REDUCING THE RISK OF SUDDEN INFANT DEATH SYNDROME (SIDS)

Applicable Standards from:

CARING FOR OUR CHILDREN

National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care

Second Edition

A Joint Collaborative Project of

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INTRODUCTION

Caring for Our Children: National Health and Safety Performance Standards for Out-of–Home Child Care Programs, 2nd Edition (*CFOC, 2nd Ed.*)was released by the American Academy of Pediatrics (AAP), American Public Health Association (APHA), the Maternal and Child Health Bureau (MCHB), and the National Resource Center for Health and Safety in Child Care (NRC) in January 2002. The full edition of *CFOC, 2nd Ed.* contains 707 standards and recommendations on all aspects regarding the health and safety of children in child care settings. These standards were developed by leading health and safety experts over a period of four years. Each standard includes rationale behind the need for such practices. The full edition is available on the NRC web site at http://nrc.uchsc.edu/CFOC/index.html. Print copies can be purchased from the American Academy of Pediatrics (www.aap.org)and the American Public Health Association (www.apha.org).

In an effort to make select subject areas more accessible to intended users, the National Resource Center for Health and Safety in Child Care (NRC) is developing smaller documents on specific subject areas. This document is a compilation of the standards on reducing the risk of Sudden Infant Death Syndrome (SIDS) in child care settings.

Sudden Infant Death Syndrome (SIDS) is the sudden death of an infant under 1 year of age, which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history (1).

In 1992 the American Academy of Pediatrics (AAP) issued a statement advising side/back sleep positions for infants in order to reduce the risk of SIDS. (In 1996 the AAP revised this recommendation saying that placement on the back is the preferred sleeping position for all healthy infants.) 1992 was also the year the first edition of *Caring for our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs* was released by a partnership consisting of AAP, APHA, and MCHB. Because the publication of *Caring for Our Children* came before the AAP statement on sleep position was issued, the first edition of *Caring for Our Children* did not contain standards on SIDS. In 1994 the National Institute for Child Health and Human Development in partnership with MCHB, AAP, SIDS Alliance and the Association of SIDS Program Professionals launched the Back to Sleep Campaign recommending placing infants on their backs to sleep in order to reduce the risk of SIDS. The campaign has enlisted many partners all working to assure the widest possible outreach with information and education to hospitals, health care providers, parents, grand parents and communities. Since the Back to Sleep Campaign was launched, the rate of SIDS has dropped from over 5,000 to under 3,000 infant deaths per year.

Child care providers touch the lives of young children and their families in many important ways and need to be included in special efforts to extend the reach of the Back to Sleep Campaign. Launched in June 2002, the Healthy Child Care America's Back to Sleep Campaign represents one such special effort. The goal of Healthy Child Care America's Back to Sleep Campaign is to prevent SIDS in child care settings. The initiative works to achieve this goal

by educating child care providers, parents and policy makers on risk reduction practices for SIDS and supporting States in their efforts to include safe sleep practices in their child care licensing regulations. This compilation of 10 standards on SIDS from the 2nd Edition of *Caring for Our Children* supports the Healthy Child Care America's Back to Sleep Campaign objective to educate child care providers, parents and policy makers on risk reduction practices for the prevention of SIDS.
Throughout this document there will be references to other standards contained in the full edition of *Caring for Our Children, 2nd Ed.* For example, in Standard 5.146 regarding soft bedding, the rationale refers to Standard 5.145 (which is in the full edition) for more information on appropriate cribs. In the web version, the user can click on the link to this standard to get to the full edition.

The intended audiences for this document are:

- child care providers who can implement these cost free strategies and reduce the number of SIDS related deaths in child care
- state regulators and policy makers who can promote the adoption of risk reduction methods into their state licensing standards
- health consultants and trainers who can promote and teach these strategies to child care providers
- parents who can demand the use of these strategies in their child's child care setting

We would like to give special thanks to Phyllis Stubbs-Wynn, MD, MPH, for her leadership in the development of the Healthy Child Care America's Back to Sleep Campaign. Thanks also goes to Andrea Furia, BA, BS, Kathleen Fernbach, BSN, RN, PHN, and George Askew, MD, FAAP, for reviewing this compilation of SIDS risk reduction standards. We would also like to thank all those individuals who contributed to *CFOC, 2nd Ed.* A listing can be viewed at: http://nrc.uchsc.edu/CFOC/PDFVersion/Acknowledgments.pdf

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

American Academy of Pediatrics
http://www.aap.org

American Public Health Association
http://www.apha.org

Association of SIDS and Infant Mortality Programs
http://www.asip1.org/

Consumer Product Safety Commission
http://www.cpsc.gov

National Institute of Child Health and Human Development
http://www.nichd.nih.gov/sids/

National SIDS Resource Center
http://www.sidscenter.org/

SIDS Alliance
http://www.sidsalliance.org/

For questions or assistance on these standards or *Caring for Our Children, 2nd Edition*, please contact:

National Resource Center for Health and Safety in Child Care
1-800-598-5437
http://nrc.uchsc.edu
natl.child.res.ctr@UCHSC.edu

(1)Willinger M, James LS, Catz C. Defining the sudden infant death syndrome (SIDS): deliberations of an expert panel convened by the National Institute of Child Health and Human Development. Pediatr Pathol. 1991;11:677-684

CAREGIVER QUALIFICATIONS

STANDARD 1.010
ADDITIONAL QUALIFICATIONS FOR CAREGIVERS SERVING CHILDREN BIRTH TO 35 MONTHS OF AGE

Caregivers shall be prepared to work with infants and toddlers and, when asked, shall be knowledgeable and demonstrate competency in tasks associated with caring for infants and toddlers:

a) Diapering;
b) Bathing;
c) Feeding;
d) Holding;
e) Comforting;
f) Putting babies down to sleep positioned on their backs and on a firm surface to reduce the risk of Sudden Infant Death Syndrome (SIDS);
g) Providing responsive and continuous interpersonal relationships and opportunities for child-initiated activities.

To help manage atypical or disruptive behaviors of children, caregivers, in collaboration with parents, shall seek professional consultation from the child's source of routine health care or a mental health professional.

RATIONALE: The brain development of infants is particularly sensitive to the quality and consistency of interpersonal relationships. Much of the stimulation for brain development comes from the responsive interactions of caregivers and children during daily routines. Children need to be allowed to pursue their interests and encouraged to reach for new skills (2).

COMMENTS: For additional qualifications and responsibilities of teachers for centers and homes serving children from birth to 35 months, see also General Qualifications for All Caregivers, STANDARD 1.007 through STANDARD 1.010; and Training, STANDARD 1.023 through STANDARD 1.036.

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

STANDARD 1.021
QUALIFICATIONS FOR HEALTH ADVOCATES

Each facility shall designate a person as health advocate to be responsible for policies and day-to-day issues related to health, development, and safety of individual children, children as a group, staff, and parents. The health advocate shall be the primary parent contact for health concerns, including health-related parent/staff observations, health-related information, and the provision of resources. The health advocate shall also identify children who have no regular source of health care and refer them to a health care provider who offers competent routine child health services.

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

The health advocate shall have documented training in the following topics that include:

a) Sudden Infant Death Syndrome (SIDS), for facilities caring for infants;
b) Control of infectious diseases, including Standard/Universal Precautions;
c) How to recognize and handle an emergency;
d) Recognition and handling of seizures;
e) Recognition of safety, hazards, and injury prevention interventions;
f) How to help parents, caregivers, and children cope with death, severe injury, and natural or man-made catastrophes;
g) Recognition of child abuse and neglect and knowledge of when to contact a consultant;
h) Organization and implementation of a plan to meet the emergency needs of children with special health needs.

RATIONALE: The effectiveness of an intentionally designated health advocate in improving the quality of performance in a facility has been demonstrated in all types of early childhood settings (4). A designated caregiver with health training is effective in developing an ongoing relationship with the parents and a personal interest in the child (1, 5). Caregivers who are better trained are more able to prevent, recognize, and correct health and safety problems. An internal

advocate for issues related to health and safety can help integrate these concerns with other factors involved in formulating facility plans.

COMMENTS: The director should assign the health advocate role to a staff member who seems to have an interest, aptitude and training in this area. This person need not perform all the health and safety tasks in the facility but should serve as the person who raises health and safety concerns. This staff person has designated responsibility for seeing that plans are implemented to ensure a safe and healthful facility (4).

A health advocate is a regular member of the staff of a center or large or small family child care home network, and is not the same as the health consultant recommended in Health Consultants, STANDARD 1.040 through STANDARD 1.044. For small family child care homes, the health advocate will usually be the caregiver. If the health advocate is not the child's caregiver, the health advocate should work with the child's caregiver. The person who is most familiar with the child and the child's family will recognize atypical behavior in the child and support effective communication with parents.

A plan for personal contact with parents should be developed, even though this contact will not be possible daily. A plan for personal contact and documentation of a designated caregiver as health advocate will ensure specific attempts to have the health advocate communicate directly with caregivers and families on health-related matters.

For additional qualifications and responsibilities of health advocates, see Training, STANDARD 1.023 through STANDARD 1.036; and Direct Care and Provisional Staff, STANDARD 1.009 through STANDARD 1.013.

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

CAREGIVER TRAINING

STANDARD 1.023 INITIAL ORIENTATION OF ALL STAFF

All new full-time and part-time staff shall be oriented to, and demonstrate knowledge of, the items listed below. The director of any center or large family child care home shall provide this training to all newly hired caregivers before they begin to care for children. For centers, the director shall document, for each new staff member, the topics covered and the dates of orientation training. Staff members shall not be expected to take responsibility for any aspect of care for which their orientation and training have not prepared them.

Small family child care home providers shall avail themselves of orientation training offered by the licensing agency, a resource and referral agency, or other such agency. This training shall include evaluation that involves demonstration of the knowledge and skills covered in the training lesson.

The orientation shall address, at a minimum:

a) Regulatory requirements;
b) The goals and philosophy of the facility;
c) The names and ages of the children for whom the caregiver will be responsible, and their specific developmental needs;
d) Any special adaptation(s) of the facility required for a child with special needs for whom the staff member might be responsible at any time;
e) Any special health or nutrition need(s) of the children assigned to the caregiver;
f) The planned program of activities at the facility. See Program of Developmental Activities, STANDARD 2.001 through STANDARD 2.027;
g) Routines and transitions;
h) Acceptable methods of discipline. See Discipline, STANDARD 2.039 through STANDARD 2.043; and Discipline Policy, STANDARD 8.008 through STANDARD 8.010;
i) Policies and practices of the facility about relating to parents. See Parent Relationships,

STANDARD 2.044 through STANDARD 2.057;

j) Meal patterns and food handling policies and practices of the facility. See Plans and Policies for Food Handling, Feeding, and Nutrition, STANDARD 8.035 and STANDARD 8.036; Food Service Records, STANDARD 8.074; Nutrition and Food Service, STANDARD 4.001 through STANDARD 4.070;

k) Occupational health hazards for caregivers, including attention to the physical health and emotional demands of the job and special considerations for pregnant caregivers. See Occupational Hazards, STANDARD 1.048; and *Major Occupational Health Hazards*, Appendix B;

l) Emergency health and safety procedures. See Plan for Urgent Medical Care or Threatening Incidents, STANDARD 8.022 and STANDARD 8.023; and Emergency Procedures, STANDARD 3.048 through STANDARD 3.052;

m) General health and safety policies and procedures, including but not limited to the following:
   1) Handwashing techniques and indications for handwashing. See Handwashing, STANDARD 3.020 through STANDARD 3.024;
   2) Diapering technique and toilet use, if care is provided to children in diapers and/or children needing help with toilet use, including appropriate diaper disposal and diaper-changing techniques. See Toilet, Diapering, and Bath Areas, STANDARD 5.116 through STANDARD 5.125; Toilet Use, Diapering, and Toilet Learning/ Training, STANDARD 3.012 through STANDARD 3.019; Toilet Learning/ Training Equipment, Toilets, and Bathrooms, STANDARD 3.029 through STANDARD 3.033;
   3) Identifying hazards and injury prevention;
   4) Correct food preparation, serving, and storage techniques if employee prepares food. See Food Safety, STANDARD 4.042 through STANDARD 4.060;
   5) Knowledge of when to exclude children due to illness and the means of illness transmission;
   6) Formula preparation, if formula is handled. See Plans and Policies for Food Handling, Feeding, and Nutrition, STANDARD 8.035 and STANDARD 8.036; and Nutrition for Infants, STANDARD 4.011 through STANDARD 4.021;
   7) Standard precautions and other measures to prevent exposure to blood and other body fluids, as well as program policies and procedures in the event of exposure to blood/body fluid. See Prevention of Exposure to Body Fluids, STANDARD 3.026;

n) Recognizing symptoms of illness. See Daily Health Assessment, STANDARD 3.001 and STANDARD 3.002;

o) Teaching health promotion concepts to children and parents as part of the daily care provided to children. See Health Education for Children, STANDARD 2.060 through STANDARD 2.063;

p) Child abuse detection, prevention, and reporting. See Child Abuse and Neglect, STANDARD 3.053 through STANDARD 3.059;

q) Medication administration policies and practices;

r) Putting infants down to sleep positioned on their backs and on a firm surface to reduce the risk of Sudden Infant Death Syndrome (SIDS).

Caregivers shall also receive continuing education each year, as specified in Continuing Education, STANDARD 1.029 through STANDARD 1.036.

RATIONALE: Upon employment, staff members should be able to perform basic sanitizing and emergency procedures. Orientation ensures that all staff members receive specific and basic training for the work they will be doing and become acquainted with their new responsibilities. Orientation programs for new employees should be specific to an individual facility since facilities and the children enrolled vary(7).

Because of frequent staff turnover, directors are obligated to institute orientation programs that protect the health and safety of children and new staff members.

Orientation and ongoing training are especially important for aides and assistant teachers, for whom preservice educational requirements are limited. Entry into the field at the level of aide or assistant teacher

should be attractive and easy for members of the families and cultural groups of the children in care to enter the field. Training ensures that staff members are challenged and stimulated, have access to current knowledge, and have access to education that will qualify them for new roles. Offering a career ladder will attract individuals into the child care field, where labor is in short supply. Ongoing training in one role can become preservice training to qualify for another role.

Health training for child care staff not only protects the children in care, infectious disease control in child care helps to prevent spread of infectious disease in the community. Young children in child care have been shown to be associated with community outbreaks.

COMMENTS: Many states have preservice education and experience qualifications for caregivers by role and function. States are including ongoing health training in their licensing requirements; the broader skills have proved important and necessary to teachers in part-day and full-day programs alike. Both full-day and part-day programs require competence in all facets of child development, not just the learning components.

Child care staff members are important figures in the lives of the young children in their care and in the wellbeing of families and the community. In the future, all training for child care staff should include more attention to health issues.

Training in conflict resolution is encouraged. Child abuse includes also children's abuse of their peers. Staff should learn how to handle conflict resolution among the children and among themselves, as well as modeling examples of conflict resolution from which children can learn.

Colleges and accrediting bodies should examine teacher preparation guidelines and substantially increase the health content of early childhood professional preparation.

For definitions of Standard precautions, Transmission-based precautions, Universal precautions, see Glossary.

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

STANDARD 1.030 CONTINUING EDUCATION FOR SMALL FAMILY CHILD CARE HOME PROVIDERS

Small family child care home providers shall have at least 24 clock hours of continuing education in areas determined by self-assessment and, where possible, by a performance review of a skilled mentor or peer reviewer.

RATIONALE: In addition to low child:staff ratio, group size, age mix of children, and stability of caregiver, the training/education of caregivers is a specific indicator of child care quality (3). Most skilled roles require training related to the functions and responsibilities the role requires. Caregivers who are better trained are better able to prevent, recognize, and correct health and safety problems.

Because of the nature of their caregiving tasks, caregivers must attain multifaceted knowledge and skills. Child health and employee health are integral to any education/training curriculum and program management plan. Planning and evaluation of training should be based on performance of the child care provider. Too often, caregivers make training choices based on what they like to learn about (their "wants") and not the areas in which their performance should be improved (their "needs").

Small family child care home providers often work alone and are solely responsible for the health and safety of small numbers of children in care. Peer review is part of the process for accreditation of family child care. Self-evaluation may not identify training needs or focus on areas in which the caregiver is particularly interested and may be skilled already.

COMMENTS: The content of continuing education for small family child care home providers may include the following topics:
a) Child growth and development;
b) Infant care;
c) Recognizing and managing minor illness;
d) Managing the care of children who require the special procedures listed in Standard 3.063;
e) Business aspects of the small family child care home;
f) Planning developmentally appropriate activities in mixed age groupings;
g) Nutrition for children in the context of preparing nutritious meals for the family;
h) Acceptable methods of discipline;
i) Organizing the home for child care;
j) Preventing unintentional injuries in the home;
k) Available community services;
l) Detecting, preventing, and reporting child abuse;
m) Advocacy skills;
n) Pediatric first aid, including management of a blocked airway and rescue breathing. See STANDARD 1.026 and STANDARD 1.027;
o) CPR (if the caregiver takes care of children with special needs or has a swimming/wading pool). See STANDARD 1.028;
p) Methods of effective communication with children and parents;
q) Mental health;
r) Evacuation drill procedures, as specified in Evacuation Plan, Drills, and Closings, STANDARD 8.024 through 8.027;
s) Occupational health hazards. See Occupational Hazards, STANDARD 1.048; and *Major Occupational Health Hazards*, Appendix B;
t) Death, dying, and the grief cycle;
u) **SIDS risk-reduction practices.**

In-home training alternatives to group training for small family child care home providers are available, such as distance courses on the Internet, listening to audiotapes or viewing videotapes with self-checklists. These training alternatives provide more flexibility for providers who are remote from central training locations or have difficulty arranging coverage for their child care duties to attend training. Nevertheless, gathering family child care home providers for training when possible provides a break from the isolation of their work and promotes networking and support. Satellite training via down links at local extension service sites, high schools, and community colleges scheduled at convenient evening or weekend times is another way to mix quality training with local availability and some networking.

TYPE OF FACILITY: *Small Family Child Care Home*

1.5 SUBSTITUTES

STANDARD 1.038 ORIENTATION OF SUBSTITUTES FOR CENTERS AND LARGE FAMILY CHILD CARE HOMES

The director of any center or large family child care home shall provide orientation training to newly hired substitutes. This training shall include the opportunity for an evaluation and a repeat demonstration of the training lesson. In centers, this orientation training shall be documented. All substitutes shall be oriented to, and demonstrate competence in, the tasks for which they will be responsible. All substitute caregivers, during the first week of employment, shall be oriented to, and shall demonstrate competence in at least the following items:
a) The names of the children for whom the caregiver will be responsible, and their specific developmental needs;
b) Any special health or nutrition need(s) of the children assigned to the caregiver;
c) The planned program of activities at the facility. See Program of Activities, STANDARD 8.042 and STANDARD 8.043; and Program of Developmental Activities, STANDARD 2.001 through STANDARD 2.027;
d) Routines and transitions;
e) Acceptable methods of discipline. See Discipline, STANDARD 2.039 through STANDARD 2.043;
f) Meal patterns and food handling policies of the facility. See Plans and Policies for Food Handling, Feeding, and Nutrition, STANDARD 8.035 and STANDARD 8.036, Food Service Records, STANDARD 8.074, and Nutrition and Food Service, STANDARD 4.001 through STANDARD 4.070;
g) Emergency health and safety procedures. See Plan for Urgent Medical Care or Threatening

Incidents, STANDARD 8.022 and STANDARD 8.023; and Emergency Procedures, STANDARD 3.048 through STANDARD 3.052;

h) General health policies and procedures as appropriate for the ages of the children cared for, including but not limited to the following:
   1) Handwashing techniques, including indications for handwashing. See Handwashing, STANDARD 3.020 through STANDARD 3.023;
   2) Diapering technique, if care is provided to children in diapers, including appropriate diaper disposal and diaper changing techniques. See Toilet, Diapering, and Bath Areas, STANDARD 5.116 through STANDARD 5.125; Toileting, Diapering, and Toilet Learning/Training, STANDARD 3.012 through STANDARD 3.019; Sanitation, Disinfection, and Maintenance of Toilet Learning/Training Equipment, Toilets, and Bathrooms, STANDARD 3.029 through STANDARD 3.033;
   3) **The practice of putting infants down to sleep positioned on their backs and on a firm surface to reduce the risk of Sudden Infant Death Syndrome, as well as general nap time routines for all ages. See STANDARD 3.008 and STANDARD 5.144 through STANDARD 5.146;**
   4) Correct food preparation and storage techniques, if employee prepares food. See Plans and Policies for Food Handling, Feeding, and Nutrition, STANDARD 8.035 and STANDARD 8.036 and Food Safety, STANDARD 4.050 through STANDARD 4.059;
   5) Formula preparation if formula is handled. See Nutrition for Infants, STANDARD 4.016 through STANDARD 4.019;
   6) Proper use of gloves in compliance with Occupational Safety and Health Administration (OSHA) bloodborne pathogens regulations. See STANDARD 3.026 and Appendix D, on proper gloving procedures;
   7) Injury Prevention and Safety.

RATIONALE: Upon employment, staff members shall be able to carry out the duties assigned to them. Because facilities and the children enrolled in them vary, orientation programs for new employees that address the health and safety of the children enrolled as well as employees' health and safety concerns specific to the site, can be most productive (6). Because of frequent staff turnover, centers and large family child care homes must institute orientation programs as needed that protect the health and safety of children and new staff.

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

PROPER SLEEP POSITION

STANDARD 3.008 SCHEDULED REST PERIODS AND SLEEP ARRANGEMENTS

The facility shall provide an opportunity for, but shall not require, sleep and rest. The facility shall make available a regular rest period for school-aged children, if the child desires. For children who are unable to sleep, the facility shall provide time and space for quiet play.

Unless the child has a note from a physician specifying otherwise, infants shall be placed in a supine (back) position for sleeping to lower the risks of Sudden Infant Death Syndrome (SIDS). Soft surfaces and gas-trapping objects such as pillows, quilts, sheepskins, soft bumpers or waterbeds shall not be placed under or with an infant for sleeping. When infants can easily turn over from the supine to the prone position, they shall be put down to sleep on their back, but allowed to adopt whatever position they prefer for sleep.
Unless a doctor specifies the need for a positioning device that restricts movement within the child's bed, such devices shall not be used.

RATIONALE: Conditions conducive to sleep and rest for younger children include a consistent caregiver, a routine quiet place, and a regular time for rest (8). Most preschool children in all-day care benefit from scheduled periods of rest. This rest may take the form of actual napping, a quiet time, or a change of pace between activities. The times of naps will affect behavior at home (10). The supine (back) position presents the least risk of SIDS (9, 10). Once infants develop the

motor skills to move from their back to their side or stomach it is safe to put them to sleep on their backs and allow them to adapt to whatever position makes them comfortable. Repositioning sleeping infants onto their backs is not recommended once the child has learned to turn over easily from supine (back) to prone (front). If a child has an illness or a disability that predisposes the child to airway obstruction in the back sleeping position, parents should give the child care provider a physician's note specifying the need for prone sleeping and any other special arrangements required for that child.

COMMENTS: In the young infant, favorable conditions for sleep and rest include being dry, well-fed, and comfortable. A school-age child care facility should make available board games and other forms of quiet play. The 1996 update to the statement prepared by the AAP Task Force on Infant Positioning and SIDS details the rationale for preferential back-positioning when caregivers put children down to sleep. Infants who are back-sleepers at home, but are put to sleep in the prone position in child care settings, have a higher risk of SIDS (9). A certain amount of "tummy time" while the child is awake and observed helps muscle development and reduces the tendency for back positioning to flatten the back of the head (10). Additional resources are available from the National SIDS Resource Center and the Back to Sleep Campaign or from the local or state health department. Contact information is located in Appendix BB.

See STANDARD 5.146, for additional information on appropriate bedding to reduce the risk of SIDS. See STANDARD 1.023 and STANDARD 1.038, regarding child care provider training on SIDS. See also STANDARD 3.089, regarding dealing with SIDS deaths.

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

REPORTING ILLNESS AND DEATH

STANDARD 3.089
DEATH (SIDS AND OTHER)

If a facility experiences the death of a child, the following shall be done:

a) If the child dies while at the facility:
   1) Immediately notify emergency medical personnel;
   2) Immediately notify the child's parents;
   3) Notify the Licensing agency;
   4) Provide age appropriate information for children and parents;

b) For a suspected Sudden Infant Death Syndrome (SIDS) death or other unexplained deaths:
   1) Seek support and information from local, state, or national SIDS resources;
   2) Provide SIDS information to the parents of the other children in the facility;
   3) Provide age-appropriate information to the other children in the facility;

c) If the child dies while not at the facility:
   1) Provide age-appropriate information for children and parents;
   2) Make resources for support available to parents and children.

d) Release specific information about the circumstances of the child's death that the child's family agrees the facility may share.

RATIONALE: The licensing agency and a SIDS program can offer support and counseling to caregivers. Following the steps described in the Standard would constitute prudent action (9). Accurate information given to the other parents and children will help them understand the event and facilitate their support of the caregiver.

COMMENTS: It is important that caregivers are knowledgeable about SIDS and that they take proper steps so that they are not falsely accused of child abuse. For information regarding preventive care and proper sleep position, see STANDARD 3.008. For information and support, contact the National SIDS Resource Center. Contact information is located in Appendix BB.

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

BREASTFEEDING

STANDARD 4.011
GENERAL PLAN FOR FEEDING INFANTS

At a minimum, meals and snacks the facility provides for infants shall contain the food in the meal and snack patterns shown in Appendix P. Food shall be appropriate for infants' individual nutrition requirements and developmental stages as determined by written instructions obtained from the child's parent or health care provider.

The facility shall encourage and support breastfeeding. Facilities shall have a designated place set aside for breastfeeding mothers who want to come during work to breastfeed (13-19).

The facility shall offer solid foods and fruit juices to infants 6 months of age and younger only upon the recommendation of the parent and the child's health professional.

RATIONALE: Human milk or iron-fortified formula is the infant's first food and supports rapid growth in both weight and length during the first year of life and beyond. Human milk, as an exclusive food, is best suited to meet the entire nutritional needs of an infant from birth until 6 months of age. Human milk is the best source of milk for infants for at least the first 12 months of age and, thereafter, for as long as mutually desired. Breastfeeding protects infants from many acute and chronic diseases and has advantages for the mother, as well.

Advantages for the infant include reduction of some of the risks that are greater for infants in group care. The advantages of breastfeeding documented by research include reduction in the incidence of diarrhea, lower respiratory disease, otitis media, bacteremia, bacterial meningitis, botulism, urinary tract infections, necrotizing enterocolitis, SIDS, insulin-dependent diabetes, lymphoma, allergic disease, ulcerative colitis, and other chronic digestive diseases (15, 16). Some evidence suggests that breastfeeding is associated with enhanced cognitive development (17, 20). Therefore, human milk is the ideal nutrient source for term and many preterm infants.

Except in the presence of rare genetic diseases, the clear advantage of human milk over any formula should lead to vigorous efforts by child care providers to promote and sustain breastfeeding for mothers who are willing to nurse their babies whenever they can and to pump and supply their milk to the child care facility when direct feeding from the breast is not possible. Even if infants receive formula during the child care day, some breastfeeding or expressed human milk from their mothers is beneficial (19).

Iron-fortified infant formula is the best next to human milk as a food for infant feeding. Supplementation with juice, cereal, and any other foods during the first 4 months of life is unnecessary and, for healthy infants, inappropriate. An adequately nourished infant is more likely to achieve normal physical and mental development, which will have long-term positive consequences on health (11, 12).

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

BEDDING

STANDARD 5.146
INFANT SLEEPING POSITION EQUIPMENT AND SUPPLIES

Infants under 12 months of age shall be placed on their backs on a firm mattress, mat or pad manufactured for sale in the United States as infant sleeping equipment, for sleep. The mattress, mat, or pad shall either be tightly fitted in furniture manufactured for sale in the United States as infant sleeping equipment or placed where the child cannot fall to a lower surface while resting. If no containing structure is used, the child shall be protected from access to hazards in the sleeping area. Waterbeds, sofas, soft mattresses, pillows, and other soft surfaces shall be prohibited as infant sleeping surfaces. All pillows, quilts, comforters, sheepskins, stuffed toys, and other soft products

shall be removed from the crib. If a blanket is used, the infant shall be placed at the foot of the crib with a thin blanket tucked around the crib mattress, reaching only as far as the infant's chest. The infant's head shall remain uncovered during sleep.

RATIONALE: Placing infants to sleep on their backs instead of their stomachs has been associated with a dramatic decrease in deaths from Sudden Infant Death Syndrome (SIDS). Infants have been found dead on their stomachs with their faces, noses, and mouths covered by soft bedding, such as pillows, quilts, comforters, and sheepskins. However, some infants have been found dead with their heads covered by soft bedding even while sleeping on their backs (21).

Mattresses, mats and pads may be used in a way that does not expose the child to the risk of injury from entrapment or falls. If the mattress, mat or pad is not contained in a crib or similar furniture manufactured for sale in the United States for sleeping of infants, the child's sleeping arrangement must prevent the child from gaining access to hazards. See STANDARD 5.145 regarding requirements and American Society for Testing Materials (ASTM) standards for cribs. Furniture made by someone who does not follow the safety standards may unwittingly expose the child to hazards.

COMMENTS: Consider using a sleeper or other sleep clothing as an alternative to blankets, using no other covering.

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

RELATED HEALTH POLICIES

STANDARD 8.005 INITIAL PROVISION OF WRITTEN INFORMATION TO PARENTS AND CAREGIVERS

At enrollment, and before assumption of supervision of children by caregivers at the facility, the facility shall provide parents and caregivers with a statement of services, policies, and procedures that shall include at least the following information along with the policies listed in STANDARD 8.004:

a) The licensed capacity, child:staff ratios, ages and number of children in care. If names of children and parents are made available, parental permission for any release to others shall be obtained;
b) Services offered to children including daily activities, **sleep positioning policies and arrangements**, napping routines, guidance and discipline policies, diaper changing and toilet learning/training methods, child handwashing, oral health, and health education. Any special requirements for a child shall be clearly defined in writing before enrollment;
c) Hours and days of operation;
d) Admissions criteria, enrollment procedures, and daily sign-in/out policies, including forms that must be completed;
e) Policies for termination and notice by the parent or the facility;
f) Policies regarding payments of fees, deposits, and refunds;
g) Planned methods and schedules for conferences or other methods of communication between parents and staff;
h) Plan for Urgent and Emergency Medical Care or Threatening Incidents. See Emergency Procedures, STANDARD 3.048 through STANDARD 3.052; and Plan for Urgent Medical Care or Threatening Incidents, STANDARD 8.022 and STANDARD 8.023.
i) Evacuation procedures and alternate shelter arrangements for fire, natural disasters, and building emergencies. See Evacuation Plan, Drills, and Closings, STANDARD 8.024 through STANDARD 8.027;
j) Nutrition. Schedule of meals and snacks. See General Requirements, STANDARD 4.001 through STANDARD 4.010; Requirements for Special Groups or Ages of Children, STANDARD 4.011 through STANDARD 4.025 and Plans and Policies for Food Handling, Feeding, and Nutrition, STANDARD 8.035 and STANDARD 8.036;
k) Policy for food brought from home. See Food Brought from Home, STANDARD 4.040 and STANDARD 4.041;
l) Policy on infant feeding. See Nutrition for Infants, STANDARD 4.011 through STANDARD 4.021 and Plans and Policies for Food Handling, Feeding, and Nutrition, STANDARD 8.035 and STANDARD 8.036;

m) Policies for staffing including the use of volunteers, helpers, or substitute caregivers, child:staff ratios, deployment of staff for different activities, authorized caregivers, methods used to ensure continuous supervision of children. See Child:Staff Ratio and Group Size, STANDARD 1.001 through STANDARD 1.005;
n) Policies for sanitation and hygiene. See Hygiene and Sanitation, Disinfection, and Maintenance, STANDARD 3.012 through STANDARD 3.040;
o) Non-emergency transportation policies. See Transportation, STANDARD 2.029 through STANDARD 2.038;
p) Presence and care of any pets or any other animals on the premises. See Animals, STANDARD 3.042 through STANDARD 3.044;
q) Policy on health assessments and immunizations. See Daily Health Assessment, STANDARD 3.001 and STANDARD 3.002; Preventive Health Services, STANDARD 3.003 through STANDARD 3.004; and Immunizations, STANDARD 3.005 through STANDARD 3.007;
r) Policy regarding care of acutely ill children, including exclusion or dismissal from the facility. See Child Inclusion/Exclusion/Dismissal, STANDARD 3.065 through STANDARD 3.068; Caring for Ill Children, STANDARD 3.070 through STANDARD 3.080; and Plan for the Care of Acutely Ill Children, STANDARD 8.011 and STANDARD 8.012;
s) Policy on administration of medications. See Medications, STANDARD 3.081 through STANDARD 3.083; and Medication Policy, STANDARD 8.021;
t) Policy on use of child care health consultants. See STANDARD 1.040 through STANDARD 1.044;
u) Policy on health education. See STANDARD 2.060 through STANDARD 2.067.
v) Policy on smoking, tobacco use, and prohibited substances. See Smoking and Prohibited Substances, STANDARD 3.041 and Policy on Smoking, Tobacco Use, Prohibited Substances, and Firearms, STANDARD 8.038 and STANDARD 8.039;
w) Policy on confidentiality of records. See STANDARD 8.054.

Parents and caregivers shall sign that they have reviewed and accepted this statement of services, policies and procedures.

RATIONALE: The *Model Child Care Health Policies* has all of the necessary text to comply with this standard organized into a single document. Each policy has a place for the facility to fill in blanks to customize the policies for a specific site. The text of the policies can be edited to match individual program operations. Since the task of assembling all the items listed in this standard is formidable, starting with a template such as *Model Child Care Health Policies* can be helpful.

COMMENTS: Parents are encouraged to interact with their own children and other children at drop-off and pick-up times and during visits at the center. Parents and caregivers, including volunteers, may have different approaches to routines than those followed by the facility. Review of written policies and procedures by all adults prior to contact with the children in care helps ensure consistent implementation of carefully considered decisions about how care should be provided at the facility.

For large and small family child care homes, a written statement of services, policies and procedures is recommended but not required. If the statement is provided orally, parents should sign a statement attesting to their acceptance of the statement of services, policies and procedures presented orally to them. *Model Child Care Health Policies* can be adapted to these smaller settings.

Copies of the current edition of *Model Child Care Health Policies* can be purchased from the National Association for the Education of Young Children (NAEYC) or from the American Academy of Pediatrics (AAP). Contact information for the NAEYC and the AAP is located in Appendix BB.

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

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