Welcome

Agenda

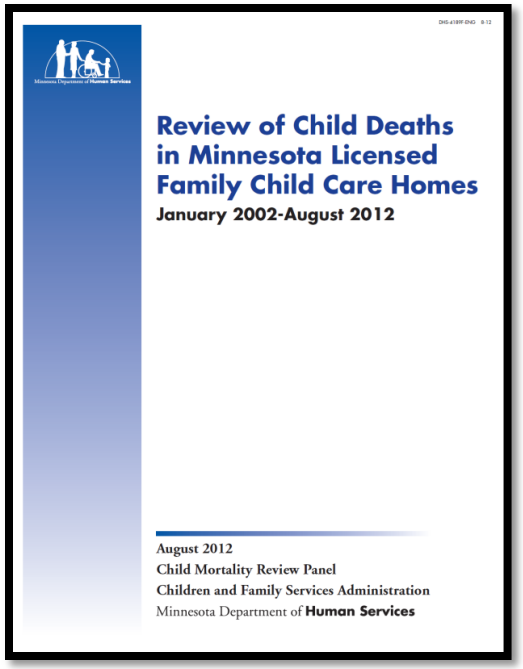
- Introductions
- Let us introduce you to the family child care profession
- Briefly about SIDS and an Overview of the Minnesota Infant Mortality Report
- Survey results and comments
- Summary comments
- Questions and Comments
- Please feel free to stay ask additional question

Family Child Care

Let us introduce you to our profession

- Our Local Association
- Minnesota Licensed Family Child Care Association
- National Association of Family Child Care

The Minnesota Infant Mortality Panel Report



- Background information
- The SIDS center report
- Overview of Review

National SIDS Resource Center

- What is SIDS
- *SIDS is the sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history.*
- the major cause of death in infants from 1 month to 1 year of age, with most deaths occurring between 2 and 4 months
- sudden and silent--the infant was seemingly healthy
- currently, unpredictable and unpreventable
- a death that occurs quickly, often associated with sleep and with no signs of suffering
- determined only after an autopsy, an examination of the death scene, and a review of the clinical history
- designated as a diagnosis of exclusion. Excludes all other reasons for death.

Minnesota Sudden Infant Death Center-

March 2012

The Minnesota Sudden Infant Death Center reports that over the past five years, there were
419 infant deaths –
47 in licensed family child care,
2 in licensed centers,
27 in other non-parental care
343 in parental care.

In the previous five years, there had been
358 infant deaths –
21 in licensed family child care,
1 in a licensed center,
22 in other non-parental care
314 in parental care.

Statewide Provider Survey of the Minnesota Infant Mortality Panel Recommendations

- There are 34 recommendations.
- FCCI in partnership with MLFCCA created and conducted this statewide survey in October 2012 on 14 items from the Minnesota Infant Mortality Panel recommendations.
- Over 8,600 providers were invited by email to participate in the survey. It had over 1100 respondents from nearly all MN counties.
- Survey results will guide association advocacy and education efforts, and policy agendas for the 2012 legislative session and input to DHS.
- A second survey will be conducted on the remaining recommendations.

Recommendation: Modify license capacity and adult to child ratios to be consistent with the best practice standards established by the National Resource Center for Health and Safety in Child Care and Early Education's "Caring for Our Children," third edition.

Table 3: Minnesota's Adult/child ratios; age distribution restrictions

Classification	Licensed capacity	Adult/child ratio	Total under school age	Total infants and toddlers
Family Daycare				
Class A	10	1 adult/10 children	6	Of the total children under school age, a combined total of no more than 3 shall be infants and toddlers. Of this total, no more than 2 shall be infants.
Specialized infant and toddler family day care				
Class B1	5	1 adult/5 children	3	No more than 3 shall be infants.
Class B2	6	1 adult/6 children	4	No more than 2 shall be infants.
Group Family Day Care				
Class C1	10	1 adult/10 children	8	Of the total children under school age, a combined total of no more than three shall be infants and toddlers. Of this total, no more than two shall be infants.
Class C2	12	1 adult/12 children	10	Of the total children under school age, no more than 2 shall be infants and toddlers. Of this total, no more than 1 shall be an infant.
Class C3	14	2 adults/14 children	10	Of the total children under school age, a combined total of no more than 4 shall be infants and toddlers. Of this total, no more than 3 shall be infants. A helper (age 13 - 17) may be used in place of a second adult caregiver when there is no more than 1 infant or toddler present.
Specialized infant and toddler group family daycare				
Class D	9	2 adults/9 children	7	Of the total children, no more than 4 shall be infants.

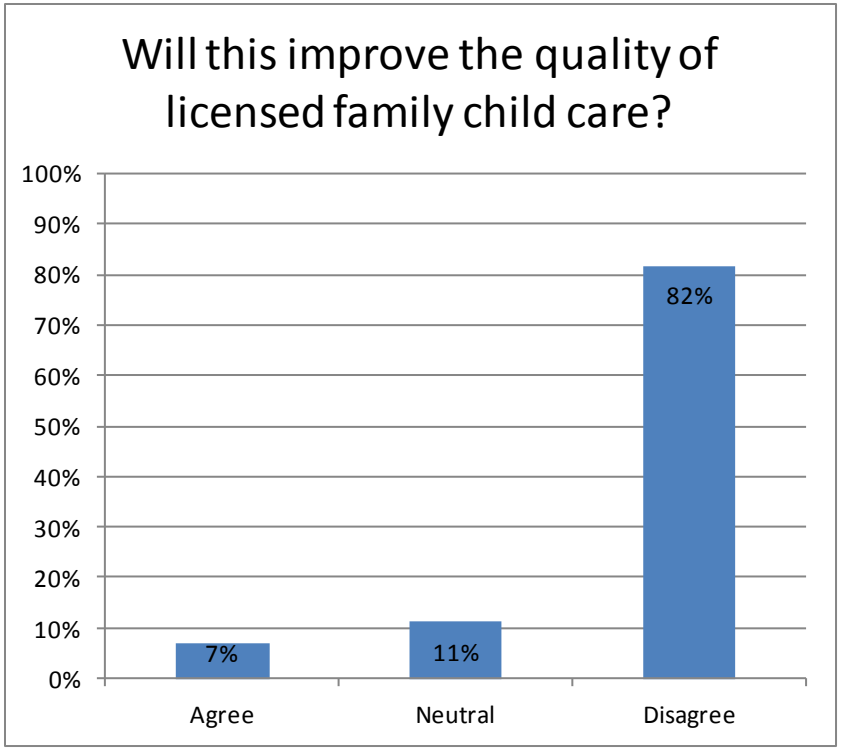
Table 4: NRC-kids ratios for large family child care homes and centers

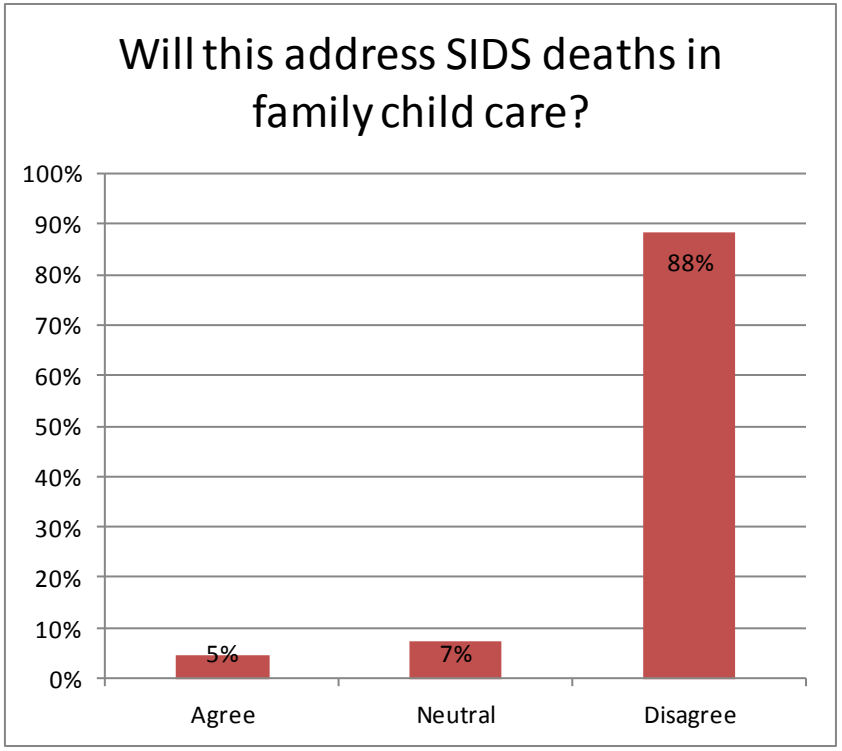
Age	Maximum child/staff ratio	Maximum group size
Less than 12 months	Two children/one adult	Six
13-23 months	Two children/one adult	Eight
24-35 months	Three children/one adult	12
3-year-olds	Seven children/ one adult	12
4-5-year-olds	Eight children /one adult	12
6-8-year-olds	10 children /one adult	12
9-12-year-olds	12 children /one adult	12

Table 5: NRC-kids ratios for small family child care homes

Age of children in care, including the provider's own children	Capacity
No children under age 2 in providers care	One–six children over 2 years of age in care
One child under age 2 in care	One–three children over age 2
Two children under age 2 in care	No children over age 2 in care

Modify license capacity and adult to child ratios to be consistent with the best practice standards established by the National Resource Center for Health and Safety in Child Care and Early Education's "Caring for Our Children," third edition.





1129 respondents

Question 1 Summary of Comments

Numerous comments reflected that child care programs may close due to insufficient income to sustain business needs and that the cost of child care to parents would have to increase to maintain a viable business.

Comments reflected great concern that unlicensed child care may increase

Infant and toddler care availability may be reduced

Part-time child care options may be reduced

Families may not be able to remain in current child care program, or sibling would be split between care programs

- ***Note: Dr. Harvey Karp, nationally renowned pediatrician, child development specialist and Assistant Professor of Pediatrics at the USC School of Medicine at MLFCCA's request, presented information about providing tools to providers that reduce tools at a July 24th 2012 meeting to DHS, MDE and MDH and noted that there is no research to support reduced ratios reduces SIDS.***

Comments

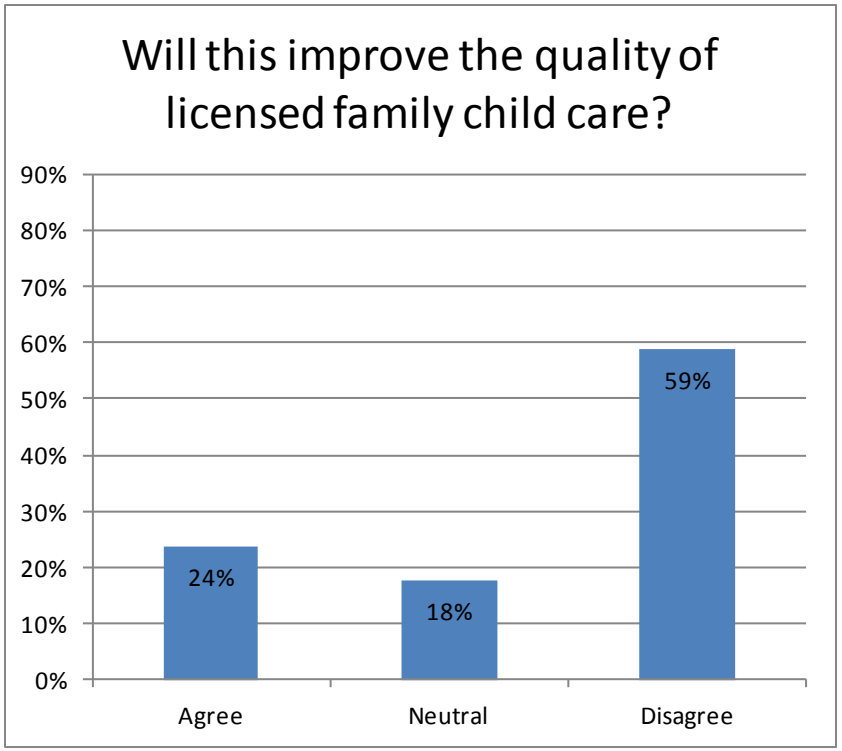
- *"The quality of care and attentiveness to children is not directly related to the number of children in care in many cases. Unfortunately, lowering numbers on all providers may not insure that those providers not offering supervision, will do better with less children."*

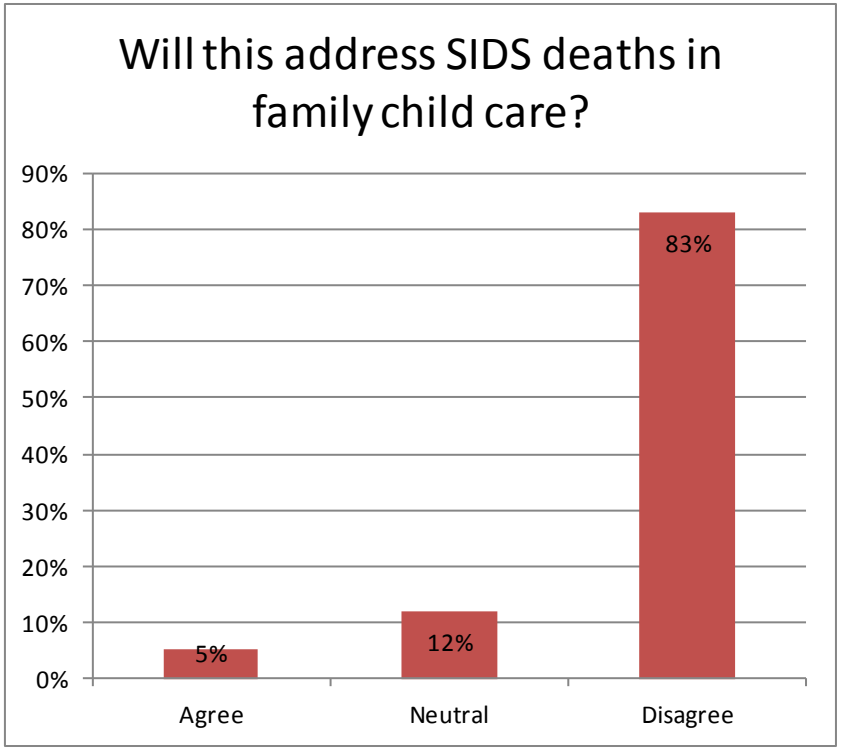
- *"I believe limiting small family child care homes to the above recommendations will make it impossible for small family child cares to stay in business. Given that it is already difficult for families to find daycare, this would seriously impact both providers and families. Providers would either need to charge a lot more to make ends meet putting a large burden on families or would be forced to go out of business. I believe that attentiveness and awareness by providers will address SIDS deaths in family child cares, not severely limiting ratios and ultimately our ability to make a living. I believe maybe a small reduction in children/adult ratios would be beneficial, but not the ones that they are recommending."*

- *"Responsible family child care providers are able to provide high quality care and safe sleeping environments for their children under the current capacity requirements. Changing the requirements will not change the quality of care given by those of us who are already following regulations"*

Require all family child care providers hold liability insurance as a requirement for licensure

Current rule or statute: Liability insurance is not required, if a provider does not carry insurance of for general liability coverage for bodily injury in the amount of at least $100,000 per person and $250,000 per occurrence the provider must give a written notice of the level of liability coverage to parents of all children in care prior to admission or when there is a change in the amount of insurance coverage and the provider shall maintain copies of the notice, signed by the parents to indicate they have read and understood it, in the provider's records on the residence.





1112 respondents

Question 2 Summary of Comments

Comments in general noted liability insurance does not reduce SIDS and providers may not be able to afford the expense.

Others comments noted that providers felt liability insurance would only financially benefit the provider.

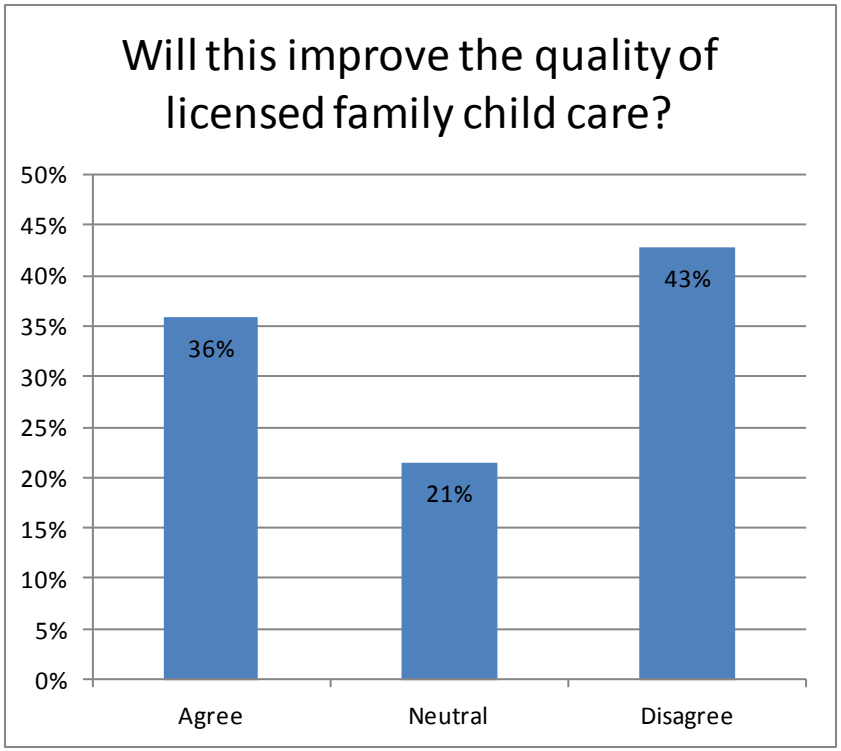
Some providers indicate that their licensers required them to show proof of liability insurance

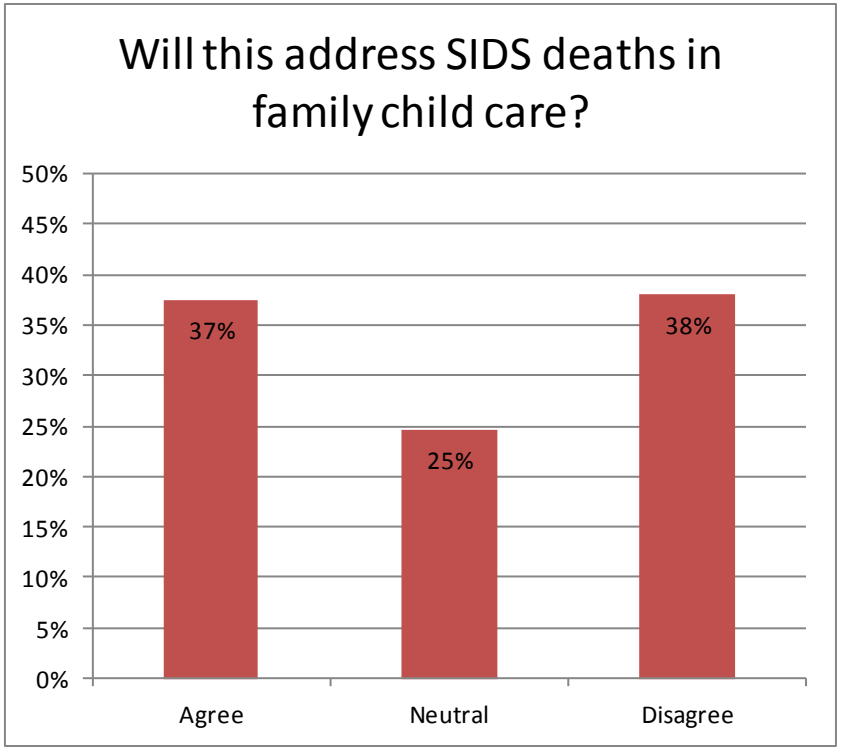
Comments:

- *"Having liability insurance is totally unrelated to quality of care provided and occurrence of SIDS deaths. It doesn't improve quality, but it does improves a provider's professionalism and protects the provider. Also how can liability insurance address SIDS deaths? It certainly can't prevent them, it may provide some type of compensation for parents if a SIDS death occurs. Any professional provider should already have adequate liability insurance."*
- *"I was told 10 years ago that we had to carry liability insurance or I couldn't be licensed."*
- *"Liability Insurance has nothing to do with the quality of care that a provider offers. Many providers cannot afford it. Personally, I would never be a day without it. I have always carried it for the maximum amount, but this has nothing to do with the high quality of care that I offer."*
- *"I feel this should be a requirement. It not only protects the parents but protects the provider and their business."*
- *"Having liability insurance does not make a provider improve their practices."*
- *"Quality care is not linked with liability insurance. SIDS is not linked to liability insurance. SIDS is linked to Sudden Unexplained Infant death--insurance will not solve this issue."*

Require that a child care provider's license be revoked when an infant in the care of a licensed child care facility is in an unsafe sleep position or unsafe sleep environment.

Current rule or statute: Does not require revocation but can lead to other negative actions including a temporary immediate suspension of license, revocation of license. In a May 2012 memo from DHS to child care providers, DHS instructed licensing staff to issue a correction order for any infant found in an unsafe sleep environment and a recommendation for a fine. The provider's license will not be renewed until the fine is paid.





1112 respondents

Question3 Summary of Comments

Comments noted the need for improved safe sleep education for parents too.

Many comments asked for clarification of what is an unsafe sleep position.

Comments question how will infants that are developmentally able to consistently roll onto tummy be interpreted by an outside agency upon inspection

Infants may fall asleep in a swing, bouncy seat, high chair or stroller on a regular basis.

Comments:

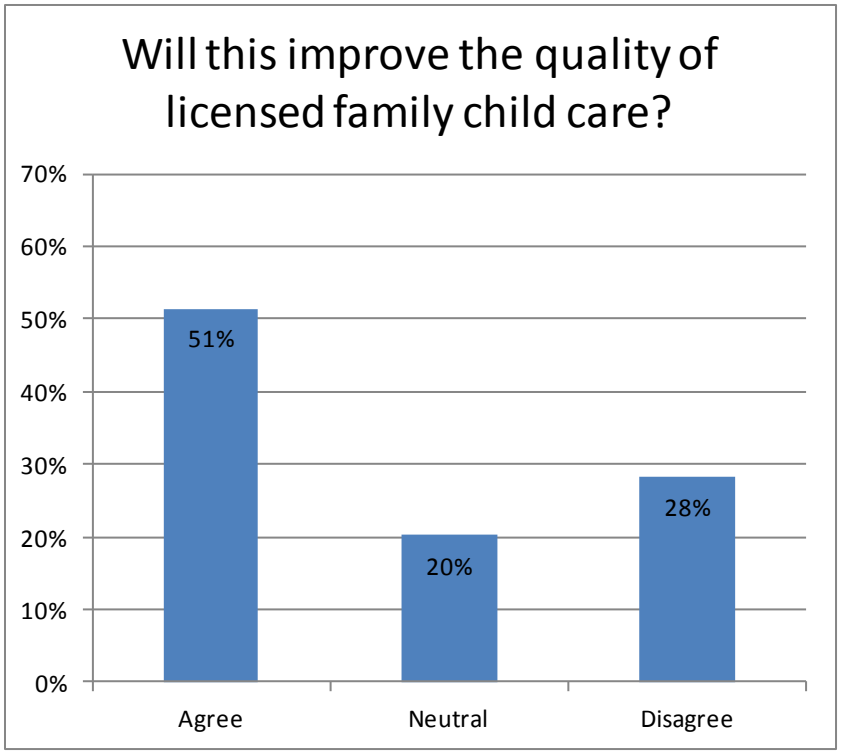
- *"Unclear as to what is defined an unsleep safe position - i.e. an infant falls asleep outside in the stroller - what is expected for a provider - take everyone inside immediately to place infant in a crib? What would be the documentation needed when an infant developmentally and consistently roll to an alternate sleep position i.e. rolls to tummy?"*
- *"Education is the key! Parents should be given instructions through the county (not the provider) about safe sleep practices, then if they feel their provider isn't doing something correct they can report it to the county better. Providers should have to give licensing the name and address of any incoming parents so they can receive reporting and safe sleep information from the county! This would also help educate parents as to the rules we are required to follow. I find I am always in an up hill battle with parents who want their babies to sleep in everything and anything besides a crib! This would help to keep the consistency of babies always sleeping in the same position at home and in child care (thus helping to prevent sids).*
- *Depending on the "unsafe" sleep position - if a child rolls over, for instance, is that unsafe? Also, what exactly is an "unsafe" sleep environment? No toys in crib, no bumper pads, or blankets, etc?*
- *Training, training, training. Supervision courses should be mandatory prior to licensing and should be required annually. That is where sleep recommendations should always be addressed and providers should be advised on best practices. Revoking a license if a baby falls asleep in a baby swing would be a very poor choice and that is a risk with that type of rule. If a baby falls asleep in a Baby Bjorn, would the license be revoked because it's not a bed? What about a stroller? That's wrong.*
- *Revocation is a strong action. Especially when unsafe sleep is loosely defined .If I am feeding lunch to the group and the infant falls asleep in the swing. Before I can move the infant my licensor shows up and cites me for unsafe sleep position.*
  This is a very possible scenario yet not deserving of revocation.
-

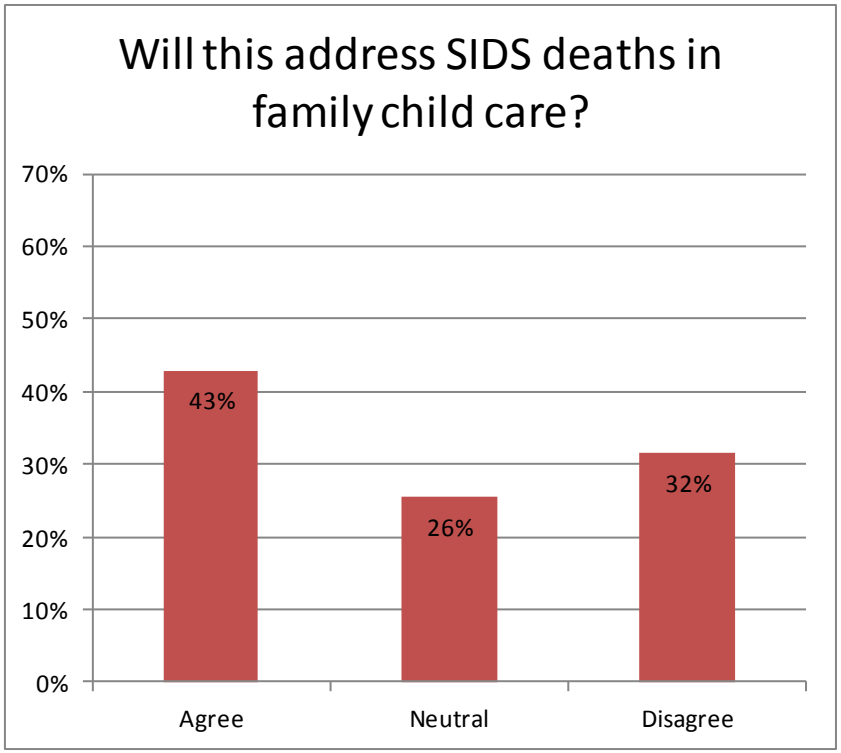
Clarify that neglect includes an infant placed in an unsafe sleep environment while in the care of a licensed child care or foster care facility.

Current rule or statute: Does not include unsafe sleep environment in the definition of neglect.
Current definition of neglect is:
Neglect is the most common form of maltreatment;. Neglect is usually involves the failure of the child's caregiver to:

- Supply the child with necessary food, clothing, shelter, medical or mental health care, or appropriate supervision
- Protect the child from conditions or actions that endanger the child
- Take steps to ensure that a child is educated according to the law.

Exposing a child to certain drugs during pregnancy and causing emotional harm to a child may also be considered neglect.





1094 responses

Question 4 Summary of Comments

Important : The recommendation did not clarify that providers could be criminally charged with neglect if they are not in compliance, which may alter the response to this recommendation.

Comments indicated great concern over the broad language of unsafe sleep environment, and would want a clear definition that would be applied consistently statewide. Interpretation county by county leads to confusion and unequal enforcement.

Comments showed agreement that a baby placed in a dangerous position, such as face down on a soft blanket unsupervised, would constitute neglect

Many noted concern that providers could be criminally charged if an infant falls asleep in a swing or in a stroller during a walk.

Comments noted unfairness of singling out providers for neglect. Parent practice and preference can include forgoing cribs for their infants , co-sleeping, sleeping in a swing, bouncy seat or car seat.

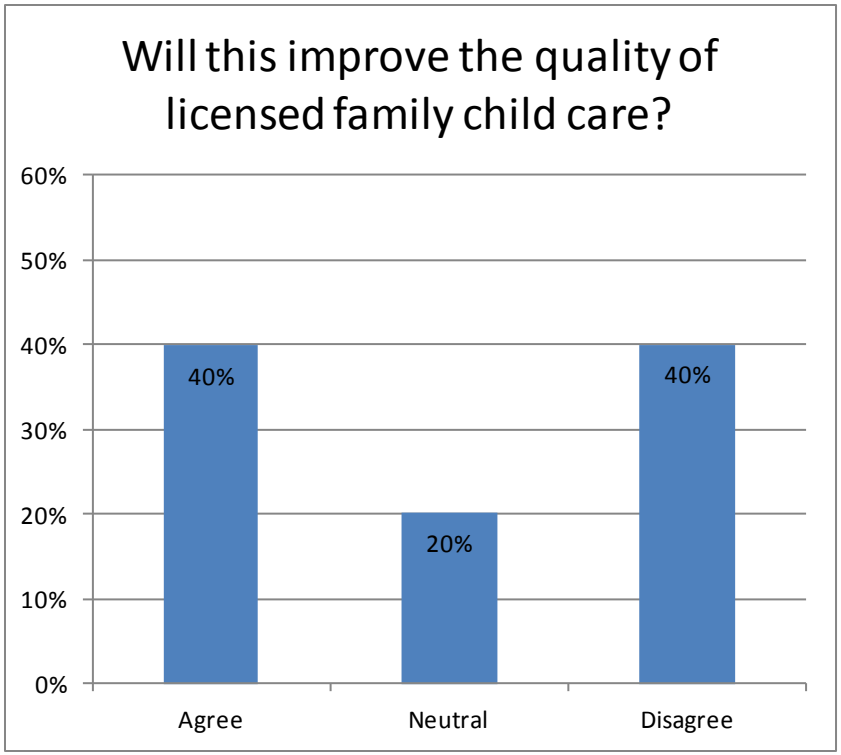
Immediate movement of infant to safe sleep versus when it is a most immediate and practical moment.

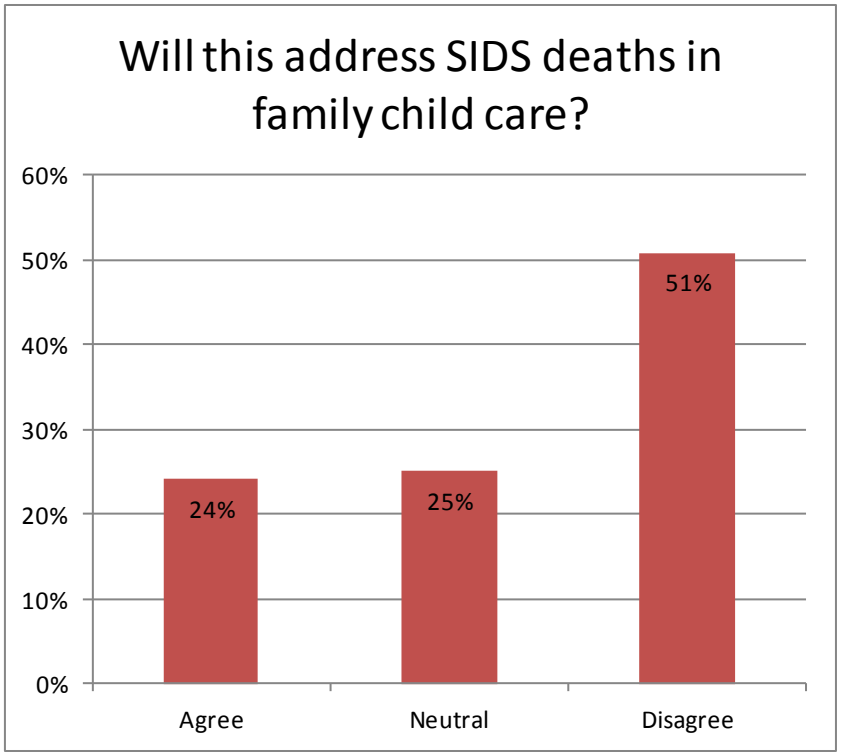
Comments:

- *"I don't think definitions change behavior. Education and knowledge of options change behavior."*
- *"The definition of "unsafe sleep position" has changed many times over many years. It may change again in the future. What is defined as "neglect" today may be found to be safe by future research studies."*
- *"It depends on what is considered unsafe sleep. Is it unsafe putting an infant on a bed with pillows around it? Of course it is! However, if it is considered to be unsafe for an infant to occasionally fall asleep in a swing , then no, that is absolutely not neglect."*
- *"Having the child sleeping in a car seat while outside in the winter is not neglect. If this is clarified, it needs to be highly defined and reasonable such as no blankets, stuffed toys in crib. If left up to each county to continue to define these laws, it's different sometimes from one street to the next."*
- *"What would be considered and unsafe sleep environment? A stroller? A swing? A bouncy seat? If a provider takes the children to the park, and the infant falls asleep in the stroller, should the provider have to take all the children back home?"*

Recommendation: Require applicants for a family child care license to complete 40 hours of DHS-approved pre-service training.

Current rule or statute: Currently first aid and CPR training are required prior to initial licensure. Before a license holder, staff person, caregiver, or helper transports a child or children under age nine in a motor vehicle, the person placing the child or children in a passenger restraint must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles and complete Shaken Baby Syndrome and SIDs training . Within the first year of licensure, the provider must complete two hours of child growth and development training. Child growth and development training can be exempted if applicant meets educational criteria.





1094 responses

Question 5 Summary of Comments

Concern was expressed about the affordability, quality, availability, and access to pre-licensure training especially in greater Minnesota.

Concern that it would become a barrier to those looking to enter the family child care profession.

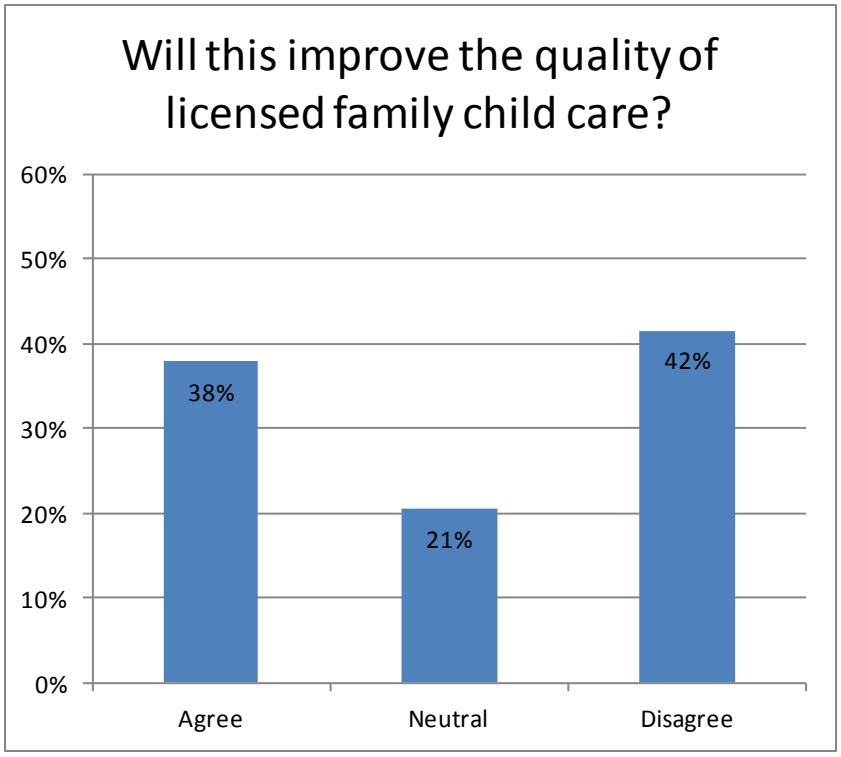
Comments suggest that many are supportive of more pre-licensure training, although many indicated that 40 hours may be excessive.

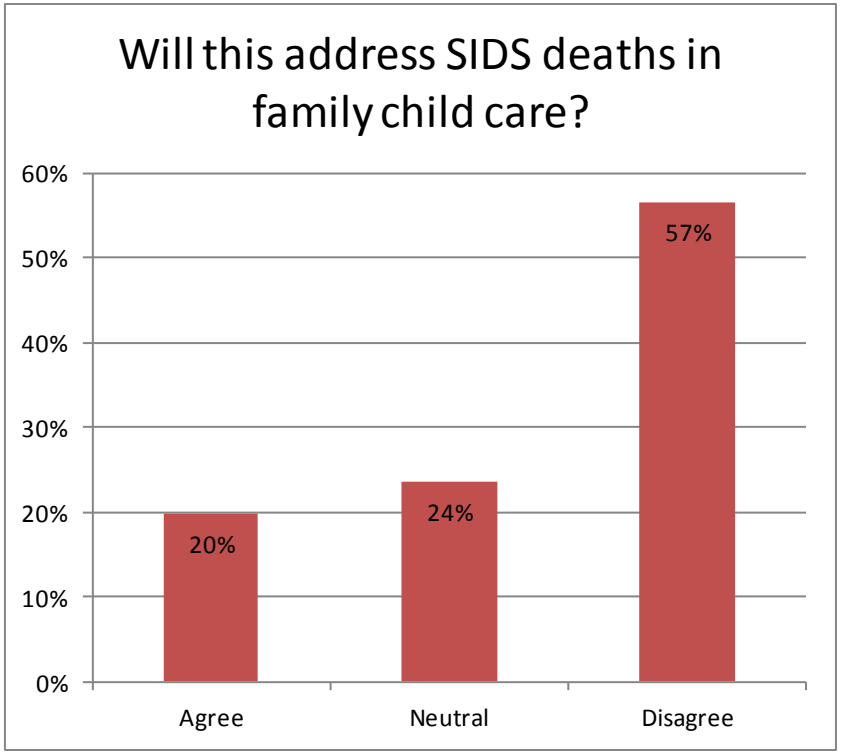
Comments:

- *"You can only take so much training on SIDS. 40 hours is a lot of training for us rural providers that have a hard time finding training close to home."*
- *"It depends on the trainings and where you have to go to get it. It takes a lot out of pocket to start up a home daycare and if you also have to pay extra for this training, whether it's gas to get there or training fees there will be a lot of unlicensed daycare homes and this will increase SIDS deaths."*
- *"How much will this cost? How will you make it accessible to all potential providers?"*
- *"I agree that quality training and education increases the quality of care provided but these trainings need to be available in every county at affordable rates. It doesn't take 40 hours to learn what steps to take to reduce SIDS."*
- *"I am such a believer in education and I don't personally think 40 hours of pre-service is too much… HOWEVER, I think many providers would feel 40 hours is too much. It is possible that 40 hours could deter some from entering the profession. As long as SIDS is part of the pre-service training requirement it would address the SIDS issue."*
- *"Education is key to this business and maybe if it were a bit more strident to get into child care, only those who are committed and would do it in an appropriate manner would become licensed. I do wonder though how they will find the money and the time to afford 40 hours of training."*

Recommendation: Require 24 hours of DHS approved annual training to be consistent with national child care standards.

Current rule or statute: The license holder and each primary caregiver must complete **eight hours** of training each year.
Ongoing training subjects must be selected from the following areas:
child growth and development training learning environment and curriculum * assessment and planning for individual needs
*interactions with children, families and communities *health, safety, and nutrition *program planning and evaluation *the cultural dynamics of early childhood development and child care.





1090 responses

Question 6 Summary of Comments

Many providers were very supportive of this recommendation and some supported even more required hours than 24.

Many expressed concern about accessibility in rural areas and cost of tripling the current training requirements.

Many commented about the time commitment child care providers already face working 50 – 60 hours per week of direct care, plus planning and prep time outside of care hours, noting the struggle they face finding time for their own families.

Some felt the current requirement of 8 hours of training was already a burden.

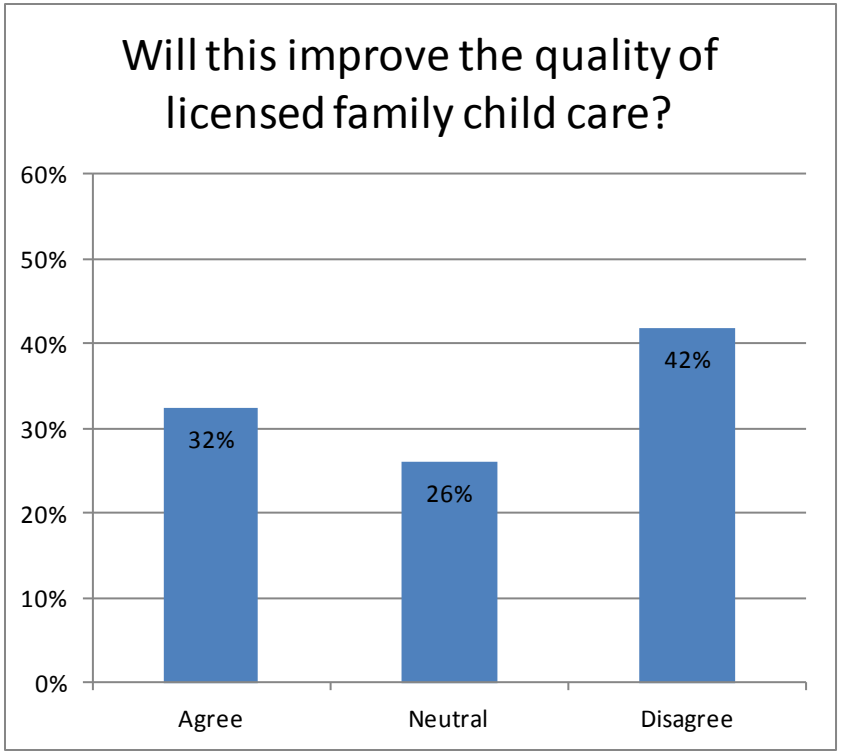
Many felt this could be increased but differed on how much was an appropriate amount.

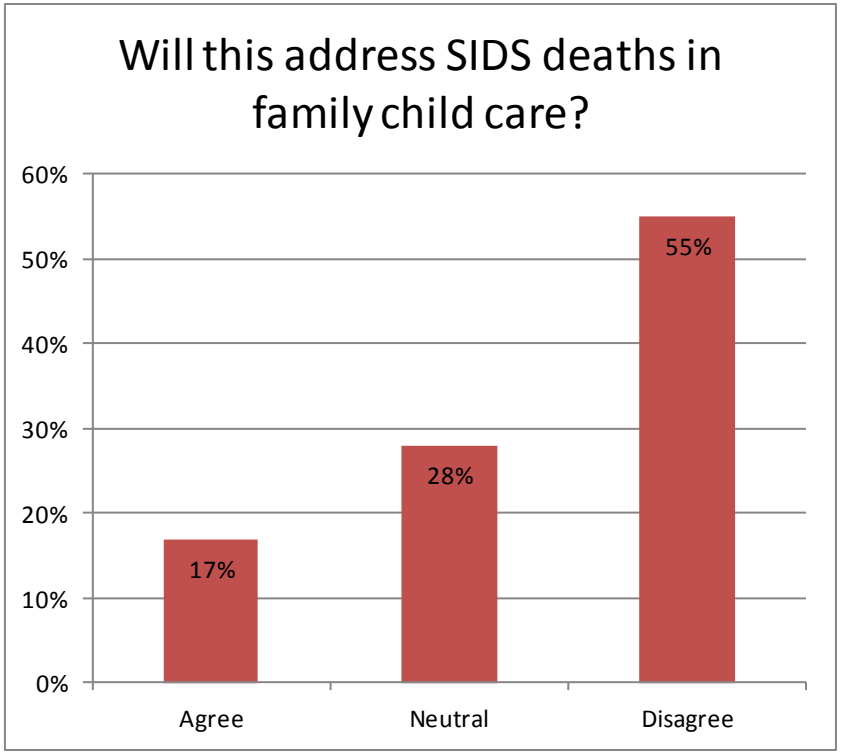
Comments:

- *"I take around 15 hours of training per year, which is hard to accomplish in my area of Minnesota. I agree that training hours should increase (not to 24 but to 15-20). I do not agree that this will address SIDS."*
- *"An educated provider is usually a better provider but giving a provider incentive to attend more classes is a better approach than requiring it."*
- *"Training is good no matter how long you have done child care but 24 hours is a lot when most of us have our own families and work a minimum of 50 hours per week."*
- *"I believe more training generally results in a better provider. I am concerned about the expense encouraging a trend towards unregulated and under educated providers."*
- *"Most of us are doing a wonderful job with 8 hours of training per year. Almost all of us work 10 – 12 hours per day without a break. Increasing our training to 24 hours per year just adds to our work load. Maybe if providers are getting corrections on their licensing visits their training requirement should be increased."*
- *"I think training will only make us better providers. 24 is a lot though, that's a minimum of two hours a month and to some providers, that may be a lot. I'm not against monthly training though I think it would help keep you on your toes."*

Recommendation: Increase the minimum age of child care "helpers" to 16 years old.

Current rule or statute: Helper means a person at least 13 years of age and less than 18 years of age who assists the provider with the care of children, and cannot be left alone with the children.





1090 responses

Question 7 Summary of Comments

Comments were neutral either because the provider did not use helpers or were against this new regulation citing that helpers should be chosen based on maturity level and not age.

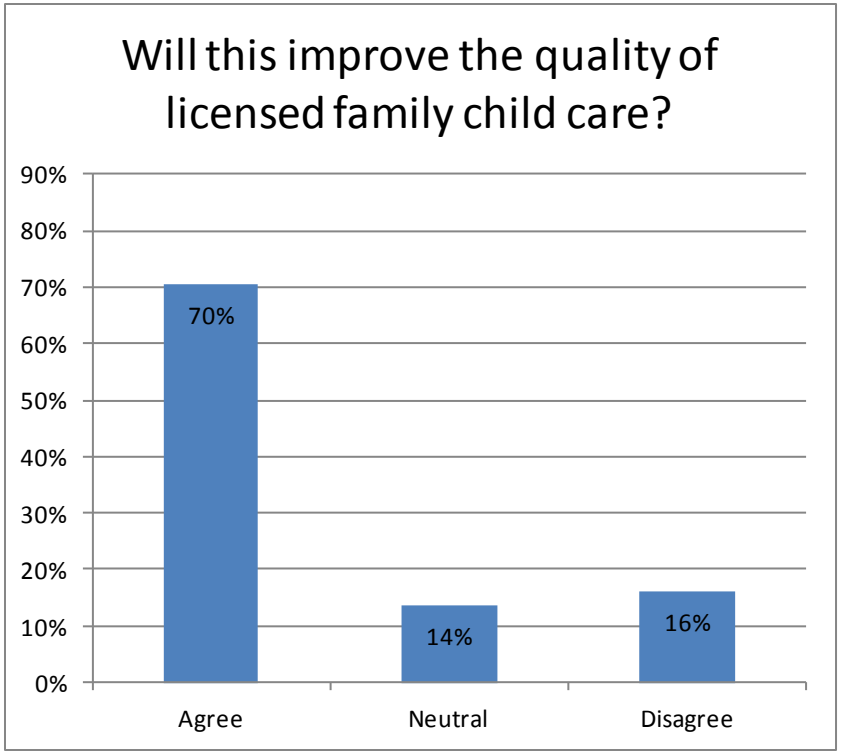
Many reiterated that helpers are not allowed to be left alone with children and therefore are always under the direct supervision on the provider. Some felt that helpers should be required to take training as well.

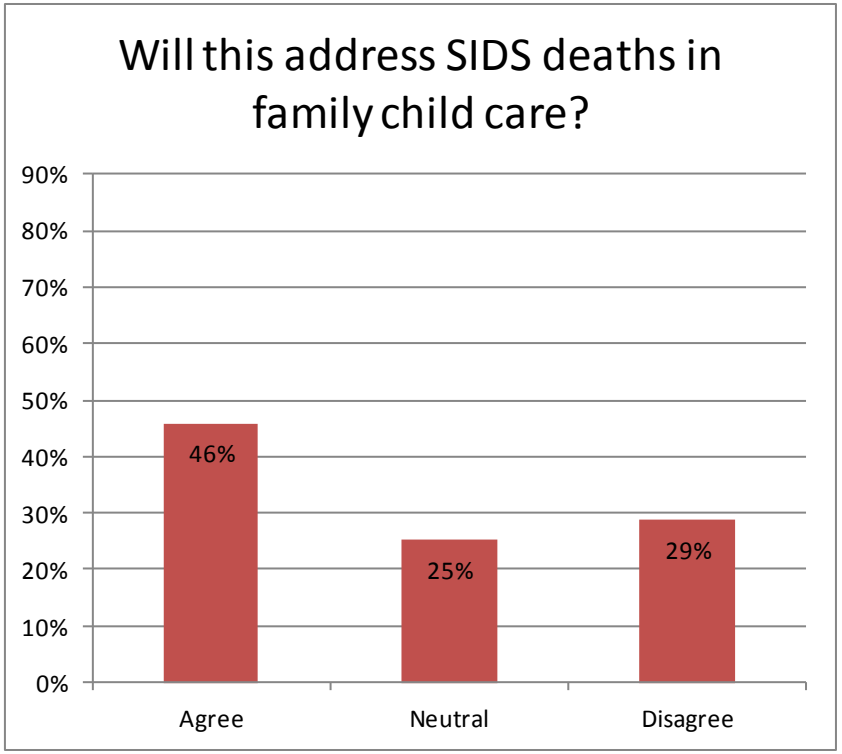
Comments:

- *"I know 12 year olds who are very mature and 20 year olds I wouldn't trust with a pet fish. Age is not as important as the maturity level of the helper."*
- *"Younger helpers can be a great addition to family child care. They tend to have lots of enthusiasm and enjoy playing games with the preschoolers."*
- *"A helper is not allowed to care for the children alone so it's still up to the provider to make sure the infant is in a safe sleep environment."*
- *"If a 12 year old can go to my neighbors house and babysit their three kids with no adult present and with no training, why can't a trained 12 year old assist in a family child care home while under supervision?"*
- *"I think helpers should be required to take more training. If these infant deaths are linked to helpers under the age of 16 then I strongly agree."*

Recommendation: Require applicants for a child care license to complete all required training before the initial license is granted.

Current rule or statute: allows applicant to complete 2 hours of child development training within the first year of licensure.





1086 responses

Question 8 Summary of Comments

Many of the comments were about the safety classes such as CPR, First Aid, Shaken Baby and SIDS and agree that these safety classes should be completed prior to licensure.

Some of the concerns were regarding what some felt was excessive training like the 40 hours being discussed should not have to be completed prior to licensure. Some of the reasons cited were time and money. Many providers work another job until their license is granted so completing a large amount of training could be a barrier for some. Starting a family child care business comes at an expense so large amounts of training would add to that.

Requiring completion of all pre-service training would require addressing accesses and availability to the required classes which is known to be a challenge in greater Minnesota. Some classes only take place in an area once every few months and it could take quite a while to fulfill requirements.

Comments:

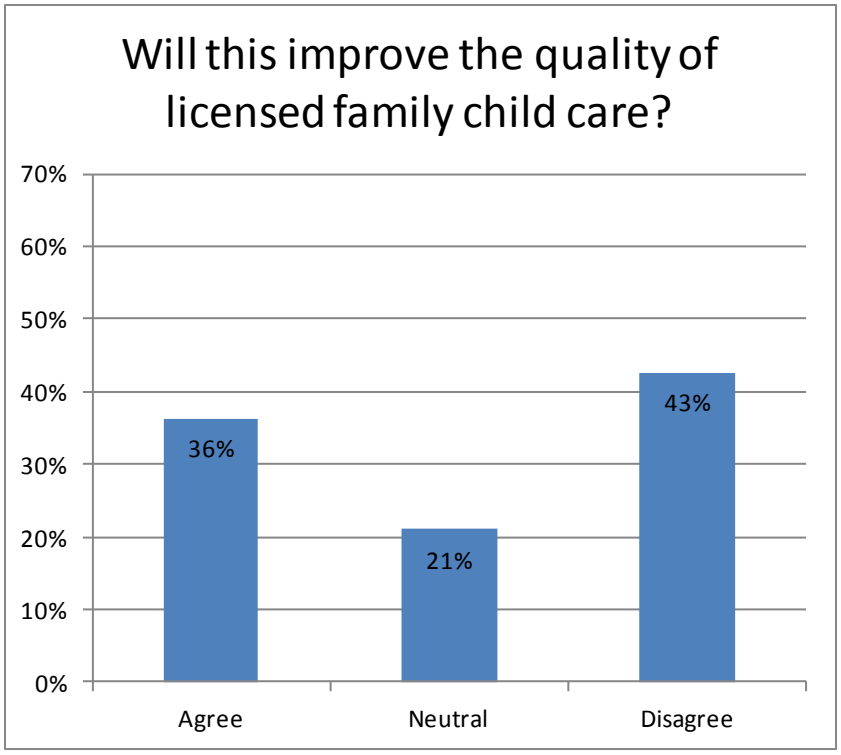
- *"I do think that CPR, First Aid and SIDS should be taken prior but just general trainings can be taken in the first year."*
- *"It only makes sense that you are trained in a job before you go to work in that field."*
- *"If you are asking 24 – 40 I think that's a lot to get done before licensure but I do think there could be set trainings that have to be completed prior."*
- *"Sometimes the necessary trainings aren't available for many months. Will people really be able to go through months and months of preparation?"*
- *"Training before operating a child care business could benefit but it has to be the right training with proper focus."*
- *"Essential Elements and and the safety classes would help providers start out on the right foot."*

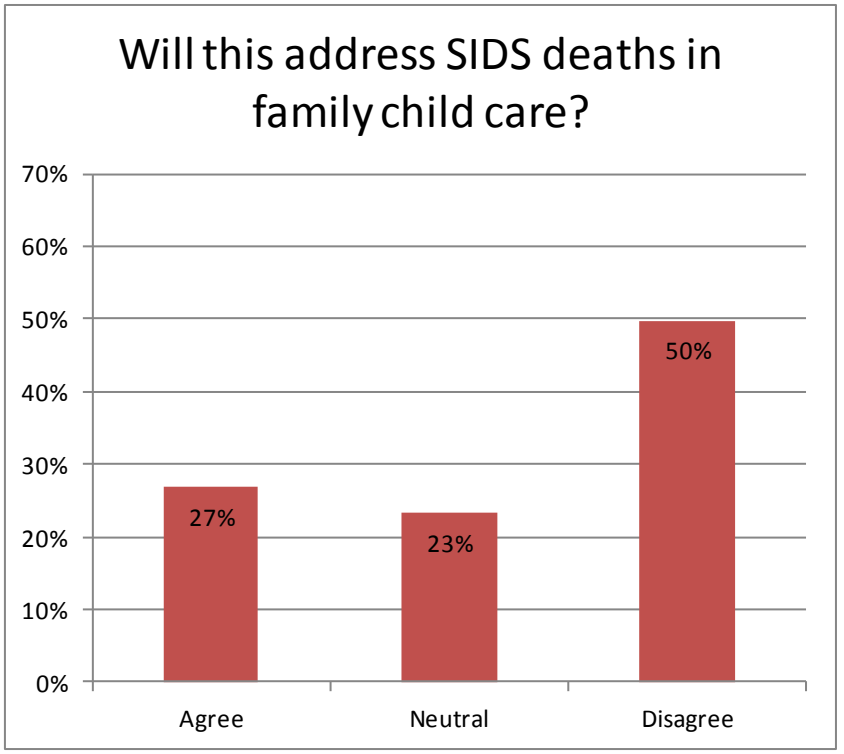
Family Child Care, Inc. FCCI Olmsted County Child Care Association

Minnesota Licensed Family Child Care Association, Inc. Member of MLFCCA

Recommendation: Require that providers must show competence to provide safe child care through a written exam to obtain child care licensure.

Current rule or statute: A written exam is not currently required. Completion of initial training, fire marshal inspection, and inspection by county licensor, complete paperwork and background check are current requirement.





1086 responses

Question 9 Summary of Comments

Many comments expressed concerned that good providers would be disqualified because some people are just not good at written exams. Others seemed to feel that a quality provider is not someone who tests well, but rather someone who provides safe, loving care. There seems to be concern of this being just one more hoop to jump through for licensure. Some felt it could keep some of the under qualified providers out of the profession.

There was a lot of questions surrounding what would be in the test that would be more effective at showing competence that is not already accomplished through the existing paperwork and home visits from licensing.

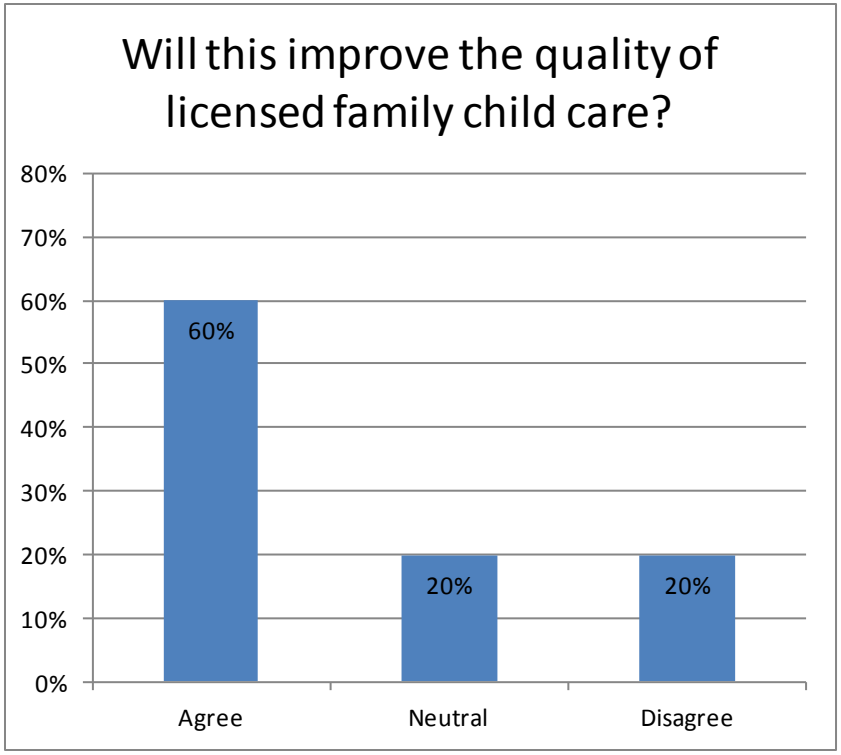
Some suggested that if a test is to be required, it be regarding the rules as statutes in place.

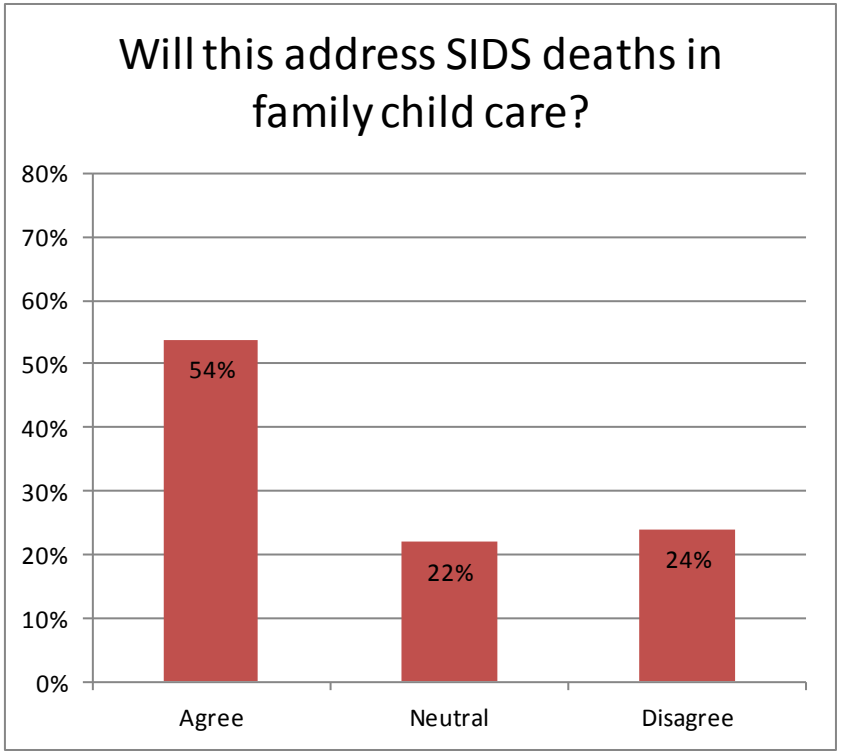
Comments:

- *"More requirements; a written exam could disqualify many very competent care providers who don't "test well"."*
- *"Anyone can take an exam. Child care is about loving these children."*
- *"I seriously doubt that a written test proves much in this application. Lots of excellent test takers would make indifferent providers."*
- *"Is that not the reason behind home visits and background checks?"*
- *"The ability to take care of children is not on paper. It's what is in the heart and the level of patience combined with a desire to work with children."*
- *"A written exam is not going to make a difference. A licensor walking through the home is and explaining what changes need to be made is."*

Recommendation: Require family child care providers to observe sleeping infants at frequent intervals.

Current rule or statute: This is not explicitly stated in rule or statute





1082 responses

Question 10 Summary of Comments

Comments indicated that providers find it common sense, good practice, and already perform frequent checks on sleeping infants. Concern is shown when "required" translates into a daily checklist and that providers would be disrupting an infant sleep.

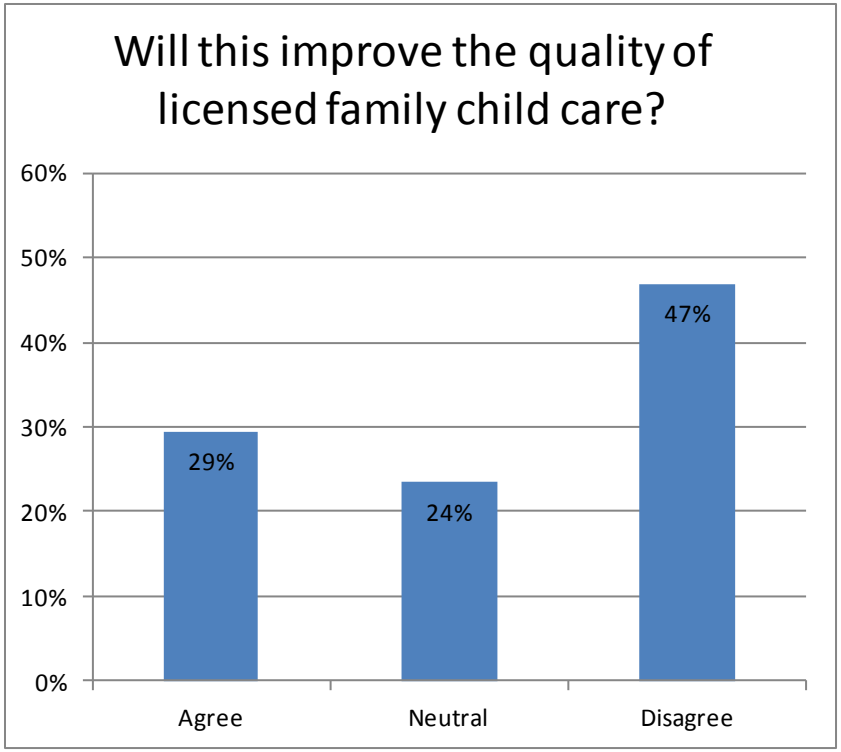
Concern that additional time filling out a checklist will take time away from caring for other children.

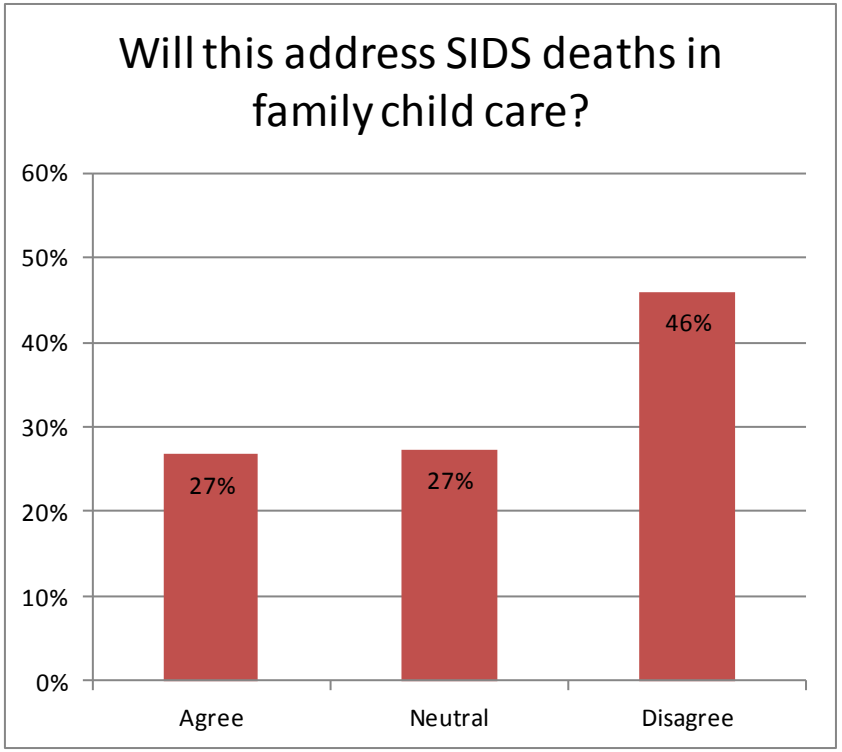
Comments:

- *"No class that I have attended has said that visually inspecting infants during sleep will decrease SIDS deaths. It does not seem like an unreasonable expectation though, as long as all licensors are expecting the exact same kind of inspection. The wording of checking color, temperature, position and chest rise and fall seems problematic to me. Are we to feel them? Take their temperature? It's very subjective."*
- *"Once again, the expectations need to be spelled out specifically and enforced evenly. Providers should observe infants at frequent intervals and this should be taught during SIDS training but "requiring" and therefore I am assuming documenting is taking away time that the provider should be performing other tasks such as direct care of the children."*
- *I think increased observations are good practice, especially to observe any potentially dangerous changes such as getting stuck in a corner or something. That said, I don't think someone who places an infant in a potentially dangerous environment is going to abide by this requirement, nor will it prevent all cases of SIDS since we do not know the cause of SIDS. I believe requiring this would increase the paperwork burden on good providers, place more suspicion and guilty until proven innocent pressure on providers. There's already a shortage of providers willing to take infants. These types of unreasonable requirements will push providers to either leave the field or stop offering infant care.*

Recommendation: Require operating an audio/visual monitoring device used when infants are sleeping, in addition to in-person checks of infants every 15 to 30 minutes.

Current rule or statute: This is not required





1082 responses

Question 11 Summary of Comments

A majority of comments were concerned with the cost of the equipment and their effectiveness. Some comments regarding technical issues, only 2 monitors can work in a home, hearing neighbors on phones, etc.

Comments were concerned monitors would be relied on and in person checks would not be conducted. Favorable comments for 30 minute checks or as needed based on child.

Comments:

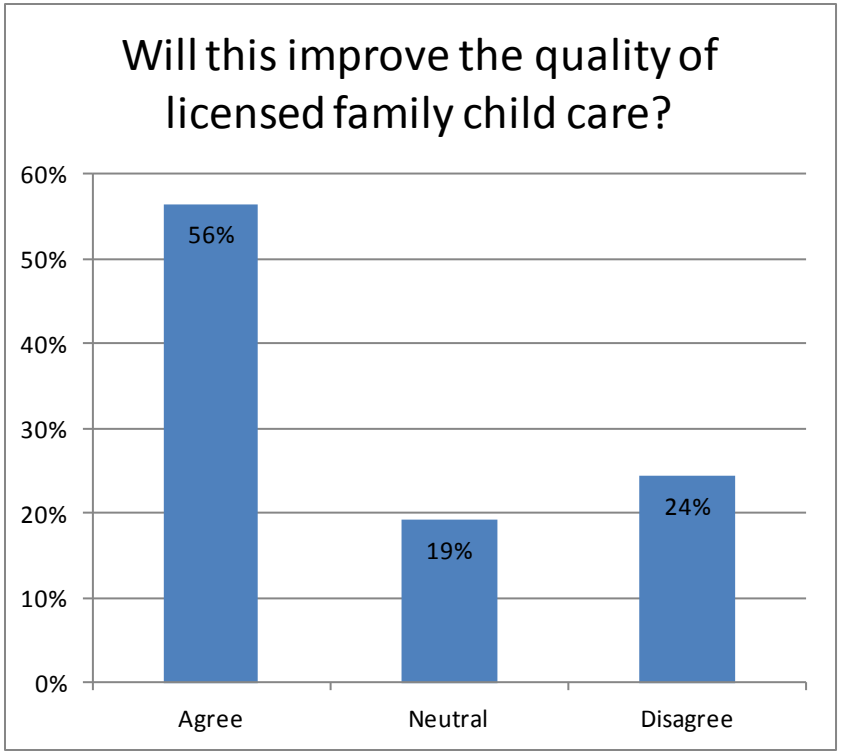
- *" I feel that this would be a great thing for daycares. I do not feel it has anything to do with an infant having SIDs in your care."*
- *"Having too many electronic monitoring in the home interfere with other frequencies. You can hear a neighbors conversation if they also have one in their home. They can interfere with wireless internet or other devices in the home. Nothing is better than in person checks."*
- *"Can a visual monitor be adjusted to view more than one infant? Will multiple monitors work within the same room/house? Can they be placed so that no cords are accessible and still visually monitor each infant? Realistic questions to be considered before making this a requirement. Also, consistency again comes into play – is one or the other required, or is audio/visual required?"*
- *"It may give a false sense of security and providers may check less often because they can see the baby sleeping and assume they are okay even though they should be physically checking."*
- *"Hands on is the best practice. I think providers may rely solely on the visual monitor This concerns me when providers often use their own bedrooms or their children's bedrooms for sleeping children during the daycare day. I think it is an invasion of their own family's privacy to require video cameras in what may be their own bedrooms! Seriously? I would not want anyone to tell me that there should be a video camera in my teenage daughter's bedroom!*
- *"I think if a provider chooses to use one for her own "Peace of Mind" then I thinks it should be left up to him/her to make that decision."*
- *"Sadly SIDS will happen even with "safe" sleeping"*
- *"This is also an excellent idea. video monitoring should be required for all sleeping children.""*
- *"Requirement: asking for someone to verify checks' are being made or a document is being fill out everyday for every nap?"*

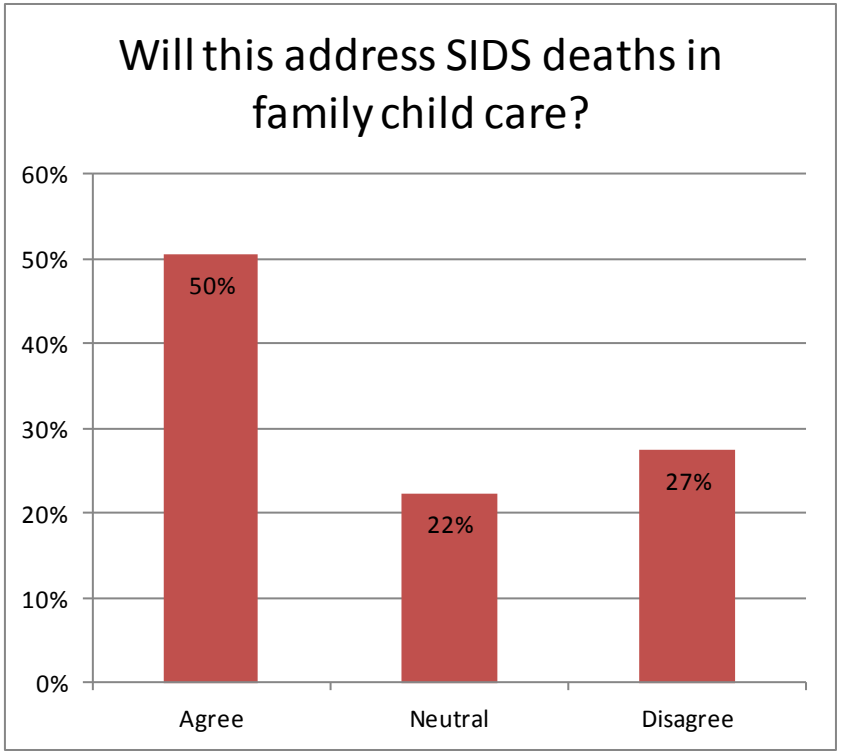
Family Child Care, Inc. FCCI Olmsted County Child Care Association

Minnesota Licensed Family Child Care Association, Inc. Member of MLFCCA

Recommendation: Require providers to check on sleeping infants by looking for chest rise, skin color, skin temperature, along with recognition of crib safety issues.

Current rule or statute: This is not required.





1075 responses

Question 12 Summary of Comments

Comments generally state that this is common sense and practice. There is much agreement that checking for chest rising is a good practice, but touching the child to determine skin temperature will disrupt an infant sleep. Checklists were of concern.

Additional comments regarding parental input on these recommendations indicate parents note this is not what they do at home and would not expect in care.

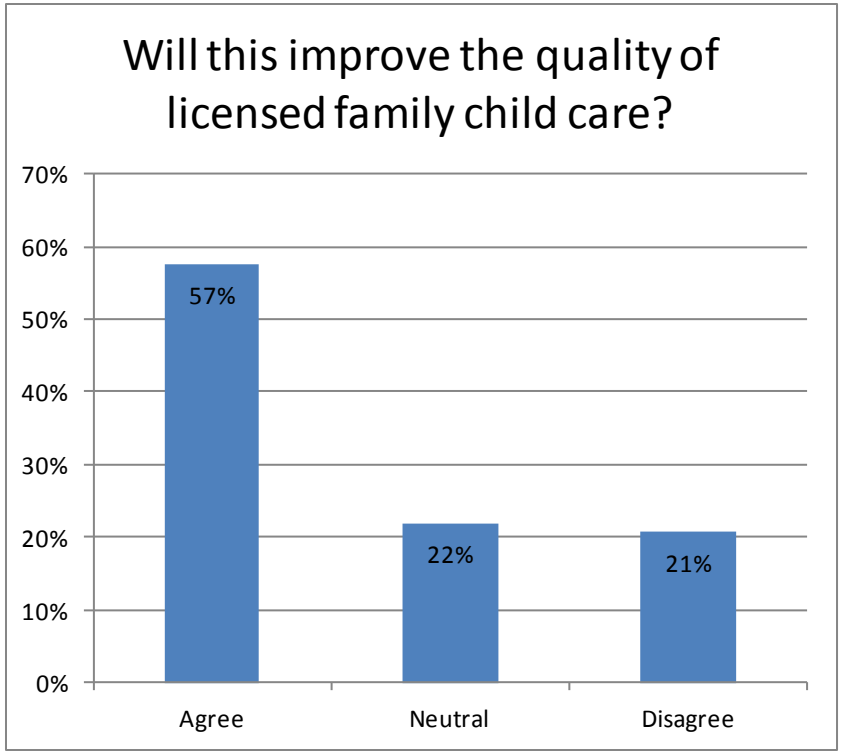
Comments support this as a training component.

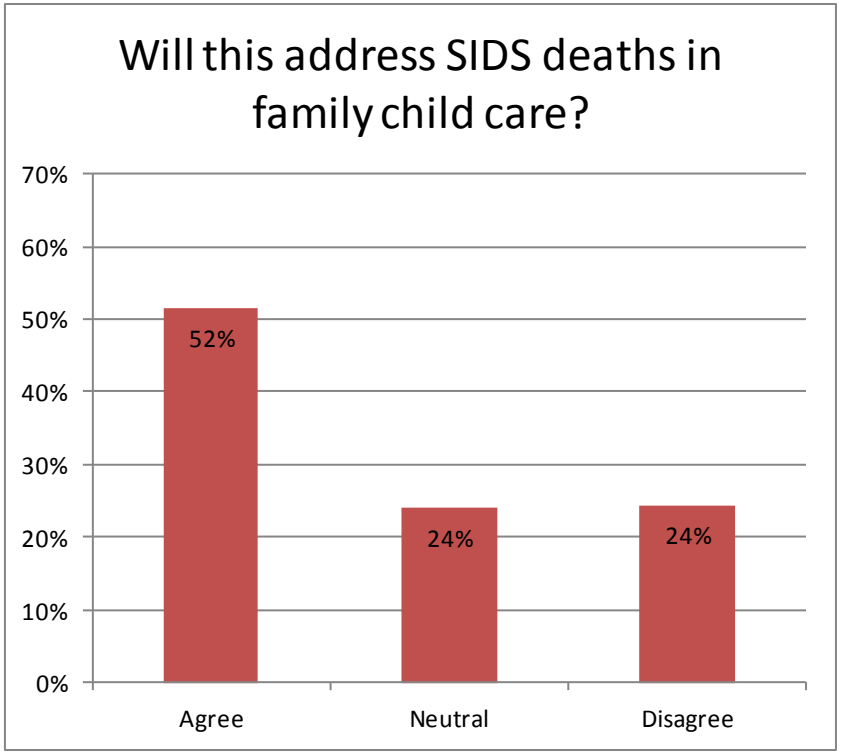
Comments:

- *"I am all for checking on the infant every 10-15 min., but that does not prevent SIDS."*
- *"The wording of checking color, temperature, position and chest rise seems problematic to me. Are we to feel them? Take their temperature? It's very subjective. It seems that we would be checking for signs of life -- will this SAVE a life? I don't know. Once again, if this goes through the expectations need to be spelled out specifically and enforced consistently."*
- *"Requiring checklist documentation will reduce quality of overall care ."*
- *"The children need to sleep!! Most of my kids stir when I simply pass by the room. If I have to touch them every 15 minutes, they'll never get a chance to sleep. I've talked to daycare parents regarding this & they think it is crazy! It s not something a parent would do @ home & they want a home environment for their kids."*
- *"Require...again who enforces?"*
- *"I think that this again should be taught and is second nature for many providers but when you say require again I am thinking that then you will insist on documentation and more paperwork for providers does not equal better care for the children."*
- *"Crib Inspections are already required. Visible checks of chest rise and skin color are acceptable. At some point, we have to let a sleeping child sleep. .... This, once again, is a training issue and is easily covered in supervision training"*

Recommendation: Require more intense supervision of infants during the first four weeks in a new child care home, and when an infant has an upper respiratory infection.

Current rule or statute: This is not required.





1075 responses

Question 13 Summary of Comments

Comments reflect that this is a common sense issue that is common sense practice. If a child illness is significant the child would not be allowed in care.

Comments question on definition of "more intense supervision" and how this will be monitored or enforced?

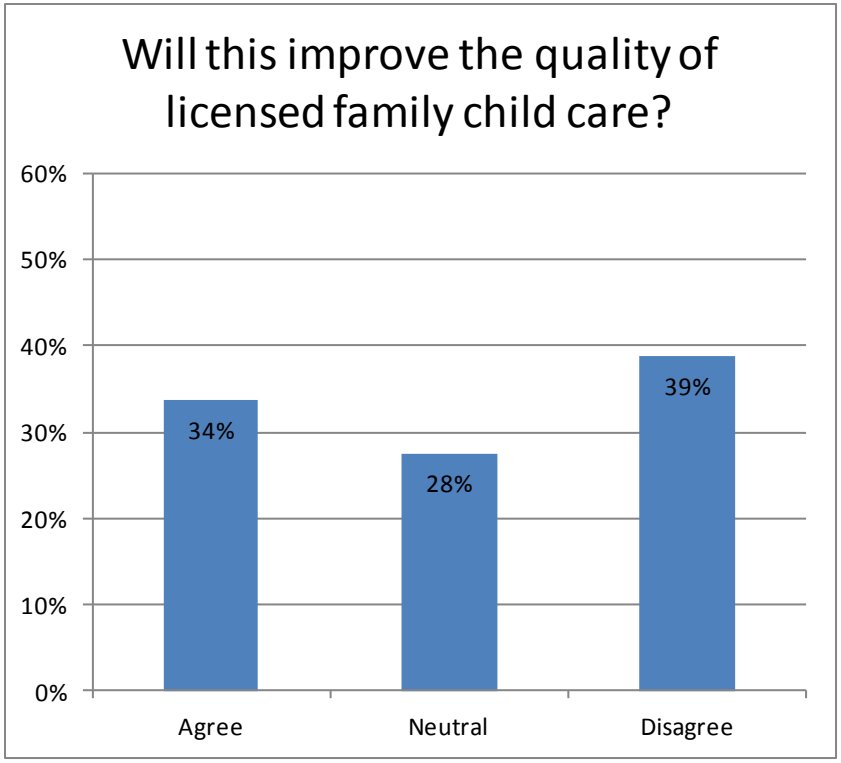
Comments also indicate this could be included as a training component.

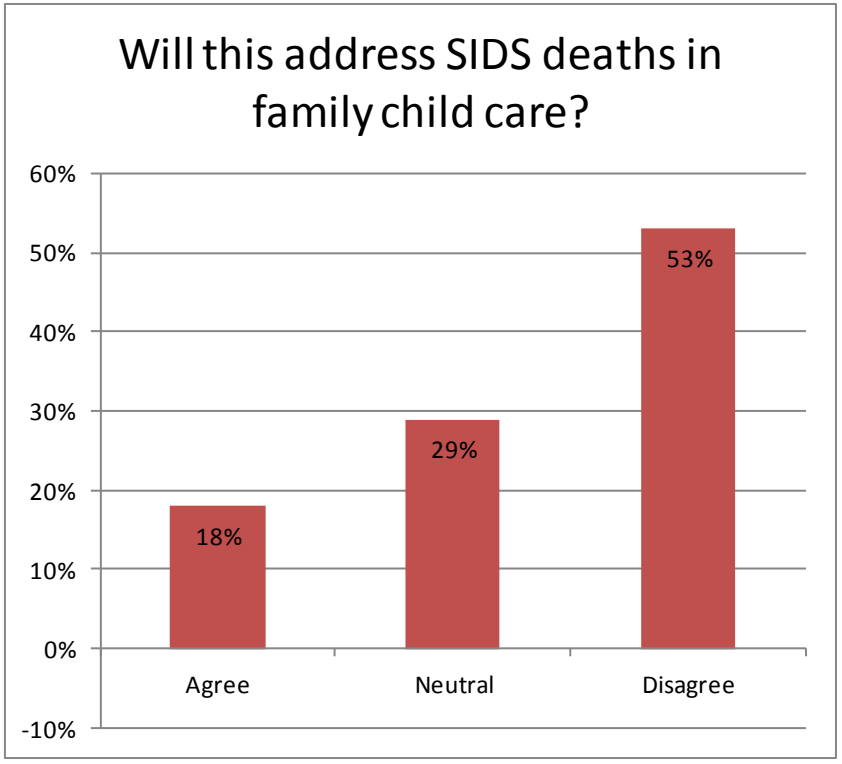
Comments:

- *"I think most of us do all these things already. The first month of a new baby you are getting used to them & their wants & needs. When an infant has a URI you already are supervising them more because they are uncomfortable & sleep less so we are doing things to try to make them feel better & more comfortable"*
- *"What is intense supervision? Sometimes a doctor will recommend a baby sleep in an upright position during upper respiratory infections, however, we can't honor that request."*
- *" I think it is a "best practice" but how will anyone monitor/enforce this requirement?"*
- *"Education, can't say it enough."*
- *"How will this be monitored or required? Again, teach best practice."*

Recommendation: Add correction orders made by county social service agencies to family child care providers available on the DHS website on the Licensing Lookup screen.

Current rule or statute: Correction orders are not currently listed on the DHS site. Correction orders are kept on file with the county licensing unit and are also posted in the childcare environment in a prominent place for two years. Current listing on DHS website includes Termination, Suspension, and Revocation and does not list the reason for the negative action.





1075 responses

Question14 Summary of Comments

Comments of support noted a parents right to know and felt it would encourage a level of accountability. Additional comments supporting online posting were for recurring, serious violations and an opportunity for providers response.

Comments noted that the current practice of posting the order in the providers home and access through the county was enough. Others noted that some orders were minor, (water temp over by 2 degrees, or missing the name of the dentist in the enrollment packet.) and would infringe on the providers privacy.

Comments indicate that parents need to ask for references, contact the licensor, interview, and observe before choosing a provider.

Comments reflected that this would not prevent SIDS.

Comments:

- *"Correction orders are available for review at the county level currently. Educate parents on where to find this kind of information."*
- *"They are already posted in providers' homes for parents to see."*
- *"Correction orders often have a very simple explanation behind them. Offering them for people to see but not hear the background for the order could easily create potential parents to overlook excellent care possibilities."*
- *"How will this reduce the incidence of SIDS??"*
- *"Parents do have a right to know what is going on with a provider but to what extent does a provider have a right? If there is definite negligence on the part of a provider that should be made available information but to pick-pick is not helpful. The parents should be checking out the home and seeing what is there for themselves."*
- *"This is a must. Parents need to be made aware of all violations."*
- *"Yes! Parents and potential customers have every right to know if the provider is not following guidelines or not providing high quality care."*

- Summary Comments
- Questions and Comments
- Closing Comments

- Remember, these are recommendations in the Minnesota Infant Mortality Report that were submitted to DHS. DHS is holding a stakeholder meeting on November 29, 2012 to discuss and/or present their legislative agenda. Any proposals from DHS must proceed through the legislative process.

Advocate for your family child care business and be in touch with legislators. Contact information is available on at www.house.leg.state.mn.us/