Rhode Island Department of Human Services
Office of Child Care, Child Care Licensing Unit
401-462-3009 | DHS.ChildCareLicensing@dhs.ri.gov

CHILD CARE LICENSING REGULATION GUIDANCE

For Child Care Center and School Age Programs

Updated: November 2022

Welcome!

The RI Department of Human Services (DHS) Child Care Licensing Unit (CCL) is excited to offer this guidance document to support the early childhood education workforce with interpreting and adhering to the child care licensing regulations.

DISCLAIMER: The materials available in this document are for informational purposes only. These materials are not intended to be relied upon as a comprehensive view of licensing regulations or legal advice. Everyone is responsible for knowing and understanding current Rhode Island laws and regulations. Current child care laws and rules can be found at the link below.

Regulations for Licensure

Child Care Center and School Age Program Regulations for Licensure:
http://www.dhs.ri.gov/Regulations

RI DHS Licensing Contact Information

For additional questions, please contact:


401-462-3009


DHS.ChildCareLicensing@dhs.ri.gov


http://www.dhs.ri.gov/Programs/CCAPLicensing.php

IMPORTANT NOTE:

The Office of Child Care is working to be as supportive as possible in helping providers meet the regulations. If you are looking for a resource, there are several of them on the DHS website under “Handbooks and Forms” found here: https://dhs.ri.gov/programs-and-services/child-care/child-care-providers/handbooks-forms. We are always updating based on questions from providers, so check back often.

Contents

Positive Interactions

Q. Per regulations 1.14.C.1.d-j; 1.14.C.2-4; 1.14.D.4.b, what types of positive interactions with children could be observed?

A. The following table outlines the types of positive interactions that may be observed.

Infants and Toddlers	The Environment Rating Scale (ERS), also utilized by BrightStars to conduct quality reviews, are grounded in research and best practices to support high quality early education and child care. The following guidance is from the Infant/Toddler Environment Rating Scale[1]. It provides specific examples of positive interactions with infants and toddlers, including: • Talk is frequent and is pleasant and warm in tone. • Providers talk to children as they play, during routines, while holding a child and socializing, when showing a child something. • Providers are responsive in talking with children, meaning they are responding to a child's interest or mood. • Providers generally respond to children's subtle communication (Example: notice when a baby shows mild hunger and warms bottle before baby becomes very upset). • Providers show sensitive individual attention and respond to children's communication throughout the day (Example: a provider stops feeding child and waits until she is ready for next spoonful). • Providers build language, meaning they add more words or ideas to expand what the child is saying (Example: if child holds up toy, they say, "Yes, that is a truck. See, it has wheels"). • Positive individual interactions are observed with *all* children in the group. • Warm physical contact is often use during learning and play activities (Example: holding a baby, sitting closely while reading together). • Providers use positive methods of guiding behavior (Example: "Use your walking feet inside" instead of "Stop running!"). • Providers help children learn to use communication to solve problems and follow up as needed. • Expectations for children are always appropriate, with no troublesome instances observed causing undue distress for children.

[1] Harms, T., Cryer, D., Clifford, R. M., & Yazejian, N. (2017). Infant/Toddler Environment Rating Scale, third edition. New York, NY: Teachers College Press. Print. Pages 33; 37; 71; 73, 75.

Preschool	The Environment Rating Scale (ERS), also utilized by BrightStars to conduct quality reviews, are grounded in research and best practices to support high quality early education and child care. The following guidance is from the Early Childhood Environment Rating Scale[2]. It provides specific examples of positive interactions with preschoolers, including: • Providers frequently ask questions that children are interested in answering. These conversations occur during indoor and outdoor free play. • Questions to engage preschoolers go beyond a "Yes" or "No" response. (Example: questions that begin with "how", "what if", "why", "tell me about"). • Providers generally give children a message of warmth through appropriate physical contact. • Providers are respectful to children and guide them positively. • Providers are supportive and comforting when children are anxious, angry, fearful, or hurt. • Providers are sensitive to children's nonverbal cues and respond appropriately. • Providers explain reasons for why they cannot permit specific behaviors. • Expectations for children are always appropriate, with no troublesome instances observed causing undue distress for children. • Providers call attention to children's feelings and the relationship between children's action and other's responses. • Providers actively involve children in solving their conflicts and problems without telling them what to do.
School Age	Examples of positive interactions with school age children include: • Providers talking and engaging with the children individually and in small – and – large groups. • Providers encourage children to participate in activities and provide alternatives where they are not interested. • Provider speaks with children at eye level in a calm, warm tone. • Providers are respectful to children and guide them positively. • Providers are sensitive to children's nonverbal cues and respond appropriately. • Providers explain reasons for why they cannot permit specific behaviors.

[2] Harms, T., Clifford, R. M., & Cryer, D. (2014). Early Childhood Environment Rating Scale, third edition (ECERS-3). New York, NY: Teachers College Press. Print. Pages 39; 73; 77.

High Risk Regulations

Q. What are regulation risk levels?

A. A risk level designates the risk of harm that may come to a child if the regulation is violated. All regulations are important in protecting the health and safety of children in care and must be followed; however, not all regulations carry the same risk of harm to a child's safety or wellbeing when violated.

Many states, such as Washington, Ohio, Texas, Florida, and Oklahoma, use risk levels to help licensors and providers identify regulations where non-compliance results in a *greater* risk of harm to children. This helps licensors and providers quickly focus on key regulations related to health and safety of children in care. Categorizing regulations based on risk also allows for appropriate corresponding corrective timelines and responses to be implemented.

The Administration for Children and Families recognizes states may choose to include risk levels in child care monitoring; however, it is not a requirement.

Q. How are risk levels identified?

A. States may choose to assign regulations risk levels using a numbering system (Example: scale of 1-low risk to 5-high risk) or category (Example: low, medium, high).

When assessing the risk of harm to a child if a regulation is violated, the following must be considered[3]:

1. What is the **probability** a child may be harmed if this regulation is violated?
2. What is the **severity** of harm that may come to a child if this regulation is violated?
3. If this regulation is **repeatedly** violated, how does this impact the risk of harm to a child?

States may also choose to review current national research, such as studies from the American Academy of Pediatrics, and best practices, such as Caring for Our Children, to better understand the probability, severity, and prevalence of injuries or harm related to regulation topics.

Q. How is Rhode Island categorizing risk levels?

In Rhode Island, DHS reviewed peer state risk levels, from Washington and Ohio, to inform the assignment of risk levels, development of corrective action response timelines, and the potential options for department enforcement actions where non-compliance is not corrected.

The below table identifies the three categories of risk (low, moderate, and high) and descriptions of these risk levels.

Risk Level	Description
Low	If this regulation is violated, there is a low/minimal risk of harm to children in care. Example: Child file is missing documentation

[3] National Center on Child Care Improvement. (July 2014). CONTEMPORARY ISSUES IN LICENSING Monitoring Strategies for Determining Compliance: Differential Monitoring, Risk Assessment, and Key Indicators. Retrieved from https://childcareta.acf.hhs.gov/sites/default/files/public/1408_differential_monitoring_final_1.pdf

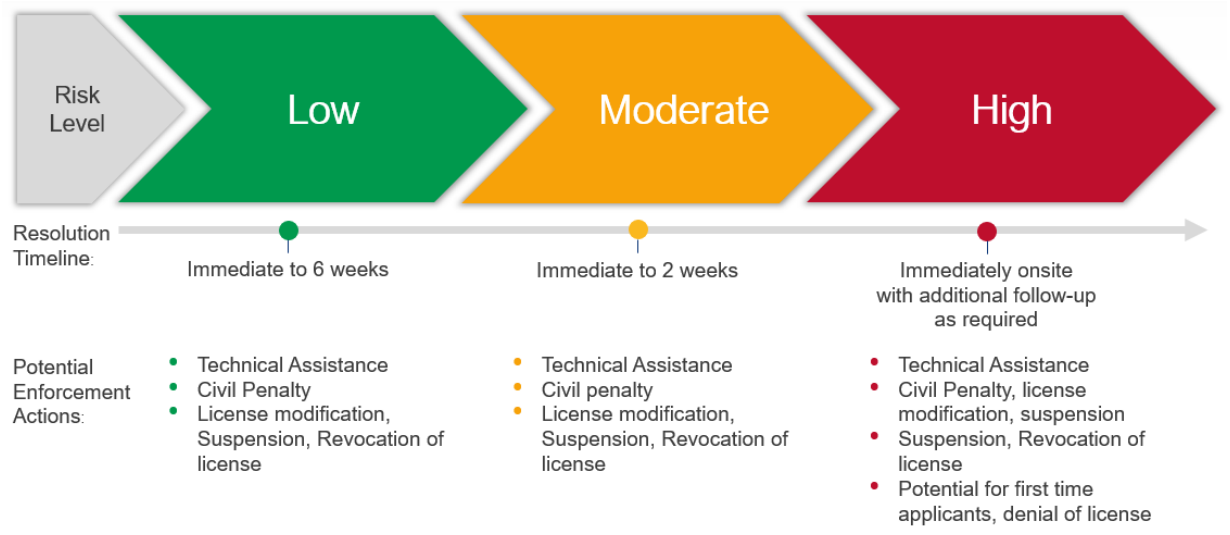
Risk Level	Description
Moderate	If this regulation is violated, there is a moderate risk of harm to children in care. There is a potential for significant harm over time if the non-compliance continues. Example: Re-stocking the first aid kit after use
High	"If this regulation is violated, would the child get hurt/harmed right now?" If the response is yes, it is likely a high-risk regulation. Example: Medication within a child's reach

Regulations which are requirements of DHS, definitions, or best practice explanations would not carry a risk level.

Q. How will risk levels impact Corrective Action Plans?

A. Since not all regulations carry the same risk of harm to a child if violated, the timeline to correct the non-compliance as well as the enforcement actions DHS may take as part of a Corrective Action Plan are tiered to correspond with the risk level. This allows for more appropriate and commensurate responses to be taken when correcting non-compliance items and it provides clear guidance for both licensors and providers.

The graphic below outlines the timelines to resolve non-compliances by risk level and potential enforcement actions DHS may take as part of a Corrective Action Plan. Please note, enforcement actions are tiered to represent the options available to DHS based on the nature and history of a specific provider's non-compliance.



Q. What if a high-risk regulation can't be fixed "immediately"?

A. Many high-risk regulations can be fixed immediately (For example: medication accessible to children can be moved to a secure area immediately). However, there may be instances when a CAP is required

for a high-risk regulation which cannot be fixed onsite. For example: the regulation related to peeling paint and damaged plaster is a high risk; if a program has damaged plaster, the immediate fix to repair the plaster may not be feasible during child care hours. In these cases, the licensor will work with the program to develop a reasonable action plan to address the high-risk regulation as quickly as possible onsite and develop a timeline to work to a permanent fix.

Q. How do I know which regulations are high risk?

A. All regulations if violated will create some risk of harm to a child. High risk regulations are identified by DHS as posing *an immediate* risk of harm to a child if violated. One way to identify a high-risk regulation is to ask, "If this regulation is violated, would the child get hurt right now?" If the response is yes, it is likely a high-risk regulation. DHS will also be providing additional guidance which notes the risk level of each regulation.

Again, all regulations are important in protecting the health and safety of children in care. It is the responsibility of providers to meet all requirements and the responsibility of licensors to monitor this achievement.

Regulation Specific Guidance

1.5.A – D
Incorporated Materials

Q. Why was this section added to the regulations this time?

A. In previous iterations of the regulations, other bodies of work were referenced with no information about where to find the specific resource. The incorporated materials section takes any of the references the Department makes to different bodies of work and puts it all in one place. Providers are now easily able to reference these bodies of work and/or research (Safe Sleep, etc.) when they are mentioned in our regulations.

1.8.C.12
Facilities used by children are above grade, as defined by the Rhode Island Building Code.

Q. How can a program show compliance with this regulation?

A. According to the Rhode Island Building Code, which references the International Building Code chapters 2 and 5, "grade plane is a reference plane representing the average of the finished ground level adjoining the building at its exterior walls[4]." It is a reference point where the levels below the grade plane would be considered the basement. Compliance with this regulation would be indicated by the building the program occupies is not in a basement.

1.7.E.
The program is responsible for adhering to the child care license which indicates the:
a. physical location of the program
b. dates of validity
c. maximum number of children
d. age groups to be served in the program
e. Other specific conditions of the license as stated in "Other Conditions"

[4] 2012 IBC Handbook. (n.d.). International Building Code. Retrieved from http://media.iccsafe.org/news/eNews/2014v11n20/2012_ibc_handbook_p32-34.pdf

Q: What is an example of an "other condition" on my license?

A: It is important for anyone who comes into your program to know what you are licensed for. The "other conditions" on your license may be applicable if you have an infant room and a toddler room to show how many children are allowed in each room. If you are in a school age program and you utilize a certain space in the school, we might put what space that is so the school will know which room is licensed by DHS. If you have anything special that has been approved by the licensing Department, it will be listed as an "other condition" on your license for documentation purposes.

1.8.1.i
Playground inspection for any new facilities applying for licensure subsequent to the date of these regulations or any previously licensed program making structural changes to their playground/playground equipment subsequent to the date of these regulations.

Q: How do I know if I need a playground inspection?

A. We will expect every new provider who opens a center or takes over an existing center to get a playground inspection. It is important that what has been put in your program is safe for children. You will also be required to get a playground inspection if you make any structural changes to your playground (for example, fencing, ground cover, update playground equipment, etc.?"

Q. How do I get a playground inspection?

A. Schedule an appointment with a Licensed Playground Inspector in your area – you can find one on www.ipema.org or contact LISC-RI for a referral to one of their trusted playground partners at riccelff@lisc.org.

1.8.B.2.a
Any construction at programs licensed prior to these Regulations will require the program to adhere to the most recent set of Regulations for the age group in which the construction is impacting.

Q: How do I know if this applies to me?

A: The most likely example of this regulation would be for infant programs. If you were grandfathered into a regulation where your infant room does not have direct access to the outside, and you decide to make any changes to this infant room that require Department approval, you are expected to also create direct access for this room. Once you do any sort of construction or make any changes to a room that has been "grandfathered in" to a regulation, you are required to adhere to the newest set of regulations.

1.8.E.3
If refrigeration is used, temperatures are maintained at 41°F or lower for refrigerator and 0°F or lower for freezer.

Q: How do I know the refrigerator and freezer are within required temperatures?

A: Check the thermometer in the refrigerator/freezer. If the program does not have a thermometer in the refrigerator/freezer, place one in and collect the readings. Thermometers are available at most supermarkets, hardware stores, and online. For example, a refrigerator thermometer is available for $7.99 at Walmart and Amazon sells the same refrigerator thermometer in a pack of two for $7.99.

Q: How do programs demonstrate their continued compliance with the required temperatures for the refrigerator and freezer?

A: A program may choose to keep a record of refrigerator and freezer temperatures on a temperature log.

1.8.F.10
Any classroom used by Infants and/or Toddlers, in a program or classroom licensed subsequent to the date of these regulations, must have direct access from the classroom to the outdoors without the use of stairs or elevators.

Q. What is the definition of "direct access?"

A. The Child Care Licensing Team defines direct access as stated in Caring for Our Children (CFOC **5.1.4.7: Access to and Awareness of Exits**, which states the following:

Caregivers/teachers should be aware of all available exit routes within the early care and education program. Each room within an early care and education program should be provided direct access to at least one of the following:

a. An exit opening directly to the outside

b. A corridor or hallway providing direct, unobstructed access to an exit to the outside

For more information, visit:
https://nrckids.org/CFOC/Database/5.1.4.7

1.8.F.11.c
Programs are required to designate space in the facility for storage of food

Q: What is considered proper food storage?

A: Food shall be stored according to the instructions on the label. Considerations for food storage, include:

- Foods should **never** be stored on the ground. At minimum, foods should be stored 6" off the ground.
- Foods should be stored in a sealed container. Masking tape, rolling/twisting bags, and/or clothes pinning are not acceptable.
- Be safe and separate – don't cross contaminate.
- Due to allergens, different foods should not be stored in the same container.
- Perishable food such as meat and poultry should be wrapped securely to maintain quality and to prevent meat juices from getting onto other food.
- Always refrigerate perishable food within 2 hours

For more information on food storage and food safety, visit:
https://www.fsis.usda.gov/wps/portal/fsis/topics/food-safety-education/get-answers/food-safety-fact-sheets/safe-food-handling

1.9.A.1
Child care programs adopt policies and procedures consistent with the RI Department of Health's Rules and Regulations Pertaining to Immunization and Communicable Disease in Preschool, School, Colleges or Universities.

Q: According to Rhode Island's immunization regulations for child care centers, who needs to be vaccinated?

A: According to the Rhode Island Department of Health, anyone who is temporarily or permanently employed by a child care program licensed by the Rhode Island Department of Human Services who has contact (either direct or indirect) with children in program must be appropriately vaccinated.

Q: What vaccinations are required annually?

A: Annually, individuals should receive 1 dose of the flu vaccine.

Q: What vaccinations are required one time?

A: The following vaccinations are required one at a time:

- 2 doses of MMR (measles, mumps, rubella) vaccine – the second dose must be administered 4 weeks after the first
- 2 doses of varicella (chickenpox) vaccine – the second dose must be administered 4 weeks after the first
- 1 dose of Tdap (tetanus, diphtheria, pertussis) vaccine

Q: Are there any exceptions to these requirements?

A: According to guidance from Rhode Island Department of Health, the following exceptions may apply:

- Child care workers do not need to receive these vaccinations if they received them in the past. This can be shown with an immunization record, a medical passport, or any other official record that shows the month, day, and year of the vaccinations.
- If someone cannot be vaccinated against a disease for medical reasons, that person is exempt from the immunization requirement for that disease. A medical exemption certificate is available online at (www.health.ri.gov/forms/exemption/MedicalImmunizationExemptionCertificateForChildcareWorkers.pdf) The Medical Exemption Certificate must be completed by a licensed healthcare provider acting within his/her scope of practice (physician, physician assistant, nurse practitioner).
- Child care workers born before 1957 are not required to get MMR vaccine.
- Child care workers born before 1980 are not required to get varicella (chickenpox) vaccine.
- Child care workers do not need to get varicella (chickenpox) vaccine if they had varicella (chickenpox or shingles) in the past. This can be demonstrated with a signed statement from a licensed healthcare provider acting within his/her scope of practice (physician, physician assistant, nurse practitioner).
- If a child care worker is already immune to a disease, vaccination against that disease is not required. Immunity must be demonstrated with laboratory evidence (also called a titer). The charges for lab tests vary, but the estimated cost is between $25 and $50 for each titer. Some insurance plans cover the cost of these lab tests. Check with your insurer.

In addition, school age only programs may also be excluded under certain circumstances. Please contact your licensor to confirm if your school age only program meets this exemption.

Q: Where can staff at child care programs be vaccinated?

A: Providers may check with their primary care physician or health insurance provider to learn more about vaccinations. For child care providers who are un- or under-insured, St. Joseph's Immunization Walk-in Clinic for Adults offers walk-in hours for individuals seeking vaccinations. St. Joseph's Immunization Walk-in Clinic is located at 21 Peace Street, Providence, Rhode Island and may be reach at 401-456-4321 to schedule an appointment.

Q: By what date do child care workers must receive flu vaccine?

A: Rhode Island Department of Health recommends receiving the flu vaccine annually by December 31.

Q: Why are staff in child care settings being required to receive these immunizations?

A: These vaccinations are required for child care workers to protect infants and children in their care. Although infants and preschool age children are required to be "age appropriately vaccinated," they are still too young to be fully vaccinated. Some vaccine series are not complete until age 5 or 6.

Q: Can child care workers wear masks during flu season instead of getting flu shots?

A: No, child care workers cannot wear masks during flu season instead of getting flu shots. This is not practical in the child care setting. People with concerns about flu vaccination can be referred to the Rhode Island Department of Health at 401-222-5960. Additionally, the Rhode Island Department of Health can provide flu educational material for child care centers and onsite training for child care workers and parents about the flu and the benefits of flu vaccine.

Q: What happens if there is an outbreak at a child care center?

A: If there is an outbreak of a disease at a child care center, the Rhode Island Department of Health will consult with the facility to determine if exclusion of any unvaccinated individuals is necessary. If this is the case, people who cannot demonstrate immunity to that disease must be fully vaccinated against that disease. This requirement is in place during outbreaks even for people born before 1957 and 1980.

Q: What should a child care center do if staff do not comply with these immunization regulations?

A: If child care center staff do not comply with these immunization regulations, they should not be permitted to work at that child care center.

For more information about immunization and these requirements, please reference the following resource:

- **Rhode Island Department of Health:** www.health.ri.gov/immunization/for/schools 401-222-5960 / RI Relay 711
- **The Centers for Disease Control and Prevention (CDC):** www.cdc.gov/vaccines
- **The Immunization Action Coalition:** www.immunize.org

Q. Where can I find more resources about vaccinations related to child care programs?

A. The Rhode Island Department of Health's website provides additional information here: https://health.ri.gov/immunization/for/schools/

Q. Where can I find the Rhode Island Department of Health regulations related to child care settings?

A. The Rhode Island Department of Health regulations may be found here:
https://rules.sos.ri.gov/regulations/part/216-30-05-3

In addition, you can find the requirements for staff here:
https://health.ri.gov/immunization/for/schools/

1.9.A.2
The parent/guardian submits evidence of an annual health examination, signed by the child's primary care provider, which includes information regarding any condition or limitation that may affect the child's general health or participation in the program

Q: How can a program show they are capturing this information?

A: DHS is developing example documents that providers may use to ensure these requirements are being met. Programs may capture this information through the program's intake/enrollment paperwork requirements. These files should be kept in the enrolled child's file, onsite. The program may also have this language included in their enrollment policy in a parent handbook or enrollment information.

1.9.B.1
In the event a child or staff member suffers from a communicable disease, of public health significance, or in the event of an outbreak of any type, the facility must: a. report the disease to RI Department of Health, Center for Acute Infectious Disease Epidemiology; b. Provide written notice to inform all parents/guardians to which communicable disease the child(ren) may have been exposed, without providing any identifying information regarding the source of the communicable disease.

Q: What illnesses are considered communicable diseases that should be reported?

A: Please refer to the Department of Health's website for a list of immediately reportable diseases and conditions, and diseases that need to be reported within four (4) days of recognition.
https://health.ri.gov/diseases/infectious/resultsreportable.php

1.9.B.2
In all matters of exclusion and readmission of children for reasons of illness, the decision of the Child Care or School Age Administrator applies. If applicable, due to communicable disease, this decision is made in consultation with a licensed physician, physician's assistant, or nurse practitioner, and RI Department of Health, Center for Acute Infectious Disease Epidemiology.

Q: How can a program demonstrate their compliance to this regulation?

A: A program may include this guidance in their policies or parent handbook. Additionally, a program may choose to have a parent provide documentation or sign a note stating when their child began receiving an antibiotic or other prescription medication; this may be retained in the child's file.

1.9.G.1
The facility, equipment, and materials are clean, free of hazards, and kept in good repair.

Q: What does a clean and hazard-free environment look like?

A: A *clean* environment is one that:
- Is free of clutter
- Is free of dust
- Is free of trash and trash receptacles are clean and not overflowing

- Has clean surfaces with no caked-on/dried up grime
- Is well-swept/mopped

A *hazard-free* environment is one with:

- No broken toys or toy bins
- All toxic substances clearly labeled and toxic materials is kept out of reach of children
- Infant and toddler areas are free of toys and materials that are choking hazards
- Painted walls are free of chipped paint
- Windows and window screens are secure
- Securely fastened doors/gates

1.9.G.2
Any product used for cleaning, sanitizing and/or disinfecting is approved by the US environmental protection agency and is used in accordance with the manufacturer's instructions.

Q. How should a program clearly identify bottles of cleaning, sanitizing, and/or disinfecting solutions?

A. This is now incorporated in the "Incorporated Materials" section of the regulations. All bottles of cleaning solution, whether made in the program or store-bought, must be clearly labeled with the solution type contained. If a product is still in the original store-bought container, it will require no additional labeling. If a solution is program made or transferred from a store-bought container to a reusable container, the container label should include the name and type of product. For example, if a program makes its own bleach solution, the hand written label on the container may say: Bleach Solution- 2 tbsp bleach, 1 quart water.

Q. What is the difference between "cleaning", "sanitizing", and "disinfecting"?

A. The following definitions come from the Environmental Protection Agency (EPA)'s toolkit for Early Learning Providers "*Green Cleaning, Sanitizing, and Disinfecting: A Curriculum for Early Care and Education*" found at: https://www.epa.gov/sites/production/files/documents/ece_curriculumfinal.pdf [epa.gov] (pg. 19-23)

- **"Cleaning:** Reduces germs, dirt, and impurities by removing them from surfaces or objects. Dirt and organic material make some disinfectants less effective, so cleaning is necessary before disinfecting in most cases."
- **"Sanitizing** is the use of a chemical product or device (like a dishwasher or a steam mop) that reduces the number of germs on surfaces or objects to a level considered safe by public health standards or requirements. Sanitizing kills most germs but not all of them."
- **"Disinfecting** uses chemicals to kill 99.999% of germs on hard, non-porous surfaces or objects." Disinfectants will not work on porous surfaces (such as cloth or soft furnishings). Disinfectants only work on clean surfaces; for example, a disinfectant will be less effective on a table top that still has food waste on the surface.

An additional resource outlining the difference between sanitizing and disinfecting comes from Caring for Our Children, Appendix J: https://nrckids.org/files/appendix/AppendixJ.pdf [nrckids.org]

1.9.G.7

The program posts in a conspicuous place and follows a regular cleaning and sanitization schedule, including provisions for deep cleaning.

Q: What would a regular cleaning and sanitization schedule look like?

A: There is a helpful example of a regular cleaning and sanitization schedule found on the DHS website for provider forms. You can find the example here: https://dhs.ri.gov/programs-and-services/child-care/child-care-providers/handbooks-forms

1.9.I.3
All animals maintained as pets or visiting the program are kept in accordance with state and local requirements, including all applicable vaccinations.

Q: How will an animal kept in a safe and sanitary look at a program?

A: Some considerations recommended by Caring for Our Children (2019) and the Center for Disease Control (CDC) for animals being kept in a safe and sanitary manner include, but are not limited to:

Animal Habitats	• Animals should be housed within some "barrier" that protects them from competition by other animals' while being fed. This also provides protection for the children when animals are feeding. • Uncaged animals, such as dogs and cats, should wear a proper collar, harness, and/or leash when on the program premises. The owner or responsible adult should stay with the animal at all times. • Animal waste shall be kept away from children and cleaned promptly.
Interaction/Access	• Fish must be inaccessible to children, meaning the water or fish itself must not be within reach of the child. (Example: If a fish bowl is on a shelf in a room child care is provided and it falls off the shelf, it becomes accessible to children). • All contact between animals and children should be supervised by a provider/adult who is close enough to remove the child immediately if the animal shows signs of distress (Example: Distress in an animal may include growling, baring teeth, tail down, ears back) or the child shows signs of treating the animal inappropriately. • All children and providers/adults who handle animals or animal-related equipment (Example: leashes, dishes, toys, etc.) should be instructed to use hand hygiene immediately after handling.

General Considerations for Health and Safety	• Any animal present at the facility, indoors or outdoors, should be:
	  ○ Trained/adapted to be with young children
	  ○ In good health
	  ○ Show no evidence of carrying any disease, fleas or ticks
	  ○ Be fully immunized, and
	  ○ Be maintained on an intestinal parasite control program.
	• Providers should consult with parents to determine special considerations for children with allergies, asthma, and other illnesses.
	• Avoid having reptiles, amphibians, poultry, rodents, or ferrets into schools, daycare centers, or other settings with children under 5 years of age due to the spread of diseases such as *Salmonella* and *E. coli.*
	• Food and beverages should not be allowed in animal areas. In addition, adults and children should not carry toys, use pacifiers, cups, and infant bottles in animal areas.

	• Animal food dishes should not be placed in areas accessible to children during hours when children are present. • Animals should not be permitted in food preparation or service areas at any time.

This section was informed by the following resources:
Caring for Our Children. (2019). 3.4.2.1 Animals that Might Have Contact with Children and Adults. Retrieved from https://nrckids.org/files/CFOC4%20pdf-%20FINAL.pdf

Teachers and Daycare Staff. (n.d.). *Healthy Pets, Healthy People.* The Center for Disease Control. Retrieved from https://www.cdc.gov/healthypets/specific-groups/schools.html

1.9.K.13
Prohibited equipment and furniture include: a) toilet training chairs; b) mobile-walkers; c) baby corrals and d) infant inclined sleepers.

Q: Can you help me understand what each of these prohibited equipment pieces are?

A: Toilet training chairs are those standalone chairs that are often used by families to toilet train children. However, these are prohibited in child care centers for several reasons. They are difficult to clean and sanitize given they are made of porous materials. Caring for Our Children strongly discourages the use of this type of toilet training chair.

Mobile walkers are equipment with wheels that an infant or toddler can be placed in. The American Academy of Pediatrics does not recommend the use of these due to the tipping hazard and number of documented injuries associated with use. They are currently attempting to ban of the sale of mobile walkers.

Baby corrals are gates used to keep children in a small space. Different then pack and plays, these are not mounted to anything creating multiple hazards to young children.

Inclined sleepers are standalone sleepers that raise an infant to a 30-degree angle. These have been the subject of many recalls and are against the American Academy of Pediatrics recommendation for safe sleep. There is also a pending ban on the sale of these.

Q: Can I use a toilet-training seat?

A: Yes, if adult sized toilets are in use. These should be cleaned and disinfected after each use and only used under the direct supervision of an adult.

1.11.B
Staff/Child Ratio, Group Size, and Age Integration

Q. What are the staff to child ratios during rest time? How do these compare to staff to child ratios when children are awake?

A. The table below outlines the staff to child ratios and maximum group sizes during rest time and when children are awake.

Age Group	During Awake Time		During Rest Times	
	Staff: Child Ratio	Max Group Size	Staff: Child Ratio	Max Group Size
Infants	1:4	8	N/A	
Toddlers	1:6	12	1:12	12
Preschool 3	1:9	18	1:18	18
Preschool 4	1:10	20	1:20	20
Preschool 5-6	1:12	24	1:24	24
School Age (K – G7+)	1:13	26	N/A	

Note: 50% or more of the children in the classroom MUST be sleeping for the "rest time ratio" to take effect.

1.11.G.14
Every staff member, within 90 days of employment, must be trained under the most recent guidelines of the American Heart Association in
a. Pediatric CPR
b. Pediatric First Aid
c. Renewal certification must occur within 90 days of expiration for both Pediatric CPR & first aid

Q: How long do I have to get all my staff CPR certified?

A: This regulation was added as a first phase towards requiring 100% CPR and first aid certification in future iterations of the regulations. At this time, it is required for all new staff to become CPR and first aid certified within 90 days of hire. All staff currently certified, must renew within 90 days of expiration. There is a group of employees who may not fall into either of these buckets. DHS strongly encourages you to work with your staff to ensure everyone is CPR and First Aid Certified, as this may be a proposed regulation in the future.

Q. Why can't I take CPR online?

A. You are able to renew your CPR online. However, the initial training must be in person to ensure that there is a strong foundational knowledge gained with the support of a CPR trained professional available to answer any questions.

1.12.A
Comprehensive Background Checks

Q: How do I know if the background check that I have done is comprehensive?

A: If you are unsure what a comprehensive background check entails, please visit the DHS website to learn more information https://dhs.ri.gov/programs-and-services/child-care/child-care-providers/background-checks

Q: Can I use a background check from a previous employer if it's been within five years?

A. Yes, if you have been consistently employed in a child care program for that period and your initial background check was comprehensive. Some exceptions can be made for individuals who have been separated from employment from a child care provider for less than 180 days

1.12.B.2.7
Option 7 (for Education Coordinator) – The individual holds a bachelor's degree in an unrelated field or an associate's degree in a field related to Early Childhood Education AND is actively participating in a DHS-approved ECE program to receive 24 ECE credits, promoted from within the program after one year of employment.

Q: What is a DHS-approved ECE program?

A: For CCAP participating providers, there are several ECE opportunities across all degree levels available to staff, free of charge, through the TEACH program. There is availability for non-CCAP participants based on the current waiting lists. Enrollment in an early childhood degree program, separate from participation in TEACH, would also be accepted. Transcript will be requested by DHS to support the employee and program in determining what options may be accepted.

Q: What does "promoted from within the program after one year of employment" mean?

A: This means that the employee you are looking to list as your Education Coordinator has been working in a teaching or supervisory level for one year of employment. Depending on your programs calendar this could be 12 months or 9 months for programs that operate on a school year calendar.

1.12.C.3
Teacher's Aide

Q: What is the difference between a teacher's assistant and a teacher's aide?

A: A teacher assistant is required to be 18 years of age, must demonstrate a level of educational attainment and is able to supervise children alone. A teacher aide is required to 16 years of age or older, does not need to demonstrate educational attainment and must always be accompanied by a person over the age of 18 when with children.

Q: What does my teacher's aide need in their file?

A: A teacher aide is required to have the same documentation as any other staff person on site. For anyone under the age of 18, fingerprints are not able to be completed until they reach 18. A comprehensive background check will only consist of a DCYF clearance for those staff. Programs may decide to include additional forms, such as parental signatures etc. when employing someone under the age of 18. This, however, is not a requirement.

1.13.A.1
The program is responsible for immediately notifying the Department, in writing, of major changes which affect the license, including:
a. change of Administrator, Education Coordinator, Site Coordinator or Night Time Care Coordinator;

b. intent to change the name of the program;
c. intent to change ownership of the program;
d. intent to change the physical address/location of the program;
e. intent to use different/additional spaces for classrooms;
f. intent to change the numbers or ages of children served; and/or
g. any other major changes in the program.

Q. How is "immediately" defined?

A. In this context, "immediately" means as soon as possible and no longer than 24 hours.

1.13.F.1.
The program maintains program files, and individual files for children and staff that are available on-site at all times.
a. If these files are stored electronically, there must be someone on site at all times who can access these records in a timely manner.

Q: So, now I can store my files on the computer instead of having paper copies?

A: Yes, but those files must be accessible to DHS during a monitoring visit. In the event an Administrator or Education Coordinator is not on site, the person identified as "in charge" must also be able to access these files. Accessible means that a licensor can review requested documents when asked. Programs that require DHS to wait on site for additional staff to come to the location or for documents to be sent to the location, will be considered noncompliant.

1.13.F.7
Records and Files
a. an application form completed by the parent/guardian containing the child's name, birth date, parent's/guardian's name, current address and phone number and work or school address and phone number;
g. Written authorization from the parent/guardian for emergency medical treatment
m. A statement signed by the parent/guardian authorizing the program to act in an emergency

Q: How can a program show they are capturing this information?

A: DHS is developing example documents that providers may use to ensure these requirements are being met. Programs may capture this information through the program's intake/enrollment paperwork requirements. These files should be kept in the enrolled child's file, onsite. The program may also have this language included in their enrollment policy in a parent handbook or enrollment information.

Q. What is the difference between parent authorization for emergency medical treatment and parent authorization for the program to act in an emergency?

A. The table below outlines the difference between these requirements:

g. Written authorization from the parent/guardian for emergency medical treatment	m. A statement signed by the parent/guardian authorizing the program to act in an emergency
This written authorization may give the provider permission to receive care from an emergency medical professional; it may include treatment on	This written authorization may give the provider permission to act in the event of a non-medical emergency. This may include moving the

or off-site. If offsite, this authorization may include the removal the child from the premises for emergency medical treatment via ambulance or personal vehicle of an active, cleared administrative-level employee with a valid RI driver's license.	child/children offsite in non-medical emergency situations, including but not limited to: • Intruder on Premises • Fire • Flooding