

Washington State's Research Agenda: A Blueprint for State Licensing and Regulatory Administration

Compiled by DCYF staff in collaboration with Dr. Richard Fiene

The following brief outlines several large child care licensing oversight changes that have been taking place over the past three years in Washington State. While some of the work has been completed and much more is to come, the entire process is a result of broad outcomes outlined in the Early Start Act (2015). Readers need to understand that some of these plans have not been implemented at this point and/or may be altered as assessments and program evaluations continue. The goal of this document is to provide this Washington state's blueprint for designing oversight systems along with effective validation and reliability studies as delineated by Zellman and Fiene's (2012) OPRE research brief. By following this blueprint, a state will be able to assess licensing measurement and evaluation tools, consider manners in which to validate its standards/rules/regulations, and understand how the entire oversight processes can, and will, impact outcomes.

Background

Mandated by the Early Start Act (2015), the Department of Children, Youth and Families (Formed in July 2018 and is inclusive of the Department of Early Learning) created a single set of licensing standards for family home and center child care licensing inclusive of continued work to incorporate Early Achievers (Washington's QRIS) and ECEAP (Early Childhood Education and Assistance Program - Washington's state preschool system). The Early Start Act stated, "The department shall streamline and eliminate duplication between Early Achievers standards and state child care rules in order to reduce costs associated with the early achievers rating cycle and child care licensing." The Early Start Act specifies that the single set of licensing standards must: (a) Provide minimum health and safety standards for child care and state-funded preschool programs; (b) Rely on the standards established in the Early Achievers program to address quality issues in participating early childhood programs; (c) Take into account the separate needs of family child care home providers and child care centers; and (d) Promote the continued safety of child care settings.

Objectives of Standards Alignment. There were five objective set forth regarding the

- Quality begins at licensing. All sites meet licensing standards as the foundation of quality.
- Standards are clear and measurable.
- Standards provide a progression from licensing through Early Achievers, and ECEAP.
- Duplication is eliminated and similar language is used across licensing, Early Achievers, and ECEAP.
- Early learning providers can see the progression of the standards and understand the expectations of Early Achievers and, if they receive funding, ECEAP.

Standards Alignment

Standards alignment began by focusing on updating the current regulations for licensing, Early Achievers, and ECEAP. Licensing regulations are the foundation for quality in licensed sites as well as Early Achievers, and ECEAP. Therefore, revising the licensing standards was the first step in aligning Early Achievers and ECEAP. DCYF began the standards alignment work in early 2015 with development of a community input process, an analysis of the existing standards, and consultation with national experts on standards development. DCYF also had to ensure consistency between family child care homes and child care centers based licensing standards as one of the first priorities of the Standards Alignment process.

In 2016, the Early Achievers and ECEAP teams began assessing and revising the standards for each of those programs with a priority of ensuring consistency between program standards and allowing for efficiency on many levels:

- Licensing, Early Achievers, and ECEAP will have clear, unduplicated requirements that are consistent across programs. For example, a standard that is included in child care licensing will no longer be listed separately for Early Achievers or ECEAP;
- Standards will build upon each other, enabling early learning providers to see the differences in standards and how Early Achievers builds on licensing and how ECEAP builds on licensing and Early Achievers;
- DCYF will plan coordinated monitoring of licensing, Early Achievers, and ECEAP to streamline the monitoring processes in order to reduce duplicate visits for providers.
- It is important to note, even as standards are aligned into one chapter many regulations remain specific to only one provider type (i.e. family home or center).

Standards were structured to make sure that there is a clear and consistent progression of the standards from licensing, Early Achievers, and ECEAP. Duplicated standards were eliminated and consistency was achieved through research, discussion and decision-making. Each standard in all three programs has been carefully considered, revised when appropriate, aligned with the other programs, and shared with community stakeholder for feedback. Figure 1 outlines the standard alignment timeline

Figure 1: Standards Alignment Timeline



Risk Assessment

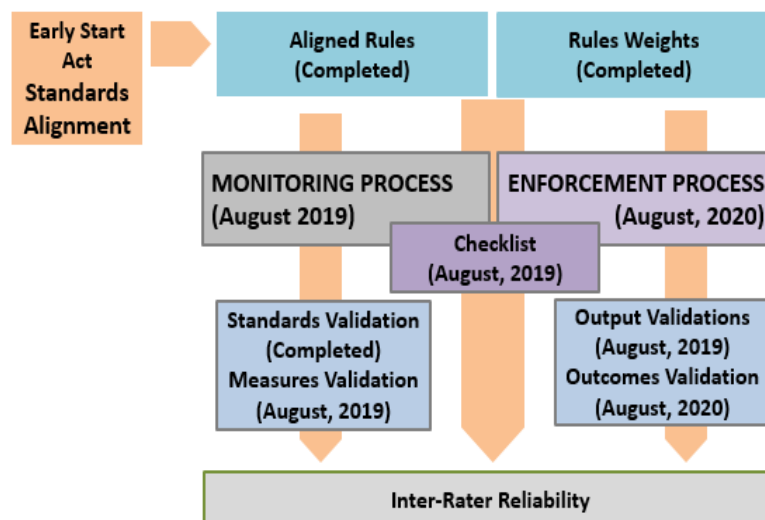
After being legislatively mandated to complete a standards alignment process as part of the Early Start Act, DCYF decided to go a step further and weight our licensing standards. The process of “weighting” licensing standards identified those rules that are most important for keeping children safe. The goals of the risk assessment were to protect children from direct and indirect harm, establish a common understanding of risk, identify and address trends, disparities and risk to children more effectively and efficiently, support consistency of actions taken for similar compliance history and, clarify the connection between not complying with a regulation and the consequences

The weighted WAC methodology adopted by DEL is founded in Dr. Richard Fiene’s national best practices model for child care weighted risk-assessment. Two parallel processes were conducted to collect input from stakeholders from across Washington: 1) Focus groups were used to collect input from key stakeholders in the field of early childhood education on which regulations within the Washington Administrative Code (WAC) should be included in a survey to be weighted in accordance with best practices for differential monitoring. 2) A Washington Weighted WAC Survey was designed to ask participants to designate the weight—or level of risk— of the proposed licensing rules. One weights were assigned to the WAC, how the weights would be used in relation to licensing compliance (i.e. enforcement) began to be developed. Finally, a plan for validating the new regulations, the WAC weights, and the new enforcement plan were developed. These two processes have yet to be implemented and are discussed further in the next section.

Upcoming and Ongoing Work

With the new chapter of aligned childcare regulations filed and set to be enacted in August of 2019, the DCYF is working to plan, test and implement the remaining monitoring support systems including the new differential monitoring checklist, the inter-rater reliability assessments and the risk assessment validation set the new enforcement/compliance approach. Figure 2 outlines the process for the remaining standards alignment work.

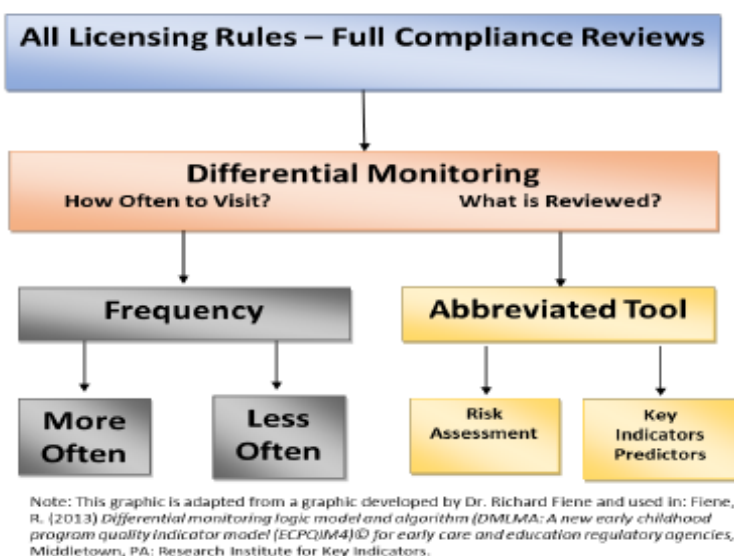
Figure 2: Standards Alignment Change Management Map



Differential Monitoring/Focused Checklist

Differential monitoring is a regulatory method to determine the frequency and depth of monitoring based on a providers' history with the regulations (Citation). Figure 3 describes how using the risk assessment and key indicator methodology can determine the type and frequency of checklists used to monitoring licensed child care programs.

Figure 3: Differential Monitoring Logic Model and Algorithm.



Currently, Washington State uses a differential system where highly compliant programs are assessed according to an abbreviated checklist using only the key indicator system. If a key indicator is found non-compliant, or a provider has a valid compliant finding since the previous monitoring visit, the licenser will complete a comprehensive checklist of all licensing rules. However, due to the addition of aligned standards as well as the risk assessment, child care licensing needed to consider changes to the differential monitoring system.

The new differential monitoring system will not only combine the risk assessment and key indicators but will also use a checklist focusing on the unique needs of each provide. This will be done by combining both an abbreviated checklist and a comprehensive checklist into one checklist system and then use only those regulations that apply to the provider. Monitoring visits will then begin with a baseline of abbreviated “applicable” regulations based on weight values. The baseline will contain key indicators, all regulations that pose an immediate risk of harm for children if found non-compliant (7 and 8 weight value) and a percentage of the remaining regulations based on risk level. For example, the baseline will have half of all regulations weighted 6, one-third weighted 5 and 4 and, one-fourth weighted 3, 2, and 1. Full compliance will be determined cumulatively over a four-year period.

Additionally, a baseline checklist may also have the ability to add historical non-compliances from the previous visit to ensure adequate follow up and that resources such as

technical assistance is being delivered where the provider needs the most assistance. Once a baseline is created, key indicators and highly risky regulations, when non-compliant, will trigger only those sections related to the non-compliance to be inspected further. This is designed to allow licensors to concentrate more heavily on areas of non-compliance while limiting time spent on areas where providers need minimal or no licensor support.

The focused checklist system is currently under development in the child care licensing data management platform and is scheduled for piloting in April 2019. The Child Care Licensing Division intends to train, test and include the focused checklist into a long term differential inter-rater reliability plan for licensing staff.

Enforcement

In conjunction with the weighting standards, a new system of enforcement was created to ensure enforcement of these rules is both timely and consistent. This approach was designed to not only incorporate the risk assessment (weights) into the new monitoring systems but was also designed to provide consistent enforcement throughout the state. This process provides needed clarity and transparency of when licensing and enforcement actions can and cannot take place.

The two-part approach consists of a 'single finding score' where each regulation has an assigned weight/risk value and each risk has pre-determined licensing and/or enforcement action possible to assist providers to return to compliance. The second part consists of the 'overall licensing score'. This is inclusive of the compilation of all single finding scores, using a mathematical equation, over a three-year period to determine a providers' overall compliance. The cumulative score value also determines any possible actions within a scale of compliance. This new approach is scheduled to go into effect once the majority of the risk assessment validations are completed in August 2020. Figure 4 and 5 explain each part of the approach.

Figure 4: Individual Weight Value and Available Compliance Actions

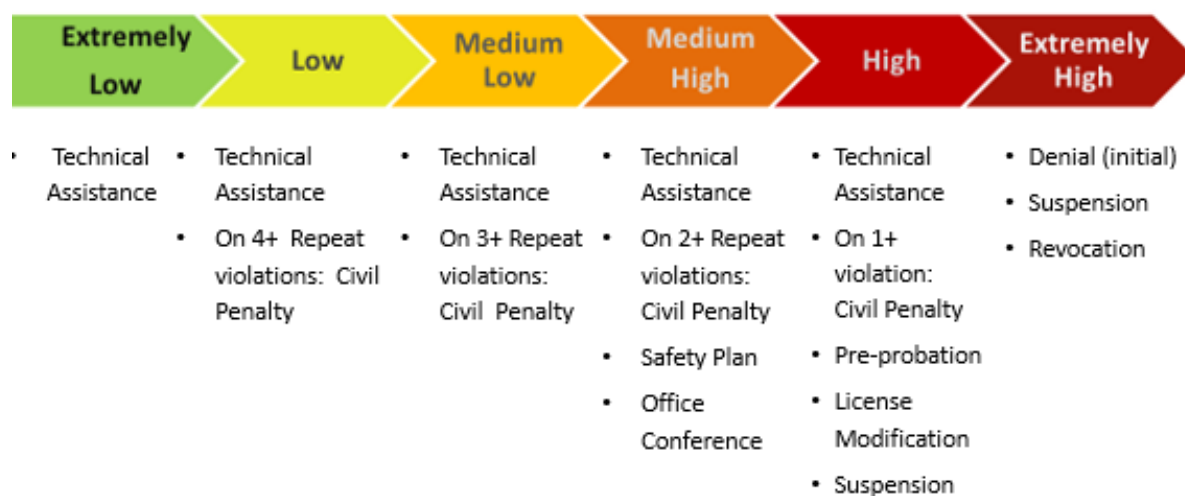
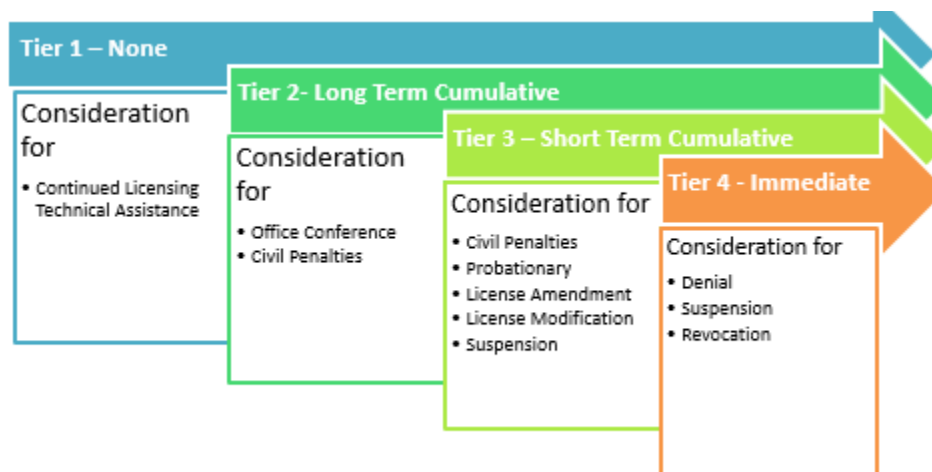


Figure 5: Cumulative Weight Value and Available Non-Compliance Actions



Validation

In order to ensure the accuracy of the risk assessment to identify relative risk to children as well as provider needs, the enforcement system will need to be validated. Validity of the aligned regulations and the enforcement plan will be determined through several different studies and will continue to be viewed as a continuous process with multiple goals:

- refining the weights and enforcement processes,
- improving system functioning, and
- increasing the credibility and value of licensing outcomes and of the licensed monitoring system as a whole.

A comprehensive validation plan includes multiple studies relying on different sources of information and asking different but related questions. These can be understood and organized around four complementary and interrelated approaches to validation and will be completed through four validation processes over the next 36 months. Please see the methodology for more detailed information.

Standards Validation. The first step was to ensure the aligned regulations correlate with national best practice through a standards validation process. Standards Validation is designed to ensure that the state regulations are aligned and correlate with the national standards. While it is expected that some state regulations exceed national standards and other will meet or fall below national standards, the overall expectation is to determine which regulations overlap and the coverage between the two (Zellman & Fiene, 2012). This step was recently completed after the final aligned rules were filed in June of 2018.

Measures Validation. This validation will measure compliance with all of the individual rules to ensure there is a high correlation between findings and enforcement/licensing actions. This process will ensure that the weight value of individual weight scores is informing licensors of appropriate actions. In short, this process will compare what did happen with what would have happened and will begin in August 2019.

Output Validation. This will discover the relationship (or correlation) between quality and compliance with the new regulations. Simply stated, a higher compliant provider (lower finding scores) should equate to a higher Early Achievers rating. Likewise, a provider with a higher finding score should also then have a lower Early Achievers rating. This process will also begin in August 2019.

Outcomes Validation. The final validation will be to compare the risk assessment rules to outcome data such as injury reports as well licensing and enforcement actions. This final validation will take place over a 12-24-month period and will begin as soon as the proposed regulation weights go into effect in August 2020. Table 1 outlines the validation timeline

Table 1: Validation Timeline

Validation Approach	What does it mean?	Completion Date
Standards	Does the WAC align with National Best Practices?	June, 2018
Measure	Are the enforcement actions taken appropriate?	May, 2020 (preliminary = April 2019)
Output	What is the relationship between quality and compliance with the new regulations?	June, 2020 (preliminary = May 2020)
Outcome	What does the data say? Are children in low risk programs less likely to get injured?	August, 2021 (Preliminary = TBD)

Definitions adapted from Zellman, G. L. & Fiene, R. (2012). *Validation of Quality Rating and Improvement Systems for Early Care and Education and School-Age Care*, Research-to-Policy, Research-to-Practice Brief OPRE 2012-29. Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Inter-Rater Reliability

The project of establishing Inter-rater reliability (IRR) of child care licensors across Washington State is currently being designed to establish a common understanding of the new aligned licensing regulations developed according the Early Start Act (2015). In addition, the system will be able to inform licensing oversight of the consistent use of the monitoring instruments through regular inter-rater checks to identify varying interpretations of regulations, gaps in training needs, and misuse of the checklist itself. The proposed plan includes a detailed and intensive mixed method training plan regarding the content of the aligned regulations as well as trainings specific to new policies and procedures. Finally, the plan is inclusive of detailed data collection methodology.

Piloting of the new IRR process began in August 2018. Several cohorts of licensing staff have been designated and strategically placed to evaluate and inform needed changes in the training and data methodology before rating of all licensing staff begin when aligned regulations are enacted and the focused checklist is implemented (August 2019). Once all

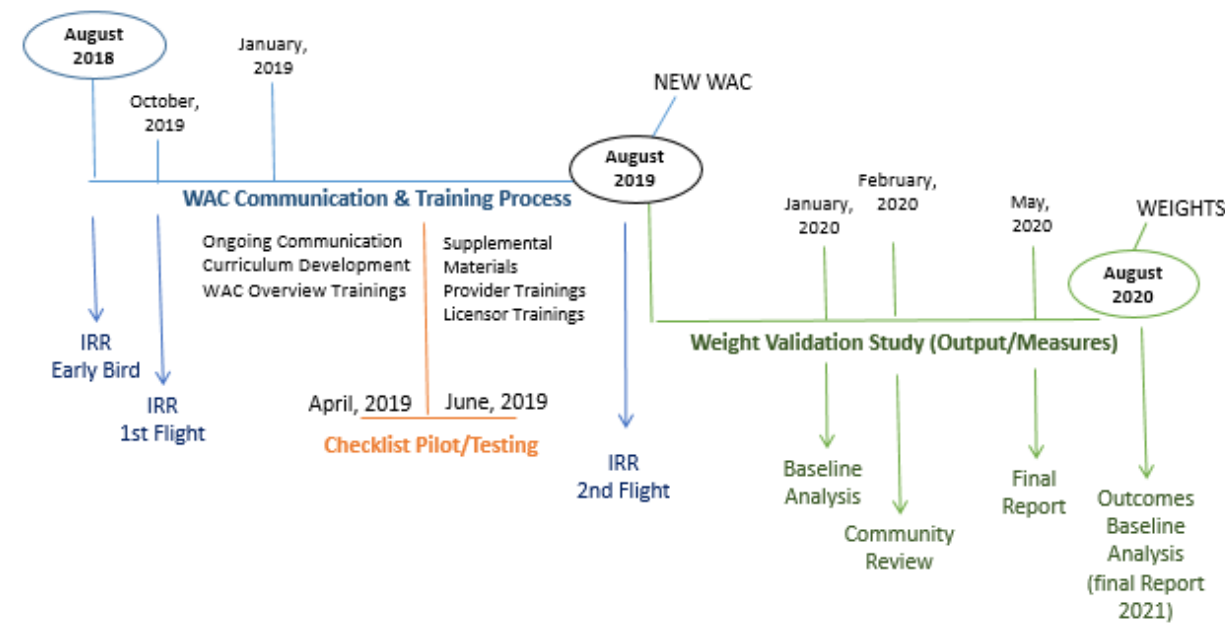
licensing staff have completed the first initial rating for absolute inter-rater reliability, child care licensing will move into a maintenance plan to ensure staff remain reliable while completing licensing oversight in a differential system. The ongoing methodology is still in development and will depend largely on the success and identified improvements during the pilot. Please reference the data methodology for more detailed information.

Conclusion

This brief provides a state example of how best to apply public policy analysis to regulatory and standards development, validation and implementation. It provides a blueprint to follow as state administrators deal with the complex task of rule formulation within the context of differential monitoring involving risk assessment and key indicators. Washington State has provided actual study examples to Zellman and Fiene's (2012) *Conceptual Framework for Validation* by applying it to licensing and regulatory compliance.

Washington staff have creatively utilized legislation to align several sets of standards, a goal that has had difficulty coming to fruition in many other states. This is a public policy approach that is both cost effective and efficient. Building upon this base they have been able to craft a plan to test both validity and reliability of the data and decisions being made related to regulatory compliance, program quality and child outcomes. Figure 6 outlines the comprehensive timeline for each of the upcoming pilots and validations.

Figure 6: Process Timeline



Weighted Validation Methodology

Gabe Ortiz and Sonya Stevens

Reviewed by Dr. Richard Fiene

Validity of the aligned regulations and the enforcement plan will be determined through several different studies and will continue to be viewed as a continuous process with multiple goals:

- refining the weights and enforcement processes,
- improving system functioning, and
- increasing the credibility and value of licensing outcomes and of the licensed monitoring system as a whole.

A carefully designed validation plan will provide a sound theoretical and empirical basis for the licensing risk assessment and enforcement plan. Ongoing validation activities, such as those listed below, that are carried simultaneously with monitoring and enforcement activities can help the licensing division improve its measures and effectiveness throughout its development and implementation (Zellman & Fiene, 2012). A comprehensive validation plan includes multiple studies relying on different sources of information and asking different but related questions. These can be understood and organized around four complementary and interrelated approaches to validation.

1. Standards Validation

Goal: Standards Validation is designed to ensure that the state regulations are aligned and correlate with the national standards. While it is expected that some state regulations exceed national standards and other will meet or fall below national standards, the overall expectation is to determine which regulations overlap and the coverage between the two (Zellman & Fiene, 2012).

Data Collection: Two forms of data will be used to calculate the correlation; the proposed aligned WAC and the national standards outlined in Stepping Stones, Caring for our Children. Regulations will be placed into a table to compare where regulations from Washington do not meet, meet, or exceed national standards.

Timeline: As the proposed aligned WACs are reviewed and approved for filing, data will be placed into the table. The process is scheduled to be complete by the end of March by Licensing Analysts. This final product will be reviewed by NARA consultant Dr. Richard Fiene and the DEL technical writing team; calculation will be completed by the second week of July.

Sample: There is no sample as this validation process will be inclusive of all the licensing regulations.

Next Steps: *As each batch of the regulations is approved for filing the licensing analysts will begin inputting the data into the standards validation template.*

- *Technical writing team will forward each batch of the aligned regulations to the licensing analysts as they are sent to the policy analyst*
- *Licensing analysts will input the regulation into the template and make the initial analysis.*
- *Second review will be completed by the technical writing team*
- *Final analysis and calculation will be completed with the assistance of the NARA consultant.*

Stakeholders: *Licensing Analysts, Technical Assistants, Dr. Richard Fiene*

2. Measures Validation

Goal: Measures the relationship with the weighted rules and the determination of the license and/or licensing actions found in the single finding scores. In other words, this validation will measure compliance with all of the individual rules to ensure there is a high correlation between findings and enforcement/licensing actions. This process will ensure that the weight value of individual weight scores is informing licensors of appropriate actions. In short, this process will compare what did happen with what would have happened. The correlation between the compliance issues and the risk assessment should be at the .50 level or higher (.50+) (Zellman & Fiene, 2012).

Data Collection: Licensor will begin licensing visits under the new regulations beginning September 2019. While the enforcement regulations (the use of the weights) will not be implemented during this time period, the weight values and calculations will continue to be collected for validation purposes. This will allow the analysis to compare licensing actions being made to what would have been prescribed using the enforcement matrix in the single finding score. Data will include individual non-compliance findings placed on a compliance agreement as well as any enforcement actions taken through the collection of legal letters and licensor notes.

Timeline: Our goal is to complete this analysis within nine months after content implementation with an initial analysis and update after six months of data collection. This will help to inform any recommended changes to the individual weight values prior to all staff enforcement training and implementation in 2020.

Selection Criteria: We will use the 400-600 monitoring visits identified in Output Validation (below) and all non-monitoring visits to collect single WAC violations beginning with the implementation of 110-300 WAC content. Due to checklist build limitations, there will be only one baseline checklist with expandable sections for all providers during the first year of implementation. However, data will need to be inclusive of all regulations to ensure validity. Therefore, we will need to identify 400 licensing monitoring visits that under currently policy would require a comprehensive checklist. It is possible we will need to pull an extra 100-200 to cover any discrepancies in reliability discovered during inter-rater reliability (see IRR methodology). We will also need to ensure there is an appropriate sample of each provider type as well as other factors such as rural/urban, language representation and so on. Because new monitoring policy allowing visits to take place anytime within a fiscal year we will need to inform the licensing units of the sites selected for long visits prior to July 1st, 2019 to ensure they will not be completed until the new regulations are in effect.

Analysis Summary: Licensing Analysts will compare the single proposed weights per violation to the actions or non-actions taken (what should have happened based on weight scores versus what did happen without the weight scores). Licensing Analysts will also use the enforcement calculation during the initial year to create a baseline validation of the overall compliance matrix: Comparing what did happen to what would happen when weights are implemented.

Next Steps: *The selection of these data is dependent on work to be completed by IT during the checklist build. Specific steps need to be considered:*

- LA's will identify the sample from the group assignment by June 15th, 2019.
- Need to consider regional and demographic representation
- Checklist build with the capability to collect scoring calculations (for LA data collection only) and any licensing or enforcement actions taken.
- Need to work with RA's and Supervisors to ensure the identified visits will be completed in the needed timeline

Stakeholders: Licensing Analysts, DCYF Information Technology, Dr. Richard Fiene

3. Output Validation

Goal: Output validation will discover the relationship (or correlation) between quality and compliance with the new regulations. Simply stated, a higher compliant provider (lower finding scores) should equate to a higher Early Achievers rating. Likewise, a provider with a higher finding score should also then have a lower Early Achievers rating.

Data Collection: For this process, we will use the same sample collected for measures validation where licensing monitoring visits are completed and simultaneous with ERS rating per licensee. In conjunction with the sample section in Measure Validation, this process will also require a crosswalk between licensing and Environmental Rating Scales (ERS) ratings to be completed. Once we have identified the areas that licensing and Early Achievers overlap we will be able to identify the comparable data that will be used. The most reliable results will be when the Early Achievers rating and the licensing monitoring visit happen within 1 – 2 months of each other. However, if visits cannot be identified within the timeline, the sample will need to ensure there is no longer than 12 months between the two visit types.

Analysis Summary: The providers ERS scoring results will be compared to the comprehensive monitoring checklist) completed by licensors. Expected correlations should be at a level of .30 or higher (.30+). The lower level of correlation is due to the fact that monitoring visits and program quality are measuring different aspects of quality such as health & safety versus overall classroom quality (Zellman & Fiene, 2012). This process will inform the enforcement's overall licensing scoring distribution (i.e. providers with higher quality will be found in tiers one and two of the overall licensing score while providers with the lowest quality will be found in tiers 3 and 4).

Timeline: Our goal is to complete this analysis within nine months after content implementation with an initial analysis and update after six months of data collection. This will help to inform any recommended changes to the overall scoring distribution and correlated enforcement actions prior to all staff enforcement training and implementation.

Selection Criteria: Selection criteria would include Early Achievers providers scheduled to be rated within the validation timeline. From these providers, a sample of providers will be identified as being due for a comprehensive checklist under current policy and procedures. If a full sample cannot be found using both Early Achievers rating schedule and comprehensive checklist timeline criteria then the selection of Early Achievers providers with the scheduled rating will take priority then the remaining sample will be selected from the licensing monitoring visits correlating with providers receiving Early Achievers ratings and will use a comprehensive checklist.

Next Steps: *Contact Rachel Brown-Kendall to ensure Early Achievers rating scales are accessible for this process to answer the following questions:*

- *Is there a window for rating that we can count on?*
- *Which providers are going to be rated within the timeframe?*
- *Do we have access to the rating scales (not just the rating/ deficiencies)?*

Stakeholders: *Licensing Analysts, Early Achievers, (potentially) Eastern Washington University, (potentially) Eastern Washington University, Dr. Richard Fiene*

4. Outcomes Validation

Goal: Outcomes validation will compare the results from the monitoring tools with any children's health and safety outcomes. Overall, this validation will answer the question; are children in low risk programs less likely to get injured? Likewise, are children in high-risk programs more likely to get injured? This validation process will allow the agency to complete an overall assessment of the risk assessment and the enforcement systems.

Data Collection: In order to complete this validation, it will be important to identify data collection points inclusive of injury reports, complaint findings and immunization records. This will allow a comparison of violations to injuries and outbreak data. The correlations between site visit inspections and child injuries/outbreaks should be .30 or higher (.30+)(Zellman & Fiene, 2012).

Timeline: It is expected that this validation study will be inclusive of 24 months of data collection ensuring regulations are completely reviewed. Regular check-in and update analyses will be scheduled. A preliminary report after 12 months after enforcement new regulations are implemented will be completed to identify outlier non-correlation between non-compliant weights on the baseline checklist and injury and outbreak data. However, full validation will be completed after 24 months after rule implementation (12 months after enforcement regulations are implemented) to include all regulations once checklist rotations are implemented. Additionally, it is recommended outcomes validation continues at regular intervals thereafter aligning with differential monitoring.

Selection Criteria: The same sample identified for output validation will be used for the initial outcomes validation process. Ongoing methodology to be determined.

Next Steps: *This validation requires three unique reports to be built from the licensing database. Each of the following reports must be considered with the checklist build:*

- *Injury reports attached to valid non-compliant findings*
- *Immunization information attached to outbreak reports in licensed care*
- *Complaint inspections with valid findings*

Stakeholders: *Licensing Analysts, DCYF Research, (potentially) Department of Health, Dr. Richard Fiene*

Inter-Rater Data Methodology

Sonya Stevens and Gabe Ortiz

Reviewed by the ESA TA Team and Dr. Richard Fiene

Background

The project of establishing Inter-rater reliability of child care licensors across Washington state is taking place to establish a common understanding of the new aligned licensing regulations developed according the Early Start Act (2015). In addition, the system will be able to inform licensing oversight of the consistent use of the monitoring instruments. The following methodology is developed to help guide the data collection methods, sample size determination, analysis and reporting.

Method

Data will be collected within three phases: (1) A small group (Early Birds) of data collectors will be utilized in order to fully assess the Inter-Rater processes and instruments including the protocols and ensuring filed practice will inform training. (2) A larger pilot (First Flight) will be used to establish quality assurance standards, and test knowledge implementation. (3) All staff (Second Flight) baseline rating and continued maintenance.

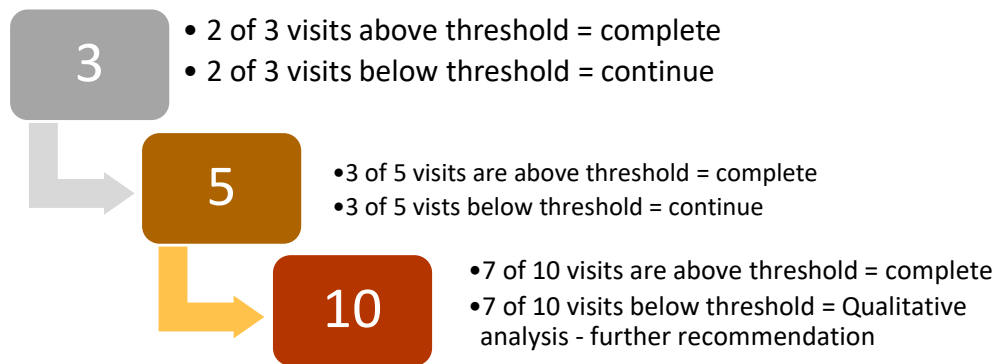
Sample

Sample for the purpose of this process means the amount of visits that will be required by each collector to determine individual reliability scores. Sample size is dependent on each collector's ability to reach a reliable threshold determined by the results of the early bird cohort in combination with empirically proven thresholds (80% using the Cohen's Kappa coefficient or 90% using simple agreement).

Phase One (Early Bird Flight): 8 data gathers

This phase will use a 3 to 5 strategy where Early Birds (EB) will be paired together to complete one to two visits to become familiar with the instrument and identify additional training needs. This could include virtual visits during the training. Once initial evaluations have been completed, Early Birds will then complete second and/or third visit for the purpose of achieving reliability as well as assessing reliability thresholds*. Once three visits are completed in the field and a data collector reaches a minimum score of 80% (Using Cohens Kappa) or higher on two or more visits they will be considered reliable. If two of the three scores are below 80% the collector will complete two more checklists. If the scores are still below 80% additional analysis will be used to identify cause, recommend changes and/or training. The data collector will then be required to start the process over until reaching the desired scores.

Note* If the inter-rater coefficient is higher than 80% for the first group then the expected levels for IRR could be higher for the following group of raters.



Phase Two (First Flight): 24 data collectors

This phase will use a 3 to 10 strategy where data collectors will be paired with an EB to complete one visit, then a second EB will be paired for the second visit and so on. Once three visits (inclusive of both family home and center) are complete and a data collector reaches a score of 80% (this amount could be higher depending on results of the Early Bird) or higher on two or more visits they will be considered reliable and complete. If two of the three scores are below 80% the collector will complete two more checklists. If the scores are still below 80% additional analysis will be used to identify cause, recommend changes and/or training. The data collector will then be required to complete five more visits before reliability can be determined.

Data Collection

Checklist Data: Data will be collected on tablet computers using the GoCanvas Application. Each team will be trained in the use of the tablet program by Technical Assistant Trainers. Data will be transmitted to DCYF secure server in Excel format, to the Licensing Analyst team. These data will document:

- Visit ID/Licensor
- Capacity; Type of Facility/Ages of Children Served
- Demographical Data: language of provider/interpreter used/language of licensor; was interpreter used
- Number of consistent/inconsistent WACs between pairs
- List WACs without agreement
- Areas on the checklist that are N/A
- Capturing all drop downs
- Time Measurements for the field visit (length of time on site, on the checklist, time of day/date stamp)
- Document comments
- How long a licensor assigned to a provider (Second Flight)

Analysis

IRR Rating: Checklists results will be generated into an excel spreadsheet and sent to the licensing analysts where results can be compared.

Quantitative: IRR scores will be determined by comparing checklist outcomes using Cohen's kappa coefficient (κ). This is a statistic calculation which measures inter-rater agreement

between all the checklist (categorical) items at any one visit. Using Kappa calculations is thought to be a more robust measure than simple percent agreement calculation, as κ takes into account the possibility of the agreement occurring by chance. Alternatively, it is also possible to use a simple agreement calculation whereby the total of agreement is divided by the total amount of items inspected. An empirically proven acceptability rate for this agreement is 90%. Agreements will be translated into a value of one and disagreements will be recorded into a zero value. Once each visit is scored, the rating will be translated onto a worksheet tracking each licenser until acceptable thresholds are met.

Qualitative: Collector narratives will be collected through weekly feedback sessions and Question and Answer forms. These will be compiled and organized in a fashion to allow for the evaluation of interpretations, record decision points and guide training. These data points are TBD.

Reporting

Once analysis is complete a report and recommendations from the Licensing Analysts will be forwarded to the decision making team.

Phase Three (All staff – year one of implementation)

A first flight reliable rater will accompany each licenser on site visits at least twice in the first year of implementation using a full checklist to determine absolute reliability. Once a licenser has two scores at or above the acceptable threshold the licenser will not be required to continue visits for the monitoring year. This will need to be inclusive of a family home and center providers. Licensers will continue to have inter-rater checks until scores reach or exceed the preset reliability level for each provider type.

Provider Sample

We will use the 400-600 monitoring visits identified for measures and output validations beginning with the implementation of 110-300 WAC content. We will first identify 400 licensing monitoring visits that under currently policy would require a comprehensive checklist. It is possible we will need to pull an extra 100-200 to cover any discrepancies in reliability discovered during inter-rater reliability. We will also need to ensure there is an appropriate sample of each provider type as well as other factors such as rural/urban, language representation and so on. Because new monitoring policy allowing visits to take place anytime within a fiscal year we will need to inform the licensing units of the sites selected for long visits prior to July 1st, 2019 to ensure they will not be completed until the new regulations are in effect.

Ongoing Inter-Rater Assessment Needs

Beginning in August 2019 through August 2020 the focus will be to ensure “absolute” reliability assessment using comprehensive checklists from the identified provider sample used during the various validation studies. After absolute reliability is determined, the department will need to identify methodology inclusive of ongoing “relative” interrater checks in the subsequent years post FY 2019/2020 completed using differential monitoring until a full data set (four year rotations) can be determined per licenser inclusive of all licensing regulations. This methodology is yet to be developed and will include extensive data collection for each licenser. New licensing staff will need to complete training and the absolute inter-rater reliability assessment within the first 12 month of employment.

Relationship of Size of ECE Programs, Non-Compliance (NC) with Licensing Rules, and QRIS Scores in the State of Washington: RIKI Technical Research Note

Richard Fiene, Ph.D.

November 2017

A question regarding the size of an early care and education (ECE) program and overall compliance with licensing rules was asked by ECE providers in the State of Washington. The purpose of this technical research note is to answer this question and other associated questions.

State of Washington staff pulled a random sample of approximately 200 ECE providers representing the state as a whole. Various descriptive and correlational analyses were used to analyze any relationships amongst the data.

Based upon the following chart (**Chart 1**) it is clear that there is no relationship between the size of an ECE program and the level of non-compliance with licensing rules ($r = .113; -.017; .178$ are all non-significant results). What are significant results are the correlations across the years of the non-compliance with licensing rules as one would expect ($r = .747; .623; .47$ are all significant at the $p < .0001$ level).

Chart 1 – Correlations of ECE Size of Program and Non-Compliance with Licensing Rules

	Size	NC1	NC2
NC1	0.113		
NC2	-0.017	0.747	
NC3	0.178	0.623	0.47

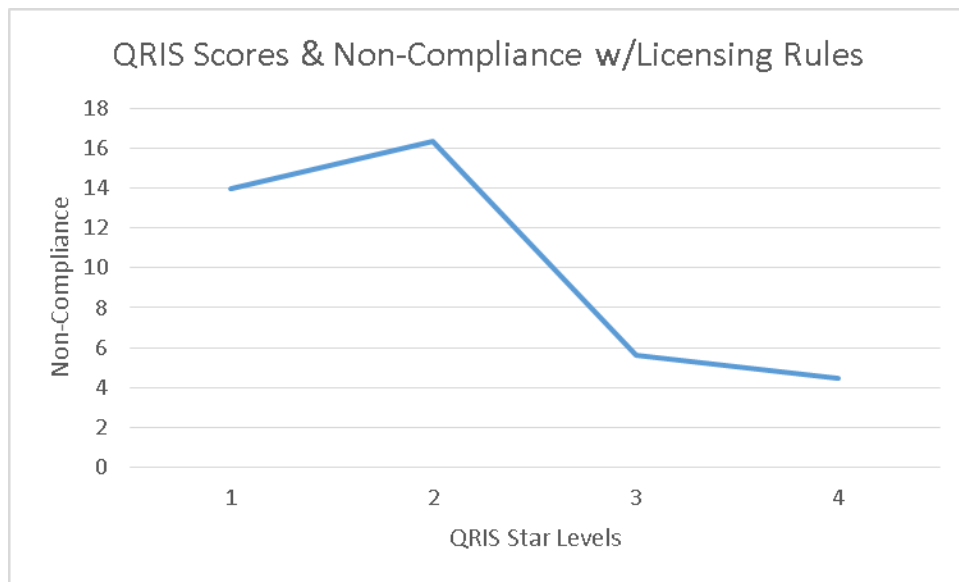
NC1 = Year 1 non-compliance (NC) with licensing rules data collection

NC2 = Year 2 non-compliance (NC) with licensing rules data collection.

NC3 = Year 3 non-compliance (NC) with licensing rules data collection.

Another very interesting question asked by State of Washington staff was the relationship between QRIS scores and non-compliance (NC) with licensing rules. The correlation did reach significance ($r = -.36; p < .008$) and there is definitely a trend in the data when graphed (see **Figure 1**). This trend demonstrates that as the QRIS Star Level increases, overall non-compliance with licensing rules decreases.

Figure 1 – Relationship Between QRIS Scores and Non-Compliance (NC) with Licensing Rules



In further analyses there also was a significant correlation between the size of an ECE program and QRIS scores ($r = .47$). And when the Star levels (1-4) were compared via One-Way ANOVA for non-compliance with licensing rules, a significant difference was found ($p < .05$) (see **Chart 2**). This is the first demonstration of a positive relationship between QRIS (Program Quality) and Licensing (Program Rule Compliance). As the Star Level increases, there is a corresponding increase in the compliance with Licensing Rules.

Chart 2 – QRIS Scores and Non-Compliance with Licensing Rules (PC x PQ)

QRIS Stars	NC1a	NC2a	NC3a	NC13
1	14.23	17.62	10.15	14.00
2	22.50	14.00	12.50	16.33
3	6.31	4.25	6.31	5.62
4	5.23	4.31	3.92	4.49

NC13 = NC1a + NC2a + NC3a where NC13 is an overall mean of the three years of data.

NC1a, NC2a, and NC3a are means for each of the year's data.



Child Care Center Abbreviated Checklist

INSPECTION TYPE

VISIT DATE

I. PROVIDER INFORMATION

PROVIDER NAME		PROVIDER ID	ISSUE DATE	
DOING BUSINESS AS		ANNIVERSARY DATE	EXPIRATION DATE	
FACILITY TYPE	TELEPHONE NUMBER	EMAIL ADDRESS		
FACILITY ADDRESS	CITY	STATE	ZIP CODE	
PRIMARY CONTACT PERSON		CAPACITY	LICENSING TYPE	
LICENSE STATUS	REFERRAL STATUS	AGE RANGE From: To:		

II. WORKER ASSIGNMENT

LICENSOR	EMAIL ADDRESS	TELEPHONE NUMBER
LICENSING SUPERVISOR	EMAIL ADDRESS	TELEPHONE NUMBER

III. HOURS OF OPERATION

DAYS OF OPERATION <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun	HOURS OF OPERATION a.m. through p.m.
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Fiene Indicators

Codes: C = Compliance D = Discussed N = Non Compliance NA = Not Applicable E = Exception Granted

Section	Requirement		Code
1010	Center Director Qualifications	Center director meets requirements/qualification	
1020	Program Supervisor Qualifications	Program supervisor meets requirements/qualifications	
2030	Staff Interaction with Children	Interactions between the staff and children are nurturing, respectful, supportive, and responsive	
2040	Behavior Management	Behavior management and guidance practices are fair, reasonable, consistent and related to the child's behavior needs and stage of development	
		Prevent and prohibit corporal punishment, verbal abuse, use of inappropriate physical restraints, or the using or withholding of food or liquids as punishment	
		Any physical restraint method must be documented in an incident report, placed in the child's individual record and a copy given to the parent	
2090	Child Ratio/Group Size	Ensure children are within continual visual and auditory range	
		Maintain required staff-to-child ratios indoors, outdoors, on field trips and during rest periods Group size: ____ Staff/child ratio: ____	
		Conduct group activities within the group size according to the age of the children	

Staff Records										
Staff Name	App	Background Check	TB Test	Program Orientation	Disaster Plan	HIV/AIDS/BBP Training	CPR Card	First Aid	STARS Training	
									Basic	10 hrs
WAC Citation	7050 (1) (a)	7050 0060 (3)	7050 (6)(e)	7050 (6)(d)(i)	5030 (6)(a)	7050 (6)(d)(iii)	7050 (6)(d)(iv)	7050 (6)(d)(iv)	7050 1060	7050 1070
Compliance Code										
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date Expired	Date Expired	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date Expired	Date Expired	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date Expired	Date Expired	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date Expired	Date Expired	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date Expired	Date Expired	<input type="checkbox"/>	<input type="checkbox"/>

Children's Records										
Child's Information	Enrollment Application	Health History	Individual Health Plan	Medical Consent	Medication Authorization	Medication Dispensed	Physical Exam Date	Health Care Providers	Immunizations	Parent Communication
WAC Citation	7010 (1)(a)	7010 (1)(d)	7010 (1)(e)	7010 (1)(f)	7010 (1)(h)	7010 (1)(j)	7010 (3)(a)	7010 (3) (f) (g)	7010 (4)(a)	2080
Compliance Code										
Child #1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child #2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child #3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child #4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child #5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Postings			
Codes: C = Compliance D = Discussed N = Non Compliance NA = Not Applicable E = Exception Granted			
Section	Requirement		Code
7080	Required Posting	Child care center license	
		Duty hours with staff names, and operating hours	
		Typical activities schedule and meal times	
		Meal and snack menus	
		Fire safety record and evacuation plans including diagram of exit routes	
		Emergency telephone numbers	
		Nondiscrimination poster	
		Required postings for staff:	
		▪ Hand-washing practices	
		▪ Diaper-changing procedures	
		▪ Disaster preparedness plan	

Postings (continued)			
Codes: C = Compliance D = Discussed N = Non Compliance NA = Not Applicable E = Exception Granted			
Section	Requirement		Code
7080	Required Posting (continued)	Written lesson plans (2010)	
		Center and health care policies and procedures (3010)	
		Notice to parents that copies of recent licensing checklists, monitoring checklists and compliance agreements for any deficiencies are available for review	
Record Keeping			
2080	Parent Communication (written)	Enrollment/admission	
3170	Food Service Standards	At least one person with a Washington state food handler’s permit to monitor food handling and service	
		Staff cooking full meals must have a food handler’s permit	
5030	Disaster Plan	Written disaster plan developed and implemented	
		Plan is annually reviewed and signed by director and staff	
		Plan is reviewed and signed by parents when children are enrolled	
		Monthly fire drill evacuation conducted and documented	
		Quarterly disaster drills conducted and documented	
7010	Children’s Files	Confidential files on premises for each child in care that include:	
		▪ Registration information	
		▪ Health history/individual child care plan	
		▪ Medications given	
		▪ Authorizations	
		▪ Copies of illness or injury reports	
		▪ Certificate of immunization status (CIS)	
7030	Attendance Records	Daily attendance record with signature on file	
7050	Personnel Records and Policies	Employment application	
		Background check for all staff	
		Complete owner, staff and volunteer personnel records on premises	
		Written documentation of training and staff meetings to include:	
		▪ Staff orientation	
		▪ Ongoing training; including annual infant safe sleep if applicable	
		▪ Blood borne pathogen training (including HIV/AIDS)	
		▪ CPR/first aid	
		▪ Food handler card (if applicable)	
		▪ STARS training	
		▪ Staff meeting	
		▪ Child abuse, neglect and exploitation	
		▪ Tuberculosis (TB) testing	
Background Clearance Requirements			
170-06	Background clearance requirements	Background clearance requirements	
Reporting			
6040	Child Abuse and Neglect	Immediate reporting of suspected child abuse, neglect, or exploitation and children are protected from child abuse and neglect as required in RCW 26.44.030	

Day Care Insurance RCW 43.215.533				
RCW	Day Care Insurance		Proof of Insurance	
Medication and First Aid/CPR				
Codes: C = Compliance D = Discussed N = Non Compliance NA = Not Applicable E = Exception Granted				
Section	Requirement			Code
1100	First Aid/CPR	First Aid/CPR requirements met		
3070	Medication	Original container/labeling requirements met		
		Medication stored inaccessible to children		
		Internal and external medication stored separately		
		Medication stored according to specific manufacturers or pharmacists directions		
		All controlled substances in locked container		
5010	First Aid Supplies	First aid supplies adequate, available in center and in vehicles and conform with center policies		
		First aid supplies are appropriately stored and inaccessible to children		
General Safety and Sanitation				
3020	Hand-Washing Procedures for Staff	Warm water and soap present		
		Hands washed at required times		
3040	Hand-Washing Procedures for Children	Warm water and soap present		
		Hands washed at required times		
170-300-0291	Infant and toddler safe sleep practices	Infant safe sleep practices are followed		
4120	Diaper Changing Procedure	Diaper changing table with barrier and area is impervious to moisture and cleanable		
		Diaper changing area cleaned and sanitized between children		
		Soiled diapers disposed of in hands-free covered containers		
		Diaper-changing area adjacent to a hand-washing sink		
5020	Safe Environment	Free from injury hazards included but not limited to: burns, drowning, choking, cuts, entrapments, falls, gun shots, hearing loss, objects falling, pinches, poisons, punctures, crushed, shocked, trapped or tripped		
		Child-height handrails		
		Guardrails for stairs, elevated play areas		
		Electrical outlets protected with tamper-resistant receptacles or non-removable covers		
		Shielded light bulbs and tubes		
		Windows screened (if applicable)		
		Sleeping equipment or indoor climbing structures are not next to windows unless safety glass installed		
		Shielded heater (if applicable)		
		Portable heaters prohibited		
		Entrance/exit doors monitored		
		Telephone accessible to staff		
		Flashlight/emergency lighting device		

General Safety and Sanitation (continued)				
Codes: C = Compliance D = Discussed N = Non Compliance NA = Not Applicable E = Exception Granted				
Section	Requirement		Code	
5040	Clean and Sanitized Environment	Surfaces must be easily cleanable using approved cleaning solution according to cleaning schedule		
		Building, equipment and premises maintained in a clean and sanitary manner		
		Premises free from rodents, insects and other pests		
		Written policies must include cleaning and sanitizing procedures		
Window Blind Pull Cords RCW 43.215.360				
RCW	Window Blind Pull Cords	Window blind cords do not form a loop		
Program, Activities and Routines				
2010	Play Materials, Equipment and Materials	Children have adequate supply of accessible, culturally relevant, age-appropriate learning materials		
		Children have a current daily schedule of activities and lesson plans that are developed to meet the children’s developmental, cultural, and individual needs		
		Include at least one (1) activity daily for each of the following:		
		Child-initiated activity (free play)		
		Staff-initiated activity (organized play)		
		Individual choices for play		
		Creative expression		
		Group activity		
		Quiet activity		
		Active activity		
		Large- and small- muscle activities		
		Indoor and outdoor play		
		Plan for smooth transitions by establishing familiar routines and using transitions as a learning experience		
		Afford staff classroom planning time		
		2130	Outdoor Play Area	A safe outdoor or equivalent play area is provided
Square footage of play area:				
Minimum 75 useable square feet per child				
Outdoor or equivalent play area used daily				
A variety of age-appropriate outdoor play equipment is provided: <ul style="list-style-type: none">▪ Climbing▪ Pulling▪ Pushing▪ Riding▪ Balancing				
Equipment and ground cover arranged to prevent child injury				
Maintenance of playground equipment to prevent child injury				

Summary, Comments and Recommendations:**Signatures:**Compliance Agreement: ☐ Yes ☐ No

Date:

Licensee Signature:

Date:

Licensor Signature:

Date:

Health Specialist Signature:

Date:

WASHINGTON'S *STEPPING STONES*¹ RISK FACTORS ANALYSIS

The purpose of this analysis is to provide Washington DCYF child care licensing administrative codes (WAC) with a basic risk factor analysis comparing its child care center rules to ***Stepping Stones (SS)*** standards. This analysis will delineate, based upon ***Stepping Stones'*** major content areas (chapters from ***Caring for our Children (CFOC)***), where there may be gaps in their child care licensing rules.

This analysis is a summary look at the comparison between ***Stepping Stones*** and Washington's child care licensing rules; it is not intended to be an in-depth crosswalk between the two sets of standards and rules. In order to do that type of analysis, ***Fiene's Stepping Stones to Validate State Rules Template*** (2013) is the suggested source to use.

This comparison was completed on the major chapter headings in ***Stepping Stones*** and ***Caring for our Children***. The following table (Table 1) provides the detail of the contents of each content area/risk factor.

Table 1 – Major Content/Risk Factor Areas (1-8) and Specific Content for Each Area

1. STAFFING	<ul style="list-style-type: none"> A. CHILD:STAFF RATIO AND GROUP SIZE B. RECRUITMENT AND BACKGROUND SCREENING C. DIRECTOR'S QUALIFICATIONS D. TEACHER'S QUALIFICATIONS E. PRE-SERVICE TRAINING F. ORIENTATION TRAINING G. FIRST AID AND CPR TRAINING H. STAFF HEALTH
2. PROGRAM ACTIVITIES FOR HEALTHY DEVELOPMENT	<ul style="list-style-type: none"> A. PROGRAM ACTIVITIES FOR INFANTS, TODDLERS, PRESCHOOLERS, AND SCHOOL AGE CHILDREN B. SUPERVISION AND DISCIPLINE C. HEALTH INFORMATION SHARING D. HEALTH EDUCATION FOR CHILDREN E. HEALTH EDUCATION FOR STAFF F. HEALTH EDUCATION FOR PARENTS

3. HEALTH PROMOTION AND PROTECTION	<ul style="list-style-type: none"> A. DAILY HEALTH CHECK B. ROUTINE HEALTH SUPERVISION C. PHYSICAL ACTIVITY AND LIMITING SCREEN TIME D. SAFE SLEEP E. ORAL HEALTH F. DIAPERING AND CHANGING SOILED CLOTHING G. HAND HYGIENE H. EXPOSURE TO BODY FLUIDS I. EMERGENCY PROCEDURES J. CHILD ABUSE AND NEGLECT K. INCLUSION/EXCLUSION DUE TO ILLNESS L. CARING FOR CHILDREN WHO ARE ILL M. MEDICATIONS
4. NUTRITION AND FOOD SERVICE	<ul style="list-style-type: none"> A. MEAL SERVICE, SEATING, SUPERVISION B. FOOD BROUGHT FROM HOME C. KITCHEN AND EQUIPMENT D. FOOD SAFETY E. MEALS FROM OUTSIDE VENDORS OR CENTRAL KITCHEN F. NUTRITION LEARNING EXPERIENCES FOR CHILDREN G. NUTRITION EDUCATION FOR PARENTS
5. FACILITIES, SUPPLIES, EQUIPMENT, AND ENVIRONMENTAL HEALTH	<ul style="list-style-type: none"> A. GENERAL LOCATION, LAYOUT, AND CONSTRUCTION OF THE FACILITY B. SPACE PER CHILD C. EXITS D. STEPS AND STAIRS E. EXTERIOR AREAS F. VENTILATION, HEATING, COOLING, AND HOT WATER G. LIGHTING H. NOISE I. ELECTRICAL FIXTURES AND OUTLETS J. FIRE WARNING SYSTEMS K. WATER SUPPLY AND PLUMBING L. SEWAGE AND GARBAGE M. INTEGRATED PEST MANAGEMENT N. PREVENTION AND MANAGEMENT OF TOXIC SUBSTANCES O. TOILET AND HANDWASHING AREAS P. DIAPER CHANGING AREAS Q. SLEEP AND REST AREAS

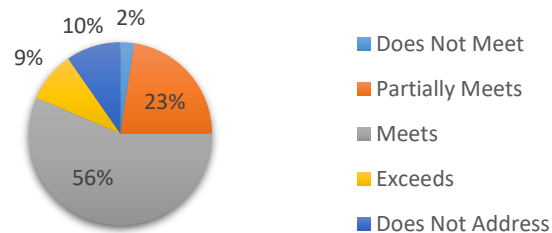
6. PLAY AREAS/PLAYGROUNDS AND TRANSPORTATION	<ul style="list-style-type: none"> A. PLAYGROUND SIZE AND LOCATION B. USE ZONES AND CLEARANCE REQUIREMENTS C. PLAY AREA AND PLAYGROUND SURFACING D. INSPECTION OF PLAY AREAS AND EQUIPMENT. E. ACCESS TO AND SAFETY AROUND BODIES OF WATER F. POOL EQUIPMENT AND MAINTENANCE G. WATER QUALITY OF POOLS H. TRANSPORTATION SAFETY
7. INFECTIOUS DISEASES	<ul style="list-style-type: none"> A. HOW INFECTIONS SPREAD B. IMMUNIZATIONS C. RESPIRATORY TRACT INFECTIONS D. ENTERIC (DIARRHEAL) INFECTIONS AND HEPATITIS A VIRUS (HAV) E. SKIN AND MUCOUS MEMBRANE INFECTIONS F. BLOODBORNE INFECTIONS G. HERPES VIRUSES H. INTERACTION WITH STATE OR LOCAL HEALTH DEPARTMENTS
8. POLICIES	<ul style="list-style-type: none"> A. HEALTH POLICIES B. EMERGENCY/SECURITY POLICIES AND PLANS C. TRANSPORTATION POLICIES D. PLAY AREA POLICIES E. FACILITY RECORDS/REPORTS F. CHILD RECORDS G. STAFF RECORDS

Table 2 and Figure 1 provides the overall comparison between **Stepping Stones** and the Washington's Child Care licensing rules in which a search of the rules was done to determine if the licensing rule did not meet, partially meet, meet, or exceeded the specific **SS** standard.

Table 2 – Overall Results

Agreement Category	#
Does Not Meet	3
Partially Meets	28
Meets	70
Exceeds	11
Does Not Address	12

Figure 1: Overall Results



Overall, 65% of WAC meet or exceeded the **Stepping Stones** standards. Combining the 23% of partially meet and the 10% of did not meet, 33% of the regulations were not considered equivalent to the **SS** standards. Finally, 12 **SS** standards were not addressed at all within the Washington rules making-up 9% of the total comparison.

Table 2 provides the general comparisons between **Stepping Stones** and the Washington's Child Care licensing rules in which a search of the rules was done to determine if the specific **SS** standard in each category was meet or not. Every time the search contained a match, it was recorded as a "1". A match included all regulations that *meet* or *exceed* the **SS** standard. When there was no match, it was recorded as a "0" and included regulations that *partially meet* or did not meet the **SS** standard. Those that were not addressed in WAC were also considered a non-match.

Table 3 – Comparison of *Stepping Stones* (SS) Standards and WAC per SS Content Area

	Total # of SS	RULES	PERCENT
Staffing	14	10	71.4
Program activities for Healthy Development/monitoring	10	7	70
Health promotion/protection	25	10	40
Nutrition & food service	13	10	76.9
Facilities, supplies, equipment, environmental health	20	16	80
Play areas/playground & transportation	22	14	63.6
Infectious disease	10	9	90
Policies	10	5	50

Legend for Table 3: Nominal scaling to determine if the Washington WAC have any reference to the specific **SS3** Standard.

It is scored 1/0 where 1 = Present and 0 = Absent. Percent is the total number of "1". Higher the percent the better.

SS CONTENT = RISK FACTOR/SS/CFOC Chapter

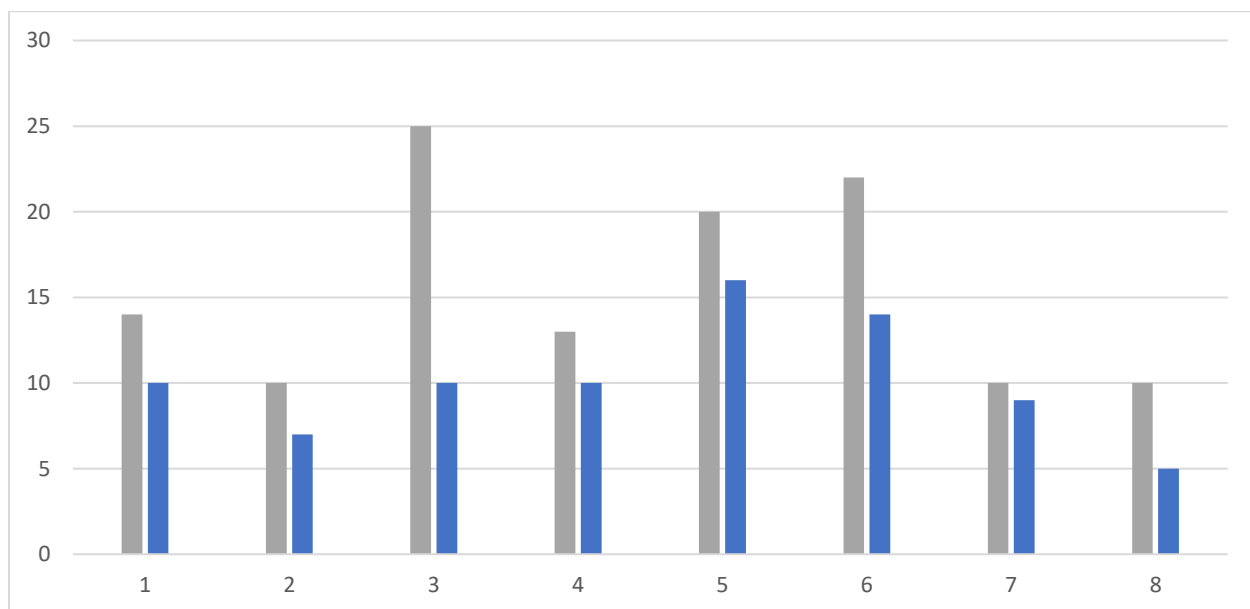
RULES = Washington Child Care Administrative Rules

PERCENT = RULES/SS

Table 3 provides you with the specific content as it relates to the risk factors. Figures 2 and 3 as well as Table 3 will provide the comparison between **SS** standards and Washington's child care licensing rules by these content areas/risk factors.

Figure 2 does this comparison by listing for each content area/risk factor the frequency count where there is a match between rules and standards.

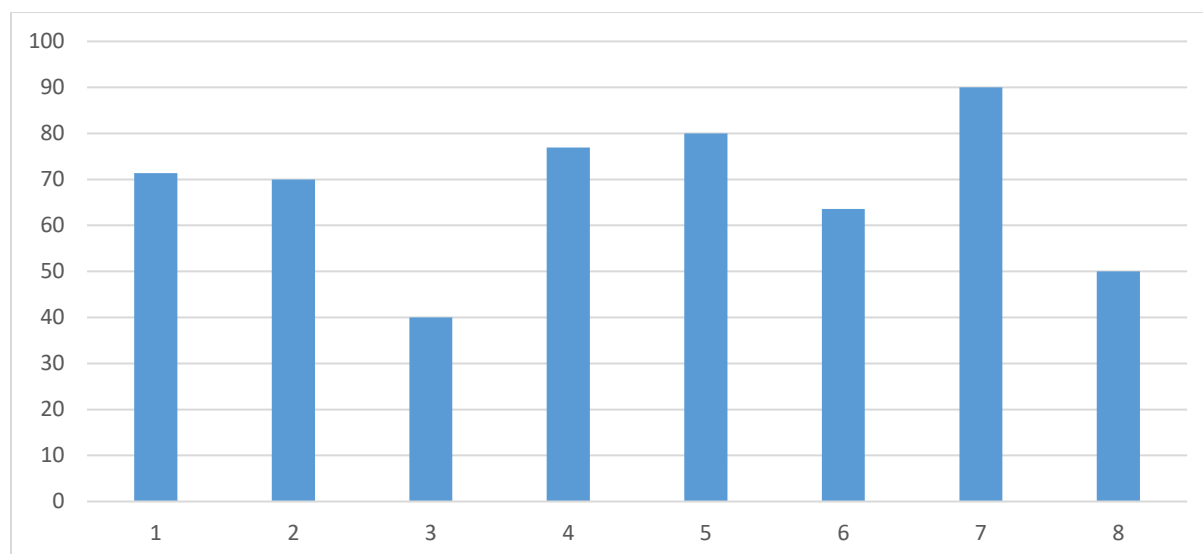
Figure 2 – Comparing *Stepping Stones* (SS) Standards and Washington's Child Care Licensing Rules



Legend for Figure 2:

- 1 = STAFFING
- 2 = PROGRAM ACTIVITIES FOR HEALTHY DEVELOPMENT
- 3 = HEALTH PROMOTION/PROTECTION
- 4 = NUTRITION AND FOOD SERVICE
- 5 = FACILITIES, SUPPLIES, EQUIPMENT, ENVIRON HEALTH
- 6 = PLAY AREAS/PLAYGROUNDS AND TRANSPORTATION
- 7 = INFECTIOUS DISEASES
- 8 = POLICIES

Figure 3 takes the data from Table 3 and Figure 2 and expresses the content areas/risk factors in the form of percent's in which the percent's represent the number of times the Washington's child care licensing rules and the ***Stepping Stones*** standards match.

Figure 3 – Percent of *Stepping Stones* Standards in Washington's Child Care Licensing Rules**Legend for Figure 3:**

- 1 = STAFFING
- 2 = PROGRAM ACTIVITIES FOR HEALTHY DEVELOPMENT
- 3 = HEALTH PROMOTION/PROTECTION
- 4 = NUTRITION AND FOOD SERVICE
- 5 = FACILITIES, SUPPLIES, EQUIPMENT, ENVIRON HEALTH
- 6 = PLAY AREAS/PLAYGROUNDS AND TRANSPORTATION
- 7 = INFECTIOUS DISEASES
- 8 = POLICIES

It is evident from Table 3 and Figures 2 and 3 that the two areas where the greatest gap between the *Stepping Stones* standards and Washington's child care licensing rules is in the Health Promotion/Protections and Policies content areas/risk factors with a match rate of 40% and 50% respectively. The highest match rates are with the Infectious Diseases (79%) and Facilities, Supplies, Equipment, Environmental Health Nutrition & Food Service (80%).

Based upon the above results there are some recommendations to be made where Washington Department of Children, Youth, and Families staff may want to focus their attention for future rule formulation in the Health Promotions/Protections (40%) and Policies (50%). It can also be noted that these two content areas also had the highest partially met agreement rates at 50% (exactly half of the overall regulations in both sections were rated as being partially met). It is recommended that in order to increase the agreement level in these two areas DCYF may focus specific attention for future rulemaking to include the missing components in these specific sections.

Notes:

1 The reason for using *Stepping Stones* rather than *Caring for our Children* is that *Stepping Stones* are the selected standards from *CFOC* that place children at greatest risk of mortality and morbidity if the standards are not complied with.

Validating the Washington State Licensed Child Care Regulations by Cross walking to *Stepping Stones 3rd Edition*

Introduction:

This analysis is the first part of the overall Validation Study of the Washington State Licensing System. This is an in-depth comparison in which the key risk assessment standards of the 3rd Edition of *Stepping Stones to Caring for Our Children* were cross walked to the Washington Administrative Codes (WAC) for child care licensing in order to validate relevance and content. The purpose of this analysis is to provide Washington Department of Children Youth and Families with a basic risk factor analysis comparing its child care center rules to *Stepping Stones (SS)* standards. This analysis will delineate, based upon *Stepping Stones*’ major content areas (chapters from *Caring for our Children (CFOC)*), where there may be gaps in their child care center rules. In order to do that type of analysis, *Fiene’s Stepping Stones to Validate State Rules Template* (2013) was used.

Legend:

- STEPPING STONES STANDARD = STEPPING STONES ARE THE SUBSET STANDARDS FROM *CARING FOR OUR CHILDREN*.
- WASHINGTON ADMINISTRATIVE CODE (WAC) = WASHINGTON CHILD CARE LICNESING RULE/REGULATION.
- ANALYSIS = EXCEEDS, MEETS, PARTIALLY MEETS, DOES NOT MEET, NOT ADDRESSED.
- ANALYSIS CLARIFICATION = PROVIDES DETAILS OF THE ANALYSIS, WHAT IT MEANS TO DCYF.
- RECOMMENDATION = BASED UPON THE ANALYSIS CLARIFICATION, RECOMMENDATION(S) ARE MADE REGARDING CHANGES TO DCYF RULE FORMULATION.
- NEXT STEPS = STEPS THAT DCYF WILL FORMULATE BASED UPON THE CROSSWALK AND ANALYSES.

References:

AAP, APHA, NRC (2011). *Caring for our children: National health and safety performance standards; Guidelines for early care and education programs. 3rd Edition*. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association.

AAP, APHA, NRC (2013). *Stepping stones to caring for our children: National health and safety performance standards; Guidelines for early care and education programs. 3rd Edition*. Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association.

Fiene (2013). *Georgia child care licensing study: Validating the core rule differential monitoring system*, Research Institute for Key Indicators, Middletown, Pennsylvania.

Zellman & Fiene (2012). *Validation of quality rating and improvement systems for early care and education and School-age care*, Washington, D.C.: OPRE and Child Trends.

Stepping Stones Standard	DEL Licensing Rule	Analysis	Analysis Clarification	Recommendation	Next Steps																											
<p>STANDARD 1.1.1. Child: staff ratios in centers should be maintained as follows during all hours of operation including during transport.</p> <p>2: Ratios Centers</p> <table><tr><td></td><td>Maximum</td><td>Maximum</td></tr><tr><td>Age</td><td>Child: Staff Ratio</td><td>Group Size</td></tr><tr><td>≤ 12 months</td><td>2:1</td><td>6</td></tr><tr><td>13-23 months</td><td>2:1</td><td>8</td></tr><tr><td>24-35 months</td><td>3:1</td><td>12</td></tr><tr><td>3 years old</td><td>7:1</td><td>12</td></tr><tr><td>4-5 years old</td><td>8:1</td><td>12</td></tr><tr><td>6-8 years old</td><td>10:1</td><td>12</td></tr><tr><td>9-12 years old</td><td>12:1</td><td>12</td></tr></table>		Maximum	Maximum	Age	Child: Staff Ratio	Group Size	≤ 12 months	2:1	6	13-23 months	2:1	8	24-35 months	3:1	12	3 years old	7:1	12	4-5 years old	8:1	12	6-8 years old	10:1	12	9-12 years old	12:1	12	<p>170-300-0356 Center capacity, ratio, and group size. (1) The department issues initial or non-expiring center early learning provider licenses. The department will not issue a center license to care for more children than permitted by the rules in this chapter. The department may issue a license to care for fewer than the maximum allowable enrolled children. For each center, licenses state:</p> <ul style="list-style-type: none">(a) The maximum number of children that may be in care at any one time (total capacity);(b) The licensed capacity for each space within the center licensed for use by children; and(c) The age range of children allowed in care. <p>Weight NA</p> <p>(2) The department determines capacity for a center early learning program after considering:</p> <ul style="list-style-type: none">(a) Square footage of the early learning program;(b) A provider’s education and on-going training;(c) The age range of children requested or approved by the department;(d) The amount of developmentally appropriate equipment, materials, and toys an early learning program can provide children to use;(e) A provider’s licensing history with the department; and(f) The number of qualified staff available to meet staff-to-child ratios. <p>Weight NA</p> <p>(3) A center licensee must not exceed the total capacity or age range stated on the child care license at any time except as provided in this section. All children on the premises, signed in to child care, on an off-site trip from the early learning program, or being transported by the early learning program staff are counted in capacity including the children of staff.</p> <ul style="list-style-type: none">(a) A center licensee must receive department approval to care for a child with special needs, pursuant to WAC 170-300-0300, if the child is older than the maximum age identified on the license. A child with documented special needs may be in care up to age 19 and must be counted in capacity and staff-to-child ratio.(b) A child with special needs who requires individualized supervision pursuant WAC 170-300-0300 does not count in the staff-to-child ratio.(c) A child who turns 13 years old permitted by chapter 170-290 WAC, as hereafter recodified or amended, must be counted in both capacity and staff-to-child ratio. <p>Weight #7</p> <p>(4) A center licensee must provide qualified staff to fulfill staffing requirements, staff-to-child ratios, group size, and mixed age grouping during operating hours, including off-site activities or when transporting children in care.</p> <p>Weight NA</p> <p>(5) In each classroom or well-defined space, the maximum group size and ratio of center staff members to children, including children related to staff or the licensee, must be:</p> <ul style="list-style-type: none">(a) Infants (birth through 11 months of age) with a:<ul style="list-style-type: none">(i) Maximum group size of 8 with a ratio of 1 staff to 4 children (1:4);(ii) Maximum group size of 9 with a ratio of 1:3;(b) Toddlers (12 through 29 months of age) with a:<ul style="list-style-type: none">(i) Maximum group size of 14 with a ratio of 1:7;	Does Not Meet	Group size and ratio are larger than recommended. WAC allows higher child to staff ratios (including transportation) and slightly higher group size.		
	Maximum	Maximum																														
Age	Child: Staff Ratio	Group Size																														
≤ 12 months	2:1	6																														
13-23 months	2:1	8																														
24-35 months	3:1	12																														
3 years old	7:1	12																														
4-5 years old	8:1	12																														
6-8 years old	10:1	12																														
9-12 years old	12:1	12																														

	<p>(ii) Maximum group size of 15 with a ratio of 1:5;</p> <p>(c) Preschoolers (30 months through 6 years of age who are not attending kindergarten or elementary school) with a maximum group size of 20 with a ratio of 1:10; and</p> <p>(d) School-age children (5 years through 12 years of age who are enrolled in or attending kindergarten or elementary school) with a maximum group size of 30 with a ratio of 1:15.</p> <p>Weight #7</p> <p>(6) A center licensee may combine children of different age groups for periods of no more than the first two hours of the day or the last two hours of the day, not to exceed two hours in any given day, provided the staff-to-child ratio and group size designated for the youngest child in the mixed group are maintained. Weight #3</p> <p>(7) Children at least five years old and enrolled in or attending kindergarten may be a part of the preschool or school-age group if developmentally appropriate and the child’s parent or guardian agrees to this placement.</p> <p>Weight NA</p> <p>(8) A center licensee must conduct activities for each group of children in a specific room or other defined space within a larger area. Weight #3</p> <p>(9) A center licensee must provide additional staff as described in WAC 170-300-0350 when children are participating in water activities or activities near water. Weight NA</p> <p>(10) When only one center staff is required to care for the only group of children on site for up to an hour at the beginning or end of the day, the center licensee must ensure:</p> <p>(a) That staff member provides an appropriate level of supervision at all times to the children in care;</p> <p>(b) That staff member is free of all other duties while providing care to children; and</p> <p>(c) A second individual with a cleared background check is on site and readily available to respond if needed, or the department approves an alternate plan.</p> <p>Weight #7</p> <p>170-300-0357</p> <p>Center mixed age group capacity, ratio, and group size.</p> <p>(1) A center early learning program must do the following to mix age groups of children in care (in addition to any specific requirements of this section):</p> <p>(a) Meet the square footage and staff-to-child ratio requirements for the youngest child present in the group;</p> <p>(b) Meet the health, safety, and developmental needs for all ages of children in the mixed group; and</p> <p>(c) Inform the department of the center’s mixed age group policy.</p> <p>Weight #6</p> <p>(2) A center early learning program must do the following to mix groups of children birth to 36 months old with a maximum group size of eight children:</p> <p>(a) Have at least two staff present with the group, consisting of one Lead Teacher and one other staff member qualified under this chapter; and</p> <p>(b) Keep a staff-to-child ratio of 1:4.</p> <p>Weight #5</p>				
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<p>(3) A center early learning program must do the following to mix groups of children birth to 36 months old with a maximum group size of nine children:</p> <p>(a) Have at least three staff present with the group, consisting of one Lead Teacher and two other staff members qualified under this chapter; and</p> <p>(b) Keep a staff-to-child ration of 1:3.</p> <p>Weight #5</p> <p>(4) A center early learning program must do the following to mix groups of children 12 to 36 months old:</p> <p>(a) Have at least two staff present with the group, consisting of one Lead Teacher and one other staff member qualified under this chapter; and</p> <p>(b) Keep a staff-to-child ratio of 1:7 with a maximum group size of 14 children.</p> <p>Weight #5</p> <p>(5) A center early learning program must do the following to mix groups of children 12 to 36 months old:</p> <p>(a) Have at least three staff present with the group, consisting of one Lead Teacher and two other staff members qualified under this chapter; and</p> <p>(b) Keep a staff-to-child ratio of 1:5 with a maximum group size of 15 children.</p> <p>Weight #5</p> <p>(6) A center early learning program must do the following to mix groups of children between 36 months old through kindergarten with a maximum group size of 20 children:</p> <p>(a) Have at least two staff present with the group, consisting of one Lead Teacher and one other staff member qualified under this chapter; and</p> <p>(b) Keep a staff-to-child ratio of 1:10.</p> <p>Weight #5</p> <p>(7) A center early learning program must do the following to mix groups of children between 36 months old through kindergarten with a maximum group size of 26 children:</p> <p>(a) Have at least three staff present with the group, consisting of one Lead Teacher and two other staff members qualified under this chapter; and</p> <p>(b) Keep a staff-to-child ratio of 1:10.</p> <p>Weight #5</p> <p>(8) A center early learning program must do the following to mix groups of children four-and-one-half to nine years old with a maximum group size of 20 children:</p> <p>(a) Have at least two staff present with the group, consisting of one Lead Teacher and one other staff member qualified under this chapter; and</p> <p>(b) Keep a staff-to-child ratio of 1:10.</p> <p>Weight #5</p> <p>(9) A center early learning program must do the following to mix groups of children four-and-one-half to nine years old with a maximum group size of 26 children:</p> <p>(a) Have at least three staff present with the group, consisting of one Lead Teacher and two other staff members qualified under this chapter; and</p> <p>(b) Keep a staff-to-child ratio of 1:10.</p> <p>Weight #5</p>				
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<p>STANDARD 1.1.1.4: Ratios and Supervision</p> <p>During Transportation</p> <p>Child: staff ratios established for out-of-home child care should be maintained on all transportation the facility provides or arranges. Drivers should not be included in the ratio. No child of any age should be left unattended in or around a vehicle, when children are in a car, or when they are in a car seat. A face-to-name count of children should be conducted prior to leaving for a destination, when the destination is reached, before departing for return to the facility and upon return. Caregivers/teachers should also remember to take into account in this head count if any children were picked up or dropped off while being transported away from the facility.</p>	<p>170-300-0005 Definitions</p> <p>“Active supervision” or “actively supervise” means a heightened standard of care beyond supervision. This standard requires an early learning provider to see and hear the children they are responsible for during higher risk activities. The provider must be able to prevent or instantly respond to unsafe or harmful events.</p> <p>“Supervise” or “supervision” means an early learning provider must be able to see or hear the children they are responsible for at all times. Early learning providers must use their knowledge of each child’s development and behavior to anticipate what may occur to prevent unsafe or unhealthy events or conduct, or to intervene in such circumstances as soon as possible. Early learning providers must also reposition themselves or the children to be aware of where children are and what they are doing during care. An early learning provider must reassess and adjust their supervision each time child care activities change. See “active supervision” for a heightened standard of care.</p> <p>170-300-0345 Supervising children.</p> <p>(2) An early learning provider must meet capacity, group size, mixed age grouping, and staff-to-child ratios while children are in care. This includes but is not limited to:</p> <p>(b) Off-site activities;</p> <p>(c) During transportation;</p> <p>Weight #7</p> <p>(5) An early learning provider must:</p> <p>(c) Actively supervise children when the children:</p> <p>(vi) Ride on public transportation</p> <p>Weight #7</p> <p>170-300-0480 Transportation and off-site activity policy.</p> <p>(1) An early learning provider must have and follow a transportation and off-site activity policy for personal or public transportation service, or non-motorized travel offered to children in care.</p> <p>(a) The transportation and off-site activity policy must include routine trips, which must not exceed two hours per day for any individual child.</p> <p>(b) Written parent or guardian authorization to transport the parent or guardian’s child. The written authorization must be:</p> <p>(i) A specific event, date, and anticipated travel time;</p> <p>(ii) A specific type of trip (for example, transporting to and from school, or transporting to and from a field trip); or</p> <p>(iii) A full range of trips a child may take while in the early learning provider’s care.</p> <p>(c) Written notices to parents or guardians, to be given at least 24 hours before field trips are taken.</p> <p>Weight #6</p> <p>(2) During travel to an off-site activity, an early learning provider must:</p> <p>(a) Have the health history, appropriate medication (if applicable), emergency information, and emergency medical authorization forms accessible for each child being transported;</p>	Partially Meets	The regulations outline the need to maintain appropriate supervision, including role call (head count), ensuring children are always attended. It Not Addressed the driver not being considered in ratio.	Consider excluding the driver from the ratio however, this would be a huge impact on Family Home providers; often there is only the one licensee present and hiring someone just to drive is a huge challenge and cost. Consider adding taking roll call/face-to-name count of children after entering into/preparing to exit the visited destination, or where all children are getting out of the vehicle with the provider/staff. Also consider adding in the written transportation policies: 170-300-0480-add another letter under (1) for staff member requirements. For example: 170-300-0480(1)(d) have emergency contact information and health history information for each staff person counted in staff/child ratio when only one staff person is present and has sole responsibility for supervision of children in care. This would account for a staff emergency if there is only one staff person counting in staff/child ratios and they are transporting. There would be some information about the staff person and who to contact at the child care facility in case of emergency.	
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	<div><div><div>(b)Have a phone to call for emergency help;</div><div>(c)Have a complete first aid kit;</div><div>(d)Maintain the staff-to-child ratio, mixed groupings, and active supervision requirements;</div><div>(e)Have at least one staff member currently certified in First Aid and CPR supervise children;</div><div>(f)Take attendance using a roll call or other method that assures all children are accounted for each time children begin and end travel to an off-site activity, and every time children enter and exit a vehicle; and</div><div>(g)Never leave children unattended in the vehicle.</div></div><div>Weight #7</div></div> <div><div>(3) When an early learning provider supplies the vehicle to transport children in care, the program and provider must:</div><div><div>(a)Follow chapter 46.61 RCW (Rules of the Road) and other applicable laws regarding child restraints and car seats;</div><div>(b)Assure that the number of passengers does not exceed the seating capacity of the vehicle;</div><div>(c)Maintain the vehicle in good repair and safe operating condition;</div><div>(d)Maintain the vehicle temperature at a comfortable level to children;</div><div>(e)Assure the vehicle has a current license and registration as required by Washington state transportation laws;</div><div>(f)Assure the vehicle has emergency reflective triangles or other devices to alert other drivers of an emergency;</div><div>(g)Assure the driver has a valid driver’s license for the type of vehicle being driven and a safe driving record for at least the last five years;</div><div>(h)Prevent any driver with a known condition that would compromise driving, supervision, or evacuation capabilities from operating program vehicles; and</div><div>(i)Have a current insurance policy that covers the driver, the vehicle, and all occupants.</div></div><div>Weight #6</div></div>														
<div><div>STANDARD 1.1.1.5: Ratios and Supervision for Swimming, Wading, and Water Play</div><div>The following child: staff ratios should apply while children are swimming, wading, or engaged in water play:</div><table><tr><th>Developmental Levels</th><th>Child: Staff Ratio</th></tr><tr><td>Infants</td><td>1:1</td></tr><tr><td>Toddlers</td><td>1:1</td></tr><tr><td>Preschoolers</td><td>4:1</td></tr><tr><td>School-age Children</td><td>6:1</td></tr></table></div>	Developmental Levels	Child: Staff Ratio	Infants	1:1	Toddlers	1:1	Preschoolers	4:1	School-age Children	6:1	<div><div>170-300-0005 Definitions</div><div>“Active supervision” or “actively supervise” means a heightened standard of care beyond supervision. This standard requires an early learning provider to see and hear the children they are responsible for during higher risk activities. The provider must be able to prevent or instantly respond to unsafe or harmful events.</div><div>“Supervise” or “supervision” means an early learning provider must be able to see or hear the children they are responsible for at all times. Early learning providers must use their knowledge of each child’s development and behavior to anticipate what may occur to prevent unsafe or unhealthy events or conduct, or to intervene in such circumstances as soon as possible. Early learning providers must also reposition themselves or the children to be aware of where children are and what they are doing during care. An early learning provider must reassess and adjust their supervision each time child care activities change. See “active supervision” for a heightened standard of care.</div></div>	Does Not Meet	Addresses ratios (School age ratios are included in a separate chapter) and includes lifesaving equipment as well as increased ratio when near larger bodies of water even when swimming is not an activity. However, the portion of the Standard requiring additional ratio is an area we would not be meeting. For example, one	Under 0350(4)(a) would we consider a staff person who is a certified lifeguard to be “on duty and present” if they were also counted in staff to child ratios? If not, we might consider adding language to (a) stating that the lifeguard is not counted in the staff: child ratio.	
Developmental Levels	Child: Staff Ratio														
Infants	1:1														
Toddlers	1:1														
Preschoolers	4:1														
School-age Children	6:1														

<p>Constant and active supervision should be maintained when any child is in or around water (4). During any swimming/wading/water play activities where either an infant or a toddler is present, the ratio should always be one adult to one infant/toddler. The required ratio of adults to older children should be met without including the adults who are required for supervision of infants and/or toddlers. An adult should remain in direct physical contact with an infant at all times during swimming or water play (4). Whenever children thirteen months and up to five years of age are in or around water, the supervising adult should be within an arm’s length providing “touch supervision” (6). The attention of an adult who is supervising children of any age should be focused on the child, and the adult should never be engaged in other distracting activities (4), such as talking on the telephone, socializing, or tending to chores. A lifeguard should not be counted in the child: staff ratio.</p>	<p>“Water activities” means early learning program activities in which enrolled children swim or play in a body of water that poses a risk of drowning for children. Water activities do not include using sensory tables.</p> <p>“Wading pool” means a pool that has a water depth of less than two feet (24 inches).</p> <p>“Swimming pool” means a pool that has a water depth greater than two feet (24 inches).</p> <p>170-300-0345 Supervising children. (5) An early learning provider must: (c) Actively supervise children when the children: (ii) Engage in water or sand play; (iii) Play in an area in close proximity to a body of water</p> <p>170-300-0350 Supervising children during water activities. (1) During water activities, an early learning provider must meet all supervision requirements of this section and WAC 170-300-0345. Weight NA</p> <p>(2) During water activities, an early learning provider must: (a) Ensure a one-to-one (1:1) staff-to-child ratio must for infants; (b) Hold or have continuous touch of infants, non-ambulatory toddlers, and children with special needs as required; and (c) Keep toddlers within arm’s length. Weight #8</p> <p>(3) An early learning provider must have written permission for water activities from each child’s parent or guardian. Weight #7</p> <p>(4) For water activities on or off the early learning program premises, where the water is more than 24 inches deep, an early learning provider must ensure: (a) A certified lifeguard is present and on duty; and (b) At least one additional staff member than would otherwise be required is present to help actively supervise if the children are preschool age or older. Weight #8</p> <p>(5) An early learning provider must have life-saving equipment readily accessible during water activities if a pool is six feet or more in any direction and two feet or more in depth. Life-saving equipment may include a ring buoy and rope, a rescue tube, or a throwing line and a shepherd’s hook that will not conduct electricity. Weight #8</p> <p>(6) If an early learning provider takes children off-site to an area with an accessible body of water more than four inches deep (for example, a park with a lake or stream) but children are not engaging in a water activity, there must be: (a) At least one more staff person than required in the staff-to-child ratio; and (b) At least one attending staff person must be able to swim. Weight #8</p>		<p>staff member could have 10 preschool age children alone. If you add in the requirement of having one more staff person present that is required, you would still only have a ratio of 10:2.</p>		
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<p>STANDARD 1.2.0.2: Background Screening</p> <p>Directors of centers and caregivers/teachers in large family child care homes should conduct a complete background screening before employing any staff member (including substitutes, cooks, clerical staff, transportation staff, bus drivers, or custodians who will be on the premises or in vehicles when children are present). The background screening should include:</p> <ul style="list-style-type: none">a) Name and address verification;b) Social Security number verification;c) Education verification;d) Employment history;e) Alias search;f) Driving history through state Department of Motor Vehicles records;g) Background screening of:<ul style="list-style-type: none">1) State and national criminal history records;2) Child abuse and neglect registries;3) Licensing history with any other state agencies (i.e., foster care, mental health, nursing homes, etc.);4) Fingerprints; and5) Sex offender registries;h) Court records;i) References. <p>All family members over age ten living in large family child care homes should also have background screenings.</p> <p>Drug tests may also be incorporated into the background screening. Written permission to obtain the background screening (with or without a drug screen) should be obtained from the prospective employee. Consent to the background investigation should be required for employment consideration.</p> <p>When checking references and when conducting employee or volunteer interviews, prospective employers should specifically ask about previous convictions and arrests, investigation findings, or court cases with child abuse/neglect or child sexual abuse. Failure of the prospective to disclose previous history of child abuse/neglect or child sexual abuse is grounds for immediate dismissal.</p> <p>Persons should not be hired or allowed to work or volunteer in the child care facility if they acknowledge being sexually attracted to children or having physically or sexually abused children, or are known to have</p>	<p>170-300-0100 General staff qualifications.</p> <p>(8) Other personnel who do not directly care for children and are not listed in subsections (1) through (7) of this section must meet the following qualifications:</p> <ul style="list-style-type: none">(a) Complete and pass a background check, pursuant to chapter 170-06, as hereafter recodified or amended <p>Weight #3</p> <p>(9) Volunteers help at early learning programs. Volunteers must meet the following qualifications:</p> <ul style="list-style-type: none">(a) Be at least 14 years old (volunteers must have written permission to volunteer from their parent or guardian if they are under 18 years old).(b) Work under the continuous oversight of a Lead Teacher, Program Supervisor, Center Director, Assistant Director, Assistant Teacher, or Family Home Licensee.(c) Regular, on-going volunteers may count in staff-to-child ratio if they:<ul style="list-style-type: none">(i) Complete and pass a background check, pursuant to chapter 170-06 WAC, as hereafter recodified or amended;(ii) Complete a TB test, pursuant to WAC 170-300-0105;(iii) Complete the training requirements, pursuant to WAC 170-300-0106;(iv) Complete program based staff policies and training, pursuant to WAC 170-300-0110; and(v) Have their professional development progress documented annually.(d) Occasional volunteers must comply with subsections (a) and (b) of this section. Occasional volunteers may include, but are not limited to, a parent or guardian helping on a field trip, special guest presenters, or a parent or guardian, family member, or community member helping with a cultural celebration. <p>Weight #4</p> <p>170-300-0105 Pre-Service requirements.</p> <p>(2) Early learning providers and household members in a family home early learning program must complete a department background check process, pursuant to chapter 170-06, as hereafter recodified or amended. Weight #7</p> <p>170-300-0475 Duty to protect children and report incidents.</p> <p>(2)An early learning provider must report by phone upon knowledge of the following to:</p> <ul style="list-style-type: none">(e) The department at the first opportunity, but in no case longer than 24 hours, upon knowledge of any person required by chapter 170-06 WAC, as hereafter recodified or amended, to have a change in their background check history due to:<ul style="list-style-type: none">(i) A pending charge or conviction for a crime listed in WAC 170-06,as hereafter recodified or amended;(ii) An allegation or finding of child abuse, neglect, maltreatment or exploitation under chapter 26.44 RCW or chapter 388-15 WAC;(iii) An allegation or finding of abuse or neglect of a vulnerable adult under chapter 74.34 RCW; or(iv) A pending charge or conviction of a crime listed in the Director’s List in chapter 170-06 WAC, as hereafter recodified or amended, from outside Washington state, or a “negative action” as defined in RCW 43.216.010. <p>Weight #8</p>	Exceeds	Federal and state Background checks are required for all personnel including volunteers inclusive of pending investigations. These regulations are meet within the background WAC chapter.		
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committed such acts. Background screenings should be repeated periodically taking into consideration state laws and/or requirements. Screenings should be repeated more frequently if there are additional concerns.				
<p>STANDARD 1.3.2.2: Qualifications of Lead Teachers and Teachers</p> <p>Lead teachers and teachers should be at least twenty-one years of age and should have at least the following education, experience, and skills:</p> <ul style="list-style-type: none">a) A Bachelor’s degree in early childhood education, school-age care, child development, social work, nursing, or other child-related field, or an associate’s degree in early childhood education and currently working towards a bachelor’s degree;b) A minimum of one year on-the-job training in providing a nurturing indoor and outdoor environment and meeting the child’s out-of-home needs;c) One or more years of experience, under qualified supervision, working as a teacher serving the ages and developmental abilities of the children in care;d) A valid certificate in pediatric first aid, including CPR;e) Thorough knowledge of normal child development and early childhood education, as well as knowledge of indicators that a child is not developing typically;f) The ability to respond appropriately to children’s needs;g) The ability to recognize signs of illness and safety/ injury hazards and respond with prevention interventions;h) Oral and written communication skills;i) Medication administration training (8). <p>Every center, regardless of setting, should have at least one licensed/certified lead teacher (or mentor teacher) who meets the above requirements working in the child care facility at all times when children are in care.</p> <p>Additionally, facilities serving children with special health care needs associated with developmental delay should employ an individual who has had a minimum of eight hours of training in inclusion of children with special health care needs.</p>	<p>170-300-0100 General staff qualifications.</p> <p>All early learning providers must meet the following requirements prior to working:</p> <p>(5) Lead Teachers are responsible for implementing the center or family home early learning program. Lead teachers develop and provide a nurturing and responsive learning environment that meets the needs of enrolled children.</p> <ul style="list-style-type: none">(a) A Lead Teacher must meet the following qualifications:<ul style="list-style-type: none">(i) Be at least 18 years old;(ii) Have a high school diploma or equivalent; and(iii) Complete the applicable pre-service requirements and training pursuant to WAC 170-300-0105.(b) A center Lead Teacher must meet the following requirements:<ul style="list-style-type: none">(i) Have an ECE Initial Certificate or equivalent as approved and verified in the electronic workforce registry by the department within five years of the date this section becomes effective, or five years from being employed or promoted into this position at any licensed early learning program.(ii) Progress towards an ECE Short Certificate or equivalent. A center Lead Teacher hired after this chapter becomes effective must have an ECE Short Certificate within two years of receiving an ECE Initial Certificate or seven years from being employed or promoted into this position at any licensed early learning program; and(iii) Have their professional development progress documented annually.(c) A family home Lead teacher must meet the following requirements:<ul style="list-style-type: none">(i) Have an ECE Initial Certificate or equivalent as approved and verified in the electronic workforce registry by the department within five years of the date this section becomes effective, or from being employed or promoted into this position at any licensed early learning program;(ii) Prior to being in charge of their early learning program 50 percent or more of the time, a family home Lead Teacher must meet the qualifications of the family home licensee and complete or be registered in orientation training required in WAC 170-300-0105(1); and(iii) Have their professional development progress documented annually; <p>Weight #4</p> <p>170-300-0105 Pre-service requirements.</p> <p>(1) All Applicants, Co-Applicants, family home licensees, Center Directors, Assistant Directors, and Program Supervisors must complete a department provided orientation for the applicable early learning program. Prior to being in charge of the early learning program 50 percent of the time or more, those newly promoted or assuming a role of one of the roles listed here must complete or be registered in orientation training. Weight #1</p> <p>(2) Early learning providers and household members in a family home early learning program must complete a department background check process, pursuant to chapter 170-06 WAC, as hereafter recodified or amended.</p> <p>Weight #7</p>	Partially Meets	Lead teachers are not required to hold a bachelor’s degree nor one year experience. The “ability” qualifications are outlined within the required in-service and preservice trainings. This chapter, while not requiring the degree does exceed pre-service training requirements. Nor does the WAC require one year of experience or a staff with 8 hours of inclusion training.	

<p>(3) Early learning providers, including volunteers and household members in a family home early learning program ages 14 and over, must provide documentation within the last 12 months by a licensed health care professional of tuberculosis (TB) testing or treatment consisting of:</p> <ul style="list-style-type: none">(a) A negative TB symptom screen and negative TB risk assessment; or(b) A previous positive FDA approved TB test and a current negative chest radiograph and documentation of clearance to safely work or reside in an early learning program; or(c) A positive symptom screening or a positive risk assessment with documentation of:<ul style="list-style-type: none">(i) A current negative FDA approved TB test;(ii) A previous or current positive FDA approved TB test; and(iii) A current negative chest radiograph and documentation of clearance to safely work or reside in an early learning program. Weight #6 <p>(4) Upon notification of TB exposure, early learning providers may be required to be retested for TB as directed by the local health jurisdiction. Weight NA</p> <p>WAC 170-300-0106 Training requirements.</p> <p>(1) Early learning providers licensed, working, or volunteering in an early learning program before the date this section becomes effective must complete the applicable training requirements of this section within three months of the date this section becomes effective unless otherwise indicated. Early learning providers hired after the date this section becomes effective must complete the training requirements of subsections (4) through (10) of this section within three months of the date of hire and prior to working in an unsupervised capacity with children. Weight #1</p> <p>(2) License applicants and early learning providers must register with the electronic workforce registry prior to being granted an initial license or working with children in an unsupervised capacity. Weight #1</p> <p>(3) License applicants, Center Directors, Assistant Directors, Program Supervisors, Lead Teachers, Assistant Teachers, and Aides must complete the Child Care Basics training as approved or offered by the department:</p> <ul style="list-style-type: none">(a) Prior to being granted a license;(b) Prior to working unsupervised with children; or(c) Within three months of the date this section becomes effective if already employed or being promoted to a new role. Weight #5 <p>(4) Early learning providers must complete the Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation training as approved or offered by the department according to subsection (1) of this section. Training must include the prevention of child abuse and neglect as defined in RCW 26.44.020. Weight #7</p> <p>(5) Early learning providers must complete the department Emergency Preparedness training as approved or offered by the department (applicable to the early learning program where they work or volunteer) according to subsection (1) of this section. Weight #5</p> <p>(6) Early learning providers licensed to care for infants must complete the Prevention and Identifying Shaken Baby Syndrome/Abuse Head Trauma training as approved or offered by the department according to subsection (1) of this section. Weight #6</p> <p>(7) Early learning providers must complete the Serving Children Experiencing Homelessness training as approved or offered by the department according to subsection (1) of this section. Weight #5</p>				
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	<p>(8) License applicants and early learning providers licensed to care for infants must complete the Safe Sleep training as approved or offered by the department. This training must be completed annually and:</p> <ul style="list-style-type: none">(a) Prior to being licensed;(b) Prior to caring for infants; or(c) According to subsection (1) of this section. Weight #7 <p>(9) Family home licensees, Center Directors, Assistant Directors, Program Supervisors, Lead Teachers, and other appropriate staff members must complete the Child Restraint training as approved or offered by the department. This training must be completed annually and:</p> <ul style="list-style-type: none">(a) Prior to being authorized to restrain an enrolled child; or(b) According to subsection (1) of this section. <p>Weight #6</p> <p>(10) Family home licensees, Center Directors, Assistant Directors, Program Supervisors, and Lead Teachers must complete the Medication Management and Administration training as approved or offered by the department prior to giving medication to an enrolled child, or as indicated in subsection (1) of this section. Weight #6</p> <p>(11) Early learning providers who directly care for children must complete the Prevention of Exposure to Blood and Body Fluids training that meets Washington State Department of Labor & Industries’ requirements prior to being granted a license or working with children. This training must be repeated pursuant to Washington State Department Labor and Industries regulations. Weight #6</p> <p>(12) Early learning providers must have a current first-aid and cardiopulmonary resuscitation (CPR) certification prior to being alone with children. Early learning providers must ensure that at least one staff person with a current first aid and CPR certificate is present with each group of children at all times.</p> <ul style="list-style-type: none">(a) Proof of certification may be a card, certificate, or instructor letter.(b) The first-aid and CPR training and certification must:<ul style="list-style-type: none">(i) Be delivered in person and include a hands-on component for first-aid and CPR demonstrated in front of an instructor certified by the American Red Cross, American Heart Association, American Safety and Health Institute, or other nationally recognized certification program; and(ii) Include child and adult CPR; and(iii) Infant CPR, if applicable. <p>Weight #7</p> <p>(13) Early learning providers who prepare or serve food to children at an early learning program must obtain a current Food Worker card prior to preparing or serving food. Food Worker cards must:</p> <ul style="list-style-type: none">(a) Be obtained online or through the local health jurisdiction; and(b) Be renewed prior to expiring. <p>Weight #4</p>				
<p>STANDARD 1.4.1.1: Pre-service Training</p> <p>In addition to the credentials listed in Standard 1.3.1.1, upon employment, a director or administrator of a center or the lead caregiver/teacher in a family child care home should provide documentation of at least thirty clock-</p>	<p>170-300-0105 Pre-service requirements.</p> <p>(1) All Applicants, Co-Applicants, family home licensees, Center Directors, Assistant Directors, and Program Supervisors must complete a department provided orientation for the applicable early learning program. Prior to being in charge of the early learning program 50 percent of the time or more, those newly promoted or assuming a</p>	Meets	Each section is addressed in the pre-service requirements		

<p>hours of pre-service training. This training should cover health, psychosocial, and safety issues for out-of-home child care facilities. Small family child care home caregivers/teachers may have up to ninety days to secure training after opening except for training on basic health and safety procedures and regulatory requirements.</p> <p>All directors or program administrators and caregivers/teachers should document receipt of pre-service training prior to working with children that includes the following content on basic program operations:</p> <ul style="list-style-type: none">a) Typical and atypical child development and appropriate best practice for a range of developmental and mental health needs including knowledge about the developmental stages for the ages of children enrolled in the facility;b) Positive ways to support language, cognitive, social, and emotional development including appropriate guidance and discipline;c) Developing and maintaining relationships with families of children enrolled, including the resources to obtain supportive services for children’s unique developmental needs;d) Procedures for preventing the spread of infectious disease, including hand hygiene, cough and sneeze etiquette, cleaning and disinfection of toys and equipment, diaper changing, food handling, health department notification of reportable diseases, and health issues related to having animals in the facility;e) Teaching child care staff and children about infection control and injury prevention through role modeling;f) Safe sleep practices including reducing the risk of Sudden Infant Death Syndrome (SIDS) (infant sleep position and crib safety);g) Shaken baby syndrome/abusive head trauma prevention and identification, including howto cope with a crying/fussy infant;h) Poison prevention and poison safety;i) Immunization requirements for children and staff;j) Common childhood illnesses and their management, including child care exclusion policies and recognizing signs and symptoms of serious illness;	<p>role of one of the roles listed here must complete or be registered in orientation training. Weight #1</p> <p>(2) Early learning providers and household members in a family home early learning program must complete a department background check process, pursuant to chapter 170-06 WAC, as hereafter recodified or amended. Weight #7</p> <p>(3) Early learning providers, including volunteers and household members in a family home early learning program ages 14 and over, must provide documentation within the last 12 months by a licensed health care professional of tuberculosis (TB) testing or treatment consisting of:</p> <ul style="list-style-type: none">(a) A negative TB symptom screen and negative TB risk assessment; or(b) A previous positive FDA approved TB test and a current negative chest radiograph and documentation of clearance to safely work or reside in an early learning program; or(c) A positive symptom screening or a positive risk assessment with documentation of:<ul style="list-style-type: none">(i) A current negative FDA approved TB test;(ii) A previous or current positive FDA approved TB test; and(iii) A current negative chest radiograph and documentation of clearance to safely work or reside in an early learning program. Weight #6 <p>(4) Upon notification of TB exposure, early learning providers may be required to be retested for TB as directed by the local health jurisdiction. Weight NA</p> <p>WAC 170-300-0106 Training requirements.</p> <p>(1) Early learning providers licensed, working, or volunteering in an early learning program before the date this section becomes effective must complete the applicable training requirements of this section within three months of the date this section becomes effective unless otherwise indicated. Early learning providers hired after the date this section becomes effective must complete the training requirements of subsections (4) through (10) of this section within three months of the date of hire and prior to working in an unsupervised capacity with children. Weight #1</p> <p>(2) License applicants and early learning providers must register with the electronic workforce registry prior to being granted an initial license or working with children in an unsupervised capacity. Weight #1</p> <p>(3) License applicants, Center Directors, Assistant Directors, Program Supervisors, Lead Teachers, Assistant Teachers, and Aides must complete the Child Care Basics training as approved or offered by the department:</p> <ul style="list-style-type: none">(a) Prior to being granted a license;(b) Prior to working unsupervised with children; or(c) Within three months of the date this section becomes effective if already employed or being promoted to a new role. Weight #5 <p>(4) Early learning providers must complete the Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation training as approved or offered by the department according to subsection (1) of this section. Training must include the prevention of child abuse and neglect as defined in RCW 26.44.020. Weight #7</p> <p>(5) Early learning providers must complete the department Emergency Preparedness training as approved or offered by the department (applicable to the early learning program where they work or volunteer) according to subsection (1) of this section. Weight #5</p>				
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<p>k) Reduction of injury and illness through environmental design and maintenance;</p> <p>l) Knowledge of U.S. Consumer Product Safety Commission (CPSC) product recall reports;</p> <p>m) Staff occupational health and safety practices, such as proper procedures, in accordance with Occupational Safety and Health Administration (OSHA) blood borne pathogens regulations;</p> <p>n) Emergency procedures and preparedness for disasters, emergencies, other threatening situations (including weather-related, natural disasters), and injury to infants and children in care;</p> <p>o) Promotion of health and safety in the child care setting, including staff health and pregnant workers;</p> <p>p) First aid including CPR for infants and children;</p> <p>q) Recognition and reporting of child abuse and neglect in compliance with state laws and knowledge of protective factors to prevent child maltreatment</p> <p>r) Nutrition and age-appropriate child-feeding including food preparation, choking prevention, menu planning, and breastfeeding supportive practices;</p> <p>s) Physical activity, including age-appropriate activities and limiting sedentary behaviors;</p> <p>t) Prevention of childhood obesity and related chronic diseases;</p> <p>u) Knowledge of environmental health issues for both children and staff;</p> <p>v) Knowledge of medication administration policies and practices;</p> <p>w) Caring for children with special health care needs, mental health needs, and developmental disabilities in compliance with the Americans with Disabilities Act (ADA);</p> <p>x) Strategies for implementing care plans for children with special health care needs and inclusion of all children in activities;</p> <p>y) Positive approaches to support diversity;</p> <p>z) Positive ways to promote physical and intellectual development</p>	<p>(6) Early learning providers licensed to care for infants must complete the Prevention and Identifying Shaken Baby Syndrome/Abuse Head Trauma training as approved or offered by the department according to subsection (1) of this section. Weight #6</p> <p>(7) Early learning providers must complete the Serving Children Experiencing Homelessness training as approved or offered by the department according to subsection (1) of this section. Weight #5</p> <p>(8) License applicants and early learning providers licensed to care for infants must complete the Safe Sleep training as approved or offered by the department. This training must be completed annually and:</p> <p> (a) Prior to being licensed;</p> <p> (b) Prior to caring for infants; or</p> <p> (c) According to subsection (1) of this section. Weight #7</p> <p>(9) Family home licensees, Center Directors, Assistant Directors, Program Supervisors, Lead Teachers, and other appropriate staff members must complete the Child Restraint training as approved or offered by the department. This training must be completed annually and:</p> <p> (a) Prior to being authorized to restrain an enrolled child; or</p> <p> (b) According to subsection (1) of this section. Weight #6</p> <p>(10) Family home licensees, Center Directors, Assistant Directors, Program Supervisors, and Lead Teachers must complete the Medication Management and Administration training as approved or offered by the department prior to giving medication to an enrolled child, or as indicated in subsection (1) of this section. Weight #6</p> <p>(11) Early learning providers who directly care for children must complete the Prevention of Exposure to Blood and Body Fluids training that meets Washington State Department of Labor & Industries’ requirements prior to being granted a license or working with children. This training must be repeated pursuant to Washington State Department Labor and Industries regulations. Weight #6</p> <p>(12) Early learning providers must have a current first-aid and cardiopulmonary resuscitation (CPR) certification prior to being alone with children. Early learning providers must ensure that at least one staff person with a current first aid and CPR certificate is present with each group of children at all times.</p> <p> (a) Proof of certification may be a card, certificate, or instructor letter.</p> <p> (b) The first-aid and CPR training and certification must:</p> <p> (i) Be delivered in person and include a hands-on component for first-aid and CPR demonstrated in front of an instructor certified by the American Red Cross, American Heart Association, American Safety and Health Institute, or other nationally recognized certification program; and</p> <p> (ii) Include child and adult CPR; and</p> <p> (iii) Infant CPR, if applicable.</p> <p>Weight #7</p> <p>(13) Early learning providers who prepare or serve food to children at an early learning program must obtain a current Food Worker card prior to preparing or serving food. Food Worker cards must:</p> <p> (a) Be obtained online or through the local health jurisdiction; and</p> <p> (b) Be renewed prior to expiring.</p> <p>Weight #4</p>				
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<p>STANDARD 1.4.2.2: Orientation for Care of Children with Special Health Care Needs</p> <p>When a child care facility enrolls a child with special health care needs, the facility should ensure that all staff members have been oriented in understanding that child’s special health care needs and have the skills to work with that child in a group setting.</p> <p>Caregivers/teachers in small family child care homes, who care for a child with special health care needs, should meet with the parents/guardians and meet or speak with the child’s primary care provider (if the parent/guardian has provided prior, informed, written consent) or a child care health consultant to ensure that the child’s special health care needs will be met in child care and to learn how these needs may affect his/her developmental progression or play with other children.</p> <p>In addition to Orientation Training, Standard 1.4.2.1, the orientation provided to staff in child care facilities should be based on the special health care needs of children who will be assigned to their care. All staff oriented for care of children with special health needs should be knowledgeable about the care plans created by the child’s primary care provider in their medical home as well as any care plans created by other health professionals and therapists involved in the child’s care. A template for a care plan for children with special health care needs can be found in Appendix O. Child care health consultants can be an excellent resource for providing health and safety orientation or referrals to resources for such training. This training may include, but is not limited to, the following topics:</p> <ul style="list-style-type: none">a) Positioning for feeding and handling, and risks for injury for children with physical/mental disabilities;b) Toileting techniques;c) Knowledge of special treatments or therapies (e.g., PT, OT, speech, nutrition/diet therapies, emotional support and behavioral therapies, medication administration, etc.) the child may need/receive in the child care setting;d) Proper use and care of the individual child’s adaptive equipment, including how to recognize defective equipment and to notify	<p>170-300-0085 Family partnerships and communication.</p> <p>(2) An early learning provider must attempt to obtain information from each child’s family about that child’s developmental, behavioral, health, linguistic, cultural, social, and other relevant information. The provider must make this attempt upon that child’s enrollment and annually thereafter. Weight #3</p> <p>(3) An early learning provider must determine how the program can best accommodate each child’s individual characteristics, strengths, and needs. The provider must utilize the information in subsection (2) of this section and seek input from family members and staff familiar with a child’s behavior, developmental, and learning patterns. Weight #3</p> <p>(4) An early learning provider must: (a) Attempt to discuss with parents or guardians information including, but not limited to: (i) A child’s strength in areas of development, health issues, special needs and other concerns; Weight #3</p> <p>170-300-0110 Program based staff policies and training.</p> <p>(2) Early learning program staff policies must include, but are not limited to:</p> <ul style="list-style-type: none">(e) Early learning program staff responsibilities for:<ul style="list-style-type: none">(xiv) Implementation of child’s individual health care or special needs plan; <p>(4) An early learning provider must develop, deliver, and document the delivery of early learning staff training specific to the early learning program and premises.</p> <ul style="list-style-type: none">(a) Training topics must include:<ul style="list-style-type: none">(i) Staff policies listed in subsections (2) and (3) of this section;(ii) Chapter 43.216 RCW; and(iii) Chapters 170-300 and 170-06 WAC, as hereafter recodified or amended.(b) Training must be updated with changes in program policies and state or federal regulations. Weight #5 <p>170-300-0300 Individual Care Plan.</p> <p>(1) An early learning provider must develop an Individual Care Plan for each child with special needs and must notify the department when a child with special needs is enrolled or identified in the early learning program. Plans and documentation required under this section must:</p> <ul style="list-style-type: none">(a) Meet the requirements of this section; Weight #5(b) Be available for department review; Weight #5(c) Have written permission from a child’s parent or guardian stating that a visiting health professional may provide services to the child at the early learning program, if applicable; Weight #5(d) Have verification that early learning program staff involved with a particular child has been trained on implementing the Individual Care Plan for that child, if applicable; Weight #5(e) Be updated annually or when there is a change in the child’s special needs; Weight #5 and(f) Be kept in the child’s file. Weight NA <p>(2) The Individual Care Plan must be signed by the parent or guardian and may be developed using a department provided template.</p> <ul style="list-style-type: none">(a) The Individual Care Plan must contain:	Meets	WAC language is intentionally broad to be inclusive of each required element. For example, toileting techniques would be inclusive of “(vii) Activity, behavioral, or environmental modifications for the child;”		
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<p>parents/guardians that repairs are needed;</p> <p>e) How different disabilities affect the child’s ability to participate in group activities;</p> <p>f) Methods of helping the child with special health care needs or behavior problems to participate in the facility’s programs, including physical activity programs;</p> <p>g) Role modeling, peer socialization, and interaction;</p> <p>h) Behavior modification techniques, positive behavioral supports for children, promotion of self-esteem, and other techniques for managing behavior;</p> <p>i) Grouping of children by skill levels, taking into account the child’s age and developmental level;</p> <p>j) Health services or medical intervention for children with special health care problems;</p> <p>k) Communication methods and needs of the child;</p> <p>l) Dietary specifications for children who need to avoid specific foods or for children who have their diet modified to maintain their health, including support for continuation of breastfeeding;</p> <p>m) Medication administration (for emergencies or on an ongoing basis);</p> <p>n) Recognizing signs and symptoms of impending illness or change in health status;</p> <p>o) Recognizing signs and symptoms of injury;</p> <p>p) Understanding temperament and how individual behavioral differences affect a child’s adaptive skills, motivation, and energy;</p> <p>q) Potential hazards of which staff should be aware;</p> <p>r) Collaborating with families and outside service providers to create a health, developmental, and behavioral care plan for children with special needs;</p> <p>s) Awareness of when to ask for medical advice and recommendations for non-emergent issues that arise in school (e.g., head lice, worms, diarrhea);</p> <p>t) Knowledge of professionals with skills in various conditions, e.g., total communication for children with deafness, beginning orientation and mobility; training for children with blindness (including arranging the physical environment effectively for such children), language promotion for children with hearing-impairment and language delay/disorder, etc.;</p> <p>u) How to work with parents/guardians and other professionals when assistive devices or medications are not consistently brought to the child care</p>	<p>(i) The child’s diagnosis, if known;</p> <p>(ii) Contact information for the primary health care provider or other relevant specialist;</p> <p>(iii) A list of medication to be administered at scheduled times, or during an emergency along with descriptions of symptoms that would trigger emergency medication;</p> <p>(iv) Directions on how to administer medication;</p> <p>(v) Allergies;</p> <p>(vi) Food allergy and dietary needs, pursuant to WAC 170-300-0186;</p> <p>(vii) Activity, behavioral, or environmental modifications for the child;</p> <p>(viii) Known symptoms and triggers;</p> <p>(ix) Emergency response plans and what procedures to perform; and</p> <p>(x) Suggested special skills training, and education for early learning program staff, including specific pediatric first aid and CPR for special health care needs.</p> <p>(b) An early learning provider must have supporting documentation of the child's special needs provided by the child’s licensed or certified:</p> <p>(i) Physician or physician's assistant;</p> <p>(ii) Mental health professional;</p> <p>(iii) Education professional;</p> <p>(iv) Social worker with a bachelor's degree or higher with a specialization in the individual child's needs; or</p> <p>(v) Registered nurse or advanced registered nurse practitioner.</p> <p>Weight NA</p> <p>(3) An early learning provider’s written plan and documentation for accommodations must be informed by any existing:</p> <p>(a) Individual education plan (IEP);</p> <p>(b) Individual health plan (IHP);</p> <p>(c) 504 plan; or</p> <p>(d) Individualized family service plan (IFSP).</p> <p>Weight NA</p> <p>170-300-0186</p> <p>Food allergies and special dietary needs.</p> <p>(1) An early learning provider must obtain written instructions (The Individual Care Plan) from the child's health care provider and parent or guardian when caring for a child with a known food allergy or special dietary requirement due to a health condition. The Individual Care Plan pursuant to WAC 170-300-0300 must:</p> <p>(a) Identify foods that must not be consumed by the child and steps to take in the case of an unintended allergic reaction;</p> <p>(b) Identify foods that can substitute for allergenic foods; and</p> <p>(c) Provide a specific treatment plan for the early learning provider to follow in response to an allergic reaction. The specific treatment plan must include the:</p> <p>(i) Names of all medication to be administered;</p> <p>(ii) Directions for how to administer the medication;</p> <p>(iii) Directions related to medication dosage amounts; and</p> <p>(iv) Description of allergic reactions and symptoms associated with the child’s particular allergies.</p> <p>Weight #8</p>				
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program or school; v) How to safely transport a child with special health care needs	<div><div>(2) An early learning provider must arrange with the parents or guardians of a child in care to ensure the early learning program has the necessary medication, training, and equipment to properly manage a child’s food allergies. Weight #8</div><div>(3) Early learning providers must review each child’s Individual Care Plan information for food allergies prior to serving food to children. Weight #7</div></div>				
STANDARD 1.4.2.3: Orientation Topics During the first three months of employment, the director of a center or the caregiver/teacher in a large familyhome should document, for all full-time and part-time staff members, additional orientation in, and the employees’ satisfactory knowledge of, the following topics: <div><div>a) Recognition of symptoms of illness and correct documentation procedures for recording symptoms of illness. This should include the ability to perform a daily health check of children to determine whether any children are ill or injured and, if so, whether a child who is ill should be excluded from the facility;</div><div>b) Exclusion and readmission procedures and policies;</div><div>c) Cleaning, sanitation, and disinfection procedures and policies;</div><div>d) Procedures for administering medication to children and for documenting medication administered to children;</div><div>e) Procedures for notifying parents/guardians of an infectious disease occurring in children or staff within the facility;</div><div>f) Procedures and policies for notifying public health officials about an outbreak of disease or the occurrence of a reportable disease;</div><div>g) Emergency procedures and policies related to unintentional injury, medical emergency, and natural disasters;</div><div>h) Procedure for accessing the child carehealth consultant for assistance;</div><div>i) Injury prevention strategies and hazard identification procedures specific to the facility, equipment, etc.;</div><div>j) Proper hand hygiene.</div></div> Before being assigned to tasks that involve identifying and responding to illness, staff members should receive orientation training on these topics. Small family child carehome caregivers/teachers should not commence	Proposed 170-300-0110 Program based staff policies and training (1) An early learning provider must have and follow written policies for early learning program staff. Staff policies must include those listed in subsection (2) and (3) of this section and must be reviewed and approved by the department prior to issuing a provider’s initial license. Providers must notify the department when substantial changes are made Weight #1 (2) Early learning program staff policies must include, but are not limited to: <div><div>(a) All of the information in the parent or guardian handbook except fees;</div><div>(b) Job descriptions, pay dates, and benefits;</div><div>(c) Professional development expectations and plans;</div><div>(d) Expectations for attendance and conduct;</div><div>(e) Early learning program staff responsibilities for:<div><div>(i) Child supervision requirements, including preventing children’s access to unlicensed space;</div><div>(ii) Child growth and development;</div><div>(iii) Developmentally appropriate curriculum;</div><div>(iv) Teacher-child interaction;</div><div>(v) Child protection, guidance and discipline techniques;</div><div>(vi) Safe sleep practices, if applicable;</div><div>(vii) Food service practices;</div><div>(viii) Off-site field trips, if applicable;</div><div>(ix) Transporting children, if applicable;</div><div>(x) Health, safety and sanitization procedures;</div><div>(xi) Medication management procedures;</div><div>(xii) Medical emergencies, fire, disaster evacuation and emergency preparedness plans;</div><div>(xiii) Mandatory reporting of suspected child abuse, neglect, and exploitation, per RCW 26.44.020 and RCW 26.44.030 and all other reporting requirements;</div><div>(xiv) Implementation of child’s individual health care or special needs plan;</div><div>(xv) Following non-smoking, vaping, alcohol and drug regulations;</div><div>(xvi) Overnight care, if applicable;</div><div>(xvii) Religious, equity and cultural responsiveness;</div><div>(xviii) Non-discrimination;</div><div>(xviv) Planned daily activities and routines;</div></div></div><div>(f) Staff responsibilities if the family home licensee, Center Director, Assistant Director, or Program Supervisor is absent from the early learning program</div><div>(g) A plan that includes how both administrative and child caretaking duties are met when a job requires such dual responsibilities.</div><div>(i) Observation, evaluation, and feedback policies. Weight NA</div></div>	Meets			

operation before receiving orientation on these topics in pre-service training	<p>(3) An early learning provider must have and follow written policies requiring staff working, transitioning, or covering breaks with the same classroom or group of children to share applicable information with each other on a daily basis regarding:</p> <ul style="list-style-type: none">(a) A child’s health needs, allergies and medication;(b) Any change in a child’s daily schedule;(c) Significant educational or developmental information;(d) Any communications from the family; and(e) Information to be shared with the family. Weight #5 <p>(4) An early learning provider must develop, deliver, and document the delivery of early learning staff training specific to the early learning program and premises.</p> <ul style="list-style-type: none">(a) Training topics must include:<ul style="list-style-type: none">(i) Staff policies listed in subsections (2) and (3) of this section;(ii) Chapter 43.216 RCW; and(iii) Chapters 170-300 and 170-06 WAC, as hereafter recodified or amended.(b) Training must be updated with changes in program policies and state or federal regulations. Weight #5				
<p>STANDARD 1.4.3.1: First Aid and CPR Training for Staff</p> <p>The director of a center or a large family child care home should ensure all staff members involved in providing direct care have documentation of satisfactory completion of training in pediatric first aid and pediatric CPR skills. Pediatric CPR skills should be taught by demonstration, practice, and return demonstration to ensure the technique can be performed in an emergency. These skills should be current according to the requirement specified for retraining by the organization that provided the training.</p> <p>At least one staff person who has successfully completed training in pediatric first aid that includes CPR should be in attendance at all times with a child whose special care plan indicates an increased risk of needing respiratory or cardiac resuscitation.</p> <p>Records of successful completion of training in pediatric first aid should be maintained in the personnel files of the facility.</p>	<p>170-300-0106 Training requirements</p> <p>(12) Early learning providers must have a current first-aid and cardiopulmonary resuscitation (CPR) certification prior to being alone with children. Early learning providers must ensure that at least one staff person with a current first aid and CPR certificate is present with each group of children at all times.</p> <ul style="list-style-type: none">(a) Proof of certification may be a card, certificate, or instructor letter.(b) The first-aid and CPR training and certification must:<ul style="list-style-type: none">(i) Be delivered in person and include a hands-on component for first-aid and CPR demonstrated in front of an instructor certified by the American Red Cross, American Heart Association, American Safety and Health Institute, or other nationally recognized certification program; and(ii) Include child and adult CPR; and(iii) Infant CPR, if applicable. Weight #7 <p>170-300-0115 Staff records.</p> <p>(1) An early learning provider must establish a records system for themselves, household members, staff, and volunteers that complies with the requirements of this chapter. Early learning program staff records must be:</p> <ul style="list-style-type: none">(a) Verified by the licensee, Center Director, Assistant Director, or Program Supervisor;(b) Entered and maintained in the electronic workforce registry, if applicable. Paper records may be discarded once entered into the electronic workforce registry and confirmed by the department;(c) Updated to delete staff names from the electronic workforce registry when no longer employed at the early learning program; and(d) Kept on-site or in the program’s administrative office in a manner that allows the department to review the records. Weight #1 <p>(2) Records for each early learning provider and staff member must include:</p> <ul style="list-style-type: none">(e) Proof of professional credentials, requirements, and training for each early learning staff member, pursuant to WAC 170-300-0100 through 0110;	Meets			

	Weight #4				
<p>STANDARD 1.4.3.2: Topics Covered in First Aid Training</p> <p>First aid training should present an overview of Emergency Medical Services (EMS), accessing EMS, poison center services, accessing the poison center, safety at the scene, and isolation of body substances. First aid instruction should include, but not be limited to, recognition and first response of pediatric emergency management in a child care setting of the following situations:</p> <ul style="list-style-type: none">a) Management of a blocked airway and rescue breathing for infants and children with return demonstration by the learner (pediatric CPR);b) Abrasions and lacerations;c) Bleeding, including nosebleeds;d) Burns;e) Fainting;f) Poisoning, including swallowed, skin or eye contact, and inhaled;g) Puncture wounds, including splinters;h) Injuries, including insect, animal, and human bites;i) Poison control;j) Shock;k) Seizure care;l) Musculoskeletal injury (such as sprains, fractures);m) Dental and mouth injuries/trauma;n) Head injuries, including shaken baby syndrome/abusive head trauma;o) Allergic reactions, including information about when epinephrine might be required;p) Asthmatic reactions, including information about when rescue inhalers must be used;q) Eye injuries;r) Loss of consciousness;s) Electric shock;t) Drowning;u) Heat-related injuries, including heat exhaustion/heat stroke;v) Cold related injuries, including frostbite;w) Moving and positioning injured/ill persons;x) Illness-related emergencies (such as stiff neck, inexplicable confusion, sudden onset of blood-red or purple rash, severe pain, temperature above	<p>No WAC found that specifically lists topics that must be included in first aid training.</p> <p>170-300-0106 Training requirements</p> <p>(12) Early learning providers must have a current first-aid and cardiopulmonary resuscitation (CPR) certification prior to being alone with children. Early learning providers must ensure that at least one staff person with a current first aid and CPR certificate is present with each group of children at all times.</p> <ul style="list-style-type: none">(a) Proof of certification may be a card, certificate, or instructor letter.(b) The first-aid and CPR training and certification must:<ul style="list-style-type: none">(i) Be delivered in person and include a hands-on component for first-aid and CPR demonstrated in front of an instructor certified by the American Red Cross, American Heart Association, American Safety and Health Institute, or other nationally recognized certification program; and(ii) Include child and adult CPR; and(iii) Infant CPR, if applicable. Weight #7	Meets	This regulation is met because each topic is standard curriculum for all First Aid/CPR training certification programs.		

<p>101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method, and looking/acting severely ill);</p> <p>y) Standard Precautions;</p> <p>z) Organizing and implementing a plan to meet an emergency for any child with a special healthcare need;</p> <p>aa) Addressing the needs of the other children in the group while managing emergencies in a child care setting;</p> <p>ab) Applying first aid to children with special health care needs.</p>				
<p>STANDARD 1.4.3.3: CPR Training for Swimming and Water Play</p> <p>Facilities that have a swimming pool should require at least one staff member with current documentation of successful completion of training in infant and child (pediatric) CPR (Cardiopulmonary Resuscitation) be on duty at all times during business hours.</p> <p>At least one of the caregivers/teachers, volunteers, or other adults who is counted in the child: staff ratio for swimming and water play should have documentation of successful completion of training in basic water safety, proper use of swimming pool rescue equipment, and infant and child CPR according to the criteria of the American Red Cross or the American Heart Association (AHA).</p> <p>For small family child care homes, the person trained in water safety and CPR should be the caregiver/teacher. Written verification of successful completion of CPR and lifesaving training, water safety instructions, and emergency procedures should be kept on file.</p>	<p>170-300-0106 Training requirements</p> <p>(12) Early learning providers must have a current first-aid and cardiopulmonary resuscitation (CPR) certification prior to being alone with children. Early learning providers must ensure that at least one staff person with a current first aid and CPR certificate is present with each group of children at all times.</p> <p>(a) Proof of certification may be a card, certificate, or instructor letter.</p> <p>(b) The first-aid and CPR training and certification must:</p> <p>(i) Be delivered in person and include a hands-on component for first-aid and CPR demonstrated in front of an instructor certified by the American Red Cross, American Heart Association, American Safety and Health Institute, or other nationally recognized certification program; and</p> <p>(ii) Include child and adult CPR; and</p> <p>(iii) Infant CPR, if applicable. Weight #7</p> <p>170-300-0350</p> <p>Supervising children during water activities.</p> <p>(1) During water activities, an early learning provider must meet all supervision requirements of this section and WAC 170-300-0345. Weight NA</p> <p>(2) During water activities, an early learning provider must:</p> <p>(a) Ensure a one-to-one (1:1) staff-to-child ratio must for infants;</p> <p>(b) Hold or have continuous touch of infants, non-ambulatory toddlers, and children with special needs as required; and</p> <p>(c) Keep toddlers within arm’s length.</p> <p>Weight #8</p> <p>(3) An early learning provider must have written permission for water activities from each child’s parent or guardian. Weight #7</p> <p>(4) For water activities on or off the early learning program premises, where the water is more than 24 inches deep, an early learning provider must ensure:</p> <p>(a) A certified lifeguard is present and on duty; and</p> <p>(b) At least one additional staff member than would otherwise be required is present to help actively supervise if the children are preschool age or older.</p> <p>Weight #8</p>	<p>Meets</p>	<p>This regulation is met because water play requires a certified lifeguard is present and on duty for all water play over 24 inches deep as well as an additional staff with CPR/First Aid training from a nationally recognized certification program</p>	

	<p>(5)An early learning provider must have life-saving equipment readily accessible during water activities if a pool is six feet or more in any direction and two feet or more in depth. Life-saving equipment may include a ring buoy and rope, a rescue tube, or a throwing line and a shepherd’s hook that will not conduct electricity. Weight #8</p> <p>(6)If an early learning provider takes children off-site to an area with an accessible body of water more than four inches deep (for example, a park with a lake or stream) but children are not engaging in a water activity, there must be:</p> <p>(a) At least one more staff person than required in the staff-to-child ratio; and</p> <p>(b) At least one attending staff person must be able to swim.</p> <p>Weight #8</p> <p>170-300-0115 Staff records.</p> <p>(1) An early learning provider must establish a records system for themselves, household members, staff, and volunteers that complies with the requirements of this chapter. Early learning program staff records must be:</p> <p>(a) Verified by the licensee, Center Director, Assistant Director, or Program Supervisor;</p> <p>(b) Entered and maintained in the electronic workforce registry, if applicable. Paper records may be discarded once entered into the electronic workforce registry and confirmed by the department;</p> <p>(c) Updated to delete staff names from the electronic workforce registry when no longer employed at the early learning program; and</p> <p>(d) Kept on-site or in the program’s administrative office in a manner that allows the department to review the records.</p> <p>Weight #1</p> <p>(2) Records for each early learning provider and staff member must include:</p> <p>(e)Proof of professional credentials, requirements, and training for each early learning staff member, pursuant to WAC 170-300-0100 through 0110;</p> <p>Weight #4</p>				
<p>STANDARD 1.4.5.1: Training of Staff Who Handle Food</p> <p>All staff members with food handlingresponsibilities should obtain training in food service and safety. The director of a center or a large family child care home or the designated supervisor for food service should be a certified food protection manager or equivalent as demonstrated by completing an accredited food protection manager course.</p>	<p>170-300-0106 Training requirements</p> <p>(13) Early learning providers who prepare or serve food to children at an early learning program must obtain a current Food Worker card prior to preparing or serving food. Food Worker cards must:</p> <p>(a) Be obtained online or through the local health jurisdiction; and</p> <p>(b) Be renewed prior to expiring.</p> <p>Weight #4</p>	Meets			
<p>STANDARD 1.4.5.2: Child Abuse and Neglect Education</p> <p>Caregivers/teachers should use child abuse and neglect prevention education to educate and establish child abuse and neglect prevention and recognition measures for the children, caregivers/teachers, and parents/guardians. The education should address physical, sexual, and psychological or emotional abuse and neglect. The</p>	<p>WAC 170-300-0106 Training requirements.</p> <p>(1) Early learning providers licensed, working, or volunteering in an early learning program before the date this section becomes effective must complete the applicable training requirements of this section within three months of the date this section becomes effective unless otherwise indicated. Early learning providers hired after the date this section becomes effective must complete the training requirements of subsections (4) through (10) of this section within three months of the date of hire and prior to working in an unsupervised capacity with children. Weight #1</p>	Meets			

<p>dangers of shaking infants and toddlers and repeated exposure to domestic violence should be included in the education and prevention materials. Caregivers/teachers should also receive education on promoting protective factors to prevent child maltreatment.</p> <p>Caregivers/teachers should be able to identify signs of stress in families and assist families by providing support and linkages to resources when needed. Children with disabilities are at a higher risk of being abused. Special training in child abuse and neglect and children with disabilities should be provided (2). Caregivers/teachers are mandatory reporters of child abuse or neglect. Caregivers/teachers should be trained in compliance with their state's child abuse reporting laws. Child abuse reporting requirements are known and available from the child care regulation department in each state.</p>	<p>(4) Early learning providers must complete the Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation training as approved or offered by the department according to subsection (1) of this section. Training must include the prevention of child abuse and neglect as defined in RCW 26.44.020. Weight #7</p> <p>(6) Early learning providers licensed to care for infants must complete the Prevention and Identifying Shaken Baby Syndrome/Abuse Head Trauma training as approved or offered by the department according to subsection (1) of this section. Weight #6</p> <p>WAC 170-300-0475 Duty to protect children and report incidents.</p> <p>(1) Pursuant to RCW 26.44.030, when an early learning provider has reasonable cause to believe that a child has suffered abuse or neglect, that provider must report such incident, or cause a report to be made, to the proper law enforcement agency or the department. "Abuse or neglect" has the same meaning here as in RCW 26.44.020. Weight #8</p> <p>170-300-0110 Program based staff policies and training.</p> <p>(2) Early learning program staff policies must include, but are not limited to:</p> <p> (e) Early learning program staff responsibilities for:</p> <p> (xii) Mandatory reporting of suspected child abuse, neglect, and exploitation, per RCW 26.44.020 and RCW 26.44.030 and all other reporting requirements;</p> <p>(4) An early learning provider must develop, deliver, and document the delivery of early learning staff training specific to the early learning program and premises.</p> <p> (a) Training topics must include:</p> <p> (i) Staff policies listed in subsections (2) and (3) of this section;</p> <p> (ii) Chapter 43.216 RCW; and</p> <p> (iii) Chapters 170-300 and 170-06 WAC, as hereafter recodified or amended.</p> <p> (b) Training must be updated with changes in program policies and state or federal regulations. Weight #5</p>				
<p>STANDARD 1.5.0.2: Orientation of Substitutes</p> <p>The director of any center or large family child care home and the small family child care home caregiver/teacher should provide orientation training to newly hired substitutes to include a review of ALL the program's policies and procedures (listed below is a sample). This training should include the opportunity for an evaluation and a repeat demonstration of the training lesson. In all child care settings the orientation should be documented. Substitutes should have background screenings.</p> <p>All substitutes should be oriented to, and demonstrate competence in, the tasks for which they will be responsible. On the first day a substitute caregiver/teacher should be oriented on the following topics:</p> <p> a) Safe infant sleep practices if an infant is</p>	<p>No WAC found that specifically addresses "substitutes."</p> <p>However, 170-300-0100 General Staff Qualifications includes qualifications for family home licensee, center licensee, center director, center assistant director, center program supervisor, lead teacher, assistant teacher, aids, other personnel who do not directly care for children, and volunteers. A substitute would need to meet the qualifications for the position that he/she is filling in for on any given day. WAC 170-300-0105 Pre-service requirements and WAC 170-300-0106 Training requirements lists the required trainings.</p> <p>170-300-0015 Licensee absence.</p> <p>(1) In a family home early learning program, the licensee must have a written plan for when the licensee will be absent but the program remains open for the care of children. If a family home licensee is absent more than ten consecutive operating days, the licensee must submit a written notification to the department and each child's parent or guardian at least two business days prior to the planned absence. Weight #5</p> <p>(2) In a center early learning program, the licensee must have a written plan for when the Director, Assistant Director, and Program Supervisor will be simultaneously absent but the program remains open for the care of</p>	Meets	While this is not directly addressed, Substitutes are required to receive the same orientation as the position they are filling.		

<p>enrolled in the program;</p> <p>b) Any emergency medical procedure/medication needs of the children;</p> <p>c) Any nutrition needs of the children.</p> <p>All substitute caregivers/teachers, during the first week of employment, should be oriented to, and should demonstrate competence in at least the following items:</p> <p>a) The names of the children for whom the caregiver/ teacher will be responsible, and their specific developmental needs;</p> <p>b) The planned program of activities at the facility;</p> <p>c) Routines and transitions;</p> <p>d) Acceptable methods of discipline;</p> <p>e) Meal patterns and safe food handling policies of the facility (special attention should be given to life-threatening food allergies);</p> <p>f) Emergency health and safety procedures;</p> <p>g) General health policies and procedures as appropriate for the ages of the children cared for, including but not limited to the following:</p> <p>1) Hand hygiene techniques, including indications for hand hygiene;</p> <p>2) Diapering technique, if care is provided to children in diapers, including appropriate diaper disposal and diaper changing techniques, use and wearing of gloves;</p> <p>3) The practice of putting infants down to sleep positioned on their backs and on a firm surface along with all safe infant sleep practices to reduce the risk of Sudden Infant Death Syndrome (SIDS), as well as general nap time routines for all ages;</p> <p>4) Correct food preparation and storage techniques, if employee prepares food;</p> <p>5) Proper handling and storage of human milk when applicable and formula preparation if formula is handled;</p> <p>6) Bottle preparation including guidelines for human milk and formula if care is provided to children with bottles;</p> <p>7) Proper use of gloves in compliance with Occupational Safety and Health Administration (OSHA) blood borne pathogens regulations;</p> <p>8) Injury prevention and safety including the role of mandatory child abuse reporter to</p>	<p>children. If the Director, Assistant Director, and Program Supervisor are simultaneously absent for more than ten consecutive operating days, an early learning provider must submit a written notification to the department and each child’s parent or guardian at least two business days prior to the planned absence. Weight #5</p> <p>(3) A written notification under this section must include the following information:</p> <p>(a) The time period of the absence;</p> <p>(b) Emergency contact information for the absent early learning provider; and</p> <p>(c) A written plan for program staff to follow that includes:</p> <p>(i) A staffing plan that meets child-to staff ratios;</p> <p>(ii) Identification of a Lead Teacher to be present and in charge;</p> <p>(iii) Early learning program staff roles and responsibilities;</p> <p>(iv) How each child’s needs will be met during the absence; and</p> <p>(v) The responsibility for meeting licensing requirements.</p> <p>Weight NA</p> <p>(4) If a Facility Licensing Compliance Agreement (FLCA) is developed as a result of early learning program staff failing to comply with licensing regulations during an absence described in this section, an early learning provider must:</p> <p>(a) Retrain early learning program staff on the Foundational Quality Standards documented on the FLCA; and</p> <p>(b) Document that the retraining occurred.</p> <p>Weight NA</p>				
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report any suspected abuse/neglect. h) Emergency plans and practices; i) Access to list of authorized individuals for releasing children.					
<p>STANDARD 2.1.1.4: Monitoring Children’s Development/Obtaining Consent for Screening</p> <p>Child care settings provide daily indoor and outdoor opportunities for promoting and monitoring children’s development. Caregivers/teachers should monitor the children’s development, share observations with parents/guardians, and provide resource information as needed for screenings, evaluations, and early intervention and treatment. Caregivers/teachers should work in collaboration to monitor a child’s development with parents/guardians and in conjunction with the child’s primary care provider and health, education, mental health, and early intervention consultants. Caregivers/teachers should utilize the services of health and safety, education, mental health, and early intervention consultants to strengthen their observation skills, collaborate with families, and be knowledgeable of community resources.</p> <p>Programs should have a formalized system of developmental screening with all children that can be used near the beginning of a child’s placement in the program, at least yearly thereafter, and as developmental concerns become apparent to staff and/or parents/guardians. The use of authentic assessment and curricular-based assessments should be an ongoing part of the services provided to all children (5-9). The facility’s formalized system should include a process for determining when a health or developmental screening or evaluation for a child is necessary. This process should include parental/guardian consent and participation.</p> <p>Parents/guardians should be explicitly invited to:</p> <ul style="list-style-type: none">a) Discuss reasons for a health or developmental assessment;b) Participate in discussions of the results of their child’s evaluations and the relationship of their child’s needs to the caregivers’/teachers’ ability to serve that child appropriately;c) Give alternative perspectives;d) Share their expectations and goals for their	<p>170-300-0055 Developmental screening and communication to parents or guardians.</p> <p>(1) An early learning provider must inform parents or guardians about the importance of developmental screenings for each child from birth through age five. Weight # 3</p> <p>(2) If not conducted on site, an early learning provider must share information with parents or guardians about organizations that conduct developmental screenings such as a local business, school district, health care provider, specialist or resource listed on the department web site. Weight # 3</p> <p>170-300-0085 Family partnerships and communication.</p> <p>(1) An early learning provider must communicate with families to identify individual children’s developmental goals. Weight #NA</p> <p>(2) An early learning provider must attempt to obtain information from each child’s family about the child’s developmental, behavioral, health, linguistic, cultural, social, and other relevant information. The provider must make this attempt upon that child’s enrollment and annually thereafter. Weight #3</p> <p>(3) An early learning provider must determine how the program can best accommodate each child’s individual characteristics, strengths, and needs. The provider must utilize the information in subsection (2) of this section and seek input from family members and staff familiar with a child’s behavior, developmental, and learning patterns. Weight #3</p> <p>(4) An early learning provider must:</p> <ul style="list-style-type: none">(a) Attempt to discuss with parents or guardians information including, but not limited to:<ul style="list-style-type: none">(i) A child’s strength in areas of development, health issues, special needs, and other concerns;(ii) Family routines or events, approaches to parenting, family beliefs, culture, language, and child rearing practices;(iii) Internal transitions within the early learning program and transitions to external services or programs, as necessary;(iv) Collaboration between the provider and the parent or guardian in behavior management; and(v) A child’s progress, at least two times per year. Weight #3(b) Communicate the importance of regular attendance for the child; Weight #3(c) Give parents or guardians contact information for questions or concerns; Weight #3(d) Give families opportunities to share their language and culture in the early learning program; Weight #3(e) Arrange a confidential time and space for individual conversations regarding children, as needed; Weight #3.(f) Allow parents or guardians access to their child during normal hours of operation, except as excluded by a court order; and Weight #5	Partially Meets	While the WAC requires providers to inform caregivers of developmental screening and encourage dialogue around the results, there is no WAC found that requires programs should have a formalized system of developmental screening with all children that can be used near the beginning of a child’s placement in the program, at least yearly thereafter, and as developmental concerns become apparent to staff and/or parents/guardians. It also does not require parent/provider meetings and the documentation thereof. Also, partial compliance (for centers) in that the WAC requires that infants be screened by a health professional, and the parents have an opportunity for participating in conversation/results.		

<p>child and have these expectations and goals integrated with any plan for their child;</p> <p>e) Explore community resources and supports that might assist in meeting any identified needs that child care centers and family child care homes can provide;</p> <p>f) Give written permission to share health information with primary health care professionals (medical home), child care health consultants and other professionals as appropriate;</p> <p>The facility should document parents’/guardians’ presence at these meetings and invitations to attend.</p> <p>If the parents/guardians do not attend the screening, the caregiver/teacher should inform the parents/guardians of the results, and offer an opportunity for discussion. Efforts should be made to provide notification of meetings in the primary language of the parents/guardians. Formal evaluations of a child’s health or development should also be shared with the child’s medical home with parent/guardian consent.</p> <p>Programs are encouraged to utilize validated screening tools to monitor children’s development, as well as various measures that may inform their work facilitating children’s development and providing an enriching indoor and outdoor environment, such as authentic-based assessment, work sampling methods, observational assessments, and assessments intended to support curricular implementation (5,9). Programs should have clear policies for using reliable and valid methods of developmental screening with all children and for making referrals for diagnostic assessment and possible intervention for children who screen positive. All programs should use methods of ongoing developmental assessment that inform the curricular approaches used by the staff. Care must be taken in communicating the results. Screening is a way to identify a child <i>at risk</i> of a developmental delay or disorder. It is not a diagnosis.</p> <p>If the screening or any observation of the child results in any concern about the child’s development, after consultation with the parents/guardians, the child should be referred to his or her primary care provider (medical home), or to an appropriate specialist or clinic for further evaluation. In some situations, a direct referral to the Early Intervention System in the respective state may</p>	<p>(g) Communicate verbally or in writing:</p> <p>(i) Changes in drop-off and pickup arrangements as needed; and</p> <p>(ii) Daily activities.</p> <p>Weight #5</p> <p>170-300-0360 Program and daily schedule.</p> <p>(1) An early learning provider must have an established program and daily schedule that is familiar to children.</p> <p>Weight #1</p> <p>(2) A schedule must be designed to meet enrolled children’s developmental, cultural, and special needs. The daily schedule must:</p> <p>(a) Be specific for each age group of children, when applicable;</p> <p>(b) Offer a variety of activities to meet children’s needs, pursuant to WAC 170-300-0150;</p> <p>(c) Meet the following daily morning or afternoon active outdoor play time requirements:</p> <p>(i) 20 minutes for each 3 hours of programming for infants (as tolerated) and toddlers;</p> <p>(ii) 30 minutes for each 3 hours of programming for children preschool age and older; and</p> <p>(iii) Programs that operate more than six hours a day must provide 90 minutes of active play for preschool age and up or 60 minutes of active play for infants and toddlers (30 minutes of which may be moderate to vigorous indoor activities).</p> <p>(d) Include scheduled and consistent times for meal service;</p> <p>(e) Include routine transportation times, if applicable;</p> <p>(f) Include rest periods, if applicable; and</p> <p>(g) Include overnight care, if applicable.</p> <p>Weight #3</p> <p>170-300-0275 Infant and toddler care.</p> <p>(4) A center early learning provider licensed to care for any infant shall employ or contract with a child care health consultant to provide health consultation to support the practices of staff working with infants and to support the needs of individual infants. Weight #5</p> <p>(6) The provider shall ensure that the child care health consultant</p> <p>(a) Conducts at least one on-site visit monthly, if an infant is enrolled, during which the consultant:</p> <p>(i) observes and assesses staff knowledge of infant health, development, and safety and offers support through training, consultation, or referral;</p> <p>(iii) Observes and assesses behavior, development, and health status of individual infants in care and make recommendations to staff or parents or guardians including if further assessment is recommended, as requested or otherwise deemed appropriate</p> <p>(b) Provides a dated, signed, written summary to the early learning provider for each visit that includes topics discussed with parents or staff, any areas of concern related to discussion, observation, assessment, or screening outcomes; and</p> <p>(c) Reports each visit to the department</p> <p>(7) The early learning provider must keep on-site a copy of the child care health consultant’s written reports along with any notes, recommended follow up, and any actions taken to address concerns identified.</p> <p>I think this demonstrates that we do have a developmental screening system in place for infants in centers.</p>				
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also be required.					
<p>STANDARD 2.1.2.2: Interactions with Infants and Toddlers</p> <p>Caregivers/teachers should provide consistent, continuous and inviting opportunities to talk, listen to, and otherwise interact with young infants throughout the day (indoors and outdoors) including feeding, changing, playing with, and cuddling them.</p>	<p>170-300-0296 Infant and toddler development.</p> <p>(1)An early learning provider must expose infants and toddlers to a developmentally appropriate curriculum.</p> <p>(2) Developmentally appropriate curriculum may include, but is not limited to:</p> <p> (a) Developing infant and toddler language and communication by:</p> <p> (i) Talking and listening to children, encouraging soft infant sounds, naming objects, feelings, and desires, and describing actions;</p> <p> (ii) Giving individual attention to children when needed;</p> <p> (iii) Playing and reading with children;</p> <p> (iv) Mirroring similar infant sounds and sharing a child’s focus of attention;</p> <p> (v) Communicating throughout the day and during feeding, changing, and cuddle times; and</p> <p> (vi) Providing materials and equipment that promote language development and communication such as soft books, interactive storybook reading, rhymes and songs, and finger puppets.</p> <p> (b) Developing infant and toddler physical and cognitive abilities by:</p> <p> (i) Allowing each infant actively supervised tummy time throughout the day when the infant is awake;</p> <p> (ii) Providing infants and toddlers freedom to explore and learn on their own on the floor;</p> <p> (iii) Providing infants and toddlers access to active outdoor playtime. An early learning provider must enforce sun safety precautions for infants younger than six months old by keeping them out of the direct sunlight and limiting sun exposure when ultraviolet rays are strongest (typically from 10:00 a.m. to 2:00 p.m.); and</p> <p> (iv) Encouraging infants and toddlers to play, crawl, pull up, and walk by using materials and equipment that promotes:</p> <p> (A) Physical and cognitive activities, for example rattles, grasping and reaching toys, busy boxes, nesting cups, small push, and pull toys, riding toys, balls, squeezable toys, books, dolls, press-together blocks, and limited use of equipment such bouncers, swings, or bopees; and</p> <p> (B) Spatial and numeracy understanding, for example counting toys, soft blocks and toys with different sizes such as measuring cups or spoons, and toys with different shapes and colors to help introduce sorting and categorization.</p> <p> (c) Developing infant and toddler social and emotional abilities by:</p> <p> (i) Providing social contact with infants and toddlers in addition to time spent feeding, diapering and bathing by playing with children, naming and acknowledging emotions, and encouraging peer interaction;</p> <p> (ii) Immediately investigating cries or other signs of distress;</p> <p> (iii) Providing comfort to an upset or hurt child;</p> <p> (iv) Positively responding to a child’s verbal and non-verbal cues;</p> <p> (v)Intervening during negative peer interactions such as when a child grabs other children’s toys, pulls hair, or bites;</p> <p> (vi) Providing physical stimulation through holding, cuddling, rocking, talking, singing, playing, carrying, and changing positions; and</p> <p> (vii) Providing materials and equipment that promote social and emotional activities such as pictures of children and adults exhibiting different emotions, pictures of infants and family members, dolls and soft toys, rattles, music, and dancing scarves. Weight #5</p>	Exceeds			
STANDARD 2.2.0.1: Methods of Supervision of	170-300-0005 Definitions	Meets			

<p>Children</p> <p>Caregivers/teachers should directly supervise infants, toddlers, and preschoolers by sight and hearing at all times, even when the children are going to sleep, napping or sleeping, are beginning to wake up, or are indoors or outdoors. School-age children should be within sight or hearing at all times. Caregivers/teachers should not be on one floor level of the building, while children are on another floor or room. Ratios should remain the same whether inside or outside.</p> <p>School-age children should be permitted to participate in activities off the premises with appropriate adult supervision and with written approval by a parent/guardian and by the caregiver. If parents/guardians give written permission for the school-age child to participate in off-premises activities, the facility would no longer be responsible for the child during the off-premises activity and not need to provide staff for the off-premises activity.</p> <p>Caregivers/teachers should regularly count children (name to face on a scheduled basis, at every transition, and whenever leaving one area and arriving at another), going indoors or outdoors, to confirm the safe whereabouts of every child at all times. Additionally, they must be able to state how many children are in their care at all times.</p> <p>Developmentally appropriate child: staff ratios should be met during all hours of operation, including indoor and outdoor play and field trips, and safety precautions for specific areas and equipment should be followed. No center-based facility or large family child care home should operate with fewer than two staff members if more than six children are in care, even if the group otherwise meets the child: staff ratio. Although centers often downsize the number of staff for the early arrival and late departure times, another adult must be present to help in the event of an emergency. The supervision policies of centers and large family child care homes should be written policies.</p>	<p>“Active supervision” or “actively supervise” means a heightened standard of care beyond supervision. This standard requires an early learning provider to see and hear the children they are responsible for during higher risk activities. The provider must be able to prevent or instantly respond to unsafe or harmful events.</p> <p>“Supervise” or “supervision” means an early learning provider must be able to see or hear the children they are responsible for at all times. Early learning providers must use their knowledge of each child’s development and behavior to anticipate what may occur to prevent unsafe or unhealthy events or conduct, or to intervene in such circumstances as soon as possible. Early learning providers must also reposition themselves or the children to be aware of where children are and what they are doing during care. An early learning provider must reassess and adjust their supervision each time child care activities change. See “active supervision” for a heightened standard of care.</p> <p>170-300-0345 Supervising children.</p> <p>(1) An early learning provider must only allow the following persons to have unsupervised access to a child in care:</p> <ul style="list-style-type: none">(a) That child’s own parent or guardian;(b) Licensees or early learning program staff authorized by the department in chapter 170-06 WAC, as hereafter recodified or amended;(c) A government representative including an emergency responder who has specific and verifiable authority for access, supported by documentation; and(d) A person authorized in writing or over the phone by that child’s parent such as a family member, family friend, or the child’s therapist or health care provider. <p>Weight #7</p> <p>(2) An early learning provider must meet capacity, group size, mixed age grouping, and staff-to-child ratios while children are in care. This includes but is not limited to:</p> <ul style="list-style-type: none">(a) Indoor and outdoor play activities;(b) Off-site activities;(c) During transportation;(d) Meal times;(e) Rest periods;(f) Evening or overnight care; and(g) When children are on different floor levels of the early learning program. Weight #7 <p>(3) An early learning provider must supervise children in care by:</p> <ul style="list-style-type: none">(a) Scanning the environment looking and listening for both verbal and nonverbal cues to anticipate problems and plan accordingly;(b) Visibly checking children on many occasions with little time in between;(c) Positioning him or herself to supervise all areas accessible to children;(d) Attending to children and being aware of what children are doing at all times;(e) Being available and able to promptly assist or redirect a child as necessary; and(f) Considering the following when deciding whether increased supervision is needed:<ul style="list-style-type: none">(i) Ages of children;(ii) Individual differences and abilities of children;(iii) Layout of the indoor and outdoor licensed space and play area;(iv) The risk associated with the activities children are engaged in; and(v) Any nearby hazards including those in the licensed or unlicensed space. <p>Weight #7</p>				
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<p>(4) An early learning program staff member may undertake other activities for a temporary time period when not required to be providing active supervision required under subsection (5)(c). Such activities include, but are not limited to, cleaning up after an activity or preparing items for a new activity. This early learning staff member must remain in visual or auditory range, and be available and able to respond if needed. Weight #7</p> <p>(5) An early learning provider must:</p> <ul style="list-style-type: none">(a) Not use devices such as a baby monitors, video monitors, or mirrors in place of supervision, unless used pursuant to WAC 170-300-0270(5);(b) Be able to hear when doors in the immediate area are opened to prevent children from leaving unsupervised;(c) Actively supervise children when the children:<ul style="list-style-type: none">(i) Interact with pets or animals;(ii) Engage in water or sand play;(iii) Play in an area in close proximity to a body of water;(iv) Use a safe route to access an outdoor play area not immediately adjacent to the early learning program;(v) Engage in planned activities in the kitchen;(vi) Ride on public transportation;(vii) Engage in outdoor play; and(viii) During field trips.(d) Ensure no infant or child is left unattended during:<ul style="list-style-type: none">(i) Diapering;(ii) Bottle feeding; or(iii) Tummy time; and(e) Provide developmentally appropriate supervision to children while bathing. <p>Weight #7</p> <p>170-300-0270 Overnight care.</p> <p>(4) An early learning provider must:</p> <ul style="list-style-type: none">(a) Supervise children until they are asleep, except where children demonstrate the need for privacy to change clothes and can safely do so; and <p>(5) An early learning provider who sleeps while children are in overnight care must:</p> <ul style="list-style-type: none">(a) Have written permission and documentation that parents are aware that the provider is sleeping while their children are in care and have read the facilities policies and procedures for overnight care; Weight #6(b) Stay awake until all children are asleep or returning to sleep; Weight #7(c) Remain on the same floor level as sleeping children at all times; Weight #7(d) Sleep in the same room with infants and toddlers; Weight #8(e) Be physically available and responsive, available to immediately respond to a child’s needs; Weight #7(f) Have alarms to alert them if a child should leave the room; Weight #7(g) Have monitoring devices to assist in hearing and visibly checking on children in each room used for sleeping; Weight #7 and(h) Be awake for the arrival and departure of each child in overnight care. Weight #7 <p>170-300-0356 Center capacity, ratio, and group size.</p>				
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	<p>(4)A center licensee must provide qualified staff to fulfill staffing requirements, staff-to-child ratios, group size, and mixed age grouping during operating hours, including off-site activities or when transporting children in care. Weight NA</p> <p>(10) When only one center staff is required to care for the only group of children on site for up to an hour at the beginning or end of the day, the center licensee must ensure:</p> <ul style="list-style-type: none">(a) That staff member provides an appropriate level of supervision at all times to the children in care;(b) That staff member is free of all other duties while providing care to children; and(c) A second individual with a cleared background check is on site and readily available to respond if needed, or the department approves an alternate plan. <p>Weight #7</p> <p>170-300-0110 Program based staff policies and training.</p> <p>(1)An early learning provider must have and follow written policies for early learning program staff. Staff policies must include those listed in subsections (2) and (3) of this section and must be reviewed and approved by the department prior to issuing a provider’s initial license. Providers must notify the department when substantial changes are made. Weight #1</p> <p>(2) Early learning program staff policies must include, but are not limited to:</p> <ul style="list-style-type: none">(e) Early learning program staff responsibilities for:<ul style="list-style-type: none">(i) Child supervision requirements, including preventing children’s access to unlicensed space; <p>(4) An early learning provider must develop, deliver, and document the delivery of early learning staff training specific to the early learning program and premises.</p> <ul style="list-style-type: none">(a) Training topics must include:<ul style="list-style-type: none">(i) Staff policies listed in subsections (2) and (3) of this section;(ii) Chapter 43.216 RCW; and(iii) Chapters 170-300 and 170-06 WAC, as hereafter recodified or amended.(b)Training must be updated with changes in program policies and state or federal regulations. <p>Weight #5</p> <p>170-300-0480 Transportation and off-site activity policy</p> <p>(2) During travel to an off-site activity, an early learning provider must:</p> <ul style="list-style-type: none">(d) Maintain the staff-to-child ratio, mixed groupings, and active supervision requirements;(e) Have at least one staff member currently certified in First Aid and CPR supervise children;(f) Take attendance using a roll call method that assures all children are accounted for each time children begin and end travel to an off-site activity, and every time children enter and exit a vehicle; and(g)Never leave children unattended in the vehicle.				
<p>STANDARD 2.2.0.10: Using Physical Restraint</p> <p>When a child with special behavioral or mental health issues is enrolled who may frequently need the cautious use of restraint in the event of behavior that endangers his or her safety or the safety of others, a behavioral care plan should be developed with input from the child’s primary care provider, mental health provider, parents/guardians, center director/family child care</p>	<p>170-300-0335 Physical restraint.</p> <p>(1)An early learning provider must have written physical restraint protocols pursuant to WAC 170-300-0490, and implement such protocols only when appropriate and after complying with all requirements of WAC 170-300-0330 and 0331. Weight NA</p> <p>(2)Physical restraint must only be used if a child’s safety or the safety of others is threatened, and must be:</p> <ul style="list-style-type: none">(a) Limited to holding a child as gently as possible to accomplish restraint;(b) Limited to the minimum amount of time necessary to control the situation;(c) Developmentally appropriate; and	Meets			

<p>home caregiver/teacher, child care health consultant, and possibly early childhood mental health consultant in order to address underlying issues and reduce the need for physical restraint.</p> <p>That behavioral care plan should include:</p> <ul style="list-style-type: none">a) An indication and documentation of the use of other behavioral strategies before the use of restraint and a precise definition of when the child could be restrained;b) That the restraint be limited to holding the child as gently as possible to accomplish the restraint;c) That such child restraint techniques do not violate the state’s mental health code;d) That the amount of time the child is physically restrained should be the minimum necessary to control the situation and be age-appropriate; reevaluation and change of strategy should be used every few minutes;e) That no bonds, ties, blankets, straps, car seats, heavy weights (such as adult body sitting on child), or abusive words should be used;f) That a designated and trained staff person, who should be on the premises whenever this specific child is present, would be the only person to carry out the restraint.	<p>(d) Only performed by early learning providers training in a restraint technique pursuant to WAC 170-300-0106(9). Weight #7</p> <p>(3) No person may use bonds, ties, blankets, straps, car seats, high chairs, activity saucers, or heavy weights (including an adult sitting on a child) to physically restrain children. Weight NA</p> <p>(4) Licensees, Center Directors, Assistant Directors, and Program Supervisors, Lead Teachers or trained staff must remove him or herself from a situation if they sense a loss of their own self-control and concern for the child when using a restraint technique if another early learning provider is present. If an early learning provider observes another staff using inappropriate restraint techniques, the staff must intervene. Weight #8</p> <p>(5) If physical restraint is used, staff must:</p> <ul style="list-style-type: none">(a) Report the use of physical restraint to the child’s parent or guardian as soon as possible, but no later than the release of the child at the end of the day, and to the department within 24 hours, pursuant to WAC 170-300-0475;(b) Assess any incident of physical restraint to determine if the decision to use physical restraint and its application were appropriate;(c) Document the incident in the child’s file, including the date, time, early learning program staff involved, duration and what happened before, during and after the child was restrained;(d) Develop a written plan with input from the child’s primary care or mental health provider, parents or guardians, to address underlying issues and reduce need for further physical restraint if:<ul style="list-style-type: none">(i) Physical restraint has been used more than once; and(ii) A plan is not already a part of the child’s Individual Care Plan; and(e) Notify the department when a written plan has been developed. Weight #7				
<p>STANDARD 2.2.0.4: Supervision Near Bodies of Water</p> <p>Constant and active supervision should be maintained when any child is in or around water (1). During any swimming/ wading/water play activities where either an infant or a toddler is present, the ratio should always be one adult to one infant/toddler. Children ages thirteen months to five years of age should not be permitted to play in areas where there is any body of water, including swimming pools, ponds and irrigation ditches, built-in wading pools, tubs, pails, sinks, or toilets unless the supervising adult is within an arm’s length providing “touch supervision”.</p> <p>Caregivers/teachers should ensure that all pools meet the Virginia Graeme Baker Pool and Spa Safety Act, requiring the retrofitting of safe suction-type devices for pools and spas to prevent underwater entrapment of children in such locations with strong suction devices that have led to deaths of children of varying ages.</p>	<p>170-300-0005 Definitions</p> <p>“Active supervision” or “actively supervise” means a heightened standard of care beyond supervision. This standard requires an early learning provider to see and hear the children they are responsible for during higher risk activities. The provider must be able to prevent or instantly respond to unsafe or harmful events.</p> <p>“Supervise” or “supervision” means an early learning provider must be able to see or hear the children they are responsible for at all times. Early learning providers must use their knowledge of each child’s development and behavior to anticipate what may occur to prevent unsafe or unhealthy events or conduct, or to intervene in such circumstances as soon as possible. Early learning providers must also reposition themselves or the children to be aware of where children are and what they are doing during care. An early learning provider must reassess and adjust their supervision each time child care activities change. See “active supervision” for a heightened standard of care.</p> <p>“Water activities” means early learning program activities in which enrolled children swim or play in a body of water that poses a risk of drowning for children. Water activities do not include using sensory tables.</p> <p>“Wading pool” means a pool that has a water depth of less than two feet (24 inches).</p>	Meets			

	<p>“Swimming pool” means a pool that has a water depth greater than two feet (24 inches).</p> <p>170-300-0345 Supervising children. (5) An early learning provider must:</p> <ul style="list-style-type: none">(c) Actively supervise children when the children:<ul style="list-style-type: none">(ii) Engage in water or sand play;(iii) Play in an area in close proximity to a body of water <p>170-300-0350 Supervising children during water activities. (7) During water activities, an early learning provider must meet all supervision requirements of this section and WAC 170-300-0345. Weight NA</p> <p>(8) During water activities, an early learning provider must:</p> <ul style="list-style-type: none">(d) Ensure a one-to-one (1:1) staff-to-child ratio must for infants;(e) Hold or have continuous touch of infants, non-ambulatory toddlers, and children with special needs as required; and(f) Keep toddlers within arm’s length. <p>Weight #8</p> <p>(9) An early learning provider must have written permission for water activities from each child’s parent or guardian. Weight #7</p> <p>(10) For water activities on or off the early learning program premises, where the water is more than 24 inches deep, an early learning provider must ensure:</p> <ul style="list-style-type: none">(a) A certified lifeguard is present and on duty; and(c) At least one additional staff member than would otherwise be required is present to help actively supervise if the children are preschool age or older. <p>Weight #8</p> <p>(11) An early learning provider must have life-saving equipment readily accessible during water activities if a pool is six feet or more in any direction and two feet or more in depth. Life-saving equipment may include a ring buoy and rope, a rescue tube, or a throwing line and a shepherd’s hook that will not conduct electricity. Weight #8</p> <p>(12) If an early learning provider takes children off-site to an area with an accessible body of water more than four inches deep (for example, a park with a lake or stream) but children are not engaging in a water activity, there must be:</p> <ul style="list-style-type: none">(a) At least one more staff person than required in the staff-to-child ratio; and(b) At least one attending staff person must be able to swim. <p>Weight #8</p>				
<p>STANDARD 2.2.0.6: Discipline Measures</p> <p>Caregivers/teachers should guide children to develop self-control and appropriate behaviors in the context of relationships with peers and adults. Caregivers/teachers should care for children without ever resorting to physical punishment or abusive language. When a child needs assistance to resolve a</p>	<p>170-300-0325 Creating a climate for healthy child development. (1) When communicating or interacting with children, an early learning provider must maintain a climate for healthy, culturally responsive child development such as:</p> <ul style="list-style-type: none">(a) Using a calm and respectful tone of voice;(b) Using positive language to explain what children can do and give descriptive feedback;(c) Having relaxed conversations with children by listening and responding to what they say. Adult conversations must not dominate the overall sound of the group;(d) Greeting children upon arrival and departure at the early learning program;	Meets			

<p>conflict, manage a transition, engage in a challenging situation, or express feelings, needs, and wants, the adult should help the child learn strategies for dealing with the situation. Discipline should be an ongoing process to help children learn to manage their own behavior in a socially acceptable manner, and should not just occur in response to a problem behavior. Rather, the adult’s guidance helps children respond to difficult situations using socially appropriate strategies. To develop self-control, children should receive adult support that is individual to the child and adapts as the child develops internal controls. This process should include:</p> <p>a) Forming a positive relationship with the child. When children have a positive relationship with the adult, they are more likely to follow that person’s directions. This positive relationship occurs when the adult spends time talking to the child, listening to the child, following the child’s lead, playing with the child, and responding to the child’s needs;</p> <p>b) Basing expectations on children’s developmental level;</p> <p>c) Establishing simple rules children can understand (e.g., you can’t hurt others, our things, or yourself) and being proactive in teaching and supporting children in learning the rules;</p> <p>d) Adapting the physical indoor and outdoor learning/play environment or family child care home to encourage positive behavior and self-regulation by providing engaging materials based on children’s interests and ensuring that the learning environment promotes active participation of each child. Well-designed child care environments are ones that are supportive of appropriate behavior in children, and are designed to help children learn about what to expect in that environment and to promote positive interactions and engagement with others;</p> <p>e) Modifying the learning/play environment (e.g., schedule, routine, activities, transitions) to support the child’s appropriate behavior;</p> <p>f) Creating a predictable daily routine and schedule. When a routine is predictable, children are more likely to know what to do and what is expected of them. This may decrease anxiety in the child. When there is less anxiety, there may be less acting out. Reminders need to be given to the children so they can anticipate and prepare themselves for transitions within the schedule. Reminders should be</p>	<p>(e) Using facial expressions such as smiling, laughing, and enthusiasm to match a child’s mood;</p> <p>(f) Using physical proximity in a culturally responsive way to speak to children at their eye level and with warm physical contact, including but not limited to, gently touching a hand or shoulder, sitting next to a child, appropriately holding younger children close while communicating;</p> <p>(g) Validating children’s feelings and show tolerance for mistakes;</p> <p>(h) Being responsive and listening to children’s requests and questions, encouraging children to share experiences, ideas, and feelings;</p> <p>(i) Observing children in order to learn about their families, cultures, individual interests, ideas, questions, and theories;</p> <p>(j) Modeling and teaching emotional skills such as recognizing feelings, expressing them appropriately, accepting others’ feelings, and controlling impulses to act out feelings;</p> <p>(k) Representing the diversity found in the early learning program and society, including gender, age, language, and abilities, while being respectful of cultural traditions, values, religion and beliefs of enrolled families; and</p> <p>(l) Interacting with staff and other adults in a positive, respectful manner.</p> <p>Weight #5</p> <p>(2) An early learning provider must encourage positive interactions between and among children with techniques such as:</p> <p>(a) Giving children several chances a day to interact with each other while playing or completing routine tasks;</p> <p>(b) Modeling social skills;</p> <p>(c) Encouraging socially isolated children to find friends;</p> <p>(d) Helping children understand feelings of others; and</p> <p>(e) Including children with special needs to play with others</p> <p>Weight #6</p> <p>170-300-0330 Positive relationships and child guidance.</p> <p>(1) An early learning provider must work to maintain positive relationships with children by using consistent guidance techniques to help children learn. Guidance techniques must adapt an early learning program’s environment, routines, and activities to a child’s strengths, developmental level, abilities, culture, community, and relate to the child’s behavior. Weight 6</p> <p>(2) Guidance techniques may include:</p> <p>(a) Coaching behavior;</p> <p>(b) Modeling and teaching social skills such as taking turns, cooperation, waiting, self-control, respect for the rights of others, treating others kindly, and conflict resolution;</p> <p>(c) Offering choices;</p> <p>(d) Distracting;</p> <p>(e) Redirecting or helping a child change their focus to something appropriate to achieve their goal;</p> <p>(f) Planning ahead to prevent problems and letting children know what events will happen next;</p> <p>(g) Explaining consistent, clear rules and involving children in defining simple, clear classroom limits;</p> <p>(h) Involving children in solving problems; and</p> <p>(i) Explaining to children the natural and logical consequence related to the child’s behavior in a reasonable and developmentally appropriate manner. Weight #6</p> <p>170-300-0450 Parent or guardian handbook and related policies.</p> <p>(1) An early learning provider must supply to each parent or guardian written policies regarding the</p>				
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<p>individualized such that each child understands and anticipates the transition;</p> <p>g) Using encouragement and descriptive praise. When clear encouragement and descriptive praise are used to give attention to appropriate behaviors, those behaviors are likely to be repeated. Encouragement and praise should be stated positively and descriptively. Encouragement and praise should provide information that the behavior the child engaged in was appropriate. Examples: “I can tell you are ready for circle time because you are sitting on your name and looking at me.” “Your friend looked so happy when you helped him clean up his toys.” “You must be so proud of yourself for putting on your coat all by yourself.” Encouragement and praise should label the behaviors, not the child (e.g., good listening, good eating, instead of good boy);</p> <p>h) Using clear, direct, and simple commands. When clear commands are used with children, they are more likely to follow them. The caregiver/teacher should tell the child what to do rather than what NOT to do. The caregiver/teacher should limit the number of commands. The caregiver/teacher should use if/ then and when/then statements with logical and natural consequences. These practices help children understand they can make choices and that choices have consequences;</p> <p>i) Showing children positive alternatives rather than just telling children “no”;</p> <p>j) Modeling desired behavior;</p> <p>k) Using planned ignoring and redirection. Certain behaviors can be ignored while at the same time the adult is able to redirect the children to another activity. If the behavior cannot be ignored, the adult should prompt the child to use a more appropriate behavior and provide positive feedback when the child engages in the behavior;</p> <p>l) Individualizing discipline based on the individual needs of children. For example, if a child has a hard time transitioning, the caregiver/teacher can identify strategies to help the child with the transition (individualized warning, job during transition, individual schedule, peer buddy to help, etc.) If a child has a difficult time during a large group activity, the child might be taught to ask for a break;</p> <p>m) Using time-out for behaviors that are persistent and unacceptable. Time-out should only be used in</p>	<p>early learning program. Each enrolled child’s record must have signed documentation stating the parent or guardian reviewed the handbook and early learning program policies. Weight #3</p> <p>(i) An early learning provider must have and follow formal written policies in either paper or electronic format, including:</p> <p>(a) A non-discrimination statement;</p> <p>(b) A family engagement and partnership communication plan;</p> <p>(f) Child guidance plan, which includes restraint policies and forbidding corporal punishment;</p> <p>(g) Expulsion policy;</p> <p>170-300-0331-Prohibited behavior, discipline, and physical removal of children.</p> <p>(1) An early learning provider must take steps to prevent and, once aware of, must not tolerate:</p> <p>(a) Profanity, obscene language, “put downs,” or cultural or racial slurs;</p> <p>(b) Angry or hostile interactions;</p> <p>(c) Threats of physical harm or inappropriate discipline such as, but not limited to spanking, biting, jerking, kicking, hitting, slapping, grabbing, shaking, pulling hair, pushing, shoving, throwing a child, or inflicting pain or humiliation as a punishment;</p> <p>(d) Intimidation, gestures, or verbal abuse including sarcasm, name calling, shaming, humiliation, teasing, derogatory remarks about a child or the child’s family;</p> <p>(e) Emotional abuse including victimizing, bullying, rejecting, terrorizing, extensive ignoring, or corrupting a child; or</p> <p>(f) Prevent a child from or punish a child for exercising religious rights;</p> <p>(g) Anyone to:</p> <p>(i) Restrict a child’s breathing;</p> <p>(ii) Bind or restrict a child’s movement unless permitted under WAC 170-300-0335;</p> <p>(iii) Tape a child’s nose, mouth, or other body part;</p> <p>(iv) Deprive a child of sleep, food, clothing, shelter, physical activity, first aid, or regular or emergency medical or dental care;</p> <p>(v) Force a child to ingest something as punishment such as hot sauce or soap;</p> <p>(vi) Interfere with a child’s ability to take care of his or her own hygiene and toileting needs;</p> <p>(vii) Use toilet learning or training methods that punish, demean, or humiliate a child;</p> <p>(viii) Withhold hygiene care, toileting care, or diaper changing from any child unable to provide such care for himself or herself;</p> <p>(ix) Expose a child to extreme temperatures as punishment;</p> <p>(x) Demand excessive physical exercise or strenuous postures. Excessive physical exercise includes, but is not limited to, running laps around the yard until overly tired, an extensive number of push-ups, having a child rest more than the child’s development requires, standing on one foot for an uncomfortable amount of time, or holding out one’s arms until tired or painful;</p> <p>(xi) Place the separated child in a closet, bathroom, locked room, outside, or in an unlicensed space; and</p> <p>(xii) Use high chairs, car seats, or other confining space or equipment to punish a child or restrict movement.</p> <p>Weight #8</p> <p>(2) An early learning provider must supervise to protect children from the harmful acts of other children. A provider must immediately intervene when they become aware that a child or children are teasing, fighting, bullying, intimidating or becoming physically aggressive. Weight #7</p>				
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<p>combination with instructional approaches that teach children what to do in place of the behavior problem. (See guidance for time-outs below.)</p> <p>Expectations for children’s behavior and the facility’s policies regarding their response to behaviors should be written and shared with families and children of appropriate age. Further, the policies should address proactive as well as reactive strategies. Programs should work with families to support their children’s appropriate behaviors before it becomes a problem.</p>	<p>(3) An early learning provider may separate a preschool age or school age child from other children when that child needs to regain control of him or herself.</p> <p>(a) During separation time, the child must remain under the appropriate level of supervision of a Licensee, Center Director, Assistant Director, Program Supervisor, Lead Teacher or an Assistant Teacher.</p> <p>(b) Separation time should be minimized, and appropriate to the needs of the individual child.</p> <p>Weight #6</p> <p>(4) If a child is separated from other children, an early learning provider must:</p> <p>(a) Consider the child’s developmental level, language skills, individual and special needs, and ability to understand the consequences of his or her actions; and</p> <p>(b) Communicate to the child the reason for being separated from the other children.</p> <p>Weight #5</p> <p>(5) If an early learning provider follows all strategies in this section, and a child continues to behave in an unsafe manner, only a Licensee, Center Director, Assistant Director, Program Supervisor, Lead Teacher, or an Assistant Teacher may physically remove the child to a less stimulating environment. Staff must remain calm and use a calm voice when directing or removing the child. Physical removal of a child is determined by that child’s ability to walk:</p> <p>(a) If the child is willing and able to walk, staff may hold the child’s hand and walk him or her away from the situation.</p> <p>(b) If the child is not willing or able to walk, staff may pick the child up and remove him or her to a quiet place where the child cannot hurt themselves or others.</p> <p>Weight #6</p>				
<p>STANDARD 2.2.0.8: Preventing Expulsions, Suspensions, and Other Limitations in Services</p> <p>Child care programs should not expel, suspend, or otherwise limit the amount of services (including denying outdoor time, withholding food, or using food as a reward/punishment) provided to a child or family on the basis of challenging behaviors or a health/safety condition or situation unless the condition or situation meets one of the two exceptions listed in this standard.</p> <p>Expulsion refers to terminating the enrollment of a child or family in the regular group setting because of a challenging behavior or a health condition. Suspension and other limitations in services include all other reductions in the amount of time a child may be in attendance of the regular group setting, either by requiring the child to cease attendance for a particular period of time or reducing the number of days or amount of time that a child may attend. Requiring a child to attend the program in a special place away from the other children</p>	<p>Expulsion.</p> <p>(1) To promote consistent care and maximize opportunities for child development and learning, an early learning provider must develop and follow expulsion policies and practices, pursuant to WAC 170-300-0486. Weight NA</p> <p>(2) An early learning provider may expel a child only if:</p> <p>(a) The child exhibits behavior that presents a serious safety concern for that child or others; and</p> <p>(b) The program is not able to reduce or eliminate the safety concern through reasonable modifications.</p> <p>Weight #5</p> <p>(3) If a child is expelled, an early learning provider must:</p> <p>(a) Review the program’s expulsion policy with the parent or guardian of the child;</p> <p>(b) Provide a record to the parent or guardian about the expulsion and the steps that were taken to avoid expulsion. The record must include the date, time, early learning program staff involved, and details of each incident that led to expulsion; and</p> <p>(c) Provide information to the parent or guardian of the child that includes, but is not limited to, community-based resources that may benefit the child. Weight #4</p> <p>(4) The early learning provider must report to the department when children are expelled. The information must include:</p> <p>(a) Child demographic data including, but not limited to, the age, race, ethnicity, and gender of the child;</p>	Meets			

<p>in the regular group setting is included in this definition.</p> <p>Child care programs should have a comprehensive discipline policy that includes an explicit description of alternatives to expulsion for children exhibiting extreme levels of challenging behaviors, and should include the program’s protocol for preventing challenging behaviors. These policies should be in writing and clearly articulated and communicated to parents/guardians, staff and others. These policies should also explicitly state how the program plans to use any available internal mental health and other support staff during behavioral crises to eliminate to the degree possible any need for external supports (e.g., local police departments) during crises.</p> <p>Staff should have access to in-service training on both a proactive and as-needed basis on how to reduce the likelihood of problem behaviors escalating to the level of risk for expulsion and how to more effectively manage behaviors throughout the entire class/group. Staff should also have access to in-service training, resources, and child care health consultation to manage children’s health conditions in collaboration with parents/guardians and the child’s primary care provider. Programs should attempt to obtain access to behavioral or mental health consultation to help establish and maintain environments that will support children’s mental well-being and social-emotional health, and have access to such a consultant when more targeted child-specific interventions are needed. Mental health consultation may be obtained from a variety of sources, as described in Standard 1.6.0.3.</p> <p>When children exhibit or engage in challenging behaviors that cannot be resolved easily, as above, staff should:</p> <p>a) Assess the health of the child and the adequacy of the curriculum in meeting the developmental and educational needs of the child;</p> <p>b) Immediately engage the parents/guardians/family in a spirit of collaboration regarding how the child’s behaviors may be best handled, including appropriate solutions that have worked at home or in other settings;</p> <p>c) Access an early childhood mental health consultant to assist in developing an effective plan to address the child’s challenging behaviors and to assist the child in developing age-appropriate, pro-social skills;</p>	<p>(b) The reason the child was expelled; and</p> <p>(c) The resources that were provided to the parent or guardian of the child.</p> <p>Weight #4</p> <p>170-300-0331-Prohibited behavior, discipline, and physical removal of children.</p> <p>(1) An early learning provider must take steps to prevent and, once aware of, must not tolerate:</p> <p>(a) Profanity, obscene language, “put downs,” or cultural or racial slurs;</p> <p>(b) Angry or hostile interactions;</p> <p>(c) Threats of physical harm or inappropriate discipline such as, but not limited to spanking, biting, jerking, kicking, hitting, slapping, grabbing, shaking, pulling hair, pushing, shoving, throwing a child, or inflicting pain or humiliation as a punishment;</p> <p>(d) Intimidation, gestures, or verbal abuse including sarcasm, name calling, shaming, humiliation, teasing, derogatory remarks about a child or the child’s family;</p> <p>(e) Emotional abuse including victimizing, bullying, rejecting, terrorizing, extensive ignoring, or corrupting a child; or</p> <p>(f) Prevent a child from or punish a child for exercising religious rights;</p> <p>(g) Anyone to:</p> <p>(i) Restrict a child’s breathing;</p> <p>(ii) Bind or restrict a child’s movement unless permitted under WAC 170-300-0335;</p> <p>(iii) Tape a child’s nose, mouth, or other body part;</p> <p>(iv) Deprive a child of sleep, food, clothing, shelter, physical activity, first aid, or regular or emergency medical or dental care;</p> <p>(v) Force a child to ingest something as punishment such as hot sauce or soap;</p> <p>(vi) Interfere with a child’s ability to take care of his or her own hygiene and toileting needs;</p> <p>(vii) Use toilet learning or training methods that punish, demean, or humiliate a child;</p> <p>(viii) Withhold hygiene care, toileting care, or diaper changing from any child unable to provide such care for himself or herself;</p> <p>(ix) Expose a child to extreme temperatures as punishment;</p> <p>(x) Demand excessive physical exercise or strenuous postures. Excessive physical exercise includes, but is not limited to, running laps around the yard until overly tired, an extensive number of push-ups, having a child rest more than the child’s development requires, standing on one foot for an uncomfortable amount of time, or holding out one’s arms until tired or painful;</p> <p>(xi) Place the separated child in a closet, bathroom, locked room, outside, or in an unlicensed space; and</p> <p>(xii) Use high chairs, car seats, or other confining space or equipment to punish a child or restrict movement.</p> <p>Weight #8</p> <p>(2) An early learning provider must supervise to protect children from the harmful acts of other children. A provider must immediately intervene when they become aware that a child or children are teasing, fighting, bullying, intimidating or becoming physically aggressive. Weight #7</p> <p>(3) An early learning provider may separate a preschool age or school age child from other children when that child needs to regain control of him or herself.</p> <p>(b) During separation time, the child must remain under the appropriate level of supervision of a Licensee, Center Director, Assistant Director, Program Supervisor, Lead Teacher or an Assistant</p>				
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<p>d) Facilitate, with the family’s assistance, a referral for an evaluation for either Part C (early intervention) or Part B (preschool special education), as well as any other appropriate community-based services (e.g., child mental health clinic);</p> <p>e) Facilitate with the family communication with the child’s primary care provider (e.g., pediatrician, family medicine provider, etc.), so that the primary care provider can assess for any related health concerns and help facilitate appropriate referrals.</p> <p>The only possible reasons for considering expelling, suspending or otherwise limiting services to a child on the basis of challenging behaviors are:</p> <p>a) Continued placement in the class and/or program clearly jeopardizes the physical safety of the child and/or his/her classmates as assessed by a qualified early childhood mental health consultant AND all possible interventions and supports recommended by a qualified early childhood mental health consultant aimed at providing a physically safe environment have been exhausted; or</p> <p>b) The family is unwilling to participate in mental health consultation that has been provided through the child care program or independently obtain and participate in child mental health assistance available in the community; or</p> <p>c) Continued placement in this class and/or program clearly fails to meet the mental health and/or social-emotional needs of the child as agreed by both the staff and the family AND a different program that is better able to meet these needs has been identified and can immediately provide services to the child.</p> <p>In either of the above three cases, a qualified early childhood mental health consultant, qualified special education staff, and/or qualified community-based mental health care provider should be consulted, referrals for special education services and other community-based services should be facilitated, and a detailed transition plan from this program to a more appropriate setting should be developed with the family and followed. This transition could include a different private or public-funded child care or early education program in the community that is better equipped to address the behavioral concerns (e.g., therapeutic preschool programs, Head Start or Early Head Start, prekindergarten programs in the public schools that have</p>	<p>Teacher.</p> <p>(c) Separation time should be minimized, and appropriate to the needs of the individual child.</p> <p>Weight #6</p> <p>(4) If a child is separated from other children, an early learning provider must:</p> <p>(c) Consider the child’s developmental level, language skills, individual and special needs, and ability to understand the consequences of his or her actions; and</p> <p>(d) Communicate to the child the reason for being separated from the other children.</p> <p>Weight #5</p> <p>(5) If an early learning provider follows all strategies in this section, and a child continues to behave in an unsafe manner, only a Licensee, Center Director, Assistant Director, Program Supervisor, Lead Teacher, or an Assistant Teacher may physically remove the child to a less stimulating environment. Staff must remain calm and use a calm voice when directing or removing the child. Physical removal of a child is determined by that child’s ability to walk:</p> <p>(c) If the child is willing and able to walk, staff may hold the child’s hand and walk him or her away from the situation.</p> <p>(d) If the child is not willing or able to walk, staff may pick the child up and remove him or her to a quiet place where the child cannot hurt themselves or others.</p> <p>Weight #6</p> <p>170-300-450 Parent or guardian handbook and related policies.</p> <p>(1) An early learning provider must supply to each parent or guardian written policies regarding the early learning program. Each enrolled child’s record must have signed documentation stating the parent or guardian reviewed the handbook and early learning program policies. Weight #3</p> <p>(2) An early learning provider must have and follow formal written policies in either paper or electronic format, including:</p> <p>(a) A non-discrimination statement;</p> <p>(b) A family engagement and partnership communication plan;</p> <p>(c) Child guidance plan, which includes restraint policies and forbidding corporal punishment;</p> <p>(d) Expulsion policy;</p>				
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<p>access to additional support staff, etc.), or public- funded special education services for infants and toddlers (i.e., Part C early intervention) or preschoolers (i.e., Part B preschool special education).</p> <p>To the degree that safety can be maintained, the child should be transitioned directly to the receiving program. The program should assist parents/guardians in securing the more appropriate placement, perhaps using the services of a local child care resource and referral agency. With parent/guardian permission, the child’s primary careprovider should be consulted and a referral for a comprehensive assessment by qualified mental health provider and the appropriate special education system should be initiated. If abuse or neglect is suspected, then appropriate child protection services should be informed. Finally, no child should ever be expelled or suspended from care without first conducting an assessment of the safety of alternative arrangements (e.g., Who will care for the child? Will the child be adequately and safely supervised at all times?)</p>				
<p>STANDARD 2.2.0.9: Prohibited Caregiver/ Teacher Behaviors</p> <p>The following behaviors should be prohibited in all child care settings and by all caregivers/teachers:</p> <p>a) The use of corporal punishment. Corporal punishment means punishment inflicted directly on the body including, but not limited to:</p> <p>1) Hitting, spanking (refers to striking a child with an open hand on the buttocks or extremities with the intention of modifying behavior without causing physical injury), shaking, slapping, twisting, pulling, squeezing, or biting;</p> <p>2) Demanding excessive physical exercise, excessive rest, or strenuous or bizarre postures;</p> <p>3) Compelling a child to eat or have in his/her mouth soap, food, spices, or foreign substances;</p> <p>4) Exposing a child to extremes of temperature.</p> <p>b) Isolating a child in an adjacent room, hallway, closet, darkened area, play area, or any other area where a child cannot be seen or supervised;</p> <p>c) Binding or tying to restrict movement, such as in a car seat (except when travelling) or taping the</p>	<p>170-300-0331-Prohibited behavior, discipline, and physical removal of children.</p> <p>(3) An early learning provider must take steps to prevent and, once aware of, must not tolerate:</p> <p>(a) Profanity, obscene language, “put downs,” or cultural or racial slurs;</p> <p>(b) Angry or hostile interactions;</p> <p>(c) Threats of physical harm or inappropriate discipline such as, but not limited to spanking, biting, jerking, kicking, hitting, slapping, grabbing, shaking, pulling hair, pushing, shoving, throwing a child, or inflicting pain or humiliation as a punishment;</p> <p>(d) Intimidation, gestures, or verbal abuse including sarcasm, name calling, shaming, humiliation, teasing, derogatory remarks about a child or the child’s family;</p> <p>(e) Emotional abuse including victimizing, bullying, rejecting, terrorizing, extensive ignoring, or corrupting a child; or</p> <p>(f) Prevent a child from or punish a child for exercising religious rights;</p> <p>(g) Anyone to:</p> <p>(i) Restrict a child’s breathing;</p> <p>(ii) Bind or restrict a child’s movement unless permitted under WAC 170-300-0335;</p> <p>(iii) Tape a child’s nose, mouth, or other body part;</p> <p>(iv) Deprive a child of sleep, food, clothing, shelter, physical activity, first aid, or regular or emergency medical or dental care;</p> <p>(v) Force a child to ingest something as punishment such as hot sauce or soap;</p> <p>(vi) Interfere with a child’s ability to take care of his or her own hygiene and toileting needs;</p> <p>(vii) Use toilet learning or training methods that punish, demean, or humiliate a child;</p> <p>(viii) Withhold hygiene care, toileting care, or diaper changing from any child unable to provide such care for himself or herself;</p> <p>(ix) Expose a child to extreme temperatures as punishment;</p> <p>(x) Demand excessive physical exercise or strenuous postures. Excessive physical exercise includes, but is not limited to, running laps around the yard until overly</p>	Meets	Addresses what behaviors should be engaged in during toilet training practices (which informs what behaviors a staff person should not engage in).	

<p>mouth;</p> <p>d) Using or withholding food as a punishment or reward;</p> <p>e) Toilet learning/training methods that punish, demean, or humiliate a child;</p> <p>f) Any form of emotional abuse, including rejecting, terrorizing, extended ignoring, isolating, or corrupting a child;</p> <p>g) Any abuse or maltreatment of a child, either as an incident of discipline or otherwise. Any child care program must not tolerate, or in any manner condone, an act of abuse or neglect of a child by an older child, employee, volunteer, or any person employed by the facility or child’s family;</p> <p>h) Abusive, profane, or sarcastic language or verbal abuse, threats, or derogatory remarks about the child or child’s family;</p> <p>i) Any form of public or private humiliation, including threats of physical punishment;</p> <p>j) Physical activity/outdoor time should not be taken away as punishment.</p>	<p>tired, an extensive number of push-ups, having a child rest more than the child’s development requires, standing on one foot for an uncomfortable amount of time, or holding out one’s arms until tired or painful;</p> <p>(xi) Place the separated child in a closet, bathroom, locked room, outside, or in an unlicensed space; and</p> <p>(xii) Use high chairs, car seats, or other confining space or equipment to punish a child or restrict movement.</p> <p>Weight #8</p> <p>(2)An early learning provider must supervise to protect children from the harmful acts of other children. A provider must immediately intervene when they become aware that a child or children are teasing, fighting, bullying, intimidating or becoming physically aggressive. Weight #7</p> <p>(3)An early learning provider may separate a preschool age or school age child from other children when that child needs to regain control of him or herself.</p> <p>(a) During separation time, the child must remain under the appropriate level of supervision of a Licensee, Center Director, Assistant Director, Program Supervisor, Lead Teacher or an Assistant Teacher.</p> <p>(b) Separation time should be minimized, and appropriate to the needs of the individual child.</p> <p>Weight #6</p> <p>(4)If a child is separated from other children, an early learning provider must:</p> <p>(a) Consider the child’s developmental level, language skills, individual and special needs, and ability to understand the consequences of his or her actions; and</p> <p>(b) Communicate to the child the reason for being separated from the other children.</p> <p>Weight #5</p> <p>(5)If an early learning provider follows all strategies in this section, and a child continues to behave in an unsafe manner, only a Licensee, Center Director, Assistant Director, Program Supervisor, Lead Teacher, or an Assistant Teacher may physically remove the child to a less stimulating environment. Staff must remain calm and use a calm voice when directing or removing the child. Physical removal of a child is determined by that child’s ability to walk:</p> <p>(a) If the child is willing and able to walk, staff may hold the child’s hand and walk him or her away from the situation.</p> <p>(b) If the child is not willing or able to walk, staff may pick the child up and remove him or her to a quiet place where the child cannot hurt themselves or others.</p> <p>Weight #6</p> <p>170-300-0220 Bathroom space and toilet training.</p> <p>(3) An early learning provider must discuss toilet training procedures with that child’s parent or guardian when a child is ready for toilet training. A provider must facilitate the toilet training process by encouraging the child with:</p> <p>(a) Positive reinforcement (which may not include food items);</p> <p>(b) Culturally sensitive methods;</p> <p>(c) Developmentally appropriate practices;</p> <p>(d) A toilet training routine developed in agreement with the parent or guardian</p>				
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<p>STANDARD 2.3.3.1: Parents’/Guardians’ Provision of Information on Their Child’s Health and Behavior</p> <p>The facility should ask parents/guardians for information regarding the child’s health, nutrition, level of physical activity, and behavioral status upon registration or when there has been an extended gap in the child’s attendance at the facility. The child’s health record should be updated if s/ he have had any changes in their health or immunization status. Parents/guardians should be encouraged to sign a release of information/agreement so that child care workers can communicate directly with the child’s medical home/ primary care provider.</p>	<p>170-300-0085 Family partnerships and communication.</p> <p>(2) An early learning provider must attempt to obtain information from each child’s family about the child’s developmental, behavioral, health, linguistic, cultural, social, and other relevant information. The provider must make this attempt upon that child’s enrollment and annually thereafter. Weight #3</p> <p>170-300-0460 Child records.</p> <p>(1) An early learning provider must keep current individualized enrollment and health records for all enrolled children, including children of staff, updated annually or more often as health records are updated.</p> <p>(a) A child’s records must be kept in a confidential manner but in an area easily accessible to staff.</p> <p>(b) A child’s parent or guardian must be allowed access to all of his or her own child’s records.</p> <p>Weight #4</p>	Partially Meets	No WAC found that addresses parents being encouraged to sign a release of information/agreement so that child care workers can communicate directly with the child’s medical home/primary care provider.		
<p>STANDARD 3.1.2.1: Routine Health Supervision and Growth Monitoring</p> <p>The facility should require that each child has routine health supervision by the child’s primary care provider, according to the standards of the American Academy of Pediatrics (AAP). For all children, health supervision includes routine screening tests, immunizations, and chronic or acute illness monitoring. For children younger than twenty-four months of age, health supervision includes documentation and plotting of sex-specific charts on child growth standards from the World Health Organization (WHO), available at http://www.who.int/child-growth/standards/en/, and assessing diet and activity. For children twenty-four months of age and older, sex-specific height and weight graphs should be plotted by the primary care provider in addition to body mass index (BMI), according to the Centers for Disease Control and Prevention (CDC). BMI is classified as underweight (BMI less than 5%), healthy weight (BMI 5%-84%), overweight (BMI 85%-94%), and obese (BMI equal to or greater than 95%).</p> <p>Follow-up visits with the child’s primary care provider that include a full assessment and laboratory evaluations should be scheduled for children with weight for length greater than 95% and BMI greater than 85%. School health services can meet this standard for school-age children in care if they meet the AAP’s standards for school-age children and if the results of each child’s</p>		Does Not Apply	No WAC found that addresses this standard.		

examinations are shared with the caregiver/teacher as well as with the school health system. With parental/guardian consent, pertinent health information should be exchanged among the child’s routine source of health care and all participants in the child’s care, including any schoolhealth program involved in the care of the child.					
<p>STANDARD 3.1.3.1: Active Opportunities for Physical Activity</p> <p>The facility should promote children’s active play every day. Children should have ample opportunity to do moderate to vigorous activities such as running, climbing, dancing, skipping, and jumping. All children, birth to six years, should participate daily in:</p> <ul style="list-style-type: none">a) Two to three occasions of active play outdoors, weather permitting (see Standard 3.1.3.2: Playing Outdoors for appropriate weather conditions);b) Two or more structured or caregiver/teacher/adult-led activities or games that promote movement over the course of the day— indoor or outdoor;c) Continuous opportunities to develop and practice age-appropriate gross motor and movement skills. <p>The total time allotted for outdoor play and moderate to vigorous indoor or outdoor physical activity can be adjusted for the age group and weather conditions.</p> <ul style="list-style-type: none">a) Outdoor play:<ul style="list-style-type: none">1) Infants (birth to twelve months of age) should be taken outside two to three times per day, as tolerated. There is no recommended duration of infants’ outdoor play;2) Toddlers (twelve months to three years) and preschoolers (three to six years) should be allowed sixty to ninety total minutes of outdoor play. These outdoor times can be curtailed somewhat during adverse weather conditions in which children may still play safely outdoors for shorter periods, but should increase the time of indoor activity, so the total amount of exercise should remain the same;b) Total time allotted for moderate to vigorous activities:<ul style="list-style-type: none">1) Toddlers should be allowed sixty to ninety minutes per eight-hour day for moderate to vigorous physical activity,	<p>No WAC found that requires two or more structured or caregiver/teacher/adult-led activities or games that promote movement over the course of the day— indoor or outdoor</p> <p>170-300-0285 Infant and toddler nutrition and feeding.</p> <p>(2) After consulting a parent or guardian, an early learning provider must implement a feeding plan for infants and toddlers that include:</p> <ul style="list-style-type: none">(l) Not leaving infants or toddlers more than 15 minutes in high chairs waiting for meal or snack time, and removing a child as soon as possible once he or she finishes eating Weight #5 <p>170-300-0145 Outdoor early learning program space.</p> <p>(4) Outdoor play space must promote a variety of age and developmentally appropriate active play areas for children in care. Activities must encourage and promote both moderate and vigorous physical activity such as running, jumping, skipping, throwing, pedaling, pushing, pulling, kicking, and climbing. Weight #1</p> <p>170-300-0147 Weather conditions and outdoor requirements.</p> <p>(1) An early learning provider must observe weather conditions and other possible hazards to take appropriate action for child health and safety. Conditions that pose a health or safety risk may include, but are not limited to:</p> <ul style="list-style-type: none">(a) Heat in excess of 100 degrees Fahrenheit or pursuant to advice of the local authority;(b) Cold less than 20 degrees Fahrenheit, or pursuant to advice of the local authority;(c) Lightning storm, tornado, hurricane, or flooding if there is immediate or likely danger;(d) Earthquake;(e) Air quality emergency ordered by a local or state authority on air quality or public health;(f) Lockdown notification ordered by a public safety authority; and(g) Other similar incidents. Weight #7 <p>(2) An early learning provider must dress children for weather conditions during outdoor play time. Weight # 5</p> <p>170-300-0360 Program and daily activity schedule.</p> <p>(1) An early learning provider must have an established program and daily schedule that is familiar to children. Weight #1</p> <p>(2) A schedule must be designed to meet enrolled children’s developmental, cultural, and special needs. The daily schedule must:</p> <ul style="list-style-type: none">(a) Be specific for each age group of children, when applicable;(b) Offer a variety of activities to meet children’s needs, pursuant to WAC 170-300-0150;(c) Meet the following daily morning or afternoon active outdoor play time requirements:<ul style="list-style-type: none">(i) 20 minutes for each 3 hours of programming for infants (as tolerated) and toddlers;(ii) 30 minutes for each 3 hours of programming for children preschool age and older; and(iii) Programs that operate more than six hours a day must provide 90 minutes of active play for preschool age and up or 60 minutes of active play for infants and toddlers (30 minutes of which may be moderate to vigorous indoor activities).	Meets			

<p>including running;</p> <p>2) Preschoolers should be allowed ninety to one hundred and twenty minutes per eight-hour day.</p> <p>Infants should have supervised tummy time every day when they are awake. Beginning on the first day at the early care and education program, caregivers/teachers should interact with an awake infant on their tummy for short periods of time (three to five minutes), increasing the amount of time as the infant shows s/he enjoys the activity.</p> <p>Time spent outdoors has been found to be a strong, consistent predictor of children’s physical activity. Children can accumulate opportunities for activity over the course of several shorter segments of at least ten minutes each. Because structured activities have been shown to produce higher levels of physical activity in young children, it is recommended that caregivers/teachers incorporate two or more short structured activities (five to ten minutes) or games daily that promote physical activity.</p> <p>Opportunities to be actively enjoying physical activity should be incorporated into part-time programs by prorating these recommendations accordingly, i.e., twenty minutes of outdoor play for every three hours in the facility.</p> <p>Active play should never be withheld from children who misbehave (e.g., child is kept indoors to help another caregiver/ teacher while the rest of the children go outside). However, children with out-of-control behavior may need five minutes or less to calm themselves or settle down before resuming cooperative play or activities.</p> <p>Infants should not be seated for more than fifteen minutes at a time, except during meals or naps. Infant equipment such as swings, stationary activity centers (ex. exersaucers), infant seats (ex. bouncers), molded seats, etc. if used should only be used for short periods of time. A least restrictive environment should be encouraged at all times.</p> <p>Children should have adequate space for both inside and outside play.</p>	<p>Weight #3</p> <p>170-300-0296 Infant and toddler development.</p> <p>(1) An early learning provider must expose infants and toddlers to a developmentally appropriate curriculum.</p> <p>(2) Developmentally appropriate curriculum may include, but is not limited to:</p> <p>(b) Developing infant and toddler physical and cognitive abilities by:</p> <p>(i) Allowing each infant actively supervised tummy time throughout the day when the infant is awake.</p> <p>(ii) Providing infants and toddlers freedom to explore and learn on their own on the floor;</p> <p>(iii) Providing infants and toddlers access to active outdoor playtime. An early learning provider must enforce sun safety precautions for infants younger than six months old by keeping them out of the direct sunlight and limiting sun exposure when ultraviolet rays are strongest (typically from 10:00 a.m. to 2:00 p.m.); and</p> <p>(iv) Encouraging infants and toddlers to play, crawl, pull up, and walk by using materials and equipment that promotes:</p> <p>(A) Physical and cognitive activities, for example rattles, grasping and reaching toys, busy boxes, nesting cups, small push, and pull toys, riding toys, balls, squeezable toys, books, dolls, press-together blocks, and limited use of equipment such bouncers, swings or bopees; and</p> <p>(B) Spatial and numeracy understanding, for example counting toys, soft blocks and toys with different sizes such as measuring cups or spoons, and toys with different shapes and colors to help introduce sorting and categorization.</p> <p>170-300-0331 Prohibited behavior, discipline, and physical removal of children.</p> <p>(1) An early learning provider must take steps to prevent and, once aware of, must not tolerate:</p> <p>(g)Anyone to:</p> <p>(iv) Deprive a child of sleep, food, clothing, shelter, physical activity, first aid, or regular or emergency medical or dental care;</p> <p>170-300-0140 Room arrangement, child-related displays, private space, and belongings.</p> <p>(6) Child useable and accessible areas must be arranged to provide sufficient space for routine care, child play, and learning activities. These areas must be designed to allow:</p> <p>(a) Allow the provider to supervise or actively supervise the children, depending on the nature of the activities;</p> <p>(b) Allow children to move freely; and</p> <p>(c) Be designed to allow for different types of activities at the same time (for example: blocks, puppets, language and literary materials, art materials, clay or play dough, music and movement, or dramatic play).</p> <p>Weight #4</p> <p>WAC 170-300-0150 Program and activities.</p> <p>(2) An early learning provider must ensure sufficient quantity and variety of materials to engage children in the early learning program (for example: arts and crafts supplies, various textured materials, construction materials, manipulative materials, music and sound devices, books, and social living equipment). Materials must:</p> <p>(a) Encourage both active physical play and quiet play activities.</p>				
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<p>STANDARD 3.1.4.1: Safe Sleep Practices and SIDS/Suffocation Risk Reduction</p> <p>Facilities should develop a written policy that describes the practices to be used to promote safe sleep when infants are napping or sleeping. The policy should explain that these practices aim to reduce the risk of sudden infant death syndrome (SIDS) or suffocation death and other infant deaths that could occur when an infant is in a crib or asleep.</p> <p>All staff, parents/guardians, volunteers and others approved to enter rooms where infants are cared for should receive a copy of the Safe Sleep Policy and additional educational information and training on the importance of consistent use of safe sleep policies and practices before they are allowed to care for infants (i.e., first day of employment/volunteering/ subbing). Documentation that training has occurred and that these individuals have received and reviewed the written policy should be kept on file.</p> <p>All staff, parents/guardians, volunteers and others who care for infants in the child care setting should follow these required safe sleep practices as recommended by the American Academy of Pediatrics (AAP) (1):</p> <p>a) Infants up to twelve months of age should be placed for sleep in a supine position (wholly on their back) for every nap or sleep time unless the infant’s primary care provider has completed a signed waiver indicating that the child requires an alternate sleep position;</p> <p>b) Infants should be placed for sleep in safe sleep environments; which includes: a firm crib mattress covered by a tight-fitting sheet in a safety- approved crib (the crib should meet the standards and guidelines reviewed/approved by the U.S. Consumer Product Safety Commission [CPSC] and ASTM International [ASTM]), no monitors or positioning devices should be used unless required by the child’s primary care provider, and no other items should be in a crib occupied by an infant except for a pacifier;</p> <p>c) Infants should not nap or sleep in a car safety seat, bean bag chair, bouncy seat, infant seat, swing, jumping chair, play pen or play yard, highchair, chair, futon, or any other type of furniture/equipment that is not a safety-approved crib (that is in compliance with the CPSC and ASTM safety standards) (4);</p>	<p>170-300-0450 Parent or guardian handbook and related policies.</p> <p>(1) An early learning provider must supply to each parent or guardian written policies regarding the early learning program. Each enrolled child’s record must have signed documentation stating the parent or guardian reviewed the handbook and early learning program policies. Weight #3</p> <p>(2) An early learning provider must have and follow formal written policies in either paper or electronic format, including:</p> <p>(i) If the early learning program offers any of the following, they must include a policy for each that applies to their program:</p> <p>(ii) infant and toddler care, covering:</p> <p>(D) Child sleep patter; and</p> <p>(E) Safe sleep requirements;</p> <p>Weight #4</p> <p>170-300-0106 Training Requirements.</p> <p>(1) Early learning providers licensed, working, or volunteering in an early learning program before the date this section becomes effective must complete the applicable training requirements of this section within three months of the date this section becomes effective unless otherwise indicated. Early learning providers hired after the date this section becomes effective must complete the training requirements of subsections (4) through (10) of this section within three months of the date of hire and prior to working in an unsupervised capacity with children. Weight #1</p> <p>(8) License applicants and early learning providers licensed to care for infants must complete the Safe Sleep training as approved or offered by the department. This training must be completed annually and:</p> <p>(a) Prior to being licensed;</p> <p>(b) Prior to caring for infants; or</p> <p>(c) According to subsection (1) of this section. Weight #7</p> <p>170-300-0110 Program based staff policies and training.</p> <p>(1) An early learning provider must have and follow written policies for early learning program staff. Staff policies must include those listed in subsection (2) and (3) of this section and must be reviewed and approved by the department prior to issuing a provider’s initial license. Providers must notify the department when substantial changes are made. Weight #1</p> <p>(2) Early learning program staff policies must include, but are not limited to:</p> <p>(a) all of the information in the parent or guardian handbook except fees;</p> <p>(e) Early learning program staff responsibilities for:</p> <p>(vi) Safe sleep practices, if applicable</p> <p>(4) An early learning provider must develop, deliver, and document the delivery of early learning staff training specific to the early learning program and premises.</p> <p>(a) Training topics must include:</p> <p>(i) Staff policies listed in subsections (2) and (3) of this section;</p> <p>(ii) Chapter 43.216 RCW; and</p> <p>(iii) Chapters 170-300 and 170-06 WAC, as hereafter recodified or amended.</p> <p>(b) Training must be updated with changes in program policies and state or federal regulations.</p> <p>Weight #5</p>	Partially Meets	<p>No WAC found that specifically requires that if an infant falls asleep in any place that is not a safe sleep environment, staff should immediately move the infant and place them in the supine position in their crib;</p> <p>No WAC found that requires the construction and use of sleeping rooms for infants separate from the infant group room is not recommended due to the need for direct supervision. In situations where there are existing facilities with separate sleeping rooms, facilities should develop a plan to modify room assignments and/or practices to eliminate placing infants to sleep in separate rooms.</p> <p>No WAC found that requires facilities should be aware of the current recommendation of the AAP about pacifier use (1). If pacifiers are allowed, facilities should have a written policy that describes relevant procedures and guidelines. Pacifier use outside of a crib in rooms and programs where there are mobile infants or toddlers is not recommended.</p>	
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<p>d) If an infant arrives at the facility asleep in a car safety seat, the parent/guardian or caregiver/teacher should immediately remove the sleeping infant from this seat and place them in the supine position in a safe sleep environment (i.e., the infant’s assigned crib);</p> <p>e) If an infant falls asleep in any place that is not a safe sleep environment, staff should immediately move the infant and place them in the supine position in their crib;</p> <p>f) Only one infant should be placed in each crib (stackable cribs are not recommended);</p> <p>g) Soft or loose bedding should be kept away from sleeping infants and out of safe sleep environments. These include, but are not limited to: bumper pads, pillows, quilts, comforters, sleep positioning devices, sheepskins, blankets, flat sheets, cloth diapers, bibs, etc. Also, blankets/items should not be hung on the sides of cribs. Swaddling infants when they are in a crib is not necessary or recommended, but rather one- piece sleepers should be used (see Standard 3.1.4.2 for more detail information on swaddling);</p> <p>h) Toys, including mobiles and other types of play equipment that are designed to be attached to any part of the crib should be kept away from sleeping infants and out of safe sleep environments;</p> <p>i) When caregivers/teachers place infants in their crib for sleep, they should check to ensure that the temperature in the room is comfortable for a lightly clothed adult, check the infants to ensure that they are comfortably clothed (not overheated or sweaty), and that bibs, necklaces, and garments with ties or hoods are removed (clothing sacks or other clothing designed for sleep can be used in lieu of blankets);</p> <p>j) Infants should be directly observed by sight and sound at all times, including when they are going to sleep, are sleeping, or are in the process of waking up;</p> <p>k) Bedding should be changed between children, and if mats are used, they should be cleaned between uses.</p> <p>The lighting in the room must allow the caregiver/teacher to see each infant’s face, to view the color of the infant’s skin, and to check on the infant’s breathing and placement of the pacifier (if used).</p> <p>A caregiver/teacher trained in safe sleep practices and approved to care for infants should be present in each</p>	<p>170-300-0115 Staff records.</p> <p>(2) Records for each early learning provider and staff member must include:</p> <p>(g) Proof of professional credentials, requirements, and training for each early learning staff member, pursuant to WAC 170-300-0105 through -0110;</p> <p>Weight #4</p> <p>170-300-0290 Infant and toddler sleep, rest, and equipment.</p> <p>(1) For infants, an early learning provider must supply a single level crib, playpen, or other developmentally appropriate sleep equipment. Providers must not use sofas, couches, or adult-sized or toddler beds for infant sleeping. Weight #6</p> <p>(2) For toddlers, an early learning provider must provide and use a single level crib, playpen, toddler bed, or other developmentally appropriate sleep equipment. An early learning provider must allow toddlers to follow their own sleep patterns. Weight #6</p> <p>(3) Sleep equipment not covered in WAC 170-300-0265 must:</p> <p>(a) Be approved by CPSC or ASTM International safety standards for use by infants and toddlers; Weight #7</p> <p>(b) Cribs must have a certificate of compliance, sticker, or documentation from the manufacturer or importer stating the crib meets 16 Code of Federal Regulations (C.F.R.) 1219 and 1220; Weight #7</p> <p>(c) Have a clean, firm, and snug-fitting mattress designed specifically for the particular equipment. Weight #7</p> <p>(d) Have a tight-fitted sheet that is designed for the sleep equipment. Weight #7</p> <p>(e) Have a moisture resistant and easily cleaned and sanitized mattress, if applicable. The mattress must be free of tears or holes and not repaired with tape. Weight #5</p> <p>(f) The sheet must be laundered at least weekly or more often, such as between uses by different children or if soiled; Weight #5</p> <p>(g) Cribs and playpens arranged side by side must be spaced at least 30 inches apart; Weight #5 and</p> <p>(h) Cribs and playpens placed end to end must have a moisture resistant and easily cleanable solid barrier if spaced closer than 30 inches.</p> <p>Weight #5</p> <p>(4) An early learning provider must immediately remove sleeping children from car seats, swings, or similar equipment not designed for sleep unless doing so would put another enrolled child at risk. Weight #7</p> <p>(5) An early learning provider must consult with a child’s parent or guardian before that child is transitioned from infant sleeping equipment to other sleep equipment. Weight: 5</p> <p>(6) An early learning provider must transition children who are able to climb out of their sleeping equipment to developmentally appropriate sleep equipment. When parents don’t agree with transitioning, the provider and parent will create a transition plan. Weight #7</p> <p>170-300-0291 Infant safe sleep practices.</p> <p>(1) An early learning provider must follow infant safe sleep practices when infants are napping or sleeping by following the current standard of American Academy of Pediatrics concerning safe sleep practices including SIDS/SUIDS risk reduction, including:</p>				
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<p>room at all times where there is an infant. This caregiver/teacher should remain alert and should actively supervise sleeping infants in an ongoing manner. Also, the caregiver/teacher should check to ensure that the infant’s head remains uncovered and re-adjust clothing as needed.</p> <p>The construction and use of sleeping rooms for infants separate from the infant group room is not recommended due to the need for direct supervision. In situations where there are existing facilities with separate sleeping rooms, facilities should develop a plan to modify room assignments and/or practices to eliminate placing infants to sleep in separate rooms.</p> <p>Facilities should be aware of the current recommendation of the AAP about pacifier use (1). If pacifiers are allowed, facilities should have a written policy that describes relevant procedures and guidelines. Pacifier use outside of a crib in rooms and programs where there are mobile infants or toddlers is not recommended.</p>	<p>(a) Actively supervising infants by visibly checking at least every 15 minutes and being within sight and hearing range, including when an infant goes to sleep, is sleeping, or is waking up; Weight #7</p> <p>(b) Placing an infant to sleep on his or her back or following the current standard of American Academy of Pediatrics. If an infant turns over while sleeping, the provider must return the infant to his or her back until the infant is able to independently roll from back to front and front to back; Weight #7</p> <p>(c) Not using a sleep positioning device unless directed to do so by an infant's health care provider. The directive must be in writing and kept in the infant’s record; Weight #7</p> <p>(d) Sufficiently lighting the room in which the infant is sleeping to observe skin color; Weight #7</p> <p>(e) Monitoring breathing patterns of an infant; Weight #7</p> <p>(f) Allowing infants to follow their own sleep patterns; Weight #6</p> <p>(g) Not allowing blankets, stuffed toys, pillows, crib bumpers, or similar items inside a crib, bassinet, or other equipment if occupied by a resting or sleeping infant; Weight #8</p> <p>(h) Not allowing a blanket or any other item to cover or drape over an occupied crib, bassinet, or other equipment where infants commonly sleep; Weight #8</p> <p>(i) Not allowing bedding, or clothing to cover any portion of an infant's head or face while sleeping, and readjusting these items when necessary; Weight #8</p> <p>(j) Visibly check on infants while sleeping and readjust blankets, bedding or clothing as needed; and Weight #8</p> <p>(k) Preventing infants from getting too warm while sleeping; which may be exhibited by indicators that include, but are not limited to, sweating; flushed, pale, or hot and dry skin, warm to the touch, a sudden rise in temperature, vomiting, refusing to drink, a depressed fontanelle, or irritability. Weight #7</p> <p>(2) An early learning provider who receives notice of a safe sleep violation must:</p> <p>(a) Post the notice in the licensed space for two weeks or until the violation is corrected, whichever is longer, pursuant to WAC 170-300-0505; Weight N/A and</p> <p>(b) Within five business days of receiving notice of the violation, provide the parents and guardians of enrolled children with:</p> <p>(i) A letter describing the safe sleep violation; and</p> <p>(ii) Written information on safe sleep practices. Weight #5</p> <p>170-300-0265 Sleep, rest, and equipment.</p> <p>(6) Mats, cots, and other sleep equipment used in an early learning program must be:</p> <p>(b) Cleaned, sanitized, and air dried at least once per week or more often as needed if used by only one child, or after each use if used by more than one child; and Weight #5</p> <p>170-300-0240 Clean and healthy environment.</p> <p>(1) Early learning program premises and program equipment must be clean and sanitary. Weight NA</p> <p>(2) Hard surfaces in early learning programs including, but not limited to, floors (excluding carpet), walls, counters, bookshelves, and tables must be smooth and easily cleanable.</p> <p>(e) If a bleach solution is used for sanitizing or disinfecting, an early learning provider must use one that is fragrance-free and follow department of health’s current Guidelines for Mixing Bleach Solutions for Child Care and Similar Environments.</p> <p>(f) If an early learning provider uses a product other than bleach, including wipes, to sanitize or disinfect, the product must be:</p> <p>(i) Approved by the department prior to use;</p> <p>(ii) Used by trained staff only;</p> <p>(iii) Registered with the EPA and have Safety Data Sheets (SDS) available;</p>				
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	<div>(iv) Used in accordance with the manufacturer’s label, which must include: (A) Directions for use; (B) A description of the safety precautions, procedures, and equipment that must be used for mixing the substitute product concentration, if applicable; (C) A description of the safety precautions and procedures if the substitute product contacts skin or is inhaled, if applicable; and (D) A description of the procedures and safety precautions for rinsing cleaned areas and cleaning equipment, if applicable. (v) Labeled as safe to use on food surfaces if the product will be used to sanitize: (A) Food contact surfaces; or (B) Items such as eating utensils or toys used by the child or put into the child’s mouth; and (vi) Fragrance-free. Weight #6</div>				
<div>STANDARD 3.2.1.4: Diaper Changing Procedure The following diaper changing procedure should be posted in the changing area, should be followed for all diaper changes, and should be used as part of staff evaluation of caregivers/teachers who diaper. The signage should be simple and should be in multiple languages if caregivers/ teachers who speak multiple languages are involved in diapering. All employees who will diaper should undergo training and periodic assessment of diapering practices. Caregivers/teachers should never leave a child unattended on a table or countertop, even for an instant. A safety strap or harness should not be used on the diaper changing table. If an emergency arises, caregivers/teachers should bring any child on an elevated surface to the floor or take the child with them. An EPA-registered disinfectant suitable for the surface material that is being disinfected should be used. If an EPA-registered product is not available, then household bleach diluted with water is a practical alternative. All cleaning and disinfecting solutions should be stored to be accessible to the caregiver/teacher but out of reach of any child. Please refer to Appendix J, Selecting an Appropriate Sanitizer or Disinfectant. Step 1: Get organized. Before bringing the child to the diaper changing area, perform hand hygiene, gather and bring supplies to the diaper changing area: a) Non-absorbent paper liner large enough to cover the changing surface from the child’s shoulders to beyond the child’s feet; b) Unused diaper, clean clothes (if you need them); c) Wipes for cleaning the child’s genitalia and</div>	<div>170-300-0110 Program based staff policies and training. (1) An early learning provider must have and follow written policies for early learning program staff. Staff policies must include those listed in subsection (2) and (3) of this section and must be reviewed and approved by the department prior to issuing a provider’s initial license. Providers must notify the department when substantial changes are made. Weight #1 (2) Early learning program staff policies must include, but are not limited to: (a) All of the information in the parent or guardian handbook except fees; (h) Observation, evaluation, and feedback policies Weight NA (4) An early learning provider must develop, deliver, and document the delivery of early learning staff training specific to the early learning program and premises. (a) Training topics must include: (i) Staff policies listed in subsections (2) and (3) of this section; (ii) Chapter 43.216 RCW; and (iii) Chapters 170-300 and 170-06 WAC, as hereafter recodified or amended. (b) Training must be updated with changes in program policies and state or federal regulations. Weight #5 170-300-0505 Postings. (1) Postings listed in subsection (2) of this section that are part of an early learning program must be clearly visible to parents, guardians, and early learning program staff. Weight #4 (2) Postings on early learning premises must include: (e) If applicable, diaper changing or stand-up diapering procedure at each diapering station, pursuant to WAC 170-300-0220 and 0221(1)(d); Weight N/A 170-300-0220 Bathroom space and toilet training. (6) If a child is developmentally ready, and an early learning provider uses a stand-up diapering procedure, it must be done in the bathroom or a diaper changing area. Weight #5. 170-300-0221 Diaper changing areas and disposal.</div>	Partially Meets	<div>No WAC found that lists specific steps to diaper changing. No WAC found that requires the diaper change be recorded in a daily log for the child.</div>		

<p>buttocks removed from the container or dispensed so the container will not be touched during diaper changing;</p> <p>d) A wet cloth or paper towel;</p> <p>e) A plastic bag for any soiled clothes or cloth diapers;</p> <p>f) Disposable gloves, if you plan to use them (put gloves on before handling soiled clothing or diapers) and remove them before handling clean diapers and clothing;</p> <p>g) A thick application of any diaper cream (e.g., zinc oxide ointment), when appropriate, removed from the container to a piece of disposable material such as facial or toilet tissue.</p> <p>Step 2: Carry the child to the changing table, keeping soiled clothing away from you and any surfaces you cannot easily clean and sanitize after the change.</p> <p>a) Always keep a hand on the child;</p> <p>b) If the child's feet cannot be kept out of the diaper or from contact with soiled skin during the changing process, remove the child's shoes and socks so the child does not contaminate these surfaces with stool or urine during the diaper changing.</p> <p>Step 3: Clean the child's diaper area.</p> <p>a) Place the child on the diaper change surface and unfasten the diaper, but leave the soiled diaper under the child;</p> <p>b) If safety pins are used, close each pin immediately once it is removed and keep pins out of the child's reach (never hold pins in your mouth);</p> <p>c) Lift the child's legs as needed to use disposable wipes to clean the skin on the child's genitalia and buttocks and prevent recontamination from a soiled diaper. If there is a need to clean between the labia of an infant girl, use only a wet cloth or paper towel. Remove stool and urine from front to back and use a fresh wipe each time you swipe. Put the soiled wipes into the soiled diaper or directly into a plastic-lined, hands-free covered can.</p> <p>Step 4: Remove the soiled diaper and clothing without contaminating any surface not already in contact with stool or urine.</p> <p>a) Fold the soiled surface of the diaper inward;</p> <p>b) Put soiled disposable diapers in a covered, plastic-lined, hands-free covered can. If reusable cloth diapers are used, put the soiled cloth diaper and its contents (without emptying or rinsing) in a plastic</p>	<p>(1) A center early learning provider must have a designated diaper changing area, including stand-up diapering, for each classroom or for every age grouping of children who require diapering. Only one diaper changing area is required at a family home early learning provider.</p> <p>(a) A diaper changing area must:</p> <p>(i) Be separate from areas where food is stored, prepared, or served;</p> <p>(ii) Have a sink with hot and cold running water, not used for food preparation and clean up;</p> <p>(iii) Have a sturdy surface or mat that:</p> <p>(A) Is not torn or repaired with tape;</p> <p>(B) Is washable;</p> <p>(C) Has a moisture resistant surface that is cleanable;</p> <p>(D) Is large enough to prevent the area underneath the diaper changing area from being contaminated with bodily fluids; and</p> <p>(iv) Be on moisture resistant, washable material that horizontally or vertically surrounds and extends at least two feet from the diaper changing station and handwashing area; and</p> <p>(v) Be uncluttered and not used for storage of any items not used in diapering a child.</p> <p>Weight #6</p> <p>(b) An early learning provider must not leave a child unattended on the diaper changing surface or mat during the diaper changing process; Weight #7</p> <p>(c) An early learning provider must not use safety belts on diaper changing tables because they are neither cleanable nor safe; Weight #6 and</p> <p>(d) An early learning provider must post an easily viewable diaper changing procedure at each station and must follow each step described in the procedure. Weight NA</p> <p>(2) If an early learning provider uses a diaper changing station, the station must:</p> <p>(a) Have a hand washing sink within arm's reach of, or be readily accessible to, an early learning provider to prevent cross contamination; and</p> <p>(b) Be on moisture resistant, washable material that horizontally or vertically surrounds and extends at least two feet from the diaper changing station and handwashing area; and either:</p> <p>(i) A table or counter large enough to accommodate the length of a child, with a protective barrier at least three and one-half (3½) inches high on all sides from the surface the child lays on; or</p> <p>(ii) A wall mounted diaper changing station that meets manufacturer guidelines and specifications in addition to the requirements of this section.</p> <p>Weight #5</p> <p>(3) If an early learning provider uses reusable or cloth diapers, the diapers must:</p> <p>(a) Not be rinsed;</p> <p>(b) Be placed in a securely sealed moisture impervious bag;</p> <p>(c) Be stored in a separate disposal container; and</p> <p>(d) Be delivered to a commercial laundry service or given to the child's parent or guardian at least daily.</p> <p>Weight #6</p> <p>(4) An early learning provider must provide a container designated for disposing of soiled diapers and diapering supplies only. The diaper disposal container must be:</p> <p>(a) Hands-free and covered with a lid to prevent cross contamination;</p> <p>(b) Lined with a disposable plastic trash bag; and</p> <p>(c) Within arm's length of the diaper changing area.</p> <p>Weight #6</p>				
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<p>bag or into a plastic-lined, hands-free covered can to give to parents/guardians or laundry service;</p> <p>c) Put soiled clothes in a plastic-lined, hands-free plastic bag;</p> <p>d) If gloves were used, remove them using the proper technique (see Appendix D) and put them into a plastic-lined, hands-free covered can;</p> <p>e) Whether or not gloves were used, use a disposable antibacterial wipe or alcohol-based hand sanitizer to clean the surfaces of the caregiver/teacher’s hands and an application to clean the child’s hands, and put the wipes, if used, into the plastic-lined, hands-free covered can. Allow sanitized hands to dry completely before proceeding;</p> <p>f) Check for spills under the child. If there are any, use the paper that extends under the child’s feet to fold over the soiled area so a fresh, unsoiled paper surface is now under the child’s buttocks.</p> <p>Step 5: Put on a clean diaper and dress the child.</p> <p>a) Slide a fresh diaper under the child;</p> <p>b) Use a facial or toilet tissue or wear clean disposable glove to apply any necessary diaper creams, discarding the tissue or glove in a covered, plastic-lined, hands-free covered can;</p> <p>c) Note and plan to report any skin problems such as redness, skin cracks, or bleeding;</p> <p>d) Fasten the diaper; if pins are used, place your hand between the child and the diaper when inserting the pin.</p> <p>Step 6: Wash the child’s hands and return the child to a supervised area.</p> <p>a) Use soap and warm water, between 60°F and 120°F, at a sink to wash the child’s hands, if you can.</p> <p>Step 7: Clean and disinfect the diaper-changing surface.</p> <p>a) Dispose of the disposable paper liner used on the diaper changing surface in a plastic-lined, hands-free covered can;</p> <p>b) If clothing was soiled, securely tie the plastic bag used to store the clothing and send home;</p> <p>b) Remove any visible soil from the changing surface with a water saturated disposable paper towel or wipe;</p> <p>c) Wet the entire changing surface with a disinfectant that is appropriate for the surface material you are treating. Follow the manufacturer’s instructions for use;</p>	<p>170-300-0240 Clean and healthy environment.</p> <p>(1) Early learning program premises and program equipment must be clean and sanitary. Weight NA</p> <p>(2) Hard surfaces in early learning programs including, but not limited to, floors (excluding carpet), walls, counters, bookshelves, and tables must be smooth and easily cleanable.</p> <p>(a) A cleanable surface must be:</p> <p>(i) Designed to be cleaned frequently and made of sealed wood, linoleum, tile, plastic, or other solid surface materials;</p> <p>(ii) Moisture resistant; and</p> <p>(iii) Free of chips, cracks, and tears.</p> <p>(c) An early learning provider must clean all surfaces before sanitizing or disinfecting. Surfaces must be cleaned with a soap and water solution or spray cleaner and rinsed. If using a spray cleaner, directions on the label must be followed.</p> <p>(e) If a bleach solution is used for sanitizing or disinfecting, an early learning provider must use one that is fragrance-free and follow department of health’s current Guidelines for Mixing Bleach Solutions for Child Care and Similar Environments.</p> <p>(f) If an early learning provider uses a product other than bleach, including wipes, to sanitize or disinfect, the product must be:</p> <p>(i) Approved by the department prior to use;</p> <p>(ii) Used by trained staff only;</p> <p>(iii) Registered with the EPA and have Safety Data Sheets (SDS) available;</p> <p>(iv) Used in accordance with the manufacturer’s label, which must include:</p> <p>(A) Directions for use;</p> <p>(B) A description of the safety precautions, procedures, and equipment that must be used for mixing the substitute product concentration, if applicable;</p> <p>(C) A description of the safety precautions and procedures if the substitute product contacts skin or is inhaled, if applicable; and</p> <p>(D) A description of the procedures and safety precautions for rinsing cleaned areas and cleaning equipment, if applicable.</p> <p>(e) Labeled as safe to use on food surfaces if the product will be used to sanitize:</p> <p>(i) Food contact surfaces; or</p> <p>(ii) Items such as eating utensils or toys used by the child or put into the child’s mouth; and</p> <p>(g) Fragrance-free.</p> <p>Weight #6</p> <p>170-300-0241 Cleaning schedules.</p> <p>(6) Toileting and diaper changing areas including, but not limited to, toilets, counters, sinks, and floors must be cleaned and disinfected daily or more often as needed. Weight #6</p> <p>(7) Diaper changing tables and changing pads must be cleaned and disinfected between children, even if using a non-absorbent covering that is discarded after each use. Weight #7</p> <p>(8) Garbage cans and receptacles must be emptied on a daily basis and cleaned and disinfected as needed. Weight #6</p>				
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<p>d) Put away the disinfectant. Some types of disinfectants may require rinsing the changetable surface with fresh water afterwards.</p> <p>Step 8: Perform hand hygiene according to the procedure in Standard 3.2.2.2 and record the diaper change in the child’s daily log.</p> <p>a) In the daily log, record what was in the diaper and any problems (such as a loose stool, an unusual odor, blood in the stool, or any skin irritation), and report as necessary.</p>	<p>(9) Diaper receptacles must be emptied, cleaned, and disinfected daily or more often as needed. Contents of a diaper receptacle must be removed from the licensed space, and replaced with a new liner at least daily or more often if odor is present. Weight #6</p> <p>(a)Garbage cans and receptacles not intended for diapers must be emptied on a daily basis and cleaned and disinfected as needed.</p> <p>Weight #6</p> <p>170-300-0200- Handwashing and hand sanitizer.</p> <p>(1) Early learning providers must comply with the following handwashing procedures or those defined by the United States Center for Disease Control and Prevention, and children should strongly be encouraged to.</p> <p>(a) Wet hands with warm water;</p> <p>(b) Apply soap to the hands;</p> <p>(c) Rub hands together to wash for at least 20 seconds;</p> <p>(d) Thoroughly rinse hands with water;</p> <p>(e) Dry hands with a paper towel, single-use cloth towel, or air hand dryer;</p> <p>(f) Turn water faucet off with using a paper towel or single use cloth towel unless it turns off automatically; and</p> <p>(g) Properly discard paper single-use cloth towels after each use. Weight #6</p> <p>(2) An early learning provider must wash and sanitize cloth towels after a single use. Soiled and used towels must be inaccessible to children. Weight #4</p> <p>(4) Early learning providers must wash their hands following handwashing procedures listed above:</p> <p>(c) Before and after diapering a child (use a wet wipe in place of handwashing during the middle of diapering if needed);</p> <p>Weight #7</p> <p>(5) Early learning providers must direct, assist, teach, and coach, children to wash their hands, using the steps listed above:</p> <p>(c) After diapering;</p> <p>170-300-0165 Safety requirements.</p> <p>(4) To ensure a safe environment for children in care, an early learning provider must comply with the following requirements:</p> <p>(e) Safe water temperature. All water accessible to enrolled children must not be hotter than 120 degrees Fahrenheit. Weight #7</p> <p>170-300-0220 –Bathroom space and toilet training.</p> <p>(1) An early learning provider must provide at least one indoor bathroom in the licensed space that complies with the following:</p> <p>(b) One working sink and faucet</p> <p>(i)Sinks and faucets must be an appropriate height and size for children. A platform may be used to accommodate the height and size of children. Platforms must be easily cleanable and resistant to moisture and slipping.</p>				
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	<p>(ii) A faucet used for hand washing must provide warm running water.</p> <p>(iii)Sinks and faucets must be located inside the bathroom or immediately outside the bathroom.</p> <p>170-300-0260 Storage of hazardous and maintenance supplies.</p> <p>(1)An early learning provider must ensure all poisonous or dangerous substances including, but not limited to fuels, solvents, oils, laundry, dishwasher, other detergents, sanitizing products, disinfectants and items labeled “keep out of reach of children” are stored:</p> <p>(a)In a location that is inaccessible to children;</p> <p>(b)Separate and apart from food preparation areas, food items, and food supplies;</p> <p>(c)In their original containers or clearly labeled with the name of the product if not in the original container; and</p> <p>(d)In compliance with the manufacturer’s directions (including not storing products near heat sources).</p> <p>Weight #7</p>				
<p>STANDARD 3.2.2.1: Situations that Require Hand Hygiene</p> <p>All staff, volunteers, and children should follow the procedure in Standard 3.2.2.2 for hand hygiene at the following times:</p> <p>a) Upon arrival for the day, after breaks, or when moving from one child care group to another;</p> <p>b) Before and after:</p> <p>1) Preparing food or beverages;</p> <p>2) Eating, handling food, or feeding a child;</p> <p>3) Giving medication or applying a medical ointment or cream in which a break in the skin (e.g., sores, cuts, or scrapes) may be encountered;</p> <p>4) Playing in water (including swimming) that is used by more than one person;</p> <p>5) Diapering;</p> <p>c) After:</p> <p>1) Using the toilet or helping a child use a toilet;</p> <p>2) Handling bodily fluid (mucus, blood, vomit), from sneezing, wiping and blowing noses, from mouths, or from sores;</p> <p>3) Handling animals or cleaning up animal waste;</p> <p>4) Playing in sand, on wooden play sets, and outdoors;</p> <p>5) Cleaning or handling the garbage.</p>	<p>170-300-0200 Handwashing and hand sanitizer.</p> <p>(4) Early learning providers must wash their hands following the handwashing procedures listed above:</p> <p>(a) When arriving at work;</p> <p>(b) After toileting a child;</p> <p>(c) Before and after diapering a child (use a wet wipe in place of handwashing during the middle of diapering if needed);</p> <p>(d) After personal toileting;</p> <p>(e) After attending to an ill child;</p> <p>(f) Before and after preparing, serving, or eating food;</p> <p>(g) Before preparing bottles;</p> <p>(h) After handling raw or undercooked meat, poultry, or fish;</p> <p>(i) Before and after giving medication or applying topical ointment;</p> <p>(j) After handling or feeding animals, handling an animal’s toys or equipment, or cleaning up after animals;</p> <p>(k) After handling bodily fluids;</p> <p>(l) After using tobacco or vapor products;</p> <p>(m) After being outdoors;</p> <p>(n) After gardening activities;</p> <p>(o) After handling garbage and garbage receptacles; and</p> <p>(p) As needed or required by the circumstances. Weight #7</p> <p>(5) Early learning providers must direct, assist, teach, and coach, children to wash their hands, using the steps listed above:</p> <p>(a) When arriving at the early learning premises;</p> <p>(b) After using the toilet;</p> <p>(c) After diapering;</p> <p>(d) After outdoor play;</p> <p>(e) After gardening activities;</p> <p>(f) After playing with animals;</p> <p>(g) After touching body fluids such as blood or after nose blowing or sneezing;</p>	Partially Meets	No WAC found that requires handwashing: before and after playing in water (including swimming) that is used by more than one person.		

Situations or times that children and staff should perform hand hygiene should be posted in all food preparation, hand hygiene, diapering, and toileting areas.	<div>(h) Before and after eating or participating in food activities including table setting; and</div> <div>(i) As needed or required by the circumstances. Weight #7</div> <div>170-300-0505- Postings.</div> <div>(1) Postings listed in subsection (2) of this section that are part of an early learning program must be clearly visible to parents, guardians, and early learning program staff. Weight #4</div> <div>(2) Postings on early learning premises must include:</div> <div>(d)Handwashing practices at each handwashing sinks, pursuant to WAC 170-300-0200(1);</div> <div>(e) If applicable, diaper changing or stand-up diapering procedure, pursuant to WAC 170-300-0220 and 0221(1)(d);</div> <div>Weight NA</div>				
<div>STANDARD 3.2.2.2: Handwashing Procedure</div> <div>Children and staff members should wash their hands using the following method:</div> <div>a) Check to be sure a clean, disposable paper (or single-use cloth) towel is available;</div> <div>b) Turn on warm water, between 60°F and 120°F, to a comfortable temperature;</div> <div>c) Moisten hands with water and apply soap (not antibacterial) to hands;</div> <div>d) Rub hands together vigorously until a soapy lather appears, hands are out of the water stream, and continue for at least twenty seconds (sing Happy Birthday silently twice) (2). Rub areas between fingers, around nailbeds, under fingernails, jewelry, and back of hands. Nails should be kept short; acrylic nails should not worn (3);</div> <div>e) Rinse hands under running water, between 60°F and 120°F, until they are free of soap and dirt. Leave the water running while drying hands;</div> <div>f) Dry hands with the clean, disposable paper or single use cloth towel;</div> <div>g) If taps do not shut off automatically, turn taps off with a disposable paper or single use cloth towel;</div> <div>h) Throw the disposable paper towel into a lined trash container; or place single-use cloth towels in the laundry hamper; or hang individually labeled cloth towels to dry. Use hand lotion to prevent chapping of hands, if desired.</div> <div>The use of alcohol based hand sanitizers is an alternative to traditional handwashing with soap and water by children over twenty-four months of age and adults on hands that are not visibly soiled. A single pump of an alcohol-based sanitizer should be dispensed. Hands should be rubbed together, distributing sanitizer to all</div>	<div>170-300-0165</div> <div>Safety requirements.</div> <div>(4) To ensure a safe environment for children in care, an early learning provider must comply with the following requirements:</div> <div>(e) Safe water temperature. All water accessible to enrolled children must not be hotter than 120 degrees Fahrenheit. Weight #7</div> <div>170-300-0200- Handwashing and hand sanitizer.</div> <div>(1) Early learning providers must comply with the following handwashing procedures or those defined by the United States Center for Disease Control and Prevention, and children should strongly be encouraged to.</div> <div>(a) Wet hands with warm water;</div> <div>(b) Apply soap to the hands;</div> <div>(c) Rub hands together to wash for at least 20 seconds;</div> <div>(d) Thoroughly rinse hands with water;</div> <div>(e) Dry hands with a paper towel, single-use cloth towel, or air hand dryer;</div> <div>(f) Turn water faucet off with using a paper towel or single use cloth towel unless it turns off automatically; and</div> <div>(g) Properly discard paper single-use cloth towels after each use. Weight #6</div> <div>(2) An early learning provider must wash and sanitize cloth towels after a single use. Soiled and used towels must be inaccessible to children. Weight #4</div> <div>(6) Hand sanitizers or hand wipes with alcohol may be used for adults and children over 24 months of age under the following conditions:</div> <div>(a) When proper handwashing facilities are not available; and</div> <div>(b) Hands are not visibly soiled or dirty.</div> <div>Weight NA</div> <div>(7) Children must be actively supervised when using hand sanitizers to avoid ingestion or contact with eyes, nose, or mouths.</div> <div>(a) Hand sanitizer must not be used in place of proper handwashing.</div> <div>(b) An alcohol-based hand sanitizer must contain 60-90% alcohol to be effective.</div>	Meets			

<p>hand and finger surfaces and hands should be permitted to airdry.</p> <p>Situations/times that children and staff should washtheir hands should be posted in all handwashing areas.</p> <p>Use of antimicrobial soap is not recommended in child care settings. There are no data to support use of antibacterial soaps over other liquid soaps.</p> <p>Children and staff who need to open a door to leave a bathroom or diaper changing area should open the door witha disposable towel to avoid possibly re-contaminating clean hands. If a child cannot open the door or turn off the faucet, they should be assisted by an adult.</p>	<p>Weight #7</p> <p>170-300-0505- Postings. (1) Postings listed in subsection (2) of this section that are part of an early learning program must be clearly visible to parents, guardians, and early learning program staff. Weight #4</p> <p>(2) Postings on early learning premises must include: (d)Handwashing practices at each handwashing sinks, pursuant to WAC 170-300-0200(1); (e) If applicable, diaper changing or stand-up diapering procedure, pursuant to WAC 170-300-0220 and 0221(1)(d);</p> <p>Weight NA</p>				
<p>STANDARD 3.2.2.3: Assisting Children with Hand Hygiene Caregivers/teachers should provide assistance with handwashing at a sink for infants who can be safely cradled in one arm and for children who can stand but not washtheir hands independently. A child who can stand shouldeither use a child-height sink or stand on a safety step at aheight at which the child’s hands can hang freely under the running water. After assisting the child withhandwashing, the staff member should wash his or her own hands. Hand hygiene with an alcohol-based sanitizer is an alternative to handwashing with soap and water by children overtwenty- four months of age and adults when there is no visible soiling of hands.</p>	<p>170-300-0200 Handwashing and hand sanitizer. (5) Early learning providers must direct, assist, teach, and coach, children to wash their hands, using the steps listed above:</p> <p>(6) Hand sanitizers or hand wipes with alcohol may be used for adults and children over 24 months of age under the following conditions: (a) When proper handwashing facilities are not available; and (b) Hands are not visibly soiled or dirty. Weight NA</p> <p>(7) Children must be actively supervised when using hand sanitizers to avoid ingestion or contact with eyes, nose, or mouths. (a) Hand sanitizer must not be used in place of proper handwashing. (b) An alcohol-based hand sanitizer must contain 60-90% alcohol to be effective. Weight #7</p> <p>170-300-0220 Bathroom space and toilet training. (1) An early learning provider must provide at least one indoor bathroom in the licensed space that has the following: (b) One working sink and faucet: (i) Sink and faucet must be appropriate height and size for children. A platform may be used to accommodate the height and size of children. Platforms must be easily cleanable and resistant to moisture and slipping.</p> <p>Weight #6</p>	Meets			
<p>STANDARD 3.2.3.4: Prevention of Exposure to Blood and Body Fluids Child care facilities should adopt the use of Standard Precautions developed for use in hospitals by The Centers for Disease Control and Prevention (CDC). Standard Precautions should be used to handle potential</p>	<p>WAC 170-300-0106 Training requirements. (11)Early learning providers who directly care for children must complete the Prevention of Exposure to Blood and Body Fluids training that meets Washington State Department of Labor & Industries’ requirements prior to being granted a license or working with children. This training must be repeated pursuant to Washington State Department Labor and Industries regulations. Weight #6</p>	Meets	This section is addressed through the WA Department of Labors and Industry requirements.		

<p>exposure to blood, including blood-containing body fluids and tissue discharges, and to handle other potentially infectious fluids.</p> <p>In child care settings:</p> <ul style="list-style-type: none">a) Use of disposable gloves is optional unless blood or blood containing body fluids may contact hands. Gloves are not required for feeding human milk, cleaning up of spills of human milk, or for diapering;b) Gowns and masks are not required;c) Barriers to prevent contact with body fluids include moisture-resistant disposable diaper table paper, disposable gloves, and eye protection. <p>Caregivers/teachers are required to be educated regarding Standard Precautions to prevent transmission of blood borne pathogens before beginning to work in the facility and at least annually thereafter. Training must comply with requirements of the Occupational Safety and Health Administration (OSHA).</p> <p>Procedures for Standard Precautions should include:</p> <ul style="list-style-type: none">a) Surfaces that may come in contact with potentially infectious body fluids must be disposable or of a material that can be disinfected. Use of materials that can be sterilized is not required.b) The staff should use barriers and techniques that:<ul style="list-style-type: none">1) Minimize potential contact of mucous membranes or openings in skin to blood or other potentially infectious body fluids and tissue discharges; and2) Reduce the spread of infectious material within the child care facility. Such techniques include avoiding touching surfaces with potentially contaminated materials unless those surfaces are disinfected before further contact occurs with them by other objects or individuals.c) When spills of body fluids, urine, feces, blood, saliva, nasal discharge, eye discharge, injury or tissue discharges occur, these spills should be cleaned up immediately, and further managed as follows:<ul style="list-style-type: none">1) For spills of vomit, urine, and feces, all floors, walls, bathrooms, tabletops, toys, furnishings and play equipment, kitchen counter tops, and diaper-changing tables in contact should be cleaned and disinfected as for the procedure for diaper changing tables in Standard 3.2.1.4, Step 7;2) For spills of blood or other potentially	<p>170-300-0500 Health policy.</p> <p>(1) An early learning provider must have and follow a written health policy reviewed and approved by the department that includes the topics listed in subsection (2) of this section. The health policy must be reviewed and approved by the department when changes are made, and as otherwise necessary. Weight NA</p> <p>(2) An early learning program’s health policy must meet the requirements of this chapter including, but not limited to:</p> <ul style="list-style-type: none">(a) A prevention of exposure to blood and body fluids plan; <p>170-300-0110 Program based staff policies and training.</p> <p>(1) An early learning provider must have and follow written policies for early learning program staff. Staff policies must include those listed in subsection (2) and (3) of this section and must be reviewed and approved by the department prior to issuing a provider’s initial license. Providers must notify the department when substantial changes are made. Weight #1</p> <p>(2) Early learning program staff policies must include, but are not limited to:</p> <ul style="list-style-type: none">(e) Early learning program staff responsibilities for:<ul style="list-style-type: none">(x) Health, safety and sanitation procedures <p>Weight #5</p> <p>(4) An early learning provider must develop, deliver, and document the delivery of early learning staff training specific to the early learning program and premises.</p> <ul style="list-style-type: none">(a) Training topics must include:<ul style="list-style-type: none">(i) Staff policies listed in subsections (2) and (3) of this section;(ii) Chapter 43.216 RCW; and(iii) Chapters 170-300 and 170-06 WAC, as hereafter recodified or amended.(b) Training must be updated with changes in program policies and state or federal regulations. <p>Weight #5</p>				
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<p>infectious body fluids, including injury and tissue discharges, the area should be cleaned and disinfected. Care should be taken and eye protection used to avoid splashing any contaminated materials onto any mucus membrane (eyes, nose, mouth);</p> <p>3) Blood-contaminated material and diapers should be disposed of in a plastic bag with a secure tie;</p> <p>4) Floors, rugs, and carpeting that have been contaminated by body fluids should be cleaned by blotting to remove the fluid as quickly as possible, then disinfected by spot-cleaning with a detergent-disinfectant. Additional cleaning by shampooing or steam cleaning the contaminated surface may be necessary. Caregivers/teachers should consult with local health departments for additional guidance on cleaning contaminated floors, rugs, and carpeting.</p> <p>Prior to using a disinfectant, clean the surface with a detergent and rinse well with water. Facilities should follow the manufacturer’s instruction for preparation and use of disinfectant (3,4). For guidance on disinfectants, refer to Appendix J, Selecting an Appropriate Sanitizer or Disinfectant.</p> <p>If blood or bodily fluids enter a mucous membrane (eyes, nose, mouth) the following procedure should occur. Flush the exposed area thoroughly with water. The goal of washing or flushing is to reduce the amount of the pathogen to which an exposed individual has contact. The optimal length of time for washing or flushing an exposed area is not known. Standard practice for managing mucous membrane(s) exposures to toxic substances is to flush the affected area for at least fifteen to twenty minutes. In the absence of data to support the effectiveness of shorter periods of flushing it seems prudent to use the same fifteen to twenty minute standard following exposure to blood borne pathogens.</p>					
<p>STANDARD 3.4.1.1: Use of Tobacco, Alcohol, and Illegal Drugs</p> <p>Tobacco use, alcohol, and illegal drugs should be prohibited on the premises of the program (both indoor and outdoor environments) and in any vehicles used by the program at all times. Caregivers/teachers should not use tobacco, alcohol, or illegal drugs off the premises</p>	<p>170-300-0420 Prohibited substances.</p> <p>(1) Chapter 70.160 RCW prohibits smoking in public places and places of employment. Weight NA</p> <p>(2) Pursuant to RCW 70.160.050, an early learning provider must:</p> <p>(a) Prohibit smoking, vaping, or similar activities in licensed indoor space, even during non-business hours; Weight #7</p>	<p>Exceeds</p>	<p>Inclusive of vaping and cannabis products</p>		

during the child care program’s paid time including break time.	<div><div><div>(b) Prohibit smoking, vaping, or similar activities in licensed outdoor space unless:<div><div>(i) Smoking, vaping or similar activities occurs during non-business hours; or</div><div>(ii) In an area for smoking or vaping tobacco products that is not a “public place” or “place of employment,” as defined in RCW 70.160.020;</div></div><div>Weight #7</div></div><div>(c) Prohibit smoking, vaping, or similar activities in motor vehicles used to transport enrolled children; Weight #7</div><div>(d) Prohibit smoking, vaping, or similar activities by any provider who is supervising children, including during field trips; Weight #7</div><div>(e) Prohibit smoking, vaping, or similar activities within twenty-five feet from entrances, exits, operable windows, and vents, pursuant to RCW 70.160.075; Weight #5 and</div><div>(f) Post “no smoking or vaping” signs. Signs must be clearly visible and located at each building entrance used as part of the early learning program. Weight #NA</div></div><div>(3) An early learning provider must:<div><div>(a) Prohibit any person from consuming or being under the influence of alcohol on licensed space during business hours;</div><div>(b) Prohibit any person within licensed space from consuming or being under the influence of illegal drugs or misused prescription drugs.</div><div>(c) Store any tobacco or vapor products, or the packaging of tobacco or vapor products in a space that is inaccessible to children;</div><div>(d) Prohibit children from accessing cigarette or cigar butts or ashes;</div><div>(e) Store any cannabis or associated paraphernalia out of the licensed space and in a space that is inaccessible to children; and</div><div>(f) Store alcohol in a space that is inaccessible to children (both opened and closed containers).</div></div><div>Weight #7</div></div><div>(4) A center early learning provider must prohibit any person from using, consuming, or being under the influence of cannabis in any form on licensed space. Weight #7</div><div>(5) A family home early learning provider must prohibit any person from using, consuming, or being under the influence of cannabis products in any form on licensed space during business hours. Weight #7</div></div>				
<div>STANDARD 3.4.3.1: Emergency Procedures When an immediate emergency medical response is required, the following emergency procedures should be utilized:<div><div>a) First aid should be employed and an emergency medical response team should be called such as 9-1-1 and/or the poison center if a poison emergency (1-800-222-1222);</div><div>b) The program should implement a plan for emergency transportation to a local emergency medical facility;</div><div>c) The parent/guardian or parent/guardian’s emergency contact person should be called as soon as practical;</div><div>d) A staff member should accompany the child to the</div></div></div>	<div>170-300-0475 Duty to protect children and report incidents.<div>(2) An early learning provider must report by phone upon knowledge of the following to:<div><div>(b) Emergency Services (911) immediately, and to the department within 24 hours:<div><div>(ii) A medical emergency that requires immediate professional medical care;</div><div>(iii) A child is given too much of any oral, inhaled or injected medication;</div><div>(iv) A child who took or received another child’s medication;</div><div>(vi) Poisoning or suspected poisoning; or</div><div>(vii) Other dangers or incidents requiring emergency response.</div></div></div><div>(c)Washington Poison Center immediately after calling 911, and to the department within 24 hours:<div><div>(i) A poisoning or suspected poisoning;</div><div>(ii) A child was given too much of any oral, inhaled, or injected medication; or</div></div></div></div></div></div>	Partially Meets	<div>No WAC found that requires that a staff member should accompany the child to the hospital and will stay with the child until the parent/guardian or emergency contact person arrives.</div> <div>No WAC found that requires that programs should develop contingency plans for emergencies or disaster situations when it may not</div>		

<p>hospital and will stay with the child until the parent/guardian or emergency contact person arrives. Child to staff ratio must be maintained, so staff may need to be called in to maintain the required ratio.</p> <p>Programs should develop contingency plans for emergencies or disaster situations when it may not be possible or feasible to follow standard or previously agreed upon emergency procedures (see also Standard 9.2.4.3, Disaster Planning, Training, and Communication). Children with known medical conditions that might involve emergent care require a Care Plan created by the child's primary care provider. All staff need to be trained to manage an emergency until emergency medical care becomes available.</p>	<p>(iii) A child who took or received another child's medication</p> <p>(iv) The provider must follow any directions provided by Washington Poison Center.</p> <p>Weight #8</p> <p>WAC 170-300-0106 Training requirements.</p> <p>(12) Early learning providers must have a current first-aid and cardiopulmonary resuscitation (CPR) certification prior to being alone with children. Early learning providers must ensure that at least one staff person with a current first aid and CPR certificate is present with each group of children at all times.</p> <p>170-300-0110 Program based staff policies and training.</p> <p>(1) An early learning provider must have and follow written policies for early learning program staff. Staff policies must include those listed in subsection (2) and (3) of this section and must be reviewed and approved by the department prior to issuing a provider's initial license. Providers must notify the department when substantial changes are made. Weight #1</p> <p>(2) Early learning program staff policies must include, but are not limited to:</p> <p>(e) Early learning program staff responsibilities for:</p> <p>(xii) Medication emergencies, fire, disaster evacuation and emergency preparedness plans</p> <p>Weight NA</p> <p>(4) An early learning provider must develop, deliver, and document the delivery of early learning staff training specific to the early learning program and premises.</p> <p>(a) Training topics must include:</p> <p>(i) Staff policies listed in subsections (2) and (3) of this section;</p> <p>(ii) Chapter 43.216 RCW; and</p> <p>(iii) Chapters 170-300 and 170-06 WAC, as hereafter recodified or amended.</p> <p>(b) Training must be updated with changes in program policies and state or federal regulations.</p> <p>Weight #5</p> <p>170-300-0300 Individual Care plan.</p> <p>(1) An early learning provider must develop an Individual Care Plan for each child with special needs, and must notify the department when a child with special needs is enrolled or identified in the early learning program. Plans and documentation required under this section must:</p> <p>(a) Meet the requirements of this section; Weight #5</p> <p>(b) Be available for department review; Weight #5</p> <p>(c) Have written permission from a child's parent or guardian stating that a visiting health professional may provide services to the child at the early learning program, if applicable; Weight #5</p> <p>(d) Have verification that early learning program staff involved with a particular child has been trained on implementing the Individual Care Plan for that child, if applicable; Weight #5</p> <p>(e) Be updated annually or when there is a change in the child's special needs; Weight #5 and</p> <p>(f) Be kept in the child's file Weight NA</p> <p>(2) The Individual Care Plan must be signed by the parent or guardian and may be developed using a department provided template.</p> <p>(a) The Individual Care Plan must contain:</p> <p>(i) The child's diagnosis if known;</p>		<p>be possible or feasible to follow standard or previously agreed upon emergency procedures</p>		
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	<p>(ii) Contact information for the primary health care provider or other relevant specialist;</p> <p>(iii) A list of medication to be administered at scheduled times, or during an emergency along with descriptions of symptoms that would trigger emergency medication;</p> <p>(iv) Directions on how to administer medication;</p> <p>(v) Allergies;</p> <p>(vi) Food allergy and dietary needs pursuant to WAC 170-300-0186;</p> <p>(vii) Activity, behavioral, or environmental modifications for the child;</p> <p>(viii) Known symptoms and triggers;</p> <p>(ix) Emergency response plans and what procedures to perform; and</p> <p>(x) Suggested special skills training, and education for early learning program staff, including specific pediatric first aid and CPR for special health care needs.</p> <p>(b) An early learning provider must have supporting documentation of the child's special needs provided by the child's licensed or certified:</p> <p>(i) Physician or physician's assistant;</p> <p>(ii) Mental health professional;</p> <p>(iii) Education professional;</p> <p>(iv) Social worker with a bachelor's degree or higher with a specialization in the individual child's needs; or</p> <p>(v) Registered nurse or advanced registered nurse practitioner.</p> <p>Weight NA</p> <p>(3) An early learning provider's written plan and documentation for accommodations must be informed by any existing:</p> <p>(a) Individual education plan (IEP);</p> <p>(b) Individual health plan (IHP);</p> <p>(c) 504 plan; or</p> <p>(d) Individualized family service plan (IFSP).</p> <p>Weight NA</p> <p>170-300-0475-Duty to protect children and report incidents.</p> <p>(4)An early learning provider must immediately report to the parent or guardian:</p> <p>(a) Their child's death, serious injury, need for emergency or poison services; or</p> <p>(b) An incident involving that child that was reported to the local health jurisdiction or the department of health. Weight #6</p> <p>170-300-0500- Health policy.</p> <p>(1) An early learning provider must have and follow a written health policy reviewed and approved by the department that includes the topics listed in subsection (2) of this section. The health policy must be reviewed and approved by the department when changes are made, and as otherwise necessary. Weight #NA</p> <p>(2) An early learning program's health policy must meet the requirements of this chapter including, but not limited to:</p> <p>(g) Medical emergencies, injury treatment and reporting;</p> <p>Weight #NA</p>		
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<p>STANDARD 3.4.4.1: Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation</p> <p>Each facility should have a written policy for reporting child abuse and neglect. Caregivers/teachers are mandated reporters of child abuse and neglect. The facility should report to the child abuse reporting hotline, department of social services, child protective services, or police as required by state and local laws, in any instance where there is reasonable cause to believe that child abuse and neglect has occurred. Every staff person should be oriented to what and how to report. Phone numbers and reporting system as required by state or local agencies should be clearly posted by every phone.</p> <p>Caregivers/teachers should receive initial and ongoing training to assist them in preventing child abuse and neglect and in recognizing signs of child abuse and neglect. Programs are encouraged to partner with primary care providers, child care health consultants and/or child protection advocates to provide training and to be available for consultation.</p> <p>Employees and volunteers in centers and large family child care homes should receive an instruction sheet about child abuse and neglect reporting that contains a summary of the state child abuse reporting statute and a statement that they will not be discharged/disciplined solely because they have made a child abuse and neglect report. Some states have specific forms that are required to be completed when abuse and neglect is reported. Some states have forms that are not required but assist mandated reporters in documenting accurate and thorough reports. In those states, facilities should have such forms on hand and all staff should be trained in the appropriate use of those forms. Parents/guardians should be notified upon enrollment of the facility's child abuse and neglect reporting requirement and procedures.</p>	<p>170-300-0476 Duty to protect children and report incidents.</p> <p>(1) Pursuant to RCW 26.44.030, when an early learning provider has reasonable cause to believe that a child has suffered abuse or neglect, that provider must report such incident, or cause a report to be made, to the proper law enforcement agency or the department. "Abuse or neglect" has the same meaning here as in RCW 26.44.020. Weight #8</p> <p>(2) An early learning provider must report by phone upon knowledge of the following to:</p> <p class="list-item-l1">(a) Law enforcement or the department at the first opportunity, but in no case longer than 48 hours:</p> <p class="list-item-l2">(iii) Any suspected physical, sexual or emotional child abuse;</p> <p class="list-item-l2">(iv) Any suspected child neglect, child endangerment, or child exploitation;</p> <p class="list-item-l2">(v) A child's disclosure of sexual or physical abuse; or</p> <p class="list-item-l2">(vi) Inappropriate sexual contact between two or more children.</p> <p>WAC 170-300-0106 Training requirements.</p> <p>(1) Early learning providers licensed, working, or volunteering in an early learning program before the date this section becomes effective must complete the applicable training requirements of this section within three months of the date this section becomes effective unless otherwise indicated. Early learning providers hired after the date this section becomes effective must complete the training requirements of subsections (4) through (10) of this section within three months of the date of hire and prior to working in an unsupervised capacity with children. Weight #1</p> <p>(4) Early learning providers must complete the Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation training as approved or offered by the department according to subsection (1) of this section. Training must include the prevention of child abuse and neglect as defined in RCW 26.44.020 and mandatory reporting requirements under RCW 26.44.030. Weight #7</p> <p>170-300-0110 Program based staff policies and training.</p> <p>(1) An early learning provider must have and follow written policies for early learning program staff. Staff policies must include those listed in subsection (2) and (3) of this section and must be reviewed and approved by the department prior to issuing a provider's initial license. Providers must notify the department when substantial changes are made. Weight #1</p> <p>(2) Early learning program staff policies must include, but are not limited to:</p> <p class="list-item-l1">(e) Early learning program staff responsibilities for:</p> <p class="list-item-l2">(xiii) Mandatory reporting of suspected child abuse, neglect, and exploitation, per RCW 26.44.020 and RCW 26.44.030 and all other reporting requirements;</p> <p>Weight NA</p> <p>(4) An early learning provider must develop, deliver, and document the delivery of early learning staff training specific to the early learning program and premises.</p> <p class="list-item-l1">(a) Training topics must include:</p> <p class="list-item-l2">(i) Staff policies listed in subsections (2) and (3) of this section;</p> <p class="list-item-l2">(ii) Chapter 43.216 RCW; and</p> <p class="list-item-l2">(iii) Chapters 170-300 and 170-06 WAC, as hereafter recodified or amended.</p>	Partially Meets	No WAC found that requires employees and volunteers in centers and large family child care homes should receive an instruction sheet about child abuse and neglect reporting that contains a summary of the state child abuse reporting statute and a statement that they will not be discharged/disciplined solely because they have made a child abuse and neglect report.		
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	<p>(b)Training must be updated with changes in program policies and state or federal regulations.</p> <p>Weight #5</p> <p>170-300-0505 Postings. (1) Postings listed in subsection (2) of this section that are part of an early learning program must be clearly visible to parents, guardians, and early learning program. Weight #4 (g) Emergency numbers and information, including but not limited to: v. The department’s Child Protective Services; Weight NA</p> <p>170-300-0450 Parent or guardian handbook and related policies. (1) An early learning provider must supply to each parent or guardian written policies regarding the early learning program. Each enrolled child’s record must have signed documentation stating the parent or guardian reviewed the handbook and early learning program policies. Weight #3</p> <p>(2) An early learning provider must have and follow formal written policies in either paper or electronic format, including: (t) The early learning provider and program staff’s duty to report incidents including reporting suspected child abuse, neglect, sexual abuse, or maltreatment; Weight #4</p>				
<p>STANDARD 3.4.4.3: Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma All child care facilities should have a policy and procedure to identify and prevent shaken baby syndrome/abusive head trauma. All caregivers/teachers who are in direct contact with children including substitute caregivers/teachers and volunteers, should receive training on preventing shaken baby syndrome/abusive head trauma, recognition of potential signs and symptoms of shaken baby syndrome/abusive head trauma, strategies for coping with a crying, fussing or distraught child, and the development and vulnerabilities of the brain in infancy and early childhood.</p>	<p>WAC 170-300-0106 Training requirements. (1) Early learning providers licensed, working, or volunteering in an early learning program before the date this section becomes effective must complete the applicable training requirements of this section within three months of the date this section becomes effective unless otherwise indicated. Early learning providers hired after the date this section becomes effective must complete the training requirements of subsections (4) through (10) of this section within three months of the date of hire and prior to working in an unsupervised capacity with children. Weight #1</p> <p>(6) Early learning providers licensed to care for infants must complete the Prevention and Identifying Shaken Baby Syndrome/Abuse Head Trauma training as approved or offered by the department according to subsection (1) of this section. Weight #6</p>	Partially Meets	No WAC found that requires a specific policy and procedure to identify and prevent shaken baby syndrome/abuse head trauma.		
<p>STANDARD 3.4.4.4: Care for Children Who Have Been Abused/Neglected Caregivers/teachers should have access to specialized training and expert advice for children with behavioral abnormalities related to abuse or neglect are enrolled.</p>		Not Addressed	No WAC found that requires caregivers/teachers to have access to specialized training and expert advice for children with behavioral abnormalities related to abuse or neglect are enrolled.		
<p>STANDARD 3.4.4.5: Facility Layout to Reduce Risk of Child Abuse and Neglect</p>	<p>170-300-0140 Room arrangement, child-related displays, private space, and belongings. (3) An early learning provider must offer or allow a child to create, a place for privacy. This space must: (a) Allow the provider to supervise children; and</p>	Partially Meets	No WAC found that requires all areas should be viewed by at least one other adult in addition to the caregiver/teacher at all		

<p>The physical layout of facilities should be arranged so that there is a high level of visibility in the inside and outside areas as well as diaper changing areas and toileting areas used by children. All areas should be viewed by at least one other adult in addition to the caregiver/teacher at all times when children are in care. For center-based programs, rooms should be designed so that there are windows to the hallways to keep classroom activities from being too private. Ideally each area of the facility should have two adults at all times. Such an arrangement reduces the risk of child abuse and neglect and the likelihood of extended periods of time in isolation for individual caregivers/teachers with children, especially in areas where children may be partially undressed or in the nude.</p>	<p>(b) Include an area accessible to children who seek or need time alone or small groups. Weight #4</p> <p>(6) Child useable and accessible areas must be arranged to provide sufficient space for routine care, child play, and learning activities. These areas must be designed to allow:</p> <p>(a) Allow the provider to supervise or actively supervise the children, depending on the nature of the activities;</p> <p>(b) Allow children to move freely; and</p> <p>(c) Be designed to allow for different types of activities at the same time (for example: blocks, puppets, language and literary materials, art materials, clay or play dough, music and movement, or dramatic play.</p> <p>Weight #4</p> <p>170-300-0345 Supervising children.</p> <p>(1) An early learning provider must only allow the following persons to have unsupervised access to a child in care:</p> <p>(a) That child’s own parent or guardian;</p> <p>(b) Licensees or early learning program staff authorized by the department in chapter 170-06 WAC, as hereafter recodified or amended;</p> <p>(c) A government representative including an emergency responder who has specific and verifiable authority for access, supported by documentation; and</p> <p>(d) A person authorized in writing or over the phone by that child’s parent such as a family member, family friend, or the child’s therapist or health care provider.</p> <p>Weight #7</p> <p>(2) An early learning provider must meet capacity, group size, mixed age grouping, and staff-to-child ratios while children are in care. This includes but is not limited to:</p> <p>(a) Indoor and outdoor play activities;</p> <p>(b) Off-site activities;</p> <p>(c) During transportation;</p> <p>(d) Meal times;</p> <p>(e) Rest periods;</p> <p>(f) Evening or overnight care; and</p> <p>(g) When children are on different floor levels of the early learning program. Weight #7</p> <p>(3) An early learning provider must supervise children in care by:</p> <p>(a) Scanning the environment looking and listening for both verbal and nonverbal cues to anticipate problems and plan accordingly;</p> <p>(b) Visibly checking children on many occasions with little time in between;</p> <p>(c) Positioning him or herself to supervise all areas accessible to children;</p> <p>(d) Attending to children and being aware of what children are doing at all times;</p> <p>(e) Being available and able to promptly assist or redirect a child as necessary; and</p> <p>(f) Considering the following when deciding whether increased supervision is needed:</p> <p>(i) Ages of children;</p> <p>(ii) Individual differences and abilities of children;</p> <p>(iii) Layout of the indoor and outdoor licensed space and play area;</p> <p>(iv) The risk associated with the activities children are engaged in; and</p> <p>(v) Any nearby hazards including those in the licensed or unlicensed space.</p> <p>Weight #7</p>		<p>times when children are in care.</p> <p>No WAC found that requires that centers’ classrooms should be designed so that there are windows to the hallways to keep classroom activities from being too private.</p>		
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	<p>(4) An early learning program staff member may undertake other activities for a temporary time period when not required to be providing active supervision required under subsection (5)(c). Such activities include, but are not limited to, cleaning up after an activity or preparing items for a new activity. This early learning staff member must remain in visual or auditory range, and be available and able to respond if needed. Weight #7</p> <p>(5) An early learning provider must:</p> <p>(a) Not use devices such as a baby monitors, video monitors, or mirrors in place of supervision, unless used pursuant to WAC 170-300-0270(5);</p> <p>(b) Be able to hear when doors in the immediate area are opened to prevent children from leaving unsupervised;</p> <p>(c) Actively supervise children when the children:</p> <p>(i) Interact with pets or animals;</p> <p>(ii) Engage in water or sand play;</p> <p>(iii) Play in an area in close proximity to a body of water;</p> <p>(iv) Use a safe route to access an outdoor play area not immediately adjacent to the early learning program;</p> <p>(v) Engage in planned activities in the kitchen;</p> <p>(vi) Ride on public transportation;</p> <p>(vii) Engage in outdoor play; and</p> <p>(viii) During field trips.</p> <p>(d) Ensure no infant or child is left unattended during:</p> <p>(i) Diapering;</p> <p>(ii) Bottle feeding; or</p> <p>(iii) Tummy time; and</p> <p>(e) Provide developmentally appropriate supervision to children while bathing.</p> <p>Weight #7</p>				
<p>STANDARD 3.5.0.1: Care Plan for Children with Special Health Care Needs</p> <p>Any child who meets these criteria should have a Routine and Emergent Care Plan completed by their primary care provider in their medical home. In addition to the information specified in Standard 9.4.2.4 for the Health Report, there should be:</p> <p>a) A list of the child’s diagnosis/diagnoses;</p> <p>b) Contact information for the primary care provider and any relevant sub-specialists (i.e., endocrinologists, oncologists, etc.);</p> <p>c) Medications to be administered on a scheduled basis;</p> <p>d) Medications to be administered on an emergent basis with clearly stated parameters, signs, and symptoms that warrant giving the medication written in lay language;</p> <p>e) Procedures to be performed;</p> <p>f) Allergies;</p> <p>g) Dietary modifications required for the health of</p>	<p>170-300-0300 Individual Care plan.</p> <p>(1) An early learning provider must develop an Individual Care Plan for each child with special needs, and must notify the department when a child with special needs is enrolled or identified in the early learning program. Plans and documentation required under this section must:</p> <p>(a) Meet the requirements of this section; Weight #5</p> <p>(b) Be available for department review; Weight #5</p> <p>(c) Have written permission from a child’s parent or guardian stating that a visiting health professional may provide services to the child at the early learning program, if applicable; Weight #5</p> <p>(d) Have verification that early learning program staff involved with a particular child has been trained on implementing the Individual Care Plan for that child, if applicable; Weight #5</p> <p>(e) Be updated annually or when there is a change in the child’s special needs; Weight #5 and</p> <p>(f) Be kept in the child’s file Weight NA</p> <p>(2) The Individual Care Plan must be signed by the parent or guardian and may be developed using a department provided template.</p> <p>(a) The Individual Care Plan must contain:</p> <p>(i) The child’s diagnosis if known;</p> <p>(ii) Contact information for the primary health care provider or other relevant specialist;</p>	Partially Meets	No WAC found that requires a child care health consultant for children with special health care needs.		

<p>the child;</p> <p>h) Activity modifications;</p> <p>i) Environmental modifications;</p> <p>j) Stimulus that initiates or precipitates a reaction or series of reactions (triggers) to avoid;</p> <p>k) Symptoms for caregiver/teachers to observe;</p> <p>l) Behavioral modifications;</p> <p>m) Emergency response plans – both if the child has a medical emergency and special factors to consider in programmatic emergency, like a fire;</p> <p>n) Suggested special skills training and education for staff.</p> <p>The Care Plan should be updated after every hospitalization or significant change in health status of the child. The Care Plan is completed by the primary care provider in the medical home with input from parents/guardians, and it is implemented in the child care setting. The child care health consultant should be involved to assure adequate information, training, and monitoring is available for child care staff.</p>	<p>(iii) A list of medication to be administered at scheduled times, or during an emergency along with descriptions of symptoms that would trigger emergency medication;</p> <p>(iv) Directions on how to administer medication;</p> <p>(v) Allergies;</p> <p>(vi) Food allergy and dietary needs pursuant to WAC 170-300-0186;</p> <p>(vii) Activity, behavioral, or environmental modifications for the child;</p> <p>(viii) Known symptoms and triggers;</p> <p>(ix) Emergency response plans and what procedures to perform; and</p> <p>(x) Suggested special skills training, and education for early learning program staff, including specific pediatric first aid and CPR for special health care needs.</p> <p>(b) An early learning provider must have supporting documentation of the child's special needs provided by the child's licensed or certified:</p> <p>(i) Physician or physician's assistant;</p> <p>(ii) Mental health professional;</p> <p>(iii) Education professional;</p> <p>(iv) Social worker with a bachelor's degree or higher with a specialization in the individual child's needs; or</p> <p>(v) Registered nurse or advanced registered nurse practitioner.</p> <p>Weight NA</p> <p>(3) An early learning provider's written plan and documentation for accommodations must be informed by any existing:</p> <p>(a) Individual education plan (IEP);</p> <p>(b) Individual health plan (IHP);</p> <p>(c) 504 plan; or</p> <p>(d) Individualized family service plan (IFSP).</p> <p>Weight NA</p> <p>170-300-0186 Food allergies and special dietary needs.</p> <p>(4) An early learning provider must obtain written instructions (The Individual Care Plan) from the child's health care provider and parent or guardian when caring for a child with a known food allergy or special dietary requirement due to a health condition. The Individual Care Plan pursuant to WAC 170-300-0300 must:</p> <p>(d) Identify foods that must not be consumed by the child and steps to take in the case of an unintended allergic reaction;</p> <p>(e) Identify foods that can substitute for allergenic foods; and</p> <p>(f) Provide a specific treatment plan for the early learning provider to follow in response to an allergic reaction. The specific treatment plan must include the:</p> <p>(i) Names of all medication to be administered;</p> <p>(ii) Directions for how to administer the medication;</p> <p>(iii) Directions related to medication dosage amounts; and</p> <p>(iv) Description of allergic reactions and symptoms associated with the child's particular allergies.</p> <p>Weight #8</p> <p>(5) An early learning provider must arrange with the parents or guardians of a child in care to ensure the early learning program has the necessary medication, training, and equipment to properly manage a child's food allergies. Weight #8</p>				
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	<div><div>(6) If a child suffers from an allergic reaction, the early learning provider must immediately:<div><div>(a) Administer medication pursuant to the instructions in that child’s Individual Care Plan;</div><div>(b) Contact 911 whenever epinephrine or other lifesaving medication has been administered; and</div><div>(c) Notify the parents and guardians of a child if it is suspected or appears that any of the following occurred, or is occurring:<div><div>(i) The child is having an allergic reaction; or</div><div>(ii) The child consumed or came in contact with a food identified by the parents or guardians that must not be consumed by the child, even if the child is not having or did not have an allergic reaction.</div></div></div><div>Weight #8</div></div></div><div><div>(7) Early learning providers must review each child’s Individual Care Plan information for food allergies prior to serving food to children. Weight #7</div></div></div>				
<div><div>STANDARD 3.5.0.2: Caring for Children Who Require Medical Procedures</div><div>A facility that enrolls children who require the following medical procedures: tube feedings, endotracheal suctioning, supplemental oxygen, postural drainage, or catheterization daily (unless the child requiring catheterization can perform this function on his/her own), checking blood sugars or any other special medical procedures performed routinely, or who might require special procedures on an urgent basis, should receive a written plan of care from the primary care provider who prescribed the special treatment (such as a urologist for catheterization). Often, the child’s primary care provider may be able to provide this information. This plan of care should address any special preparation to perform routine and/or urgent procedures (other than those that might be required in an emergency for any typical child, such as cardiopulmonary resuscitation [CPR]). This plan of care should include instructions for how to receive training in performing the procedure, performing the procedure, a description of common and uncommon complications of the procedure, and what to do and who to notify if complications occur. Specific/relevant training for the child care staff should be provided by a qualified health care professional in accordance with state practice acts.</div><div>Facilities should follow state laws where such laws require RN’s or LPN’s under RN supervision to perform certain medical procedures. Updated, written medical orders are required for nursing procedures.</div></div>	<div><div>170-300-0300 Individual Care plan.</div><div>(1) An early learning provider must develop an Individual Care Plan for each child with special needs, and must notify the department when a child with special needs is enrolled or identified in the early learning program. Plans and documentation required under this section must:<div><div>(a) Meet the requirements of this section; Weight #5</div><div>(b) Be available for department review; Weight #5</div><div>(c) Have written permission from a child’s parent or guardian stating that a visiting health professional may provide services to the child at the early learning program, if applicable; Weight #5</div><div>(d) Have verification that early learning program staff involved with a particular child has been trained on implementing the Individual Care Plan for that child, if applicable; Weight #5</div><div>(e) Be updated annually or when there is a change in the child’s special needs; Weight #5 and</div><div>(f) Be kept in the child’s file Weight NA</div></div></div><div><div>(2) The Individual Care Plan must be signed by the parent or guardian and may be developed using a department provided template.</div><div>(a) The Individual Care Plan must contain:<div><div>(i) The child’s diagnosis if known;</div><div>(ii) Contact information for the primary health care provider or other relevant specialist;</div><div>(iii) A list of medication to be administered at scheduled times, or during an emergency along with descriptions of symptoms that would trigger emergency medication;</div><div>(iv) Directions on how to administer medication;</div><div>(v) Allergies;</div><div>(vi) Food allergy and dietary needs pursuant to WAC 170-300-0186;</div><div>(vii) Activity, behavioral, or environmental modifications for the child;</div><div>(viii) Known symptoms and triggers;</div><div>(ix) Emergency response plans and what procedures to perform; and</div><div>(x) Suggested special skills training, and education for early learning program staff, including specific pediatric first aid and CPR for special health care needs.</div></div></div><div><div>(b) An early learning provider must have supporting documentation of the child’s special needs provided by the child’s licensed or certified:<div><div>(i) Physician or physician’s assistant;</div><div>(ii) Mental health professional;</div><div>(iii) Education professional;</div></div></div></div></div></div>	Meets			

	<div>(iv) Social worker with a bachelor's degree or higher with a specialization in the individual child's needs; or</div> <div>(v) Registered nurse or advanced registered nurse practitioner.</div> <div>Weight NA</div> <div>(3) An early learning provider's written plan and documentation for accommodations must be informed by any existing:</div> <div>(a) Individual education plan (IEP);</div> <div>(b) Individual health plan (IHP);</div> <div>(c) 504 plan; or</div> <div>(d) Individualized family service plan (IFSP).</div> <div>Weight NA</div>				
<div>STANDARD 3.6.1.1: Inclusion/Exclusion/ Dismissal of Children</div> <div>Preparing for managing illness:</div> <div>Caregivers/teachers should:</div> <div>a) Encourage all families to have a backup plan for child care in the event of short or long term exclusion;</div> <div>b) Review with families the inclusion/exclusion criteria and clarify that the program staff (not the families) will make the final decision about whether children who are ill may stay based on the program's inclusion/ exclusion criteria and their ability to care for the child who is ill without compromising the care of other children in the program;</div> <div>c) Develop, with a child care health consultant, protocols and procedures for handling children's illnesses, including care plans and an inclusion/ exclusion policy;</div> <div>d) Request the primary care provider's note to readmit a child if the primary care provider's advice is needed to determine whether the child is a health risk to others, or if the primary care provider's guidance is needed about any special care the child requires (1);</div> <div>e) Rely on the family's description of the child's behavior to determine whether the child is well enough to return, unless the child's status is unclear from the family's report.</div> <div>Daily health checks as described in Standard 3.1.1.1 should be performed upon arrival of each child each day.</div>	<div>170-300-0450 Parent or guardian handbook and related policies.</div> <div>(1) An early learning provider must supply to each parent or guardian written policies regarding the early learning program. Each enrolled child's record must have signed documentation stating the parent or guardian reviewed the handbook and early learning program policies. Weight #3</div> <div>(2) An early learning provider must have and follow formal written policies in either paper or electronic format, including:</div> <div>(v) Description of where the parent or guardian may find and review the early learning program's:</div> <div>(i) Health policy;</div> <div>(vii) Other relevant program policies.</div> <div>Weight #4</div> <div>170-300-0500 Health policy.</div> <div>(1) An early learning provider must have and follow a written health policy reviewed and approved by the department that includes the topics listed in subsection (2) of this section. The health policy must be reviewed and approved by the department when changes are made, and as otherwise necessary. Weight NA</div> <div>(2) An early learning program's health policy must meet the requirements of this chapter including, but not limited to:</div> <div>(d) Observing children for illness daily;</div> <div>(e) Exclusion and return of ill children, staff, or any other person in the program space;</div> <div>(f) Contagious disease notification;</div> <div>Weight NA</div> <div>170-300-0205 Child, staff, and household member illness.</div> <div>(1) An early learning provider must observe all children for signs of illness when they arrive at the early learning program and throughout the day. Parents or guardians of a child should be notified, as soon as possible, if the child develops signs or symptoms of illness. Weight NA</div>	Partially Meets	<div>No WAC found that requires that caregivers/teachers should encourage all families to have a backup plan for child care in the event of short or long term exclusion.</div> <div>No WAC found that requires that caregivers/teachers develop, with a child care health consultant, protocols and procedures for handling children's illnesses, including care plans and an inclusion/ exclusion policy;</div>		

<p>Staff should objectively determine if the child is ill or well. Staff should determine which children with mild illnesses can remain in care and which need to be excluded.</p> <p>Staff should notify the parent/guardian when a child develops new signs or symptoms of illness. Parent/guardian notification should be immediate for emergency or urgent issues. Staff should notify parents/guardians of children who have symptoms that require exclusion and parents/guardians should remove the child from the child care setting as soon as possible. For children whose symptoms do not require exclusion, verbal or written notification of the parent/ guardian at the end of the day is acceptable. Most conditions that require exclusion do not require a primary care provider visit before reentering care.</p> <p>Conditions/symptoms that do not require exclusion:</p> <ul style="list-style-type: none">a) Common colds, runny noses (regardless of color or consistency of nasal discharge);b) A cough not associated with an infectious disease (such as pertussis) or a fever;c) Watery, yellow or white discharge or crusting eye discharge without fever, eye pain, or eyelid redness;d) Yellow or white eye drainage that is not associated with pink or red conjunctiva (i.e., the whites of the eyes);e) Pink eye (bacterial conjunctivitis) indicated by pink or red conjunctiva with white or yellow eye mucous drainage and matted eyelids after sleep. Parents/ guardians should discuss care of this condition with their child’s primary careprovider, and follow the primary care provider’s advice. Some primary care providers do not think it is necessary to examine the child if the discussion with the parents/guardians suggests that the condition is likely to be self-limited. If two unrelated children in the same program have conjunctivitis, the organism causing the conjunctivitis may have a higher risk for transmission and a child health care professional should be consulted;f) Fever without any signs or symptoms of illness in children who are older than six months regardless of whether acetaminophen or ibuprofen was given. Fever (temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method) is an indication of the body’s	<p>(2) If an early learning provider becomes ill, a Licensee, Center Director, Assistant Director, or Program Supervisor must determine whether that person should be required to leave the licensed early learning space. Weight NA</p> <p>(3) When a child becomes ill, an early learning provider (or school nurse, if applicable) must determine whether the child should be sent home or separated from others. A provider must supervise the child to reasonably prevent contact between the ill child and healthy children. Weight #6</p> <p>(4) An ill child must be sent home or reasonably separated from other children if:</p> <ul style="list-style-type: none">(a) The illness or condition prevents the child from participating in normal activities;(b) The illness or condition requires more care and attention than the early learning provider can give;(c) The required amount of care for the ill child compromises or places at risk the health and safety of other children in care; or(d) There is a risk that the child’s illness or condition will spread to other children or individuals. <p>Weight # 6</p> <p>(5) Unless covered under an individual care plan or protected by the ADA, an ill child, staff member, or other individual must be sent home or isolated from children in care if he or she has:</p> <ul style="list-style-type: none">(a) A fever 101 degrees Fahrenheit for children over 2 months (100.4 degrees F for an infant younger than 2 months) by any method, and behavior change or other signs and symptoms of illness (including sore throat, earache, headache, rash, vomiting, diarrhea);(b) Vomiting 2 or more times in the previous 24 hours;(c) Diarrhea where stool frequency exceeds 2 stools above normal per 24 hours for that child or whose loose stool contains more than a drop of blood or mucus;(d) A rash not associated with heat, diapering, or an allergic reaction;(e) Open sores or wounds discharging bodily fluids that cannot be adequately covered with waterproof dressing or mouth sores with drooling;(f) Lice, ringworm, or scabies. Individuals with head lice, ringworm, or scabies must be excluded from the child care premises beginning from the end of the day the head lice or scabies was discovered. The provider may allow an individual with head lice or scabies to return to the premises after receiving the first treatment; or(g) A child who appears severely ill, which may include lethargy, persistent crying, difficulty breathing, or a significant change in behavior or activity level indicative of illness. <p>Weight #7</p> <p>(6) At the first opportunity, but in no case longer than 24 hours of learning that an enrolled child, staff member, volunteer or household member has been diagnosed by a health care professional with a contagious disease listed, as now and hereafter amended, an early learning provider must provide written notice to the department, the local health jurisdiction, and the parents or guardians of the enrolled children. Weight #7</p> <p>(7) An early learning provider must not take ear or rectal temperatures to determine a child’s body temperature.</p> <ul style="list-style-type: none">(a) Providers must use developmentally appropriate methods when taking infant or toddler temperatures (for example, digital forehead scan thermometers or underarm auxiliary methods);(b) Oral temperatures may be taken for preschool through school-age children if single use covers are used to prevent cross contamination; and(c) Glass thermometers containing mercury must not be used. Weight #6 <p>(8) An early learning provider may readmit a child into care, staff member, volunteer or household member into the early learning program area with written permission of a health care provider or health jurisdiction stating the</p>				
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<p>response to something, but is neither a disease nor a serious problem by itself. Body temperature can be elevated by overheating caused by overdressing or a hot environment, reactions to medications, and response to infection. If the child is behaving normally but has a fever of below 102°F per rectum or the equivalent, the child should be monitored, but does not need to be excluded for fever alone;</p> <p>g) Rash without fever and behavioral changes;</p> <p>h) Lice or nits (exclusion for treatment of an active lice infestation may be delayed until the end of the day);</p> <p>i) Ringworm (exclusion for treatment may be delayed until the end of the day);</p> <p>j) Molluscum contagiosum (do not require exclusion or covering of lesions);</p> <p>k) Thrush (i.e., white spots or patches in the mouth or on the cheeks or gums);</p> <p>l) Fifth disease (slapped cheek disease, parvovirus B19) once the rash has appeared;</p> <p>m) Methicillin-resistant Staphylococcus aureus, or MRSA, without an infection or illness that would otherwise require exclusion. Known MRSA carriers or colonized individuals should not be excluded;</p> <p>n) Cytomegalovirus infection;</p> <p>o) Chronic hepatitis B infection;</p> <p>p) Human immunodeficiency virus (HIV) infection;</p> <p>q) Asymptomatic children who have been previously evaluated and found to be shedding potentially infectious organisms in the stool. Children who are continent of stool or who are diapered with formed stools that can be contained in the diaper may return to care. For some infectious organisms, exclusion is required until certain guidelines have been met.</p> <p>Note: These agents are not common and caregivers/ teachers will usually not know the cause of most cases of diarrhea;</p> <p>r) Children with chronic infectious conditions that can be accommodated in the program according to the legal requirement of federal law in the Americans with Disabilities Act. The act requires that child care programs make reasonable accommodations for children with disabilities and/or chronic illnesses, considering each child individually.</p> <p>Key criteria for exclusion of children who are ill:</p> <p>When a child becomes ill but does not require immediate</p>	<p>individual may safely return after being diagnosed with a contagious disease listed in WAC 246-110-010(3), as now and hereafter amended. Weight #5</p>				
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<p>medical help, a determination must be made regarding whether the child should be sent home (i.e., should be temporarily “excluded” from child care). Most illnesses do not require exclusion. The caregiver/teacher should determine if the illness:</p> <ul style="list-style-type: none">a) Prevents the child from participating comfortably in activities;b) Results in a need for care that is greater than the staff can provide without compromising the health and safety of other children;c) Poses a risk of spread of harmful diseases to others. <p>If any of the above criteria are met, the child should be excluded, regardless of the type of illness. The child should be removed from direct contact with other children and should be monitored and supervised by a single staff member known to the child until dismissed from care to the care of a parent/guardian or a primary care provider. The area should be where the toys, equipment, and surfaces will not be used by other children or adults until after the ill child leaves and after the surfaces and toys have been cleaned and disinfected.</p> <p>Temporary exclusion is recommended when the child has any of the following conditions:</p> <ul style="list-style-type: none">a) The illness prevents the child from participating comfortably in activities;b) The illness results in a need for care that is greater than the staff can provide without compromising the health and safety of other children;c) An acute change in behavior - this could include lethargy/lack of responsiveness, irritability, persistent crying, difficult breathing, or having a quickly spreading rash;d) Fever (temperature above 101°F [38.3°C] orally, above 102°F [38.9°C] rectally, or 100°F [37.8°C] or higher taken axillary [armpit] or measured by an equivalent method) and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, diarrhea). An unexplained temperature above 100°F (37.8°C) axillary (armpit) or 101°F (38.3°C) rectally in a child younger than six months should be medically evaluated. Any infant younger than two months of age with any fever should get urgent medical attention. See COMMENTS Below for important information about taking temperatures;e) Diarrhea is defined by watery stools or decreased					
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<p>form of stool that is not associated with changes of diet. Exclusion is required for all diapered children whose stool is not contained in the diaper and toilet-trained children if the diarrhea is causing soiled pants or clothing. In addition, diapered children with diarrhea should be excluded if the stool frequency exceeds two or more stools above normal for that child, because this may cause too much work for the caregivers/teachers. Readmission after diarrhea can occur when diapered children have their stool contained by the diaper (even if the stools remain loose) and when toilet-trained children are continent. Special circumstances that require specific exclusion criteria include the following (2):</p> <p>1) Toxin-producing <i>E. coli</i> or <i>Shigella</i> infection, until stools are formed and the test results of two stool cultures obtained from stools produced twenty-four hours apart do not detect these organisms;</p> <p>2) <i>Salmonella</i> serotype Typhi infection, until diarrhea resolves. In children younger than five years with <i>Salmonella</i> serotype Typhi, three negative stool cultures obtained with twenty-four-hour intervals are required; people five years of age or older may return after a twenty-four-hour period without a diarrheal stool. Stool cultures should be collected from other attendees and staff members, and all infected people should be excluded;</p> <p>f) Blood or mucus in the stools not explained by dietary change, medication, or hard stools;</p> <p>g) Vomiting more than two times in the previous twenty-four hours, unless the vomiting is determined to be caused by a non-infectious condition and the child remains adequately hydrated;</p> <p>h) Abdominal pain that continues for more than two hours or intermittent pain associated with fever or other signs or symptoms of illness;</p> <p>i) Mouth sores with drooling unless the child's primary care provider or local health department authority states that the child is noninfectious;</p> <p>j) Rash with fever or behavioral changes, until the primary care provider has determined that the illness is not an infectious disease;</p> <p>k) Active tuberculosis, until the child's primary care provider or local health department states child is on appropriate treatment and can return;</p> <p>l) Impetigo, until treatment has been started;</p>					
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<p>m) Streptococcal pharyngitis (i.e., strep throat or other streptococcal infection), until twenty-four hours after treatment has been started;</p> <p>n) Head lice until after the first treatment (note: exclusion is not necessary before the end of the program day);</p> <p>o) Scabies, until after treatment has been given;</p> <p>p) Chickenpox (varicella), until all lesions have dried or crusted (usually six days after onset of rash);</p> <p>q) Rubella, until six days after the rash appears;</p> <p>r) Pertussis, until five days of appropriate antibiotic treatment;</p> <p>s) Mumps, until five days after onset of parotid gland swelling;</p> <p>t) Measles, until four days after onset of rash;</p> <p>u) Hepatitis A virus infection, until one week after onset of illness or jaundice if the child's symptoms are mild or as directed by the health department. (Note: immunization status of child care contacts should be confirmed; within a fourteen-day period of exposure, incompletely immunized or unimmunized contacts from one through forty years of age should receive the hepatitis A vaccine as post exposure prophylaxis, unless contraindicated.) Other individuals may receive immune globulin. Consult with a primary care provider for dosage and recommendations;</p> <p>v) Any child determined by the local health department to be contributing to the transmission of illness during an outbreak.</p>					
<p>STANDARD 3.6.1.2: Staff Exclusion for Illness</p> <p>Please note that if a staff member has no contact with the children, or with anything with which the children come into contact, this standard may not apply to that staff member.</p> <p>A facility should not deny admission to or send home a staff member or substitute with illness unless one or more of the following conditions exists. The staff member should be excluded as follows:</p> <p>a) Chickenpox, until all lesions have dried and crusted, which usually occurs by six days;</p> <p>b) Shingles, only if the lesions cannot be covered by clothing or a dressing until the lesions have crusted;</p> <p>c) Rash with fever or joint pain, until diagnosed not to be measles or rubella;</p> <p>d) Measles, until four days after onset of the rash (if</p>	<p>170-300-0500 Health policy.</p> <p>(1) An early learning provider must have and follow a written health policy reviewed and approved by the department that includes the topics listed in subsection (2) of this section. The health policy must be reviewed and approved by the department when changes are made, and as otherwise necessary. Weight NA</p> <p>(2) An early learning program's health policy must meet the requirements of this chapter including, but not limited to:</p> <p>(d) Observing children for illness daily;</p> <p>(e) Exclusion and return of ill children, staff, or any other person in the program space;</p> <p>(f) Contagious disease notification;</p> <p>Weight NA</p> <p>170-300-0205 Child, staff, and household member illness.</p> <p>(5) Unless covered under an individual care plan or protected by the ADA, an ill child, staff member, or other individual must be sent home or isolated from children in care if he or she has:</p>	Exceeds	By listing general symptoms for the various diseases the WAC covers more than listed in CFOC		

<p>the staff member or substitute is immunocompetent);</p> <p>e) Rubella, until six days after onset of rash;</p> <p>f) Diarrheal illness, stool frequency exceeds two or more stools above normal for that individual or blood in stools, until diarrhea resolves; if <i>E. coli</i> 0157:H7 or <i>Shigella</i> is isolated, until diarrhea resolves and two stool cultures are negative, for <i>Salmonella</i> serotype Typhi, three stool cultures collected at twenty-four hour intervals and resolution of diarrhea is required;</p> <p>g) Vomiting illness, two or more episodes of vomiting during the previous twenty-four hours, until vomiting resolves or is determined to result from non-infectious conditions;</p> <p>h) Hepatitis A virus, until one week after symptom onset or as directed by the health department;</p> <p>i) Pertussis, until after five days of appropriate antibiotic therapy;</p> <p>j) Skin infection (such as impetigo), until treatment has been initiated; exclusion should continue if lesion is draining AND cannot be covered;</p> <p>k) Tuberculosis, until noninfectious and cleared by a health department official or a primary care provider;</p> <p>l) Strep throat or other streptococcal infection, until twenty-four hours after initial antibiotic treatment and end of fever;</p> <p>m) Head lice, from the end of the day of discovery until after the first treatment;</p> <p>n) Scabies, until after treatment has been completed;</p> <p>o) Haemophilus influenzae type b (Hib), prophylaxis, until antibiotic treatment has been initiated;</p> <p>p) Meningococcal infection, until appropriate therapy has been administered for twenty-four hours;</p> <p>q) Respiratory illness, if the illness limits the staff member's ability to provide an acceptable level of child care and compromises the health and safety of the children.</p> <p>Caregivers/teachers who have herpes cold sores should not be excluded from the child care facility, but should:</p> <p>a) Cover and not touch their lesions;</p> <p>b) Carefully observe hand hygiene policies.</p>	<p>(a) A fever 101 degrees Fahrenheit for children over 2 months (100.4 degrees F for an infant younger than 2 months) by any method, and behavior change or other signs and symptoms of illness (including sore throat, earache, headache, rash, vomiting, diarrhea);</p> <p>(b) Vomiting 2 or more times in the previous 24 hours;</p> <p>(c) Diarrhea where stool frequency exceeds 2 stools above normal per 24 hours for that child or whose loose stool contains more than a drop of blood or mucus;</p> <p>(d) A rash not associated with heat, diapering, or an allergic reaction;</p> <p>(e) Open sores or wounds discharging bodily fluids that cannot be adequately covered with waterproof dressing or mouth sores with drooling;</p> <p>(f) Lice, ringworm, or scabies. Individuals with head lice, ringworm, or scabies must be excluded from the child care premises beginning from the end of the day the head lice or scabies was discovered. The provider may allow an individual with head lice or scabies to return to the premises after receiving the first treatment; or</p> <p>(g) A child who appears severely ill, which may include lethargy, persistent crying, difficulty breathing, or a significant change in behavior or activity level indicative of illness.</p> <p>Weight #7</p> <p>(8) An early learning provider may readmit a child into care, staff member, volunteer or household member into the early learning program area with written permission of a health care provider or health jurisdiction stating the individual may safely return after being diagnosed with a contagious disease listed in WAC 246-110-010(3), as now and hereafter amended. Weight #5</p> <p>170-300-0120 Providing for personal, professional, and health needs of staff.</p> <p>(2) An early learning provider must be excluded from the early learning premises when that provider's illness or condition poses a risk of spreading a harmful disease or compromising the health and safety of others. The illnesses and conditions that require a staff member to be excluded are pursuant to WAC 170-300-0205. Weight #6</p> <p>(3) If a staff person has not been vaccinated, or has not shown documented immunity to a vaccine preventable disease, that person may be required by the local health jurisdiction or the department to remain off-site during an outbreak of a contagious disease described in WAC 246-110-010, as now and hereafter amended. Weight NA</p> <p>(4) An early learning program's Health policy, pursuant to WAC 170-300-0500, must include provisions for excluding or separating staff with a contagious disease described in WAC 246-110-010, as now and hereafter amended. Weight NA</p>				
STANDARD 3.6.1.4: Infectious Disease Outbreak Control	<p>170-300-0205 Child, staff, and household member illness.</p> <p>(8) An early learning provider may readmit a child into care, staff member, volunteer or household member into the early learning program area with written permission of a health care provider or health jurisdiction stating the</p>	Meets			

<p>During the course of an identified outbreak of any reportable illness at the facility, a child or staff member should be excluded if the health department official or primary care provider suspects that the child or staff member is contributing to transmission of the illness at the facility, is not adequately immunized when there is an outbreak of a vaccine preventable disease, or the circulating pathogen poses an increased risk to the individual. The child or staff member should be readmitted when the health department official or primary care provider who made the initial determination decides that the risk of transmission is no longer present.</p>	<p>individual may safely return after being diagnosed with a contagious disease listed in WAC 246-110-010(3), as now and hereafter amended. Weight #5</p> <p>170-300-0210 Immunizations and exempt children. (7) If an outbreak of a vaccine-preventable disease occurs within the early learning program, an early learning provider must notify the parents or guardians of children exempt from that disease and children without vaccination documents. A provider may exclude the child from the child care premises for the duration of the outbreak of that vaccine-preventable disease. Weight #7</p> <p>170-300-0120 Providing for personal, professional, and health needs of staff. (2) An early learning provider must be excluded from the early learning premises when that provider's illness or condition poses a risk of spreading a harmful disease or compromising the health and safety of others. The illnesses and conditions that require a staff member to be excluded are pursuant to WAC 170-300-0205. Weight #6</p> <p>(3) If a staff person has not been vaccinated, or has not shown documented immunity to a vaccine preventable disease, that person may be required by the local health jurisdiction or the department to remain off-site during an outbreak of a contagious disease described in WAC 246-110-010, as now and hereafter amended. Weight NA</p> <p>(4) An early learning program's Health policy, pursuant to WAC 170-300-0500, must include provisions for excluding or separating staff with a contagious disease described in WAC 246-110-010, as now and hereafter amended. Weight NA</p>				
<p>STANDARD 3.6.2.10: Inclusion and Exclusion of Children from Facilities That Serve Children Who Are Ill</p> <p>Facilities that care for children who are ill who have conditions that require additional attention from the caregiver/ teacher, should arrange for or ask the child care health consultant to arrange for a clinical health evaluation, by a licensed primary care provider, for each child who is admitted to the facility. These facilities should include children with conditions listed in Standard 3.6.1.1 if their policies and plans address the management of these conditions, except for the following conditions which require exclusion from all types of child care facilities that are not medical care institutions (such as hospitals or skilled nursing facilities):</p> <ul style="list-style-type: none">a) Fever (see COMMENTS section for definition of fever) and a stiff neck, lethargy, irritability, or persistent crying;b) Diarrhea (loose stools, not contained in the diaper, that are two or more greater than normal frequency) and one or more of the following:<ul style="list-style-type: none">1) Signs of dehydration, such as dry mouth, no tears, lethargy, sunken fontanelle (soft spot on the head);	<p>170-300-0436 Variance from department rules (WAC). (1) The department cannot provide variance from a requirement in state (RCW) or federal law. Weight NA</p> <p>(2) Upon written request of an applicant, licensee, Center Director, Assistant Director, or Program Supervisor, the department may grant a variance from a rule in this chapter if the proposed program alternative does not jeopardize the health, safety, or welfare of the children in care. Weight NA</p> <p>(3) A request for variance from a rule in this chapter must be:</p> <ul style="list-style-type: none">(a) Submitted in writing on the department's form to the local licensing office;(b) Approved by the department director or the director's designee prior to the early learning provider implementing the variance from the rule; and(c) For a specific program approach or methodology. Weight #1 <p>(4) A granted variance may be time specific or may remain in effect for as long as the early learning provider continues to comply with the conditions of the variance. If the variance from the rule is time limited, the provider must not exceed the timeframe established by the department. Weight NA</p>	Not Addressed	WAC 170-300 does not specifically address facilities that serve children who are ill other than the 'variance' WAC (see below)		

<div>2) Blood or mucus in the stool until it is evaluated for organisms that can cause dysentery;</div> <div>3) Diarrhea caused by <i>Salmonella</i>, <i>Campylobacter</i>, <i>Giardia</i>, <i>Shigella</i> or <i>E.coli</i> 0157:H7 until specific criteria for treatment and return to care are met.</div> <div>c) Vomiting with signs of dehydration and inability to maintain hydration with oral intake;</div> <div>d) Contagious stages of pertussis, measles, mumps, chickenpox, rubella, or diphtheria, unless the child is appropriately isolated from children with other illnesses and cared for only with children having the same illness;</div> <div>e) Untreated infestation of scabies or head lice;</div> <div>f) Untreated infectious tuberculosis;</div> <div>g) Undiagnosed rash WITH fever or behavior change;</div> <div>h) Abdominal pain that is intermittent or persistent and is accompanied by fever, diarrhea, or vomiting;</div> <div>i) Difficulty in breathing;</div> <div>j) An acute change in behavior;</div> <div>k) Undiagnosed jaundice (yellow skin and whites of eyes);</div> <div>l) Other conditions as may be determined by the director or child care health consultant;</div> <div>m) Upper or lower respiratory infection in which signs or symptoms require a higher level of care than can be appropriately provided.</div>					
<div>STANDARD 3.6.2.2: Space Requirements for Care of Children Who Are Ill</div> <div>Environmental space utilized for the care of children who are ill with infectious diseases and cannot receive care in their usual child care group should meet all requirements for well children and include the following additional requirements:</div> <div>a) If the program for children who are ill is in the same facility as the well-child program, well children should not use or share furniture, fixtures, equipment, or supplies designated for use with children who are ill unless it has been cleaned and sanitized before use by well children;</div> <div>b) Indoor space that the facility uses for children who are ill, including hallways, bathrooms, and kitchens, should be separate from indoor space used</div>	<div>170-300-0436 Variance from department rules (WAC).</div> <div>(1) The department cannot provide variance from a requirement in state (RCW) or federal law. Weight NA</div> <div>(2) Upon written request of an applicant, licensee, Center Director, Assistant Director, or Program Supervisor, the department may grant a variance from a rule in this chapter if the proposed program alternative does not jeopardize the health, safety, or welfare of the children in care. Weight NA</div> <div>(3) A request for variance from a rule in this chapter must be:<div>(a) Submitted in writing on the department's form to the local licensing office;</div><div>(b) Approved by the department director or the director's designee prior to the early learning provider implementing the variance from the rule; and</div><div>(c) For a specific program approach or methodology.</div>Weight #1</div> <div>(4) A granted variance may be time specific or may remain in effect for as long as the early learning provider</div>	Not Addressed	WAC 170-300 does not specifically address facilities that serve children who are ill other than the 'variance' WAC		

<p>with well children; this reduces the likelihood of mixing supplies, toys, and equipment. The facility may use a single kitchen for ill and well children if the kitchen is staffed by a cook who has no child care responsibilities other than food preparation and who does not handle soiled dishes and utensils until after food preparation and food service are completed for any meal;</p> <p>c) Children whose symptoms indicate infections of the gastrointestinal tract (often with diarrhea) who receive care in special facilities for children who are ill should receive this care in a space separate from other children with other illnesses to reduce the likelihood of disease being transmitted between children by limiting child-to-child interaction, separating staff responsibilities, and not mixing supplies, toys, and equipment;</p> <p>d) If the facility cares for children with chickenpox, these children require a room with separate ventilation with exhaust to, and air exchange with, the outside (3);</p> <p>e) Each child care room should have a handwashing sink that can provide a steady stream of water, between 60°F and 120°F, at least for ten seconds. Soap and disposable paper towels should be available at the handwashing sink at all times. A hand sanitizing dispenser is an alternative to traditional handwashing;</p> <p>f) Each room where children who wear diapers receive care should have its own diaper changing area adjacent to a handwashing sink and/or hand sanitizer dispenser.</p>	<p>continues to comply with the conditions of the variance. If the variance from the rule is time limited, the provider must not exceed the timeframe established by the department. Weight NA</p>				
<p>STANDARD 3.6.2.5: Caregiver/Teacher Qualifications for Facilities That Care for Children Who Are Ill</p> <p>Each caregiver/teacher in a facility that cares for children who are ill should have at least two years of successful work experience as a caregiver/teacher in a regular well-child facility prior to employment in the special facility. In addition, facilities should document, for each caregiver/teacher, twenty hours of pre-service orientation training on care of children who are ill beyond the orientation training specified in Standards 1.4.2.1 through Standard 1.4.2.3. This training should include the following subjects:</p> <p>a) Pediatric first aid and CPR, and first aid for</p>	<p>170-300-0436 Variance from department rules (WAC).</p> <p>(1) The department cannot provide variance from a requirement in state (RCW) or federal law. Weight NA</p> <p>(2) Upon written request of an applicant, licensee, Center Director, Assistant Director, or Program Supervisor, the department may grant a variance from a rule in this chapter if the proposed program alternative does not jeopardize the health, safety, or welfare of the children in care. Weight NA</p> <p>(3) A request for variance from a rule in this chapter must be:</p> <p>(a) Submitted in writing on the department’s form to the local licensing office;</p> <p>(b) Approved by the department director or the director’s designee prior to the early learning provider implementing the variance from the rule; and</p>	Not Addressed	WAC 170-300 does not specifically address facilities that serve children who are ill other than the ‘variance’ WAC		

<p>choking;</p> <p>b) General infection-control procedures, including:</p> <ul style="list-style-type: none">1) Hand hygiene;2) Handling of contaminated items;3) Use of sanitizing chemicals;4) Food handling;5) Washing and sanitizing of toys;6) Education about methods of disease transmission. <p>c) Care of children with common mild childhood illnesses, including:</p> <ul style="list-style-type: none">1) Recognition and documentation of signs and symptoms of illness including body temperature;2) Administration and recording of medications;3) Nutrition of children who are ill;4) Communication with parents/guardians of children who are ill;5) Knowledge of immunization requirements;6) Recognition of need for medical assistance and how to access;7) Knowledge of reporting requirements for infectious diseases;8) Emergency procedures. <p>d) Child development activities for children who are ill;</p> <p>e) Orientation to the facility and its policies.</p> <p>This training should be documented in the staff personnel files, and compliance with the content of training routinely evaluated. Based on these evaluations, the training on care of children who are ill should be updated with a minimum of six hours of annual training for individuals who continue to provide care to children who are ill.</p>	<p>(c) For a specific program approach or methodology.</p> <p>Weight #1</p> <p>(4) A granted variance may be time specific or may remain in effect for as long as the early learning provider continues to comply with the conditions of the variance. If the variance from the rule is time limited, the provider must not exceed the timeframe established by the department. Weight NA</p>				
<p>STANDARD 3.6.3.1: Medication Administration</p> <p>The administration of medicines at the facility should be limited to:</p> <ul style="list-style-type: none">a) Prescription or non-prescription medication (over-the-counter [OTC]) ordered by the prescribing health professional for a specific child with written permission of the parent/guardian. Written orders from the prescribing health professional should specify medical need, medication, dosage, and length of time to give medication;b) Labeled medications brought to the child care facility by the parent/guardian in the original container (with a label that includes the child's name,	<p>170-300-0215 Medication</p> <p>(1) Managing medication. A medication management policy must include, but is not limited to, safe medication storage, reasonable accommodations for giving medication, mandatory medication documentation, and forms pursuant to WAC 170-300-0500. Weight NA</p> <p>(2) Medication Training. An early learning provider must not give medication to a child if the provider has not successfully completed:</p> <ul style="list-style-type: none">(a) An orientation about the early learning program's medication policies and procedures; and(b) The department standardized training course in medication administration that includes a competency assessment pursuant to WAC 170-300-0106(10) or equivalent training; and(c) If applicable, a training from a child's parents and guardian (or an appointed designee) for special medical procedures that are part of a child's Individual Care Plan. This training must be documented and signed by the provider and the child's parent or guardian (or designee). Weight #6	Meets			

<p>date filled, prescribing clinician’s name, pharmacy name and phone number, dosage/instructions, and relevant warnings).</p> <p>Facilities should not administer folk or homemade remedy medications or treatment. Facilities should not administer a medication that is prescribed for one child in the family to another child in the family.</p> <p>No prescription or non-prescription medication (OTC) should be given to any child without written orders from a prescribing health professional and written permission from a parent/guardian. Exception: Non-prescription sunscreen and insect repellent always require parental consent but do not require instructions from each child’s prescribing health professional.</p> <p>Documentation that the medicine/agent is administered to the child as prescribed is required. “Standing orders” guidance should include directions for facilities to be equipped, staffed, and monitored by the primary care provider capable of having the special health care plan modified as needed. Standing orders for medication should only be allowed for individual children with a documented medical need if a special care plan is provided by the child’s primary care provider in conjunction with the standing order or for OTC medications for which a primary care provider has provided specific instructions that define the children, conditions and methods for administration of the medication. Signatures from the primary care provider and one of the child’s parents/guardians must be obtained on the special care plan. Care plans should be updated as needed, but at least yearly.</p>	<p>(3) Medication Administration. An early learning provider must not give medication to any child without written and signed consent from that child’s parent or guardian, must administer medication pursuant to directions on the medication label, and using appropriate cleaned and sanitized medication measuring devices.</p> <p>Weight #8</p> <p>(a) An early learning provider must administer medication to children in care as follows:</p> <p>(i) Prescription Medication. Prescription medication must only be given to the child named on the prescription. Prescription medication must be prescribed by a health care professional with prescriptive authority for a specific child. Prescription medication must be labeled with:</p> <p>(A) A child’s first and last name;</p> <p>(B) The date the prescription was filled;</p> <p>(C) The name and contact information of the prescribing health professional;</p> <p>(D) The expiration date, dosage amount, and length of time to give the medication; and</p> <p>(E) Instructions for the administration, storage and accompanied with medication authorization form that has the medical need and the possible side effects of the medication.</p> <p>Weight #7</p> <p>(ii) Non-prescription oral medication. Non-prescription (over-the-counter) oral medication brought to the early learning program by a parent or guardian must be in the original packaging.</p> <p>(A) Non-prescription (over-the-counter) medication needs to be labeled with child’s first and last name and accompanied with medication authorization form that has the expiration date, medical need, dosage amount, age, and length of time to give the medication. Early learning providers must follow the instructions on the label or the parent must provide a medical professional’s note; and</p> <p>(B) Non-prescription medication must only be given to the child named on the label provided by the parent or guardian.</p> <p>Weight #7</p> <p>(iii) Other non-prescription medication: An early learning provider must receive written authorization from a child’s parent or guardian and health care provider with prescriptive authority prior to administering if the item does not include age, expiration date, dosage amount, and length of time to give the medication:</p> <p>(A) Vitamins;</p> <p>(B) Herbal supplements;</p> <p>(C) Fluoride supplements;</p> <p>(D) Homeopathic or naturopathic medication; and</p> <p>(E) Teething gel or tablets (amber bead necklaces are prohibited). Weight #6</p> <p>(iv) Non-medical items. A parent or guardian must annually authorize an early learning provider to administer the following non-medical items:</p> <p>(A) Diaper ointments (used as needed and according to manufacturer’s instructions);</p> <p>(B) Sunscreen</p> <p>(C) Lip balm or lotion;</p>				
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	<p>(D) Hand sanitizers or hand wipes with alcohol, which may be used only for children over 24 months old; and</p> <p>(E) Fluoride toothpaste for children two years old or older. Weight #2</p> <p>(v) An early learning provider may allow children to take his or her own medication with parent or guardian authorization. The early learning staff member must observe and document that the child took the medication. Weight #7</p> <p>(vi) An early learning provider must not give or permit another to give any medication to a child for the purpose of sedating the child unless the medication has been prescribed for a specific child for that particular purpose by a qualified health care professional. Weight #8</p> <p>(b) Medication Documentation (excluding non-medical items). An early learning provider must keep a current written medication log that includes:</p> <p>(i) A child’s first and last name;</p> <p>(ii) The name of the medication that was given to the child;</p> <p>(iii) The dose amount that was given to the child;</p> <p>(iv) Notes about any side effects exhibited by the child;</p> <p>(v) The date and time of each medication given or reasons that a particular medication was not given; and</p> <p>(vi) The name and signature of the person that gave the medication. Weight NA</p> <p>(c) Medication must be stored and maintained as directed on the packaging or prescription label, including applicable refrigeration requirements. An early learning provider must comply with the following additional medication storage requirements:</p> <p>(i) Medication must be inaccessible to children;</p> <p>(ii) Controlled substances must be locked in a container or cabinet which is inaccessible to children;</p> <p>(iii) Medication must be kept away from food in a separate, sealed container; and</p> <p>(iv) External medication (designed to be applied to the outside of the body) must be stored to provide separation from internal medication (designed to be swallowed or injected) to prevent cross contamination. Weight #7</p> <p>(d) An early learning provider must return a child’s unused medication to that child’s parent or guardian. If this is not possible, a provider must follow the Food and Drug Administration (FDA) recommendations for medication disposal. Weight #5</p> <p>(e) An early learning provider must not accept or give to a child homemade medication, such as diaper cream or sunscreen. Weight #6</p>				
<p>STANDARD 3.6.3.2: Labeling, Storage, and Disposal of Medications</p> <p>Any prescription medication should be dated and kept in the original container. The container should be labeled by a pharmacist with:</p> <ul style="list-style-type: none">• The child’s first and last names;• The date the prescription was filled;	<p>170-300-0215 Medication</p> <p>(1) Managing medication. A medication management policy must include, but is not limited to, safe medication storage, reasonable accommodations for giving medication, mandatory medication documentation, and forms pursuant to WAC 170-300-0500. Weight NA</p> <p>(2) Medication Training. An early learning provider must not give medication to a child if the provider has not successfully completed:</p> <p>(a) An orientation about the early learning program’s medication policies and procedures; and</p>	Meets			

<div><ul style="list-style-type: none">• The name of the prescribing health professional who wrote the prescription, the medication’s expiration date;• The manufacturer’s instructions or prescription label with specific, legible instructions for administration, storage, and disposal;• The name and strength of the medication.</div> <div>Over-the-counter medications should be kept in the original container as sold by the manufacturer, labeled by the parent/guardian, with the child’s name and specific instructions given by the child’s prescribing health professional for administration.</div> <div>All medications, refrigerated or unrefrigerated, should:<ul style="list-style-type: none">• Have child-resistant caps;• Be kept in an organized fashion;• Be stored away from food;• Be stored at the proper temperature;• Be completely inaccessible to children.</div> <div>Medication should not be used beyond the date of expiration. Unused medications should be returned to the parent/ guardian for disposal. In the event medication cannot be returned to the parent or guardian, it should be disposed of according to the recommendations of the US Food and Drug Administration (FDA) (1). Documentation should be kept with the child care facility of all disposed medications. The current guidelines are as follows:<div><div>a) If a medication lists any specific instructions on how to dispose of it, follow those directions.</div><div>b) If there are community drug take back programs, participate in those.</div><div>c) Remove medications from their original containers and put them in a sealable bag. Mix medications with an undesirable substance such as used coffee grounds or kitty litter. Throw the mixture into the regular trash. Make sure children do not have access to the trash.</div></div></div>	<div>(b) The department standardized training course in medication administration that includes a competency assessment pursuant to WAC 170-300-0106(10) or equivalent training; and</div> <div>(c) If applicable, a training from a child’s parents and guardian (or an appointed designee) for special medical procedures that are part of a child’s Individual Care Plan. This training must be documented and signed by the provider and the child’s parent or guardian (or designee). Weight #6</div> <div>(3) Medication Administration. An early learning provider must not give medication to any child without written and signed consent from that child’s parent or guardian, must administer medication pursuant to directions on the medication label, and using appropriate cleaned and sanitized medication measuring devices.</div> <div>Weight #8</div> <div>(a) An early learning provider must administer medication to children in care as follows:<div><div>(i) Prescription Medication. Prescription medication must only be given to the child named on the prescription. Prescription medication must be prescribed by a health care professional with prescriptive authority for a specific child. Prescription medication must be labeled with:<div><div>(A) A child’s first and last name;</div><div>(B) The date the prescription was filled;</div><div>(C) The name and contact information of the prescribing health professional;</div><div>(D) The expiration date, dosage amount, and length of time to give the medication; and</div><div>(E) Instructions for the administration, storage and accompanied with medication authorization form that has the medical need and the possible side effects of the medication.</div></div></div></div><div>Weight #7</div><div>(ii) Non-prescription oral medication. Non-prescription (over-the-counter) oral medication brought to the early learning program by a parent or guardian must be in the original packaging.<div><div>(A) Non-prescription (over-the-counter) medication needs to be labeled with child’s first and last name and accompanied with medication authorization form that has the expiration date, medical need, dosage amount, age, and length of time to give the medication. Early learning providers must follow the instructions on the label or the parent must provide a medical professional’s note; and</div><div>(B) Non-prescription medication must only be given to the child named on the label provided by the parent or guardian.</div></div></div><div>Weight #7</div><div>(iii) Other non-prescription medication: An early learning provider must receive written authorization from a child’s parent or guardian and health care provider with prescriptive authority prior to administering if the item does not include age, expiration date, dosage amount, and length of time to give the medication:<div><div>(A) Vitamins;</div><div>(B) Herbal supplements;</div><div>(C) Fluoride supplements;</div><div>(D) Homeopathic or naturopathic medication; and</div><div>(E) Teething gel or tablets (amber bead necklaces are prohibited). Weight #6</div></div></div></div>				
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	<p>(iv) Non-medical items. A parent or guardian must annually authorize an early learning provider to administer the following non-medical items:</p> <ul style="list-style-type: none">(A) Diaper ointments (used as needed and according to manufacturer’s instructions);(B) Sunscreen(C) Lip balm or lotion;(D) Hand sanitizers or hand wipes with alcohol, which may be used only for children over 24 months old; and(E) Fluoride toothpaste for children two years old or older. Weight #2 <p>(v) An early learning provider may allow children to take his or her own medication with parent or guardian authorization. The early learning staff member must observe and document that the child took the medication. Weight #7</p> <p>(vi) An early learning provider must not give or permit another to give any medication to a child for the purpose of sedating the child unless the medication has been prescribed for a specific child for that particular purpose by a qualified health care professional. Weight #8</p> <p>(b) Medication Documentation (excluding non-medical items). An early learning provider must keep a current written medication log that includes:</p> <ul style="list-style-type: none">(i) A child’s first and last name;(ii) The name of the medication that was given to the child;(iii) The dose amount that was given to the child;(iv) Notes about any side effects exhibited by the child;(v) The date and time of each medication given or reasons that a particular medication was not given; and(vi) The name and signature of the person that gave the medication. Weight NA <p>(c) Medication must be stored and maintained as directed on the packaging or prescription label, including applicable refrigeration requirements. An early learning provider must comply with the following additional medication storage requirements:</p> <ul style="list-style-type: none">(i) Medication must be inaccessible to children;(ii) Controlled substances must be locked in a container or cabinet which is inaccessible to children;(iii) Medication must be kept away from food in a separate, sealed container; and(iv) External medication (designed to be applied to the outside of the body) must be stored to provide separation from internal medication (designed to be swallowed or injected) to prevent cross contamination. Weight #7 <p>(d) An early learning provider must return a child’s unused medication to that child’s parent or guardian. If this is not possible, a provider must follow the Food and Drug Administration (FDA) recommendations for medication disposal. Weight #5</p> <p>(e) An early learning provider must not accept or give to a child homemade medication, such as diaper cream or sunscreen. Weight #6</p>				
STANDARD 3.6.3.3: Training of Caregivers/	170-300-0215 Medication	Partially Meets	While WAC requires medication administration		

<p>Teachers to Administer Medication</p> <p>Any caregiver/teacher who administers medication should complete a standardized training course that includes skill and competency assessment in medication administration. The trainer in medication administration should be a licensed health professional. The course should be repeated according to state and/or local regulation. At a minimum, skill and competency should be monitored annually or whenever medication administration error occurs. In facilities with large numbers of children with special health care needs involving daily medication, best practice would indicate strong consideration to the hiring of a licensed health care professional. Lacking that, caregivers/teachers should be trained to:</p> <ul style="list-style-type: none">a) Check that the name of the child on the medication and the child receiving the medication are the same;b) Check that the name of the medication is the same as the name of the medication on the instructions to give the medication if the instructions are not on the medication container that is labeled with the child's name;c) Read and understand the label/prescription directions or the separate written instructions in relation to the measured dose, frequency, route of administration (ex. by mouth, ear canal, eye, etc.) and other special instructions relative to the medication;d) Observe and report any side effects from medications;e) Document the administration of each dose by the time and the amount given;f) Document the person giving the administration and any side effects noted;g) Handle and store all medications according to label instructions and regulations. <p>The trainer in medication administration should be a licensed health professional: Registered Nurse, Advanced Practice Registered Nurse (APRN), MD, Physician's Assistant, or Pharmacist</p>	<p>(2) Medication Training. An early learning provider must not give medication to a child if the provider has not successfully completed:</p> <ul style="list-style-type: none">(a) An orientation about the early learning program's medication policies and procedures; and(b) The department standardized training course in medication administration that includes a competency assessment pursuant to WAC 170-300-0106(10) or equivalent training; and(c) If applicable, a training from a child's parents and guardian (or an appointed designee) for special medical procedures that are part of a child's Individual Care Plan. This training must be documented and signed by the provider and the child's parent or guardian (or designee). Weight #6 <p>WAC 170-300-0106 Training requirements.</p> <p>(1) Early learning providers licensed, working, or volunteering in an early learning program before the date this section becomes effective must complete the applicable training requirements of this section within three months of the date this section becomes effective unless otherwise indicated. Early learning providers hired after the date this section becomes effective must complete the training requirements of subsections (4) through (10) of this section within three months of the date of hire and prior to working in an unsupervised capacity with children. Weight #1</p> <p>(10) Family home licensees, Center Directors, Assistant Directors, Program Supervisors, and Lead Teachers must complete the Medication Management and Administration training as approved or offered by the department prior to giving medication to an enrolled child, or as indicated in subsection (1) of this section. Weight #6</p> <p>170-300-0110 Program based staff policies and training.</p> <p>(1) An early learning provider must have and follow written policies for early learning program staff. Staff policies must include those listed in subsection (2) and (3) of this section and must be reviewed and approved by the department prior to issuing a provider's initial license. Providers must notify the department when substantial changes are made. Weight #1</p> <p>(2) Early learning program staff policies must include, but are not limited to:</p> <ul style="list-style-type: none">(e) Early learning program staff responsibilities for:(xi) Medication management procedures <p>Weight NA</p> <p>(4) An early learning provider must develop, deliver, and document the delivery of early learning staff training specific to the early learning program and premises.</p> <ul style="list-style-type: none">(a) Training topics must include:<ul style="list-style-type: none">(i) Staff policies listed in subsections (2) and (3) of this section;(ii) Chapter 43.216 RCW; and(iii) Chapters 170-300 and 170-06 WAC, as hereafter recodified or amended.(b) Training must be updated with changes in program policies and state or federal regulations. <p>Weight #5</p>		training it does not outline specific components and allows for it to be a department developed course rather than by a health professional		
<p>STANDARD 4.2.0.10: Care for Children with Food Allergies</p> <p>When children with food allergies attend the early care and education facility, the following should occur:</p>	<p>170-300-0186 Food allergies and special dietary needs.</p> <p>(1) An early learning provider must obtain written instructions (The Individual Care Plan) from the child's health care provider and parent or guardian when caring for a child with a known food allergy or special dietary requirement due to a health condition. The Individual Care Plan pursuant to WAC 170-300-0300 must:</p> <ul style="list-style-type: none">(a) Identify foods that must not be consumed by the child and steps to take in the case of an unintended	Meets			

<p>a) Each child with a food allergy should have a care plan prepared for the facility by the child’s primary care provider, to include:</p> <p>1) Written instructions regarding the food(s) to which the child is allergic and steps that need to be taken to avoid that food;</p> <p>2) A detailed treatment plan to be implemented in the event of an allergic reaction, including the names, doses, and methods of administration of any medications that the child should receive in the event of a reaction. The plan should include specific symptoms that would indicate the need to administer one or more medications;</p> <p>b) Based on the child’s care plan, the child’s caregivers/ teachers should receive training, demonstrate competence in, and implement measures for:</p> <p>1) Preventing exposure to the specific food(s) to which the child is allergic;</p> <p>2) Recognizing the symptoms of an allergic reaction;</p> <p>3) Treating allergic reactions;</p> <p>c) Parents/guardians and staff should arrange for the facility to have necessary medications, proper storage of such medications, and the equipment and training to manage the child’s food allergy while the child is at the early care and education facility;</p> <p>d) Caregivers/teachers should promptly and properly administer prescribed medications in the event of an allergic reaction according to the instructions in the care plan;</p> <p>e) The facility should notify the parents/guardians immediately of any suspected allergic reactions, the ingestion of the problem food, or contact with the problem food, even if a reaction did not occur;</p> <p>f) The facility should recommend to the family that the child’s primary care provider be notified if the child has required treatment by the facility for a food allergic reaction;</p> <p>g) The facility should contact the emergency medical services system immediately whenever epinephrine has been administered;</p> <p>h) Parents/guardians of all children in the child’s class should be advised to avoid any known allergens in class treats or special foods brought into the early care and education setting;</p> <p>i) Individual child’s food allergies should be posted prominently in the classroom where staff can view</p>	<p>allergic reaction;</p> <p>(b) Identify foods that can substitute for allergenic foods; and</p> <p>(c) Provide a specific treatment plan for the early learning provider to follow in response to an allergic reaction. The specific treatment plan must include the:</p> <p>(i) Names of all medication to be administered;</p> <p>(ii) Directions for how to administer the medication;</p> <p>(iii) Directions related to medication dosage amounts; and</p> <p>(iv) Description of allergic reactions and symptoms associated with the child’s particular allergies.</p> <p>Weight #8</p> <p>(2) An early learning provider must arrange with the parents or guardians of a child in care to ensure the early learning program has the necessary medication, training, and equipment to properly manage a child’s food allergies. Weight #8</p> <p>(3) If a child suffers from an allergic reaction, the early learning provider must immediately:</p> <p>(a) Administer medication pursuant to the instructions in that child’s Individual Care Plan;</p> <p>(b) Contact 911 whenever epinephrine and other lifesaving medication has been administered; and</p> <p>(c) Notify the parents or guardians of a child if it is suspected or appears that any of the following occurred, or is occurring:</p> <p>(i) The child is having an allergic reaction; or</p> <p>(ii) The child consumed or came in contact with a food identified by the parents or guardians that must not be consumed by the child, even if the child is not having or did not have an allergic reaction. Weight #8</p> <p>(4) Early learning provider must review each child’s Individual Care Plan information for food allergies prior to serving food to children. Weight #7</p> <p>170-300-0110 Program based staff policies and training.</p> <p>(1) An early learning provider must have and follow written policies for early learning program staff. Staff policies must include those listed in subsection (2) and (3) of this section and must be reviewed and approved by the department prior to issuing a provider’s initial license. Providers must notify the department when substantial changes are made. Weight #1</p> <p>(2) Early learning program staff policies must include, but are not limited to:</p> <p>(e) Early learning program staff responsibilities for:</p> <p>(xiv) Implementation of a child’s individual health care or special needs plan;</p> <p>Weight NA</p> <p>(4) An early learning provider must develop, deliver, and document the delivery of early learning staff training specific to the early learning program and premises.</p> <p>(a) Training topics must include:</p> <p>(i) Staff policies listed in subsections (2) and (3) of this section;</p> <p>(ii) Chapter 43.216 RCW; and</p> <p>(iii) Chapters 170-300 and 170-06 WAC, as hereafter recodified or amended.</p> <p>(b) Training must be updated with changes in program policies and state or federal regulations.</p> <p>Weight #5</p> <p>170-300-0215 Medication</p>				
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<p>and/or wherever food is served;</p> <p>j) The written child care plan, a mobile phone, and the proper medications for appropriate treatment if the child develops an acute allergic reaction should be routinely carried on field trips or transport out of the early care and education setting.</p>	<p>(3) Medication Administration. An early learning provider must not give medication to any child without written and signed consent from that child’s parent or guardian, must administer medication pursuant to directions on the medication label, and using appropriate cleaned and sanitized mediation measuring devices. Weight #8</p> <p>(c) Medication must be stored and maintained as directed on the packaging or prescription label, including applicable refrigeration requirements. An early learning provider must comply with the following additional medication storage requirements:</p> <p>(i) Medication must be inaccessible to children;</p> <p>(ii) Controlled substances must be locked in a container or cabinet which is inaccessible to children;</p> <p>(iii) Medication must be kept away from food in a separate, sealed container; and</p> <p>(iv) External medication (designed to be applied to the outside of the body) must be stored to provide separation from internal medication (designed to be swallowed or injected) to prevent cross contamination. Weight #7</p> <p>170-300-0505 Postings.</p> <p>(1) Postings listed in subsection (2) of this section that are part of an early learning program must be clearly visible to parents, guardians, and early learning program. Weight #4</p> <p>(2) Postings on early learning premises must include:</p> <p>(c) Dietary restrictions, known allergies, and nutrition requirements, if applicable, in a location easily accessible for staff but not available to those who are not parents or guardians of the enrolled child, pursuant to 170-300-0186(8).</p> <p>Weight NA</p> <p>170-300-0480Transportation and off-site activity policy.</p> <p>(4) During travel to an off-site activity, an early learning provider must:</p> <p>(a) Have the health history, appropriate medication (if applicable), emergency information, and emergency medical authorization forms accessible for each child being transported;</p> <p>(b) Have a phone to call for emergency help;</p> <p>(c) Have a complete first aid kit;</p> <p>Weight #7</p>				
<p>STANDARD 4.2.0.6: Availability of Drinking Water</p> <p>Clean, sanitary drinking water should be readily available, in indoor and outdoor areas, throughout the day. Water should not be a substitute for milk at meals or snacks where milk is a required food component unless it is recommended by the child’s primary care provider. On hot days, infants receiving human milk in a bottle can be given additional human milk in a bottle but should not be given water, especially in the first six months of life. Infants receiving formula and water can be given additional formula in a bottle. Toddlers and older children will need additional water as physical activity and/or hot temperatures cause their needs to increase. Children should learn to drink water from a cup or drinking fountain without mouthing the fixture. They</p>	<p>170-300-0235 Safe sources of drinking water.</p> <p>(1) Hot and cold running water must be directly plumbed to the early learning program premises. Weight #7</p> <p>(2) An early learning provider must use a Washington state certified water laboratory accredited by the department of ecology to test the program water supply for lead and copper.</p> <p>(a) All fixtures used to obtain water for preparing food or infant formula, drinking, or cooking must be tested prior to licensing approval and at least once every six years;</p> <p>(b) Testing must be done pursuant to current environmental protection agency standards; and</p> <p>(c) A copy of the water testing results must be kept on the licensed premises or in the program’s administrative office.</p> <p>Weight #7</p> <p>(3) If the test results are at or above the current EPA lead action level, an early learning provider must do the following within 24 hours:</p> <p>(a) Consult with department of health for technical assistance;</p>	Exceeds			

should not be allowed to have water continuously in hand in a “sippy cup” or bottle. Permitting toddlers to suck continuously on a bottle or sippy cup filled with water, in order to soothe themselves, may cause nutritional or in rare instances, electrolyte imbalances. When tooth brushing is not done after a feeding, children should be offered water to drink to rinse food from their teeth.	<p>(b) Close the early learning program to prevent children from using or consuming water, or supply bottled or packaged water to meet the requirements of this chapter;</p> <p>(c) Notify all parents and guardians of enrolled children of the test results;</p> <p>(d) Notify the department of the water test results and steps taken to protect enrolled children; and</p> <p>(e) Notify the department once lead and copper levels are below the current EPA action level.</p> <p>Weight #7</p> <p>(4) If an early learning program space receives water from a private well, the well must comply with chapter 173-160 WAC minimum standards for construction and maintenance of wells, as now and hereafter amended.</p> <p>(a) Well water must be tested within six months of the date this section becomes effective and at least once every 12 months thereafter for E. coli bacteria and nitrates by a Washington state certified laboratory accredited by the department of ecology to analyze drinking water. To achieve desirable results the test must indicate:</p> <p>(i) No presence of E. coli bacteria; and</p> <p>(ii) The presence of less than ten parts per million (ppm) for nitrates. If test results for nitrates are greater than five but less than ten ppm, the water must be retested within six months.</p> <p>(b) If well water tests positive for E. coli bacteria, or greater than ten ppm for nitrates, the provider must:</p> <p>(i) Stop using the well water in the child care premises within 24 hours;</p> <p>(ii) Inform the local health jurisdiction, department of health and the department of the positive test results; and</p> <p>(iii) If directed to do so by the department, discontinue child care operations until repairs are made to the water system and water tests indicate desirable results pursuant to subsection (4)(a) of this section.</p> <p>(c) If the department determines that child care operations may continue while an unsafe water system is being repaired or while the provider installs treatment, the provider must:</p> <p>(i) Provide an alternate source of water, approved by the department; and</p> <p>(ii) Re-test until water tests indicate desirable results pursuant to subsection (4)(a) of this section.</p> <p>Weight #7</p> <p>(5) An early learning provider must notify the department within two to four hours of when the water connection to an early learning program space is interrupted for more than one hour, or the water source becomes contaminated.</p> <p>(a) The department may require the early learning provider to temporarily close until the water connection is restored or the water source is no longer contaminated; or</p> <p>(b) The provider must obtain an alternative source of potable water such as bottled or packaged water. The amount of the alternative source of potable water must be sufficient to ensure compliance with the requirements of this chapter for safe drinking water, handwashing, sanitizing, dishwashing, and cooking.</p> <p>Weight #7</p> <p>170-300-0236 Safe drinking water.</p> <p>(1) An early learning program’s drinking water must:</p> <p>(a) Be offered multiple times throughout the day and be readily available to children at all times;</p> <p>(b) Be offered in outdoor play areas, in each classroom for centers, and in the licensed space for family homes;</p> <p>(c) Be served in a manner that prevents contamination;</p>				
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	<p>(d) Not be obtained from a handwashing sink used with toileting or diapering; and (e) Be served fresh daily or more often as needed. Weight #6</p> <p>(2) Drinking fountains at an early learning program must: (a) Not be attached to handwashing sinks or disabled; (b) Not be located in bathrooms; (c) Not be a “bubble type” fountain (the water flow must form an arch); (d) Be cleaned and sanitized daily, or more often as needed; and (e) Be located above water impervious flooring. Weight #6</p> <p>170-300-0180 Meal and snack schedule. (2) An early learning provider must offer children the opportunity for developmentally appropriate tooth brushing activities after each meal or snack. (a) Tooth brushing activities must be safe, sanitary, and educational. (b) Tooth brushes used in an early learning program must be stored in a manner that prevents cross contamination. (c) The parent or guardian of a child may opt out of the daily tooth brushing activities by signing a written form. Weight #1</p> <p>170-300-0185 Menus, milk, and food. To ensure proper nutrition of children in care, an early learning provider must comply with the child nutrition requirements described in this section.</p> <p>(1) Meals, snack foods, and beverages provided to children in care must comply with the requirements contained in the most current edition of the USDA Child and Adult Care Food Program (CACFP) Handbook, or the USDA National School Lunch and School Breakfast Program standards. (a) An early learning provider must supply dated menus. (b) Food and beverage substitutions to a scheduled menu must be of equal nutritional value. (c) An early learning provider must only serve water, unflavored milk or 100% fruit or vegetable juice. (d) An early learning provider must limit the consumption of 100% fruit juice to no more than 4-6 ounces per day for children between one and six years old, and 8-12 ounces per day for children seven through twelve years old. Weight #5</p> <p>170-300-0285 Infant and toddler nutrition and feeding. (1) An early learning provider must have and follow written policies on providing, preparing, and storing breast milk or infant formula and food. Weight NA</p> <p>(2) After consulting a parent or guardian, an early learning provider must implement a feeding plan for infants and toddlers that include: (c) Serving only breast milk or infant formula to an infant, unless the child's health care provider offers a written order stating otherwise. Weight #6 (d) When bottle feeding, an early learning provider must: (iv) Not allow infants or toddlers to be propped with bottles or given a bottle or cup when lying down. Weight #6</p>				
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<p>STANDARD 4.2.0.8: Feeding Plans and Dietary Modifications</p> <p>Before a child enters an early care and education facility, the facility should obtain a written history that contains any special nutrition or feeding needs for the child, including use of human milk or any special feeding utensils. The staff should review this history with the child’s parents/guardians, clarifying and discussing how parental/guardian home feeding routines may differ from the facility’s planned routine. The child’s primary care provider should provide written information about any dietary modifications or special feeding techniques that are required at the early care and education program and these plans should be shared with the child’s parents/guardians upon request.</p> <p>If dietary modifications are indicated, based on a child’s medical or special dietary needs, the caregiver/teacher should modify or supplement the child’s diet to meet the individual child’s specific needs. Dietary modifications should be made in consultation with the parents/guardians and the child’s primary care provider. Caregivers/teachers can consult with a nutritionist/registered dietitian.</p> <p>Reasons for modification of a child’s diet may be related to food sensitivity. Food sensitivity includes a range of conditions in which a child exhibits an adverse reaction to a food that, in some instances, can be life threatening. Modification of a child’s diet may be related to a food allergy, inability to digest or to tolerate certain foods, need for extra calories, need for special positioning while eating, diabetes and the need to match food with insulin, food idiosyncrasies, and other identified feeding issues. Examples include celiac disease, phenylketonuria, diabetes, severe food allergy (anaphylaxis), and others. In some cases, a child may become ill if the child is unable to eat, so missing a meal could have a negative consequence, especially for diabetics.</p> <p>For a child identified with special health care needs for dietary modification or special feeding techniques, written instructions from the child’s parent/guardian and the child’s primary care provider should be provided in the child’s record and carried out accordingly. Dietary</p>	<p>170-300-0085 Family partnerships and communication. (2) An early learning provider must attempt to obtain information from each child’s family about the child’s developmental, behavioral, health, linguistic, cultural, social, and other relevant information. The provider must make this attempt upon that child’s enrollment and annually thereafter. Weight #3</p> <p>(4) An early learning provider must: (a) Attempt to discuss with parents or guardians information including, but not limited to: (i) A child’s strength in areas of development, health issues, special needs, and other concerns;</p> <p>170-300-0460 Child records. (2) Each child’s enrollment record must include the following: (e) A plan for special or individual needs of the child, if applicable, including parent or guardian signature, pursuant to WAC 170-300-0300;</p> <p>170-300-0190 Parent or guardian provided food and Written Food Plans. (1) A Written Food Plan must be developed by the provider and child’s parent or guardian, signed by all parties, and followed when accommodating a child’s: (a) Special feeding needs; (b) Special diets; (c) Religious or cultural preferences; (d) Family preference; or (e) Other needs Weight #3</p> <p>(2) An early learning provider may allow or require parents or guardians to bring food for their child. Weight NA</p> <p>(3) If a parent or guardian provides meals for their child, an early learning provider must: (a) Notify the parent or guardian in writing of the USDA CACFP requirements for each meal; and (b) Supplement a child’s meal that does not satisfy USDA CACFP requirements if necessary. Weight #5</p> <p>(4) On special occasions, such as birthdays, an early learning provider may allow parents or guardians to bring in snacks that may not satisfy the nutritional requirements for all children. The snacks provided must be limited to: (a) Store purchased fruits and vegetables (uncut); (b) Foods prepackaged in the original manufacturer containers; or (c) Snacks prepared, cooked, or baked at home by parents or guardians of a child in care. Prior to serving, an early learning provider must receive written permission from each child’s parent or guardian stating their child may consume food prepared, cooked, or baked by another child’s parent or guardian. Weight #4</p> <p>170-300-0186 Food allergies and special dietary needs.</p>	Meets	No WAC found that requires that the nutritionist/registered dietitian should approve menus that accommodate needed dietary modifications. However, CFOC lists this as “may”		

<p>modifications should be recorded. These written instructions must identify:</p> <ul style="list-style-type: none">a) The child’s full name and date of instructions;b) The child’s special needs;c) Any dietary restrictions based on the special needs;d) Any special feeding or eating utensils;e) Any foods to be omitted from the diet and any foods to be substituted;f) Limitations of life activities;g) Any other pertinent special needs information;h) What, if anything, needs to be done if the child is exposed to restricted foods. <p>The written history of special nutrition or feeding needs should be used to develop individual feeding plans and, collectively, to develop facility menus. Disciplines related to special nutrition needs, including nutrition, nursing, speech, occupational therapy, and physical therapy, should participate when needed and/or when they are available to the facility.</p> <p>The nutritionist/registered dietitian should approve menus that accommodate needed dietary modifications. The feeding plan should include steps to take when a situation arises that requires rapid response by the staff, such as a child’s choking during mealtime or a child with a known history of food allergies demonstrating signs and symptoms of anaphylaxis (severe allergic reaction, e.g., difficulty breathing or severe redness and swelling of the face or mouth). The completed plan should be on file and accessible to the staff and available to parents/guardians upon request.</p>	<p>(1) An early learning provider must obtain written instructions (The Individual Care Plan) from the child’s health care provider and parent or guardian when caring for a child with a known food allergy or special dietary requirement due to a health condition. The Individual Care Plan pursuant to WAC 170-300-0300 must:</p> <ul style="list-style-type: none">(a) Identify foods that must not be consumed by the child and steps to take in the case of an unintended allergic reaction;(b) Identify foods that can substitute for allergenic foods; and(c) Provide a specific treatment plan for the early learning provider to follow in response to an allergic reaction. The specific treatment plan must include the:<ul style="list-style-type: none">(i) Names of all medication to be administered;(ii) Directions for how to administer the medication;(iii) Directions related to medication dosage amounts; and(iv) Description of allergic reactions and symptoms associated with the child’s particular allergies.Weight #8 <p>(2) An early learning provider must arrange with the parents or guardians of a child in care to ensure the early learning program has the necessary medication, training, and equipment to properly manage a child’s food allergies. Weight #8</p> <p>(3) If a child suffers from an allergic reaction, the early learning provider must immediately:</p> <ul style="list-style-type: none">(a) Administer medication pursuant to the instructions in that child’s Individual Care Plan;(b) Contact 911 whenever epinephrine and other lifesaving medication has been administered; and(c) Notify the parents or guardians of a child if it is suspected or appears that any of the following occurred, or is occurring:<ul style="list-style-type: none">(i) The child is having an allergic reaction; or(ii) The child consumed or came in contact with a food identified by the parents or guardians that must not be consumed by the child, even if the child is not having or did not have an allergic reaction. Weight #8 <p>(4) Early learning provider must review each child’s Individual Care Plan information for food allergies prior to serving food to children. Weight #7</p>				
<p>STANDARD 4.3.1.11: Introduction of Age-Appropriate Solid Foods to Infants</p> <p>A plan to introduce age-appropriate solid foods (complementary foods) to infants should be made in consultation with the child’s parent/guardian and primary care provider. Age-appropriate solid foods may be introduced no sooner than when the child has reached the age of four months, but preferably six months and as indicated by the individual child’s nutritional and developmental needs.</p> <p>For breastfed infants, gradual introduction of iron-fortified foods may occur no sooner than around four months, but preferably six months and to complement</p>	<p>170-300-0285 Infant and toddler nutrition and feeding.</p> <p>(1) An early learning provider must have and follow written policies on providing, preparing, and storing breast milk or infant formula and food. Weight NA</p> <p>(2) After consulting a parent or guardian, an early learning provider must implement a feeding plan for infants and toddlers that include:</p> <ul style="list-style-type: none">(a) A plan to support the needs of a breastfeeding mother and infant by:<ul style="list-style-type: none">(i) Providing an area for mothers to breastfeed their infants; and(ii) Providing educational materials and resources to support breastfeeding mothers; Weight #4(b) Feeding infants and toddlers when hungry according to their nutritional and developmental needs, unless medically directed; Weight #6(c) Serving only breast milk or infant formula to an infant, unless the child’s health care provider offers a written order stating otherwise; and Weight #6(d) When bottle feeding, an early learning provider must:	Exceeds	WAC addresses developmentally appropriate but not before 4 months and introduces additional feeding safety measures		

<p>the human milk. Modification of basic food patterns should be provided in writing by the child's primary care provider.</p> <p>Evidence for introducing complementary foods in a specific order or rate is not available. The current best practice is that the first solid foods should be single-ingredient foods and should be introduced one at a time at two- to seven-day intervals (1).</p>	<p>(i) Test the temperature of bottle contents before feeding to avoid scalding or burning the child's mouth;</p> <p>(ii) Hold infants and, when developmentally appropriate, toddlers to make eye contact and talk to them;</p> <p>(iii) Stop feeding the infant or toddler when he or she shows signs of fullness; and</p> <p>(iv) Not allow infants or toddlers to be propped with bottles or given a bottle or cup when lying down. Weight #6</p> <p>(e) Transitioning a child to a cup only when developmentally appropriate; Weight #5</p> <p>(f) Introducing age-appropriate solid foods no sooner than four months of age, based on an infant's ability to sit with support, hold his or her head steady, close his or her lips over a spoon, and show signs of hunger and being full, unless identified in Written Food Plan pursuant to 170-300-0190 or written medical approval; Weight #5</p> <p>(g) Not adding food, medication, or sweeteners to the contents of a bottle unless a health care provider gives written consent; Weight #6</p> <p>(h) Not serving 100% juice or any sweetened beverages (for example, juice drinks, sports drinks, or tea) to infants less than 12 months old, unless a health care provider gives written consent, and helping prevent tooth decay by only offering juice to children older than 12 months from a cup; Weight #5</p> <p>(i) Increasing the texture of the food from strained, to mashed, to soft table foods as a child's development and skills progress between six and twelve months of age. Soft foods offered to older infants should be cut into pieces ¼ inch or smaller to prevent choking; Weight #6</p> <p>(j) Allowing older infants or toddlers to self-feed soft foods from developmentally appropriate eating equipment; Weight 4</p> <p>(k) Placing infants or toddlers who can sit up on their own in high chairs or at an appropriate child-size table and chairs when feeding solid foods or liquids from a cup, and having an early learning provider sit with and observe each child eating. If high chairs are used, each high chair must:</p> <p>(i) Have a base that is wider than the seat;</p> <p>(ii) Have a safety device, used each time a child is seated, that prevents the child from climbing or sliding down the chair;</p> <p>(iii) Be free of cracks and tears; and</p> <p>(iv) Have a washable surface.</p> <p>Weight #5</p> <p>(l) Not leaving infants or toddlers more than 15 minutes in high chairs waiting for meal or snack time, and removing a child as soon as possible once he or she finishes eating; Weight #5</p> <p>(m) Preventing infants or toddlers from sharing the same dish or utensil; Weight 4</p> <p>(n) Not serving any uneaten food from the serving container after the intended meal; and Weight 4</p> <p>(o) Not serving food to infants or toddlers using polystyrene foam (Styrofoam) cups, bowls, or plates. Weight #6</p>				
<p>STANDARD 4.3.1.3: Preparing, Feeding, and Storing Human Milk</p> <p>Expressed human milk should be placed in a clean and sanitary bottle with a nipple that fits tightly or into an equivalent clean and sanitary sealed container to prevent spilling during transport to home or to the facility. Only cleaned and sanitized bottles, or their equivalent, and nipples should be used in feeding. The bottle or container should be properly labeled with the infant's full name and the date and time the milk was expressed. The bottle</p>	<p>170-300-0281 Breast milk.</p> <p>(1) When a parent or guardian provides breast milk, an early learning provider must:</p> <p>(a) Immediately refrigerate or freeze the breast milk; Weight #7</p> <p>(b) Label the breast milk container with the child's first and last name and the date received; Weight #6</p> <p>(c) Store frozen breast milk at zero degrees Fahrenheit or less, and in a closed container to prevent contamination; and Weight #6</p> <p>(d) Keep frozen breast milk for no more than 30 days upon receipt and return any unused frozen breast milk to the parent after 30 days; Weight #4</p>	Meets			

<p>or container should immediately be stored in the refrigerator on arrival.</p> <p>The mother’s own expressed milk should only be used for her own infant. Likewise, infant formula should not be used for a breastfed infant without the mother’s written permission.</p> <p>Bottles made of plastics containing BPA or phthalates should be avoided (labeled with #3, #6, or #7). Glass bottles or plastic bottles labeled BPA-free or with #1, #2, #4, or #5 are acceptable.</p> <p>Non-frozen human milk should be transported and stored in the containers to be used to feed the infant, identified with a label which will not come off in water or handling, bearing the date of collection and child’s full name. The filled, labeled containers of human milk should be kept refrigerated. Human milk containers with significant amount of contents remaining (greater than one ounce) may be returned to the mother at the end of the day as long as the child has not fed directly from the bottle.</p> <p>Frozen human milk may be transported and stored in single use plastic bags and placed in a freezer (not a compartment within a refrigerator but either a freezer with a separate door or a standalone freezer). Human milk should be defrosted in the refrigerator if frozen, and then heated briefly in bottle warmers or under warm running water so that the temperature does not exceed 98.6°F. If there is insufficient time to defrost the milk in the refrigerator before warming it, then it may be defrosted in a container of running cool tap water, very gently swirling the bottle periodically to evenly distribute the temperature in the milk. Some infants will not take their mother’s milk unless it is warmed to body temperature, around 98.6°F. The caregiver/teacher should check for the infant’s full name and the date on the bottle so that the oldest milk is used first. After warming, bottles should be mixed gently (not shaken) and the temperature of the milk tested before feeding.</p> <p>Expressed human milk that presents a threat to an infant, such as human milk that is in an unsanitary bottle, is curdled, smells rotten, and/or has not been stored following the storage guidelines of the Academy of Breastfeeding Medicine as shown later in this standard,</p>	<p>(2) Frozen breast milk must be kept in the refrigerator at a temperature of 39 degrees Fahrenheit for up to 24 hours after thawed. Weight #6</p> <p>(3) Thawed breast milk that has not been served within 24 hours must be labeled “do not use” and returned to the parent or guardian. Weight #4</p> <p>(4) An early learning provider must return any unused refrigerated, not been previously frozen, bottles or containers of breast milk to the parent at the end of the child’s day, or label “do not use”. Weight #4</p> <p>(5) An early learning provider must thaw frozen breast milk in the refrigerator, under warm running water, in a container with warm water, or in a bottle warmer. Weight #6</p> <p>(6) An early learning provider must not thaw or heat breast milk in a microwave oven or on the stove. Weight #7</p> <p>(7) An early learning provider must obtain parental consent prior to feeding infant formula to an otherwise breastfed infant. Weight #6</p> <p>170-300-0280 Bottle preparation.</p> <p>(1) An early learning provider may allow parents to bring from home filled bottles clearly labeled with the date and infant's first and last name for daily use. Bottles must be immediately refrigerated. Weight #5</p> <p>(2) A bottle preparation area including a sink must:</p> <ul style="list-style-type: none">(a) Be located at least eight feet from any diaper changing tables or counters and sinks used for diaper changing; or(b) Be physically separated from the diaper changing area by means of a barrier to prevent cross contamination. If a barrier is used, it must be:<ul style="list-style-type: none">(i) Smooth and easily cleanable;(ii) Sealed, if made of wood;(iii) Moisture resistant; and(iv) Extend at least 24 inches in height from the counter or changing surface.(v) Solid without cracks, breaks or separation Weight #6 <p>(3) To prepare bottles, an early learning provider must:</p> <ul style="list-style-type: none">(a) Clean bottles and nipples before each use using warm soapy water and a bottlebrush and sanitize by boiling in hot water for one minute, or pursuant to WAC 170-300-0198;(b) Wash hands in a sink cleaned and sanitized prior to preparing bottles;(c) Obtain water from a sink used for bottle or food preparation only, or from another approved source, such as bottled water. Water from a handwashing or diaper changing sink may not be used for bottle preparation;(d) Use bottles and nipples in good repair with no cracks;(e) Use glass or stainless-steel bottles or use plastic bottles labeled with "1," "2," "4," or "5" on the bottle. A plastic bottle must not contain the chemical bisphenol-A or phthalates;(f) Prepare infant formula according to manufacturer’s directions and never serve infant formula past the expiration date on the container;(g) Not heat a bottle in a microwave;(h) Warm bottles under running warm water, in a container of water, or a bottle warmer not to exceed temperatures warmer than 120 degrees Fahrenheit;				
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<p>should be returned to the mother.</p> <p>Some children around six months to a year of age may be developmentally ready to feed themselves and may want to drink from a cup. The transition from bottle to cup can come at a time when a child’s fine motor skills allow use of a cup. The caregiver/teacher should use a clean small cup without cracks or chips and should help the child to lift and tilt the cup to avoid spillage and leftover fluid.</p> <p>The caregiver/ teacher and mother should work together on cup feeding of human milk to ensure the child is receiving adequate nourishment and to avoid having a large amount of human milk remaining at the end of feeding. Two to three ounces of human milk can be placed in a clean cup and additional milk can be offered as needed. Small amounts of human milk (about an ounce) can be discarded.</p> <p>Human milk can be stored using the following guidelines from the Academy of Breastfeeding Medicine:</p> <table><tr><th>Location</th><th>Temperature</th></tr><tr><td>Countertop, table</td><td>Room temp. (25°C)</td></tr><tr><td>Insulated cooler bag</td><td>5°F – 39°F or -15°C</td></tr><tr><td>Refrigerator</td><td>39°F or 4°C</td></tr><tr><td>Freezer compartment of a refrigerator</td><td>5°F or -15°C</td></tr><tr><td>Freezer compartment of refrigerator with separate doors</td><td>0°F or -18°C</td></tr><tr><td>Chest or upright deep freezer</td><td>-4°F or -20°C</td></tr></table>	Location	Temperature	Countertop, table	Room temp. (25°C)	Insulated cooler bag	5°F – 39°F or -15°C	Refrigerator	39°F or 4°C	Freezer compartment of a refrigerator	5°F or -15°C	Freezer compartment of refrigerator with separate doors	0°F or -18°C	Chest or upright deep freezer	-4°F or -20°C	<p>(i) Keep bottle nipples covered if bottles are prepared ahead;</p> <p>(j) Store prepared and unserved bottles in the refrigerator;</p> <p>(k) Not allow infants or toddlers to share bottles or cups when in use; and</p> <p>(l) Throw away contents of any formula bottle not fully consumed within one hour (partially consumed bottles must not be put back into the refrigerator). Weight #6</p>				
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<p>STANDARD 4.3.1.5: Preparing, Feeding, and Storing Infant Formula</p> <p>Formula provided by parents/guardians or by the facility</p>	<p>170-300-0280 Bottle preparation.</p> <p>(1) An early learning provider may allow parents to bring from home filled bottles clearly labeled with the date and infant's first and last name for daily use. Bottles must be immediately refrigerated. Weight #5</p> <p>(2) A bottle preparation area including a sink must:</p>	Partially Meets	There is no WAC containing that formula provided by parents/guardians or by the facility should come in a																

<p>should come in a factory-sealed container. The formula should be of the same brand that is served at home and should be of ready-to-feed strength or liquid concentrate to be diluted using water from a source approved by the health department. Powdered infant formula, though it is the least expensive formula, requires special handling in mixing because it cannot be sterilized. The primary source for proper and safe handling and mixing is the manufacturer’s instructions that appear on the can of powdered formula. Before opening the can, hands should be washed. The can and plastic lid should be thoroughly rinsed and dried. Caregivers/teachers should read and follow the manufacturer’s directions. If instructions are not readily available, caregivers/ teachers should obtain information from the World Health Organization’s <i>Safe Preparation, Storage and Handling of Powdered Infant Formula Guidelines</i> at http://www.who.int/ food safety/publications/micro/pif2007/en/index.html (8). The local WIC program can also provide instructions.</p> <p>Formula mixed with cereal, fruit juice, or any other foods should not be served unless the child’s primary care provider provides written documentation that the child has a medical reason for this type of feeding.</p> <p>Iron-fortified formula should be refrigerated until immediately before feeding. For bottles containing formula, any contents remaining after a feeding should be discarded.</p> <p>Bottles of formula prepared from powder or concentrate or ready-to-feed formula should be labeled with the child’s full name and time and date of preparation. Any prepared formula must be discarded within one hour after serving to an infant. Prepared powdered formula that has not been given to an infant should be covered, labeled with date and time of preparation and child’s full name, and may be stored in the refrigerator for up to twenty-four hours.</p> <p>An open container of ready-to-feed, concentrated formula, or formula prepared from concentrated formula, should be covered, refrigerated, labeled with date of opening and child’s full name, and discarded at forty-eight hours if not used (7,9). The caregiver/teacher should always follow manufacturer’s instructions for mixing and storing of any formula preparation.</p> <p>Some infants will require specialized formula because of</p>	<p>(a) Be located at least eight feet from any diaper changing tables or counters and sinks used for diaper changing; or</p> <p>(b) Be physically separated from the diaper changing area by means of a barrier to prevent cross contamination. If a barrier is used, it must be:</p> <ul style="list-style-type: none">(i) Smooth and easily cleanable;(ii) Sealed, if made of wood;(iii) Moisture resistant; and(iv) Extend at least 24 inches in height from the counter or changing surface.(v) Solid without cracks, breaks or separation <p>Weight #6</p> <p>(3) To prepare bottles, an early learning provider must:</p> <ul style="list-style-type: none">(a) Clean bottles and nipples before each use using warm soapy water and a bottlebrush and sanitize by boiling in hot water for one minute, or pursuant to WAC 170-300-0198;(b) Wash hands in a sink cleaned and sanitized prior to preparing bottles;(c) Obtain water from a sink used for bottle or food preparation only, or from another approved source, such as bottled water. Water from a handwashing or diaper changing sink may not be used for bottle preparation;(d) Use bottles and nipples in good repair with no cracks;(e) Use glass or stainless-steel bottles or use plastic bottles labeled with "1," "2," "4," or "5" on the bottle. A plastic bottle must not contain the chemical bisphenol-A or phthalates;(f) Prepare infant formula according to manufacturer’s directions and never serve infant formula past the expiration date on the container;(g) Not heat a bottle in a microwave;(h) Warm bottles under running warm water, in a container of water, or a bottle warmer not to exceed temperatures warmer than 120 degrees Fahrenheit;(i) Keep bottle nipples covered if bottles are prepared ahead;(j) Store prepared and unserved bottles in the refrigerator;(k) Not allow infants or toddlers to share bottles or cups when in use; and(l) Throw away contents of any formula bottle not fully consumed within one hour (partially consumed bottles must not be put back into the refrigerator). Weight #6 <p>WAC 170-300-0285 Infant and toddler nutrition and feeding.</p> <p>(2) After consulting a parent or guardian, an early learning provider must implement a feeding plan for infants and toddlers that include:</p> <ul style="list-style-type: none">(g) Not adding food, medication, or sweeteners to the contents of a bottle unless a health care provider gives written consent;		<p>factory-sealed container. The formula should be of the same brand that is served at home and should be of ready-to-feed strength</p>		
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allergy, inability to digest certain formulas, or need for extra calories. The appropriate formula should always be available and should be fed as directed. For those infants getting supplemental calories, the formula may be prepared in a different way from the directions on the container. In those circumstances, either the family should provide the prepared formula or the caregiver/teacher should receive special training, as noted in the infant’s care plan, on how to prepare the formula.				
<p>STANDARD 4.5.0.10: Foods that Are Choking Hazards Caregivers/teachers should not offer to children under four years of age foods that are associated with young children’s choking incidents (round, hard, small, thick and sticky, smooth, compressible or dense, or slippery). Examples of these foods are hot dogs and other meat sticks (whole or sliced into rounds), raw carrot rounds, whole grapes, hard candy, nuts, seeds, raw peas, hard pretzels, chips, peanuts, popcorn, rice cakes, marshmallows, spoonful’s of peanut butter, and chunks of meat larger than can be swallowed whole. Food for infants should be cut into pieces one- quarter inch or smaller, food for toddlers should be cut into pieces one-half inch or smaller to prevent choking. In addition to the food monitoring, children should always be seated when eating to reduce choking hazards. Children should be supervised while eating, to monitor the size of food and that they are eating appropriately (for example, not stuffing their mouths full).</p>	<p>170-300-0195 Food service, equipment, and practices. (1) An early learning provider preparing or serving food must comply with the current department of health Washington State Food and Beverage Workers’ Manual and supervise services that prepare or deliver food to the early learning program. Weight #5</p> <p>(2) Snacks and meals must be prepared and served by an early learning provider who possesses a valid and current Food Worker card pursuant to WAC 170-300-0106(13), unless the food is provided pursuant to WAC 170-300-0196(3). Weight NA</p> <p>(3) An early learning provider must:</p> <ul style="list-style-type: none">(a) Supply durable and developmentally appropriate individual eating and drinking equipment, or developmentally appropriate single use disposable items;(b) Clean and sanitize eating and drinking equipment after each use. Water cups or bottles must be cleaned and sanitized daily if designated for a single child;(c) Ensure plastic eating and drinking equipment does not contain BPA (a chemical used in hard plastic bottles and as a protective lining in food and beverage cans) or have cracks or chips;(d) Use gloves, utensils, or tongs to serve food;(e) Serve meals or snacks on plates, dishware, containers, trays, or napkins or paper towels, if appropriate. Food should not be served directly on the eating surface; and(f) Be respectful of each child’s cultural food practices. <p>Weight #5</p> <p>(4) An early learning provider must:</p> <ul style="list-style-type: none">(a) Serve each child individually or serve family style dining, allowing each child the opportunity to practice skills such as passing shared serving bowls and serving themselves; and(b) Sit with children during meals. <p>Weight #3</p> <p>170-300-0285 Infant and toddler nutrition and feeding. (2) After consulting a parent or guardian, an early learning provider must implement a feeding plan for infants and toddlers that include:</p> <ul style="list-style-type: none">(i) Increasing the texture of the food from strained, to mashed, to soft table foods as a child’s development and skills progress between six and twelve months of age. Soft foods offered to older infants should be cut into pieces ¼ inch or smaller to prevent choking; Weight #6	Partially Meets	Food Choking guidelines in WAC are specific to infants and are not inclusive of all children 4 and under.	

	<p>(k) Placing infants or toddlers who can sit up on their own in high chairs or at an appropriate child-size table and chairs when feeding solid foods or liquids from a cup, and having an early learning provider sit with and observe each child eating. If high chairs are used, each high chair must:</p> <ul style="list-style-type: none">(i)Have a base that is wider than the seat;(ii)Have a safety device, used each time a child is seated, that prevents the child from climbing or sliding down the chair;(iii)Be free of cracks and tears; and(iv)Have a washable surface; <p>Weight #5</p>				
<p>STANDARD 4.5.0.6: Adult Supervision of Children Who Are Learning to Feed Themselves</p> <p>Children in mid-infancy who are learning to feed themselves should be supervised by an adult seated within arm’s reach of them at all times while they are being fed. Children over twelve months of age who can feed themselves should be supervised by an adult who is seated at the same table or within arm’s reach of the child’s highchair or feeding table. When eating, children should be within sight of an adult at all times.</p>	<p>170-300-0195 Food service, equipment, and practices.</p> <p>(4) An early learning provider must:</p> <ul style="list-style-type: none">(b) Sit with children during meals. <p>170-300-0285 Infant and toddler nutrition and feeding.</p> <p>(2) After consulting a parent or guardian, an early learning provider must implement a feeding plan for infants and toddlers that include:</p> <ul style="list-style-type: none">(k) Placing infants or toddlers who can sit up on their own in high chairs or at an appropriate child-size table and chairs when feeding solid foods or liquids from a cup, and having an early learning provider sit with and observe each child eating. If high chairs are used, each high chair must:(i)Have a base that is wider than the seat;(ii)Have a safety device, used each time a child is seated, that prevents the child from climbing or sliding down the chair;(iii)Be free of cracks and tears; and(iv)Have a washable surface; <p>Weight #5</p>	Meets			
<p>STANDARD 4.5.0.9: Hot Liquids and Foods</p> <p>Adults should not consume hot liquids above 120°F in child care areas (3). Hot liquids and hot foods should be kept out of the reach of infants, toddlers, and preschoolers.</p> <p>Hot liquids and foods should not be placed on a surface at a child’s level, at the edge of a table or counter, or on a tablecloth that could be yanked down. Appliances containing hot liquids, such as coffee pots and crock pots, should be kept out of the reach of children. Electrical cords from any appliance, including coffee pots, should not be allowed to hang within the reach of children. Food preparers should position pot handles toward the back of the stove and use only back burners when possible.</p>	<p>170-300-0165 Safety requirements.</p> <p>(1) An early learning provider must keep indoor and outdoor early learning program space, materials, and equipment free from hazards and in safe working condition. Equipment and toys purchased and used must be compliant with CPSC guidelines or ASTM standards, as now and hereafter amended. Playground equipment and surfaces must meet the requirements of WAC 170-300-0146. Weight NA</p> <p>(3) An early learning provider must take measures intended to prevent other hazards to children in care in early learning program space including, but not limited to:</p> <ul style="list-style-type: none">(b) Burns. Equipment, materials, or products that may be hot enough to injure a child must be made inaccessible to children; Weight #7 <p>(4) To ensure a safe environment for children in care, an early learning provider must comply with the following requirements:</p> <ul style="list-style-type: none">(e) Safe water temperature. All water accessible to children must not be hotter than 120 degrees Fahrenheit. Weight #7 <p>(5) To ensure a safe environment for children in care, an early learning provider must comply with the following electrical requirements:</p> <ul style="list-style-type: none">(a) In areas accessible to children, electrical outlets must have automatic shutters that only allow electrical plugs to be inserted (tamper-resistant) or that are covered by blank plates or other tamper-resistant covers appropriate to the electrical outlet;	Meets	This WAC addresses appliances generally by requiring providers to take measures to prevent burns including equipment.		

	<p>(b) Outlets near sinks, tubs, toilets, or other water sources must be inaccessible to children or be tamper-resistant and equipped with a ground fault circuit interrupter (GFCI) outlet type;</p> <p>(c) Electrical cords must be in good working condition, not torn or frayed, and not have any exposed wires;</p> <p>(d) Electrical cords must be plugged directly into a wall outlet or a surge protector;</p> <p>(e) Power strips with surge protectors may be used but must not be accessible to children in care;</p> <p>(f) Extension cords may only be used for a brief, temporary purpose and must not replace direct wiring; and</p> <p>(g) Electrical devices accessible to children must not be plugged into an electrical outlet near a water source such as sink, tub, water table, or swimming pool.</p> <p>Weight #7</p>				
<p>STANDARD 4.8.0.1: Food Preparation Area</p> <p>The food preparation area of the kitchen should be separate from eating, play, laundry, toilet, and bathroom areas and from areas where animals are permitted. The food preparation area should not be used as a passageway while food is being prepared. Food preparation areas should be separated by a door, gate, counter, or room divider from areas the children use for activities unrelated to food, except in small family child care homes when separation may limit supervision of children.</p> <p>Infants and toddlers should not have access to the kitchen in child care centers. Access by older children to the kitchen of centers should be permitted only when supervised by staff members who have been certified by the nutritionist/ registered dietitian or the center director as qualified to follow the facility’s sanitation and safety procedures.</p> <p>In all types of child care facilities, children should never be in the kitchen unless they are directly supervised by a caregiver/teacher. Children of preschool-age and older should be restricted from access to areas where hot food is being prepared. School-age children may engage in food preparation activities with adult supervision in the kitchen or the classroom. Parents/guardians and other adults should be permitted to use the kitchen only if they know and follow the food safety rules of the facility. The facility should check with local health authorities about any additional regulations that apply.</p>	<p>170-300-0245 Laundry and equipment.</p> <p>(1) Laundry and laundry equipment at an early learning program must be inaccessible to children and separated from areas where food is prepared to prevent cross contamination. Weight #4</p> <p>170-300-0198 Food preparation areas.</p> <p>(5) An early learning provider may use the kitchen for actively supervised cooking or food preparation activities with children in care. Weight NA</p> <p>170-300-0225 Pets and animals.</p> <p>(4) An early learning provider must:</p> <p> (e) Not allow pets and animals in the kitchen during food preparation and ensure pets and animals do not come into contact with food, food preparation, or serving areas while food is served;</p> <p> (f) Not use a sink that is used for cleaning food or utensils to clean pet supplies;</p> <p>Weight #6</p> <p>WAC 170-300-0221 Diaper changing areas and disposal.</p> <p>(1) A center early learning provider must have a designated diaper changing area, including stand-up diapering, for each classroom or for every age grouping of children who require diapering. Only one diaper changing area is required at a family home early learning provider.</p> <p> (a) A diaper changing area must:</p> <p> (i) Be separate from areas where food is stored, prepared, or served;</p>	Partially Meets	WAC only addresses the kitchen should be separated from the laundry, not allow pets or unsupervised access to children in the food preparation area. All other components are missing.		
<p>STANDARD 4.8.0.3: Maintenance of Food Service Surfaces and Equipment</p>	<p>170-300-0198 Food preparation areas.</p> <p>(1) An early learning provider or staff must clean and sanitize food preparation areas and eating surfaces before and after each use pursuant to 170-300-0241(1)(a). Weight NA</p>	Meets			

All surfaces that come into contact with food,including tables and countertops, as well as floors and shelving in the food preparation area should be in good repair, free of cracks or crevices, and should be made of smooth, non-porous material that is kept clean and sanitized. All kitchen equipment should be clean and should be maintained inoperable condition according to the manufacturer’s guidelines for maintenance and operation. The facility should maintain an inventory of food service equipment that includes the date of purchase, the warranty date, and a history of repairs.	(2) In an early learning program’s food preparation area, kitchens must: (a) Have walls, counter tops, floors, cabinets, and shelves that are: (i) Maintained in good repair, including, but not limited to, being properly sealed without chips, cracks, or tears; and (ii) Moisture resistant. (b) Have a properly maintained and vented range hood, exhaust fan, or operable window; and (c) Have a properly maintained and working refrigerator, freezer, or a combination refrigerator and freezer with sufficient space for proper storage and cooling of food. Weight #6				
STANDARD 4.9.0.2: Staff Restricted from Food Preparation and Handling Anyone who has sings or symptoms of illness, including vomiting, diarrhea, and infectious skin sores that cannotbe covered, or who potentially or actually is infected with bacteria, viruses or parasites that can be carried in food, should be excluded from food preparation and handling. Staff members may not contact exposed, ready-to-eat food with their bare hands and should use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves, or dispensing equipment. No one with open or infected skin eruptions should work in the food preparation area unless the injuries are covered with nonporous (such as latex or vinyl), single use gloves. In centers and large family child care homes, staff members who are involved in the process of preparing or handling food should not change diapers. Staff members who work with diapered children should not prepare or serve foodfor older groups of children. When staff members who are caring for infants and toddlers are responsible for changing diapers, they should handle food only for the infantsand toddlers in their groups and only after thoroughly washing their hands. Caregivers/teachers who prepare food should wash their hands carefully before handling any food, regardless of whether they change diapers. When caregivers/teachers must handle food, staffing assignments should be made to foster completion of the food handling activities by caregivers/teachers of older children, or by caregivers/teachers of infants and toddlers before the caregiver/teacher assumes other caregiving duties for that day. Aprons worn in the food service area must be clean and should be removed when diaper changing or when using the toilet.	170-300-0195 Food service, equipment, and practices. (1) An early learning provider preparing or serving food must comply with the department of health Washington State Food and Beverage Workers’ Manual and supervise services that prepare or deliver food to the early learning program. Weight #5 (2) Snacks and meals must be prepared and served by an early learning provider who possesses a valid and current Food Worker card pursuant to WAC 0106(13), unless the food is provided pursuant to WAC 170-300-0196(3). Weight # NA (3) An early learning provider must: (d) Use gloves, utensils, or tongs to serve food; Weight #5	Meets	Via the requirements of department of health Washington State Food and Beverage Workers’ Manual		

<p>STANDARD 4.9.0.3: Precautions for a Safe Food Supply</p> <p>All foods stored, prepared, or served should be safe for human consumption by observation and smell. The following precautions should be observed for a safe food supply:</p> <ul style="list-style-type: none">a) Home-canned food; food from dented, rusted, bulging, or leaking cans, and food from cans without labels should not be used;b) Foods should be inspected daily for spoilage or signs of mold, and foods that are spoiled or moldy should be promptly and appropriately discarded;c) Meat should be from government-inspected sources or otherwise approved by the governing health authority (3);d) All dairy products should be pasteurized and Grade A where applicable;e) Raw, unpasteurized milk, milk products; unpasteurized fruit juices; and raw or undercooked eggs should not be used. Freshly squeezed fruit or vegetable juice prepared just prior to serving in the child care facility is permissible;f) Unless a child’s health care professional documents a different milk product, children from twelve months to two years of age should be served only human milk, formula, whole milk or 2% milk (6). Note: For children between twelve months and two years of age for whom overweight or obesity is a concern or who have a family history of obesity, dyslipidemia, or CVD, the use of reduced-fat milk is appropriate only with written documentation from the child’s primary health care professional (4). Children two years of age and older should be served skim or 1% milk. If cost-saving is required to accommodate a tight budget, dry milk and milk products may be reconstituted in the facility for cooking purposes only, provided that they are prepared, refrigerated, and stored in a sanitary manner, labeled with the date of preparation, and used or discarded within twenty-four hours of preparation;g) Meat, fish, poultry, milk, and egg products should be refrigerated or frozen until immediately before use (5);h) Frozen foods should be defrosted in one of four ways: In the refrigerator; under cold running water; as part of the cooking process, or by removing food	<p>170-300-0195 Food service, equipment, and practices.</p> <p>(1) An early learning provider preparing or serving food must comply with the current department of health Washington State Food and Beverage Workers’ Manual and supervise services that prepare or deliver food to the early learning program. Weight #5</p> <p>(2) Snacks and meals must be prepared and served by an early learning provider who possesses a valid and current Food Worker card pursuant to WAC 0106(13), unless the food is provided pursuant to WAC 170-300-0196(3). Weight NA</p> <p>170-300-0196 Food sources.</p> <p>(1) Food prepared and served from an early learning program must not be tampered with or spoiled. Weight #8</p> <p>(2) Food prepared and served from an early learning program must be obtained from an approved source licensed and inspected by the local health jurisdiction, the Washington State Department of Agriculture (WSDA), or the USDA. Food items not approved to be served to children in care include:</p> <ul style="list-style-type: none">(a) Meat, fish, poultry, eggs, or milk that has not been inspected by the USDA or WSDA;(b) Home canned food;(c) Game meat or other meat that has not been inspected by the WSDA or USDA;(d) Leftover food that was previously served from outside of the early learning program; or(e) Food from roadside stands selling without a permit. Weight # 6 <p>(3) Food not prepared on-site by an early learning provider, pursuant to WAC 170-300-0195(2), must be provided by:</p> <ul style="list-style-type: none">(a) A licensed food service establishment, kitchen, or catering business that meets department of health food service requirements (chapter 246-215 WAC, as now and hereafter amended) and is regularly inspected by a local health jurisdiction;(b) A parent or guardian for his or her own children; or(c) A manufacturer of prepackaged food. Weight #6 <p>(4) Fruits and vegetables (produce) grown on site in a garden as part of an early learning program may be served to children as part of a meal or snack. Prior to preparing and serving:</p> <ul style="list-style-type: none">(a) The produce must be thoroughly washed and scrubbed in running cold water to remove soil and other contaminants;(b) Damaged or bruised areas on the produce must be removed; and(c) Produce that shows signs of rotting must be discarded. Weight # 3 <p>170-300-0197 Safe food practices.</p> <p>(1) Early learning providers must wash their hands, pursuant to WAC 170-300-0200. Weight NA</p> <p>(2) Early learning providers must store, prepare, cook hold food, and wash dishes pursuant to WAC 170-300-0195. Weight NA</p> <p>(3) For all foods offered by the provider or given to an enrolled child by a parent or guardian, the provider must:</p> <ul style="list-style-type: none">(a) Provide appropriate refrigeration to preserve foods from spoiling. Foods that may be subject to spoiling include, but are not limited to, meats, cooked potatoes, cooked legumes, cooked rice, sprouts, cut melons, cut cantaloupes, milk, and cheese; and	Exceeds	WAC does not allow home-canned foods. Milk is addressed by requiring USDA or WSDA inspection. Preparation and Cooking temperatures are outline in the department of health Washington State Food and Beverage Workers’ Manual		
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<p>from packaging and using the defrost setting of a microwave oven (5). Note: Frozen human milk should not be defrosted in the microwave;</p> <p>i) Frozen foods should never be defrosted by leaving them at room temperature or standing in water that is not kept at refrigerator temperature (5);</p> <p>j) All fruits and vegetables should be washed thoroughly with water prior to use (5);</p> <p>k) Food should be served promptly after preparation or cooking or should be maintained at temperatures of not less than 135°F for hot foods and not more than 41°F for cold foods (12);</p> <p>l) All opened moist foods that have not been served should be covered, dated, and maintained at a temperature of 41°F or lower in the refrigerator or frozen in the freezer, verified by a working thermometer kept in the refrigerator or freezer (12);</p> <p>m) Fully cooked and ready-to-serve hot foods should be held for no longer than thirty minutes before being served, or promptly covered and refrigerated;</p> <p>n) Pasteurized eggs or egg products should be substituted for raw eggs in the preparation of foods such as Caesar salad, mayonnaise, meringue, eggnog, and ice cream. Pasteurized eggs or egg products should be substituted for recipes in which more than one egg is broken and the eggs are combined, unless the eggs are cooked for an individual child at a single meal and served immediately, such as in omelets or scrambled eggs; or the raw eggs are combined as an ingredient immediately before baking and the eggs are fully cooked to a ready-to-eat form, such as a cake, muffin or bread;</p> <p>o) Raw animal foods should be fully cooked to heat all parts of the food to a temperature and for a time of; 145°F or above for fifteen seconds for fish and meat; 160°F for fifteen seconds for chopped or ground fish, chopped or ground meat or raw eggs; or 165°F or above for fifteen seconds for poultry or stuffed fish, stuffed meat, stuffed pasta, stuffed poultry or stuffing containing fish, meat or poultry.</p>	<p>(b) Refrigerate foods requiring refrigeration at 41 degrees Fahrenheit or less and freeze foods required to be frozen at 10 degrees Fahrenheit or less. Weight #7</p> <p>(4) Food must be stored as follows:</p> <p>(a) In original containers or in clean, labeled, dated, and airtight food grade containers, if appropriate.</p> <p>(b) Food not required to be refrigerated or frozen must not be stored directly on the floor;</p> <p>(c) In a manner that prevents contamination;</p> <p>(d) Food and food service items (such as utensils, napkins, and dishes) must not be stored in an area with toxic materials (such as cleaning supplies, paint, or pesticides);</p> <p>(e) Food that is past the manufacturer's expiration or "best served by" date must not be served to enrolled children; and</p> <p>(f) Raw meat must be stored in the refrigerator or freezer below cooked or ready to eat foods. Weight #7</p> <p>(5) For food requiring temperature control, a center early learning program must maintain a food temperature log by using a calibrated and working metal stem-type or digital food thermometer. Weight #5</p> <p>(6) Prior to storing leftover food in a refrigerator or freezer, an early learning provider must label the food with the date the leftover food was opened or cooked. Weight #5</p> <p>(7) An early learning provider may serve leftover food that originated from the early learning program if the leftover food was not previously served and:</p> <p>(a) Refrigerated leftover food must be stored and then served again within 48 hours of originally being prepared; or</p> <p>(b) Frozen leftover food must be promptly served after thawing and being cooked. Weight #5</p> <p>(8) Frozen food must be thawed by one of the following methods:</p> <p>(a) In a refrigerator;</p> <p>(b) Under cool running water inside a pan placed in a sink with the drain plug removed; or</p> <p>(c) In a microwave if the food is to be cooked immediately as part of the continuous cooking process. Weight #6</p>				
<p>STANDARD 5.1.1.2: Inspection of Buildings</p> <p>Newly constructed, renovated, remodeled, or altered buildings should be inspected by a public inspector to assure compliance with applicable building and fire</p>	<p>170-300-0415 Zoning, codes, and ordinances.</p> <p>(1) The department adopts and incorporates by reference the Washington state building code (chapter 19.27 RCW), as now and hereafter amended.</p>	Meets			

codes before the building can be made accessible to children.	<p>(2) Early learning program space comply with the Washington state building code or local building code as enacted at the time of licensure. Facility modifications must comply with WAC 170-300-0402. Weight #6</p> <p>(3) Prior to licensing, an applicant must contact state, city, and local agencies that may regulate the early learning program. An early learning provider must obtain regulations and comply with the direction given by such agencies. These agencies may include, but are not limited to, the Washington state Department of Labor and Industries, the Washington state Fire Marshal, the Washington state Department of Health, and local health jurisdiction. Weight NA</p> <p>(4) Prior to licensing, a center early learning applicant must:</p> <ul style="list-style-type: none">(a) Have a certificate of occupancy issued by the local building, planning, or zoning department, or a local equivalent if locality does not have the certificate of occupancy; and(b) Be inspected and approved by the State Fire Marshal <p>Weight #NA</p> <p>170-300-0402 Changing early learning program space or location</p> <p>(1) An early learning provider must notify the department prior to making a change to early learning program space that may impact the health, safety, or welfare of enrolled children. Such changes include but are not limited to:</p> <ul style="list-style-type: none">(a) Moving early learning programs to a different, residence, building, or facility (even if the new location is on the same premises);(b) An early learning program altering planned use of space including, but not limited to the ages of children served in a room or previously unlicensed areas;(c) Modifying facilities in a way that requires a permit under the Washington state building code or by a local jurisdiction, such as remodeling or renovating early learning program space; and(d) Changing outdoor play areas, such as adding or altering the type of surface or altering stationary climbing or play equipment. <p>Weight #5</p> <p>(2) An early learning provider must submit to the department the new proposed floor plan prior to making changes under subsections (1)(a) through (1)(c) of this section. Weight #5</p> <p>(3) An early learning provider planning a change under subsection (1)(a) of this section must also:</p> <ul style="list-style-type: none">(a) Submit a complete application, pursuant to WAC 170-300-0400, as soon as the provider plans to move and has an identified address, but not more than 90 calendar days before moving;(b) Not significantly change or move a center early learning program until the department has first inspected the new location and determines it meets the requirements in this chapter and RCW 43.216.305; and(c) Not operate a family home early learning program for more than two weeks following the move before having the department inspect the new location, pursuant to RCW 43.216.305. Weight #6				
<p>STANDARD 5.1.1.3: Compliance with Fire Prevention Code</p> <p>Every twelve months, the child care facility should obtain written documentation to submit to the regulatory licensing authority that the facility complies with a state-</p>	<p>170-300-0170 Fire safety.</p> <p>(2) An early learning provider must arrange for a fire safety inspection annually. A provider must arrange fire safety inspection with a local government agency. If a local government agency is not available to conduct a fire safety inspection, a provider must inspect for fire safety using the State Fire Marshal form. Weight #6</p>	Partially Meets	While the requirement to have a certified inspector is included, there is the option a provider can do the inspection if the Fire Marshal is not available.		

approved or nationally recognized Fire Prevention Code. If available, this documentation should be obtained from a fire prevention official with jurisdiction where the facility is located. Where fire safety inspections or a Fire Prevention Code applicable to child care centers is not available from local authorities, the facility should arrange for a fire safety inspection by an inspector who is qualified to conduct such inspections using the National Fire Protection Association’s <i>NFPA 101: Life Safety Code</i> .					
<p>STANDARD 5.1.1.5: Environmental Audit of Site Location</p> <p>An environmental audit should be conducted before construction of a new building; renovation or occupation of an older building; or after a natural disaster, to properly evaluate and, where necessary, remediate or avoid sites where children’s health could be compromised (1,3).</p> <p>The environmental audit should include assessments of:</p> <ul style="list-style-type: none">a) Potential air, soil, and water contamination on child care facility sites and outdoor play spaces;b) Potential toxic or hazardous materials in building construction; andc) Potential safety hazards in the community surrounding the site. <p>A written environmental audit report that includes any remedial action taken should be kept on file.</p>	<p>170-300-0410 License and program location.</p> <p>(1) An applicant for a license under this chapter must be at least 18 years old. Weight NA</p> <p>(2) A licensee refers to the individual or organization:</p> <ul style="list-style-type: none">(a) Whose name appears on a license issued by the department; Weight NA(b) Responsible for complying with the standards in this chapter, chapter 43.216 RCW, chapter 170-06 WAC, as hereafter recodified or amended, and other applicable laws or rules; Weight NA(c) Responsible for training early learning program staff on the Foundational Quality Standards in this chapter; Weight NA and(d) Who resides on the early learning program premises (family home child care only), pursuant to RCW 43.216.010. Weight #6 <p>(3) Early learning program space must be located:</p> <ul style="list-style-type: none">(a) On a site free from known environmental hazards; Weight #6(b) In an area where non-emergency services and utilities can serve the early learning program space; Weight NA and(c) In an area served by emergency fire, medical, and police during the hours the early learning provider provides care to children. Weight NA <p>(4) An early learning provider must prevent enrolled children from being exposed to the following known hazards within and around the licensed premises:</p> <ul style="list-style-type: none">(a) Lead based paint;(b) Plumbing and fixtures containing lead or lead solders;(c) Asbestos;(d) Arsenic, lead, or copper in the soil or drinking water;(e) Toxic mold; and(f) Other identified toxins or hazards. Weight #8	Not Addressed	WAC does not mention the need for an environmental audit		

	<p>(5) An early learning provider must place address numbers or signage on the outside of the house or building that contains the early learning program space. The numbers or signage must be legible and plainly visible from the street or road serving the premises. Weight #4</p> <p>(6) A license applicant planning to open an early learning program in the designated Tacoma smelter plume (counties of King, Pierce, and Thurston) must contact the state department of ecology (DOE) and complete and sign an access agreement with DOE to evaluate the applicant’s property for possible arsenic and lead soil contamination. Weight NA</p>				
<p>STANDARD 5.1.6.6: Guardrails and Protective Barriers</p> <p>Guardrails, a minimum of thirty-six inches in height, should be provided at open sides of stairs, ramps, and other walking surfaces (e.g., landings, balconies, porches) from which there is more than a thirty-inch vertical distance to fall. Spaces below the thirty-six inches height guardrail should be further divided with intermediate rails or balusters as detailed in the next paragraph.</p> <p>For preschoolers, bottom guardrails greater than nine inches but less or equal to twenty-three inches above the floor should be provided for all porches, landings, balconies, and similar structures. For school age children, bottom guardrails should be greater than nine inches but less or equal to twenty inches above the floor, as specified above.</p> <p>For infants and toddlers, protective barriers should be less than three and one-half inches above the floor, as specified above. All spaces in guardrails should be less than three and a half inches. All spaces in protective barriers should be less than three and one-half inches. If spaces do not meet the specifications as listed above, a protective material sufficient to prevent the passing of a three and one-half inch diameter sphere should be provided. Where practical or otherwise required by applicable codes, guardrails should be a minimum of forty-two inches in height to help prevent falls over the open side by staff and other adults in the child care facility.</p>	<p>170-300-0165 Safety requirements.</p> <p>(4) To ensure a safe environment for children in care, an early learning provider must comply with the following requirements:</p> <p> (f) Stairway safety.</p> <p> (i) There must not be clutter or obstructions in the stairway;</p> <p> (ii) All stairways (indoor and outdoor), not including play structures, must meet local building codes pursuant to RCW 43.216.340.</p> <p> (A) Open stairways with no walls on either side must have handrails with slats (balusters) that prevent a child from falling off either side of the stairway.</p> <p> (B) Stairways with a wall on only one side must have a handrail with slats (balusters) on the side without the wall that prevents a child from falling off the stairway.</p> <p> (C) Stairways with a wall on both sides must have a handrail no higher than 38 inches on at least one side of the stairway; and</p> <p> (iii) Stairways must have a pressure gate, safety gate or door to keep stairs inaccessible to infants and toddlers when not in use. Openings between slats on pressure or safety gates must not be large enough to allow a sphere that is three and one-half (3½) inches wide to pass through. Weight #7</p> <p> (g) Platforms and decks. All platforms and decks used for child care activities must meet local building codes pursuant to RCW 43.216.340 within six months of the date this section becomes effective. This does not include play equipment. All platforms and decks with a drop zone of more than 18 inches must have guardrails in sections without steps. Weight #7</p>	Meets			
<p>STANDARD 5.2.1.10: Gas, Oil, or Kerosene Heaters, Generators, Portable Gas Stoves, and Charcoal and Gas Grills</p>	<p>170-300-0170 Fire safety.</p> <p>(3) To ensure a safe environment for children in care, an early learning provider must comply with the following fire safety requirements:</p> <p> (b) Furnaces and other heating devices.</p>	Meets			

<p>Unvented gas or oil heaters and portable open-flame kerosene space heaters should be prohibited. Gas cooking appliances, including portable gas stoves, should not be used for heating purposes. Charcoal grills should not be used for space heating or any other indoor purposes.</p> <p>Heat in units that involve flame should be vented properly to the outside and should be supplied with a source of combustion air that meets the manufacturer's installation requirements.</p>	<p>(i) Paper, rubbish, or other combustible materials must be at least three feet from furnaces, fireplaces, or other heating devices;</p> <p>(ii) Furnaces and other heating devices must be inaccessible to children in care; and</p> <p>(iii) An appliance or heating device that has a surface capable of burning a child or reaching 110 degrees Fahrenheit must be inaccessible to children in care unless a program activity involves such an appliance or device and children are being actively supervised.</p> <p>(d) Open flame devices, candles, matches and lighters.</p> <p>(i) Except for the use of a gas kitchen range, open flame devices must not be used in early learning program space or any other space accessible to children in care during operating hours.</p> <p>(ii) Candles must not be used during operating hours.</p> <p>(iii) Matches and lighters must be inaccessible to children.</p> <p>(e) Portable heaters and generators. Portable heaters or fuel powered generators must not be used inside early learning program space during operating hours.</p> <p>(i) In case of an emergency, a generator may be used but must be placed at least 15 feet from buildings, windows, doors, ventilation intakes, or other places where exhaust fumes may be vented into the premises or early learning space; and</p> <p>(ii) Appliances must be plugged directly into a generator or into a heavy duty outdoor-rated extension cord that is plugged into a generator.</p>				
<p>STANDARD 5.2.4.2: Safety Covers and Shock Protection Devices for Electrical Outlets</p> <p>All electrical outlets accessible to children who are not yet developmentally at a kindergarten grade level of learning should be a type called "tamper-resistant electrical outlets." These types of outlets look like standard wall outlets but contain an internal shutter mechanism that prevents children from sticking objects like hairpins, keys, and paperclips into the receptacle (2). This spring-loaded shutter mechanism only opens when equal pressure is applied to both shutters such as when an electrical plug is inserted (2,3).</p> <p>In existing child care facilities that do not have "tamper-resistant electrical outlets," outlets should have "safety covers" that are attached to the electrical outlet by a screw or other means to prevent easy removal by a child. "Safety plugs" should not be used since they can be removed from an electrical outlet by children (2,3). All newly installed or replaced electrical outlets that are accessible to children should use "tamper-resistant electrical outlets."</p> <p>In areas where electrical products might come into contact with water, a special type of outlet called Ground Fault Circuit Interrupters (GFCIs) should be installed (2). A GFCI is designed to trip before a deadly</p>	<p>170-300-0165 Safety requirements.</p> <p>(5) To ensure a safe environment for children in care, an early learning provider must comply with the following electrical requirements:</p> <p>(a) In areas accessible to children, electrical outlets must have automatic shutters that only allow electrical plugs to be inserted (tamper-resistant) or are covered by blank plates or other tamper-resistant covers appropriate to the electrical outlet;</p> <p>(b) Outlets near sinks, tubs, toilets, or other water sources must be inaccessible to children or be tamper-resistant and equipped with a ground fault circuit interrupter (GFCI) outlet type;</p> <p>(c) Electrical cords must be in good working condition, not torn or frayed, and not have any exposed wires;</p> <p>(d) Electrical cords must be plugged directly into a wall outlet or a surge protector;</p> <p>(e) Power strips with surge protectors may be used but must not be accessible to children in care;</p> <p>(f) Extension cords may only be used for a brief, temporary purpose and must not replace direct wiring; and</p> <p>(g) Electrical devices accessible to children must not be plugged into an electrical outlet near a water source such as sink, tub, water table, or swimming pool. Weight #7</p>	Meets			

electrical shock can occur (1). To ensure that GFCIs are functioning correctly, they should be tested at least monthly (2). GFCIs are also available in a tamper-resistant design.					
STANDARD 5.2.4.4: Location of Electrical Devices Near Water No electrical device or apparatus accessible to children should be located so it could be plugged into an electrical outlet while a person is in contact with a water source, such as a sink, tub, shower area, water table, or swimming pool.	170-300-0165 Safety requirements. (5) To ensure a safe environment for children in care, an early learning provider must comply with the following electrical requirements: (g) Electrical devices accessible to children must not be plugged into an electrical outlet near a water source such as sink, tub, water table, or swimming pool. Weight #7	Meets			
STANDARD 5.2.5.1: Smoke Detection Systems and Smoke Alarms In centers with new installations, a smoke detection system (such as hard-wired system detectors with battery back-up system and control panel) or monitored wireless batteryoperated detectors that automatically signal an alarm through a central control panel when the battery is low or when the detector is triggered by a hazardous condition should be installed with placement of the smoke detectors in the following areas: a) Each story in front of doors to the stairway; b) Corridors of all floors; c) Lounges and recreation areas; d) Sleeping rooms. In large and small family child care homes, smoke alarms that receive their operating power from the buildingelectrical system or are of the wireless signal-monitored-alarm system type should be installed. Battery-operated smoke alarms should be permitted provided that the facilitydemonstrates to the fire inspector that testing, maintenance, and battery replacement programs ensure reliability of power to the smoke alarms and signaling of a monitored alarm when the battery is low and that retrofitting the facility to connect the smoke alarms to the electrical system would becostly and difficult to achieve. Facilities with smoke alarms that operate using power from the building electrical system should keep a supply of batteries and battery-operated detectors for use during power outages.	170-300-0170 Fire safety. (1) An early learning provider must comply with the State Building Code, as now and hereafter amended, pursuant to RCW 19.27.031. Weight #7 (3) To ensure a safe environment for children in care, an early learning provider must comply with the following fire safety requirements: (g) Fire alarms and smoke and carbon monoxide detectors. (i) An early learning provider must have and maintain at least one smoke detector per licensed sleeping area and one per floor. Pursuant to the State Building Code, center early learning providers must comply with WAC 51-50-0907, as now and hereafter amended, and family early learning providers must comply with WAC 51-51-0314, as now and hereafter amended; and (ii) An early learning provider must have and maintain carbon monoxide detectors. Pursuant to the State Building Code, the State Building Code, center early learning providers must comply with WAC 51-50-0915, as now and hereafter amended, and family early learning providers must comply with WAC 51-51-0315, as now and hereafter amended. (h) Backup method to sound an alarm. In addition to working smoke detectors, an early learning provider must have another method to alert all staff and enrolled children of a fire, emergency situation, or drill.	Meets			

<p>STANDARD 5.2.7.6: Storage and Disposal of Infectious and Toxic Wastes</p> <p>Infectious and toxic waste should be stored separately from other wastes, and should be disposed of in a manner approved by the regulatory health authority.</p>	<p>(11) Early learning providers who directly care for children must complete the Prevention of Exposure to Blood and Body Fluids training that meets Washington State Department of Labor & Industries’ requirements prior to being granted a license or working with children. This training must be repeated pursuant to Washington State Department Labor and Industries regulations. Weight #6</p> <p>170-300-0500 Health policy.</p> <p>(1) An early learning provider must have and follow a written health policy reviewed and approved by the department that includes the topics listed in subsection (2) of this section. The health policy must be reviewed and approved by the department when changes are made, and as otherwise necessary. Weight NA</p> <p>(2) An early learning program’s health policy must meet the requirements of this chapter including, but not limited to:</p> <p>(1) A prevention of exposure to blood and body fluids plan;</p>	Not Addressed	WAC Not Addressed the storage and disposal of “infectious and toxic waste. Per WAC 170-300-0106 there are requirements for training and per WAC 170-300-0500 the requirement for a plan.		
<p>STANDARD 5.2.8.1: Integrated Pest Management</p> <p>Facilities should adopt an integrated pest management program (IPM) to ensure long-term, environmentally sound pest suppression through a range of practices including pest exclusion, sanitation and clutter control, and elimination of conditions that are conducive to pest infestations. IPM is a simple, common-sense approach to pest management that eliminates the root causes of pest problems, providing safe and effective control of insects, weeds, rodents, and other pests while minimizing risks to human health and the environment (2,4).</p> <p>Pest Prevention: Facilities should prevent pest infestations by ensuring sanitary conditions. This can be done by eliminating pest breeding areas, filling in cracks and crevices; holes in walls, floors, ceilings and water leads; repairing water damage; and removing clutter and rubbish on the premises (5).</p> <p>Pest Monitoring: Facilities should establish a program for regular pest population monitoring and should keep records of pest sightings and sightings of indicators of the presence of pests (e.g., gnaw marks, frays, rub marks).</p> <p>Pesticide Use: If physical intervention fails to prevent pest infestations, facility managers should ensure that targeted, rather than broadcast applications of pesticides are made, beginning with the products that pose least exposure hazard first, and always using a pesticide applicator who has the licenses or certifications required by state and local laws.</p> <p>Facility managers should follow all instructions on pesticide product labels and should not apply any</p>	<p>170-300-0255 Pest control.</p> <p>(1) An early learning provider must take appropriate steps to safely prevent or control pests that pose a risk to the health and safety of adults and children in and around the licensed space. Pest control steps must include: Weight #7</p> <p>(a) Prevention. A provider must take steps to prevent attracting pests including, but not limited to, identifying and removing food and water sources that attract pests.</p> <p>(b) Inspection. Indoor and outdoor areas in and around the licensed space must be inspected for evidence of pests. A provider must document the date and location if evidence is found.</p> <p>(c) Identification. Pests found in the licensed space must be identified and documented so the pest may be properly removed or exterminated.</p> <p>(d) Management. A provider must document steps taken to remove or exterminate the pests if found in the licensed space.</p> <p>(e) Notification. If pesticides are used, the early learning provider must notify the parents or guardians of enrolled children what pesticide will be applied and where it will be applied no less than 48 hours before application, unless in cases of emergency (such as a wasp nest).</p> <p>(f) Application. Pesticide must be applied to early learning program space when children are not present. When pesticide is applied, center providers must comply with chapter 17.21 RCW and family home providers must comply with the pesticide manufacturer’s instructions.</p> <p>Weight NA</p> <p>(2) An early learning provider must have a pest control policy that emphasizes prevention and natural, non-chemical, low-toxicity methods where pesticides or herbicides are used as a last resort (i.e. Integrated Pest Management). Weight NA</p> <p>170-300-0148- Gardens in outdoor early learning program space.</p> <p>(3) Any herbicide or pesticide must be applied pursuant to the product manufacturer’s directions. The product must not be applied while children are present. Children must not apply the product or have access to the garden during the manufacturer’s prescribed waiting period following application. Weight #7</p> <p>170-300-0450 Parent or guardian handbook and related policies.</p> <p>(1) An early learning provider must supply to each parent or guardian written policies regarding the early learning program. Each enrolled child’s record must have signed documentation stating the parent or guardian reviewed the handbook and early learning program policies. Weight #3</p> <p>(2) An early learning provider must have and follow formal written policies in either paper or electronic</p>	Meets			

<p>pesticide in a manner inconsistent with label instructions. Material Safety Data Sheets (MSDS) are available from the product manufacturer or a licensed exterminator and should be on file at the facility. Facilities should ensure that pesticides are never applied when children are present and that re-entry periods are adhered to.</p> <p>Records of all pesticides applications (including type and amount of pesticide used), timing and location of treatment, and results should be maintained either on-line or in a manner that permits access by facility managers and staff, state inspectors and regulatory personnel, parents/guardians, and others who may inquire about pesticide usage at the facility. Facilities should avoid the use of sprays and other volatilizing pesticide formulations. Pesticides should be applied in a manner that prevents skin contact and any other exposure to children or staff members and minimizes odors in occupied areas. Care should be taken to ensure that pesticide applications do not result in pesticide residues accumulating on tables, toys, and items mouthed or handled by children, or on soft surfaces such as carpets, upholstered furniture, or stuffed animals with which children may come in direct contact (3).</p> <p>Following the use of pesticides, herbicides, fungicides, or other potentially toxic chemicals, the treated area should be ventilated for the period recommended on the product label.</p> <p>Notification: Notification should be given to parents/guardians and staff before using pesticides, to determine if any child or staff member is sensitive to the product. A member of the child care staff should directly observe the application to be sure that toxic chemicals are not applied on surfaces with which children or staff may come in contact.</p> <p>Registry: Child care facilities should provide the opportunity for interested staff and parents/guardians to register with the facility if they want to be notified about individual pesticide applications before they occur.</p> <p>Warning Signs: Child care facilities must post warning signs at each area where pesticides will be applied. These signs must be posted forty-eight hours before and seventy-two hours after applications and should be sufficient to restrict uninformed access to treated areas.</p> <p>Record Keeping: Child care facilities should keep records of pesticide use at the facility and make the</p>	<p>format, including::</p> <p>(v) Description of where the parent or guardian may find and review the early learning program's:</p> <p>(i) Health policy:</p> <p>Weight #4</p> <p>170-300-0500 Health policy.</p> <p>(1) An early learning provider must have and follow a written health policy reviewed and approved by the department that includes the topics listed in subsection (2) of this section. The health policy must be reviewed and approved by the department when changes are made, and as otherwise necessary. Weight NA</p> <p>(2) An early learning program's health policy must meet the requirements of this chapter including, but not limited to:</p> <p>(l) Pest control policies;</p> <p>Weight #NA</p> <p>170-300-0505 Postings.</p> <p>(1) Postings listed in subsection (2) of this section that are part of an early learning program must be clearly visible to parents, guardians, and early learning program staff.</p> <p>Weight #4</p> <p>(2) Postings on early learning premises must include:</p> <p>(f) Pesticide treatment, if applicable, pursuant to RCW 43.216.280 and 17.21.410(1)(d);</p> <p>Weight NA</p> <p>170-300-0465 Retaining facility and program records.</p> <p>(5) An early learning provider must keep the following records available for department review:</p> <p>(o) Pesticide use (seven years);</p> <p>Weight #1</p>				
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<p>records available to anyone who asks. Record retention requirements vary by state, but federal law requires records to be kept for two years (7). It is a good idea to retain records for a minimum of three years.</p> <p>Pesticide Storage: Pesticides should be stored in their original containers and in a locked room or cabinet accessible only to authorized staff. No restricted-use pesticides should be stored or used on the premises except by properly licensed persons. Banned, illegal, and unregistered pesticides should not be used.</p>				
<p>STANDARD 5.2.9.1: Use and Storage of Toxic Substances</p> <p>The following items should be used as recommended by the manufacturer and should be stored in the original labeled containers:</p> <ul style="list-style-type: none">a) Cleaning materials;b) Detergents;c) Automatic dishwasher detergents;d) Aerosol cans;e) Pesticides;f) Health and beauty aids;g) Medications;h) Lawn care chemicals;i) Other toxic materials. <p>Material Safety Data Sheets (MSDS) must be available on- site for each hazardous chemical that is on the premises.</p> <p>These substances should be used only in a manner that will not contaminate play surfaces, food, or food preparation areas, and that will not constitute a hazard to the children or staff. When not in active use, all chemicals used inside or outside should be stored in a safe and secure manner in a locked room or cabinet, fitted with a child-resistive opening device, inaccessible to children, and separate from stored medications and food.</p> <p>Chemicals used in lawn care treatments should be limited to those listed for use in areas that can be occupied by children.</p> <p>Medications can be toxic if taken by the wrong person or in the wrong dose. Medications should be stored safely (see Standard 3.6.3.1) and disposed of properly (see Standard 3.6.3.2).</p> <p>The telephone number for the poison center should be</p>	<p>170-300-0260 Storage of hazardous and maintenance supplies.</p> <p>(1) An early learning provider must ensure all poisonous or dangerous substances including, but not limited to fuels; solvents, oils, laundry, dishwasher, and other detergents, sanitizing products, disinfectants and items labeled “keep out of reach of children” are stored:</p> <ul style="list-style-type: none">(a) In a location that is inaccessible to children;(b) Separate and apart from food preparation areas, food items, and food supplies;(c) In their original containers or clearly labeled with the name of the product if not in the original container; and(d) In compliance with the manufacturer’s directions (including not storing products near heat sources). <p>Weight #7</p> <p>(2) Storage areas and storage rooms must:</p> <ul style="list-style-type: none">(a) Be inaccessible to children;(b) Have locking doors or other methods to prevent child access;(c) Have moisture resistant and easily cleanable floors;(d) Have a designated maintenance or janitorial utility sink, or another method to dispose of wastewater (kitchen sinks must not be used for disposal of wastewater); and(e) Be kept clean and sanitary. <p>Weight #7</p> <p>(3) Center early learning program space with storage areas and rooms that contain chemicals, utility sinks, or wet mops must be ventilated to the outdoors with an exterior window or mechanical ventilation to prevent the buildup of odors, fumes, or other hazards. Weight #6</p> <p>(4) Family home providers must store and maintain chemicals and wet mops in a manner that minimizes the buildup of odors, fumes, or other hazards. Weight #6</p> <p>(5) Saws, power tools, lawn mowers, toilet plungers, toilet brushes, and other maintenance and janitorial equipment must be inaccessible to children. Weight #7</p> <p>170-300-0240 Clean and healthy environment.</p> <p>(2) Hard surfaces in early learning programs, including, but not limited to, floors (excluding carpet), walls, counters, bookshelves, and tables must be smooth and easily cleanable.</p> <ul style="list-style-type: none">(f) If an early learning provider uses a product other than bleach, including wipes, to sanitize or disinfect, the product must be:(i) Approved by the department prior to use;	Meets		

<p>posted in a location where it is readily available in emergency situations (e.g., next to the telephone).Poison centers are open twenty-four hours a day, seven days a week, and can be reached at 1-800-222-1222.</p>	<p>(ii) Used by trained staff only;</p> <p>(iii) Registered with the EPA and have Safety Data Sheets (SDS) available;</p> <p>(iv) Used in accordance with the manufacturer’s label, which must include:</p> <p>(A) Directions for use;</p> <p>(B) A description of the safety precautions, procedures, and equipment that must be used for mixing the substitute product concentration, if applicable;</p> <p>(C) A description of the safety precautions and procedures if the substitute product contacts skin or is inhaled, if applicable; and</p> <p>(D) A description of the procedures and safety precautions for rinsing cleaned areas and cleaning equipment, if applicable.</p> <p>170-300-0505 Postings.</p> <p>(1) Postings listed in subsection (2) of this section that are part of an early learning program must be clearly visible to parents, guardians, and early learning program staff.</p> <p>Weight #4</p> <p>(2) Postings on early learning premises must include:</p> <p>(g) Emergency numbers and information, including but not limited to:</p> <p>(iv) Washington poison center toll-free number; and</p> <p>Weight NA</p>				
<p>STANDARD 5.2.9.13: Testing for Lead</p> <p>In all centers, both exterior and interior surfaces covered by paint with lead levels of 0.06% and above, or equal to or greater than 1.0 milligram per square centimeter and accessible to children, should be removed by a safe chemical or physical means or made inaccessible to children, regardless of the condition of the surface.</p> <p>In large and small family child care homes, flaking or deteriorating lead-based paint on any surface accessible to children should be removed or abated according to health department regulations. Where lead paint is removed, the surface should be refinished with lead-free paint or non-toxic material. Sanding, scraping, or burning of lead-based paint surfaces should be prohibited. Children and pregnant women should not be present during lead renovation or lead abatement activities.</p> <p>Any surface and the grounds around and under surfaces that children use at a child care facility, including dirt and grassy areas should be tested for excessive lead in a location designated by the health department. Caregivers/ teachers should check the U.S. Consumer Product Safety</p>	<p>170-300-0410 License and program location.</p> <p>(3) Early learning program space must be located:</p> <p>(a) On a site free from known environmental hazards; Weight: 6</p> <p>(4) An early learning provider must prevent enrolled children from being exposed to the following known hazards within and around the licensed premises:</p> <p>(a) Lead based paint;</p> <p>(b) Plumbing and fixtures containing lead or lead solders;</p> <p>(c) Asbestos;</p> <p>(d) Arsenic, lead, or copper in the soil or drinking water;</p> <p>(e) Toxic mold; and</p> <p>(f) Other identified toxins or hazards. Weight #8</p> <p>170-300-0150 Program and activities.</p> <p>(1) An early learning provider must supply children in care with early learning materials and equipment that are age and developmentally appropriate. For each age group of children in care, a provider must supply a variety of materials that satisfy individual, developmental, and cultural needs. Early learning materials must be:</p> <p>(e) Nonpoisonous and free of toxins. If an early learning provider is using prepackaged art materials, the materials must be labeled “non-toxic” and meet ASTM standard D-4236 as described in 16 C.F.R. 1500. 14(b)(8)(i), as now and hereafter amended; Weight #6</p>	Meets			

Commission’s Website, http://www.cpsc.gov , for warnings of potential lead exposure to children and recalls of play equipment, toys, jewelry used for play, imported vinyl mini-blinds and food contact products. If they are found to have toxic levels, corrective action should be taken to prevent exposure to lead at the facility. Only nontoxic paints should be used.	<p>(h) Removed from the early learning program space once an item has been recalled by CPSC. Weight #6</p> <p>170-300-0295 Infant and toddler programs and activities.</p> <p>(2) An early learning provider must ensure an adequate supply of age and developmentally appropriate program materials and equipment for infants and toddlers. Materials and equipment must meet individual, developmental, and cultural needs of children in care, and must be:</p> <p>(b) Nonpoisonous, free of toxins, and meet ASTM D-4236 labeling requirements for chronic health hazards;</p> <p>(h) Removed from the early learning premises as soon as a provider becomes aware an item has been recalled by CPSC.</p> <p>Weight #NA</p> <p>WAC 170-300-0165 Safety requirements.</p> <p>(1) An early learning provider must keep indoor and outdoor early learning program space, materials, and equipment free from hazards and in safe working condition. Equipment and toys purchased and used must be compliant with CPSC guidelines or ASTM standards, as now and hereafter amended. Playground equipment and surfaces must meet the requirements of WAC 170-300-0146. Weight NA.</p>				
<p>STANDARD 5.2.9.2: Use of a Poison Center</p> <p>The poison center should be called for advice about any exposure to toxic substances, or any potential poisoning emergency. The national help line for the poison center is 1-800-222-1222, and specialists will link the caregiver/teacher with their local poison center. The advice should be followed and documented in the facility’s files. The caregiver/teacher should be prepared for the call by having the following information for the poison center specialist:</p> <p>a) The child’s age and sex;</p> <p>b) The substance involved;</p> <p>c) The estimated amount;</p> <p>d) The child’s condition;</p> <p>(e) The time elapsed since ingestion or exposure. The caregiver/teacher should not induce vomiting unless instructed by the poison center.</p>	<p>170-300-0475 Duty to protect children and report incidents.</p> <p>(2) An early learning provider must report by phone upon knowledge of the following to:</p> <p>(c) Washington Poison Center immediately after calling 911, and to the department within 24 hours:</p> <p>(i) A poisoning or suspected poisoning;</p> <p>(ii) A child who is given too much of any oral, inhaled, or injected medication; or</p> <p>(iii) A child who took or received another child’s medication.</p> <p>(iv) A provider must follow any directions provided by Washington Poison Center.</p> <p>Weight #8</p> <p>(3) In addition to reporting to the department by phone or e-mail, an early learning provider must submit a written incident report of the following on a department form within 24 hours:</p> <p>(a) Situations that required an emergency response from Emergency Services (911), Washington Poison Center, or department of health;</p> <p>Weight #5</p> <p>WAC 170-300-0465 Retaining facility and program records.</p> <p>(4) An early learning provider must keep the following records available for department review: (j) Child incident and illness logs.</p>	Meets			
<p>STANDARD 5.2.9.3: Informing Staff Regarding Presence of Toxic Substances</p> <p>Employers should provide staff with hazard information, including access to and review of the Material Safety Data Sheets (MSDS) as required by the Occupational Safety and Health Administration (OSHA), about the</p>	<p>170-300-0240 Clean and healthy environment.</p> <p>(1) Early learning program premises and program equipment must be clean and sanitary. Weight NA</p> <p>(2) Hard surfaces in early learning programs, including, but not limited to, floors (excluding carpet), walls, counters, bookshelves, and tables must be smooth and easily cleanable.</p> <p>(a) A cleanable surface must be:</p> <p>(i) Designed to be cleaned frequently and made of sealed wood, linoleum, tile, plastic, or other solid surface materials;</p>	Meets			

presence of toxic substances such as formaldehyde, cleaning and sanitizing supplies, insecticides, herbicides, and other hazardous chemicals in use in the facility. Staff should always read the label prior to use to determine safety in use. For example, toxic products regulated by the Environmental Protection Agency (EPA) will have an EPA signal word of CAUTION, WARNING, or DANGER. Where nontoxic substitutes are available, these nontoxic substitutes should be used instead of toxic chemicals. If a nontoxic product is not available, caregivers/teachers should use the least toxic product for the job. A CAUTION label is safer than a WARNING label, which is safer than a DANGER label.	<div>(ii) Moisture resistant; and</div> <div>(iii) Free of chips, cracks, and tears.</div> <div>(b) An early learning provider must have at least 24 inches of moisture resistant and cleanable material or barrier around sinks, drinking fountains, and toilets.</div> <div>(c) An early learning provider must clean all surfaces before sanitizing or disinfecting. Surfaces must be cleaned with a soap and water solution or spray cleaner and rinsed. If using a spray cleaning, directions on the label must be followed.</div> <div>(d) Aerosol sprays and air fresheners must not be used during child care hours.</div> <div>(e) If a bleach solution is used for sanitizing or disinfecting, an early learning provider must use one that is fragrance-free and follow department of health’s current Guidelines for Mixing Bleach Solutions for Child Care and Similar Environments.</div> <div>(f) If an early learning provider uses a product other than bleach, including wipes, to sanitize or disinfect, the product must be:<div>(i) Approved by the department prior to use;</div><div>(ii) Used by trained staff only;</div><div>(iii) Registered with the EPA and have Safety Data Sheets (SDS) available;</div><div>(iv) Used in accordance with the manufacturer’s label, which must include:<div>(A) Directions for use;</div><div>(B) A description of the safety precautions, procedures, and equipment that must be used for mixing the substitute product concentration, if applicable;</div><div>(C) A description of the safety precautions and procedures if the substitute product contacts skin or is inhaled, if applicable; and</div><div>(D) A description of the procedures and safety precautions for rinsing cleaned areas and cleaning equipment, if applicable.</div></div><div>(v) Labeled as safe to use on food surfaces if the product will be used to sanitize:<div>(A) Food contact surfaces; or</div><div>(B) Items such as eating utensils or toys used by the child or put into the child’s mouth; and</div></div><div>(vi) Fragrance-free.</div><div>Weight #6</div></div>				
STANDARD 5.2.9.5: Carbon Monoxide Detectors Carbon monoxide detector(s) should be installed in child care settings if one of the following guidelines is met: <div>a) The child care program uses any sources of coal, wood, charcoal, oil, kerosene, propane, natural gas, or any other product that can produce carbon monoxide indoors or in an attached garage;</div> <div>b) If detectors are required by state/local law or state licensing agency.</div> Facilities must meet state or local laws regarding carbon monoxide detectors. Detectors should be tested monthly.	170-300-0170 Fire safety. <div>(1) An early learning provider must comply with the State Building Code, as now and hereafter amended, pursuant to RCW 19.27.031. Weight #7</div> <div>(3) To ensure a safe environment for children in care, an early learning provider must comply with the following fire safety requirements:<div>(g) Fire alarms and smoke and carbon monoxide detectors.<div>(i) An early learning provider must have and maintain at least one smoke detector per licensed sleeping area and one per floor. Pursuant to the State Building Code, center early learning providers must comply with WAC 51-50-0907, as now and hereafter amended, and family early learning providers must comply with WAC 51-51-0314, as now and hereafter amended; and</div></div></div>	Meets			

Batteries should be changed at least yearly. Detectors should be replaced at least every five years.	<p>(ii) An early learning program must have and maintain carbon monoxide detectors. Pursuant to the State Building Code, the State Building Code, center early learning providers must comply with WAC 51-50-0915, as now and hereafter amended, and family early learning providers must comply with WAC 51-51-0315, as now and hereafter amended.</p> <p>170-300-0465 Retaining facility and program records. (1) An early learning provider must keep the records required in this chapter for a minimum of three years unless otherwise indicated. Weight #1</p> <p>(5) An early learning provider must keep the following records available for department review: (g) Monthly testing of smoke and carbon monoxide detectors; Weight #1</p>				
<p>STANDARD 5.3.1.12: Availability and Use of a Telephone or Wireless Communication Device</p> <p>The facility should provide at all times at least one working non-pay telephone or wireless communication device for general and emergency use:</p> <p>a) On the premises of the child care facility; b) In each vehicle used when transporting children; c) On field trips.</p> <p>Drivers, while transporting children should not operate a motor vehicle while using a mobile telephone or wireless communications device when the vehicle is in motion or a part of traffic, with the exception of use of a navigational system or global positioning system device.</p>	<p>170-300-0120 Providing for personal, professional, and health needs of staff. (1) A licensee must provide for the personal and professional needs of staff by: (b) Having a readily accessible phone to use for emergency calls or to contact the parents of enrolled children; and Weight #4</p> <p>170-300-0166 Emergency preparation and exiting. (1) To be properly prepared for an emergency, an early learning program must have an emergency preparedness plan pursuant to WAC 170-300-0470. Weight NA</p> <p>(2) An early learning provider must have the following in case of an emergency: (b) A working telephone must be available for use with sufficient backup power to function for at least five hours. Weight #6</p> <p>170-300-0480 Transportation and off-site activity policy. (2) During travel to an off-site activity, an early learning provider must: (b) Have a phone to call for emergency help;</p>	Meets			
<p>STANDARD 5.4.5.2: Cribs</p> <p>Facilities should check each crib before its purchase and use to ensure that it is in compliance with the current U.S. Consumer Product Safety Commission (CPSC) and ASTM safety standards.</p> <p>Recalled or “second-hand” cribs should not be used or stored in the facility. When it is determined that a crib is no longer safe for use in the facility, it should be dismantled and disposed of appropriately.</p> <p>Staff should only use cribs for sleep purposes and should ensure that each crib is a safe sleep environment. No child of any age should be placed in a crib for a time-out or for disciplinary reasons. When an infant becomes large enough or mobile enough to reach crib latches or potentially climb out of a crib, they should be transitioned to a different sleeping environment (such as a cot or sleeping mat).</p>	<p>170-300-0135 Routine care, play, learning, relaxation, and comfort. (1) An early learning provider must have accessible and child-size furniture and equipment (or altered and adapted in a family home early learning program) in sufficient quantity for the number of children in care. Tables must not be bucket style. Weight #4</p> <p>(2) Furniture and equipment must be: (a) Maintained in a safe working condition; (b) Developmentally and age appropriate; (c) Visually inspected at least weekly for hazards, broken parts, or damage. All equipment with hazardous, broken parts, or damage must be repaired as soon as possible and must be in accessible to children until repairs are made according to the manufacturer’s instructions, if available; Weight #5</p> <p>170-300-0165 Safety requirements (1) An early learning provider must keep indoor and outdoor early learning program space, materials, and equipment free from hazards and in safe working condition. Equipment and toys purchased and used must be compliant with CPSC guidelines or ASTM standards, as now and hereafter amended. Playground equipment and surfaces must meet the requirements of WAC 170-300-0146. Weight NA</p>	Partially Meets	There is no WAC requiring Staff should inspect each crib before each use to ensure that hardware is tightened and that there are not any safety hazards. If a screw or bolt cannot be tightened securely, or there are missing or broken screws, bolts, or mattress support hangers, the crib should not be used.		

<p>Each crib should be identified by brand, type, and/or product number and relevant product information should be kept on file (with the same identification information) as long as the crib is used or stored in the facility.</p> <p>Staff should inspect each crib before each use to ensure that hardware is tightened and that there are not any safety hazards. If a screw or bolt cannot be tightened securely, or there are missing or broken screws, bolts, or mattress support hangers, the crib should not be used.</p> <p>Safety standards document that cribs used in facilities should be made of wood, metal, or plastic. Crib slats should be spaced no more than two and three-eighths inches apart, with a firm mattress that is fitted so that no more than two fingers can fit between the mattress and the crib side in the lowest position. The minimum height from the top of the mattress to the top of the crib rail should be twenty inches in the highest position. Cribs with drop sides should not be used. The crib should not have cornerpost extensions (over one-sixteenth inch). The crib should have no cutout openings in the head board or footboard structure in which a child's head could become entrapped. The mattress support system should not be easily dislodged from any point of the crib by an upward force from underneath the crib. All cribs should meet the ASTM F1169-10a Standard Consumer Safety Specification for Full-Size Baby Cribs, F406-10b Standard Consumer Safety Specification for Non-Full-Size Baby Cribs/Play Yards, or the CPSC 16 CFR 1219, 1220, and 1500 – Safety Standards for Full-Size Baby Cribs and Non-Full-Size Baby Cribs; Final Rule.</p> <p>Cribs should be placed away from window blinds or draperies.</p> <p>As soon as a child can stand up, the mattress should be adjusted to its lowest position. Once a child can climb out of his/her crib, the child should be moved to a bed. Children should never be kept in their crib by placing, tying, or wedging various fabric, mesh, or other strong coverings over the top of the crib.</p> <p>Cribs intended for evacuation purpose should be of a design and have wheels that are suitable for carrying up to five non-ambulatory children less than two years of age to a designated evacuation area. This crib should be used for evacuation in the event of fire or other emergency. The crib should be easily moveable and should be able to fit through the designated fire exit.</p>	<p>(2) An early learning provider must take steps to prevent hazards to children including, but not limited to:</p> <ul style="list-style-type: none">(b) Eliminating and not using in the licensed space, pursuant to RCW 43.216.380, any window blinds or other window coverings with pull cords or inner cords capable of forming a loop and posing risk of strangulation to children;<ul style="list-style-type: none">(i) Window blinds and other window coverings that have been manufactured or properly retrofitted in a manner that eliminates the formation of loops posing a risk of strangulation are allowed; and(ii) A window covering must not be secured to the frame of a window or door used as an emergency exit in a way that would prevent the window or door from opening easily; Weight #7(g) Cribs, play pens, bassinets, infant beds, and indoor climbing structures must not be placed next to windows, to prevent harm from shattered glass, unless the window is made of safety glass. Weight #6 <p>170-300-0290 Infant and toddler sleep, rest, and equipment.</p> <p>(1) For infants, an early learning provider must supply a single level crib, playpen, or other developmentally appropriate sleep equipment. Providers must not use sofas, couches, or adult-sized or toddler beds for infant sleeping. Weight #6</p> <p>(2) For toddlers, an early learning provider must supply a single level crib, playpen, toddler bed, or other developmentally appropriate sleep equipment. An early learning provider must allow toddlers to follow their own sleep patterns. Weight #6</p> <p>(3) Sleep equipment not covered in WAC 170-300-0265 must:</p> <ul style="list-style-type: none">(a) Be approved by CPSC or ASTM International safety standards for use by infants and toddlers; Weight #7(b) Cribs must have a certificate of compliance, sticker, or documentation from the manufacturer or importer stating the crib meets 16 Code of Federal Regulations (C.F.R.) 1219 and 1220; Weight #7(c) Have a clean, firm, and snug-fitting mattress designed specifically for the particular equipment; Weight #7(d) Have a tight-fitted sheet that is designed for the sleep equipment; Weight #7(e) Have a moisture resistant and easily cleaned and sanitized mattress, if applicable. The mattress must be free of tears or holes and not repaired with tape; Weight #5(f) The sheet must be laundered at least weekly or more often, such as between uses by different children or if soiled; Weight #5(g) Cribs and playpens arranged side by side must be spaced at least 30 inches apart; Weight #5 and(h) Cribs and playpens placed end to end must have a moisture resistant and easily cleanable solid barrier if spaced closer than 30 inches. Weight #5 <p>(4) An early learning provider must immediately remove sleeping children from car seats, swings, or similar equipment not designed for sleep unless doing so would put another enrolled child at risk. Weight #7</p> <p>(5) An early learning provider must consult with a child's parent or guardian before the child is transitioned from infant sleeping equipment to other sleep equipment. Weight #5</p>				
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<p>(6) An early learning provider must transition children who are able to climb out of their sleeping equipment to developmentally appropriate sleep equipment. When parents don't agree with transitioning, the provider and parent will create a transition plan. Weight #7</p> <p>170-300-0291 Infant safe sleep practices. (1) An early learning provider must follow infant safe sleep practices when infants are napping or sleeping by following the current standard of American Academy of Pediatrics concerning safe sleep practices including SIDS/SUIDS risk reduction, including:</p> <ul style="list-style-type: none">(a) Actively supervising infants by visibly checking at least every 15 minutes and being within sight and hearing range, including when an infant goes to sleep, is sleeping, or is waking up; Weight #7(b) Placing an infant to sleep on his or her back or following the current standard of American Academy of Pediatrics. If an infant turns over while sleeping, the provider must return the infant to his or her back until the infant is able to independently roll from back to front and front to back; Weight #7(c) Not using a sleep positioning device unless directed to do so by an infant's health care provider. The directive must be in writing and kept in the infant's record; Weight #7(d) Sufficiently lighting the room in which the infant is sleeping to observe skin color; Weight #7(e) Monitoring breathing patterns of an infant; Weight #7(f) Allowing infants to follow their own sleep patterns; Weight #6(g) Not allowing blankets, stuffed toys, pillows, crib bumpers, or similar items inside a crib, bassinet, or other equipment if occupied by a resting or sleeping infant; Weight #8(h) Not allowing a blanket or any other item to cover or drape over an occupied crib, bassinet, or other equipment where infants commonly sleep; Weight #8(i) Not allowing bedding, or clothing to cover any portion of an infant's head or face while sleeping, and readjusting these items when necessary; Weight #8(j) Visibly check on infants while sleeping and readjust blankets, bedding or clothing as needed; and Weight #8(k) Preventing infants from getting too warm while sleeping; which may be exhibited by indicators that include, but are not limited to, sweating; flushed, pale, or hot and dry skin, warm to the touch, a sudden rise in temperature, vomiting, refusing to drink, a depressed fontanelle, or irritability. Weight #7 <p>(2) An early learning provider who receives notice of a safe sleep violation must:</p> <ul style="list-style-type: none">(a) Post the notice in the licensed space for two weeks or until the violation is corrected, whichever is longer, pursuant to WAC 170-300-0505; Weight NA and(b) Within five business days of receiving notice of the violation, provide the parents or guardians of enrolled children with:<ul style="list-style-type: none">(i) A letter describing the safe sleep violation; and(ii) Written information on safe sleep practices.Weight #5 <p>170-300-0470 Emergency preparedness plan. (2) The written emergency preparedness plan must cover at minimum:</p> <ul style="list-style-type: none">(a) Disaster plans, including fires that may require evacuation:<ul style="list-style-type: none">(iv) How the early learning provider will evacuate children, especially those who cannot walk independently. This may include infant evacuation cribs (for center early learning programs), children with disabilities, functional needs requirements, or other special needs;Weight #4				
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	<p>170-300-0465 Retaining facility and program records. (1) An early learning provider must keep the records required in this chapter for a minimum of three years unless otherwise indicated. Weight #1</p> <p>(5) An early learning provider must keep the following records available for department review: (b)Furniture, sleep, and play equipment forms and specifications; Weight #1</p> <p>170-300-0331 Prohibited behavior, discipline, and physical removal of children. (1) An early learning provider must take steps to prevent and, once aware of, must not tolerate: (g) Anyone to: (xii) Use high chairs, car seats, or other confining space or equipment to punish a child or restrict movement. Weight #8</p>				
<p>STANDARD 5.5.0.6: Inaccessibility to Matches, Candles, and Lighters Matches, candles, and lighters should not be accessible to children.</p>	<p>170-300-170 Fire safety. (3) To ensure a safe environment for children in care, an early learning provider must comply with the following safety requirements: (d) Open flame devices, candles, matches and lighters. (i) Except for the use of a gas kitchen range, open flame devices must not be used in early learning program space or any other space accessible to children in care during operating hours. (ii) Candles must not be used during operating hours. (iii) Matches and lighters must be inaccessible to children. Weight #7</p>	Meets			
<p>STANDARD 5.5.0.7: Storage of Plastic Bags Plastic bags, whether intended for storage, trash,diaper disposal, or any other purpose, should be stored out of reach of children.</p>	<p>170-300-165 Safety requirements. (2) An early learning provider must take steps to prevent hazards to children including, but not limited to: (d) Making inaccessible to children plastic bags and other suffocation hazards; Weight #7</p>	Meets			
<p>STANDARD 5.5.0.8: Firearms Centers should not have any firearms, pellet or BB guns (loaded or unloaded), darts, bows and arrows, cap pistols, stun guns, paint ball guns, or objects manufactured forplay as toy guns within the premises at any time. If present in a small or large family child care home, these items mustbe unloaded, equipped with child protective devices, and kept under lock and key with the ammunition locked separately in areas inaccessible to the children. Parents/guardians should be informed about this policy.</p>	<p>170-300-0165 Safety requirements. (2) An early learning provider must take steps to prevent hazards to children including, but not limited to: (e) Ensuring firearms, guns, weapons, and ammunition are not on the premises of a center early learning program. Firearms, guns, weapons, and ammunition on the premises of a family home early learning program must be stored in a locked gun safe or locked room inaccessible to children. If stored in a locked room, each gun must be stored unloaded and with a trigger lock or other disabling device. The locked room must be inaccessible to children at all times; Weight #8</p> <p>170-300-0450Parent or guardian handbook and related policies. (1)An early learning provider must supply to each parent or guardian written policies regarding the early learning program. Each enrolled child’s record must have signed documentation stating the parent or</p>	Meets			

	<p>guardian reviewed the handbook and early learning program policies. Weight #3</p> <p>(2)An early learning provider must have and follow formal written policies in either paper or electronic format, including:</p> <p>(i) If the early learning program offers any of the following, they must include a policy for each that applies to their program:</p> <p>(viii) How weapons on the premises are secured;</p>				
<p>STANDARD 6.1.0.3: Rooftops as Play Areas</p> <p>A rooftop used as a play area should be enclosed with a fence from four to six feet high, in accordance with local ordinance, and the bottom edge should be less than three and one-half inches from the base (1). The fence should be designed to prevent children from climbing it. An approved fire escape should lead from the roof to an open space at the ground level that meets the safety standards for outdoor play areas.</p>	<p>170-300-0145 Outdoor early learning program space.</p> <p>(6) Licensed outdoor play areas must be enclosed with a fence or barrier that is intended to prevent children from exiting and discourages climbing. If the outdoor play area is enclosed by a barrier that is not a fence, the barrier may be a wall constructed with brick, stone, or a similar material. Weight #7</p> <p>(8) Fences, barriers, and gates must be in good condition, have no gap through which a sphere with a diameter of three and one-half (3½) inches can pass, and have a minimum height of 48 inches or conform to applicable local codes. Weight #6</p> <p>(9) The opening between a fence post and gate or fence post and building must have no gap through which a sphere with a diameter of three and one-half (3½) inches can pass. Weight #6</p>	Not Addressed	No WAC found that specifically addresses rooftops as play areas.		
<p>STANDARD 6.1.0.4: Elevated Play Areas</p> <p>Elevated play areas that have been created using a retaining wall should have a guardrail, protective barrier, or fence running along the top of the retaining wall.</p> <p>If the exposed side of the retaining wall is higher than two feet, a fence not less than six feet high should be installed. The bottom edge of the fence should be less than three and one-half inches from the base and should be designed to prevent children from climbing it. Fences should be designed so all spaces are less than three and one-half inches (1). If the height of the exposed side of the retaining wall is two feet or lower, a guardrail should be installed if caring for preschool and school-age children. The space between the bottom of the guardrail and the ground should be more than nine inches but less than or equal to twenty-three inches. For school-age children, the space between the bottom of the guardrail and the ground should be more than nine inches but less than or equal to twenty-eight inches. If caring for infants or toddlers, a protective barrier should be installed. The space between the barrier and the ground should be less than three and one-half inches and should be from four to six feet in height.</p>	<p>170-300-0145 Outdoor early learning program space.</p> <p>(6) Licensed outdoor play areas must be enclosed with a fence or barrier that is intended to prevent children from exiting and discourages climbing. If the outdoor play area is enclosed by a barrier that is not a fence, the barrier may be a wall constructed with brick, stone, or a similar material. Weight #7</p> <p>(8) Fences, barriers, and gates must be in good condition, have no gap through which a sphere with a diameter of three and one-half (3½) inches can pass, and have a minimum height of 48 inches or conform to applicable local codes. Weight #6</p> <p>(9) The opening between a fence post and gate or fence post and building must have no gap through which a sphere with a diameter of three and one-half (3½) inches can pass. Weight #6</p> <p>170-300-0165 Safety requirements.</p> <p>(4) To ensure a safe environment for children in care, an early learning provider must comply with the following requirements:</p> <p>(g) Platforms and decks. All platforms and decks used for child care activities must meet local building codes pursuant to RCW 43.216.340 within six months of the date this section becomes effective. This does not include play equipment. All platforms and decks with a drop zone of more than 18 inches must have guardrails in sections without steps. Weight #7</p>	Meets			

<p>STANDARD 6.1.0.6: Location of Play Areas Near Bodies of Water</p> <p>Outside play areas should be free from the following bodies of water:</p> <ul style="list-style-type: none">a) Unfenced swimming and wading pools;b) Ditches;c) Quarries;d) Canals;e) Excavations;f) Fish ponds;g) Water retention or detention basins;h) Other bodies of water.	<p>170-300-0175 Water hazards and swimming pools.</p> <p>To prevent injury or drowning and ensure the health and safety of children, an early learning provider must comply with the requirements described in this section.</p> <p>(1) The following bodies of water must be inaccessible to children in care by using a physical barrier with a locking mechanism:</p> <ul style="list-style-type: none">(a) Swimming pools when not being used as part of the early learning program, hot tubs, spas and jet tubs;(b) Ponds, lakes, storm retention ponds, ditches, fountains, fish ponds, landscape pools or similar bodies of water; and(c) Uncovered wells, septic tanks, waste water, wastewater tanks, below grade storage tanks, farm manure ponds or other similar hazards. Weight #8 <p>(3) Filtered wading pools must be inaccessible to children when not in use. Wading pools that do not have a filtering system are not permitted in the early learning program space. Weight #7</p> <p>(4) For bodies of water not located in early learning program space, but that are in close proximity, a physical barrier on the property must make such bodies of water inaccessible to children in care. Weight #8</p>	Meets			
<p>STANDARD 6.1.0.8: Enclosures for Outdoor Play Areas</p> <p>The outdoor play area should be enclosed with a fence or natural barriers. Fences and barriers should not prevent the observation of children by caregivers/teachers. If a fence is used, it should conform to applicable local building codes in height and construction. Fence posts should be outside the fence where allowed by local building codes. These areas should have at least two exits, with at least one being remote from the buildings.</p> <p>Gates should be equipped with self-closing and positive self-latching closure mechanisms. The latch or securing device should be high enough or of a type such that children cannot open it. The openings in the fence and gates should be no larger than three and one-half inches. The fence and gates should be constructed to discourage climbing. Play areas should be secured against inappropriate use when the facility is closed.</p> <p>Wooden fences and playground structures created out of wood should be tested for chromated copper arsenate (CCA). Wooden fences and playground structures created out of wood that is found to contain CCA should be sealed with an oil-based outdoor sealant annually.</p>	<p>170-300-0145 Outdoor early learning program space.</p> <p>(6) Licensed outdoor play areas must be enclosed with a fence or barrier that is intended to prevent children from exiting and discourages climbing. If the outdoor play area is enclosed by a barrier that is not a fence, the barrier may be a wall constructed with brick, stone, or a similar material. Weight #7</p> <p>(7) Licensed outdoor play areas must be enclosed to deter people without permission from entering the area. Weight #7</p> <p>(8) Fences, barriers, and gates must be in good condition, have no gap through which a sphere with a diameter of three and one-half (3½) inches can pass, and have a minimum height of 48 inches or conform to applicable local codes. Weight #6</p> <p>(9) The opening between a fence post and gate or fence post and building must have no gap through which a sphere with a diameter of three and one-half (3½) inches can pass. Weight #6</p> <p>(10) An early learning provider must not install any wooden fence, playground structure, or furniture if it contains chromated copper arsenate (CCA), creosote or pentachlorophenol. If wooden fences, structures, and furniture are suspected of having CCA they must be tested. If CCA is present, fences, structures, and furniture must be removed or sealed with an oil-based outdoor sealant annually or as needed within six months of the date this section becomes effective. Weight #6</p> <p>(11) Within six months of the date this section becomes effective or prior to licensing, exiting mechanism on gates from a licensed outdoor play area to unlicensed space must be equipped with a self-closing and self-latching mechanism (shuts automatically when released from an individual’s control). A gate that is not an emergency exit must be locked or self-closing and self-latching. Weight #6</p> <p>(12) Outdoor play areas must have two exits that must not be partially or entirely blocked, with at least one exit located away from the building. Weight #5</p>	Meets			

<p>STANDARD 6.2.3.1: Prohibited Surfaces for Placing Climbing Equipment</p> <p>Equipment used for climbing should not be placed over, or immediately next to, hard surfaces such as asphalt, concrete, dirt, grass, or flooring covered by carpet or gym mats not intended for use as surfacing for climbing equipment. All pieces of playground equipment should be placed over and surrounded by a shock-absorbing surface. This material may be either the unitary or the loose-fill type, as defined by the U.S. Consumer Product Safety Commission (CPSC) guidelines and ASTM International (ASTM) standards, extending at least six feet beyond the perimeter of the stationary equipment. These shock-absorbing surfaces must conform to the standard stating that the impact of falling from the height of the structure will be less than or equal to peak deceleration of 200G and a Head Injury Criterion (HIC) of 1000 and should be maintained at all times. Organic materials that support colonization of molds and bacteria should not be used. All loose fill materials must be raked to retain their proper distribution, shock-absorbing properties and to remove foreign material. This standard applies whether the equipment is installed outdoors or indoors.</p>	<p>170-300-0146 Equipment and surfaces in outdoor early learning space.</p> <p>(1) Playground equipment and surfacing used by an early learning provider must comply with applicable CPSC guidelines, as now and hereafter amended including, but not limited to, installing, arranging, designing, constructing, and maintaining outdoor play equipment and surfacing.</p> <p>(a) Climbing play equipment must not be placed on or above concrete, asphalt, packed soil, lumber, or similar hard surfaces;</p> <p>(b) The ground under swings and play equipment must be covered by a shock absorbing material (grass alone is not an acceptable) such as:</p> <p>(i) Pea gravel at least nine inches deep;</p> <p>(ii) Playground wood chips at least nine inches deep;</p> <p>(iii) Shredded recycled rubber at least six inches deep; or</p> <p>(iv) Any material that has a certificate of compliance, label, or documentation stating it meets ASTM standards F1292-13 and F2223-10, as now and hereafter amended.</p> <p>Weight #6</p> <p>(2) Permanently anchored outdoor play equipment must not be placed over septic tank areas or drain fields, and must be installed according to the manufacturer’s directions. Weight #6</p> <p>(3) Handmade playground equipment must be maintained for safety or removed when no longer safe. Prior to construction of new handmade playground equipment, the provider must notify the department and have plans and a materials list available upon request. Weight #6</p>	Meets			
<p>STANDARD 6.2.4.4: Trampolines</p> <p>Trampolines, both full and mini-size, should be prohibited from being used as part of the child care program activities both on-site and during field trips.</p>	<p>170-300-0146 Equipment and surfaces in outdoor early learning space.</p> <p>(4) Bouncing equipment including, but not limited to, trampolines, rebounders and inflatable equipment must be inaccessible and locked. This requirement does not apply to bounce balls designed to be used by individual children. Weight #7</p> <p>WAC 170-300-0480 addresses field trips - nothing was found about the use of trampolines on field trips.</p>	Meets			
<p>STANDARD 6.2.5.1: Inspection of Indoor and Outdoor Play Areas and Equipment</p> <p>The indoor and outdoor play areas and equipment should be inspected daily for the following:</p> <p>a) Missing or broken parts;</p> <p>b) Protrusion of nuts and bolts;</p> <p>c) Rust and chipping or peeling paint;</p> <p>d) Sharp edges, splinters, and rough surfaces;</p> <p>e) Stability of handholds;</p> <p>f) Visible cracks;</p> <p>g) Stability of non-anchored large play equipment (e.g., playhouses);</p> <p>h) Wear and deterioration.</p>	<p>170-300-0135 Routine care, play, learning, relaxation, and comfort.</p> <p>(2) Furniture and equipment must be:</p> <p>(c) Visually inspected at least weekly for hazards, broken parts, or damage. All equipment with hazardous, broken parts, or damage must be repaired as soon as possible and must be inaccessible to children until repairs are made according to the manufacturer’s instructions, if available; Weight #5</p> <p>170-300-0145 Outdoor early learning program space.</p> <p>(1) An early learning provider must visually inspect outdoor program space and equipment daily to ensure areas and equipment are free of hazards. Weight #6</p> <p>WAC 170-300-0165 Safety Requirements.</p> <p>(3) An early learning provider must take measures intended to prevent other hazards to children in care in early learning program space including, but not limited to: (g) Equipment in poor condition. Equipment in poor condition (loose parts, rusty parts, flaking paint, or other dangers) must be repaired, removed, or made inaccessible to children. Weight #4</p>	Partially Meets	No WAC found requiring licensee to document inspection.		

Observations should be documented and filed, and the problems corrected. Facilities should conduct a monthly inspection.					
<p>STANDARD 6.3.1.1: Enclosure of Bodies of Water</p> <p>All water hazards, such as pools, swimming pools, stationary wading pools, ditches, fish ponds, and water retention or detention basins should be enclosed with a fence that is four to six feet high or higher and comes within three and one-half inches of the ground. Openings in the fence should be no greater than three and one-half inches. The fence should be constructed to discourage climbing and kept in good repair.</p> <p>If the fence is made of horizontal and vertical members (like a typical wooden fence) and the distance between the tops of the horizontal parts of the fence is less than forty- five inches, the horizontal parts should be on the swimming pool side of the fence. The spacing of the vertical members should not exceed one and three-quarters inches.</p> <p>For a chain link fence, the mesh size should not exceed one and one-quarter square inches.</p> <p>Exit and entrance points should have self-closing, positive latching gates with locking devices a minimum of fifty-five inches from the ground.</p> <p>A wall of the child care facility should not constitute one side of the fence unless the wall has no openings capable of providing direct access to the pool (such as doors, windows, or other openings).</p> <p>If the facility has a water play area, the following requirements should be met:</p> <ul style="list-style-type: none">a) Water play areas should conform to all state and local health regulations;b) Water play areas should not include hidden or enclosed spaces;c) Spray areas and water-collecting areas should have a non-slip surface, such as asphalt;d) Water play areas, particularly those that have standing water, should not have sudden changes in depth of water;e) Drains, streams, water spouts, and hydrants should not create strong suction effects or water-jet forces;f) All toys and other equipment used in and around the water play area should be made of	<p>170-300-0175 Water hazards and swimming pools.</p> <p>To prevent injury or drowning and ensure the health and safety of children, an early learning provider must comply with the requirements described in this section.</p> <p>(1) The following bodies of water must be inaccessible to children in care by using a physical barrier with a locking mechanism:</p> <ul style="list-style-type: none">(a) Swimming pools when not being used as part of the early learning program, hot tubs, spas and jet tubs;(b) Ponds, lakes, storm retention ponds, ditches, fountains, fish ponds, landscape pools or similar bodies of water; and(c) Uncovered wells, septic tanks, waste water, wastewater tanks, below grade storage tanks, farm manure ponds or other similar hazards. Weight #8 <p>(2) An early learning provider must comply with the following requirements when using a swimming pool as part of the early learning program:</p> <ul style="list-style-type: none">(b) Audible alarms must be on all doors, screens, and gates in licensed areas that lead to a swimming pool. The alarm must be sufficient to warn staff when children enter the outdoor area and could access the swimming pool; Weight #8 <p>(3) Filtered wading pools must be inaccessible to children when not in use. Wading pools that do not have a filtering system are not permitted in the early learning program space. Weight #7</p> <p>(4) For bodies of water not located in early learning program space, but that are in close proximity, a physical barrier on the property must make such bodies of water inaccessible to children in care. Weight #8</p>	Meets	<p>While the fence type and size are not outlined WAC states: (1) The following bodies of water must be inaccessible to children in care by using a physical barrier with a locking mechanism:</p> <p>With the added measure of: (b) Audible alarms must be on all doors, screens, and gates in licensed areas that lead to a swimming pool. The alarm must be sufficient to warn staff when children enter the outdoor area and could access the swimming pool;</p>		

sturdy plastic or metal (no glass should be permitted); g) Water play areas in which standing water is maintained for more than twenty-four hours should be treated according to Standard 6.3.4.1, and inspected for glass, trash, animal excrement, and other foreign material.					
STANDARD 6.3.1.2: Accessibility to Above- Ground Pools Above-ground pools should have non-climbable sidewalls that are at least four feet high or should be enclosed withan approved fence. When the pool is not in use, steps should be removed from the pool or otherwise protected toensure that they cannot be accessed.	170-300-0145 Outdoor early learning program space. (6) Licensed outdoor play areas must be enclosed with a fence or barrier that is intended to prevent children from exiting and discourages climbing. If the outdoor play area is enclosed by a barrier that is not a fence, the barrier may be a wall constructed with brick, stone, or a similar material. Weight #7 (7) Licensed outdoor play areas must be enclosed to deter people without permission from entering the area. Weight #7 (8) Fences, barriers, and gates must be in good condition, have no gap through which a sphere with a diameter of three and one-half (3½) inches can pass, and have a minimum height of 48 inches or conform to applicable local codes. Weight #6 (9) The opening between a fence post and gate or fence post and building must have no gap through which a sphere with a diameter of three and one-half (3½) inches can pass. Weight #6 (10) An early learning provider must not install any wooden fence, playground structure, or furniture if it contains chromated copper arsenate (CCA), creosote or pentachlorophenol. If wooden fences, structures, and furniture are suspected of having CCA they must be tested. If CCA is present, fences, structures, and furniture must be removed or sealed with an oil-based outdoor sealant annually or as needed within six months of the date this section becomes effective. Weight #6 (11) Within six months of the date this section becomes effective or prior to licensing, exiting mechanism on gates from a licensed outdoor play area to unlicensed space must be equipped with a self-closing and self-latching mechanism (shuts automatically when released from an individual’s control). A gate that is not an emergency exit must be locked or self-closing and self-latching. Weight #6 (12) Outdoor play areas must have two exits that must not be partially or entirely blocked, with at least one exit located away from the building. Weight #5 170-300-0175 Water hazards and swimming pools. To prevent injury or drowning and ensure the health and safety of children, an early learning provider must comply with the requirements described in this section. (1) The following bodies of water must be inaccessible to children in care by using a physical barrier with a locking mechanism: (a) Swimming pools when not being used as part of the early learning program, hot tubs, spas and jet tubs;	Exceeds			

	<p>(b) Ponds, lakes, storm retention ponds, ditches, fountains, fish ponds, landscape pools or similar bodies of water; and</p> <p>(c) Uncovered wells, septic tanks, waste water, wastewater tanks, below grade storage tanks, farm manure ponds or other similar hazards. Weight #8</p> <p>(2) An early learning provider must comply with the following requirements when using a swimming pool as part of the early learning program:</p> <p>(b) Audible alarms must be on all doors, screens, and gates in licensed areas that lead to a swimming pool. The alarm must be sufficient to warn staff when children enter the outdoor area and could access the swimming pool; Weight #8</p> <p>(3) Filtered wading pools must be inaccessible to children when not in use. Wading pools that do not have a filtering system are not permitted in the early learning program space. Weight #7</p> <p>(4) For bodies of water not located in early learning program space, but that are in close proximity, a physical barrier on the property must make such bodies of water inaccessible to children in care. Weight #8</p>				
STANDARD 6.3.1.4: Safety Covers for Swimming Pools When not in use, in-ground and above-ground swimming pools should be covered with a safety cover that meets or exceeds the ASTM International (ASTM) standard “F1346- 03: Standard performance specification for safety covers and labeling requirements for all covers for swimming pools, spas, and hot tubs” (2).		Not Addressed	No WAC found that addresses covering swimming pools.		
STANDARD 6.3.1.6: Pool Drain Covers All covers for the main drain and other suction ports of swimming and wading pools should be listed by a nationally recognized testing laboratory in accordance with ASME/ ANSI standard “A112.19.8: Standard for Suction Fittings for Use in Swimming Pools, Wading Pools, Spas and Hot Tubs,” and should be used under conditions that do not exceed the approved maximum flow rate, be securely anchored using manufacturer-supplied parts installed per manufacturer’s specifications, be in good repair, and be replaced at intervals specified by manufacturer. Facilities with one outlet per pump, or multiple outlets per pump with less than thirty-six inches center-to-center distance for two outlets, must be equipped with a Safety Vacuum Release System (SVRS) meeting the ASME/ANSI standard “A112.19.17: Manufactured Safety Vacuum Release Systems for Residential and Commercial Swimming Pool, Spas, Hot Tub and Wading Pool Suction Systems” or ASTM International (ASTM) standard “F2387-04: Standard Specification for Manufactured SVRS for	170-300-0175 Water hazards and swimming pools. To prevent injury or drowning and ensure the health and safety of children, an early learning provider must comply with the requirements described in this section. (2) An early learning provider must comply with the following requirements when using a swimming pool as part of the early learning program: (e) A swimming pool must not be used if the main drain cover is missing; and Weight #8	Meets			

Swimming Pools, Spas, and Hot Tubs” standards, as required by the <i>Virginia Graeme Baker Pool and Spa Safety Act</i> , Section 1404(c)(1)(A)(I)(1,2).					
STANDARD 6.3.2.1: Lifesaving Equipment Each swimming pool more than six feet in width, length, or diameter should be provided with a ring buoy and rope, a rescue tube, or a throwing line and a shepherd’s hook that will not conduct electricity. This equipment should belong enough to reach the center of the pool from the edge of the pool, should be kept in good repair, and should be stored safely and conveniently for immediate access. Caregivers/ teachers should be trained on the proper use of this equipment so that in emergencies, caregivers/teachers will use equipment appropriately. Children should be familiarized with the use of the equipment based on their developmental level.	170-300-0350 Supervising children during water activities. (4) For water activities on or off the early learning program premises, where the water is more than 24 inches deep, an early learning provider must ensure: <ul style="list-style-type: none"> (a) A certified lifeguard is present and on duty; and (b) At least one additional staff member than would otherwise be required is present to help actively supervise if the children are preschool age or older. Weight #8 (5) An early learning provider must have life-saving equipment readily accessible during water activities if a pool is six feet or more in any direction and two feet or more in depth. Life-saving equipment may include a ring buoy and rope, a rescue tube, or a throwing line and a shepherd’s hook that will not conduct electricity. Weight #8	Meets			
STANDARD 6.3.5.1: Hot Tubs, Spas, and Saunas Children should not be permitted in hot tubs, spas, or saunas in child care. Areas should be secured to prevent any access by children.	170-300-0175 Water hazards and swimming pools. To prevent injury or drowning and ensure the health and safety of children, an early learning provider must comply with the requirements described in this section. <ul style="list-style-type: none"> (1) The following bodies of water must be inaccessible to children in care by using a physical barrier with a locking mechanism: <ul style="list-style-type: none"> (a) Swimming pools when not being used as part of the early learning program, hot tubs, spas and jet tubs; Weight #8 	Meets			
STANDARD 6.3.5.2: Water in Containers Bathtubs, buckets, diaper pails, and other open containers of water should be emptied immediately after use.	170-300-0175 Water hazards and swimming pools. To prevent injury or drowning and ensure the health and safety of children, an early learning provider must comply with the requirements described in this section. <ul style="list-style-type: none"> (5) Five-gallon buckets or other similar containers must not be used for infant or toddler water play. Weight #8 (6) If a provider uses water tables or similar containers, the tables or containers must be emptied and sanitized daily, or more often if necessary. Weight # 4 170-300-0220 Bathroom space and toilet training. (2) If an early learning program space is equipped with a bathtub or shower, the provider must: <ul style="list-style-type: none"> (a) Only give a bath or shower to a child with consent from that child’s parent or guardian; (b) Only use the bath or shower: <ul style="list-style-type: none"> (i) To clean a child after an accident, such as diarrhea or vomiting; or (ii) During non-standard hours; (c) Ensure the area around a bathtub or shower is resistant to slipping or equipped with a conveniently located grab bar; and 	Partially Meets	Inclusive of emptying and sanitizing however, (6) does not necessarily mean that the water table or container would be emptied when not in use/immediately after use. This could be interpreted to mean that they have to be cleaned daily, or more often if they get dirty.		

	(d) Keep the bathtub or shower inaccessible to children when not in use by children (in center early learning programs only). Weight #6				
STANDARD 6.4.1.2: Inaccessibility of Toys or Objects to Children Under Three Years of Age Small objects, toys, and toy parts available to children under the age of three years should meet the federal small parts standards for toys. The following toys or objects should not be accessible to children under three years of age: a) Toys or objects with removable parts with a diameter less than one and one-quarter inches and a length between one inch and two and one-quarter inches; b) Balls and toys with spherical, ovoid (egg shaped), or elliptical parts that are smaller than one and three-quarters inches in diameter; c) Toys with sharp points and edges; d) Plastic bags; e) Styrofoam objects; f) Coins; g) Rubber or latex balloons; h) Safety pins; i) Marbles; j) Magnets; k) Foam blocks, books, or objects; l) Other small objects; m) Latex gloves; n) Bulletin board tacks; o) Glitter.	170-300-0165 Safety requirements. (2) An early learning provider must take steps to prevent hazards to children including, but not limited to: (a) Making inaccessible to infants and toddlers any equipment, material, or objects that may pose a risk of choking, aspiration, or ingestion. For the purposes of this section, equipment, material, or objects that have a diameter or overall dimension of one and three-quarter (1 ¾) inches or less shall be considered items that may pose a risk of choking, aspiration, or ingestion. Small parts from larger equipment, material, or objects that have a diameter or overall dimension of one and three-quarter (1 ¾) inches or less, that may become detached from the larger equipment, materials, or object shall also be considered items that may pose a risk of choking, aspiration, or ingestion; Weight #6 (d) Making inaccessible to children plastic bags and other suffocation hazards; Weight #7 (3) An early learning provider must take measures intended to prevent other hazards to children in care in early learning program space including, but not limited to: (a) Cuts, abrasions, and punctures. Equipment, materials, and other objects on the premises that have splintered edges, sharp edges, points, protruding nails, bolts, or other dangers must be repaired, removed, or made inaccessible to children; Weight #5 (g) Equipment in poor condition. Equipment in poor condition (loose parts, rusty parts, flaking paint, or other dangers) must be repaired, removed, or made inaccessible to children. Weight #4 170-300-0295 Infant and toddler programs and activities. (2)An early learning provider must ensure an adequate supply of age and developmentally appropriate program materials and equipment for infants and toddlers. Materials and equipment must meet individual, developmental, and cultural needs of children in care, and must be: (b) Nonpoisonous, free of toxins, and meet ASTM D-4236 labeling requirements for chronic health hazards; (c) Large enough to prevent swallowing or choking; (d) Safe and in good working condition; (h) Removed from the early learning premises as soon as a provider becomes aware an item has been recalled by CPSC. Weight NA 170-300-0285 Infant and toddler nutrition and feeding. (2)After consulting a parent or guardian, an early learning provider must implement a feeding plan for infants and toddlers that include: (o) Not serving food to infants or toddlers using polystyrene foam (Styrofoam) cups, bowls, or plates. Weight #6	Exceeds	WAC is inclusive of all potentially hazardous items to children of all ages		
STANDARD 6.4.1.5: Balloons Infants, toddlers, and preschool children should not be permitted to inflate balloons, suck on or put balloons in their mouths nor have access to uninflated or underinflated balloons. Children under eight should not have access to latex balloons or inflated latex objects that	No WAC found that specifically addresses balloons	Does Not Meet			

are treated as balloons and these objects should not be permitted in the child care facility.					
STANDARD 6.4.2.2: Helmets All children one year of age and over should wear properly fitted and approved helmets while riding toys with wheels (tricycles, bicycles, etc.) or using any wheeled equipment (rollerblades, skateboards, etc.). Helmets should be removed as soon as children stop riding the wheeled toys or using wheeled equipment. Approved helmets should meet the standards of the U.S. Consumer Product Safety Commission (CPSC) (5). The standards sticker should be located on the bike helmet. Bike helmets should be replaced if they have been involved in a crash, the helmet is cracked, when straps are broken, the helmet can no longer be worn properly, or according to recommendations by the manufacturer (usually after three years).		Not Addressed	No WAC found that specifically addresses helmets		
STANDARD 6.5.1.1: Competence and Training of Transportation Staff At least one adult who accompanies or drives children for field trips and out-of-facility activities should receive training by a professional knowledgeable about child development and procedures, to ensure the safety of all children. The caregiver should hold a valid pediatric first aid certificate, including rescue breathing and management of blocked airways. Any emergency medications that a child might require, such as self-injecting epinephrine for life-threatening allergy, should also be available at all times as well as a mobile phone to call for medical assistance. Child: staff ratios should be maintained on field trips and during transport, the driver should not be included in these ratios. No child should ever be left alone in the vehicle. All drivers, passenger monitors, chaperones, and assistants should receive instructions in safety precautions. Transportation procedures should include: a) Use of developmentally appropriate safety restraints; b) Proper placement of the child in the motor vehicle in accordance with state and federal child restraint laws and regulations and recognized best practice; c) Training in handling of emergency	170-300-0345 Supervising children. (2) An early learning provider must meet capacity, group size, mixed age grouping, and staff-to-child ratios while children are in care. This includes but is not limited to: (b) Off-site activities; (c) During transportation; Weight #7 (5) An early learning provider must: (c) Actively supervise children when the children: (vi) Ride on public transportation (viii) During field trips. Weight #8 170-300-0480 Transportation and off-site activity policy. (1) An early learning provider must have and follow a transportation and off-site activity policy for personal or public transportation service, or non-motorized travel offered to children in care. (a) The transportation and off-site activity policy must include routine trips, which must not exceed two hours per day for any individual child. (b) Written parent or guardian authorization to transport the parent or guardian's child. The written authorization must be: (i) A specific event, date, and anticipated travel time; (ii) A specific type of trip (for example, transporting to and from school, or transporting to and from a field trip); or (iii) A full range of trips a child may take while in the early learning provider's care. (c) Written notices to parents or guardians, to be given at least 24 hours before field trips are	Partially Meets	Not found in WAC: , the driver should not be included in these ratios. and d) Knowledge of appropriate routes to emergency facility; e) Defensive driving; f) Child supervision during transport, including never leaving a child unattended in or around a vehicle; g) Issues that may arise in transporting children with behavioral issues (e.g., temper tantrums or		

<p>medical situations. If a child has a chronic medical condition or special health care needs that could result in an emergency (such as asthma, diabetes, or seizures), the driver or chaperone should have written instructions including parent/guardian emergency contacts, child summary health information, special needs and treatment plans, and should:</p> <p>1) Recognize the signs of a medical emergency;</p> <p>2) Know emergency procedures to follow (3);</p> <p>3) Have on hand any emergency supplies or medications necessary, properly stored out of reach of children;</p> <p>4) Know specific medication administration (ex. a child who requires EpiPen or diazepam);</p> <p>5) Know about water safety when field trip is to a location with a body of water.</p> <p>d) Knowledge of appropriate routes to emergency facility;</p> <p>e) Defensive driving;</p> <p>f) Child supervision during transport, including never leaving a child unattended in or around a vehicle;</p> <p>g) Issues that may arise in transporting children with behavioral issues (e.g., temper tantrums or oppositional behavior).</p> <p>The receipt of such instructions should be documented in a personnel record for any paid staff or volunteer who participates in field trips or transportation activities. Vehicles should be equipped with a first aid kit, fire extinguisher, seat belt cutter, and maps. At least one adult should have a functioning cell phone at hand. Information, names of the children and parent/guardian contact information should be carried in the vehicle along with identifying information (name, address, and telephone number) about the child care center.</p>	<p>taken.</p> <p>Weight #6</p> <p>(2)During travel to an off-site activity, an early learning provider must:</p> <p>(a)Have the health history, appropriate medication (if applicable), emergency information, and emergency medical authorization forms accessible for each child being transported;</p> <p>(b)Have a phone to call for emergency help;</p> <p>(c)Have a complete first aid kit;</p> <p>(d)Maintain the staff-to-child ratio, mixed groupings, and active supervision requirements;</p> <p>(e)Have at least one staff member currently certified in First Aid and CPR supervise children;</p> <p>(f)Take attendance using a roll call or other method that assures all children are accounted for each time children begin and end travel to an off-site activity, and every time children enter and exit a vehicle; and</p> <p>(g)Never leave children unattended in the vehicle.</p> <p>Weight #7</p> <p>(3)When an early learning provider supplies the vehicle to transport children in care, the program and provider must:</p> <p>(a)Follow chapter 46.61 RCW (Rules of the Road) and other applicable laws regarding child restraints and car seats;</p> <p>(b)Assure that the number of passengers does not exceed the seating capacity of the vehicle;</p> <p>(c)Maintain the vehicle in good repair and safe operating condition;</p> <p>(d)Maintain the vehicle temperature at a comfortable level to children;</p> <p>(e)Assure the vehicle has a current license and registration as required by Washington state transportation laws;</p> <p>(f)Assure the vehicle has emergency reflective triangles or other devices to alert other drivers of an emergency;</p> <p>(g)Assure the driver has a valid driver's license for the type of vehicle being driven and a safe driving record for at least the last five years;</p> <p>(h)Prevent any driver with a known condition that would compromise driving, supervision, or evacuation capabilities from operating program vehicles; and</p> <p>(i)Have a current insurance policy that covers the driver, the vehicle, and all occupants.</p> <p>Weight #6</p> <p>170-300-110 Program based staff policies and training.</p> <p>(1) An early learning provider must have and follow written policies for early learning program staff. Staff policies must include those listed in subsections (2) and (3) of this section and must be reviewed and approved by the department prior to issuing a provider's initial license. Providers must notify the department when substantial changes are made. Weight #1</p> <p>(2) Early learning program staff policies must include, but are not limited to:</p> <p>(c) Early learning program staff responsibilities for:</p>		<p>oppositional behavior).</p> <p>The receipt of such instructions should be documented in a personnel record for any paid staff or volunteer who participates in field trips or transportation activities.</p>		
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	<div>(i) Child supervision requirements, including preventing children’s access to unlicensed space; (ii) Child growth and development; (iv) Teacher-child interaction; (v) Child protection, guidance and discipline techniques; (viii) Off-site field trips, if applicable; (ix) Transporting children, if applicable; (xi) Medication management procedures; (xii) Medical emergencies, fire, disaster evacuation and emergency preparedness plans; (xiv) Implementation of child’s individual health care or special needs plan; Weight NA</div> <div>(4) An early learning provider must develop, deliver, and document the delivery of early learning staff training specific to the early learning program and premises. (a) Training topics must include: (i) Staff policies listed in subsections (2) and (3) of this section; (ii) Chapter 43.216 RCW; and (iii) Chapters 170-300 and 170-06 WAC, as hereafter recodified or amended. (b) Training must be updated with changes in program policies and state or federal regulations. Weight #5</div>				
<div>STANDARD 6.5.1.2: Qualifications for Drivers Any driver who transports children for a child care program should be at least twenty-one years of age and should have: a) A valid commercial driver’s license that authorizes the driver to operate the vehicle being driven; b) Evidence of a safe driving record for more than five years, with no crashes where a citation was issued; c) No alcohol, prescription or over-the-counter medications, or other drugs associated with impaired ability to drive, within twelve hours prior to transporting children. Drivers should ensure that any prescription or over-the-counter drugs taken will not impair their ability to drive; d) No tobacco, alcohol, or drug use while driving; e) No criminal record of crimes against or involving children, child neglect or abuse, substance abuse, or any crime of violence; f) No medical condition that would compromise driving, supervision, or evacuation capability including fatigue and sleep deprivation; g) Valid pediatric CPR and first aid certificate if</div>	<div>170-300-0106 Training requirements (12) Early learning providers must have a current first-aid and cardiopulmonary resuscitation (CPR) certification prior to being alone with children. Early learning providers must ensure that at least one staff person with a current first aid and CPR certificate is present with each group of children at all times. (a) Proof of certification may be a card, certificate, or instructor letter. (b) The first-aid and CPR training and certification must: (i) Be delivered in person and include a hands-on component for first-aid and CPR demonstrated in front of an instructor certified by the American Red Cross, American Heart Association, American Safety and Health Institute, or other nationally recognized certification program; (ii) Include child and adult CPR; and (iii) Infant CPR, if applicable. Weight #7</div> <div>170-300-0480 Transportation and off-site activity policy. (1) An early learning provider must have and follow a transportation and off-site activity policy for personal or public transportation service, or non-motorized travel offered to children in care. (a)The transportation and off-site activity policy must include routine trips, which must not exceed two hours per day for any individual child. (b)Written parent or guardian authorization to transport the parent or guardian’s child. The written authorization must be: (i)A specific event, date, and anticipated travel time; (ii)A specific type of trip (for example, transporting to and from school, or transporting to and from a field trip); or</div>	Meets	WAC 170-06 also outlines requirements for background clearance.		

<p>transporting children alone.</p> <p>The driver’s license number and date of expiration, vehicle insurance information, and verification of current state vehicle inspection should be on file in the facility. The child care program should require drug testing when noncompliance with the restriction on the use of alcohol or other drugs is suspected.</p>	<p>(iii)A full range of trips a child may take while in the early learning provider’s care.</p> <p>(c)Written notices to parents or guardians, to be given at least 24 hours before field trips are taken. Weight #6</p> <p>(2)During travel to an off-site activity, an early learning provider must:</p> <p>(a)Have the health history, appropriate medication (if applicable), emergency information, and emergency medical authorization forms accessible for each child being transported;</p> <p>(b)Have a phone to call for emergency help;</p> <p>(c)Have a complete first aid kit;</p> <p>(d)Maintain the staff-to-child ratio, mixed groupings, and active supervision requirements;</p> <p>(e)Have at least one staff member currently certified in First Aid and CPR supervise children;</p> <p>(f)Take attendance using a roll call or other method that assures all children are accounted for each time children begin and end travel to an off-site activity, and every time children enter and exit a vehicle; and</p> <p>(g)Never leave children unattended in the vehicle. Weight #7</p> <p>(3)When an early learning provider supplies the vehicle to transport children in care, the program and provider must:</p> <p>(a)Follow chapter 46.61 RCW (Rules of the Road) and other applicable laws regarding child restraints and car seats;</p> <p>(b)Assure that the number of passengers does not exceed the seating capacity of the vehicle;</p> <p>(c)Maintain the vehicle in good repair and safe operating condition;</p> <p>(d)Maintain the vehicle temperature at a comfortable level to children;</p> <p>(e)Assure the vehicle has a current license and registration as required by Washington state transportation laws;</p> <p>(f)Assure the vehicle has emergency reflective triangles or other devices to alert other drivers of an emergency;</p> <p>(g)Assure the driver has a valid driver’s license for the type of vehicle being driven and a safe driving record for at least the last five years;</p> <p>(h)Prevent any driver with a known condition that would compromise driving, supervision, or evacuation capabilities from operating program vehicles; and</p> <p>(i)Have a current insurance policy that covers the driver, the vehicle, and all occupants. Weight #6</p>				
<p>STANDARD 6.5.2.2: Child Passenger Safety</p> <p>When children are driven in a motor vehicle other than a bus, school bus, or a bus operated by a common carrier, the following should apply:</p> <p>a) A child should be transported only if the child is</p>	<p>170-300-0480 Transportation and off-site activity policy.</p> <p>(3)When an early learning provider supplies the vehicle to transport children in care, the program and provider must:</p> <p>(a)Follow chapter 46.61 RCW (Rules of the Road) and other applicable laws regarding child</p>	Meets			

<p>restrained in developmentally appropriate car safety seat, booster seat, seat belt, or harness that is suited to the child’s weight, age, and/or psychological development in accordance with state and federal laws and regulations and the child is securely fastened, according to the manufacturer’s instructions, in a developmentally appropriate child restraint system.</p> <p>b) Age and size-appropriate vehicle child restraint systems should be used for children under eighty pounds and under four-feet-nine-inches tall and for all children considered too small, in accordance with state and federal laws and regulations, to fit properly in a vehicle safety belt. The child passenger restraint system must meet the federal motor vehicle safety standards contained in the Code of Federal Regulations, Title 49, Section 571.213 (especially Federal Motor Vehicle Safety Standard 213), and carry notice of such compliance.</p> <p>c) For children who are obese or overweight, it is important to find a car safety seat that fits the child properly. Caregivers/teachers should not use a car safety seat if the child weighs more than the seat’s weight limit or is taller than the height limit. Caregivers/teachers should check the labels on the seat or manufacturer’s instructions if they are unsure of the limits. Manufacturer’s instructions that include these specifications can also be found on the manufacturer’s Website.</p> <p>d) Child passenger restraint systems should be installed and used in accordance with the manufacturer’s instructions and should be secured in back seats only.</p> <p>e) All children under the age of thirteen should be transported in the back seat of a car and each child not riding in an appropriate child restraint system (i.e., a child seat, vest, or booster seat), should have an individual lap-and-shoulder seat belt (2).</p> <p>f) For maximum safety, infants and toddlers should ride in a rear-facing orientation (i.e., facing the back of the car) until they are two years of age or until they have reached the upper limits for weight or height for the rear-facing seat, according to the manufacturer’s instructions (1). Once their seat is adjusted to face forward, the child passenger must ride in a forward-facing child safety seat (either a convertible seat or a combination seat) until</p>	<p>restraints and car seats;</p> <p>(b)Assure that the number of passengers does not exceed the seating capacity of the vehicle;</p> <p>RCW 46.61.687 Child passenger restraint required—Conditions—Exceptions—Penalty for violation—Dismissal—Noncompliance not negligence—Immunity.</p> <p>(1) Whenever a child who is less than sixteen years of age is being transported in a motor vehicle that is in operation and that is required by RCW <u>46.37.510</u> to be equipped with a safety belt system in a passenger seating position, or is being transported in a neighborhood electric vehicle or medium-speed electric vehicle that is in operation, the driver of the vehicle shall keep the child properly restrained as follows:</p> <p>(a) A child must be restrained in a child restraint system, if the passenger seating position equipped with a safety belt system allows sufficient space for installation, until the child is eight years old, unless the child is four feet nine inches or taller. The child restraint system must comply with standards of the United States department of transportation and must be secured in the vehicle in accordance with instructions of the vehicle manufacturer and the child restraint system manufacturer.</p> <p>(b) A child who is eight years of age or older or four feet nine inches or taller shall be properly restrained with the motor vehicle's safety belt properly adjusted and fastened around the child's body or an appropriately fitting child restraint system.</p> <p>(c) The driver of a vehicle transporting a child who is under thirteen years old shall transport the child in the back seat positions in the vehicle where it is practical to do so.</p>				
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<p>reaching the upper height or weight limit of the seat, in accordance with the manufacturer’s instructions (10). Plans should include limiting transportation times for young infants to minimize the time that infants are sedentary in one place.</p> <p>g) A booster seat should be used when, according to the manufacturer’s instructions, the child has outgrown a forward-facing child safety seat, but is still too small to safely use the vehicle seat belts (for most children this will be between four feet nine inches tall and between eight and twelve years of age) (1).</p> <p>h) Car safety seats, whether provided by the child’s parents/guardians or the child care program, should be labeled with the child passenger’s name and emergency contact information.</p> <p>i) Car safety seats should be replaced if they have been recalled, are past the manufacturer’s “date of use” expiration date, or have been involved in a crash that meets the U.S. Department of Transportation crash severity criteria or the manufacturer’s criteria for replacement of seats after a crash (3,11).</p> <p>j) The temperature of all metal parts of vehicle child restraint systems should be checked before use to prevent burns to child passengers.</p> <p>If the child care program uses a vehicle that meets the definition of a school bus and the school bus has safety restraints, the following should apply:</p> <p>a) The school bus should accommodate the placement of wheelchairs with four tie-downs affixed according to the manufactures’ instructions in a forward-facing direction;</p> <p>b) The wheelchair occupant should be secured by a three-point tie restraint during transport;</p> <p>c) At all times, school buses should be ready to transport children who must ride in wheelchairs;</p> <p>d) Manufacturers’ specifications should be followed to assure that safety requirements are met.</p>					
<p>STANDARD 6.5.2.4: Interior Temperature of Vehicles</p> <p>The interior of vehicles used to transport children should be maintained at a temperature comfortable to children. When the vehicle’s interior temperature exceeds 82°F and providing fresh air through open windows cannot</p>	<p>170-300-0480 Transportation and off-site activity policy.</p> <p>(2)During travel to an off-site activity, an early learning provider must:</p> <p>(f) Take attendance using a roll call or other method to assure all children are accounted for each time children begin and end travel to an off-site activity, and every time children enter and exit a vehicle; and</p> <p>(g) Never leave children unattended in the vehicle.</p>	Meets			

reduce the temperature, the vehicle should be air-conditioned. When the interior temperature drops below 65°F and when children are feeling uncomfortably cold, the interior should be heated. To prevent hyperthermia, all vehicles should be locked when not in use, head counts of children should be taken after transporting to prevent a child from being left unintentionally in a vehicle, and children should never be intentionally left in a vehicle unattended.	<div>Weight #7</div> <div>(3)When an early learning provider supplies the vehicle to transport children in care, the program and provider must:<div>(d)Maintain the vehicle temperature at a comfortable level to children;</div></div> <div>Weight #6</div>				
STANDARD 6.5.3.1: Passenger Vans Child care facilities that provide transportation to children, parents/guardians, staff, and others should avoid the use of fifteen-passenger vans whenever possible. Other vehicles, such as vehicles meeting the definition of a “school bus,” should be used to fulfill transportation of child passengers in particular. Conventional twelve-to fifteen-passenger vans cannot be certified as school buses by the National Highway Traffic Safety Administration (NHTSA) standards (2,4), and thus cannot be sold or leased, as new vehicles, to carry students on a regular basis. Caregivers/teachers should be knowledgeable about the laws of the state(s) in which their vehicles, including passenger vans, will be registered and used.	No WAC found that specifically addresses passenger vans.	Not Addressed			
STANDARD 7.2.0.2: Unimmunized Children If immunizations have not been or are not to be administered because of a medical condition (contraindication), a statement from the child’s primary care provider documenting the reason why the child is temporarily or permanently medically exempt from the immunization requirements should be on file. If immunizations are not to be administered because of the parents/guardians’ religious or philosophical beliefs, a legal exemption with notarization, waiver or other state-specific required documentation signed by the parent/guardian should be on file. The parent/guardian of a child who has not received the age-appropriate immunizations prior to enrollment and who does not have documented medical, religious, or philosophical exemptions from routine childhood immunizations should provide documentation of a scheduled appointment or arrangement to receive immunizations. This could be a scheduled appointment	170-300-0210 Immunizations and exempt children. (1) Before attending an early learning program, a child must be vaccinated against or show proof of acquired immunity for the vaccine-preventable disease, pursuant to chapter 246-105 WAC, as now and hereafter amended. An early learning provider may accept children without proof of vaccinations or immunity as otherwise indicated in this section. <div>Weight NA</div> (2) An early learning provider must receive for each enrolled child: <div>(a) A current and complete department of health certificate of immunization status (CIS) or certificate of exemption (COE) or other department of health approved form, pursuant to WAC 246-105-050, as now and hereafter amended; or</div> <div>(b) A current immunization record from the Washington State Immunization Information System (WA IIS).</div> <div>Weight #3</div> (3) To accept a child who is not current with their immunizations, an early learning provider must give written notice to that child’s parent or guardian stating the child may be accepted if the immunizations are completed as soon as possible and: <div>(a) Prior to enrollment the parent or guardian provides written proof the child is scheduled to be immunized; or</div>	Meets			

<p>with the primary care provider or an upcoming immunization clinic sponsored by a local health department or health care organization. An immunization plan and catch-up immunizations should be initiated upon enrollment and completed as soon as possible according to the “Recommended Immunization Schedules for Persons Aged 0 Through 18 Years – United States, 2011” from the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). Parents/guardians of children who attend an unlicensed child care facility should be encouraged to comply with the “Recommended Immunization Schedules” (6).</p> <p>If a vaccine-preventable disease to which children are susceptible occurs in the facility and potentially exposes the unimmunized children who are susceptible to that disease, the health department should be consulted to determine whether these children should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements.</p>	<p>(b) The parent or guardian provides a signed and dated statement detailing when the child’s immunizations will be brought up to date. Weight# 3</p> <p>(4) An early learning provider must maintain and update each child’s records relating to immunizations or exemptions, or plans to bring immunizations current. These records must be available in the licensed space or easily accessible for review by department licensors, health specialists, and health consultants. Weight NA</p> <p>(5) An early learning provider may accept homeless or foster children into care without the records listed in this section if the child’s family, case worker, or health care provider offers written proof that he or she is in the process of obtaining the child’s immunization records. Weight #3</p> <p>(6) An early learning provider may exclude a child from care according to the criteria listed in WAC 246-105-080, as now and hereafter amended. Weight NA</p> <p>(7) If an outbreak of a vaccine-preventable disease occurs within an early learning program, an early learning provider must notify the parents or guardians of children exempt from that disease and children without vaccination documents. A provider may exclude the child from the child care premises for the duration of the outbreak of that vaccine-preventable disease. Weight #7</p> <p>(8) An early learning provider may have a written policy stating children exempted from immunization by their parent or guardian will not be accepted into care unless that exemption is due to an illness protected by the ADA or WLAD or by a completed and signed COE. Weight NA</p> <p>170-300-0460 Child records.</p> <p>(1) An early learning provider must keep current individualized enrollment and health records for all enrolled children, including children of staff, updated annually or more often as health records are updated.</p> <p>(a) A child’s record must be kept in a confidential manner but in an area easily accessible to staff.</p> <p>(b) A child’s parent or guardian must be allowed access to all of his or her own child’s records. Weight #4</p> <p>(3) A health record is required for every child who is enrolled and counted in an early learning program’s capacity. A health record must include:</p> <p>(a) An immunization record, pursuant to WAC 170-300-0210(1); Weight #5</p> <p>170-300-0475</p> <p>Duty to protect children and report incidents.</p> <p>(2) An early learning provider must report by phone upon knowledge of the following to:</p> <p>(d) The local health jurisdiction or the department of health immediately, and to the department within 24 hours about an occurrence of food poisoning or reportable contagious disease as defined in chapter 246-110 WAC, as now or hereafter amended;</p>				
STANDARD 7.2.0.3: Immunization of	170-300-0120 Providing for personal, professional, and health needs of staff.	Meets			

<p>Caregivers/Teachers</p> <p>Caregivers/teachers should be current with all immunizations routinely recommended for adults by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) as shown in the “Recommended Adult Immunization Schedule” at http://www.cdc.gov/vaccines/recs/schedules/default.htm#adult/. This schedule is updated annually at the beginning of the calendar year and can be found in Appendix H.</p> <p>Caregivers/teachers should have received the recommended vaccines in the following categories: (1,2)</p> <p>a) Vaccines recommended for all adults who meet the age requirements and who lack evidence of immunity (i.e., lack documentation of vaccination or have no evidence of prior infection):</p> <ol style="list-style-type: none">1) Tdap/Td;2) Varicella-zoster;3) MMR (measles, mumps, and rubella);4) Seasonal influenza;5) Human papillomaviruses (HPV) (eleven through twenty-six years of age);6) Others as determined by the ACIP and state and local public health authorities. <p>b) Recommended if a specific risk factor is present:</p> <ol style="list-style-type: none">1) Pneumococcal;2) Hepatitis A;3) Hepatitis B;4) Meningococcal;5) Others as determined by the ACIP and state and local public health authorities. <p>c) If a staff member is not appropriately immunized for medical, religious or philosophical reasons, the child care facility should require written documentation of the reason.</p> <p>d) If a vaccine-preventable disease to which adults are susceptible occurs in the facility and potentially exposes the unimmunized adults who are susceptible to that disease, the health department should be consulted to determine whether these adults should be excluded for the duration of possible exposure or until the appropriate immunizations have been completed. The local or state health department will be able to provide guidelines for exclusion requirements.</p>	<p>(3) If a staff person has not been vaccinated, or has not shown documented immunity to a vaccine preventable disease, that person may be required by the local health jurisdiction or the department to remain off-site during an outbreak of a contagious disease described in WAC 246-110-010, as now and hereafter amended. Weight NA</p>				
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<p>STANDARD 7.3.3.1: Influenza Immunizations for Children and Caregivers/Teachers</p> <p>The parent/guardian of each child six months of age and older should provide written documentation of current annual vaccination against influenza unless there is a medical contraindication or philosophical or religious objection.</p> <p>Children who are too young to receive influenza vaccine before the start of influenza season should be immunized annually beginning when they reach six months of age. Staff caring for all children should receive annual vaccination against influenza. Ideally people should be vaccinated before the start of the influenza season (as early as August or September) and immunization should continue through March or April.</p>	<p>170-300-0210 Immunizations and exempt children.</p> <p>(1) Before attending an early learning program, a child must be vaccinated against or show proof of acquired immunity for the vaccine-preventable disease, pursuant to chapter 246-105 WAC, as now and hereafter amended. An early learning provider may accept children without proof of vaccinations or immunity as otherwise indicated in this section. Weight NA</p> <p>(2) An early learning provider must receive for each enrolled child:</p> <p>(a) A current and complete department of health certificate of immunization status (CIS) or certificate of exemption (COE) or other department of health approved form, pursuant to WAC 246-105-050, as now and hereafter amended; or</p> <p>(b) A current immunization record from the Washington State Immunization Information System (WA IIS). Weight #3</p> <p>(3) To accept a child who is not current with their immunizations, an early learning provider must give written notice to that child’s parent or guardian stating the child may be accepted if the immunizations are completed as soon as possible and:</p> <p>(a) Prior to enrollment the parent or guardian provides written proof the child is scheduled to be immunized; or</p> <p>(b) The parent or guardian provides a signed and dated statement detailing when the child’s immunizations will be brought up to date. Weight# 3</p> <p>(4) An early learning provider must maintain and update each child’s records relating to immunizations or exemptions, or plans to bring immunizations current. These records must be available in the licensed space or easily accessible for review by department licensors, health specialists, and health consultants. Weight NA</p> <p>(5) An early learning provider may accept homeless or foster children into care without the records listed in this section if the child’s family, case worker, or health care provider offers written proof that he or she is in the process of obtaining the child’s immunization records. Weight #3</p> <p>(6) An early learning provider may exclude a child from care according to the criteria listed in WAC 246-105-080, as now and hereafter amended. Weight NA</p> <p>(7) If an outbreak of a vaccine-preventable disease occurs within an early learning program, an early learning provider must notify the parents or guardians of children exempt from that disease and children without vaccination documents. A provider may exclude the child from the child care premises for the duration of the outbreak of that vaccine-preventable disease. Weight #7</p> <p>(8) An early learning provider may have a written policy stating children exempted from immunization by their parent or guardian will not be accepted into care unless that exemption is due to an illness protected by the ADA or WLAD or by a completed and signed COE. Weight NA</p>	Not Addressed	<p>No WAC found that requires staff to receive annual vaccination against influenza.</p> <p>WAC 170-300-0210 addresses children’s immunizations. DOH recommends the influenza vaccine but does not require it.</p>		
<p>STANDARD 7.3.3.2: Influenza Control</p>	<p>170-300-0205 Child, staff, and household member illness.</p>	Meets			

<p>When influenza is circulating in the community, facilities should encourage parents/guardians to keep children with symptoms of acute respiratory tract illness with fever at home until their fever has subsided for at least twenty-four hours without use of fever reducing medication.</p> <p>Caregivers/teachers with symptoms of acute respiratory tract illness with fever also should remain at home until their fever subsides for at least twenty-four hours.</p>	<p>(1) An early learning provider must observe all children for signs of illness when they arrive at the early learning program and throughout the day. Parents or guardians of a child should be notified, as soon as possible, if the child develops signs or symptoms of illness. Weight NA</p> <p>(2) If an early learning provider becomes ill, a Licensee, Center Director, Assistant Director, or Program Supervisor must determine whether that person should be required to leave the licensed early learning space. Weight NA</p> <p>(3) When a child becomes ill, an early learning provider (or school nurse, if applicable) must determine whether the child should be sent home or separated from others. A provider must supervise the child to reasonably prevent contact between the ill child and healthy children. Weight #6</p> <p>(4) An ill child must be sent home or reasonably separated from other children if:</p> <ul style="list-style-type: none">(a) The illness or condition prevents the child from participating in normal activities;(b) The illness or condition requires more care and attention than the early learning provider can give;(c) The required amount of care for the ill child compromises or places at risk the health and safety of other children in care; or(d) There is a risk that the child’s illness or condition will spread to other children or individuals. <p>Weight # 6</p> <p>(5) Unless covered by an individual care plan or protected by the ADA, an ill child, staff member, or other individual must be sent home or isolated from children in care if he or she has:</p> <ul style="list-style-type: none">(a) A fever 101 degrees Fahrenheit for children over 2 months (or 100.4 degrees F for an infant younger than 2 months) by any method, and behavior change or other signs and symptoms of illness (including sore throat, earache, headache, rash, vomiting, diarrhea);(b) Vomiting 2 or more times in the previous 24 hours;(c) Diarrhea where stool frequency exceeds 2 stools above normal per 24 hours for that child or whose stool contains more than a drop of blood or mucus;(d) A rash not associated with heat, diapering, or an allergic reaction;(e) Open sores or wounds discharging bodily fluids that cannot be adequately covered with a waterproof dressing or mouth sores with drooling;(f) Lice, ringworm, or scabies. Individuals with head lice, ringworm, or scabies must be excluded from the child care premises beginning from the end of the day the head lice or scabies was discovered. The provider may allow an individual with head lice or scabies to return to the premises after receiving the first treatment; or(g) A child who appears severely ill, which may include lethargy, persistent crying, difficulty breathing, or a significant change in behavior or activity level indicative of illness. <p>Weight # 7</p> <p>(6) At the first opportunity, but in no case longer than 24 hours of learning that an enrolled child, staff member, volunteer or household member has been diagnosed by a health care professional with a contagious disease listed in WAC 246-110-010(3), as now and hereafter amended, an early learning provider must provide written notice to the department, the local health jurisdiction, and the parents or guardians of the enrolled children. Weight #7</p> <p>(7) An early learning provider must not take ear or rectal temperatures to determine a child’s body temperature.</p> <ul style="list-style-type: none">(a) Providers must use developmentally appropriate methods when taking infant or toddler temperatures (for example, digital forehead scan thermometers or underarm auxiliary methods);(b) Oral temperatures may be taken for preschool through school-age children if single use covers are used to prevent cross contamination; and				
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	<p>(c) Glass thermometers containing mercury must not be used. Weight #6</p> <p>(8) An early learning provider may readmit a child, staff member, volunteer or household member into the early learning program area with written permission of a health care provider or health jurisdiction stating the individual may safely return after being diagnosed with a contagious disease listed in WAC 246-110-010(3), as now and hereafter amended. Weight #5</p> <p>170-300-0450 Parent or guardian handbook and related policies. (1)An early learning provider must supply to each parent or guardian written policies regarding the early learning program. Each enrolled child’s record must have signed documentation stating the parent or guardian reviewed the handbook and early learning program policies. Weight #3</p> <p>(2)An early learning provider must have and follow written policies in either paper or electronic format, including: (v)Description of where the parent or guardian may find and review the early learning program’s (i) Health policy; Weight #4</p> <p>170-300-0500 Health policy. (1) An early learning provider must have and follow a written health policy reviewed and approved by the department that includes the topics listed in subsection (2) of this section. The health policy must be reviewed and approved by the department when changes are made, and as otherwise necessary. Weight NA</p> <p>(2) An early learning program’s health policy must meet the requirements of this chapter including, but not limited to: (d)Observing children for illness daily; (e)Exclusion and return of ill children, staff, or any other person in the program space; (f)Contagious disease notification; Weight NA</p>				
<p>STANDARD 7.3.5.1: Recommended Control Measures for Invasive Meningococcal Infection in Child Care</p> <p>Identification of an individual with invasive meningococcal infection in the child care setting should result in the following:</p> <ul style="list-style-type: none">a) Immediate notification of the local or state health department;b) Notification of parents/guardians about child care contacts to the person with invasive meningococcal infection;c) Assistance with provision of antibiotic prophylaxis and vaccine receipt, as advised by the local or state health department, to child care contacts;	<p>170-300-0205 Child, staff, and household member illness. (6) At the first opportunity, but in no case longer than 24 hours of learning that an enrolled child, staff member, volunteer, or household member has been diagnosed by a health care professional with a contagious disease listed in WAC 246-110-010(3), as now and hereafter amended, and early learning provider must provide written notice to the department, the local health jurisdiction, and the parents or guardians of the enrolled children. Weight #7</p> <p>170-300-0450 Parent or guardian handbook and related policies. (1)An early learning provider must supply to each parent or guardian written policies regarding the early learning program. Each enrolled child’s record must have signed documentation stating the parent or guardian reviewed the handbook and early learning program policies. Weight #3</p> <p>(2)An early learning provider must have and follow written policies in either paper or electronic format, including: (v)Description of where the parent or guardian may find and review the early learning program’s (i) Health policy; Weight #4</p> <p>170-300-0500 Health policy.</p>	Meets	No WAC found that specifically addresses Invasive Meningococcal Infection; however WAC 170-300-0205 requires reporting contagious condition listed on DOH Notifiable Conditions List (Meningococcal Disease is listed on the DOH Notifiable Conditions List)		

d) Frequent updates and communication with parents/ guardians, health care professionals, and local health authorities.	(1) An early learning provider must have and follow a written health policy reviewed and approved by the department that includes the topics listed in subsection (2) of this section. The health policy must be reviewed and approved by the department when changes are made, and as otherwise necessary. Weight NA (2) An early learning program’s health policy must meet the requirements of this chapter including, but not limited to: (d)Observing children for illness daily; (e)Exclusion and return of ill children, staff, or any other person in the program space; (f)Contagious disease notification; Weight NA				
STANDARD 7.3.5.2: Informing Public Health Authorities of Meningococcal Infections Meningococcal disease is designated as notifiable at the national level, and local and/or state public health department authorities should be notified immediately about the occurrence of invasive meningococcal disease in a child care facility. Timely reporting results in early recognition of outbreaks and prevention of additional infections. Facilities should cooperate with their local or state health department officials in notifying parents/guardians of children who attend the facility about exposures to children with invasive meningococcal infections. Early intervention minimizes anxiety and concern that may result from identification of an attendee with an invasive meningococcal infection. This may include providing local health officials with the names and telephone numbers of parents/guardians of children in involved classrooms or facilities.	170-300-0205 Child, staff, and household member illness. (6) At the first opportunity, but in no case longer than 24 hours of learning that an enrolled child, staff member, volunteer, or household member has been diagnosed by a health care professional with a contagious disease listed in WAC 246-110-010(3), as now and hereafter amended, and early learning provider must provide written notice to the department, the local health jurisdiction, and the parents or guardians of the enrolled children. Weight #7	Meets	No WAC found that specifically addresses Invasive Meningococcal Infection; however WAC 170-300-0205 requires reporting contagious condition listed on DOH Notifiable Conditions List (Meningococcal Disease is listed on the DOH Notifiable Conditions List)		
STANDARD 7.3.9.1: Immunization with Streptococcus Pneumoniae Conjugate Vaccine (PCV13) Pneumococcal conjugate (PCV13) vaccine is recommended for all children from two through fifty-nine months of age, including children in child care facilities. The vaccine is recommended to be administered at two, four, six, and twelve through fifteen months of age (1-3,5). Healthy children between twenty-four and fifty-nine months of age who are not immunized completely for their age should be administered one dose of PCV13 (3,5). Children two years of age or older at high risk of invasive disease	170-300-0210 Immunizations and exempt children. (1) Before attending an early learning program, a child must be vaccinated against or show proof of acquired immunity for the vaccine-preventable disease, pursuant to chapter 246-105 WAC, as now and hereafter amended. An early learning provider may accept children without proof of vaccinations or immunity as otherwise indicated in this section. Weight NA (2) An early learning provider must receive for each enrolled child: (a) A current and complete department of health certificate of immunization status (CIS) or certificate of exemption (COE) or other department of health approved form, pursuant to WAC 246-105-050, as now and hereafter amended; or (b) A current immunization record from the Washington State Immunization Information System (WA IIS).	Meets	WAC 170-300-0210 addresses children’s immunizations. DOH requires PCV/PPSV (Pneumococcal) vaccine for children attending child care.		

caused by <i>Streptococcus pneumoniae</i> (including sickle cell disease, asplenia, HIV, chronic illness, cochlear implant or immunocompromised) who have received their recommended doses of PCV should receive <i>S. pneumoniae</i> polysaccharide vaccine two or more months after receipt of the last dose of PCV (1-3,5).	<p>Weight #3</p> <p>(3) To accept a child who is not current with their immunizations, an early learning provider must give written notice to that child’s parent or guardian stating the child may be accepted if the immunizations are completed as soon as possible and:</p> <p>(a) Prior to enrollment the parent or guardian provides written proof the child is scheduled to be immunized; or</p> <p>(b) The parent or guardian provides a signed and dated statement detailing when the child’s immunizations will be brought up to date.</p> <p>Weight# 3</p> <p>(4) An early learning provider must maintain and update each child’s records relating to immunizations or exemptions, or plans to bring immunizations current. These records must be available in the licensed space or easily accessible for review by department licensors, health specialists, and health consultants. Weight NA</p> <p>(5) An early learning provider may accept homeless or foster children into care without the records listed in this section if the child’s family, case worker, or health care provider offers written proof that he or she is in the process of obtaining the child’s immunization records. Weight #3</p> <p>(6) An early learning provider may exclude a child from care according to the criteria listed in WAC 246-105-080, as now and hereafter amended. Weight NA</p> <p>(7) If an outbreak of a vaccine-preventable disease occurs within an early learning program, an early learning provider must notify the parents or guardians of children exempt from that disease and children without vaccination documents. A provider may exclude the child from the child care premises for the duration of the outbreak of that vaccine-preventable disease. Weight #7</p> <p>(8) An early learning provider may have a written policy stating children exempted from immunization by their parent or guardian will not be accepted into care unless that exemption is due to an illness protected by the ADA or WLAD or by a completed and signed COE. Weight NA</p>				
<p>STANDARD 7.4.0.1: Control of Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections</p> <p>Facilities should employ the following procedures, in addition to those stated in Child and Staff Inclusion/Exclusion/ Dismissal, Standards 3.6.1.1-3.6.1.4, to prevent and control infections of the gastrointestinal tract (including diarrhea) or hepatitis A (1-3):</p> <p>a) Toilet trained children who cannot use a toilet for all bowel movements while attending the facility and who develop diarrhea, as defined in Standard 3.6.1.1, should be removed from the facility by their parent/guardian. Exclude diapered children if stool is not contained in the diaper, stool frequency exceeds two or more stools above normal for that child, blood or mucus in the stool, abnormal color of stool, no urine</p>	<p>170-300-0205 Child, staff, and household member illness.</p> <p>(1) An early learning provider must observe all children for signs of illness when they arrive at the early learning program and throughout the day. Parents or guardians of a child should be notified, as soon as possible, if the child develops signs or symptoms of illness. Weight NA</p> <p>(2) If an early learning provider becomes ill, a Licensee, Center Director, Assistant Director, or Program Supervisor must determine whether that person should be required to leave the licensed early learning space. Weight NA</p> <p>(3) When a child becomes ill, an early learning provider (or school nurse, if applicable) must determine whether the child should be sent home or separated from others. A provider must supervise the child to reasonably prevent contact between the ill child and healthy children. Weight #6</p> <p>(4) An ill child must be sent home or reasonably separated from other children if:</p> <p>(a) The illness or condition prevents the child from participating in normal activities;</p> <p>(b) The illness or condition requires more care and attention than the early learning provider can give;</p> <p>(c) The required amount of care for the ill child compromises or places at risk the health and safety of other children in care; or</p>	Meets	<p>(c) Diarrhea where stool frequency exceeds 2 stools above normal per 24 hours for that child or whose stool contains more than a drop of blood or mucus;</p> <p>(3) When a child becomes ill, an early learning provider (or school nurse, if applicable) must determine whether the child should be sent home or separated from others. A provider must supervise the child to reasonably prevent contact between</p>		

<p>output in eight hours, jaundice, fever with behavior change, or looks or acts ill. Pending arrival of the parent/guardian, the child should not be permitted to have contact with other children or be placed in areas used by adults who have contact with children in the facility. This should be accomplished by removing the child who is ill to a separate area of the child care program or, if not possible, to a separate area of the child's room. The area should be one where the child is supervised by an adult known to the child, and where the toys, equipment, and surfaces will not be used by other children or adults until after the child who is ill leaves and after the surfaces and toys have been disinfected. When moving a child to a separate area of the facility creates problems with supervision of the other children, as occurs in small family child care homes, the child who is ill should be kept as comfortable as possible, with minimal contact between children who are ill and well children, until the parent/guardian arrives. Caregivers/teachers with diarrhea as defined in Standard 3.6.1.2 should be excluded. Separation and exclusion of children or caregivers/teachers should not be deferred pending health assessment or laboratory testing to identify an enteric pathogen.</p> <p>b) A child who develops jaundice (when skin and white parts of the eye are yellow) while attending child care should be separated from other children and the child's parent/guardian should be contacted to remove the child. The child should remain separated from other children as described above until the parent/guardian arrives and removes the child from the facility.</p> <p>c) Exclusion for diarrhea should continue until either the diarrhea stops or the continued loose stools are deemed not to be infectious by a licensed health care professional. Exclusion for hepatitis A virus (HAV) should continue for one week after onset of jaundice.</p> <p>d) Alternate care for children with diarrhea or hepatitis A in special facilities for children who are ill should be provided in facilities that can provide separate care for children with infections of the gastrointestinal tract (including diarrhea) or hepatitis A.</p> <p>e) Children and caregivers/teachers who excrete intestinal pathogens but no longer have diarrhea generally may be allowed to return to child care once the diarrhea resolves, except for the case of</p>	<p>(d) There is a risk that the child's illness or condition will spread to other children or individuals. Weight # 6</p> <p>(5) Unless covered by an individual care plan or protected by the ADA, an ill child, staff member, or other individual must be sent home or isolated from children in care if he or she has:</p> <p>(a) A fever 101 degrees Fahrenheit for children over 2 months (or 100.4 degrees F for an infant younger than 2 months) by any method, and behavior change or other signs and symptoms of illness (including sore throat, earache, headache, rash, vomiting, diarrhea);</p> <p>(b) Vomiting 2 or more times in the previous 24 hours;</p> <p>(c) Diarrhea where stool frequency exceeds 2 stools above normal per 24 hours for that child or whose stool contains more than a drop of blood or mucus;</p> <p>(d) A rash not associated with heat, diapering, or an allergic reaction;</p> <p>(e) Open sores or wounds discharging bodily fluids that cannot be adequately covered with a waterproof dressing or mouth sores with drooling;</p> <p>(f) Lice, ringworm, or scabies. Individuals with head lice, ringworm, or scabies must be excluded from the child care premises beginning from the end of the day the head lice or scabies was discovered. The provider may allow an individual with head lice or scabies to return to the premises after receiving the first treatment; or</p> <p>(g) A child who appears severely ill, which may include lethargy, persistent crying, difficulty breathing, or a significant change in behavior or activity level indicative of illness. Weight # 7</p> <p>(6) At the first opportunity, but in no case longer than 24 hours of learning that an enrolled child, staff member, volunteer or household member has been diagnosed by a health care professional with a contagious disease listed in WAC 246-110-010(3), as now and hereafter amended, an early learning provider must provide written notice to the department, the local health jurisdiction, and the parents or guardians of the enrolled children. Weight #7</p> <p>(7) An early learning provider must not take ear or rectal temperatures to determine a child's body temperature.</p> <p>(a) Providers must use developmentally appropriate methods when taking infant or toddler temperatures (for example, digital forehead scan thermometers or underarm auxiliary methods);</p> <p>(b) Oral temperatures may be taken for preschool through school-age children if single use covers are used to prevent cross contamination; and</p> <p>(c) Glass thermometers containing mercury must not be used. Weight #6</p> <p>(8) An early learning provider may readmit a child, staff member, volunteer or household member into the early learning program area with written permission of a health care provider or health jurisdiction stating the individual may safely return after being diagnosed with a contagious disease listed in WAC 246-110-010(3), as now and hereafter amended. Weight #5</p>		<p>the ill child and healthy children.</p>		
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<p>infections with <i>Shigella</i>, Shiga toxin-producing <i>E. coli</i> (STEC), or <i>Salmonella enterica</i> serotype Typhi. For <i>Shigella</i> and STEC, resolution of symptoms and two negative stool cultures are required for readmission, unless state requirements differ. For <i>Salmonella</i> serotype Typhi, resolution of symptoms and three negative stool cultures are required for return to child care. For <i>Salmonella</i> species other than serotype Typhi, documentation of negative stool cultures are not required from asymptomatic people for readmission to child care.</p> <p>f) The local health department should be informed immediately of the occurrence of HAV infection or an increased frequency of diarrheal illness in children or staff in a child care facility.</p> <p>g) Recommended post-exposure prophylaxis for hepatitis A includes administration of hepatitis A vaccine or immune globulin to all previously unimmunized staff members and attendees of a child care facility in which a person with hepatitis A is identified.</p> <p>h) If there has been an exposure to a person with hepatitis A or diarrhea in the child care facility, caregivers/teachers should inform parents/guardians, in cooperation with the health department, that their children may have been exposed to children with HAV infection or to another person with a diarrheal illness.</p>					
<p>STANDARD 7.5.10.1: <i>Staphylococcus Aureus</i> Skin Infections Including MRSA</p> <p>The following should be implemented when children or staff with lesions suspicious for <i>Staphylococcus aureus</i> infections are identified:</p> <p>a) Lesions should be covered with a dressing;</p> <p>b) Report the lesions to the parent/guardian with a recommendation for evaluation by a primary care provider;</p> <p>c) Exclusion is not warranted unless the individual meets any of the following criteria:</p> <p>1) Care for other children would be compromised by care required for the person with the <i>S. aureus</i> infection;</p> <p>2) The individual with the <i>S. aureus</i> infection has fever or a change in behavior;</p> <p>3) The lesion(s) cannot be adequately covered by a bandage or the bandage needs frequent</p>	<p>170-300-0205 Child, staff, and household member illness.</p> <p>(1) An early learning provider must observe all children for signs of illness when they arrive at the early learning program and throughout the day. Parents or guardians of a child should be notified, as soon as possible, if the child develops signs or symptoms of illness. Weight NA</p> <p>(2) If an early learning provider becomes ill, a Licensee, Center Director, Assistant Director, or Program Supervisor must determine whether that person should be required to leave the licensed early learning space. Weight NA</p> <p>(3) When a child becomes ill, an early learning provider (or school nurse, if applicable) must determine whether the child should be sent home or separated from others. A provider must supervise the child to reasonably prevent contact between the ill child and healthy children. Weight #6</p> <p>(4) An ill child must be sent home or reasonably separated from other children if:</p> <p>(a) The illness or condition prevents the child from participating in normal activities;</p> <p>(b) The illness or condition requires more care and attention than the early learning provider can give;</p> <p>(c) The required amount of care for the ill child compromises or places at risk the health and safety of other children in care; or</p> <p>(d) There is a risk that the child's illness or condition will spread to other children or individuals.</p> <p>Weight # 6</p>	Meets	(e) Open sores or wounds discharging bodily fluids that cannot be adequately covered with a waterproof dressing or mouth sores with drooling;		

<p>changing;</p> <p>4) A health care professional or health department official recommends exclusion of the person with <i>S. aureus</i> infection.</p> <p>Meticulous hand hygiene following contact with lesions should be practiced. Careful hand hygiene and sanitization of surfaces and objects potentially exposed to infectious material are the best ways to prevent spread. Children and staff in close contact with an infected person should be observed for symptoms of <i>S. aureus</i> infection and referred for evaluation, if indicated.</p> <p>A child may return to group child care when staff members are able to care for the child without compromising their ability to care for others, the child is able to participate in activities, appropriate therapy is being given, and the lesions can be covered. <i>S. aureus</i> skin infections initially may appear as red raised areas that may become pus-filled abscesses or “boils,” surrounded by areas of redness and tenderness. Fever and other symptoms including decreased activity, bone and joint pain, and difficulty breathing may occur when the infection occurs in other body systems. If any of these signs or symptoms occur, the child should be evaluated by his/her primary care provider.</p>	<p>(5) Unless covered by an individual care plan or protected by the ADA, an ill child, staff member, or other individual must be sent home or isolated from children in care if he or she has:</p> <p>(a) A fever 101 degrees Fahrenheit for children over 2 months (or 100.4 degrees F for an infant younger than 2 months) by any method, and behavior change or other signs and symptoms of illness (including sore throat, earache, headache, rash, vomiting, diarrhea);</p> <p>(b) Vomiting 2 or more times in the previous 24 hours;</p> <p>(c) Diarrhea where stool frequency exceeds 2 stools above normal per 24 hours for that child or whose stool contains more than a drop of blood or mucus;</p> <p>(d) A rash not associated with heat, diapering, or an allergic reaction;</p> <p>(e) Open sores or wounds discharging bodily fluids that cannot be adequately covered with a waterproof dressing or mouth sores with drooling;</p> <p>(f) Lice, ringworm, or scabies. Individuals with head lice, ringworm, or scabies must be excluded from the child care premises beginning from the end of the day the head lice or scabies was discovered. The provider may allow an individual with head lice or scabies to return to the premises after receiving the first treatment; or</p> <p>(g) A child who appears severely ill, which may include lethargy, persistent crying, difficulty breathing, or a significant change in behavior or activity level indicative of illness.</p> <p>Weight # 7</p> <p>(6) At the first opportunity, but in no case longer than 24 hours of learning that an enrolled child, staff member, volunteer or household member has been diagnosed by a health care professional with a contagious disease listed in WAC 246-110-010(3), as now and hereafter amended, an early learning provider must provide written notice to the department, the local health jurisdiction, and the parents or guardians of the enrolled children. Weight #7</p> <p>(7) An early learning provider must not take ear or rectal temperatures to determine a child’s body temperature.</p> <p>(a) Providers must use developmentally appropriate methods when taking infant or toddler temperatures (for example, digital forehead scan thermometers or underarm auxiliary methods);</p> <p>(b) Oral temperatures may be taken for preschool through school-age children if single use covers are used to prevent cross contamination; and</p> <p>(c) Glass thermometers containing mercury must not be used. Weight #6</p> <p>(8) An early learning provider may readmit a child, staff member, volunteer or household member into the early learning program area with written permission of a health care provider or health jurisdiction stating the individual may safely return after being diagnosed with a contagious disease listed in WAC 246-110-010(3), as now and hereafter amended. Weight #5</p>				
<p>STANDARD 7.5.6.1: Immunization for Measles</p> <p>All children in a child care facility should have received age-appropriate immunizations with measles, mumps, and rubella (MMR) vaccine or with measles, mumps, rubella, and varicella (MMRV) vaccine (1). If a case of measles occurs in a child care setting, interrupting subsequent spread depends on prompt immunization of people at risk of exposure or people already exposed who cannot provide documentation of measles immunity, including date of immunization. Children and adults in child care who are not</p>	<p>170-300-0210 Immunizations and exempt children.</p> <p>(1) Before attending an early learning program, a child must be vaccinated against or show proof of acquired immunity for the vaccine-preventable disease, pursuant to chapter 246-105 WAC, as now and hereafter amended. An early learning provider may accept children without proof of vaccinations or immunity as otherwise indicated in this section. Weight NA</p> <p>(2) An early learning provider must receive for each enrolled child:</p> <p>(a) A current and complete department of health certificate of immunization status (CIS) or certificate of exemption (COE) or other department of health approved form, pursuant to WAC 246-105-050, as now and hereafter amended; or</p> <p>(b) A current immunization record from the Washington State Immunization Information System (WA IIS).</p>	Meets	WAC 170-300-0210 addresses children’s immunizations. DOH requires MMR (Measles, Mumps, Rubella) vaccine for children attending child care.		

<p>immunized or not age-appropriately immunized against measles should be excluded from care immediately if the child care facility has been notified of a documented case of measles occurring in a child or adult in the center. These children should not be allowed to return to the facility until at least two weeks after the onset of rash in the last case of measles, as determined by health department officials. Adults born before 1957 can be considered immune to measles. Adults born during or after 1957 should receive one or more doses of MMR vaccine unless they have a medical contraindication, documentation of one or more dose of vaccine, history of measles based on primary care provider diagnosis, or laboratory evidence of immunity.</p>	<p>Weight #3</p> <p>(3) To accept a child who is not current with their immunizations, an early learning provider must give written notice to that child's parent or guardian stating the child may be accepted if the immunizations are completed as soon as possible and:</p> <p>(a) Prior to enrollment the parent or guardian provides written proof the child is scheduled to be immunized; or</p> <p>(b) The parent or guardian provides a signed and dated statement detailing when the child's immunizations will be brought up to date.</p> <p>Weight# 3</p> <p>(4) An early learning provider must maintain and update each child's records relating to immunizations or exemptions, or plans to bring immunizations current. These records must be available in the licensed space or easily accessible for review by department licensors, health specialists, and health consultants. Weight NA</p> <p>(5) An early learning provider may accept homeless or foster children into care without the records listed in this section if the child's family, case worker, or health care provider offers written proof that he or she is in the process of obtaining the child's immunization records. Weight #3</p> <p>(6) An early learning provider may exclude a child from care according to the criteria listed in WAC 246-105-080, as now and hereafter amended. Weight NA</p> <p>(7) If an outbreak of a vaccine-preventable disease occurs within an early learning program, an early learning provider must notify the parents or guardians of children exempt from that disease and children without vaccination documents. A provider may exclude the child from the child care premises for the duration of the outbreak of that vaccine-preventable disease. Weight #7</p> <p>(8) An early learning provider may have a written policy stating children exempted from immunization by their parent or guardian will not be accepted into care unless that exemption is due to an illness protected by the ADA or WLAD or by a completed and signed COE. Weight NA</p> <p>170-300-0120 Providing for personal, professional, and health needs of staff.</p> <p>(3) If a staff person has not been vaccinated, or has not shown documented immunity to a vaccine preventable disease, that person may be required by the local health jurisdiction or the department to remain off-site during an outbreak of a contagious disease described in WAC 246-110-010, as now and hereafter amended. Weight NA</p>				
<p>STANDARD 9.2.3.12: Infant Feeding Policy</p> <p>A policy about infant feeding should be developed with the input and approval from the nutritionist/registered dietitian and should include the following:</p> <p>a) Storage and handling of expressed human milk;</p> <p>b) Determination of the kind and amount of commercially prepared formula to be prepared for infants as appropriate;</p> <p>c) Preparation, storage, and handling of infant formula;</p> <p>d) Proper handwashing of the caregiver/teacher and</p>	<p>170-300-0450 Parent or guardian handbook and related policies.</p> <p>(1) An early learning provider must supply to each parent or guardian written policies regarding the early learning program. Each enrolled child's record must have signed documentation stating the parent or guardian reviewed the handbook and early learning program policies. Weight #3</p> <p>(2) An early learning provider must have and follow formal written policies in either paper or electronic format, including:</p> <p>(i) If the early learning program offers any of the following, they must include a policy for each that applies to their program:</p> <p>(ii) Infant and toddler care, covering:</p> <p>(B) Feeding;</p>	Partially Meets	<p>WAC outlines the need for feeding Policy but does not clarify:</p> <p>b) Determination of the kind and amount of commercially prepared formula to be prepared for infants as appropriate;</p> <p>k) Specification of the number of children</p>		

<p>the children;</p> <p>e) Use and proper sanitizing of feeding chairs and of mechanical food preparation and feeding devices, including blenders, feeding bottles, and food warmers;</p> <p>f) Whether expressed human milk, formula, or infant food should be provided from home, and if so, how much food preparation and use of feeding devices, including blenders, feeding bottles, and food warmers, should be the responsibility of the caregiver/teacher;</p> <p>g) Holding infants during bottle-feeding or feeding them sitting up;</p> <p>h) Prohibiting bottle propping during feeding or prolonging feeding;</p> <p>i) Responding to infants' need for food in a flexible fashion to allow cue feedings in a manner that is consistent with the developmental abilities of the child (policy acknowledges that feeding infants on cue rather than on a schedule may help prevent obesity) (1,2);</p> <p>j) Introduction and feeding of age-appropriate solid foods (complementary foods);</p> <p>k) Specification of the number of children who can be fed by one adult at one time;</p> <p>l) Handling of food intolerance or allergies (e.g., cow's milk, peanuts, orange juice, eggs, wheat).</p> <p>Individual written infant feeding plans regarding feeding needs and feeding schedule should be developed for each infant in consultation with the infant's primary care provider and parents/guardians.</p>	<p>Weight #4</p> <p>170-300-0280 Bottle preparation.</p> <p>(1) An early learning provider may allow parents to bring from home filled bottles clearly labeled with the date and infant's first and last name for daily use. Bottles must be immediately refrigerated. Weight #5</p> <p>(2) A bottle preparation area must:</p> <p>(a) Include a sink; and</p> <p>(b) Be located at least eight feet from any diaper changing tables or counters and sinks used for diaper changing; or</p> <p>(c) Be physically separated from the diaper changing area by means of a barrier to prevent cross contamination. If a barrier is used, it must be:</p> <p>(i) Smooth and easily cleanable;</p> <p>(ii) Sealed, if made of wood;</p> <p>(iii) Moisture resistant;</p> <p>(iv) Extend at least 24 inches in height from the counter or changing surface; and</p> <p>(v) Solid without cracks, breaks or separation.</p> <p>Weight #6</p> <p>(3) To prepare bottles, an early learning provider must:</p> <p>(a) Clean bottles and nipples before use using warm soapy water and a bottlebrush and sanitize by boiling in hot water for one minute, or pursuant to WAC 170-300-0198;</p> <p>(b) Clean and sanitize the sink used for preparing bottles;</p> <p>(c) Obtain water from a sink used for bottle or food preparation only, or from another approved source, such as bottled water. Water from a handwashing or diaper changing sink may not be used for bottle preparation;</p> <p>(d) Use bottles and nipples in good repair (with no cracks);</p> <p>(e) Use glass or stainless steel bottles, or use plastic bottles labeled with "1," "2," "4," or "5" on the bottle. A plastic bottle must not contain the chemical bisphenol-A or phthalates;</p> <p>(f) Prepare infant formula according to manufacturer's directions and never serve infant formula past the expiration date on the container;</p> <p>(g) Not heat a bottle in a microwave;</p> <p>(h) Warm bottles under running warm water, in a container of water, or in a bottle warmer;</p> <p>(i) Keep bottle nipples covered if bottles are prepared ahead;</p> <p>(j) Store prepared and unserved bottles in the refrigerator;</p> <p>(k) Not allow infants or toddlers to share bottles or cups when in use; and</p> <p>(l) Throw away contents of any formula bottle not fully consumed within one hour (partially consumed bottles must not be put back into the refrigerator). Weight #6</p> <p>170-300-0281 Breast milk.</p> <p>(1) When a parent or guardian provides breast milk, an early learning provider must:</p> <p>(a) Immediately refrigerate or freeze the breast milk; Weight #7</p> <p>(b) Label the breast milk container with the child's first and last name and the date received; Weight #6</p> <p>(c) Store frozen breast milk at zero degrees Fahrenheit or less, and in a closed container to prevent contamination; and Weight #6</p> <p>(d) Keep frozen breast milk for no more than 30 days upon receipt and return any unused frozen breast milk to the parent after 30 days. Weight #4</p>		<p>who can be fed by one adult at one time;</p> <p>Individual written infant feeding plans regarding feeding needs and feeding schedule should be developed for each infant in consultation with the infant's primary care provider and parents/guardians.</p>		
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<p>(2) Frozen breast milk must be kept in the refrigerator at a temperature of 39 degrees Fahrenheit for up to 24 hours after thawed. Weight #6</p> <p>(3) Thawed breast milk that has not been served within 24 hours must be labeled “do not use” and returned to the parent or guardian. Weight #4</p> <p>(4) An early learning provider must return any unused refrigerated, not been previously frozen, bottles or containers of breast milk to the parent at the end of the child’s day, or label “do not use”. Weight #4</p> <p>(5) An early learning provider must thaw frozen breast milk in the refrigerator, under warm running water, in a container with warm water, or in a bottle warmer. Weight #6</p> <p>(6) An early learning provider must not thaw or heat breast milk in a microwave oven or on the stove. Weight #7</p> <p>(7) An early learning provider must obtain parental consent prior to feeding infant formula to an otherwise breastfed infant. Weight #6</p> <p>170-300-0285 Infant and toddler nutrition and feeding.</p> <p>(1) An early learning provider must have and follow written policies on providing, preparing, and storing breast milk or infant formula and food. Weight NA</p> <p>(2) After consulting a parent or guardian, an early learning provider must implement a feeding plan for infants and toddlers that include:</p> <p> (a) A plan to support the needs of a breastfeeding mother and infant by:</p> <p> (i) Providing an area for mothers to breastfeed their infants; and</p> <p> (ii) Providing educational materials and resources to support breastfeeding mothers; Weight #4</p> <p> (b) Feeding infants and toddlers when hungry according to their nutritional and developmental needs, unless medically directed; Weight #6</p> <p> (c) Serving only breast milk or infant formula to an infant, unless the child's health care provider offers a written order stating otherwise; and Weight #6</p> <p> (d) When bottle feeding, an early learning provider must:</p> <p> (i) Test the temperature of bottle contents before feeding to avoid scalding or burning the child's mouth;</p> <p> (ii) Hold infants and, when developmentally appropriate, toddlers to make eye contact and talk to them;</p> <p> (iii) Stop feeding the infant or toddler when he or she shows signs of fullness; and</p> <p> (iv) Not allow infants or toddlers to be propped with bottles or given a bottle or cup when lying down. Weight #6</p> <p> (e) Transitioning a child to a cup only when developmentally appropriate; Weight #5</p> <p> (f) Introducing age-appropriate solid foods no sooner than four months of age, based on an infant’s ability to sit with support, hold his or her head steady, close his or her lips over a spoon, and show signs of hunger and being full, unless identified in Written Food Plan pursuant to WAC 170-300-0190 or written medical approval; Weight #5</p> <p> (g) Not adding food, medication, or sweeteners to the contents of a bottle unless a health care provider gives written consent; Weight #6</p>				
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	<p>(h) Not serving 100% juice or any sweetened beverages (for example, juice drinks, sports drinks, or tea) to infants less than 12 months old, unless a health care provider gives written consent, and helping prevent tooth decay by only offering juice to children older than 12 months from a cup; Weight #5</p> <p>(i) Increasing the texture of the food from strained, to mashed, to soft table foods as a child’s development and skills progress between six and twelve months of age. Soft foods offered to older infants should be cut into pieces ¼ inches or smaller to prevent choking; Weight #6</p> <p>(j) Allowing older infants or toddlers to self-feed soft foods from developmentally appropriate eating equipment; Weight #4</p> <p>(k) Placing infants or toddlers who can sit up on their own in high chairs or at an appropriate child-size table and chairs when feeding solid foods or liquids from a cup, and having an early learning provider sit with and observe each child eating. If high chairs are used, each high chair must:</p> <ul style="list-style-type: none">(i) Have a base that is wider than the seat;(ii) Have a safety device, used each time a child is seated, that prevents the child from climbing or sliding down the chair;(iii) Be free of cracks and tears; and(iv) Have a washable surface; <p>Weight #5</p> <p>(l) Not leaving infants or toddlers more than 15 minutes in high chairs waiting for meal or snack time, and removing a child as soon as possible once he or she finishes eating; Weight #5</p> <p>(m) Preventing infants or toddlers from sharing the same dish or utensil; Weight #4</p> <p>(n) Not serving any uneaten food from the serving container after the intended meal; and Weight #4</p> <p>(o) Not serving food to infants or toddlers using polystyrene foam (Styrofoam) cups, bowls, or plates. Weight #6</p> <p>170-300-0200 Handwashing and hand sanitizer.</p> <p>(1) Early learning providers must comply with the following handwashing procedures or those defined by the United States Center for Disease Control and Prevention, and children should strongly be encouraged to:</p> <ul style="list-style-type: none">(a) Wet hands with warm water;(b) Apply soap to the hands;(c) Rub hands together to wash for at least 20 seconds;(d) Thoroughly rinse hands with water;(e) Dry hands with a paper towel, single-use cloth towel, or air hand dryer;(f) Turn water faucet off with using a paper towel or single use cloth towel unless it turns off automatically; and(g) Properly discard paper single-use cloth towels after each use. Weight #6 <p>(2) An early learning provider must wash and sanitize cloth towels after a single use. Soiled and used towels must be inaccessible to children. Weight #4</p> <p>(6) Hand sanitizers or hand wipes with alcohol may be used for adults and children over 24 months of age under the following conditions:</p> <ul style="list-style-type: none">(a) when proper handwashing facilities are not available; and(b) Hands are not visibly soiled or dirty. <p>Weight NA</p> <p>170-300-0198 Food preparation areas.</p>				
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	<p>(1) An early learning provider or staff must clean and sanitize food preparation areas and eating surfaces before and after each use, pursuant to 170-300-0241(1)(a). Weight NA</p> <p>(2) In an early learning program’s food preparation area, kitchens must:</p> <p> (a) Have walls, counter tops, floors, cabinets, and shelves that are:</p> <p> (i) Maintained in good repair including, but not limited to, being properly sealed without chips, cracks, or tears; and</p> <p> (ii) Moisture resistant.</p> <p> (b) Have a properly maintained and vented range hood, exhaust fan, or operable window; and</p> <p> (c) Have a properly maintained and working refrigerator, freezer, or a combination refrigerator and freezer with sufficient space for proper storage and cooling of food.</p> <p> Weight #6</p> <p>(3) An early learning provider must:</p> <p> (a) Have at least eight feet between the food preparation area and any diaper changing tables or counters and sinks used for diaper changing;</p> <p> (b) Clean and sanitize a sink immediately before using it to prepare food to be served to children in care;</p> <p> (c) Use a colander or other method to prevent food and kitchen utensils from touching the sink basin; and</p> <p> (d) Clean dishes, pans, baby bottles, and kitchen utensils as follows:</p> <p> (i) Cleaning and sanitizing with an automatic dishwasher that uses heat or chemicals to sanitize; or</p> <p> (ii) Hand washing, rinsing, sanitizing, and allowing to air dry.</p> <p> Weight #6</p> <p>(4) Center early learning programs licensed after the date this chapter becomes effective must have:</p> <p> (a) A handwashing sink separate from dishwashing facilities;</p> <p> (b) A food preparation sink located in the food preparation area; and</p> <p> (c) A method to clean and sanitize dishes, pans, kitchen utensils, and equipment in the food preparation area using:</p> <p> (i) A two-compartment sink and an automatic dishwasher that sanitizes with heat or chemicals; or</p> <p> (ii) A three-compartment sink method (sink one is used to wash, sink two is used to rinse, sink three contains a sanitizer, and the dishes are allowed to air dry).</p> <p> Weight #6</p> <p>(5) An early learning provider may use the kitchen for actively supervised cooking or food preparation activities with children in care. Weight NA</p>				
<p>STANDARD 9.2.3.15: Policies Prohibiting Smoking, Tobacco, Alcohol, Illegal Drugs, and Toxic Substances</p> <p>Facilities should have written policies addressing the use and possession of tobacco products, alcohol, illegal drugs, prescription medications that have not been</p>	<p>170-300-450 Parent or guardian handbook and related policies.</p> <p>(1)An early learning provider must supply to each parent or guardian written policies regarding the early learning program. Each enrolled child’s record must have signed documentation stating the parent or guardian reviewed the handbook and the early learning program policies. Weight #3</p> <p>(2)An early learning provider must have and follow formal written policies in either paper or electronic</p>	Exceeds	Policies must also include vape and cannabis products/paraphernalia		

<p>prescribed for the user, and unauthorized potentially toxic substances. Policies should include that all of these substances are prohibited inside the facility, on facility grounds, and in any vehicles that transport children at all times. Policies should specify that smoking is prohibited at all times and in all areas used by the children in the program. Smoking is also prohibited in any vehicles that transport children.</p> <p>Policies must also specify that use and possession of all substances referred to above is prohibited during all times when caregivers/teachers are responsible for the supervision of children, including times when children are transported, when playing in outdoor play areas not attached to the facility, and during field trips. Child care centers and large family child care homes should provide information to employees about available drug, alcohol, and tobacco counseling and rehabilitation, and any available employee assistance programs.</p>	<p>format, including:</p> <p>(d) Alcohol, tobacco, cannabis use and prohibition of illegal drugs; Weight #4</p> <p>170-300-110 Program based staff policies and training. (1) An early learning provider must have and follow written policies for early learning program staff. Staff policies must include those listed in subsections (2) and (3) of this section and must be reviewed and approved by the department prior to issuing a provider's initial license. Providers must notify the department when substantial changes are made. Weight #1</p> <p>(2) Early learning program staff policies must include, but are not limited to:</p> <p>(e) Early learning program staff responsibilities for:</p> <p>(xv) Following non-smoking, vaping, alcohol and drug regulations; Weight NA</p> <p>170-300-0420 Prohibited substances. (1) Chapter 70.160 RCW prohibits smoking in public places and places of employment. Weight NA</p> <p>(2) Pursuant to RCW 70.160.050, an early learning provider must:</p> <p>(a) Prohibit smoking, vaping, or similar activities in licensed indoor space, even during non-business hours; Weight #7</p> <p>(b) Prohibit smoking, vaping, or similar activities in licensed outdoor space unless:</p> <p>(i) Smoking, vaping or similar activities occurs during non-business hours; or</p> <p>(ii) In an area for smoking or vaping tobacco products that is not a "public place" or "place of employment," as defined in RCW 70.160.020; Weight #7</p> <p>(c) Prohibit smoking, vaping, or similar activities in motor vehicles used to transport enrolled children; Weight #7</p> <p>(d) Prohibit smoking, vaping, or similar activities by any provider who is supervising children, including during field trips; Weight #7</p> <p>(e) Prohibit smoking, vaping, or similar activities within twenty-five feet from entrances, exits, operable windows, and vents, pursuant to RCW 70.160.075; Weight #5 and</p> <p>(f) Post "no smoking or vaping" signs. Signs must be clearly visible and located at each building entrance used as part of the early learning program. Weight NA</p> <p>(3) An early learning provider must:</p> <p>(a) Prohibit any person from consuming or being under the influence of alcohol on licensed space during business hours;</p> <p>(b) Prohibit any person within licensed space from consuming or being under the influence of illegal drugs or misused prescription drugs.</p> <p>(c) Store any tobacco or vapor products, or the packaging of tobacco or vapor products in a space that is inaccessible to children;</p> <p>(d) Prohibit children from accessing cigarette or cigar butts or ashes;</p> <p>(e) Store any cannabis or associated paraphernalia out of the licensed space and in a space that is inaccessible to children; and</p> <p>(f) Store alcohol in a space that is inaccessible to children (both opened and closed containers). Weight #7</p>				
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	<p>(4) A center early learning provider must prohibit any person from using, consuming, or being under the influence of cannabis in any form on licensed space. Weight #7</p> <p>(5) A family home early learning provider must prohibit any person from using, consuming, or being under the influence of cannabis products in any form on licensed space during business hours. Weight #7</p>				
<p>STANDARD 9.2.3.2: Content and Development of the Plan for Care of Children and Staff Who Are Ill</p> <p>All child care facilities should have written policies for the management and care of children and staff who are ill. The facility's plan for the care of children and staff who are ill should be developed in consultation with the facility's child care health consultant and other health care professionals to address current understanding of the technical issues of contagion and other health risks. This plan should include:</p> <ul style="list-style-type: none">a) Policies and procedures for urgent and emergency care;b) Admission and inclusion/exclusion policies;c) A description of illnesses common to children in child care, their management, and precautions to address the needs and behavior of the child who is ill, as well as to protect the health of other children and staff;d) A procedure to obtain and maintain updated individual care plans for children and staff with special health care needs;e) A procedure for documenting the name of person affected, date and time of illness, a description of symptoms, the response of the caregiver/teacher or other staff to these symptoms, who was notified (such as a parent/guardian, primary care provider, nurse, physician, or health department), and the response;f) Medication policy;g) Seasonal and pandemic influenza policy;h) Staff illness-guidelines for exclusion and reentry. <p>In group care, the facility should address the well-being of all those affected by illness: the child, the staff, parents/ guardians of the child, other children in the</p>	<p>170-300-0500 Health policy.</p> <p>(1) An early learning provider must have and follow a written health policy reviewed and approved by the department that includes the topics listed in subsection (2) of this section. The health policy must be reviewed and approved by the department when changes are made, and as otherwise necessary. Weight NA</p> <p>(2) An early learning program's health policy must meet the requirements of this chapter including, but not limited to:</p> <ul style="list-style-type: none">(a) A prevention of exposure to blood and body fluids plan;(b) Meals, snacks, and food services including guidelines for food allergies and food brought from home;(c) Handwashing and hand sanitizer use;(d) Observing children for signs of illness daily;(e) Exclusion and return of ill children, staff, or any other person in the program space;(f) Contagious disease notification;(g) Medical emergencies, injury treatment and reporting;(h) Immunization tracking;(i) Medication management, storage, administration and documentation;(j) Care for pets and animals that have access to licensed space and the health risks of interacting with pets and animals;(k) How general cleaning will be provided and how areas such as food contact surfaces, kitchen equipment, toys, toileting equipment, and laundry will be cleaned, sanitized and disinfected;(l) Pest control policies;(m) Caring for children with special needs or health needs, including allergies, as listed in the child's record; and(n) Dental hygiene practices and education. <p>Weight NA</p> <p>170-300-0110 Program based staff policies and training.</p> <p>(1) An early learning provider must have and follow written policies for early learning program staff. Staff policies must include those listed in subsections (2) and (3) of this section and must be reviewed and approved by the department prior to issuing a provider's initial license. Providers must notify the department when substantial changes are made. Weight #1</p> <p>(2) Early learning program staff policies must include, but are not limited to:</p> <ul style="list-style-type: none">(e) Early learning program staff responsibilities for:(x) Health, safety, and sanitation procedures; <p>Weight NA</p>	Meets			

<p>facility and their parents/guardians, and the community. The priority of the policy should be to meet the needs of the child who is ill and the other children in the facility. The policy should address the circumstances under which separation of the affected individual (child or staff person) from the group is required; the circumstances under which the staff, parents/guardians, or other designated persons need to be informed; and the procedures to be followed in these cases. The policy should take into consideration:</p> <ul style="list-style-type: none">a) The physical facility;b) The number and the qualifications of the facility’s personnel;c) The fact that children do become ill frequently and at unpredictable times;d) The fact that adults may be on staff with known health problems or may develop health problems while at work;e) The fact that working parents/guardians often are not given leave for their children’s illnesses;f) The amount of care the child who is ill requires if the child remains in the program, can staff devote the time for caring of a child who is ill in the classroom without leaving other children unattended, and can the child participate in any of the classroom activities.					
<p>STANDARD 9.2.3.9: Written Policy on Use of Medications</p> <p>The facility should have a written policy for the administration of any prescription or non-prescription (over-the-counter [OTC]) medication. The policy should address at least the following:</p> <ul style="list-style-type: none">a) The use of written parental/guardian consent forms for each prescription and OTC medication to be administered at the child care facility. The consent form should include:<ul style="list-style-type: none">1) The child’s name;2) The name of the medication;3) The date(s) and times the medication is to be given;4) The dose or amount of medication to be given;5) How the medication is to be administered;6) The period of time the consent form is valid, which may not exceed the length of time the medication is prescribed for, the expiration date of the medication or one year, whichever is	<p>170-300-0500 Health policy.</p> <p>(1) An early learning provider must have and follow a written health policy reviewed and approved by the department that includes the topics listed in subsection (2) of this section. The health policy must be reviewed and approved by the department when changes are made, and as otherwise necessary. Weight NA</p> <p>(2) An early learning program’s health policy must meet the requirements of this chapter including, but not limited to:</p> <ul style="list-style-type: none">(i) Medication management, storage, administration and documentation;(m)Caring for children with special needs or health needs, including allergies, as listed in the child’s file; and <p>Weight NA</p> <p>170-300-0186 Food allergies and special dietary needs.</p> <p>(1) An early learning provider must obtain written instructions (The Individual Care Plan) from the child’s health care provider and parent or guardian when caring for a child with a known food allergy or special dietary requirement due to a health condition. The Individual Care Plan pursuant to WAC 170-300-0300 must:</p> <ul style="list-style-type: none">(a)Identify foods that must not be consumed by the child and steps to take in the case of an unintended allergic reaction;(b)Identify foods that can substitute for allergenic foods; and	<p>Partially Meets</p>	<p>WAC and required DEL trainings do not address:</p> <ul style="list-style-type: none">2) Prohibition of administering OTC cough and cold medication;3) Not administering a new medication for the first time to a child while he or she is in child care;4) If the instructions are unclear or the supplies needed to measure doses or administer the medication are not available or not in good working condition;		

<p>less.</p> <p>b) The use of the prescribing health professional’s authorization forms for each prescription and OTC medication to be administered at the child care facility.</p> <p>c) The circumstances under which the facility will agree to administer medication. This may include the administration of:</p> <p>1) Topical medications such as non-medicated diaper creams, insect repellants, and sun screens;</p> <p>2) OTC medicines for fever including acetaminophen and ibuprofen;</p> <p>3) Long-term medications that are administered daily for children with chronic health conditions that are managed with medications;</p> <p>4) Controlled substances, such as psychotropic medications;</p> <p>5) Emergency medications for children with health conditions that may become life-threatening such as asthma, diabetes, and severe allergies;</p> <p>6) One-time medications to prevent conditions such as febrile seizures.</p> <p>d) The circumstances under which the facility will not administer medication. This should include:</p> <p>1) No authorization from parent/guardian and/or prescribing health professional;</p> <p>2) Prohibition of administering OTC cough and cold medication;</p> <p>3) Not administering a new medication for the first time to a child while he or she is in child care;</p> <p>4) If the instructions are unclear or the supplies needed to measure doses or administer the medication are not available or not in good working condition;</p> <p>5) The medication has expired;</p> <p>If a staff person or his/her backup who has been trained to give that particular medication is not present (in the case of training for medications that require specific skills to administer properly, such as inhalers, injections, or feeding tubes/ports).</p> <p>e) The process of accepting medication from parents/ guardians. This should include:</p> <p>1) Verifying the consent form;</p> <p>2) Verifying the medication matches what is on the consent form;</p>	<p>(c) Provide a specific treatment plan for the early learning provider to follow in response to an allergic reaction. The specific treatment plan must include the:</p> <p>(i) Names of all medication to be administered;</p> <p>(ii) Directions for how to administer the medication;</p> <p>(iii) Directions related to medication dosage amounts; and</p> <p>(iv) Description of allergic reactions and symptoms associated with the child’s particular allergies. Weight #8</p> <p>(2) An early learning provider must arrange with the parents or guardians of a child in care to ensure the early learning program has the necessary medication, training, and equipment to properly manage a child’s food allergies. Weight #8</p> <p>(3) If a child suffers from an allergic reaction, the early learning provider must immediately:</p> <p>(a) Administer medication pursuant to the instructions in that child’s Individual Care Plan;</p> <p>(b) Contact 911 whenever epinephrine or other lifesaving medication has been administered; and</p> <p>(c) Notify the parents or guardians of a child if it is suspected or appears that any of the following occurred, or is occurring:</p> <p>(i) The child is having an allergic reaction; or</p> <p>(ii) The child consumed or came in contact with a food identified by the parents or guardians that must not be consumed by the child, even if the child is not having or did not have an allergic reaction. Weight #8</p> <p>(4) Early learning providers must review each child’s Individual Care Plan information for food allergies prior to serving food to children. Weight #7</p> <p>170-300-0215 Medication</p> <p>(1) Managing medication. A medication management policy must include, but is not limited to, safe medication storage, reasonable accommodations for giving medication, mandatory medication documentation, and forms pursuant to WAC 170-300-0500. Weight NA</p> <p>(2) Medication Training. An early learning provider must not give medication to a child if the provider has not successfully completed:</p> <p>(a) An orientation about the early learning program’s medication policies and procedures;</p> <p>(b) The department standardized training course in medication administration that includes a competency assessment pursuant to WAC 170-300-0106(10) or equivalent training; and</p> <p>(c) If applicable, a training from a child’s parents or guardian (or an appointed designee) for special medical procedures that are part of a child’s Individual Care Plan. This training must be documented and signed by the provider and the child’s parent or guardian (or designee). Weight #6</p> <p>(3) Medication Administration. An early learning provider must not give medication to any child without written and signed consent from that child’s parent or guardian, must administer medication pursuant to directions on the medication label, and using appropriate cleaned and sanitized medication measuring devices. Weight #8</p> <p>(a) An early learning provider must administer medication to children in care as follows:</p> <p>(i) Prescription Medication. Prescription medication must only be given to the child named on the prescription. Prescription medication must be prescribed by a health care</p>				
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<p>3) Accepting authorization for prescription medications from the child’s prescribing health professional only if the medications are in their original container and have the child’s name, the name of the medication, the dose and directions for giving the medication, the expiration date of the medication, and a list of warnings and possible side effects;</p> <p>4) Accepting authorization for OTC medications from the child’s prescribing health professional only if the authorization indicates the purpose of the medication and time intervals of administration, and if the medications are in their original container and include the child’s name, the name of the medication, dose and directions for use, an expiration date for the medication, and a list of warnings and possible side effects;</p> <p>5) Verifying that a valid Care Plan accompanies all long-term medications (i.e., medications that are to be given routinely or available routinely for chronic conditions such as asthma, allergies, and seizures);</p> <p>6) Verifying any special storage requirements and any precautions to take while the child is on the prescription or OTC medication.</p> <p>f) The proper handling and storage of medications, including:</p> <p>1) Emergency medications – totally inaccessible to children but readily available to supervising caregivers/teachers trained to give them;</p> <p>2) Medications that require refrigeration;</p> <p>3) Controlled substances;</p> <p>4) Expired medications;</p> <p>5) A policy to insure confidentiality;</p> <p>6) Storing and preparing distribution in a quiet area completely out of access to children;</p> <p>7) Keeping all medication at all times totally inaccessible to children (e.g., locked storage);</p> <p>8) Whether to require even short-term medications be kept at the facility overnight.</p> <p>g) The procedures to follow when administering medications. These should include:</p> <p>1) Assigning administration only to an adequately trained, designated staff;</p> <p>2) Checking the written consent form;</p> <p>3) Adhering to the “six rights” of safe</p>	<p>professional with prescriptive authority for a specific child. Prescription medication must be labeled with:</p> <p>(A) A child’s first and last name;</p> <p>(B) The date the prescription was filled;</p> <p>(C) The name and contact information of the prescribing health professional;</p> <p>(D) The expiration date, dosage amount, and length of time to give the medication; and</p> <p>(E) Instructions for the administration, storage and accompanied with medication authorization form that has the medical need and the possible side effects of the medication.</p> <p>Weight #7</p> <p>(ii) Non-prescription oral medication. Non-prescription (over-the-counter) oral medication brought to the early learning program by a parent or guardian must be in the original packaging.</p> <p>(A) Non-prescription (over-the-counter) medication needs to be labeled with child’s first and last name and accompanied with medication authorization form that has the expiration date, medical need, dosage amount, age, and length of time to give the medication. Early learning providers must follow the instructions on the label or the parent must provide a medical professional’s note; and</p> <p>(B) Non-prescription medication must only be given to the child named on the label provided by the parent or guardian.</p> <p>Weight #7</p> <p>(iii) Other non-prescription medication: An early learning provider must receive written authorization from a child’s parent or guardian and health care provider with prescriptive authority prior to administering if the item does not include age, expiration date, dosage amount, and length of time to give the medication:</p> <p>(A) Vitamins;</p> <p>(B) Herbal supplements;</p> <p>(C) Fluoride supplements;</p> <p>(D) Homeopathic or naturopathic medication; and</p> <p>(E) Teething gel or tablets (amber bead necklaces are prohibited).</p> <p>Weight #6</p> <p>(iv) Non-medical items. A parent or guardian must annually authorize an early learning provider to administer the following non-medical items:</p> <p>(A) Diaper ointments (used as needed and according to manufacturer’s instructions);</p> <p>(B) Sunscreen;</p> <p>(C) Lip balm or lotion;</p> <p>(D) Hand sanitizers or hand wipes with alcohol, which may be used only for children over 24 months old; and</p> <p>(E) Fluoride toothpaste for children two years old or older.</p> <p>Weight #2</p> <p>(v) An early learning provider may allow children to take his or her own medication with parent or guardian authorization. The early learning staff member must observe and document that the child took the medication. Weight #7</p> <p>(vi) An early learning provider must not give or permit another to give any medication to a child for the purpose of sedating the child unless the medication has been prescribed for a specific child for that particular purpose by a qualified health care professional. Weight #8</p>				
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<p>medication administration (child, medication, time/date, dose, route, and documentation) (1);</p> <p>4) Documenting and reporting any medication errors;</p> <p>5) Documenting and reporting and adverse effects of the medication;</p> <p>6) Documenting and reporting whether the child vomited or spit up the medication.</p> <p>h) The procedures to follow when returning medication to the family, including:</p> <p>1) An accurate account of controlled substances being administered and the amount being returned to the family;</p> <p>2) When disposing of unused medication, the remainder of a medication, including controlled substances.</p> <p>i) The disposal of medications that cannot be returned to the parent/guardian.</p> <p>A medication administration record should be maintained on an ongoing basis by designated staff and should include the following:</p> <p>a) Specific, signed parental/guardian consent for the caregiver/teacher to administer medication including documentation of receiving controlled substances and verification of the amount received;</p> <p>b) Specific, signed authorization from the child’s prescribing health professional, prescribing the medication, including medical need, medication, dosage, and length of time to give medication.</p> <p>c) Information about the medication including warnings and possible side effects;</p> <p>d) Written documentation of administration of medication and any side effects;</p> <p>e) Medication errors log.</p> <p>The facility should consult with the State Board of Nursing, other interested organizations and their child care health consultant about required training and documentation for medication administration. Based on the information, the facility should develop and implement a plan regarding medication administration training (9).</p>	<p>(b) Medication Documentation (excluding non-medical items). An early learning provider must keep a current written medication log that includes:</p> <p>(i) A child’s first and last name;</p> <p>(ii) The name of the medication that was given to the child;</p> <p>(iii) The dose amount that was given to the child;</p> <p>(iv) Notes about any side effects exhibited by the child;</p> <p>(v) The date and time of each medication given or reasons that a particular medication was not given; and</p> <p>(vi) The name and signature of the person that gave the medication. Weight NA</p> <p>(c) Medication must be stored and maintained as directed on the packaging or prescription label, including applicable refrigeration requirements. An early learning provider must comply with the following additional medication storage requirements:</p> <p>(i) Medication must be inaccessible to children;</p> <p>(ii) Controlled substances must be locked in a container or cabinet which is inaccessible to children;</p> <p>(iii) Medication must be kept away from food in a separate, sealed container; and</p> <p>(iv) External medication (designed to be applied to the outside of the body) must be stored to provide separation from internal medication (designed to be swallowed or injected) to prevent cross contamination. Weight #7</p> <p>(d) An early learning provider must return a child’s unused medication to that child’s parent or guardian. If this is not possible, a provider must follow the Food and Drug Administration (FDA) recommendations for medication disposal. Weight #5</p> <p>(e) An early learning provider must not accept or give to a child homemade medication, such as diaper cream or sunscreen. Weight #6</p>				
STANDARD 9.2.4.1: Written Plan and Training for Handling Urgent Medical Care or Threatening Incidents	<p>170-300-0475- Duty to protect children and report incidents.</p> <p>(1) Pursuant to RCW 26.44.030, when an early learning provider has reasonable cause to believe that a child has suffered abuse or neglect, that provider must report such incident, or cause a report to be made, to the proper law enforcement agency or the department. “Abuse or neglect” has the same meaning here as in RCW 26.44.020.</p> <p>Weight #8</p>	Partially Meets	WAC Not Addressed: f) Mental health emergencies; g) Health and safety emergencies involving		

<p>The facility should have a written plan for reporting and managing what they assess to be an incident or unusual occurrence that is threatening to the health, safety, or welfare of the children, staff, or volunteers. The facility should also include procedures of staff training on this plan. The management, documentation, and reporting of the following types of incidents, at a minimum, that occur at the child care facility should be addressed in the plan:</p> <ul style="list-style-type: none">a) Lost or missing child;b) Suspected maltreatment of a child (also see state’s mandates for reporting);c) Suspected sexual, physical, or emotional abuse of staff, volunteers, or family members occurring while they are on the premises of the child care facility;d) Injuries to children requiring medical or dental care;e) Illness or injuries requiring hospitalization or emergency treatment;f) Mental health emergencies;g) Health and safety emergencies involving parents/guardians and visitors to the program;h) Death of a child or staff member, including a death that was the result of serious illness or injury that occurred on the premises of the child care facility, even if the death occurred outside of child care hours;i) The presence of a threatening individual who attempts or succeeds in gaining entrance to the facility. <p>The following procedures, at a minimum, should be addressed in the plan for urgent care:</p> <ul style="list-style-type: none">a) Provision for a caregiver/teacher to accompany a child to a source of urgent care and remain with the child until the parent/guardian assumes responsibility for the child;b) Provision for the caregiver/teacher to provide the medical care personnel with an authorization form signed by the parent/guardian for emergency	<p>(2) An early learning provider must report by phone upon knowledge of the following to:</p> <ul style="list-style-type: none">(a) Law enforcement or the department at the first opportunity, but in no case longer than 48 hours:<ul style="list-style-type: none">(i) The death of a child while in the early learning program’s care or the death from injury or illness that may have occurred while the child was in care;(ii) A child’s attempted suicide or talk about attempting suicide;(iii) Any suspected physical, sexual or emotional child abuse;(iv) Any suspected child neglect, child endangerment, or child exploitation;(v) A child’s disclosure of sexual or physical abuse; or(vi) Inappropriate sexual contact between two or more children.(b) Emergency Services (911) immediately, and to the department within 24 hours:<ul style="list-style-type: none">(i) A child missing from care, triggered as soon as staff realizes the child is missing;(ii) A medical emergency that requires immediate professional medical care;(iii) A child who is given too much of any oral, inhaled, or injected medication;(iv) A child who took or received another child’s medication;(v) A fire or other emergency;(vi) Poisoning or suspected poisoning; or(vii) Other dangers or incidents requiring emergency response.(c) Washington Poison Center immediately after calling 911, and to the department within 24 hours:<ul style="list-style-type: none">(i) A poisoning or suspected poisoning;(ii) A child who is given too much of any oral, inhaled, or injected medication; or(iii) A child who took or received another child’s medication;(iv) The provider must follow any directions provided by Washington Poison Center.(d) The local health jurisdiction or the department of health immediately, and to the department within 24 hours about an occurrence of food poisoning or reportable contagious disease as defined in chapter 246-110 WAC, as now or hereafter amended;(e) The department at the first opportunity, but in no case longer than 24 hours, upon knowledge of any person required by chapter 170-06 WAC, as hereafter recodified or amended, to have a change in their background check history due to:<ul style="list-style-type: none">(i) A pending charge or conviction for a crime listed in WAC 170-06, as hereafter recodified or amended;(ii) An allegation or finding of child abuse, neglect, maltreatment or exploitation under chapter 26.44 RCW or chapter 388-15 WAC;(iii) An allegation or finding of abuse or neglect of a vulnerable adult under chapter 74.34 RCW; or(iv) A pending charge or conviction of a crime listed in the Director’s List in chapter 170-06 WAC, as hereafter recodified or amended, from outside Washington state, or a “negative action” as defined in RCW 43.216.010. <p>Weight #8</p> <p>(3) In addition to reporting to the department by phone or e-mail, an early learning provider must submit a written incident report of the following on a department form within 24 hours:</p> <ul style="list-style-type: none">(a) Situations that required an emergency response from Emergency Services (911).		parents/ guardians and visitors to the program;		
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	<p>Washington Poison Center, or department of health;</p> <p>(b)Situations that occur while children are in care that may put children at risk including, but not limited to, inappropriate sexual touching, neglect, physical abuse, maltreatment, or exploitation; and</p> <p>(c)A serious injury to a child in care.</p> <p>Weight #5</p> <p>(3)An early learning provider must immediately report to the parent or guardian:</p> <p>(a)Their child’s death, serious injury, need for emergency or poison services; or</p> <p>(b)An incident involving their child that was reported to the local health jurisdiction or the department of health.</p> <p>Weight #6</p> <p>170-300-0500- Health policy.</p> <p>(1) An early learning provider must have and follow a written health policy reviewed and approved by the department that includes the topics listed in subsection (2) of this section. The health policy must be reviewed and approved by the department when changes are made, and as otherwise necessary. Weight NA</p> <p>(2) An early learning program’s health policy must meet the requirements of this chapter including, but not limited to:</p> <p>(g)Medical emergencies, injury treatment and reporting;</p> <p>Weight NA</p> <p>170-300-470 Emergency preparedness plan.</p> <p>(1)An early learning provider must have and follow a written emergency preparedness plan. The plan must be reviewed and approved by the department prior to when changes are made. Emergency preparedness plans must:</p> <p>(a)Be designed to respond to fire, natural disasters, and other emergencies that might affect the early learning program;</p> <p>(b)Be specific to the early learning program and able to be implemented during hours of operation;</p> <p>(c)Address what the provider would do if he or she has an emergency and children may be left unsupervised;</p> <p>(d)Address what the early learning program must do if parents are not able to get to their children for up to three days;</p> <p>(e)Must follow requirements in chapter 212-12 WAC , as now or hereafter amended (Fire Marshal Standards) and the State Fire Marshal’s office requirements if a center early learning program;</p> <p>(f)Be reviewed at program orientation, annually with all early learning program staff with documented signatures, and when the plan is updated; and</p> <p>(g)Be reviewed with parents or guardians when a child is enrolled and when the plan is updated.</p> <p>Weight #5</p> <p>(2)The written emergency preparedness plan must cover at a minimum:</p> <p>(a)Disaster plans, including fires that may require evacuation:</p> <p>(i)An evacuation floor plan that identifies room numbers or names of rooms, emergency exit pathways, emergency exit doors, and for family home based programs, emergency exit windows if applicable;</p> <p>(ii)Methods to be used for sounding an alarm and calling 911;</p>				
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	<p>(iii)Actions to be taken by a person discovering an emergency;</p> <p>(iv)How the early learning provider will evacuate children, especially those who cannot walk independently. This may include infant evacuation cribs (for center early learning programs), children with disabilities, functional needs requirements, or other special needs;</p> <p>(v)Where the alternate evacuation location is;</p> <p>(vi)What to take when evacuating children, including:</p> <p>(A)First-aid kit(s);</p> <p>(B)Copies of emergency contact information;</p> <p>(C)Child medication records; and</p> <p>(D)Individual children's medication, if applicable;</p> <p>(vii)How the provider will maintain the required staff-to-child ratio and account for all children;</p> <p>(viii)How parents or guardians will be able to contact the early learning program; and</p> <p>(ix)How children will be reunited with their parents or guardians after the event;</p> <p>(b)Earthquake procedures including:</p> <p>(i)What a provider will do during an earthquake;</p> <p>(ii)How a provider will account for all children; and</p> <p>(iii)How a provider will coordinate with local or state officials to determine if the licensed space is safe for children after an earthquake.</p> <p>(c)Public safety related lockdown scenarios where an individual at or near an early learning program is harming or attempting to harm others with or without a weapon. This plan must include lockdown of the early learning program or shelter-in-place steps including:</p> <p>(i)How doors and windows will be secured to prevent access, if needed; and</p> <p>(ii)Where children will safely stay inside the early learning program; and</p> <p>(d)How parents or guardians will be contacted after the emergency ends.</p> <p>Weight #4</p> <p>(3)An early learning provider must keep on the premises a three day supply of food, water, and life-sustaining medication for the licensed capacity of children and current staff for use in case of an emergency. Weight #4</p> <p>(4)An early learning provider must practice and record emergency drills with staff and children as follows:</p> <p>(a)Fire and evacuation drill once each calendar month;</p> <p>(b)Earthquake, lockdown, or shelter-in-place drill once every three calendar months;</p> <p>(c)Emergency drills must be conducted with a variety of staff and at different times of the day, including in the evening and during overnight hours for early learning programs that care for children during those hours; and</p> <p>(d)Drills must be recorded on a department form and include:</p> <p>(i) The date and time of the drill;</p> <p>(ii) The number of children and staff who participated;</p> <p>(iii) The length of the drill; and</p> <p>(iv) Notes about how the drill went and how it may be improved.</p> <p>Weight #6</p> <p>(5)In areas where local emergency plans are already in place, such as school districts, an early learning program may adopt or amend such procedures when developing their own plan. Weight NA</p>				
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	<p>170-300-0450- Parent or guardian handbook and related policies.</p> <p>(1)An early learning provider must supply to each parent or guardian written policies regarding the early learning program. Each enrolled child’s record must have signed documentation stating the parent or guardian reviewed the handbook and early learning program policies. Weight #3</p> <p>(2)An early learning provider must have and follow formal written policies in either paper or electronic format, including:</p> <ul style="list-style-type: none">(s)Emergency preparedness plan;(t)The early learning provider and program staff’s duty to report incidents, including reporting suspected child abuse, neglect, sexual abuse, or maltreatment;(v)Description where the parent or guardian may find and review the early learning program’s:<ul style="list-style-type: none">(i)Health policy;(ii)Staff policies, if applicable;(vii)Other relevant program policies. <p>Weight #4</p> <p>170-300-0110 Program based staff policies and training.</p> <p>(1)An early learning provider must have and follow written policies for early learning program staff. Staff policies must include those listed in subsections (2) and (3) of this section and must be reviewed and approved by the department prior to issuing a provider’s initial license. Providers must notify the department when substantial changes are made. Weight #1</p> <p>(2) Early learning program staff policies must include, but are not limited to:</p> <ul style="list-style-type: none">(e) Early learning program staff responsibilities for:<ul style="list-style-type: none">(x) Health, safety and sanitization procedures;(xii) Medical emergencies, fire, disaster evacuation and emergency preparedness plans;(xiii) Mandatory reporting of suspected child abuse, neglect, and exploitation, per RCW 26.44.020 and RCW 26.44.030 and all other reporting requirements; <p>Weight NA</p>				
<p>STANDARD 9.2.4.3: Disaster Planning, Training, and Communication</p> <p>Facilities should consider how to prepare for and respond to emergency or natural disaster situations and develop written plans accordingly. All programs should have procedures in place to address natural disasters that are relevant to their location (such as earthquakes, tornados, tsunamis or flash floods, storms, and volcanoes) and all hazards/disasters that could occur in any locationincluding acts of violence, bioterrorism/terrorism, exposure to hazardous agents, facility damage, fire, missing child, power outage, and other situations that mayrequire evacuation, lock-down, orshelter-in-place.</p> <p>Written Emergency/Disaster Plan:</p>	<p>170-300-471 Emergency preparedness plan.</p> <p>(1)An early learning provider must have and follow a written emergency preparedness plan. The plan must be reviewed and approved by the department prior to when changes are made. Emergency preparedness plans must:</p> <ul style="list-style-type: none">(a)Be designed to respond to fire, natural disasters, and other emergencies that might affect the early learning program;(b)Be specific to the early learning program and able to be implemented during hours of operation;(c)Address what the provider would do if he or she has an emergency and children may be left unsupervised;(d)Address what the early learning program must do if parents are not able to get to their children for up to three days;(e)Must follow requirements in chapter 212-12 WAC , as now or hereafter amended (Fire Marshal Standards) and the State Fire Marshal’s office requirements if a center early learning program;(f)Be reviewed at program orientation, annually with all early learning program staff with documented signatures, and when the plan is updated; and(g)Be reviewed with parents or guardians when a child is enrolled and when the plan is updated. <p>Weight #5</p>	Partially Meets	WAC Not Addressed: f) Identification of primary and secondary meeting places and plans for reunification of parents/ guardians with their children; 5) Procedures that might be implemented in the event of an outbreak, epidemic, or other infectious disease emergency (e.g., reviewing relevant immunization records, keeping symptom records, implementing tracking		

<p>Facilities should develop and implement a written plan that describes the practices and procedures they use to prepare for and respond to emergency or disaster situations. This Emergency/Disaster Plan should include:</p> <p>a) Information on disasters likely to occur in or near the facility, county, state, or region that require advance preparation and/or contingency planning;</p> <p>b) Plans (and a schedule) to conduct regularly scheduled practice drills within the facility and in collaboration with community or other exercises;</p> <p>c) Mechanisms for notifying and communicating with parents/guardians in various situations (e.g., Website postings; email notification; central telephone number, answering machine, or answering service messaging; telephone calls, use of telephone tree, or cellular phone texts; and/or posting of flyers at the facility and other community locations);</p> <p>d) Mechanisms for notifying and communicating with emergency management public officials;</p> <p>e) Information on crisis management (decision-making and practices) related to sheltering in place, relocating to another facility, evacuation procedures including how non-mobile children and adults will be evacuated, safe transportation of children including children with special health care needs, transporting necessary medical equipment obtaining emergency medical care, responding to an intruder, etc.;</p> <p>f) Identification of primary and secondary meeting places and plans for reunification of parents/guardians with their children;</p> <p>g) Details on collaborative planning with other groups and representatives (such as emergency management agencies, other child care facilities, schools, emergency personnel and first responders, pediatricians/health professionals, public health agencies, clinics, hospitals, and volunteer agencies including Red Cross and other known groups likely to provide shelter and related services);</p> <p>h) Continuity of operations planning, including backing up or retrieving health and other key records/files and managing financial issues such as paying employees and bills during the aftermath of the disaster;</p> <p>i) Contingency plans for various situations that address:</p> <p>1) Emergency contact information and procedures;</p>	<p>(2)The written emergency preparedness plan must cover at a minimum:</p> <p>(a)Disaster plans, including fires that may require evacuation:</p> <p>(i)An evacuation floor plan that identifies room numbers or names of rooms, emergency exit pathways, emergency exit doors, and for family home based programs, emergency exit windows if applicable;</p> <p>(ii)Methods to be used for sounding an alarm and calling 911;</p> <p>(iii)Actions to be taken by a person discovering an emergency;</p> <p>(iv)How the early learning provider will evacuate children, especially those who cannot walk independently. This may include infant evacuation cribs (for center early learning programs), children with disabilities, functional needs requirements, or other special needs;</p> <p>(v)Where the alternate evacuation location is;</p> <p>(vi)What to take when evacuating children, including:</p> <p>(A)First-aid kit(s);</p> <p>(B)Copies of emergency contact information;</p> <p>(C)Child medication records; and</p> <p>(D)Individual children's medication, if applicable;</p> <p>(vii)How the provider will maintain the required staff-to-child ratio and account for all children;</p> <p>(viii)How parents or guardians will be able to contact the early learning program; and</p> <p>(ix)How children will be reunited with their parents or guardians after the event;</p> <p>(b)Earthquake procedures including:</p> <p>(i)What a provider will do during an earthquake;</p> <p>(ii)How a provider will account for all children; and</p> <p>(iii)How a provider will coordinate with local or state officials to determine if the licensed space is safe for children after an earthquake.</p> <p>(c)Public safety related lockdown scenarios where an individual at or near an early learning program is harming or attempting to harm others with or without a weapon. This plan must include lockdown of the early learning program or shelter-in-place steps including:</p> <p>(i)How doors and windows will be secured to prevent access, if needed; and</p> <p>(ii)Where children will safely stay inside the early learning program; and</p> <p>(d)How parents or guardians will be contacted after the emergency ends.</p> <p>Weight #4</p> <p>(3)An early learning provider must keep on the premises a three day supply of food, water, and life-sustaining medication for the licensed capacity of children and current staff for use in case of an emergency. Weight #4</p> <p>(4)An early learning provider must practice and record emergency drills with staff and children as follows:</p> <p>(a)Fire and evacuation drill once each calendar month;</p> <p>(b)Earthquake, lockdown, or shelter-in-place drill once every three calendar months;</p> <p>(c)Emergency drills must be conducted with a variety of staff and at different times of the day, including in the evening and during overnight hours for early learning programs that care for children during those hours; and</p> <p>(d)Drills must be recorded on a department form and include:</p>		<p>procedures and corrective actions, modifying exclusion and isolation guidelines, coordinating with schools, reporting or responding to notices about public health emergencies);</p> <p>6) Procedures for staff to follow in the event that they are on a field trip or are in the midst of transporting children when an emergency or disaster situation arises;</p> <p>7) Staff responsibilities and assignment of tasks (facilities should recognize that staff can and should be utilized to assist in facility preparedness and response efforts, however, they should not be hindered in addressing their own personal or family preparedness efforts, including evacuation).</p>		
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<p>2) How the facility will care for children and account for them, until the parent/guardian has accepted responsibility for their care;</p> <p>3) Acquiring, stockpiling, storing, and cycling to keep updated emergency food/water and supplies that might be needed to care for children and staff for up to one week if shelter-in-place is required and when removal to an alternate location is required;</p> <p>4) Administering medicine and implementing other instructions as described in individual special care plans;</p> <p>5) Procedures that might be implemented in the event of an outbreak, epidemic, or other infectious disease emergency (e.g., reviewing relevant immunization records, keeping symptom records, implementing tracking procedures and corrective actions, modifying exclusion and isolation guidelines, coordinating with schools, reporting or responding to notices about public health emergencies);</p> <p>6) Procedures for staff to follow in the event that they are on a field trip or are in the midst of transporting children when an emergency or disaster situation arises;</p> <p>7) Staff responsibilities and assignment of tasks (facilities should recognize that staff can and should be utilized to assist in facility preparedness and response efforts, however, they should not be hindered in addressing their own personal or family preparedness efforts, including evacuation).</p> <p>Details in the Emergency/Disaster Plan should be reviewed and updated bi-annually and immediately after any relevant event to incorporate any best practices or</p>	<p>(i) The date and time of the drill;</p> <p>(ii) The number of children and staff who participated;</p> <p>(iii) The length of the drill; and</p> <p>(iv) Notes about how the drill went and how it may be improved.</p> <p>Weight #6</p> <p>(5) In areas where local emergency plans are already in place, such as school districts, an early learning program may adopt or amend such procedures when developing their own plan. Weight NA</p> <p>170-300-0110 Program based staff policies and training.</p> <p>(1) An early learning provider must have and follow written policies for early learning program staff. Staff policies must include those listed in subsections (2) and (3) of this section and must be reviewed and approved by the department prior to issuing a provider's initial license. Providers must notify the department when substantial changes are made. Weight #1</p> <p>(2) Early learning program staff policies must include, but are not limited to:</p> <p>(e) Early learning program staff responsibilities for:</p> <p>(x) Health, safety and sanitization procedures;</p> <p>(xii) Medical emergencies, fire, disaster evacuation and emergency preparedness plans;</p> <p>(xiii) Mandatory reporting of suspected child abuse, neglect, and exploitation, per RCW 26.44.020 and RCW 26.44.030 and all other reporting requirements;</p> <p>Weight NA</p> <p>170-300-0450- Parent or guardian handbook and related policies.</p> <p>(1) An early learning provider must supply to each parent or guardian written policies regarding the early learning program. Each enrolled child's record must have signed documentation stating the parent or guardian reviewed the handbook and early learning program policies. Weight #3</p> <p>(2) An early learning provider must have and follow formal written policies in either paper or electronic format, including:</p> <p>(s) Emergency preparedness plan;</p> <p>(v) Description where the parent or guardian may find and review the early learning program's:</p> <p>(i) Health policy;</p> <p>(ii) Staff policies, if applicable;</p> <p>(vii) Other relevant program policies.</p> <p>Weight #4</p> <p>WAC 170-300-0470 Emergency Preparedness Plan.</p> <p>(2) The written emergency preparedness plan must cover at minimum:</p> <p>(a) Disaster plans, including fires that may require evacuation:</p> <p>(ix) How children will be reunited with their parents or guardians after the event; Weight #4</p>				
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<p>lessons learned into the document.</p> <p>Facilities should identify in advance which agency or agencies would be the primary contact for them regarding child care regulations, evacuation instructions, and other directives that might be communicated in various emergency or disaster situations.</p> <p>Training:</p> <p>Staff should receive training on emergency/disaster planning and response. Training should be provided by emergency management agencies, educators, child care health consultants, health professionals, or emergency personnel qualified and experienced in disaster preparedness and response. The training should address:</p> <ul style="list-style-type: none">a) Why it is important for child care facilities to prepare for disasters and to have an Emergency/Disaster Plan;b) Different types of emergency and disaster situations and when and how they may occur;<ul style="list-style-type: none">1) Natural Disasters;2) Terrorism (i.e., biological, chemical, radiological, nuclear);3) Outbreaks, epidemics, or other infectious disease emergencies;c) The special and unique needs of children, appropriate response to children’s physical and emotional needs during and after the disaster, including information on consulting with pediatric disaster experts;d) Providing first aid, medications, and accessing emergency health care in situations where there are not enough available resources;e) Contingency planning including the ability to be flexible, to improvise, and to adapt to ever-changing situations;f) Developing personal and family preparedness plans;g) Supporting and communicating with families;h) Floor plan safety and layout;i) Location of emergency documents, supplies, medications, and equipment needed by children and staff with special health care needs;j) Typical community, county, and state					
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<p>emergency procedures (including information on state disaster and pandemic influenza plans, emergency operation centers, and incident command structure);</p> <p>k) Community resources for post-event support such as mental health consultants, safety consultants;</p> <p>l) Which individuals or agency representatives have the authority to close child care programs and schools and when and why this might occur;</p> <p>m) Insurance and liability issues;</p> <p>n) New advances in technology, communication efforts, and disaster preparedness strategies customized to meet children’s needs.</p> <p>Communicating with Parents/Guardians:</p> <p>Facilities should share detailed information about facility disaster planning and preparedness with parents/guardians when they enroll their children in the program, including:</p> <p>a) Portions of the Emergency/Disaster Plan relevant to parents/guardians or the public;</p> <p>b) Procedures and instructions for what parents/guardians can expect if something happens at the facility;</p> <p>c) Description of how parents/guardians will receive information and updates during or after a potential emergency or disaster situation;</p> <p>d) Situations that might require parents/guardians to have a contingency plan regarding how their children will be cared for in the unlikely event of a facility closure. Facilities should conduct an annual drill, test, or “practice use” of the communication options/mechanisms that are selected.</p>					
<p>STANDARD 9.2.4.5: Emergency and Evacuation Drills/Exercises Policy</p> <p>The facility should have a policy documenting that emergency drills/exercises should be regularly practiced for geographically appropriate natural disasters and human generated events such as:</p> <p>a) Fire, monthly;</p> <p>b) Tornadoes, on a monthly basis in tornado season;</p> <p>c) Floods, before the flood season;</p> <p>d) Earthquakes, every six months;</p>	<p>170-300-0470 Emergency preparedness plan.</p> <p>(1)An early learning provider must have and follow a written emergency preparedness plan. The plan must be reviewed and approved by the department prior to when changes are made. Emergency preparedness plans must:</p> <p>(a)Be designed to respond to fire, natural disasters, and other emergencies that might affect the early learning program;</p> <p>(b)Be specific to the early learning program and able to be implemented during hours of operation;</p> <p>(c)Address what the provider would do if he or she has an emergency and children may be left unsupervised;</p> <p>(d)Address what the early learning program must do if parents are not able to get to their children for up to three days;</p>	Meets			

<p>e) Hurricanes, annually; f) Threatening person outside or inside the facility; g) Rabid animal; h) Toxic chemical spill; i) Nuclear event.</p> <p>All drills/exercises should be recorded. Please see Standard 9.4.1.16: Evacuation and Shelter-in-Place Drill Record for more information.</p> <p>A fire evacuation procedure should be approved and certified in writing by a fire inspector for centers, and by a local fire department representative for large and small family child care homes, during an annual on-site visit when an evacuation drill is observed and the facility is inspected for fire safety hazards.</p> <p>Depending on the type of disaster, the emergency drill may be within the existing facility such as in the case of earthquakes or tornadoes where the drill might be moving to a certain location within the building (basements, away from windows, etc.) Evacuation drills/exercises should be practiced at various times of the day, including naptime, during varied activities and from all exits. Children should be accounted for during the practice.</p> <p>The facility should time evacuation procedures. They should aim to evacuate all persons in the specific number of minutes recommended by the local fire department for the fire evacuation, or recommended by emergency response personnel.</p> <p>Cribs designed to be used as evacuation cribs, can be used to evacuate infants, if rolling is possible on the evacuation route(s).</p>	<p>(e) Must follow requirements in chapter 212-12 WAC, as now or hereafter amended (Fire Marshal Standards) and the State Fire Marshal's office requirements if a center early learning program; (f) Be reviewed at program orientation, annually with all early learning program staff with documented signatures, and when the plan is updated; and (g) Be reviewed with parents or guardians when a child is enrolled and when the plan is updated. Weight #5</p> <p>(2) The written emergency preparedness plan must cover at a minimum:</p> <p>(a) Disaster plans, including fires that may require evacuation:</p> <p>(i) An evacuation floor plan that identifies room numbers or names of rooms, emergency exit pathways, emergency exit doors, and for family home based programs, emergency exit windows if applicable; (ii) Methods to be used for sounding an alarm and calling 911; (iii) Actions to be taken by a person discovering an emergency; (iv) How the early learning provider will evacuate children, especially those who cannot walk independently. This may include infant evacuation cribs (for center early learning programs), children with disabilities, functional needs requirements, or other special needs; (v) Where the alternate evacuation location is; (vi) What to take when evacuating children, including:</p> <p>(A) First-aid kit(s); (B) Copies of emergency contact information; (C) Child medication records; and (D) Individual children's medication, if applicable;</p> <p>(vii) How the provider will maintain the required staff-to-child ratio and account for all children; (viii) How parents or guardians will be able to contact the early learning program; and (ix) How children will be reunited with their parents or guardians after the event;</p> <p>(b) Earthquake procedures including:</p> <p>(i) What a provider will do during an earthquake; (ii) How a provider will account for all children; and (iii) How a provider will coordinate with local or state officials to determine if the licensed space is safe for children after an earthquake.</p> <p>(c) Public safety related lockdown scenarios where an individual at or near an early learning program is harming or attempting to harm others with or without a weapon. This plan must include lockdown of the early learning program or shelter-in-place steps including:</p> <p>(i) How doors and windows will be secured to prevent access, if needed; and (ii) Where children will safely stay inside the early learning program; and</p> <p>(d) How parents or guardians will be contacted after the emergency ends. Weight #4</p> <p>(3) An early learning provider must keep on the premises a three day supply of food, water, and life-sustaining medication for the licensed capacity of children and current staff for use in case of an emergency. Weight #4</p> <p>(4) An early learning provider must practice and record emergency drills with staff and children as follows:</p>				
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	<p>(a)Fire and evacuation drill once each calendar month;</p> <p>(b)Earthquake, lockdown, or shelter-in-place drill once every three calendar months;</p> <p>(c)Emergency drills must be conducted with a variety of staff and at different times of the day, including in the evening and during overnight hours for early learning programs that care for children during those hours; and</p> <p>(d)Drills must be recorded on a department form and include:</p> <p>(i)The date and time of the drill;</p> <p>(ii)The number of children and staff who participated;</p> <p>(iii)The length of the drill; and</p> <p>(iv)Notes about how the drill went and how it may be improved.</p> <p>Weight #6</p> <p>(5)In areas where local emergency plans are already in place, such as school districts, an early learning program may adopt or amend such procedures when developing their own plan. Weight NA</p>				
<p>STANDARD 9.4.1.10: Documentation of Parent/Guardian Notification of Injury, Illness, or Death in Program</p> <p>The facility should document that a child’s parent/guardian was notified immediately in the event of a death of their child, of an injury or illness of their child that required professional medical attention, or if their child was lost/missing.</p> <p>Documentation should also occur noting when law enforcement was notified (immediately) in the event of a death of a child or a lost/missing child.</p> <p>The facility should document in accordance with state regulations, its response to any of the following events:</p> <p>a) Death;</p> <p>b) Serious injury or illness that required medical attention;</p> <p>c) Reportable infectious disease;</p> <p>d) Any other significant event relating to the health and safety of a child (such as a lost child, a fire or other structural damage, work stoppage, or closure of the facility).</p> <p>The caregiver/teacher should call 9-1-1 to insure immediate emergency medical support for a death or serious injury or illness. They should follow state regulations with regard to when they should notify state agencies such as the licensing agency and the local or state health department about any of the above events.</p>	<p>170-300-475 Duty to protect children and report incidents.</p> <p>(1) Pursuant to RCW 26.44.030, when an early learning provider has reasonable cause to believe that a child has suffered abuse or neglect, that provider must report such incident, or cause a report to be made, to the proper law enforcement agency or the department. “Abuse or neglect” has the same meaning here as in RCW 26.44.020.</p> <p>Weight #8</p> <p>(2) An early learning provider must report by phone upon knowledge of the following to:</p> <p>(a)Law enforcement or the department at the first opportunity, but in no case longer than 48 hours:</p> <p>(i) The death of a child while in the early learning program’s care or the death from injury or illness that may have occurred while the child was in care;</p> <p>(ii)A child’s attempted suicide or talk about attempting suicide;</p> <p>(iii)Any suspected physical, sexual or emotional child abuse;</p> <p>(iv)Any suspected child neglect, child endangerment, or child exploitation;</p> <p>(v)A child’s disclosure of sexual or physical abuse; or</p> <p>(vi)Inappropriate sexual contact between two or more children.</p> <p>(b)Emergency Services (911) immediately, and to the department within 24 hours:</p> <p>(i)A child missing from care, triggered as soon as staff realizes the child is missing;</p> <p>(ii)A medical emergency that requires immediate professional medical care;</p> <p>(iii)A child who is given too much of any oral, inhaled, or injected medication,</p> <p>(iv)A child who took or received another child’s medication;</p> <p>(v)A fire or other emergency;</p> <p>(vi)Poisoning or suspected poisoning; or</p> <p>(vii)Other dangers or incidents requiring emergency response.</p> <p>(c)Washington Poison Center immediately after calling 911, and to the department within 24 hours:</p> <p>(i)A poisoning or suspected poisoning;</p> <p>(ii)A child who is given too much of any oral, inhaled, or injected medication; or</p> <p>(iii)A child who took or received another child’s medication;</p> <p>(iv)The provider must follow any directions provided by Washington Poison Center.</p> <p>(d)The local health jurisdiction or the department of health immediately, and to the department within 24 hours about an occurrence of food poisoning or reportable contagious disease as defined in chapter 246-110 WAC, as now or hereafter amended;</p>	Meets			

	<p>(e)The department at the first opportunity, but in no case longer than 24 hours, upon knowledge of any person required by chapter 170-06 WAC, as hereafter recodified or amended, to have a change in their background check history due to:</p> <p>(i)A pending charge or conviction for a crime listed in WAC 170-06,as hereafter recodified or amended;</p> <p>(ii)An allegation or finding of child abuse, neglect, maltreatment or exploitation under chapter 26.44 RCW or chapter 388-15 WAC;</p> <p>(iii)An allegation or finding of abuse or neglect of a vulnerable adult under chapter 74.34 RCW; or</p> <p>(iv)A pending charge or conviction of a crime listed in the Director’s List in chapter 170-06 WAC, as hereafter recodified or amended, from outside Washington state, or a “negative action” as defined in RCW 43.216.010.</p> <p>Weight #8</p> <p>(3)In addition to reporting to the department by phone or e-mail, an early learning provider must submit a written incident report of the following on a department form within 24 hours:</p> <p>(a)Situations that required an emergency response from Emergency Services (911), Washington Poison Center, or department of health;</p> <p>(b)Situations that occur while children are in care that may put children at risk including, but not limited to, inappropriate sexual touching, neglect, physical abuse, maltreatment, or exploitation; and</p> <p>(c)A serious injury to a child in care.</p> <p>Weight #5</p> <p>(4)An early learning provider must immediately report to the parent or guardian:</p> <p>(a)Their child’s death, serious injury, need for emergency or poison services; or</p> <p>(b)An incident involving their child that was reported to the local health jurisdiction or the department of health.</p> <p>Weight #6</p>				
<p>STANDARD 9.4.1.12: Record of Valid License, Certificate, or Registration of Facility</p> <p>Every facility should hold a valid license or certificate, or documentation of, registration prior to operation as required by the local and/or state statute.</p>	<p>170-300-0010 License required.</p> <p>(1) An individual or entity that provides child care and early learning services for a group of children, birth through twelve years of age, must be licensed by the department, pursuant to RCW 43.216.250, unless exempt under RCW 43.216.010(2) and WAC 170-300-0025. Weight NA</p> <p>(2) The department must not license a department employee or a member of the employee’s household if the employee is involved directly, or in an administrative or supervisory capacity in the:</p> <p>(a) Licensing process;</p> <p>(b) Placement of a child in a licensed early learning program; or</p> <p>(c) Authorization of payment for the child in care.</p> <p>Weight NA</p> <p>(3) A license is required when an individual provides child care and early learning services in his or her family home:</p> <p>(a) Outside the child’s home on a regular and ongoing basis for one or more children not related to the licensee; or</p> <p>(b) For preschool age children for more than four hours a day.</p> <p>(c) As used in this chapter, “not related” means not any of the relatives listed in RCW 43.216.010(2)(a).</p>	Exceeds			

	<p>Weight NA</p> <p>(4) The department may license a center located in a private family residence when the portion of the residence accessible to children is:</p> <p>(a) Used exclusively for children during the center's operating hours or when children are in care; or</p> <p>(b) Separate from the family living quarters.</p> <p>Weight NA</p> <p>170-300-0400 Application materials.</p> <p>(1) After completing a department orientation, an applicant must submit a complete license application packet, pursuant to chapter 43.216 RCW. This requirement also applies to a change of ownership. A complete license application packet includes:</p> <p>(a) Professional and background information about the applicant:</p> <p>(iii) A Washington state business license or a tribal, county, or city business or occupation license, if applicable;</p> <p>170-300-0425 Initial, non-expiring, dual licenses, and license modification.</p> <p>(1) The department may issue an initial license when an early learning program applicant demonstrates compliance with health and safety requirements of this chapter but may not be in full compliance with all requirements, pursuant to RCW 43.216.315.</p> <p>(a) An initial license is valid for six months from the date issued.</p> <p>(b) At the department's discretion, an initial license may be extended for up to three additional six month periods, not to exceed a total of two years.</p> <p>(c) The department must evaluate the early learning provider's ability to follow requirements contained in this chapter during the initial license period.</p> <p>Weight NA</p> <p>(2) The department may issue a non-expiring license to a licensee operating under an initial license who demonstrates compliance with the requirements of this chapter during the period of initial licensure, pursuant to RCW 43.216.305.</p> <p>Weight NA</p> <p>(3) A licensee must submit annual compliance documents at least 30 calendar days prior to that provider's anniversary date. A provider's anniversary date is the date the first initial license was issued. Pursuant to RCW 43.216.305, the required annual compliance documents are:</p> <p>(a) The annual nonrefundable license fee;</p> <p>(b) A declaration on the department's form indicating:</p> <p>(i) The intent to continue operating a licensed early learning program;</p> <p>(ii) The intent to cease operation as a licensed early learning program;</p> <p>(iii) A change in the early learning program's operational hours or dates; or</p> <p>(iv) The intent to comply with all licensing rules.</p> <p>(c) Documentation of completed background check applications as determined by the department's established schedule, pursuant to RCW 43.216.270(2); and</p> <p>(d) For each individual required to have a background check clearance, the early learning provider must verify current background checks or require the individual to submit a background check application at least 30 calendar days prior to the anniversary date.</p>				
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	<p>Weight NA</p> <p>(4) If a licensee fails to meet the requirements for continuing a non-expiring license by their anniversary date, the licensee’s current license expires. The early learning provider must submit a new application for licensure, pursuant to RCW 43.216.305(3). Weight NA</p> <p>(5) Nothing about the non-expiring license process in this section may interfere with the department’s established monitoring practices, pursuant to RCW 43.216.305(4)(a). Weight NA</p> <p>(6) A licensee has no right to an adjudicative proceeding (hearing) to appeal the expiration, nonrenewal, or non-continuation of a non-expiring license resulting from a failure to comply with the requirements of this section. Weight NA</p> <p>(7) A licensee must have department approval to hold dual licenses (for example: an early learning program license and another care giving license, certification, or similar authorization). Weight #6</p> <p>(8) If the department determines that a licensee is not meeting all applicable requirements and regulations:</p> <p>(a) The department and licensee may agree to modify the child care license;</p> <p>(b) The licensee may give up one of the licenses, certifications, or authorizations;</p> <p>or</p> <p>(c) The department may suspend, deny, or revoke the early learning license, pursuant to RCW 43.216.325.</p> <p>Weight NA</p> <p>(9) An early learning provider must report within 24 hours:</p> <p>(a) To the department and local authorities: a fire or other structural damage to the early learning program space or other parts of the premises; Weight #7</p> <p>(b) To the department:</p> <p>(i) A retirement, termination, death, incapacity, or change of the Program Director, or Program Supervisor, or change of ownership or incorporation of a provider; Weight #7</p> <p>(ii) When a provider becomes aware of a charge or conviction against themselves, a staff person or, applicable household member, pursuant to WAC 170-06-0043, as hereafter recodified or amended; Weight #7</p> <p>(iii) When a provider becomes aware of an allegation or finding of abuse, neglect, maltreatment, or exploitation of a child or vulnerable adult made against themselves, a staff person, or a household member, if applicable; Weight #7</p> <p>(iv) A change in the number of household members living within a family home early learning program space. This includes individuals 14 years old or older that move in or out of the home, or a resignation or termination, pursuant to RCW 43.216.390. A birth or death affecting the number of household members must be reported within 24 hours or at first opportunity; Weight #3 and</p> <p>(v) Any changes in the early learning program hours of operation to include closure dates.</p> <p>Weight #3</p>				
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	<p>(10) Prior to increasing capacity of an early learning program, the licensee, Center Director, Assistant Director, or Program Supervisor must request and be approved to increase capacity by the department. Weight #5</p> <p>(11) Licensee, Center Director, Assistant Director, or Program Supervisor must have State Fire Marshal or department approval and comply with local building ordinances following a significant change under WAC 170-300-0402(1)(a) through (c), if applicable. Weight NA</p> <p>(12) Licensee, Center Director, Assistant Director, or Program Supervisor must notify the department within 30 calendar days when liability insurance coverage under RCW 43.216.700 has lapsed or been terminated. Weight #4</p>				
<p>STANDARD 9.4.2.6: Contents of Medication Record</p> <p>The file for each child should include a medication record maintained on an ongoing basis by designated staff for all prescription and non-prescription (over-the-counter [OTC]) medications. State requirements should be checked and followed. The medication record for prescription and non- prescription medications should include the following:</p> <p>a) A separate consent signed by the parent/guardian for each medication the caregiver/teacher has permission to administer to the child; each consent should include the child’s name, medication, time, dose, how to give the medication, and start and end dates when it should be given;</p> <p>b) Authorization from the prescribing health professional for each prescription and non-prescription medication; this authorization should also include potential side effects and other warnings about the medication (exception: non-prescription sunscreen and insect repellent always require parental/guardian consent but do not require instructions from each child’s individual medical provider);</p> <p>c) Administration log which includes the child’s name, the medication that was given, the dose, the route of administration, the time and date, and the signature or initials of the person administering the medication. For medications given “as needed,” record the reason the medication was given. Space should be available for notations of any side-effects noted after the medication was given or if the dose was not retained because of the child vomiting or spitting out the medication. Documentation should also be made of attempts to give medications that were refused by the child;</p>	<p>170-300-0215 Medication</p> <p>(1) Managing medication. A medication management policy must include, but is not limited to, safe medication storage, reasonable accommodations for giving medication, mandatory medication documentation, and forms pursuant to WAC 170-300-0500. Weight NA</p> <p>(2) Medication Training. An early learning provider must not give medication to a child if the provider has not successfully completed:</p> <p>(a) An orientation about the early learning program’s medication policies and procedures;</p> <p>(b) The department standardized training course in medication administration that includes a competency assessment pursuant to WAC 170-300-0106(10) or equivalent training; and</p> <p>(c) If applicable, a training from a child’s parents or guardian (or an appointed designee) for special medical procedures that are part of a child’s Individual Care Plan. This training must be documented and signed by the provider and the child’s parent or guardian (or designee). Weight #6</p> <p>(3) Medication Administration. An early learning provider must not give medication to any child without written and signed consent from that child’s parent or guardian, must administer medication pursuant to directions on the medication label, and using appropriate cleaned and sanitized medication measuring devices. Weight #8</p> <p>(a) An early learning provider must administer medication to children in care as follows:</p> <p>(i) Prescription Medication. Prescription medication must only be given to the child named on the prescription. Prescription medication must be prescribed by a health care professional with prescriptive authority for a specific child. Prescription medication must be labeled with:</p> <p>(A) A child’s first and last name;</p> <p>(B) The date the prescription was filled;</p> <p>(C) The name and contact information of the prescribing health professional;</p> <p>(D) The expiration date, dosage amount, and length of time to give the medication; and</p> <p>(E) Instructions for the administration, storage and accompanied with medication authorization form that has the medical need and the possible side effects of the medication. Weight #7</p> <p>(ii) Non-prescription oral medication. Non-prescription (over-the-counter) oral medication brought to the early learning program by a parent or guardian must be in the original packaging.</p>	<p>Partially Meets</p>	<p>WAC Not Addressed:</p> <p>b) Authorization from the prescribing health professional for each prescription and non-prescription medication;</p> <p>e) Nonprescription medications should be brought to the facility in the original container, labeled with the child’s complete name and administered according to the authorization completed by the person with prescriptive authority;</p> <p>Our WAC only requires parent/guardian permission.</p>		

<p>d) Information about prescription medication brought to the facility by the parents/guardians in the original, labeled container with a label that includes the child’s name, date filled, prescribing clinician’s name, pharmacy name and phone number, dosage/ instructions, and relevant warnings. Potential side effects and other warnings about the medication should be listed on the authorization form;</p> <p>e) Nonprescription medications should be brought to the facility in the original container, labeled with the child’s complete name and administered according to the authorization completed by the person with prescriptive authority;</p> <p>f) For medications that are to be given or available to be given for the entire year, a Care Plan should also be in place (for instance, inhalers for asthma or epinephrine for possible allergy);</p> <p>g) Side effects.</p>	<p>(A) Non-prescription (over-the-counter) medication needs to be labeled with child’s first and last name and accompanied with medication authorization form that has the expiration date, medical need, dosage amount, age, and length of time to give the medication. Early learning providers must follow the instructions on the label or the parent must provide a medical professional’s note; and</p> <p>(B) Non-prescription medication must only be given to the child named on the label provided by the parent or guardian.</p> <p>Weight #7</p> <p>(iii) Other non-prescription medication: An early learning provider must receive written authorization from a child’s parent or guardian and health care provider with prescriptive authority prior to administering if the item does not include age, expiration date, dosage amount, and length of time to give the medication:</p> <p>(A) Vitamins;</p> <p>(B) Herbal supplements;</p> <p>(C) Fluoride supplements;</p> <p>(D) Homeopathic or naturopathic medication; and</p> <p>(E) Teething gel or tablets (amber bead necklaces are prohibited).</p> <p>Weight #6</p> <p>(iv) Non-medical items. A parent or guardian must annually authorize an early learning provider to administer the following non-medical items:</p> <p>(A) Diaper ointments (used as needed and according to manufacturer’s instructions);</p> <p>(B) Sunscreen;</p> <p>(C) Lip balm or lotion;</p> <p>(D) Hand sanitizers or hand wipes with alcohol, which may be used only for children over 24 months old; and</p> <p>(E) Fluoride toothpaste for children two years old or older.</p> <p>Weight #2</p> <p>(v) An early learning provider may allow children to take his or her own medication with parent or guardian authorization. The early learning staff member must observe and document that the child took the medication. Weight #7</p> <p>(vi) An early learning provider must not give or permit another to give any medication to a child for the purpose of sedating the child unless the medication has been prescribed for a specific child for that particular purpose by a qualified health care professional. Weight #8</p> <p>(b) Medication Documentation (excluding non-medical items). An early learning provider must keep a current written medication log that includes:</p> <p>(i) A child’s first and last name;</p> <p>(ii) The name of the medication that was given to the child;</p> <p>(iii) The dose amount that was given to the child;</p> <p>(iv) Notes about any side effects exhibited by the child;</p> <p>(v) The date and time of each medication given or reasons that a particular medication was not given; and</p> <p>(vi) The name and signature of the person that gave the medication. Weight NA</p> <p>(c) Medication must be stored and maintained as directed on the packaging or prescription label, including applicable refrigeration requirements. An early learning provider must comply with the following additional medication storage requirements:</p> <p>(i) Medication must be inaccessible to children;</p>				
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	<p>(ii) Controlled substances must be locked in a container or cabinet which is inaccessible to children;</p> <p>(iii) Medication must be kept away from food in a separate, sealed container; and</p> <p>(iv) External medication (designed to be applied to the outside of the body) must be stored to provide separation from internal medication (designed to be swallowed or injected) to prevent cross contamination. Weight #7</p> <p>(d) An early learning provider must return a child’s unused medication to that child’s parent or guardian. If this is not possible, a provider must follow the Food and Drug Administration (FDA) recommendations for medication disposal. Weight #5</p> <p>(e) An early learning provider must not accept or give to a child homemade medication, such as diaper cream or sunscreen. Weight #6</p> <p>170-300-460 Child records.</p> <p>(1)An early learning provider must keep current individualized enrollment and health records for all children, including enrolled children of staff, updated annually or more often as health records are updated.</p> <p>(a)A child’s records must be kept in a confidential manner in an area easily accessible to staff.</p> <p>(b) A child's parent or guardian must be allowed access to all of his or her own child’s records. Weight #4</p> <p>(4)A health record is required for every child who is enrolled and counted in an early learning program’s capacity. A health record must include:</p> <p>(c)A medication authorization and administration log, pursuant to WAC 170-300-0215, if applicable; Weight #4</p>				
<p>STANDARD 10.4.2.1: Frequency of Inspections for Child Care Centers</p> <p>The licensing inspector should make an onsite inspection to measure compliance with licensing rules prior to issuingan initial license and at least two inspections each year toeach center and large and small family child care home thereafter. At least one of the inspections should be unannounced and more if needed for the facility to achieve satisfactory compliance or is closed at any time (1). SuffICIENT numbers of licensing inspectors should be hired to provideadequate time visiting and inspecting facilities to insurecompliance with regulations</p> <p>The number of inspections should not include those inspections conducted for the purpose of investigating complaints. Complaints should be investigated promptly, based on severity of the complaint. States are encouraged to post the results of licensing inspections, including complaints, on the Internet for parent and public review.</p> <p>Parents/guardians should be provided easy access to the licensing rules and made aware of how to report complaints to the licensing agency.</p>	<p>170-300-0001 Intent and authority.</p> <p>(4) Pursuant to this chapter, the department will periodically monitor and assess early learning programs to determine compliance with these Foundational Quality Standards. Weight NA</p> <p>170-300-0425 Initial, non-expiring, dual licenses, and license modification.</p> <p>(1) The department may issue an initial license when an early learning program applicant demonstrates compliance with health and safety requirements of this chapter but may not be in full compliance with all requirements, pursuant to RCW 43.216.315.</p> <p>(a) An initial license is valid for six months from the date issued.</p> <p>(b) At the department's discretion, an initial license may be extended for up to three additional six month periods, not to exceed a total of two years.</p> <p>(c) The department must evaluate the early learning provider's ability to follow requirements contained in this chapter during the initial license period. Weight NA</p> <p>(2) The department may issue a non-expiring license to a licensee operating under an initial license who demonstrates compliance with the requirements of this chapter during the period of initial licensure, pursuant to RCW 43.216.305. Weight NA</p> <p>(3) A licensee must submit annual compliance documents at least 30 calendar days prior to that provider’s anniversary date. A provider’s anniversary date is the date the first initial license was issued. Pursuant to RCW 43.216.305, the required annual compliance documents are:</p>	Partially Meets	Per Policy and CCDF requirements, unannounced visits are annual. WAC does not outline number of visits: at least two inspections each year toeach center and large and small family child care home thereafter. Complaints are also addressed in policy and procedures		

	<p>(a) The annual nonrefundable license fee;</p> <p>(b) A declaration on the department’s form indicating:</p> <p> (i) The intent to continue operating a licensed early learning program;</p> <p> (ii) The intent to cease operation as a licensed early learning program;</p> <p> (iii) A change in the early learning program’s operational hours or dates; or</p> <p> (iv) The intent to comply with all licensing rules.</p> <p>(c) Documentation of completed background check applications as determined by the department’s established schedule, pursuant to RCW 43.216.270(2); and</p> <p>(d) For each individual required to have a background check clearance, the early learning provider must verify current background checks or require the individual to submit a background check application at least 30 calendar days prior to the anniversary date.</p> <p>Weight NA</p> <p>(4) If a licensee fails to meet the requirements for continuing a non-expiring license by their anniversary date, the licensee’s current license expires. The early learning provider must submit a new application for licensure, pursuant to RCW 43.216.305(3). Weight NA</p> <p>(5) Nothing about the non-expiring license process in this section may interfere with the department’s established monitoring practices, pursuant to RCW 43.216.305(4)(a). Weight NA</p> <p>(6) A licensee has no right to an adjudicative proceeding (hearing) to appeal the expiration, nonrenewal, or non-continuation of a non-expiring license resulting from a failure to comply with the requirements of this section. Weight NA</p> <p>(7) A licensee must have department approval to hold dual licenses (for example: an early learning program license and another care giving license, certification, or similar authorization). Weight #6</p> <p>(8) If the department determines that a licensee is not meeting all applicable requirements and regulations:</p> <p> (a) The department and licensee may agree to modify the child care license;</p> <p> (b) The licensee may give up one of the licenses, certifications, or authorizations; or</p> <p> (c) The department may suspend, deny, or revoke the early learning license, pursuant to RCW 43.216.325.</p> <p>Weight NA</p> <p>(9) An early learning provider must report within 24 hours:</p> <p> (a) To the department and local authorities: a fire or other structural damage to the early learning program space or other parts of the premises; Weight #7</p> <p> (b) To the department:</p> <p> (i) A retirement, termination, death, incapacity, or change of the Program Director, or Program Supervisor, or change of ownership or incorporation of a provider; Weight #7</p>				
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	<p>(ii) When a provider becomes aware of a charge or conviction against themselves, a staff person or, applicable household member, pursuant to WAC 170-06-0043, as hereafter recodified or amended; Weight #7</p> <p>(iii) When a provider becomes aware of an allegation or finding of abuse, neglect, maltreatment, or exploitation of a child or vulnerable adult made against themselves, a staff person, or a household member, if applicable; Weight #7</p> <p>(iv) A change in the number of household members living within a family home early learning program space. This includes individuals 14 years old or older that move in or out of the home, or a resignation or termination, pursuant to RCW 43.216.390. A birth or death affecting the number of household members must be reported within 24 hours or at first opportunity; Weight #3 and</p> <p>(v) Any changes in the early learning program hours of operation to include closure dates. Weight #3</p> <p>(10) Prior to increasing capacity of an early learning program, the licensee, Center Director, Assistant Director, or Program Supervisor must request and be approved to increase capacity by the department. Weight #5</p> <p>(11) Licensee, Center Director, Assistant Director, or Program Supervisor must have State Fire Marshal or department approval and comply with local building ordinances following a significant change under WAC 170-300-0402(1)(a) through (c), if applicable. Weight NA</p> <p>(12) Licensee, Center Director, Assistant Director, or Program Supervisor must notify the department within 30 calendar days when liability insurance coverage under RCW 43.216.700 has lapsed or been terminated. Weight #4</p> <p>170-300-0016 Inactive status – voluntary and temporary closure.</p> <p>(10) The department may pursue enforcement actions after three failed attempts to monitor an early learning program if:</p> <p>(a) The early learning provider has not been available to permit the monitoring visits;</p> <p>(b) The monitoring visits were attempted within a three month span to the monitoring due date; and</p> <p>(c) The department attempted to contact the provider by phone during the third attempted visit while still on the early learning premises. Weight NA</p>				
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Washington State Department of

Early Learning

Standards Alignment Project

Focused Checklist

&

Enforcement Approach



Early Start Act, Alignment Goals

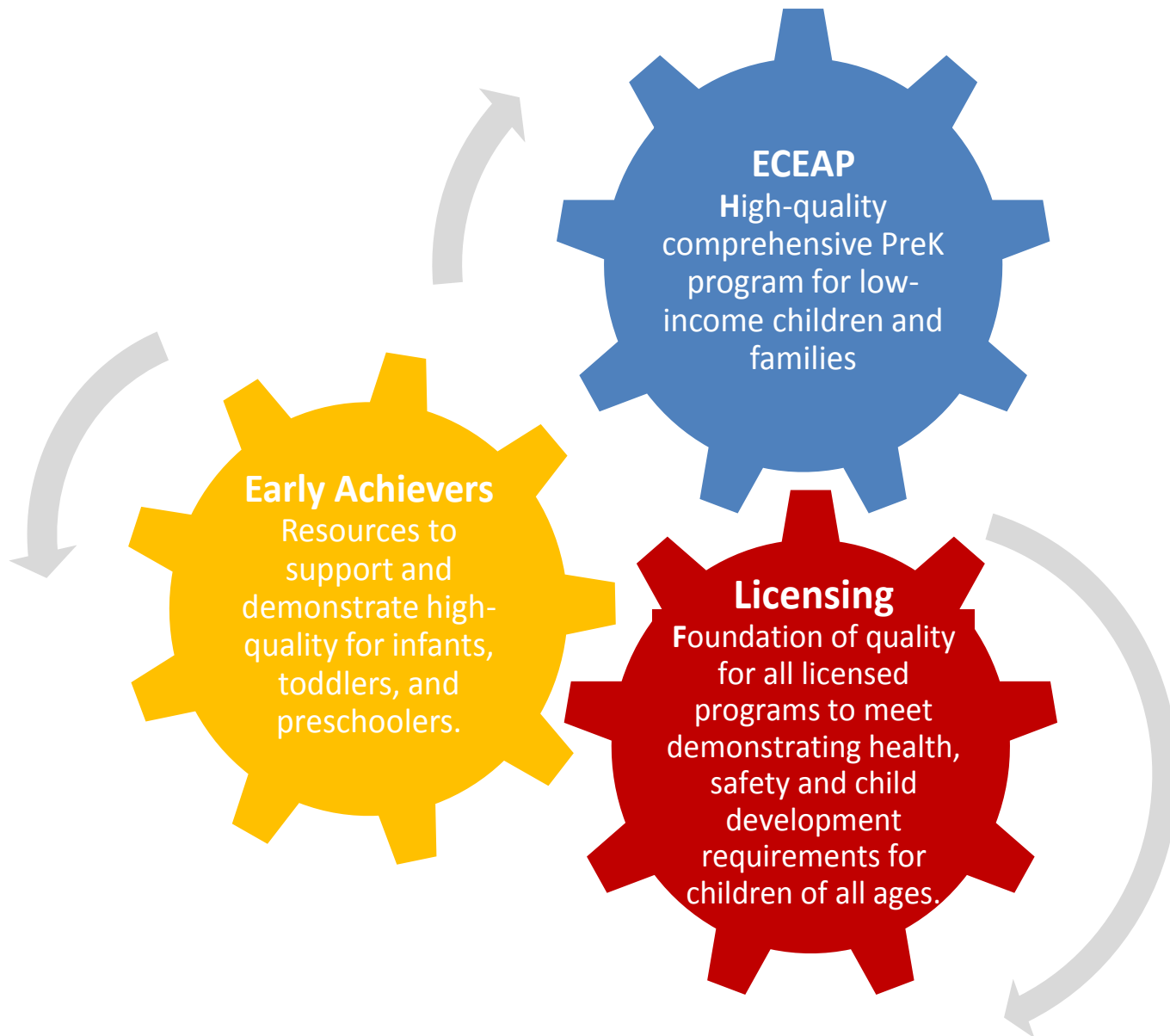
...The Early Achievers program must establish a common set of expectations and standards that define, measure, and improve the quality of early learning and child care settings.

... implement a single set of licensing standards for child care and the early childhood education and assistance program.

The new licensing standards *must*:

- Provide minimum health and safety standards for child care and preschool programs;
- Rely on the standards established in the early achievers program to address quality issues in participating early childhood programs;
- Take into account the separate needs of family care providers and child care centers; and
- Promote the continued safety of child care settings.






Standards Alignment Focus


Duplication

-  Standard is repeated in licensing and/or Early Achievers and/or ECEAP


Language Inconsistencies

-  Different words are used in licensing and/or Early Achievers and/or ECEAP even though the concepts are the same

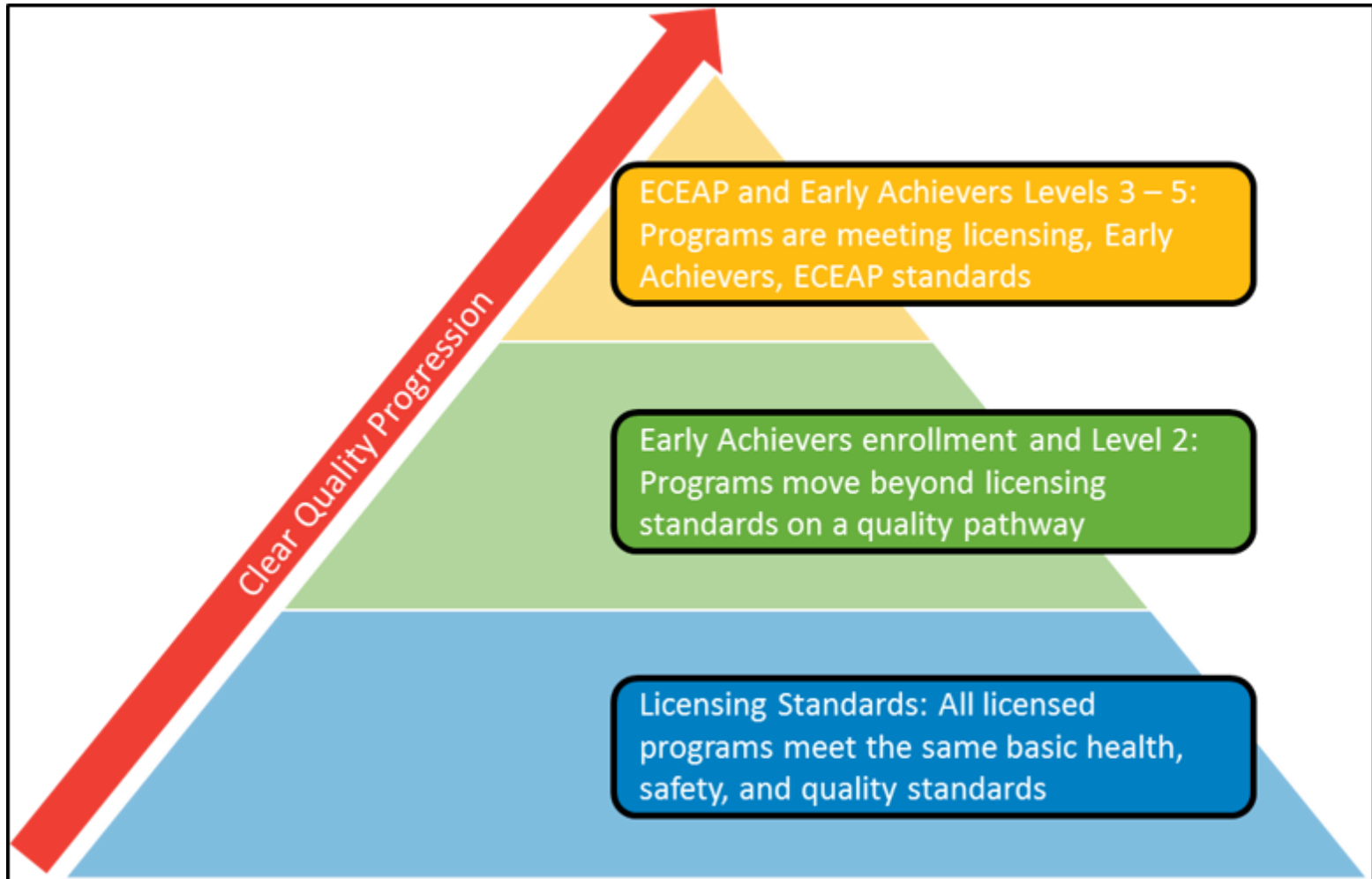
Progression

-  Standards logically build on one another between & across licensing, Early Achievers and ECEAP

Dual Language Learners

-  Children who acquire two or more languages simultaneously, who learn a second language while continuing to develop their first language, or who are unable to communicate effectively in English because their primary language is not English and they have not developed fluency in the English language yet

Standards Alignment – Creating a Progression

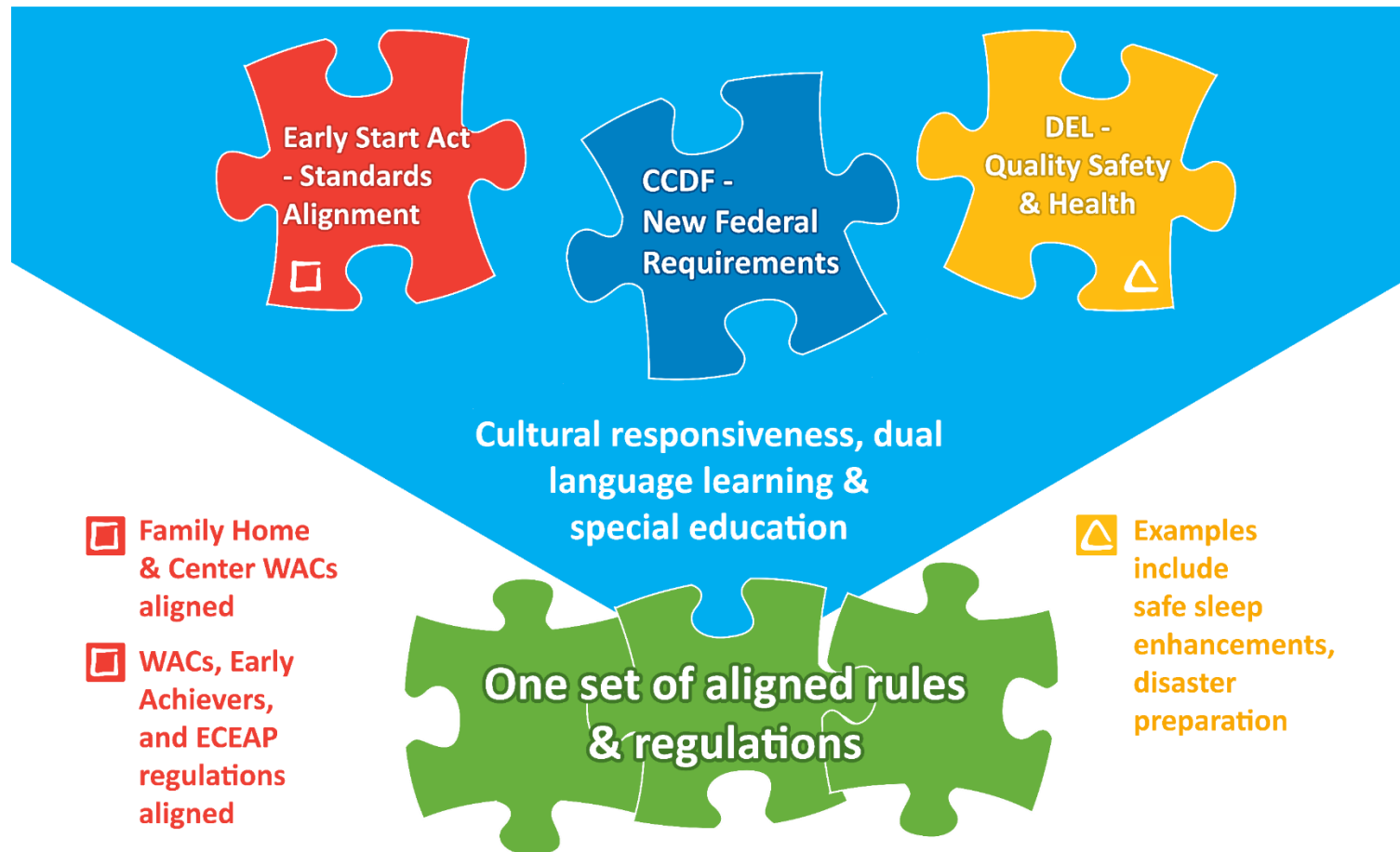


WAC Alignment

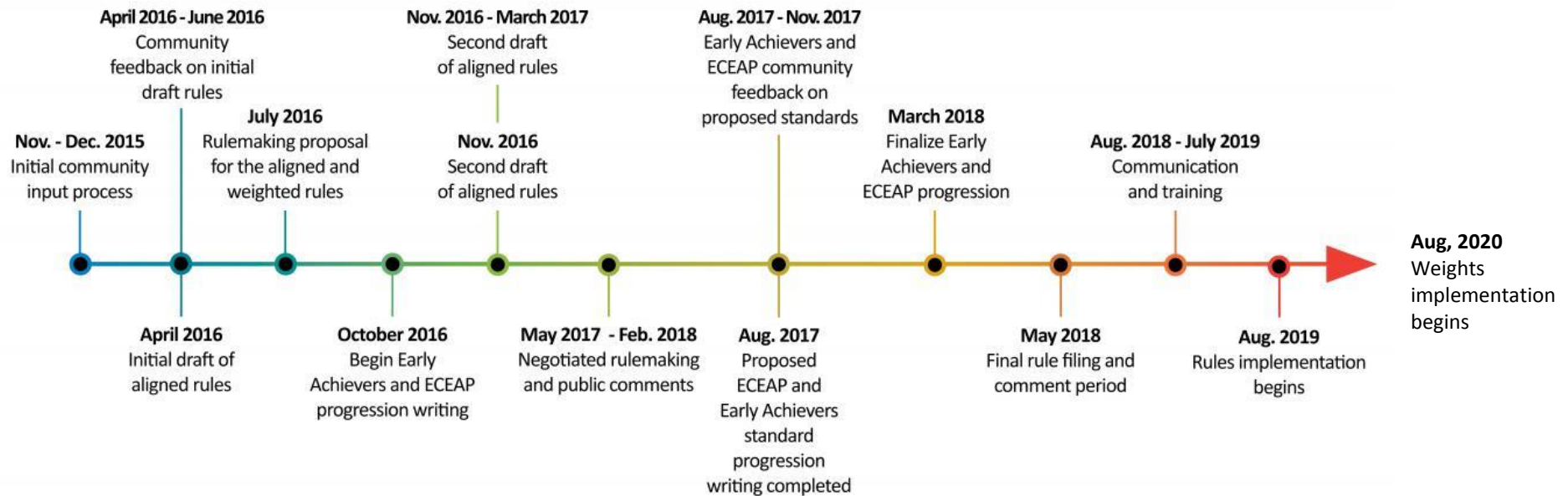
Changes in the federal child care law, increased knowledge and research, and DEL policy priorities all inform this revision.

Updating DEL's Rules & Regulations

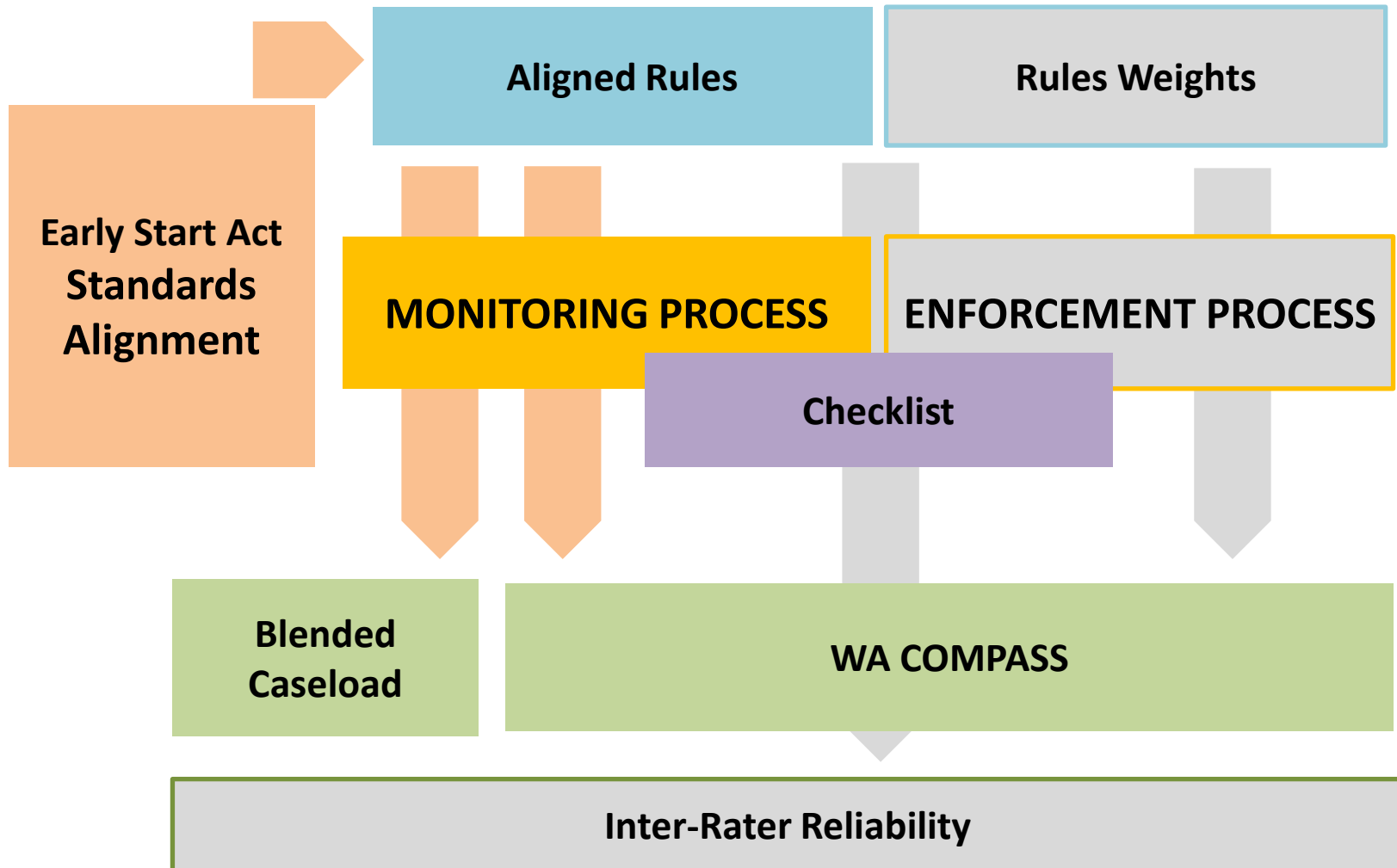
More than just aligning standards



Standards Alignment Timeline



Standards Alignment, Change Management Map



Checklist Design

The focused monitoring
checklist approach for
licensing rules

Monitoring Theory

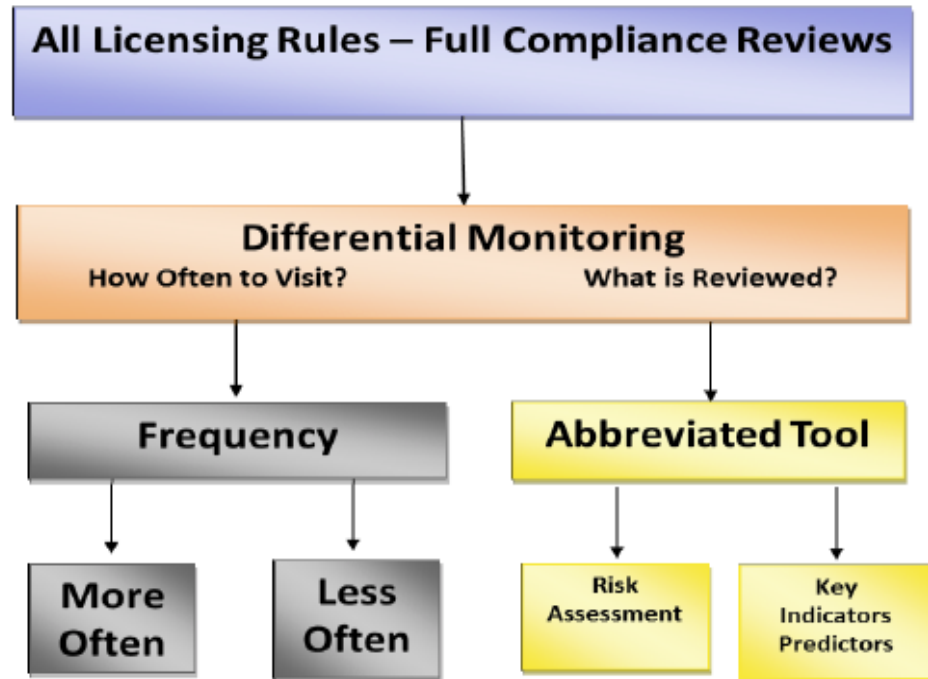
Research Based Methodology – WA Approach

Dr. Richard Fiene Research

Differential Monitoring: A regulatory method for determining the *frequency or depth of monitoring* based on an assessment of a facility's history of compliance with rules

Key Indicators: An approach that focuses on identifying and monitoring those rules that statistically predict compliance with all the rules.

Risk Assessment: An approach that focuses on identifying and monitoring those rules that place children at *greater risk of mortality or morbidity* if violations or citations occur



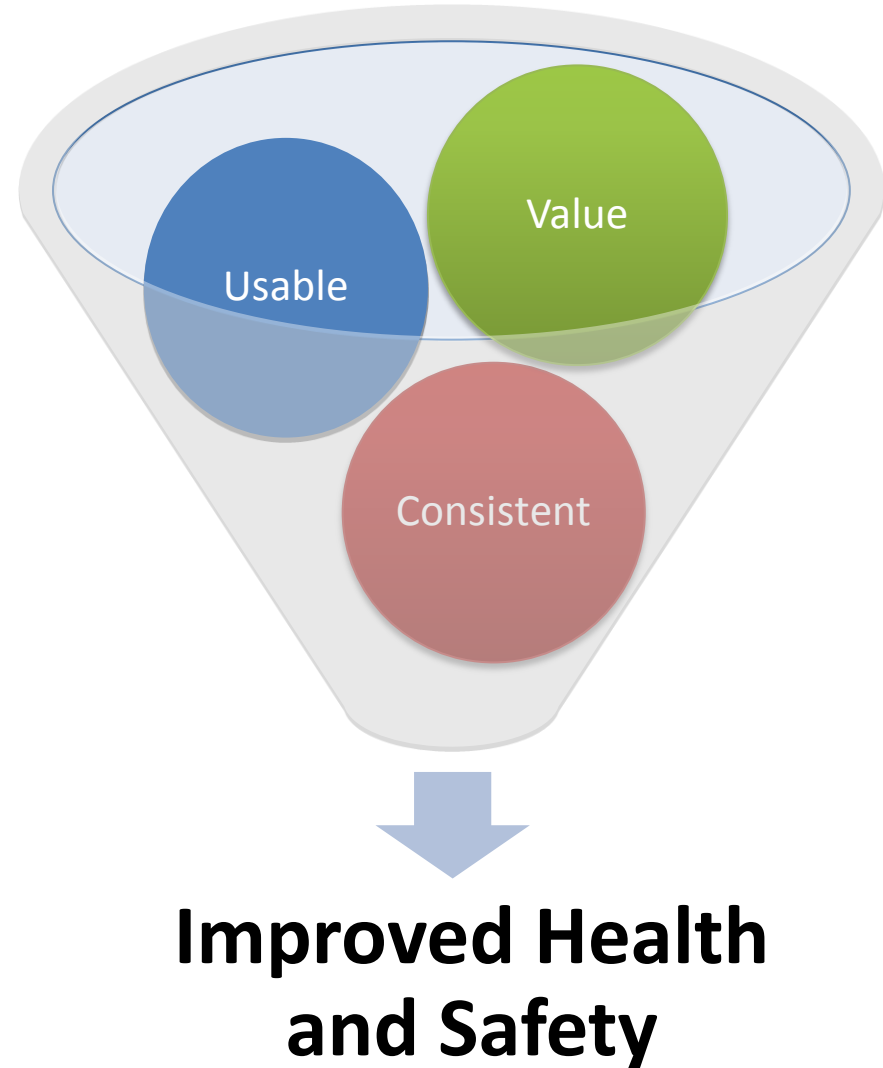
Note: This graphic is adapted from a graphic developed by Dr. Richard Fiene and used in: Fiene, R. (2013) *Differential monitoring logic model and algorithm (DMLMA: A new early childhood program quality indicator model (ECPQIMA)® for early care and education regulatory agencies*, Middletown, PA: Research Institute for Key Indicators.

Why – Changing the Checklist

For the checklist to be reliable, it must be **consistent**

For the checklist to be effective, it must be **usable**

For the checklist to be trusted, **value** must be placed in the outcomes



Why - Identified Challenges

Rater-drift:

Checklist are always the same

Compliance blindness:

Ignores individual needs of provider

Inter-rater reliability:

Licensors inconsistency

Risk-assessment:

Regulations are all treated equally

Focused Monitoring Checklist

Rater-drift:

Individualized checklist for each provider

Compliance blindness:

Focus on where providers need support

Inter-rater reliability:

Consistent focus on checklist items

Risk-assessment:

Provides a greater level of protection for children by creating a common understanding of risk

The focused Checklist Content Areas

9 sections

Intent & Authority

Child Outcomes/Family Engagement

Interactions/Curriculum

Program Oversight

Environment - Indoor

Environment - Outdoor/General

Food and Nutrition

Infant Toddler

Professional Development

The Baseline

Each section will always have:

- Fiene Key Indicators
- Regulations most critical to children's **immediate** health and safety (**weights #7 and #8**)
- Rotating regulations of the remaining weight values
- No more than 3 (possible) historical “findings” per section

Rule Rotation



Rules that will not be placed on the baseline checklist:

- Any regulation with **Weight N/A**
- Regulations that do not impose a duty on the provider
- Regulations that do not apply to the provider

Findings that are *not* on the checklist

- DEL will still provide and document **Technical Assistance**

*** Example** – Rotation will be determined based on NRM weight results

Weight		8	7	6	5	4	3	2	1
Rotation		Always on Baseline		2 Years	3 Years		4 years		

Checklist Expansion

- Checklist expansion only happens if a **Fiene Indicator** or **heavy weighted** regulation is found non-compliant.
- Checklist expansion only of the **section** within which a “risky” violation is found (not the entire checklist).

A provider's **strengths are rewarded** with lower oversight in those areas and **support is focused** where providers need it the most!

The Pilot

Why - Pilot *Before* Implementation

Validation ensures fair and consistent oversight:

- Standards – Measures – Outputs – Outcomes

Reliability addresses the issues of shared knowledge and understanding

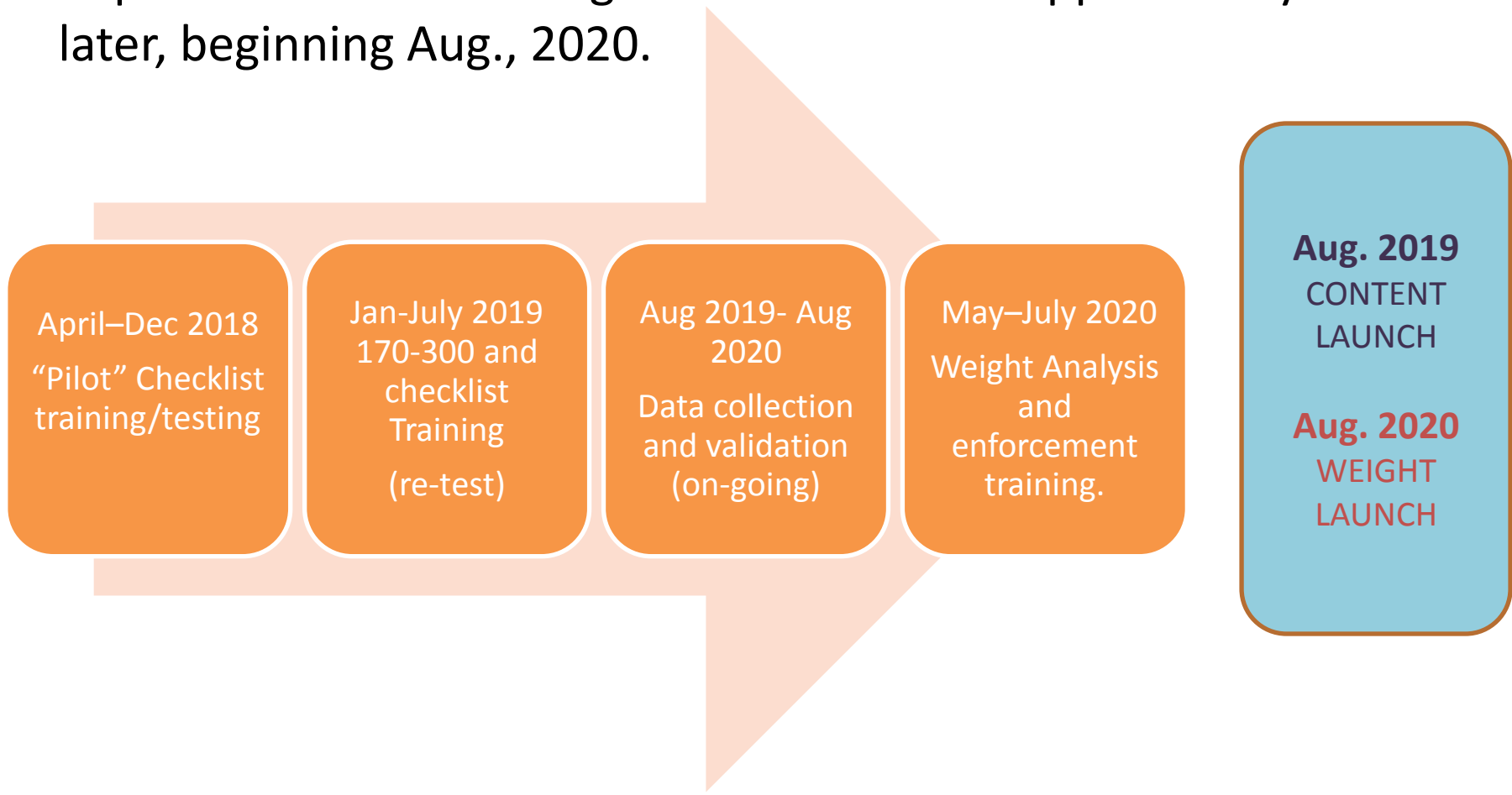
Testing ensures a seamless transition

Types of Validation

Validation Approach	What does it mean?
1 Standards Approach	Does the WAC align with National Best Practices?
2 Measure Approach	Do highly-non compliant programs have higher risk scores while compliant programs have lower risk scores?
3 Output Approach	Are the enforcement actions taken appropriate?
4 Outcome Approach	What does the data say? Are children in low risk programs less likely to get injured?

Proposed Timeline

Implement the *content* on our current timeline (Aug, 2019) and implement all of the weighted enforcement approach a year later, beginning Aug., 2020.



Enforcement Approach

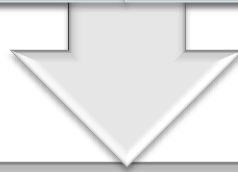
Project Background and Introduction

Rules and Enforcement for DEL - Examples

Revised Code of Washington

Grants Director authority to take administrative actions

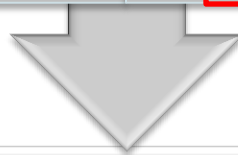
RCW 43.215.300(1) and (3)



Washington Administrative Code

Deny, suspend, revoke license; FLCAs, Non-referral, and civil fines

WAC 170-295-0100 to 0140
WAC 170-296A-8000 to 8400







DEL Policies and Procedures

Steps to issue DEL enforcement actions

Licensors policies 10.2.1 to 10.4.1

Current Challenges

-  Current WAC language is unclear
-  WACs do not “fill in gaps” of RCWs
-  Inconsistent enforcement throughout state
-  Unwritten rules → a lack of transparency in enforcement

Two Prong Approach

P1. Single Finding Score

- ☐ Any Current Site Visit

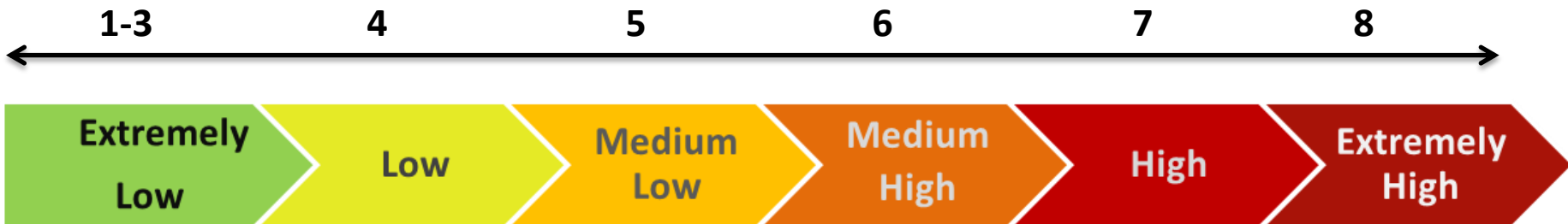
- ☐ Single WAC Weight → Action

P2. Overall Licensing Score

- ☐ Inclusive of Licensing History

- ☐ Overall Score = Possible Action

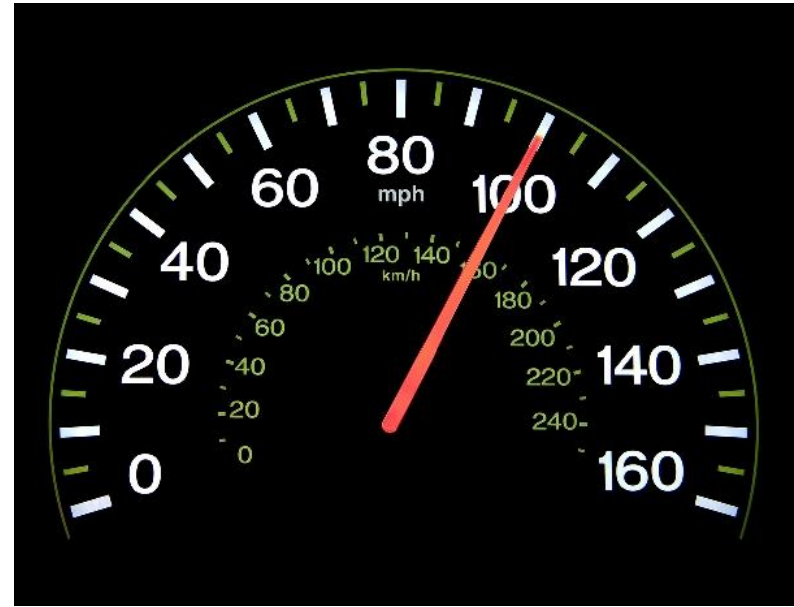
P1 Single Finding Scores/Enforcement Actions



- | | | | | | |
|--|--|--|--|---|--|
| <ul style="list-style-type: none"> • Technical Assistance | <ul style="list-style-type: none"> • Technical Assistance • On 4+ Repeat violations: Civil Penalty | <ul style="list-style-type: none"> • Technical Assistance • On 3+ Repeat violations: Civil Penalty | <ul style="list-style-type: none"> • Technical Assistance • On 2+ Repeat violations: Civil Penalty • Safety Plan • Office Conference | <ul style="list-style-type: none"> • Technical Assistance • On 1+ violation: Civil Penalty • Pre-probation • License Modification • Suspension | <ul style="list-style-type: none"> • Denial • Suspension • Revocation |
|--|--|--|--|---|--|

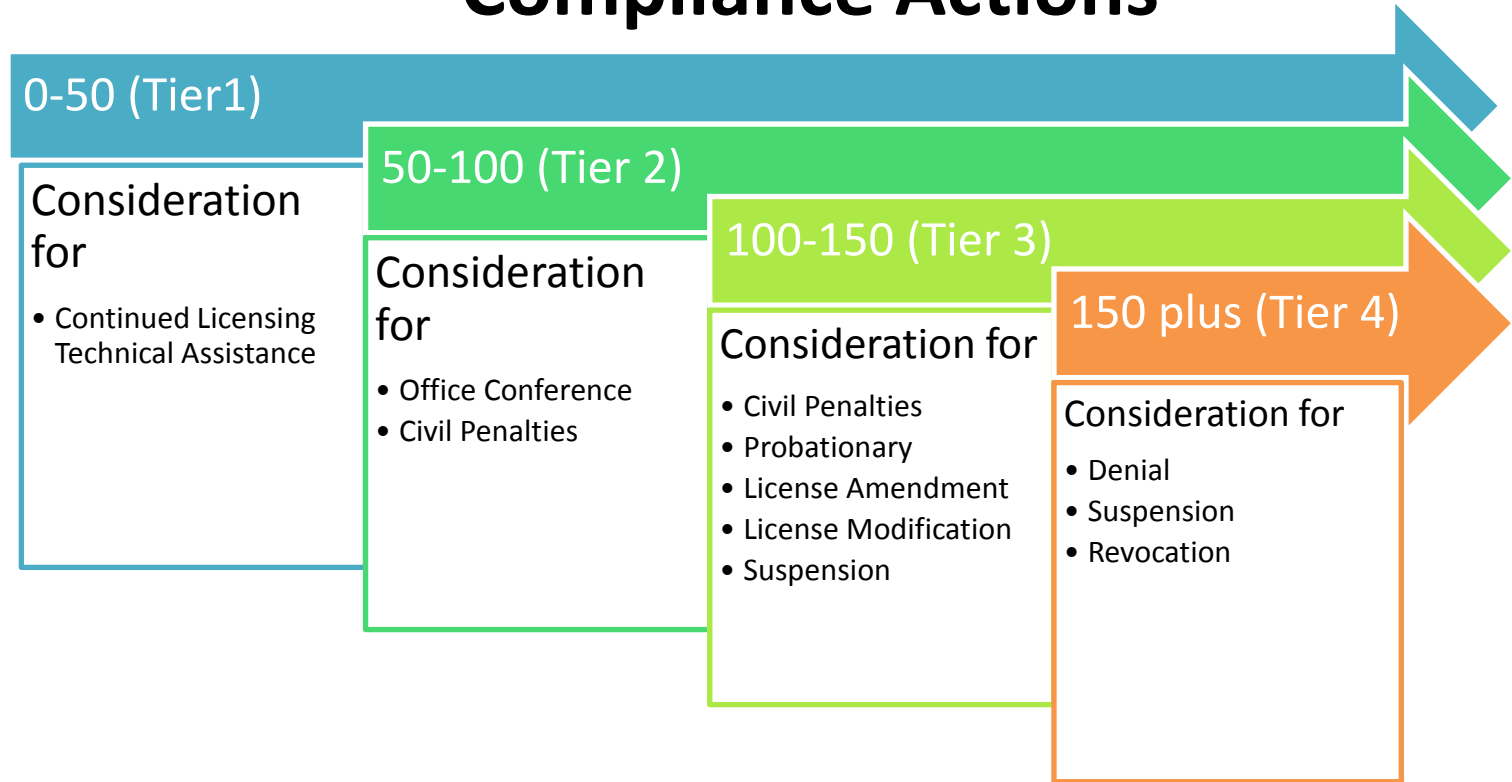
P1

Snapshot Enforcement Analogy



- 2 mph over → small fine
- 60 mph vs 100 mph on 55 mph freeway
- Lower speed limit = higher risk (school zone)

Overall License Score/Adverse and Compliance Actions



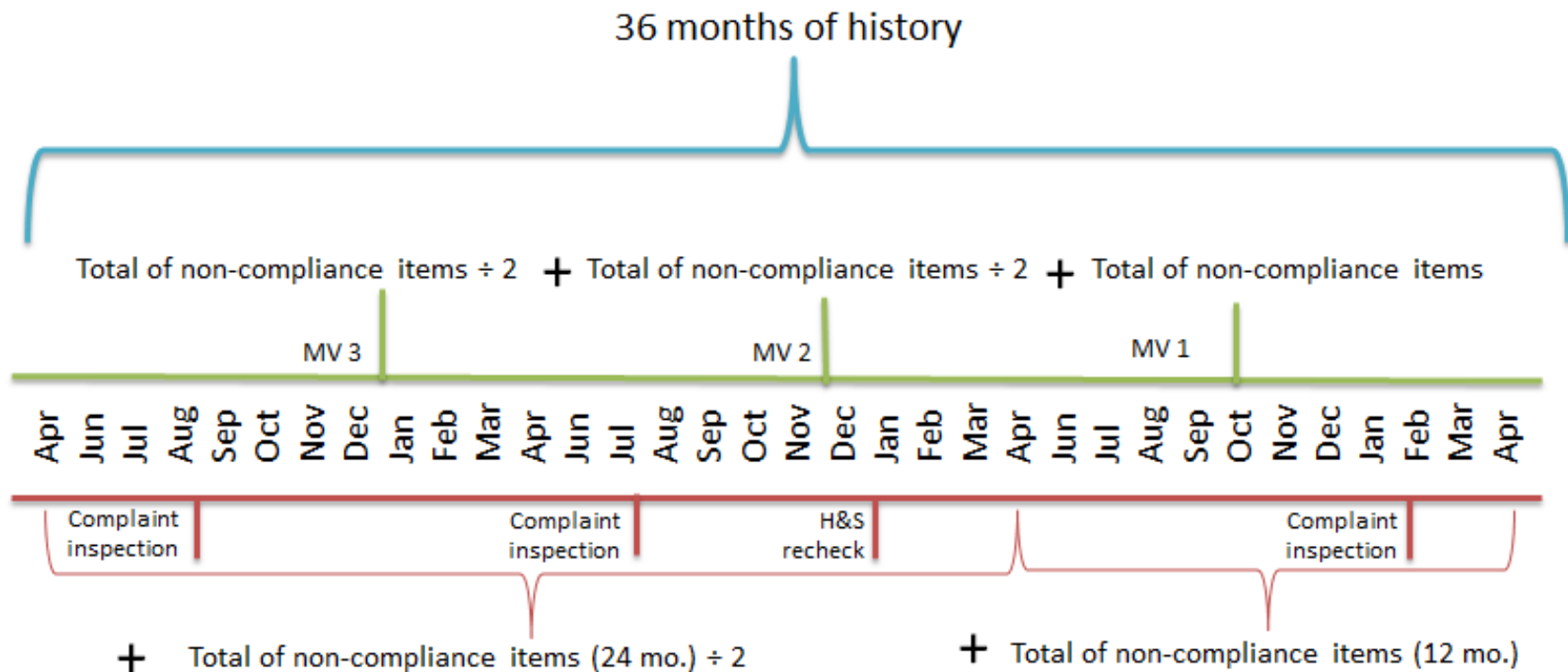
- Multiple data points over 3 year history
- Data points → equation to calculate 'licensing score'
- Lower licensing scores = higher compliance

Aggregate Enforcement Analogy



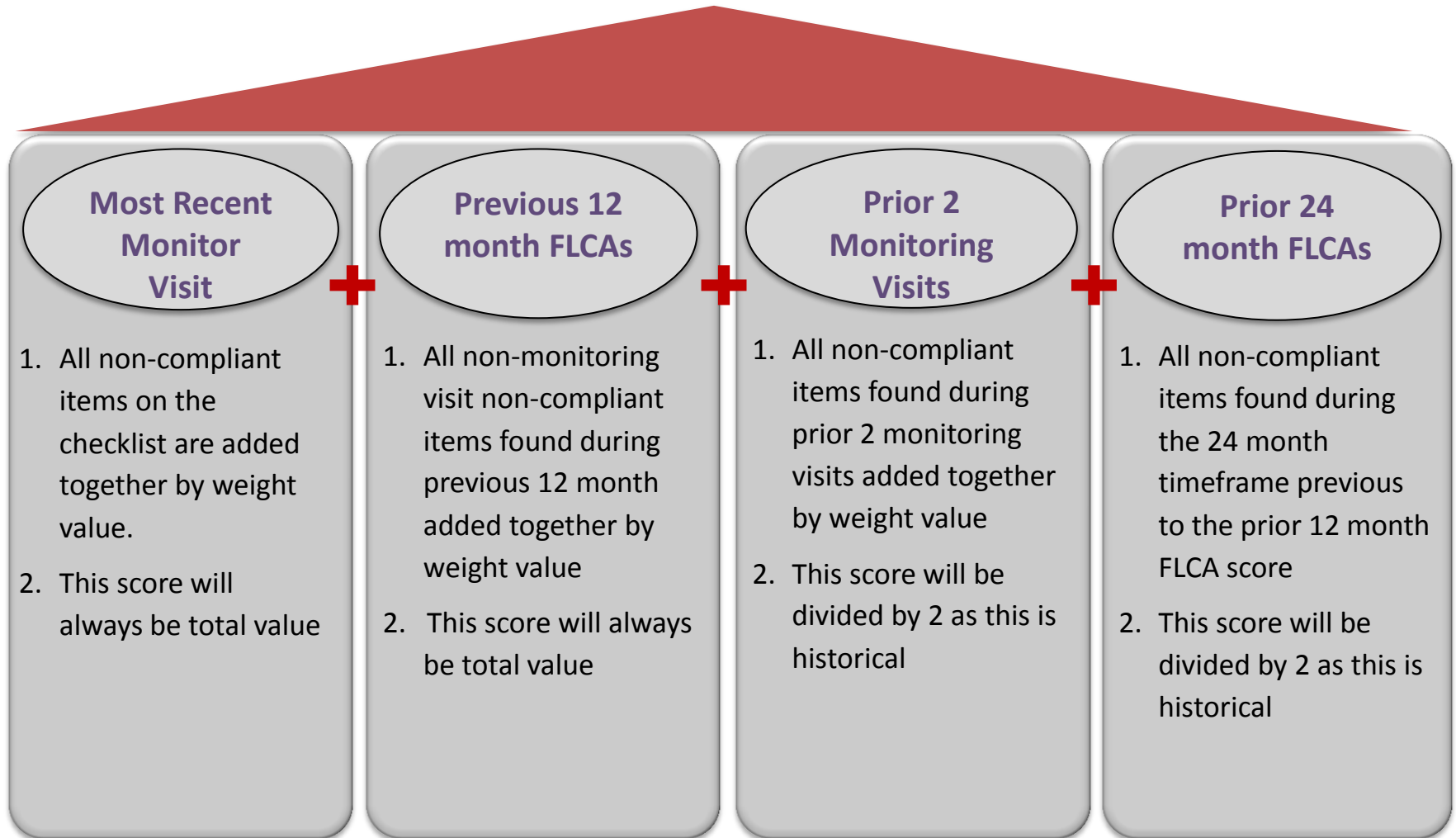
- Clean licensing history = no points
- Points fall off after 3 years
- Rewards more recent compliance (older infractions count less)

- 🕒 The calculation will consider only the **3** most recent annual monitoring visits.
- 📅 The calculation will consider only **36** months of history.



Calculating the Overall License Score

Current MV Score + 12 Month Non-MV scores + (Prior 2 MV Score ÷ 2) + (Prior 24 Month Non-MV scores ÷ 2)



Ensuring Fair and Reasonable Scoring

Licensing staff
will **NOT** do the
calculations

P1

Single
Findings
Score

1. WAC violations will automatically be linked to licensing actions by WA Compass according to weight values once a licensor uploads the checklist and FLCA into the system.
2. Individual non-compliant WACs that qualify, will automatically be flagged for civil penalties by the system.
3. Recommendations for enforcement actions falling within each of the levels would be sent to the licensor and supervisor.
4. Decisions for further action will be made by the licensing team.
5. Weights falling in Level 6 and above will include the RA; scores in Level 7 and above will also include the SLA in decision making.

P2

Overall
Licensing
Score

1. Scores will be calculated by the system once the FLCA is complete and uploaded into the system.
2. Recommendations for further actions will be sent to the licensing team.
3. Decisions for further action will be made by the licensing team.
4. Scores falling in Tier 3 and above will include the RA in decision making; scores in Tier 4 will include the SLA in decision making.

Questions?

THE THEORY OF REGULATORY COMPLIANCE AND FOCUSED MONITORING IN WASHINGTON STATE

Richard Fiene, Ph.D.
Sonya Stevens, Ed.D.

Regulatory Compliance Monitoring Paradigms Introduction

- This presentation provides some key elements to the two dominating paradigms (Relative versus Absolute) for regulatory compliance monitoring based upon the Theory of Regulatory Compliance. See the next slide for the key elements summarized for the Monitoring Paradigms. These key elements are all inter-related and at times are not mutually exclusive.
- This presentation also provides a specific research study in the State of Washington that clearly demonstrates the use of the Theory of Regulatory Compliance as conducted by one of the authors. It is an innovative approach to operationalizing the theory in practice.

Regulatory Compliance Monitoring Paradigms

- **Relative** <-----> **Absolute**
- *Substantial* <-----> *Monolithic*
- *Differential Monitoring* <-----> *One size fits all monitoring*
- *Not all standards are created equal* <-----> *All standards are created equal*
- *Do things well* <-----> *Do no harm*
- *Strength based* <-----> *Deficit based*
- *Formative* <-----> *Summative*
- *Program Quality* <-----> *Program Compliance*
- *100-0 scoring* <-----> *100 or 0 scoring*
- *QRIS* <-----> *Licensing*
- *Non Linear* <-----> *Linear*

Regulatory Compliance Monitoring Paradigms Organizational Key Element

- ***Relative versus Absolute Regulatory Compliance Paradigm:***
this is an important key element in how standards/rules/regulations are viewed when it comes to compliance. For example, in an absolute approach to regulatory compliance either a standard/rule/regulation is in full compliance or not in full compliance. There is no middle ground. It is black or white, no shades of gray. It is 100% or zero. In defining and viewing these two paradigms, this dichotomy is the organizational key element for this presentation.

Moving the Paradigm Needle Using Research

“A Mixed Method Program Evaluation of Annual Inspections Conducted in Childcare Programs in Washington State”

Dr. Sonya Stevens
Licensing Analyst
Washington State DCYF

Using Research to Inform Decisions

Step 1: What is the problem?

Step 2: What does the literature say?

Step 3: What is the Purpose?

Step 4: What are the methods?

Step 5: What are the results?

Step 6: What is next?

What was the Problem?

Like many other states Washington developed a monitoring model founded on proven methodology but did not test it for reliability and validity

Rater-drift:

Checklist are always the same

Compliance blindness:

Ignores individual needs of the provider

Inter-rater reliability:

Licensors inconsistency

Risk-assessment:

Regulations are all treated equally

The Problem

The problem was that the reliability of the monitoring tools and the social validity of the monitoring process used to assess annual compliance of licensed childcare centers has not been determined.

Literature Review

- Licensing analysts report (Washington State, 2014)
- Subjective-objective dichotomy (Amirkhanyan, Kim & Lambright, 2013)
- Consistency and objectivity = effectiveness of monitoring (Alkon, Rose, Wolff, Kotch & Aronson, 2015).
- Inconsistent use = distrust of the licensing system (Kayira, 2016)

The Purpose

“The purpose of this mixed method evaluation study was to determine the reliability of the focused monitoring tool and social validity of the focused monitoring processes used to monitor the foundational health and safety of childcare programs in Washington State.”

Research Questions

RQ1. How do stakeholders describe the value, usefulness, and effects of state administrated focused monitoring?

RQ2. What is the interrater reliability of the focused monitoring observation tool used to assess the foundational health and safety concerns that must be met by state licensed early childhood programs?

Methodology

Research Design

- Context, Input, Process, Product (CIPP) Evaluation (Stufflebeam & Shinkfield, 2007)
 - Delineated needed information
 - Obtained the information
 - Synthesized the information to make programmatic decisions

Data Collection

- Historical DEL analysis and documents
- 7 Licensors
- 5 Provider sites
- 6 Providers
- Consent was collected for each participant

Instrument

- DEL internal databases
- Ad Hoc meeting field notes
- Licensing field notes/FLCA
- Focused monitoring checklist
- Interviews

Data Analysis

- NVivo™ coding/Descriptive analyses
- Simple agreement calculation

Demographics

(Small samples can be effective!)

6 Providers statewide (n=6)

Eastern(16.5%)

Northwest (16.5%)

Southwest (67%)

South King County (0%)

7 Licensors statewide (n=7)

Eastern(29%)

Northwest (43%),

Southwest (14%),

South King County (14%)

**13
participants**

Mean experience = 12.25 years

Minimum years = 1 year

Maximum years = 25 years

Mean experience = 5.07 years

Minimum years = 1.5 years

Maximum years = 17 years

Data Analysis Results: Context

- Compliance (CO) = 20
- Differential monitoring (DM) = 17
- Current checklist challenges (CCC) = 15

Cod e List	Field Notes Reference s	Historical Data References	Literature References	Tota l
CO	2	3	15	20
DM	1	3	13	17
CC C	15	0	0	15
FM	1	6	5	12
RN	8	3	1	12
CU	3	5	0	8
QI	0	0	7	7
SH	1	2	3	6
NC	2	2	2	6
SS	3	0	2	5
WR	0	0	2	2

Data Analysis Results: Input

■ **Challenges Checklist Development (CCD) = 18**

- Redundancy
- Not enough detail/clarity
- Abbreviated checklist is always the same
- Inconsistent use/Excessive add-a-WAC
- Rule on the checklist may not apply

■ **Current development challenges (CDC) = 8**

- Checklist with rotating random items
- Reduce redundant items/eliminate unneeded items
- Provide resources specific to each provider
- Include weights (risk assessment)

Data Analysis Results: Process

- **Informed program needs (IPN) and effect quality (EQ) = 74**

The focused checklist did/would:

- Identify historical patterns
- Increase in time and focus
- Reduce workload

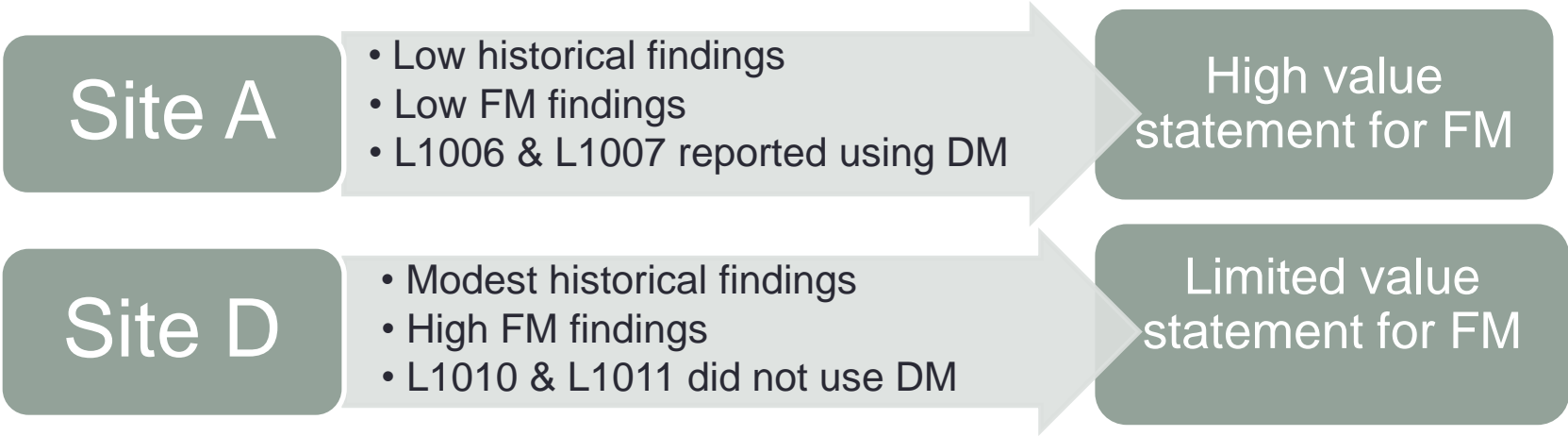
- **Not informing program needs (NIPN) and not affecting quality (NEQ) = 13.**

The focused checklist did not/would not:

- Resolve repeat violations (potential for getting stuck in one area)
- Be easy for new licensors
- Identify all areas of non-compliance
 - ❖ Did not use differential monitoring

Data Analysis Results: Process

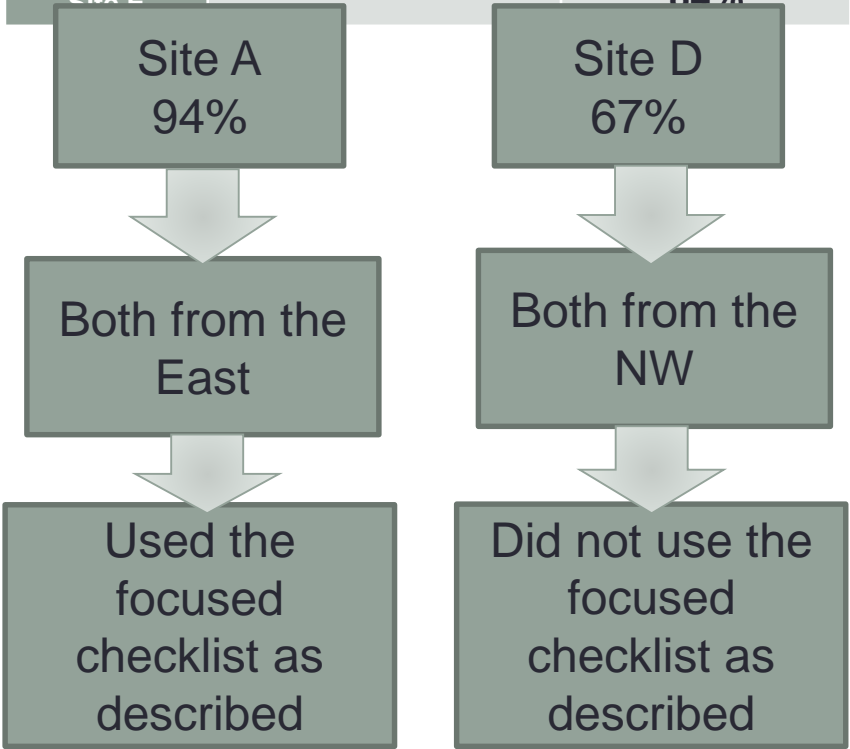
Provider Site	Licensor ID #	Provider Participant #	# of Historical Non-Compliant Items	# of Study Non-Compliant Items
A	L1006/L1007	P1001	1	2
B	L1009/L1012	P1002/P1022	5	22
C	L1006/L1008	P1003	0	14
D	L1010/L1011	P1004	13	41
E	L1006/L1008	P1005	12	7



Data Analysis: Inter-Rater Reliability

Participation ID (location)	Site A (E)	Site B (SW)	Site C (SW)	Site D (NW)	Site E (SW)
P1001 (E)	X				
P1002 (SW)		X			
P1022 (SW)		X			
P1003 (SW)			X		
P1004 (NW)					X
P1005 (SW)				X	
L1006 (E)	X		X		X
L1007 (E)	X				
L1008 (SW)			X		X
L1009 (SK)		X			
L1010 (NW)				X	
L1011 (NW)				X	
L1012 (NW)		X			

Site #	Licensors Participation #	Inter-Rater Reliability
Site A	L1006/L1007	94%
Site B	L1009/L1012	79%
Site C	L1006/L1008	70%
Site D	L1010/L1011	67%
Site E	L1006/L1008	84%



Data Analysis Results: Product

Substantial value and increased
usefulness in the focused monitoring
tool!


Results/Implications

RQ1. There is connection between the beliefs a checklist is helpful for program improvement and the usability of the checklist system


- Redundancy
- Relevancy
- Consistency

RQ2. Performance of onsite inspections varied in reliability and objectivity

- Regional/Office
- Training



The accurate use of the checklist resulted in higher levels of social buy-in of the focused monitoring tool to inform program needs and quality improvement.

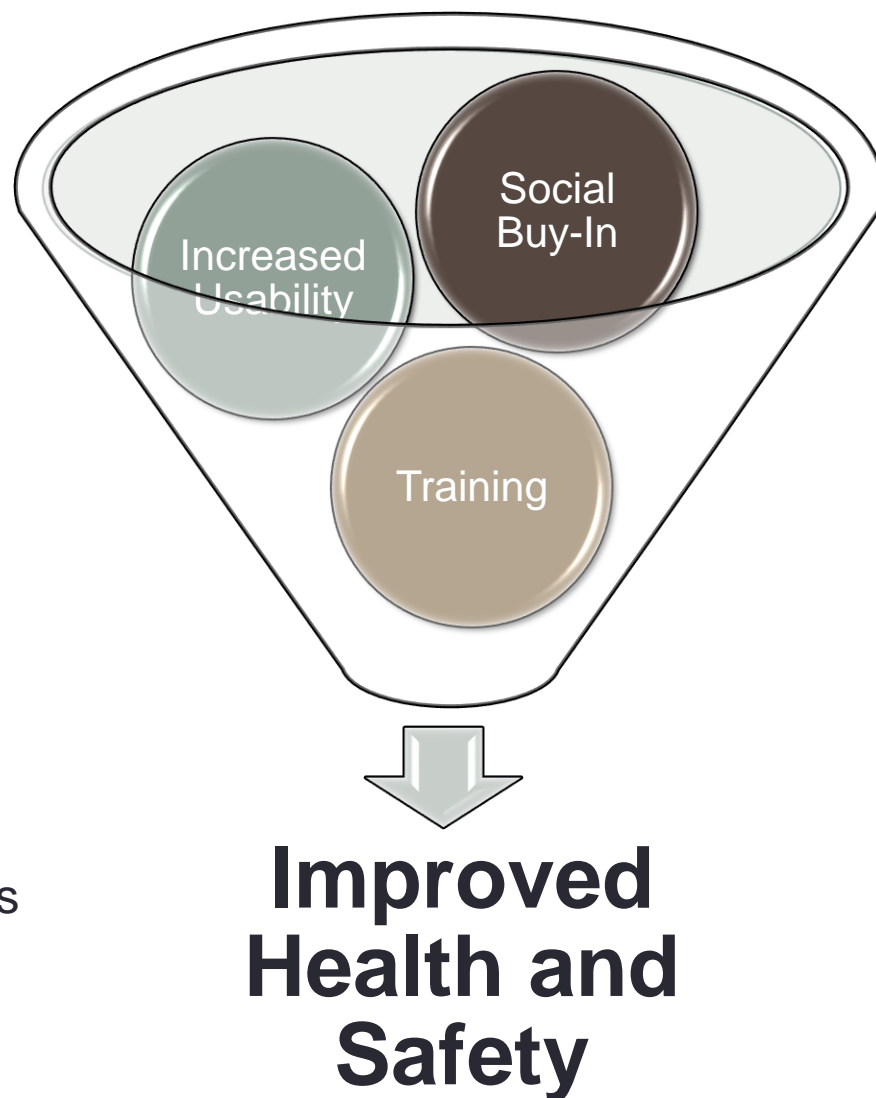


We know:

1. There must be **user consistency** for a tool to be reliable
2. There must be reliability for there to be **trust and value** placed in the outcomes
3. A tool must be usable to be **effective**

We learned:

1. The focused monitoring system is socially valid with mixed levels of reliability
2. Social buy in of the tool directly effects how it's used
3. Training and supervision are key to reliability



What are We Doing Now?

Focused Checklist

- ✓ Each checklist will begin with a baseline of regulations that must be inspected at every monitoring visit based
 - Key indicators
 - High Risk
 - Historical needs
 - Remaining regulations rotated based on weight values
- ✓ Section expand when a key indicator or heavy weight regulation is non-compliant

No Longer on the Checklist

- Regulations that do not impose a duty on the provider
- Regulations that do not apply to the provider
- Regulations that are not on the rotation and the section does not expand (licensors may still provide **Technical Assistance**)

8	7	6	5	4	3	2	1
Always on Baseline		2 Years	3 Years		4 years		

A provider's **strengths are rewarded** with lower oversight in those areas and **support is focused** where providers need it the most!



The Focused Monitoring System: Not so Absolute!

- Focused visits allow more time and resources with problem programs and less time and resources with exception programs.
- Focus is both on doing no harm and doing things well.
- There is an emphasis on constant quality improvement by providing technical assistance on non-critical regulations without the punitive actions.
- When looking at regulations it is clear that certain ones have more of an Impact on outcomes than others.
- Programs are monitored with the inclusion of past compliance history.

Did we find the sweet spot? Only time and research will tell!

Next steps

1. Build and test the checklist in the management system
2. Create and implement extensive training curriculum for providers and licensors
3. Develop and implement a system for inter-rater reliability checks
4. Implementation August 2020

Take A-Ways

- Research should be used to inform decisions
- Research doesn't need to be expensive or complicated
- Research should be accessible

Thank you for your attention.
Are there any questions?



Washington State Department of

Early Learning

Standards Alignment, Proposed Licensing Rules

Negotiated Rulemaking

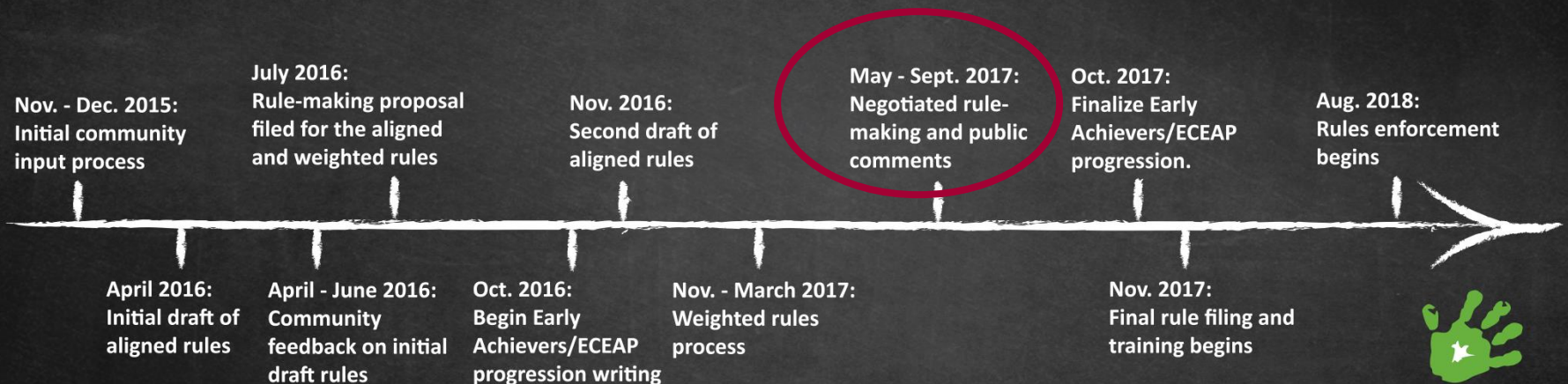
Risk-Assessment: Weights & Enforcement

Dr. Richard Fiene

October 12, 2017



We are committed to creating and maintaining high quality early learning environments that protect and nurture children and prepare them for kindergarten.



Introduction



Richard Fiene, PhD.

Psychology and human
development at Penn State
University.

Working to improve the overall
quality of care for young
children:

- Key indicators

- Risk assessment

- Differential monitoring

Why Weights?

Risk assessment = Theory of Regulatory Compliance

- All rules were not created equal nor administered equally.
- Many rules were administered in a very differential manner.

Licensing risk assessment or weighting of rules

Stepping Stones to Caring for Our Children.

By using the risk assessment methodology, it naturally leads us to more focused or differential monitoring where a subset of rules based upon their risk assessment are measured rather than the full set of rules.

Risk Assessment Matrix (RAM)

- ✓ Likelihood that a particular rule will be out of compliance or when reviewed shows systemic problems.
- ✓ Determine the percentage or frequency of this rule being of concern.

Validation Process

The first approach in validating the risk assessment rules is to compare the state's rules to ***Stepping Stones to Caring for Our Children*** which is the default set of national rules developed via the risk assessment methodology. **Standards Approach.**

The second approach in validating the risk assessment rules is to correlate the risk assessment scores along with full compliance scores to make certain that the risk assessment rules non-compliance is occurring in the more highly non-compliant programs. **Measures Approach.**

Validation Process

The third approach in validating the risk assessment rules is to match the decisions being made regarding the level of licensing and the risk assessment scores. Again there should be a high correlation between the two. **Output Approach.**

The fourth and final approach in validating is to compare the risk assessment rules to outcome data such as the health and safety of children through injury reports, etc. **Outcome Approach.**

Final Thoughts

- The four approaches are taken from Zellman and Fiene's (2012) research brief on ***Validating QRIS*** which has direct applicability to licensing systems as well.
- Approaches 1 and 2 are relatively short time frames because the necessary data to be compared are readily available. If Approach 3 is done retrospectively it can be accomplished relatively quickly but if new data are needed, then a minimum of 6 months will be needed. The last Approach 4 usually takes the longest because the data are not usually collected systematically. This step can easily take a year to complete.
- I would also recommend that you look at the ***Office of Child Care and Assistant Secretary's Office for Planning and Evaluation Briefs on Licensing and Monitoring systems*** which will provide additional guidance on the latest research into this methodology and how it ties into differential monitoring in general.