



FACT SHEET

BRONCHIOLITIS

Pennsylvania Chapter

What is bronchiolitis?

Bronchiolitis is a condition of infants and toddlers sometimes characterized by rapid breathing, deep cough and loud wheezing, often accompanied by fever. Typically, bronchiolitis is preceded by 3 to 5 days of symptoms of a cold. In some cases, babies can cough for weeks after their first symptoms. The usual length of illness is 10-14 days.

The symptoms of bronchiolitis are due to inflammation of the air tubes in the chest. The inflammation is caused by a virus infection to which the body responds with swelling of the smaller air tubes of the lungs called bronchioles. The common virus that usually causes bronchiolitis is Respiratory Syncytial Virus (RSV). Other respiratory viruses can cause bronchiolitis too.

About half the infants and toddlers who get bronchiolitis continue to get episodes of wheezing when they catch colds, but in most cases, the wheezing problem goes away by the time they are 3 years of age.

How is bronchiolitis spread?

It is spread by direct or close contact with infected children. The prominent cough sprays infected droplets onto hands and surfaces and into the air, spreading the virus. The virus may persist on environmental surfaces for several hours and for one half hour or more on the hands.

Bronchiolitis follows the patterns of spread of viral respiratory infections -- peaking annually in the late fall and winter (January and February) each year. Spread of the virus among household and child care contacts is common. Adults and older children may have RSV when they have a common cold or laryngitis.

How long are people with bronchiolitis contagious?

The period of viral shedding is usually 3 to 8 days; but may be longer in young infants in whom shedding could continue for as long as 3 to 4 weeks.

What can parents and child care providers do?

- Obtain written instructions from health providers about any special care a child will require on returning to child care after an episode of bronchiolitis.
- Ensure close communication between parents and staff after the child returns about any continued treatment plan.
- Keep a record of the child's illnesses in the child's health record at the child care facility. Not every illness will require medical care, but the log of illnesses can inform the health professional about the child's need for more care between episodes.
- Keep the child's head elevated for sleeping. An easy way to elevate the child's head is to raise the head end of the child's cot or crib with phone book under legs or edge of the head end of the rest equipment.
- Give ill children lots of clear liquids to drink.
- Wash your hands carefully, especially after contact with respiratory secretions.
- Ventilate the environment daily.

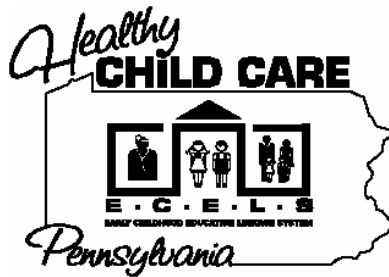
- Clean and sanitize surfaces in the environment used by children and adults in the program daily during peak period of respiratory disease and at other times, according to the routine schedule in *Caring for Our Children, the National Health and Safety Performance Standards for Out-of-Home Child Care*.

When must children with bronchiolitis be excluded from a child care facility?

Young children with viral bronchiolitis who are unable to participate in the child care activities, those having too much difficulty breathing and feeding for caregivers to give them attention without neglecting the other children, those unable to take in usual amounts of fluids, and those acting sick and irritable should be excluded until they require a level of care that can be given to them by their child care providers.

Reference: American Academy of Pediatrics and American Public Health Association, *Caring for Our Children, the National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care* 2nd edition, 2002. (On the Internet at <http://nrc.uchsc.edu>)

Reviewed and updated by: Frances C. Gross, DO, FAAP 2/01
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FACT SHEET

FEVER

Pennsylvania Chapter

What is a fever?

Fever is a well known symptom that people use to identify a child who may be ill. Fever (a rise in the body temperature above normal) is common in young children and is rarely harmful. There are many causes of fever other than illness. Exercise, environmental conditions, individual variations in baseline body temperature and teething may be associated with body temperatures above what is commonly thought to be the “normal” level.

What Can Parents and Child Care Providers Do?

- Remove sweaters or blankets from child.
- Offer small, frequent amounts of clear liquids at room temperature.
- Give acetaminophen if you have the parent’s consent and a doctor’s written instructions for use.
- Use cool baths to decrease temperatures over 102° F that don’t drop with acetaminophen alone.

Get the child to a medical professional for evaluation right away if:

- An infant under 8 weeks of age has a temperature of 100° F axillary or 101° F rectally.
- Any child who looks or acts very ill or seems to be getting worse quickly.
- Any child who has neck pain with movement.

Reference: American Academy of Pediatrics and American Public Health Association. Caring for Our Children: National health and Safety Performance Standards for Out-of-Home Child Care, 2nd edition, 2002.

Reviewed by: Susan S. Aronson MD, FAAP, 11/04





FACT SHEET

PREVENTING SPREAD of INFECTIOUS DISEASE IN CHILD CARE

Pennsylvania Chapter

1. Practice good hygiene daily.

- All staff, volunteers and children should wash their hands according to guidelines in the *Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care*, 2nd Edition, 2002 (on the Internet at <http://nrc.uchsc.edu>)
- Provide a hand washing poster at each sink and keep liquid soap, paper towels and hand lotion within reach. (Downloads of health and safety posters are available on the Internet from <http://www.globalhealthychildcare.org>)
- Use proper diapering techniques detailed in *Caring for Our Children*.
- Use disposable gloves when handling potentially blood-contaminated materials. Dispose of gloves immediately after finishing the clean up and sanitizing all surfaces.
- The best waste receptacles for contaminated materials are foot operated or hands-free, covered containers that are lined with plastic bags.

2. Maintain a clean, sanitized environment.

- Follow the table for frequency and type of routine cleaning and sanitizing for surfaces that is found in *Caring for Our Children* 2nd Edition, page 106.
- Use detergent and a water rinse to clean hard surfaces including tabletops, counters, doorknobs, and telephones. Surfaces must be visibly clean before you can sanitize them.
- To sanitize, wet visibly clean surfaces by spraying them with a fresh sanitizing solution until they are glistening. An inexpensive sanitizing solution is (1) tablespoon of bleach to a quart of water, mixed fresh daily. The solution must be mixed fresh daily because enough bleach evaporates from the solution over the course of the day that by the second day, it is no longer at the required concentration. Allow the sprayed surfaces to air dry or wipe them dry after a contact time of at least 2 minutes. Instead of bleach, you can use another EPA sanitizer according to the manufacturer's instructions on the label. Be sure to note the toxicity of any chemicals you use and safeguard children from exposure to them.
- Vacuum carpets daily and shampoo them when children will not be present until the carpets are dry. Clean the carpets monthly in infant areas, and at least every 3 months in other areas, as well as when they are soiled.

Use a detergent to clean all surfaces in contact with a spill of a body fluid. Clean floors, rugs and carpeting that have been contaminated by body fluids by blotting to remove the fluid as quickly as possible, then clean and sanitize by spot-cleaning, shampooing, or steam-cleaning the contaminated surface. Cleaning and sanitizing rugs and carpeting that have been contaminated by body fluids is challenging. Trying to extract as much of the contaminating material as possible before it penetrates the surface to lower layers helps to minimize this challenge. Cleaning and sanitizing the surface without damaging it requires use of special cleaning agents designed for use on rugs, or steam cleaning.

- Use safe washable toys, especially for infants. Place mouthed toys in a container labeled “soiled toys”. Before using them again, wash them with detergent, rinse well, then spray or immerse in sanitizing solution for at least 2 minutes. Alternately, wash the toys in a sanitizing dishwasher.
- Ventilate the rooms daily. In cold or very hot weather, ventilate the rooms while children are outdoors or elsewhere, then close up to allow the room temperature to return to a comfortably heated or air conditioned level.

3. Protect children in the child care facility.

- Have a health consultant tour the facility and advise on infection control.
- Use the Immunization Dose Counter available from the American Academy of Pediatrics (send a self-addressed stamped business envelope to Publications, 141 Northwest Point Blvd, Elk Grove Village, IL 60006) or subscribe to WellCareTracker™ (available at www.WellCareTracker.org) to review each child’s immunization record to be sure children’s records are up to date.
- Assure that children drink enough liquids daily. Water or milk is best, with no more than 4 ounces of full strength juice per day.
- Place each child’s labeled rest equipment at least 3 feet apart. Have children rest head to toe. Rest equipment should be cleaned and sanitized weekly or at least monthly.
- Keep personal items labeled. Never share hats or combs. Avoid dress-up clothing when there is a skin infection present in the facility.

Reference: American Academy of Pediatrics and the American Public Health Association. *Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care*, 2nd edition 2002

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FACT SHEET

Pennsylvania Chapter

UNIVERSAL, STANDARD AND TRANSMISSION-BASED PRECAUTIONS AS THEY APPLY TO CHILD CARE SETTINGS

The terms “Universal Precautions” “Standard Precautions” and “Transmission-based Precautions” were developed for applications in medical and industrial settings. They apply to child care with some adjustments from their meaning in other settings.

What are Standard Precautions?

Standard Precautions apply to contact with non-intact skin, mucous membranes, blood, all body fluids, and excretions except sweat, whether or not they contain visible blood. They include general methods of infection prevention are indicated for both children and adults in the early education and child care setting. These methods reduce the risk of transmission of microorganisms that can cause infection, even when those spreading the micro-organisms do not appear to be ill.

Standard precautions involve cleaning and sanitizing contaminated surfaces in addition to the use of barriers described in Universal Precautions. Unlike medical care settings, gowns and masks are not required in early education and child care facilities. Appropriate barriers to use in include materials such as disposable diaper table paper, disposable towels, and surfaces that can be sanitized. Use of non-porous gloves is optional except when blood or blood containing body fluids may be involved. (See “Wearing Gloves” below.)

What are Universal Precautions?

Universal Precautions apply to blood, other body fluids containing blood, semen, and vaginal secretions, but not to feces, nasal secretions, sputum, sweat, tears, urine, saliva and vomit unless these others contain visible blood or are likely to contain blood. Universal precautions include avoiding injuries caused by sharp instruments or devices and the use of protective barriers such as gloves, gowns, aprons, masks, or protective eyewear, which can reduce the risk of exposure of the worker's skin or mucous membranes that could come in contact with materials that may contain blood-borne pathogens while the worker is providing first aid or care.

What are Transmission-based Precautions?

Transmission-based Precautions are precautions in addition to Standard Precautions that are required where airborne, droplet and contact transmission of infectious organisms may occur. In addition to hand washing, cleaning and sanitation of surfaces, these include use of a room shared only by those who are infected with the same infectious agent (with negative-pressure ventilation when airborne spread is involved), use of masks for infections spread by the airborne and droplet routes, and use of gowns and gloves for diseases spread by contact.

Although gloves need not be worn in feeding human milk (breastmilk) or cleaning up spilled human milk, human milk can be contaminated with infectious materials. Wearing gloves to clean up a big spill of human milk is a reasonable, but is an optional additional precaution. While human milk can be contaminated with blood from a cracked nipple, the risk of transmission of infection to caregivers who are feeding expressed breast milk is very low.

Either single-use disposable gloves or utility gloves should be used. Single-use disposable gloves should be used only once and then discarded immediately without being handled. If utility gloves are used, they should be cleaned after every use with soap and water and then dipped in bleach solution up to the wrist. The gloves should then be taken off and hung to dry. The utility gloves should be worn, not handled, during this cleaning and sanitizing procedure.

What method should be used to apply Standard Precautions?

For spills of body fluids, urine, feces, blood, saliva, nasal discharge, eye discharge, injury or tissue discharges, and human milk, use the following step-by-step approach:

1. Pick up the spill using disposable towels and tools that can be sanitized afterward. Be careful not to splash any of the contaminated materials around.
2. Use a detergent to clean all surfaces in contact with the spill. Clean floors, rugs and carpeting that have been contaminated by body fluids by blotting to remove the fluid as quickly as possible, then clean and sanitize by spot-cleaning, shampooing, or steam-cleaning the contaminated surface. Cleaning and sanitizing rugs and carpeting that have been contaminated by body fluids is challenging. Trying to extract as much of the contaminating material as possible before it penetrates the surface to lower layers helps to minimize this challenge. Cleaning and sanitizing the surface without damaging it requires use of special cleaning agents designed for use on rugs, or steam cleaning.
3. For spills of vomit, urine, human milk, and feces, on floors, walls, bathrooms, tabletops, toys, kitchen counter tops, and diaper-changing tables: first clean the surface with detergent, then rinse the cleaned surface, and then apply a sanitizing solution. If the solution is a 1:64 dilution of bleach water (1 tablespoon of bleach to a quart of water prepared fresh daily from domestic bleach) the surface must be thoroughly wet and left in contact with the bleach solution for 2 minutes. If some other dilution or chemical is used to sanitize, follow the manufacturer's instructions.
4. Dispose of any blood-contaminated material in a plastic bag with a secure tie.

What should caregivers do when there has been a possible exposure to blood?

Stay calm and rational. Bacteria and viruses carried in the blood, such as hepatitis B virus, pose a small but specific risk in the child care setting. Blood and direct blood-derived fluids (such as watery discharges from injuries) pose the highest potential risk, because these body fluids contain the highest concentration of viruses. Hepatitis B virus can survive in a dried state in the environment for at least a week and perhaps even longer. Some other body fluids such as saliva contaminated with blood or blood-associated fluids may contain live virus (such as hepatitis B virus) but at lower concentrations than are found in blood. Other body fluids, including urine and feces, do not pose a risk with blood borne diseases unless they are visibly contaminated with blood, although these fluids do pose a risk with other infectious diseases.

Mucous membrane exposure to blood is unlikely to cause disease unless the person whose blood was transferred has a blood-borne disease. Instances in which one child draws blood of another individual during biting or otherwise gets blood from another person on mucous membranes are very rare, but can cause considerable concern. Child bites do not often break the skin and when the skin is broken, bleeding begins a few seconds later, usually after the biter releases the bitten flesh. Despite the fact that biting is a common behavior by young children, transmission of blood borne disease by biting in child care has not been reported.

Nevertheless, if blood transfer has occurred, exposing a mucous membrane to blood from another individual (e.g. blood from another individual is visible in the mouth of a biter), this should be treated as an accidental exposure to a potential HIV-containing body fluid. HIV testing may not account for a potential exposure to the virus from the time between a previous test and the exposure. The person who has experienced a mucous membrane exposure to blood should be tested up to 9 months after the exposure if the status of the donor of the blood is unknown.

When a mucous membrane blood exposure occurs, child care providers should:

- Inform the exposed adult or the parents of the child who had a mucous membrane exposure to someone else's blood that:
 - 1) The adult or child was exposed to another person's blood;
 - 2) The risk of transmission of HIV is very small;
 - 3) The exposed adult or the parents of the exposed child should notify the primary care physician of the exposure;
 - 4) The person who was exposed to blood should have a baseline test for HIV.
- Inform the person whose blood was involved (or the legal guardians if that person is a child) about the incident and ask:
 - 1) If the person whose blood is involved ever had an HIV test and, if so, if those results could be shared with the exposed adult or parents of the exposed child;
 - 2) If that person does not know or has never had an HIV test if that person would be willing to have one and share results with the exposed adult or the parents of the child who was exposed.

Some children and adults may unknowingly be infected with HIV or other infectious agents, such as hepatitis B virus, as these agents may be present in blood or body fluids. Thus, the staff in all facilities should adopt standard precautions for all blood spills and possible exposure to blood. The Occupational Safety and Health Administration (OSHA) requires a facility plan and annual training of staff members who may be exposed to blood as a condition of their employment. These OSHA requirements apply to child care workers who are employees. The sanctions for failing to comply with OSHA requirements can be costly, both in fines and in health consequences. Child care providers should take the necessary steps to meet OSHA requirements. Regional offices of OSHA are listed with other federal agencies in the telephone directory. ECELS-Healthy Child Care PA has an On-line Self-Learning Module that guides early education and child care providers through the development of a facility plan at www.ecels-healthychildcarepa.org.

What should caregivers do if a child has been fed the milk of another child's mother?

Promote breastfeeding at every opportunity, but be careful so a human milk mix-up doesn't happen. Feeding human milk to babies has benefits that include preventing disease in the short term as well as throughout life. Child care providers should do everything they can to encourage families of infants to try to use human milk for as many milk feedings as possible. Human milk is a body fluid, and can carry infectious agents. So, with rare exceptions, babies should drink their own mother's milk only.

Instances in which one child is mistakenly fed another child's bottle should not occur if proper procedures are used. Caregivers must be sure that all infant feeding bottles are labeled with the child's name and date of preparation and that they check the label on the bottle every time they start to feed. A mix-up could happen if the caregiver picks up a bottle that was prepared for another child, or one that another child dropped or put down. Risk of HIV transmission from expressed human milk that another child has drunk is believed to be low because:

- In the United States, women who know they are HIV-positive are advised not to breastfeed their infants;
- Compounds present in human milk, together with time and cold temperatures, act to destroy the HIV present in expressed human milk.

If a mix-up occurs, it must be treated as an accidental exposure to a potential hepatitis B, hepatitis C, CMV (cytomegalovirus) or HIV-containing body fluid. All infants should have been immunized against hepatitis b, and CMV is a common infection for young children. To address the concern about transmission of HIV by human milk when a mix-up occurs, providers should:

- Inform the parents of the child who was given the wrong bottle that:
 1. Their child was given another child's bottle of expressed human milk;
 2. The risk of transmission of HIV is very small;
 3. They should notify the child's physician of the exposure;
 4. The child should have a baseline test for HIV.
- Inform the mother who expressed the human milk of the bottle switch and ask:
 1. If she has ever had an HIV test and, if so, if she would be willing to share the results with the parents of the exposed child;
 2. If she does not know if she has ever had an HIV test, if she would be willing to contact her obstetrician and find out, and if she has, share the results with the parents;
 3. If she has never had an HIV test, if she would be willing to have one and share results with the parents;
 4. When the human milk was expressed and how it was handled before being brought to the facility.
- Since HIV testing may not account for a potential exposure to the virus from the time in between the previous test and the exposure, an infant should be tested up to 9 months after the exposure if the status of the donor mother is unknown. If an infant is exposed to expressed human milk from someone else's mother, that infant should complete the hepatitis b vaccination series, if the series is not complete already.

Reference: American Academy of Pediatrics and the American Public Health Association. *Caring for Our Children, the National Health and Safety Performance Standards: Guidelines for Out-of-Home Care*, 2nd edition, 2002.

Prepared by: Susan S. Aronson MD, FAAP 11-04





FACT SHEET

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

Pennsylvania Chapter

What is ADHD?

Attention Deficit Hyperactivity Disorder is marked by poor ability to pay attention, easy distractibility, a high activity level, and impulsivity. They often don't finish tasks or chores. Children with ADHD are inattentive at home, school, or child care and often have poor social skills. These traits begin early, generally before children reach age 6 or 7 years. About 3-5% of school age children are diagnosed with ADHD.

What causes ADHD?

Doctors aren't sure what causes ADHD. But experts agree that *biological* factors cause ADHD, not a child's parents. Children with ADHD are difficult to care for. Parents and caregivers often need advice and support to work with children with ADHD.

How do I know if a child has ADHD?

Normally, preschoolers are very energetic. They prefer running, climbing, wrestling, and vigorous play over sitting quietly. They have limited insight and judgment, and often act before they think about consequences. Preschoolers have short attention spans and may be quite distractible, especially in noisy environments. Many have not developed social skills for resolving conflicts, sharing, or cooperating and get into fights or arguments.

It's hard to tell if a preschooler has ADHD because all children this age have a high activity level, impulsivity, limited attention, and aggression. However, parents, teachers, and caregivers, often recognize children whose activity level or inattention is extreme for their age. These children are the most active and least attentive in the classroom. Frequently, they fail to complete activities, take toys out to play with, but then jump to something else after barely getting started. They may have difficulty in learning letters, numbers, and other pre-academic skills. Children with ADHD have difficulty making friends and demand extra adult attention.

What should I do if I think a child has ADHD?

1. Talk with the child's parents. Get a complete picture of the child's traits and behaviors in other settings. You might say to parents, "We're concerned because your child is extremely active." Offer the parents documentation (such as ECELS-Healthy Child Care PA Behavioral Data Collection Sheet) that supports your observations. Parents may feel guilty about their child's problems. If the parents are experiencing similar problems with the child, support them by saying, "It must be so difficult for you. We'll work on this problem together."
2. If parents share your concerns, suggest they contact their child's primary care provider. Hyperactivity and inattention may indicate problems other than ADHD. Avoid labeling a child unnecessarily.
3. Try the behavior management techniques listed below. Many of these changes will benefit the entire class.

What can I do to manage the behavior of a child with ADHD?

- *Modify the environment.* Children with ADHD often show the greatest problems in loud or busy environments. Lower the classroom noise level and use a calm, quiet voice when you want the child's attention.
- *Simplify social situations.* Limit the number of children interacting at one time. Point out social cues to the child with ADHD and interpret them if necessary. You might say, "Your friend wants to share this toy. How can you share it with her?"
- *Maintain structure.* Children with ADHD, as well as children developing typically, do better when they know what to expect. Make a daily schedule and stick to it.
- *Increase the child's motivation to pay attention.* Children with ADHD can settle and concentrate under some circumstances. They are more likely to pay attention when there are rewards for doing so and when there are consequences for not doing so. Identify rewards and consequences for the whole group. Natural rewards work best. Try saying, "We can go outside when we finish with clean-up."
- *Provide clear instructions.* Communicate clearly and quietly. Make sure the child is paying attention by touching his chin and getting him to look at you. Break complex instructions into small chunks and ask children to repeat the instruction.
- *Celebrate successes.* Praise the child for concentrating and completing work. This reward increases the child's motivation. Don't forget to provide opportunities for children to be active. For example, allow children to talk or jump between activities.

Are medications OK for preschoolers with ADHD?

Medications are available for children of all ages with ADHD. Common medications include Ritalin, Dexedrine, Cylert, Tenex, Adderall, and Catapres. Some of these medications must be given during the school day to be effective. Medications are somewhat less effective in children under 6 than they are in older children.

Many families and physicians are reluctant to use medication in preschoolers. The impact of long-term use of ADHD medication for preschoolers has not been well researched. ADHD medicines are associated with side effects such as poor appetite, irritability, moodiness, or social withdrawal in very young children.

ADHD medications are most useful for reducing problems that interfere with learning. Often, medications for preschoolers in child care can be postponed. Behavioral strategies are usually more important for this age group. Consultation with educators and behavior specialists in early intervention programs may be useful. In some cases, medicine may be necessary.

What is the long term outlook for children with ADHD?

Problems may subside as children get older and have opportunities to choose activities and exert control over their lives. Adults should help children with ADHD understand their behaviors and lead them to situations where a high activity level is desirable. It's important for children with ADHD to maintain a healthy self-concept. Parents, teachers, and caregivers can encourage a healthy self-concept by giving love, attention, and appreciation of the child's strengths.

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FACT SHEET

BEHAVIOR PROBLEMS – Overview

Pennsylvania Chapter

What can child care providers do about children with behavior problems?

Child care providers often see early indications of behavior problems in the young children in their care. Child care providers can support the child during times of stress. This support may prevent serious difficulties. Child care providers can also provide valuable information to families, primary care physicians, and mental health professionals to assist them in diagnosis and treatment of severe problems.

When do children develop behavior problems?

Sometimes healthy and well-adjusted children experience environmental stress, which leads to behavior problems. When these stresses occur, monitor children closely and describe any changes in their moods or behaviors. Children's responses to stress vary greatly. Some children show mild reactions while others show severe problems. If children have high quality, consistent and supportive relationships with family and child care providers, it may lessen the effects of stress.

Some children show behavior problems without any obvious preceding stressful event. These problems also vary from mild to severe. Do not assume that the family is the cause of a behavior problem. The family may already feel grief and guilt because the child is experiencing problems. Do not increase those feelings.

What are the stressful environmental situations for children when child care providers should monitor the child's behaviors?

- **Changes in the parent or caregiver.** Children may become separated from their primary loved one if a parent is ill, hospitalized or dies, or if parents separate or become divorced. The child loses physical contact and emotional support from the parent.
- **Problems in the family relationships.** Conflict between parent figures or between the parent and child may be very stressful. Conflict often accompanies problems of communication. Domestic violence is an extreme form of conflict in which parents or caregivers behave violently toward one another. Sometimes the violence spreads and children become victims of abuse. Abuse results in the physical or emotional harm to the child. It may take the form of physical injury or sexual mistreatment. It may include emotional or psychological abuse, such as when the child feels completely rejected or repeatedly terrified.
- **Inadequate care.** Parents or caregivers may not supervise the child well, respond to the child's needs, or place reasonable limits on the child's behavior. They may be harsh in discipline, too permissive, or inconsistent. Sometimes parents and caregivers may overprotect the child and not let the child do what other children are doing at that age.
- **Problems with individual family members.** Many problems that parents and caregivers face affect their children. For example, if a parent has an illness, the condition may affect the parent's ability to care for and nurture the child. Similarly, mental disorders or problems with alcohol or drug use can impair the competence of parents. Physical or mental health problems of siblings also affect the parents and other children. When parents experience

religious or spiritual problems, convert to a new religion, or move to an area with a different culture, the children may also feel the stress. Some parents have difficulty with reading and the children also experience stress when the parent must read.

- **Changes in the family.** Some changes in the family are not bad but are still stressful for children. For example, the birth of a sibling, adoption, or the blending of families may increase the number of playmates for a child. However, it can also be stressful. When parents or caregivers have problems at work or lose their job, both the children and the adults may feel the stress at home. When a family moves to a new area, even a nicer home, the children may miss their old home and experience stress.
- **Community problems.** Sometimes, the source of stress is one or more conditions in the community. Some families experience social discrimination or isolation. Housing or schools may not be adequate. There may be considerable violence on the streets or fear of violence. In an unsafe neighborhood, parents may not allow their children to go outside to play. Then they cannot interact with peers and discharge their energy. Children become particularly distressed if they witness violence. Living in poverty increases the risk of behavior and emotional problems, because of the associated stresses. About one in four children live in poverty.

What are common behavioral or emotional problems in young children?

Many children experience difficulties for hours or days at a time. The following behaviors and emotions become problems when they occur over long periods of time or are extreme.

- **Emotions and moods.** Children may cry often for no obvious reason. They may have quick changes of moods. They may become sad or withdrawn and refuse to play with other children or talk with adults. They may get no pleasures out of play.
- **Activity level and attention.** Some children are very active and disorganized. They may not be able to concentrate on games or stories.
- **Negative behavior.** Children may throw frequent temper tantrums. They also may get angry easily. They may fight with their friends. They may refuse to do the things adults ask of them. They may strike out at caregivers who are trying to comfort them. These behaviors are particular problems in children over the age of 3 years.
- **Problems in eating, elimination, and sleep.** Some children refuse to eat; others eat too much. Some may lose control of their bladder during the day or at night after toilet training has occurred. Some children may want to sleep more than usual. Others may have difficulty relaxing for a nap or falling asleep at night. Sleep deprivation may add to their other behavioral difficulties.
- **Problems with relationships.** Children may show dramatic changes in how they relate to others. They may become extremely distressed when a parent or child care provider walks away from them. This may make it very hard for parents to leave their children at the child care setting. Children may become very clingy. They may become afraid of being alone. On the other hand, some children become indifferent. They may go to anyone, an adult they trust or a stranger. Some children avoid eye contact, stare, and refuse to let others help them. They may isolate themselves from their friends and caregivers.
- **Developmental problems.** Children may lose developmental skills they had previously mastered. For example, a child who was toilet trained may need to go back to diapers. A child who was speaking in sentences may revert to single words. A child who was able to

feed herself independently may require adult help. A child, who was able to play independently or with other children, may not be able to play alone or to socialize.

What can parents and child care providers do to help children showing behavior problems?

- **Discuss the issues.** Parents or child care providers can speak with each other about the child's behavior early in the process. Do not wait until the child's behavior or moods have deteriorated seriously. Begin with a description of the child's problems. You might say to a parent, "I notice that your child is crying a lot at school. It is difficult for me to comfort him." If you know the stressful situation you might say, "Since her father has been in the hospital, Sarah has been eating poorly at school. What do you see at home?"
- **Be supportive of the child.** Remain calm. Use supportive language. You might say, "I know you feel sad, but please try to eat a little." Provide comfort when possible. Praise the child when she does something appropriate. Be gentle. It is easy to arouse children who are under stress.
- **Maintain the structure of the program.** Children may find going through the usual schedules very helpful. Keep a predictable program. Do not insist that the child participate fully. Gently remind the child that he/she is welcome in the group.
- **Encourage communication.** Allow the child to talk about the problems. Sometimes the child will act out the stress in play. Communicate with the child through play some ways to handle the stress. For example, use a doll to demonstrate how the child might express, in words, "sad" or "angry" feelings. Provide positive reinforcement when the child's behavior is appropriate.
- **Limit dangerous or hurtful behaviors.** Provide clear messages that tantrums, aggression, and other problem behaviors are not acceptable. Give the child acceptable alternatives. For example, tell the child to express his anger but not to hurt his friends. Use the familiar discipline techniques such as time-out if a child misbehaves.
- **Keep an accurate log of the problem behaviors.** It is difficult to remember all the problem behaviors, including when they occurred, what happened before the problem, and what helped the child. Keep a diary of the behaviors. Consider using the Behavior Data Collection Sheet, provided by ECELS for this diary.

When should a child care provider refer a child for further evaluation?

Several factors may trigger a referral.

- The problems have lasted several weeks to months.
- The problems are severe or getting worse.
- Your supportive care and interventions do not help.
- The child is unable to function well in the child care setting.
- The family is extremely distressed or the stresses are getting worse.

Who you refer to depends on the child's condition and the resources in your community. The primary care physician is always a good starting place. The physician may know about the family's circumstances and may be able to provide additional support. It is also easier in many cases to refer the child to a pediatrician or family doctor than to a psychiatrist or psychologist. However, some families may appreciate an immediate referral to a mental health professional. Know the names of professionals in your area that work with children. Provide a note for that

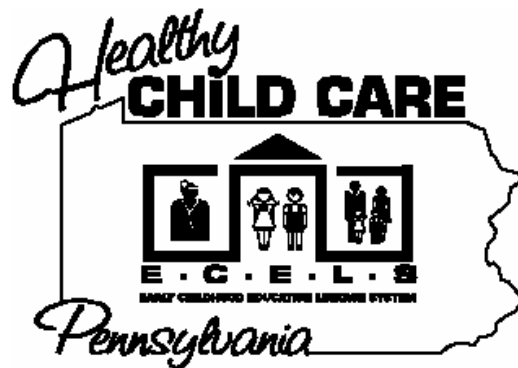
professional of your observations and concerns, if the parent gives you permission to communicate with the professional.

If you make a referral to a mental health professional for behavior problems, try to maintain the child in your program. This stability may be very helpful to the child and family. You may be able to arrange for behavioral consultation in your community so that you can improve your interventions with the child and family. Call the ECELS office for advice on the steps to follow when seeking referral.

Reference: Based on *“The Classification of Child and Adolescent Mental Diagnoses in Primary Care: Diagnostic and Statistical Manual for Primary Care (DSM-PC) Child and Adolescent Version.”* Elk Grove Village, IL: American Academy of Pediatrics, 1996.

Prepared by: Heidi M. Feldman, MD, PhD, FAAP, UCLID Center at the University of Pittsburgh 1998

Reviewed by: Susan S. Aronson, MD, FAAP 11-04



FACT SHEET



**DISCIPLINE:
TEACHING TO CHANGE
A YOUNG CHILD'S BEHAVIOR**

Pennsylvania Chapter

Many children exhibit behaviors that adults do not like. They may throw a ball in the house, or refuse to clean up their toys, or hit other children. How can child care providers manage these problem behaviors? Four helpful steps are:

- Understand the cause of the behavior.
- Have a good relationship with the child.
- Encourage good behavior.
- Decrease problem behaviors.

Here is more detail about each step:

Understanding the cause of the behavior

Sometimes the problem behavior may be the result of a child's personality, or "temperament." For example, some children are extremely active. They like to run and throw. They may be so active and noisy that they bother other children or adults. If a child's behavior relates to his temperament, you may shape this behavior but you are unlikely to change the child totally. Sometimes children need help to express their temperament in a positive way. For example, an active child who bothers other children inside the building may need more time for outdoor play. Create an environment where children can express their temperaments safely and positively.

Sometimes a problem behavior in child care is not a problem in other settings. For example, parents may feel proud that their child is quiet and non-assertive. The child's behavior may be appropriate for her culture. Some families teach children not to look at an adult when that adult is speaking to them. In these cases, it may be inappropriate for the child care provider to change the child's behavior. Try to understand the family's beliefs and cultural practices. A meeting with the parent(s) can help. The child care provider must describe the behavior without criticizing the parent or child. For example, the child care provider can say to a parent, "Sometimes Katy's running is a problem at the facility." or "Please help me understand why your child looks away when I speak with her."

Sometimes children have a lot of stress at home or in the community. They react to stress with negative emotions or problem behaviors. If you notice a change in the child's behavior, inform the parent(s). You may say, "I notice that Jonathan is fighting more than he used to. Do you have any ideas about why this is happening?"

Have a good relationship with the child.

To help children to change their behavior, adults should have a good relationship with them. Children will be most able to change when they feel good about themselves. Adults can help children feel positive and capable. Children want to please the adults they like and respect.

To build a good relationship with children, you must meet their needs. Praise children when they are showing good behavior. For example, you might praise children when they are playing quietly, sharing a toy with another child, waiting for a turn, or trying to be helpful. You can use short messages such as, "That was great!" or "I like how well you are waiting." You can also provide a hug, a smile, or a pat on the back. Try to be honest. Do not be sarcastic.

For example, do not say, “I like the way you are sitting” to a child who is running around. Children do not understand a sarcastic message. Instead, say, “I would like you to sit down.”

Many times, adults can give children choices appropriate to their developmental level. This builds a good relationship. For example, you can ask the child, “Which of these two games would you like to play?” Or “Would you like to have apple juice or milk with your lunch?” Choices make the child feel respected. This helps the children respect you in return. When children want to comply, it may help to offer a choice. For example, if a child is refusing to lie down at naptime, you can say, “You must lie down, but you can choose a book to look at on your mat.” Never give children an option that you do not want them to choose.

Encourage good behaviors.

Behavior is usually learned. It is shaped by the results, or “consequences.” Behaviors that are rewarded are likely to continue. You can reward a child by praising her for finishing a chore. Sometimes just a smile will be enough. Another reward is telling a parent what a good job the child did when the child listened.

Consequences that follow naturally or logically from a previous event are called “natural reinforcers.” Natural reinforcers are very good methods for shaping behavior. For example, if a child’s rough behavior broke the toy, then he cannot play with that toy any more. You can use natural reinforcers to change behavior. For example, you can tell the class, “We will go outside when the room is clean.” The trip outside becomes the natural reward for the clean up.

Do not reinforce behaviors you do not like. For example, if you laugh at a child’s tantrum, it may increase the number of tantrums. If you give the child food every time she is upset, it might teach the child that eating is the way to handle stress. If you pay a lot of attention every time a child throws a tantrum, the child may begin to have more tantrums. Your attention may be a reward for the tantrum, even though you did not intend it to be.

Remember to pay more attention when the child’s behavior is appropriate than when the child is acting out. Make sure to encourage good behaviors and when necessary, take steps to decrease problem behaviors.

Decrease undesirable behavior.

Children learn faster when they receive rewards for good behavior than when they are punished for problem behavior. However, all children will demonstrate behaviors that should be changed. Punishments, called “negative reinforcements,” may work under some circumstances. There are many different ways to give negative reinforcements.

One way is to withdraw positive behavior or rewards. If you have a good relationship with a child and usually provide lots of praise, ignoring the child is negative reinforcement. You tell children you want them to change by ignoring the problem behavior. Often, the most powerful punishment occurs as a result of natural consequences. Sometimes negative or unpleasant consequences follow naturally from the child’s behavior. For example, if one child hits another child and the second child walks away, the effect serves as a negative reinforcement. The child is left alone.

Another effective punishment is a logical consequence. If the child scribbles on the wall, take the crayon away. Encourage the child to help clean the wall. Plan and use punishments consistently to make them work. Restrict the child’s use of the crayons for a day or so, and say, “You cannot use the crayons. You must learn to use crayons on paper not on the wall.” When the child seems to understand, give the crayons to the child and say, “You may use crayons as long as you use them on paper and not on the wall.”

Punishments include taking away privileges. For example, if a child hits, you may decrease the time he has for his favorite activity, like his time on the swing set or at the computer.

Punishments can also be uncomfortable or undesirable circumstances that the adult requires because of the child's behavior. Most children want to be near the adults and part of the group. A form of punishment is making the child sit away from his caregivers and friends. You might try saying to a 5 year old, "You hit your friend. You must sit by yourself for five minutes."

To work, punishment should occur immediately after the problem behavior occurs. Adults should remain calm when they punish a child. Very little discussion is usually necessary. Long discussions confuse young children. You can say, "You colored on the wall. You cannot play with crayons."

Child care providers may not spank children. Child care regulations prohibit all forms of physical punishment. Spanking is not a good method for teaching children how to behave properly. They learn what not to do, but not what they should do. Spanking does not foster a good relationship between the adult and the child. Children feel shamed, hurt and angry when a caregiver hits them. They learn that hitting is a way to show disapproval.

Punishment is never enough for shaping behavior. Punishment shows a child what behavior is unacceptable. Children need specific information about what behavior **is** acceptable. For example, if a child hits his friend, in addition to any punishment, the adult can say, "Tell him you are angry. Do not hit." If a child runs where only walking is safe, tell him to walk rather than run.

Time-out

Sometimes adults cannot think of natural or logical consequences when a child misbehaves. Sometimes children are too upset to listen to what the adult is saying. Sometimes children hurt other children or adults physically. Handling the injury may need to take priority over all else. These are times to use a time-out. To use time-out, follow these steps:

1. Choose a spot where you want children to go after they have misbehaved. Make sure that the children know ahead of time, the spot for time out and the rules that determine what behaviors would send them to time-out ahead. Use time-out consistently and for only a few behaviors you want to change. Do not change the rules when the child misbehaves because you will slow the learning process.
2. When a child does the problem behavior, tell that child to go to time-out. For example, you can say, "You hit your friend. Go to time-out." Many children will walk to the right spot. If a child refuses to go, gently lead the child to the spot by the hand. If a child refuses to sit in the spot, you may need to hold that child. Sit behind and hold the child gently, but firmly. Sitting behind the child will make it difficult for the child to kick or bite. Do not talk to or make eye contact with the child whose behavior you are trying to change during time-out.
3. Time-out should last one minute for each birthday. A 4-year old would stay in time-out 4 minutes. Use a timer to let the child and adult know when the time-out is complete. It also separates the adult from the punishment to some degree. At the end of the time-out, resume activity and attention as it was before the problem behavior occurred.

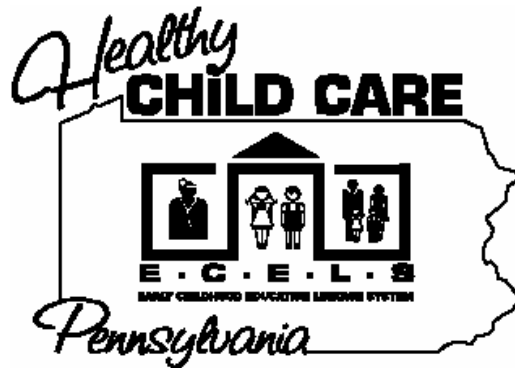
Sometimes this form of time-out is impossible. For example, on a field trip, the child cannot go to the familiar spot. Instead, you may remain silent for the same amount of time. Most children find this negative reinforcement. You could take the child's toy away for the same amount of time. Sometimes time-away is better than time out. For example, if the child threw the blocks at another child, then he may need time away from the blocks.

Summary

Children need to learn the rules of the home and classroom. Parents, teachers, and child care providers must teach the children these rules. Discipline is education about how to behave with other individuals and how to control your impulses. Discipline requires a positive relationship between adult and child. Adults teach children a lot by their own behavior because children imitate adults. A calm and kind approach to discipline encourages learning. Children understand consistent rules that are stated clearly, simply and briefly. Long explanations confuse young children. Punishment should be reserved for circumstances where all other methods fail. In the context of a positive relationship, a simple time-out that separates the child from the group has a powerful impact on the child's learning. Physical methods are prohibited in child care or school setting.

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Reviewed by: Susan S. Aronson, MD, FAAP 11-04





FACT SHEET

REPETITIVE BEHAVIORS

Pennsylvania Chapter

What are repetitive behaviors?

Repetitive behaviors are physical or verbal behaviors that a child engages in repeatedly. The most common repetitive behaviors are head banging, thumb sucking, and rocking. These common examples may not be problem behaviors. Other examples may be hand flapping, repeated play or constant return to a specific play pattern or particular toy, spinning objects, saying the same sounds or words over and over, or walking repeatedly in the same pattern around a room. Sometimes these behaviors appear to be nervous tics. These repetitive behaviors may interfere with a child's learning or social interactions.

Why would a child engage in repetitive behaviors?

There are many possible reasons.

- Boredom.
- Anxiety or worry.
- To avoid a task or activity.
- Self-stimulation or self-soothing.
- To gain attention.
- The child does not know how to approach a situation or activity.
- Difficulty in self-regulation, such as dealing with emotions, comfort, or falling asleep.
- A characteristic of a specific condition or disability.

If you are not sure why the behavior happens, ask yourself "What does the behavior accomplish?" You may be able to figure out a reason. In some cases, children may engage in repetitive behaviors and adults may not be able to figure out the reason.

What can parents and child care providers do to reduce common repetitive behaviors?

- Create a predictable and structured environment that encourages self-regulation, independence, and choice. For example, put up a set of pictures to let children know the schedule for the day. Use a musical tone to warn children that they will need to change their activity in two minutes.
- Change routines or schedules to meet individual needs. For example, if the children seem particularly active on a given day, shorten their time sitting and increase their time in outdoor play.
- Try to control stimuli such as noise, light, people, and confusion. You may use carpeting, soft lighting, or soothing background music to reduce stimulation. Speak in a conversational tone and do not yell.
- Provide opportunities for children to make choices. For example, you can ask children whether they want to drink milk or juice at lunch and to choose their toys.
- Introduce the child to new places, procedures, and people in small steps. Warn children when a change is about to occur. You can say, "We are going to meet a new person this afternoon."
- Encourage functional and useful activities. For example, show a child how to roll a toy car and play with it appropriately rather than spin it around. Show the child the pictures in the magazine rather than let the child simply flip through the pages.

- Encourage social interaction skills with peers. Children use repetitive behaviors when they are alone. You can often get a child to join the group by bringing out a toy that all the children really like.

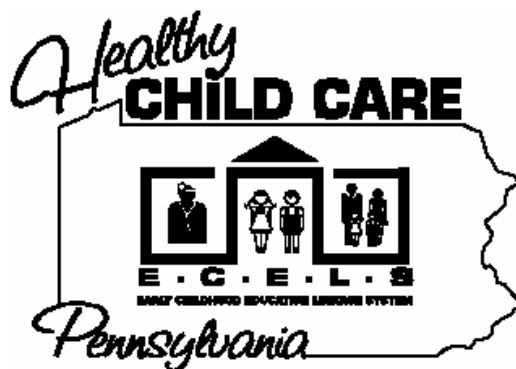
What can be done to reduce persistent and difficult repetitive behaviors?

- Encourage the child to use a functional communication system. You can say, “I like when you tell me with words that you are angry.”
- Be positive and praise desirable behaviors. You can say, “You thought of a new way to use that toy. Good job.”
- Use clear and simple language to tell the child what you want him/her **to do**, not what **not to do**. You can say, “Please tell me with your words that you do not know how to do this.”
- Provide appropriate modeling experiences and opportunities for making choices. For example, if the child does a repetitive behavior to avoid a task, offer a choice between two tasks. For example, you can say, “It is clean-up time. Do you want to throw away the paper cups or wipe the table with the sponge?”
- If the child engages in repetitive behaviors, redirect him/her to something else that is appropriate. We call this finding a “functional equivalent.” You can redirect by getting the child’s attention and changing the material or activity. For example, if the child is repeating the same phrase over and over, see if you can get him to sing a song.
- Praise or reward the child for the appropriate new response or successive approximations of the desired behavior.

The children who are of greatest concern are those who injure themselves or others, do not respond to the steps described, or who have other delays or behavior problems. Be sure to discuss with the parents the behaviors you have seen and the steps you have taken to reduce those behaviors. Refer children who are of concern for a further assessment of development or behavior to a health professional or agency.

Prepared by: Leslie McKinney, M.Ed., UCLID Center at the University of Pittsburgh, 1998

Reviewed by: Susan S. Aronson, MD, FAAP 11-04





FACT SHEET

Pennsylvania Chapter

ASTHMA

What is asthma?

Asthma is a respiratory disease that causes the lungs to be hypersensitive to different triggers. Things that trigger a child's asthma are colds, exercise, pets, pollens and cigarette smoke. When children have symptoms from asthma, they will cough and wheeze. Wheezing occurs when the muscles tighten around the tiny swollen airways and extra mucus is produced. During an asthma episode, the child has difficulty exhaling (breathing out). The child may have tightness in the chest with coughing and spitting up mucus. The attack can frighten children and they may appear tired, agitated, irritable or listless. A child may not be obviously wheezing and still be having asthma related symptoms such as coughing.

What causes asthma attacks?

Asthma attacks are caused by triggers. If a child does not have contact with these triggers, there are no asthma symptoms. The most common trigger for childhood asthma is a viral infection (the common cold). Other common triggers are:

- Allergens such as pets, dust mites, cockroaches, pollens, molds and grass.
- Sudden changes of temperature.
- Smoke from cigarettes, pipes, fireplaces or wood stoves.
- Odors from paint, aerosol sprays, cleaning materials, and perfumes.
- Strenuous exercise in cold or damp weather.
(Do **not** limit exercise unless the child is sick with asthma. A child who is physically fit has stronger lungs.)

What can parents and child care providers do?

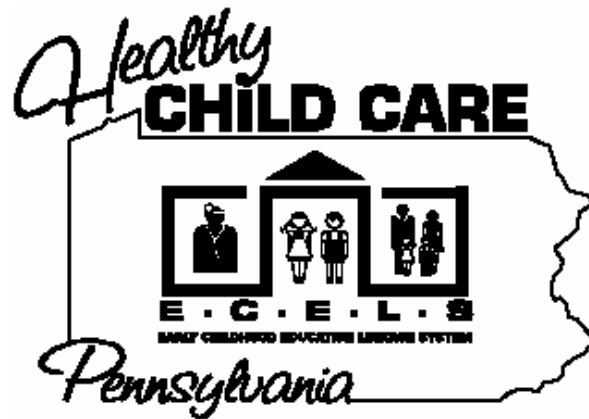
- If children are old enough to use a peak flow meter, use it daily to detect early symptoms.
- Keep children with asthma away from triggers that are known to cause their wheezing.
- Have written asthma plan from health provider of what to do when asthma symptoms begin.
- Have medication (which is usually delivered by a nebulizer or inhaler) available when an asthma episode occurs.
- Keep the child calm, relaxed and sitting upright.
- Use communication closely with parents, especially when the child has symptoms.
- Use communication note book between parents and health providers to foster smooth transition from school to home.
- Recognize when a child needs medical reevaluation for asthma by a physician. e.g. when the child coughs at night, coughs with exercise, wakes at night, or has wheezing that is poorly controlled by the usual medications.
- From the website of the National Heart, Lung and Blood Institute www.nhlbi.nih.gov, select "asthma," then "children," to obtain more information to support children with asthma. This website also has a useful checklist "How Asthma-Friendly is Your Child Care Setting?" The direct link to the checklist is http://www.nhlbi.nih.gov/health/public/lung/asthma/chc_chk.htm

When must children with asthma be excluded from a child care facility?

Most children with asthma can participate in their usual daily activities. Adults should know what triggers to avoid at home and in the classroom environment. If a child tends to cough and wheeze routinely during exercise, the staff should notify the parents. If asthma symptoms begin during exercise, a child can be asked to stop the activity, relax quietly and be given the prescribed medication. Remember - your observations and concerns are very important in providing good asthma control for these children.

Reference: Materials from the National Heart, Lung and Blood Institute, American Lung Association, Asthma and Allergy Foundation of America

Revised by: Susan S. Aronson MD, FAAP 11-04





FACT SHEET

ASTHMA & TOBACCO SMOKE

Pennsylvania Chapter

Facts about Asthma and Tobacco Smoke

- Tobacco smoke is the number one poison in childhood.
- Asthma is the most common chronic illness in childhood.
- Together they create a very serious health concern for children.

Children who breathe secondhand smoke have more asthma attacks. Each year smoking or secondhand smoke cause one million attacks of asthma and 26,000 new cases of asthma.

Why is tobacco smoke so harmful for individuals with asthma? Asthma is a lung disease that occurs in people with sensitive airways. The airways react faster and stronger to things that irritate them. When someone inhales pollution or fumes, the airways normally contract or clamp down to protect the lungs from a harmful substance. The airways will relax as the lungs become accustomed to this irritant, but the irritant will now travel deeper into the lungs to cause more damage.

Asthma is a lung disease that is triggered by something that irritates sensitive airways and causes them to contract. When the sensitive airways try to relax, they go into spasm and start to open and close repeatedly. Over time, this causes swelling of the airways which leads to all of the asthma symptoms: cough, wheeze and shortness of breath. Tobacco smoke not only causes the airways to contract, but it also burns the airways from the heat and chemicals in the cigarette. Smoking causes lung cancer, a leading and preventable cause of death in the nation. There is no reason to expose anyone to this harmful substance.

Smoke is an avoidable asthma trigger. Without smoke exposure, a person with asthma will experience fewer sick days. Often children with asthma will become symptom-free and be able to reduce or stop their asthma medication when they are no longer exposed to smoke in the air they breathe.

Children with asthma have no control over their environments. As a parent, guardian, or caregiver you need to protect children from exposure to environmental tobacco smoke. You can keep your child's environment smoke-free.

Consult your American Lung Association or American Cancer Society on smoking cessation programs and additional information on secondhand smoke.

Written by: Frances C. Gross, DO, FAAP - 1998

Reviewed by: Susan S. Aronson, MD, FAAP 11-04





FACT SHEET

CHILDREN WITH DIABETES

Pennsylvania Chapter

What is diabetes?

Normally the human body makes insulin in response to the blood sugar level. In most children with diabetes, no insulin is produced and must be given by daily injection. Children with diabetes need to eat a healthy diet, exercise, and have fun, just like other children.

What level of blood Sugar is normal?

For people who do not have diabetes, blood sugar stays within a fairly constant range. For children with diabetes, doctors recommend keeping the blood sugar as close to normal as possible. (Blood sugar levels vary depending on the time since the person last ate, but are usually above 70 and below 150 mg/dL of blood.)

Managing childhood diabetes

Managing diabetes requires frequent blood tests, diet adjustments, and for most children with diabetes, insulin injections that depend on the child's activity level, diet, and blood sugar measurements. Some children receive their insulin via a needle that stays under their skin and is connected to a mechanical insulin pump. Discuss the child's care plan with the parents and the child's health care provider.

What is low blood sugar?

Both the rate of drop of blood sugar and the actual blood sugar level are factors in whether a child has low blood sugar symptoms. Blood sugar levels may drop for the following reasons:

- Not enough food was eaten to match the insulin given.
- The child exercised more than usual, using up available food.
- A meal or snack was delayed.

A child with low blood sugar or a rapid drop in blood sugar level may be:

Hungry	Shaky	Sleepy
Uncoordinated	Pale	Having a headache
Cranky	Disoriented	Crying for no reason
Confused	Vomiting	

There are several ways to check blood sugar with a simple blood test. To treat low blood sugar, you need to give the child sugar in any of the following forms:

- orange juice
- granulated sugar
- regular sugared soda
- jam, jelly
- gel-type cake icing

If the child doesn't want to take these but is still alert, you may need to place some gel-type cake icing into the side of his mouth, and rub his cheek. Be careful he doesn't choke.

If the blood sugar becomes too low, the child may become unconscious or have a seizure. If the child becomes unconscious or has a seizure, call EMS.

After you give sugar, try to have the child eat a small snack with carbohydrate and protein such as cheese and crackers or a peanut butter sandwich. Children with diabetes should never have their normal food withheld.

What is high blood sugar?

Sugar levels may rise for the following reasons:

- Emotional upset
- Illness
- Missing an insulin injection
- Lack of exercise
- Eating too much food with sugar in it

A child with high blood sugar may be:

- Thirsty
- Urinating frequently
- Complaining of upset stomach

If you suspect high blood sugar, you should check the blood sugar level. For high blood sugar, the child will need to drink a lot of sugar-free liquid such as water or sugar-free soda.

Sometimes doctors want you to check for ketones in the urine with special urine test strips (dipsticks). Children with a high blood sugar levels or ketones in their urine may need an extra dose of insulin. Toilet privileges should **never** be denied or delayed for the child with diabetes.

Diabetes is a lifelong condition. The goal is to help the child learn to take care of him/herself. The child's physician and parents will help guide you on the specifics for the individual child.

For more information, please consult the child's physician, parents and the ECELS A/V library.

Prepared by: Staff of the Early Childhood Education Linkage System, PA Chapter of the American Academy of Pediatrics, 1999

Reviewed by: Susan S. Aronson, MD, FAAP 11-04





FACT SHEET

CHILDREN WITH SEIZURES

Pennsylvania Chapter

What is a seizure?

Brain cells communicate by using electricity. There are many different kinds of seizures (also called convulsions or fits), but they all have one thing in common: they all happen when too much electricity flows, that is, too many brain cells are talking at once. Brain cells talk to one another all the time, which is how the brain sees, hears, feels, and makes the body move. But when too many brain cells talk at the same time, it interrupts the normal brain activity, and the result is a seizure. This overactivity exhausts the brain cells, and so children are often very sleepy and confused after a seizure.

What causes some children to have a seizure?

- fever
- infection of brain tissue
- injury of brain tissue
- abnormal brain development

What will a child do during a seizure?

What happens to a child during a seizure depends on what part of the brain is involved. When the whole brain is involved, the seizure is called “generalized”; when only one part of the brain is involved, the seizure is called “partial”. The most common generalized seizures are either **grand mal** or **petit mal**.

In a **grand mal** seizure, a child will go stiff all over, or shake all over. Usually people go stiff first, then start to shake. Often, they will fall to the ground, and may hurt themselves. The stiffness and shaking may stop the patient from breathing while they are going on. Usually, the whole seizure lasts no more than 3 or 4 minutes. During the seizure, children are unable to think clearly. After this type of seizure, children are often confused and sleepy.

In **petit mal** seizures, children may stop and stare for a few seconds in the middle of whatever they are doing, and afterwards they will continue what they were doing without knowing that they had a seizure. However, not all children who are staring are having a seizure. The child who is having a seizure will not be able to respond to you while it is happening. They will also have no memory of anything that happened while they were having the seizure. Children do not fall down during a petit mal seizure. These are also called “absence” seizures.

Partial seizures are either **complex** or **simple**. Partial seizures that make it impossible to think clearly are called **complex partial seizures**. If a child is able to think clearly during a seizure, it is a **simple partial seizure**.

In a **simple partial seizure**, a child may do any number of things, such as start to shake one part of their body, like an arm. The child may experience things which are not really happening, such as hearing sounds or smelling things, or seeing things. But the important thing about these seizures is that the child is not confused, although they may be frightened.

In a **complex partial seizure**, a child will be confused. When this happens, children may sit still and may not answer when you speak to them. You may wonder if the child is having a petit mal seizure, but these seizures are usually longer than petit mal seizures. In a complex partial seizure, a child may behave in a very strange way. People may think that the child is “crazy.” After the seizure is over, children may be confused or sleepy for a time. When they have rested, they are able to think clearly again.

A seizure may start in one part of the brain, and spread to other parts. When this happens, a child may become confused. If the seizure spreads to the whole brain, the child may have a grand mal seizure.

What should caregivers do for a child who has seizures?

We try to prevent seizures, or “fits”, by giving children medicine. However, when a seizure happens, it helps to know what to do. Caregivers should receive instructions about the individual child’s type of seizure and what to do from the child’s health care provider.

Seizures often scare people who do not know about them, but usually they will not harm the child who has one. A child may be harmed during a seizure if the child falls, or has a seizure that lasts a long time. When a child is injured by a seizure, or if the seizure has lasted longer than 15 minutes, or this is his first seizure, the child should be rushed to the hospital, usually in an ambulance.

For most seizures, though, all that needs to be done is to be sure that the child doesn’t hurt him or herself.

How to Keep a Child Safe During a Seizure.

If a child is having a partial seizure, be very kind and gentle. You may have to stop the child from doing things which are dangerous. Watch out for a grand mal seizure, if the seizures spreads.

- If a child is about to have a grand mal seizure, try to stop the child from falling. Lay him on his side, in a place where the shaking will not cause him to hurt himself. Do not try to stop the shaking, and do not try to stop him from biting his tongue. If he stops breathing, it is not because he has swallowed his tongue. You should not put anything in his mouth once the seizure has started. If oxygen is available, you should give it to the child to breathe after the seizure is over, or in between seizures.
- If a child has never had a seizure before or if a generalized seizure lasts longer than 15 minutes (not counting the confusion after the seizure is over), call EMS. If there is more than one short seizure in a child known to have seizures, and the child does not return to clear thinking in between, activate emergency evaluation procedure for that child.
- After a grand mal seizure, children may be confused. They may hurt themselves because they do something strange. Treat them gently, and protect them until their usual behavior returns.

When should medicines be used to stop seizures?

When a seizure will not stop on its own, a medicine can be given into the blood which will make it stop. That is why a child with a very long seizure should be taken to a hospital emergency room.

The best way to stop seizures is to prevent them. That is why some children are given medicine for their seizures. Almost always, the medicine is given several times a day, every day. For the medicine to work, the child must have enough medicine in his or her blood stream at all times, throughout the day.

Seizure medicines can occasionally cause side effects. If a child gets a rash, or bruises too early, or gets too many nosebleeds, or has stomach pain, or cannot walk straight, or is too sleepy, the dose or type of medicine may need to be changed. People who care for children with seizures need to be on the lookout for these kinds of side effects.

Seizure medicines can affect attention, behavior and learning. You may notice the changes when medications are added, increased, changed or stopped. Information on these changes can be useful to parents and physicians. Share your observations with parents.

Prepared by: ECELS- Healthy Child Care PA, 1999

Reviewed by: Cheryl L. Hausman, MD, FAAP, 5/8/96., Susan S. Aronson MD, FAAP 11-04





FACT SHEET

HAND HYGIENE IN CHILD CARE

Pennsylvania Chapter

1. When to Wash:

Adults and children in child care settings should wash their hands with soap and water in each of the situations listed in ***Caring for Our Children*** Standards 3.020 and whenever their hands are visibly dirty or soiled.

- a) Upon arrival for the day or when moving from one child care group to another;
- b) **Before and After:**
 - Eating, handling food, or feeding a child,
 - Giving medication,
 - Playing in water that is used by more than one person;
- c) **After:**
 1. Diapering,
 2. Using the toilet or helping a child use a toilet,
 3. Handling bodily fluid (mucus, blood, vomit) from sneezing, wiping and blowing noses, from mouths, or from sores,
 4. Handling uncooked foods, especially raw meat and poultry,
 5. Handling pets and other animals,
 6. Playing in sandboxes,
 7. Cleaning or handling the garbage.

2. Alcohol-based Hand Rubs (liquid, gel or foam hand sanitizers):

- a) Limit use of alcohol-based hand rubs to areas of the child care facility that are inaccessible to children, e.g., in a kitchen that is off-limits to children or in the maintenance equipment area. These products should not be accessible to children.
- b) Discourage alcohol-based hand rubs for hand hygiene in child use areas. If used, it should be limited to situations where there is no visible soil on the hands, where sinks are not available, and where the use and control of containers of the chemical sanitizer can ensure that no child can have independent use of the container or dispenser.
- c) Be sure that hand hygiene using alcohol-based hand rubs conform to the manufacturer's instructions. The procedure for using alcohol-based rubs should include:
 - Applying the required volume of the product to the palm of one hand and rubbing hands together, covering all surfaces of the hands and fingers until the hands are dry. The required volume should keep the hand surfaces wet for at least 15 seconds or longer if so indicated by the manufacturer.
 - Checking the dispenser systems for hand hygiene rubs on a regular schedule to be sure they deliver the required volume of the product and that they do not become clogged or malfunction in some way.
 - Storing supplies of alcohol-based hand rubs in cabinets or areas approved for flammable materials.

3. **Fingernails:** Do not wear artificial fingernails or extenders when working in child care. Keep natural nail tips less than ¼ inch long.
4. **Rings:** Limit hand jewelry to simply finger bands to make it easy to clean and sanitize under and around them.
5. **Contact with Body Fluids:** Follow Standard Precautions for Child Care whenever contact with body fluids occurs. (See *Caring for Our Children*, p. 492)
6. **Staff Training:** Educate all personnel about hand hygiene and the importance of appropriate hand hygiene practices to their health and the health of the children.
7. **Monitoring and Evaluation:** Monitor hand hygiene with unannounced and regular direct observation. When hand rubs are used, check how much of the product is being used to be sure the appropriate amounts get used up as a way to verify the staff who are authorized to use this method of hand hygiene are continuing to use the material as they should.

References:

American Academy of Pediatrics and the American Public Health Association, *Caring for Our Children, National Performance Standards for Health and Safety in Child Care:-- Guidelines for Out-of-Home Child Care*, Second Edition, 2002.

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