The CH+ Scoring Protocol (β Version): A Comprehensive Methodology for Evaluating Compliance and Quality

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Abstract

This article introduces the beta version of the CH+ Scoring Protocol, a comprehensive mathematical model designed to quantify compliance and program quality within early care and education regulatory systems. The protocol integrates Program Quality Indicators (PQI) and Regulatory Weighting/Compliance History (RWCH), while applying risk-stratified reduction factors for foundational and risk-based non-compliances. The scoring thresholds and application examples are presented to demonstrate how differential weighting distinguishes between low, provisional, and high-quality providers. By modularizing the base score and reduction multipliers, this paper presents a mathematically rigorous and scalable approach to compliance evaluation.

1 Introduction

The ongoing evolution of regulatory science necessitates robust methodologies that move beyond binary compliance checks to nuanced, differentially weighted scoring protocols. The CH+ Scoring Protocol (β Version) addresses this by synthesizing key indicators, risk assessment rules, and quality metrics into a single, comprehensive score. This approach allows regulatory agencies to effectively categorize programs into actionable tiers ranging from denial to very high quality, ensuring a standardized, mathematically sound basis for evaluating human services and child care compliance.

2 Methodology and Formula Components

To ensure clarity, scalability, and mathematical rigor, the CH+ β protocol is structured modularly. The formula separates positive foundational metrics (the Base Score) from risk-based penalizations (Reduction Multipliers), which account for the severity and frequency of non-compliances.

2.1 The Base Score (S_{base})

The base score relies on two core variables weighted by their relative importance to program quality and historical compliance:

- **PQI (Quality Indicators from CCEEHM):** Ranges from $+10$ to $+40$. Weight multiplier: 3.
- **RWCH (ACR/GS Ratios and Group Size Compliance from CCEEHM):** Ranges from -20 to $+20$. Weight multiplier: 2.

The base score isolates the positive points before any penalties are applied:

$$S_{\text{base}} = 3\sum \text{PQI} + 2\sum \text{RWCH} \tag{1}$$

2.2 The Reduction Multipliers

Risk rules operate as step-down reduction factors. Instead of applying linear arithmetic subtraction, distinct multipliers (M) evaluate specific non-compliance thresholds using piecewise notation.

Foundational Compliance (M_{FC}): Evaluates Key Indicator Rules. A severe lack of foundational compliance results in a full nullification of the score.

$$M_{\text{FC}} = \begin{cases} 0 & \text{if FC} \leq -2 \\ 0.5 & \text{if FC} = -1 \\ 1 & \text{if FC} = 0 \end{cases} \tag{2}$$

High-Risk Rules ($M_{\text{F-}}$): Accounts for False Negatives in high-risk scenarios. Even a single occurrence warrants a full null reduction.

$$M_{\text{F-}} = \begin{cases} 0 & \text{if F-} \leq -1 \\ 1 & \text{if F-} = 0 \end{cases} \tag{3}$$

Low-Risk Rules ($M_{\text{F+}}$): Accounts for False Positives in low-risk scenarios, utilizing a graduated penalty system.

$$M_{\text{F+}} = \begin{cases} 0 & \text{if F+} \leq -3 \\ 0.67 & \text{if F+} \in \{-1, -2\} \\ 1 & \text{if F+} = 0 \end{cases} \tag{4}$$

2.3 The Final Equation

The final CH+ β score integrates the base quality metrics with the defined risk factors. The Base Score is multiplied by the applicable reduction factors:

$$CH + \beta = S_{\text{base}} \times (M_{\text{FC}} \times M_{\text{F-}} \times M_{\text{F+}}) \tag{5}$$

3 Scoring Tiers

The final calculated score determines the regulatory standing of the program:

- **Less than 30:** Low quality, Denial
- **30 – 70:** Medium quality, Provisional
- **71+:** High quality, Full compliance
- **90+:** Very High quality

CH+ Scoring Protocol (β)

Extended Reference Matrix — 500 Simulated Application Outcomes

Distribution Summary (n=500):
Very High Quality (90+): 82 | High Quality (71-89): 28 | Medium Quality / Provisional (30-70): 260 | Low Quality / Denial (<30): 130

PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
20	-20	0	0	-1	13	Low Quality (Denial) — Reduced by F+ NC
30	10	0	0	0	110	Very High Quality
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
30	0	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
20	-10	0	0	-1	27	Low Quality (Denial) — Reduced by F+ NC
30	0	0	-1	0	0	Low Quality (Denial) — Nullified by F- Non-Compliance
20	10	0	0	0	80	High Quality
30	-20	0	0	0	50	Medium Quality (Provisional)
20	-10	0	0	0	40	Medium Quality (Provisional)
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
20	-10	0	0	0	40	Medium Quality (Provisional)
40	0	0	0	-2	80	High Quality — Reduced by F+ NC
30	0	0	0	0	90	Very High Quality
20	10	-1	0	-1	27	Low Quality (Denial) — Heavily reduced by FC and F+ NCs
20	10	0	0	0	80	High Quality
20	0	0	0	0	60	Medium Quality (Provisional)
20	20	0	0	0	100	Very High Quality
10	0	0	0	0	30	Medium Quality (Provisional)
20	20	0	-1	-2	0	Low Quality (Denial) — Nullified by F- Non-Compliance
10	0	0	0	0	30	Medium Quality (Provisional)
20	-10	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
30	0	0	0	-2	60	Medium Quality (Provisional) — Reduced by F+ NC
30	0	0	0	0	90	Very High Quality

PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
30	0	0	0	0	90	Very High Quality
20	-20	-1	0	-2	7	Low Quality (Denial) — Heavily reduced by FC and F+ NCs
20	-10	-1	0	0	20	Low Quality (Denial) — Reduced by FC NC
20	-10	0	0	0	40	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
40	0	0	0	0	120	Very High Quality
20	0	0	0	0	60	Medium Quality (Provisional)
10	0	0	0	-2	20	Low Quality (Denial) — Reduced by F+ NC
10	0	0	0	0	30	Medium Quality (Provisional)
40	0	0	0	-2	80	High Quality — Reduced by F+ NC
20	-10	0	0	0	40	Medium Quality (Provisional)
30	0	-2	0	0	0	Low Quality (Denial) — Nullified by FC Non-Compliance
20	10	0	0	0	80	High Quality
20	0	0	0	0	60	Medium Quality (Provisional)
30	0	0	-1	-2	0	Low Quality (Denial) — Nullified by F- Non-Compliance
40	10	-1	0	0	70	Medium Quality (Provisional) — Reduced by FC NC
20	0	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
20	0	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
40	0	0	0	0	120	Very High Quality
40	0	0	0	0	120	Very High Quality
20	0	-1	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
10	-10	0	0	0	10	Low Quality (Denial)
10	10	0	0	-1	34	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
30	0	0	0	0	90	Very High Quality
20	0	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
40	-10	0	0	-2	67	Medium Quality (Provisional) — Reduced by F+ NC
30	10	0	0	-2	74	High Quality — Reduced by F+ NC

PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
30	0	-2	0	0	0	Low Quality (Denial) — Nullified by FC Non-Compliance
30	0	0	0	0	90	Very High Quality
10	-10	0	0	-1	7	Low Quality (Denial) — Reduced by F+ NC
30	0	0	0	0	90	Very High Quality
40	10	0	0	0	140	Very High Quality
10	0	0	0	-1	20	Low Quality (Denial) — Reduced by F+ NC
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
40	0	-1	0	0	60	Medium Quality (Provisional) — Reduced by FC NC
10	0	-1	0	-2	10	Low Quality (Denial) — Heavily reduced by FC and F+ NCs
30	0	0	0	-1	60	Medium Quality (Provisional) — Reduced by F+ NC
30	0	0	0	-2	60	Medium Quality (Provisional) — Reduced by F+ NC
30	20	-1	0	0	65	Medium Quality (Provisional) — Reduced by FC NC
30	0	-1	0	-2	30	Medium Quality (Provisional) — Heavily reduced by FC and F+ NCs
30	0	0	0	-2	60	Medium Quality (Provisional) — Reduced by F+ NC
30	0	-1	0	0	45	Medium Quality (Provisional) — Reduced by FC NC
30	0	0	0	0	90	Very High Quality
30	20	0	0	0	130	Very High Quality
40	0	-1	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
20	20	0	0	0	100	Very High Quality
30	0	0	0	0	90	Very High Quality
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
10	0	0	0	-2	20	Low Quality (Denial) — Reduced by F+ NC
30	0	0	0	0	90	Very High Quality
20	-10	0	0	-1	27	Low Quality (Denial) — Reduced by F+ NC
40	0	0	0	0	120	Very High Quality
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
20	-10	0	0	0	40	Medium Quality (Provisional)
30	0	0	0	0	90	Very High Quality

PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
10	0	0	0	0	30	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
10	0	0	-1	0	0	Low Quality (Denial) — Nullified by F- Non-Compliance
10	0	-1	0	-2	10	Low Quality (Denial) — Heavily reduced by FC and F+ NCs
30	20	0	-1	-2	0	Low Quality (Denial) — Nullified by F- Non-Compliance
20	0	0	0	0	60	Medium Quality (Provisional)
30	0	0	0	0	90	Very High Quality
20	0	0	0	0	60	Medium Quality (Provisional)
10	0	0	0	0	30	Medium Quality (Provisional)
10	0	0	0	0	30	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
40	0	0	0	-1	80	High Quality — Reduced by F+ NC
20	-20	0	0	-2	13	Low Quality (Denial) — Reduced by F+ NC
40	0	0	0	-1	80	High Quality — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
30	0	0	0	0	90	Very High Quality
20	-20	0	0	0	20	Low Quality (Denial)
20	-10	0	0	0	40	Medium Quality (Provisional)
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
30	0	0	0	0	90	Very High Quality
40	0	0	0	-1	80	High Quality — Reduced by F+ NC
30	10	0	0	0	110	Very High Quality
10	0	0	0	-1	20	Low Quality (Denial) — Reduced by F+ NC
30	-10	0	0	0	70	Medium Quality (Provisional)
30	20	0	0	0	130	Very High Quality
30	20	0	0	0	130	Very High Quality
30	0	0	0	-2	60	Medium Quality (Provisional) — Reduced by F+ NC
20	-10	-2	0	0	0	Low Quality (Denial) — Nullified by FC Non-Compliance
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC

PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
30	-10	-2	0	-2	0	Low Quality (Denial) — Nullified by FC Non-Compliance
30	0	0	-1	0	0	Low Quality (Denial) — Nullified by F- Non-Compliance
30	0	0	0	-1	60	Medium Quality (Provisional) — Reduced by F+ NC
20	10	-1	0	-2	27	Low Quality (Denial) — Heavily reduced by FC and F+ NCs
20	0	0	0	0	60	Medium Quality (Provisional)
30	-10	0	0	0	70	Medium Quality (Provisional)
30	0	0	0	-2	60	Medium Quality (Provisional) — Reduced by F+ NC
10	0	0	0	-1	20	Low Quality (Denial) — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
30	0	0	0	0	90	Very High Quality
20	0	0	0	0	60	Medium Quality (Provisional)
20	-10	0	0	0	40	Medium Quality (Provisional)
30	-10	0	0	-1	47	Medium Quality (Provisional) — Reduced by F+ NC
40	0	0	0	0	120	Very High Quality
20	-10	0	0	0	40	Medium Quality (Provisional)
40	0	0	0	-2	80	High Quality — Reduced by F+ NC
20	10	0	0	0	80	High Quality
20	-10	-1	0	-2	13	Low Quality (Denial) — Heavily reduced by FC and F+ NCs
20	-10	0	0	0	40	Medium Quality (Provisional)
20	0	-2	0	-1	0	Low Quality (Denial) — Nullified by FC Non-Compliance
20	0	0	0	0	60	Medium Quality (Provisional)
20	10	-2	0	-1	0	Low Quality (Denial) — Nullified by FC Non-Compliance
20	0	-1	0	0	30	Medium Quality (Provisional) — Reduced by FC NC
30	-10	0	0	0	70	Medium Quality (Provisional)
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
30	0	0	0	-1	60	Medium Quality (Provisional) — Reduced by F+ NC
20	0	-1	0	0	30	Medium Quality (Provisional) — Reduced by FC NC
20	10	-1	0	0	40	Medium Quality (Provisional) — Reduced by FC NC
20	0	0	0	0	60	Medium Quality (Provisional)

PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
30	0	-1	0	0	45	Medium Quality (Provisional) — Reduced by FC NC
10	-20	0	0	0	-10	Low Quality (Denial)
10	20	-1	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
40	0	0	0	-1	80	High Quality — Reduced by F+ NC
20	0	-1	0	0	30	Medium Quality (Provisional) — Reduced by FC NC
20	0	0	0	0	60	Medium Quality (Provisional)
30	10	0	0	0	110	Very High Quality
40	10	0	0	0	140	Very High Quality
20	20	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
30	0	0	0	0	90	Very High Quality
30	0	0	0	0	90	Very High Quality
40	0	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
20	0	0	0	0	60	Medium Quality (Provisional)
10	20	-1	0	0	35	Medium Quality (Provisional) — Reduced by FC NC
30	0	0	0	0	90	Very High Quality
30	20	0	0	0	130	Very High Quality
40	0	-1	0	0	60	Medium Quality (Provisional) — Reduced by FC NC
30	0	-1	0	-2	30	Medium Quality (Provisional) — Heavily reduced by FC and F+ NCs
20	0	0	-1	0	0	Low Quality (Denial) — Nullified by F- Non-Compliance
10	0	0	0	0	30	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
30	0	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
20	-20	0	0	-2	13	Low Quality (Denial) — Reduced by F+ NC
30	0	0	0	-1	60	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
30	0	0	0	-1	60	Medium Quality (Provisional) — Reduced by F+ NC
30	-20	0	0	-2	34	Medium Quality (Provisional) — Reduced by F+ NC

PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
40	0	0	0	-1	80	High Quality — Reduced by F+ NC
30	0	0	0	0	90	Very High Quality
30	0	0	0	0	90	Very High Quality
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
20	0	-1	0	0	30	Medium Quality (Provisional) — Reduced by FC NC
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
30	-10	0	0	0	70	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
40	0	-2	0	0	0	Low Quality (Denial) — Nullified by FC Non-Compliance
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
20	10	0	0	-1	54	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
30	10	0	0	-1	74	High Quality — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
40	0	-1	0	0	60	Medium Quality (Provisional) — Reduced by FC NC
30	0	-1	0	0	45	Medium Quality (Provisional) — Reduced by FC NC
10	20	0	-1	-2	0	Low Quality (Denial) — Nullified by F- Non-Compliance
30	20	-2	0	0	0	Low Quality (Denial) — Nullified by FC Non-Compliance
30	-20	0	0	-1	34	Medium Quality (Provisional) — Reduced by F+ NC
30	0	-1	0	0	45	Medium Quality (Provisional) — Reduced by FC NC
20	-20	-1	0	-2	7	Low Quality (Denial) — Heavily reduced by FC and F+ NCs
20	-10	-1	0	0	20	Low Quality (Denial) — Reduced by FC NC
20	-10	-1	0	0	20	Low Quality (Denial) — Reduced by FC NC
10	10	0	0	-1	34	Medium Quality (Provisional) — Reduced by F+ NC
30	10	0	0	0	110	Very High Quality
20	-10	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
10	0	0	-1	-2	0	Low Quality (Denial) — Nullified by F- Non-Compliance

PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
10	0	0	-1	0	0	Low Quality (Denial) — Nullified by F- Non-Compliance
20	-10	0	0	0	40	Medium Quality (Provisional)
30	0	0	0	-1	60	Medium Quality (Provisional) — Reduced by F+ NC
20	-10	0	0	-1	27	Low Quality (Denial) — Reduced by F+ NC
20	0	-1	0	0	30	Medium Quality (Provisional) — Reduced by FC NC
40	-20	-1	0	0	40	Medium Quality (Provisional) — Reduced by FC NC
20	-10	0	0	0	40	Medium Quality (Provisional)
30	0	0	0	0	90	Very High Quality
30	0	0	0	-1	60	Medium Quality (Provisional) — Reduced by F+ NC
20	-10	0	0	0	40	Medium Quality (Provisional)
30	10	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
10	0	0	0	0	30	Medium Quality (Provisional)
40	-10	0	0	0	100	Very High Quality
20	0	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
30	0	0	0	0	90	Very High Quality
20	0	0	0	0	60	Medium Quality (Provisional)
10	0	0	0	0	30	Medium Quality (Provisional)
40	-10	-1	0	0	50	Medium Quality (Provisional) — Reduced by FC NC
30	10	0	0	0	110	Very High Quality
20	-10	0	0	-1	27	Low Quality (Denial) — Reduced by F+ NC
30	0	-2	0	0	0	Low Quality (Denial) — Nullified by FC Non-Compliance
20	0	0	0	0	60	Medium Quality (Provisional)
30	0	0	0	-2	60	Medium Quality (Provisional) — Reduced by F+ NC
30	20	-1	0	-1	44	Medium Quality (Provisional) — Heavily reduced by FC and F+ NCs
10	10	-1	0	0	25	Low Quality (Denial) — Reduced by FC NC
30	0	0	0	-2	60	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
30	0	0	0	0	90	Very High Quality

PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
30	0	0	0	0	90	Very High Quality
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
10	0	0	0	0	30	Medium Quality (Provisional)
20	-10	0	0	0	40	Medium Quality (Provisional)
30	-10	0	0	0	70	Medium Quality (Provisional)
30	10	0	0	0	110	Very High Quality
10	10	-1	0	0	25	Low Quality (Denial) — Reduced by FC NC
30	0	0	0	0	90	Very High Quality
30	0	-1	0	0	45	Medium Quality (Provisional) — Reduced by FC NC
30	0	0	0	0	90	Very High Quality
20	0	0	0	0	60	Medium Quality (Provisional)
10	0	-1	0	-1	10	Low Quality (Denial) — Heavily reduced by FC and F+ NCs
30	10	0	0	0	110	Very High Quality
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
20	-10	0	0	0	40	Medium Quality (Provisional)
10	0	0	0	0	30	Medium Quality (Provisional)
30	-10	-1	0	-1	23	Low Quality (Denial) — Heavily reduced by FC and F+ NCs
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
20	10	0	0	0	80	High Quality
20	-10	0	0	0	40	Medium Quality (Provisional)
30	0	0	0	0	90	Very High Quality
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
10	-10	0	0	-1	7	Low Quality (Denial) — Reduced by F+ NC
30	10	-1	0	0	55	Medium Quality (Provisional) — Reduced by FC NC
10	0	-2	0	0	0	Low Quality (Denial) — Nullified by FC Non-Compliance

PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
20	10	0	0	-1	54	Medium Quality (Provisional) — Reduced by F+ NC
30	0	-1	0	-1	30	Medium Quality (Provisional) — Heavily reduced by FC and F+ NCs
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	-1	0	0	30	Medium Quality (Provisional) — Reduced by FC NC
10	-10	-1	0	-1	3	Low Quality (Denial) — Heavily reduced by FC and F+ NCs
30	10	0	0	-1	74	High Quality — Reduced by F+ NC
10	0	0	0	-1	20	Low Quality (Denial) — Reduced by F+ NC
30	-10	0	0	-1	47	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	-1	0	-2	20	Low Quality (Denial) — Heavily reduced by FC and F+ NCs
20	10	-2	0	0	0	Low Quality (Denial) — Nullified by FC Non-Compliance
20	0	-2	0	-2	0	Low Quality (Denial) — Nullified by FC Non-Compliance
10	0	0	0	0	30	Medium Quality (Provisional)
10	10	-1	0	-1	17	Low Quality (Denial) — Heavily reduced by FC and F+ NCs
20	10	0	0	-2	54	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	-2	0	0	0	Low Quality (Denial) — Nullified by FC Non-Compliance
40	10	0	0	0	140	Very High Quality
20	10	0	0	-1	54	Medium Quality (Provisional) — Reduced by F+ NC
20	-20	0	0	-2	13	Low Quality (Denial) — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
20	-20	0	0	0	20	Low Quality (Denial)
10	10	0	0	0	50	Medium Quality (Provisional)
20	-10	0	0	0	40	Medium Quality (Provisional)
20	0	0	-1	0	0	Low Quality (Denial) — Nullified by F- Non-Compliance
20	0	-2	0	0	0	Low Quality (Denial) — Nullified by FC Non-Compliance
20	0	-2	0	0	0	Low Quality (Denial) — Nullified by FC Non-Compliance

PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
30	0	0	0	-1	60	Medium Quality (Provisional) — Reduced by F+ NC
30	0	0	0	-2	60	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
30	-10	0	0	0	70	Medium Quality (Provisional)
10	-10	0	0	0	10	Low Quality (Denial)
40	0	0	0	0	120	Very High Quality
20	0	-1	0	0	30	Medium Quality (Provisional) — Reduced by FC NC
20	10	0	0	0	80	High Quality
40	0	0	0	0	120	Very High Quality
30	0	0	0	-2	60	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
30	0	-2	0	-3	0	Low Quality (Denial) — Nullified by FC, F+ Non-Compliance
40	-10	0	0	-2	67	Medium Quality (Provisional) — Reduced by F+ NC
30	20	0	0	-1	87	High Quality — Reduced by F+ NC
10	-10	0	0	0	10	Low Quality (Denial)
20	0	0	0	0	60	Medium Quality (Provisional)
30	0	0	0	-1	60	Medium Quality (Provisional) — Reduced by F+ NC
20	-10	0	0	0	40	Medium Quality (Provisional)
20	0	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
20	10	0	0	-2	54	Medium Quality (Provisional) — Reduced by F+ NC
20	10	0	0	-1	54	Medium Quality (Provisional) — Reduced by F+ NC
30	0	0	0	0	90	Very High Quality
30	10	0	0	-1	74	High Quality — Reduced by F+ NC
30	0	0	0	0	90	Very High Quality
30	-20	0	0	-2	34	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
30	0	0	0	0	90	Very High Quality
40	0	0	0	0	120	Very High Quality
30	0	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance

PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
20	10	0	0	0	80	High Quality
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
30	10	0	0	0	110	Very High Quality
10	0	0	0	0	30	Medium Quality (Provisional)
40	-10	0	0	-1	67	Medium Quality (Provisional) — Reduced by F+ NC
30	0	-1	0	0	45	Medium Quality (Provisional) — Reduced by FC NC
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
20	10	0	0	0	80	High Quality
10	0	0	0	-1	20	Low Quality (Denial) — Reduced by F+ NC
20	0	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
10	0	0	0	0	30	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	-1	0	0	30	Medium Quality (Provisional) — Reduced by FC NC
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
40	0	0	0	0	120	Very High Quality
30	0	0	0	-2	60	Medium Quality (Provisional) — Reduced by F+ NC
20	10	0	0	0	80	High Quality
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	-1	-1	0	Low Quality (Denial) — Nullified by F- Non-Compliance
10	20	0	0	0	70	Medium Quality (Provisional)
40	0	0	0	0	120	Very High Quality
10	-10	0	0	0	10	Low Quality (Denial)
20	0	0	0	0	60	Medium Quality (Provisional)
40	0	0	0	-2	80	High Quality — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
30	20	0	0	-1	87	High Quality — Reduced by F+ NC
30	-20	0	-1	-1	0	Low Quality (Denial) — Nullified by F- Non-Compliance
30	0	0	0	0	90	Very High Quality

PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
20	0	-1	0	-1	20	Low Quality (Denial) — Heavily reduced by FC and F+ NCs
10	10	0	0	0	50	Medium Quality (Provisional)
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
30	0	0	0	0	90	Very High Quality
20	0	0	0	0	60	Medium Quality (Provisional)
40	0	0	0	-1	80	High Quality — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	-2	0	0	0	Low Quality (Denial) — Nullified by FC Non-Compliance
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
30	0	0	0	0	90	Very High Quality
40	10	-2	0	0	0	Low Quality (Denial) — Nullified by FC Non-Compliance
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
10	0	0	0	-1	20	Low Quality (Denial) — Reduced by F+ NC
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
10	0	0	0	-2	20	Low Quality (Denial) — Reduced by F+ NC
20	10	-1	0	0	40	Medium Quality (Provisional) — Reduced by FC NC
40	0	0	0	0	120	Very High Quality
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
20	10	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
20	0	-1	-1	-2	0	Low Quality (Denial) — Nullified by F- Non-Compliance
30	-20	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
20	20	0	0	-2	67	Medium Quality (Provisional) — Reduced by F+ NC
30	0	0	0	0	90	Very High Quality
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
30	0	0	0	0	90	Very High Quality
10	0	0	0	0	30	Medium Quality (Provisional)
30	20	0	0	0	130	Very High Quality

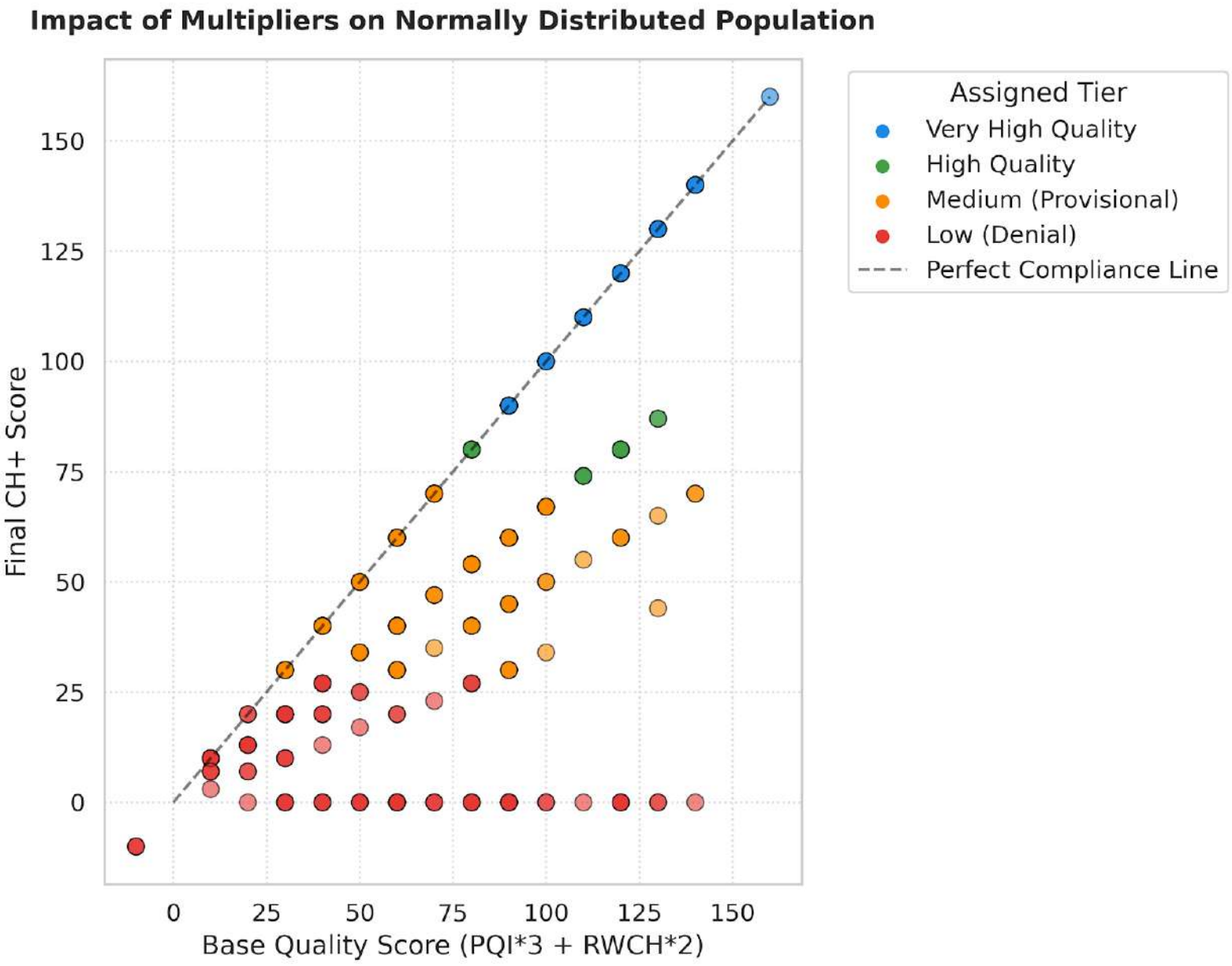
PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
30	0	0	0	0	90	Very High Quality
20	0	-1	0	0	30	Medium Quality (Provisional) — Reduced by FC NC
10	10	0	0	0	50	Medium Quality (Provisional)
10	-10	0	0	0	10	Low Quality (Denial)
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	-1	0	0	30	Medium Quality (Provisional) — Reduced by FC NC
30	-10	0	0	0	70	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
10	0	0	0	0	30	Medium Quality (Provisional)
30	0	0	0	0	90	Very High Quality
20	10	0	0	-2	54	Medium Quality (Provisional) — Reduced by F+ NC
30	0	0	0	0	90	Very High Quality
40	10	0	0	0	140	Very High Quality
20	0	0	-1	-1	0	Low Quality (Denial) — Nullified by F- Non-Compliance
20	20	0	0	-2	67	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
20	-10	0	0	-1	27	Low Quality (Denial) — Reduced by F+ NC
20	-20	0	0	-1	13	Low Quality (Denial) — Reduced by F+ NC
20	0	-1	0	0	30	Medium Quality (Provisional) — Reduced by FC NC
20	10	0	0	-2	54	Medium Quality (Provisional) — Reduced by F+ NC
20	0	-1	0	0	30	Medium Quality (Provisional) — Reduced by FC NC
10	-20	0	0	0	-10	Low Quality (Denial)
30	0	0	0	-2	60	Medium Quality (Provisional) — Reduced by F+ NC
10	0	0	0	-1	20	Low Quality (Denial) — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
10	0	0	0	0	30	Medium Quality (Provisional)
40	10	-1	0	0	70	Medium Quality (Provisional) — Reduced by FC NC
20	20	-1	0	-1	34	Medium Quality (Provisional) — Heavily reduced by FC and F+ NCs
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
20	10	0	0	-2	54	Medium Quality (Provisional) — Reduced by F+ NC

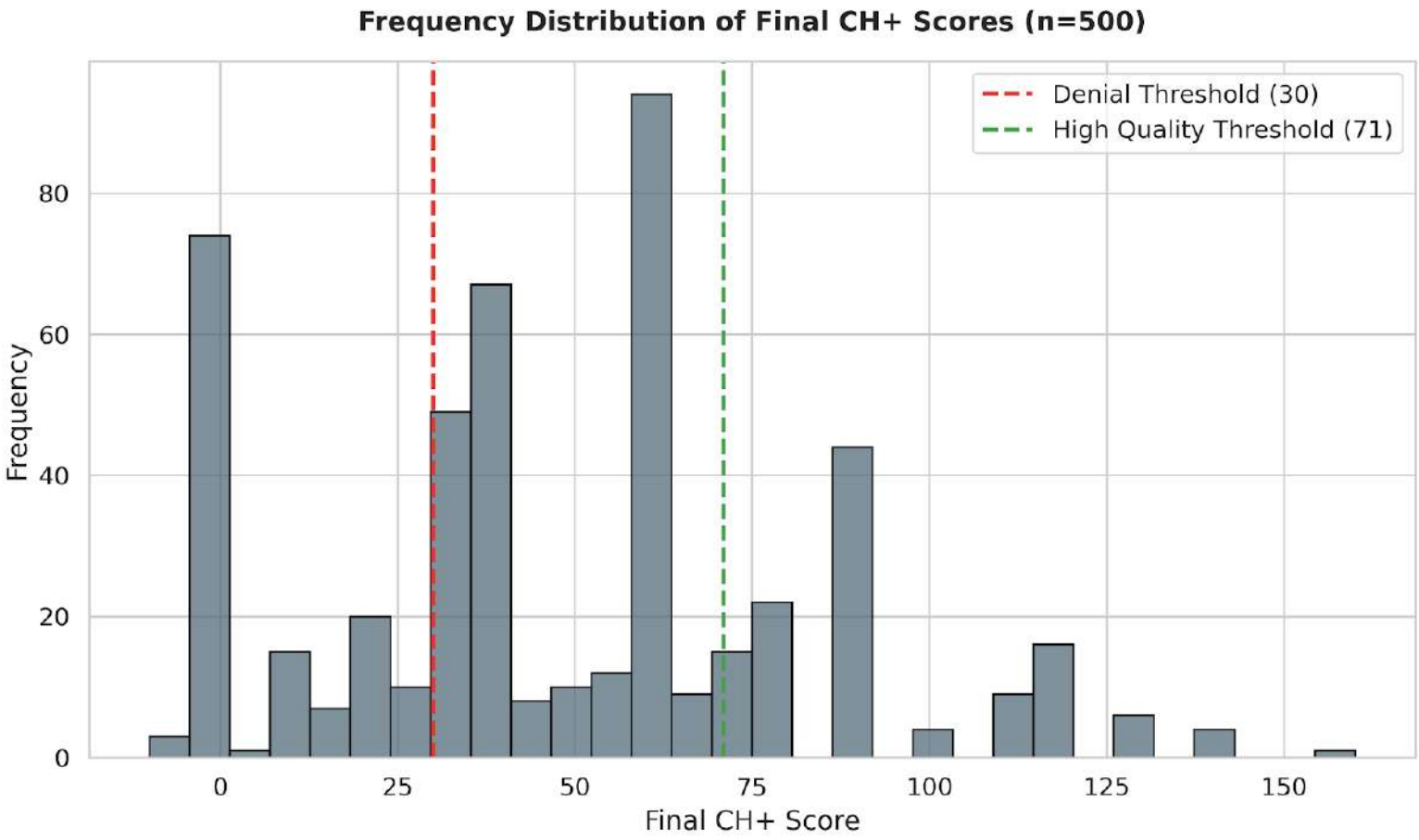
PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
40	0	-2	0	0	0	Low Quality (Denial) — Nullified by FC Non-Compliance
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
10	0	0	0	-1	20	Low Quality (Denial) — Reduced by F+ NC
20	10	0	0	-1	54	Medium Quality (Provisional) — Reduced by F+ NC
20	0	-1	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
10	10	-2	0	-3	0	Low Quality (Denial) — Nullified by FC, F+ Non-Compliance
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
20	10	-1	0	0	40	Medium Quality (Provisional) — Reduced by FC NC
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
30	0	0	0	0	90	Very High Quality
30	20	0	0	0	130	Very High Quality
30	-10	0	0	-2	47	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
40	0	0	0	-2	80	High Quality — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
10	0	0	0	0	30	Medium Quality (Provisional)
40	-20	-1	0	-2	27	Low Quality (Denial) — Heavily reduced by FC and F+ NCs
40	-10	0	0	0	100	Very High Quality
20	10	0	0	0	80	High Quality
20	0	-2	0	-1	0	Low Quality (Denial) — Nullified by FC Non-Compliance
30	0	-1	0	0	45	Medium Quality (Provisional) — Reduced by FC NC
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
10	0	0	0	-2	20	Low Quality (Denial) — Reduced by F+ NC
30	0	0	0	-2	60	Medium Quality (Provisional) — Reduced by F+ NC

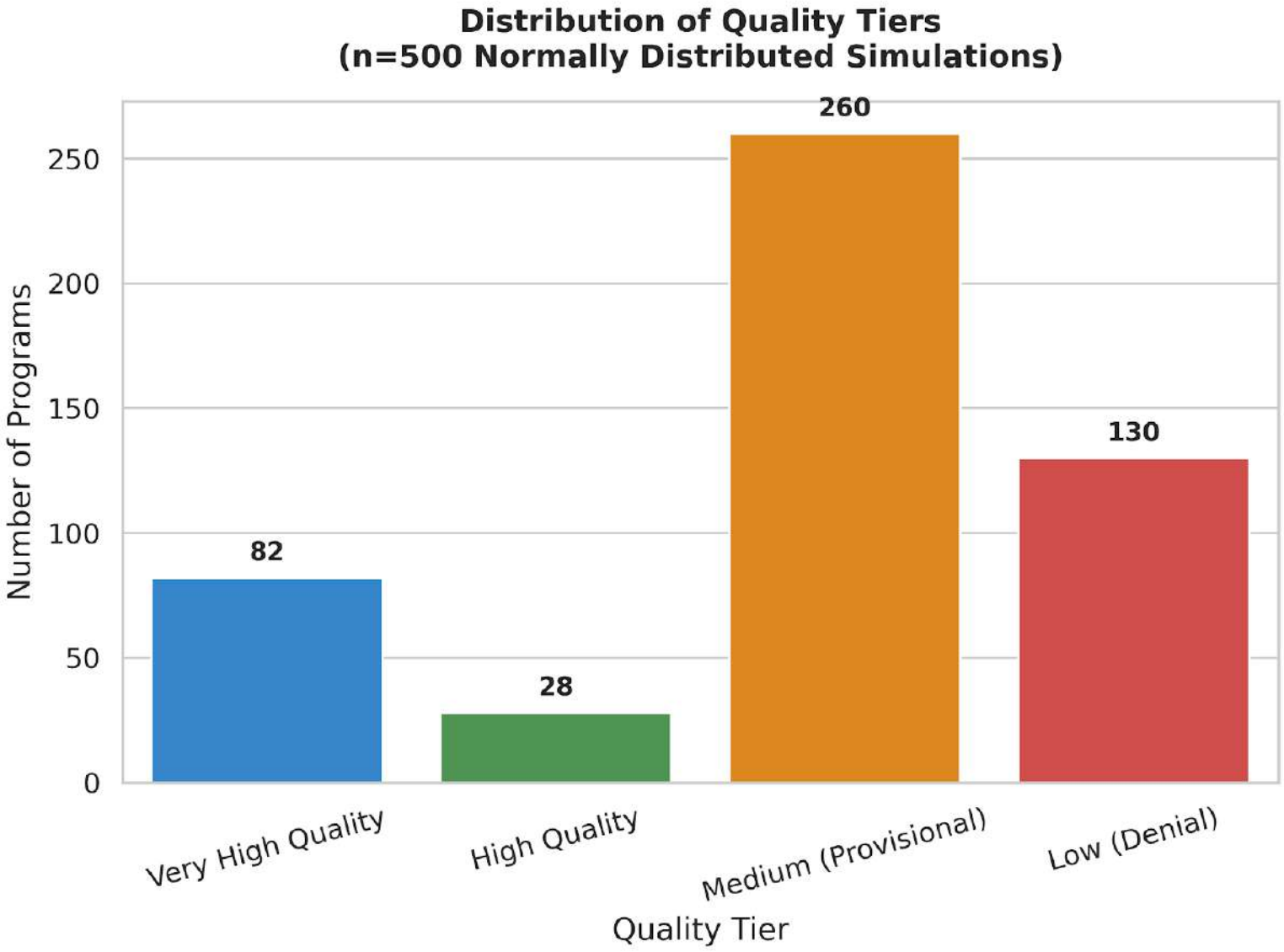
PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
30	0	0	0	0	90	Very High Quality
40	0	0	0	0	120	Very High Quality
10	-10	0	0	0	10	Low Quality (Denial)
30	0	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
30	0	-2	0	0	0	Low Quality (Denial) — Nullified by FC Non-Compliance
30	0	0	-1	0	0	Low Quality (Denial) — Nullified by F- Non-Compliance
30	-20	0	-1	0	0	Low Quality (Denial) — Nullified by F- Non-Compliance
20	10	0	0	-1	54	Medium Quality (Provisional) — Reduced by F+ NC
10	0	0	0	0	30	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
10	-20	0	0	0	-10	Low Quality (Denial)
10	-10	0	0	0	10	Low Quality (Denial)
10	0	0	0	0	30	Medium Quality (Provisional)
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
40	20	0	0	0	160	Very High Quality
10	0	0	0	0	30	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
40	0	0	0	0	120	Very High Quality
20	10	-1	-1	0	0	Low Quality (Denial) — Nullified by F- Non-Compliance
20	10	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
40	0	0	0	0	120	Very High Quality
20	0	-1	0	0	30	Medium Quality (Provisional) — Reduced by FC NC
20	0	0	0	0	60	Medium Quality (Provisional)
40	0	0	0	0	120	Very High Quality
30	10	0	0	0	110	Very High Quality
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
10	20	0	0	0	70	Medium Quality (Provisional)
40	0	0	0	0	120	Very High Quality

PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
30	0	0	0	-1	60	Medium Quality (Provisional) — Reduced by F+ NC
30	0	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
30	0	0	-1	0	0	Low Quality (Denial) — Nullified by F- Non-Compliance
10	0	0	0	0	30	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
40	-10	-1	0	0	50	Medium Quality (Provisional) — Reduced by FC NC
20	0	0	0	0	60	Medium Quality (Provisional)
30	0	0	0	0	90	Very High Quality
30	0	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
20	-10	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
20	0	0	0	0	60	Medium Quality (Provisional)
10	0	0	0	0	30	Medium Quality (Provisional)
30	0	0	0	0	90	Very High Quality
10	10	0	0	0	50	Medium Quality (Provisional)
20	10	0	0	0	80	High Quality
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
30	0	0	0	0	90	Very High Quality
10	-10	0	0	-1	7	Low Quality (Denial) — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
20	0	0	-1	0	0	Low Quality (Denial) — Nullified by F- Non-Compliance
20	-10	0	0	0	40	Medium Quality (Provisional)
20	-20	0	0	-3	0	Low Quality (Denial) — Nullified by F+ Non-Compliance
20	0	0	0	-2	40	Medium Quality (Provisional) — Reduced by F+ NC
20	-10	0	0	0	40	Medium Quality (Provisional)
20	0	0	0	-1	40	Medium Quality (Provisional) — Reduced by F+ NC
30	0	0	0	-1	60	Medium Quality (Provisional) — Reduced by F+ NC
30	0	-1	0	-1	30	Medium Quality (Provisional) — Heavily reduced by FC and F+ NCs
20	20	0	0	-1	67	Medium Quality (Provisional) — Reduced by F+ NC

PQI	RWCH	FC	F-	F+	SCORE	COMMENTS / CLASSIFICATION
20	20	0	0	-2	67	Medium Quality (Provisional) — Reduced by F+ NC
20	20	0	0	-2	67	Medium Quality (Provisional) — Reduced by F+ NC
20	0	0	0	0	60	Medium Quality (Provisional)
10	0	0	0	0	30	Medium Quality (Provisional)
20	0	0	0	0	60	Medium Quality (Provisional)
20	10	-2	0	0	0	Low Quality (Denial) — Nullified by FC Non-Compliance
40	0	-1	-1	-2	0	Low Quality (Denial) — Nullified by F- Non-Compliance
10	10	0	0	-2	34	Medium Quality (Provisional) — Reduced by F+ NC


Impact of Multipliers on Normally Distributed Population
Final CH+ Score
Base Quality Score (PQI*3 + RWCH*2)
0
25
50
75
100
125
150
Assigned Tier
Very High Quality
High Quality
Medium (Provisional)
Low (Denial)
Perfect Compliance Line


Frequency Distribution of Final CH+ Scores (n=500)
Denial Threshold (30)
High Quality Threshold (71)
Frequency
0
20
40
60
80
0
25
50
75
100
125
150
Final CH+ Score


Distribution of Quality Tiers
(n=500 Normally Distributed Simulations)
Number of Programs
0
50
100
150
200
250
82
28
260
130
Very High Quality
High Quality
Medium (Provisional)
Low (Denial)
Quality Tier

SELQKII

Assessor's Guide to Using Saskatchewan's Early Learning and Child Care Quality Key Indicator Instrument (SK Quality Tool)

Purpose

This document is intended to provide additional information and clarification of terms to provide consistent interpretation and scoring of items by all assessors.

General Information

Ten Quality Key Indicators make up the Saskatchewan's Early Learning and Child Care Program Quality Key Indicator Instrument (SK Quality Tool).

These ten quality key indicators were taken from previous studies conducted over the past 40 years by Dr Richard Fiene utilizing the Regulatory Compliance Key Indicator metric (RCKIm). The tool was validated in a study in the spring of 2023 in the Province of Saskatchewan. Observer notes from this project were used to make some final modifications to the tool to make the tool more user friendly. All this work was done as a collaborative effort between the Ministry of Education staff and the National Association for Regulatory Administration (NARA) consultant pool.

The details about how to obtain the necessary data to determine if a program meets the Key Quality Indicators are delineated in the appropriate indicator in the SK Quality Tool. Additional information is provided in this document including clarification of terms to ensure accurate and consistent data collection and scoring.

Part 1 - Quality Key Indicators (QKI) 1 – 5 will be collected via record or document review, interviewing individuals, or observation. Part 2 - Quality Key Indicators (QKI) 6 – 10 will be collected via observations in the classrooms throughout the assessment.

Some indicators will be assessed once, (for the entire centre) and some will be completed multiple times (for each room/group in the centre). Please read the indicator carefully to identify whether a single or multiple assessments/observations are necessary.

When an indicator is assessed multiple times (multiple groups), the score will be averaged to obtain a centre score. Individual scores are available to support a deeper understanding of the assessment process and to support follow-up planning for the centre and individual groups/educators.

Not all indicators will be completed for all age groups. Quality Indicators six and eight are not assessed for infant or toddler groups. Quality Indicator seven is not assessed for preschool groups.

Scoring for some indicators involves calculating the average for all groups/educators. This may result in an answer that is not a whole number (includes a decimal). If this occurs, round the answer to achieve a whole number (numbers with .1 to .4 would round down and numbers with .5 to .9 would round up. For example, 2.3 would round to 2 and 3.5 would round to 4.

There is a table on page 2 of the tool to record group information. This is very important to provide accurate and consistent information. Ensure you are recording data for the correct group for each item. This applies for every indicator, even those for specific age groups e.g. if group 5 is an infant group, then on Quality indicator 7, record the data for this group under Group 5, even if this means groups 1-4 are left blank.

Lines or columns can be added or removed from data collection tables as needed.

Assessors are not required to maintain a copy of the completed report. They should delete the assessment results after confirmation of receipt by the Ministry of Education has been received.

Reporting Concerns Identified During Observation

If you observe an instance where children are in immediate danger from child abuse or neglect, you must contact the Ministry of Social Services.

If you observe health/safety concerns that are a significant concern but not immediate danger, contact ministry personnel (Early Learning and Child Care consultant and/or the Senior Consultant) the same day through a phone call or email.

Minor health/safety concerns should be noted in the comments or an attached page/document and submit as a separate document with the assessment. This information will be shared with the early learning and child care consultant to follow up on.

Definitions

Child care centre - a facility that provides child care services, but does not include family child care homes or group family child care homes.

Exemptions - Saskatchewan's Child Care Regulations require that 20% of staff must be certified as ECE III. An additional 30% must be ECE II. Centres that do not meet these requirements can apply for an exemption for a staff member who is taking classes towards achieving the certification. An exemption granted by the Ministry of Education to meet licensing requirements is not a certification level.

Infants - children aged six weeks to 18 months (children less than six weeks old may attend a teen student support centre). Ratio of one adult for every three infants is required. Maximum group size is six.

Mixed Age groups - various ages together in one group. (some centres are licensed for mix ages and all centres can do this at beginning or end of day) If there are mixed age groups present, then all relevant Quality Indicators must be assessed for the ages of the children present.

Preschooler/Preschool aged - children aged 30 months to completion of Kindergarten. Ratio of one adult for every ten children is required. Maximum group size is 20.

Room/group - many child care centres operate with one group per room and can be assessed in this way. In some cases, centres with large rooms may have multiple groups utilizing the same space. If these are independent groups then they are to be assessed separately. To determine if the groups are to be assessed separately consider if the children rarely interact/spend only a small portion of the day with each other and whether the educators have separate routines and activities for the children.

Toddler - children aged 18 to 30 months of age. Ratio of one adult for every five children is required. Maximum group size is ten.

Quality Indicator 1 Number of ECE III's (Educator Certification)

- This item is assessed for the entire centre, not by room/group.
- The centre director should have a completed the *Staff Certification Levels- SK Quality Tool* form and provide this to the assessor; or
- If the observer is an Early Learning and Child Care Consultant then the Staff Information Summary form, can be used to obtain the data for this item.
- Proof of certification levels can be requested from the centre director. A copy of the certification should be in each staff member's file. If documentation of certification is not available, then it cannot be credited for this indicator.
- Include only the staff who have a responsibility for working with the children and the programming. Staff who do not regularly work with the children are <u>not</u> included in the calculation. For example, a director who works the floor for one to two hours a day would not be considered teaching staff. They would have to be working with the children a minimum of 65 hours a month to be included in the calculation.
- Exemptions - An exemption granted by the Ministry of Education to meet licensing requirements is not a certification level. For example, an early childhood educator (ECE) with a level III exemption would not be counted as an ECE III in the indicator. There are no exceptions, even if they state they only have one class left, they have completed all the classes and just need to apply, or they have applied and haven't received it yet. Proof of application for certification is not equivalent to the actual certification. For example, a staff may have recently completed classes and provide a copy of the application for certification. This can be noted in the comments but is not to be credited as certification. Until they have the certificate from the Ministry of Education, credit cannot be given.
- No documentation other than a certificate from the Saskatchewan Ministry of Education will be accepted as proof of ECE III certification. (e.g. B.Ed or other degree/certificate - these must be assessed by the Ministry of Education to determine if the courses taken are applicable to early childhood)

QUALITY INDICATOR 2): Stimulating and Dynamic Environment

This item is assessed for all rooms.

If two groups share one room, then make note of this in the comments section and only score the room once.
If groups rotate rooms, also note this in the comments section. Attempt the score the room the group spends the majority of their time.

1. **Co-teaching -** assessor observes, discusses or documents that indicates the staff collaborate and share information about planning, observations and reflections of children's activities/behaviours, decisions to be made, and/or materials to be used. A respectful partnership is evident, even if there is a discrepancy in certification levels and responsibilities, ideas of both educators are respected, and both members contribute to the planning and implementing of activities.

Simple decisions about whether to change activities or who will change a diaper are not sufficient. Sharing space and supervising play are also not sufficient. There must be evidence of higher-level collaboration and co-teaching which is directly connected to the children's learning experiences. (e.g. sharing observation regarding a child's development, suggesting an activity/material that would extend learning/add to a project).

2. **Children as competent learners** - depending on the age of the children, there may be variation in how this is evident. One consideration is whether materials are accessible to the children to access independently or whether they need to ask for the educator to get them. Language used by the educator can be another indicator with "I knew you could figure it out" or "you are really strong to carry that bucket by yourself" supporting competence and "Let me show you the right way" or "wait for an adult to help you" not supporting competence. Equipment and materials provided are also a factor. Are there child sized items to support children to complete tasks on their own (small pitcher so they can pour their own drinks, sink at a level they can reach) or materials to support independence such as a stool to be able to reach to the sink)?

3. **Authentic and meaningful materials** - having real items rather than 'toy' ones. Examples of this include real plates, flower vase, phone, shovel, etc. rather than plastic ones, having a class made alphabet or number chart, or emotion posters featuring the children. Also having quality materials to use in learning activities such as paint, clay, and a variety of loose parts to create art rather than just crayons and markers. Meaningful materials can also include culturally relevant materials such as empty food containers from a variety of items that the children would have present in their homes.

4. **Meaningful choices-** children can make decisions and have some control over their own learning and daily experience. This can include what activities/materials they would like to explore, whether they would like to participate or observe a new activity or when they are done eating. This does not mean children make all the decisions, adults still provide guidance and boundaries to ensure safety and positive learning opportunities for all children.

5. **Children's work displayed** - children's creations/art are displayed respectfully in the learning environment. This could include frames or other ways that show the importance and value of the items. One bulletin board of items held with tacks or sticky tack is not sufficient, items should also not be tattered or ripped. Consider placement, prominence and extra attention given to the display (frames, enhancements such as branches, natural materials, artifacts, lighting etc.).

6. **Family photos** - photos of the family are displayed in the early learning environment. This should be in a location that children are able to observe during the day. If there are more children than photos, assessor may ask about this. Credit can be given but a comment can also be added that acknowledges this and whether the centre would be able to take and add a photo for the missing children. *Please note the location of the display in the comments.*

7. **Documentation** - of learning is displayed and discusses holistic development and learning. This should be recent enough to be relevant to the children who are present. This should include photos/images and/or examples of children's work accompanied with text to provide a description of the activities and learning. At least one example should be less than three months ago. Additional documentation may be displayed in other areas for additional purposes such as informing parents and visitors of development and learning as part of program information. Electronic documentation through apps (SeeSaw, HiMama etc.) can be given credit if they include specific content regarding the child's learning and development. A simple photo and description (e.g. photo will the following description - Ava being silly playing play dough this morning) does not get credit.
   If the primary method for documentation is electronic, there should be at least one current example on display for each group (can be a printed version of an electronic creation).

8. **Culture and beliefs** - the learning program includes images, artifacts, items, music, food, or printed materials that represent the cultures of the children, families and staff. If the population of the centre appears to be homogeneous, are there attempts to provide exposure/build awareness of other cultures. This includes First Nations children's literature, art etc. Consider whether there is information/materials present that provide information about who the people are/what is important to the people that spend time in this space?

9. **Books and print materials** - there is at least one area where books are accessible and available to children. They are mostly in good condition (less than 10% ripped or missing pages). There should be a variety of quality literature including both fiction and non-fiction appropriate to the ages and interests of the children. At least two other examples of printed materials should be present (menu, magazine, flyer, open/closed sign, labels etc.).

10. **Writing materials** - children have access to a variety of mark-making materials such as crayons, markers, paint, chalk, paper, whiteboards, clipboards as well as examples of text to imitate such as children's name cards or other meaningful and visible print. For infants and toddlers, credit can be given if educators provide at least one opportunity daily for children to explore these materials, which can be confirmed through observation of the activity or display(s) of art demonstrating this activity occurs.

11. **Children's interests and projects** - evidence of the children's interest and current projects can be observed in the learning environment. This can include photos, materials, books, project plan etc. This could be as simple as materials for toddlers to dump and fill, photos and building materials in response to a new building going up in the neighbourhood etc. There should be some evidence that this came from observations of children's behaviour or questions they were asking rather than teacher-directed activities/seasonal crafts that all look the same.

QUALITY INDICATOR 3): Developmentally Appropriate Curriculum Based on Assessments of Each Child

This item is to be assessed for the entire centre.

The ten records to be examined must include samples from various ages and groups in the centre. These records can be formal, such as portfolios kept for each child or a more informal, anecdotal type of record keeping. The key is that there is a record that can be looked at. It is not adequate if the teacher says they do it from memory. It needs to be written down and documented. This can include electronically as long as the key elements are present.

Emergent Curriculum is Practiced (3.1)

The assessor will ask to see what is used to guide the curriculum. There should be a written document that clearly delineates the parameters of the philosophy, activities, guidance, and resources needed for the particular curricular approach. *Play and Exploration* and the *Essential Learning Experiences* are acceptable curriculum resources.

The developmental assessment can be home-grown or a more standardized off-the shelf type of assessment (e.g. Ages and Stages Questionnaire (*ASQ) - and add this to glossary -3), the key being its ability to inform the various aspects of the curriculum. The purpose of the assessments is not to compare children but rather to compare the developmental progress of individual children as they experience the activities of the curriculum.

To get credit for this item, the child's record must include a developmental assessment or observational notes as well as notes/documentation of adaptations or responsive planning that considers the child's development and/or interests.

Children and Educators are Co-learners (3.2)

In documentation of the children's learning or project planning documents, there must be evidence that the children and educators are exploring ideas together. Assessors can ask educators about the planning process. ***Educators who select the topics/themes and learning activities for the children do not get credit for this item***. Educators who state that they use the ideas/questions from the children to inform planning must provide some evidence to support this in order to be given credit for the item.

Learning Activities are Documented and Displayed and Used to Plan Future Learning (3.3)

Documentation of the child's learning can be created electronically or in hard copy (paper). Documentation could be displayed either within the centre or through an electronic format. The documentation or an accompanying document must include reflection and planning of potential future activities to extend the learning of wither the individual child or the group. Add examples that there're is actual evidence - notes, sticky notes etc.

QUALITY INDICATOR 4): Relationships with Families

This indicator is to be assessed for the entire centre

Communications may originate from centre leadership or other single source to all families or from individual educators to families of children in their group. Assessors may interview various educators to confirm if the communication practices are completed consistently across all groups.

Communication with family members should be documented to enable early childhood educators to assess the need for follow-up communication and/or responsive program adjustments/additions.

Early childhood educators should have dedicated time when they are available to talk with family members either in person or by phone. Family members are encouraged to share their experiences and knowledge of their child as well as raise any questions or concerns.

1. Communication, education, and informational materials and opportunities for families are delivered in a way that meets their diverse needs. This information may include general information on child development, parenting support/services available in the community or invitations to meetings/activities connected to the children's learning. Meeting diverse needs of families can include having a translator for important conversations, translated materials available, hanging paper copies in the centres and sending electronic information, providing information at multiple entry points etc.
2. The child care centre communicates with families using at least two different modes (online app, emails, newsletters, posters etc.), and at least one mode promotes two-way communication. This provides options for families to use a method that they are comfortable with.
3. The program engages in ongoing two-way communication. Evidence of two-way communication must be confirmed. Communication examples must demonstrate respect for each family's strengths, choices, & goals for their children. Needs an example. May need to be translated. Response to parent not wanting child to nap

QUALITY INDICATOR 5): Families Receive Information on Their Child's Progress Regularly

This indicator is to be assessed for the entire centre.

Interviews. Assessors may interview various educators to confirm if the practices are completed consistently across all groups.

The sharing of developmental information can occur in person or in a written or electronic format. This can also include events where families and children can complete activities to learn more about child development.

The report/document with information on their child's developmental progress could also include a learning story.

#4 also states that all these interactions are done in a culturally and linguistically appropriate way representing the parents being served. This would include accommodating families who are English Language Learners (translating written documents, having a translator present if necessary). Options

should also be provided to make families comfortable (location, food/beverages, allowing additional people to be present).

PART 2 - OBSERVATIONS:
Quality Indicators 6-10 are to be observed to gather reliable and valid information.

Quality key indicators 6, 7 and 8, are taken from ECERS-3 or ITERS-3. Assessors can refer to these tools or All About the ECERS-3 or All About the ITERS-3 for further clarification if necessary.
It is also recommended that these indicators assessed/observed throughout the observation and not just during key activity times.

QUALITY INDICATOR 6): Educators Encourage Children to Communicate

This indicator is only to be assessed for preschool aged or mixed aged groups that include preschool aged children. This indicator is not assessed for infant or toddler groups.

Interactions between children and staff need to be observed in the multiple interactions in various locations for credit to be given. Things to look for would be more back and forth conversations rather than one-way conversations/instructions where educators are telling children what to do.
Are children encouraged to describe what they are doing, how they feel about what they are doing, and why they are doing particular activities? Educators should expand upon children's conversations. Children talk more when there is an interested person who listens to them.

These opportunities can occur anywhere in the classroom or outside, such as in the dramatic play area, tabletop activities or in the play yard.

Materials that encourage communication include telephones, puppets, dolls, flannel/magnetic boards, and dramatic play props such as small people and animals, with barns, or dollhouses. These create opportunities for conversation among children as they assume different roles. The staff in a high-quality early childhood classroom will use both activities and materials to encourage growth in receptive and expressive language skills.

QUALITY INDICATOR 7): Infant/Toddler Language Observation

This indicator is only to be assessed for infant, toddler or mixed aged groups that include infant and toddler aged children. This indicator is not assessed for preschool groups.

Conversations and questions should be used with all children, even young infants. Conversations using verbal and nonverbal turn-taking should be considered when scoring.

Most conversations and questions initiated by infants will be nonverbal, such as widening of baby's eyes or waving arms and legs. Observe staff response to such nonverbal communication. For infants and toddlers, the responsibility for starting most conversations and asking questions belongs to the staff. As children become more able to initiate communication, staff should modify their approach to allow children to take on a greater role in initiating conversations and asking questions.

Staff should provide answers to questions/commentary as to what the child may be thinking (based om observations on the child's behaviour) if the child cannot verbally respond. As children build an

expressive vocabulary, and are more able to respond, questions should start to include those that the child can answer.

QUALITY INDICATOR 8): Educators Use Language to Develop Reasoning Skills (Preschool)

This indicator is only to be assessed for preschool aged or mixed aged groups that include preschool aged children. This indicator is not assessed for infant or toddler groups.

Assessors will need to observe very carefully as this standard can be difficult to determine because it is tying language and cognition together. Again, this opportunity can occur in any setting in or out of the classroom because it is the basis for problem solving using language. Also look for educators redirecting children's conversations when appropriate. Staff should use language to talk about logical relationships using materials that stimulate reasoning. Using materials, staff can demonstrate concepts such as same/different, classifying, sequencing, one-to-one correspondence, spatial relationships, and cause and effect.

QUALITY INDICATOR 9): Educators Listen Attentively When Children Speak

This item is assessed for all rooms.

It is recommended that this indicator be assessed/observed throughout the observation period and not just consecutively to provide a more comprehensive view of the typical interactions in the room/group. It should be observed in two-minute blocks ten times for a total of 20 minutes.

For this item, ensure the observations are of the educators regularly assigned to the group/class (not any staff covering breaks etc.).

All educators in the room are observed (including full-time, part-time and casual staff) and their interactions observed as there can be variation in the interaction styles and practices.

Children should have the attention of the specific educator they are addressing. Educators should not be looking/walking away or unduly preoccupied with others. They should be at the child's level and making eye contact.

QUALITY INDICATOR 10): Educators Speak Warmly to Children

This item is assessed for all rooms.

Ten two-minute observations are to be completed for a total of 20 minutes.

It is recommended that this indicator be assessed/observed throughout the observation period and not just consecutively to provide a more comprehensive view of the typical interactions in the room/group rather than only during one activity.

For this item, ensure the observations are of the educators regularly assigned to the group/class (not any staff covering breaks etc.). If for some reason an educator leaves the group, the assessor may be able to

complete the observation at a later time in the day. It the educator is required to leave for an emergency etc. then this will be noted in the comments and this educator will not be included in the scoring.

All educators in the room are observed (including full-time, part-time and casual staff) and their interactions rated as there can be variation in the interactions styles and practices.

Scoring examples

1- Never/not at all - No interaction or harsh tone of voice/yell at child or
2- Somewhat /few interactions - Wandering and limited engagement or sitting with a child but ignoring or decent interactions but not on child's level
3- Quite a bit/Many instances - Fairly consistent but may have missed an initiation from a child
4- Very Much/Consistently - very responsive, smiling, maintain eye contact, warm tone of voice

SELQKII

Saskatchewan's Early Learning and Child Care Quality Key Indicator Instrument

(SK Quality Tool)

Centre Name:

City/town:

Age group Info:

# of Infant groups

# of toddler groups

# of preschool groups

Date(s) of Observation(s):

Assessor Name:

Saskatchewan's Early Learning and Child Care Program Quality Key Indicator Instrument

(SK Quality Tool)

For additional information and/or clarification of terms to support consistent interpretation and scoring please refer to the *Assessor's Guide to Using Saskatchewan's Early Learning and Child Care Quality Key Indicator Instrument.*

Some indicators are observed for the centre as a whole and some items are assessed for each room/group. Please identify the groups below. **Ensure scoring by group number is consistent through all indicators. Do this even when all groups are not being observed.**

Group	**Age Group** (Infant/Toddler/Preschool)	**Educators**	**Number of Children**
1			
2			
3			
4			
5			
6			

QUALITY INDICATOR 1): Number of ECE III Educators (Document Review)

In this case, we are interested in the number of ECEIII certified early childhood educators (ECEIII's). For this item, include only those educators who have a responsibility for working with the children and the programming.

How to Measure:
Assessors will review staff records to determine the number of staff who have these credentials in early childhood education. Record the number of ECEs with the appropriate qualifications and divide them by the total number of ECEs to come up with a percent for the centre.

Calculate this indicator for the entire centre but include only the early childhood educators (ECE) who work over 65 hours/month.
Note: An exemption, granted by the Ministry of Education to meet licensing requirements is not a certification level.

Scoring for Quality Indicator 1:

The total number of ECEIII certified early childhood educators _____

The total number of early childhood educators who work over 65 hours/month _____

Total ECEIII teaching staff divided by the total number of ECE x 100 _____ (%).

Then based on the percentage, you can find the score of 1-4 as per the chart below.

Circle the Appropriate Level	1 = 0 to 25%	2= 26 to 50%	3 = 51 to 75%	4 = 76 to 100%

Comments:

QUALITY INDICATOR 2): Stimulating and Dynamic Environment (Observation) all rooms

The criteria for measuring this are drawn from ***Play and Exploration: Early Learning Program Guide.*** The program is child centered and children are viewed as competent learners.

How to Measure:

Below is the checklist of items that should be present. This item is to be observed for each group/room. Write "Y" for Yes and "N" for No whether the item is observed and/or present in the room.

	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Co-teaching is evident.						
Children are viewed as competent learners & can access materials independently.						
Authentic and meaningful materials are used with children.						
Children are provided with meaningful choices.						
Children's work/art displayed respectfully.						
Family photos are displayed in the early learning program.						
Documentation of learning is displayed and discusses holistic development.						
Environment reflects the culture and beliefs of the children, families and staff.						
Variety of books and other print materials are available throughout the room.						
A variety of writing materials are accessible to children most of the time.						
There is evidence of the children's interests and projects in the room.						

Scoring for Quality Indicator 2:
For each group, total up the number of items where you recorded a "Y" and record in the table below.

	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Total number of Y's (by group)						
For each group, divide by 11 (number of items you observed)						
For each group, x 100 to come up with a percent						

Add the percentages of each group together. Record the total here: _____

Divide by the number of groups and record here _____ %. (This is the percentage for the entire centre).

Then based on the percentage, you can find the score of 1-4 as per the chart below.

Circle the Appropriate Level	**1 = 0 to 25%**	**2= 26 to 50%**	**3 = 51 to 75%**	**4 = 76 to 100%**

Comments: (include where the photos are located)

Group 1
Group 2
Group 3

Group 4
Group 5
Group 6

QUALITY INDICATOR 3): Developmentally Appropriate Curriculum Based on Assessments of Each Child (Document Review) entire centre

The key for this quality indicator is that the program is following an individualized prescribed planning document when it comes to curriculum. It does not mean it is a canned program, in fact, it shouldn't if it is based upon the individual needs of each child's developmental assessment.
There should also be a developmental assessment which is clearly tied to the curriculum.

Is there a developmental assessment used with children? If so, what tool is used: _____

The following key elements should be present when assessing this quality indicator.

1. The program practices emergent curriculum, allowing the interests of the children to determine the learning content. The curriculum is informed by individual developmental assessments of each child in the respective classrooms.
2. The children and educators are co-learners in the exploration of projects.
3. Learning activities of the children are documented, displayed in the learning environment, and used to plan further learning activities.

How to Measure:
Take a sample of ten individual children's records and consider the above three elements for each record. You should be asking yourself if there is a clear link between an assessment and the developmentally appropriate curriculum so that an individualized learning approach is being undertaken and each child's developmental needs are taken into consideration.

Record whether you can identify evidence of the practice occurring. All three blocks need to be examined for each child/record (1-10).

		1	2	3	4	5	6	7	8	9	10
3.1	**Emergent Curriculum**										
3.2	**Children and Educators are Co-learners**										
3.3	**Learning Activities Documented, Displayed & Used to Plan Future Learning**										

Total of All Three Key Elements
All three key elements must be present to receive credit. If all three key elements have a 'Yes' for that individual child/record, then record 'Yes' in the corresponding block below.

1	2	3	4	5	6	7	8	9	10

Scoring for Quality Indicator 3:
Count the number of positive records ('Yes' for all three elements) _____

Calculate the percentage of positive records.
Divide the number of positive records by 10 then x 100 = _____ %.

Then based on the percentage, you can find the score of 1-4 as per the chart below.

Circle the Appropriate Level	**1 = 0 to 25%**	**2= 26 to 50%**	**3 = 51 to 75%**	**4 = 76 to 100%**

Comments:

3.1
3.2
3.3

QUALITY INDICATOR 4): Relationships with Families (Document Review/Interview) entire centre

Communication and building relationships with family members enables early childhood educators to assess the need for follow-up communication, plan meaningful learning activities and/or responsive program adjustments/additions.

How to Measure:
Look for the following three examples in policies developed by the program and/or determine if they have been carried out with families. It will be necessary to interview staff to complete this indicator and some examples/documentation must be observed to confirm.

1. The program provides communication, education, and informational materials and opportunities for families that are delivered in a way that meets their diverse needs.
Y/N_____

2. The program communicates with families using different modes of communication, and at least one mode promotes two-way communication.
Y/N _____

3. The program engages in ongoing two-way communication. Communication demonstrates respect for each family's strengths, choices, & goals for their children.
Y/N ____

Scoring for Quality Indicator 4:
Record the number of Yes's (Y's): _____ (Range: 0 – 3). Divide by 3 then x 100 = _____%.
Then based on the percentage, you can find the score of 1-4 as per the chart below.

Circle the Appropriate Level	**1 = 0 to 25%**	**2= 26 to 50%**	**3 = 51 to 75%**	**4 = 76 to 100%**

Comments:

4.1
4.2
4.3

QUALITY INDICATOR 5): Families Receive Information on Their Child's Progress Regularly (Document Review) entire centre

The results and possible responses to the developmental assessment (as per quality indicator #3) should be the focus of a parent conference/discussion. Parental feedback about the assessment and how it compares to their experiences at home is an excellent comparison point. All these interactions should be done in a culturally and linguistically appropriate way representing the parents/families being served.

How to Measure:
Look in policies/documentation developed by the program to determine if and how families receive information of their child's developmental progress. Record the number of reports completed or parent conferences over the past year. It will be necessary to interview staff to complete this indicator if you cannot determine from the records that the conferences or reports were completed.

1. The program has regularly scheduled (at least twice/year) parent conferences/events in which the children's developmental progress is discussed AND provides the family with a report/document with information on their child's developmental progress.
   Y/N _____ If "Yes" then go to number 4. If "No", then go to number 2.

2. The program has regularly scheduled (at least twice/year) parent conferences/events in which the children's developmental progress is discussed, but it does not provide a report/document with information on their child's developmental progress.
   Y/N _____ If "Yes" then go to number 4. If "No", then go to number 3.

3. If the program does not have regularly scheduled (at least twice/year) parent conferences/events, does it provide the family with a report/document with information on their child's developmental progress.
   Y/N _____ Go to Number 4.

4. All these interactions are done in a culturally and linguistically appropriate way representing the parents being served.
   Y/N _____

Scoring for Quality Indicator 5:
If #1 was 'Yes', then score 3 points.
If #2 was 'Yes', then score 2 points.
If #3 was 'Yes', then score 1 point.
If #4 was 'Yes', then add 1 point to the score to obtain the total score.
If the answer to all questions is No then score 0 points.

Record the number of points: _____ (Range: 0 - 4)

Comments:

QUALITY INDICATOR 6): Educators Encourage Children to Communicate (Observation)
Preschool Group *NOTE: If there is not a preschool room/group, then skip to Quality Indicator 7.*

How to Measure:
Observe the classroom for a minimum of 15 minutes. Once completed, consider where the classroom falls based on the following:

Number 1 **Mark each item as "Y" for Yes or "N" for No**	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Staff balance listening and talking appropriately for age and abilities of children during communication activities, for example: leave time for children to respond; verbalize for child with limited communication skills.						
Staff link children's spoken communication with written language, for example: write down what children dictate & read it back to them; help them write notes to parents.						
If both items are evident, record the score of 4 in the scoring table and this quality indicator is complete. If they are not both evident, go to number 2.						

Number 2 **Mark each item as "Y" for Yes or "N" for No**	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Communication activities take place during both free play and group times, for example: child dictates story about painting; small group discusses trip to store.						
Materials that encourage children to communicate are accessible in a variety of interest centres, for example: small figures and animals in block area; puppets and flannel board pieces in book area; toys for dramatic play outdoors or indoors.						
If both items are evident, record the score of 3 in the scoring table and this quality indicator is complete. If they are not both evident, go to number 3.						

Number 3 **Mark each item as "Y" for Yes or "N" for No**	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Some activities are used by staff w/children to encourage them to communicate.						
Some materials are accessible to encourage children to communicate.						
Communication activities are generally appropriate for the children in the group.						
If all three of these items are evident, record the score of 2 in the scoring table and this quality indicator is complete. If they are not both evident, go to number 4.						

Number 4 **Mark each item as "Y" for Yes or "N" for No**	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
No activities are used by staff to encourage children to communicate, for example: not talking about drawings, dictating stories, sharing ideas at circle time, finger plays, singing songs.						
Very few materials accessible that encourage children to communicate.						
Record the score of 1 in the scoring table and this quality indicator is complete.						

Scoring for Quality Indicator 6:

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6

Add the points for each group together and record here: _____

Divide the total by the number of groups and record the number of points: _____ (Range: 0 - 4)

Comments:

Group 1
Group 2
Group 3
Group 4
Group 5
Group 6

QUALITY INDICATOR 7): Infant/Toddler Language (Observation)

Infant and/or Toddler Group NOTE: If there is not an infant/toddler group/room, then skip to Quality Indicator 8.

How to Measure:

Observe the classroom for a minimum of 15 minutes. Once completed, consider where the classroom falls based on the following:

Number 1 **Mark each item as "Y" for Yes or "N" for No**	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Staff frequently have turn taking conversations with children throughout the observations. Many appropriate questions are used throughout the observation, during both play and routines.						
Staff ask children appropriate questions, wait a reasonable time for child response, and then answer if needed, for example: "Are you hungry? . . . Yes, you are!"; "Where's the ball? . . . There it is! You found the ball".						
If all these items are evident, record the score of 4 in the scoring table and this quality indicator is complete. If they are not both evident, go to number 2.						

Number 2 **Mark each item as "Y" for Yes or "N" for No**	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Staff initiate engaging conversations with children throughout the observation, for example: show enthusiasm; use tone that attracts child's attention.						
Staff often personalize questions and/or conversations for individual children, for example: talk about children's families, preferences, interests; what they are playing with; what they did over weekend; child's mood; use child's name.						
Staff often pay attention to children's questions, verbal or nonverbal, and answer in a satisfying manner for the child.						
Staff ask questions children are interested in, for example: make the questions funny or mysterious; use interesting tone; meaningful and not difficult to answer.						

If all these items are evident, record the score of 3 in the scoring table and this quality indicator is complete. If they are not both evident, go to number 3.

Number 3 **Mark each item as "Y" for Yes or "N" for No**	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Staff sometimes initiate conversations with children, for example: babble back and forth with baby; copy baby's sounds; respond to baby's crying with verbal response; have short back and forth toddler interactions.						
Staff sometimes ask children appropriate questions and wait for the child to respond, for example: ask baby if she likes toy and pay attention as baby smiles; ask toddler what he is eating and wait for him to think of word(s).						
Staff respond neutrally or positively to children who can't answer questions. Questions asked are sometimes meaningful to children, for example: child responds with interest; does not ignore staff questions.						
If all three of these items are evident, record the score of 2 in the scoring table and this quality indicator is complete. If they are not both evident, go to number 4.						

Number 4 **Mark each item as "Y" for Yes or "N" for No**	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Staff never initiate turn-taking conversations with children, for example: rarely encourage baby to babble back; simple back and forth exchanges with verbal children never observed.						
Staff never initiate turn-taking conversations with children, for example: rarely encourage baby to babble back; simple back and forth exchanges with verbal children never observed.						
Staff questions are often not appropriate for children, for example: no questions are asked, too difficult to answer, or carry a negative message.						
Staff respond negatively when children can't answer questions, for example: "You should know this"; "You did not listen".						
Record the score of 1 in the scoring table and this quality indicator is complete.						

Scoring for Quality Indicator 7:

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6

Add the points for each group together and record here: _____

Divide the total by the number of groups and record the number of points: _____ (Range: 0 - 4)

Comments:

Group 1
Group 2
Group 3
Group 4
Group 5
Group 6

QUALITY INDICATOR 8): Educators Use Language to Develop Reasoning Skills (Observation)
Preschool Group *NOTE: If there is not a preschool room/group, then skip to Quality Indicator 9.*

This standard is tying language and cognition together and is the basis for problem solving using language.

How to Measure:
Observe the classroom for a minimum of 15 minutes. Once completed, consider where the classroom falls based on the following.

Number 1 **Mark each item as "Y" for Yes or "N" for No**	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Staff encourage children to reason throughout the day, using actual events and experiences as a basis for concept development, e.g.: children learn sequence by talking about their experiences in the daily routine or recalling the sequence of a cooking project.						
Concepts are introduced based upon children's interests or needs to solve problems, for example: talk children through balancing a tall block building, help children figure out how many spoons are needed to set a table.						
If both items are evident, record the score of 4 in the scoring table and this quality indicator is complete. If they are not both evident, go to number 2.						

Number 2 **Mark each item as "Y" for Yes or "N" for No**	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Staff talk about logical relationships while children play with materials that stimulate reasoning, for example: sequence cards, same/different games, size and shape toys, sorting games, numbers and math games.						
Children are encouraged to talk through or explain their reasoning when solving problems, for example: why they sorted objects into different groups, in what way two pictures are the same or different.						
If both items are evident, record the score of 3 in the scoring table and this quality indicator is complete. If they are not both evident, go to number 3.						

Number 3 **Mark each item as "Y" for Yes or "N" for No**	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Staff sometimes talk about logical relationships or concepts, e.g.: explain that outside time comes after snacks, point out differences in sizes of blocks children use.						
Some concepts are introduced appropriately for ages and abilities of children in group, using words and experiences, for example: guide children with questions and words to sort big and little blocks or to figure out why ice melts.						
If both items are evident, record the score of 2 in the scoring table and this quality indicator is complete. If they are not both evident, go to number 4.						

Number 4 **Mark each item as "Y" for Yes or "N" for No**	Group 1	Group 2	Group 3	Group 4	Group 5	Group 6
Staff do not talk with children about logical relationships, for example: ignore children's questions and curiosity about why things happen, do not call attention to sequence of daily events, differences and similarity in number, size, shape, cause and effect.						
Concepts are introduced inappropriately, for example: concepts too difficult for age and abilities of children, inappropriate teaching methods used such as worksheets without any concrete experiences; teacher gives answers w/o helping children to figure things out.						
Record the score of 1 in the scoring table and this quality indicator is complete.						

Scoring for Quality Indicator 8:

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6

Add the points for each group together and record here: _____

Divide the total by the number of groups and record the number of points: _____ (Range: 0 - 4)

QUALITY INDICATOR 9): Educators Listen Attentively When Children Speak (Observation)

This quality indicator focuses on the early childhood educator(s) looking directly at the children, nodding to indicate interest, rephrasing comments, and engaging in meaningful conversations. The intent is to observe all children and educators in the room.

How to Measure:
Conduct two-minute timed observations of educators in the classroom, recording each time you observe. Record 10 different observation periods. It is recommended that these are not consecutive.

Please use the following Likert Scale of 1-4 to assess your recordings:
1 = Never/Not at All;
2 = Somewhat/Few Instances;
3 = Quite a Bit/Many Instances;
4 = Very Much/Consistently):
Record in the table below for each group.

Group 1 Observations:											
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Educator 1											
Educator 2											
Educator 3											
Add the total for each educator together and divide by the number of educators to get an average score for this group. Record this number in the box to the right.											

Group 2 Observations:											
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Educator 1											
Educator 2											
Educator 3											
Add the total for each educator together and divide by the number of educators to get an average score for this group. Record this number in the box to the right.											

Group 3 Observations:											
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Educator 1											
Educator 2											
Educator 3											
Add the total for each educator together and divide by the number of educators to get an average score for this group. Record this number in the box to the right.											

Group 4 Observations:											
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Educator 1											
Educator 2											
Educator 3											
Add the total for each educator together and divide by the number of educators to get an average score for this group. Record this number in the box to the right.											

Group 5 Observations:											
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Educator 1											
Educator 2											
Educator 3											
Add the total for each educator together and divide by the number of educators to get an average score for this group. Record this number in the box to the right.											

Group 6 Observations:											
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Educator 1											
Educator 2											
Educator 3											
Add the total for each educator together and divide by the number of educators to get an average score for this group. Record this number in the box to the right.											

Scoring for Quality Indicator 9:
Once all the observations are made, add up the results in the totals column for each educator.

Add the total for each educator in the group together and divide by the number of educators in the group to get an average score for the group. Record those scores here:

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6

Add the totals for each group together. Record the number here: _____

Divide by the number of groups. Record the number here: _____

(Divide this result by 10) = _____ (1-4)

Comments:

QUALITY INDICATOR 10): Educators Speak Warmly to Children (Observation)

This quality indicator focuses on the early childhood educator(s) using in a caring voice and body language with every child. Educators do not use harsh language or commands in speaking to children. Educators are on the child's level, making eye contact.

How to Measure:
Complete 2-minute observations of the educator's warmth during interactions with the children as described above. Rate using the Likert Scale below and record in the table for the appropriate educator and group. Record ten different observation periods. It is recommended that these are not consecutive but spread over the observation period.

- 1 = Never/Not at All
- 2 = Somewhat/Few Instances
- 3 = Quite a Bit/Many Instances
- 4 = Very Much/Consistently

Group 1 Observations:											
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Educator 1											
Educator 2											
Educator 3											
Add the total for each educator together and divide by the number of educators to get an average score for this group. Record this number in the box to the right.											

Group 2 Observations:											
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Educator 1											
Educator 2											
Educator 3											
Add the total for each educator together and divide by the number of educators to get an average score for this group. Record this number in the box to the right.											

Group 3 Observations:											
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Educator 1											
Educator 2											
Educator 3											
Add the total for each educator together and divide by the number of educators to get an average score for this group. Record this number in the box to the right.											

Group 4 Observations:											
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Educator 1											
Educator 2											
Educator 3											
Add the total for each educator together and divide by the number of educators to get an average score for this group. Record this number in the box to the right.											

Group 5 Observations:											
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Educator 1											
Educator 2											
Educator 3											
Add the total for each educator together and divide by the number of educators to get an average score for this group. Record this number in the box to the right.											

Group 6 Observations:											
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
Educator 1											
Educator 2											
Educator 3											

Add the total for each educator together and divide by the number of educators to get an average score for this group. Record this number in the box to the right.	

Scoring for Quality Indicator 10:
Once all the observations are made, add up the results in the totals column for each educator.

Add the total for each educator in the group together and divide by the number of educators in the group to get an average score for the group. Record those scores here:

Group 1	Group 2	Group 3	Group 4	Group 5	Group 6

Add the totals for each group together. Record the number here: _____

Divide by the number of groups. Record the number here: _____

(Divide this result by 10) = _____ (1-4)

Comments:

Group 1
Group 2
Group 3
Group 4
Group 5
Group 6

Saskatchewan's Early Learning and Child Care Quality Key Indicator Instrument (SK Quality Tool) Scoring Summary

Child Care Centre Name:

Program Quality Indicator	Score (1-4)
1	
2	
3	
4	
5	
6 (Preschool groups only**)**	
7 (Infant/toddler groups only)	
8 (Preschool groups only)	
9	
10	
Total Score	
Program Quality Level	

Interpreting the Score = Program Quality Level

Determine the appropriate Column for the child care entre based on the age groups of children in the centre. This will also correspond to the number of program quality indicators that were assessed.
Find the assessed score under the appropriate column to determine the quality level.

Quality Level	Infant/Toddler (No Preschool groups) 8 indicators assessed	Preschool (No Infant/Toddler Groups) 9 indicators assessed	Infant/Toddler and Preschool Groups 10 indicators assessed
High	Score of 28 or higher	Score of 32 or higher	Score of 36 or higher
Medium-High	Score of 22-27	Score of 26-31	Score of 30-35
Medium-Low	Sore of 12-21	Score of 16-25	Score of 20-29
Low	Score of 11 or less	Score of 15 or less	Score of 19 or less

Baseline Quality Assessment Results

Introduction

After a child care centre has undergone an assessment with the SK Quality Tool, it is important to understand what to do with the results. This document provides information to understand the impact of the assessment, share the assessment results with relevant parties, identify areas of success, and set goals for improvement.

Impact

Completing a quality assessment and using the results to identify follow-up actions can have a significant and positive impact on the children who attend the program.

One of the key benefits of assessing a child care centre's program is that it creates awareness of current strengths as well as ways to improve the program. This intentional program improvement can provide an even better experience for children and help them achieve their full potential. The assessment includes examining the qualifications and experience of the staff, the curriculum and learning materials provided, and the overall quality of care. A thorough assessment can identify areas where improvements are needed and by addressing these areas, the centre ensures that children receive high-quality care and education.

Assessing the early learning program can also have a positive impact on the staff. It can help to identify areas where they might need additional training or support and enable them to reflect on their practices and improve their skills. This can lead to greater job satisfaction, improved staff retention, and a more positive work culture.

Another benefit of assessment is that it assists in creating a culture of continuous improvement and learning within the centre. By regularly evaluating and reflecting on their practices, staff can identify areas for growth and development and work together to make meaningful changes that benefit children. This can lead to a more dynamic and vibrant program that is responsive to the needs of children and families.

Overall, assessing the early learning program of a child care centre is a crucial process that can have a significant impact on the quality of care and education that children receive. By promoting a culture of continuous improvement, centers can create an environment that supports the overall development, and wellbeing of children, and prepares them for success in school and life.

Sharing Assessment Results

Once an assessment has been conducted, it is important to communicate the results to all relevant parties, such as, board of directors, staff members and possibly parents/guardians. This will involve understanding how to communicate the assessment findings in a clear and concise manner, highlighting the areas of strength, and outlining the areas that require improvement.

The first step will be to share the results of the assessment with the board of directors. Having a dedicated time to sit with the board of directors and discuss the results of the assessment conducted in the child care facility is an important step in ensuring that the facility is providing quality care to the children in its care. This can involve explaining

the assessment process, and how the results show successes and areas for improvements for the centre. It is important that the board be involved in this process as they are the licensee of the centre.

Sharing the results of an assessment can be a positive and productive experience. It provides an opportunity for the facility to showcase its commitment to providing quality care to the children in its care and to demonstrate its ongoing efforts to improve services. Presenting the results in a clear and concise manner can help the board of directors understand the indicators of quality and their role in supporting quality improvement. This can lead to constructive discussions and collaboration between the board and the facility staff.

Furthermore, this dedicated time can be used to discuss strategies and interventions for addressing any areas of concern identified by the assessment. This may involve discussing potential resources and support services that can be provided to the staff, the roles and responsibilities to complete the identified actions, as well as outlining a plan for monitoring progress and evaluating the effectiveness of the actions put in place.

Celebrate Successes

Presenting the results can also be an opportunity for the facility to celebrate successes and achievements. By highlighting the positive outcomes of the assessment, the facility can demonstrate its dedication to the children's well-being and development. This is an important step as it helps to motivate staff, build morale, and reinforce the positive aspects of the program. Celebrating successes can be achieved through various means, such as holding a staff meeting or sending out a newsletter.

Identify Improvements

The assessment process is designed to support the centre by also identifying areas of improvement that will help you enhance services. Working together as a team to brainstorm and problem solve together will enable the centre to identify innovative and practical actions to build quality in the early learning program.

The assessment will also help you to benchmark the centre's performance against industry standards and best practices. This will give you a better understanding of where the centre stands and what you need to do to improve its performance.

Making Short-Term and Long-Term Goals

The assessment can help the centre to set short-term and long-term goals.

Short-term goals may include improving communication between staff and parents or changing practices with regard to interactions with children. These goals are designed to provide more immediate benefits to the centre and its children and help improve the quality of care provided.

Long-term goals, on the other hand, may include increasing staff certification levels, training staff to use a developmental screening/assessment tool and share results with families, or working with families to build awareness of cultures and how to incorporate cultural materials into the centres in meaningful ways. These goals require careful planning and execution and may take several years to achieve. However, they will improve the quality of care provided over the long term.

It's essential to regularly review and update the child care centre's goals to ensure that they remain relevant and achievable. By setting clear goals and working towards them, you can help the centre grow and provide the best possible care to children.

Process

1. To support sharing and understanding of assessment results and development of an action plan in response to the results, share a copy of this handout and the Baseline Quality Assessment Information Sheet with all members of the board and staff.

2. Schedule meetings dedicated to reviewing the results and discussing responses and actions. Highlight areas where the centre did well and discuss what may have contributed to this success. Highlight areas where the centre may have scored lower and discuss barriers and suggestions.

3. Identify 1-3 priority areas of improvement and actions to support growth in this area.
   You may wish to use the following questions to help guide the discussion:
   - What are the most important areas to improve, and why? (establish priorities)
   - What are some specific goals you have for the centre in the next few months?
   - What are some specific goals you have for the centre in the next year or two?
   - How will you measure progress towards achieving the goals?
   - What resources do we need to achieve our goals? (refer to the ministry resource list to support)
   - What external factors may affect the ability to achieve the goals? How can these risks be mitigated?
   - How will the goals be communicated to staff, parents, and stakeholders?
   - How will achieving these goals benefit the children, their families, and the centre as a whole?
   - How will you communicate progress to staff, parents, and stakeholders?

Conclusion

The SK Quality Tool is an early learning program assessment tool, specifically created for the Saskatchewan context.

Centres can use results to identify areas for improvement and create a plan focused on improving the early learning program. This can create a more positive and supportive work environment where everyone can thrive.

Research shows that quality education and care early in life lead to better health, education, and employment outcomes later in life.

Interpreting SK Quality Tool Scores

The Saskatchewan's Early Learning and Child Care Quality Key Indicator Instrument (SK Quality Tool) has 10 quality indicators. Research has identified these indicators as an effective way to measure current program quality levels. The indicators are:

1. Staff education levels
2. Environment (as per Play and Exploration: Early Learning Program Guide)
3. Developmentally Appropriate Curriculum Based on Assessments of Each Child
4. Relationships with Families
5. Regular Progress Updates to Families about their Children
6. Encouraging Children to Communicate (Preschool Groups)
7. Language Development for Infants and Toddlers (Infant and Toddler Groups)
8. Use of Language to Develop Reasoning Skills (Preschool Groups)
9. Active Listening to Children by Educators
10. Warm Communication Style of Educators towards Children

Each indicator receives a score between 1 and 4 with 1 being the lowest and 4 being the highest possible score.

The SK Quality Tool provides a total centre score. Some of the items will have multiple scores recorded as each group at the centre will be observed and receive their own score. These scores are then averaged to determine the centre score for the indicator.

Individual group scores can be examined by leadership and staff to identify individual learning goals where appropriate.

Depending on the ages of the children, the number of indicators that are scored may vary. This will impact the possible total score that a centre could receive. For example:

- Indicator 7 is specific to infants and toddlers. If the centre does not have children in the infant and toddler categories, this indicator will not be scored. (Max score is 36 with 9 indicators scored)
- Indicators 6 and 8 are specific to preschool aged children. If the centre does not have children in the preschool age category, then these indicators will not be scored. (Max score is 32 with 8 indicators scored)
- Centres that have both toddler and preschool aged children will have all indicators scored. (Max score is 40)

The total score (with acknowledgement of the number of indicators assessed) determines the Program Quality Level as identified in the table below:

Quality Level	**Infant/Toddler (No Preschool)** 8 indicators assessed	**Preschool (No Infant/Toddler)** 9 indicators assessed	**Infant/Toddler and Preschool** 10 indicators assessed
High	Score of 28 or higher	Score of 32 or higher	Score of 36 or higher
Medium-High	Score of 22-27	Score of 26-31	Score of 30-35
Medium-Low	Sore of 12-21	Score of 16-25	Score of 20-29
Low	Score of 11 or less	Score of 15 or less	Score of 19 or less

Every centre's journey is unique. There are different contexts and factors that influence the progress or barriers that are faced by the program and/or the staff. Quality levels are defined as follows:

Low - Starting the Quality Journey

- Centres at this level need to focus on the basics and build a strong foundation. They may have experienced a lot of change/disruption or other significant barriers. It is important to create a clear and simple plan to improve quality- set achievable goals, closely monitor progress and not avoid overwhelming with too much too fast. It is important to achieve a safe, secure and predictable space for children, staff and families.

Medium-Low - Exploring Quality

- Centres at this level have built a foundation of quality. There may however be some gaps or areas to reinforce in the foundation as they continue to build higher level practices including reflection and intention into all aspects of the child care program and decision making. Programs at this level are often trying out some quality practices but may not be implementing them consistently.

Medium-High - Realizing Quality

- Centres at this level have built a strong program and may only need to make some slight adjustments in their program, reflecting deeply to examine the intention behind their practices and how to elevate them to next level to maximize the learning potential for children and staff.

High - Achieving Quality

- Centres at this level have achieved high quality. The centre has qualified staff who work as a team to provide quality learning experiences, prioritize relationships, and inspire curiosity and co-learning in the program. Educators consider themselves to be life-long learners. They can clearly articulate what they do in their work with children as well as *why* they do it and what they are wondering, considering, and observing to support where the learning may go next.

SK Quality Assessment – Action Plan

The SK Quality Tool examines ten indicators that research has identified as signs that children are receiving high-quality care and education in their early years. These indicators are:

1. Staff education levels
2. Environment (as per *Play and Exploration: Early Learning Program Guide*)
3. Developmentally Appropriate Curriculum Based on Assessments of Each Child
4. Relationships with Families
5. Regular Progress Updates to Families about their Children
6. Encouraging Children to Communicate (Preschool Groups)
7. Language Development for Infants and Toddlers (Infant and Toddler Groups)
8. Use of Language to Develop Reasoning Skills (Preschool Groups)
9. Active Listening to Children by Educators
10. Warm Communication Style of Educators towards Children

Prior to developing an action plan in response to the SK Quality Assessment completed at the centre, discussions should have occurred with educators, centre leadership and the board of directors. Those discussions will inform planning in terms of priorities and areas of interest to explore and identifying goals and actions to make positive changes (see Baseline Quality Assessment Results handout).

One to three priorities should be identified to allow for focused work to occur and to ensure the plan is manageable. The plans should include both short term and long-term actions (three-year plan) to show development and growth as well as sustained focus over time to ensure the area of the key indicator becomes firmly embedded into the regular practices at the centre.

Please submit completed plans to eceed@gov.sk.ca with a cc: to the Early Learning and Child Care (ELCC) Consultant assigned to the centre.

ELCC Consultants are a resource and support and will have regular discussion regarding Action Plans during unscheduled drop-in visits, when in attendance at board meetings and as part of the annual review of the child care centre license.

There are many resources to support professional learning and development related to the indicators of quality. A list of resources, organized by indicator, can be accessed here. This list will be updated as new opportunities become available.

SK Quality Assessment – Action Plan

Priority 1- Quality Indicator identified for improvement	**Why is this important to us?**

Preparing
Do we currently have sufficient data/information and knowledge to make improvements in this area?
Do we need to learn more to understand more deeply and develop an effective response?
Do we need to complete additional assessments (e.g. ECERS/ITERS) or observations (e.g. resource sheets E & F from *Leading for Change*)?
What professional learning opportunities and resources are available? Please refer to the Resources to Support Action Planning in Response to SK Quality Tool Assessment
Are there partners and or experts that we could connect with to learn more?

Planning - consider actions for up to three years to build and reinforce skills and practices

Actions to support priority 1	**Dates - anticipated start/completion**	**Roles - who is involved and how?**

SK Quality Assessment – Action Plan

Priority 2- Quality Indicator identified for improvement	**Why is this important to us?**

Preparing
Do we currently have sufficient data/information and knowledge to make improvements in this area?
Do we need to learn more to understand more deeply and develop an effective response?
Do we need to complete additional assessments or observations?
What professional learning opportunities and resources are available? Please refer to the Resources to Support Action Planning in Response to SK Quality Tool Assessment
Are there partners and or experts that we could connect with to learn more?

Planning - consider actions for up to three years to build and reinforce skills and practices

Actions to support priority 2	**Dates - anticipated start/completion**	**Roles - who is involved and how?**

SK Quality Assessment – Action Plan

Priority 3- Quality Indicator identified for improvement	**Why is this important to us?**

Preparing
Do we currently have sufficient data/information and knowledge to make improvements in this area?
Do we need to learn more to understand more deeply and develop an effective response?
Do we need to complete additional assessments or observations?
What professional learning opportunities and resources are available? Please refer to the Resources to Support Action Planning in Response to SK Quality Tool Assessment
Are there partners and or experts that we could connect with to learn more?

Planning - consider actions for up to three years to build and reinforce skills and practices

Actions to support priority 3	**Dates - anticipated start/completion**	**Roles - who is involved and how?**

SK Quality Assessment – Action Plan

Monitoring Progress and Responding How will you measure progress? Consider options to assess growth in the area/what does success look like? Has 'Quality Updates' been added as an agenda item for all Board/PAC meetings/staff meetings/AGM? Are there other partners/interested parties who should/could be included? Do additional actions need to be added/modified based on progress to date?

Section 2: Contact Hour (CH) Metric

One starts the Contact Hour (CH) metric methodology by asking the following six questions (The six questions should be asked of each grouping that is defined by a classroom or a well-defined group within each classroom tied to a specific adult-child ratio.):

1.When does your first teaching staff arrive or when does your facility open (TO1)?
2.When does your last teaching staff leave or when does your facility close (TO2)?
3.Number of teaching/caregiving staff (TA)?
4.Number of children on your maximum enrollment day (NC)?
5.When does your last child arrive (TH1)?
6.When does your first child leave (TH2)?

After getting the answers to these questions, the following formulae can be used to determine contact hours (CH) based upon the relationship between when the children arrive and leave (TH) and how long the facility is open (TO):

$$CH = ((NC\ (TO + TH)) / 2) / TA;$$

$$CH = (NC \times TO) / TA;$$

$$CH = ((NC \times TO) / 2) / TA;$$

$$CH = (NC^2) / TA$$

Where: CH = Contact Hours; NC = Number of Children; TO = Total number of hours the facility is open (TO2 - TO1); TA = Total number of teaching staff, and TH = Total number of hours at full enrollment (TH2 - TH1).

By knowing the number of contact hours (CH) it will be possible to rank order the exposure time of adults with children. Theoretically, this metric could then be used to determine that the greater contact hours is correlated with the increased non-regulatory compliance with adult-child ratios as determined in the below table (Table 1).

Table 1: Contact Hour (CH) Conversion Table (RS Model(1.0)) (Fiene, 2020©)

Taking into Account Exposure Time and Density

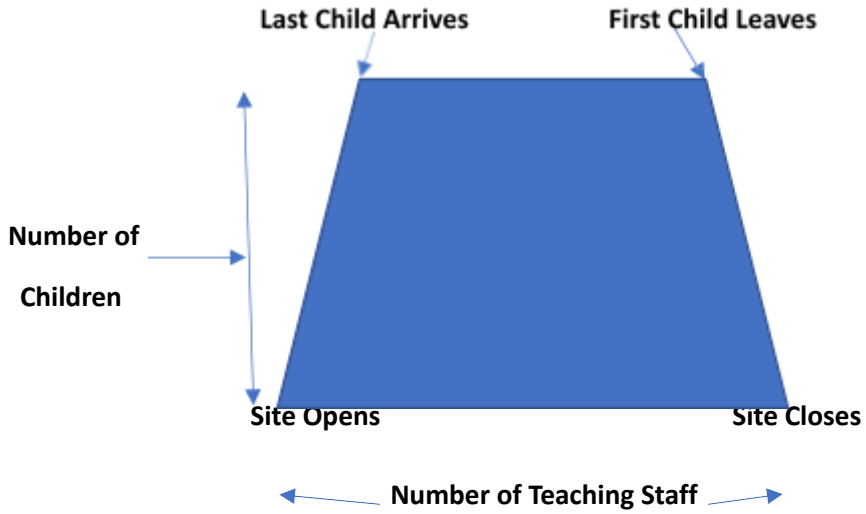
Group Size, Staff Child Ratio, Number of Children and Staff

<---------- Adult-Child Ratios (Relatively Weighted Contact Hours)---------->

NC	CH	1:1	2:1	3:1	4:1	5:1	6:1	7:1	8:1	9:1	10:1	11:1	12:1	13:1	14:1	15:1
1	8	**8**	8	8	8	8	8	8	8	8	8	8	8	8	8	8
2	16	**8**	**16**	16	16	16	16	16	16	16	16	16	16	16	16	16
3	24	**8**	12	**24**	24	24	24	24	24	24	24	24	24	24	24	24
4	32	**8**	**16**	16	**32**	32	32	32	32	32	32	32	32	32	32	32
5	40	**8**	13	20	20	**40**	40	40	40	40	40	40	40	40	40	40
6	48	**8**	**16**	**24**	24	24	**48**	48	48	48	48	48	48	48	48	48
7	56	**8**	14	19	28	28	28	**56**	56	56	56	56	56	56	56	56
8	64	**8**	**16**	21	**32**	32	32	32	**64**	64	64	64	64	64	64	64
9	72	**8**	14	**24**	24	36	36	36	36	**72**	72	72	72	72	72	72
10	80	**8**	**16**	20	27	**40**	40	40	40	40	**80**	80	80	80	80	80
11	88	**8**	15	22	29	29	44	44	44	44	44	**88**	88	88	88	88
12	96	**8**	**16**	**24**	**32**	32	**48**	48	48	48	48	48	**96**	96	96	96
13	104	**8**	15	21	26	35	35	52	52	52	52	52	52	**104**	104	104
14	112	**8**	**16**	22	28	37	37	**56**	56	56	56	56	56	56	**112**	112
15	120	**8**	15	**24**	30	**40**	40	40	60	60	60	60	60	60	60	**120**
16	128	**8**	**16**	21	**32**	32	43	43	**64**	64	64	64	64	64	64	64
17	136	**8**	15	23	27	34	45	45	45	68	68	68	68	68	68	68
18	144	**8**	**16**	**24**	29	36	**48**	48	48	**72**	72	72	72	72	72	72
19	152	**8**	15	22	30	38	38	51	51	51	76	76	76	76	76	76
20	160	**8**	**16**	23	**32**	**40**	40	53	53	53	**80**	80	80	80	80	80
21	168	**8**	15	**24**	28	34	42	**56**	56	56	56	84	84	84	84	84
22	176	**8**	**16**	22	29	35	44	44	59	59	59	**88**	88	88	88	88
23	184	**8**	15	23	31	37	46	46	61	61	61	61	92	92	92	92
24	192	**8**	**16**	**24**	**32**	38	**48**	48	**64**	64	64	64	**96**	96	96	96
25	200	**8**	15	22	29	**40**	40	50	50	67	67	67	67	100	100	100
26	208	**8**	**16**	23	30	35	42	52	52	69	69	69	69	**104**	104	104
27	216	**8**	15	**24**	31	36	43	54	54	**72**	72	72	72	72	108	108
28	224	**8**	**16**	22	**32**	37	45	**56**	56	56	75	75	75	75	**112**	112
29	232	**8**	15	23	29	39	46	46	58	58	77	77	77	77	77	116
30	240	**8**	**16**	**24**	30	**40**	**48**	48	60	60	80	80	80	80	80	**120**

This table is based upon the assumptions that the child care is 8 hours in length (TO) and that the full enrollment is present for the full 8 hours (TH). This is unlikely to ever occur but it gives us a reference point to measure adult child contact hours in the most efficient manner. Based upon the relationship between TO and TH based upon the algorithms, select from one of the formulae from the previous page (formulae 1 - 4) to determine how well the actual Relatively Weighted Contact Hours (RWCH) match with this table. If the RWCH exceed the respective RWCH in this table, then the facility would be over ratio on ACR standards, in other words, they would be overpopulated.

Figure 1: Contact Hour Diagram Paradigm and Schematic



The above diagram (Figure 1) depicts how the number of staff and children help to construct the contact hour formula. Depending on when the children arrive and leave could change the shape from a trapezoid to a rectangle or square or triangle. Please see the following potential density distributions which could impact these changes in the above contact hour diagram.

Potential Density Distributions
Taking into Account Number of Children, Staff, and Exposure Time

Here are some basic key relationships or elements related to the Contact Hour (CH) methodology.

- RWCH = ACR
- CH = GS = NC
- NC and CH are highly correlated
- ACR and GS are static, not dynamic
- CH makes them dynamic by making them 2-D by adding in Time (T)
- ΣACR = GS
- GS = total number of children NC
- ACR = children / adult

ACR = Adult Child Ratio, GS = Group Size, RWCH = Relatively Weighted Contact Hours, NC = Number of Children.

Possible Density Displays of Contact Hours (Horizontal Axis = Time (T); Vertical Axis = NC):

This density distribution should result in the lowest CH but probably not very likely to occur. Essentially what would happen is that full enrollment would be a single point which means that the last child arrives when the first child is leaving. Very unlikely but possible.

This density distribution is probably the most likely scenario when it comes to CH in which the children gradually, albeit rather steeply, arrive at the facility and also leave the facility gradually. They don't all show up at the same time nor leave at the same time. However, the arriving and leaving will be a rather close time frame.

This scenario is unlikely but is used as the reference point for CH because it provides the most efficient model. This is where all the children arrive and leave at the same time. Very unlikely, but I guess it could happen. The important element here is its efficiency in that all contact hours are covered, so although a lesser amount of CH is not as efficient it does demonstrate compliance with ACR and GS which is one of the purposes of CH. As the bottom two distributions will demonstrate, CHs above this level would either depict a program that is open for an extended time or where there are too many children present and the facility is out of compliance with GS and/or ACR.

This distribution would indicate that the facility is open for an extended time and exceeds the number of total CH as depicted in the reference square standard. Although not out of compliance with GS or ACR, this could become a determining factor when looking at the potential overall exposure of adults and children when we are concerned about the spread of an infectious diseases, such as what happened with COVID19. Are facilities that are high on a CH measurement more prone to the spread of infectious diseases?

This depiction clearly indicates a very high CH and non-compliance with ACR and GS. This is the reason for designing the CH methodology which was to determine these levels of regulatory compliance as its focus.

Revised April 2015

A Parent's Guide *to Choosing Safe and Healthy Child Care*













A Parent's Guide to
Choosing Safe and Healthy Child Care

More and more, research tells us that our children's healthy development depends on safe and positive experiences during the first few years of life. If you are a parent/guardian who works during these early years, choosing good child care is one of the most important decisions you will ever make for your child.

To help you make the right choice for your child, researchers have identified 13 guidelines to think about when choosing a child care program.

You might want to visit several different child care programs, either centers or family child care homes, before you decide which one is best for your family. Call each child care program and schedule an appointment for your visit. Once you are there, stay for at least an hour to watch activities, check the surroundings, and ask questions. This form provides a place for you to note which guidelines are met; the checklist below provides a place where you can make notes on up to 3 different child care programs. Research shows that if a program follows guidelines, it is more likely to be a safe and healthy place for your child.

Considering these guidelines can help you find a place where you can feel comfortable leaving your child.

Child Care ✓checklist

Supervision

- ✔ Are children supervised at all times, even when they are sleeping?
- ✔ How do the caregivers/teachers discipline children?

Hint: Discipline should be positive, clear, consistent, and fair.

Handwashing and Diapering

- ✔ Do all caregivers/teachers and children wash their hands often, especially before eating and after using the bathroom or changing diapers?
- ✔ Is the place where diapers are changed clean?
- ✔ Do caregivers/teachers always keep a hand on the child while diapering?
- ✔ Do caregivers/teachers remove the soiled diaper without dirtying any surface not already in contact with stool or urine?
- ✔ Do caregivers/teachers clean and disinfect the surface after finishing the changing process?

Hint: Hands should be scrubbed with soap and water for at least 20 seconds and then rinsed and dried. The water faucet should be turned off with a paper towel.

Director Qualifications

- ✔ Does the director of a child care center have a bachelor's degree in a child-related field?
- ✔ Has the director worked in child care for at least 3 years?
- ✔ Does the director understand what children need to grow and learn?

Child Care ✓checklist

Lead Teacher Qualifications

- ✔ Does the lead teacher in a child care center have a bachelor's degree in a child-related field?
- ✔ Has the teacher worked in child care for at least 1 year?
- ✔ Does the teacher give children lessons and toys that are right for their ages?

Child:Staff Ratio and Group Size

- ✔ How many children are being cared for in the child care program?
- ✔ How many caregivers/teachers are there?

Hint: Your child will get more attention if each caregiver/teacher has fewer children to take care of.

Immunizations

- ✔ Is your child up-to-date on all of the required immunizations?
- ✔ Does the child care program have records proving that the other children in care are up-to-date on all their required immunizations?
- ✔ Are the caregivers/teachers up-to-date on all of the recommended immunizations?

Toxic Substances

- ✔ Are toxic substances like cleaning supplies and pest killers kept away from children?
- ✔ Has the building been checked for dangerous substances like radon, lead, and asbestos?
- ✔ Is poison control information posted?

Emergency Plan

- ✔ Does the child care program have an emergency plan if a child is injured, sick, or lost?
- ✔ Does the child care program have first aid kits?
- ✔ Does the child care program have information about who to contact in an emergency?

Disaster Drills

- ✔ Does the child care program have a plan in case of a disaster like a fire, tornado, flood, blizzard, earthquake or acts of violence?
- ✔ Does the child care program do practice drills once every month?

Child Abuse

- ✔ Can caregivers/teachers be seen by others at all times, so a child is never alone with one caregiver/teacher?
- ✔ Have all caregivers/teachers gone through a background check?
- ✔ Have the caregivers/teachers been trained how to prevent child abuse, how to recognize signs of child abuse, and how to report suspected child abuse?

Child Care ✓checklist

Medications

- ✔ Does the child care program keep medication out of reach from children?
- ✔ Are the caregivers/teachers trained and the medications labeled to make sure the right child gets the right amount of the right medication at the right time?

Staff Training/First Aid

- ✔ Have caregivers/teachers been trained how to keep children healthy and safe from injury and illness?
- ✔ Do they know how to do first aid and CPR?
- ✔ Have they been trained to understand and meet the needs of children of different ages?
- ✔ Are all child care staff, volunteers, and substitutes trained on and implementing infant back sleeping and safe sleep policies to reduce the risk of SIDS (Sudden Infant Death Syndrome, crib death)?

Hint: When infants are sleeping, are they on their backs with no pillows, quilts, stuffed toys, or other bedding in the crib with them?

Playgrounds

- ✔ Is the playground inspected for safety often?
- ✔ Is the playground surrounded by a fence?
- ✔ If there is a sandbox, is it clean?
- ✔ Is the playground equipment safe, with no sharp edges, and kept in good shape?
- ✔ Are the soil and playground surfaces checked often for dangerous substances and hazards?
- ✔ Is equipment the right size and type for the age of children who use it?

For Dr. Richard Fiene's research paper, *13 Indicators of Quality Child Care: Research Update,* go to: http://aspe.hhs.gov/hsp/ccquality-ind02/.

For more information on choosing a safe and healthy child care setting, contact your local child care resource and referral agency by checking Child Care Aware, a national consumer education parent hotline and web delivery system at: http://www.childcareaware.org or calling 1-800-424-2246,

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Revised April 2015

Caring for Our Children Basics Health and Safety Standards Alignment Tool for Child Care Centers and Family Child Care Homes

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Introduction

Caring for Our Children Basics (CFOCB)[1] represents the **minimum** health and safety standards experts believe should be in place where children are cared for outside their own homes, whether in a home-based program or center-based facility. It does not, however, represent all standards that should be present to achieve the highest quality of care and early learning. For example, the caregiver training requirements outlined in these standards are designed only to prevent harm to children, not to ensure children's optimal development and learning.

Although use of *Caring for Our Children Basics* is **voluntary**, the Administration for Children and Families (ACF) hopes *Caring for Our Children Basics* will be a helpful resource for States and other entities as they work to improve health and safety standards in both licensing and quality rating improvement systems (QRIS). This tool provides a simple format for States and Territories to compare their current early childhood program requirements and standards against the recommended health and safety standards in CFOCB. It may also be used as a reference by the following:

- Professional development program staff when reviewing training content
- Licensing staff and policy developers when drafting new standards or best practice guidelines and training new staff
- Quality rating and improvement system staff when developing and evaluating quality standards
- Training and technical assistance professionals in their work with child care providers
- Advocates and advisory councils as a blueprint for long-term planning

Instructions

1. Compare state licensing or QRIS standards to *Caring for Our Children Basics* (CFOCB). State licensing or QRIS standards can be copied into the standard section. The notes section can be used to document gaps in state standards or ways state standards exceed CFOCB standards.
2. Indicate whether the state standards reflect full, partial, or no alignment with each CFOCB standard.

   Full alignment means the two standards **align with one another on every element, but may not match word for word**. For example, CFOCB 1.4.3.1, First Aid and CPR Training for Staff, reads as follows: "All staff members involved in providing direct care to children should have up-to-date documentation of satisfactory completion of training in pediatric first aid and current certification in pediatric CPR. Records of successful completion of training in pediatric first aid and CPR should be maintained in the personnel files of the facility."

[1] Caring for Our Children Basics (CFOCB) is the result of work from both Federal and non-Federal experts. The Office of Child Care, Office of Head Start, Office of the Deputy Assistant Secretary for Early Childhood, and the Maternal and Child Health Bureau were instrumental in this effort. CFOCB is available at http://www.acf.hhs.gov/programs/ecd/caring-for-our-children-basics.

CFOCB is based on Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, Third Edition (CFOC3), developed by the American Academy of Pediatrics, the American Public Health Association, and the National Resource Center for Health and Safety in Child Care and Early Education, with funding from the Maternal and Child Health Bureau. CFOC3 is a collection of 686 national standards that represent the best evidence, expertise, and experience in the country on quality health and safety practices and policies that should be followed in today's early care and education settings. CFOC3 is often used by state regulatory agencies when they are revising and updating state child care regulations. CFOC3 is available at http://cfoc.nrckids.org/.

Check Alignment Level	State Standard	Notes
☒ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**	The state standard reads, "All caregivers with direct care responsibilities must have current certification in pediatric CPR and documentation of current training in pediatric first aid. Training records must be on file at the operation and available for review upon request."	The following elements are found in both standards: applies to *all* persons who provide *direct care*, requires *pediatric first aid and pediatric CPR*, training must be *current*, and *documentation* must be *at the facility.*

Partial alignment means the state standard **aligns with CFOCB on most but not all elements**. The following example uses the same CFOCB standard, 1.4.3.1, First Aid and CPR Training for Staff. "All staff members involved in providing direct care to children should have up-to-date documentation of satisfactory completion of training in pediatric first aid and current certification in pediatric CPR. Records of successful completion of training in pediatric first aid and CPR should be maintained in the personnel files of the facility."

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☒ **Partial Alignment** ☐ **No Alignment**	The state standard reads, "All direct caregivers must complete pediatric first aid training. *At least one person per center, group or classroom must have training in pediatric CPR*. Training records must be on file at the facility."	The state standard does not require that *all* caregivers be certified in *pediatric CPR*.

No alignment indicates that the state standard significantly varies from CFOCB; that is, **fewer than half of the elements align with one another, no elements align with one another, or there is no state standard that aligns with CFOCB**. The following example uses the same CFOCB standard, 1.4.3.1, First Aid and CPR Training for Staff. "All staff members involved in providing direct care to children should have up-to-date documentation of satisfactory completion of training in pediatric first aid and current certification in pediatric CPR. Records of successful completion of training in pediatric first aid and CPR should be maintained in the personnel files of the facility."

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☒ **No Alignment**	The state standard reads, "All staff members involved in providing direct care to children should have up-to-date documentation of satisfactory completion of training in first aid. *At least one person per center, group or classroom must have training in CPR*."	The state standard does not require *pediatric* first aid or *pediatric* CPR. Only one person per classroom is required to have CPR training, not all direct caregivers. Training records are not addressed in the standard.

3. In addition to capturing alignment similarities and differences, the notes section can be used to capture information for implementation plans, stakeholder comments, ideas for future rule and standard development, or where the current state standard exceeds CFOCB recommendations. It can also be noted if the CFOCB standard is addressed in other ways such as policies or guidance.
4. Because this tool is lengthy, users can start by completing the sections of greatest interest by clicking on the topic title in the Table of Contents.

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CFOCB Health and Safety Standards Alignment Tool

Staffing

1.1.1.1–1.1.1.5 Ratios for Centers and Family Child Care Homes

Appropriate ratios should be kept during all hours of program operation. Children with special health care needs or who require more attention due to certain disabilities may require additional staff on-site, depending on their needs and the extent of their disabilities.

In center-based care, child-provider ratios should be determined by the age of the majority of children and the needs of children present.

Age	Child Care Centers Maximum Child: Provider Ratio
≤12 months	4:1
13-23 months	4:1
24-35 months	4:1–6:1
3-year-olds	9:1
4- to 5-year-olds	10:1

In **family child care homes**, the provider's own children under the age of 6, as well as any other children in the home temporarily requiring supervision, should be included in the child: provider ratio. In family child care settings where there are mixed age groups that include infants and toddlers, a maximum ratio of 6:1 should be maintained and no more than two of these children should be 24 months or younger. If all children in care are under 36 months, a maximum ratio of 4:1 should be maintained and no more than two of these children should be 18 months or younger. If all children in care are 3 years old, a maximum ratio of 7:1 should be preserved. If all children in care are 4 to 5 years of age, a maximum ratio of 8:1 should be maintained.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

1.2.0.2 Background Screening

All caregivers/teachers and staff in early care and education settings (in addition to any individual age 18 and older, or a minor over age 12 if allowed under State law and if a registry/database includes minors, residing in a family child care home) should undergo a complete background screening upon employment and once at least every five years thereafter. Screening should be conducted as expeditiously as possible and should be completed within 45 days after hiring. Caregivers/teachers and staff should not have unsupervised access to children until screening has been completed. Consent to the background investigation should be required for employment consideration.

The comprehensive background screening should include the following:

a. A search of the State criminal and sex offender registry or repository in the State where the child care staff member resides, and each State where such staff member resided during the preceding 5 years;

b. A search of State-based child abuse and neglect registries and databases in the State where the child care staff member resides, and each State where such staff member resided during the preceding 5 years; and

c. A Federal Bureau of Investigation fingerprint check using Next Generation Identification.

Directors/programs should review each employment application to assess the relevancy of any issue uncovered by the complete background screening, including any arrest, pending criminal charge, or conviction, and should use this information in employment decisions in accordance with state laws.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

1.4.1.1/1.4.2.3 Pre-service Training/Orientation

Before or during the first three months of employment, training and orientation should detail health and safety issues for early care and education settings including, but not limited to, typical and atypical child development; pediatric first aid and CPR; safe sleep practices, including risk reduction of Sudden Infant Death Syndrome/Sudden Unexplained Infant Death (SIDS/SUID); poison prevention; shaken baby syndrome and abusive head trauma; standard precautions; emergency preparedness; nutrition and age-appropriate feeding; medication administration; and care plan implementation for children with special health care needs. Caregivers/teachers should complete training before administering medication to children. See Standard 3.6.3.3 for more information. All directors or program administrators and caregivers/teachers should document receipt of training.

Providers should not care for children unsupervised until they have completed training in pediatric first aid and CPR; safe sleep practices, including risk reduction of Sudden Infant Death Syndrome/Sudden Unexplained Infant Death (SIDS/SUID); standard precautions for the prevention of communicable disease; poison prevention; and shaken baby syndrome/abusive head trauma.

Check Alignment Level	Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

1.4.3.1 First Aid and CPR Training for Staff

All staff members involved in providing direct care to children should have up-to-date documentation of satisfactory completion of training in pediatric first aid and current certification in pediatric CPR. Records of successful completion of training in pediatric first aid and CPR should be maintained in the personnel files of the facility.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

1.4.4.1/1.4.4.2 Continuing Education for Directors, Caregivers/Teachers in Centers, and Family Child Care Homes

Directors and caregivers/teachers should successfully complete intentional and sequential education/professional development in child development programming and child health, safety, and staff health based on individual competency and any special needs of the children in their care.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

1.4.5.2 Child Abuse and Neglect Education

Caregivers/teachers should be educated on child abuse and neglect to establish child abuse and neglect prevention and recognition strategies for children, caregivers/teachers, and parents/guardians. The education should address physical, sexual, and psychological or emotional abuse and neglect. 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.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

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Program Activities for Healthy Development

2.1.1.4 Monitoring Children's Development/Obtaining Consent for Screening

Programs should have a process in place for age-appropriate developmental and behavioral screenings for all children at the beginning of a child's enrollment in the program, at least yearly thereafter, and as developmental concerns become apparent to staff and/or parents/guardians. Providers may choose to conduct screenings, themselves; partner with a local agency/health care provider/specialist who would conduct the screening; or work with parents in connecting them to resources to ensure that screening occurs. This process should consist of parental/guardian education, consent, and participation as well as connection to resources and support, including the primary health care provider, as needed. Results of screenings should be documented in child records.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

2.1.2.1/2.1.3.1 Personal Caregiver/Teacher Relationships for Birth to Five-Year-Olds

Programs should implement relationship-based policies and program practices that promote consistency and continuity of care, especially for infants and toddlers. Early care and education programs should provide opportunities for each child to build emotionally secure relationships with a limited number of caregivers/teachers. Children with special health care needs may require additional specialists to promote health and safety and to support learning.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

2.2.0.1 Methods of Supervision of Children

In **center-based programs**, caregivers/teachers should directly supervise children under age 6 by sight and sound at all times. In **family child care settings**, caregivers should directly supervise children by sight or sound. When children are sleeping, caregivers may supervise by sound with frequent visual checks.

Developmentally appropriate child-to-staff ratios should be met during all hours of operation, and safety precautions for specific areas and equipment should be followed. Children under the age of 6 should never be inside or outside by themselves.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

2.2.0.4 Supervision Near Water

Constant and active supervision should be maintained when any child is in or around water. During swimming and/or bathing where an infant or toddler is present, the ratio should always be one adult to one infant/toddler. During wading and/or water play activities, the supervising adult should be within an arm's length providing "touch supervision." Programs should ensure that all pools have drain covers that are used in compliance with the Virginia Graeme Baker Pool and Spa Safety Act.[2]

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

2.2.0.8 Preventing Expulsions, Suspensions, and Other Limitations in Services

Programs should have a comprehensive discipline policy that includes developmentally appropriate social-emotional and behavioral health promotion practices as well as discipline and intervention procedures that provide specific guidance on what caregivers/teachers and programs should do to prevent and respond to challenging behaviors. Programs should ensure all caregivers/teachers have access to pre- and in-service training on such practices and procedures. Practices and procedures should be clearly communicated to all staff, families, and community partners, and implemented consistently and without bias or discrimination. Preventive and discipline practices should be used as learning opportunities to guide children's appropriate behavioral development.

Programs should establish policies that eliminate or severely limit expulsion, suspension, or other exclusionary discipline (including limiting services); these exclusionary measures should be used only in extraordinary circumstances where there are serious safety concerns that cannot otherwise be reduced or eliminated by the provision of reasonable modifications.

[2] "The *Virginia Graeme Baker Pool & Spa Safety Act* (P&SS Act) was enacted by Congress and signed by President Bush on December 19, 2007. Designed to prevent the tragic and hidden hazard of drain entrapments and eviscerations in pools and spas, the law became effective on December 19, 2008. The Consumer Product Safety Commission is empowered to implement and enforce the requirements of the P&SS Act" (U.S. Consumer Product Safety Commission. Pool safely [Web site]. Retrieved from http://www.poolsafely.gov/cpsc/.).

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

2.2.0.9 Prohibited Caregiver/Teacher Behaviors

The following behaviors should be prohibited in all early care and education settings:

a. The use of corporal punishment, including, but not limited to:
   i. Hitting, spanking, shaking, slapping, twisting, pulling, squeezing, or biting;
   ii. Demanding excessive physical exercise, excessive rest, or strenuous or bizarre postures;
   iii. Compelling a child to eat or have in his/her mouth soap, food, spices, or foreign substances;
   iv. Exposing a child to extremes of temperature.

d. 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;

e. Binding, tying to restrict movement, or taping the mouth;

f. Using or withholding food or beverages as a punishment;

g. Toilet learning/training methods that punish, demean, or humiliate a child;

h. Any form of emotional abuse, including rejecting, terrorizing, extended ignoring, isolating, or corrupting a child;

i. Any abuse or maltreatment of a child;

j. Abusive, profane, or sarcastic language or verbal abuse, threats, or derogatory remarks about the child or child's family;

k. Any form of public or private humiliation, including threats of physical punishment;

l. Physical activity/outdoor time taken away as punishment;

m. Placing a child in a crib for a time-out or for disciplinary reasons.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

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Health Promotion and Protection

3.1.3.1 Active Opportunities for Physical Activity

Programs should promote developmentally appropriate active play for all children, including infants and toddlers, every day. Children should have opportunities to engage in moderate to vigorous activities indoors and outdoors, weather permitting.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

3.1.4.1 Safe Sleep Practices and SIDS Risk Reduction

All staff, parents/guardians, volunteers, and others who care for infants in the early care and education setting should follow safe sleep practices as recommended by the American Academy of Pediatrics (AAP).[3] Cribs must be in compliance with current U.S. Consumer Product Safety Commission (CPSC) and ASTM International safety standards.[4] See Standard 5.4.5.2 for more information.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

[3] American Academy of Pediatrics. (2012). A child care provider's guide to safe sleep. Retrieved from http://www.healthychildcare.org/PDF/SIDSchildcaresafesleep.pdf.
[4] U.S. Consumer Product Safety Commission. (n.d.). Safe to sleep – crib information center [Web page]. Retrieved from http://www.cpsc.gov/en/Safety-Education/Safety-Education-Centers/cribs/.

3.1.5.1 Routine Oral Hygiene Activities

Caregivers/teachers should promote good oral hygiene through learning activities including the habit of regular tooth brushing.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

3.2.1.4 Diaper Changing Procedure

The following diaper changing procedure should be posted in the changing area and followed to protect the health and safety of children and staff:

- Step 1: Before bringing the child to the diaper changing area, perform hand hygiene and bring supplies to the diaper changing area.
- Step 2: Carry/bring the child to the changing table/surface, keeping soiled clothing away from you and any surfaces you cannot easily clean and sanitize after the change. Always keep a hand on the child.
- Step 3: Clean the child’s diaper area.
- Step 4: Remove the soiled diaper and clothing without contaminating any surface not already in contact with stool or urine.
- Step 5: Put on a clean diaper and dress the child.
- Step 6: Wash the child’s hands and return the child to a supervised area.
- Step 7: Clean and disinfect the diaper-changing surface. Dispose of the disposable paper liner if used on the diaper changing surface in a plastic-lined, hands-free, covered can. If clothing was soiled, securely tie the plastic bag used to store the clothing and send home.
- Step 8: Perform hand hygiene and record the diaper change, diaper contents, and/or any problems.

Caregivers/teachers should never leave a child unattended on a table or countertop. A safety strap or harness should not be used on the diaper changing table/surface.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

3.2.2.1 Situations that Require Hand Hygiene

All staff, volunteers, and children should abide by the following procedures for hand washing, as defined by the U.S. Centers for Disease Control and Prevention (CDC):[5]

a. Upon arrival for the day, after breaks, or when moving from one group to another.

b. Before and after:

- Preparing food or beverages;
- Eating, handling food, or feeding a child;
- Brushing or helping a child brush teeth;
- 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;
- Playing in water (including swimming) that is used by more than one person; and
- Diapering.

c. After:

- Using the toilet or helping a child use a toilet;
- Handling bodily fluid (mucus, blood, vomit);
- Handling animals or cleaning up animal waste;
- Playing in sand, on wooden play sets, and outdoors; and
- Cleaning or handling the garbage.

Situations or times that children and staff should perform hand hygiene should be posted in all food preparation, diapering, and toileting areas.

[Note: **Family child care homes** are exempt from posting procedures for hand washing but should follow all other aspects of this standard.]

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

[5] U.S. Centers for Disease Control and Prevention. (2015). When & how to wash your hands [Web page]. Retrieved from http://www.cdc.gov/handwashing/when-how-handwashing.html.

3.3.0.1 Routine Cleaning, Sanitizing, and Disinfecting

Programs should follow a routine schedule of cleaning, sanitizing, and disinfecting. Cleaning, sanitizing, and disinfecting products should not be used in close proximity to children, and adequate ventilation should be maintained during use.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

3.2.3.4 Prevention of Exposure to Blood and Body Fluids

Early care and education programs should adopt the use of Standard Precautions, developed by the Centers for Disease Control and Prevention (CDC),[6] to handle potential exposure to blood and other potentially infectious fluids. Caregivers and teachers are required to be educated regarding Standard Precautions before beginning to work in the program and annually thereafter. For center-based care, training should comply with requirements of the Occupational Safety and Health Administration (OSHA).

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

3.4.1.1 Use of Tobacco, Alcohol, and Illegal Drugs

Directors, caregivers, volunteers, and staff should not be impaired due to the use of alcohol, illegal drugs or prescription medication during program hours. Tobacco, alcohol, and illegal drug use should be prohibited on the premises (both indoor and outdoor environments) and in any vehicles used by the program at all times. In **family child care settings**, tobacco and alcohol should be inaccessible to children.

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[6] Standard precautions include the use of hand washing and appropriate personal protective equipment such as gloves, gowns, and masks whenever touching or exposure to patients' body fluids is anticipated.

Siegel, J. D., Rhinehart, E., Jackson, M., Chiarello, L., & the Healthcare Infection Control Practices Advisory Committee. (2007). *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*. Atlanta: U.S. Center for Disease Control and Prevention. Retrieved from http://www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf.

Fairfax, R. E. (2007). OSHA requirements for providing training for first aid, CPR, and BBP for prompt treatment of injured employees at various workplaces [Interpretation of standard]. Retrieved from https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=INTERPRETATIONS&p_id=25627.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

3.4.3.1 Emergency Procedures

Programs should have a procedure for responding to situations when an immediate emergency medical response is required. Emergency procedures should be posted and readily accessible. Child-to-provider ratios should be maintained, and additional adults may need to be called in to maintain the required ratio. Programs should develop contingency plans for emergencies or disaster situations when it may not be possible to follow standard emergency procedures. All providers and/or staff should be trained to manage an emergency until emergency medical care becomes available.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

3.4.4.1 Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation

Because caregivers/teachers are mandated reporters of child abuse and neglect, each program should have a written policy for reporting child abuse and neglect. The written policy should specify that in any instance where there is reasonable cause to believe that child abuse or neglect has occurred, the individual who suspects child abuse or neglect should report directly to the child abuse reporting hotline, child protective services, or the police, as required by state and local laws.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

3.4.4.3 Preventing and Identifying Shaken Baby Syndrome and Abusive Head Trauma

All programs should have a policy and procedure to identify and prevent shaken baby syndrome and 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 and abusive head trauma; recognition of potential signs and symptoms of shaken baby syndrome and 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.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

3.4.5.1 Sun Safety Including Sunscreen

Caregivers/teachers should ensure sun safety for themselves and children under their supervision by keeping infants younger than six months out of direct sunlight, limiting sun exposure when ultraviolet rays are strongest and applying sunscreen with written permission of parents/guardians. Manufacturer instructions should be followed.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

3.4.6.1 Strangulation Hazards

Strings and cords long enough to encircle a child's neck, such as those on toys and window coverings, should not be accessible to children in early care and education programs.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

3.5.0.1 Care Plan for Children with Special Health Care Needs

Children with special health care needs are defined as ". . . those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally" (McPherson, 1998).

Any child who meets these criteria in an early care and education setting should have an up-to-date Routine and Emergent Care Plan,[7] completed by their primary health care provider with input from parents/guardians, included in their on-site health record and readily accessible to those caring for the child. Community resources should be used to ensure adequate information, training, and monitoring is available for early care and education staff. Caregivers should undergo training in pediatric first aid and CPR that includes responding to an emergency for any child with a special health care need.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

3.6.1.1 Inclusion/Exclusion/Dismissal of Children

The program should notify parents/guardians when children develop 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 children from the early care and education setting as soon as possible. For children whose symptoms do not require exclusion, verbal or written notification to the parent/guardian at the end of the day is acceptable. Most conditions that require exclusion do not require a primary health care provider visit before re-entering care.

When a child becomes ill but does not require immediate medical help, a determination should be made regarding whether the child should be sent home. The caregiver/teacher should determine if the illness:

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;
d. Causes a fever and behavior change or other signs and symptoms (e.g., sore throat, rash, vomiting, and diarrhea). An unexplained temperature above 100 °F (37.8 °C) (armpit) in a child younger than 6 months should be medically evaluated. Any infant younger than 2 months of age with fever should get immediate medical attention.

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[7] *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, third edition*. Standard 3.5.0.1, Care plan for children with special health care needs. Retrieved from http://cfoc.nrckids.org/StandardView/3.5.0.1.

Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, third edition. Appendix O, Care plan for children with special health needs. Retrieved from http://cfoc.nrckids.org/WebFiles/AppendicesUpload/AppendixO.pdf.

If any of the above criteria are met, the child should be removed from direct contact with other children and monitored and supervised by a staff member known to the child until dismissed to the care of a parent/guardian, primary health care provider, or other person designated by the parent. The local or state health department will be able to provide specific guidelines for exclusion.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

3.6.1.4 Infectious Disease Outbreak Control

During the course of an identified outbreak of any reportable illness at the program, a child or staff member should be excluded if the local health department official or primary health care provider suspects that the child or staff member is contributing to transmission of the illness, 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 health care provider who made the initial determination decides that the risk of transmission is no longer present. Parents/guardians should be notified of any determination.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

3.6.3.1/3.6.3.2 Medication Administration and Storage

The administration of medicines at the facility should be limited to:

a. Prescription or non-prescription medication (over-the-counter) ordered by the prescribing health professional for a specific child with written permission of the parent/guardian. Prescription medication should be labeled with the child's name; date the prescription was filled; name and contact information of the prescribing health professional; expiration date; medical need; instructions for administration, storage, and disposal; and name and strength of the medication.

b. Labeled medications (over-the-counter) brought to the early care and education facility by the parent/guardian in the original container. The label should include the child's name; dosage; relevant warnings as well as specific; and legible instructions for administration, storage; and disposal.

Programs should never administer a medication that is prescribed for one child to another child. Documentation that the medicine/agent is administered to the child as prescribed is required. Medication should not be used beyond the date of expiration. Unused medications should be returned to the parent/guardian for disposal.

All medications, refrigerated or unrefrigerated, should have child-resistant caps; be stored away from food at the proper temperature, and be inaccessible to children.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

3.6.3.3 Training of Caregivers/Teachers to Administer Medication

Any caregiver/teacher who administers medication should complete a standardized training course that includes skill and competency assessment in medication administration. The course should be repeated according to state and/or local regulation and taught by a trained professional. Skill and competency should be monitored whenever an administration error occurs.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

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Nutrition and Food Service

4.2.0.3 Use of U.S. Department of Agriculture (USDA), Child and Adult Care Food Program (CACFP) Guidelines

Programs should serve nutritious and sufficient foods that meet the requirements for meals of the child care component of the USDA CACFP as referenced in 7 CFR 226.20.[8]

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

4.2.0.6 Availability of Drinking Water

Clean, sanitary drinking water should be readily accessible in indoor and outdoor areas, throughout the day. On hot days, infants receiving human milk in a bottle may be given additional human milk, and those receiving formula mixed with water may be given additional formula mixed with water. Infants should not be given water, especially in the first six months of life.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

[8] Child and Adult Care Food Program, 7 C.F.R. § 226 (2013). Retrieved from http://www.fns.usda.gov/sites/default/files/CFR226.pdf.

U.S. Department of Agriculture Food and Nutrition Service. (n.d.). Child care meal pattern. Retrieved from http://www.fns.usda.gov/sites/default/files/Child_Meals.pdf.

U.S. Department of Agriculture Food and Nutrition Service. (n.d.). Infant meal pattern. Retrieved from http://www.fns.usda.gov/sites/default/files/Infant_Meals.pdf.

4.2.0.10 Care for Children with Food Allergies

Each child with a food allergy should have a written care plan that includes:

a. Instructions regarding the food(s) to which the child is allergic and steps to be taken to avoid that food;

b. A detailed treatment plan to be implemented in the event of an allergic reaction, including the names, doses, and methods of prompt administration of any medications. The plan should include specific symptoms that would indicate the need to administer one or more medications.

Based on the child's care plan and prior to caring for the child, caregivers/teachers should receive training for, demonstrate competence in, and implement measures for:

a. Preventing exposure to the specific food(s) to which the child is allergic;

b. Recognizing the symptoms of an allergic reaction;

c. Treating allergic reactions.

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.

The program should notify the parents/guardians immediately of any suspected allergic reactions, as well as the ingestion of or contact with the problem food even if a reaction did not occur. The program should contact the emergency medical services system immediately whenever epinephrine has been administered.

Each child's food allergies should be posted prominently in the classroom and/or wherever food is served with permission of the parent/guardian.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

4.3.1.3 Preparing, Feeding, and Storing Human Milk

Programs should develop and follow procedures for the preparation and storage of expressed human milk that ensures the health and safety of all infants, as outlined by the Academy of Breastfeeding Medicine Protocol #8; Revision 2010,[9] and prohibits the use of infant formula for a breastfed infant without parental consent. The bottle or container should be properly labeled with the infant's full name and date; and should only be given to the specified child. Unused breast milk should be returned to parent in the bottle or container.

[9] Academy of Breastfeeding Medicine Protocol Committee. (2010). ABM clinical protocol #8: Human milk storage information for home use for full-term infants. *Breastfeeding Medicine, 5*(3), 127–30. Retrieved from http://www.bfmed.org/Media/Files/Protocols/Protocol%208%20-%20English%20revised%202010.pdf.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

4.3.1.5 Preparing, Feeding, and Storing Infant Formula

Programs should develop and follow procedures for the preparation and storage of infant formula that ensures the health and safety of all infants. Formula provided by parents/guardians or programs should come in sealed containers. The caregiver/teacher should always follow the parent or manufacturer's instructions for mixing and storing of any formula preparation. If instructions are not readily available, caregivers/teachers should obtain information from the World Health Organization's Safe Preparation, Storage and Handling of Powdered Infant Formula Guidelines.[10] Bottles of prepared or ready-to-feed formula should be labeled with the child's full name, time, and date of preparation. Prepared formula should be discarded daily if not used.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

4.3.1.9 Warming Bottles and Infant Foods

Bottles and infant foods can be served cold from the refrigerator and do not have to be warmed. If a caregiver/teacher chooses to warm them, or a parent requests they be warmed, bottles should be warmed under running, warm tap water; using a commercial bottle warmer, stove top warming methods, or slow-cooking device; or by placing them in container of warm water. Bottles should never be warmed in microwaves. Warming devices should not be accessible to children.

[10] World Health Organization. (2007). *Safe Preparation, Storage and Handling of Powdered Infant Formula: Guidelines*. Geneva: World Health Organization. Retrieved from http://www.who.int/foodsafety/publications/micro/pif_guidelines.pdf.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

4.5.0.10 Foods that Are Choking Hazards

Caregivers/teachers should not offer foods that are associated with young children's choking incidents to children under 4 years of age. Food for infants should be cut into pieces ¼ inch or smaller, food for toddlers should be cut into pieces ½ inch or smaller to prevent choking. Children should be supervised while eating, to monitor the size of food and that they are eating appropriately.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

4.8.0.1 Food Preparation Area Access

Access to areas where hot food is prepared should only be permitted when children are supervised by adults who are qualified to follow sanitation and safety procedures.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

4.9.0.1 Compliance with U.S. Food and Drug Administration (FDA) Food Code and State and Local Rules

The program should conform to applicable portions of the FDA Food Code[11] and all applicable state and local food service rules and regulations for centers and family child care homes regarding safe food protection and sanitation practices.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

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[11] U.S. Food and Drug Administration. (2013). *Food Code 2013.* College Park, MD: Author. http://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm374275.htm.

Facilities, Supplies, Equipment, and Environmental Health

5.1.1.2 Inspection of Buildings

Existing and/or newly constructed, renovated, remodeled, or altered buildings should be inspected by a building inspector to ensure compliance with applicable state and local building and fire codes before the building can be used for the purpose of early care and education.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

5.1.1.3 Compliance with Fire Prevention Code

Programs should comply with a state-approved or nationally recognized fire prevention code, such as the National Fire Protection Association (NFPA) 101: Life Safety Code.[12]

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

5.1.1.5 Environmental Audit of Site Location

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. A written report that includes any remedial action taken should be kept on file.

The audit should include assessments of:

a. Potential air, soil, and water contamination on program sites and outdoor play spaces;
b. Potential toxic or hazardous materials in building construction, such as lead and asbestos; and
c. Potential safety hazards in the community surrounding the site.

[12] National Fire Protection Association. (2015). *NFPA 101: Life Safety Code*. Quincy, MA: Author. Retrieved from http://www.nfpa.org/codes-and-standards/document-information-pages?mode=code&code=101.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

5.1.6.6 Guardrails and Protective Barriers

Guardrails or protective barriers, such as baby gates, 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 30 inch vertical distance to fall.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

5.2.4.2 Safety Covers and Shock Protection Devices for Electrical Outlets

All accessible electrical outlets should be “tamper-resistant electrical outlets” that contain internal shutter mechanisms to prevent children from sticking objects into receptacles. In settings 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” may also be used if they cannot be easily removed from outlets by children and do not pose a choking risk.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

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.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

5.2.8.1 Integrated Pest Management

Programs should adopt an integrated pest management program 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.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

5.2.9.1 Use and Storage of Toxic Substances

All toxic substances should be inaccessible to children and should not be used when children are present. Toxic substances should be used as recommended by the manufacturer and stored in the original labeled containers. The telephone number for the poison control center should be posted and readily accessible in emergency situations.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

5.2.9.5 Carbon Monoxide Detectors

Programs should meet state or local laws regarding carbon monoxide detectors, including circumstances when detectors are necessary. Detectors should be tested monthly, and testing should be documented. Batteries should be changed at least yearly. Detectors should be replaced according to the manufacturer's instructions.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

5.3.1.1/5.5.0.6/5.5.0.7 Safety of Equipment, Materials, and Furnishings

Equipment, materials, furnishings, and play areas should be sturdy, safe, in good repair, and meet the recommendations of the CPSC.[13] Programs should attend to, including, but not limited to, the following safety hazards:

a. Openings that could entrap a child's head or limbs;
b. Elevated surfaces that are inadequately guarded;
c. Lack of specified surfacing and fall zones under and around climbable equipment;
d. Mismatched size and design of equipment for the intended users;
e. Insufficient spacing between equipment;
f. Tripping hazards;
g. Components that can pinch, sheer, or crush body tissues;
h. Equipment that is known to be of a hazardous type;
i. Sharp points or corners;
j. Splinters;
k. Protruding nails, bolts, or other parts that could entangle clothing or snag skin;
l. Loose, rusty parts;
m. Hazardous small parts that may become detached during normal use or reasonably foreseeable abuse of the equipment and that present a choking, aspiration, or ingestion hazard to a child;
n. Strangulation hazards (e.g., straps, strings, etc.);
o. Flaking paint;

[13] Schools, parks, multiple-family dwellings, public child care facilities, restaurants and recreational developments, and other public-use facilities should reference the *Public Playground Safety Handbook*, CPSC publication number 325, available at http://www.cpsc.gov//PageFiles/122149/325.pdf.

Homes and residential child care facilities should reference *the Outdoor Home Playground Safety Handbook*, CPSC publication number 324, available at http://www.cpsc.gov//PageFiles/122146/324.pdf.

p. Paint that contains lead or other hazardous materials; and

q. Tip-over hazards, such as chests, bookshelves, and televisions.

Plastic bags that are large enough to pose a suffocation risk as well as matches, candles, and lighters should not be accessible to children.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

5.3.1.12 Availability and Use of a Telephone or Wireless Communication Device

The facility should provide at all times at least one working non-pay telephone or wireless communication device for general and emergency use on the premises of the child care program, in each vehicle used when transporting children, and on field trips. While transporting children, drivers should not operate a motor vehicle while using a mobile telephone or wireless communications device when the vehicle is in motion or traffic.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

5.4.5.2 Cribs and Play Yards

Before purchase and use, cribs and play yards should be in compliance with current CPSC and ASTM International safety standards that include ASTM F1169-10a Standard Consumer Safety Specification for Full-Size Baby Cribs, ASTM F406-13, 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.[14]

Programs should only use cribs for sleep purposes and ensure that each crib is a safe sleep environment as defined by the American Academy of Pediatrics.[15] Each crib should be labeled and used for the infant's exclusive use. Cribs and mattresses should be thoroughly cleaned and sanitized before assignment for use by another child. Infants should not be placed in the cribs with items that could pose a strangulation or suffocation risk. Cribs should be placed away from window blinds or draperies.

[14] U.S. Consumer Product Safety Commission. (n.d.). Safe to sleep – crib information center [Web page]. Retrieved from http://www.cpsc.gov/en/Safety-Education/Safety-Education-Centers/cribs/.
[15] American Academy of Pediatrics. (2012). A child care provider's guide to safe sleep. Retrieved from http://www.healthychildcare.org/PDF/SIDSchildcaresafesleep.pdf.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

5.5.0.8 Firearms

Center-based programs should not have firearms or any other weapon on the premises at any time. If present in a family child care home, parents should be notified and these items should be 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.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

5.6.0.1 First Aid and Emergency Supplies

The facility should maintain up-to-date first aid and emergency supplies in each location in which children are cared. The first aid kit or supplies should be kept in a closed container, cabinet, or drawer that is labeled and stored in a location known to all staff, accessible to staff at all times, but locked or otherwise inaccessible to children. When children leave the facility for a walk or to be transported, a designated staff member should bring a transportable first aid kit. In addition, a transportable first aid kit should be in each vehicle that is used to transport children to and from the program. First aid kits or supplies should be restocked after each use.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

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Play Areas/Playgrounds and Transportation

6.1.0.6/6.1.0.8/6.3.1.1 Location of Play Areas near Bodies of Water/Enclosures for Outdoor Play Areas/Enclosure of Bodies of Water

The outdoor play area should be enclosed with a fence or natural barriers. Fences and barriers should not prevent the supervision of children by caregivers/teachers. If a fence is used, it should be in good condition and conform to applicable local building codes in height and construction. These areas should have at least two exits, with at least one being remote from the buildings.

Gates should be equipped with self-closing and positive self-latching closure mechanisms that are high enough or of a type such that children cannot open it. The openings in the fence and gates should be no larger than 3 ½ inches. The fence and gates should be constructed to discourage climbing. Outside play areas should be free from unsecured bodies of water. If present, all water hazards should be inaccessible to unsupervised children and enclosed with a fence that is 4 to 6 feet high or higher and comes within 3 ½ inches of the ground.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

6.2.3.1 Prohibited Surfaces for Placing Climbing Equipment

Equipment used for climbing should not be placed over, or immediately next to, hard surfaces not intended for use as surfacing for climbing equipment. All pieces of playground equipment should be placed over a shock-absorbing material that is either the unitary or the loose-fill type extending beyond the perimeter of the stationary equipment. Organic materials that support colonization of molds and bacteria should not be used. This standard applies whether the equipment is installed outdoors or indoors. Programs should follow CPSC guidelines and ASTM International Standards F1292-13 and F2223-10.[16]

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

[16] Schools, parks, multiple-family dwellings, public child care facilities, restaurants and recreational developments, and other public-use facilities should reference the *Public Playground Safety Handbook*, CPSC publication number 325, available at http://www.cpsc.gov//PageFiles/122149/325.pdf.

Homes and residential child care facilities should reference the *Outdoor Home Playground Safety Handbook*, CPSC publication number 324, available at http://www.cpsc.gov//PageFiles/122146/324.pdf.

6.2.5.1 Inspection of Indoor and Outdoor Play Areas and Equipment

The indoor and outdoor play areas and equipment should be inspected daily for basic health and safety, including, but not limited to:

a. Missing or broken parts;
b. Protrusion of nuts and bolts;
c. Rust and chipping or peeling paint;
d. Sharp edges, splinters, and rough surfaces;
e. Stability of handholds;
f. Visible cracks;
g. Stability of non-anchored large play equipment (e.g., playhouses);
h. Wear and deterioration
i. Vandalism or trash

Any problems should be corrected before the playground is used by children.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

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 be long enough to reach the center of the pool from the edge of the pool, kept in good repair, and stored safely and conveniently for immediate access. Caregivers/teachers should be trained on the proper use of this equipment. Children should be familiarized with the use of the equipment based on their developmental level.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

6.3.5.2 Water in Containers

Bathtubs, buckets, diaper pails, and other open containers of water should be emptied immediately after use.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

6.5.1.2 Qualifications for Drivers

In addition to meeting the general staff background check standards, any driver or transportation staff member who transports children for any purpose should have:

a. A valid driver's license that authorizes the driver to operate the type of vehicle being driven;
b. A safe driving record for more than 5 years, with no crashes where a citation was issued, as evidenced by the state Department of Motor Vehicles records;
c. No use of alcohol, drugs, or any substance that could impair abilities before or while driving;
d. No tobacco use while driving;
e. No medical condition that would compromise driving, supervision, or evacuation capability;
f. Valid pediatric CPR and first aid certificate if transporting children alone.

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.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

6.5.2.2 Child Passenger Safety

When children are driven in a motor vehicle other than a bus, all children should be transported only if they are restrained in a developmentally appropriate car safety seat, booster seat, seat belt, or harness that is suited to the child's weight and age in accordance with state and federal laws and regulations. The child should be securely fastened, according to the manufacturer's instructions. The child passenger restraint system should meet the

federal motor vehicle safety standards contained in 49 CFR 571.213[17] and carry notice of compliance. Child passenger restraint systems should be installed and used in accordance with the manufacturer's instructions and should be secured in back seats only.

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.

If the program uses a vehicle that meets the definition of a school bus and the school bus has safety restraints, the following should apply:

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;
b. The wheelchair occupant should be secured by a three-point tie restraint during transport;
c. At all times, school buses should be ready to transport children who must ride in wheelchairs;
d. Manufacturers' specifications should be followed to assure that safety requirements are met.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

6.5.2.4 Interior Temperature of Vehicles

The interior of vehicles used to transport children for field trips and out-of-program activities should be maintained at a temperature comfortable to children. All vehicles should be locked when not in use, head counts of children should be taken before and after transporting to prevent a child from being left in a vehicle, and children should never be left in a vehicle unattended.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

[17] U.S. Centers for Disease Control and Prevention. (2015). Injury prevention & control: Motor vehicle safety [Web page]. Retrieved from http://www.cdc.gov/motorvehiclesafety/.

Child Restraint Systems, 49 C.F.R. § 571.213 (2014). Retrieved from https://www.gpo.gov/fdsys/pkg/CFR-2014-title49-vol6/pdf/CFR-2014-title49-vol6-sec571-213.pdf.

6.5.3.1 Passenger Vans

Early care and education programs that provide transportation for any purpose to children, parents/guardians, staff, and others should not use 15-passenger vans when avoidable.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

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Infectious Disease

7.2.0.1 Immunization Documentation

Programs should require that all parents/guardians of enrolled children provide written documentation of receipt of immunizations appropriate for each child's age. Infants, children, and adolescents should be immunized as specified in the "Recommended Immunization Schedules for Persons Aged 0 Through 18 Years," developed by the Advisory Committee on Immunization Practices of the CDC, the American Academy of Pediatrics, and the American Academy of Family Physicians.[18] Children whose immunizations are not up-to-date or have not been administered according to the recommended schedule should receive the required immunizations, unless contraindicated or for legal exemptions.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

7.2.0.2 Unimmunized Children

If immunizations have not been or are not to be administered because of a medical condition, a statement from the child's primary health 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.

Parents/guardians of an enrolling or enrolled infant who has not been immunized due to the child's age should be informed if/when there are children in care who have not had routine immunizations due to exemption. 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. Children who are in foster care or experiencing homelessness as defined by the McKinney-Vento Act[19] should receive services while parents/guardians are taking necessary actions to comply with immunization requirements of the program. An immunization plan and catch-up immunizations should be initiated upon enrollment and completed as soon as possible.

If a vaccine-preventable disease to which children are susceptible occurs 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.

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[18] U.S. Centers for Disease Control and Prevention. (2015). Recommended immunization schedule for persons aged 0 through 18 years. Retrieved from http://www.cdc.gov/vaccines/schedules/downloads/child/0-18yrs-schedule.pdf.

[19] National Coalition for the Homeless. (2006). McKinney-Vento Act. NCH fact sheet 18. Washington, DC: Author. Retrieved from http://web.archive.org/web/20071203073025/http://www.nationalhomeless.org/publications/facts/McKinney.pdf.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

7.2.0.3 Immunization of Caregivers/Teachers

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"[20] in the following categories:

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); and

b. Recommended if a specific risk factor is present.

If a staff member is not appropriately immunized for medical, religious, or philosophical reasons, the program should require written documentation of the reason. 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.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

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[20] U.S. Centers for Disease Control and Prevention. (2015). 2015 recommended immunizations for adults: by age. Retrieved from http://www.cdc.gov/vaccines/schedules/downloads/adult/adult-schedule-easy-read.pdf.

Policies

9.2.4.1 Written Plan and Training for Handling Urgent Medical Care or Threatening Incidents

The program should have a written plan for reporting and managing any incident or unusual occurrence that is threatening to the health, safety, or welfare of the children, staff, or volunteers. Caregiver/teacher and staff training procedures should also be included. The management, documentation, and reporting of the following types of incidents should be addressed:

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 program;
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 early care and education program, even if the death occurred outside of early care and education hours;
i. The presence of a threatening individual who attempts or succeeds in gaining entrance to the facility.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

9.2.4.3/9.2.4.5 Disaster Planning, Training and Communication/Emergency and Evacuation Drills

Early care and education programs should consider how to prepare for and respond to emergency situations or natural disasters that may require evacuation, lock-down, or shelter-in-place and have written plans, accordingly. Written plans should be posted in each classroom and areas used by children. The following topics should be addressed, including but not limited to regularly scheduled practice drills, procedures for notifying and updating parents, and the use of the daily class roster(s) to check attendance of children and staff during an emergency or drill when gathered in a safe space after exit and upon return to the program. All drills/exercises should be recorded.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

9.2.4.7 Sign-In/Sign-Out System

Programs should have a sign-in/sign-out system to track those who enter and exit the facility. The system should include name, contact number, relationship to facility (e.g., parent/guardian, vendor, guest, etc.), and recorded time in and out. [Note: Family child care is exempt.]

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

9.2.4.8 Authorized Persons to Pick Up Child

Children may only be released to adults authorized by parents or legal guardians whose identity has been verified by photo identification. Names, addresses, and telephone numbers of persons authorized to pick up child should be obtained during the enrollment process and regularly reviewed, along with clarification/documentation of any custody issues/court orders. The legal guardian(s) of the child should be established and documented at this time.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

9.4.1.12 Record of Valid License, Certificate, or Registration of Facility or Family Child Care Home

Every facility and/or child care home should hold a valid license, certificate, or documentation of registration prior to operation as required by the local and/or state statute.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

9.4.2.1 Contents of Child Records

Programs should maintain a confidential file for each child in one central location on-site and should be immediately available to the child's caregivers/teachers (who should have parental/guardian consent for access to records), the child's parents/guardians, and the licensing authority upon request. The file for each child should include the following:

a. Pre-admission enrollment information;
b. Admission agreement signed by the parent/guardian at enrollment;
c. Initial and updated health care assessments, completed and signed by the child's primary care provider, based on the child's most recent well care visit;
d. Health history completed by the parent/guardian at admission;
e. Medication record;
f. Authorization form for emergency medical care;
g. Results of developmental and behavioral screenings;
h. Record of persons authorized to pick up child;
i. Written informed consent forms signed by the parent/guardian allowing the facility to share the child's health records with other service providers.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

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10.4.2.1 Frequency of Inspections for Child Care Centers and Family Child Care Homes

Licensing inspectors or monitoring staff should make on-site inspections to measure program compliance with health, safety, and fire standards prior to issuing an initial license and no less than one, unannounced inspection each year thereafter to ensure compliance with regulations. Additional inspections should take place if needed for the program to achieve satisfactory compliance or if the program is closed at any time. 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 should post results of licensing inspections, including complaints, on the internet for parent and public review. Parents/guardians should have easy access to licensing rules and made aware of how to report complaints to the licensing agency.

Sufficient numbers of licensing inspectors should be qualified to inspect early care and education programs and trained in related health and safety requirements among other requirements of the State licensure.

Check Alignment Level	State Standard	Notes
☐ **Full Alignment** ☐ **Partial Alignment** ☐ **No Alignment**		

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ADMINISTRATION FOR CHILDREN & FAMILIES

National Resource Center for Health and Safety in Child Care and Early Education

Stepping Stones to Caring for Our Children

Compliance/Comparison Checklist

Stepping Stones to Caring for Our Children **was developed to be used by multiple audiences to prevent harm and adverse outcomes in children in all early care and education settings.**

Suggestions for Use of the Compliance/Comparison Checklist:

- **By licensing staff who want to compare *Stepping Stones* standards to the subject areas covered in their state regulations and determine where there are gaps and where regulations should be added.**
- **By caregivers/teachers/directors who want to be sure they are complying with those standards that have the most potential to prevent harm to children in their settings.**
- **By families who want to be sure their child's early care and education program is complying with these important standards.**
- **By child care health consultants and trainers to assess what topics need to be covered when consulting or training caregivers/teachers/directors.**

Compliance/Comparison Checklist

CFOC Standard Number	*CFOC Online Database* Standard Title	Compliance/ Comparison	
		Yes	No
Chapter 1 - Staffing			
1.1.1.1	Ratios for Small Family Child Care Homes		
1.1.1.2	Ratios for Large Family Child Care Homes and Centers		
1.1.1.3	Ratios for Facilities Serving Children with Special Health Care Needs and Disabilities		
1.1.1.4	Ratios and Supervision During Transportation		
1.1.1.5	Ratios and Supervision for Swimming, Wading, and Water Play		

***CFOC* Standard Number**	***CFOC Online Database* Standard Title**	**Compliance/ Comparison**	
		Yes	**No**
1.2.0.2	Background Screening		
1.3.1.1	General Qualifications of Directors		
1.3.2.2	Qualifications of Lead Teachers and Teachers		
1.3.3.1	General Qualifications of Family Child Care Caregivers/Teachers to Operate a Family Child Care Home		
1.4.1.1	Pre-service Training		
1.4.2.2	Orientation for Care of Children with Special Health Care Needs		
1.4.2.3	Orientation Topics		
1.4.3.1	First Aid and CPR Training for Staff		
1.4.3.2	Topics Covered in First Aid Training		
1.4.3.3	CPR Training for Swimming and Water Play		
1.4.5.1	Training of Staff Who Handle Food		
1.4.5.2	Child Abuse and Neglect Education		
1.5.0.1	Employment of Substitutes		
1.5.0.2	Orientation of Substitutes		
1.6.0.1	Child Care Health Consultants		
Chapter 2 - Program Activities for Healthy Development			
2.1.1.4	Monitoring Children's Development/Obtaining Consent for Screening		
2.1.2.1	Personal Caregiver/Teacher Relationships for Infants and Toddlers		
2.2.0.1	Methods of Supervision of Children		
2.2.0.4	Supervision Near Bodies of Water		
2.2.0.6	Discipline Measures		
2.2.0.8	Preventing Expulsions, Suspensions, and Other Limitations in Services		
2.2.0.9	Prohibited Caregiver/Teacher Behaviors		
2.2.0.10	Using Physical Restraint		
2.3.3.1	Parents'/Guardians' Provision of Information on their Child's Health and Behavior		

CFOC Standard Number	*CFOC Online Database* Standard Title	Compliance/ Comparison	
		Yes	No
Chapter 3 - Health Promotion and Protection			
3.1.2.1	Routine Health Supervision and Growth Monitoring		
3.1.3.1	Active Opportunities for Physical Activity		
3.1.3.2	Playing Outdoors		
3.1.4.1	Safe Sleep Practices and SIDS Risk Reduction		
3.1.5.1	Routine Oral Hygiene Activities		
3.2.1.4	Diaper Changing Procedure		
3.2.2.1	Situations that Require Hand Hygiene		
3.2.2.2	Handwashing Procedure		
3.2.2.3	Assisting Children with Hand Hygiene		
3.2.3.4	Prevention of Exposure to Blood and Body Fluids		
3.3.0.1	Routine Cleaning, Sanitizing, and Disinfecting		
3.4.1.1	Use of Tobacco, Alcohol, and Illegal Drugs		
3.4.3.1	Emergency Procedures		
3.4.3.3	Response to Fire and Burns		
3.4.4.1	Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation		
3.4.4.3	Preventing and Identifying Shaken Baby Syndrome/Abusive Head Trauma		
3.4.5.1	Sun Safety Including Sunscreen		
3.4.6.1	Strangulation Hazards		
3.5.0.1	Care Plan for Children with Special Health Care Needs		
3.5.0.2	Caring for Children Who Require Medical Procedures		
3.6.1.1	Inclusion/Exclusion/Dismissal of Children		
3.6.1.2	Staff Exclusion for Illness		
3.6.1.4	Infectious Disease Outbreak Control		
3.6.3.1	Medication Administration		
3.6.3.2	Labeling, Storage, and Disposal of Medications		
3.6.3.3	Training of Caregivers/Teachers to Administer Medication		

CFOC **Standard Number**	***CFOC Online Database*** **Standard Title**	**Compliance/ Comparison**	
		Yes	**No**
Chapter 4 - Nutrition and Food Service			
4.2.0.3	Use of USDA - CACFP Guidelines		
4.2.0.6	Availability of Drinking Water		
4.2.0.8	Feeding Plans and Dietary Modifications		
4.2.0.10	Care for Children with Food Allergies		
4.3.1.3	Preparing, Feeding, and Storing Human Milk		
4.3.1.5	Preparing, Feeding, and Storing Infant Formula		
4.3.1.9	Warming Bottles and Infant Foods		
4.3.1.11	Introduction of Age-Appropriate Solid Foods to Infants		
4.5.0.6	Adult Supervision of Children Who Are Learning to Feed themselves		
4.5.0.9	Hot Liquids and Foods		
4.5.0.10	Foods that Are Choking Hazards		
4.8.0.1	Food Preparation Area		
4.8.0.3	Maintenance of Food Service Surfaces and Equipment		
4.9.0.2	Staff Restricted From Food Preparation and Handling		
4.9.0.3	Precautions for a Safe Food Supply		
Chapter 5 - Facilities, Supplies, Equipment, and Environmental Health			
5.1.1.2	Inspection of Buildings		
5.1.1.3	Compliance with Fire Prevention Code		
5.1.1.5	Environmental Audit of Site Location		
5.1.3.2	Possibility of Exit From Windows		
5.1.4.1	Alternate Exits and Emergency Shelter		
5.1.5.4	Guards At Stairway Access Openings		
5.1.6.6	Guardrails and Protective Barriers		
5.2.1.1	Fresh Air		
5.2.1.10	Gas, Oil or Kerosene Heaters, Generators, Portable Gas Stoves, and Charcoal and Gas Grills		
5.2.1.11	Portable Electric Space Heaters		
5.2.4.2	Safety Covers and Shock Protection Devices for Electrical Outlets		

***CFOC* Standard Number**	***CFOC Online Database* Standard Title**	**Compliance/ Comparison**	
		Yes	**No**
5.2.4.4	Location of Electrical Devices Near Water		
5.2.5.1	Smoke Detection Systems and Smoke Alarms		
5.2.6.3	Testing for Lead and Copper Levels in Drinking Water		
5.2.7.6	Storage and Disposal of Infectious and Toxic Wastes		
5.2.8.1	Integrated Pest Management		
5.2.9.1	Use and Storage of Toxic Substances		
5.2.9.2	Use of a Poison Center		
5.2.9.3	Informing Staff Regarding Presence of Toxic Substances		
5.2.9.4	Radon Concentrations		
5.2.9.5	Carbon Monoxide Detectors		
5.2.9.13	Testing for Lead		
5.3.1.1	Safety of Equipment, Materials, and Furnishings		
5.3.1.12	Availability and Use of a Telephone or Wireless Communication Device		
5.4.5.2	Cribs		
5.5.0.6	Inaccessibility to Matches, Candles and Lighters		
5.5.0.7	Storage of Plastic Bags		
5.5.0.8	Firearms		
5.6.0.1	First Aid and Emergency Supplies		
5.7.0.4	Inaccessibility of Hazardous Equipment		
Chapter 6 - Play Areas/Playgrounds and Transportation			
6.1.0.6	Location of Play Areas Near Bodies of Water		
6.1.0.8	Enclosures for Outdoor Play Areas		
6.2.1.9	Entrapment Hazards of Play Equipment		
6.2.3.1	Prohibited Surfaces for Placing Climbing Equipment		
6.2.4.4	Trampolines		
6.2.5.1	Inspection of Indoor and Outdoor Play Areas and Equipment		

CFOC **Standard Number**	***CFOC Online Database*** **Standard Title**	**Compliance/ Comparison**	
		Yes	**No**
6.3.1.1	Enclosure of Bodies of Water		
6.3.1.4	Safety Covers for Swimming Pools		
6.3.1.6	Pool Drain Covers		
6.3.2.1	Lifesaving Equipment		
6.3.5.1	Hot Tubs, Spas, and Saunas		
6.3.5.2	Water in Containers		
6.4.1.2	Inaccessibility of Toys or Objects to Children Under Three Years of Age		
6.4.1.5	Balloons		
6.4.2.2	Helmets		
6.5.1.1	Competence and Training of Transportation Staff		
6.5.1.2	Qualifications for Drivers		
6.5.2.2	Child Passenger Safety		
6.5.2.4	Interior Temperature of Vehicles		
6.5.3.1	Passenger Vans		
Chapter 7 - Infectious Diseases			
7.2.0.2	Unimmunized Children		
7.2.0.3	Immunization of Caregivers/Teachers		
7.3.3.1	Influenza Immunizations for Children and Caregivers		
7.3.3.2	Influenza Control		
7.3.5.1	Recommended Control Measures for Invasive Meningococcal Infection in a Child Care Center		
7.4.0.1	Control of Enteric (Diarrheal) and Hepatitis A Virus (HAV) Infections		
7.5.10.1	Staphylococcus Aureus Skin Infections Including MRSA		
Chapter 9 - Policies			
9.2.3.2	Content and Development of the Plan for Care of Children and Staff Who Are Ill		
9.2.3.12	Infant Feeding Policy		

***CFOC* Standard Number**	***CFOC Online Database* Standard Title**	**Compliance/ Comparison**	
		Yes	**No**
9.2.4.1	Written Plan and Training for Handling Urgent Medical Care or Threatening Incidents		
9.2.4.3	Disaster Planning, Training and Communication		
9.2.4.5	Emergency and Evacuation Drills/Exercises Policy		
9.2.4.7	Sign-In/Sign-Out System		
9.2.4.8	Authorized Persons to Pick Up Child		
9.4.1.10	Documentation of Parent/Guardian Notification of Injury, Illness or Death in Program		
9.4.1.12	Record of Valid License, Certificate or Registration of Facility		
9.4.2.6	Contents of Medication Record		
Chapter 10 - Licensing and Community Action			
10.4.2.1	Frequency of Inspections for Child Care Centers, Large Family Child Care Homes, and Small Family Child Care Homes