



# NORTHSTAR LEARNING CENTERS

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## Health and Safety Manual

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## Introduction

### **Purpose of this manual**

Programs that serve children and youth have no greater responsibility than ensuring their health and safety, especially while they are participating in the program. Indeed, if programs cannot keep participating children and youth safe and healthy, then all other goals that the programs may have for them are beside the point. This *Health and Safety Manual* has been developed by NorthStar Learning Centers to provide employees at all levels with a general reference document to assist them in providing safe, healthy programs for children, youth, and families. Consistent with current trends in the public health field, the contents of this manual reflect a broad definition of health and safety among children, youth, and families. Staff job performance and competency will be measured by, among other things, adherence to the policies and procedures contained in this manual.

### **What this manual contains**

Some parts of the manual (such as the medical emergency plan, the injury prevention plan and procedures, and the evacuation plan and procedures) apply to all programs and will be reviewed by all employees. Other sections describe procedures relating to a specific program or set of programs; for example, supervision of children, safe medication administration, and sanitation and hygiene mainly pertain to our early childhood and afterschool programs.

The level of detail included in the manual varies widely among the different sections. For some critical activities such as the medical emergency plan, toileting and diaper changing, cleanup of blood and other bodily fluids, and medication administration, the section provides fully detailed procedures. On some topics, however, such as injury prevention, the section provides an overview and is intended to serve as a general information resource.

### **Availability**

Because of new requirements and standards, NorthStar like many other organizations, has turned our health and safety policy manual into an electronic document to make updating easier and ensure that employees refer to the most current version. During their initial orientation, new employees will be instructed on how to access the Online *Health and Safety Manual* at the NorthStar website <http://www.northstarlc.org/> and assigned to read it and become familiar with the policies, procedures, and practices they will be expected to follow. Then and at any time thereafter, employee should not hesitate to ask their supervisor or program administrator for further information or clarification. An up-to-date paper copy of this manual will be placed in each facility in a designated place near a telephone that can be used for making emergency calls.

### **Revising this manual**

This *Health and Safety Manual* is informed by numerous sources, including, but not limited to:

- 1) Massachusetts Department of Early Education and Care licensing standards and technical assistance papers for early childhood and afterschool programs;
- 2) *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs* by American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education;
- 3) Council on Accreditation standards for child and youth development programs.

This manual will always be a work in progress. Recent events suggest that children's programs are vulnerable to new threats. We regularly review and amend our health and safety policies,

procedures, and practices to align with new research findings and recommendations, to respond to emerging social issues and concerns, and to comply with new laws, regulations, and accreditation standards. The organization's health care consultant approves any changes in its health and safety policies, procedures, and practices.

Maintaining safe, healthy, and secure workplace and program environments requires open, ongoing communication between all employees, including administrators and directors, on all facility safety, health, and security issues. We welcome questions, comments, and suggestions concerning the *Health and Safety Manual*, including concerns about what isn't covered that should be. We strongly encourage you to bring your feedback to the attention of your supervisor or any other administrator.

► As used in this manual, the term "parent" includes legal guardian or person in a parental relationship.

# 1. Managing Personal Health and Safety Emergencies

Part 1 of this *Health and Safety Manual* is intended to assist staff in responding to emergency situations that generally involve an individual child or a small group of children:

- 1) Injuries requiring medical or dental care;
- 2) Serious illness requiring hospitalization;
- 3) Suspected sexual, physical, and emotional abuse or neglect of a child;
- 4) A lost or missing child.

## 1-1 Emergency Phone Access and Numbers

All staff will have ready access to a facility phone, cell phone, or other communication device that enables them to immediately summon help in an emergency.

The telephone numbers of the New Bedford and Police departments, Southcoast Hospitals Group, the state Poison Control Center, the Department of Early Education and Care (EEC), and the Department of Children and Families (DCF) will be posted by each phone with an outside line. Emergency contact information for each child and staff member will be kept in a readily accessible location. The Business Office and the director will maintain phone numbers for contractors/contacts (in the case of leased facilities or school-based program sites) who provide or arrange specific types of building repairs for each program facility. Business Office staff or the director will call these contractors/offices about problems with electricity, heating, plumbing, snow removal, general maintenance, and trash removal. The list of emergency phone numbers, along with copies of children's emergency contact information and authorization for emergency transport, will be taken along anytime children leave the program facility on a program-sponsored excursion. Emergency phone numbers will be updated at least every 6 months.

## 1-2 Medical Emergency Plan

### Plan for immediate medical assistance

When a child/youth sustains an actual or suspected injury, looks or seems very sick, or was possibly exposed to hazardous materials, staff will:

1. Assess life/health issues immediately. Anytime you know, reasonably believe, or are unsure whether any delay in emergency medical attention poses a risk of permanent impairment or loss of life, call 911 right away to summon emergency medical services. Whenever practicable, include more than one trained staff member in assessing an injury or apparent illness. It is especially important to consider the possible severity of a head injury. In some cases an injury may warrant immediate medical attention and in other cases an injury may need continued observation to determine if symptoms for a possible concussion are present. A call to 911, however, ensures expert opinion.
2. Provide appropriate first aid for the injured child/youth and observe for any changes that warrant further assistance. Another staff member takes other children/youth to another area or room. In EEC-licensed programs, we are required to maintain appropriate staff-child ratios during a medical emergency. In youth programs, staff should ensure that program youth on site remain safely supervised.
3. Notify the child's/youth's parent or the parent's emergency contact. Provide immediate, full, and accurate verbal notification to parent regarding an injury (with written notification to the parent within 48 hours). Ask the parent to come and pick up their child or, if response time is a factor, have the parent meet their child where they are being transported—unless on a field trip, the emergency room of St. Luke's Hospital, 101 Page Street, New Bedford. If the parent can't be immediately located by phone, enlist the emergency contacts to help reach them. A designated staff person will continue efforts to make direct contact with the parent.

#### Call emergency medical services immediately if:

- You believe the child's/youth's life is at risk or there is a risk of permanent injury.
- The child/youth has difficulty breathing or is unable to speak.
- The child's/youth's skin or lips look blue, purple, or gray.
- The child/youth has rhythmic jerking of arms and legs and a loss of consciousness (seizure).
- The child/youth is unconscious.
- The child/youth is acting strangely, much less alert, or much more withdrawn than usual.
- The child/youth is less and less responsive.
- The child/youth has increasing or severe pain anywhere.
- The child/youth has any of the following after a head injury: decrease in level of alertness, confusion, headache, vomiting, irritability, or difficulty walking.
- The child/youth has a head injury where the skin is split wide open or gaping and may need stitches.
- The child/youth has a cut or a burn that is large, deep, and/or won't stop bleeding.
- The child/youth is vomiting blood.
- The child/youth has a severe stiff neck, headache, and fever.
- The child/youth is seriously dehydrated: sunken eyes, lethargic, not making tears, not urinating.

4. Accompany the child/youth to the hospital. In all cases, a staff person who knows the child/youth and the circumstances of their illness or injury must accompany them to the

hospital and remain there to inform and support the parent when they arrive. The staff member should bring the child's emergency information, including a listing of the child's health care providers. The staff member's responsibility extends beyond accompanying and remaining with the child/youth until the parent can assume responsibility. Where going to a hospital can be stressful and emotionally draining for the parent as well as their injured/ill child, the staff member should expect a range of emotions/responses from the parent and be prepared to provide basic emotional support to them as they attempt to cope with the emergency situation. If the child/youth is hospitalized, center/program staff should check in with their family until the child returns home.

### **After the event**

Complete post-incident notifications and reporting:

1. Inform the program administrator/supervisor and executive director as soon as practical about the emergency medical treatment, hospitalization, or death of a child/youth at the program.
2. Complete an injury report form. As soon as possible after first aid is administered, obtain the following information:
  - *What was the child doing?*
  - *Was any equipment involved?*
  - *Was another child involved?*
  - *Were any hazards involved?*
  - *Were there any witnesses?*
  - *What did the witnesses see?*

Obtain all information regarding the injury from staff members before they leave for the day. Have an employee who witnessed the accident or onset of illness complete an injury report form as soon after the incident as practical. The director/supervisor should review the completed form to ensure its accuracy, factualness, and specificity. Give to the parent within 24 hours of the injury or onset of illness—preferably, on the same day that the incident occurred—and place a copy in the child's/youth's file and, in the case of an EEC-licensed facility, the facility's injury log.

3. Immediately inform the appropriate state agency—EEC for children enrolled in EEC-licensed programs or DCF for youth participating in DCF-funded programs—about an emergency medical treatment, hospitalization, or death of a child/youth from an injury or illness that occurred at the program. If the illness or injury occurred at an EEC-licensed facility, the director must complete an EEC injury report or a program injury report that includes all required information; include all pertinent information and any attachments (such as copies of the first aid and CPR certification of employees who administered first aid or CPR and, if available, documentation of emergency medical treatment). Submit required documentation to EEC within 5 business days of the injury or illness.
4. Report suspected child abuse or neglect. As mandated reporters, employees must notify the DCF area office if they reasonably believe the child's/youth's injury or illness resulted from abuse or neglect, no matter where the suspected abuse or neglect may have occurred. To make a report at after 5 p.m. and on weekends and holidays, staff must call the MA Child Abuse Emergency Line: 800-792-5200 (anytime of the day or night). Within 48 hours after making the oral report, they must submit a written report to the DCF area office.
5. Direct all inquiries about the emergency situation to the executive director or their designee. Do not make a statement of any kind about the situation to anyone other than NorthStar staff, the police, or DCF and EEC investigators.
6. Be prepared to inform staff, children, families, and the community. In response to serious illness, hospitalization, or death related to program participation, the executive director will

inform employees, families, and the community as appropriate. As the media often reports on situations without full or correct details, it is important that the parents of all children/youth in the program are made aware of the incident. Media representatives will be allowed access to the program at a time when employees and families have been informed and when such visits will cause the least amount of disruption to the program.

### **Urgent situations that require medical attention**

Some children/youth may have urgent medical needs that do not necessarily require ambulance transport but still need medical attention. The box below lists some of these situations. The parent should be immediately informed of the following conditions. If staff or the parent cannot reach the physician within 1 hour, the child/youth should be brought to the hospital.

#### **Seek medical attention within 1 hour when:**

- A child/youth of any age has a fever and looks more than mildly ill;
- A child less than 2 months (8 weeks) old has a fever;
- A child/youth develops a quickly spreading purple or red rash;
- A child's/youth's stool contains a large volume of blood;
- A child/youth gets a cut that may need stitches;
- A child/youth experiences any medical condition specifically identified in their individual care plan requiring parental notification.

*For EEC-licensed programs:* If the emergency is non-life threatening and the child is transported to the hospital by the center/program, one staff member will drive and another staff will accompany the child/youth for comfort. Ensure that the child is properly restrained in an appropriately-sized car seat or in a seat belt.

If the parent comes to pick up the child/youth and needs assistance, staff may offer to drive to the hospital or to accompany the parent and child/youth.

### **Standard precautions**

Only employees who hold a current pediatric first aid certificate can administer emergency aid, including treatment of minor injuries such as cuts, scrapes, and bruises. Consistently follow standard precautions when treating accidents:

1. Disposable latex (vinyl for those allergic to latex) gloves should be worn if there is contact with any blood, blood-containing fluids, or any bodily fluids if the staff member has cuts or breaks on their hands.
2. If a child/youth requires aid right away, a blanket or article of clothing can serve as a barrier until the staff member can put on gloves.
3. If a child's/youth's personal clothing is spattered with blood or blood-containing body fluids, it should be changed as soon as possible, placed in a sealed plastic bag that is labeled with the child's/youth's name, and returned to the parent at the end of the day.

### **Minor injury reporting requirements**

Any injury, even if it does not require first aid, requires parent notification the same day the injury occurred, whenever possible, and not more than 24 hours after the incident occurred.

For any incident that requires minor first aid or emergency medical attention, staff must complete an injury report that includes:

- *The child's name;*
- *Date of the injury;*



- *Time of the injury;*
- *Location where the injury occurred;*
- *Description of the injury and how it occurred;*
- *Names of employees who witnessed the accident or injury;*
- *Names of persons who administered first aid or medical care;*
- *First aid or medical care required;*
- *Notice to the director about the accident or injury.*

Give the completed form to the child's/youth's parent within 24 hours and place a copy in the child's/youth's file.

## 1-3 Preparedness for Medical Emergencies

### **Required emergency information on file**

Emergency information on file for each child will include:

- 1) The name, address, and phone number of a child's parent;
- 2) Names and phone numbers of persons to contact in case of emergency when the parent is unavailable;
- 3) Source of health care;
- 4) Authorization for emergency medical treatment when the parent cannot be contacted when an emergency occurs;
- 5) Permission to provide first aid and/or CPR.

A copy of the emergency information will be given to staff for each child in their care. Drivers will receive a copy of emergency information for each child they transport to and from the facility.

### **First aid kits**

A first aid kit should be readily available for each group of children in care, including during field trips, outdoor play, neighborhood walks, and transportation. The first aid kit must be accessible to staff, but out of children's reach. It should not be stored in a hot vehicle or left in direct heat.

The first aid kit should be stocked with all the items in the first aid kit inventory on the following page. The lead staff member for each group of children will be responsible for restocking the first aid kit after each use and for inventorying their kit monthly. Center directors/site coordinators will make sure that adequate first aid supplies are at the facility.

### **Availability of employees trained in emergency aid**

Within 6 months of continuous employment, all employees who work with children must be certified in pediatric first aid and CPR training. Copies of certifications will be kept in their personnel files. The director will ensure that at least 1 employee with current certification in first aid and CPR is at the facility whenever children are in attendance. The health care consultant must approve the first aid and CPR course.

### **Emergency preparedness away from the facility**

When taking children off premises either by walking or by vehicle, staff will bring:

- 1) The daily attendance log;
- 2) Emergency information on each child, including telephone numbers of their parent, emergency contact persons, source of health care, permission for emergency medical treatment, and permission for the administration of first aid and CPR;
- 3) A fully-stocked first aid kit, including any emergency medication, with written instructions for use, needed for a child in the group (such as a bee/insect sting kit—if child with severe allergy is in attendance);
- 4) A cell phone for contacting the facility and summoning emergency medical assistance, parents, and the program.



## 1-5 Child Abuse Policy and Reporting

Program staff have an important role in preventing, detecting, and intervening in child abuse and neglect. They are responsible for ensuring the safety and well-being of children while in their care and for acting on their behalf when there is reason to suspect abuse and/or neglect has occurred.

DCF defines child abuse and neglect as:

**Abuse:** a non-accidental act by a caretaker upon a child under the age of 18 that causes or creates substantial injury or risk of injury. Abuse can be physical, sexual, or emotional. Physical abuse happens when a child is hurt through beating, shaking, kicking, burning or other types of bodily harm. A child can end up suffering from bruised, fractured or broken bones, internal injuries, or even death. Denying children the basic necessities they need to thrive is also considered physical abuse.

**Neglect:** includes the failure by a caretaker, either deliberately or through negligence or inability, to take actions necessary to provide a child with minimally adequate food, clothing, shelter, medical care, supervision, emotional stability and growth, or other essential care.

### Employee reporting responsibilities

Under Massachusetts law, any person who is paid to work with children in either a public- or private-sector facility is considered to be a “mandated reporter.” As a mandated reporter, a NorthStar employee has a legal obligation to immediately report their observations or suspicions of child abuse or neglect to DCF *irrespective of who is implicated*: a colleague, friend, senior staff member, volunteer, parent, visitor or other child or youth. While such situations can be awkward and complex, you must manage your sensitivities or discomforts because your duty of care to the child or youth remains your paramount legal, professional and moral responsibility.

Child abuse reports must be made immediately, or as soon as practically possible, by phone. Within 48 hours after making the oral report, the employee must submit a written report to the DCF area office and give a copy to their program director. Mandated reporters cannot file “51A” reports anonymously because of their professional capacity in caring for children.

1. Any employee who witnesses, suspects, or receives a report of neglect and/or abuse of a child attending one of our programs should promptly report the allegation to the director or next-in-line supervisor if the director may be responsible for the abuse and/or neglect.
2. A mandated reporter’s duty to report known or suspected child abuse and/or neglect is an individual responsibility. You should file a 51A report on your own. In making such a report, you must immediately inform the director or next-in-line supervisor and provide them with a copy of the written report as soon as they complete it.
3. Making a child abuse report won’t have any bearing on the reporting employee’s status or position within the agency unless it is proven they knowingly made a false report.
4. DCF will make an initial determination whether or not to support the report. If DCF does not support the report and employees still believe that the child is in danger, the director will contact the DCF investigator and explain why they continue to believe that the child is at risk. All follow-up action will be documented.
5. If the child’s parent is suspected of abuse or neglect, the employee who filed the report with DCF will meet with them as soon as possible about their decision to report them for child abuse and neglect. The investigation procedure, including its purpose of providing support to families in need and of protecting children, will be explained to them. All meetings and phone contact with parents suspected of abuse or neglect will be documented.

6. If the family is currently involved with DCF and has a DCF social worker, that worker will be notified as soon as possible regarding agency concerns that the child is being abused and/or neglected.
7. An employee may request, as a condition of participating in an interview with a DCF or EEC investigator, to have their supervisor or other agency administrator present in the interview.
8. The director will keep copies of all 51A reports and follow-up documentation.

It is not acceptable to minimize, ignore, or delay responding to observations or suspicions of child abuse or neglect. In particular, supervisory staff are barred from:

- 1) Instructing staff in a mandatory reporting situation to not to make a report;
- 2) Failing to report suspicion of abuse or neglect internally and, when required, to DCF.

Finally, it isn't your role as an employee to investigate an allegation or suspicion of child abuse. Let DCF and/or law enforcement investigate allegations or suspicions.

### **Reports alleging abuse or neglect of a child while attending a NorthStar program**

If a report is filed alleging that a child was abused or neglected while in the care of one of our programs, NorthStar will fulfill all reporting requirements, take immediate steps to protect all children attending the program, promptly conduct an internal investigation, and fully cooperate with any external investigation.

1. The director will inform the EEC regional office immediately after filing a 51A report, or learning that a 51A report has been filed, alleging abuse or neglect of a child occurred at the program or during a program-related activity.
2. The executive director will be notified as soon as possible regarding all reports alleging abuse or neglect of a child while attending an agency program or during an agency-related activity. An employee accused of abuse or neglect of a child will not work directly with children until DCF renders a finding that does not support the allegation.
3. Even if an allegation of child abuse/neglect against an employee is not substantiated, we may enact environmental, personnel, policy, and/or procedural changes based on findings of the internal and/or external investigation. After investigation by DCF and/or law enforcement, we may conduct an internal review to determine what went wrong and how a similar scenario could be prevented in the future. For example, was a policy or a procedural step not followed? How could the organization's procedures be modified to prevent a recurrence?

### **Employee responsibility for child abuse and/or neglect**

Any employee is identified as responsible for an incident of child abuse and/or neglect if:

- 1) They admit to causing the abuse or neglect, or
- 2) They are convicted of the abuse or neglect in a criminal proceeding, or
- 3) EEC determines, based upon its own investigation or a DCF "51B" investigation decision, that there is reasonable cause to believe that the employee caused the abuse or neglect while children were at the program.

Any employee who is found responsible for an act of child abuse and/or neglect will be discharged.

### **Confidentiality**

Information pertaining to allegations of child abuse and/or neglect will not be released or discussed except on a "need to know" basis. The executive director will handle all inquiries and communications with the media or other outside parties regarding an allegation. If the executive director is the subject of the allegation, the board president will serve as or designate a spokesperson for questions and

inquiries. Staff will be informed about to whom they should direct the press. In no case should any other employee comment publicly about an allegation of abuse or neglect.

During or following an investigation, the executive director may schedule meetings with employees and with parents of children in our programs to address reactions and explain the investigative process.

## 1-6 Using Policies to Prevent Child Sexual Abuse

We have developed policies explicitly directed toward the goal of preventing child sexual abuse before it occurs. These policies are grounded in the public health understanding that reducing child sexual abuse is the responsibility of adults rather than putting the onus on the child to learn to protect themselves from sexual abuse.

### Appropriate and inappropriate/harmful behaviors

Appropriate, positive interactions between staff and children/youth and among children/youth are essential in supporting positive child and youth development, making children and youth feel valued, and providing the caring connections that serve as protective factors for children and youth. Conversely, inappropriate or harmful interactions put children and youth at risk for adverse physical and emotional outcomes. In staff orientation and training, we identify behaviors that fall into the broad categories of appropriate and inappropriate:

Inappropriate/harmful	Appropriate
<p><u>Physical Contact</u></p> <ol style="list-style-type: none"> <li>1. Touch or speak to a child/youth in a sexual way.</li> <li>2. Inflict any physical abuse such as striking, spanking, shaking, slapping.</li> <li>3. Engage in frontal hugs and bear hugs.</li> <li>4. Pat on the head (demeaning in some cultures).</li> <li>5. Restrain a child/youth (unless they are an immediate danger to self or others).</li> <li>6. Be rough with children/youth in behavior management—e.g., yank arm, grab shoulder.</li> <li>7. Roughhouse (aggressive physical contact, often for fun, where child/youth not in control of their body).</li> </ol>	<p><u>Physical Contact</u></p> <p>Appropriate physical behavior includes contact that maintains physical boundaries at all times and only comprises touches that are public and non-sexual such as:</p> <ol style="list-style-type: none"> <li>1) Pats on the back or shoulder;</li> <li>2) Child-initiated side hugs;</li> <li>3) Fist bumps, shaking hands, high fives, hand signs and greetings;</li> <li>4) Holding hands to safely cross the street.</li> </ol> <p>Even physical contact that is considered “appropriate” must be in response to the needs of the child/youth—not initiated by the staff member.</p>
<p><u>Other Actions</u></p> <ol style="list-style-type: none"> <li>1. Inflict any emotional abuse such as humiliating, ridiculing, threatening, or degrading children and/or youth.</li> <li>2. Use inappropriate consequences for behavior—e.g., deny snack or other comfort.</li> <li>3. Tell a child/youth not to divulge to a parent what a staff member said or did.</li> <li>4. Spend inappropriate amounts of time with a particular child or youth.</li> <li>5. Overstep other professional boundaries—e.g., have very personal conversations with a youth, accept or give gifts to a child or youth without the knowledge of their parent or guardian.</li> </ol>	<p><u>Other Actions</u></p> <ol style="list-style-type: none"> <li>1. Use praise and positive reinforcement rather than criticism, competition, or comparison when working with children and/or youth.</li> </ol>

<p><u>Procedures</u></p> <ol style="list-style-type: none"> <li>1. Supervisory staff instruct employee in mandatory reporting situation not to make a report.</li> <li>2. Unauthorized off-hours contact—e.g., baby-sitting, movies, sleepovers, inviting children to their homes, weekend trips, dating, social networking and texting. Any exceptions require written documentation and prior administrator approval.</li> <li>3. Fail to fully cooperate with an internal, DCF, or police investigation.</li> </ol>	<p><u>Procedures</u></p> <ol style="list-style-type: none"> <li>1. Respond to family crisis situations at any time if off-hours crisis intervention is part of a staff member's job description.</li> <li>2. Comply with the state mandatory reporting regulations and agency policies and procedures to report suspected child abuse.</li> <li>3. Cooperate fully in any response of abuse of children and/or youth.</li> </ol>
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### **Protective practices for staff in one-to-one interactions with a child/youth**

Our one-on-one mentoring/case management program for DCF-referred children and youth has been developed in close conjunction with the referring agency, with both agencies agreeing that the benefits of one-to-one child/youth mentoring by an appropriately trained, carefully screened, well-supervised case manager outweigh the potential risks of the services being largely delivered in one-to-one settings. To reduce the risk of abuse or unfounded allegations of abuse, staff must observe the following guidelines:

1. Only appropriately trained, carefully screened case managers (never a student intern or volunteer) can meet one-to-one with a child/youth.
2. Clearly communicate with the parent about the program, including activities and staff codes of conduct/rules/behavior. Keep the parent informed and involved in an ongoing relationship.
3. Make it public as possible. When meeting one-on-one with a child or youth, the more visible, public and busy the location the better. If meeting in a room or office, leave the door open or move to an area that can be readily observed by others passing by.
4. Keep your supervisor informed about one-to-one activities/meetings—preferably in advance, but granting case managers on-the-scene, time-sensitive decision-making power within the referral agency's service plan.
5. Avoid physical affection that can be misinterpreted. Limit affection to pats on the shoulder, high-fives, and handshakes.
6. Document and immediately report any unusual incidents, including disclosures of abuse or maltreatment, behavior problems and how they were handled, injuries, or any interactions that might be misinterpreted.

Much of our transportation of children/youth is unavoidably one-to-one. Case managers transport children and youth in an agency van or their personal vehicle to appointments, court appearances, community meetings, and other appropriate destinations. Our supervised family visitation center staff transport DCF-referred children to and from supervised visits. Staff can transport children/youth in a private or NorthStar vehicle only with explicit program permission and following proper procedures outlined in NorthStar transportation services.

### **Risk of interactions between children/youth**

Staff responsible for supervising a group of children/youth must remain in sight and hearing of that group until relieved by another appropriately qualified staff member. Exceptions to visual supervision include bathroom or changing room use. In this situation, staff should respect child/youth privacy but stand outside the bathroom door—close enough where they can quickly intervene if necessary. Each



program develops age-appropriate procedures to ensure the safety of children and youth using restrooms or changing rooms.

Generally, staff should avoid placing children/youth of widely differing ages (more than 3 years) in the same group. If this isn't possible, staff should closely supervise the group to ensure a safe social environment for all. Avoid sending younger children to bathrooms when they are in use by older children.

### **Maintaining safe environments**

A critical strategy for protecting children and youth is always knowing their whereabouts when they are participating in our programs.

1. Visibility. We use the following methods to increase visibility:
  - Have clear lines of sight throughout our facilities.
  - Secure areas not used for program purposes to prevent children/youth from being isolated (e.g., lock closets and storage rooms).
  - Maintain bright lighting in all areas.
2. Privacy when toileting, showering, changing clothes. We reduce risk by providing children and youth with privacy during activities such as toileting, showering, and changing clothes (mostly in the context of off-site activities, particularly overnight educational excursions). To be considered is not just the risk of child sexual abuse by staff, however. Staff must be vigilant regarding the risk of inappropriate or harmful contact among children and youth.
3. Access control. In our facilities, we monitor who is present at all times and have procedures for admitting people outside of our organization and under what circumstances. For the protection of the people we serve, visitors, and staff, we control entry to our facilities. At our facility entrances, the doors have latches that can be electronically controlled from an office or reception area. These access-controlled doors, used in conjunction with an intercom, allow visitors to be identified before being "buzzed in."

### **Monitoring staff behavior and interactions to reduce risk**

We use multiple monitoring methods to get a clear picture of how individuals are interacting—including regular and random observation (e.g., roving and checking interactions throughout an activity period) and maintaining frequent contact with employees and children/youth who regularly interact off-site. Documenting that monitoring has occurred emphasizes to employees that it is an essential, nonnegotiable part of our organization's child sexual abuse prevention efforts. Besides using written records, we provide positive reinforcement when positive, supportive and healthy behaviors and interactions are observed.

Monitoring behavior and interactions within our organization is everyone's business. While we expect supervisors to question confusing or uncertain behaviors and practices, line staff are often in a better position to know what is happening on a daily basis within their programs. All employees are required to report any behaviors and practices that may be harmful.

Staff may observe behaviors in other staff that they view to be inappropriate rather than abusive or that borders on violating a professional boundary. Either directly or going through their own supervisor, the observing staff member must ensure that the staff concerned are made aware that their actions could impact negatively on children/youth and on themselves. This kind of professional advice may be particularly helpful to newly hired staff.

### **Responding to problem sexual behavior when it is directed at staff**

If a child/youth's problem sexual behavior is directed toward a staff member, the staff member must immediately, firmly, and respectfully deter the child/youth's actions. This immediacy is particularly

important where other children/youth may be witnessing the behavior. The staff member should promptly report the information to their supervisor. The staff member and their supervisor should document the incident that initially prompted concern. In developing a subsequent plan of action and communication, the staff member and their supervisor should seek assistance from a senior staff member or in-house clinician on how to actively manage the situation in a way that respects the emotional well-being of the child/youth and provides support to the staff member. The parent should be contacted unless there are reasonable grounds to believe that informing the parent will create risks for the child/youth. Generally, staff should arrange a meeting with the parent to discuss immediate responses and a longer-term behavior support plan. Communicating with the parent in a compassionate, informed way can help reduce the stigma, silence, and isolation that all too often surround children/youth with sexual behavior problems.

While case managers and other direct care staff can play a critical part in the immediate and long-term supportive response provided to children/youth and their parents, the specific professional counseling required to support children/youth and their parents in these circumstances must be provided by appropriately trained, qualified professionals. The program must assist the child/youth and their parent in accessing these services and establishing links with the professionals involved. The program has responsibility to offer a plan of support appropriate for the staff member, particularly for case managers whose relative isolation in responding to off-site situations puts them at higher risk.

## 1-7 Missing Child or Youth

### Prevention

To prevent a situation in which a child or youth becomes separated from the group, staff will count children/youth frequently in all settings—whether at the program facility or on a field trip. A staff person will be responsible for performing a “sweep” of an area or vehicle that the children or youth are leaving to ensure that no child is overlooked.

### Field trip contingency measures

Staff will identify and implement specific systems for speedy location of missing children or youth such as accessible identification and contact information for the children/youth and instructions to older children and youth about what to do if they become separated from the group. Staff will not make the child’s name visible to a stranger who might use the child’s name to lure the child from the group.

### Procedures to locate a missing child or youth

Staff will promptly contact the police after an initial search of the facility or area is made and it is determined that a child or youth is missing or lost and/or an attempt to establish their whereabouts (such as their confirmed pick-up by an authorized person) is unsuccessful.

1. Call 911 immediately and provide the following information:
  - *Child’s/youth’s name and age;*
  - *Their home address;*
  - *Physical description of the child/youth, including any distinguishing marks and the clothing they were wearing;*
  - *Medical status, as appropriate;*
  - *Time and location where the child/youth was last seen;*
  - *Person with whom the child/youth was last seen.*
2. In EEC-licensed programs, maintain required child-staff ratios and proper supervision of the other children at all times. Stay calm and talk with the other children in a reassuring manner.
3. Conduct a search of all areas of the facility and immediate surrounding area. If a child or youth is missing on a field trip, program staff will promptly notify the site management to request assistance in the search for the child/youth.
4. Provide the child’s/youth’s information and picture (if available) to police upon their arrival.
5. Immediately notify the parent that their child is missing and inform them of the circumstances and steps being taken. Also inform the program administrator and the executive director as soon as possible about the situation.

### Post-incident procedures

In the aftermath of the incident, NorthStar will take the following actions:

1. Coordinate any needed crisis counseling for children/youth and staff.
2. Conduct an internal investigation of the incident to establish the cause of the incident and enact corrective measures to prevent the incident from recurring.
3. Complete required post-incident notifications and reporting.
4. Fully cooperate with any external investigation of the incident.

## 1-8 Youth Suicide Prevention Policy

Where suicide is the second leading cause of death for our youth ages 10-24, it is critically important that youth programs and school districts take a proactive approach to preventing deaths by suicide. At NorthStar, we have put in place evidence-based policies and procedures to prevent, assess the risk of, intervene in, and respond to youth suicidal behavior. (Note: Largely because suicide is very rare in elementary school age children, we refer to “youth” only in this policy.)

To ensure this policy regarding suicide prevention is properly adopted, implemented, and updated, NorthStar has appointed the director of clinical services to serve as the suicide prevention point of contact for the organization. They will ensure that the policy is reviewed annually and updated to align with changes in best practice.

### Scope

This policy covers actions that take place at NorthStar facilities, at NorthStar-sponsored off-premises activities, and on NorthStar-provided buses or vehicles transporting program participants. This policy applies to the entire NorthStar community, including employees, interns, volunteers, and youth and families in our programs.

This policy is meant to be aligned with other policies and initiatives supporting the physical, emotional, and behavioral health of youths more broadly. Preventing suicide depends on a holistic approach that promotes healthy lifestyles, families, and communities.

### Definitions

At risk. A youth is defined as high risk for suicide if they have made a suicide attempt, have the intent to die by suicide, or have displayed a significant change in behavior suggesting the onset or deterioration of a mental health condition. The youth may have thought about suicide, including potential means of death and may have a plan. In addition, the youth may show feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain.

Crisis team. An internal multidisciplinary team headed by the clinical services director and including trained staff is responsible for crisis preparedness, effective intervention/ response, and recovery support.

Postvention. Suicide postvention include activities that reduce risk and promote healing after a suicide death.

Risk assessment. An evaluation of a youth who may be at risk for suicide, conducted by a trained mental health professional. This assessment is designed to elicit information regarding the youth’s intent to die by suicide, previous history of suicide attempts, presence of a suicide plan and its level of lethality and availability, presence of support systems, and level of hopelessness and helplessness, mental status, and other relevant risk factors.

Risk factors for suicide. Characteristics or conditions that increase the chance that a person may try to take their life. Suicide risk tends to be highest when someone has several risk factors at the same time. Risk factors may encompass biological, psychological, and or social factors in the individual, family, and environment. Groups of youth at elevated risk for suicide include those living with mental and/ or substance use disorders, those who engage in self-harm or have attempted suicide, those in out-of-home settings, those experiencing homelessness, American Indian-Alaska Native youth, LGBTQ (lesbian, gay, bisexual, transgender, and questioning) youth, youth bereaved by suicide, and those with medical conditions or certain types of disabilities.

Self-harm. Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Can be categorized as either nonsuicidal or suicidal. Although self-harm often lacks suicidal intent, youth who engage in self-harm are more likely to attempt suicide.

**Suicide.** Death caused by self-directed injurious behavior with any intent to die as a result of the behavior. The coroner's or medical examiner's office must first confirm that the death was a suicide before any community program or school official may state this as the cause of death.

**Suicide attempt.** A self-injurious behavior for which there is evidence that the person had at least some intent to kill themselves. A suicide attempt may result in death, injuries, or no injuries. A mixture of ambivalent feelings such as wish to die and desire to live is a common experience with most suicide attempts. Therefore, ambivalence is not a sign of a less serious or less dangerous suicide attempt.

**Suicidal behavior.** Suicide attempts, intentional injury to self-associated with at least some level of intent, developing a plan or strategy for suicide, gathering the means for a suicide plan, or any other overt action or thought indicating intent to end one's life.

**Suicide contagion.** The process by which suicidal behavior or a suicide influences an increase in the suicidal behaviors of others. Guilt, identification, and modeling are each thought to play a part in contagion. Though rare, suicide contagion can result in a cluster of suicides. The effect of contagion appears to be strongest among adolescents.

**Suicidal ideation.** Thinking about, considering, or planning for self-injurious behavior that may result in death. A desire to be dead without a plan or intent to end one's life is still considered suicidal ideation and should be taken seriously.

### **Prevention: Information and training**

**Suicide prevention resources for youth.** Suicide prevention resource materials for youth are available at all NorthStar facilities. They include lists of websites for youth on how to get help for oneself and for friends who may be at risk for suicide.

**Staff training.** All NorthStar staff in all job categories who regularly interact with youth must have training on youth suicide prevention that includes:

- 1) Suicide risk factors, warning signs, and protective factors;
- 2) How to talk with a youth about thoughts of suicide;
- 3) How to respond appropriately to the youth who has suicidal thoughts. Such responses shall include constant supervision of any student judged to be at risk for suicide and an immediate referral for a suicide risk assessment;
- 4) Emphasis on immediately referring (same day) any youth who is identified to be at risk of suicide for assessment while staying under constant monitoring by staff member;
- 5) Emphasis on reducing stigma associated with mental illness and that early prevention and intervention can drastically reduce the risk of suicide;
- 6) The impact of traumatic stress on emotional and mental health;
- 7) Common misconceptions about suicide.

Training should be grounded in the mental health model of suicide prevention and not encourage the use of the stress model to explain suicide.

**Documentation.** In cases of suicidal risk, the organization should maintain a confidential record of actions taken. This will help ensure that appropriate assessment, monitoring, and support are provided as well as document the organization's efforts to intervene and protect the youth.

### **Prevention: Assessment and referral of youth identified to be at risk of suicide**

When a youth is identified by a staff person or a peer as potentially suicidal (i.e., talks about suicide, presents overt risk factors such as agitation or intoxication, the act of self-harm occurs, or a youth

self-refers), the youth should be seen by a NorthStar-employed mental health professional as soon as possible (within the same day) to assess risk and facilitate referral. If there is no mental health professional available, a trained staff member will fill this role until a mental health professional can be brought in. Staff will continuously supervise the youth to ensure their safety.

The clinical services director and the executive director should be made aware of the situation as soon as reasonably possible.

Parent notification and involvement. In situations where a youth is assessed at risk for suicide, the youth's parent should be contacted as soon as practicable. If the youth has exhibited any kind of suicidal behavior, the parent should be counseled on "means restriction"—i.e., limiting their child's access to mechanisms for carrying out a suicide attempt.

The staff member will assist the youth's parent with urgent referral. When appropriate, this may include calling emergency services or bringing the youth to the local crisis center, but in most cases will involve setting up an outpatient mental health or primary care appointment and communicating the reason for referral to the healthcare provider. Staff will seek parental permission to communicate with outside mental health care providers regarding their child.

***Exception to immediate parent notification:*** Through discussion with the youth, a NorthStar-employed mental health professional will assess whether there is further risk of harm due to parent notification. If the mental health professional believes, in their professional capacity, that contacting the parent would endanger the health or well-being of the youth, they, in consultation with the clinical services director, may delay such contact as appropriate. If contact is delayed, the reasons for the delay should be documented.

Care for other youth. If a peer alerted the staff to the risk situation, a debriefing for this individual should take place and any further intervention provided as necessary.

Referrals and LGBTQ youth. LGBTQ youth are at heightened risk for suicidal behavior, which may be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimization. It is, therefore, especially important that staff be trained to support at-risk LGBTQ youth with sensitivity and cultural competency. Staff should not make assumptions about a youth's sexual orientation or gender identity and affirm youth who do decide to disclose this information. Information about a youth's sexual orientation or gender identity should be treated as confidential and not disclosed to parents, guardians, or third parties without the youth's permission. Additionally, when referring youths to other service providers and resources, it is important to connect LGBTQ youths with LGBTQ-affirming local health and mental health service providers. Affirming service providers are those that adhere to best practices guidelines regarding working with LGBTQ program participants as specified by their professional association (e.g., <http://www.apa.org/pi/lgbt/resources/guidelines.aspx>).

### **Intervention: Suicide attempt at a NorthStar facility or event**

In the case of a suicide attempt while at a NorthStar program or event, staff should:

1. Follow the plan for immediate medical assistance, including immediately calling emergency medical assistance and providing appropriate first aid.
2. Remain with the youth and provide support, safety, and continuous supervision.
3. Move all other youth out of the immediate area as soon as possible and ensure appropriate supervision.
4. Notify the clinical services director or designee and the executive director.
5. Immediately contact the parent and ask them to come to the program or the hospital.

6. If the youth is known to be currently in counseling, attempt to inform their treatment provider of what occurred and the actions taken.
7. Promptly follow up with any youth or staff who might have witnessed the attempt, and contact their parents; arrange for the provision of supportive counseling and document all actions taken.
8. Release the youth only to their parent, a law enforcement official, or emergency medical staff.

### **Youth's re-entry to program**

For youth returning to a program after a mental health crisis (e.g., suicide attempt or psychiatric hospitalization), a NorthStar-employed mental health professional or other trained staff member will meet with the youth's parent and if appropriate, meet with the youth to discuss re-entry and appropriate next steps to ensure the youth's readiness for return to the program.

1. A NorthStar-employed mental health professional or other designee will be identified to coordinate with the youth, their parent, and any outside mental health care providers.
2. The parent will be expected to provide documentation from a mental health care provider that the youth has undergone examination and that they are no longer a danger to themselves or others.
3. The designated staff person will periodically check in with the youth to help them readjust to the program and address any ongoing concerns.

### **Intervention: Suicide attempt in progress outside of NorthStar**

If a staff member becomes aware of a suicide attempt by a youth that is in progress in an out-of-program location, the staff member should immediately:

1. Call the police and/or emergency medical services (911).
2. Inform the youth's parent.
3. Inform the NorthStar clinical services director and executive director.

If the youth contacts the staff member and expresses suicidal ideation, the staff member should maintain contact with the youth (either in person, online, or on the phone). The staff member should then enlist the assistance of another person to contact the police while keeping communicating with the youth.

### **Intervention: Suicide attempt by a program youth that occurs outside the program**

When NorthStar staff become aware that a youth in one of our programs has attempted suicide outside the program, NorthStar must protect the privacy of the youth and maintain a confidential record of the actions taken to intervene, support, and protect the youth. The following steps should be implemented:

1. Contact the parents and offer support to the family. Discuss with the parent how they would like NorthStar to respond to the attempt while minimizing any rumors among youth and staff.
2. Obtain permission from the parent to share information to ensure the facts regarding the crisis is correct. In the absence of confirmation that this was a suicide attempt, the incident should be treated as an injury.
3. Provide care and determine appropriate support to affected friends.
4. Offer to the youth and parent steps for re-integration to the program.

### **Postvention: Responding after a suicide occurs**

Immediately following news of a death by suicide of a NorthStar program participant, the crisis team should meet to prepare and implement the organization's postvention response.

1. Verify the death. Staff should confirm the death and determine the cause of death through communication with a coroner's office, local hospital, the youth's parent, or police department. Even when a case is widely known as being an obvious instance of suicide, it should not be labeled as such until after a cause of death ruling has been made. If the cause of death has been confirmed as suicide but the parent or guardian will not permit the cause of death to be disclosed, NorthStar will not share the cause of death but will use the opportunity to discuss suicide prevention with youth.
2. Assess the situation. The crisis team should consider how severely the death is likely to affect other youth and identify which youth are most likely to be affected. The crisis team should also consider how recently other traumatic events have occurred within the NorthStar community and the time of year of the suicide.
3. Share information. Before the death is officially classified as a suicide by the coroner's office, the death can and should be reported to staff, youth, and parents with an acknowledgement that its cause is unknown. Inform the staff that a sudden death has occurred, preferably in a staff meeting. Write a statement for staff members to share with youth. The statement should include the basic facts of the death and known funeral arrangements (without providing details of the suicide method), recognition of the sorrow the news will cause, and information about the resources available to help youth cope with their grief. Organization-wide assemblies should be avoided. The crisis team should prepare a letter (with the input and permission from the youth's parent) to send home with youth that includes facts about the death, information about what NorthStar is doing to support youth, the warning signs of suicidal behavior, and a list of resources available.
4. Avoid the contagion effect. It should be explained in the staff meeting described above that one purpose of trying to identify and give services to other high-risk youth is to prevent another death. The crisis team should work with staff to identify youth who are most likely to be significantly affected by the death. In the staff meeting, the crisis team will review suicide warning signs and procedures for reporting youths who generate concern.
5. Initiate support services. Youth identified as being more likely to be affected by the death should be assessed by NorthStar-employed mental health professionals to determine the level of support needed. The crisis team should coordinate support services for youth and staff in need of individual and small-group counseling, including referring to mental health service provision to ensure a smooth transition from the crisis intervention phase to meeting underlying or ongoing mental health needs.
6. Develop memorial plans. The organization should not create on-site physical memorials (e.g., photos, flowers), funeral services, or fly the flag at half-mast because it may sensationalize the death and encourage suicide contagion. Programs should not be canceled for the funeral. Any program-based memorials (e.g., small gatherings) should include a focus on how to prevent future suicides and prevention resources available.

### **Responding to the media after a suicide**

Just as research suggests that sensational news reporting on suicides may encourage "copycat suicides" or suicide "contagion," so other kinds of news coverage may help discourage additional suicides. This said, NorthStar has a responsibility to promote media and online coverage of suicide that contributes to raising suicide awareness and encourages those who are vulnerable or at risk to seek help. To ensure that we stay on message, the executive director (or their designee) should be NorthStar's sole media spokesperson. Staff should refer all inquiries from the media directly to the spokesperson. The spokesperson will:

1. Prepare a statement for the media including the facts of the death, postvention plans, and available resources. The statement should not include confidential information, speculation about victim motivation, means of suicide, or personal family information.



2. Answer all media inquiries. Instead of dictating what should be reported, the spokesperson should explain the potential for suicide contagion associated with certain types of reports and should suggest ways to minimize the risk for contagion. Media should be asked to offer the community information on suicide risk factors, warning signs, and resources available.

## 2. Going to a Safe Area in an Emergency

In this section, we describe general procedures for 4 pre-planned protective actions to move children and staff to a safe place in the event of an emergency situation affecting a specific facility or that is a larger-scale event:

- 1) Immediate Evacuation (our general evacuation procedures)
- 2) Evacuation to Host Facility
- 3) Shelter-in-Place
- 4) Lockdown

Each staff member must understand their responsibilities in any given situation.

As facts become known, and conditions change, the initial protective action may be amended by the director. Response to a violent situation may begin with a lockdown, but later turn into an evacuation.

Recent events suggest that children's programs are vulnerable to new threats. No set of procedures can adequately address all possible scenarios. Nor do these protocols fathom the fear and angst we may feel regarding having to contemplate the "unthinkable"—namely, the extraordinary lengths we may have to go to keep the children and youth in our care and ourselves out of harm's way—and to human acts of violence, one might add human-induced climate change and the resulting frequency and severity of extreme weather events for which we must plan protective actions. This said, we have to adopt a trauma-informed approach to not only in helping the children and youth we serve, but also in orienting, training, supervising, and supporting our staff—many of whom bear the scars of earlier violence-related traumas. Therefore, discussion and training about protective actions may reopen wounds and therefore must incorporate acknowledgement and facilitate healing again.

## 2-1 Emergency Items

**For EEC-licensed programs:** The following is a list of emergency items to always have available in the event we must take protective action. The emergency items should be divided into 2 kits—one for the most critical supplies that should be with the children and staff at all times, and one for food, games, toys, and other play materials the program might use in sheltering in place and if evacuated, could do without, if necessary. (The host facility to which we would be evacuated would have food and water.) It is critical that the emergency backpacks are not so heavy and cumbersome that they slow down the evacuation process.

<b>Checklist for Emergency Backpacks</b>		Director	Teacher/ group leader
<b>Emergency documents</b>	• Attendance logs		X
	• Children's emergency information forms	X	X
	• Emergency medical treatment consent forms		X
<b>First aid</b>	• First aid kit		X
	• Children's medications	X	EpiPen
<b>Sanitation</b>	• Diapers and wipes		X
	• Hand sanitizer		X
	• Moist towelettes and tissues		X
<b>Communication</b>	• Charged cell phones	X	X
	• Portable battery-operated radio with extra batteries	X	
	• Notepad and pens/pencils	X	
<b>Safety</b>	• Flashlight with extra batteries	X	
<b>Checklist for Emergency Supplies</b>			
<b>Food</b>	<ul style="list-style-type: none"> <li>• Non-perishable, easy-to-serve food items such as granola bars and crackers (<i>Consider children's food allergies when storing food items</i>)</li> <li>• Formula for infants</li> <li>• Disposable cups</li> </ul>		
<b>Comfort and safety</b>	<ul style="list-style-type: none"> <li>• Duct tape and scissors to seal doors and windows in the event of sheltering-in-place</li> <li>• Bedding and blankets to provide warmth and comfort if utilities fail</li> <li>• Books and other materials to keep children occupied</li> </ul>		

### Responsibility for emergency supplies

At each facility, the director or designated emergency preparedness coordinator is responsible for assembling and maintaining emergency supplies. Those materials not kept in the emergency backpack should be stored in a large container such as a sturdy plastic, covered tote with handles for carrying. Yearly and preferably every six months, food and medical supplies should be rotated.

## 2-2 Immediate Evacuation

**For EEC-licensed programs:** Evacuation is implemented when conditions outside the building or off site are safer than inside or on site. It requires the orderly movement of everyone to a predetermined safe “assembly area” outside that is at least 50 feet away from the building and routes by which emergency vehicles may arrive. Evacuation procedures are posted next to each exit at each facility.

During some disasters, however, it may be safer to keep the children and staff in the facility instead of evacuating or it may be necessary because it is not possible or safe to evacuate. In consultation with the program administrator and emergency service personnel, directors will have to decide whether to stay when there is a disaster inside or outside the building.

### Director actions

When faced with a situation calling for evacuation:

1. Call 911. Be ready to provide location, all available details of situation, and your cell phone number.
2. Give instruction to evacuate to the designated assembly area.
3. Close all windows and doors, if it can be done safely.
4. Turn off lights, electrical equipment, cooking appliances, water faucets, and air conditioning and heating systems.
5. Lock the exterior doors.
6. Make sure everyone is out of the building. Before leaving the building, conduct a final, thorough “sweep” of all areas (whether or not children are allowed in those areas), including the program space, storage areas, kitchen, offices, hallways, children’s and adult bathrooms, stairwells, and entryways to ensure that all children have been evacuated. *(Note: If a child who should have been evacuated with their group is located as a result of a final “sweep” during an evacuation drill, investigate the circumstances that led to failure to evacuate the child and plan how to avoid such problems in the future.)*
7. Take with you:
  - Children’s emergency information forms
  - Children’s medications stored in the office
  - Charged cell phone
  - Portable battery-operated radio with extra batteries
8. When outside the building, account for all children and staff to make sure that everyone has been safely evacuated.
9. Brief emergency services when they arrive. Evaluate the situation with the help of responding agencies and determine if it is safe to enter the facility. If not, determine if it is necessary to move to a host facility or to stay put until it is safe to re-enter the building.

### Teacher/group leader actions

1. Direct your group of children out of the building to the designated assembly area (preferably one teacher leading the children and one teacher following behind). Maintain child-staff ratios at all times.
2. If possible and time allows, have children take jackets and coats.
3. Use alternative route if the designated route is unsafe.

4. Give children clear, simple instructions about exiting the facility. At the sound of the alarm, children should immediately stop their activities and proceed in an orderly manner to the exit door.
5. Carry infants who can't walk out of the building on their own or put them in specially-designed evacuation cribs that can readily be wheeled through the exit doors outside to the assembly area.
6. Evacuate children who have ambulatory difficulty, use wheelchairs, or other equipment that must be transported with the child (such as an oxygen ventilator) by methods planned in consultation with fire safety officials. Non-teaching staff at the facility should help evacuate infant/toddler groups or older children who need assistance.
7. Take in your group emergency backpack:
  - *The attendance log;*
  - *Children's emergency information forms;*
  - *Emergency medical treatment consent forms;*
  - *First aid kit;*
  - *Children's medications.*
8. Turn off lights and equipment.
9. Take attendance as soon as the children arrive in the assembly area to be sure that no child has been left behind.
10. Have children sit down if possible. Ensure that children remain a safe distance from traffic, including the arrival of emergency vehicles.

### **Evacuation drills**

Evacuation drills with all groups of children and all staff are conducted at least every month. The timing of the drills should be varied to include early morning, mealtimes, and rest times. Children should be appropriately prepared for and reassured during drills. The director documents the date, time, exit routes, number of participating children, and effectiveness of each drill in an Evacuation Drill Log.

At any time when a fire alarm is sounded, employees should never assume that it is a drill. A representative of the municipal Fire Department will observe at least 1 drill per year. (The New Bedford Fire Department presently conducts drills in center-based early childhood programs on a quarterly basis.)

### **Fire alarms and equipment**

All employees should know the locations of pull alarms and fire extinguishers in their program facility, how to operate them, and how to report a fire.

## 2-3 Evacuating to a Host Facility

If an emergency requires that children and staff be out of their program facility for an extended period of time, evacuation and moving to a pre-established host facility may be necessary. The children will remain at the host facility under the supervision and care of staff while parents or their emergency contacts are notified of the situation and children are picked up or transported home.

### Director actions

If evacuation to a host facility is necessary, the director should coordinate transportation of children and staff to the host facility as well as continued care of children until they are transported home or picked up by their parents or authorized persons. After evacuating staff and children:

1. Notify the program administrator and the executive director and, if possible, consult with them regarding appropriate response actions to be taken.
2. Notify the host facility of the pending arrival of children and staff. Arrange transportation and coordinate the movement of children and staff to the host facility.
3. Place a sign on the main entry door indicating the site where children and staff are going.
4. Lock the doors.
5. Notify parents of children by phone. If evacuation/relocation is part of a larger area evacuation, also notify families by radio broadcast on WBSM.
6. Coordinate the return of children and staff to the program facility when it is safe to do so. If it is not safe or feasible to return to the program facility, arrange for children to be transported home or picked up at the host facility.

### Teacher/group leader actions

Teachers/group leaders should know the whereabouts of every child at all times:

1. Maintain child-staff ratios at all times during evacuation and relocation.
2. Account for all children at every transition, including when they board and get off vehicles.
3. Normalize the situation for the children and minimize the psychosocial stresses experienced in emergency situations by engaging them in group activities, assigning them "jobs," and giving them information about the situation appropriate to their ability to understand. Help them feel safe and secure at the host facility.
4. Stay with children at the host facility until they are all transported home or picked up by their parents or authorized persons.

### Host facilities

The Family Handbook for EEC-licensed programs lists where children would be evacuated to in an emergency:

**Site-specific emergency** (confined to the facility or its immediate area) such as a fire or loss of heat and we cannot stay there:

Boys' and Girls' Club of Greater New Bedford  
166 Jenney Street, New Bedford  
508-992-8011

**Emergency encompassing a larger area** that requires a large-scale evacuation to New Bedford's main mass care shelter:

New Bedford High School  
230 Hathaway Boulevard, New Bedford  
508-997-4511, ext. 2301

## 2-4 Sheltering-in-Place

Sheltering-in-place keeps the occupants inside a building and out of danger. Local authorities may issue orders for shelter-in-place during an accidental release of toxic chemicals or other emergencies that threatens air quality. When sheltering-in-place because of a hazardous materials/chemical release, staff should “seal the center” to provide greater protection from external airborne contaminants. Severe or threatening weather conditions, like severe thunderstorms or tornado warnings, may also prompt a facility to shelter-in-place. Once emergency personnel give the order to seek shelter immediately, don’t leave the building until official notification that the danger has passed is given or it is obvious the severe storm has passed through the area.

Programs should choose an interior room in the facility with as few windows and doors as possible. In a large facility, it may be necessary to seal more than one room. Staff and children may move freely within the shelter area. People would most likely not be sheltering in place for more than a few hours.

### Director actions

1. Instruct children and staff to go inside as quickly as possible to the sheltering-in-place room. Bring emergency supplies (see checklist above) to the sheltering-in-place room.
2. Prevent exposure to the outside air:
  - a. Turn off all fans, heating, cooling, and ventilation systems immediately.
  - b. Shut and lock all outside doors and windows. Close as many interior doors as possible.
  - c. Seal all windows, doors, and air vents in the rooms with plastic sheeting and duct tape. Push a wet towel up against the gap between the door and the floor. Use tape to cover any heating/air conditioning vents, electrical outlets, and other openings. If sheeting and tape aren’t available, improvise and use what you have to create a barrier between the program and the contamination—such as blankets and clothing, plastic food wrapping, wax paper, or aluminum foil. Keep water in sink and toilet drain traps. Lower shades and blinds and keep children and staff away from windows.
3. Extinguish all pilot lights and sources of flame.
4. If you are told there is danger of explosion, close the window shades, blinds, or curtains. To avoid injuries, keep children away from windows.
5. Stay in touch with responding agencies/emergency personnel.
6. Inform parents by cell phone about the emergency situation and response. Advise them not to pick children up from the facility until the incident is over. The presence of parents searching for their children will only cause confusion and may lead to exposure to toxic chemicals. Once sheltered in place, you will not want to open the door to let parents in and out.

### Teacher/group leader actions

1. Take children to the designated shelter-in-place room and shut the door. Take attendance as soon as they arrive in the shelter area.
2. Provide meals/snacks to sheltered children and staff if the duration of the emergency warrants. Drink stored water, though sinks and toilets may be used.
3. Remain calm and reassuring. Involve children in fun learning activities, including reading books.

4. If determined necessary, you can provide a minimal amount of breathing protection by covering mouths and noses with damp cloths.
5. Remain in place and await further instructions from director or emergency services.

When emergency personnel give “all clear” assurance:

1. Unseal the windows and doors. Open the windows and doors to air out the facility. Turn fans, heating, ventilation, and air conditioning systems back on.
2. Resume normal operations.



## 2-5 Lockdown

If there is a violent or potentially violent person inside or immediately outside the facility, the best procedure may be to lock all interior doors and to protect the staff and children in their rooms. To do this requires immediate action on the part of staff and should be done quietly and in an orderly manner. Where shelter-in-place calls for closed, unlocked doors and allows for the free movement of children and staff within the shelter area, lockdown requires closing and locking doors immediately after which no one is allowed to enter or exit.

The danger posed and lockdown decision should be broadly communicated in plain and specific language. The use of code words or phrases is not recommended as this can be confusing to parents, visitors, or new staff members. The announcement should be calm and clear. In the event that staff and children are not inside the building—such as on a field trip or on a walk—inform the staff of the situation via phoning or texting, including the nature and whereabouts of the danger, so that they can keep children in their care in a safe location or, if near the facility, move them away from the danger.

### **Director actions**

1. If a violent or potentially violent person is not yet in the building, alert staff of the potential danger. Ensure that all exterior doors are locked.
2. If a violent or potentially violent person comes into the facility, immediately have someone call 911.
3. If the individual cannot be isolated and chooses to leave the premises, allow them the freedom to exit, making sure to note car make and model, license plate, and the directions of their travel. Communicate this information immediately to the 911 dispatcher.
4. If a violent or potentially violent person gains access to your facility and remains, immediately call 911 and seek advice on how to handle the situation.
5. Indicate to another staff member a condition may exist for a lockdown. If there is reason to suspect that the individual has a weapon, then order a lockdown as soon as possible.
6. Try to isolate the person from as many adults and children as possible. Seek to move the individual to an office, break room, conference room, or other less populated area.
7. If the violent or potentially violent person entered a classroom, seek to move them into the least utilized portion of the room.
8. Remain calm and be polite. Do not attempt to physically restrain or block their movement.
9. Await arrival of law enforcement personnel, who will assume control of the situation.
10. Through whatever means seems most effective, provide parents with a brief description of the emergency, how it was handled, and if appropriate, what steps are being taken in its aftermath.

### **Teacher/group leader actions**

While the director or other staff member is talking to the violent or potentially violent individual, others should direct unaffected groups of children to move to locations around the facility that are farthest from the incident point.

1. Quickly check the hall and restrooms closest to their classrooms to get children into the rooms to be secured.

2. Lock all doors. Do not open the door for anyone. Once room is secured, no one is allowed to enter or exit under any circumstances until room is cleared by law enforcement or “all clear” is issued by the director.
3. Use a doorstop or other wedge to keep door closed. Also barricade the door with available heavy furniture.
4. Turn off the lights and audio equipment. Cover the windows by closing blinds or shades or using black paper.
5. Keep children away from windows and doors. Encourage them to get under tables and behind cabinets. Turn classroom tables on their sides to use as shields. Instruct children, according to their ability to understand, to keep quiet, sit out of view of the windows, and act as if no one is in the room.
6. Maintain (as best you can) a calm atmosphere in the room, keeping alert to children’s emotional needs. (Tip: gather in a story circle behind a table and gather infants into 1 or 2 cribs (preferably on wheels) along with items to help keep them quiet, such as bottles, pacifiers, and small, quiet toys.)
7. Have cell phone within reach at all times. Turn cell phones to vibrate mode. Use cell phones only for communicating vital emergency information. Information should always be clear and direct and, as much as possible, communicate the whereabouts of the intruder so that others can make an informed decision as to their best option to protect the children.
8. Ignore any fire alarm activation.
9. Be prepared for lengthy stay (2-4 hours).
10. Do not evacuate until room is cleared by law enforcement or an “all clear” signal is given by the director.

**Controlled evacuation**

While the decision to remain in a room or location that can be secured and barricaded is the preferable option if the threat is in close proximity and no means of safe exit are available, relying on lockdown alone can endanger occupants in a violent intruder situation. Be alert to opportunities to evacuate some of the children when there is a clear means of evacuation that will not cross the path of the threat. With rapid, silent evacuation being the goal, the importance of staff and children responding quickly and calmly is critical.

## 2-6 Restoring Operations

In the aftermath of the emergency, the agency will restore essential services for children, youth, and families as soon as practicably possible. The City of New Bedford's Emergency Management Department identifies steps that agencies should take to resume normal operations after an emergency affecting a facility:<sup>1</sup>

1. Prioritize repairs according to restoration needs. Maintain records of all damage-related expenses.
2. Compile damage estimates and a list of damaged goods and equipment.
3. Notify NorthStar insurance carriers. Consult with the New Bedford Emergency Management Department on the availability of financial assistance and loans in disaster situations.
4. Major repair or restoration efforts should be coordinated with insurance and appropriate government agencies such as the EEC for permits and licensing.
5. Keep families served by the agency informed of progress and the timeframe for restoration of operations, and alternative site information if applicable. If possible, assist families with alternative or temporary service options to ease the strain on families.
6. Involve children and families in restoration activities where possible to provide closure to the emergency situation and return to normal operations.

### Recovering from an emergency

Returning the program, staff, and children to a normal routine as soon as possible will support the recovery process. Nevertheless, an emergency can dramatically impact the psychological and physical well-being of children and adults. It is important to have reasonable expectations for staff and children during the emergency when coping ability may be low and frustrations run high.

Following are some ways you can help the children in your care cope with their feelings:

1. Reassure the children that they will not be left alone and that you are there to protect them.
2. Be aware of changes in a child's behavior, but also know that some children may not outwardly show their distress.
3. Give simple, but truthful answers to children's questions and make sure they understand your answers. Don't give more information than the children can use and understand.
4. Give children opportunities to express their feelings through activities such as play-acting, using dolls, storytelling, painting, or drawing.
5. Be especially supportive of the children's feelings and need to be close. Give lots of hugs, smiles, and kind words.
6. If possible, take a moment away from the children and make sure you address your own fears and anxieties by talking with other adults.

Despite best efforts to provide support and reassurance to children and adults, they may continue to experience symptoms and reactions which may indicate a need for professional consultation. These symptoms may include:

1. **Children:** Withdrawn behavior, depression, helplessness, generalized fear, loss of verbal skills, sleep disturbance, loss of toileting skills, anxious attachment and clinging, uncharacteristic hostility or acting out.

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<sup>1</sup> Emergency Management Department, City of New Bedford, *Day Care Facility Emergency Planning Guidance* (New Bedford, MA: Author, 2003).

2. **Adults:** Withdrawal or depression, feelings of inadequacy and helplessness, difficulty in concentration, slowness to respond, substance abuse, psychosomatic or real physical symptoms (headache, bladder/bowel problems, chest pains, cramps, sleep disturbance, change in food consumption patterns).

In close consultation with other NorthStar staff, the director will identify and arrange for credentialed, appropriately trained mental health workers to provide counseling to children, families, and staff after a crisis. Because recovery from a crisis happens over time, the services of these mental health workers may be required over an extended time period. Parents will be informed about actions that the agency intends to take to help children recover from the crisis.

### 3. Larger-scale Health and Safety Hazards

Part 3 of this *Health and Safety Manual* is intended to assist staff in responding to natural and technological hazards that may affect the immediate area in which a NorthStar facility is located or all or most of the NorthStar's service delivery area.

The director of early education and care will be responsible for obtaining complete, up-to-date written instructions from the City of New Bedford's Emergency Management Department (and other emergency preparedness authorities in municipalities in which the agency operates facilities) regarding what to do in the event of specific emergency situations that may occur in the area. This part of the manual is based on the New Bedford Emergency Management Department's *Group Day Care Facility Emergency Planning Guidance*. In all emergency situations, NorthStar will fully cooperate with local emergency response officials and follow their instructions and recommendations.

The executive director will make decisions on how to respond to larger-scale safety hazards (such as snow or storms) that affect the entire or much of the area in which the agency operates. In facility-based responses to hazards, everyone will know their role in advance and the chain of decision-making authority within the facility:

1. In the absence of specific instructions from emergency management officials, the director will decide whether to evacuate or to shelter in place and under what circumstances. If possible, they will consult with their program administrator and the executive director prior to making a decision.
2. If the director is absent or incapacitated by the hazard, the staff member who is normally assigned the role of designated administrator in the absence of the director should take over.
3. All children should be accounted for at all times. Staff should alert each other whenever the responsibility for the care of a child is being transferred from one staff member to another.
4. An emergency situation can have a lasting effect on children's healthy development and well-being. In responding to an emergency, staff will help children cope with their feelings, fears, and needs during and after the emergency. Staff will comfort the children, explain the situation according to their ability to understand, involve them where possible in emergency activities, and model for them how to remain calm.
5. When an emergency situation arises, visitors may be at the facility who are not familiar with the emergency plan. In responding to the emergency, staff will assist these individuals as well as the children in care.

Anyone who learns about a significant health or safety hazard should notify agency management so that appropriate action can be taken. Their telephone numbers are included on the Emergency Phone Number list posted in each facility.

## 3-1 Severe Weather

Providing essential services for children and families, the agency and its staff must be prepared to operate during severe weather conditions. The agency will not close unless hazardous weather conditions exist or other extraordinary circumstance occurs. It is therefore *likely* that the agency will be *open* when area schools and businesses may have closed due to snow or other severe weather.

The executive director will decide upon the closure of any facility. If the executive director decides prior to opening hours not to open one or more facilities due to snow or storm or other emergency circumstance, families will be notified by WBSM radio broadcasts of closings.

If snow or storm necessitates the closure of a facility during normal operating hours, the director will notify parents or their emergency contacts by phone to arrange for early pickup or transportation home. If weather conditions prevent parents from reaching the facility to pick up their children, the director will plan and implement extended care for the children (maintaining appropriate child-staff ratios) until such time as the parents can safely pick up their children.

### **Transportation services**

Our EEC-licensed early childhood education and afterschool programs will remain open, when feasible, on days when there is heavy snowfall or other severe weather. If the agency's own drivers and/or the contract transportation provider deem driving to be hazardous, no transportation will be provided. Notice that agency-provided transportation services will not be operating will be included in local radio broadcasts of program cancellations. When the agency cancels transportation services because of severe weather conditions, but its facilities are open, parents may bring their children to the program.

### **Weather information**

The agency will access timely severe weather information as well as routine weather forecasts:

1. The National Weather Service issues storm watch and warnings over its NOAA Weather Radio system. A severe weather "Watch" means that conditions are present that could cause a weather emergency in the areas mentioned. A severe weather "Warning" means severe weather is expected and precautions should be taken in the affected areas.
2. Because of the New Bedford area's vulnerability to storms, area commercial radio stations also provide timely severe weather information.
3. The television Weather Channel (Channel 47) is another source of weather information.

### **Hurricanes**

Even though the New Bedford area has been hit by major hurricanes, hurricanes are not addressed in this manual. Because of advance warning capability, it is unlikely that a facility would be open during a hurricane event.

### **Thunderstorms and high winds**

In the event of thunderstorms and lightening as well as high winds, center directors/site coordinators should respond as follows:

1. Direct all children and staff inside the facility.
2. Secure outdoor objects that could blow away or cause injury to people or damage to the facility if airborne.
3. During severe thunderstorms, relocate children and staff to inner areas of the facility.
4. During periods of high winds, keep children and staff away from glassed areas if possible.

5. During lightning storms, do not handle electrical equipment or water faucets.
6. Resume normal operations when the severe weather event has passed.

### **Snow/ice storms**

Although winter storms are usually not a surprise, changes in weather conditions—especially in coastal areas—can result in earlier-than-anticipated and/or greater-than-predicted snowfall. Severe snowstorms and ice storms can result in the shutdown of facilities, closed roads, and damage to power lines (loss of electrical power) and structures.

1. Based on weather predictions and public officials' responses, the executive director or designee will consider pre-storm closing (the night before) or early closing.
2. The agency will monitor updated weather forecasts and winter storm warnings and advisories. Central administrative personnel will maintain close contact with center directors/site coordinators as existing and anticipated weather conditions are reviewed and decisions are made.
3. If the facility must close during hours of operation because of snow or storm, the director will notify parents by phone
4. If weather conditions prevent a parent from reaching the facility to pick up their child, staff will care for the child (maintaining proper child-staff ratios) until such time as the parent or emergency contact person can safely pick up the child.
5. If there is a loss of electric power or heat at one or more of its facilities, the agency will follow its utility disruption procedures.
6. The director will arrange for snow and ice removal as well as possible debris removal such as fallen trees.

### **Tornadoes**

Tornadoes do occur in Massachusetts, with later spring and summer presenting the most favorable conditions whereby tornadoes can form. Weather fronts that can produce tornadoes may also generate heavy rain, wind, and hail that can cause serious damage.

1. A Tornado Watch means that a tornado is likely over a large area.
2. A Tornado Warning means there is likelihood of a tornado within the given area based on radar or actual sighting. It is usually accompanied by conditions indicated for Severe Thunderstorm Warning.

In response to a Tornado Warning, staff should:

1. Discontinue outdoor activity. Direct children and staff to a pre-identified shelter-in-place area in the facility. Keep children in the center of rooms and away from corners because they attract debris. Account for all children and staff.
2. Bring emergency backpacks and other emergencies supplies.
3. If caught outside (on a field trip, for example), seek shelter in a low-lying area.
4. Exit the shelter-in-place area when the warning has expired.
5. Check for injuries and administer first aid as appropriate. Call 911 for emergency medical assistance, if needed.
6. If the building is damaged, use caution when exiting and entering it. Be alert for broken glass and downed trees and power lines.
7. Evacuate and move to a host facility if the facility is unsafe for occupancy.

## 3-2 Utility Disruption

In any kind of utility loss:

1. Call the pertinent utility company and determine the extent of the outage.
2. Decide whether utility loss poses an inconvenience (no lights in summer) or a hazard (no heat in January). Consider that our EEC-licensed facilities must be able to meet EEC regulations and requirements for water use, heat, and power to remain open.
3. Determine the scope of the outage. Is it just the facility, the neighborhood, or the entire city?
4. Try to determine how much time will be required to correct problem. Consider remaining in the facility if utilities are to be restored soon or the facility will be closed soon for the day.
5. Determine if prolonged occupation of the facility is inadvisable.

### **When the electrical power goes out**

Loss of electrical power may result from a weather-related event, by human error, or other accident. In the event of a power outage, the director will:

1. Check the circuit breakers or fuses on the service panel.
2. Report loss of electrical power immediately to the Business Office and the utility company, explain the situation, and request assistance. Find out if the power outage is confined to the facility or includes the neighborhood or surrounding areas.
3. Check that the battery-operated emergency lighting system has been automatically activated. Locate flashlights and batteries.
4. Move children and staff to areas with natural light and/or emergency lighting.
5. Avoid opening freezers and freezer compartments where food is stored.
6. Unless the power failure is accompanied by an emergency situation (such as a fire or flood), keep the children at the facility. Consider the projected duration of the power outage in connection with:
  - Safety and comfort of the children and staff
  - Impact on children with special needs
  - Refrigeration of food and ability to prepare meals
  - Operation of smoke/fire detectors, ventilation, and telephone systems
  - Impact on the overall learning environment
7. If the power outage is lengthy, notify parents by phone to arrange for early pickup or transportation home. Transport children whose parents or emergency contacts cannot be reached to another program facility, if space permits, or to the primary host facility. Notify parents and arrange for pickup and transportation from the alternative site.
8. If it is necessary to leave the building, staff will evacuate to the pre-designated host facility. Staff should look for and avoid downed power lines.
9. Resume normal operations when power has been restored.

### **When there is no heat**

Temperature in rooms that children use should be maintained at not less than 65°F at 0°F outside and at not more than the outside temperature when the outside temperature is above 80°F. Loss of heat may result from power failure, disruption of the fuel supply, or heating equipment failure. In the event of heat loss, the director will:



1. Report the loss of heat immediately to the Business Office and other appropriate persons. Establish whether heat loss is confined to the facility and may require equipment repair or includes the neighborhood or surrounding areas.
2. Move children and staff to warmer areas of the facility.
3. Provide blankets to keep the children and staff warm.
4. If safe temperatures cannot be maintained within the facility, phone parents to arrange for early pickup or transportation home. Children whose parents or emergency contacts can't be reached will be transported to another NorthStar facility, if space permits, or to the primary host facility. Notify parents and arrange for pickup and transportation from the host facility.
5. Resume normal operations when heat has been restored.

**When there is no water**

In the event of water loss, the director should:

1. Immediately report the disruption of the facility's water supply to the Business Office and to the New Bedford Water Department. Find out if the disruption of the water supply is confined to the facility or includes the neighborhood or surrounding areas.
2. Use bottled water for drinking, handwashing, other sanitation and hygiene procedures, and toilet flushing. Use wipes for handwashing and sanitation until more water is delivered.
3. Determine the feasibility of continued operations with alternative water sources.
4. Procure needed water if the facility is to remain open.
5. If necessary, evacuate to a host facility. Notify parents and arrange for pickup and transportation from the pre-designated host facility.
6. Resume normal operations when the water supply has been restored.

**Gas odor/leak**

If a gas odor is detected, notify director immediately.

1. If gas leak is inside the building, immediately evacuate children and staff; close doors behind you but leave a window open.
2. Don't touch electric switches, thermostats or appliance controls; they may cause sparks. Don't activate the fire alarm system or any other electrical equipment.
3. Call 911 from outside the building.
4. Notify utility company for emergency service.
5. Consult with utility company and fire personnel to determine next steps.
6. Notify parents immediately if evacuation looks to be long term or if children are moved to host facility.

### 3-3 Fire or Risk of Explosion

Each facility will have a fire emergency plan that includes an evacuation procedure, marked exits, fire/smoke detectors, fire extinguishers, safe storage and use of flammable materials, fire safety training, and fire drills.

Anyone who discovers smoke, fire, or risk of explosion will pull the fire alarm and notify the municipal fire department by calling 911 from a safe location after being sure that evacuation of the building occurs.

1. Evacuate children and staff to a safe distance (at least 50 feet away) from the building using the established fire plan. Keep children away from roadways and other access routes that may be used by responding emergency vehicles.
2. If it can be done safely, close doors to the location of the fire to confine the fire. The last person to leave a room will close the doors to that room.
3. Use a fire extinguisher where safe and necessary.
4. Outside the building, check for injuries and administer emergency aid as needed.
5. Meet responding fire department personnel and direct them to the fire's location.
6. Promptly call the program administrator and executive director.
7. Evacuate to a host facility if the weather is inclement or the building cannot be reoccupied for a long or indefinite period.
8. Allow return to the facility when fire department officials indicate it is safe to do so.
9. Complete necessary notifications and reporting of the incident.

#### **Fire drills**

Fire evacuation procedures should be practiced at least monthly at varied times of day.

## 3-4 Flooding

While New Bedford and the surrounding area are not vulnerable to river or flash flooding, storm surge flooding may result from hurricanes. Localized flooding may also result from a combination of excessive rainfall and an overburdened city storm drainage system. Program facilities may be vulnerable to localized flooding, especially basement flooding, due to poor rainwater runoff.

In the event of flooding, the director will:

1. Close and evacuate the facility if necessary, following evacuation recommendations or directives from local public safety officials.
2. Direct the evacuation and move to a host facility.
3. After flooding has abated, coordinate inspection of the facility and utility services prior to allowing reentry.
4. Allow reentry of the facility by children and staff when the facility has been determined to be safe.

## 3-5 Earthquake

Minor earthquakes occur throughout New England. There is some potential for more serious earthquakes. Damage to structures and utilities and injury to people from falling debris is possible.

1. During an earthquake, staff should remain calm to communicate reassurance to the children.
2. Staff and children should take cover from falling objects indoors and outside.
3. For staff and children who are indoors, they should remain there.
  - Take cover under desks, tables, or other heavy furniture.
  - Keep children away from windows, doors, and outside walls.
  - Stay away from windows and look out for falling objects.
4. For staff and children who are outdoors, they should remain in the open.
  - Move away from the facility if possible.
  - Move away from utility poles, overhead wires, and trees if possible.
  - Stay away from likely routes of rescue vehicles if possible.
5. After the event, staff and children inside the facility should evacuate to open areas outside.
6. Staff and children shouldn't reenter the facility until authorities have checked it for possible structural damage, gas line leaks, and other utility disruptions.
7. At all times, staff should ensure that all children are accounted for.
8. Staff should provide emergency aid as needed. Call 911 for emergency medical assistance if needed.

## 3-6 Pandemic Flu Policy

### **Purpose**

The purpose of this pandemic flu policy is to ensure that our employees know what is expected of them in the event of a serious worldwide or national influenza outbreak. It outlines specific steps that NorthStar takes to safeguard employees' health and well-being during a flu pandemic while ensuring our ability to maintain essential operations and continue providing essential services to the families we serve.

NorthStar's administrative team is responsible for ensuring our organization's ability to continue operating in emergencies, while taking into account the nature and seriousness of conditions at hand. The administrative team will incorporate new evidence-based practices and information into emergency-response and operations-continuity planning and preparedness initiatives. Every employee has a responsibility to themselves and their coworkers to take action to prevent the influx and spread of influenza among employees and the people we serve. You will be required to follow this emergency policy in the event of a pandemic influenza outbreak.

### **Pandemic flu defined**

A pandemic is a global disease outbreak. An influenza pandemic occurs when a new influenza virus emerges for which there is little or no immunity in the human population, begins to cause serious illness and then spreads worldwide. Unlike natural disasters or terrorist events, an influenza pandemic will be widespread, affecting multiple areas of the United States and other countries at the same time. A pandemic will also be an extended event, with possible multiple waves of outbreaks in the same geographic area; each outbreak could last 6 to 8 weeks and may occur over a year or more.

Pandemic influenza poses serious global threats to public health, our economy, and our ways of life. It conceivably can cost billions of dollars in productivity losses resulting from absenteeism, payouts of sick leave or workers' compensation, and lost sales; disrupt transportation and communication services on which we all depend; and impede delivery of necessary goods and services.

Although some scientists do not agree, many experts believe that it is not a matter of *if* a pandemic will occur again; it is a matter of *when*. Inability to predict when such a disease might strike and with what severity makes it incumbent on NorthStar to consider how our business and program operations might be affected and to articulate what needs to be done to respond to an outbreak.

### **Outside authorities and partners**

NorthStar acknowledges that during an influenza pandemic, local, state, or federal authorities might prohibit or severely curtail individuals' access to and use of public services and public transportation; close or prevent access to buildings or public highways; isolate or quarantine buildings' occupants; and prevent inter- or intrastate delivery of goods and services. We cannot predict and have no control over such authorities' actions and acknowledge our legal duty to comply with outside authorities' directives.

During an influenza pandemic, NorthStar will partner with local, state, and federal emergency-response and health agencies to ensure legal compliance with emergency-response protocols to which NorthStar is subject and to coordinate efforts to maintain safety and security in and outside the workplace.

### **Remote work opportunities**

To reduce potential exposure to the influenza among employees and the families we serve, we are prepared to continue program operations by having employees work from home and communicate remotely with each other and the families we serve. We are prepared to use social media

communications platforms such as Zoom to stay connected with and support program participants, to conduct team meetings and supervision, and to communicate and collaborate with community partners and funders. No doubt, some of the innovative solutions to communicating remotely will change the future of our work beyond flu pandemics.

**Security.** In communicating remotely with other employees and with families we serve, maintaining the confidentiality, security, and integrity of program participants' personal information should always remain a top concern. We are committed to providing a safe and secure virtual meeting environment that ensures privacy and security. Safeguards used to protect Zoom-enabled meetings include passwords and waiting rooms.

**Accountability.** Understand that you are fully accountable for your postings and other electronic communications that are job-related, particularly online activities conducted with a NorthStar email address, or while using NorthStar property, networks, or resources.

### **Training**

All employees will receive training in reference to this policy and exposure control. Training will also ensure that employees have the necessary technological capabilities to maintain consistent, high-quality connections with coworkers, families and partners while working remotely.

### **Prevention**

All employees are at risk of exposure to flu viruses, both in and outside the workplace; therefore, NorthStar requires all employees to participate in training to become informed about what they can do to reduce the possibility of an influenza infection when a flu outbreak occurs:

- **Practice good hygiene.** Start by washing your hands thoroughly with soap and hot water frequently or by using alcohol-based/waterless hand hygiene products. Avoid touching your mouth, nose and eyes if your hands are not clean.
- **Practice cough etiquette.** Cover your mouth with a tissue and cough into the tissue. If you don't have a tissue, cough or sneeze into your upper sleeve or elbow, not your hands. Stay clear of anybody who is coughing or sneezing. Be sure to educate family members and children and make sure they have a supply of tissues handy or know how to cough into their elbow, not their hands.
- **Practice social distancing.** Reduce the frequency, proximity, and duration of contact between people. Remain at least 6 feet apart from other people. Meetings of 10 or more individuals should be canceled or rescheduled to a phone call or online platform. Non-essential business travel should be avoided. Working, commuting, shopping, etc. during off hours is also a time to maintain social distancing.
- **Keep equipment clean.** Don't use other person's phones, keyboards, desks or appliances without first disinfecting the appliance or surface with an antiviral cleaning wipe/product.
- **Wear cloth face masks.** The Centers for Disease Control and Prevention (CDC) is advising the use of simple cloth face masks that cover your entire nose and mouth as a voluntary public health measure to slow the spread of a virus. CDC recommends wearing cloth face masks in public settings where other social distancing measures are difficult to maintain (e.g., supermarkets and pharmacies) especially in areas of significant community-based transmission. Homemade face masks, however, should be considered an "additive" to social distancing, not a substitute. The CDC urges people to use homemade cloth face masks, while saving surgical masks and N-95 respirators for healthcare workers and other medical first responders. Homemade cloth masks should be washed regularly, with regular detergent and in regular washing machine cycles, and can be reused without reducing their effectiveness. The CDC has produced a guide on how to make a face mask at home. NorthStar will make every effort to maintain adequate supplies of protective cloth face masks, produced according to CDC guidelines, for our employees.

- Stay home. During a pandemic influenza outbreak, as determined by the state or federal government, employees who have flu-like symptoms (fever, dry cough, sore throat, sore muscles, stuffy/runny nose, and headache) are required to stay home from work. Use your provided sick leave and seek medical attention within the first couple of days. Don't come into the office or jobsite where you could expose other employees and their families.
- See a doctor. Seek professional medical attention as soon as you think you may be ill. The longer you wait the greater the chance of serious illness.
- Get flu shots. Get your seasonal influenza vaccine, unless prevented to do so because of allergies or other health reasons.

### Influenza safety supplies

NorthStar will make a concerted effort to maintain adequate supplies of cloth face masks, disposable gloves, and antibacterial hand gels and wipes, which we can require workers to use.

### Basic influenza information

Influenza is commonly known as the flu, which is a virus infection. Key differences between seasonal flu and pandemic flu include:

Seasonal Flu	Pandemic Flu
Outbreaks follow predictable seasonal patterns; occurs annually, usually in winter, in temperate climates.	Occurs rarely; the 20th century had pandemics in 1918, 1957, and 1968. The last time a pandemic was declared was in 2010 for the H1N1 virus.
Usually some immunity built up from previous exposure.	No previous exposure; little or no preexisting immunity.
Young children, elderly, and those with certain underlying health conditions are at increased risk for serious complications—usually not healthy adults.	Healthy people may be at increased risk for serious complications.
Health systems can usually meet public and patient needs.	Health systems may be overwhelmed.
Vaccine developed based on known flu strains and available for annual flu season.	Vaccine probably would not be available in the early stages of a pandemic.
Adequate supplies of antivirals are usually available.	Effective antivirals may be in limited supply.
Average deaths in the U.S. from the flu are about 36,000/year.	Number of deaths could be much higher.
Symptoms include fever, cough, runny nose, and muscle pain. Deaths are often caused by pneumonia or other complications.	Symptoms may be more severe and complications more frequent.
Generally causes modest impact on society (e.g., some school closing, encouraging people who are sick to stay home).	May cause major impact on society (e.g., widespread restrictions on travel, public gatherings, closings of schools and businesses).
Impact on domestic and world economy is manageable.	Has potential for severe impact on domestic and world economy.

Flu viruses spread in respiratory droplets caused by coughing or sneezing. The flu viruses are also

known to be spread when a person makes contact with a contaminated surface such as an infected person's hand, countertop, desk, telephone, keyboard and any other surface that respiratory droplets may contact and then the person touches their mouth, nose, or eyes.

Most healthy adults may be able to infect others one day before the virus symptoms appear and up to 5 days after becoming sick. That means a person can pass on the flu to someone else before they know and while they are sick. Viruses can be spread very easily through an office, while commuting, in the home, while shopping, and in any other environment where people come together.



## 4. Preventing Violence and Reducing Its Impact

NorthStar is committed to providing a work and program environment that is as free as possible from violence of any kind. Employees at all levels are responsible for assisting and cooperating in making facilities safe and secure for children, youth, and families and those who work there. All employees should at all times treat coworkers, people in our programs, and others with whom they have work-related contact in a respectful and considerate manner.

Violence may not only cause physical injury, but also trauma for children and youth, along with those who care for them. Planning and preparation can reduce the incidence of violence and the harm that it can do.

While much emergency management planning on the heels of “9/11” focuses on the threat of global terrorism, the human threat to children and those who care for them is most likely to take the form of violence perpetrated within families and neighborhoods.

### **Connecting the dots to address the many forms of violence**

As the connections between different forms of violence become clearer, we can see how violence leads to more violence and the “pile-up” of violence in certain neighborhoods and communities. Understanding how different forms of violence are linked to one another, we can think strategically and apply that understanding to decrease all forms of violence:

Violence takes many forms, including intimate partner violence, sexual violence, child maltreatment, bullying, suicidal behavior, and elder abuse and neglect. These forms of violence are interconnected and often share the same root causes. They can also all take place under one roof, or in a given community or neighborhood and can happen at the same time or at different stages of life. Understanding the overlapping causes of violence and the things that can protect people and communities is important, and can help us better address violence in all its forms.<sup>2</sup>

Organizations can work together to have a broad-based violence prevention/intervention effect in the community. When we transcend professional boundaries, we can tackle violence as the multifaceted problem that it is:

Professionally we have silos, and we operate in these silos we've got to break down. Across the country, people working to prevent child abuse are right across the hall from people working on violence against women, and they don't work together. As we go into communities to bring everybody to the table, don't let people say, “I work on child abuse, but this is about gang violence.” Don't let people say, “I work on violence against women, and this is about child abuse.” This thing, all this violence, is connected.<sup>3</sup>

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<sup>2</sup> N. Wilkins, B. Tsao, M. Hertz, R. Davis, J. Klevens, *Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence* (Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention Oakland, CA: Prevention Institute, 2014), 1.

<sup>3</sup> Deborah Prothrow-Stith, Harvard School of Public Health, quoted in Wilkin et al., *Connecting the Dots*, 6.

## 4-1 Child Guidance

Our child guidance policy is an integral part of making our early education and afterschool programs safe, secure, and violence-free.

Child guidance works better than punishment. Our child guidance policy is part of our effort to make our programs safe, secure, and violence-free. The state prohibits early education and afterschool programs from:

- ☒ *Using or threatening to spank or use other physical punishment*
- ☒ *Subjecting children to cruel or severe punishment such as any form of public or private humiliation or verbal or physical abuse or neglect*
- ☒ *Abusive treatment, including: any time of hitting inflicted in any manner upon the body, shaking, threats; emotional abuse, including rejecting, ignoring, isolating, or scaring a child; abusive, profane, or derogatory remarks about the child or their family*
- ☒ *Denying or threatening to deny a child outdoor time, meals or snacks; forcing a child to eat or otherwise making them eat against their will, or in any way using food as a consequence*
- ☒ *Inappropriate toilet training practices such as disciplining a child for not using the toilet, leaving a child in soiled clothing, or forcing them to remain on the toilet*
- ☒ *Confining a child to a swing, high chair, crib, playpen or any other piece of equipment for an extended period of time in lieu of supervision*
- ☒ *Too much time-out. Time-out may not exceed one minute for each year of the child's age and must take place within an educator's view.*

### Methods of child guidance

The agency's child guidance plan is designed to promote children's ability to assume personal responsibility and responsibility for others, to exercise self-control, to make safe choices, and to behave appropriately in their relationships with peers and adults. Behavioral goals include respecting the property of others and respecting (including not misusing or intentionally damaging) the property of the program. Staff should use child guidance methods that reflect the child's developmental stage and capacity to understand and learn from the method.

1. Plan for appropriate behavior. Staff expectations and planning of the program environment and daily schedule should support the program's behavioral goals for children.
  - *Expectations:* Establish clear, developmentally-appropriate limits and apply them consistently. Involve children in making group rules on what is acceptable behavior.
  - *Environment:* Arrange play items and materials to encourage active learning and independence by placing them on open shelves where children can reach and return them. Design children's spaces to promote smooth traffic flow between interest centers and to minimize children's disruption of each other's activities. Make available play items and materials that reflect children's interests and abilities.
  - *Scheduling:* Children are more likely to behave inappropriately when they are bored, waiting, hurried, or not allowed time to relax after an exciting activity. Promote appropriate behavior by providing children with ample opportunity to select activities and to move between them at their own pace. Manage routines and transitions in creative ways that engage the children and minimize waiting.
2. Reinforce positive behavior. Recognize children's appropriate behavior.

3. Establish and reinforce that physical and verbal aggression are unacceptable. Protect children and encourage their appropriate behavior by quickly and calmly interrupting aggressive physical or verbal behavior.
4. Model desired behavior. Consistently show respect, self-control, and consideration toward children and other adults.
5. Redirect children. Steer children away from negative behavior to engaging in positive activity rather than removing them from all activity. For example, when a child splashes other children at the water table, redirect them by introducing new materials and ideas. If the child persists in the negative behavior, ask them to choose another activity. To help the child to understand and learn from the experience, present natural and logical consequences of negative behavior (such as not being able to play at the water table for a time as a consequence of splashing others).
6. Selectively use “time-out.” For children 3 and over, we use “time-out” only to help the child regain self-control and reflect—never as a punishment. Program staff take into account the child’s developmental stage and ability to learn from “time-out.” Staff avoid its overuse and limit “time-out” to 3-4 minutes. Whenever possible, a staff member is available to help the child process their “time-out.” Infants and toddlers are too young to cognitively understand the consequence of “time-out.”
7. Teach new skills. Show children positive alternatives rather than just telling them “no.” Help children to express their anger, frustration, sadness, and other feelings in acceptable ways, to recognize other children’s feelings, and to balance their own needs and wants with those of others. Whenever possible, encourage children to peacefully solve their own problems without adult intervention. For example, if 2 children are fighting over a toy, take the toy and invite the children to come up with a solution.
8. Ignore inappropriate behavior. While hurtful or dangerous behavior should be immediately interrupted, ignoring negative behavior that is simply unpleasant can sometimes serve to discourage it. Focusing on children’s inappropriate behavior can invite negative attention-getting behavior.
9. Achieve cooperation between the program and the family. Child guidance is most effective when program staff and the child’s family develop common understanding and expectations and are consistent in their approach. Staff and parents can work together to identify and address the causes behind children’s challenging behavior.
10. Undertake evaluation and appropriate intervention. If a child continues to behave in aggressive or disruptive ways, staff may, with parent approval, get a professional assessment. Any determination about the program’s ability to accommodate the child will be based on objective information obtained through consultation with appropriate health care professionals and staff experiences with the child. The child’s continued attendance of the program may be conditioned on the family’s participation in designing and carrying out specific intervention procedures to manage the child’s problem behavior and effect positive behavior. The intervention plan may include mental health counseling or other specialized services.

## 4-2 No Weapons Policy

No weapons are allowed in or on the premises of any agency facility. Weapons include firearms, knives (other than kitchen knives used in food preparation and penknives used to cut string or open cartons), brass knuckles, martial arts equipment, clubs, bats, and explosives. Any employee found with a weapon in the workplace may be subject to corrective action, up to and including termination.

### **Weapon found in the facility<sup>4</sup>**

If a gun, knife, or other weapon is found in the facility, staff should:

1. Move children out of the room in which it was found.
2. Do not touch the weapon.
3. Inform the director.
4. Talk with the children about the incident.

In consultation with the program administrator, the director will determine whether to notify the police.

### **Child found to have a weapon in their possession**

If a child is found to have a gun, knife, or other weapon on their person, staff should:

1. Calmly direct the child to put the weapon down.
2. Move the children out of the room.
3. Inform the director.
4. Notify the child's parent.
5. Talk with the children about the incident.

In consultation with the program administrator, the director will determine whether to notify the police.

### **Youth or adult possession of a weapon**

If a youth or adult has or might have a weapon, calmly ask them to place any weapons in a neutral location while talking calmly with them. Never attempt to disarm or accept a weapon from the person in question.

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<sup>4</sup> The protocols in this and the following section are from Department of Human Services and Children's Services Division, City of Chicago and the Rainbow House Institute for Choosing Non-Violence, *Caring for children in dangerous times: A protocol for responding to violence*. (Chicago, IL: Authors, 1995).

## 4-3 Violence near a Facility

Programs are affected not only by workplace violence, but also by the incidence of violence in the surrounding community. This section provides plans for responding to violent incidents that may erupt near our facilities.

### **Gunfire near a facility**

In gun violence, stray bullets may kill or maim an unintended victim at a distance from where a gun is used. If gun violence occurs near a facility, staff should:

1. Direct children and staff to take cover in interior doorways or hallways. Instruct everyone to get down on the floor. Keep everyone away from windows.
2. Inform other staff in the facility.
3. Shut and lock all outside doors. Close as many interior doors as possible.
4. Call the police. Note the time that the call is made.
5. Talk with the children in a reassuring, honest manner at a level they can understand: "We're doing everything we can to keep you safe. You can help by staying down, listening carefully, and cooperating."
6. Note the time of the police arrival.
7. Promptly notify the program administrator and the executive director.
8. Complete reporting requirements.
9. Decide upon how to inform parents (verbally, send notes home, schedule a meeting). Provide information on the possible effects the incident may have on their child and recommendations on how to help their child cope with the incident.
10. Provide children with opportunities to talk about the incident. Offer play and art activities to help the children cope with the violent incident and promote resilience.
11. Arrange for crisis counseling to assist children, their families, and staff, if needed.
12. Meet with staff to review the details of the incident, validate positive performance by staff, assess police response, and modify facility response plan as needed.
13. Communicate appreciation or concerns to the police regarding their response.

### **Fight near a facility**

If fighting erupts near a facility, follow the above procedures even when weapons are not evident. Consider that any fight could escalate to gun violence. Quickly direct the children to interior doorways and hallways. Explain along the lines of "It's not safe to watch or be near people when they fight. We're going to do everything we can to keep you safe. You can help by listening, moving quickly, and cooperating."

### **Violence when children are outside the facility**

Especially in high-violence neighborhoods, staff should be prepared for the possibility of violent incidents happening when children are outside on a playground or on neighborhood walks. If a violent situation starts:

1. Immediately bring the children together. Some children who are exposed to high levels of gunfire and fighting may not recognize the danger. Talk with the children in a calm, reassuring tone of voice: "It's not safe for us to be here. You can help by listening carefully and doing what we say. Please move quickly and stay together."
2. Determine the location or direction of the violence.

3. Leave the area quickly and return to the facility as soon as possible. If the violence occurs when children and staff are at some distance from the facility, seek shelter in a nearby store, school, church, library, or neighbor's home.
4. Ensure that all children are accounted for at all times.
5. After returning to the facility or taking shelter, call the police to report the violence and its location. Identify yourself as staff and the name of the agency and indicate the presence of children.
6. If sheltering in a community location, notify the director as soon as possible.
7. Back at the facility or having taken shelter, assure the children that they are in a safe place away from the violence. Assess how much they understood about the violent situation. Explain what happened according to their ability to understand.
8. Back at the facility, document the incident and how staff and children responded. Submit to the director.
9. Encourage children to talk about what happened and about their feelings. Use the incident to talk about non-violent conflict resolution. Use art and play to help children cope with the violence.

The director should:

1. Review staff documentation to ensure objectivity, accuracy, and completeness.
2. Inform the program administrator and executive director of the incident.
3. Establish how to inform parents about the incident.
4. Provide staff with an opportunity to talk about the incident, express their feelings, evaluate their own performance, and make recommendations about how the response plan could be improved.
5. Assess police response. Acknowledge good service and register concern about a slow or otherwise poor response.

## 4-4 Bomb Threats

Bombs are the weapon most frequently chosen by terrorists, both inside and outside the U.S. The following plan outlines response measures to be taken at agency-operated facilities.<sup>5</sup>

### Procedure during a bomb threat call

All calls of a threatening nature will be taken seriously and immediately reported to the local police. During a bomb threat call, the person receiving the call should:

1. Note the time of the call and the exact wording of the bomb threat.
2. Be calm and courteous, listen carefully, and don't interrupt the caller.
3. If caller ID is available, record the caller's phone number.
4. Listen closely to the caller's voice and speech patterns and background noises:
  - Vocal characteristics: *loud, high-pitched, raspy, intoxicated, soft, deep, other?*
  - Speech: *fast, slow, distinct, distorted, stuttering, nasal, slurred, other?*
  - Grammar: *excellent, good, fair, poor, other?*
  - Accent: *local, other?*
  - Manner: *calm, angry, rational, irrational, coherent, incoherent, deliberate, emotional, righteous, jovial?*
  - Background noises: *machines, animals, music, quiet, office, voices, factory, airplanes, house (TV), party, traffic, other?*
5. Try to obtain the following information from the caller:
  - *When is the bomb going to explode?*
  - *Where is the bomb?*
  - *What does the bomb look like?*
  - *What kind of bomb is it?*
  - *What will cause the bomb to explode?*
  - *Did you place the bomb?*
  - *Why?*
  - *What is your address?*
  - *What is your name?*
  - *From where are you calling?*
6. If the building is occupied, tell the caller that detonation could cause injury or death.
7. Do not hang up the phone! Keep the caller on the phone as long as possible. Continue to ask them questions. Have someone else use another phone to call authorities.
8. Write down everything the caller said.

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<sup>5</sup> Cited by the New Bedford Emergency Management Department, this escalating security plan is from the *Proactive Handbook for the Threat of Terrorism in Schools* (Texas School Safety Center, Southwest Texas State University, San Marcos, TX), [http://www.txssc.swt.edu/terrorism\\_proactive\\_Handbook.pdf](http://www.txssc.swt.edu/terrorism_proactive_Handbook.pdf).

**Response plan**

Following is a sequenced response plan based on the severity of a bomb threat:

	<b>Level 1: Program receives a bomb threat call.</b>	<b>Level 2 Following a bomb threat call, staff find a suspicious object.</b>	<b>Level 3 An explosion has occurred.</b>
<b>Immediately</b>	<ul style="list-style-type: none"> <li>• Call 911 and inform the operator about the nature of the call.</li> <li>• Notify the program administrator and the executive director.</li> </ul>	<ul style="list-style-type: none"> <li>• Report the object to the director.</li> <li>• Secure the immediate area. Under no circumstances should it be touched, tampered with or moved.</li> <li>• Call 911.</li> <li>• Notify the program administrator and the executive director that a potential device was found.</li> <li>• Carry out standard evacuation procedures as specified in the emergency plan.</li> </ul>	<ul style="list-style-type: none"> <li>• Call 911.</li> <li>• Implement the building evacuation plan (minimum safe distance is from 1,000–3,000 feet).</li> <li>• Be aware that there may be additional explosions.</li> <li>• Account for all children and staff.</li> <li>• Keep children calm and in one location.</li> <li>• Provide emergency aid as needed</li> <li>• Designate staff to meet emergency vehicles.</li> <li>• Direct medical personnel to injured people.</li> <li>• Allow emergency response personnel to take control of the site.</li> </ul>
<b>Next 15 minutes</b>	<ul style="list-style-type: none"> <li>• Complete a detailed written record of call.</li> <li>• Review the written record of call. Assess the caller’s familiarity with the facility (by their description of the bomb location).</li> <li>• Assign 2 persons familiar with the facility to conduct a visual search of the building. Ensure that suspicious items are not moved.</li> <li>• Decide whether to evacuate or to keep the children in the facility.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide emergency and law enforcement personnel with a description and location of the package.</li> <li>• Allow emergency response personnel to take control of the scene.</li> <li>• During inclement weather and a possible prolonged search, move students to an alternate location.</li> </ul>	<ul style="list-style-type: none"> <li>• Notify parents of any injured children.</li> <li>• Arrange for emergency transportation of children and staff, if necessary.</li> </ul>



<b>Next 45 minutes</b>	<ul style="list-style-type: none"> <li>Review the facts and determination whether to evacuate or to keep children in the facility.</li> <li>Brief all staff members on the facts and the decision.</li> </ul>	
<b>Rest of the day (same for all levels)</b>	<ul style="list-style-type: none"> <li>Terminate the emergency, allow reentry into the facility, and resume normal operations when responding emergency officials declare the facility safe.</li> <li>Document the incident and complete required reporting.</li> <li>Keep the program administrator and the executive director informed.</li> <li>As instructed by the executive director, provide appropriate information to the media.</li> <li>Hold a staff meeting and provide details. Encourage staff to talk about their feelings and assess their performance.</li> <li>Decide upon an appropriate way to inform parents.</li> </ul>	
<b>Subsequent days (same for all levels)</b>	<ul style="list-style-type: none"> <li>Meet with key staff and review the response.</li> <li>Update the plan, if needed.</li> <li>Meet with parents.</li> <li>Arrange for crisis counseling to assist children, their families, and staff, if needed.</li> </ul>	

## 4-5 Preventing and Responding to Workplace Violence

While management is committed to a proactive preventative approach to violence and risk, all employees are expected to support a culture of safety in the workplace. But no matter how effective organizational measures are in preventing incidents, there are no guarantees against workplace violence. Workplace violence can take many forms and may be inflicted by an abusive employee, a manager, supervisor, coworker, client or program participant, or even a stranger. Whatever the cause or whoever the perpetrator, no threatening or violent behavior against workers is acceptable and no incident of workplace violence of any type will be ignored.

### Training

All employees must complete training developed and offered by the state Executive Office of Health and Human Services (EOHHS) to educate human service workers about workplace violence and how to reduce it, including early recognition of individuals at risk of perpetrating workplace violence. New employees must participate in the EOHHS-offered training within the first 3 months of employment. All employees must participate in such training at least once every 2 years. We are required to keep a written record of such participation. NorthStar will provide employees with additional training on specific safety and security hazards associated with their unit or job and facility.

### Defining workplace violence

The National Institute for Occupational Safety and Health defines workplace violence as “violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty.” We broadly define workplace violence to encompass not only physical assaults and threats of assault, but also verbal violence—threats, verbal abuse, hostility, harassment, bullying, and any other behavior that causes others to feel unsafe—which can cause significant emotional trauma and stress, even if no physical injury occurs. Examples of workplace violence include:

- 1) Verbally threatening to people or property worker regardless of whether the person making the threat has the ability to carry out their threat;
- 2) Leaving threatening notes at or sending threatening e-mails to a workplace;
- 3) Moving aggressively into another's personal space;
- 4) Throwing objects regardless of the size or type of object thrown or whether a person is the target of the thrown object;
- 5) Pounding one's fist on a desk or door or shaking one's fist in a coworker's face;
- 6) Destroying NorthStar property or personal property of another;
- 7) Bringing a weapon or imitation weapon to work;
- 8) Using racist epithets or other derogatory remarks associated with hate crime threats.

Workplace violence can include situations in which 2 program participants are fighting and a worker is injured while trying to intervene. The program participants may not have intended their violence to harm anyone else, but they used physical force that caused physical injury to the worker.

Any questions about what constitutes threatening or violent behavior should be directed to your supervisor or any administrator. If they don't know, they will promptly seek clarification.

*In carrying out this and other policies, it is essential that all employees understand that no existing NorthStar policy, practice or procedure is intended to disallow decisions designed to prevent a threat from being carried out, a violent act from occurring or a life-threatening situation from developing.*

### Types of workplace violence

Workplace violence has been classified as to “type” depending on the perpetrator’s relationship to the worker or workplace. Based on a workplace violence risk assessment, we have established a prevention and crisis response plan for each type:

Types of workplace violence	Description	Who does it most affect?
<i>Type 1: Violence by Strangers</i>	Violent acts usually committed in connection with robbery that could target our facilities or employees who work out in the community	Workers dealing with cash, working late hours and/or working alone
<i>Type 2: Violence by Program Participants</i>	Violence directed at employees by persons participating in our programs.	Health care, social services, education
<i>Type 3: Violence by Coworkers</i>	Violence against coworkers, supervisors, or managers by a current or former employee; coworker bullying. Though workers killing coworkers gets a lot of media attention, violence among coworkers is relatively rare.	Not associated with a specific type of workplace or occupation
<i>Type 4: Violence by Personal Relations</i>	Violence in the workplace by someone who confronts an employee with whom they have or had a personal relationship outside of work	Victims are mostly women
<u>Violence in community settings</u> is treated separately, since the perpetrator may be a stranger, the person the employee is visiting, or a family member or friend in the home. See 4-5(e) Working Off Site Safely.		

The Centers for Disease Control and Prevention injury center calls for a cross-cutting approach to reducing violence based on understanding of the interconnectedness of different forms of violence. An across-the-board violence reduction strategy is to show courtesy, trust, equity, and mutual respect to coworkers, to the people in our programs, and to all others.

### Take immediate action when incidents occur

Who you contact and when should depend on the seriousness of the situation.

Non-emergency Situations	Emergency Situations
<p>A situation is considered a <i>non-emergency</i> if:</p> <ol style="list-style-type: none"> <li>1) No injury has occurred;</li> <li>2) You don't feel you or anyone else is in immediate danger (e.g., no weapons); BUT</li> <li>3) A person's words or gestures have induced fear of physical harm in another person.</li> </ol> <p>To defuse a violent or potentially violent situation:</p> <ol style="list-style-type: none"> <li>1. Encourage and assist parties to resolve their differences by non-violent means;</li> <li>2. If the situation escalates, but there are no weapons or personal injury, follow the steps listed under the Non-Emergency (threatening) Response Procedure.</li> </ol>	<p>A situation is an <i>emergency</i> if:</p> <ol style="list-style-type: none"> <li>1) An injury has occurred; OR</li> <li>2) There is an immediate threat of physical harm or injury.</li> </ol> <p>For example, the parties to a violent altercation cannot be separated, or if it would be too dangerous for another employee or manager to separate the parties. If possible, the Emergency Response Procedure should be followed whenever an emergency occurs.</p>

After assessing whether a situation is emergency or non-emergency, respond accordingly:

<b>Non-Emergency (threatening) Response Procedure</b>	<b>Emergency Response Procedure</b>
<p><b>Step 1.</b> Notify supervisor. If the supervisor is the threatening individual, notify any administrator.</p> <p><b>Step 2.</b> On-site manager contacts the executive director or designee.</p> <p><b>Step 3.</b> Executive director assigns staff to investigate.</p> <p><b>Step 4.</b> Executive director meets with investigative staff to assess follow-up options.</p> <p><b>Step 5.</b> If appropriate, implement corrective action.</p> <p><b>Step 6.</b> If the situation escalates to an emergency or possible emergency, follow the steps outlined in the Emergency Response Procedure.</p> <p><b>Step 7.</b> Executive director oversees regular review of incidents.</p>	<p><b>Step 1.</b> First person on the scene quickly assesses the situation and risk. Evacuate the incident area.</p> <p><b>Step 2.</b> If perceived as an incident of danger such as personal injury, violence involving weapons or threat of weapons, immediately call 911 (police). If police are summoned, they will take charge of investigation.</p> <p><b>Step 3.</b> Notify the site supervisor or manager, who in turn calls the executive director.</p> <p><b>Step 4.</b> Assess medical need and obtain medical assistance.</p> <p><b>Step 5.</b> As appropriate, first manager on the scene separates the parties involved until they can be interviewed. Interview threatened or injured workers and witnesses.</p> <p><b>Step 6.</b> Management secures affected areas to safeguard evidence and assesses damage.</p> <p><b>Step 7.</b> Management seeks immediate intervention assistance from trauma response provider, including safety plans for those affected.</p>

### **Post-incident reporting and response**

Immediate trauma intervention assistance. Following are basic supports provided at the scene:

1. If you believe you can and desire to, assess the emotional state of those around you and determine if you can safely help stabilize them emotionally while you wait for professional assistance to arrive.
2. When help arrives, trained crises responders will assess the nature and extent of the intervention that is called for and take over responsibility for stabilizing the situation and providing crisis management.

Response protocols. Following a threat or an incident of workplace violence, the on-site supervisor/manager, working in close conjunction with other members of management, should:

1. Complete an incident report that details the incident, where and when the incident occurred, who was present/involved, a description of injuries, factors contributing to the event and whether or not medical services were advised and/or accessed.
2. Complete required post-incident notifications and reporting.
3. Offer assistance to employees in filing charges when assaulted.
4. Provide financial compensation for damage to personal property.
5. Offer voluntary referrals to Employee Assistance program services.
6. Conduct debriefings with employees and witnesses. Acknowledge that victims and witnesses may suffer psychological trauma, fear of returning to work, feelings of incompetence, guilt, and powerlessness. Discuss the circumstances of the incident with staff members. Recognize employees' positive response during the incident and invite recommendations on how to avoid similar situations in the future and, where incidence of violence or abuse cannot be anticipated or avoided, how to improve the response.

7. Develop a safety plan in response to the incident.

Intervening with observers of the incident. If the threatening or violent incident occurred in a program serving children or youth:

1. Inform parents in writing as soon as possible—preferably the day of the incident and not later than the next business day. Include a brief factual description of the incident, what staff did to protect children/youth, how the children/youth responded after the incident, how staff helped them to process the experience, and what parents can do to help their child cope with what happened. Meet with parents, if appropriate.
2. Encourage children/youth to talk about the incident. Consider building in art and music activities as part of the therapeutic follow-up. Provide crisis counseling, if needed.

### **Investigation**

All claims of workplace violence will be immediately investigated. We will separately interview all persons involved, including any witnesses, to obtain an accurate account of the incident. We will advise those employees who may be subject to corrective action based on the incident to choose someone to be present during the interview.

While witnesses may be advised that the matters discussed during the investigation will be treated discreetly to the extent possible and allowable by law, witnesses cannot be promised absolute confidentiality. We will seek to protect witness statements to the extent allowable under applicable laws if a witness has expressed safety concerns with regard to their participation in an investigation.

► For a more detailed description of internally investigating reports of workplace violence, see section 9-2 “How to Report Discrimination, Harassment, or Violence” in our *Employee Handbook*.

Based on the results of the investigation, management will take proportionate corrective action, when warranted. This response may include, but is not limited to, evaluation by external professionals, suspension and/or termination of any business relationship, reassignment of job duties, suspension or termination of employment, and/or criminal prosecution of persons involved.

### **No retaliation**

No employee shall be subject to corrective action for good faith reporting of threatening or violent behavior. Anyone who retaliates against a person for reporting workplace violence or for cooperating with an investigation of a workplace violence incident will be subject to corrective action up to and including termination of employment.

### **Evaluation**

After a violent incident, we will evaluate what took place before and during the incident to determine if everything was done that could have been done to have prevented the incident and what can be done to prevent it from happening again. If possible, we will obtain police reports and recommendations. We will document any corrective measures adopted to prevent the incident from recurring.

At least annually, the executive director will direct a review of all emergency and non-emergency (threatening) incidents and whether the policy and response procedures are being implemented effectively. The review will help us identify deficiencies in our workplace violence prevention and response plan and modify the plan accordingly. In updating our plan, we will also consider new strategies for dealing with workplace violence as they emerge.

## 4-5(a) Type 1: Violence by Strangers

### **Worksite analysis**

The economic situation within a community is an important consideration in workplace violence prevention. Poverty and unemployment—linked with increased levels of violence—run high in areas where our facilities are located and staff conduct many of their home and community-based visits.

On the other hand, our facilities seem at relatively low risk for robbery or other criminal acts by strangers inasmuch as limited money transactions take place, we don't store or dispense drugs, we aren't known as having numerous high-value items that could be readily sold on the streets, and generally lots of people are around when we are open.

Youth and family workers, however, encounter special risks due to working alone in the community outside of a fixed worksite.

### **Prevention measures at facilities**

Based on our worksite analysis, measures we have taken to reduce the likelihood of robbery include:

- 1) Limiting accessible cash to small amounts at any work site by making frequent bank deposits and maintaining a very limited petty cash system;
- 2) Counting money out of view of non-employees;
- 3) Varying the time of day when bank deposits are made;
- 4) Requiring staff to keep all facility entrances locked at all times.

Controlling entry to our facilities. At our facility entrances, the doors have latches that can be electronically controlled from an office or reception area. These access-controlled doors, used in conjunction with an intercom, allow visitors to be screened before being “buzzed in.”

### **Response to unknown persons**

If an unknown person seeks or gains entry into a facility, employees should:

1. Approach the stranger in a respectful, friendly manner to “assist” them, asking them to identify themselves and the purpose of their visit.
2. Promptly inform the director of any visitor who has difficulty explaining their presence.
3. If the person does not have a legitimate reason for being on the premises, politely ask them to leave.
4. Call 911 for police assistance, if needed or if in doubt.

### **Working late in our facilities**

When working beyond our normal business hours:

1. Work in pairs whenever possible.
2. Lock your office door when alone.
3. Tell someone where you are.
4. Keep emergency numbers handy.
5. Keep your cell phone charged, on and handy.
6. Park under lights.
7. Have your car key ready.
8. Lock your car door when leaving.

**Employee response during a robbery or other criminal act**

The following safety measures should be followed in all contexts—whether the robbery is being committed at a facility or in a community setting. To de-escalate a potentially violent situation, our policy is that employees should not resist or pursue outside people who are committing a robbery or other crime:

1. Remain calm and handle the entire procedure as if you are carrying out a regular work task. Most robberies last under 2 minutes. The longer it takes, the more nervous the robber becomes; so keep it short and smooth. Don't delay or argue.
2. Listen carefully to what the robber says and obey instructions.
3. Don't try to physically stop the robber and don't chase them—both responses can quickly lead to violence. Don't jeopardize your own safety or that of your coworkers.
4. Give the robber the cash and/or items they want. Your life and health are worth much more.
5. Warn the robber of any surprises. Inform them about whereabouts of other employees so they are not startled if someone appears.
6. Observe what the robber is wearing, their size, mannerisms, and distinguishing characteristics, but don't stare.
7. Without jeopardizing your safety, observe in which direction they leave and, if applicable, what type of vehicle they are driving.
8. Call police and give them information you have. Don't touch the crime scene or disturb evidence. Ask witnesses to wait for the police.
9. Immediately notify your supervisor, program head, and the executive director.

## 4-5(b) Type 2: Violence by Program Participants

The most effective way to reduce the potential of violent acts by program youth and their families is to build and maintain open, friendly relationships with them based on mutual recognition and respect. Employees should listen to family members, acknowledge their beliefs and preferences for their children whether or not they agree with the program's goals or policies, and attempt to resolve any significant differences in a constructive, respectful way.

While the entry doors to our facilities are locked for security reasons, people in our programs are admitted without delay or conditions and enjoy relative freedom of movement within facilities. Restricting access would run counter to the intent to make families feel welcomed at all times.

### **Program youth violence prevention**

Programs should help youth to develop a sense of personal responsibility and inner control so that they can manage their own behavior in socially appropriate ways. To this end, staff:

1. Review youth and family history for mention of any past violent or assaultive behavior or incarceration for violent acts.
2. Attend training on recognizing early warning signs of violent behavior, non-violent conflict resolution, and diffusing potentially explosive situations involving youth and adults.
3. Give youth clear guidelines that verbal abuse and aggressive physical behavior toward staff members or their peers are unacceptable. Enlist youth in developing behavioral guidelines and limits.
4. Intervene quickly, calmly, and firmly when youth become verbally abusive or physically aggressive.
5. Use curricular activities and "teachable moments" to help youth to recognize and accept their own feelings and to express those feelings in socially acceptable ways.
6. Anticipate conflicts between youth and de-escalate challenging behavior.
7. Encourage youth to apply non-violent conflict resolution skills at home, in their neighborhoods, and in the community at large.
8. Promote feeling empathy and respect for others. Encourage relationship-building with peers and adults across gender, ethnic, language, age groupings, including youth with special needs.
9. Encourage cooperation rather than competition.
10. Recognize and model desirable behavior.
11. Arrange for professional counseling and anger management training for youth who exhibit warning signs often connected with abusive or violent behavior.

### **Responding to a potentially violent youth**

If a program youth causes concern because of serious threats or some other indication that they might become violent, immediately talk with them.

1. If it appears that the youth is at risk and refuses to talk, is argumentative, responds defensively, or continues to express violent or dangerous thoughts or plans, arrange for an immediate evaluation by a mental health professional with expertise in evaluating children and youth. Any serious threat must be assessed in the context of the individual youth's past behavior, personality, and current stressors.
2. While waiting for professional intervention, closely supervise a youth who has made serious threats.



3. In an emergency situation or if the youth or family refuses help, contact the police for assistance or take the youth to the nearest emergency room or crisis center for evaluation.

Immediate evaluation and appropriate ongoing treatment of youth who make serious threats or appear to be potentially violent can help the troubled youth and reduce the risk of tragedy.

### **Dealing with angry parents**

When a parent is angry, intimidating, or threatening, try to recognize whether they are acutely stressed as opposed to posing a credible threat of violence reasonably likely to be carried out:

1. Attempt to defuse the situation using a calm, low, friendly tone of voice and body language that presents a neutral, nonthreatening, and interested demeanor. Consider that the parent may be acutely stressed because they feel overwhelmed and/or frustrated with the “system,” have perhaps had past experiences when they felt ignored or rejected and expect a “replay,” have perhaps learned that being angry is the only way to get what they need, or are stressed or angry about something else that happened earlier that day or week.
2. Direct them, if possible, away from other children and/or program youth at the facility.
3. Actively listen. Empathize out loud, calmly and slowly: “You are feeling upset/ frustrated.” Repeat this kind of statement (“You feel...”) several times as needed.
4. Validate them. Acknowledge the parent’s perception: “If I were in your shoes, I would be upset too.” (Bear in mind that there are always different ways of interpreting a given situation and your goal is to be helpful.)
5. Let the parent know that you will help them within your ability to do so or you will send for additional help: “What can we do to help?” Then work with them to find a feasible way to help address their problem or issue. As needed, summon your supervisor for assistance; maybe they will have ideas on what the program can do to help. Communicate what steps staff will take and what the parent can expect of the program; don’t promise more than the program can deliver.
6. Check back with the parent to ensure that they are satisfied with the program response.

Call the police to manage a parent who does not respond to staff efforts to defuse their anger, continues to appear out of control, and may pose a safety risk to themselves or to others. Do not attempt to physically restrain or remove them.

### **Training**

When confronted with a threatening or violent program participant or parent, employees need both training and flexibility to deal creatively with these fluid, unpredictable situations. We provide the Crisis Prevention Institute’s *Nonviolent Crisis Intervention* training program to our youth-serving staff on strategies for safely resolving situations when encountering anxious, hostile, or violent behavior.

## 4-5(c) Type 3: Violence by Coworkers

NorthStar's position is that no threatening or violent behavior by one worker toward another is acceptable. Because of its susceptibility to misinterpretation, our policy no longer refers to a *zero-tolerance* standard. Where a zero-tolerance policy concerning workplace violence was originally intended to establish a standard of acceptable behavior, any violation of a company's zero tolerance policy it now likely to result in automatic discharge. An FBI publication notes:

With regard to workplace violence, employers should make clear that zero tolerance in the original sense of the phrase applies—that is, no threatening or violent behavior is acceptable and no violent incident will be ignored. Company violence prevention policies should require action on all reports of violence, without exception. That does not mean, however, that a rigid, one-size-fits-all policy of automatic penalties is appropriate, effective or desirable. It may even be counterproductive, since employees may be more reluctant to report a fellow worker if he is subject to automatic termination regardless of the circumstances or seriousness of the offense.<sup>6</sup>

Violence among coworkers and managers can take many forms. For example, an individual employee may threaten other employees or their supervisor, a manager may harass workers, or a group of workers may act disrespectfully to their supervisors and each other, or behave in other inappropriate, potentially violent ways. To further complicate matters, the causes of this type of violence can stem from the workplace itself or from outside of work. The cause may be personal problems that employees bring to work such as a physical or mental health problem, financial difficulties, marital or relationship problems, caring for an elderly or sick relative, child care concerns, or drug or alcohol abuse.

As an employer, NorthStar is obliged to do everything that is reasonably necessary to protect the life, safety, and health of employees, including the adoption of practices, means, methods, operations, and processes reasonably adequate to prevent create a safe and healthful workplace.

### **Responsible hiring**

Preventing worker-on-worker violence begins during the hiring process by identifying and screening out potentially violent people before hiring.

### **Training in policies and reporting**

New employee orientation and subsequent training covers our definitions of workplace violence, anti-violence policy, and what is acceptable behavior on the job. Training supports comprehensive reporting of all prohibited behaviors among employees—which is critical in preventing worker-on-worker violence.

### **Early prevention**

When the violence comes from an employee, there is a much greater chance that coworkers and supervisors will spot some warning sign in the form of observable behavior. That knowledge, along with an appropriate prevention program, can reduce the potential for violence or prevent it altogether.

Our plan takes into account our workplace culture: work atmosphere, relationships, and supervisory and management styles. Elements in that culture that reduce the likelihood of violence by employees include:

1. Respect and dignity in all interactions;
2. Appreciation of coworkers' individual contributions;

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<sup>6</sup> U. S. Department of Justice & Federal Bureau of Investigation. *Workplace violence: Issues in response*. (2002). Rugala, E. A., E. A. & Isaacs, A. R. (eds.), pp. 29-30, [http://www.fbi.gov/stats-services/publications/workplace-violence\\_80pp.pdf](http://www.fbi.gov/stats-services/publications/workplace-violence_80pp.pdf).

3. Understanding of cultural diversity to develop sensitivity to racial, ethnic, and other issues and differences.
4. Focus on problem-solving instead of placing blame;
5. Alertness to early warning signs that a coworker is losing control.

### **Complaint procedure**

Intimidating or threatening behavior can be an early warning sign of a person being prone to physical violence in the future. Therefore, we want to know when threats or incidents occur and will take them all seriously. We apply our workplace violence prevention policy consistently and fairly to all employees, including supervisors and management.

1. Reporting procedure. We encourage all employees, line staff as well as management, to report disturbing behavior, threats, aggressive behavior, or possible danger signs to their next-in-line supervisor who is not involved in the conduct or any administrator they feel comfortable to talk to.
2. Interim measures. When acts of intimidation, threats of violence, or acts of violence are reported, we will promptly take steps to minimize risks. Depending on the unique facts of the situation, appropriate interim measures may be reporting the incident to the police or placing the reported perpetrator on leave, pending the completion of an internal investigation. We may get assistance from specially trained professionals to evaluate the situation (including how to protect employees who report threats from retaliation by the person making the threat) and recommend resources and an appropriate course of action.
3. Investigation. We will promptly investigate complaints where there is a reasonable concern that the employee's behavior might cause harm to themself or to others. We will also fully cooperate with any police investigation.
4. Corrective action. Corrective action in response to employee acts or threats of workplace violence will be proportionate to the offense, consistent, and fair. In some circumstances, we may require professional employee counseling or medical and/or psychological evaluation to determine fitness for duty.

## 4-5(d) Type 4: Violence by Personal Relations

A person who has a personal relationship with a worker (such as a spouse or former spouse, current or former intimate partner or a family member) may physically harm, or attempt or threaten to physically harm, that worker at work. In these situations, domestic violence is considered workplace violence. When domestic violence spills over into the workplace, it can lead to employee absenteeism, turnover, reduced productivity, increased health care expenses, and increased risk of violence in the workplace.

### **Recognizing the signs of domestic violence**

It is important that all employees know how best to respond to the effects of domestic violence in the workplace. They should be aware of physical or behavioral changes in other employees. The victim may:

- 1) Try to cover bruises;
- 2) Be sad, lonely, withdrawn, and afraid;
- 3) Have trouble concentrating on a task;
- 4) Apologize for the abuser's behavior;
- 5) Be nervous when the abuser is in the workplace;
- 6) Make last-minute excuses or cancellations;
- 7) Use drugs or alcohol to cope;
- 8) Miss work frequently or more often than usual.

The abuser may interfere with the victim while at work by:

- 1) Repeatedly phoning or emailing the victim;
- 2) Stalking and/or watching the victim;
- 3) Showing up at the workplace and pestering coworkers with questions about the victim (*Where is she? Who is she with? When will she be back?*);
- 4) Displaying jealous and controlling behaviors;
- 5) Lying to coworkers (*She's sick today, she's out of town, etc.*);
- 6) Threatening coworkers (*If you don't tell me, I will . . .*);
- 7) Verbally abusing the victim or coworkers;
- 8) Destroying the victims' or the organization's property;
- 9) Physically harming the victim and/or coworkers.

Any employee can help when a coworker is a victim of domestic violence. Without attempting to diagnose them, talk to the victim privately about what you or others have seen. Express concern for the worker's safety. Encourage them to get help.

### **Support and assistance to employees in domestic violence situations**

NorthStar will make every effort to assist an employee experiencing threats of violence. Disclosures by employees that they are experiencing a domestic violence problem will be kept confidential whenever possible. Specifically, we will provide:

- 1) Information about what local resources are available (e.g., emotional, legal, or financial counseling; battered women's shelter);

- 2) Assistance in obtaining a protective “stay-away” court order against an abusive partner or other harasser;
- 3) Work site change, if feasible;
- 4) Advisement that victims of domestic violence may be eligible for unemployment insurance benefits;
- 5) Leave options for employees experiencing threats of violence.

If an employee needs to be absent from work due to threats of violence, the length of the absence will be determined by the individual's situation through collaboration with the employee and management. Employees and managers are encouraged to first explore paid leave options that can be arranged to help the employee cope with the situation without having to take a formal unpaid leave of absence. Depending on circumstances, this may include:

- 1) Arranging flexible work hours so the employee can seek protection, go to court, look for new housing, enter counseling, arrange child care, etc.
- 2) Considering use of sick time, job sharing, paid leave, informal unpaid leave, etc., particularly if requests are for relatively short periods.

If an employee in a domestic violence situation applies for or obtains a protective or restraining order, they are strongly encouraged to list our facilities as being protected areas and to provide their supervisor or program director with a copy of the petition and declarations used to seek the order, a copy of any temporary protective or restraining order granted, a copy of any protective or restraining order that is made permanent, and a description of the threatening individual who is subject to the order. These documents, along with a photo of your abuser, will aid us in responding to a potential violation of any order.

In cases where a domestic violence situation is a credible threat to the workplace, we will take preventative measures to respond to that threat. Any person who makes substantial threats, exhibits threatening behavior, or engages in violent acts on NorthStar premises shall be removed from the premises as quickly as safety permits, and shall remain off NorthStar premises pending the outcome of an investigation. NorthStar will initiate a decisive and appropriate response. That may include, but is not limited to, suspension and/or termination of employment, and/or seeking arrest and prosecution of the person or persons involved.

**For assistance with a domestic violence situation, call:**

- The Women’s Center (New Bedford/Fall River) 24-hour hotline: 508-999-6636
- SafeLink Domestic Violence 24-hour statewide hotline: 877-785-2020
- GLBTQ Domestic Violence Project 24-hour statewide hotline: 800-832-1901

**If you are in immediate danger, call 911 at the safest opportunity.**

## 4-5(e) Working Off Site Safely

Some of our employees work in a variety of community settings, where they may be vulnerable to a variety of safety risks. In many situations, the off-site work involves an employee working alone. The key principle is that a home visit should place no one at unreasonable risk and that identified minor risks are consciously managed. Following are essential safety measures you are expected to take to protect yourself when you are working “in the field”:

### Letting people know about your whereabouts

When you are “in the field,” you should ensure that your office (supervisor, manager, coworker) is aware of your whereabouts and plans.

1. Prepare a weekly work plan so that your supervisor knows where and when visits are being undertaken and the expected return times.
2. Sign out on the office whiteboard prior to each field visit so it is known where you’re going.
3. Report back to your office when a visit is concluded and your progress toward your next scheduled meeting.

### Plan your visit

1. Consider all available information about the safety and attending risks of the proposed visit. Tell your supervisor if you feel apprehensive about an upcoming meeting. Try to have a coworker accompany you if you anticipate problems.
2. Review the intake form for possible concerns of violence or substance abuse.
3. Mentally rehearse the visit and what you need to accomplish.
4. Have your identification badge visible to show that you’re acting in a professional capacity.
5. Notify the parent that you are coming and purpose of the visit/meeting.
6. Wear clothes and shoes that provide freedom of movement. Don’t wear a lot of jewelry.
7. Always carry your cell phone with you.
8. Lock purse / valuables in your car prior to leaving for a visit.
9. Don’t carry weapons of any kind, including pepper spray. Weapons can easily be used against you.

### Approaching the house

1. Drive with doors locked.
2. Be aware of your surroundings.
3. Park in a visible area and lock the car doors. Don’t block anyone’s parking space.

### During the visit

1. If the door is unlocked or ajar yet no one answers your knock, don’t enter the home.
2. Don’t enter the house if the parent isn’t at home.
3. Introduce yourself clearly when going to someone’s home, letting the family know who you are. Restate the purpose of your visit.
4. Visually check others present during visit.
5. Assess the child’s/youth’s emotional state.

6. Maintain a respectful, courteous, and patient attitude.
7. Speak with the child/youth where the parent is present or clearly visible. Don't interview the child/youth in their bedroom.
8. Respect the family's home, emotions, and personal space. Always wait to be invited to sit.
9. Leave if you feel threatened or if you notice unlawful or peculiar behavior. Report your concerns to your supervisor.
10. Visually check the surrounding area or parking area when leaving.
11. Return to your car with key ready, check the front and back seat and floor before getting in.

### **Defusing techniques**

When the person you are visiting becomes angry or upset:

1. Keep the situation from escalating; try to stay calm and listen attentively.
2. Avoid sudden movements.
3. Avoid confrontation.
4. Maintain eye contact and personal space.
5. Use a calm tone when speaking. Don't argue with the person.
6. If the situation continues to escalate, leave.

### **Cultural influences on risk perception**

In the literature on assessing safety risks out in the field, we are told to rely on intuition and gut feelings. But there is an underside to intuition and emotions that we each need to stay aware of. Some of our unexamined intuitions and feelings will steer us the wrong way. Despite our best intentions, we all carry biases we have been socialized to believe about different ethnic groups, genders, people with disabilities, elderly people, and other groups. Bias can distort affect perceptions, undermine objectivity, and impede relationships—and, yes, skew our sense of workplace, neighborhood, and community safety. In the field, employee bias can result in misreading a situation and over- or underreacting to safety threats.

While safety assessments based on the violence-related risk factors (such as condition of the person you are visiting, family history, neighborhood and home environment) are considered more culturally fair, they are still not completely fair. They are still normed based on the perspectives and values of the prevailing group, which can create bias against other groups.

### **Training**

Case managers should participate in annual training (or case supervision as needed) that develops and maintains their ability to work off site safely, including skill building in risk assessment, risk management, techniques to defuse threats of violence, and understanding the impact and how to manage secondary trauma. Employees should also enroll in training courses that help them learn about racism, stereotypes and bias as they relate to safety in this field.

We cannot rely on professional development alone, however, to teach cultural competence. Becoming and remaining multiculturally competent is a lifelong learning process that demands constant work, study, and development. Make a personal effort to identify and challenge your own biases. Increase your exposure to groups you are less comfortable with and actively pursue relationships with people who don't fit stereotypes. Ask questions that will help you understand experiences and perspectives different from your own.

## 5. Injury Prevention Plan

### 5-1 Assessing the Physical Environment

Children and youth develop their motor skills by engaging in increasingly challenging kinds of movement. Because they typically learn new skills by trial and error, they inevitably experience some occasions of failure. While risk-taking is inherent in motor skill development and other learning, staff can minimize the incidence and severity of injury by accurately assessing children's/youth's skill levels, giving them opportunities to take on incremental challenges where success is within reach, and providing appropriate levels of supervision. Early childhood/afterschool environments and program activities should provide opportunities for children to develop their motor skills through experimentation and exploration of safe alternatives. The director is responsible for ensuring that facilities and equipment are maintained in good repair and in a sanitary condition and are free from sharp or protruding objects and other health and safety hazards.

#### **Toy safety**

Early childhood teachers must check toys accessible to children less than 4 years of age using a small object tester or ruler. Objects are prohibited that have removable parts, have a diameter of less than 1¼ inch and a length of less than 2¼ inches, or are small enough to fit completely in a child's mouth. Children under 4 years old shouldn't have access to latex balloons, plastic bags, or Styrofoam objects.

Toys that develop sharp edges, have bolts or screws that have unthreaded, or present risk of injury from common use should be repaired or discarded.

#### **Daily inspection of facilities**

Staff should conduct a safety inspection of the facility, including hallways and bathrooms, each day before children arrive and remove or repair any hazard that may cause injury. Staff should inform their director of any inappropriate item found or any hazard that they cannot remove or repair themselves.

#### **Toxic substances, medication, and hazardous items**

Staff should store all potentially dangerous materials where they are inaccessible to children—either in locked cabinets or storage areas higher than 4 feet from the floor. "Dangerous materials" include, but are not limited to, aerosol cans, cleaning fluids and supplies such as bleaches and detergents, disinfectants, polishes, matches, pesticides, sharp-pointed and sharp-edged instruments, plastic bags, purses, medication, and medical supplies.

All potentially toxic materials such as pesticides, toxic cleaning materials, aerosol cans, poisons must be used according to manufacturers' instructions and under the director's supervision. The agency will attempt, where feasible, to identify, procure, and use non-toxic alternatives to commonly used toxic substances.



## 5-2 Keeping Children and Youth Safe through Active Supervision

To ensure their safety and well-being, all children and youth must be appropriately supervised at all times while attending our programs. No child should be allowed to go beyond a staff member's range of direct supervision. To maintain adequate supervision and monitoring, staff are expected to stay actively engaged with participating children/youth. Even with a satisfactory ratio of staff members to children/youth, the children/youth are not being monitored if all of the staff are off to the side absorbed in their own conversations.

### **Keeping children safe in our EEC-licensed early childhood and afterschool programs**

In our EEC-licensed programs, at least 2 staff members will always be on site when children are in attendance. Staff should regularly count children at every transition and whenever leaving one area and arriving at another to confirm where every child is at all times. On an ongoing basis, staff will assess the environment to improve visibility and hearing of children's activities.

1. In infant/toddler and preschool programs, staff directly supervise children by sight and sound at all times, even when the children are sleeping. Staff closely supervise very young children to ensure that their activities always remain within the limits of safe risk-taking.
2. We have diaper-changing stations that are forward-facing to the classroom. This allows the teachers to change a child's diaper while never having their back to the classroom. With the high number of diaper changes that occur per day, this setup enables teachers to both change a diaper and monitor the classroom at the same time.
3. In our afterschool program, supervision includes awareness of and responsibility for the ongoing activity of each child. As children enter school, they show increasing ability to set appropriate limits of risk-taking on their own. Children may, with staff permission, go to the bathroom independently. Adult guidance will be available when requested or needed and staff will regularly monitor the activities of each child. Children attending our afterschool program will be permitted to participate in activities outside the program as approved by their parent and the director/site coordinator.

To maintain the required child-staff ratios in EEC-licensed programs at all times, the agency employs substitutes when regular employees are absent from work. Substitutes and volunteers work under direct supervision and are not left alone with a group of children at any time. A substitute who is regularly employed by the program, is familiar with the children in the group, and has the appropriate staff qualifications may be considered staff and may function in the same way as the staff member for whom they are substituting.

### **Keeping children and youth safe in programs not licensed by EEC**

In our programs not licensed by EEC, there is no standard child-staff ratio for all situations. When making decisions about ratios, we consider contextual variables such as:

- 1) Age and developmental level of participating children/youth;
- 2) Risk of the activity;
- 3) Location of the activity. Is it in a classroom that is easy to monitor or at a park, where it is easier to lose track of individuals?

Overnight activities. Our recommended supervision ratio for overnight or off-site events is one staff member for every 5 children/youth. For overnight or other extended off-site events, staff should avoid situations where they are alone with an unrelated child/youth. A "two deep" strategy having 2 or more staff supervise children/youth is highly recommended. Another staff should be made aware prior to an unavoidable one-on-one situation.

**Evaluating individual participants' abilities and skills**

Within each age group, there may be wide variation in children's motor skill development as well as their ability to make safe choices. Staff will identify and provide higher levels of supervision to individual children who, due to adversity and trauma, may be characterized as having "low protective factors" and, therefore, "vulnerable." Such children may have difficulty in establishing and staying within the bounds of acceptable risk-taking and thereby expose themselves and/or others to serious injury.

**Supervision of higher-risk areas and activities**

Staff should provide different levels of supervision for spaces and activities according to the risks they present. They should remind children/youth of the inherent dangers and, as needed, instruct them on proper techniques. Staff should closely control higher-risk activities. For example, they should appropriately position themselves when children are on climbers, slides, and swings.

**Walking trips**

On walking trips, staff should teach children/youth the rules of pedestrian safety by instruction, personal example, and verbal reinforcement. Staff must keep younger children together through having an adult hold a child's hand, having children holding hands with a child holding an adult's hand, or other means that keeps every child physically connected to an adult at all times. A designated staff member should supervise children at the front and another staff member at the back of each group.

**Periodic safety record review**

Each facility must maintain a record of "any unusual or serious incidents, including, but not limited to, behavioral incidents, accidents, property destruction or emergencies." Staff involved in or observing the incident should complete the EEC-provided Incident Report form. The early education and care director will review each facility's central log of all injury and incident reports at least monthly to identify and address problem areas.

## 5-3 Physical Activity and Outdoor Time

Recognizing the close association between physical activity and health among children, our early education programs—and afterschool program when operating on a full-day basis—schedule at least 60 minutes of physical activity daily. When weather permits, we take time for physical activity beyond the constraints of the classroom to the outdoors. The outdoors motivates children to exercise and develop body mastery; in outdoor spaces, children can generally enjoy more freedom in their play. In turn, children who have regular access to the outdoors gain competence in moving through the larger world. As one writer put it, “Given that most of our evolution as a species occurred in the outdoors, children surely need to experience being outside.”<sup>7</sup> Infants should have opportunities for gross motor play during their time outdoors.

Weather conditions that present a significant health risk include wind chill at or below 15°F and heat index at or above 90°F, as indicated by the National Weather Service. Air quality conditions that pose a serious health risk are identified by announcements from local health authorities or through ozone (smog) alerts. When such air quality conditions occur, staff should keep children indoors where air conditioners ventilate indoor air to the outdoors. Children with respiratory health problems such as asthma should not play outdoors when local health authorities announce that the air quality is nearing unhealthy levels.

### **Warm weather protection**

During outdoor play, staff will take appropriate measures to protect children from the sun, including using shade, sun-protective clothing, and sunscreen with UVB-ray and UVA-ray protection of SPF-15 or higher, with parent permission as described in the medication administration policy. Children should be encouraged to drink water during extended outdoor activity in warm weather. In warm weather, children’s clothing should be lightweight and light-colored. Children should be encouraged to wear hats to protect them from the sun.

### **Cold weather protective measures**

Staff should ensure that children wear dry, multi-layered clothing when spending time outdoors in cold weather. Extra outer cold weather clothing and accessories should be on hand for use by children who do not have proper clothing for outdoor play in cold weather. Staff should check children’s extremities for normal color and warmth at least every 15 minutes.

### **Outdoor play areas**

EEC-licensed early childhood education and afterschool program facilities must have an outdoor play area that is next to the indoor facilities or that is not more than 1/8-mile from the facility. The play area must offer both sunlit areas and areas shaded by trees, tents, awnings, or the like. The outdoor play areas for all programs will be free of hazards, including, but not limited to:

- 1) Access to a busy street;
- 2) Poisonous plants;
- 3) Debris, broken glass, chipped, flaking or peeling paint;
- 4) Dangerous machinery, tools, and construction materials;
- 5) Rusty or broken play equipment.

All play apparatuses will be of safe design, developmentally appropriate for the age groups using it, and in good repair. They must be installed according to the manufacturer’s instructions and specifications. Wood materials must be sanded smooth and should be inspected regularly for splintering. All play apparatuses must be surrounded by a shock-absorbing surface.

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<sup>7</sup> Mary S. Rivkin, *The Great Outdoors: Restoring Children’s Right to Play Outside* (Washington, DC: National Association for the Education of Young Children, 1995), p. 6.

The outdoor play area has to be configured so that all areas are visible to staff at all times. All playground equipment must be arranged so that children using one apparatus do not collide or otherwise interfere with children playing on or running to another apparatus.

### **Riding toys**

Tricycles and other riding toys used by young children must be:

- 1) Be spokeless;
- 2) Be steerable;
- 3) Be of a size appropriate for the child;
- 4) Have a low center of gravity;
- 5) Be in good working condition and not have protruding parts that could injure children.

### **Safety helmets**

All children must wear approved safety helmets when riding toys with a wheelbase of more than 20 inches in diameter. Before a child uses a riding toy, staff should assist the child in adjusting and fastening the helmet. Helmets are not designed to protect the neck or the face. Children should be encouraged to always ride with caution. Children must remove their helmets before they can use playground equipment (since the helmet can catch on a playground apparatus and thereby lead to strangulation).

As pieces of protective equipment, helmets should be treated with care. Dents, cracks, punctures, and other damage that may not be readily visible can severely reduce the helmet's capability to protect the wearer.

### **Swimming and wading activities**

When children are at the beach, pond, lake, or swimming pool, a certified lifeguard must be on duty. Before initially entering the water, all children should be instructed on basic water safety measures. They should not be allowed to push each other, hold each other under water, or run around the pool. Children are not permitted to bring any flotation devices into the water. Children should be instructed to call for help only in the event of a real emergency. At all times, a staff member certified in CPR must be in the water with the children.

During any swimming or wading activity where either an infant or toddler is present, the ratio should always be 1 adult to 1 infant/toddler. An adult must remain in direct physical contact with infants at all times during swimming or wading. While preschoolers are wading or swimming, the ratio should be at least 1 adult to 4 preschoolers.

## 5-4 Transporting Children and Youth Safely

This plan addresses the safety and supervision of children in traveling between their homes and our EEC-licensed programs.

► For driver requirements, safe driving practice, driver reporting requirements, and accident procedures, refer to Vehicle and Safe Driving Policy in our *Employee Handbook*.

Persons responsible for the transportation of children attending our EEC-licensed programs are:

<b>Transportation coordinator</b>	Marlene Barros Director of Early Education and Care	<i>Office: (508) 991-5997 Cell: (508) 415-9242</i>
<b>Contact person during transport times</b>	Marlene Barros Director of Early Education and Care	<i>Office: (508) 991-5997 Cell: (508) 415-9242</i>

### Modes of travel for children

Following are the ways in which children travel between their homes and our programs and who is responsible for supervision during travel:

<b>Modes of travel</b>	<b>Person responsible for child's safety and supervision</b>
Parent transports their own child in a private vehicle	Parent
Walking with parent or other family member	Parent
Walking without adult supervision	Parent
Buses operated by contracted provider: <u>Reliable Bus Lines</u> 978 Nash Rd, New Bedford, MA 02746 (508) 992-0342	Bus monitor, with assistance from driver

### Transportation of children with disabilities

Whenever possible, children with disabilities will be transported in the same vehicles used to transport other children.

### Vehicle requirements

All vehicles used to transport children must be licensed, equipped, and insured according to state laws and regulations, including:

- 1) Be registered and inspected in accordance with state law;
- 2) Have liability insurance coverage as required by law;
- 3) Conform to state school bus requirements (Minimum Standards for Construction and Equipment of School Buses) if used to transport more than 8 children at any one time;
- 4) Meet applicable state requirements if used to transport 8 or fewer passengers;
- 5) Not carry hazardous objects or materials when transporting children.

### Driver requirements

Drivers of any vehicle transporting children must:

- 1) Be licensed in accordance with the laws of the state;
- 2) Have a good driving record;

- 3) Have received, along with bus monitors, an orientation about the transportation plan;
- 4) Ensure that the number of children and adults transported in a vehicle at any one time does not exceed the manufacturer's stated capacity for the vehicle;
- 5) Have current first aid and CPR certification;
- 6) Be alert and not distracted by telephone, radio, or other communications;
- 7) Be regularly assigned to specific routes;
- 8) Not smoke at any time in vehicles.

The agency will use an appropriately-trained and -licensed substitute driver when the regularly assigned driver is unavailable.

### **Procedures to account for children using our transportation services**

This section spells out transportation roles, responsibilities, and procedures to account for all children who use our transportation services and to make sure no child is left alone in a vehicle at any time, including ensuring all children have departed bus at the end of all trips (morning, afternoon and during field trips or other special trips).

1. Passenger log. The driver or bus monitor must carry and complete a passenger log for each trip, identifying the first and last name of each child transported, the time picked up, and the time dropped off. A sibling group shall not be listed as a single entry.
2. Pickup procedures. As each child is picked up and seated in the vehicle, the driver or bus monitor shall record in the passenger log the time the child was placed in the vehicle.
3. Drop-off procedures. As each child is released from the vehicle, the driver or bus monitor shall record in the passenger log the time the child was dropped off.
4. When an infant or toddler is picked up or dropped off at home, from a designated stop, or from a program, the parent, program staff member, or other authorized person shall initial the passenger log indicating that the child was placed on or received from the vehicle.
5. Complete vehicle inspection after every trip. The vehicle must be checked by the driver and someone other than the driver at the end of each trip after the children are unloaded to ensure there are no children left in the vehicle. The "reviewer" shall be the bus monitor or, in the case of a van that does not require a bus monitor, a receiving staff member at the program facility.
  - Driver responsibilities. Immediately upon dropping off the last child, the driver shall walk to the back of the vehicle to check for anything or anyone left in the vehicle, look in and under all seats and compartments or recesses, and sign the passenger log, with their full name and time, certifying completion of the post-trip walk-through and inspection. They should then give the passenger log to either the bus monitor or the receiving staff member at the program facility.
  - Bus monitor or reviewer responsibilities. The bus monitor or receiving staff member at the program facility ("reviewer") shall immediately walk to the back of the vehicle, look in and under all seats and compartments or recesses to ensure that there are no children in the vehicle, and sign the transportation log with their full name and time to certify their post-trip inspection. The bus monitor or reviewer shall immediately notify the transportation provider and the program facility regarding any discrepancies on the passenger log (e.g., the number of children who boarded the vehicle does not match the number of children that were released from the vehicle).
6. Parent/program notification. When a child who receives agency-provided transportation services does not arrive within 30 minutes of their regularly scheduled arrival time and the parent has not provided notification of absence or delay, the program facility shall

immediately contact the transportation provider to determine whether the child was picked up that day, and if so, to determine the child's location. If the transportation provider cannot be reached, the program shall then inform the parent that the child has not arrived. If the program cannot directly speak with a parent, the program shall then contact the child's emergency contact person. If a program is unable to reach the transportation provider, parent, or emergency contact, the program should contact the agency to determine the location of the child. When the program reaches a person who can confirm the location of the child, the program shall note the location of the child, the name of the individual spoken to, and the time on the attendance sheet.

If a child who is transported in a private passenger vehicle or in a vehicle supplied by a public school fails to arrive at the program within 30 minutes of their scheduled arrival time, the program should contact the parent and/or the school to determine the child's location, unless notified by the parent or the school that the child will be absent or will arrive later than scheduled that day.

### **Seat restraint requirements**

When a vehicle is in motion, each child must be fastened in a correctly installed safety seat, seat belt, or harness federally approved for the child's weight, height, and age. Vehicle child restraint systems should be secured in back seats only. Infants must ride facing the back of the vehicle until they are 1 year old and weigh 20 pounds. Children in child seat restraints cannot ride facing a passenger side airbag. Car seat harness straps must be properly adjusted to fit the child using the seat. A booster child safety seat should be used when the child has outgrown a convertible child safety seat but is too small to fit properly in a vehicle safety belt.

Staff will encourage parents to consistently use age-appropriate, size-appropriate seat restraints when driving with children in their car or truck. If a parent does not use appropriate seat restraints for their child, staff will remind them of the risk involved and that state law mandates their use. Staff may work with local organizations and public safety personnel to organize area-based initiatives to distribute and install free or low-cost child restraints in family vehicles.

### **Interior vehicle temperature**

The interior temperature of vehicles used to transport children will be maintained at a level that is comfortable for children. The driver should ask the children in the vehicle if they are comfortable.

1. In hot weather, opening the windows to reduce the vehicle's interior temperature is healthier for children than using air conditioning. When a vehicle's interior temperature exceeds 82°F even with the windows opened, the driver should use air conditioning to cool the temperature to a comfortable level for children. (Excessive use of air conditioning can increase respiratory problems and trigger asthma.)
2. When the interior temperature drops below 65°F and when children are feeling uncomfortably cold, the driver should use the heater.

### **Reporting requirements**

Anyone whose job duties include driving must inform the Business Office and provide documentation of any changes in their status as a driver, including:

- 1) Change in license status. License suspension, revocation, cancellation or other change by the end of the business day that the licensing action is taken;
- 2) Motor vehicle accident. Any kind of car accident in which they are a driver—regardless of fault or whether it occurred on or off the job—at the earliest possible opportunity and any penalty, fine, imprisonment, fee, or other adverse action imposed by a court in connection with the car accident as soon as you become aware of it;

- 3) Traffic citation. Citation for any traffic violation by the end of the business day on which the citation is received. While parking tickets won't affect a driver's insurability, any parking ticket issued on an agency-owned or -leased vehicle should be promptly reported.

NorthStar must immediately notify EEC of any motor vehicle accident when transporting children enrolled in our EEC-licensed programs.

### **Child/youth behavior during transportation**

Staff should instruct children and youth, as passengers and as walkers, on safe transportation behavior in a manner consistent with their ability to understand and in the context that young children should develop skills that will assist them in taking responsibility for their own health and safety.

For EEC-licensed programs, the transportation coordinator will ensure that there are systems, schedules, and routines in place that promote predictability and security for children and prevent behavior problems:

1. Staff continuity. One particular driver is regularly assigned to each route.
2. Positive behavior support. Drivers and bus monitors are expected to interact with children in a professional, friendly, and caring manner using positive behavior support strategies and encouraging amiable interactions and conversation among the children. Just as other transition times between activities during the program day are integral to the child's program experience and should support their development and learning, so transportation of children should support goals that our programs have for children. Monitors should encourage children to engage in safe activities while riding on the bus.
3. Regular schedule. We give parents a specific time that the bus/van will pick their child up in the morning and drop them off in the afternoon.
4. Supervision. Children will never be left alone in a bus or van.
5. Travel time. Children will not transported for more than 45 minutes per one-way trip on a regular basis.
6. Information-sharing. The driver and bus monitor will be informed about any medical, behavioral, or other information that may assist them in safely transporting a child.

When more than 8 children are being transported, a bus monitor is required. The bus monitor will have primary responsibility for behavior management on the bus. The bus monitor will inform the center/program director of behavior problems on the bus and work with classroom staff to ensure that strategies used for behavior management are consistent in the classroom and on the bus.

In response to challenging behavior (e.g., unbuckling seat belts), the bus monitor will:

1. Restate the rules and give positive support to those who are following the rules.
2. Use natural consequences including removing objects, activities, and giving verbal redirection.
3. Sit beside the child or move the child to another seat.
4. Move the child to the front seat of the bus with no other child next to them.

If dangerous behavior (e.g., refusing to remain seated) persists, the driver may pull over to the side of the street to address the child's behavior. In response to dangerous or persistent challenging behavior, the transportation coordinator may consider removing bus privileges. Since drivers should not normally be responsible for addressing children's inappropriate behavior while driving and the van does not have a monitor, there is a lower threshold for loss of van privileges due to challenging



or dangerous behavior. Any incident resulting in loss of bus/van privileges will be followed up immediately with:

- 1) A meeting including, if possible, the parent, the transportation coordinator, the child's teacher or group leader, and any outside agency consultants working with the child;
- 2) Development of a temporary behavior plan or modification of existing plan so the child can ride the bus or van the next day.

The transportation coordinator will maintain ongoing documentation and progress reports regarding children's behavior problems while riding the bus or van.

### **Inclement weather**

Severe weather may result in closures to schools, even as NorthStar remains open for regular business. We will not close unless hazardous weather conditions exist or other emergency circumstance occurs. We may decide to open our programs but not provide transportation for children in our programs because of hazardous road conditions

When inclement weather is expected, our transportation provider will survey major and minor road conditions, monitor existing and anticipated weather patterns as reported by weather outlets, and provide a recommendation on the safety of transporting children. In consultation with the NorthStar transportation coordinator, the transportation provider will come to a decision whether or not to provide transportation services for the day. When at all possible, the final decision will be made the night before and not later than 6 a.m. the following morning. Notice of no transportation will be included in local radio broadcasts of closings.

If a major snowfall or snowfall alert occurs while our programs are in session, the transportation provider, in consultation with the NorthStar transportation coordinator, will evaluate the effect weather conditions have on safe transportation of children and may decide to move up bus departure time before traffic conditions deteriorate.

### **Response to a medical emergency**

Emergency preparedness during transportation includes:

1. Easily accessible in each vehicle used to transport children are a first aid kit, a seat belt cutter, and emergency information for each child and copies of special care plans for children who require special medical procedures. The special care plan indicates any special equipment, staffing, or care in the vehicle that the child will need to be transported to and from the program. If a child has a chronic medical condition that could result in an emergency (such as asthma, diabetes, or seizures), the driver or bus monitor will have written instructions, special needs, and treatments plans, and will be trained to recognize the signs of a medical emergency, know the emergency procedures to follow, and have on hand necessary supplies or medications.
2. Drivers and bus monitors are required to have current certification in pediatric first aid and CPR.
3. Drivers and bus monitors carry a cell phone, along with a list of emergency phone numbers, for summoning emergency medical assistance and contacting the agency.

In the event of an emergency requiring medical attention to a child while on a bus or van:

1. Stop the bus/van in a safe area and turn on the hazard lights.
2. Call 911 and state the nature of the emergency. Then call the agency.
3. Attend to the needs of the child, including administering first aid if necessary.

4. Wait for emergency medical services or police before moving the bus/van.
5. Check the child's medical emergency form for further information or instructions.

### **Emergency transportation plan in the event of a vehicle breakdown**

If a vehicle breaks down, the driver must immediately call the transportation coordinator or, if they can't be reached, another contact person for a substitute vehicle. Program staff will notify parents of any delay.

### **Parent authorization and responsibilities**

For families whose children are enrolled in our EEC-licensed programs, we must have written parental authorization for each child's individual transportation plan. In using NorthStar-provided transportation services, parents have the following responsibilities to ensure that their children arrive and leave the program safely:

1. Make sure that their child is ready at the designated time. As stated in the Family Handbook, the bus or van will wait for 2 minutes and then continue on its route. If the child is not present at the pick-up location, the parent will have to bring them to the program.
2. Make sure their child is put in the right vehicle (not the vehicle of another service provider).
3. Ensure that there is a person at home or at the designated drop-off location who is authorized to receive the child. As stated in the Family Handbook, children will be released off the bus only to people who you have authorized to receive the child. If an authorized adult isn't there at the established drop-off time, the driver will bring the child back to the program, and the parent will be responsible for picking them up before closing time.
4. Provide the driver and the agency with an alternative drop-off point if an adult will not be home when the child is scheduled to arrive at home.

### **Responsibilities of outside transportation providers**

Any written agreement with an outside transportation provider must include their acceptance of the following conditions:

1. Fully comply with EEC transportation standards and all other state regulations governing the transportation of children, youth, and adults served by our programs.
2. Maintain insurance coverage for vehicles used to transport children as required by law.
3. Have a backup vehicle available that can be dispatched in case of emergency.
4. Use properly licensed and trained substitute drivers when a regularly assigned driver is unavailable.
5. Immediately notify our transportation coordinator of any accidents, vehicle breakdowns, or moving violations that are cited while children are being transported.

Our transportation coordinator will meet as needed with contracted transportation providers to resolve any transportation problems.

## 5-5 Field Trip Safety

Field trips broaden children's/youth's world of experience. Excursions to coastal areas, woodlands, and other outdoor places promote children's knowledge of natural environments, their empathy with nature, and their predisposition to act responsibly toward the environment. Field trips connect children and youth to their community's history and culture. Visits to colleges and universities help youth appreciate the importance of advancing their education.

1. When faced with adverse weather conditions on the day of a planned field trip, staff will consult with the director regarding the advisability of canceling or postponing it.
2. Each child or youth will be assigned to an adult for every part of the field trip. When taking children off premises, staff will bring:
  - The daily attendance log;
  - Emergency contact information on each child, permission for emergency medical treatment, permission for the administration of first aid and CPR, and individual emergency care plans;
  - A first aid kit;
  - A charged cell phone in case of an emergency.
4. Children and youth must be transported in vehicles equipped with proper seat restraints.
5. Staff must make sure that all children/youth are accounted for before the vehicle leaves the facility, when the children/youth disembark at the field trip destination, when they reenter the vehicle, and again when they disembark from the vehicle upon return to the facility. Staff are required to conduct a "sweep" of the vehicle each time that the vehicle is parked to make sure no child or youth is left on the vehicle.
6. Upon arrival at a field trip destination, staff should identify hazards and take appropriate measures to prevent children/youth from accessing any part of the setting that may be unsafe for them. Any body of water (such as a swimming pool, beach, pond, brook, swamp, or salt marsh) should be considered a possible hazard. When children or youth are near or in any body of water, staff who are currently certified in CPR must remain directly beside or in the water.

### Additional requirements for EEC-licensed programs include:

1. When taking children off premises, staff will bring the daily attendance log.
2. In the enrollment process and thereafter on a yearly basis, staff will obtain written permission from parents to take their child off the premises to a list of specified places (such as libraries, parks, and museums). Staff will obtain additional parent consent to take their child to any location not on this list.
3. The same staff-child ratios required at the facility will be maintained on the vehicle to and from the field trip destination. The driver will not be counted as staff in the ratio.
4. Children must be counted at least every 15 minutes while on a field trip.
5. On field trips beyond the immediate neighborhood of the program facility, children will wear identifying information that gives the program's name and phone number.
6. A staff member must accompany any child who uses a public rest room.

**Field trip food safety**

Bacteria can quickly multiply to dangerous levels when foods such as sandwiches are left at room temperature. Foods to be eaten on field trips should be kept safe by using one of the following methods:

1. Freeze sandwiches overnight. They will thaw by lunchtime.
2. Pack sandwiches in a cooler with ice or other cold source.

Foods that need to be kept cold:	Foods that do not need to be kept cold:
<ul style="list-style-type: none"> <li>• Tuna and egg salads</li> <li>• Meat and poultry sandwiches and salads</li> <li>• Milk, cheese, and yogurt</li> <li>• Peeled or cut fruits and vegetables</li> </ul>	<ul style="list-style-type: none"> <li>• Peanut butter sandwiches</li> <li>• Cookies and crackers</li> <li>• Unopened juice bottles or boxes</li> <li>• Whole fruits</li> </ul>

**Handling and administration of medication on field trips**

Staff must take necessary steps so that children on medications, including children with known chronic health conditions who may need emergency medications, can go on field trips. The person who is delegated to administer medications on the field trip will carry each medication in its original container—put in a small zip-lock bag with a copy of the prescriber's orders and a copy of the parent authorization form.

Counting and administering controlled medications on overnight field trips. Prior to leaving on an overnight field trip and upon return, doses of medications classified as *controlled substances* must be counted by the parent and a program staff member. The staff member who makes and records the count on the Medication Inventory for Controlled Substances form and the parent sign the medication log attesting to the entry. The Medication Inventory for Controlled Substances form will be kept in the Medication Log Book with the corresponding parental authorization to administer medication at the program form. Controlled substances cannot be delivered to the program by youth.

One staff member who is knowledgeable about the risks inherent with controlled substances will maintain primary control of the medication supply. The drug supply will be secured in a locked container; an inventory and accountability systems for the keys will be maintained.

Controlled medications will be counted at the beginning of each day by the designated staff person and another staff member. The count will be recorded on the Medication Inventory for Controlled Substances form and initialed by both counters.

Controlled substances cannot be self-administered by youth; they must be administered by the designated staff person to verify that the medication has been consumed and to maintain an accurate pill count. Each dose of the controlled substance that is administered is recorded and subtracted from the total count remaining.

If a discrepancy is found, the designated staff person will immediately notify the field trip leader, and appropriate steps will be initiated.

## 6. Admission and Attendance

### 6-1 Enrollment and Attendance Requirements

Before a child attends a NorthStar EEC-licensed early childhood or afterschool program, staff acquaints the children and their parent with the facility, staff, schedule, and policies. During the enrollment process, the parent receives a copy of the Family Handbook, which includes many of the agency's health and safety policies and procedures. This *Health and Safety Manual* is available to parents upon their request.

#### **Parent authorizations**

Prior to a child's first day of attendance, the program must receive the following written authorizations from parents:

- 1) Consents for emergency first aid and transportation to St. Luke's Hospital or, on field trips outside the New Bedford area, to the nearest hospital;
- 2) A list of persons authorized by the parent to take the child from the program or receive the child at the end of the program day; and
- 3) General permission to take the child off the premises to a list of specified places.

#### **Required medical examinations**

Parents must submit a written physician's statement that indicates that the child has had a complete physical examination within 1 year prior to admission. This requirement should be met before the child's first day of attendance, but no later than 1 month after admission. If the program does not receive documentation of the required physical examination within the 1-month grace period, state licensing requires that the child be excluded from the program. The physical examination required upon enrollment must be repeated annually.

All children attending our EEC-licensed early childhood program must be screened for lead poisoning before they turn 13 months old. The physical examination and blood lead test requirements shall be waived if the child's parent verifies in writing that they object to such examinations on the grounds they would conflict with their religious beliefs.

#### **Immunizations**

To protect the health of children attending our EEC-licensed early childhood and afterschool programs, immunizations are required according to the current schedule recommended by the state Department of Public Health. Staff will regularly review children's immunization records to help parents know when their children need immunizations. Children whose immunizations are not up to date may not attend the program until properly immunized.

The only allowable exceptions are children with a documented medical or religious reason for not getting a vaccine:

1. If immunizations are not given because of a medical condition, a written statement from the child's health care provider indicating the reason why the child is exempt from the immunization requirement shall be on file.
2. Parents whose religious beliefs exempt their child from the immunization requirement shall sign a waiver that will be kept in their child's file.

If an outbreak of a vaccine-preventable disease occurs in the facility, the agency may, as instructed or recommended by health authorities, exclude unimmunized children for their own protection during the period of possible exposure or until the child receives the age-appropriate immunizations (whichever comes first).

**Suspension/termination from the program**

State licensing regulations require that we suspend early childhood and afterschool services for families who do not provide evidence of their child's annual physical examination, updated immunizations, and lead screening. Continued failure to provide such documentation will result in termination of services.

**Parent responsibility for their child's attendance**

Staff should stress to parents the importance of regular attendance—that their child will get the most benefit from our program if they come every day.

Parents are expected to promptly notify the program facility that their child will be absent or will arrive later than scheduled that day. The program shall note on the attendance sheet the absence or late arrival of the child on the appropriate day and, if known, the name of the person who notified the program of the absence or the late arrival. Families may lose services because of irregular attendance and/or repeated failure to notify the program of their child's absence.

**Managing transitions**

Change can be stressful for children and their families. When a child leaves a program for any reason, staff will prepare the child for the transition in a manner consistent with their ability to understand. When a child's termination from the program is sudden, staff may, if they know the child's whereabouts, send them a simple good-bye note and perhaps other children's drawings or other keepsake.

## 6-2 Children with Special Medical Conditions

### **Admissions policy**

According to the letter and spirit of the Americans with Disabilities Act, we make every possible effort to include a child with special needs. We recognize the benefits for typically developing children and those with disabilities to be together in early childhood and afterschool programs.

When a child needs accommodations to participate in our program, we consult with the parent to determine what environmental, scheduling, or other programmatic changes would be necessary and whether they are feasible for our program. We are prepared to work with parents to identify community resources to assist with inclusion.

We may deny services to a child with special needs if:

- 1) The accommodations requested would be too difficult or expensive to undertake—even with resources available through health programs and other outside funding sources;
- 2) The child poses a direct threat to the safety of others (as with a child with a severe emotional or behavioral disorder) and the situation cannot be remedied by reasonable methods or modifications; or
- 3) The child's needs fundamentally alter the nature of the program

If we deny services to a child with special needs, we will assist the parent in finding a more appropriate program.

### **Special care plans**

A special care plan will be completed by a health professional for any child who has asthma, severe allergic reactions, diabetes, medically-indicated special feedings, seizures, hearing impairments, vision problems, or any other condition that requires accommodation in the program. The special care plan will identify all appropriate specific measures to be taken to meet the child's health requirements. With written permission from their child's health care practitioner, parents can train staff on how to follow their child's individual health care plan.

1. The special care plan will describe routine and emergency management that might be required by the child while at the program or while being transported to and from the program. This plan will include specific instructions for staff observations, any special medical procedure, how to obtain training in carrying out the procedure, and how to respond and who to notify if complications occur. A qualified health care professional will train staff on performing any special medical procedure.
2. The information contained in the special care plan will remain confidential and will be shared with staff only on a "need to know" basis to meet the needs of the child.
3. If the child requires emergency medical attention, staff will give the emergency response team the child's written special care plan.

### **Children with allergies**

Food, pollen, pets, insect bites and stings, medication, and other substances can cause an allergic reaction in children. Allergic reactions can range from mild skin or gastrointestinal symptoms to severe reactions with possibly fatal complications, including the swelling and closure of the airway that can lead to an inability to breathe. Therefore, it is critical that early childhood, afterschool, and other youth-serving programs have special care plans for children with food or other allergies and the ability to properly implement such plans for the treatment of allergic reactions:

1. When a parent informs staff that their child has allergies, the program will require a special care plan prepared by the child's health care provider. The special care plan must include:

- Written instructions regarding the food or other substances to which the child is allergic and measures that need to be taken to avoid those substances;
  - A detailed treatment plan to be carried out if the child has an allergic reaction, including the names, doses, and methods of administration of any medication that the child should receive in the event of a reaction. The plan should identify specific symptoms that would indicate the need to give one or more medications to the child.
2. Based on the child's special care plan, staff who regularly work with the child will be informed about measures for:
    - Preventing exposure to the specific substances to which the child is allergic;
    - Identifying the symptoms of an allergic reaction;
    - Treating allergic reactions.
  3. Parents and the director will arrange for the facility to have on hand necessary medications, proper storage of such medications, and the equipment and training to manage the child's allergy while the child is in the program's care.
  4. Staff will promptly and properly administer prescribed medications when a child has an allergic reaction.
  5. Staff will notify the parent of any suspected allergic reactions or the child's exposure to food or other substance to which they are allergic, even if the child did not have a reaction.
  6. Staff will immediately call for emergency medical services after epinephrine has been administered.
  7. When a child with allergies goes on a field trip or is being transported between home and the facility, staff will bring their written special care plan and any medications that the child should receive in the event of a reaction.

► Inclusion of children with food allergies is discussed in more detail in Part 5 Food Preparation, Handling, and Feeding.

### **Children with asthma**

Each enrolled child with asthma must have a special care plan prepared for the program by the child's health care provider that includes:

- 1) Written instructions about how to avoid the conditions that are known to trigger asthma symptoms for the child;
- 2) When the child's asthma should be treated at the program;
- 3) Name, doses, and method of any medications (for example, inhalers) that the child should receive for an acute episode and for ongoing prevention;
- 4) When the next update of the special care plan is due.

Based on the child's special care plan, their teachers/staff will be trained to:

- 1) Prevent exposure of the asthmatic child to conditions known to trigger the child's asthma;
- 2) Recognize the symptoms of asthma;
- 3) Treat acute episodes.



Parents and staff will arrange for the necessary medications and equipment to be at the program while the child is in attendance. Trained staff should promptly and properly give prescribed medications in accordance with the special care plan. Staff must immediately notify the child's parents if emergency medication is required. The program will notify parents of any change in asthma symptoms when that change occurs.

The facility shall take the following steps to reduce common asthma triggers:

1. Encourage the use of allergen impermeable rest mats, cots, and crib/mattress covers.
2. Consider the prohibition of pets (particularly furred or feathered animals).
3. Prohibit smoking inside the facility or on the playground.
4. Discourage the use of perfumes, scented cleaning products, and other fumes.
5. Quickly fix leaky plumbing or other sources of excess water.
6. Frequently vacuum carpets and upholstered furniture when the children are not present.
7. Store all food in airtight containers, clean up all food crumbs or spilled liquids, and properly dispose of garbage and trash.
8. Use integrated pest management methods to get rid of pests (i.e., use the least hazardous treatments first and progressing to more toxic treatments only if needed).
9. Keep children indoors when local weather forecasts predict unhealthy ozone levels or high pollen counts.

## 6-3 Screening, Assessment, and Referral

### **Initial screening**

For children entering our early education programs, we obtain developmental history from a screening questionnaire completed by parents during enrollment.

### **Child assessment**

We use 2 appropriate, valid, and reliable assessment tools to identify strengths and gaps in children's learning and development. In addition to The Creative Curriculum assessment tools used in our early education programs, we use the Devereux Early Childhood Assessment (DECA) in both our early education and afterschool programs.

The Creative Curriculum. In our early education programs, the child's teacher completes The Creative Curriculum developmental checklist within 45 calendar days of the child's program entry and subsequently every 3 months.

Devereux Early Childhood Assessment. Research shows that early social and emotional competence is the foundation for all later development and a key predictor of later success in school and in life. We use the DECA as a screening tool and an assessment planning system that considers children's social/emotional skills levels. We initially apply the DECA to all children to distinguish those who probably have social/emotional problems from those who probably do not. In this way, it facilitates access to DECA intervention aimed at strengthening young children's protective factors and thereby increasing their long-term resilience. For children receiving DECA intervention, we compare pre-test scores with results from post-tests conducted six months later to determine their progress and program effectiveness.

### **Progress reports**

Infants, toddlers, and preschoolers. The Creative Curriculum assessments and progress reports are completed on the same schedule. Referencing The Creative Curriculum assessment results, we prepare a progress report for parents. Beyond providing them with a copy, we encourage parents to meet with their child's teacher. Copies of the assessment results and progress report are filed in the child's records at the program.

School-age children. Covering all major domains of child development, progress reports are completed and shared with parents every 3 months. A copy is kept in the child's file.

### **Referral process**

When children who need services obtain them early on, they are less likely to need educational intervention or special services later on. The Creative Curriculum and DECA assessment results lead to informed, timely referrals for academic or other further evaluation and specific interventions such as speech and language therapy, occupational therapy, and mental health counseling. Whenever staff have a physical, mental, social, or health concern about a child, they should complete a services referral form and submit it to the center/program director.

Before recommending a child for evaluation, the center/program director will review the completed services referral form and any relevant information in the child's file. When practicable, they will consult with a professional who has specialized training in the area of concern and who has observed the child's experience in the program.

Parent involvement. If there is reason to believe that a child may benefit from additional services, we will schedule a meeting with their parent to inform them of the concern and the availability of evaluation and intervention services. At the meeting, we will give the parent a written report stating the reason for making a referral for evaluation and additional services, a brief summary of the program's observations supporting the referral, and any effort the program may have made to

address the concern. The director will, whenever practicable, give the parent an opportunity to consult with an appropriate professional to discuss the reasons for the referral, the proposed evaluation tool and procedures, and possible remediation strategies if the existence of a learning or developmental problem is established.

If the child is 2½ years old or older, we will inform and assist the parent in exercising their right to services from the public school system in the city/town in which the family lives. If the child is under the age of 3, we will advise and assist the parent in accessing early intervention services.

Follow-up. With prior written parent consent, we may arrange for an evaluation to be done by an appropriately trained professional. If early intervention, speech, language, occupational therapy, mental health counseling, or other support is identified as a service that may benefit the child, we will, with parent permission, arrange for the child to receive such services at the facility that the child attends or refer the parent to services provided by other agencies at their own locations. If the parent needs extra support in the referral process, we may, with parent consent, contact the service provider for them. We will support the parent as decision-maker, keep them informed, and maintain a confidential file of assessment results, recommendations and referrals, and the child's progress in treatment.

If it is determined that the child does not need or is ineligible to receive additional services, staff will review the child's progress at the program at least every 3 months to determine whether they should make another referral.

Record of referrals. The program director will keep a written record of any referral, including meeting with parent and results of any professional assessment, in the child's file.

Referral resources. We will maintain up-to-date listings of area educational, medical, mental health, and social services to which they can refer families and, where applicable, negotiate for their on-site provision. Program and agency administrators will also work with:

- 1) Other service providers to facilitate interagency collaboration and the sharing of relevant and appropriate information such as assessments and follow-up services, while safeguarding parental rights governing information-sharing;
- 2) Community planning and advocacy groups, neighborhood organizations, government agencies, other service providers, and families to develop better ways of supporting families in meeting their needs.

Oversight. Program administrators will periodically review the effectiveness of their program's referral process and ensure that their program complies with applicable laws and funder requirements. They will arrange for staff training and, where appropriate, clinical supervision on making appropriate referrals and following through on intervention plans.

## 6-4 Children's Illnesses

Informed by national standards, we have developed protocols and procedures for handling children's illnesses in our EEC-licensed programs, including care plans and an inclusion/exclusion policy.

In daily health checks performed upon arrival of each child each day, staff should objectively determine if the child is ill or well. Staff should determine which children with mild illnesses can remain in care and which need to be excluded.

Staff should notify the parent when a child develops new signs or symptoms of illness. Parent notification should be immediate for emergency or urgent issues. Staff should notify parents of children who have symptoms that require exclusion and parents should pick up their child from the program as soon as possible. For children whose symptoms do not require exclusion, verbal or written notification of the parent at the end of the day is fine.

### **Conditions/symptoms that do not require exclusion**

There are few illnesses for which children should be excluded from our programs. Most children with mild contagious illness do not need to stay home from our programs. Usually the child has already exposed others before seeming sick. Other illnesses such as impetigo and conjunctivitis stop being contagious shortly after treatment is started.

Conditions/symptoms that do not require exclusion include:

- 1) Common colds, runny noses (regardless of color or consistency of nasal discharge).
- 2) A cough not associated with fever, rapid or difficult breathing, wheezing, or cyanosis (blueness of skin or mucous membranes).
- 3) Pinkeye (bacterial conjunctivitis) indicated by pink or red conjunctiva with white or yellow eye mucous drainage and matted eyelids after sleep. This may be thought of as a cold in the eye. Exclusion is no longer required for this condition. Health care professionals may vary on whether or not to treat pinkeye with antibiotic drops. The role of antibiotics in treatment and preventing spread of conjunctivitis is unclear. Most children with pinkeye get better after 5 or 6 days without antibiotics. Parents should discuss care of this condition with their child's primary health care provider and follow the primary health care provider's advice. Some primary health care providers do not think it is necessary to examine the child if the discussion with the parent suggests that the condition is likely to be self-limited. If no treatment is provided, the child should be allowed to remain in care. If the child's eye is painful, a health care professional should examine the child. If 2 or more children in a group develop pinkeye in the same period, the program should seek advice from the program's health consultant or a public health agency.
- 4) Watery, yellow or white discharge or crusting eye discharge without fever, eye pain, or eyelid redness.
- 5) Yellow or white eye drainage that is not associated with pink or red conjunctiva (ie, the whites of the eyes).
- 6) Fever without any signs or symptoms of illness in infants and children who are older than 4 months regardless of whether acetaminophen or ibuprofen was given. For this purpose, *fever* is defined as temperature above 101°F by any method. These temperature readings do not require adjustment for the location where they are made. They are simply reported with the temperature and the location, as in "101°F in the armpit/axilla."

*Fever is an indication of the body's response to something but is neither a disease nor a serious problem by itself. Body temperature can be elevated by overheating caused by overdressing or a hot environment, reactions to medications, and response to infection. If the child is behaving*

*normally but has a fever, the child should be monitored but does not need to be excluded for fever alone. For example, an infant with a fever after an immunization who is behaving normally does not require exclusion.*

- 7) Rash without fever and behavioral changes. *Exception:* Call EMS (911) for rapidly spreading bruising or small blood spots under the skin.
- 8) Impetigo lesions should be covered, but treatment may be delayed until the end of the day. As long as treatment is started before return the next day, no exclusion is needed.
- 9) Lice or nits treatment may be delayed until the end of the day. As long as treatment is started before returning the next day, no exclusion is needed.
- 10) Ringworm treatment may be delayed until the end of the day. As long as treatment is started before returning the next day, no exclusion is needed.
- 11) Scabies treatment may be delayed until the end of the day. As long as treatment is started before returning the next day, no exclusion is needed.
- 12) Molluscum contagiosum (does not require covering of lesions).
- 13) Thrush (i.e., white spots or patches in the mouth or on the cheeks or gums).
- 14) Fifth disease (slapped cheek disease, parvovirus B19) once the rash has appeared.
- 15) Methicillin-resistant *Staphylococcus aureus* (MRSA) without an infection or illness that would otherwise require exclusion. Known MRSA carriers or colonized individuals should not be excluded.
- 16) Cytomegalovirus infection.
- 17) Chronic hepatitis B infection.
- 18) HIV infection.
- 19) Asymptomatic children who have been previously evaluated and found to be shedding potentially infectious organisms in the stool. Children who are continent of stool or who are diapered with formed stools that can be contained in the diaper may return to care. For some infectious organisms, exclusion is required until certain guidelines have been met. **Note:** These agents are not common, and teachers will usually not know the cause of most cases of diarrhea.
- 20) Children with chronic infectious conditions that can be accommodated in the program according to the legal requirement of federal law in the Americans With Disabilities Act. The act requires that early childhood education programs make reasonable accommodations for children with disabilities and/or chronic illnesses, considering each child individually.

### **Criteria for exclusion of children who are ill**

When a child becomes ill but does not require immediate medical help, a determination should be made regarding whether the child should be sent home. Most illnesses do not require exclusion. The director, in close consultation with the child's teacher, should determine if the illness:

- 1) Prevents the child from participating comfortably in activities;
- 2) Results in a need for care that is greater than the staff can provide without compromising the health and safety of other children; or
- 3) Poses a risk of spread of harmful diseases to others.

If any of these criteria are met, the child should be excluded, regardless of the type of illness.

Temporary exclusion is recommended when the child has any of the following conditions:

- 1) The illness prevents the child from participating comfortably in activities.
- 2) The illness results in a need for care that is greater than the staff can provide without compromising the health and safety of other children.
- 3) A severely ill appearance—this could include lethargy/lack of responsiveness, irritability, persistent crying, difficult breathing, or having a quickly spreading rash.
- 4) Fever (temperature over 101°F by any method) with a behavior change in infants older than 2 months. For infants younger than 2 months, a fever (temperature over 100.4°F by any method) with or without a behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, diarrhea) requires exclusion and immediate medical attention.
- 5) Diarrhea is defined by stools that are more frequent or less formed than usual for that child and not associated with changes in diet. Exclusion is required for all diapered children whose stool is not contained in the diaper and toilet-trained children if the diarrhea is causing “accidents.” In addition, diapered children with diarrhea should be excluded if stool frequency exceeds 2 stools more than typical for that child during the time in the program day, because this may cause too much work for the teachers, or if stools contain blood or mucus. Readmission after diarrhea can occur when diapered children have their stool contained by the diaper (even if the stools remain loose) and when toilet-trained children are not having “accidents,” and when stool frequency is no more than 2 stools more than typical for that child during the time in the program day.

Special circumstances that require specific exclusion criteria include:

- 1) A health care professional should clear the child or staff member for readmission for all cases of diarrhea with blood or mucus. Readmission can occur following the requirements of the local health department authorities.
- 2) Vomiting more than 2 times in the previous 24 hours, unless the vomiting is determined to be caused by a noninfectious condition and the child remains adequately hydrated.
- 3) Abdominal pain that continues for longer than 2 hours or intermittent pain associated with fever or other signs or symptoms of illness.
- 4) Mouth sores with drooling that the child cannot control unless the child’s primary health care provider or local health department authority states that the child is noninfectious.
- 5) Rash with fever or behavioral changes, until the primary health care provider has determined that the illness is not an infectious disease.
- 6) Active tuberculosis, until the child’s primary health care provider or local health department states child is on appropriate treatment and can return.
- 7) Impetigo, only if the child has not been treated after notifying family at the end of the prior program day. Exclusion is not necessary before the end of the day as long as the lesions can be covered.
- 8) Streptococcal pharyngitis (ie, strep throat) until at least 12 hours after treatment has been started.
- 9) Head lice, only if the child has not been treated after notifying the family at the end of the prior program day. **Note:** Exclusion is not necessary before the end of the program day.
- 10) Scabies, only if the child has not been treated after notifying the family at the end of the prior program day. **Note:** Exclusion is not necessary before the end of the program day.
- 11) Chickenpox (varicella), until all lesions have dried or crusted (usually 6 days after onset of rash and no new lesions have appeared for at least 24 hours).
- 12) Rubella, until 7 days after the rash appears.

- 13) Pertussis, until 5 days of appropriate antibiotic treatment.
- 14) Mumps, until 5 days after onset of parotid gland swelling.
- 15) Measles, until 4 days after onset of rash.
- 16) Hepatitis A virus infection, until 1 week after onset of illness or jaundice if the child's symptoms are mild or as directed by the health department. **Note:** Protection of the others in the group should be checked to be sure everyone who was exposed has received the vaccine or receives the vaccine immediately.
- 17) Any child determined by the local health department to be contributing to the transmission of illness during an outbreak.

### **Procedures when a child requires exclusion**

If a child who seemed well at drop-off becomes ill or a mildly ill child becomes sicker during the time they are at the program, the director determines whether the child meets or does not meet the exclusion criteria for participation and the child's need for care relative to the staff's ability to provide care. If uncertain about the nature or management of a child's illness, they may seek advice from our health care consultant. Whether the decision is to allow the child to stay or leave the program, the director or the child's teacher/group leader calls the parent to discuss the symptoms and how the program plans to manage the situation.

If the child is deemed too ill to stay in the program, the director will contact the parent to pick up the child as soon as possible. While awaiting pickup, the child will be supervised by someone who knows the child well and who will continue to observe the child for new or worsening symptoms. The director will make decisions on a case-by-case basis about providing care that is comfortable for the child while awaiting parent pickup, considering factors such as the child's age, surroundings, potential risk to others, and type and severity of symptoms the child is exhibiting. The child should be supervised by someone who knows the child well and who will continue to observe the child for new or worsening symptoms. If symptoms allow the child to remain in their usual care setting while awaiting pickup, the child will be kept comfortable in a quiet corner of their classroom or office where they can be separated from other children by at least 3 feet until the child leaves to help minimize exposure of people not previously in close contact with the child. The location will be within sight of a familiar EEC-qualified teacher/group leader who can, with extra attention to hygiene and sanitation, attend to the child's needs for food, drink, rest, play materials, and comfort until they are picked up. All who have been in contact with the ill child should wash their hands. Toys, equipment, and surfaces used by the ill child should be cleaned and disinfected after the child leaves.

The director will discuss the signs and symptoms of illness with the parent who is assuming care and review guidelines for the child's return to the program. If necessary, provide the family with a written communication that may be given to the primary health care provider. The communication should include onset time of symptoms, observations about the child, vital signs and times (e.g., temperature of 101.5°F at 10:30 a.m.), and any actions taken and the time actions were taken (e.g., ½ tsp children's acetaminophen given orally at 11:00 a.m.). The nature and severity of symptoms and requirements of the local or state health department will determine the need for medical consultation. Telephone advice and electronic transmissions of instructions are acceptable without an office visit.

If the child has been seen by their primary health care provider, follow the advice of the primary care provider for return to the program.

If the child seems well to the family and no longer meets criteria for exclusion, there is no need to ask for further information from the primary health care provider when the child returns to care. Children who had been excluded from care do not necessarily need to have an in-person visit with a health care professional.

1. Document actions in the child's file with date, time, symptoms, and actions taken (and by whom); sign and date the document.
2. In collaboration with the local health department, notify parents of contacts to the child with presumed or confirmed reportable infectious disease.

The director should make the decision about whether a child meets or does not meet the exclusion criteria for participation and the child's need for care relative to the staff's ability to provide care. If parents and program staff disagree, and the reason for exclusion relates to the child's ability to participate or the teacher's ability to provide care for the other children, the teacher should not be required to accept responsibility for the care of the child.

### **Reporting children's exposures to a communicable disease**

Some communicable diseases must be reported to public health authorities so that control measures can be used. Each year the director of early education and care will obtain an updated list of reportable diseases from the MA Department of Public Health's Division of Communicable Disease Control. We will contact the local health department if there is a question of a reportable (harmful) infectious disease in a child or staff member in the facility. Clusters of mild respiratory illness, ear infections, and certain dermatological conditions are common and generally do not need to be reported. If there are conflicting opinions from different primary care providers about the management of a child with a reportable infectious disease, the health department has the legal authority to make a final determination.

We will inform parents in writing whenever a contagious disease such as measles or salmonella has been introduced into one of our programs.

Parents should inform staff if children have been exposed to a contagious disease—e.g., when another child in the family has chicken pox. It may be beneficial to share this information with families in the program. If so, the reporting family's information will remain confidential; however, this will help staff and families observe the other children for symptoms and could assist their medical provider in making a diagnosis.



## 6-5 Staff Health Requirements

The following requirements will apply to all staff who have any contact with the children or with anything with which the children come in contact. Other health and safety policies that apply to employees are contained in the *Employee Handbook*.

### **Pre-employment requirements**

Before beginning work in a children's program, any staff member or substitute must meet the following requirements:

1. Evidence of a physical examination performed within 1 year prior to employment.
2. Evidence of immunity for measles, mumps, and rubella. The agency cannot require such certification of any staff member who states in writing that vaccination or immunization conflicts with their religious beliefs.
3. A negative Mantoux TB test or x-ray in accordance with current MA Department of Public Health regulations. Repeated TB testing will not be required unless symptoms of possible TB or exposure to someone who has high risk of TB occurs.
4. The Occupational Safety and Health Administration (OSHA) requires that employers of individuals who may be expected to have job-related exposures to blood or other potentially infectious materials (for example, when performing first aid) must offer immunization against hepatitis B to such individuals either prior to exposure or anytime thereafter (see Bloodborne Pathogens Exposure Control Plan below).

### **Ongoing health requirements**

In their day-to-day supervision of the program, the director will visually and verbally assess the staff for signs of ill health. Staff may have their work limited or modified and be required to have a health exam if their health status, to the extent that it affects their ability to do the work required, is uncertain.

Staff are required to have a health exam every 2 years. Documentation from the health care provider that the staff member has been examined should indicate any limitations in their ability to work with children. If, in the agency's judgment, a staff member's physical condition requires a current physical examination, the agency may require them to provide documentation of a current physical examination and indication of any physical limitations in working with children.

All employees are expected to take appropriate health precautions to ensure the health and safety of coworkers, children, families, and themselves. Adults as well as children are capable of spreading infectious disease. They are expected to remain away from work as long as their illness is considered to be contagious. When requested, they must provide a physician's statement certifying that it is safe for them to return to work.

Although disclosure cannot be required, staff members who are infected with the human immunodeficiency virus (HIV) or who are hepatitis B carriers may care for children provided they can competently perform their job duties and do not have open lesions that cannot be adequately covered or other conditions that allow contact with their blood.

## 6-6 Safe Medication Administration

To safely carry out medication administration requests from parents, we have a system in place that includes having staff trained and ready to give the medication, document and store the medication, and communicate with the parent and the child's health care provider.<sup>8</sup> We do not give the first dose of any medication to a child, except under extraordinary circumstances and with parental consent.

### Training to administer medication

Every staff person who administers medication must be trained and demonstrate competence. Training must include the *6 rights* of medication administration and recognizing and reporting any side effects/adverse reactions from medications. Any staff authorized to administer medication will be evaluated annually on their ability to follow our medication administration procedures.

### Step-by-step medication administration procedures

Staff should adhere to the following procedures when administering medications. Concentrate on following procedures. Don't allow yourself to be distracted.

1. Wash hands before giving medication to each child to ensure it is a clean procedure.
2. Verify authorization from parent and/or prescriber; check the label and/or manufacturer's instructions. Seek help when questions arise.
3. Get medication and other necessary items from storage.
4. Check the label for name, time, medication, dose, and route when removing from storage.
5. Prepare and give medications in a well-lit area.
6. Prepare the correct dosage of medication without touching medication, if possible.
7. Check the label and/or manufacturer's instructions for name, time, medication, dose, and route while preparing the correct dose.
8. Check the label and/or manufacturer's instructions for name, time, medication, dose, and route before returning the container to the storage cabinet.
9. Do not leave medication unattended.
10. Identify the child. Ask them to say their name, when appropriate. Nonverbal children may need third-party assistance with identification.
11. Take measures to protect children's information. Inform staff who need the information, while ensuring that need-to-know staff maintain data privacy.
12. Verify the child's allergies verbally by asking the student and by checking the student health records. Also verify contraindications to medicine. Watch for typical adverse medication reactions. If an adverse reaction is evident, contact the director, parent, or licensed prescriber, according to program policy.
13. If the child questions whether it is the right medication, stop and verify the medication against records, with the parent, or with the registered pharmacist.
14. Apply child development principles when giving children medication (e.g., school-age children do not want to be considered unique). Explain the procedure to the child in accordance with their ability to understand.
15. Position the child properly for medication administration.

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<sup>8</sup> Based on *Minnesota Guidelines for Medication Administration in Schools* (May 2005; updated September 2005), <http://www.health.state.mn.us/divs/cfh/shs/pubs/medadmin/index.html>.

16. Administer medication according to the “6 rights” (right child, right time, right medicine, right dose, right route, and right documentation).
17. Discuss the administration procedure with the child and carefully observe them while giving the medication.
18. Record the name, time, medication, dose, route, and person administering the medication, and any unusual observations immediately after giving the medication.
19. Accurately document the transfer and witnessed disposal of medications.
20. Clean, return, and/or dispose of equipment as appropriate.
21. Wash hands after giving medication to an individual child.

### **The 6 rights of safe medication administration**

Staff should use the “6 rights” (which adds “right” documentation to the “5 rights”) every time they give medication as a mental checklist to remember the crucial elements of the process:

1. Right child. *Properly identify the child:*
  - Check that the name of the child on the medication and the child receiving the medication are the same.
  - If you do not know the child, check the child’s identity with a reliable person and, if developmentally-appropriate, ask the child their name.
2. Right medication. *Administer the correct medication:*
  - Prescription medication must be in the original pharmacy-labeled container indicating the child’s name, the name and strength of the medication, the date that the prescription was filled, the name of the health care provider who wrote the prescription, the medication’s expiration date, and administration and storage instructions. Unless authorized by written order of the child’s physician, medication can only be administered according to directions on the container.
  - Over-the-counter medications must be kept in the original manufacturer-labeled container. The container should be labeled by the parent with the child’s name and specific instructions from the child’s health care provider for administering it.
  - The medication supplied by the parent must exactly match the Medication Consent Form. Generic medication cannot be accepted as a substitute for brand name medication. If the child’s health care provider wrote both the generic name and the brand name on the written instructions, you can accept either the generic or brand name medication from the parent.
  - Staff should not administer medication beyond the date of expiration on the container or beyond the expiration of the instructions provided by the physician. Instructions that state that the medication may be used whenever needed must be renewed by the physician at least annually.
3. Right time. *Administer the medication at the prescribed time:*
  - Check the Medication Consent Form for the time the medication is to be given.
  - Check the child’s medication administration log to see if the medication has already been given by another staff member.
  - Before administering a non-prescription medication for which a physician has given a standing order, staff should attempt to contact the child’s parent unless a child urgently

- needs the medication or when contacting the parent will unreasonably delay giving the medication. The parent must be notified in writing each time a non-prescription medication is administered to a child.
- For physician-ordered medications to be given for a recurring problem, emergency situation, or chronic condition, the instructions should include the child's name, the name and dose of the medication, how often the medication may be given, the conditions for use, and any precautions to follow. For "as needed" medication, the right time to administer the medication is when the child is showing the symptoms specified by the child's health care provider on the Medication Consent Form.
  - Be aware of any doses of an "as needed" medication the child may have received while not in your program so you know that you are giving the medicine when a new dose can be given as written by the child's health care provider.
4. Right dose. *Administer the right amount of medication:*
- Give the exact amount of the medication specified on the Medication Consent Form and the pharmacy label.
  - Use the administration device supplied by the parent or a standardized measuring tool to accurately measure the dose.
5. Right route. *Use the prescribed method of medication administration:*
- Check the Medication Consent Form and medication label for the prescribed method of medication administration.
6. Right documentation. *Promptly and accurately document the medication administration:*
- Keep written records of all prescription and non-prescription medication, including topical non-prescription medications, administered to each child.
  - Maintain a log for each child specific to each medication they receive. The log should include the child's name, the name and dosage of the medication, the time and date the medication was given, the initials of the person administering the medication, and side effects if any. Complete documentation in unalterable ink immediately after giving the medication.
  - If the medication is dropped on the floor, the child refuses to take the medication, spits out the medication, or any other unusual occurrence happens, make note of it and contact the child's parent.
  - Retain the completed or discontinued medication log in the child's file.

### **Procedure in case of a medication error**

If an error in medication administration occurs, staff should take the following steps:

1. Identify the nature of the error.
2. Document the error in the child's medication log.
3. Monitor the child's behavior and physical symptoms. If the child's symptoms are life-threatening, call 911 prior to calling parents.
4. Notify the parent and child's health care provider.
5. If unable to contact the child's health care provider or licensed prescriber, contact the Poison Control Center for instructions. Give the name and dose of the medication given in error, the

child's age and approximate weight, and the name, dose, and time of last administration of other medications being taken by the student.

6. Document in detail what the medication error was and actions taken.
7. Notify the EEC if the wrong medication is given or hospitalization results from the medication error.

### Self-administration of medication

Staff should give all medication to elementary school-aged children, except that, with written parent consent, a child may administer their own medication under staff supervision. With written parent consent and authorization of the child's physician, children with asthma may carry their own inhalers and use them as needed, without direct staff supervision. Staff should be made aware of individual children who have asthma and may use their inhalers as needed.

If there is disagreement about a child's self-carrying and/or self-administration of medication, a meeting will be held among all those involved, including the child's parent, to address differences of opinion and develop a plan, keeping as a priority the child's health and safety.

### Complementary and alternative medicines

No substance should be administered to any child without the express written request of the parent. As with all medications administered at the program, complementary and alternative medicines should be provided by the parent and in an original container with proper labeling (name of student, date, name of medication, dose, time of administration, prescriber as appropriate, and expiration date) and manufacturer's indications and contraindications. Staff should be aware that complementary and alternative medicines can frequently interact with other prescribed and non-prescribed medications. Parents should be encouraged to seek guidance from the child's health care provider about drug interactions.

### Consent and documentation requirements

Following is a summary of consent and documentation requirements for administering medications:

Type of medication	Written parental consent required	Health care practitioner authorization required	Logging required
All prescription	Yes	Yes. Must be in original container with original label containing the name of the child affixed.	Yes, including name of child, dosage, date, time, and staff signature. Missed doses must be noted, with reasons why dose was missed.
Oral non-prescription	Yes, renewed weekly with dosage, times, days and purpose	Yes. Must be in original container with original label containing the name of the child affixed.	Yes, including name of child, dosage, date, time, and staff signature. Missed doses must be noted, with reasons why dose was missed.
Unanticipated non-prescription for mild symptoms (e.g., acetaminophen, ibuprofen, antihistamines)	Yes, renewed annually	Yes. Must be in original container with original label containing the name of the child affixed.	Yes, including name of child, dosage, date, time, and staff signature.

Topical non-prescription medications (e.g., petroleum jelly, baby powder, diaper rash ointments, and anti-bacterial ointments that are applied to wounds, rashes, or broken skin)	Yes, renewed annually	Yes. Must be in original container, labeled with the child's name, and used only for that child.	Yes, including name of child, dosage, date, time, and staff signature.
Topical, non-prescription such as sunscreen, insect repellent, and other ointments that are not applied to open wounds, rashes, or broken skin	Yes, renewed annually	No. With notification to parents, program may supply items or parents may send in preferred brands of such items for their own child's use.	No.

### Procedure for transporting children's medication

Children's medications are transported according to the following procedure:

1. The parent should phone the facility when sending in medication with their child so that staff can expect the arrival of the medication.
2. The parent should put the medication in a small, sealed plastic bag (to prevent spillage) and place that in a paper bag clearly labeled with their child's name.
3. The parent should give the bagged medication to the bus monitor or driver, who will deliver it to staff at the program. The bus monitor or driver should ensure that the medication is inaccessible to children and will safeguard against its spillage or loss.

### Storage

Medications must be stored in a secure location that it inaccessible to children, but accessible to staff responsible for administering them; keep in mind that emergency medications must be immediately available. Controlled substances must be stored in a locked drawer or cabinet. Medication must be stored separately from food and toxic materials. Medications should be stored at the temperature recommended for that type of medication. Those requiring refrigeration should be stored in a locked refrigerator specifically for medications or a separate container in a refrigerator that is not accessible to children. Each medication should be stored in its original pharmacy- or manufacturer-labeled container.

### Disposal of unused medication

Return all unused, discontinued, or outdated medications to the parent and document their return. If they cannot be returned to the parent, discard in a manner recommended by the MA Department of Public Health's Drug Control Program (617-973-0800).

## 6-7 Drop-off and Pick-up of Children

### **Authorization to pick up children**

At each licensed early childhood education and afterschool program facility, the director will maintain in the files a list of names, addresses, and telephone numbers of persons authorized by the parent to pick up their child for them, receive their child at the end of the day, or take the child out of the facility for other reasons. When a parent wants to authorize additional persons to pick up their children, or revoke authorization of individuals to take the child out of the facility, they must indicate such changes in writing. If a custodial parent experiences domestic violence and obtains a court order or some other legal remedy, the parent is required to notify the facility of change in authorized persons for picking up the child.

No child will be released without the presence or permission of the custodial parent. Any authorized person who is not recognized by staff will be required to provide photo identification such as a driver's license or work or school ID before the child is released to them.

### **Sign-in/sign-out procedure**

Parents who bring a child to or take them from the program facility will sign the children in and out of the facility on an attendance log, noting the time of arrival and departure, and make sure that the staff responsible for the care of the child know that the child is being dropped off or picked up.

### **Children who walk**

With written parent consent, children may walk to and from the agency's afterschool program. If staff feel that the child is not ready to make their own way to and from the program, the director will meet with the parent to resolve the difference in opinion, with the child's health and safety being the first and foremost concern.

### **Policy for when an unauthorized person wants to take a child out of the facility**

If an unauthorized person seeks to take a child out of the facility, staff will explain to them that the program cannot release a child without the presence or permission of the custodial. If an unauthorized person maintains their intention to take the child, they will be informed that program protocol will be to call for police intervention. If an unauthorized person forcibly removes the child from the facility, the director will immediately request police assistance and notify the custodial parent of the child.

### **Policy for handling persons who may pose a safety risk**

Staff shall not release a child to anyone who they believe cannot safely bring the child home. In determining whether to release a child into the custody of a person who, based on observed behavior and speech, appears to be under the influence of alcohol or drugs, staff will consider mode of travel, degree of self-control, alertness, coherence, balance, and the like. If the parent or authorized person seems unable to safely care for the child, staff may request that an emergency contact person come to pick up the child. If no one is available to care for the child, staff may contact DCF for guidance.

### **Procedure when no authorized person can be reached to pick up a child**

When no authorized person picks up a child, staff will attempt to reach each authorized contact. If these efforts prove unsuccessful, staff may call the DCF after-hours hotline to ask for help in returning the child to their home. Staff are responsible for the child's protection and must remain on duty until the child is picked up by an authorized person or placed in the care of child protective services.

## 7. Sanitation and Hygiene

### 7-1 General Infection Control Plan and Procedures

By adhering to the following sanitation and hygiene measures, staff can significantly reduce the risk of transmission of infection diseases to themselves and children in our programs. Consistency is critical because people who don't look or act sick can transmit infectious illnesses.

#### Handwashing

Properly washing and cleaning hands is the most effective way to prevent the spread of infection. All staff, volunteers, and children will use the following procedure to wash their hands:

1. Moisten hands with water and apply liquid soap. Vigorously rub hands with soap and water for at least 10 seconds, including between fingers, under and around nail beds, backs of hands, and any jewelry.
2. Rinse hands well under running water with fingers down so water flows from wrists to fingers. Leave the water running.
3. Dry hands with a paper towel.
4. Use a towel to turn off the faucet and, if inside a toilet room with a closed door, use the towel to open the door. Discard the towel in an appropriate receptacle.
5. Apply hand lotion, if needed.

Staff monitor young children's independent handwashing and assist them as needed.

If a child is too heavy to hold for handwashing at the sink and can't be brought to the sink for handwashing, use disposable wipes or a damp paper towel moistened with a drop of liquid soap to clean their hands. Then wipe the child's hands with a paper towel wet with clear water. Dry their hands with a fresh paper towel. (**Note:** This method is less effective than washing at the sink with running water.)

All staff, volunteers, and children will properly wash their hands:

- 1) Upon arrival, when moving from one group of children to another, or coming in from outdoors;
- 2) Before and after:
  - Eating, handling food, or feeding a child;
  - Giving medication;
  - Playing in water used by more than one person;
- 3) After:
  - Diapering and toileting;
  - Handling bodily fluids (mucus, blood, vomit) and wiping noses, mouths, and sores;
  - Handling garbage;
  - Handling pets or other animals or their equipment;
  - Playing in sandboxes;
  - After cleaning.



**Handwashing sinks**

Each early childhood education classroom has a handwashing sink that is located so staff can visually supervise the group of children while completing routine hand washing or having children wash their hands. Handwashing sinks are not to be used for bathing children, removing smeared fecal material, washing/rinsing soiled clothing, or cleaning equipment used in toileting.

**Practice of other hygiene rules**

In accordance with their ability to understand, children will be taught hygiene rules, including:

1. Cough and sneeze correctly:
  - Always use a tissue to catch a sneeze or cough or to wipe a runny nose. Then discard the tissue and wash your hands.
  - When coughing or sneezing, turn away from people and direct it toward the floor and/or cover your mouth when coughing or sneezing.
  - If the cough or sneeze is a surprise, cover it with a bare hand, then wash immediately without touching anything on the way.
2. Keep personal items apart:
  - Toothbrushes, hairbrushes, hair ornaments, clothing, eating utensils, cups, bottles, and food should never be shared with other children.
  - Each child should use only their own cot or crib unless the bedding is changed and the surfaces are wiped with a disinfectant solution. Cots must be labeled and stored so that blankets do not come into contact with those of other children. Cribs must be at least 2 feet apart.

**Supervision of children's activities**

Group play, especially among younger children, is closely supervised to ensure that toys, food, bottles, or anything else in contact with body secretions are not shared. We use disposable tissues to wipe off drools.

**Communal water play**

When offering communal water play, staff must observe the following guidelines:

1. Use fresh potable water and change the water before a new group of children comes to participate in the water play activity.
2. Drain the water when the activity period is completed with each group of children.
3. Do not allow children with sores on their hands to take part in the water play.
4. Disinfect the container and toys before each use of the water table.
5. Closely supervise water play activity to ensure no child drinks the water or has contact between body fluids (from their nose, mouth, or eyes) and the water in the water table.

**Infant room footwear**

To maintain a sanitary floor area for the infants to crawl, explore and learn, all staff and visitors to our infant classrooms must place clean "shoe booties" over their shoes upon entry.

**Plan to evaluate staff compliance with infection control procedures**

In the context of the day-to-day operation of the program, the director observes and provides feedback on each staff member's adherence to the program's infection control plan and procedures. These observations may help identify staff training needs.

## 7-2 Closing Procedures

The facility's closing procedures support multiple health and safety functions by:

- 1) Identifying cleaning tasks to be completed toward the end of the operational day to facilitate the off-hours facility cleaning process;
- 2) Reducing the fire hazard posed by cooking appliances being inadvertently left on overnight;
- 3) Reducing the possibility of a break-in, which could result in equipment loss, damage to the facility, a dangerous item such as a weapon being left in the facility, and disruption of services.

### Facility Closing Procedures

#### 1. Leave the facility neat, clean, and presentable for the next day of operation.

a. Each teaching team is responsible for the following "housekeeping" tasks:

- Leave each classroom/children's activity area neat and orderly, with the floor picked up, and swept if possible.
- Place chairs on the tables to facilitate floor cleaning.
- Leave the counter and furniture tops clean and clear of clutter.
- Return all food to the facility kitchen (except for food stored in a classroom refrigerator, if available).

b. End-of-the-day staff should:

- Leave the kitchen sinks and counters clean.
- Flush toilets as needed and leave the bathroom doors open for ventilation.

#### 2. Help the agency practice energy conservation and reduce the risk of fire

- Make sure all lights, with the exception of security lighting, and all water faucets are turned off.
- Make sure the ovens and the top burners of the kitchen stoves are off.
- Make sure that the heat is turned down to 60°F (in colder weather) and the air conditioning units and fans are turned off (in warmer weather).

#### 3. Make sure the facility is secure:

- Check that windows, exterior doors, and office doors are locked.
- Set the security alarm.

### Waste receptacles

Waste receptacles in areas used by children, parents, and staff must be in good repair, kept clean, and emptied daily

## 7-3 Cleaning, Sanitizing, and Disinfecting

This section describes the means, methods, and frequency of cleaning, sanitizing, and disinfecting our ECC-licensed early childhood education and afterschool programs. It is also intended as a guide to safe cleaning of all of our facilities.

### Knowing when and how to clean, sanitize, and disinfect

Cleaning, sanitizing, and disinfecting accomplish increasingly higher levels of germ elimination and involve distinctly different solutions. A goal of safe cleaning is effective germ control using the safest amount of cleaning, sanitizing, and disinfecting products. As a general rule, sanitize surfaces and objects that are touched by many hands and food areas and items; disinfect only surfaces and objects that come in contact with bodily fluids.

Task	Method	Solution/Product	Purpose/Result
<b>Cleaning</b> Towels, wash-cloths, sheets, other coverings, machine washable fabric toys	Scrub, wash, wipe and rinse surface to physically remove visible dirt, debris, and sticky film. Use a brush to get crevices clean. Rinse in clean water.  <i>Always clean before sanitizing or disinfecting.</i>	Regular (not antibacterial) soap or detergent with warm water	Through the friction of cleaning, removes most germs and exposes any remaining germs to the effects of a sanitizer or disinfectant used later.
<b>Sanitizing</b> Bibs, toys mouthed by a child, bottles, all surfaces used for eating, cleaning equipment	Cover the cleaned surface area with <i>sanitizing</i> solution. Immerse toys in solution. Allow to air dry or follow the manufacturer's recommendation before wiping off.	Bleach and water solution mixed to the correct ratio per EEC's instructions or a sanitizer with an EPA registration label	Destroys enough germs to make it unlikely that someone touching the surface will contact germs and become ill.
<b>Disinfecting</b> Diapering areas, bathrooms, equipment used for cleaning body fluids	Cover the cleaned area with <i>disinfecting</i> solution. Leave the solution to air dry or follow the manufacturer's recommendation before wiping off.	Bleach and water solution or a bleach or a disinfectant with an EPA registration label	Kills nearly 100% of the germs on a surface or object—specifically intended to eliminate the spread of bloodborne illnesses such as Hepatitis B and HIV.
<b>Special Precautions Treatment</b> Vomit or blood	Cover the area or equipment <u>while wearing gloves</u> .	Same disinfecting solution	Same disinfecting purpose and result

### Cleaning products

We are committed to using biodegradable, least-toxic cleaning products. Many ingredients in cleaning products can make indoor air unhealthy to breathe, irritate the skin and eyes, harm the respiratory tract, as well as damage the natural environment.

### Using bleach to sanitize and disinfect

**Preparation.** Working containers of sanitizing and disinfecting solutions must be prepared each day, since bleach solutions gradually lose their strength. When preparing sanitizing or disinfecting

dilutions always add bleach to water. (This helps to avoid bleach splashes caused by adding water to bleach.)

<b>Sanitizing dilution for 8.25% bleach</b>	<b>Disinfecting dilution for 8.25% bleach</b>
<ul style="list-style-type: none"> <li>• 2 teaspoons bleach to 1 gallon cool water</li> <li>• 1 teaspoon bleach to 1/2 gallon cool water</li> <li>• 1/2 teaspoon bleach to 1 quart cool water</li> <li>• 1/4 teaspoon bleach to 1 pint cool water</li> </ul>	<ul style="list-style-type: none"> <li>• 1/2 cup bleach to 1 gallon cool water</li> <li>• 1/4 cup bleach to 1/2 gallon cool water</li> <li>• 2 tablespoons bleach to 1 quart cool water</li> <li>• 1 tablespoon bleach to 1 pint cool water</li> </ul>

The dilutions for bleach concentrations other than 8.25% are available in the Safe Cleaning and Products Fact Sheet on the EEC website.

Application. Know when to sanitize and when to disinfect and prudently use the appropriate dilution for sanitizing and for disinfecting (stronger). If used correctly, low concentrations of bleach reliably sanitize and disinfect non-porous surfaces.

1. Bleach solutions should be applied with a disposable cloth rinsed in the solution and discarded after each use, or with a non-disposable cloth that is laundered in hot water and dried after each use. Paper towels also may be used. For all methods of applying bleach solutions, surfaces should be visibly wet.
2. If using a spray bottle, adjust the setting to produce a heavy spray or stream instead of a fine mist when possible. The fine mist could contain particles of chemicals that can trigger asthma or allergy like symptoms.
3. Allow for the contact time specified on the label of the bleach product.
4. Apply when children are not present in the area and allow for fresh air ventilation when possible until surfaces have air dried.

Storage. Working containers of sanitizers or disinfectants (such as spray bottles) must be labeled as sanitizing or disinfecting solutions; kept out of the reach of children; and stored separately from food items. Open containers used to sanitize dishes or toys must be used out of the reach of children.

### **Alternatives to bleach**

Bleach is a chemical irritant and is now designated as an asthma-causing substance. While using methods and tools to reduce exposure to bleach and create a safer environment, NorthStar is exploring transitioning to bleach-free sanitizers and disinfectants that are also safe for asthma. Our intent to make our children's programs bleach-free environments aligns with the recommendations of the MA Department of Public Health and EEC that children's programs begin using EPA-registered sanitizing and disinfecting products as soon as they become available.

### **“Clean is not a smell”**

No air fresheners. Air fresheners and deodorizers can contain hundreds of chemicals, some of them toxic in very small amounts. “Natural” air fresheners have been found to be no safer. Pollutants emitted from air fresheners have been linked to serious health problems; children are especially vulnerable. Moreover, the use of an air freshener can also violate the Americans with Disabilities Act, because people who experience disabling health effects from air fresheners cannot access the facility. For this reason, we use ventilation instead of air fresheners and remove sources of odors rather than mask with chemicals.

On the other hand, products called "fragrance-free" and "unscented" are not necessarily less hazardous. Even if a product does not contain a fragrance, it could still contain other chemicals that are toxic or hazardous.

**Schedule for cleaning, sanitizing, and disinfecting**

Area	Clean	Sanitize	Disinfect	Frequency
Play tables	✓	✓		At least daily.
All surfaces used for eating, including mixed use tables	✓	✓		Before and after serving food.
Bibs (used by only one child)	✓	✓		Good judgment should be used in deciding whether a bib can be reused before washing.
Thermometers	✓	✓		After each use.
Toys mouthed by infants and toddlers	✓	✓		Closely supervise to prevent shared mouthing of these toys. Clean after each use; clean, sanitize daily.
Toys used by children who do not put these objects in their mouths	✓			Clean at least weekly and when obviously soiled.
Pacifiers (labeled and used by only one child)	✓	✓		Clean after each use; clean, sanitize daily.
Bottles, eating and drinking utensils	✓	✓		After each use.
Cribs and cots	✓	✓		At least weekly, before use by another child, and whenever soiled or wet
Sheets, washcloths, blankets	✓			At least weekly, before use by another child, and whenever soiled or wet
Machine washable fabric toys	✓			Launder at least weekly, before use by another child, and whenever soiled or wet.
Washcloths used for multiple purposes	✓			Launder after each use.
Water tables and water play equipment	✓		✓	Before each use.
Sinks and sink faucets (except when used following toileting activities)	✓	✓		Daily and when soiled.
Mops, cloths, or other cleaning equipment <i>when not used for cleaning body fluids</i>	✓	✓		After each use.
Mops, cloths, or other cleaning equipment <i>used for cleaning body fluids</i>	✓		✓	After each use.
Diaper changing tables	✓		✓	After each child's use.
Toilets bowls, seats, and handles	✓		✓	Daily and immediately when visibly soiled.
Diaper pails	✓		✓	At least daily, including lids.
Sinks and faucets after toileting activities	✓		✓	At least daily.
Smooth surfaced, nonporous floors	✓	✓		Daily, all spills cleaned up immediately.

We clean, sanitize, and disinfect more frequently in response to an outbreak of infectious illness, if there is known contamination, or when recommended by health authorities to control certain infectious diseases.

## 7-4 Children's Personal Hygiene

Responsibility for taking care of young children's personal hygiene needs shifts, as one source put it, "from something caregivers do for their children to something children learn to do for themselves."

### **Washing a child's face**

When washing a child's face, use a separate disposable material for each child.

### **Change of clothing**

Staff make sure that extra clean, dry indoor and outdoor clothing is available to change a child's clothing when wet or soiled.

1. While parents of young children are expected to provide a change of clothing for their child, facilities have additional clean indoor and outdoor clothing on hand for changing purposes in the event that a child does not have a change of clothing from home. For children under 2 years 9 months old and/or not toilet trained, facilities have a change of clothing for each child.
2. Place soiled or wet clothing in a tightly-tied plastic bag, label with the child's name, and store apart from other items to be sent home.

### **Combs and hairbrushes**

Combs and hairbrushes brought from home are never shared.

### **Personal storage**

Each child has their own separate storage space.

### **Tooth brushing program**

Dental hygiene is an essential part of personal hygiene. Children attending our EEC-licensed early childhood education and afterschool programs regularly brush their teeth, based on MA Department of Public Health's Office of Oral Health guidelines.

*Infants.* For infants, we wipe the baby's mouth with a clean wet cloth after feeding (even before teeth erupt). We begin brushing when the first tooth erupts in the child's mouth.

*Toddlers and preschoolers.* We start teaching children to use a toothbrush when they are about 2 years old. Children use individual child-sized toothbrushes, with a very small smear or pea-sized amount of fluoride toothpaste to strengthen teeth. Staff instruct children on how to brush their teeth and closely monitor their efforts. For children who are learning this activity, staff thoroughly brush the child's teeth after the child has finished brushing.

*School-age children.* At least once daily, school-age children attending full-day programs brush their teeth. Staff supervise and help them until age of 8—the age most children acquire fine motor skills.

Supplies. Center directors are responsible for ordering tooth brushing supplies for their facility:

*Toothbrushes.* We provide each child with an age appropriate toothbrush labeled with their name. We replace toothbrushes about every 3 months or earlier if a child has been ill with a cold, flu, or bacterial infection. We also replace a toothbrush when bristles that look frayed or fan out.

*Toothpaste.* We have children use mint-flavored toothpaste with fluoride and approved by the American Dental Association. (Using fruity flavors encourages children to eat the toothpaste.) We store toothpaste in a secure cabinet, out of children's' reach.

Storing toothbrushes. After children finish brushing, they rinse their toothbrushes thoroughly with tap water. Staff help young children fit their brush into the toothbrush holder with bristles up to air dry. In the holders, stored toothbrushes do not touch each other to prevent spread of germs.

Communicating with parents about your tooth brushing program. We inform parents about our tooth brushing program during enrollment. Parents are asked if their child has any possible allergies to ingredients or additives in toothpaste. Parents who don't want their children to brush their teeth at the program must annually complete a tooth brushing non-participation form for each of their children. This form is filed in the child's record at the program.

## 7-5 Diaper Changing

Staff make diaper changing a happy, healthy, safe, interactive, nurturing experience for the child.

### Checking for the need to change diapers

Change diapers when they are found to be wet or soiled. Check diapers for wetness and feces at least hourly. Open and visually check at least every 2 hours and whenever the child indicates discomfort or shows behavior that suggests a wet or soiled diaper.

### Diaper changing procedure

Diaper changing should be done only in a designated diapering area. Food handling will not be permitted in diapering areas. Surfaces in diapering areas must be kept clean, waterproof, and free of cracks, tears, and crevices.

Staff should label all containers of lotions and cleaning items with each child's name and instructions and store them out of children's reach.

The following diaper changing procedure are posted in the changing area and always followed.

<p><b>Step 1</b></p>	<p>Before bringing the child to the changing area, wash your hands and collect all needed items. Keep everything off the diapering surface except the items you will completely use up during the diaper changing:</p> <ul style="list-style-type: none"> <li>• A sheet of non-absorbent paper that will cover the diaper-changing surface from the child's chest to the child's feet;</li> <li>• A fresh diaper, clean clothes (if needed);</li> <li>• Wipes removed from the container or dispensed so that the container will not be touched during diaper changing;</li> <li>• Disposable, non-porous gloves;</li> <li>• A plastic bag for any soiled clothes;</li> <li>• A dab of diapering cream (to be applied with written parent consent) removed from the container to a piece of disposable material such as a facial or toilet tissue.</li> </ul> <p>Put the containers off the diapering surface and where they cannot be touched during the diaper process.</p>
<p><b>Step 2</b></p>	<p>Carry the child to the changing table, keeping soiled clothing from touching you. Always keep a hand on the child; never leave them on the changing table unattended. Avoid contact with soiled items. Anything that comes in contact with stool or urine is a source of germs and must be cleaned and sanitized after the diaper change. Bag soiled clothes and, later, securely tie the plastic bag and store it apart from other items to be sent home.</p>
<p><b>Step 3</b></p>	<p>Unfasten the diaper, but leave the soiled diaper under the child. Hold the child's feet to raise the child out of the soiled diaper and use disposable wipes to clean the diaper area. Remove stool and urine from front to back and use a fresh wipe each time. Put the soiled wipes into the soiled diaper. Note and report any skin problems such as redness.</p>



<b>Step 4</b>	Remove the soiled diaper, clean soiled surfaces, and then remove gloves. Fold the diaper over and secure it with the tabs. Put it into a step can with a tight-fitting cover operated by a foot pedal and a disposable plastic liner. If reusable diapers are being used, put the diaper into the plastic-lined step can for those diapers or in a separate plastic bag to be sent home for laundering. Do not rinse or handle the contents of the diaper. Check for spills under the child. If there is visible soil, remove any large amount with a wipe, then fold the disposable paper over on itself from the end under the child's feet so that a clean paper surface is under the child. Remove the gloves if gloves are being used and put them directly into the step can.
<b>Step 5</b>	Put on a clean diaper: slide the diaper under the child, adjust it, apply any skin cream, ointment, or powder as authorized by the parent, and fasten the diaper. Dress the child before removing them from the diapering surface. A change of clothing will be available for each child. In addition to clothing brought from home by each child, extra, the program will have clothing on hand for changing purposes. Facility-provided clothing will be laundered after being worn by a child.
<b>Step 6</b>	Clean the child's hands, using soap and water at a sink if possible. If the child is too heavy to hold for handwashing and cannot stand at the sink, use disposable wipes or soap and water with disposable paper towels to clean the child's hands. Take the child back to the group.
<b>Step 7</b>	Clean and disinfect the diapering area: <ul style="list-style-type: none"> <li>a. Dispose of the table liner into the step can.</li> <li>b. Clean any visible soil from the changing table.</li> <li>c. Disinfect the table by spraying it so that the entire surface is wet with bleach solutions (1 tablespoon of household bleach to 1 quart of water, mixed fresh daily). Leave the bleach on the surface for 2 minutes. The surface can then be wiped dry or left to air-dry.</li> <li>d. Empty, wash, and sanitize the diaper pail at least daily.</li> </ul>
<b>Step 8</b>	Wash hands thoroughly and record the diaper change in the child's daily log.

**Parent notification**

Staff must inform the child's parent at the end of each day whenever a topical medication is applied to a diaper rash.

## 7-6 Toileting

### **Toileting area and equipment**

Toilets will be located in rooms separate from rooms in which children play, eat, and rest. Toilets will be adapted for independent use by children. In facilities that do not have child-sized toilets, safe step aids and toilet seat adapters that are easy to wash and sanitize shall be used. Toilets, step aids, toilet seat adapters, and other surfaces used by children for toileting will be cleaned and sanitized daily and when visibly soiled.

School-age children will have gender-separated bathrooms that afford individual privacy.

The director will ensure that toilet paper and holders, paper towels, soap dispensers, and disposable non-porous gloves are on hand and available within easy reach of all users. In the context of everyday supervision, they should monitor toileting areas to confirm that proper handwashing and cleaning procedures are consistently followed.

### **Toileting procedures**

Children may use the toilet at their request. In addition, there are routine times for toileting such as before rest time and before a group leaves the building to engage in outdoor play, take a walk, or go on a field trip. Children less than 5 years old and older children who require assistance will be accompanied to the bathroom by staff.

After using the toilet, children will wash their hands with soap and running water and dry their hands with a paper towel. After assisting children with toileting, staff must adhere to handwashing routines before leaving the bathroom and again before food handling.

Elementary school-aged children should also have frequent opportunities to use the toilet. Staff should remind them to wash their hands after toileting.

### **Toilet learning/training**

Program staff will adopt an individualized approach to toilet training based on the child's developmental level rather than their age and the family's readiness to carry out this learning/training at home. Staff should acknowledge and respect a family's preferences and cultural expectations for toilet learning/training. For children who have not yet learned to use the toilet, staff should not initiate toilet learning/training until the child's family is prepared to support their child's learning and the child exhibits an understanding of the concept of cause and effect, an ability to communicate; and the physical ability to remain dry for up to 2 hours.

Staff should help children achieve bowel and bladder control in a manner that instills pride and confidence. No child should be punished for soiling, wetting, or not using the toilet. Soiled or wet clothing must be placed in tightly-tied plastic bags and stored apart from other items to be sent home. While families are expected to bring in a change of clothing for their child, the program will maintain extra clothing for changing purposes.

### **Potty chairs**

Because potty chairs pose a risk of spreading infectious diarrhea, their use is not recommended. If family preference calls for their use, they will be individually assigned and stored in the bathroom. After each use, they shall be emptied into a toilet, cleaned in a designated utility sink that is not used for washing hands, and sanitized.

## 7-7 Bloodborne Pathogens Exposure Control Plan

### Introduction

In compliance with the OSHA Bloodborne Pathogens Standard, we have developed an exposure control plan to minimize the risk of exposure to bloodborne pathogens. Bloodborne pathogens are pathogenic microorganisms that are present in human blood and can cause disease in humans.

As required, the exposure control plan will be reviewed at least on an annual basis and updated when necessary.

### Rationale of OSHA standard

The OSHA Bloodborne Pathogens Standard is designed to protect workers, particularly those in the health care profession, from exposure to the hepatitis B virus (HBV), the human immunodeficiency virus (HIV), and other bloodborne pathogens. Of the diseases caused by these viruses, hepatitis B is the most common. Hepatitis B infection may lead to chronic illness such as cirrhosis and liver cancer and death. HIV causes AIDS, for which there currently is no cure and which eventually results in death. These viruses as well as other organisms that cause bloodborne diseases are found in human blood and certain other human body fluids.

### Exposure determination

The agency has determined that all early childhood, afterschool and youth-serving employees could be "reasonably anticipated," in the course of performing their job duties, to come in contact with blood and other potentially infectious materials.

### Responsibility for infection control

Responsibility for preventing exposure to bloodborne pathogens resides at all staff levels:

1. Program administrators are responsible for ensuring that facilities and programs under their management are in compliance with the exposure control plan and that appropriate post-exposure evaluation and follow-up occur after an exposure incident.
2. All center directors/site coordinators are responsible for maintaining a safe work environment that protects the employees under their supervision. This responsibility entails:
  - Assuring that all employees under their immediate direction and control are provided with bloodborne pathogen safety training;
  - Recognizing the safety and health hazards to which they may be exposed;
  - Ensuring that there are adequate supplies of nonporous disposable gloves, items contained in the first aid kits, and cleaning materials;
  - Verifying that all employees know and follow the work practices and procedures specified in the exposure control plan; and
  - Reporting and investigating any exposure incidents.
3. "At risk" employees are responsible for:
  - Attending training on the control of bloodborne pathogens;
  - Reading and understanding the agency's exposure control plan;
  - Developing good personal exposure control work habits—i.e., conducting all tasks and procedures in accordance with the exposure control plan; and
  - Informing supervisors of exposure incidents.

**Compliance methods**

This Bloodborne Pathogens Exposure Control Plan is intended to serve as a supplement to procedures already in place such as routine handwashing, utilization of nonporous disposable gloves, and spill cleanup procedures. Employees should follow standard precautions (formerly referred to as “universal precautions”) in handling any fluid that might contain blood or other body fluids. Standard precautions require treating all blood, fluids that may contain blood, and other bodily fluids as potentially infectious.

**Cleaning up bodily fluids**

Spills of body fluids, feces, nasal and eye discharges, saliva, urine, and vomit will be immediately cleaned up and surfaces sanitized:

1. Use a barrier such as disposable latex or vinyl gloves to clean it up without hand contact with the spilled material.
2. Take care to avoid getting any potentially infectious material that you are handling in your eyes, nose, or mouth or into any open sores you may have.
3. Clean and disinfect any surfaces such as countertops and floors onto which fluids have been spilled.
4. Discard fluid contaminated material in a securely sealed plastic bag.
5. Mops used to clean up body fluids will be cleaned, rinsed with a disinfecting solution, wrung as dry as possible, and hung to dry completely.
6. Wash hands afterward, even though you wore gloves.

**Laundry procedures**

Laundry such as sheets that is contaminated with blood or other potentially infectious materials should be handled as little as possible; it should not be sorted or rinsed in the area of use. Employees who handle contaminated laundry should wear nonporous gloves to prevent contact with blood or other potentially infectious materials. Such laundry should be placed either directly in an on-site washing machine (if available) or in appropriately marked bags.

**Hepatitis B vaccine**

The best way to prevent hepatitis B infection is:

1. Follow standard precautions;
2. Receive the hepatitis B vaccine.

All employees identified as being “at risk” of coming into contact with blood or other potentially infectious materials will be offered the hepatitis B vaccine, at no cost to the employee, unless they have previously received the complete hepatitis B vaccination series, antibody testing has revealed that they are immune, or the vaccine is contraindicated for medical reasons. The vaccine will be offered after the employee has received bloodborne pathogens training and within 10 working days of their initial assignment.

All employees who decline the hepatitis B vaccination must sign an OSHA-required statement indicating their refusal. If an employee initially declines the vaccine, they may choose to receive the series at any later time during their employment. If an employee is exposed to blood or potentially infectious materials on the job, they may request the series at that time. If administered immediately after exposure, the vaccine is extremely effective at preventing the disease.

The hepatitis B vaccination is given in a series of 3 shots. The second shot is given 1 month after the first, and the third shot follows 5 months after the second. This series gradually builds up the body's immunity to the Hepatitis B virus. The vaccine is made from yeast cultures; there is no danger of contracting the disease from getting the shots, and, once vaccinated, a person does not need to receive the series again. If, at a future date, the U.S. Public Health Service recommends a routine booster dose of hepatitis B vaccine, it shall be made available at the agency's expense.

### **Immediate post-exposure response**

An exposure incident is defined as skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that has resulted in the course of an employee's work. Employees should wash their hands or other skin with soap and water or flush mucous membranes with water as soon as possible following an exposure incident such as a splash of blood to the eyes. If handwashing facilities are not available (for example, on a field trip), they should use antiseptic wipes from a first aid kit. If this alternative is used, the employee should wash their hands with soap and running water as soon as possible. After an exposure incident, the employee should seek immediate medical attention at the nearest medical facility.

### **Post-exposure evaluation and follow-up**

Following an exposure incident, the exposed employee will be offered a confidential medical evaluation and follow-up, including at least the following elements:

- 1) Documentation of the route(s) of exposure;
- 2) A description of the circumstances under which the exposure occurred;
- 3) The identification and testing of the "source" individual if feasible—parents aren't required to share information about their child's hepatitis B viral status;
- 4) Testing the exposed employee's blood if they consent;
- 5) Post-exposure treatment of the employee;
- 6) Counseling;
- 7) Evaluation of any reported illness.

To help them evaluate the exposed employee, the health care professional will be provided with:

- 1) A copy of this plan;
- 2) A copy of the OSHA Bloodborne Pathogen regulations;
- 3) A description of the exposed employee's duties as they relate to the exposure incident;
- 4) Documentation of the route(s) of exposure;
- 5) A description of the circumstances under which the exposure occurred;
- 6) Medical records applicable to treatment of the employee, including whether they have received the hepatitis B vaccination series.

The evaluating health care professional will submit their written opinion on the need for hepatitis B vaccination following the exposure. The written opinion will be limited to the following information:

- 1) That the employee was informed of the results of the evaluation;
- 2) That the employee was informed about any medical conditions resulting from exposure to blood or other infectious materials that require further evaluation or treatment.

All other findings or diagnoses will remain confidential and will not appear in the written report. The employee will receive a copy of the evaluating health care professional's written opinion within 15 days of its completion.

**Employee awareness training**

All direct care and supervisory employees are required to be certified in emergency first aid and CPR. An element in our first-aid training program is learning the importance of universal precautions and body substance isolation to provide protection from bloodborne pathogens and other potentially infectious materials. Training includes a general discussion on bloodborne diseases and their transmission, appropriate work practices and use of disposable gloves, hepatitis B vaccine procedures, response to emergencies involving blood, how to handle exposure incidents, and the post-exposure evaluation and follow-up program.

**Recordkeeping**

All medical records regarding occupational exposures will be kept on file in the Business Office for the duration of employment plus 30 years. These records will remain confidential and will include the following:

- 1) The employee's name and social security number;
- 2) Their hepatitis B vaccination status (including dates);
- 3) Results of any examinations, medical testing, and follow-up procedures;
- 4) A copy of the health care professional's written opinion;
- 5) A copy of information provided to the health care professional.

All training records should be kept for on file in the Business Office for 3 years. They should indicate the dates of training, contents of the training program, trainer's name and qualifications, names and job titles of all persons attending the sessions.

## 7-8 Integrated Pest Management

Insects, rodents, and other pests can damage food, supplies, and the facility itself and can transmit diseases, including food-borne illnesses. This integrated pest management (IMP) plan is intended to control pests with the least possible hazard to people, property, and the environment.

### IPM plan development and submission requirements

State law requires that schools, early education centers, and afterschool programs prepare site-specific IPM plans that minimize the risks to children from exposure to pesticides. More information is available at the state Department of Agricultural Resources website <http://mass.gov/agr/imp>. This website includes a step-by-step process for the online development and submission of a program's IMP plan. IPM plans must be filed electronically each year with the Pesticide Bureau of the state Department of Agricultural Resources. In addition to filing these IPM plans with the Pesticide Bureau, the school, early education center, or afterschool program must keep a signed copy of the plan on the premises.

### IPM strategies

Because the long-term effects of toxic substances are unknown, the agency has a "no pesticide" policy that prevents pest infestations through sanitation, repair, and other practices.

1. Protect openings from pests. The agency will ensure that the foundation, floors, walls, ceilings, roof, windows, and exterior doors of each facility do not have openings that allow insects, flies, and rodents to enter.
  - Cover ventilation pipes, ducts, and other entry points with heavy steel mesh screen.
  - Seal all cracks in floors and walls.
  - Screen all windows and other openings used for ventilation to prevent insect entry.
2. Deny pests food and shelter. Since a clean, sanitary facility offers insects and rodents little in the way of food and shelter, the stray pest that may gain entry into the facility cannot thrive or multiply.
  - Remove garbage and waste from rooms used by children, families, and staff at the end of each day. Wash, rinse, and sanitize trash containers regularly. Keep them tightly covered and promptly clean up spills around them.
  - Store non-refrigerated food in containers with tight lids.
  - Keep all food and supplies at least 6 inches off the floor.
  - Refrigerate foods such as powdered milk, cocoa, and nuts after opening. These foods attract insects, but most insects become inactive below 41°F.
  - Clean and sanitize the facility thoroughly. Promptly clean food preparation equipment after use and remove grease accumulation from vents and stoves. Careful cleaning eliminates the food supply, destroys insect eggs, and reduces the number of places pests can safely take shelter.
  - Secure lids on trash containers outside the facility.

### Emergency pesticide applications

An emergency waiver for a pesticide application can be granted by the local Board of Health in the event that a pest problem poses an immediate threat to human health and where no viable alternatives to rectify the problem are available. The waiver allows the facility to waive the initial (2 working days) written notification requirement. Notification must be given to children, parents, and staff immediately following the emergency pesticide application.

## 7-9 Animals

While animals can provide valuable learning opportunities for children, there are significant risks of injury, infection, and aggravation of allergies from contact between children and animals. Therefore, staff must plan carefully and secure prior approval from the director when keeping animals at the facility, having animals visit the facility, and when visiting a farm, zoo, or local pet store. Staff should also consult with parents to determine special considerations needed for children who are immunocompromised, have allergies, or have asthma, which can be triggered or exacerbated by fur-bearing animals.

### **No animals with fur or feather in our facilities**

Animal allergens can trigger allergic reactions and asthma. To reduce asthma and allergy triggers, we do not keep animals or permit them in our program facilities—except to meet ADA requirements for service animals or, on rare occasions, when he host visiting live animal presentations and when students with asthma or allergies are appropriately accommodated.

### **Educational wildlife programs**

NorthStar strives to offer learning opportunities that connect children with the natural world around them, including promoting a familiarity and respect for wildlife. To that end, we on occasion bring educational wildlife programs to our facilities that are interactive and involve live animal presentations. We also visit the Buttonwood Park Zoo (New Bedford, MA), which has a focus on local wildlife.

1. On-site live animal presentations. To help children learn about animals, we on occasion arrange for educational wildlife programs to bring local animals as teaching tools to our program facilities. Before allowing any animal to visit a program facility, the teacher must submit a written request to the director that includes the educational objective, plan of care, and safety and health considerations. All animals must be in good health and show no evidence of disease. They must be presented by professional naturalists who have experience handling them and are knowledgeable regarding attending disease issues. Each program is designed to be appropriate for the age group receiving the program.

To control allergy risks, we designate specific areas in the classroom or facility grounds in which the animals are presented. After the program, we clean and disinfect all areas in the classroom where animals have been present. Outdoor live animal presentations should take place in areas where children do not routinely play or gather.

Prior to bringing animals to our program facilities, we inform parents of the live animal presentation, including its benefits and risks, and obtain written parental permission for their child to participate in the program. We do not involve infants in animal activities.

2. Field trips to the Buttonwood Park Zoo. We take children in our toddler, preschool, and afterschool programs to the Buttonwood Park Zoo, where they can look at the animals and learn about their behaviors without touching the animals.

### **Supervision of animal contact**

The following guidelines apply to both on-site and off-site supervised contact with animals:

1. When an animal isn't in its cage, it must be controlled by a naturalist who is knowledgeable about the animal and the risks it may pose.
2. Instruct children on the humane and safe procedures to follow when in close proximity to animals (e.g., not to provoke or startle animals or touch them when they are near food).
3. We do not allow infants or toddlers to have direct contact with animals.



4. All contact between animals and children must be supervised by the presenter or teacher who is close enough to ensure humane and safe treatment of the animal, prevent close contact between the animal and children's faces, and immediately remove the child if the animal seems distressed (e.g., growling, baring teeth, tail down, ears back) or the child shows signs of treating the animal inappropriately.
5. Children are not allowed to feed animals directly from their hands or have access to animal food.
6. Keep human food away from animal contact areas; do not allow animals in areas where human food and drink are prepared, served, or consumed.
7. Children and staff should wash their hands immediately after contact with animals or animal-related equipment (e.g., leashes, dishes, toys).
8. In the event of an animal bite or scratch, staff will implement an emergency response as appropriate to the situation and notify the child's parent or their emergency contact as soon as practical.

**Service animals**

Trained dog guides or service animals in use by a person with a disability are allowed in our facilities. The director may ask the person if the animal is a service animal, what training the animal has received, and what service the animal provides.

## 7-10 Plants

Plants can have curricular, health (producing oxygen), and aesthetic value in children's programs. Many plants are essentially nontoxic when ingested in small to modest amounts. The director will be responsible for checking that all plants that are accessible to children receive the appropriate care instructions and meet the following guidelines:

1. Don't introduce plants that are poisonous, generate a lot of pollen, or drop small flowers or leaves.
2. Regularly dust plants.
3. Do not allow children to put plants in their mouths and teach them never to eat unknown plants.
4. Have children and staff follow handwashing procedures after handling plants.

Staff should phone the Poison Control Center before treating a child who has eaten a plant not known to be safe and follow their instructions. Their parent should be immediately notified.

<b>Poisonous Plants (not a complete list)</b>		<b>Safe Plants (not a complete list)</b>
<p><b><u>Flower garden plants</u></b>            Autumn Crocus            Bleeding heart            Chrysanthemum            Daffodil            Four-o'clocks            Foxglove            Hyacinth            Hydrangea            Iris            Jonquil            Lily of the valley            Morning glory            Narcissus            Snow of the mountain</p> <p><b><u>Trees and shrubs</u></b>            Black locust            Boxwood            Chokeberry            Elderberry            English yew            Ground ivy            Holly            Horse chestnut            Juniper            Oak tree            Rhododendron            Water hemlock            Yew</p>	<p><b><u>House plants</u></b>            Bird of paradise            Castor bean            Dumbcane            English ivy            Rosary Pea            Jerusalem cherry            Mistletoe            Mother-in-law            Oleander            Philodendron            Poinsettia</p> <p><b><u>Wild plants</u></b>            Belladonna            Bittersweet            Buttercups            Jack-in-the-pulpit            Larkspur            Monkshood            Mushrooms (certain ones)            Nightshade            Poison ivy, oak, sumac            Skunk cabbage</p> <p><b><u>Vegetable garden plants</u></b>            Asparagus            Sprouts, green parts of potato            Rhubarb leaves            Green parts of tomato</p>	<p>African Violet            Aluminum Plant            Anthurium, Taliflower            Aphelandra            Baby tears            Begonia            Blood leaf            Boston fern            Christman cactus            Coleus            Corn plant            Dracaena            Emerald ripple            Hen-and-chickens            Hoya            Impatiens            Jade Plant            Parjor palm            Pepronia            Prayer plant            Rubber plant            Schefflera            Sensitive plant            Snake plant            Spider plant            Swedish ivy            Velvet, purple passion            Wandering jew (inch plant)            Wax plant            Weeping fig            Yellow day lily</p>

## 8. Food Preparation, Handling, and Feeding

Part 8 mainly pertains to our EEC-licensed programs, which serve meals and snacks through the child care component of the U.S. Department of Agriculture (USDA), Child and Adult Care Food Program (CACFP). Our participation in CACFP helps give children and youth the nutrition they need.

### 8-1 Food Safety

All food and beverages must be stored, prepared, and served in ways that keep them clean, free from spoilage, and safe for human consumption. All meals and snacks and their purchase, preparation, storage, and service will meet the age-appropriate meal and snack requirements of the child care component of CACFP and all applicable state and local food service regulations.

#### **Requirements for a safe food supply**

To promote safe, healthy eating, only pasteurized dairy products and juices should be served. Fruits and vegetables must be washed thoroughly with water before use, since soil particles and contaminants on fruits and vegetables can cause illness.

#### **Food storage**

All foods should be stored in ways to protect them from contamination:

1. All foods stored in the refrigerator except fresh, whole fruits and vegetables must be covered or wrapped to protect them from contamination.
2. Refrigerators will be maintained below 40°F. Freezers will be maintained below 0°F.
3. Food that does not require refrigeration will be stored in their original, unopened containers at least 6 inches above the floor in clean, dry, well-ventilated areas.
4. Food that has been served and not eaten from individual plates, containers, and family-style serving bowls should be discarded.

## 8-2 Food Service Plan

Children develop their attitudes toward food and eating habits early on in life. Research indicates that a well-balanced diet coupled with regular age-appropriate physical activity can reduce risk of chronic diseases later in life. A primary responsibility of early childhood education and afterschool programs is to provide food learning experiences for children and to foster good nutritional habits. At no additional cost to families, our licensed early childhood education and afterschool programs provide children breakfast, lunch and mid-morning and mid-afternoon snacks that are appetizing, nourishing, and varied. Lunches are prepared by an off-site food service provider.

### **Compliance with food service requirements**

The director of early education and care is responsible for ensuring that our nutrition program fully complies with nutrition and food service guidelines. One of their duties is to arrange for staff to receive training on USDA food service requirements, choking prevention, and other food-related health and safety issues.

### **Off-site preparation and transportation of food**

Contracted food service providers are expected to fully comply with all food safety requirements. Any off-site facility as which food is prepared is required to have a food service permit or evidence of inspection from the municipal health department. Food must be transported in approved insulated meal carriers. Hot foods must be kept at or above 140°F after they are fully cooked; cold foods must be kept at or below 40°F. These temperatures have to be maintained until the foods are served. Staff at the receiving facility will check and log food temperatures using a food thermometer.

### **Menus**

Reviewed and approved by the director of early education and care, menus will include familiar foods that represent the children's cultures and a variety of nutritious foods with which children may not be familiar. In the context of learning good eating habits, children will have developmentally-appropriate opportunities to participate in menu planning. A current weekly menu will be posted in a prominent location to inform parents about food served in the facility. We provide copies of the menu to parents upon request. Making the menus available to parents in this way can help inform them about proper nutrition. The facility will date and keep these menus on file. The menus will be amended to reflect any changes in the food actually served. Any substitutions should be of equal nutritional value.

### **Special nutrition or feeding issues**

When a parent informs staff that their child has special nutrition or feeding issues, the program shall require written documentation of the reason. If the dietary restriction is because of the family's religious beliefs or preferences, the parent must provide a complete list of specific foods to be avoided. The list will be kept in the child's file, while a copy will be conspicuously posted in the child's classroom and/or wherever food is served.

If the nutritional or feeding issues stem from a medical condition, the program shall require a special care plan prepared by the child's health care provider that indicates:

- 1) The child's special requirements relating to diet, swallowing, and related feeding needs, including any foods to be excluded from their diet and any foods to be substituted;
- 2) Procedures to follow when a food-related situation requires rapid staff response;
- 3) Any other relevant information about the child's special needs.

### **Availability of drinking water**

Water must be offered to children at frequent intervals and upon a child's request.

## 8-3 Inclusion of Children with Food Allergies

An estimated 8% of children have food allergies, with young children affected most. Food-allergic children should not be excluded from program activities solely based on their food allergy.

### **Parental responsibility**

Parents, with the help of the child's health care provider, must:

1. Inform the program of the child's allergies.
2. Work with program staff to develop a plan that accommodates the child's needs throughout the program's schedule of activities as well as an individualized Food Allergy Action Plan.
3. Provide written medical documentation, instructions, and medications as directed by the child's health care provider, using the Food Allergy Action Plan as a guide.
4. Provide properly labeled medications and promptly replace medications after use or upon expiration.
5. Educate the child, in accordance with their age and ability to understand, in the self-management of their food allergy, including:
  - Safe and unsafe foods;
  - Strategies for avoiding exposure to unsafe foods;
  - Symptoms of allergic reactions;
  - How and when to tell an adult they may be having an allergy-related problem;
  - How to read food labels.
6. Review policies and procedures with the program staff, the child's health care provider, and the child (if age-appropriate) after a reaction has occurred.
7. Provide current emergency contact information.

In most cases, staff will be able to provide safe foods, provided that they have detailed information on the specific foods to be avoided. In other cases, especially for children with multiple food allergies, the parents may have to take responsibility for providing all or most of the child's food.

### **Program responsibility**

Staff must make the program environment and activities as safe as possible for the food-allergic child by working closely with the child's parents, the child's health care provider, and the child themselves:

1. Review the health records submitted by parents and their child's health care provider.
2. Have the center director/program coordinator work with parents and their children (if developmentally-appropriate) to establish and, as needed, revise prevention plans.
3. Ensure that all program staff, including drivers who transport children, understand food allergies and effective food avoidance, can recognize symptoms, and know what to do in an emergency. Work with program staff to reduce the food-allergic child's exposure to problem foods, including:
  - Discouraging food-sharing between children through close supervision and repeated instruction;
  - Avoiding the use of food products in projects/activities, displays, and classroom/ program celebrations;

- Washing children’s hands and faces and cleaning all surfaces that were in contact with food;
  - Establishing and enforcing a “no eating” policy on vehicles transporting children between their homes and the facility.
4. Prominently post individual child’s food allergies in the classroom and/or wherever food is served.
  5. Ensure that the facility has the necessary medications, that they are appropriately stored, and that an emergency kit is available that contains a physician’s standing order for epinephrine. Epinephrine should be kept in a secure but unlocked location that is easily accessible to delegated program staff.
  6. Allow children to carry their own epinephrine, if age- and developmentally-appropriate, after approval from the child’s health care provider and parent.
  7. Designate appropriately trained program staff to administer epinephrine in an emergency. Be prepared to handle an allergic reaction. Ensure that an appropriately trained staff member is accessible and available at all times during the program day to promptly and properly administer prescribed medications in the event of allergic reaction according to the child’s Food Allergy Action Plan.
  8. Develop a plan that enables food-allergic children to safely participate in off-site events and field trips, including:
    - Evaluating the appropriateness of trips when considering the needs of students—e.g., a trip to a dairy farm should not be scheduled for a class with a milk-allergic student;
    - Discussing the off-site event or field trip with the family of the food-allergic child to decide appropriate strategies for managing the food allergy;
    - Bringing the food-allergic child’s Food Allergy Action Plan and medications;
    - Identifying the food-allergic child to staff and chaperones who will be supervising children during the event or trip, what foods they must avoid, symptoms of an allergic reaction, and who will be carrying the child’s emergency medications;
    - Ensuring that the child’s emergency medications go wherever the child goes;
    - Carrying a cell phone to place emergency calls, if necessary, and making certain all staff and chaperones know who has cell phones;
    - Finding out where the nearest hospital is from the field trip destination and having a plan to transport the child there in case of an emergency;
    - Designating a staff member to check the safety of any food served to that child and effective avoidance of problem foods.
  9. Practice the Food Allergy Action Plans before an allergic reaction occurs to assure their effectiveness.
  10. Take the food-allergic child’s complaints seriously. If they tell staff that they are not feeling well, compare the symptoms with those listed on their Food Allergy Action Plan. If the child is having an allergic reaction, promptly administer prescribed medications. (If epinephrine is administered but not needed, the child may experience increased heart rate and nervousness. A delay in the administration of emergency medication, particularly epinephrine, can result in a severe or fatal allergic reaction.)
  11. Notify parents of any suspected allergic reactions, their child’s eating the problem food, or their contact with the problem food, even if a reaction did not occur.

12. Notify the child's health care provider if the child has received treatment by the facility for a food allergic reaction. Contact the emergency medical services system immediately whenever epinephrine has been administered.
13. Advise parents of all children in the child's group to avoid any known allergies in treats or special foods brought into the facility for the group.
14. Review policies and prevention plans with program staff, the parent, the child's health care provider, and the child themselves (in a developmentally-appropriate manner) after a reaction has occurred.
15. Follow federal and/or state laws and regulations regarding sharing medical information about the student.
16. Interrupt and address harassment against a food-allergic child. Educate children about the nature of food allergies.

**Child's responsibility**

In accordance with their developmental level, food-allergic children should be encouraged to take an increasingly active role in the care and management of their food allergies and reaction:

1. Children shouldn't trade food with others.
2. Children shouldn't eat anything with unknown ingredients or known to contain any food allergens.
3. Children should notify an adult immediately if they eat something they believe may contain the food to which they are allergic.

## 8-4 Food Brought from Home

Parents have the option of sending meals and snacks from home. Received by parents during the enrollment process, the Family Handbook contains a written list of nutritious foods for families who want to send meals from home.

1. Food brought from home will be labeled with the child's name and the date. Perishable home-provided foods that require refrigeration will be kept below 40°F.
2. Leftover food will be discarded. The only food that may be returned to the family is food that does not require refrigeration, that arrived at the facility in a commercially-wrapped package, and that was never opened.
3. While we support parent choice regarding foods their children eat, we will supplement a child's home-provided meal if the nutritional content seems to be inadequate. Staff will inform the parent if food brought from home is being supplemented on a regular basis. Staff will check for food allergies before providing supplemental food.
4. Perishable food brought from home to be shared with the other children must be store-bought and in its original package. Baked goods may be made at home if they are fully cooked, do not require refrigeration, and were made with newly purchased ingredients. There must be enough for all the children.



## 8-5 Nutrition for Infants

Staff will work closely with every parent to provide healthy, developmentally-appropriate food for infants and toddlers. Staff involvement in feeding infants will reflect their understanding that feeding and eating experiences factor importantly in infants' relationship-building, aid in their motor coordination, cognitive, language, and social skill development, shape their attitudes about food, and promote long-term healthy eating habits.

### **Breastfeeding promotion policy**

Breastfeeding is widely recognized around the world as the healthiest method of infant feeding. We support and encourage the breastfeeding mother's decision to continue to breastfeed her child. In keeping with this philosophy, our program will:

1. Provide a welcoming atmosphere that encourages mothers to initiate and continue breastfeeding after returning to work or school.
2. Train staff on the benefits of breastfeeding and on the practices that support a breastfeeding mother.
3. Train staff on how to store, handle and feed expressed human milk.
4. Provide a designated space for mothers to breastfeed their children on site (such as a rocking chair).

Staff will accept human milk in ready-to-feed sanitary containers labeled with the infant's name and date and store it in a refrigerator for no longer than 48 hours (or no more than 24 hours if the breast milk was previously frozen) or in a freezer at 0°F or below for no longer than 3 months. Staff will gently mix, not shake, the milk before feeding to preserve special infection-fighting and nutritional components in human milk.

### **Infant feeding guidelines**

Programs will provide food appropriate for each infant's individual nutrition requirements and use safe, developmentally-appropriate approaches to feeding infants. During the enrollment process, individualized plans for feeding infants will be developed with their parent. General guidelines for feeding infants include:

1. Except for human milk, staff will serve only formula and infant food that comes to the program in factory-sealed containers (e.g., ready-to-feed powder or concentrate formulas and baby food jars) prepared according to the manufacturer's instructions unless documented otherwise in writing. Parents may send it prepared. Formula sent from home will be labeled with the child's name.
2. Bottle warming. Bottle warmers, microwave ovens, and crockpots cannot be used to warm infant bottles or other infant foods. The safest approach is to serve bottles either cold or at room temperature. If parents ask to have an infant's bottle warmed before feeding, the bottle may be held under warm running water or placed in a container of warm tap water. The container of water must not be heated on the stove or in a microwave. The temperature of the water cannot exceed 120°F. The container should not be accessible to children or placed where it could tip or fall into the children's area. The educator should not hold an infant while removing the bottle from the warm water. Bottles must not be left to warm for more than 5 minutes. After warming, bottles shall be mixed gently and the temperature of the milk tested before feeding. The milk or formula should feel warm, but not hot. (Excessive shaking of human milk may affect the nutritional value as may excessive heating.)
3. Bottles must be individually identified with a label that won't come off during washing or handling.

4. Bottle feedings must not contain solid foods unless the child's health care provider provides written instructions to do so.
5. Staff should respond to infants' need for food in a flexible manner and feed them "on demand" unless the parent and the child's health care provider give written instructions to the contrary. An immediate response to the infant, demand feeding meets an infant's emotional as well as nutritional needs.
6. For bottle feeding, staff members should always hold infants who are unable to sit. Whenever possible, the same staff member will feed an infant during most of that infant's feedings. Early relationships between an infant and caregiver involving feeding serve as a foundation for an infant's development of lifelong eating behavior.
7. A staff member will bottle feed only 1 infant at a time.
8. For safety and sanitation reasons, infants can't have bottles in their crib or carry bottles with them.
9. Staff should discard after 1 hour any human milk or formula that is served but not completely consumed or refrigerated.
10. After each use, bottles, bottle caps, nipples, and other equipment used for bottle feeding must be cleaned and sanitized.
11. Only formula or breast milk will be served to infants under 12 months old. Only whole, pasteurized milk will be served to children between 12 and 24 months old who are not on formula or breast milk. Skim milk, reconstituted nonfat dry milk, and 1-2% milk will not be served to children younger than 24 months old, except at the written direction of the child's parent and the child's health care provider.

### **Feeding solid foods to infants**

Close communication and collaboration with parents is critical in appropriately feeding the infants in your care as they develop. The parent, the infant's doctor, and you can all help inform the appropriate introduction of solid foods at home and in the program. Strongly recommended is that feeding age-appropriate solid foods should occur no sooner than 4 months and preferably at 6 months. Age-appropriate solid food given before an infant is developmentally ready may be linked with allergies and digestive problems.

Commercially packaged baby food should be served from a bowl or cup and not directly from the commercial container unless the entire container will be used for one feeding. Uneaten food in dishes should be thrown away.

Staff should cut foods into pieces no larger than a quarter-inch square for infants, according to each child's chewing and swallowing capability.

## 8-6 Healthy Food and Eating Practices

The importance of providing nourishing food in adequate amounts for infants also applies to toddlers, preschoolers, and school-age children.

### **Staff role in promoting good nutritional practices**

Positive staff attitudes and enthusiastic, creative food presentation are essential to successful introduction of nutritious foods and promotion of good nutritional habits. Staff members who work directly with children will teach, model, and otherwise encourage good eating practices among children and their families. Food brought to the facility by staff will be stored in the kitchen and eaten only during break periods when away from the children.

### **Safe eating**

Staff cut foods into pieces no larger than ½-inch square for toddlers/twos, according to each child's chewing and swallowing capability. Staff don't offer children under 4 years old the following foods:

- Hot dogs, whole or sliced into rounds;
- Whole grapes;
- Nuts;
- Popcorn;
- Raw peas;
- Hard pretzels;
- Spoonfuls of peanut butter;
- Chunks of raw carrots or meat larger than can be swallowed whole.

Staff ensure that children are seated when eating to reduce the possibility of choking.

### **Meal and snack times**

Meal and snack times are opportunities to promote healthy eating as well as development of motor coordination, cognitive and social skills.

1. Staff should encourage toddlers to use their fingers and/or a spoon to feed themselves and to hold and drink from a cup.
2. Children should have opportunities to help set the table, serve food, and clean the table. Use of small pitchers, limited amounts in service dishes, and staff assistance enable preschool children to learn how to serve themselves. Children's involvement in serving food promotes independence, motor skill development, language development, and social competence. Staff should closely supervise and assist children in family style service to prevent contamination or waste of food.
3. Children should eat in social groups with staff members, who encourage appropriate conversation, interaction, and eating behavior. Children with disabilities will fully participate in meal and snack times with their peers. Snack and mealtimes should be positive, relaxed occasions in which children can eat at a reasonable, leisurely rate.
4. Children should be encouraged to eat a variety of nourishing foods, but not forced to eat a specified food or amount of food. Food should not be offered as a reward or denied as a punishment.
5. Staff should ensure that each child receives an adequate amount of food. If a child misses a meal or snack because of a deviation from their regular schedule (such as arriving late or leaving early), they should be offered food of equal nutrient value.
6. Staff should offer age- and individually-appropriate alternative activities for children who have finished their snack or meal.

## 9. Rest and Sleep Policy

Consistent use of safe rest and sleep practices contributes importantly to the healthy development and well-being of children.

### 9-1 Opportunities to Rest

Our early education programs provide a rest period each day that accommodates the individualized rest needs of children—a period of tranquility that can include the child being asleep or engaged in quiet activities. Accordingly, staff should avoid behavior guidance strategies in the context of rest time that lead a child to associate the rest environment, which should be calm and secure, as a disciplinary setting.

Children who do not fall asleep or awaken early are offered quiet developmentally-appropriate activities (e.g., books, board games, drawing) for the remainder of the rest period. All children who fall asleep are closely monitored, with specific attention to their breathing patterns.

On days our afterschool program operates on a full-day schedule, we offer a quiet time when children can read, write, play board or card games, or do a visual art project.

#### **Unscheduled rest opportunities**

Outside of scheduled rest time, toddlers, preschoolers, and school-age children can rest or engage in quiet, solitary play in a readily-monitored area away from group activities.

#### **Infants**

Each infant is assigned their own individual crib. The crib mattress is lowered to protect a baby who can push up on their hands and knees, sit, or stand.

Each infant also has their own sleeping schedule, reflecting their internal “clock” and parent preferences. Staff record each infant’s sleeping time for their parents.

#### **Transitioning an infant from a crib to a cot**

Typically, we move a child at 12 months old from sleeping in a crib to a cot. In deciding whether or not to move the infant to a cot, we consider in consultation with their parent:

- 1) The infant’s size and whether they are developmentally ready to move from a crib to cot—e.g., when they are able to independently stand up in their crib;
- 2) Any medical reasons that would conflict with moving the infant to a cot.

We also consider whether we can ensure that all infants sleeping on cots can be safely evacuated without delay. To this end, we:

- 1) Review and update evacuation procedures if necessary;
- 2) Conduct emergency evacuation drills without the cribs so that staff and children are familiar with the new procedure.

## 9-2 Safe Sleep for Infants

Sudden Infant Death Syndrome (SIDS) is the unexpected death of a seemingly healthy infant for whom no cause of death can be determined. It is the leading cause of death in children under 1 year old. Most SIDS deaths are associated with sleep. To reduce the risk of SIDS, we follow the recommendations of the American Academy of Pediatrics (AAP) and the Consumer Product Safety Commission on safe sleep practices for infants up to 1 year old. Where infants are at increased risk for dying from SIDS in early childhood programs, we are especially vigilant in providing the safest sleep environment for the infants in our care.

### **Infant sleeping position**

Back to sleep. We place babies up to 1 year old on their backs for sleeping, unless the baby's health care provider orders otherwise in writing. While we put infants to sleep on their backs, once they can roll over on their own, we let them adopt their own position of comfort.

Special care plan. We require a physician to complete a special care plan for a non-back sleeper that explains the medical need for a different position, how the infant should be placed to sleep, and how long the instructions should be followed. We will keep this special care plan on file and inform all staff, including substitutes and volunteers, of this special situation. We will also put a sign on the baby's crib indicating how they should be placed to sleep, without indicating their medical condition.

### **Infant sleeping equipment**

1. Use a firm sleep surface. We use safety-approved cribs and firm, tightly fitting mattresses covered with a fitted sheet.
2. Keep soft objects and loose bedding out of the crib. We follow the AAP recommendation that infants should sleep in a bare crib with no pillows, quilts, comforters, sheepskins, stuffed toys, or other soft objects.
3. If an infant falls asleep in a car seat on the way to the program, we move them to their crib or cot. In the process, we may remove outdoor clothing so that they aren't dressed too warmly.

### **Putting an infant to sleep**

1. We won't put a baby to sleep sucking on a bottle, since that puts them at risk of choking and ear infections.
2. After feeding and before putting an infant to sleep, we gently wipe any milk residue from their gums. Allowing babies to fall asleep with milk pooled in their mouth can lead to serious dental caries in their developing teeth.
3. Use of a pacifier. If an infant uses one to go to sleep, we offer them a pacifier (without a cord or clip, which pose a strangulation risk) while putting them down to sleep. We don't put the pacifier back in their mouth if it falls out while they are asleep. We clean pacifiers between each use and regularly check them for tears.
4. When an infant falls asleep in a stroller when their class is outside, we follow safe sleep procedures, including making sure:
  - They are supervised all the time;
  - Nothing interferes with their breathing (stroller straps secure but not too tight, no blankets or soft objects in the stroller);
  - They are positioned so they can breathe freely;
  - They aren't overheated by being overdressed.

**Active supervision of infants' safe sleeping**

We actively supervise infants by sight and sound at all times, including when they are going to sleep, are sleeping, and are in the process of waking up. We make sure the infant's head remains uncovered and readjust their clothing as needed. We ensure that room lighting allows the teacher to see each infant's face, to view the color of their skin, and to check on their breathing and placement of the pacifier (if used).

**Not just "Back to Sleep," but "Tummy Time" too**

To address concerns about positional plagiocephaly (flat head or flat spot on head)—usually from back sleeping—we provide supervised "tummy time" daily, when an infant is awake and alert. This measure not only takes pressure off the back of their head, but also allows the infant to stretch and strengthen their head, neck, shoulder and back muscles they will need to learn important motor skills (e.g., how to push up, roll over, sit up, crawl, and pull to a stand).

**Staff training**

All staff, substitute staff, and volunteers have to be trained on safe sleep practices before they are allowed to care for infants. Training addresses the importance of consistent use of safe sleep practices, along with providing direct, active, and ongoing supervision when infants are falling to sleep, sleeping, or becoming awake. We keep documentation of training completion on file.

All staff who work with infants are required to renew their safe sleep training with each 2-year licensing cycle.

**Ensuring compliance**

We closely monitor infant-toddler classrooms to make sure safe sleep practices are consistently followed:

1. At least weekly, the on-site director conducts unannounced, random checks of the infant-toddler rooms to ensure compliance with required safe sleep practices for infants under 1 year old. Available for EEC review, documentation of these checks includes the date and times they are conducted, teachers present, number of children, and what was observed.
2. If EEC finds noncompliance, we take immediate steps to correct it, retrain all educators in infant safe sleep, and notify parents as required by EEC.

**Educating parents**

Recognizing the important role early childhood providers have to play in SIDS prevention, we freely give written information on SIDS risk reduction practices to parents of infants, whether or not they are interested in enrolling their child in our program.

1. During the enrollment process with parents of infants, we discuss SIDS risk reduction and our safe sleep practices to prevent SIDS. We also encourage consistent use of safe sleep practices at home.
2. When we refuse parental requests that are at odds with safe sleep practices, we try to offer safer options—for example:
  - If a parent wants a blanket to be used, we recommend using sleep clothing with no other covering over the infant or infant sleep sacks designed to keep the infant warm without the possible hazard of head covering.
  - If a parent brings in a special sleep toy for their infant, we explain that our safe sleep plan disallows stuffed animals or other padded material in cribs, but that we can use the special sleep toy to comfort their baby before we put them down to sleep.