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Health and Safety Requirements for Program Reopening during the COVID-19 Pandemic

Section 1: Program Administration

In the process of reopening our Department of Early Education and Care-licensed early childhood education and school-age/afterschool programs during the ongoing coronavirus disease 2019 (COVID-19) pandemic, we are instituting the following health and safety requirements to protect staff, children, and their families from the community spread of COVID-19, while providing for the continuity of teaching and learning.

The following policies and procedures are consistent with EEC and other applicable state requirements and informed by the US Centers for Disease Control and Prevention (CDC) guidelines. We will continue to collaborate, share information, and review plans with the City of New Bedford health officials to help protect the whole community, including those with special health needs and other high-risk populations. Prior to reopening, we will train all employees on our new health and safety protocols. As additional information becomes available, we will update these health and safety policies and protocols to prevent the spread of COVID-19 among our staff, children, and their families.

Program Name- NorthStar Learning Centers, Inc.
Designated Administrator responsible for preparedness Plan: The following administrators will be responsible for the implementation and monitoring of the preparedness plan**.**

1. **Site:** Shawmut Avenue Center
   Contact: Marlene Barros, Director of Early Education & Afterschool Programs
   Telephone: (508) 415-9242
   Email: mbarros@northstarlc.org

2. **Site:** Business Park Center
   Contact: Jennie Antunes, Center Director
   Telephone: (508) 863-1267
   Email: jantunes@northstarlc.org

3. **Site:** NorthstarLC-SCHOONER Afterschool Program
   Contact: Jewel Collins, Afterschool Program Director
   Telephone: (508) 971-2945
   Email: jcollins@northstarlc.org

STAFF PLAN:

Staff training and support

Prior to reopening, we will train staff in all areas of program operation to ensure protocols are implemented safely and effectively in all programs. Specifically, training will cover:

(1) Information about COVID-19, including how the illness is spread, how to prevent its spread, symptoms, and when to seek medical assistance for sick children or employees.

(2) The hazards of the cleaning products used in the programs in accordance with Occupational Safety Hazard Administration (OSHA)'s Hazard Communication standard (29 CFR 1910.1200).

(3) When to use PPE, what PPE is necessary, how to properly put on, use, and take off PPE, and how to properly dispose of PPE;

(4) Our current sick leave policy in the context of promoting the importance of staff not coming to work if they have COVID-19 symptoms (e.g., a frequent cough, sneezing, fever, difficulty breathing, chills, muscle pain, headache, sore throat, or recent loss of taste or smell) or if they or someone they live with has been diagnosed with COVID-19;

(5) Instructions on what to do if they develop symptoms. At a minimum, any staff member must immediately notify their supervisor and the City of New Bedford health department if they develop symptoms of COVID-19. The health department will provide guidance on what actions need to be taken.

We will encourage all staff age 65 or older or with serious underlying health conditions to talk to their healthcare provider to assess their risk and to determine if they must stay home or follow additional precautions.

Group size and staffing

Required ratios and maximum group sizes. To provide the level of supervision required to adhere to these health and safety requirements, the following staff-child ratios for different program types must be maintained at all times during the program day**.**

Programs will meet all EEC staffing requirements for their specific program types. To maintain required staffing levels, we have a plan for securing trained back-up staff.

Age	Staff-Child Ratio		Maximum Group Size
Infant (birth—14 months)	1:3	2:7	7
Toddler (*15 – 32 months)*	1:4	2:9	9
Preschool (≥*33 months up to kindergarten)*	1:10		10
School-age *(elementary school-aged)*	1:10		10

Following are guidelines on managing ratios and group sizes:

1. Children should remain in groups as small as possible. Programs may assign children to multiple groups of 10, provided physical distancing is maintained between and within groups. When dividing rooms, create a clear barrier with cones, chairs, tables, etc. to ensure a minimum 6 feet of distance.

2. The number of adults assigned to each group of children should be minimized, appropriate to the needs of the program and the children. Most importantly, adults should not move between cohorts of children.

3. Just as it is important to maintain staff continuity, so we will strive to keep the same children with each group and include children from the same family in the same group, to the greatest extent possible.

Preventing COVID-19 spreading in program facilities

Recommended is to supply as much outside air as possible. Specifically:

1. Increase air supply and exhaust ventilation. Expanded operation times are recommended for buildings with mechanical ventilation. Consider keeping the ventilation on 24/7 with lower ventilation rates when people are absent. Exhaust ventilation systems of toilets should be left on 24/7.

2. Use more window-driven natural ventilation. Even in buildings with mechanical ventilation, open windows can be used to boost ventilation. Increase circulation of outdoor air as much as possible by opening windows and doors, using fans (must be inaccessible to young children), and achieving crossflows through buildings. Don't open windows and doors, however, if doing so poses a safety or health risk (e.g., allows pollen in or exacerbates asthma symptoms) to children in the facility.

Other risk-reduction strategies

1. No field trips, events, or extracurricular activities will be conducted in our programs to avoid non-essential individuals from entering the program space.

2. Where feasible and subject to prior approval, administrative staff should telework from their homes.

Classroom space / Physical distancing

Strategies to Reduce the Transmission of COVID-19

It is understood that educating young children while maintaining physical distancing is especially difficult because they learn best from active interaction with other children and adults. To prevent the spread of COVID-19, however, programs must attempt to maintain at least 6 feet of distance at all times and limit contact between individuals and groups, whenever possible.

Physical distancing of at least 6 feet must be encouraged for children and staff at all times, including, but not limited to, during all activities (e.g., meal times, napping), transitions (e.g., waiting for bathrooms, going/returning from outdoors), and transportation (e.g., on buses).

To support a physical distancing of 6 feet between individuals, programs must have a minimum of 42 square feet per child, with 144 square feet per child being the ideal, to maintain proper physical distancing. Decisions about organization of the program space must be guided by the program's ability to implement adequate and consistent physical distancing, especially in terms of use of common spaces that need to be shared by all children. Program staff must review the physical distancing requirements for children in the program and be prepared to support children with adjustment to new systems and routines.

1. Spaces for children must be organized in a way that allows staff to enforce and maintain consistent physical distancing guidelines. Rearrange furniture and play spaces to maintain 6 feet of separation, when possible. Areas occupied by individual groups must be defined by permanent walls, movable walls, or other partitions.

2. Remove all communal water, sand, and sensory tables and activities that bring children in close proximity with each other and involve shared materials.

3. Offer more opportunities for individual play, including setting up individual play activity stations like puzzles and art. Space activity areas/centers as far apart as possible.

4. Ensure adequate supplies to minimize sharing of high-touch materials to the extent possible (art supplies, equipment, etc. assigned to a single child per use) or limit use of supplies and equipment by one group of children at a time and clean and disinfect between uses. If possible, touchless trash cans should be utilized and located throughout the program space.

5. Use opportunities to reduce time spent indoors by bringing children outside, weather permitting. Stagger groups' outdoor play to maintain physical distancing. Confine outdoor activities to program grounds. Limit travel off the program facility premises for all children and staff, including canceling all field trips and interagency, or program, groups and activities.

6. Refrain from games and activities that encourage physical contact or proximity of less than 6 feet, like tag or circle time.

7. Put each child's meal on a plate, to limit the use of shared serving utensils.

8. For napping, place cots, cribs, and mats 6 feet apart, with heads in opposite directions.

9. Discontinue activities that require or may require direct staff support, close contact, or rescue, except where necessary to support participation for children with special needs.

10. Provide individually labeled storage containers or cubbies where children's belongings do not touch.

Food Service Plan

To promote food safety:

1. Meals and snacks will be served in children's classrooms, in accordance with physical

distancing guidelines.

2. Meals will no longer be served family-style; staff will prepare each child's plate so that multiple children are not using the same serving utensils.

3. Whenever possible, snacks must be pre-packaged or ready to serve in individual portions to minimize handling and preparation.

4. Eating utensils, cups, bottles, and food should never be shared with other children.

5. Sinks used for food preparation must not be used for any other purposes.

6. Staff must ensure children wash hands prior to and immediately after eating.

7. Staff must wash their hands before preparing food and after helping children to eat.

8. Tables, chairs, high chairs, and high chair trays used for meals need to be cleaned and sanitized before and after use.

9. All food contact surfaces, equipment, and utensils used for the preparation, packaging, or handling of food products must be washed, rinsed, and sanitized before each use. Additionally, programs must frequently clean non-food contact surfaces, such as doorknobs, tabletops, and chairs. Use sanitizers approved by the EPA for use against COVID-19 and for food-contact surfaces.

10. When disinfecting for COVID-19, use an EPA-registered disinfectant and follow the label directions for food-contact surfaces when using the chemical near or on utensils and food-contact surfaces. Make sure to follow the contact time, which is the amount of time the surface should be visibly wet.

Section 2. PARENT COMMUNICATOIN

Sharing Information with Families

Exposure or illness

In the event there is a spread or someone has be identified with the COVID-19 virus. We will take the following steps to notify families. The program will report the exposure to the local Health Department and will seek guidance on the steps to take, i.e., classroom or program closure.

The program director or the designated administration in their absence will notify families by phone as well as written notification and the steps the program has in place according to the recommendation of our local health department.

The goal of the parent communication plan is to ensure reasonable measures are in place to:

1. Communicate with families should an exposure or positive case occur;

2. Ensure family interactions support the prevention of illness and infection at drop off and pick up;

3. The program will have current telephone numbers and email addresses on families to ensure they are reachable during program hours of operations either by mobile or work telephone numbers.

Even while maintaining social distance, we will continue building relationships with families, including letting parents know that we are thinking about their family. Staff will have regular phone and electronic communication with families. Besides providing important information, we need to keep updated on how parents are feeling and doing during these challenging, uncertain times; offering compassion and caring can reduce parental stress.

We will reach out to families in a variety of ways to ensure that all parents receive critical information and feel connected about reopening our programs, including our new health and safety protocols, how we will work closely with state and local health departments, and afford parents the opportunity to ask questions and express their concerns. Prior to reopening, we will conduct a Zoom meeting as well as providing information by email, direct postal mail, phone, texting, and group messaging—all the while keeping in mind that some families may not have internet access. Communication will be conducted in English and Spanish. With social distancing a barrier to direct communication, we will find out how each parent prefers to stay in touch. We will obtain parents' email addresses and home, work, and mobile phone numbers so that we can reach them at any time. Where COVID-19 prevention policies limit direct contact with parents, we are developing a system to check with parents daily on the status of their children when children are dropped off at the facility.

We will send new consent forms by email and, for families who do not have internet access or are not comfortable with email communication, by direct postal mail. We will provide information to parents about:

a) COVID-19, including symptoms, transmission, prevention, when to seek medical attention, information on COVID-19 testing locations and how to share information with their children in developmentally-appropriate ways
b) New health and safety protocols for preventing and responding to infection and illness, including parents' responsibility to self-screen at home prior to coming to the program for the day and, upon arrival at the program facility screening children and parents before the child is allowed to enter the program facility

To prepare for the potential of program attendees or staff showing symptoms while at the program, programs will have a response and communication plan in place that includes informing staff, families, and the city health department. If a child becomes symptomatic at the program, their parent would be immediately notified and requested to pick up their child as soon as possible. The following staff members will be responsible for sharing information with parents in the event of exposure or illness at the program:

a) Shawmut Avenue—Marlene Barros
b) Business Park—Jennie Antunes
c) SCHOONER Afterschool/Summer Program—Jewel Collins

Section 3. SUPPORT SERVICES

Children with Special Needs, Vulnerable Children, and Infants and Toddlers

Children with Special Medical Conditions

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, especially during the new health and safety guidelines during the COVID-19 reopening guidelines. We are prepared to work with parents to identify whether the program is able to accommodate the needs of their child and provide them with community resources to finding a more appropriate program.

Working with families of children with Special Conditions

1. Review medical information submitted by parents and determine whether and how many high-risk children are in attendance.
2. Request parents of high-risk children to discuss with their healthcare provider about whether the program is a safe option for the child and if additional protections are necessary.
3. Discuss with the parent any concerns they have with the new protocols and how we can best meet the needs of their child while adhering to the COVID-19 protocols and the new health and safety practices.

Caring for Infant and toddlers

We understand the critical factor that nurturance plays in working with infants and toddlers and meeting their individual needs, especially during this reopening phase, so we are committed to creating a seamless transition for children who are returning to our programs. Staff will be trained on the new required health and safety practices and follow strict hygiene and infection control practices to keep themselves and the young children healthy and safe while in the program. Staff will implement creative ways of promoting the children's social and emotional well-being as social distancing should not mean social isolation.

As infants and toddlers are not able to verbalize when they don't feel well, staff must be attentive to any changes in a very young child's behavior. If the child starts to look lethargic and is not eating as well, the staff will notify the parent to determine whether the child's pediatrician must be contacted. If a toddler is showing signs of respiratory distress and having difficulty breathing, the staff must call 911 and notify the parents immediately.

Staff Safety Protocol

1. Staff will wear a protective covering; i.e., long-sleeved, button-down, or oversized shirt over their clothing, long hair will be tied up during washing and feeding activities and holding children.
2. Staff must change outer clothing if body fluids from the child get on it.

3. Staff must change the child's clothing if body fluids get on it.
4. Staff must wash their hands, neck, and anywhere touched by a child's secretions.
5. Soiled clothing must be placed in a plastic bag until it can be sent home with the child to be washed.
6. Staff and Infants and toddlers will have multiple changes of clothes on hand.
7. All staff must follow safe and sanitary diaper changing procedures. Procedures must be posted in all diaper changing areas, and must include:

Diaper changing procedure
Staff will use disposable gowns when diaper chaning, if a child has an accident, or if a child shows an symteoms. The personal protective equipment used by the staff will be immediately disposed of in an appropriate manner.

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

Checking for the need to change diapers:

- 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 will 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 will 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.

Step 1	*Before bringing the child to the changing area, wash your hands, and collect all the needed items. Gloves must be worn. Keep everything off the diapering surface except the items you will use during the diaper changing:* • A sheet of non-absorbent paper that will cover the diaper-changing surface from the child's chest to the child's feet; • A fresh diaper, clean clothes (if needed); • Wipes removed from the container or dispensed so that the container will not be touched during diaper changing; • Disposable, non-porous gloves; • A plastic bag for any soiled clothes; • 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; • The containers will be taken off the diapering surface, and place where they

	cannot be touched during the diaper process.
Step 2	*Carry child to the changing table, keeping soiled clothing from touching the staff.* Always keeping a hand on the child; never leaving them on the changing table unattended. Avoiding contact with soiled items. Anything that comes in contact with stool or urine is a source of germs and will 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.
Step 3	*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.
Step 4	*Remove the soiled diaper, clean stained 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 that are being used, and put them directly into the step can. Wash hands and put on fresh gloves.
Step 5	*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.
Step 6	*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.
Step 7	*Clean and disinfect the diapering area:* a. Dispose of the table liner into the step can. b. Clean any visible soil from the changing table. 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. d. Empty, wash, and sanitize the diaper pail at least daily.
Step 8	Wash hands thoroughly and record the diaper change in the child's daily log. Replace gloves

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.

TOILETING

Toileting area and equipment
Toilets are located in rooms separate from rooms in which children play, eat, and rest and are 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 disinfected shall be used. Toilets, step aids, toilet seat adapters, and other surfaces used by children for toileting will be cleaned and disinfected after each use daily and when visibly soiled. They will be cleaned and disinfected at the end of each program day.

School-age children will have gender-separated bathrooms that afford individual privacy. Toilets, toilet seats, and other surfaces used by children for toileting will be cleaned and disinfected after each use daily and when visibly soiled. They will be cleaned and sanitized at the end of each program day.

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. 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.

Plan #2: CLEANING PLAN

<u>Cleaning, Sanitizing, and Disinfecting</u>
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.

During the COVID-19 pandemic, we need to intensify programs' routine cleaning, sanitizing, and disinfecting practices, paying extra attention to frequently touched objects and surfaces, including doorknobs, bathrooms and sinks, and keyboards.

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.
While cleaning and disinfecting, staff must wear gloves as much as possible. Handwashing or use of an alcohol-based hand sanitizer after these procedures is required, whether or not gloves are used.

Task	Method	Solution/Product	Purpose/Result
Cleaning Towels, washcloths, 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. *Always clean before sanitizing or disinfecting.*	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.

Sanitizing Bibs, toys mouthed by a child, bottles, all surfaces used for eating, cleaning equipment	Cover the cleaned surface area with *sanitizing* solution. Immerse toys in solution. Allow to air dry or follow the manufacturer' 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.
Disinfecting Diapering areas, bathrooms, equipment used for cleaning body fluids	Cover the cleaned area with *disinfecting* solution. Leave the solution to air dry or follow the manufacturer's recommendation before wiping off.	Bleach and water solution or a bleach a disinfectant with an EPA registration label	Kills nearly 100% of the germs on a surface object—specifically intended to eliminate the spread of bloodborne illnesses such as Hepatitis B and HIV.
Special Precautions Treatment 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 least-toxic, child-safe 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.

1. Programs will use EPA-registered disinfectants and sanitizers for use against COVID-19. Follow directions on the label, including ensuring that the disinfectant or sanitizer is approved for the type of surface (such as food-contact surfaces) being treated.
2. When EPA-approved disinfectants are not available, a dilute bleach solution can be used. For example, add 1/3 cup of household bleach to 1 gallon of water OR 4 teaspoons of bleach per quart of water. Alternatively, a 70% alcohol can be applied.
3. Bleach solutions will be prepared daily to ensure their ability to safely sanitize or disinfect. When preparing sanitizing or disinfecting solution, staff will always add bleach to water, not visa-verse as a precaution. This helps to avoid bleach splashes caused by adding water to bleach. Use either the sanitizing or the disinfecting solution as specified above. Never mix household bleach with ammonia or any other cleanser.
4. Programs must not prepare cleaning solutions in close proximity to children. Many cleaning agents can be irritants and trigger acute symptoms in children with asthma or other respiratory conditions.
5. Check the label to see if your bleach is intended for disinfection and ensure the product is not past its expiration date. Unexpired household bleach will be effective against COVID-19 when adequately diluted. Some bleaches, such as those designed for safe use on colored clothing or for whitening, may not be suitable for disinfection.

Proper application

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

1. To ensure effective cleaning and disinfecting, always clean surfaces with soap and water first, then disinfect using a diluted bleach solution, alcohol solution with at least 70% alcohol, or an EPA- approved disinfectant for use against the virus that causes COVID-19. Cleaning first will allow the disinfecting product to work as intended to destroy germs on the surface.
2. Use all cleaning products according to the manufacturer's instructions for concentration, application, contact time, and proper ventilation. Leave the solution on the surface for at least 1 minute.
3. All sanitizing and disinfecting solutions must be used in areas with adequate ventilation and never in close proximity to children as not to trigger acute symptoms in children with asthma or other respiratory conditions. Do not spray chemicals around children. If possible, move children to another area or have someone distract them away from the area where a chemical is being used.
4. Only single-use paper towels should be used for cleaning, sanitizing, and disinfecting. Sponges should not be used for sanitizing or disinfecting.
5. 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.
6. Apply when children are not present in the area and allow for fresh air ventilation when possible until surfaces and equipment have air-dried. Do not wipe dry unless it is a product instruction. Provide close supervision to ensure that children are not able to touch the surface until it is completely dry.
7. Open containers used to sanitize dishes or toys will be used out of the reach of children.
8. We will avoid aerosols because they contain propellants that can affect breathing.

Storage

To safely store cleaning products:

1. Keep cleaning products in their original containers. If this is not possible, label the alternate container to prevent errors.
2. All working containers of sanitizing and disinfecting solutions must be labeled properly to identify the contents, kept out of the reach of children, and stored separately from food items. Do not store sanitizing and disinfecting solutions in beverage containers.
3. Keep all stored chemicals 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 Massachusetts 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.

Cleaning, sanitizing, and disinfecting indoor play areas

Programs must follow these guidelines for cleaning, sanitizing, and disinfecting indoor play areas:

1. Children's books, like other paper-based materials such as mail or envelopes, are not considered a high risk for transmission and do not need additional cleaning or disinfection procedures. Programs should conduct regular inspection and disposal of books or other paper-based materials that are heavily soiled or damaged.
2. Machine washable fabric toys should not be used in the program.
3. Toys that children have placed in their mouths or that are otherwise contaminated by body secretions or excretions must be set aside until they are cleaned by hand by a person wearing gloves. Clean with water and detergent, rinse, sanitize with an EPA-registered sanitizer, and air-dry or clean in a mechanical dishwasher.
4. For electronics, such as tablets, touch screens, keyboards, and remote controls, remove visible contamination if present. Consider putting a wipeable cover on electronics. Follow manufacturer's instruction for cleaning and disinfecting. If no guidance, use alcohol-based wipes or sprays containing at least 70% alcohol. Wait in accordance with product manufacturer's directions and then dry surface thoroughly or allow to air dry. Provide cleaning materials for older children to clean their own electronics.

Cleaning, sanitizing, and disinfecting outdoor play areas

Programs should follow these guidelines for cleaning, sanitizing, and disinfecting outdoor play areas:

1. Programs cannot use communal parks and playgrounds, including public offsite playgrounds as well as playgrounds shared by multiple programs or houses. Playgrounds shared by multiple programs and houses may be used provided there is a plan for proper cleaning and disinfection between each group's use.
2. High-touch surfaces made of plastic or metal, including play structures, tables and

benches, should be frequently cleaned and disinfected.

3. Cleaning and disinfection of wooden surfaces or groundcovers (mulch, sand) is not recommended.

Cleaning, sanitizing, and disinfecting after a potential exposure
If a program suspects a potential exposure, staff must clean and disinfect as follows.

1. Close off areas visited by the ill persons. Open outside doors and windows and use ventilating fans to increase air circulation in the area. Wait 24 hours or as long as practical before initiating cleaning and disinfection. Each program facility must plan for availability of alternative space while areas are out of use.

2. Staff must clean and disinfect all areas such as offices, bathrooms, common areas, shared electronic equipment (e.g., tablets, touch screens, keyboards) used by the ill persons, focusing especially on frequently touched surfaces or when recommended by health authorities to control certain infectious diseases.

3. Professional cleaning company completes program cleaning 3 times per week in addition to staff daily cleaning.

Additional considerations
Programs must also comply with the following precautions:

1. Staff clothing containing blood or bodily fluids must not be worn again until after being laundered at the warmest temperature possible.
2. Programs must comply with OSHA's standards on Bloodborne Pathogens (29 CFR 1910.1030), including proper disposal of regulated waste and PPE (29 CFR 1910.132)
3. 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 surface 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.Clean and disinfect any surfaces such as countertops and floors onto which fluids have been spilled.
3. Discard fluid contaminated material in a securely sealed plastic bag.
4. 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.
5. Wash hands afterward, even though you wore gloves.

Laundry procedures
Laundry such as sheets that is contaminated with blood or other potentially infectious materials will be handled as little as possible; it should not be sorted or rinsed in the area of use. Employees who handle contaminated laundry will 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 ten 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 five 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 the 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 the 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.

Programs will follow CDC infection control guidelines designed to protect individuals from exposure to diseases spread by blood, bodily fluids, or excretions that may spread infectious disease. Health precautions include, but are not limited to, the use of personal protective equipment (PPE), proper disposal containers for contaminated waste, handwashing and proper handling of bodily waste.

- Non-latex gloves are provided and used for the clean-up of blood and bodily fluids.
- Used gloves and any other materials containing blood or other bodily fluids are discarded in a lined, covered container. Only material saturated/dripping with blood is considered medical waste and must be stored and disposed in accordance with applicable regulations. Materials such as band-aids and tissues containing minimal blood are not considered medical waste.

- Contaminated clothing must be sealed in a plastic container or bag, labeled with the child's name, and returned to the parent at the end of the day.
- Sharps waste must be stored and disposed of in appropriate sharps containers with the word "biohazard" and the universal biohazard symbol.

Maintaining an adequate inventory of cleaning and other essential supplies
To ensure that an adequate supply of cleaning and other essential supplies (e.g., gloves, masks, sanitizer, and face shields) are on hand, the program director will inventory weekly and order additional supplies as needed.

Cleaning, Sanitizing, Disinfecting Schedule

Area	Clean	Sanitize	Disinfect	Frequency
Play tables	✓	✓		Before and after use.
Chairs	√	√		Midday, end of the day and when obviously soiled.
All surfaces used for eating, including mixed use tables	✓	✓		Before and after serving food.
Bibs (used by only one child)	✓	✓		After each use after drinking or eating.
Non-Touch Thermometers	✓	✓		After each use.
Toys or other objects mouthed by children	✓	✓		Closely supervise children to ensure that all objects that they put in their mouths are removed for cleaning (Children have their own material box. Mouthed toys will be cleaned and sanitized before returning to box)
Toys used by children who do not put these objects in their mouths	✓	√		Midday and end of the day or when obviously soiled.
Machine washable toys				No longer used
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	✓	✓		After use.
Sheets and blankets	✓			At least weekly, machine washed and whenever soiled or wet, bagged blankets stored in child's cubby
Frequent touched surfaces, doors, cabinet handles, and countertops	√	√		daily
Frequent touched electronics, keyboards, tablets and phones	√	√		Cleaned with alcohol base wipes
Playground apparatus and equipment	√	√		After each group
Washcloths used for multiple purposes				N/A
Sinks and sink faucets	✓	✓		After each use.
Mops, cloths, or other cleaning equipment *when not used for cleaning body fluids*	✓	✓		After each use.

Mops, cloths, or other cleaning equipment *used for cleaning body fluids*	✓		√	After each use.
Diaper changing tables	√		√	After each use.
Toilets bowls, seats, handles and bathroom sinks	✓		✓	After each use.
Diaper pails	✓		✓	Midday and end of the day, including lids.
Smooth surfaced, nonporous floors	✓	✓		End of the day, all spills cleaned up immediately.
Rugs	√			Vacuumed end of the day

Clean, sanitizing, and disinfecting will be conducted daily and 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.

FACE MASKS AND COVERING

Personal Protective Equipment (PPE) and Face Masks

Programs should encourage the wearing of masks or cloth face coverings during the program day. Whenever 6 feet of physical distancing is not possible, masks should be worn.

1. To slow the spread of COVID-19, program staff are encouraged to wear a cloth face covering while serving children and interacting with parents and families. Program staff are required to wear a cloth face-covering whenever 6 feet of physical distancing is not possible. Programs are encouraged to consider the use of transparent face coverings to allow for the reading of facial expressions, which is essential for child development.

2. When possible and at the discretion of the child's parent, programs should encourage the wearing of masks or cloth face coverings for children age two and older who can safely and appropriately wear, remove, and handle masks. Additional guidance on use of face coverings and masks by children is as follows:
    - Children under the age of 2 years should not wear face coverings or masks.
    - When children can be safely kept at least 6 feet away from others, then they do not need to be encouraged to wear a mask.
    - Masks must not be worn while children are eating/drinking, sleeping, and napping. Strict and consistent physical distancing will be practiced at all times during these activities. Masks do not need to be worn while engaging in active outdoor play, if children are able to keep physical distance from others.
    - Children 2 years of age and older must be supervised when wearing a mask. If wearing the face-covering causes the child to touch their face more frequently, staff must reconsider whether the mask is appropriate for the child.
3. Families should provide their children with a sufficient supply of clean masks and face coverings for their child to allow replacing the covering as needed. These families must have a plan for routine cleaning of masks and face coverings, clearly mark masks with child's name and room number, if applicable, and clearly distinguish which side of the covering should be worn facing outwards so they are worn properly each day. If

families are unable to provide masks, programs should provide masks for children and youth, as necessary. Masks and face coverings must be routinely washed (at least daily and any time the mask is used or becomes soiled) depending on the frequency of use. When possible, masks must be washed in a washing machine in hot water and dried fully before using it again. If a washing machine is unavailable, masks must be washed with soap and hot water and allowed to dry thoroughly before using it again.

4. If using a disposable mask, follow CDC guidance on proper daily removal. Grasp the bottom ties or elastics of the mask, then the ones at the top, and remove without touching the front. Discard in a waste container and immediately wash hands or use an alcohol-based hand sanitizer.
5. Programs must enforce the wearing of face masks by parents when on the premises and at all times during drop-off and pick-up. Programs must regularly remind families and staff that all individuals are encouraged to adhere to the CDC's recommendations for wearing a mask or cloth face covering whenever going out in public and/or around other people.
6. Programs must teach and reinforce use of cloth face coverings among all program staff. Face coverings are most essential at times when physical distancing is not possible. Staff must be frequently reminded not to touch the face covering and to wash their hands frequently. We will provide information to all staff on proper use, removal, and washing of cloth face coverings.

Exceptions to use of face masks/coverings

Exceptions for wearing face masks include situations that may inhibit an individual from wearing a face mask safely. These may include, but are not limited to:

(1) Children under the age of 2 years;

(2) Children who cannot safely and appropriately wear, remove, and handle masks;

(3) Children who have difficulty breathing with the face covering or who are unconscious, incapacitated, or otherwise unable to remove the cover without assistance;

(4) Children with severe cognitive or respiratory impairments that may have a difficult time tolerating a face mask;

(5) Children where the only option for a face covering presents a potential choking or strangulation hazard;

(6) Individuals who cannot breathe safely with a face covering, including those who require supplemental oxygen to breathe;

(7) Individuals who, due to a behavioral health diagnosis or an intellectual impairment, are unable to wear a face covering safely; and

(8) Individuals who need to communicate with people who rely upon lip-reading.

When to use gloves

Program staff must wear gloves when appropriate and at all times during the following activities. Programs should consult with a child's medical records and identify any allergies

when determining type of gloves to use. Handwashing or use of an alcohol-based hand sanitizer before and after these procedures is always required, whether or not gloves are used.

(1) Diapering;
(2) Program cleaning;
(3) Food preparation;
(4) Screening activities requiring contact; and
(5) Applying sunscreen.

Additional guidance on using gloves
To reduce cross-contamination, disposable gloves should always be discarded in the following circumstances:

(1) Visible soiling or contamination with blood, respiratory or nasal secretions or other body fluids occurs;
(2) Any signs of damage (e.g., holes, rips, tearing) or degradation are observed;
(3) After four hours of continuous use;
(4) Removing gloves for any reason, since disposable glove "reuse" increases the risk of tearing and contamination;
(5) Following diapering, food preparation, applying sunscreen, and screening activities requiring contact.

After removing gloves for any reason, hand hygiene should be performed with alcohol-based hand sanitizer or soap and water.

Plan #3: ISOLATION AND DISCHARGE

Name of person(s) that will develop and maintain an emergency back-up plan
Below is the contact information of the program staff responsible for maintaining the emergency back-up plan and the local board of health contact information.

- **Program Administrator**
  Marlene Barros, Director of Early Education Programs
  Cell phone number: 508-415-9242
  Address: 725 Shawmut Avenue, New Bedford, MA 02746
  Email address: mbarros@northstarlc.org

- **Designated Administrator**
  Jennie Antunes, Center Director
  Cell phone number: 508-863-1267
  Address: 267 Samuel Barnet Boulevard, New Bedford, MA 02745
  Email address: jantunes@northstarlc.org

- **Department of Public Health**
  Damon Chaplin, Director of the New Bedford Health Department
  Office Phone number: 508-991-6199
  Address:1213 Purchase Street, New Bedford, MA 02740
  Email address: damon.chaplin@newbedford-ma.gov

Exclusion Guidelines for COVID-19

Planning for isolation and discharge of sick children and staff. Programs should be prepared for individual exposure events to occur in their facilities, regardless of the level of community transmission:

Designate a separate space, with a door if possible, to keep sick children and staff separate from well children and staff until they can be sent home. Isolated children must be supervised at all times. A separate bathroom must be made available for use by sick individuals only. Others must not enter isolation room/space without PPE appropriate to the care setting. A location with an open window and/or good air circulation is optimal.

1. Have an emergency backup plan for staff coverage in case a child or staff becomes sick.
2. Know the contact information for the local board of health in the city or town in which the program is located.
3. Have masks and other cloth face coverings available for use by children and staff who become symptomatic until they have left the premises of the program.
4. Designate a separate exit from the exit used to regularly exit for those being sent home due to suspected infection.

If a child becomes symptomatic. If a child becomes symptomatic, programs must:

1. Immediately isolate from other children and minimize exposure to staff.
2. Whenever possible, cover children's (age 2 and older) noses and mouths with a mask or cloth face covering.
3. Contact the child's parents to arrange for the child picked up as soon as possible.
4. Follow the program's plan for the transportation of a child who has developed symptoms and who relies on program transportation.

If a staff member becomes symptomatic.

Staff who come down with symptoms while at work should notify their supervisor immediately and prepare to leave the workplace. If necessary, the staff member should take measures to avoid coming in contact with other staff and children.

Staff will regularly self-monitor during the day to screen for new symptoms. If new symptoms are detected among a staff member, follow the requirements above on how to handle symptomatic individuals.

A staff member with symptoms and who feels they can work should notify their supervisor, who can determine how to facilitate a telework arrangement until the employee is no longer contagious. In this instance, no formal remote work agreement is necessary.

If a child or staff contracts COVID-19.
Sick children or staff members who are COVID-19 positive or symptomatic and presumed to have COVID-19 must not return until they have met the criteria for discontinuing home isolation and have consulted with a health care provider. Determine the date of symptom onset for the child/staff. Determine if the child/staff attended/worked at the program while symptomatic or during the 2 days before symptoms began. Identify what days the child/staff attended/worked during that time. Determine who had close contact with the child/staff at the program during those days (staff and other children).

If the individual tests positive for COVID-19 but is asymptomatic, isolation may be discontinued when at least 10 days have passed from the date of the positive test, as long as the individual remains asymptomatic. For example, if the individual was tested on April 1, isolation may be discontinued on or after April 11 if the individual still has no symptoms.

Notifying required parties.
In the event that a program experiences an exposure, the program director must notify:

(1) Program staff of their possible exposure in the program, while maintaining confidentiality as required by the Americans with Disabilities Act (ADA);

(2) New Bedford board of health if a child or staff is COVID-19 positive.

(3) Funding and licensing agencies, if a child or staff member has tested positive.

Self-isolating following exposure or potential exposure. In the event that a staff member or child is exposed to a sick or symptomatic person, the following protocols must be followed:

1. If a child or staff has been exposed to COVID-19, regardless of whether the individual has symptoms or not, the child or staff must not be permitted to enter the program space and must be sent home. Exposed individuals must be directed to stay home for at least 14 days after the last day of contact with the person who is sick. The program must consult the local board of health for guidance on quarantine for other children and staff and what additional precautions will be needed to ensure the program space is safe for continued child care services.

2. If an exposed child or staff subsequently tests positive or their health care provider indicates that they have confirmed COVID-19, they must be directed to stay home for a minimum of 10 days from the 1st day of symptoms appearing and be fever-free for 72 hours without fever-reducing medications and experience significant improvements in symptoms. Release from isolation is under the jurisdiction of the local board of health where the individual resides.

3. If a child's household member or staff's household member tests positive for COVID-19, the child or staff must self-quarantine for 14 days after the last time they could have been exposed.

If an exposed child or staff remains asymptomatic and/or tests negative for COVID-19. If the exposed individual remains asymptomatic and/or tests negative for COVID-19, they must remain in quarantine and continue to monitor for the full 14 days.

Section 3: LOCAL BOARD OF HEALTH ENGAGEMENT

We are in regular communication with the Director of the New Bedford Health Department, Mr. Damon Chaplin, and have consulted and reviewed our reopening plan with him. The Health Department has agreed to immediately notify us of any changes on the COVID-19 virus and best practices to maintain the health and safety procedures in our programs, which includes social distancing, wearing face, mask or face coverings, protective gear in case a child or staff develops symptoms and is required to be isolated and discharged from the programs.

Our center director will contact the local health department:

- When a child or staff member who is in contact with others has a reportable disease;
- If a reportable illness occurs among the staff, children, or families involved with the program;
- For assistance in managing a suspected outbreak. Generally, an outbreak can be considered to be two or more unrelated (e.g., not siblings) children with the same diagnosis or symptoms in the same group within one week. Clusters of mild respiratory illness, ear infections, and certain dermatological conditions are common and generally do not need to be reported.

Reporting staff or children's exposures to a COVID-19 virus
We will inform parents verbally as well in writing if a child or staff have been exposed to the COVID-19 virus, according to the regulations and recommendations of the Division of Communicable Disease Control, Massachusetts Department of Public Health. The reporting exposure of staff and children's information will remain confidential. We will also follow-up with the parents to ensure that their child is not exhibiting any symptoms.

Section 4: Program Closures and Absences

The programs will take the following steps for monitoring and communicating with families, staff, and the local Board of Public Health and The Department of Early Education and Care –EEC regarding closures and absences related to the COVID-19 quarantine or potential spread.

Program administrators met with our local department of health director on June 15, 2020, to obtain information on best practices and information on program closures during this time of COVID-19.

1. <u>Communicating with Families</u>
   Our Health and Safety policy requires parents to inform us when their children will be absent. Parents indicate reasons for their child's absence, and that information is documented on our Family Communication Log. If the family reports symptoms associated with COVID-19 or any other respiratory illnesses, we will encourage them to contact their health care provider and provide them with the locations of our area testing locations.

Parents will be informed in by phone and in writing of any possible exposure and will be given the instructions for isolating at home and for how long if the local department of health finds it necessary. The center director will notify the Director of Early Education and Care, NorthStar Learning Centers-Executive Director, The Department of Early Education and Care (EEC), and other funding agencies.

2. Communicating with Staff
   We ask that employees inform us as soon as they realize they will be unable to work – before the start of their workday. The earlier we receive notice that a staff member will be absent from work, the more time we have to arrange staffing to cover your absence.

3. Sick leave for unexpected circumstances.
   If illness, injury exposure to contagious diseases or an illness or injury of an immediate family member prevents you from coming to work, the staff must follow the program's established call-in procedures. Normally, the staff should make the call and speak to their supervisor or the person authorized to take such messages. If the first-level supervisor isn't available, then the staff member should contact succeeding higher levels in the chain of supervision to ensure official notification of absence. Notifying coworkers or asking coworkers to tell a supervisor will not be considered as meeting this requirement. Unless otherwise instructed by the supervisor, the staff member should phone each day that they will be out on sick leave to report their condition and anticipated return to work. Failure to follow these procedures may result in an unpaid unexcused absence.

Testing Locations

Below are the local COVID-19 testing sites:

- Hawthorn Medical Associates
- SouthCoast Health
- Greater New Bedford Community Health Center
- CVS Pharmacy.

Monitoring absences and potential closures

Program administrators will monitor absences of children and staff and will notify the local department of health and seek their guidance to determine our next steps for program closures; i.e., such as closing a classroom or the program, the possibility of moving to a licensed pre-established space to allow for a professional cleaning company to complete a deep cleaning of of the classroom and any other contaminated space after ventilating the classroom for 48 hours.

The center director will notify the local board of health regarding an individual testing positive for COVID-19, and in partnership with the local Department of Health, we will determine if it is necessary to close a classroom or the program and determine the number of days the

class or program will remain closed. We will also seek guidance from the DPH to determine what individuals were exposed and if they need to isolate at home for 14 days.

The families and staff will be informed of the exposure while maintaining confidentiality as well as the steps the local Department of Health recommends to ensure the health and safety of children and staff in the program.

Plan #4: MEDICATION ADMINISTRATION PLAN

For each enrolled child, programs will maintain on file a physician's, nurse practitioners, or physician's assistant's certification that the child has been successfully immunized in accordance with the current DPH's recommended schedules.

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.[1] 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 the following procedures. Don't allow themselves 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.

[1] 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.

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.
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 the 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 parent should label the container 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. A 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.

Asthma medication

People with moderate to severe asthma have a higher risk of getting seriously ill from COVID-19. People should continue to take their asthma medication as usual during the pandemic. Keeping asthma symptoms under control is one of the best methods people with asthma can take to protect themselves. There is no evidence that asthma medications will increase the risk of contracting the virus or worsen outcomes of COVID-19.

People should manage acute asthma episodes with an inhaler such as albuterol. The use of nebulizers is not permitted because a nebulizer can increase the risk of sending COVID-19 virus particles in the air, potentially transmitting the virus to others nearby.

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 parenta consent require	Health care practition authorization require	Logging required
All prescription	Yes	Yes. Must be in the original container with original label containing t name of the child affixed.	Yes, including the 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 the original container with original label containing t name of the child affixed.	Yes, including the 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.,	Yes, renewed annually	Yes. Must be in the original container with original label containing the name of the child	Yes, including the name of child, dosage, date, time, and staff signature.

acetaminophen, ibuprofen, antihistamines)		affixed.	
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).

The program will designate the following staff as adequately trained and prepared to support children with health care needs with the necessary provisions of health care, such as administration of medication needed throughout the day.

1. **Shawmut Avenue Center**
   Program Director
   - Marlene Barros

   Lead Teacher(s)-
   - Maribel Da Silva
   - Kim Silva
   - Renee Stevens
   - Norma Drayton

2. **Business Park Center**
   Program Director
   - Jennie Antunes

   Lead Teacher(s)
   - LaVerne Oliver,
   - Wendy Mellor

3. **NorthStar LC SCHOONER Program**
   Program Director
   - Jewel Collins

   Group Leaders-
   - Jason Cruz,
   - Carmen Guzman

Plan #5: Transportation

The program will contract with Reliable Transportation Company to provide transportation for children in our program. This plan will be in addition to our agency Transportation Plan currently in place.

Health and Safety Training and protocols
All drivers and monitors will receive training on, at a minimum, proper cleaning, and disinfecting techniques, proper use and disposal of PPE, safe product usage guidelines, and proper methods to empty and dispose of used tissues and other trash. Additionally, drivers and monitors will be trained on the new health and safety protocols, including social distancing and face mask use, and how to respond when a child appears ill.

Screening
Screenings will be conducted before children, bus drivers, and monitors staff on board the bus. Driver/monitor screening will be documented on the Daily Screening Log. Drivers, monitors, and children's parents will be asked about COVID-19 symptoms and whether anyone in their home has had COVID-19 symptoms or a positive test. An affirmative response on any of these points will result in exclusion. The parent will sign the Children's Daily Screening Log. Both screening logs will be submitted to the program daily.

Social Distancing
Compliance with 6-foot social distancing between children on the bus will be accomplished by following the CDC recommendation of seating one child per seat, every other row. Drivers will also establish a buffer zone around them on the bus (i.e., no one sits in the front two rows if possible). Another adopted social distancing strategy will be having children board starting from the back on the bus and working toward the front while exiting front to back. Windows will be kept open to promote airflow. If not possible or comfortable to open windows, the bus ventilation system should be set to high.

Routes with fewer children aboard to accommodate social distancing will reduce the time of each run. The program will also encourage families to drop their children off to minimize possible exposure to vehicles.

Transportation Cleaning Schedule
Required daily completion and submission of the Transportation Cleaning Log (based on CDC guidelines for cleaning and disinfecting non-emergency vehicles) will help ensure that cleaning and disinfection procedures are followed consistently and correctly; the log will identify what items and areas must be cleaned, sanitized, and disinfected and with what frequency. The ready provision of appropriate cleaning products and supplies for use against the virus that causes COVID-19 will support compliance with cleaning, sanitizing, and disinfecting procedures.

Schedule for Cleaning, Sanitizing, and Disinfecting Vehicles

The interior of each vehicle must be cleaned and either swept or vacuumed thoroughly after each morning and evening route and disinfected at least once each day.

Vehicle	Clean	Sanitize	Disinfect	Frequency
Interior	√			Swept or vacuumed after each AM and PM route.
High touch surfaces, buttons, handholds, pull cords, rails, steering wheel, door handles, shift knobs, dashboard controls and stanchions	√		√	After each route, disinfected after last AM and PM route
Floors	√		√	After each route, disinfected after AM and PM route
Remove trash				After each route
Wipe heat and air conditioners	√		√	Before first Am route and after each route, disinfect after AM and PM route
Spot cleaning walls and seat	√		√	When soil is obvious, disinfect after AM and PM route
Dust horizontal surfaces	√		√	Before the first AM route and after the last PM route
Clean spills	√			Immediately
Soft or porous surfaces (fabric, upholstery, carpets)	√		√	Weekly or when soil is obvious

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 with primary responsibilities for transporting children attending our programs are:

Transportation coordinator	Marlene Barros Director of Early Education and Care	*Office:* (508) 991-5997 *Cell:* (508) 415-9242
Contact persons during transport times	Marlene Barros- 508-415-9242 Jennie Antunes	*Office:* (508) 985-1915 *Cell:* (508) 863-1267

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:

Modes of travel	Person responsible for the child's safety and supervision
Private passenger vehicle with parent or other driver	Parent
Walking with parent or other family member	Parent
Walking without adult supervision	Parent
Buses operated by contracted provider: Reliable Bus Line 978 Nash Rd, New Bedford, MA 02746 (508) 992-0342	Bus monitor, with assistance from the 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 and afternoon).

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 one year old and weight 20 pounds. Children in child seat restraints

cannot ride facing a passenger-side airbag. Car seat harness straps must be adjusted appropriately 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 degrees 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 degrees F, and when children are feeling uncomfortably cold, the driver should use the heater.

Reporting requirements
Anyone whose job duties including 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 involved as 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 be 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 eight 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 an 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 another 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 on 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. The 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 an 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 and monitor new transportation health and safety requirements.

The program will designate the following staff to assist children with handwashing and sanitizing hands upon arrival after exiting the vehicle and again prior to departure before boarding:

Shawmut Avenue Center
Staff #1 – Maribel Da Silva
Staff#2 – Renee Stevens
Staff #3 – Norma Drayton
Staff #4 – Marlene Barros

Business Park Center
Staff #1 - Jennie Antunes
Staff #2 - LaVerne Oliver
Staff #3 - Wendy Mellor
Staff #4 - Jennie Antunes

NorthStar LC SCHOONER Program
Staff #1 - Carmen Guzman
Staff #2 - Jonathan Silva-Jones
Staff #3 - Jewel Collins
Staff #4 - Jason Cruz