



Child Care Health Connections

A health and safety newsletter for California child care professionals

Published by the California Childcare Health Program (CCHP),
a program of the University of California, San Francisco School of Nursing (UCSF)

July – August 2004 • Volume 17 • Number 4

Morning Health Checks

One of the best ways to help keep the children in your program healthy is by performing a morning health check—a quick daily health assessment of each child made *upon arrival and before the parent leaves*. This welcoming routine can establish many things and is good health and safety policy. It will help you better understand each child, help children feel comfortable, reduce the spread of illness by excluding children with obvious signs of illness, and foster better communication with parents. You can also conduct health checks during the course of the day if you are concerned about how a child feels.

Signs to observe

When conducting a morning health check, watch for the following:

- general mood and changes in behavior (happy, sad, cranky, sluggish, sleepy, unusual behavior)
- fever or elevated body temperature (if there is a change in the child's behavior or appearance)

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**Need a free
telephone consultation
on health and safety
in child care?
Call the Healthline at
(800) 333-3212**

Vaccine Safety Is Reaffirmed

by Eva Guralnick, CCHP Staff Member

An independent expert committee of the Institute of Medicine has published a report concluding there is no connection between the measles-mumps-rubella (MMR) vaccine and autism. The committee did not conduct any new research, but reviewed the extensive studies done by other researchers. The results were so conclusive that the committee did not recommend any change in current vaccination schedules, and suggested that available funding for research into causes of autism look in more promising areas. This is great news in the fight against measles.

Because diseases like measles have become so rare recently, some parents may think that they can safely forego their children's vaccinations. But the battle against vaccine-preventable diseases is far from over. For example, measles caused an estimated 770,000 *deaths* in 2000 worldwide, according to the United States Centers for Disease Control and Prevention. While it is mostly eradicated in the United States, with only 37 confirmed cases in 2002, the last measles outbreak in this country affected more than 55,000 people from 1989 to 1991. Children and adults who are unimmunized or only partially immunized are at risk of catching very serious and life-threatening illnesses when there is another outbreak—and in our age of easy global travel, diseases from far-away countries are only a plane ride away.

Vaccines are a very effective, safe, cost-effective and heavily tested method of preventing infectious diseases. However, some parents still may decide not to have

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Child Care Health Connections®

Child Care Health Connections is a bimonthly newsletter published by the California Childcare Health Program (CCHP), a community-based program of the University of California, San Francisco School of Nursing Department of Family Health Care Nursing. The goals of the newsletter are to promote and support a healthy and safe environment for all children in child care reflecting the state's diversity; to recreate linkages and promote collaboration among health and safety and child care professionals; and to be guided by the most up-to-date knowledge of the best practices and concepts of health, wellness and safety.

Six issues of *Child Care Health Connections* are published during the year in odd-numbered months at the subscription rate of \$25 per year.

Newsletter articles may be reprinted without permission if credit is given to the newsletter and a copy of the issue in which the reprint appears is forwarded to the California Childcare Health Program at the address below.

Subscriptions, renewals, inquiries and reprint inquiries: please contact Maleya Joseph at mjoseph@ucsfchildcarehealth.org or at (510) 281-7938.

CCHP Program Office (new address!)

1333 Broadway, Suite 1010
Oakland, CA 94612
Phone: (510) 839-1195 (same)
Fax: (510) 839-0339 (same)

Healthline: (800) 333-3212

E-mail: healthline@ucsfchildcarehealth.org

Newsletter Editors

A. Rahman Zamani, MD, MPH
Eva Guralnick
Judy Calder, RN, MS
Judith Kunitz, MA
Mardi Lucich, MED
Eileen Walsh, RN, MPH

Information provided in *Child Care Health Connections* is intended to supplement, not replace, medical advice.

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Major support for this publication is provided by the California Department of Education, Child Development Division, Healthy Child Care California and First 5 California (formerly the California Children and Families Commission).

ASK THE NURSE...

Splinter Removal

by Judy Calder RN, MS



Q Splinters seem to be a big issue in the summer. What's the best thing for me to do when a child in my program gets a splinter, and what steps should I take to make sure splinters don't happen?

A When it comes to splinters, the big question is how much first aid can you, as a child care provider, perform? Certainly, small slivers that can be easily removed from a cooperative child should not be a problem. The usual first aid recommendations apply. Wash your hands and use tweezers to grab the splinter. Carefully pull it out at the same angle it went in. Wash the area with soap and water and pat it dry. Notify the parent and observe for signs of infection such as swelling, redness or pus.

When is it time to call the parents?

If you have tried and are unable to remove a splinter, if the child is uncooperative because of pain, or if the splinter is deeply embedded, near the eyes or under a fingernail or toenail, then by all means call the parents and ask that their health care provider be notified for advice.

Parents may want to try using a sterilized pin to ease a sliver out. However, attempts to remove a deeply imbedded splinter may push it in deeper, or break it off. In these cases, remind parents that it's better that removal be done by the health care provider or an urgent care center, since local pain medication can be given before removal.

Keep in mind that slivers from wood, thorns or cactus spines tend to trigger an inflammatory response and they should be removed before redness and swelling begin. For this reason, if you cannot remove the splinter yourself, immediately notify the parent and ask them to seek advice from their health care provider so it can be removed as soon as possible.

Making sure splinters don't happen

Many splinters can be avoided by regular checks of your child care environment. Make certain the surfaces on which children play are smooth and free of splintery areas—look at chairs, tables, railings, fences, floors, decks, etc.

Children tend to get splinters in their feet, especially in warm summer months, so you may also want to establish a footwear policy. Formal summer footwear recommendations are nowhere to be found, and child care programs have different policies that range from allowing only closed shoes such as sneakers (the safest) to allowing any kind of shoe. Open-toed sandals don't fully protect against stubs, dropped objects, or splinters. Common sense might guide you to recommend either closed shoes, or shoes appropriate for running and climbing and that are non-trip (no flip-flops, or floppy sandals) and non-slip (no hard plastic) shoes. ♦

Reference

Chan, C., & Salam, G. (2003) Splinter Removal. *American Family Physician*, 67, 12, 2557- 2562.

Toilet Learning: A Partnership Between Parents and Providers

by Mardi Lucich, MA

Toilet learning is a major developmental experience that commonly occurs in child care, where providers are often the first to recognize when a child is ready. Many parents turn to providers for their expertise in helping a child learn how to use the toilet because they find that providers' guidance and participation in the toileting learning process is invaluable. When providers and parents work together as partners, toilet learning is a much easier process for everyone.

- The start of toilet learning should always be based on a child's developmental level rather than age or the adult's anxiousness or eagerness to start. For instance, is the child able to imitate? Can the child communicate the need to eliminate? Can the child pull clothes on and off? Attempting toilet learning before a child is ready can create stress and anxiety for the child, and in turn delay the process. Instead, team with parents to help the child get ready and support learning at her or his own pace.
- Toilet learning should begin when the child show signs of interest and readiness—this is the valuable window of opportunity that providers should help parents identify and respond to. The child needs to be willing and cooperative, not fearful of or fighting the process. And it is best not to start if there are other changes the child is also experiencing, such as a recent move, new sibling, new child care setting, etc.
- Toilet learning is a multi-step process and setbacks are common, should be expected, and do not necessarily mean failure. Remind parents that the child is taking a temporary step back to a more comfortable place, which helps to support a natural step towards progress.
- Toilet learning should follow a sequential plan that is consistent both in child care and at home. Make use of normal routines to establish regular potty times, which helps to make toileting a habit.
- Promote toileting skills within the context of helping the child develop self-esteem and independence. Ensure that the learning experience is positive, natural and nonthreatening, so that the child feels confident. Because toilet learning involves discussing, undressing, going, wiping, dressing, flushing and hand washing, reinforce the child's success at each step.
- Include toilet learning activities as part of the daily curriculum. Read stories and sing songs about using the potty, or organize games that reinforce skills associated with toileting.
- Welcome and encourage parents to speak freely about concerns they have about their child's development or problems with toilet learning. If necessary, suggest that the parents visit their health care provider for a physical evaluation and some further information on strategies and techniques.

For additional support on the topic or a list of children's books on toilet learning, contact the Healthline at (800) 333-3212. ◆

Violence in Children's Lives

by Kim Walker, RN, MSN, CPNP

Many children are exposed to violence in their neighborhoods and homes. Living with violence includes living in a home or neighborhood where verbal threats, intimidation and assaults are common. Witnessing violence is frightening and can lead to long-term negative effects in young children. Child care providers play an important nurturing role for children exposed to violence by providing a sense of safety and well-being. This is accomplished by having predictable routines, giving loving and responsive care, providing a safe and healthy environment, and modeling appropriate behaviors.

There are many useful ways to respond to a child who has witnessed violence. First, take time to understand what the child thinks happened. Validate the child's feelings by reflecting back the emotion(s) the child shares. Allow the child to tell the story through words or pictures, but consider the effect the story may have on others if shared. It may not be appropriate for the group and instead should be private.

A child who witnesses violence may develop behaviors and physical reactions such as trouble sleeping, headaches, stomachaches, loss of appetite, and aggressive, impulsive or withdrawn behavior. The child may have difficulty remembering and/or learning, or regress in previously acquired skills, leading to bedwetting or thumb sucking. And because of children's inexperience, they often worry more as a result. Such children will benefit from patience and understanding, not discipline.

Child care providers will certainly have feelings and reactions to violence

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The Effects of Television Viewing on Young Children

by Eileen Walsh, RN, MPH

Television viewing can have a negative effect on children's health, development and behavior. Time children spend watching television is time not spent engaged in a creative activity or interacting with others. Researchers and children's advocates agree that television viewing is not appropriate for very young children, and that older children's viewing should be carefully monitored and kept within safe time limits. Below are some suspected negative effects of television viewing.

Violence and Aggressive Behavior. Research studies have shown that children exposed to violent images on television are initially frightened and traumatized. With repeated exposure, they can become desensitized to the real effects of violence. Such children may act aggressively, with no sense of consequences.¹

Poor Nutrition and Obesity. Children need time for active play and exercise, to develop muscles and to maintain cardiovascular fitness. Television viewing is sedentary, and provides none of these benefits. And children who view television are vulnerable targets of advertisements for food products of poor nutritional value.¹

Tobacco and Alcohol. Television programs which glamorize smoking and drinking send a message to children that substance use is normal adult behavior.

School Readiness. A recent study showed that children who were regular viewers of mainstream television had smaller vocabularies and less developed math skills than children who viewed no television or children's educational programs only.²

Attention Problems. Another study found children who spent more daily hours viewing television at ages 1 and 3 had higher rates of attention problems at age 7.³

What can we do?

- Avoid television for children under age 2. Very young children need frequent human interaction for social, emotional and cognitive development.
- For children age 2 years and over, limit viewing to educational programs designed for children, and for only short periods of time.
- Stay with children when the television is on, to monitor their reactions and answer questions.
- Teach children to be critical viewers of commercials.
- Evaluate the nutritional value of foods promoted on television, and offer children healthy alternatives.
- Create a family television policy. Be clear with children about how much and what types of viewing are permitted. Adults should consistently enforce the policy.

References

¹American Academy of Pediatrics, Committee on Public Education (1999). *Media education*; *Pediatrics*; 104(2): 341-343.

²Wright, J.C. et al. (2001). *The relations of early television viewing to school readiness and vocabulary of children from low income families: The early window project*; *Child Development*; 72(5):1347-66.

³Christakis, D.A. et al. (2004). *Early television exposure and subsequent attentional problems in children*. *Pediatrics*; 113(4): 708-713.

New Beginnings

by Abbey Alkon, RN, PhD

Child Care Health Linkages Project is entering a new phase. The funding for the 20 county subcontracts for child care health consultation programs ends September 30, 2004. Many of these programs will be sustained with county funding and/or local First 5 funding. The California Child-care Health Program will continue training and support for health and child care professionals as Child Care Health Consultants and Child Care Health Advocates until December 31, 2005, funded by First 5 California. The training and support will be extended to First 5 School Readiness staff working in child care settings throughout the state. Regional trainings will be provided starting January 1, 2005. The training schedule will be posted on our Web site this fall.

We also are pleased to announce that Wendy Wayne, RN, EdD started on May 21, 2004, as the Project Coordinator of the State Early Childhood Comprehensive Systems grant. This grant was awarded by the federal Maternal and Child Health Bureau to our state MCH department. UCSF School of Nursing is the subcontracting agency; Project Co-Directors are Abbey Alkon at UCSF-CCHP and Ellen Buchanan at state MCH. Wendy comes to this position with many years of experience in public health, child care and administration. Most recently, she was the Administrator of the Division of Child Development and Family Services at Kern County's Superintendent of Schools. Wendy is a public health nurse, childbirth educator and women's health care Nurse Practitioner. She will work half-time and travel throughout California collecting and summarizing the state's needs for integrating health into early childhood comprehensive systems. Welcome Wendy!

Overweight and Obesity: The Growing Problem

by A. Rahman Zamani, MD, MPH

Obesity is not only a problem for adults, its dramatic increase in children has become a disturbing national epidemic and public health concern that warrants our attention. In the United States, 10 percent of children between ages 5 and 17 are obese and more than 30 percent are overweight (*International Obesity Task Force, 2004*). Overweight children are more likely to become overweight adults.

When is a child obese?

Obesity means having too much body fat in relation to lean body mass. A measurement of Body Mass Index (BMI) is used to assess overweight and obesity. BMI is the ratio of weight in kilograms to the square of height in meters (kg/m^2). BMI between the 85th and 95th percentiles for age and sex is considered at risk of overweight, and BMI above the 95th percentile is considered overweight or obese.

Why do children become overweight?

While in some cases heredity and genes play a role, very few children are overweight because of underlying medical problems. The most important and preventable causes of childhood obesity are unhealthy eating habits (poor diet) and low level of physical activity (including too much time spent in front of a computer or watching television). When a child eats more calories than his body can burn, the extra calories are stored as fat. Everyone has some stored fat, but too much fat results in the unhealthy condition of being overweight.

What are the health consequences of obesity?

Obesity in children is a serious issue

with many health and social consequences that often continue into adulthood.

Physical risks of being overweight.

Obese children have shown an alarming increase in the incidence of type 2 diabetes, a disease that previously was typically seen in adults. Many obese children have high cholesterol and blood pressure levels, which are risk factors for developing heart disease and stroke. Obese children also have a high incidence of orthopedic problems, liver disease, asthma and certain types of cancer. One of the most severe problems for obese children is sleep apnea (interrupted breathing while sleeping). In some cases this can lead to problems with learning and memory.

Social and emotional outcomes. Social discrimination may be more disturbing to an overweight child than physical health problems. Research shows that obesity can be harmful to children's mental health. Children who are teased frequently can develop low self-esteem, behavior and learning problems, and depression.

What is the best way to help children reduce weight?

Management of obesity in children is often focused on slowing or stopping the progress of weight gain rather than a weight loss. This way the child will grow into his or her normal body weight over a period of months to years. Parents and child care providers can play a very important role in helping overweight children. The following three interventions will help:

Physical activity. Evidence shows that

promoting exercise to burn calories helps more than restricting calories, and it's more fun. Offer regular opportunities for children to engage in physical activities. Organize indoor and outdoor activities and reduce screen time (television, computer, videos) to two or less hours per day.

Diet management. Provide nutritious meals and snacks based on the Food Guide Pyramid for children. While keeping lots of water, fruits, vegetables, yogurt and low-fat snacks available, keep fatty and sugary snacks to a minimum, especially sugar sweetened beverages such as soda. Never put a child on a low-calorie diet. You can lower the amount of fat in food, but maintain calories by increasing the consumption of fruit, vegetables, cereals and bread.

Behavior modification. The best thing parents and child care providers can do to help children make healthy food choices is to be good role models. Avoid using food as a reward or punishment. Have family meals and set a good example by eating a wide variety of food. Find reasons to praise your child's behavior. And discourage children from teasing each other about their size and weight. Teasing can emotionally harm children, leading to low self-esteem, depression and further weight gain.

References & Resources

AAP Policy Statement: Pediatrics Vol. 112 No. 2 August 2003, pp. 424-430.

Centers for Disease Control and Prevention Obesity and Overweight Information (www.aap.org/obesity/family.htm).

American Obesity Association (www.obesity.org).



Health & Safety Notes California Childcare Health Program



Thumb, Finger or Pacifier Sucking

All healthy newborns start life and sustain it with an urge to suck. Embryos have been observed sucking their thumbs while in the womb. Sucking is one of a baby's inherent reflexes that is an essential ability for basic survival—if it were not present, the infant would not seek food or nourishment.

For many infants, the sucking instinct is not satisfied by feedings alone. Non-nutritive sucking, that is sucking thumbs, fingers, pacifiers and other objects, is a healthy normal behavior and offers young children a feeling of security, comfort, pleasure and relaxation during the first few years of life. This habit helps children to cope with different situations and emotions. Virtually all young children at one time or another place their fingers, fist, pacifier, thumb, or other objects in their mouth to suck. As children grow and develop, most naturally discontinue this habit.

Thumb and Finger Sucking

Thumb and finger sucking is a natural, normal behavior for infants. Most young children suck their thumbs or fingers at some time, and it is an appropriate and useful behavior that allows them to soothe and entertain themselves. Children usually turn to their thumb or finger when they are tired, stressed, upset or bored. And it is not unusual for a thumb or finger sucker to simultaneously engage in other self-comforting behaviors like pulling at a strand of hair, touching the ear, or holding on to a favorite blanket or toy. Even when the habit lingers past infancy, thumb or finger sucking is rarely something to be concerned about. The majority of children give up such habits on their own by age 2. If children do not stop on their own, the habit should be discouraged after age 4.

Pacifiers

Some children prefer sucking a pacifier to a thumb or finger. Pacifier use elicits strong responses from

parents and caregivers. Some oppose it because of the way it looks. Some feel that it's "pacifying" a child with an object. And others believe that using the pacifier can harm the child. But pacifiers do not cause any medical or psychological problems, and like thumb or finger sucking, using a pacifier during the early years of development generally does not permanently alter the position of the teeth or jaw. If a child wants to suck beyond what nursing or bottle-feeding provides, a pacifier will satisfy that need.

Tips for Safe Use of Pacifiers

- Pacifiers should not be used to replace or delay meals; they should only be offered after meals or between feedings. It may be tempting to offer a pacifier to a child when it's easy for you. However, it is best to let the child decide whether and when to use it.
- Pacifiers should be of one-piece construction made with a firm nontoxic material that can be sterilized. They should have a soft nipple, air holes for ventilation, and have a shield that is wider than the child's mouth.
- *Never* tie a pacifier to a child's crib, or hang pacifiers around their neck or hands. This is very dangerous and could cause strangulation.
- *Never* dip a pacifier into honey or anything sweet before giving to a child.
- *Never* put a pacifier in your mouth first before giving to a child.
- Do not let children share each other's pacifiers.
- Frequently check the pacifier, especially the nipple end, to make sure it has not become brittle and to see whether the rubber has changed color or is torn; discard if the nipple has become sticky, swollen, or cracked.
- Never substitute a bottle nipple for a pacifier.

- Pacifiers have a tendency to fall on the ground and children's hands are often dirty, so make sure to wash pacifiers and children's hands often with mild soap and rinse with water to limit exposure to germs.

Thumb or Finger Sucking Versus a Pacifier

There are definitely conflicting views on this. Some feel that the pacifier may cause more dental problems, is more unsanitary, and may hinder successful breastfeeding, while others feel that breaking the pacifier habit is easier than with the thumb or finger because a pacifier can be taken away. Studies have shown that children who suck their thumbs or fingers generally have a greater difficulty breaking their habit than do children who use pacifiers.

Should You Be Concerned?

A primary concern is to avoid dental problems that may occur if a child continues thumb, finger or pacifier sucking during the emergence of the adult (permanent) teeth, around age 5. After permanent teeth come in, thumb, finger and pacifier sucking may cause problems with the proper growth of the mouth and alignment of the teeth. According to the American Academy of Pediatric Dentistry, extensive sucking of thumbs, fingers or pacifiers has a tendency to put pressure against and push the front teeth out of alignment causing teeth to protrude. This pressure is likely to cause changes to the roof of the mouth, an open bite (vertical gap between upper and lower front teeth), or overbite (horizontal gap between upper and lower front teeth). It is possible that these conditions will self-correct, especially if the habit ceases before the eruption of the adult teeth.

Conclusively, experts agree that prolonged sucking of thumbs, fingers or pacifiers during and after the eruption of the permanent teeth can hinder proper growth and development of the teeth and gums. Sucking of the thumb or finger or use of a pacifier beyond 6 to 7 years of age can affect the shape of a child's mouth or teeth, resulting in reparative orthodontia later on. If you notice changes in the roof of the child's mouth (palate) or in the way the teeth are lining up, then encourage the child's family to talk with their pediatrician or pediatric dentist.

How to Help a Child Stop the Habit

Children generally forego non-nutritive sucking long before any permanent damage is done. However, some children need to be helped to stop the habit before it will cease. Attempts to steer children away from the habit can backfire if they are not tempered with positive support and guidance. Refrain from harsh words, nagging, teasing, belittling, pulling the finger or pacifier out of a child's mouth, or punishing the child to stop the behavior. These methods may upset the child, increase anxiety and stress, and worsen the habit.

- Parents and caregivers can assist children with strong emotional support through a variety of methods. Start by gradually weaning children from the habit over time. Explain that they must stop the habit in order for their teeth to come in straight.
- Children often suck their thumbs when feeling insecure or needing comfort. Focus on correcting the cause of the anxiety and provide comfort to the child.
- Involve older children in choosing the method of stopping. Have a special place for the pacifier that's out of sight, so that children must ask for it.
- Praise and reward children when they don't suck their thumb or use the pacifier. Look for times when the children do not have the thumb, finger or pacifier in their mouth, and provide words of encouragement, a pat or hug. Let them know that you are aware of the effort they are making to change the habit and that you appreciate it.
- Star charts, daily rewards and gentle reminders, especially during the daytime hours, are also very helpful.

by Mardi Lucich, MA

Reference

American Academy of Pediatric Dentistry Fast Facts at www.aapd.org/pdf/FastFacts02-03.pdf.

California Childcare Health Program • 1333 Broadway, Suite 1010 • Oakland, CA 94612-1926

Telephone 510-839-1195 • Fax 510-839-0339 • Healthline 1-800-333-3212 • www.ucsfchildcarehealth.org

When a Child with Diabetes Enters Your Program

by Eileen Walsh, RN, MPH and Mardi Lucich, MA

Diabetes is a serious illness in which the body is unable to process and store sugar properly. In some cases, symptoms of diabetes or side effects of diabetes treatment can create a life-threatening emergency. When a child with diabetes is enrolled in child care, the provider becomes an integral part of the child's diabetes care team. With careful planning and adherence to their schedules and needs, children with diabetes can participate fully and safely in child care.

Identify the care team

Your first step in caring for a child with diabetes is to identify a care team to create a plan that will guide staff in the management of the child's diabetes in child care. This team must include the child's parents and any staff who will be working with the child. It may also include other adults who are designated contacts for the family, and a Public Health nurse, school nurse, or Child Care Health Consultant. Optimally, the care team will meet prior to the child's enrollment to create the care plan, and then periodically to discuss the child's progress and revise the plan as necessary.

Develop a care plan

The care plan should describe the child's daily diabetes management routine. According to Community Care Licensing, providers are allowed to perform blood sugar checks on the children in their care. To do this, you need training from the child's parents, using the child's equipment. Child care providers are not allowed to give insulin injections (this can only be done by the parents or a medical provider). The child's care plan should indicate who will give insulin if needed during child care hours, and must include a reliable means of reaching the designees in case of emergency.

The care plan should also describe how to handle situations that commonly occur in diabetes. The plan should indicate the target blood sugar range identified by the medical provider for the child, and should indicate at what time(s) the provider needs to perform a check. It should give clear directions on what steps to take if the child's blood sugar is outside the target range. (For example, the plan should specify which foods the parents prefer be given to their child when blood sugar levels are too low and give clear directions about how soon after treatment the blood sugar should be re-checked.) To help the provider recognize signs of distress, the plan should describe symptoms the child is known to show during episodes of unstable blood sugar.

Healthy food policies in child care

Children with diabetes need nutritious meals and snacks at regular intervals throughout the day. Concentrated sources of sugar, such as candy, ice cream, cakes and cookies, are generally off-limits for these children. As a provider, you have the authority to create a food policy that encourages families to bring in safe and nutritious foods, but discourages them from bringing in unhealthy sweets, whether for their own child or for sharing.

Resources

Call the Healthline at (800) 333-3212 for the Health and Safety Note *Diabetes in the Child Care Setting*, resources on celebrating special occasions without reliance on sugary foods, and forms and examples that will help you create a successful care plan.

Challenging Behavior

by Joanna Farrer

"Providers are screaming for help in managing behavior because it's the burr under the saddle, it's the thing that causes them a lot of grief," said a Child Care Health Consultant who participated in a CCHP focus group in 2002. The Child Care Health Linkages Evaluation Project conducted nine such focus groups with 44 CCHCs who discussed their roles and responsibilities, and the barriers and facilitators to their work.

Clearly, behavior problems in child care present difficult issues for both child care providers and CCHCs. CCHCs often work with providers when behavior problems emerge, to analyze the problems and minimize the effects on the child's overall health and ability to learn. Their comments include:

- "They're misbehaving because they can't hear."
- "We have a population of children who have been prenatally substance exposed to something and teachers are seeing different behaviors in the classroom... I want to help them know how to deal with those things."
- "The providers in our area have a lot of need with behavior... it's a big deal and they have absolutely nothing available to them, so I'm trying to find some models and some resources."

CCHCs need training and resources to address behavioral concerns with child care providers and parents. They can also help meet the need for behavioral health services by establishing and strengthening valuable linkages between child care providers, health care providers and community resources.

Eliminate Childhood Lead Poisoning by 2010

by Jan Schilling, MPH, MS, RD, California Department of Health Services, Childhood Lead Poisoning Prevention Branch

Advocates for children's health have made great strides in informing the public about the dangers of exposure to lead. Lead poisoning prevention programs have been so successful that both the National Healthy People Campaign and the California Childhood Lead Poisoning Prevention Branch have established the ambitious goal of eliminating elevated blood lead levels in children by 2010.

Currently, elevated blood lead levels are defined at or greater than 10 micrograms per deciliter. Children with even higher lead levels, persisting at 15 micrograms per deciliter or greater, or one value of 20 micrograms per deciliter, receive special public health and environmental services at their local Childhood Lead Poisoning Prevention Program.

Who is most at risk?

Hispanic children make up over 80 percent of those with higher blood lead levels in California. These children may come in contact with lead through

- contaminated paint, dust and soil in homes built before 1978;
- food prepared, served or stored in pottery that contains lead;
- brightly colored ethnic remedies such as azarcon and greta;
- several types of Mexican candy; and
- grasshoppers, a traditional snack food in Oaxaca and other parts of Mexico.

Poor nutrition is a frequent problem for lead-poisoned children, as they are frequently found to be anemic and in low-income minority families whose iron, calcium and vitamin C intake are inadequate for healthy growth and development. Adequate intake of these three critical nutrients may protect against lead absorption. Nutritional counseling should help these children obtain a well-balanced and age-appropriate diet.

Each child participating in a publicly funded program for low-income children is considered at risk for lead poisoning. Every health care provider is required by California regulation to test each child for elevated lead levels who receives services from a publicly funded program for low-income children (such as Medi-Cal, CHDP, Healthy Families or WIC). Blood lead testing should be done when the child is 12 and 24 months of age, or any time up to 72 months if the child has not previously been tested. A blood lead test may be done concurrently with a hemoglobin test. Keep the health care providers you work with aware of this requirement.

Children not in low-income programs should be evaluated to determine if they are at risk for exposure to lead-based paint. Ask if they have spent a lot of time in a place built before 1978 that has peeling or chipped paint or that has recently been renovated. If the family answers "yes" or "don't know," a blood lead test should be done.

Your creative help is needed in developing strategies to prevent elevated blood lead levels and to effectively manage those children who are lead poisoned. The California Childhood Lead Poisoning Prevention Branch invites you to contribute ideas by e-mailing jschilli@dhs.ca.gov, calling (510) 622-4876, or faxing (510) 622-5002.

-Health Checks, continued from page 1

- skin rashes, itchy skin or scalp, unusual spots, swelling or bruises
- complaints of pain and not feeling well
- other signs and symptoms of illness (such as severe coughing, sneezing, breathing difficulties, discharge from nose, ears or eyes, diarrhea, vomiting and so on)
- reported illness in child or family members since last date of attendance

Use All Your Senses

Listen to what the child and parents tell you about how the child is feeling. Is the child's voice hoarse, is he having trouble breathing, or is he coughing?

Look at the child from her level. Observe for signs of crankiness, tiredness, pain or discomfort. Does the child look pale, have a rash or sores, a runny nose or eyes?

Feel the child's cheek and neck for warmth, clamminess or bumps as a casual way of greeting.

Smell the child for unusual odor in the breath, diaper or stool.

Using findings to make decisions

If you have concerns about a child, discuss them with the parent right then. If you decide the child will remain, be sure to discuss how you will care for the child and at what point you will call the parent if things worsen. If the child stays all day, inform the parent about changes in the child's health status.

Remember that only a few illnesses require exclusion of sick children to ensure protection of other children and staff. Your program should develop a clear exclusion policy and enforce it consistently. For information, call the Healthline at (800) 333-3212.

Reference

Health and Safety in the Child Care Setting: Prevention of Infectious Disease. California Childcare Health Program. Module 1, Second Edition. 2001.

EVENTS

July

Eye Injury Prevention Month.

Materials available from American Academy of Ophthalmology. (415) 447-0213; www.aao.org/aao/patients/eyemd/injury.cfm.

July 8–9

SPARK Early Childhood Institute. San Diego, CA. (800) SPARK-PE; jfrank@sparkpe.org.

July 21–23, 2004

Building a Culture of Technology for Teaching and Learning in K-12.

University of California College Prep Online. Santa Cruz, CA. www.uccp.org/institute/general.html; (866) 482-7737.

July 25–30, 2004

California Teachers Association Summer Institute.

UCLA Campus. www.cta.org; (650) 552-5395.

August

National Immunization Awareness Month.

National Partnership for Immunization. Free promotional kits. www.partnersforimmunization.org; (703) 836-6110.

Aug 9–10

Ready, Set, Go! Leading the Way to School Success.

Northern California Early Childhood Education Conference. Sacramento, CA. (916) 263-4073.

Aug 18–21

Transracial Adoption Summit. Oakland, CA. PACT; (510) 243-9970.

August 1–7

14th Annual World Breastfeeding Week.

La Leche League USA. www.llusa.org/llusa/wbw.html.

PRODUCT WATCH

Recalls and Product Alerts

Below is a summary of items recalled voluntarily and preventively. As always, take the recalled item out of circulation and contact the appropriate company to find out about replacements, parts, refunds or other instructions.

Wondering if an item you purchased second-hand may have been recalled? Find out by checking for it on the U.S. Consumer Product Safety commission Web site at www.cpsc.gov, or call (800) 638-2772. Check to see if items have been recalled before you donate them to thrift stores or pass them on to families as well.

| Recalled Item | Defect | Contact Information |
|--|--|--|
| Backyard Products Swings | Chains on the swing can detach during use and cause the child to fall to the ground and possibly suffer injuries. | Backyard Products (800) 841-4351 |
| Children's Board Books with Sound Maker | The sound maker mounted inside a plastic covering on the last page of the books poses a choking hazard to young children if removed. | DK Publishing (800) 505-4726 recall@dk.com |
| Vinyl Mirror Books | The mirror in the books can crack or break, posing a laceration hazard to young children. | Detach and mail the mirror page of the product to Kids II at 1015 Windward Ridge Parkway, Alpharetta, GA 30005 for a refund. |
| Ride-on toy trucks under five model names: Butterfly Girl, Fire Rescue, Mermaid, Police Car and Tonka Construction Crew. | The screw and nut assembly attaching the steering wheel can come loose, posing a choking and aspiration hazard to young children. | Tek Nek toys (888) 661-0222 www.teknekt toys.com www.babytrend.com |

Correction

The May-June 2004 issue of *Child Care Health Connections* contained an inaccurate statement in the article on Medication Administration. According to Community Care Licensing regulations in California, non-prescription medications may be given in child care as long as (1) the child's parent or guardian provides written approval and instructions, and (2) the instructions given by the parent are consistent with the instructions given on the product's packaging label. Additionally, *Caring for our Children*, the national reference for health and safety standards in child care, recommends that providers ensure that a non-prescription medication only be given when the child's primary care provider has recommended it. The standards do not require written consent from a medical provider for non-prescription medications, but they do encourage child care providers to verify with parents that the physician has approved the treatment.

Tuberculosis Screening

by Judith Kunitz, MA

Tuberculosis screening is required by California Community Care Licensing for all child care staff. The requirement includes regular staff, substitutes and volunteers in the child care setting. The rationale for tuberculosis screenings of child care staff is that young children are especially at risk for tuberculosis, a serious respiratory infection that is caused by a bacterial infection that enters the lungs. Young children often acquire this disease from infected adults. Tiny droplets of saliva that are coughed or sneezed into the air spread the disease. Tuberculosis spreads most easily in indoor environments, especially crowded and poorly ventilated rooms.

Tuberculosis (TB) testing for child care staff has moved from regular TB screenings to risk assessment and symptom review. Staff members must have their tuberculosis status assessed at the beginning of employment (or volunteering) with a one-step or two-step Mantoux intradermal skin test. This test must be performed by or under the supervision of a physician not more than one year prior to or seven days after employment in a child care facility. If the test is negative, it does not need to be repeated during the employment period, unless the child care provider develops the signs and/or symptoms of the disease, as determined by a medical health professional. Signs of active TB include chronic cough, coughing up blood, a fever lasting more than two weeks, night sweats, weight loss and feeling very tired. There are no regulations regarding re-testing. A staff member with a positive skin test should be under the care and management of a physician who will annually conduct a symptom review of the patient, and will provide further screening and treatment, such as a chest x-ray or medication, as needed.

Resources

American Academy of Pediatrics (www.aap.org).

Caring for our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs (Standard 6.014).

California Community Care Licensing Regulations (www.cclcd.ca.gov).

National Resource Center for Health and Safety in Child Care (<http://nrc.uchsc.edu>).

-Violence in Children's Lives, continued from page 3

in the lives of the children they care for and the community they live in. We work hard to understand children, read cues, question what behavior is trying to communicate, set limits, provide comfort, and support growth through play. It is always important for the children in our care that we emphasize responsiveness and nurturing, with predictable and consistent routines, each day, but when the children in our care are witnesses to violence, these principles are even more important.

If a child in your care needs more support for issues related to violence than you can provide, talk to the child's parent or guardian. The Healthline at (800) 333-3212 can offer information on finding extra support or services for families.

References

The Safe Havens Training Project. www.misterrogers.org/early_care/violence_main.asp.

Caring for Infants and Toddlers in Violent Environments: Hurt, Healing, and Hope, ZERO TO THREE Study Group on Violence. Joy D. Osofsky and Emily Fenichel, Eds. 1994.



-Vaccine Safety, continued from page 1

their children immunized, whether for medical, religious or personal reasons. Although children are required by the California School Immunization Law to be appropriately immunized against diseases prior to attending licensed child care settings, there are exemptions. There are *medical exemptions*, which are granted when a child should not get some or all shots due to temporary or permanent medical reasons. In this case, parents must provide child care providers with a physician's statement. There are also *religious and personal beliefs exemptions*. In these cases, families are asked to sign the Personal Beliefs Affidavit on the back of the "blue card." This is granted only for reasons of personal belief, not as a matter of convenience to the parent.

Child care providers can help protect children from vaccine-preventable illnesses in several ways.

- Establish an immunization tracking system to remind parents to bring in their child's immunization record so you can update the "blue card." It's especially important as the fall school season approaches.
- Provide information for parents on the importance and benefits of immunization.
- Establish a policy stating that there may be unimmunized or under-immunized children in your program. Explain what will happen in case of an outbreak. The National Health and Safety Standards recommends that these children be excluded during outbreaks for their own protection. Maintain a confidential list of these children so they may be quickly identified and excluded.

For immunization resources, call the Healthline at (800) 333-3212.

References

U.S. Centers for Disease Control and Prevention National Immunization Program. www.cdc.gov/nip.

California Childcare Health Program. (2004). *Unimmunized Children in the Child Care Setting Health and Safety Note.*

HEALTH and SAFETY RESOURCES

CalAsthma, from Community Action to Fight Asthma, highlights studies, policy updates, fact sheets and resources on asthma in California. Includes information on hospitalization rates for asthma by legislative district. www.calasthma.org.

Making the Case for Early Care and Education, from Berkeley Media Studies Group, is a guide to media advocacy for child care advocates. Topics include developing media strategies and pitching stories. www.bmsg.org/content/58.php.

Preschool for All, from California First Five. Planning guide and toolkit to help First 5 county commissions, education agencies, early care and education providers, and families improve access to high-quality preschool programs. www.cfc.ca.gov/SchoolReady.htm.

Quality Pre-Kindergarten: Key to Crime Prevention and School Success, from Fight Crime: Invest in Kids, shows how quality child care cuts crime, leads to higher academic achievement, and saves money. www.fightcrime.org/reports/PreKBrief.pdf.

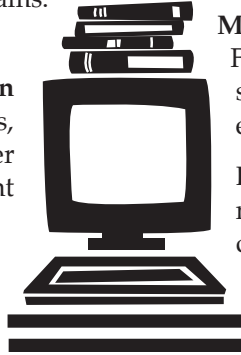
Tips for Preventing Injuries, from Children's Hospital of San Diego. Fact sheets on childhood injury prevention in English and Spanish. www.chsd.org.

Child Care in Poor Communities: Early Learning Effects of Type, Quality and Stability, finds that children from low-income California families develop early reading and language skills faster in child care centers than in home-based care, and found no greater levels of aggression or stress in children who spend long hours in child care. <http://news-service.stanford.edu/news/2004/february11/childcaresr-211.html>.

Statute-at-a-Glance, from the National Clearinghouse on Child Abuse and Neglect Information, offers a searchable online database of California statutes on child abuse and neglect and child welfare. <http://nccanch.acf.hhs.gov/general/legal/statutes/sag/allsearch.cfm>.

Many School Lunches Fail Fat Test, from California Food Policy Advocates, provides county-by-county summaries of school meal data and tips to help parents take action. www.cfpa.net/press.

Promoting School Success, from the Child Development Policy Institute Education Fund, examines how children learn, the long-term cost benefits of early care and education, the importance of providers, and communication across disciplines. Online at www.childlinkca.org/pdf/ProSchSuc.pdf.



University of California, San Francisco
Child Care Health Connections
School of Nursing
Department of Family Health Care Nursing
San Francisco, CA 94143-0606

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