

# Child Care Health Consultation Improves Health and Safety Policies and Practices

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**Objective.**—To evaluate the effects of county-level child care health consultation intervention programs on child care centers' health and safety policies and practices.

**Methods.**—A 3-year experimental study was conducted in 5 California counties and 111 licensed child care centers (73 intervention, 38 comparison) participated at the baseline and post-intervention times. Trained research assistants conducted objective observations with a Policies Checklist and Health and Safety Checklist, which were composed of key national health and safety standards.

**Results.**—At baseline, both groups were not significantly different on the Policies Checklist and the Health and Safety Checklist. At the post-intervention time, intervention centers had significantly more and higher-quality written health and safety policies on 9 of the 10 policies rated (medication administration, care of mildly ill children, exclusion of ill children, clean-

ing and sanitizing, handwashing, daily health checks, inclusion of children with special needs, emergency preparedness, staff health) than comparison centers. At the postintervention time, intervention centers improved their health and safety practices in the areas of emergency preparedness and handwashing, controlling for consultation model, time in study, and director turnover. Both groups improved their indoor and outdoor facilities and overall Health and Safety Checklist means.

**Conclusions.**—Child care health consultation programs can improve the written health and safety policies and may improve practices in child care centers.

**KEY WORDS:** child care; child health; consultant; health and safety

*Academic Pediatrics* 2009;9:366–70

More than 60% of children younger than 6 years of age attend child care,<sup>1</sup> and the health and safety in these programs are primary concerns for child care staff and families.<sup>1,2</sup> Although child care offers opportunities to promote children's physical and mental health,<sup>3,4</sup> young children in child care have high rates of infectious diseases.<sup>5</sup> During the past 10 years, child care health consultants have been trained to address the health and safety needs of young children in child care by providing guidance and technical assistance to child care providers, children, and families.<sup>6,7</sup> These health consultants are health professionals (eg, nurses, physicians) who conduct health and safety assessments, review and develop health policies, conduct staff and parent trainings (eg, childhood illnesses), observe health practices (eg, handwashing), review child health records, develop collaborative health plans for children with special health needs, and provide resources and referrals.<sup>7–9</sup> Health consultants work with child care providers to help them adhere to state licensing regulations and national health and safety (NHS) performance standards, established by

the American Academy of Pediatrics, American Public Health Association, and National Resource Center for Health and Safety in Child Care.<sup>8</sup> The NHS standards recommend that health consultants visit child care centers monthly if they serve children under 2 years of age, quarterly if they serve children 2 years and older, and annually for family child care homes. Although health consultants have been trained in 50 states (S. Cianciolo, National Training Institute, personal communication), most child care programs have not previously worked with health consultants.

In California, First 5 California (formerly the California Children and Families Commission) supported the Child Care Health Linkages Project for \$10.1 million over 3 years to support 20 county-level child care health consultation programs, establish standardized training for health professionals as health consultants and child care professionals as child care health advocates, and conduct an experimental study in 5 counties on the effect of the consultation services. The description of the health consultant and health advocate roles, training, and child care health consultation programs are available elsewhere.<sup>7,10,11</sup> Here, we address the question, what is the effect of child care health consultation on child care centers' health and safety policies and practices?

## METHODS

### Study Design, Setting, and Participants

A 3-year experimental study was conducted in 5 counties that participated in the Child Care Health Linkages project.

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Received for publication April 9, 2008; accepted May 13, 2009.

Counties were selected on the basis of geography (urban, rural, or mixed), population density (from low to high), and poverty rate (at least 27% of children younger than 6 living in poverty). Centers were selected if they were licensed, cared for infants/toddlers and/or preschool-age children, and had no child care health consultation services. Centers were matched by geographic location, enrollment size, children's ages, and ethnic diversity and then randomly assigned to intervention and comparison groups. One county administrator did not comply with the experimental design and offered health consultation to all centers. One county was unable to employ a nurse as a health consultant, so they hired a full-time health advocate who provided the consultation services. The study protocol was approved by the University of California, San Francisco, Committee on Human Research.

### Intervention

The health consultant programs were administered by county-level agencies: Department of Public Health ( $n = 2$ ), Child Care Resource and Referral Agency ( $n = 1$ ), County Office of Education ( $n = 1$ ), and a community-based organization ( $n = 1$ ). Health consultants worked a minimum of 50% time. They visited an average of 34 centers and averaged 20 contacts per center each year. Two counties had county-based health advocates who worked full time with the health consultant, and 3 counties had center-based health advocates who were child care providers paid to work on health and safety issues in their respective centers. Common health topics covered during consultation were written policies, infection control, sanitation and hygiene, children with special needs, and inclusion/exclusion of ill children.

### Instruments

Demographic data on children's characteristics were reported by parents and center characteristics were collected during director interviews.

#### *California Childcare Health Program Health and Safety Policies Checklist*

The 60-item Policies Checklist was based on the North Carolina Department of Health and Human Services, Quality Enhancement Project for Infants and Toddlers Child Care Evaluation Summary form (<http://www.healthychildcare.org/CCHR.cfm>) and on the NHS standards.<sup>8</sup> It included policies on handwashing (2 items), medication administration (10 items), care of mildly ill children (3 items), exclusion of ill children (3 items), transportation safety (8 items), inclusion of children with special needs (5 items), cleaning and sanitizing (11 items), emergency preparedness (6 items), staff health (9 items), and daily health check (3 items). A trained research assistant completed the Policies Checklist at baseline and post-intervention times by recording if the program had written health and safety policies and the quality of each policy. Each policy was rated on the percentage of NHS items present divided by the total items for each policy; items were rated as poor (25% of items met), fair (50%

of items met), good (75% of items met), or excellent (100% of items met), then aggregated as either poor/fair or good/excellent.

#### *California Childcare Health Program Health and Safety Checklist*

The 66-item Health and Safety Checklist was composed of key NHS standards<sup>8,12</sup> and has been shown to have content and construct validity.<sup>13</sup> Trained research assistants observed health and safety practices in one classroom per center for 2 to 4 hours. Each checklist item was rated as completely meets, partially meets, or does not meet standard. Six of the original 10 subscales, 2 of which have good reliability (diapering and outdoor/indoor equipment, with Cronbach alpha values of .70 and .61, respectively),<sup>13</sup> were included in the analyses: emergency procedures (10 items), equipment (18 items), facilities (8 items), handwashing (6 items), diapering (7 items), and food preparation and eating (12 items). Research assistants achieved 90% interrater reliability on the checklist each study year.

## RESULTS

Most children were 3 to 5 years of age (62%), and 38% were infants and toddlers. They were European American, not Latino (41%), Latino (26%), African American (23%), Asian American (4%), mixed race (3%), Native American (1%), and uncertain (1%). Director turnover was 15% ( $n = 104$  centers) and not significantly different by intervention or comparison centers. The mean (SD) time between baseline and postintervention measures was 16.5 (4.5) months, which was not significantly different by intervention or comparison centers.

Data were collected in 127 child care centers (82 intervention, 45 comparison) at baseline and 130 centers after intervention. Sixteen centers dropped out and were replaced by 19 centers. Policies Checklists were completed at 85 centers, and Health and Safety Checklists were completed at 111 centers at both time points.

### Policies Checklist

At baseline, there were no significant differences between the intervention and comparison centers on health and safety policies (Table 1). At the post-intervention time, the intervention centers had significantly more written and higher quality policies than comparison centers on 9 of the 10 policies: handwashing ( $\chi^2_2 = 20.54$ ,  $P < .05$ ), medication administration ( $\chi^2_2 = 8.61$ ,  $P < .05$ ), care of mildly ill children ( $\chi^2_2 = 10.55$ ,  $P < .05$ ), exclusion of ill children ( $\chi^2_2 = 12.96$ ,  $P < .05$ ), inclusion of children with special needs ( $\chi^2_2 = 7.03$ ,  $P < .05$ ), cleaning and sanitizing ( $\chi^2_2 = 15.34$ ,  $P < .05$ ), emergency preparedness ( $\chi^2_2 = 8.70$ ,  $P < .05$ ), staff health ( $\chi^2_1 = 10.92$ ,  $P < .05$ ), and daily health check ( $\chi^2_1 = 4.79$ ,  $P < .05$ ).

Matched Wilcoxon signed-rank tests showed that the intervention centers demonstrated significant improvements in the number of written policies and the quality of policies from baseline to the post-intervention time on

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