Animal Visits

Summer is a great time to see animals at a local fair or farm, to visit a petting zoo, or to have animals come visit an early education and child care facility. As cute as baby goats, ducklings and other animals can be, many of these animals carry germs that can make people sick.

Here are some ways to make visits with animals a safe, fun and healthy experience for all.

1. Hand Washing: Children and caregivers should wash their hands with soap and water after petting animals, touching animals, or even being in the animal area. Everyone in the group should wash hands whether or not they touched the animals. Find out in advance if soap and water are available. Don’t visit if you find out the facility doesn’t provide hand washing facilities. You can use hand sanitizers for children with visibly clean hands who are 24 months or older, but some animal germs are resistant to alcohol. As a make-do until you can get to soap and water, carry a plastic bag of paper towels wet with soapy water and a bag of paper towels just wet with plain water to clean and rinse the children's hands. Wash with running water as soon as you can.

2. Shoes: The bottoms of shoes can have animal waste on them after being in an animal exhibit. Check shoes to see if they need to be cleaned before they bring animal waste into vehicles and buildings. Be sure to wash hands after removing and/or cleaning shoes.

3. Surfaces: Clean and sanitize all the surfaces touched by an animal or by people who touched the animal during animal visits.

4. Eating: Children and teachers/caregivers should not eat in animal areas. They should not share their food with the animals either. Some petting zoos will provide food for their visitors to feed the animals. Be sure to review the guidelines for safe feeding of animals with exhibit staff. Remember to wash hands immediately after contact with animals and again before eating a snack or lunch.

5. Safety: Supervise young children at all times when around animals. Children should not put anything in the animal’s mouths – no fingers, toys, or foods. (Exhibit staff can give instructions for feeding the animals. Teachers/caregivers should decide if it is safe.) All strollers, sippy cups, diaper bags, and toys should be left outside of the animal area.

With these precautions you can have great visits!

Contributed by Sarah Macdonald, MD, FAAP – CHOP Network High Point (Photo: Google Images)

Transitions: Hand Washing to Eating

ECELS is collecting transition ideas. How do you get all the children's hands washed, and keep their hands clean until they sit together to eat? Without a sink for every child to wash at the same time, what activities do you use for children who wash first to wait for those who wash last? Send your favorite ideas to ecels@paaap.org or fax them to 484-446-3255. We hope to collect good ideas to share in an upcoming issue of Health Link Online or as a Health Capsule.
Autism Resources

Autism spectrum disorder (ASD) is a developmental disability. ASD causes social, communication and behavioral difficulties. Children with ASD can be diagnosed and start to receive services as early as 2 years of age. Children with ASD can receive free services that help minimize their disability. These services can be provided at home, in a child care center, nursery school, play group, Head Start program, early childhood special education classroom or other settings.

Early education and child care providers can help identify children who might have ASD. Observations of a child’s behavior and development are essential. Early diagnosis and intervention can make a big difference. With therapy, many children with ASD can significantly reduce their disability. Learn about the signs and common symptoms of ASD on the CDC website at http://www.cdc.gov/ncbddd/autism/signs.html.

Watch every child for achievement of expected developmental milestones. Adapt the curriculum to reinforce newly achieved milestones and help children progress to the next level. The CDC offers a list of developmental milestones that children typically achieve by specific ages. This list of milestones for children from birth to 5 years of age is at http://www.cdc.gov/ncbddd/actearly/milestones/index.html. Check for any delay meeting the developmental milestones. If you are concerned, suggest the family discuss the concern with their child’s health care provider. Also, encourage the family to contact the Early Intervention (EI) help line without delay. The child should not lose the opportunity for early diagnosis and therapy. Call the EI system’s CONNECT Helpline at 1-800-692-7288. EI provides local services to children at no cost to the family. Learn more about Pennsylvania’s Early Intervention program at http://www.portal.state.pa.us/portal/server.pt/community/early_intervention/8710.

Mold and Moisture

Molds grow quickly in moist areas. They are a potent cause of allergy symptoms. Quick response to moisture collections is key. Clean up mold and moisture on hard surfaces with water and a detergent, then dry the surfaces so no moisture remains. Remove surfaces that cannot be completely cleaned.

Pay attention to the humidity of the air. Hardware stores sell inexpensive devices that measure humidity levels. Aim for an indoor humidity between 30% and 60%. Dehumidifiers remove moisture from the air. Use them where needed to keep humidity in the healthful range. For more information about how to safely clean mold and manage moisture in educational facilities, go to the Environmental Protection Agency website: http://www.epa.gov/mold/index.html. Some of the materials are available in Spanish as well as in English.*

*Keystone STARS programs that have concerns about mold or other environmental health issues may apply for a mini-grant for up to $5000. Application deadline: 7/31/15. See http://www.pakeys.org; search for “mini-grants program.”

Toddlers and Preschoolers: Helping parents form positive parent-child relationships

“Essentials for Parenting Toddlers and Preschoolers” is a free, online resource from the Centers for Disease Control and Prevention. It helps parents learn skills that form the foundation of a positive parent-child relationship. Fun video demonstrations show proven strategies. The site includes expert advice about common concerns. The tips include how to focus on encouraging good behavior, while decreasing misbehavior.

You can view these user-friendly materials by going to the CDC website at http://www.cdc.gov. Then put “Essentials for Parenting” in the search box.
Attention Deficit Hyperactivity Disorder—Are We Doing All We Can?

Is there a child in the early education program who is more active than the other children? Is this a child who doesn’t seem to pay attention or follow directions? Such children are very hard to handle!

Teachers/caregivers, the child’s family and the child will benefit from seeking guidance about how to care for a child with this behavior. Teachers should talk with a supervisor about a good way to share their concerns with the child’s family. The family may have similar concerns and not know where to turn for help.

Behavioral problems, inattention, hyperactivity, or impulsivity are symptoms of attention-deficit/hyperactivity disorder (ADHD). The American Academy of Pediatrics publishes clinical practice guidelines. One of these specifies how to assess, diagnose and treat children as young as 4 years of age who have ADHD symptoms. The guideline says that the child’s health care provider should do an assessment that includes a complete health history, vision, hearing and developmental-behavioral screening and a physical exam. The assessment may reveal one or more problems that require further evaluation.

With parent consent, the early education staff should offer to share with the child’s health care provider any information the program has collected about the child. Include any developmental-behavioral screening or observations. You can use the Behavioral Data Collection Sheet, a form in the Tools tab of the ECELS website. This sharing of information can be a valuable contribution to the health professional’s assessment.

The initial treatment for preschool-aged children with ADHD is evidence-based family and/or teacher-administered behavior therapy. Plan with the child’s therapist and family how the program staff should handle the child’s behavior. Consistent approaches at home and in the education program usually work well. The best way to do this is to have a written Care Plan.

Pedicractic health professionals will be aware of local options for behavior therapy for young children. A good starting point for families and teachers/caregivers to learn about “challenging behaviors” is to go to the PA Promise for Children website, www.papromiseforkids.org. Click on the “Help Your Child Grow” heading on the home page. Then select “Dealing with Challenging Behavior.” Caring for a child’s challenging behavior is difficult. However, the child will benefit when program staff, the child’s family and the child’s health care provider make and carry out a plan together.

Contributed by Beth DelConte, MD, FAAP - ECELS Pediatric Advisor

Reference: Center for Disease and Prevention (CDC)/Attention Deficit Hyperactivity Disorder (ADHD) http://www.cdc.gov/ncbddd/adhd/guidelines.html

Food Preparation Techniques for Tasty & Healthful School Meals

View free, online demonstrations of step-by-step, easy ways to prepare foods for children’s meals and snacks. Culinary Institute chefs show the proper techniques in 16 print and 51 brief video lessons. The foods are from the United States Department of Agriculture’s collection of recipes for schools. The National Food Service Management Institute at the University of Mississippi hosts the website with this excellent professional development resource.

In addition to the videos and print lessons, the website offers six online courses that allow users to earn continuing education credits. The print and video lessons, online courses and USDA recipes are at http://nfsmi.org/Templates/TemplateDefault.aspx?qs=cEIEPTlixNg.
Diaper Rash Prevention and Management

Infants and toddlers in diapers often get rashes—everything from tiny red bumps to more irritated tender areas.

Why do babies get rashes? One or more conditions can cause a diaper rash. The enzymes that help digest food can be irritating when they come out with feces (poop) into the diaper. Wet diapers can cause irritation where they are in contact with the skin. This is more likely to occur where the diaper rubs the creases of the upper thighs. Yeast growing in the warm, wet diaper areas can be another cause of diaper rash.

Some tips to help prevent diaper rashes are:

**Change diapers often.** Changing a diaper before it gets very wet and as soon after a child has a bowel movement helps. Prolonged contact of the skin with moisture from pee and/or feces irritates the skin.

**Avoid irritating soaps and wipes.** Use unscented and alcohol-free diaper wipes or just water rather than other skin cleaning products. Scented soaps and wipes that have alcohol in them can irritate a baby’s bottom. The ingredients in many soaps remove the skin’s natural oils. Without these normal oils on the skin, skin irritation is more likely.

If the diaper area is red and irritated, clean the skin by patting it with a diaper wipe, with cotton balls soaked in warm water or with freshly laundered, well-rinsed, soft, washcloths wet with water. Avoid rubbing the skin. Always use a fresh wipe, or different wet wash cloth each time you swipe. Once soiled, store reusable cloths in a washable, plastic-lined, tightly covered receptacle until they can be laundered.

**Consider use of a barrier product.** Ask the family to discuss with the child’s health care professional the use of a barrier product if an infant has ongoing difficulty with diaper rash. Barrier diaper creams or ointments can help protect the skin from irritation caused by rubbing on the moist and/or soiled surface of a diaper. They are over-the-counter products that contain petroleum or zinc oxide. If the child has had a problem with diaper rash that requires use of a barrier medication, the program should have instructions from the child’s health care provider and permission from the child’s parent to use it. The product’s container should have the child’s name and instructions for use too. Put 2 or 3 tablespoons of the barrier cream on a facial tissue and bring it that way to the diaper changing surface. (Do not bring any of the containers of supplies to the diapering surface. Everything on the diapering surface will need to be disinfected after the diaper change.)

Apply the barrier in a thick layer, spreading it gently and smoothly across the diaper area. Be sure to cover the creases of the upper thighs under the edge of the diaper. When cleaning the child, remove only the soiled barrier product. Rubbing to remove the unsoiled lower layer of barrier product will irritate the skin.

The recommended medication administration and diaper changing procedures are in *Caring for Our Children, (CFOC3)* Standards 3.6.3.1 and 3.6.3.2 for medication administration and Standard 3.2.1.4 for the diaper changing procedure. Access these standards at [www.nrckids.org](http://www.nrckids.org).

Follow the instructions from the child’s health care provider and the CFOC3 recommended procedures when using any diaper cream. Some diaper creams contain active ingredients that are not for prolonged use. Documentation of the product applications can be as simple as having a check mark in a diaper cream column on a diaper change log sheet. Note the date and time of the diaper changes there. This lets families know about the frequency of diaper changes and use of recommended medication.

If a diaper rash is bleeding, seems very sore to the child, or lasts more than a few days, be sure to seek guidance from the child’s health care provider and check the procedures being used by anyone who is changing the child’s diaper.

Contributed by Sarah Macdonald, MD, FAAP, CHOP Care Network High Point
Medication Measurement

Many children’s medicines come in liquid form. Household spoons may be handy for giving children liquid medicines, but using them is not a good way to give the correct dose. Parents and educators should use a syringe, special medicine cup, special dosing spoon or dropper. These devices are marked in milliliters (mL).

Different household teaspoons hold different amounts of liquids. Tablespoons vary in size too. A spoon that gives too little medicine may keep the medicine from working. If a spoon gives too much medicine, the overdose may cause a serious problem. For example, repeatedly giving a child too much acetaminophen (Tylenol®) can lead to liver failure. More than 70,000 children go to emergency rooms each year for accidental medicine overdoses. Use of the wrong measuring device causes some of these.

Many liquid medicines come with a special dose measuring device calibrated to accurately measure the particular medication. Be sure to use it. If there is no device with the medication, a pharmacist can provide one. If a syringe is used, squirt the medication slowly and gently between the child’s tongue and the side of the mouth. This makes it easier for the child to swallow the medicine.

The American Academy of Pediatrics urges parents, physicians and pharmacists to use only metric measurements for oral liquid medications. Metric measurements for liquids in milliliters (ml) or cubic centimeters (cc) should be on prescriptions, medication labels, and dosing devices. This helps children get the correct dose of medication. Do not measure liquid medication in teaspoons or tablespoons.

Please share this information with teachers/caregivers and families. Download and display the new poster in English and in Spanish. Copy and distribute the updated article - also available in both English and Spanish. To access the article in in Spanish, click on “en Español” on the page. On the same page, you can listen to the article read to you in English or Spanish.

Families and early childhood educators need to understand how much medicine to give. They should know how often and how long to give it. If they are uncertain about the instructions, they should not give the medication until they have asked the child’s health care provider about how to do it. Use the forms in the Medication Administration Packet, Appendix X in Model Child Care Health Policies, 5th edition. This publication is available at www.ecels-healthychildcare pa.org.

Health professionals recommend keeping medicine out of children’s reach. Use child safety caps, understanding that these are not “child-proof.” They make it harder for the child to open the medicine, giving adults more time to stop the child from getting the medicine. Check labels carefully before giving two medicines together because they may have the same ingredient. Do not mix medicine with food unless the instructions on the medicine say to do so. Also, urge families to bring a list of all medicines the child is taking each time the child sees a health professional.

For medicine mistakes, call the Poison Help number at 800-222-1222. If the child is unconscious, not breathing or having seizures, call 911 first. Be careful when getting rid of unused medicines. In some places, you can drop off medicines at a police department. Make sure to remove labels with personal details. Another way to safely dispose of medicines is to mix them with coffee grounds or kitty litter in a plastic bag you can seal. Throw this sealed bag away in a trash container where children and animals can’t get to it. Don’t dump the medicine in the toilet or drain, unless the medicine label says it is safe to do it. If you aren’t sure how to dispose of a medicine, ask a pharmacist about what to do.

Contributed by Nancy Alleman, ECELS Lead Training and Technical Assistance Coordinator, in collaboration with Ian M. Paul, M.D., M.Sc., FAAP, a member of the American Academy of Pediatrics Committee on Drugs.
Staff Health Risk in Pregnancy

Since 1986, conference workshops, professional journal articles, manuals, national standards, and sample forms have described the risk to an unborn child if a pregnant mother is exposed to certain infections that commonly spread in groups of young children. Employers of female early education staff of child-bearing age should educate their staff members about this risk. They should urge them to discuss with their health care providers how to reduce their risk.

Cytomegalovirus (CMV) is one of the infections that pose a risk to an unborn child. CMV is a common infection among young children, usually without symptoms. Between 30% and 70% of children less than 3 years of age in child care excrete the virus in their urine, saliva and blood at any one time. Excretion of the virus may occur intermittently for years after the first infection. Women who work in child care may or may not be immune to the strains of CMV infecting children in their care. If a woman has her first CMV infection while pregnant, or has a CMV infection with a different strain than the one she had previously, her unborn child is more likely to be infected.

In utero (congenital) CMV infection occurs in only 1% of live births. However, CMV is the most common viral infection of babies before they are born and the most common cause of sensorineural hearing loss. About 10% of the CMV-infected babies have some symptoms or signs at birth. Those who do may have devastating multi-organ damage. These include poor growth, liver damage, brain damage, hearing loss, blindness, underdeveloped brains and developmental delay. About half of infants who have some symptoms of CMV at birth develop hearing loss from damaged nerves that are needed to carry sound sensations to the brain from the ear. About 15% of those who are infected but have no symptoms of CMV infection at birth develop this type of hearing loss as they grow older. In many children, the degree of hearing loss is progressive.

Nurses who conscientiously practice recommended hand hygiene don’t get CMV infections from their CMV infected patients at a higher rate than other women. Teachers/caregivers of groups of young children could similarly reduce their risk by practicing hand hygiene after every contact with urine, saliva or blood. However, achieving this level of hand hygiene is challenging in group care. Teachers/caregivers have contact with more than one drooling child at a time, and frequently touch saliva coated toys or other surfaces. They change diapers or soiled underwear for children in their group multiple times a day.

At the least, women who teach groups of young children need to know how to reduce the risk if they might become or are pregnant. When properly informed, they can consider three options: 1) be very careful about practicing hand hygiene, 2) decide to provide care for preschool or older children instead of infants and toddlers when pregnancy is possible, or 3) choose to work in settings where they have less risk of contact with body secretions of young children.

Employers should explain CMV and other common occupational health risks verbally pre-employment. The information should be in an employee handbook given to each staff member, and discussed at a staff meeting at least once a year. It’s best practice to use a Staff Health Assessment form that lists the common occupational risks. The list may prompt the health care provider who completes the form to assess and discuss these risks. Many health care professionals are unaware of the tasks performed by women whose work involves close contact with groups of young children. A list of these occupational risks is in Caring for Our Children, Managing Infectious Diseases in Child Care and Schools, and in Model Child Care Health Policies. Each of these publications has a sample Staff Health Assessment Form too.

Teach early education staff members about each of their occupational risks. Then have them sign a statement acknowledging the teaching received, that they understand and know how to reduce each risk, and that with this knowledge, they accept the risks.