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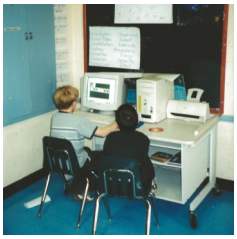
Screen Time, Digital Media Literacy: What's an ECE Practitioner to Do?

Two expert policy statements make recommendations about the appropriate use of media by young children. One is a statement from the National Association for the Education of Young Children (NAEYC) in partnership with the Fred Rogers Center for Early Learning and Children's Media (FRC). The other is from the American Academy of Pediatrics (AAP).

Digital media devices are appearing faster than researchers can determine how their use affects young children. Children have access to electronic tablets, cell phones, digital cameras and computers. While we wait for definitive research, we must rely on the expert policy statements from NAEYC-FRC and the AAP.

Caring for Our Children, third edition (CFOC3) 2011[1] includes the recommendations for early care and education facilities of two national organizations, the American Academy of Pediatrics and the American Public Health Association. CFOC Standard 2.2.0.3 cites AAP policy that discourages TV viewing for children younger than 2 years of age. In addition, the standard says that the total screen time for older children during child care hours should be no more than 30 minutes once each week. This allowable 30 minutes should be only for physical activity or educational purposes. In child care, children should use computers for no more than 15 minutes at a time, except for school-age children doing homework assignments and use of assistive computers by children with special needs.



While at home, children often exceed the policy of no more than a total of 1-2 hours of screen time per 24 hours.[2] This passive screen time displaces more developmentally appropriate activities. Examples of better activities are mutual conversation with or reading by caregivers, and active floor time for development of gross and fine motor skills.

Researchers have found that having a television on in the background decreases the amount of speaking that a caregiver engages in with an infant by 80%! When caregivers and infants "speak" or babble to each other, the infants learn language. Listening to television conversation does not teach infants to speak.

A study that examined 12, 24, and 36-month-old children found that background television reduced the length of time that a child played. Excessive passive screen time viewing can decrease physical activity. It also reduces the child's focused attention during play. A major goal for all children is to develop their ability to focus on a task. In addition, watching TV exposes children to commercials promoting sugary and fattening foods.

The Pennsylvania's Office of Child Development and Early Learning (OCDEL) has an initiative which aims to guide the field in the appropriate use of digital media in early childhood settings.

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First Aid Corner - Bruises & Swelling

1. Apply cold with a cloth between the cold source and the injury for up to 30 minutes at a time, then remove it briefly to restore normal circulation before applying cold again.
2. Put pressure on a bruised or swollen area with a stretchy roll of bandage. Make it only tight enough to press on the injured area, but not to cut off blood flow to it. Check the color of tissue below the site of injury to be sure it remains pink, and not pale or blue.
3. Elevate the injured part except when you suspect a broken bone or spinal injury.

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Dr. Barbara Minzenberg, Deputy Secretary of OCDEL, and Dr. Beth DelConte agree that children need to be digital media literate for a successful future. Those who are "at risk" for school failure will benefit most from being "literate" in the use and selection of interactive technological tools.

NAEYC's 2012 policy statement[3] defines *interactive media* as "digital and analog materials, including software programs, applications (apps), broadcast and streaming media, some children's television programming, e-books, the Internet, and other forms of content designed to facilitate active and creative use by young children and to encourage social engagement with other children and adults." "Non-interactive media include certain television programs, videos, DVDs, and streaming media now available on a variety of screens." Non-interactive technology tools and media are not included in NAEYC's definition of effective and appropriate use. Non-interactive media can lead to passive viewing and over-exposure to screen time for young children. They are not substitutes for interactive and engaging uses of digital media or for interactions with adults and other children. NAEYC-FRC and AAP policy statements emphasize that screen time, when used, should be interactive. The key word is interactive!

Dr. Roberta Schomburg, a Fred Rogers Fellow, writes that, "during the preschool years, young children are developing a sense of initiative and creativity. They are curious about the world around them and about learning. They are exploring their ability to create and communicate using a variety of media (crayons, felt-tip markers, paints and other art materials, blocks, dramatic play materials, miniature life figures) and through creative movement, singing, dancing, and using their bodies to represent ideas and experiences. Digital technologies provide one more outlet for them to demonstrate their creativity and learning." Dr. Schomburg offers the following examples of appropriate use of digital media for preschool-age children:

- Explore digital storytelling with children.
- Co-create digital books with photos of the children's play or work.
- Attach digital audio files (to the created books) with the child as the narrator.
- Capture photos of block buildings or artwork that children have created.
- Videotape dramatic play to replay for children.
- Use video-conferencing software to communicate with families and children in other places.

Technology and media use must be appropriate to the age, developmental and language level, needs, interests and abilities of each child. Most technology and media are inappropriate for children from birth to 2 years of age. No documented research supports an association between passive viewing of screen media and specific learning outcomes in infants and toddlers. Infants and toddlers need responsive interactions with adults. Mobile, multi-touch screens and newer technologies have changed the way our youngest children interact with images, sounds, and ideas. Caregivers/teachers must be sure that any exposure to technology and media is limited to developmentally appropriate, standards-based, and intentional activities. It is not a substitute for direct interpersonal interaction. It should include shared joint attention and language-rich interactions.

This article was written by Beth DelConte, MD, FAAP- ECELS Pediatric Advisor with contributions by Roberta L. Schomburg, PhD, Associate Dean and Professor, Carlow University School of Education, Pittsburgh and Barbara G. Minzenberg, PhD, Deputy Secretary, PA Departments of Education and Public Welfare, Office of Child Development and Early Learning.

References:

[1]Caring for Our Children: National health and safety performance standards; Guidelines for early care and education programs. 3rd edition. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association. Available at http://nrckids.org (accessed 4/3/13.)

[2]Media Use by Children Younger than 2 Years, AAP Policy Statement, Council on Communications and Media, http://pediatrics.aappublications.org/content/early/2011/10/12/peds.2011-1753.full.pdf+html (accessed 4/3/13.)

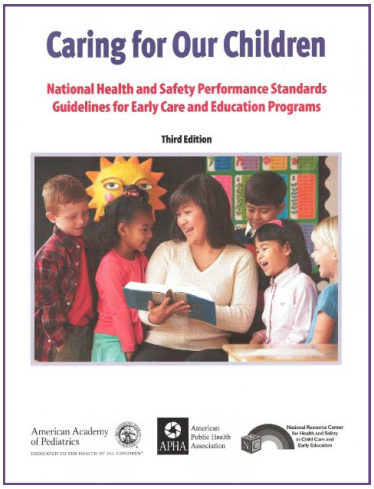
[3]Technology and Interactive Media as Tools in Early Childhood Programs Serving Children from Birth through Age 8, A joint position statement of the National Association for the Education of Young Children and The Fred Rogers Center for Early Learning and Children's Media at Saint Vincent College, www.naeyc.org/files/naeyc/file/positions/PSTECH98.PDF (accessed 4/3/13.)

Active Supervision: What is Required?

Active supervision minimizes harm to children from injury and illness. It is an essential component of quality care. Requirements for active supervision appear in the *Environmental Rating Scales*, *Caring For Our Children,* 3rd edition and in the *Head Start Performance Standards.*

Many states use the Environmental Rating Scales to measure quality in group care.[1] Comparable items directly related to active supervision appear in the 4 rating scales: ITERS-R (infant-toddlers), ECERS-R, (Early Childhood) FCCERS-R (family child care) and SACCERS (school age child care). For better scores on items 29 and 30 of the ECERS, staff members must:

- Protect safety, including preventing dangerous situation before they occur
- Position themselves to see all areas, and move around as needed
- Offer help when needed and remain aware of the whole group even when working with one child or a small group
- Talk with children about what they are doing and intervene to manage problems
- Organize the environment to enhance play and promote positive child-to-child social interactions.



Caring for Our Children 3rd edition (CFOC3)[2] is the prime national reference for health and safety in early care and education programs. CFOC3 is a widely cited publication of the American Academy of Pediatrics, the American Public Health Association and the National Resource Center for Health and Safety in Child Care and Early Education.

Among the many CFOC3 standards related to supervision are those that describe the overall methods of supervision (Std. 2.2.0.1), keeping children safe during feeding (Std. 4.5.0.6) ,water activities (1.1.1.5) , sleep and rest (Std. 3.1.4.1), transport (Std. 6.5.2) and when children are ill (Std. 3.6.2) too.

Supervision must be by sight and hearing at all times, in the room when inside, and in the same space outside. Supervision methods should include:

- Count children, name to face on a scheduled basis, at every transition, and whenever leaving an area and arriving at another area. At all times, each caregiver/teacher must be able to state how many children and which children are in her care. Counting should occur at least every 15 minutes, using a timing device to remind staff to count.
- Maintain required child:staff ratios at all times, on the facility premises, and during excursions off-site
- Follow specific safety precautions for each area and all equipment
- Have at least 2 staff members present at all times if more than 6 children are in care
- Assign caregivers/teachers to individual children, and if using "zone" supervision with staff assigned to an area, then intentionally notify staff in another area when a specific child is moving from one staff member's zone of supervision to another's.
- Keep children out of any area not easily observed by a staff member so a child can't hide from adult view. Keep gates and doors shut to keep a child from wandering off.

Head Start Performance Standards require active supervision.[3] The specific standards involved are 45 CFR 1304.52, 1304.53, 1306.32, and 1306.35. A Head Start Fact Sheet about active supervision includes vignettes and key strategies for active supervision.[4] Although written for Head Start, these key strategies are applicable to all age groups, in any type of group care program and for all activities:

- Set up the environment – Keep furniture at waist height or shorter, avoid clutter, make all spaces fully observable
- Position staff – Choose locations of adults that enable hearing and seeing all the children and having a clear path to each child if it is necessary to take quick action. Caregivers/ teachers stay close to children who might need special help or support.
- Scan and count – Keep checking the location and activity of each child. Count the children frequently and especially during transitions from one location to another.

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- Listen – Pay attention to the sounds in the environment. Use sounds such as a bell attached to doors in the room, or equipment being moved for use that needs close supervision.
- Anticipate children's behavior – Be aware of typical behavior and possible unusual behavior. Specific characteristics or stress experienced by an individual child may require modifying supervision, planned activities or other elements to help a child succeed and avoid harm of harming others.
- Engage and redirect – Give children opportunities to problem solve, using observation to intercede when the child needs support.

The Head Start Fact Sheet offers some reflective questions to help assess current practices, and then implement improvements. Consider combining the requirements in the ERS, CFOC3 and in the Head Start Fact sheet into a checklist to use with the reflective questions during a staff meeting. Suggest a way that each caregiver/teacher could have a turn to observe and share with those observed what they saw, using the items on the checklist to observe groups of children other than their own. Talking about what is expected and observing for each element will raise everyone's awareness about active supervision. Collaboration among co-workers is essential to achieve active supervision.

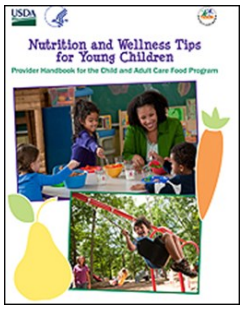
References

[1]Harms T, Cryer D, Clifford D, ECERS-R 2005. ITERS-R 2006. FCCERS 2007, SACERS 1995. Environment rating scales, Frank Porter Graham Child Development Institute, University of North Carolina. Print copies from Teachers College Press. Updated Notes for Clarification from the Environmental Rating Scales Institute http://www.ersi.info/index.html (accessed 3/10/2013.)

[2]National Resource Center for Health and Safety in Child Care and Early Education. (2011). Caring for our children. HHS/HRSA/MCHB. Retrieved from: http://nrckids.org/CFOC3/ (accessed 3/10/2013.)

[3]Head Start Program, Performance Standards, 45 CFR Chapter XIII, (10-1-09 Edition) http://eclkc.ohs.acf.hhs.gov/hslc — select Policy & Regulation tab, and then open the PDF file (accessed 3/17/2013)

[4] The Early Childhood Learning & Knowledge Center of Head Start at http://eclkc.ohs.acf.hhs.gov/hslc - search for "Active Supervision" (accessed 3/10/2013.)



Nutrition and Wellness Tips for Young Children

In February 2013, the U.S. Department of Agriculture (USDA) Team Nutrition released a new Provider Handbook. Find the handbook online at www.teamnutrition.usda.gov. Although you can use the online handbook on-now, hard copy print copies will be available free of charge for online ordering in the summer of 2013. The handbook is for users of the Child and Adult Care Food Program (CACFP) and anyone else involved with an early education and child care program.

This handbook includes a series of 10 tip sheets with advice about wellness. There are 10 Nutrition Tip Sheets, 4 Active Play Tip Sheets, and 2 Appendices. The appendices are about Choking Prevention and Care for Children with Food Allergies. Use the tip sheets to plan healthful meals and activities for children ages 2 to 6 years old.

Breastfeeding & Early Childhood Educators

Ample research shows that babies have the best chance for a healthy life when their mothers breastfeed them for a year or more. Early care and education providers can make a difference by sharing information and supporting a mother's willingness to breastfeed. Supporting the needs of breastfeeding mothers in early care and education programs is easy.

Breastfeeding provides many benefits for both mother and baby. Mothers who breastfeed have a lower risk of breast cancer, obesity, and diabetes. Babies who are **formula fed** have a **higher** risk of cancer, diabetes, obesity and Sudden Infant Death Syndrome (SIDS.) Breastfeeding is also economical and very convenient. Sharing information about breastfeeding helps mothers make an important decision about their health and the health of their baby.

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Early childhood educators can encourage mothers of infants to breastfeed by telling them about the benefits of breastfeeding and what the program is willing to do to help. A breastfeeding mother will be reassured by hearing about how caregivers/teachers will store her milk, and how they will make sure that her baby gets only her milk. Ask about the mother's schedule. Ask her to leave enough labeled bottles of her breast milk so that her baby can be fed if she gets delayed at pick-up time.

In the national health and safety performance standards for child care, *Caring for Our Children* states, "Facilities should encourage, provide arrangements for and support breastfeeding." Specific recommended actions in Standard 4.3.1.1 include:

- Organize a quiet, comfortable, and clean place in the facility for mothers to breastfeed their babies. Provide an electric outlet there so that mothers can pump their breast milk. Parents and staff members can use this place to breastfeed.
- Provide a list of community resources that offer help with breastfeeding.
- Find out whether the mother is feeding the baby on a schedule or on cue. Ask her if she wants the facility feeding of her baby timed so the baby is hungry and eager to breastfeed at pick up time.
- Include a breastfeeding policy in the written policies for the facility. To retrieve a sample breastfeeding policy for use in child care facilities, see the ECELS Breastfeeding Friendly Child Care Self-Learning Module at http://www.ecels-healthychildcarepa.org. Successfully completing the module provides two hours of PA Keys Professional Development Credit. The module meets the STAR Level 2 Performance Standard for Health and Safety and addresses several ITERS-R categories also.

Receiving, storing, preparing and feeding breastmilk requires attention to some specifics addressed in *Caring for Our Children*, Standards 4.3.1.3 and 4.3.1.4. Some of the key points are listed below:

- Instruct mothers to:
  - ◊ Clean and sanitize the bottle, nipples and any spill-proof container used to hold the milk in a dishwasher or by hand in the same way she washes dishes, glassware and tableware. Glass bottles or plastic bottles labeled BPA-free or with #1, #2, #4, or #5 are acceptable. Single use plastic bags sold for storage and subsequent feeding of human milk are OK.
  - ◊ *Use waterproof ink* on a label that will stay on the bottle if the milk bottle or bag is warmed in water. Write the infant's full name, date and time the milk was expressed on the label. Put the expressed human milk in the labeled bottle or bag and place it in a spill-proof container. Either refrigerate or freeze the milk. It's a good idea to bring it to the facility in an insulated container to keep it cool.
  - ◊ On arrival, store the bottle or container in the facility refrigerator, or, if frozen, in a freezer section or stand-alone freezer, not in a compartment shared with a refrigerator.
- As with formula feeding, remember hand hygiene before and after every feeding.
- Use the mother's expressed milk only for her own infant. Check the infant's full name and the date on the bottle so that the oldest milk is used first and for the right child. *The only exception is in the case of siblings. If twin A gets milk labeled for Twin B, that is fine.*
- Thaw frozen human milk in the refrigerator or under cool, running tap water. Warm milk for feeding briefly in bottle warmers or under warm running water so that the temperature does not exceed 98.6°F. Swirl, but do not shake the milk container gently to distribute the temperature evenly. Test the temperature of the milk before feeding.
- Do not use infant formula for a breastfed infant without the mother's written permission.

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- At the end of the day, return to the mother any human milk of more than an ounce left in a container that was not used for direct feeding.
- Older infants may drink expressed human milk from a clean cup with the help of a caregiver/teacher to avoid spills.
- Show and explain to the mother why the program did not feed any milk from an unsanitary bottle, or milk that is curdled, smells rotten, and/or has not been stored according to the storage guidelines of the American Academy of Breastfeeding Medicine. These are the guidelines in *Caring for Our Children*, Standard 4.3.1.3.

The support a child care program gives to continue breastfeeding for at least the first year of life can make a difference for many years after.

Contributed by Nikki Lee, Lactation Consultant, Philadelphia Department of Public Health and **Dottie Schell, Program Director,** Breastfeeding Education, Support and Training (BEST)

In this Issue:

Lead Poisoning: PA News

Lead damages brain and other body tissues. Even low levels of exposure can irreversibly reduce a child's ability to learn. Lead can cause challenging behaviors too. Chips and dust from old lead-based paint is the main source for childhood lead poisoning. Just a little wear and tear inside or outside an old building can loosen lead paint dust or chips. Lead can be in room dust and in soil around buildings. The hand-to-mouth activities of young children make them very vulnerable.

Lead-containing paint was banned in 1978. The PA Department of Health estimates that 70% of PA homes were built before 1978. PA ranks 4th in the nation for having the most houses built before 1978. For decades, health professionals focused on individual home exposures. Although many child care programs use buildings built before 1978, no state-wide requirement exists for doing lead checks in these facilities.

Many health professionals screen children for the need to do blood lead testing by asking about the age of the child's home. Few think to ask about the age or condition of other places where the child routinely spends time. Blood levels of less than 10 micrograms/deciliter can affect the child's mental and physical health. In 2012, the Centers for Disease Control and Prevention lowered this threshold for harm to 5 micrograms/deciliter.

PA child care regulations prohibit "peeled or damaged paint or damaged plaster… on indoor or outdoor surfaces in the child care facility." (See regulation PA §3270.77, §3280.77, §3290.75.) The national health and safety best practice Standard 5.2.9.13 in *Caring for Our Children* (CFOC) specifies testing for lead in child care facilities. In addition to painted surfaces, the standard requires testing of the grounds, grassy areas and dirt around and under outdoor surfaces that children use.

For suggestions about how to have lead tests done in a child care facility, contact the state, county or municipal Department of Health. Currently, the Childhood Lead Poisoning Prevention Program (CLPPP) may provide education to families or child care home providers, and in some cases may assist with testing homes to identify sources of lead. Local CLPPP providers can be found at the state Department of Health website: http://www.portal.state.pa.us/portal/server.pt?open=514&objID=558056&mode=2

In July 2013, Pennsylvania will implement a new program, "Lead and Healthy Homes" that may provide a way to reduce lead exposure in home-based child care facilities. For more information, contact Tara Landis at talandis@pa.gov or 717-772-2762.

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