care settings there is a risk of acquiring infections which can harm a fetus. These infections include Chicken Pox (Varicella), CMV (cytomegalovirus), Fifth Disease (Erythema Infectiosum), and Rubella (German measles or 3-day measles).

8. Recommendations for adult immunizations are available at: *http://www.doh.wa.gov/cfh/Immunize/adult_immunization.htm*

CHILD ABUSE AND NEGLECT

1. Child care providers are state mandated reporters of child abuse and neglect; we immediately report suspected or witnessed child abuse or neglect to Child Protective Services (CPS). The phone # for CPS is 1-800-609-8764.

2. Signs of child abuse or neglect are documented on _a form in the child's file_ *(name of report form),* which is located at the director's desk *(where).*

3. Training on identifying and reporting child abuse and neglect is provided to all staff and documentation kept in staff files.

4. Licensor is notified of any CPS report made.

ANIMALS ON SITE

□X We have no animals on site or animal visitors at any time.

□ We have animals on site

□ We have animal visitors: □ regularly □occasionally

1. We have an animal policy, which is located ________________________________.

2. Animals at or visiting our center are carefully chosen in regards to care, temperament, health risks, and appropriateness for young children. We do not have birds of the parrot family that may carry psittacosis, a respiratory illness. We do not have reptiles and amphibians that typically carry salmonella, bacteria that can cause serious diarrhea disease in humans, with more severe illness and complications in children.

3. Parents are notified in writing when animals will be on the premises. Children with an allergic response to animals are accommodated.

4. Animals, their cages, and any other animal equipment are never allowed in kitchen or food preparation areas.

5. Children and adults wash hands after feeding animals or touching/handling animals or animal homes or equipment.

INJURY LOG

Date & Time	Child's First & Last Name	Injury	Where/ Equipment Involved	Action Taken	Staff Involved

March 2007
Adapted from Public Health Seattle-King County Child Care Health Program

First Aid Kit Checklist

	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
First Aid Guide													
Band-Aids (different sizes)													
Tweezers for surface splinters													
Sterile gauze pads (2, 3, and 4 inch sizes)													
Roller bandages													
Large triangular bandage													
Adhesive tape													
Small scissors													
Gloves (Nitrile or latex, non-powdered)													
CPR mouth barrier													
Ipecac Syrup (2 unexpired bottles per center or family home)													

March 2007
Adapted from Public Health Seattle-King County Child Care Health Program

Illness Log

Date & Time Identified	Check Appropriate Box		Child's First & Last Name	Symptoms of Illness or Diagnosis, if known	**Action Taken** Persons notified Child sent home? Parent/guardian notification posted?	Staff Involved
	Child at home	Child at center				

March 2007
Adapted from Public Health Seattle-King County Child Care Health Program

Controlled Substances in Child Care Centers

Child Care Center Name____
Child's Name:_________________________________ Diagnosis: ______________________________________
Medication: __________________________________ Date Received: ______________________________
Amount Received: ____________________________ Refrigeration Required: □ Yes □ No
Start Date: __________________________________ Stop Date : _____________________________________
Amount Returned to Parent/Guardian: ___________ Date Returned: ____________

DATE	TIME	STARTING AMOUNT/ QUANTITY	AMOUNT/QUANTITY GIVEN	SIGNATURE 1	SIGNATURE 2

Signature______________________________________ Print Name__________________________________
Signature______________________________________ Print Name__________________________________
Signature_______________________ _______________ Print Name__________________________________

March 2007
Adapted from Public Health Seattle-King County Child Care Health Program

Individual Plans of Care

Child’s Name	Health or Other Concern	Date Care Plan Completed	Date Care Plan Updated			

March 2007
Adapted from Public Health Seattle-King County Child Care Health Program

Alternate Cleaning/Sanitizing/Disinfecting Chemicals

The nationwide standard for sanitizing in child care is a bleach and water solution. All chemicals/cleaning and sanitizing products other than soap and bleach must be approved by the Department of Early Learning for use in child care. Products must be used according to label instructions. (Complete the following for each product used.)

- Product name: ____.
- Product is used to □clean □sanitize the following:
  ____
  ____.
- Product is labeled for use on food contact surfaces (if used in kitchens or food preparation areas, on tables or high chair trays, for infant and toddler toys, or in infant and toddler areas).
- The contact time required for sanitizing/disinfecting is ____________________.
  (Product must remain wet on surface for this amount of time.)
- Rinsing after use ______ *(is/is not)* required.
- Other manufacturer instructions:
  ____
  ____
  ____
  ____.

This Product was approved by ___________________________________ from the Department of Early Learning on _____________________.

March 2007
Adapted from Public Health Seattle-King County Child Care Health Program

3 –DAY EMERGENCY MEDICATION AUTHORIZATION FORM

(These medications are to be used only in case of disaster requiring the child to remain at care past the usual hours)

Child's Name	**Date of Birth/Age:**
Name of Medication:	**Reason for Medication:**
Start Date:	**Stop Date:**
☐ **Scheduled Times to be given:**	**Amount to be given:**
☐**Medication is to be given as needed for the following symptoms:**	
Possible Side Effects:	☐**Oral** ☐**Topical** ☐**Other**
☐ **Above information consistent with label?**	**Requires Refrigeration:** ☐ **yes** ☐ **no**
Special Instructions:	

Parent /Guardian Signature **Date**

Daytime Phone Number

Physician Signature (required) **Date**

Physician Phone Number

March 2007
Adapted from Public Health Seattle-King County Child Care Health Program

Child Care Disaster Drill Record

Date of Drill: ________________________________ **Name of Child Care** ___________________________________

Brief Description of Drill

Rooms Participating in Drill

Objectives	Evaluation	Changes to be Made	When Changes Made

Name of Person Organizing Drill ____

March 2007
Adapted from Public Health Seattle-King County Child Care Health Program