

First Aid and Cardiopulmonary Resuscitation (CPR) Information

This is a summary of researched information on appropriate steps that can be used when CPR or First Aid is needed. This is a training document and is **not a certification** for CPR or First Aid. To be in compliance with Utah child care licensing regulations, any person alone at the facility, transporting children or accompanying children on an offsite activity would be required to have current CPR and First Aid certification (R381-100-10(2), R381-100-20(5)(d), R381-100-21(2), R430-90/50-10(2), R430-90/50-20(3)(d), R430-90-21(2).

You should know the names of the people in your child care facility or home who are certified in first aid and CPR. When an injury or incident happens if you are not personally certified you can call for the trained co-worker to assist you. For emergencies, a key component of providing proper care is to summon the emergency medical services by calling 911. While waiting, those trained to perform first aid can act within the bounds of their knowledge. It is important for those not trained to assist and remain calm.

First Aid Information

The key aim of first aid can be summarized in three key points, sometimes known as “the three P’s”:

Preserve Life: The first aim is to preserve life by carrying out emergency first aid procedures. This may include CPR. Remember though, this includes preserving your own life. You should never put yourself or others in danger. This is why the first stage is to assess the area and check for any dangers.

Prevent Further Harm: The patient may need to be moved away from any cause of harm. This also includes applying first aid techniques to prevent worsening of the condition, such as applying pressure to stop bleeding or stabilizing an injury to prevent a potential fracture from moving.

Promote Recovery: Arrange for prompt emergency medical help. Simple first aid can significantly affect the long-term recovery. For example, quickly cooling a burn may reduce the risk of long-term scarring and will encourage early healing.

CPR Information

Cardiopulmonary resuscitation (CPR) is a lifesaving technique useful in emergencies when someone is not breathing or their heart has stopped. The American Heart Association recommends that everyone – untrained bystanders and medical personnel alike – begin CPR with chest compressions as soon as possible. It has been proven that good effective CPR results in better outcomes and survival rates. A quick summary of steps is located on the second page.

There are four key points to keep in mind when performing CPR:

Push Hard, Push Fast: Forceful, fast compressions provide better circulation of blood and oxygen. Fast means at least 100 compressions per minute to the accurate depth.

Allow Full Chest Recoil: Relaxing the pressure on the chest between compressions allows the heart to refill and pump more blood.

Minimize Interruption: Blood flow stops if compressions stop. Efforts should be made not to interrupt chest compressions.

Early Defibrillation: Victims have a better chance of surviving when CPR is performed in combination with early defibrillation.

References: <http://www.lifesavingsociety.com/media/100282/98pushhardpushfastinsert2011.pdf>
<http://www.firstaidforfree.com/the-aims-of-first-aid-three-ps/>
<http://www.mayoclinic.org/first-aid/first-aid-cpr/basics/art-20056600>
<http://texasonsitcpr.com/study-guide2.pdf>

Summary of CPR Steps for Adults, Children and Infants

ACTION	INFANT (Less than one year)	CHILD	ADULT (8 years of age and older)
Assess the Scene	Check the scene for safety		
Check for Response	Tap and Shout – Check for normal breathing		
Phone 911	Yell for help! After giving 5 sets of 30 compressions and 2 breaths, if you are alone phone 911		Yell for help! Call 911 and if available send someone to get AED
Check for Pulse	No pulse felt within 10 seconds (check for at least 5 seconds but no more than 10 seconds)		
Check for Breathing	Open airway using head-tilt/chin-lift, take no more than 5 seconds to look for normal breathing using visual cues such as chest rise.		
Start CPR	If victim is unresponsive and not breathing normally, immediately start CPR beginning with chest compressions (30 compressions : 2 breaths)		
Compression Rate	At least 100 per minute		
Compression Location	Just below nipple line on breastbone	Lower half of the breastbone	
Compression Depth	About 1 ½ inches	About 2 inches	At least 2 inches
Chest Wall Recoil	Allow complete recoil between compressions. Rotate every 2 minutes		
Compression Interruptions	Minimize interruptions in chest compressions to less than 10 seconds		
Compressions to Ventilation Ratio	30:2 1 or 2 Rescuer	30:2 Single Rescuer 15:2 2 Rescuer	
Defibrillation	Attach and use AED as soon as available. Minimize interruptions in chest compressions before and after shock; resume CPR beginning with compressions immediately after each shock.		

References: <http://www.lifesavingsociety.com/media/100282/98pushhardpushfastinsert2011.pdf>
<http://www.firstaidforfree.com/the-aims-of-first-aid-three-ps/>
<http://www.mayoclinic.org/first-aid/first-aid-cpr/basics/art-20056600>
<http://texasonsitecpr.com/study-guide2.pdf>

Homeless Children in Care



WHO?

Homeless children are individuals who lack a fixed, regular and adequate nighttime residence. This includes children:

- Sharing housing due to loss of housing, economic hardship or a similar reason.
- Living in motels, hotels, trailer parks, or campgrounds due to lack of adequate alternative accommodations.
- Living in emergency or transitional shelters.
- Awaiting foster care placement.
- Residing in a location that is not designed or intended for human sleeping accommodations (e.g. park benches, etc.)
- Living in cars, parks, public spaces, abandoned buildings, substandard housing or bus or train stations.

HOW DO YOU KNOW?

Sometimes it is hard to know if a child in your care is homeless. Families will not always self-identify, often due to fear, shame and embarrassment. Simply asking a family if they are homeless is not a good strategy. Providers should ask families to describe their living situation and whether that situation is permanent. If a family seems unsure when asked, a provider could offer options to choose from, such as car, motel, shelter or living temporarily with family or friends.

Potential signs that a child may be homeless include poor health and nutrition, unmet medical and dental needs, chronic hunger (may hoard food), fatigue, poor hygiene, lack of showers or baths, wearing the same clothes for several days, poor self-esteem, extreme shyness, difficulty socializing and trusting people, aggression, protective of parents and anxiety late in the day. Parents or children can make statements like, "We've been moving around a lot;" "Our address is new — I don't remember it;" "We are staying with relatives until we get settled;" or "We are going through a bad time right now."

15,808

children under the age of six were identified as homeless in Utah in 2013.

More than half were under the age of



WHAT IS REQUIRED?

All Child Care Providers are required to be in compliance with the McKinney-Vento Act when enrolling homeless children who meet the definition provided.

One requirement is that the facility enrolls homeless children without documentation required of other children, including immunization records. The family has 90 days after enrollment to provide the records needed.

The provider could create a special form that collects only the essential information needed to enroll or apply, such as names and birthdates. The information should be self-reported by the family, and could include a signed affidavit. The form shall clearly define expectations of what documentation is still needed and when it must be submitted.



HOW CAN YOU HELP?

The impacts of homelessness on children, especially young children, may lead to changes in brain architecture that can interfere with learning, emotional self-regulation, cognitive skills and social relationships. Children experiencing homelessness are sick four times as often as other children, experience four times the rate of developmental delays and have three times the rate of emotional and behavioral problems. They wonder if they will have roofs over their heads at night and what will happen to their families. Some techniques to help stabilize a child include the following.

Active Listening. Active listening is perhaps the most important technique that you can use:

- Encouraging the expression of feelings.
- Acknowledging the real loss or tragedy experienced by a family.
- Reflecting feelings expressed by the child.
- Normalizing the child's reactions.
- Conveying acceptance of the child, but not of destructive behaviors.
- Reframing the child's statements or behaviors to emphasize the positives.
- Focusing on the "here and now".
- Confronting inconsistencies in child statements or behaviors in tactful ways.
- Summarizing and bringing closure to emotional topics.

Providing Information. Information about community resources and assistance in accessing those resources, such as access to a computer, can help families.

Modeling a Sense of Humor and Fun. Some children need to be able to relax and take themselves and their situations less seriously. Showing a sense of humor about one's own mistakes lets children know that no one is perfect and that laughter is sometimes the best medicine.

Showing Enthusiasm. Your enthusiasm promotes feelings of enthusiasm in a child. The child can begin to gain confidence in their own abilities to resolve a crisis when they see the caregiver as someone who believes they can do so, too.

Instilling Realistic Hope. Your ability to instill hope in a child is critical in motivating children to try new coping strategies. Help the child to see his or her strengths. Encouraging the child to try new approaches imparts hope.

Questioning. In periods of crisis, it is important for children to be able to organize their thoughts. Asking questions is

one way to help children start thinking clearly again. For example, "What have you already tried?" and "What do you want to try next?" are questions that can lead children toward a better alternative.

Child care providers should also proactively offer multiple options for parents to check in on their children particularly for families new to child care. Homeless families may find it especially difficult to entrust their children to child care providers because of previous negative experiences or their trauma histories. Allowing parents to call or visit as desired, and to be offered these options from the moment of first engagement, may allay some of these fears.

RESOURCES FOR HOMELESS FAMILIES

If you suspect a family is homeless, you can refer the parents to the following for assistance:

- Help hotlines: Dial 211 for up-to-date services
- Homeless Shelter Directory: homelesshelterdirectory.org/utah.html — Provides search tools and links for:
 - ♦ Department of Housing and Urban Development offices
 - ♦ Supplemental Nutrition Assistance Program (SNAP)
 - ♦ Food banks
 - ♦ Legal assistance
 - ♦ Local tenant rights, laws and protections
 - ♦ Social Security offices
 - ♦ Homeless veterans resources
 - ♦ United Way
 - ♦ Jobs and job training
 - ♦ Skills training and counseling

SPECIAL THANKS:

- HomelessChildrenAmerica.org
- *Supporting Children and Families Experience Homelessness: CCDF State Guide*, naehcy.org
- National Center for Homeless Education
- National Alliance to End Homelessness
- Utah Comprehensive Report on Homelessness





Guidance Matters

Dan Gartrell

From Rules to Guidelines Moving to the Positive

At the end of a wing in an elementary school, a prekindergarten class walks past primary grade classrooms four times a day. The preschoolers have trouble remembering not to talk. With doors open due to the school's old air conditioning system, their chatter distracts the primary children and their teachers. The principal discusses the problem with Renilda and Cathi, the pre-K teachers. They agree to figure out a way to have the preschoolers walk in line more quietly.

Renilda recalls a group punishment from her own schooldays—when some children talked in line, the entire class had to “practice” walking up and down the hall five times in complete silence. Renilda shares with Cathi how she still feels bummed out about the experience—she wasn't one of the ones talking—and how negative the class felt toward the “talkers” and upset they were with the teacher.

Not wanting to introduce the negative dynamics of group punishment in their classroom, the two teachers hold a class meeting. They matter-of-factly explain the problem to the children and ask what would help them remember to walk quietly. The teachers acknowledge each idea the children offer. One child says, “We could be mommy and daddy elephants. We have to tiptoe so we don't wake the babies.” Everyone likes this idea, and they decide to try it.

As the children line up the next day, the teachers ask them if they remember how they are going to walk quietly. The children remember. When the class tiptoes by the principal's office, he

notices them and declares, “I like how you boys and girls are walking quietly down the hall.”

“Shh,” one child says, “you'll wake the babies.”

The problem with rules

Think about the likely differences in learning climate in these settings:

- One classroom has the rule, “No talking in line.” Another has the guideline, “We are quiet in line so we don't wake the babies” (or with older students, “. . . so we don't bother children in other classrooms”).
- One classroom has the rule, “Don't hand in work with careless mistakes.” Another has the guideline, “Mistakes are okay. We just need to learn from them.”

In a *Young Children* article worth revisiting, Wien (2004) makes the case that rules tend not to be helpful in

early childhood communities. Rules are usually stated as negatives. In fact, the way most rules are worded, it seems as if adults expect children to break them (Wien 2004). For example, with the rule “No hitting,” teachers often feel pressure to be hypervigilant for this behavior, and then basically can only ignore the behavior or punish the child when it happens—limited options indeed. Even when rules are not totally negative, such as “Be nice to your friends,” they may have an unspoken “or else” implication in teachers' minds.

When an adult enforces rules with children, the children know they have done something wrong. However, the negative experience in rule enforcement does not teach them what to do instead (Readdick & Chapman 2000); for example, “You know the rule, no hitting! Go to the time-out chair.” Busy with enforcement, adults easily forget the importance of teaching children positive strategies like using words or walking away as alternatives to hurting a classmate.

Rules can cause teachers to label children, lump them in groups, and enforce rules accordingly: be lenient with the “good children,” who mostly obey rules, and be strict with the “naughty children,” who often break rules. Studies show that children

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Portions of this article originally appeared in *Exchange* magazine (July/August 2010; www.ChildCareExchange.com).

A study guide for this article is available through www.naeyc.org/memberlogin. This column is also available in an online archive at www.naeyc.org/jc/columns.

Guidance Matters has a new schedule. It appears in the January, May, and September issues of *Young Children*.

frequently subjected to punitive rule enforcement feel rejected, develop negative self-images, and may have long-term problems with aggressiveness in school and life (Ladd 2008; Ettekal & Ladd 2009).

Professor Gary Ladd, at Arizona State University, and his associates have conducted landmark studies on the long-term impact of rejection on young children (Ladd 2006; Buhs, Ladd, & Herald-Brown 2010). Such children are rejected by peers, who are bothered by their classmate's aggression, and by teachers, who punish the children for breaking the rules. (Remember that time-out is really temporary expulsion from the group [Readdick & Chapman 2000].)

Rules tend to reduce teaching to law enforcement. A rule-enforcement orientation can make teachers stricter than they really want to be (Gartrell 2010a). A joke about this is the teacher who meant only "not to smile until Christmas"—but didn't smile for 30 years! Over those years, what are the implications for the groups this adult leads? For the teacher's aspirations to be a positive professional?

Toward guidelines

The purpose of having guidelines is to teach children to use them. For instance, with the guideline "We are friendly with our mates," the adult can calm down an upset child, then teach the child how to use friendlier words to express her feelings. (This teaching is built on a positive adult-child relationship that the adult is always working to improve [Watson 2003].) In this sense, guidelines are not just "permissive rules"—a common misperception (Gartrell 2010a). When there is danger of harm, teachers must be firm—but firm and friendly, not firm and harsh.

Techniques like *guidance talks* and *conflict mediation* work well, along with *class meetings*, in the firm but friendly teaching of guidelines (Gartrell 2010a). The expectation is that children live up to guidelines all the time, not just sometimes. Guidelines identify classroom standards that teachers assist children (and other adults in the classroom) to learn and to use.

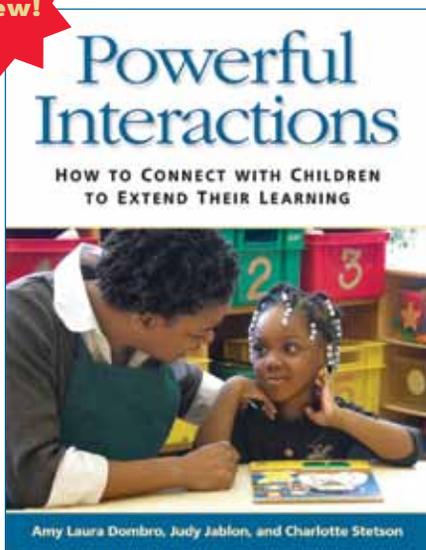
When adults model positive expectations, they teach children the skills

they need for civil living (Copple & Bredekamp 2009). From the guideline "We are friendly with our mates," a child extrapolates saying, "Please share the markers." Perhaps with a teacher looking on, the comment invites dialogue and problem resolution. This set of interactions sure beats demanding, refusing, grabbing, pushing away, and the teacher's enforcing a "No fighting" rule.

With infants and toddlers, guidelines are expectations in teachers' minds. Teachers consistently refer to and model them in teaching prosocial behaviors. An example is "Friendly touches, Freddie," as the teacher helps Freddie give gentle pats to another child.

With older children, writing and posting guidelines provides a functional literacy activity as well as a quick visual reminder. Just a few guidelines work well; one classroom (as mentioned) had only one: "We are friendly with our mates." (These teachers preferred the term *mates*, as in *classmates*, to *friends*. They respected the children's right to define their own friendships.)

Tune out...tune in...and connect with children.



Powerful Interactions: How to Connect with Children to Extend Their Learning

Amy Laura Dombro, Judy Jablon, and Charlotte Stetson

Powerful interactions may only last a few minutes, but in that time the teacher tunes out distractions and tunes into the child, launching a learning experience tailored to that child. Written by the authors of *The Power of Observation*, this book guides you through the three steps of *Powerful Interactions* (be present, connect, extend learning) in a series of self-guided lessons enlivened with tips, hints, invitations to reflect, and vignettes.

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In the elementary grades, three or four guidelines work well (too many makes things complicated) (Gartrell 2010). Examples are

- We are friendly with others and ourselves.
- We solve problems together.
- Mistakes are okay. We just need to learn from them.

Class meetings

In the vignette Renilda and Cathi use a guidance fundamental, the class meeting, to engage children in working with guidelines. Teachers remark that solutions to problems reached through class meetings—such as tiptoeing like mommy and daddy elephants—are frequently more creative than what they themselves might have come up with (Gartrell 2010b). Class meetings can involve children in setting new guidelines and re-teach the use of existing ones (Gartrell 2006). Teachers often hold class meetings at the beginning of the year to invite the group to develop a few overall guidelines (Vance & Jimenez Weaver 2002). Class meetings empower children to be contributing citizens of a learning community, work together to attain a sense of belonging, and develop individual responsibility (Vance & Jimenez Weaver 2002; DeVries & Zan 2003).

Toward the positive

As I see it, moving to the positive requires an attitude shift by the teacher from being a technician to being a professional. A technician operates with the ongoing mission of rule enforcement. In contrast, a teacher who is a professional continuously makes judgments about situations based on a mission to understand and guide—a mission greatly aided by the use of guidelines that transcend rules and their baggage.

In the process of becoming more effective professionals, teachers need to trust in and refine their developing skills of observation, communication, and relationship building. Change, which often takes some courage, begins within the mind of the teacher. Adults learn even as they teach, and that is a good thing—for the children and for the adults.

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The January 2012 issue of NEXT for Young Children includes a ready-to-use training outline related to content from this article. NAEYC members can access NEXT for Young Children in the newly enhanced members only section of the website through www.naeyc.org/login. Not a member? Visit www.naeyc.org/membership to get this resource and more!

Coming this winter!

What You Need to Lead an Early Childhood Program: Emotional Intelligence in Practice

by Holly Elissa Bruno

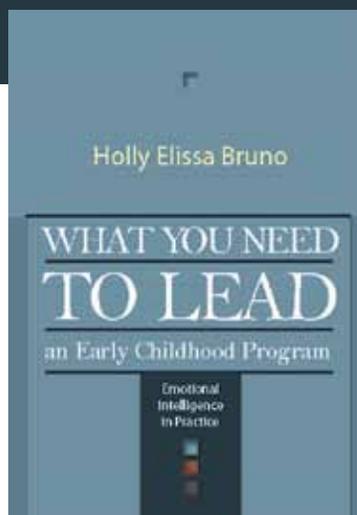
To become leaders, early childhood education students must understand how to build dynamic relationships with staff, families, and the community, as well as learn all the facts and figures about early childhood administration. Bruno skillfully breathes life into previously dry topics like regulatory legislation, facilities management, and budgeting. The author infuses every chapter with vibrantly engaging authentic case studies. *What You Need to Lead* is a text students will want to read.

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Get Involved with PCAU Events

- Pinwheels for Prevention Campaign during April - (Child Abuse Prevention month)
- Golf "FORE" Utah Kids
- Blue Tie Gala
- Joining Forces Conference on Child Abuse and Family Violence



"In order to prevent child abuse and neglect, behaviors that damage children must be stopped before they begin."*

*Prevent Child Abuse America (2010), "Why Prevention Matters" series, Prevention Creates the Future by Transforming Culture.

How You Can Help...

You can help PCAU through donations of either your time or your money. Please visit pcautah.org to learn more about these opportunities. PCAU is a 501C(3) public charity. PCAU provides child abuse prevention education and in-home parenting programs. We also support prevention policies and legislation to protect children from abuse and neglect.

**We are all responsible for reporting suspected child abuse. To report suspected abuse call
(855) 323-3237**



Prevent Child Abuse

Utah

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**Prevent Child Abuse
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**Because
Prevention
Matters...**

Since 1982 Prevent Child Abuse Utah (PCAU) has led the state in providing child abuse prevention education and services for children, families, faculty and members of the community. PCAU provides the following:



SCHOOL-BASED PROGRAMS

Child Abuse Prevention

Serves Kindergarten - 12th Grade

Teaches children how to keep their bodies safe and increases knowledge of abuse so they know how and why to report child abuse.

Bullying Prevention

Serves Kindergarten - 9th Grade

Students are empowered to stand up to bullying through learning about the roles of the bully, the target and the witness. Additionally, students learn about the five types of bullying.

Internet Safety

Serves 3rd - 12th Grade

Dangers on the internet and abduction prevention tips are discussed in addition to the importance of keeping personal information safe.

Healthy Relationships

Serves 7th - 12th Grade

Students are taught the differences between healthy and unhealthy relationships. They come to understand how someone can have power and control over another person and are instructed on warning signs and abuse prevention.

Shaken Baby Syndrome

Serves 7th-12th Grade

Teaches students the skills to cope with a crying baby in order to prevent damage to the baby's brain as a result of being shaken.

Faculty and Community Training

Prevention Specialists offer an interactive discussion on how to recognize and report child abuse. Training is provided on what to look for, including the signs and symptoms of abuse. Instructions are provided on how to respond to disclosures.

Do you know the 3 Safety Rules?



UH - OH

Recognize



Resist



Report

All School-Based Programs offered by PCAU are approved by the Utah State Office of Education

Parents as Teachers

Parents as Teachers is an evidenced-based, in-home prevention program. Utilizing in-home visits, this program provides expectant mothers and new parents with the education and support they need for the first 3 years of their baby's life.

The goal of the Parents as Teachers in-home visits is to promote positive parent-child interaction, bonding, healthy childhood, growth and development to enhance family functioning.

Parents as Teachers Focus Includes:

- Social-emotional relationships
- Parenting skills
- School readiness
- Coping and problem-solving skills
- Crisis management
- Linkage to community resources / health care

Referrals Accepted By:

Hospitals, mental health agencies, health clinics, social service agencies and self referrals.

SAFE FAMILIES UTAH

Safe Families Utah (SFU) is an in-home parenting program that provides short-term crisis care and intervention for families having struggles with their children.

Safe Families Utah empowers children and parents to work together to create a safe, nurturing home environment. Families complete a series of approximately 10 in-home parenting sessions with an additional three months of follow up.

Families Learn:

- Reasonable expectations from children
- Awareness of individual needs and feelings
- Healthy and effective discipline
- Improved self esteem
- Empathy for others / establishing routines

SFU Accepts Participants Referred By:

Utah Department of Child and Family Services, mental health agencies, domestic violence shelters, court-ordered parenting classes and self referrals.

Supporting a Child

Children need reassurance that they are worthwhile and have done nothing wrong. It is important for child care providers to provide the following for a child who has disclosed abuse or neglect:

Security

The child needs to know that she/he can trust you and that her/his disclosure will not be made public. She/he needs to know that you will remain supportive.

Structure

The child needs routine. This provides for a sense of security and may be the only structure provided in his/her life. After the child is more confident, she/he will need less direction from you.

Consistency and Predictability

The child needs to know, in advance, that you have expectations of her/him and what these expectations are. Be consistent in your relationship with her/him.

Identity

A child who has been abused will usually suffer from poor self-image. Share positive feedback and praise with the child to help develop a positive self-image.

Sense of Belonging

The child will often lack confidence and pull away from her/his peers. Help her/him become part of the group. Praise and encourage group involvement.



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Reporting Child Abuse

A Guide for Utah Day Care Providers



Reporting Child Abuse

Utah Child Abuse Reporting Law

The law requires:

- Any person who has reason to believe a child has been subjected to abuse or neglect to immediately notify the nearest Utah Division of Child and Family Services or law enforcement agency.
- Any person who observes a child being subjected to conditions that would result in abuse or neglect to immediately notify the nearest Utah Division of Child and Family Services or law enforcement agency.

Failure to obey this law constitutes a class "B" misdemeanor and is punishable by up to six months in jail and/or a \$1,000 fine. Utah Code Ann. 62A-4a-411 (1994)

Making A Report

The best way to help stop child abuse is to report it. All reports to the Utah Division of Child and Family Services and the Department of Health remain strictly confidential.

Any person making a report in good faith is immune from any liability.

Once a report is received, the case is assigned a priority depending on the seriousness of the abuse and the risk to the child.

Licensing standards require compliance with the Child Abuse Reporting Law and staff of the Department of Health. The Department of Health will investigate violations of abuse and failure to report by providers.

Indicators of Child Abuse

If a child talks about being abused, take him or her seriously. Some possible indicators of abuse may include:

Physical Abuse

Physical Indicators

- unexplained bruises
- unexplained burns
- confinement
- unexplained welts

Behavioral Indicators

- Easily Frightened
- Wary of Physical contact
- Afraid to go home
- Destructive to others or self

Sexual Abuse

Physical Indicators

- bed-wetting
- soiling
- chronic constipation

Behavioral Indicators

- Withdrawal or depression
- Passive behavior
- Aggressive behavior
- poor self esteem
- lack of eye contact with adults
- knowledge of sexual acts beyond their years

Emotional Abuse

Physical Indicators

- delayed physically
- ulcers
- developmental lags

Behavioral Indicators

- Poor self-esteem
- Difficulty expressing feelings
- Problems with relationships
- Habit disorders

Neglect

Physical Indicators

- abandonment
- thin, starvation
- lack of supervision
- lack of medical care
- frequent absent or tardy
- poor hygiene

Behavioral Indicators

- Steals, begs
- Self Destructive
- Failure to thrive

It Happens Too Often

2015 Child Abuse Statistics

- Five children die every day in the U.S. because of child abuse.
- 20,614 child abuse referrals were reported to Utah DCFS.
- 34% of those referrals were substantiated.
- During FY 2015, Sexual Abuse was the most frequently supported allegation category.*

*2015 Utah Division of Child and Family Services Annual Report

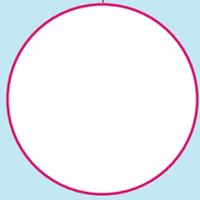
Help Stop Child Abuse

Alert day care providers can identify the early signs and symptoms of child abuse and take the first step toward helping children and families.

Remember, you only need to have reason to believe abuse has occurred. To report, call your local DCFS or law enforcement agency.

Reporting Hotline 1-855-323-3237

With your help, we can make a difference!



HOW TO CALM A CRYING BABY

Check physical needs first:

- Is the baby hungry?
- Thirsty?
- Need to be burped?
- Too hot or too cold?
- Dirty diaper?

Check for signs of illness/fever:

If you think the baby may be sick, seek medical attention immediately.

I will make a plan

Make a conscious decision to never shake a baby. Creating a plan for coping with the crying can help.



Use the reverse side of this door hanger to make your plan. Keep it handy for you and others who care for your child, or visit CalmACryingBaby.org

Discuss Your Plan

Talk to your baby's caregivers about the best way to calm your baby.



NEVER SHAKE A BABY

Keep this as a reference for everyone who cares for your baby.

SHAKEN BABY SYNDROME PREVENTION

Become a part of the solution. Take a moment to stand with us against the most preventable form of child abuse. Together, we can ensure every child is safe from the danger of shaking.

To learn more about how to calm a crying baby and more about Shaken Baby Syndrome, visit calmacryingbaby.org.

There is always someone close at hand when you call Children's Hospital Colorado's ParentSmart Healthline. Caring pediatric nurses are available 24/7 to answer your questions. Call ParentSmart Healthline at 720-777-0123.



Fussy Baby Network® Colorado

All babies cry, but some cry more than others. Fussy Baby Network Colorado is a program for parents who have concerns about their baby's fussiness during the first year of life. The Fussy Baby team is available to talk by phone via our "Warmline" to listen and to provide support and resources.

Call 877-6-CRYCARE (1-877-627-9227) or visit FussyBabyNetworkColorado.org

Noticing Child Abuse or Neglect Isn't Always Easy. Calling Is.

The Colorado Child Abuse and Neglect Hotline is designed to provide one, easy-to-remember toll-free phone number for individuals to use statewide to report suspected child abuse and neglect. Call the hotline at 1-844-CO-4-Kids or 1-844-264-5437.



IN THIS MOMENT I WILL ASK FOR HELP.

Prevent Shaken Baby Syndrome

**IN THIS
MOMENT
I WILL REMEMBER
SHE'S JUST A BABY.**

It is normal for babies to cry and it is normal to feel frustrated when they won't stop.

Sometimes, in the moment, you might feel like you're going to lose control. **In that moment, do not shake the baby.** No matter how bad it gets or how tired and frustrated you feel, shaking the baby, putting the baby down roughly or throwing the baby is never the answer. Instead, calm yourself and calm your baby.

WHY DO BABIES CRY?

Babies communicate by crying. They cry to tell you that they:

- Are hungry or thirsty
- Are tired
- Are uncomfortable
- Need their diaper changed
- Feel ill or have gas
- Are scared or lonely
- Are frustrated
- Are teething
- Need to be burped
- Are colicky

Some babies cry before bed or naptime. Sometimes the answer is as simple as feeding the baby or changing a diaper. But other times, the crying seems to go on forever and nothing works to stop it. It is normal for some babies to cry for several hours each day.

CalmACryingBaby.org

WHAT HAPPENS WHEN YOU SHAKE A BABY?

No one plans to shake a baby, but doing it, even for a second, can cause serious injury or even death.

Shaken Baby Syndrome is a serious type of brain injury that can occur when an infant or toddler is violently shaken. Babies' neck muscles aren't strong and don't provide much support for their large heads. When someone forcefully shakes a baby, the baby's brain repeatedly strikes the inside of the skull, injuring the brain.

Shaking a baby—or any other type of violent behavior—is a serious form of child abuse with serious consequences for both the child and the adult.

MAKE A PLAN.

Know what to do and not do when your baby is crying. When you feel frustrated, overwhelmed or angry:

1 Choose a Calming Technique

- Swaddle the baby
- Use "white noise" or rhythmic sounds like a vacuum cleaner or washing machine
- Offer a pacifier
- Sing or talk to the baby
- Gently swing or rock the baby
- Put the baby in a car seat and take a ride in the car
- Take the baby for a walk in the stroller
- Hold the baby close and breathe calmly and slowly

2 Choose a Coping Technique

- Call the doctor for support or medical advice
- Call a friend or relative for support
- Have someone come over and give you a break
- Put the baby in a safe place like a crib, close the door, and check back when you're calm

Try each of the above for a few minutes before trying something else. **If nothing seems to work, it is okay to leave the baby in a safe place, like a crib or infant seat, and take time to calm down.** Leave the room. Shut the door. Take a few deep breaths. Call a friend or family member.

Who will you call when you need help?

Name/Phone: _____

Name/Phone: _____

For more information, visit CalmACryingBaby.org

Shaking a baby can cause severe brain damage, blindness, hearing loss, learning problems, seizure disorders, cerebral palsy, paralysis and even death.

A CHILD CARE PROVIDER'S GUIDE TO SAFE SLEEP

Helping you to reduce the risk of SIDS

DID YOU KNOW?

- About one in five sudden infant syndrome (SIDS) deaths occur while an infant is being cared for by someone other than a parent. Many of these deaths occur when infants who are used to sleeping on their backs at home are then placed to sleep on their tummies by another caregiver. We call this "unaccustomed tummy sleeping."
- Unaccustomed tummy sleeping increases the risk of SIDS. Babies who are used to sleeping on their backs and placed to sleep on their tummies are 18 times more likely to die from SIDS.

WHO IS AT RISK FOR SIDS?

- SIDS is the leading cause of death for infants between 1 month and 12 months of age.
- SIDS is most common among infants that are 2-4 months old. However, babies can die of SIDS until they are 1 year old.

Because we don't know what causes SIDS, safe sleep practices should be used to reduce the risk of SIDS in every infant under the age of 1 year.

KNOW THE TRUTH... SIDS IS NOT CAUSED BY:

- Immunizations
- Vomiting or choking

WHAT CAN CHILD CARE PROVIDERS DO?

Follow these guidelines to help protect the infants in your care:

CREATE A SAFE SLEEP POLICY

Create and use a written safe sleep policy—Reducing the Risk of Sudden Infant Death Syndrome, Applicable Standards from Caring for Our Children National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs outlines safe sleep policy guidelines. Visit <http://nrc.uchsc.edu/SPINOFF/SIDS/SIDS.htm> to download a free copy.

A SAFE SLEEP POLICY SHOULD INCLUDE THE FOLLOWING:

- Healthy babies should always sleep on their backs. Because babies sleeping on their sides are more likely to accidentally roll onto their stomach, the side position is not as safe as the back and is not recommended.
- Require a physician's note for non-back sleepers that explains why the baby should not use a back-sleeping position, how the child should be placed to sleep, and a time frame that the instructions are to be followed.

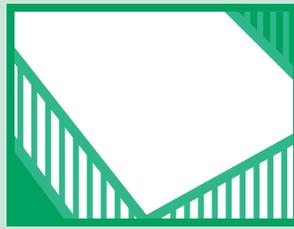
- Use safety-approved cribs and firm mattresses (cradles and bassinets may be used, but choose those that are JPMA (Juvenile Products Manufacturers Association) certified for safety).
- Keep cribs free of toys, stuffed animals, and extra bedding.
- If a blanket is used, place the child's feet to the foot of the crib and tuck in a light blanket along the sides and foot of the mattress. The blanket should not come up higher than the infant's chest. Sleep clothing, such as sleepers, sleep sacks, and wearable blankets, are good alternatives to blankets.
- Sleep only 1 baby per crib.
- Keep the room at a temperature that is comfortable for a lightly clothed adult.
- Do not use wedges or infant positioners, since there's no evidence that they reduce the risk of SIDS.
- Never allow smoking in a room where babies sleep, as exposure to smoke is linked to an increased risk of SIDS.
- Have supervised "tummy time" for babies who are awake. This will help babies strengthen their muscles and develop normally.
- Teach all staff, substitutes, and volunteers about safe sleep policies and practices and be sure to review these practices often.

When a new baby is coming into the program, be sure to talk to the parents about your safe sleep policy and how their baby sleeps. If the baby sleeps in a way other than on her back, the child's parents or guardians need a note from the child's physician that explains how she should sleep, the medical reason for this position and a time frame for this position. This note should be kept on file and all staff, including substitutes and volunteers, should be informed of this special situation. It is also a good idea to put a sign on the baby's crib.

If you are not sure of how to create a safe sleep policy, work with a child care health consultant to create a policy that fits your child care center or home.



Face up to wake up – healthy babies sleep safest on their backs.



Do not place pillows, quilts, pillow-like toys, or anything in the crib.



If a light blanket is needed, tuck all sides along bottom half of crib, below baby's arms.



Supervised tummy time during play is important to baby's healthy development.

SAFE SLEEP PRACTICES

- Practice SIDS reduction in your program by using the *Caring for Our Children* standards.
- Always place babies to sleep on their backs during naps and at nighttime.
- Don't cover the heads of babies with a blanket or overbundle them in clothing and blankets.
- Avoid letting the baby get too hot. The infant could be too hot if you notice sweating, damp hair, flushed cheeks, heat rash, and/or rapid breathing. Dress the baby lightly for sleep. Set the room temperature in a range that is comfortable for a lightly clothed adult.
- Talk with families about the importance of sleep positioning, and encourage them to follow these guidelines at home.

SAFE SLEEP ENVIRONMENT

- Place babies to sleep only in a safety-approved crib with a firm mattress and a well-fitting sheet. Don't place babies to sleep on chairs, sofas, waterbeds, or cushions. Adult beds are NOT safe places for babies to sleep.
- Toys and other soft bedding, including fluffy blankets, comforters, pillows, stuffed animals, and wedges should not be placed in the crib with the baby. These items can impair the infant's ability to breathe if they cover his face.
- The crib should be placed in an area that is always smoke-free.

OTHER RECOMENDATIONS

- Support parents who want to breastfeed or feed their children breast milk.
- Talk with a child care health consultant about health and safety in child care.
- Have a plan to respond if there is an infant medical emergency.
- Be aware of bereavement/grief resources.

AM I A CHILD CARE PROVIDER?

Some child care providers are professionals with college degrees and years of experience, but other kinds of child care providers could be grandparents, babysitters, family friends, or anyone who cares for a baby. These guidelines apply to any kind of child care provider. If you ever care for a child who is less than 12 months of age, you should be aware of and follow these safe sleep practices.

If you have questions about safe sleep practices please contact Healthy Child Care America at the American Academy of Pediatrics at childcare@aap.org or 888/227-5409. Remember, if you have a question about the health and safety of an infant in your care, ask the baby's parents if you can talk to the baby's doctor.

RESOURCES:

American Academy of Pediatrics
<http://www.aappolicy.org>
The Changing Concept of Sudden Infant Death Syndrome: Diagnostic Coding Shifts, Controversies Regarding the Sleeping Environment, and New Variables to Consider in Reducing Risk
<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;116/5/1245.pdf>

Healthy Child Care America
<http://www.healthychildcare.org>

Caring for Our Children, National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care, Second Edition. Visit the National Resource Center for Health and Safety in Child Care and Early Education Web site at <http://nrc.uchsc.edu/> to download a free copy. Hard copies are available from the American Academy of Pediatrics Bookstore at <http://www.aap.org>.

Healthy Kids, Healthy Care
<http://www.healthykids.us>

National Institute for Child and Human Development Back to Sleep Campaign
 Order free educational materials from the Back to Sleep Campaign at <http://www.nichd.nih.gov/sids/sids.cfm>

First Candle/SIDS Alliance
<http://www.firstcandle.org>

Association of SIDS and Infant Mortality Programs
<http://www.asip1.org/>

CJ Foundation for SIDS
<http://www.cjsids.com/>

National SIDS and Infant Death Resource Center
<http://www.sidscenter.org/>

The Juvenile Products Manufacturers Association
<http://www.jpma.org/>

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™