
 **NATIONAL CENTER ON**
Early Childhood Health and Wellness

An Introduction to a Culture of Safety



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National Center on Early Childhood Health and Wellness
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Who's Here Today?




- Directors
- Managers
- Teachers or home visitors
- Family service staff
- Transportation staff
- TTA providers
- Federal staff
- Parents
- Others



Training Objectives

- Define and identify characteristics of a culture of safety
- Understand how a culture of safety prevents injuries and promotes child wellbeing
- Describe the ten actions for a culture of safety








"Keeping every child safe and secure and feeling loved every moment while in their care is foundational to Head Start and Early Head Start programs."

Ann Linehan
Deputy Director
Office of Head Start

January 3, 2018
Letter to Head Start Grantees
and Delegate Agencies



Safety is a core value



<http://www.nohs.org/page/cultureofsafety>





In a Culture of Safety, Everyone:

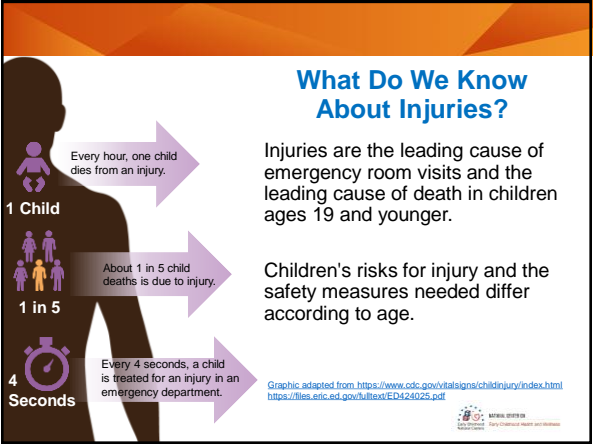
- Observes the environment and identifies safety concerns before harm occurs
- Speaks up when they have a safety concern
- Acts quickly to remedy an unsafe situation
- Supports others to openly discuss mistakes as a source of learning
- Works together to change practices so safety incidents do not reoccur

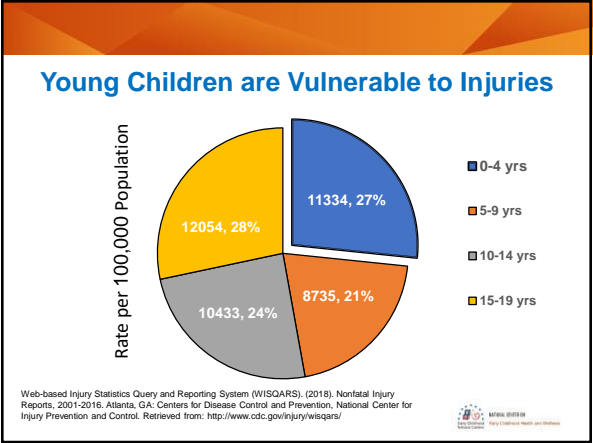
<http://www.npsf.org/page/culturesofsafety>
<https://psnet.ahrq.gov/primer/primer/5/Culture-of-Safety>

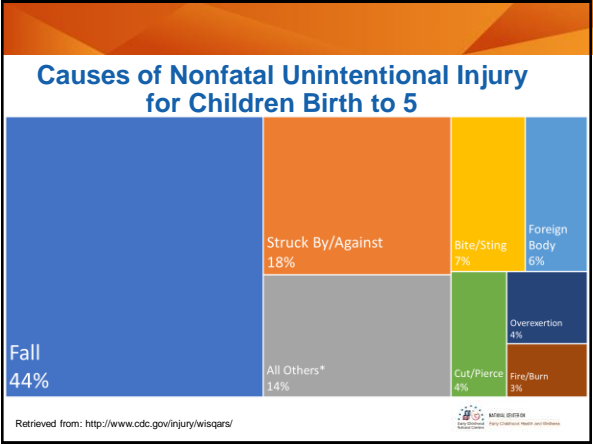
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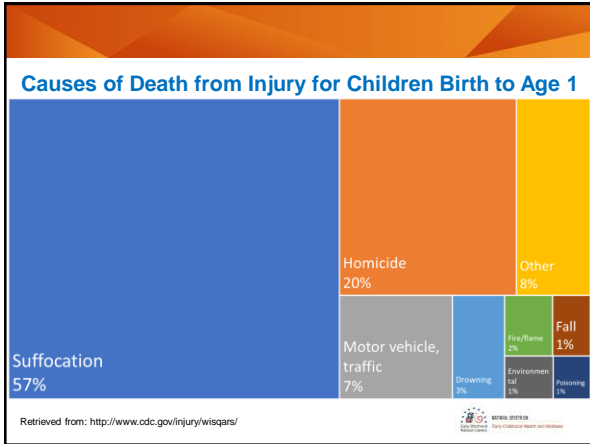
Injuries are Predictable

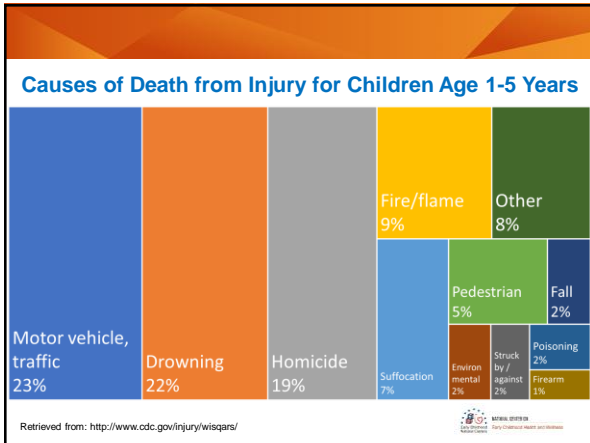
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Injuries in Your Program

What are the most common injuries you see?

How do your children get injured?

NATIONAL CENTER FOR HEALTH STATISTICS
Data from the National Child Mortality Surveillance System

Injuries in Your Program

In ECE programs, incidents and injuries are more likely:

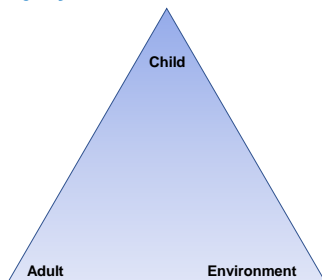
- During a transition
- At the beginning of the program year
- On playgrounds
- As a result of falls



Injuries are Preventable



Injury Prevention Framework



<https://files.eric.ed.gov/fulltext/ED424025.pdf>



Remember a Time...



...when a child in your program was injured or left unattended.

- Were there circumstances or factors that may have predicted the incident?
- What could you have done to prevent it?
- What were the child, adult, and environmental factors that contributed to what happened?



10 Actions for a Culture of Safety



The 10 Actions for a Culture of Safety

1. **Use Data to Make Decisions:** Program and incident data serve as an important resource to help managers and staff evaluate children's safety.
2. **Actively Supervise:** Children are never alone or unsupervised. Staff position themselves so that they can observe, count, and listen at all times.
3. **Keep Environments Safe and Secure:** Programs create, monitor, and maintain hazard-free spaces.
4. **Make Playgrounds Safe:** Regularly inspected, well-maintained, age-appropriate and actively supervised outdoor play spaces allow children to engage in active play, explore the outdoors, and develop healthy habits.
5. **Transport Children Safely:** Programs implement and enforce policies and procedures for drivers, monitors, children, and families using school buses, driving to and from the program, or walking.
6. **Report Child Abuse and Neglect:** Managers and staff follow mandated reporting statutes and procedures for reporting suspected child abuse and neglect.
7. **Be Aware of Changes that Impact Safety:** Staff anticipate and prepare for children's reactions to transitions and changes in daily routine, within and outside of the program.
8. **Model Safe Behaviors:** Staff establish nurturing, positive relationships by demonstrating safe behaviors and encouraging other adults and children to try them.
9. **Teach Families about Safety:** Staff engage families about safety issues and partner with them about how to reduce risks to prevent injuries that occur in the home.
10. **Know Your Children and Families:** Staff plan activities with an understanding of each child's developmental level and abilities, and the preferences, culture, and traditions of their families. This includes everything from maintaining current emergency contact information to understanding families' perceptions about safety and injury prevention.

<https://eclkc.ohs.acf.hhs.gov/publication/10-actions-create-culture-safety>



Activity

Ready, Set, Go!

Instructions:

Your team has been assigned one of the 10 actions. Please take 3 minutes as a group and brainstorm at least 5 reasons why **YOUR** action is the most important. Choose a reporter to tell us why your action is the most important aspect of a culture of safety.



Use Data to Make Decisions



Use Data to Reduce Injuries



Collect Data

Caring for Our Children: National Health and Safety Performance Standards

Incident Report Form

Fill in all blanks and boxes that apply:

Name of Program: _____ Phone: _____

Address of Facility: _____

Child's Name: _____ Sex: M/F Birthdate: ____/____/____ Incident Date: ____/____/____

Time of Incident: ____:____ am/pm Witnesses: _____

Name of Legal Guardian/Parent Notified: _____ Notified by: _____ Time Notified: ____:____ am/pm

BMS (911) or other medical professional ☐ Not notified ☐ Notified Time Notified: ____:____ am/pm

Location where incident occurred: ☐ Playground ☐ Classroom ☐ Bathroom ☐ Hall ☐ Kitchen ☐ Dining Room ☐ Gym ☐ Office ☐ Stairway ☐ Unknown ☐ Other (specify): _____

Equipment / Product involved: ☐ Climber ☐ Slide ☐ Swing ☐ Playground Surface ☐ Sandbox ☐ Tricycle/Bike ☐ Handtoy (specify): _____ ☐ Other Equipment (specify): _____

Cause of Injury (describe): _____

☐ Fall to surface: Estimated height of fall: ____ feet. Type of surface: _____ ☐ Hit or pushed by child ☐ Struck by object ☐ Ingested or choked ☐ Insect sting/bite ☐ Animal bite ☐ Exposure to cold ☐ Other (specify): _____

<http://nckids.org/files/appendix/AppendixCC.pdf>

Activity

You are assigned to review reports when children are injured in the classroom or on the playground and enter the data into the computer.

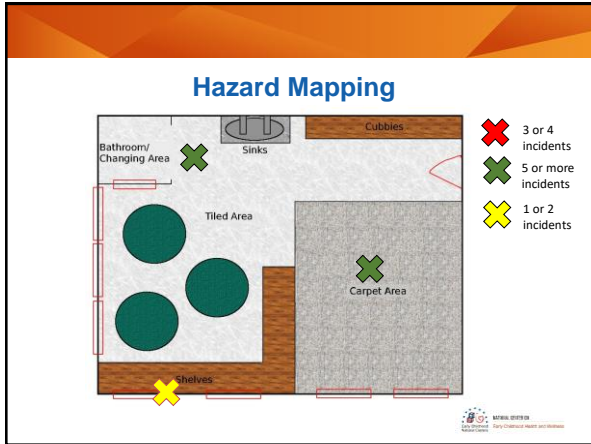
As you enter the data, you notice that certain children and certain locations in the classroom are frequently appearing on the reports.

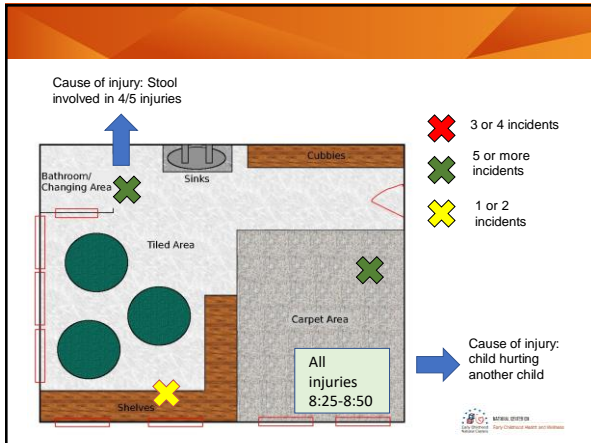
How can you learn more about possible trends?



Incident Data Tracking Sheet

Incident Mapping Data										
Classroom: Daypres, 3 year old Classroom										
Month: October 2015										
Child Name	Age	Date	Time	Location	Equipment	Product	Incident Type	Severity	Reported By	Notes
JK	3.1	10/1/15	8:50 AM	classroom	desk	N/A	child hit by another child	minor	teacher	
BC	3.9	10/2/15	10:05 AM	classroom	desk	N/A	child hit by another child	minor	teacher	
BC	3.9	10/2/15	11:30 AM	playground	big slide	N/A	child pushed by another child	minor	teacher	
JK	3.1	10/2/15	11:25 AM	playground	N/A	N/A	child tripped and hit while running	minor	teacher	
PT	3.9	10/3/15	2:03 PM	classroom	desk	desk	child hit off of desk	minor	teacher	
JK	3.1	10/7/15	11:25 AM	playground	tricycle	N/A	child collided with another child	minor	teacher	
JK	3.1	10/7/15	3:23 PM	classroom	desk	N/A	child tripped on desk floor	minor	teacher	
BC	3.9	10/7/15	8:45 AM	classroom	desk	N/A	child hit by another child	minor	teacher	
DM	3	10/7/15	4:20 PM	classroom	desk	desk	child tripped while pointing desk	minor	teacher	
BC	3.9	10/7/15	10:20 AM	classroom	desk	N/A	child hit by another child	minor	teacher	
CC	3.9	10/7/15	11:40 AM	playground	small slide	N/A	child hit by another child	minor	teacher	
PM	3.1	10/7/15	10:20 AM	classroom	desk	N/A	child tripped	minor	teacher	
TC	3.4	10/8/15	8:50 AM	classroom	desk	N/A	child pushed by another child	minor	teacher	
BC	3.9	10/8/15	9:05 AM	playground	sandbox	N/A	child hit by another child	minor	teacher	
MM	3.9	10/15/15	9:40 AM	classroom	desk	N/A	child hit by another child	minor	teacher	
JK	3.1	10/15/15	9:50 PM	playground	swing	N/A	child hit while swinging	minor	teacher	
LP	3.4	10/16/15	10:30 AM	classroom	desk	N/A	child tripped while walking on desk	minor	teacher	
BC	3.9	10/16/15	8:50 AM	classroom	desk	N/A	child tripped by another child	minor	teacher	





Next Steps?

- Make an educated guess about what's contributing to injuries
- Gather additional information, if needed
- Implement a change to address the cause of injuries
- Evaluate your new safety measures to see if they are working

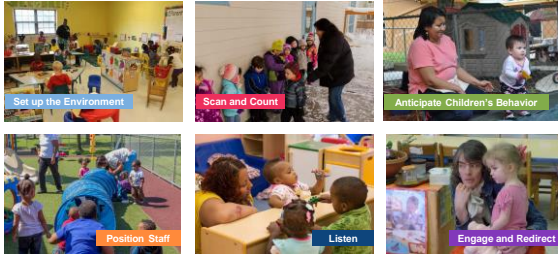
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Six Strategies in Active Supervision



<https://edkic.ohs.acf.hhs.gov/safety-practices/article/keep-children-safe-using-active-supervision>

What is a fail safe or redundant system?

"A part that has the same function as another part and that exists so that the entire system will not fail if the main part fails."

-Merriam Webster Dictionary





Virtual Lab School

Supervision and Accountability Indoors and Outdoors: Maintaining Accountability
<https://www.virtuallabschool.org/preschool/safe-environments/lesson-4>



Sharpen Your Skills



- Identify strengths and barriers to active supervision in each picture
- Think about how you will use this information to create safer environments

Identify active supervision


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#1



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#2



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Activity: Active Supervision on Playgrounds and Buses



Keep Environments Safe and Secure



- Children learn through exploration and experimentation
- Staff create, monitor, and maintain hazard-free spaces
- Identifying risks and removing hazards
 - Prevents injuries before they happen
 - Allows children to safely engage in learning
 - Increases children's opportunities to grow in all developmental domains



Steps to Ensure a Safe Environment

- Conduct a safety check
- Identify and prioritize hazards
- Report, repair, and maintain facilities & equipment
- Obtain safety equipment
- Educate everyone about maintenance and monitoring



Examples of Evidence-Based Checklists

This form is titled 'Daily and Weekly Playground Inspection and Maintenance Form'. It includes a table for recording inspection results with columns for 'Date', 'Time', 'Inspector', 'Findings', and 'Action'. The table has multiple rows for recording data. Below the table, there is a section for 'Inspector's Signature' and 'Date'.

<http://ecdc.healthychildcare.org/tools/checklists>

This form is titled 'Health and Safety Checklist for Early Care and Education Programs'. It is based on the 'National Health and Safety Performance Standards'. The form includes a table for recording inspection results with columns for 'Date', 'Time', 'Inspector', 'Findings', and 'Action'. The table has multiple rows for recording data. Below the table, there is a section for 'Inspector's Signature' and 'Date'.

https://cchp.ucsf.edu/sites/g/files/tksrra181f/1-31-2019_HS_Checklist.pdf

Checklist Activity

Findings:
Bookshelves have peeling and flaking paint



In your program, if this was your finding on a routine check of the environment:

1. What are your immediate next steps?
2. How do you prevent this from occurring again?
3. Which members of your management team do you need to engage?



Checklist Activity

Findings:

First aid kit for outdoor trips was missing gloves



In your program, if this was your finding on a routine check of the environment:

1. How do you address this issue?
2. How do you prevent this from occurring again?
3. Which members of your management team need to be engaged?



Scenarios for Discussion

- Monitoring visit indicated the program did not ensure toilets and handwashing facilities were clean and in good repair. The Health and Safety Checklist contained a section on the conditions of bathrooms, but there was nothing noted about the issues identified in the girls' bathroom.
- Monitoring visit indicated the program did not have a clear, consistent, or effective process for ensuring the safety and maintenance of all facilities. There were large tree stumps around playground equipment. A review of Health and Safety Checklists found no indication the tree stumps were reported as safety hazards.



Make Playgrounds Safe



Maximize Learning by Reducing Risk



Consider:

How do you promote the benefits of outdoor play while minimizing the risk for serious injury?



Key Playground Safety Considerations

- Plan for a safe playground through safe, age-appropriate design
- Maintain use zones and impact-absorbing surfaces
- Implement daily inspections to identify injury risks
- Promote active supervision

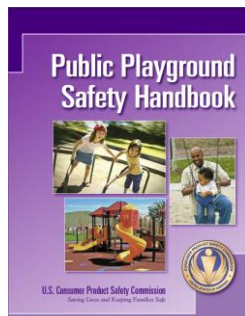




ASTM INTERNATIONAL



www.cpsc.gov/53fs-public/025.pdf ;
www.cpsc.gov/PageFiles/122149/025s.pdf





NPPS National Program for Playground Safety

Standards Research Training Products & Services

You are here: Home > Training >

Training

- Login Here
- **Online Training**
 - Available Courses
 - Certified Supervisor for Outdoor Environments
 - Playground Supervision Training for Child Care Providers
 - Early Childhood Outdoor Play Inspectors Course
 - Re-Certification for Early Childhood Play

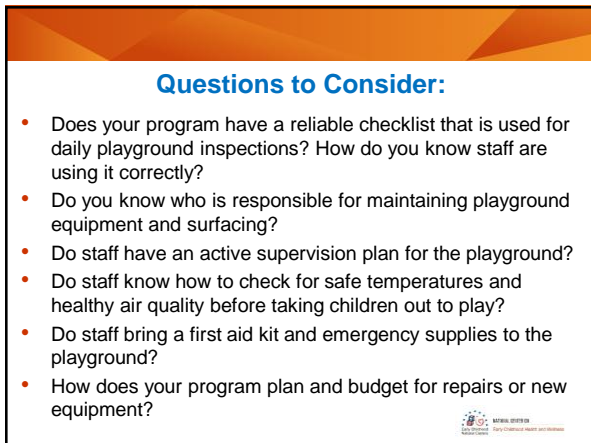
Online Training

The National Program for Playground Safety has several interactive online courses covering a variety of topics on developing and maintaining safe and appropriate outdoor play environments for children. Courses are run through the University of Northern Iowa's online learning system and can be taken on your own time at your own pace. CEUs are available for some of the courses.

Upon completion of all course requirements participants will receive a certificate from our national organization. Our courses have been approved for training credit by multiple state licensing agencies. Please contact your licensing agency with any questions on training credit approval specific to your state.

<http://playgroundsafety.org/training/online-training/available-courses>


NPPS
NATIONAL PROGRAM FOR PLAYGROUND SAFETY
Early Childhood Health and Wellness



Questions to Consider:

- Does your program have a reliable checklist that is used for daily playground inspections? How do you know staff are using it correctly?
- Do you know who is responsible for maintaining playground equipment and surfacing?
- Do staff have an active supervision plan for the playground?
- Do staff know how to check for safe temperatures and healthy air quality before taking children out to play?
- Do staff bring a first aid kit and emergency supplies to the playground?
- How does your program plan and budget for repairs or new equipment?

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Discussion: Problem Solving

A daily inspection report from 5 days earlier indicates a railing on a 5 foot climber is loose and missing two bolts.

What would you do?



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Transport Children Safely



Describing the Problem - One Child's Story



https://www.youtube.com/watch?v=_PWWAS8moA0

Consider safety practices for drivers, monitors,
children and families

- Using school buses
- Driving to/from program
- Walking





Account for Children at all Times

<https://eckkc.ohs.acf.hhs.gov/transportation/article/child-passenger-safety>

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WHERE'S BABY? LOOK BEFORE YOU LOCK!

Current Temperature

OUTSIDE CURRENTLY	INSIDE YOUR CAR AFTER 30 MINUTES
47°	81°

Video

<https://www.safekids.org/preventing-heatstroke>

NATIONAL CENTER
ON EARLY CHILDHOOD HEALTH AND WELLNESS

Report Child Abuse and Neglect



CHILD WELFARE
INFORMATION GATEWAY
Child Welfare Report and Review

Everyone Who Works in An ECE Program is a Mandated Reporter

Mandatory Reporters of Child Abuse and Neglect

All states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands have statutes identifying personnel who are required to report suspected child abuse/neglect to an appropriate agency, such as child protective services, a law enforcement agency, or a designated child abuse reporting center.

Child Welfare Information Gateway
Child Welfare Information Gateway
1000 20th St., Suite 200
Washington, DC 20036
1-800-394-7312
www.childwelfare.gov

What is Child Abuse and Neglect? Recognizing the Signs and Symptoms

The Child Welfare Information Gateway provides information on child abuse and neglect, including definitions, signs and symptoms, and reporting requirements. This fact sheet is part of a series of resources available on the Child Welfare Information Gateway website.

Child Welfare Information Gateway
Child Welfare Information Gateway
1000 20th St., Suite 200
Washington, DC 20036
1-800-394-7312
www.childwelfare.gov

<https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/mandat/>

<https://www.childwelfare.gov/pubs/factsheets/whatiscan.cfm>

CHILD WELFARE
INFORMATION GATEWAY
Child Welfare Report and Review



Virtual Lab School

Child Abuse Prevention, Identification and Reporting: Problems in Child Development
Center: <https://www.virtuallabschool.org/school-age/safe-environment/lesson-7>

CHILD WELFARE
INFORMATION GATEWAY
Child Welfare Report and Review

Discussion

How do you ensure that staff, volunteers, and substitutes are aware of reporting procedures?



Managing Stress

Research shows that:

- Caregivers who are stressed find it more difficult to offer praise, nurturance, and the structure that young children need
- Caregivers who are stressed are more likely to use harsh discipline
- Children whose caregivers are under high stress tend to have more challenging behavior

Center for Early Childhood Mental Health Consultation
Georgetown University Center for Child and Human Development
<http://www.ecmhc.org/relaxation.html>



How Recently Have You Felt Valued at Work?



32% It's been a while
26% This week
24% Today
16% Within the past month
2% At my annual evaluation



Staff Wellness Strategies to Support Child Safety



- Reflective supervision
- Peer support
- Mindfulness
- Yoga
- Other wellness activities



Stretch Break



Be Aware of Changes that Impact Safety



Classroom Transitions



TIPS FOR TEACHERS
CLASSROOM TRANSITIONS

MATERIALS ADAPTATIONS

Prepare children to move from one activity or setting to another.	<ul style="list-style-type: none"> Provide verbal cues before transitions (e.g., "The recess is back, it's almost clean up time"). Use nonverbal signaling, showing pictures of the next activity, beating a drum.
Plan for transitions.	<ul style="list-style-type: none"> List the number of transitions in a day. Plan your schedule so that children have adequate time to finish projects or activities before the transition. Plan for who each child will be responsible for during the transition.
Provide activities for the children so time passes more quickly.	<ul style="list-style-type: none"> Engage with meaning to one activity. Play word or guessing games while waiting for the bus to arrive. Provide physical activity during up after an activity.
Individualize transition strategies.	<ul style="list-style-type: none"> Provide individualized supports so children who need extra help during transitions (e.g., photos depicting the next activity to help anticipate what's next, identifying peers in a child's home language or sign language, an individual warning to a child that it will soon be time to clean up materials in one activity).
Help children become more independent across the year as they make transitions from one activity to another.	<ul style="list-style-type: none"> Allow children to move independently from one area to another as they prepare to do an activity. For example, for children to finish and moving together (e.g., as children finish work, they are encouraged to go to the next activity). Teach children to help others (e.g., have children move materials from one activity to another or one child help another child gather their materials). Help children self-monitor during transitions (e.g., children can be asked to think about how quickly or quietly they moved from one activity to another).
Provide positive attention to the children following the transitions that go smoothly.	<ul style="list-style-type: none"> Give very specific positive feedback after transitions. Take time to give specific feedback on the child's behavior in the transition area and then wait to the next to get ready for the next.

Resources on classroom transitions at <https://edkc.ohs.acf.hhs.gov/video/classroom-transitions>



Transition Cue Cards



MATERIALS
Early Childhood Health and Wellness

3.1.1 - Daily Health Check



Chapter 3: Health Promotion and Protection

3.1 Health Promotion in Child Care

3.1.1 Daily Health Check

Standard 3.1.1.1: Conduct of Daily Health Check

Every day, a trained staff member should conduct a health check of each child. This health check should be conducted as soon as possible after the child enters the child care facility and whenever a change in the child's behavior or appearance is noted while that child is in care. The health check should address:

- Reported or observed illness or injury affecting the child or family members since the last date of attendance;
- Reported or observed changes in behavior of the child (such as lethargy or irritability) or in the appearance (e.g., sores) of the child from the previous day at home or the previous day's attendance at child care;
- Skin rashes, impetigo, itching or scratching of the skin, itching or scratching of the scalp, or the presence of one or more live crawling lice;
- A temperature check if the child appears ill (a daily screening temperature check is not recommended);
- Other signs or symptoms of illness and injury (such as drainage from eyes, vomiting, diarrhea, cuts/lacerations, pain, or feeling ill).

The caregiver/teacher should gain information necessary to complete the daily health check by direct observation of the child, by querying the parent/guardian, and, where applicable, by conversation with the child.

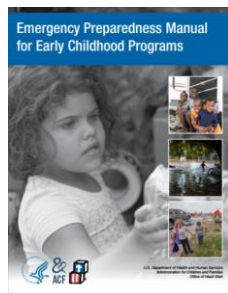
<http://nrckids.org/CFOCDatabase/3.1.1.1>



MATERIALS
Early Childhood Health and Wellness

Plan Ahead for Unexpected Events

- Emergencies
- Emergency Medications
- First Aid Kits



<https://edkc.ohs.acf.hhs.gov/publication/emergency-preparedness-manual-early-childhood-programs>



MATERIALS
Early Childhood Health and Wellness

Activity: Safety During Transitions



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Model Safe Behaviors



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- Children learn by watching what their caregivers do
- Establish nurturing, positive relationships that include demonstrating safe behaviors
- Managers and staff should jointly develop safety rules







- Educate families about safety issues
 - Hazard identification
 - Child development
 - Supervision
- Partner with them to reduce risks at home
 - Home safety inspections
 - Escape routes
 - Childproofing
- Use family partnerships to foster home safety
- Assist families to acquire safety devices

A photograph of a woman with glasses and a brown jacket writing in a notebook. Two young children, a girl and a boy, are sitting next to her, looking at the notebook. The background shows a room with shelves and toys.

A small logo for the National Center for Children's Health and Safety, featuring a stylized figure and the text "NATIONAL CENTER FOR CHILDREN'S HEALTH AND SAFETY".

KidsHealth / For Parents / Kitchen: Household Safety Checklist

Kitchen: Household Safety Checklist

Reviewed by: [Kate M. Cronan, MD](#)

Listen | Aa |

Kitchen

- Are knives, forks, scissors, and other sharp tools in a drawer with a childproof latch?
- Have you installed a dishwasher lock so kids can't open it while it's running and can't reach breakable dishes, knives, and other dangerous objects?
- Have you installed a stove lock and have knob protectors been placed on the stove knobs?
- Does your oven range have an anti-tip bracket installed?

<https://kidshealth.org/en/parents/household-checklist.html>

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Tips for Keeping Infants and Toddlers Safe: A Developmental Guide for Home Visitors

During the first three years, children are constantly growing and acquiring new skills and knowledge. Surveillance systems have shown that injury is the leading threat to the health and well-being of young children. When families understand how children can get hurt and know what to do to protect them, infants and toddlers can learn and grow safely.¹

Many injuries occur in the home where young children spend most of their time. As a home visitor, you can help families prevent childhood injuries. Whether families bring up concerns or you introduce the topic, safety is an important part of your work with families.


Use this tool to share safety tips with families. Each section includes a review of child development and how it relates to injury prevention strategies. It also includes safety tips organized by families' daily routines. Some tips apply to all children, while others address the developmental needs of children in a specific age group. When a family has children at different developmental levels, review the safety tips for each.

Home visitors can use this tool to:


- Learn safety tips to share with families
- Explain the reasons for specific safety measures
- Support families to build safe daily routines for children of all ages and developmental abilities

¹Hertzog, B., & Cornett, M. (2018). Developing a Conceptual Model of Young Children's Risk of Unintentional Injury and Implications for Prevention Strategies. *Health Psychology Review*, 22.


Explore Resources



Young Infants




Mobile Infants



Toddlers

<https://eclkc.ohs.acf.hhs.gov/safety-practices/article/tips-keeping-infants-toddlers-safe-developmental-guide-home-visitors>

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A Guide to Safety Conversations with Families

<https://eclkc.ohs.acf.hhs.gov/publication/home-visitors-guide-safety-conversations>

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How to Have a Safety Conversation



Conversations with families about safety should be:

- Child/family-focused
- Mutually respectful
- Culturally responsive



Resources for Families

- CDC's Information on Safety in the Home & Community for Parents with Infants & Toddlers
<https://www.cdc.gov/parents/infants/safety.html>
- Safe Kids Worldwide: Home Safety for Babies (English and Spanish)
https://www.safekids.org/safetytips/field_age/babies-0%E2%80%9312-months/field_venues/home
- NCECHW Safety and Injury Prevention Resource List
<https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/no-search/safety-injury-prevention-resource-list.pdf>



Know Your Children and Families



Ongoing Child Assessment Helps Staff Determine Each Child's Developmental Level

- Learn the Signs. Act Early.
<https://www.cdc.gov/ncbddd/actearly/>
- Developmental Screening, Assessments, and Evaluations for Infants and Toddlers
<https://eclkc.ohs.acf.hhs.gov/video/developmental-screening-assessments-evaluations-infants-toddlers>
- Infant and Toddler Development, Screening, and Assessment
<https://www.zerotothree.org/resources/72-infant-and-toddler-development-screening-and-assessment>



Individualize Care by Knowing Each Child


- Know children's individual interests and skills
- Recognize challenges
- Anticipate when children need support
- Intervene before problems arise



Parents are Active Partners in a Culture of Safety



Know the preferences, culture, and traditions of your families



<https://edkic.ohs.acf.hhs.gov/family-engagement/article/building-partnerships-families-series>

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Early Childhood Research and Promotion

RECAP



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Early Childhood Research and Promotion



Culture of Safety

The 10 Actions for a Culture of Safety

1. **Use Data to Make Decisions:** Program and incident data serve as an important resource to help managers and staff evaluate children's safety.
2. **Actively Supervise:** Children are never alone or unsupervised. Staff position themselves so that they can observe, count, and listen at all times.
3. **Keep Environments Safe and Secure:** Programs create, monitor, and maintain hazard-free spaces.
4. **Make Playgrounds Safe:** Regularly inspected, well-maintained, age-appropriate and actively supervised outdoor play spaces allow children to engage in active play, explore the outdoors, and develop healthy habits.
5. **Transport Children Safely:** Programs implement and enforce policies and procedures for drivers, monitors, children, and families using school buses, driving to and from the program, or walking.
6. **Report Child Abuse and Neglect:** Managers and staff follow mandated reporting statutes and procedures for reporting suspected child abuse and neglect.
7. **Be Aware of Changes that Impact Safety:** Staff anticipate and prepare for children's reactions to transitions and changes in daily routine, within and outside of the program.
8. **Model Safe Behaviors:** Staff establish nurturing, positive relationships by demonstrating safe behaviors and encouraging other adults and children to try them.
9. **Teach Families about Safety:** Staff engage families about safety issues and partner with them about how to reduce risks to prevent injuries that occur in the home.
10. **Know Your Children and Families:** Staff plan activities with an understanding of each child's developmental level and abilities, and the preferences, culture, and traditions of their families. This includes everything from maintaining current emergency contact information to understanding families' perceptions about safety and injury prevention.

<https://eclkc.ohs.acf.hhs.gov/publication/10-actions-create-culture-safety>

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Everybody has a role in keeping children safe

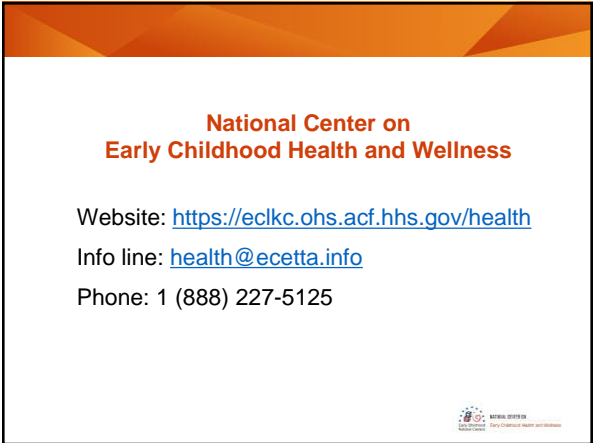
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NEXT STEPS



NATIONAL SYSTEM
FOR CHILDREN'S HEALTH AND WELLNESS





10 Actions to Create a Culture of Safety



NATIONAL CENTER ON
Early Childhood Health and Wellness

Maribel is 18 months old. She has tumbled, tripped, and stumbled her way into toddlerhood. Throughout her travels, Maribel has never been hurt. The surfaces she explores absorb her falls; she is startled but then gets back up and tries again. Her family and teachers have created an environment for her where she can learn new skills without fear of injury. In Maribel's program, all staff are responsible for every child's safety.



Every Child Has the Right to Be Safe

In all early care and education (ECE) programs*, directors, managers, staff, and families embrace the belief that children have the right to be safe by creating a culture of safety. They provide:

“an environment that encourages people to speak up about safety concerns, makes it safe to talk about mistakes and errors, and encourages learning from these events.”¹

Children are safer when everyone works together to improve the strategies they use in homes, centers, and the community so children don't get hurt.

* Early care and education programs include center-based early childhood settings and family child care homes as well as home visiting programs.

Injuries are preventable and ECE programs and family child care homes are expected to prevent them. Safety and injury prevention requirements are found throughout the Head Start and Child Care Development Fund requirements. Staff* demonstrate safe practices to prevent injuries to children and teach families to recognize and eliminate hazards. Programs that create a culture of safety enhance a child's school readiness and empower families to live healthy and safe lives.

* Staff includes program leaders, teachers, family child care providers, and home visitors—all adults who work in early care and education programs.

School readiness begins with health!

45 CFR §1302.47 Safety practices. (a)

A program must establish, train staff on, implement, and enforce a system of health and safety practices that ensure children are kept safe at all times. A program should consult [*Caring for Our Children Basics*](#) for additional information to develop and implement adequate safety policies and practices.

<https://eclkc.ohs.acf.hhs.gov/policy/45-cfr-chap-xiii/1302-47-safety-practices>

[Licensing and other regulatory systems](#) establish health and safety standards to ensure the well-being of children in all early care and education settings.

Why is a Culture of Safety Important?

Young children develop rapidly, exploring and experimenting to build new skills and learn what is safe. To promote their optimal development, each program plans, implements, and evaluates actions that provide safe environments for children to be active and competent learners.

Young children are at high risk for several types of injuries.

- Falls are the most frequent cause of injuries to young children. Children in this age group are also more likely to be hit by objects, stung or bitten, and choke on objects.²
- Unintentional injuries are the primary cause of fatalities for young children. Of these, drowning is the leading cause of death.^{3,4}
- Traumatic brain injury rates for children ages 0-4 are higher than rates for any other age group and almost twice the rate for the next highest age group (ages 15– 24).⁵

Yet, injury prevention works! Programs can keep children safe by coordinating and integrating basic actions into program activities and by using safety devices such as smoke alarms and carbon monoxide detectors, childproof medication containers, and child passenger safety seats.



This resource guide describes 10 actions that programs can take to promote a culture of safety. Each action includes a description of:

- What it is
- Why it matters
- Steps for implementation
- Additional resources

You can use this tool to:

- Introduce and reinforce safety and injury-prevention strategies
- Identify and remove hazards, and plan new actions to strengthen a culture of safety
- Find resources to learn more about each action

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10 Actions to Create a Culture of Safety

The 10 actions are science-informed injury prevention strategies used by ECE programs that prioritize children's safety and well-being.

The 10 Actions for a Culture of Safety

1. **Use Data to Make Decisions:** Program and incident data serve as an important resource to help managers and staff evaluate children's safety.
2. **Actively Supervise:** Children are never alone or unsupervised. Staff position themselves so that they can observe, count, and listen at all times.
3. **Keep Environments Safe and Secure:** Programs create, monitor, and maintain hazard-free spaces.
4. **Make Playgrounds Safe:** Regularly inspected, well-maintained, age-appropriate and actively supervised outdoor play spaces allow children to engage in active play, explore the outdoors, and develop healthy habits.
5. **Transport Children Safely:** Programs implement and enforce policies and procedures for drivers, monitors, children, and families using school buses, driving to and from the program, or walking.
6. **Report Child Abuse and Neglect:** Managers and staff follow mandated reporting statutes and procedures for reporting suspected child abuse and neglect.
7. **Be Aware of Changes that Impact Safety:** Staff anticipate and prepare for children's reactions to transitions and changes in daily routine, within and outside of the program.
8. **Model Safe Behaviors:** Staff establish nurturing, positive relationships by demonstrating safe behaviors and encouraging other adults and children to try them.
9. **Teach Families about Safety:** Staff engage families about safety issues and partner with them about how to reduce risks to prevent injuries that occur in the home.
10. **Know Your Children and Families:** Staff plan activities with an understanding of each child's developmental level and abilities, and the preferences, culture, and traditions of their families. This includes everything from maintaining current emergency contact information to understanding families' perceptions about safety and injury prevention.

Everyone in ECE programs works together to realize a culture of safety, and each person understands their role and responsibilities in preventing injuries. Programs also use their management systems to integrate these 10 actions into all of their activities.

1. Use Data to Make Decisions



What it is:

In order to make informed decisions, programs can prepare; collect; aggregate, analyze, and compare; and use and share data to plan, implement, and evaluate injury-prevention strategies. Injury and incident data are an important source of information to evaluate and enhance children's safety and identify strategies that are most effective.

Why it matters:

As indicated in the [National Action Plan for Child Injury Prevention](#), better data can help programs make changes to keep children safe. Injury patterns and child abuse and neglect can be discerned from data and can be used to prevent future problems. Data on typical injuries (scanning for hazards, providing close supervision, etc.) can also help to prevent them.⁶ Programs can use their injury and incident data to look at the who, what, where, when, why, and how of injuries; identify and eliminate hazards; and utilize strategies that promote a culture of safety.

Steps to implement:

Prepare. Review the data that your program already collects and how you collect it. If your data doesn't indicate whether or your injury-prevention strategies are effective, develop a plan to collect additional data. For example, consider:

- What information do you already collect through ongoing monitoring or other activities?
- What additional data do you need to understand how, what, when, where, and why injuries and incidents occur?
- What tools do you use to collect the data?
- Do you need training on data-collection activities?

Collect. Consider:

- Who will collect the data?
- Who will enter the data into your recordkeeping and reporting system?
- Who will check the data for accuracy?

10 Actions to Create a Culture of Safety

Tools that programs may use to collect their injury and incident data include:

- Injury and incident reports: Use these reports to document events during program activities that result in an injury to children and/or adults. The CFOC Standards Database includes an [Incident Report Form](#) and a [Child Injury Report Form](#).
- Safety checklists: Use a checklist to identify and document hazards within the environment. Checklists are available for [homes](#), [centers](#), and [playgrounds](#).
- Facility maintenance logs: Use information from these logs to track the status of repairs or replacement of equipment after a hazard has been reported.
- [Hazard mapping](#): Use maps to pinpoint the locations where injuries happen more often so you can take preventive actions.

Aggregate, Analyze, and Compare. Once you have collected your data, review the data to determine the number of and causes of incidents and injuries in your program.

Be sure you understand:

- What the information tells you
- What you are doing that is working well
- Trends and patterns of injury that you need to address

Use and Share. Make decisions based on your analysis of the data and share this information with all stakeholders. Make immediate changes to remove safety hazards, and study patterns of injury to problem solve the issues that these trends reveal. Data analysis should inform:

- Changes to policies and procedures
- Changes in practice
- New or revised data-collection activities
- New priorities or updated action plans

Additional resources:

[Hazard Mapping for Early Care and Education Programs](#)

[Data in Head Start and Early Head Start: Digging into Data.](#)

[A Resource Guide for Head Start Programs: Moving Beyond a Culture of Compliance to a Culture of Continuous Improvement.](#) OPRE Report # 2015-02.



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2. Actively Supervise



Photo courtesy of NCQTL

What it is:

To ensure children are never left alone or unsupervised, staff position themselves so that they can observe, count, and listen at all times. They also use their knowledge of each child's development and abilities to anticipate children's behavior and redirect children when necessary. Staff use active supervision in classrooms, family child care homes, socializations, on playgrounds and buses, and in all other ECE environments.

45 CFR §1302.90 Personnel policies.(c)(1)(v)

The standards of conduct in the Head Start Program Performance Standards require programs to: Ensure no child is left alone or unsupervised by staff, consultants, contractors, or volunteers while under their care.

<https://eclkc.ohs.acf.hhs.gov/policy/45-cfr-chap-xiii/1302-90-personnel-policies>

Why it matters:

Young children are more likely to get injured when they are left unattended. Lower levels of adult supervision are associated with higher odds of more severe injury in young children. Having an attentive adult nearby is the best way to prevent injuries.⁷

Staff need a systematic, easy-to-use process to set up the environment, observe, and interact with children to promote child safety. Active supervision offers an effective strategy for adults to look, listen, and engage to prevent childhood injuries.

Steps to implement:

Set up the environment. Set up the environment so you can supervise children at all times. When activities are grouped together and furniture is at waist height or lower, it is easier to see and hear children. Make sure small spaces are clutter free and big spaces are set up so that children have clear play areas that you can observe.



Position staff. Plan where staff will position themselves to see and hear all of the children. Make sure there are always clear paths to where children are playing, sleeping, and eating so you can react quickly when necessary. Stay close to children who may need additional support so you can offer assistance when needed.

Additionally, center directors or other adults (“floating staff”) may walk around the center to ensure all children are well supervised. When necessary these individuals also relieve teachers who need to leave the room temporarily.

Scan and count. To account for the children in your care, continually scan the entire environment to know where everyone is and what they are doing. Count the children frequently. This is especially important during transitions when children are moving from one location to another.

Listen. Specific sounds or the absence of them may signify reason for concern. Listen closely to children to identify signs of potential danger. Programs that think systemically implement additional strategies to safeguard children. For example, placing bells on doors can alert you when a child enters or leaves the room.

Anticipate children's play. Use what you know about each child’s individual interests and skills to predict what they will do. Create challenges that children are ready for and support them so they can succeed. Recognize when children may get upset or take a dangerous risk. Use information from a [daily health check](#) (e.g., illness, allergies, lack of sleep or food) to anticipate children’s behavior. Knowing what to expect can help you protect children from harm.

Engage and redirect. Know when to offer children support. Wait until children are unable to solve problems on their own to get involved. Offer different levels of assistance or redirection depending on each individual child’s needs.

Additional resources:

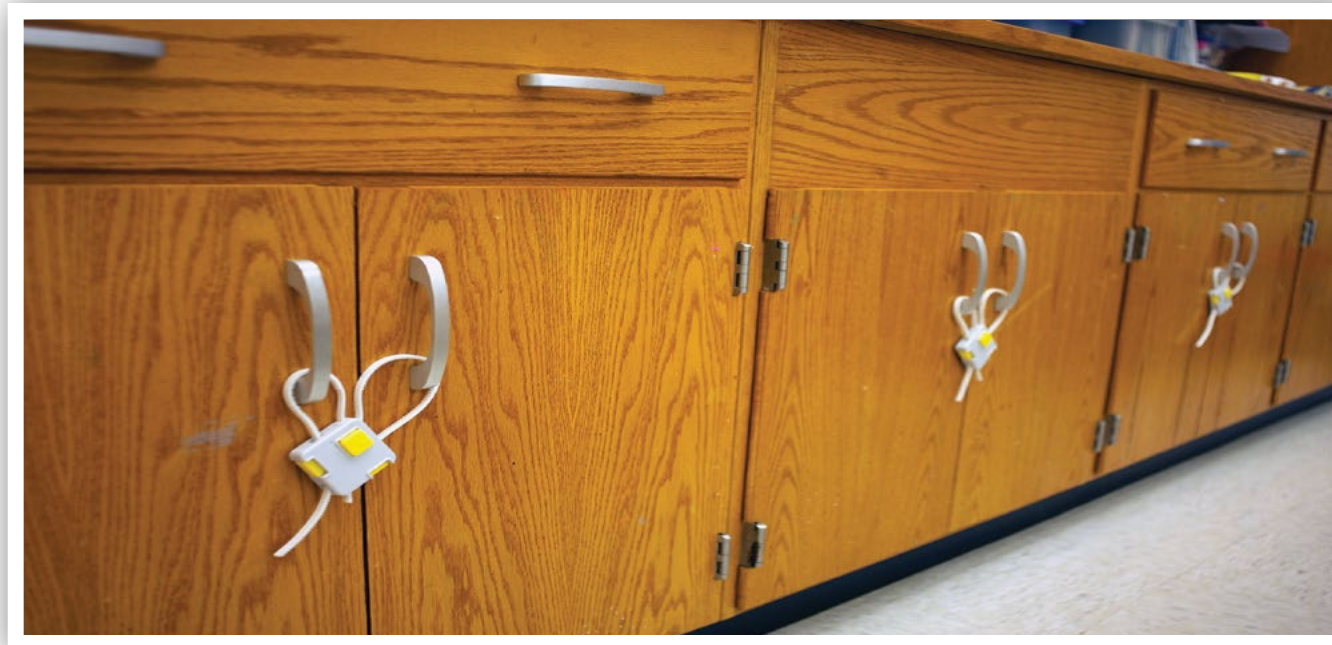
[Keep Children Safe Using Active Supervision](#)

CFOC Standard [2.2.0.1](#): Methods of Supervision of Children

[Program Administrator Guide to Evaluating Child Supervision Practices](#)

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3. Keep Environments Safe and Secure



What it is:

Children's spaces are free of hazards that could lead to injuries. Hazards may involve:

- Elements like heat or cold that could lead to burns, heat stroke, frostbite, or death.
- Objects like tools, appliances, furniture, and small toys that could lead to cuts, burns, bruises, broken bones, and choking.
- Chemicals like bleach, cleaning fluids, medications, and craft materials that could lead to poisoning or burns.
- Animals or insects like dogs, gerbils, hamsters, bees, mosquitoes, ants, and wasps that could lead to bites, poisoning, stings, and infections.
- Mold, mildew, and structural damage that could lead to chronic health issues (e.g., asthma), cuts, bruises, and falls.

Maintaining a safe and secure environment involves either removing hazards or storing them in locked cabinets away from children.

Why it matters:

Each year, approximately 2.8 million children go to the hospital emergency department for injuries caused by falling.⁸ Additionally, suffocation is the leading cause of unintentional injury death for infants age 1 and younger, and drowning is the leading cause of injury death for children ages 1-4.⁹ Children learn through exploration and experimentation. Removing hazards from a child's environment increases their opportunities to grow in all developmental domains. Adults who identify risks and remove hazards prevent injuries before they happen, allowing children to safely engage in learning.

Steps to implement:

Conduct a safety check. Before every use, review the safety of a center (including halls and classrooms), playground, and/or family child care home using a [safety checklist](#). Checklists should include the smallest, easiest-to-miss hazards. To ensure your checklist covers all of the important elements, consider reviewing [Caring for Our Children](#).

10 Actions to Create a Culture of Safety

Identify hazards and prioritize repairs. Use your safety checklist to:

- Record the results of your safety inspection, report all identified hazards to the appropriate staff member or administrator, and prioritize repairs.
- Remove any damaged materials or hazards including chemicals, objects, cords on window blinds, and other items such as drawstrings on children's clothing that could cause injury.
- Limit access to any areas with unsafe equipment until repairs are completed.
- Work with your supervisor, facilities manager, or center director to identify potential hazards and ensure ongoing preventive maintenance of the facility.

Use facility maintenance systems to report, repair, and maintain facilities. When you identify hazards in centers, family child care homes, and socialization spaces, submit a maintenance report regarding your findings. Use this report to determine next steps, including:

- Removing the hazard or preventing access to the hazardous area
- Repairing damaged equipment
- Replacing equipment as needed

Obtain equipment that may eliminate or reduce injury. This includes safety gates, electrical plug covers, bicycle and tricycle helmets, smoke alarms and carbon monoxide detectors, appropriate types and amounts of surfacing on floors and the ground, and locks on cabinets and doors. Providing equipment that allows children to explore their environment safely contributes to healthy development and school readiness.

Educate children, families, and staff about maintaining and monitoring safe environments. Programs can promote a culture of safety by:

- Using materials and equipment that are appropriate for the age, size, and developmental level of the children.
- Training staff on how to complete and use safety checklists.
- Developing and consistently implementing policies and procedures for facilities, materials, and equipment maintenance.
- Conducting ongoing monitoring activities to make sure that environments are safe for children.

Additional resources:

[Strategic Maintenance Planning Tool](#)

[Daily and Monthly Playground Maintenance Form](#)

[Head Start Health and Safety Screener](#)

www.Recalls.gov

[Childproofing Your Home](#)

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4. Make Playgrounds Safe



What it is:

Children climb, run, and play safely in outdoor environments that meet federal, tribal, state, and local requirements and best practices for age-appropriate playground equipment. Staff conduct inspections and report and/or remove any hazards before each use to maintain safe, high-quality playgrounds.

Why it matters:

About 75% of nonfatal injuries related to playground equipment occur on public playgrounds.¹⁰ Most occur at schools and child care centers.¹¹ Children ages 4 and younger are often injured on climbers, swings, and slides.¹²

All children need opportunities to play in safe outdoor environments in order to develop a healthy active lifestyle. A well-designed and well-maintained outdoor learning environment allows children to engage in active play. They are also able to explore the outdoors and develop healthy habits that support their physical, social and emotional, and cognitive development.

Steps to implement:

Install safe structures. A safe outdoor play space starts with selecting and correctly installing structures that are safe and appropriate for the age and developmental level of the children. Make sure that:

- Equipment meets Consumer Product Safety Commission (CPSC) recommendations and American Society for Testing and Materials (ASTM) standards.
- Whoever installs the structures follows the manufacturer's guidance.
- The play space design separates active play areas such as swings and slides from quieter activities such as the sandbox, nature exploration, and dramatic play. See the [National Program for Playground Safety](#) for more details.

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Maintain impact-absorbing surface. A playground surface is the material that lies under and around swings, slides, climbers, and other playground equipment to cushion a child's fall. Unsafe playground surfacing material is the leading cause of playground injury. Surfaces such as asphalt, cement, dirt, and grass are not acceptable. Children falling on these surfaces have an increased risk of serious injury. Loose fill material such as sand, pea gravel, wood chips, engineered wood fiber, rubber mulch, or materials such as tiles, mats, or poured-in-place rubber can safely cushion a child's fall.

When choosing surface material, consider:

- **Budget:** The cost of the surface materials, as well as short- and long-term maintenance and replacement costs.
- **Utilization:** The number and ages of the children using the space, and whether anyone else has access to the play areas on nights and weekends.
- **Labor:** The time that it will take for staff to maintain the product on a regular basis.
- **Climate:** Temperatures, wind conditions, and precipitation, which will impact surface materials.
- **Accessibility:** Very few loose fill materials are accessible for wheelchair users without significant accommodations such as a special wheelchair. Engineered wood fibers provide better access. Solid materials are best for people with mobility impairments.

Install loose fill materials at a depth of 12 inches to allow for compaction, and maintain a depth of at least 9 inches.

Remember, even the best surfacing can't prevent all injuries. Guardrails and protective barriers are also required to minimize the likelihood of accidental falls from elevated platforms. Always check with the manufacturer to determine which product best meets your program's needs.

Keep fall zones clear. The area under and around equipment is known as a "fall zone." (Check the [Public Playground Safety Handbook](#) for specific fall zone measurements.) These areas must be free of structural hazards such as benches, barrels, fences, and other pieces of play equipment. They should also be free of movable hazards like trikes, toys, rocks, and groups of children. Because children at play often move objects around, keeping fall zones clear requires vigilance. A playground surface cannot work if a child falls onto a hard object instead of the surface.

Actively supervise. Review the steps to implement [Action 2, Actively Supervise](#). These strategies apply to indoor as well as outdoor activity. Be intentional. When setting up the environment, be sure to consider sight lines, distances between activity areas, and potential areas of concern such as a gate or wall.

During outdoor play many children may be moving around constantly. Programs may want to consider developing a plan for playground supervision so staff position themselves where they can see all of the children and easily reach them. Position staff to maximize the number of children they can see at any one time, and focus on the areas where children are most likely to get hurt. Staff continually scan, count, and listen.

Children transitioning from one activity to another are at a greater risk for injury. Anticipate children's behavior on specific pieces of equipment and areas of the play space. If there are too many children on one structure or if they are misusing it, redirect them to another part of the playground. If a staff person must leave the playground, remaining staff should reposition themselves so that no child is left unsupervised.



Inspect and repair. Outdoor play spaces are subject to a great deal of wear and tear. Once safe, age- and developmentally-appropriate equipment has been correctly installed, it still requires regular inspections and maintenance. Just as in [Action 3, Keep Environments Safe and Secure](#), use a comprehensive safety checklist before each use of an outdoor space and/or playground. This “check” will identify hazards that may have appeared overnight.

A daily safety check will also alert you to any pieces of equipment that may have broken or worn out since their last use. Loose or missing parts and sharp edges often cause playground injuries. Be sure you know how to complete the checklist, fill it out accurately, and follow your program’s policies and procedures to promptly report any hazards. Remove or restrict children’s access to any immediate hazards. Use your facility’s maintenance system to report and repair equipment and a tracking system to make sure that the work is completed.

Additional resources:

[Playground Safety Poster](#)

[Consumer Product Safety Commission—Playgrounds](#)

[Active Play Safety Checklist & Planning Tool](#)

[Resources for Safe Playgrounds](#)



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5. Transport Children Safely

What it is:

Transportation services present a range of safety considerations for programs. Programs create, consistently implement, and enforce policies and procedures for driver qualifications, vehicle inspections, and pedestrian safety. Programs have, and communicate to staff and families, a plan for safe, supervised drop-off and pick-up points and pedestrian crosswalks in the vicinity of the facility. Training for transportation staff and contractors includes measures to account for children at all times, especially when they are getting on and off the vehicle. Finally, programs provide pedestrian safety education to children, families, and staff as they move through the community, whether they walk to program activities, ride in their family car, or take public transportation.

Why it matters:

Motor vehicle injuries are a leading cause of death among children in the United States.¹³ Additionally, on average, about 40 children die from heatstroke in vehicles each year.¹⁴ Programs that transport children or provide contracted transportation services must ensure that they meet all safety requirements and comply with state laws. Programs also must educate families about the importance of choosing and always using a [car seat](#) that is right for their child's age, size (height and weight), and developmental level, and installing it in their vehicle correctly. Promoting safe transportation protects children as they travel to and from program activities and within their community.

Steps to implement:

Develop a transportation plan for your program.

Each program determines whether to provide transportation. Programs that do provide these services make sure that staff supervise children during their ride and when they transition off the vehicle so no child is ever left alone.

ECE centers, Head Start programs, and family child care homes need to plan for:

- Pre-trip bus inspections
- [Proper use of child safety restraint systems in school buses](#)
- Bus driver and monitor training
- [Active supervision](#) strategies for bus monitors
- Bus and pedestrian-safety education for children and families

Transportation plans may include:

- Pick-up and drop-off policies and procedures
- Emergency policies and procedures
- Evacuation drills
- Schedule of regular maintenance
- Support for families to acquire and correctly install child passenger safety car seats
- Education about safe use of public transportation



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Plans may include other elements, but these activities will help children travel safely.

Implement and assess the transportation

plan. In order to promote children's safety when they travel to or from their program, programs that transport children need to collect data about their transportation practices. As in [Action 1, Use Data to Make Decisions](#), use the information you collect, aggregate, and analyze and compare to determine if children are safe:

- Has any child been injured or left unattended when traveling in or on a vehicle?
- Are children, families, and staff aware of safe transportation practices? Do they know and consistently follow the program's policies and procedures?
- What strategies have been most effective? What strategies need to be improved? What areas of need or challenges remain?

The answers to these questions will help your program determine what is working well and areas that may need improvement. You assess and make changes to program practices if needed to address any area of concern immediately. For example, bus monitors may need more training on active supervision, or families may need more support in developing drop-off and pick-up routines.

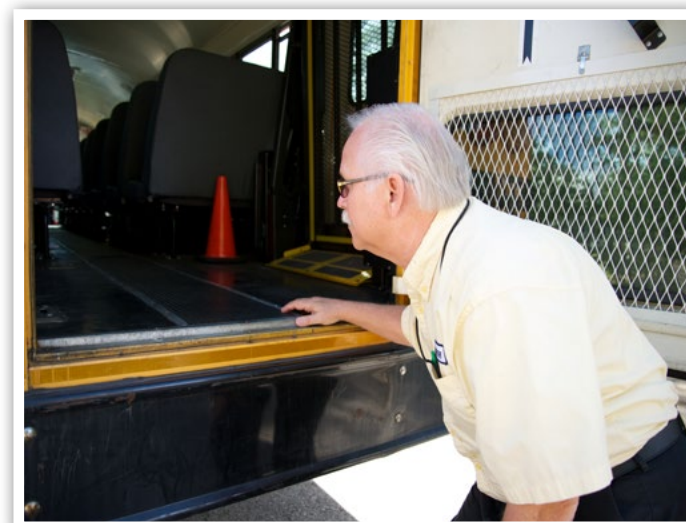
Additional resources:

[Active Supervision on Buses](#)

[Supervising Children on Head Start Buses: A Webinar from the Head Start National Center on Health](#)

[Child Passenger Safety Laws](#)

[Keeping Children Safe in Vehicles: A Guide for Families and Caregivers](#)



6. Report Child Abuse and Neglect

What it is:

ECE programs are responsible for making sure that every child is safe. When someone suspects a child may be abused or neglected, they adhere to mandated reporting statutes and their policies and procedures for reporting suspected child abuse and neglect.

Child abuse includes physical, sexual, psychological, and emotional abuse. Other components of abuse include shaken baby syndrome/acute head trauma and repeated exposure to violence, including domestic violence. Neglect can occur when the parent/guardian does not meet the child's basic needs and encompasses physical, medical, educational, and emotional neglect.

CFOC Standard [3.4.4.1](#): Recognizing and Reporting Suspected Child Abuse, Neglect, and Exploitation

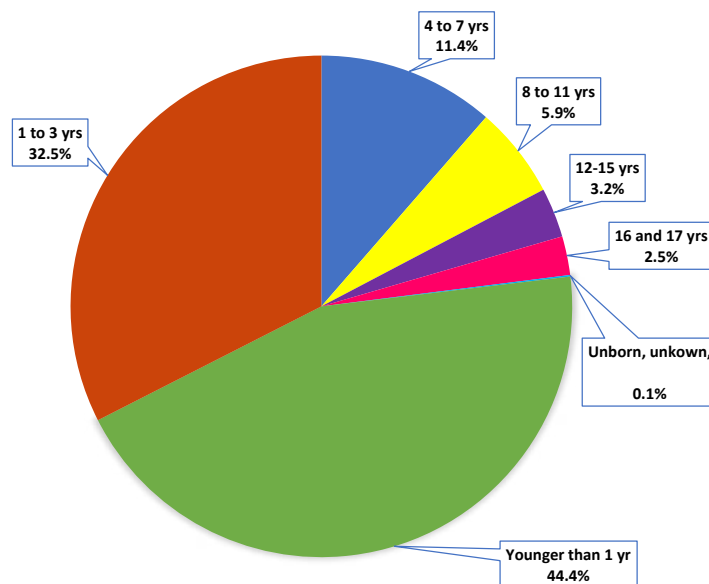
Why it matters:

Young children are more likely to experience maltreatment than any other age group.¹⁵ Almost three-quarters (70 percent) of child fatalities in FY 2016 involved children younger than 3 years, and children younger than 1 year accounted for 44.4 percent of all fatalities. (See Figure 1)

Caring for young children can be stressful, particularly for families living in poverty who may be experiencing other significant stressors. Rates of child abuse and neglect are 5 times higher for children in families with low socio-economic status compared to children in families with higher socio-economic status.¹⁶

Recognizing and reporting suspected child abuse and neglect can protect children from injury.

Figure 1: Child Abuse and Neglect Fatality Victims by Age, 2016¹⁷



Steps to implement:

Develop policies and procedures for identifying and reporting child abuse and neglect that align with state licensing requirements. In each state, licensing requirements specify mandatory reporting [requirements](#). Your program policies should include these requirements, specific information about each staff member's role as a mandated reporter, and the procedures to follow when a staff member identifies and reports any suspected child abuse and neglect by a parent/guardian or an adult working or volunteering in the program.

Train staff on strategies to identify child abuse and neglect. All staff members need to be able to recognize [possible signs of child abuse and neglect](#). There are many resources to support training. Work with your community partners and the Head Start Health Services Advisory Committee (HSAC) to identify available resources for your training; then ensure that all staff receive it.

Train staff in the policies and procedures for reporting child abuse and neglect. All staff need to know your program's policies and procedures for reporting, as they are often the first to notice signs of abuse or neglect. It is important to remember that your program's responsibility is merely to inform child protective services if staff suspect a child has experienced abuse and neglect. An investigator from the child protection agency will make the final determination.

A staff member may have questions and concerns about filing a report. Your training should address the impact that filing a report may have on the child, family, staff, and program. Providing [reflective supervision](#) offers an opportunity to discuss concerns while enforcing the need to file a report. Supervisors help staff to understand that this legal requirement is a way to protect a child from an unsafe environment.

Follow up on all child abuse and neglect reports with child protective agencies to ensure they have all of the information they need. Identification is only the first step. Following up with the professionals who investigate child abuse and neglect cases ensures that your program has done everything possible to protect a child from harm.

You can also provide professional development opportunities for staff to learn about the [Five Protective Factors in Strengthening Families™](#), a research-informed approach to increase family strengths, enhance child development, and reduce the likelihood of child abuse and neglect.¹⁸

Challenging behavior is frequently cited as a major contributor to teacher stress.¹⁹ Caregivers who are stressed are more likely to use harsh discipline. Encourage staff to use [positive behavioral supports](#) to address children's challenging behaviors. These interventions are effective classroom management strategies that support children's social and emotional development.

Additional resources:

[Child Abuse and Neglect](#)

[Child Abuse and Neglect Fatalities 2016: Statistics and Interventions](#)

[Mandated Reporting of Child Abuse and Neglect. ACF-IM-HS-15-04](#)

[2018 Prevention Resource Guide](#)

7. Be Aware of Changes that Impact Safety

What it is:

Programs identify transitions and changes in the environment, which include changes in caregiver, activity, or location. These transitions may make children more vulnerable to injury, so programs then plan additional ways to keep children safe. This could include:

- Using a [daily health check](#) or family observations to anticipate issues a child may have (for example, illness, hunger, sleepiness, or side effects from a new medication).
- Anticipating that children may react when a familiar staff member or caregiver is not available and a “substitute” is in place.
- Accommodating for changes in the regular routines of a center or family child care home by giving children opportunities to become comfortable with these changes (for example, substitute staff, special events, facilities maintenance, and emergency preparedness).
- Identifying changes in family routines that may result in increased risk of injury (for example, a new drop-off routine or other changes in schedule).

Staff recognize the impact of transitions and changes in daily routine and provide additional support for children who are more likely to have trouble with these changes. They also practice [active supervision](#) to protect children from injury.

Why it matters:

Children tend to:

- React to even the smallest of shifts—a new nipple on the bottle, a new food on their plate, or a slight change in a regular routine.
- Thrive on order and predictable routines to feel safe and secure.
- Need lots of time and support to get comfortable in new surroundings or with new people before they adjust.

- Have more tantrums, which can be triggered by either minor changes (a new pair of shoes) or more major ones (a new babysitter). Tantrums can also occur during everyday transitions, when children are asked to stop doing something they are happily involved in to begin another activity (for example, before going from playtime to lunch).²⁰

Schedules and routines create predictability and stability for young children. Children feel more secure because they know what to expect. Adults are better able to protect children when they can anticipate a child’s reaction.

Steps to implement:

Anticipate and plan for all types of changes in:

- Daily routines (for example, drop off and pick up, daytime sleep schedules, mealtimes, or self-care routines, particularly dressing and toileting).
- Family structure (for example, new babies, new family members, loss of family members, separation, or divorce).



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- Family circumstances (for example, new or lost jobs; new or lack of housing; new household members; new or lack of resources such as transportation, health insurance, and other important supports).
- Staffing (for example, staff absences, new staff or volunteers, substitute staff, changes in staffing patterns or assignments).

Develop contingency or fail-safe plans.

Contingency planning is a method for helping children and adults prepare for changes in their lives. Plan for contingencies such as new staff members, caregivers, or routines; field trips or other special events, or disruptions caused by facilities maintenance or repair. Planning for how to respond to such contingencies with help you meet the needs of children and staff.

Talking with families about having a back-up plan can be helpful with many planning issues, including developing safety plans. This approach can also help families manage changes in their daily routine, such as changes to pick-up and drop-off routines. For example, if a different adult is planning to drop off their child, you can suggest they place a “[Look Before You Lock](#)” sticker on the dashboard. This reminds the adult to remove their child from the car or booster seat when getting out of the car.

Train staff and educate families about

processes for contingencies. Once contingency plans are in place, everyone needs to know when and how to use them. Professional development activities can help adults adapt to change and reinforce safety messages. Ongoing monitoring and reflective supervision can help you determine if additional supports are needed.

Practice, review, and revise plans to ensure they work.

Having contingency plans does not mean that they will always be effective. Develop a schedule to practice new routines in your center or family child care home, assess how well they work, and make revisions if needed based on the data you collect. Practicing how to respond to an emergency or even a minor change in routine means that plans become rote, so when something happens unexpectedly, everyone knows what to do.

Additional resources:

[Tips for Keeping Children Safe: A Developmental Guide](#)

[Transitions](#)

[News You Can Use: Transitions](#)

[Emergency Preparedness Manual for Early Childhood Programs](#)

[The National Center for Pyramid Model Innovations](#)

8. Model Safe Behaviors

What it is:

A culture of safety comes from within a program. When all adults engage in safe behaviors, everyone is better protected from injury. Modeling safe behaviors is an important part of the nurturing, positive relationships staff establish with children and families. Staff demonstrate safe behaviors, then prompt other adults and children to use them too.

Why it matters:

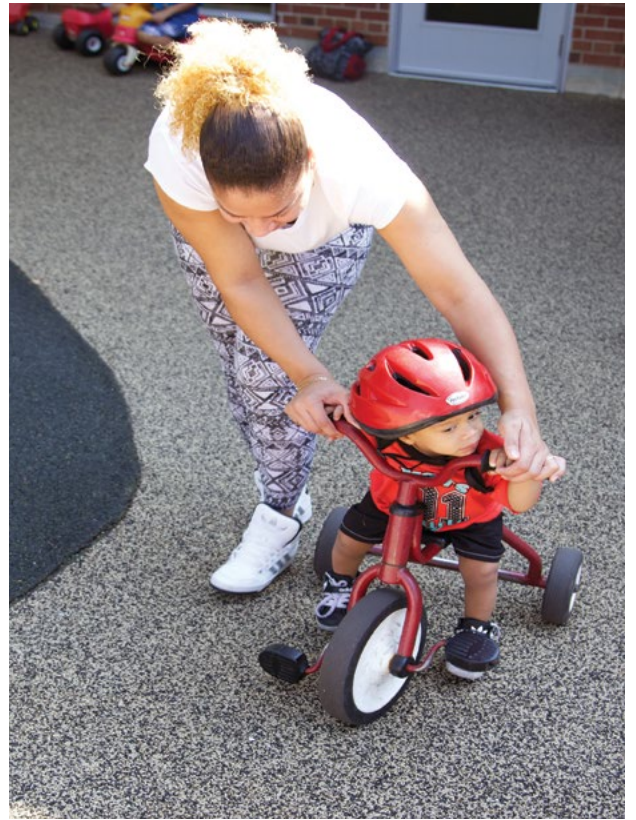
Family members and caregivers make decisions about child safety based on social norms, beliefs about whether an injury is preventable, parenting style (permissive vs. strict), and self-efficacy.²¹ Children learn by watching what their caregivers do, making it even more important for adults to practice safe behaviors. Offering children positive role models will help them see, repeat, and practice safe behaviors.

Steps to implement:

Establish safety rules. Develop safety rules with everyone's input. Include easy-to-use strategies that fit within daily routines. For example, during an infant socialization, serve age-appropriate foods to demonstrate how to reduce the risk of choking. On the playground, stay close to children who are still building their motor skills when they are climbing on play structures. These are both examples of simple, concrete, and easy actions to take.

Enhance safety practices through reflective supervision. Both children and adults may need support to learn a new approach. Help staff understand and practice new safety strategies. Celebrate what they do well and identify areas for improvement.

Set the expectation by fulfilling it. Program leaders who lead by example are more likely to positively impact the behaviors of children and other adults. Implementing strategies every day provides a stronger example for others to follow.



Additional resources:

CFOC [Appendix B](#): Major Occupational Health Hazards.

CFOC Standard [2.4.1.2](#): Staff Modeling of Healthy and Safe Behavior and Health and Safety Education Activities.

[Staff as Healthy Role Models](#)

9. Teach Families about Safety



What it is:

Most injuries to young children happen in the home.²² Programs include discussions about home safety during conversations with families. For Head Start programs, these conversations begin during the family partnership process. Educating families about safety risks to young infants, mobile infants, toddlers, and preschool children; completing home safety checks; identifying safe sleep and other safe practices; and helping families obtain safety devices can reduce the number and severity of injuries that occur in the home.

Why it matters:

Economic realities often affect parents' ability to alter their home to create a safer environment for their child. Children who live in poverty often live in substandard, crowded homes, in unsafe neighborhoods, and may be exposed to environmental pollution. Their parents often experience poor health, economic stresses, and discrimination. These families are least able to make

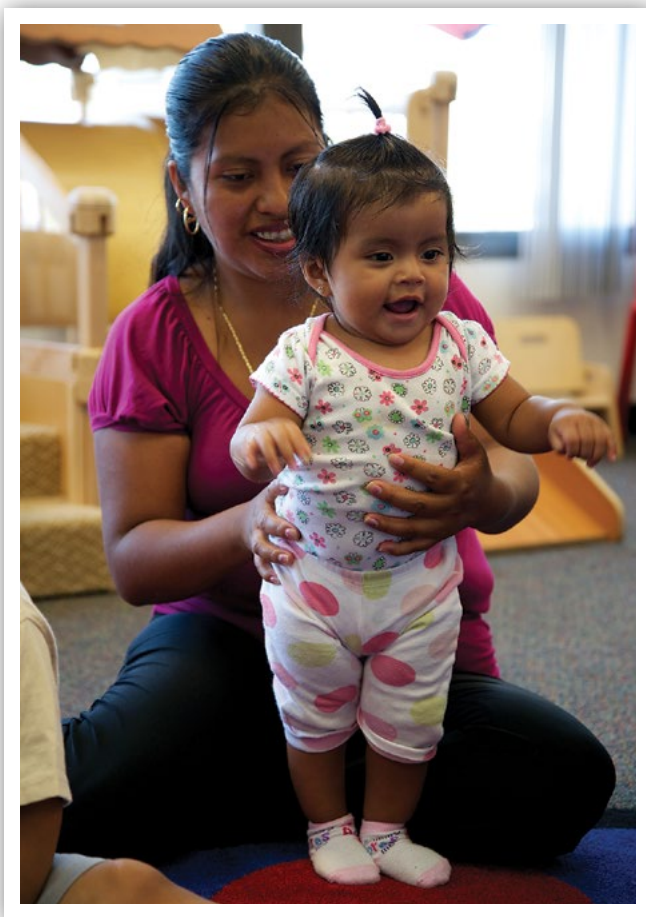
the changes they want and need in their homes and communities.²³

Staff can help prevent injuries by helping families become more aware of risks to children's safety. Some families need support to eliminate hazards, obtain safety equipment, or learn [active supervision](#). But when families have the information and resources they need, they can prevent many injuries at home.

Steps to implement:

Use family engagement activities and conversations about family priorities and goals to encourage home safety. This can help define what areas of home safety to address and how to individualize support to meet the needs of families. For example, a family whose landlord has refused to correct building violations (e.g., exposed nails in the floor) may need support to feel empowered to advocate for better living conditions.

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With the family, conduct a home safety inspection. Using a comprehensive checklist can help families and staff discuss home safety topics. Together they can identify, prioritize, and focus on injury-prevention strategies. Home visitors and family child care providers are in a unique position to support families when they know about common childhood injuries and how to eliminate hazards from the home.

Provide ongoing educational opportunities for families to learn more about safety issues from community experts. Use community partners and members of the Health Services Advisory Committee (HSAC) to find local experts to provide training on safety topics of interest to families. These experts can offer additional information and resources that families may not be able to access on their own.

Support families in acquiring resources to improve the safety of their home. With the family's permission, connect with community partners or your HSAC to find resources that families may need to make their homes safer. These might include:

- Electrical socket covers
- Oven protectors
- Guard rails
- Plastic covers for banisters or railings
- Bathtub thermometers
- Bumpers for furniture
- Gates for stairs and doorways
- Doorknob covers
- Locks for cabinets and drawers
- Any other home safety devices

Additional resources:

[Safety and Injury Prevention: Health Tips for Families](#)

[Injury Prevention Starts at Home](#)

[Family Support and Well-being](#)

[SaferProducts.gov](#)

10. Know Your Children and Families

What it is:

Staff understand each child's development level and abilities and each family's preferences, culture, and traditions. They are thus able to plan activities to meet the needs of each child and family.

Engaging in mutually respectful goal-oriented partnerships with families helps them feel welcomed, safe, and respected while building trusting relationships over time.²⁴ Programs can build relationships with families using the family-partnership process, ongoing child-assessment, self-reflection, and two-way communication to create safe and engaging learning opportunities. These experiences promote children's healthy development, family well-being, and positive parent-child relationships.

Why it matters:

Children's development in all areas occurs most rapidly during the first 5 years of life, setting the stage for all later development.²⁵ Each child grows at a different rate and has unique skills, abilities, and challenges. Parents commonly underestimate their infant's motor skills and overestimate their cognitive skills and judgment.²³ Staff who understand a child's strengths and needs can individualize the curriculum to promote safe learning opportunities for each child.

Additionally, families may have a different cultural perspective or different expectations of their child's behavior based on their beliefs and traditions. Staff who respect each family's beliefs, experiences, and traditions are able to acknowledge and support parents' efforts to establish a safe environment for their child.



Steps to implement:

Get to know and support each family.

Individualizing services for parents and expectant families includes strategies to keep children safe at home and in the community. Head Start programs can use the family partnership process to help families identify and follow up on goals for their children and themselves.

Conduct ongoing child assessments to learn about each child's skills, abilities, and challenges. Adults are better able to create safe environments, supervise children effectively, and use strategies that protect children from injury when they have a clear developmental picture of what each child can do. Use formal and informal ongoing child assessment to individualize children's experiences and plan activities that help them build the skills they need to move toward independence safely.

10 Actions to Create a Culture of Safety

Maintain a system of ongoing communication with families. Establish two-way communication with families to understand:

- Children's abilities in and out of program activities
- Families' expectations and priorities
- Successes and challenges in promoting the safety of everyone in the household
- Family resources and needs

This information can help you individualize on an ongoing basis.

Support children's individualized learning and development in safe, well-supervised environments. Identify, implement, and assess injury-prevention strategies using information collected from:

- Ongoing child assessments
- Communication with families
- The family-partnership process (in Head Start programs)

These information provides the basis for individualized decision-making discussed in [Action 1, Use Data to Make Decisions](#). Use strategies that research indicates work well for a specific developmental stage or characteristic that matches the child and family. For example, when a child moves from crawling to cruising and walking, adults remove any hazards within the child's reach and provide safe, age-appropriate objects that will support the child in learning to walk independently.

Maintain accurate family information.

Use recordkeeping and other communication systems to ensure that your program has accurate information about:

- Emergency contacts
- Consent for individuals who are permitted to pick up children at the center, home, or bus stop
- Changes in routines and schedules to ensure children are always released to an authorized adult

Additional resources:

[Tips for Keeping Children Safe: A Developmental Guide](#)

[A Guide to Safety Conversations](#)

[Dual Language Learners Program Assessment \(DLLPA\): Users' Guide](#)

[Protect the Ones You Love: Child Injuries Are Preventable](#)

Summary

These 10 actions integrate management systems and program services that are already in place. From using data to keeping environments safe and secure and modeling safe behaviors, they enhance what programs already do and foster a culture of safety for all enrolled children. Programs that implement the 10 actions will strengthen their injury-prevention efforts and make environments safe for children to play and learn.

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ACTIVE SUPERVISION TOOLKIT

All staff¹ in an early care and education (ECE) program² have a responsibility to protect the children in their care. Active supervision is the most effective way to prevent injuries and keep children safe. The Administration for Children and Families' Training and Technical Assistance system's National Centers offer many resources to help ECE programs build a comprehensive, agency-wide approach to active supervision. This toolkit will help ECE program leaders, teachers, and family child care providers use these resources to strengthen their active supervision policies and practices.

The toolkit includes three sections. Each section offers ways to improve child supervision.

What is Active Supervision?

Explains the six strategies of active supervision

How Do Early Care and Education Programs Support Active Supervision?

- *Describes how to implement the six strategies in infant/toddler and preschool programs*
- *Describes two-way communication with families to support improved child supervision practices*
- *Includes a section for program leaders in all ECE programs*
- *Includes a section on the role of Head Start program leadership in implementing active supervision in Head Start programs*

Active Supervision Resource Guide

Lists National Center resources that support agency-wide efforts to implement child supervision

What is Active Supervision?

Staff must directly supervise infants, toddlers, and preschoolers at all times during all daily routines, including sleeping, eating, and diapering or bathroom use. Active supervision includes six strategies that are essential for creating safe environments and allowing children to explore their environments safely. Active supervision requires focused attention and intentional observation of children at all times. Programs that use active supervision never leave children unattended.

¹ Staff includes program leaders, teachers, family child care providers, and home visitors—all adults who work in early care and education programs.

² Early care and education programs include center-based early childhood settings and family child care homes as well as home visiting programs. While children's needs do not differ, the way adults meet children's needs in each of these programs may vary.





The six strategies of active supervision are:

1. **Set up the environment:** Staff set up the environment so they have clear sightlines and access to children. The height and arrangement of furniture and equipment allow effective monitoring and supervision of children at all times.
2. **Position Staff:** Staff carefully plan where they will position themselves in the environment to prevent harm to children. They place themselves so that they can see and hear all of the children in their care. They make sure there are always clear paths to where children are playing, sleeping, and eating so they can react quickly when necessary. Staff stay close to children who may need additional support.
3. **Scan and count:** Staff are always able to account for the children in their care. They continuously scan the entire environment so everyone knows where each child is and what they are doing. They count the children frequently and use name-to-face recognition by visually identifying each child. This is especially important during transitions when children are moving from one location to another.
4. **Listen:** Staff listen closely to children to identify signs of potential danger. Specific sounds or the absence of them may signify reason for concern. They may employ additional strategies to safeguard children. For example, bells added to doors may alert staff when a child leaves or enters the room.
5. **Anticipate children's behavior:** Staff use their knowledge of each child's development and abilities to anticipate what they will do. Staff who know what to expect are better able to protect children from harm.
6. **Engage and redirect:** Staff provide individualized, responsive caregiving and intervene when children are unable to problem-solve on their own. They may offer different levels of assistance or redirection depending on each individual child's needs.

How Do Early Care and Education Programs Support Active Supervision?

Keeping children safe is a top priority for all ECE programs. Implementing the active supervision strategies requires leadership, planning, tracking and ongoing monitoring, and professional development. The strategies are useful in all environments. This includes classrooms, family child care homes, playgrounds, and on [vehicles](#) when programs are transporting children. Home visitors can modify the strategies to share with families during home visits. The strategies are particularly important to use when children arrive, leave, and transition between activities and when there are changes in staffing patterns or children's routines. In addition, staff recognize when children need additional support and help them solve problems as they arise.

Using active supervision and paying close attention to children's activities and exploration keeps children safe and supports school readiness. Many resources are available to help staff [keep children safe using active supervision](#). [Tips for Keeping Children Safe: A Developmental Guide](#) describes the safety needs of infants, toddlers, and preschoolers who attend center-based programs. [Tips for Keeping Infants and Toddlers Safe: A Developmental Guide for Home Visitors](#) offers safety tips to share with families in home-based (home visiting) programs. Programs can use the information in these developmental guides to train new staff or refresh staff understanding of active supervision strategies. Additional guidelines for supervising infants and young children are included in *Caring for Our Children (CFOC)* [Standard 2.2.0.1: Methods of Supervision of Children](#). These resources can also help orient parents who volunteer in the classroom.



Infant and Toddler Settings

Children in ECE programs may receive care in center-based programs or family child care homes or through home-based services. Staff may supervise children of similar ages or mixed-age groupings. It is important that staff use active supervision strategies in the context of their individual program design.

All programs serving infants and toddlers care for children in small groups. Low adult/child ratios and primary caregiving practices encourage responsive interactions between children and their caregivers. In family child care homes where there are one or two caregivers, [primary caregiving](#) occurs naturally. Primary caregiving is a relationship-based practice and is the process of assigning each child (and family) to a teacher who will serve as the primary source of information and care for the child. In center-based programs, a primary caregiving approach can ensure responsive care that fosters strong connections between teachers and children. Primary caregiving also helps adults build awareness of each child's development. [Individualizing Care for Infants and Toddlers](#) offers resources about program structures and staff practices that support responsive caregiving.



Nurturing, safe, engaging environments are central to the quality care that supports active supervision. [News You Can Use: Environment as Curriculum for Infants and Toddlers](#) and “[Creating a Responsive Environment for Infants and Toddlers](#)” in the [Infant/Toddler Curriculum Series](#) are two resources that describe how to create and maintain safe, interesting, and welcoming learning environments for infants and toddlers. [Supporting Outdoor Play and Exploration for Infants and Toddlers](#) outlines issues to consider when taking infants and toddlers outdoors. It focuses on planning and creating outdoor play spaces and learning opportunities as well as program policies and procedures. Planned transitions are another important part of effective child supervision. The resource [News You Can Use: Transitions](#) offers ways to support children through the many transitions in Early Head Start and is applicable to all ECE programs.

Ultimately, carefully planned environments, adults who support nurturing and engaged caregiving, and well-planned, responsive care routines support active supervision in infant and toddler environments.

Preschool Settings

Staff create safe environments by arranging the classroom or family child care area so that they can see, hear, and quickly reach children at all times. A brief video and related resources on [Designing Environments](#) offer tips for setting up a preschool classroom to support children's learning and staff supervision.

Staff can best supervise children by positioning themselves strategically so they can easily see, hear, and quickly reach children at all times. Three planning tools help staff think intentionally about positioning. A [staff zoning chart](#) and [classroom zoning map](#) from the in-service suite on zoning show how zoning encourages children's learning and keeps children safe. Posting [Tips for Teachers: Zoning to Maximize Learning](#) in a visible spot can remind staff to use effective zoning practices. A [transition planning chart](#) from the [in-service suite](#) on classroom transitions supports safe transitions in center-based programs.

Anticipating children's behaviors and knowing when to engage and redirect children are two critical active supervision skills. The [Being Aware of Children's Needs](#) in-service suite offers techniques for focusing on children's needs. The [Anticipating Problem Situations](#) tool in the [Behavior Guidance: Problem Solving in the Moment](#) in-service suite offers scenarios to help adults anticipate problems. Supervisors can use this [Observation Form](#) to help teaching staff think about ways to anticipate children's behavior. The presentation from the



Behavior Guidance: Redirecting Behavior in-service suite includes strategies to address problems before they occur.

Communicating about children's needs and schedule changes helps staff work together to keep children safe and the classroom running smoothly. The *Teacher-to-Teacher Talk Tips for Teachers* reminds teachers of the importance of communicating well for effective teamwork.

The Role of Program Leaders

In all ECE programs, program leaders ensure that staff meet child safety and supervision regulations and best practices. When everyone understands their role in and responsibility for implementing safety practices and has the knowledge and skills to keep children safe at all times, the result is more effective child supervision and lower rates of injury. Programs that think systemically about child supervision use active supervision strategies to create safe learning environments for infants, toddlers, and preschool children in all ECE settings.

Each program should develop policies and procedures for how staff will actively supervise children at all times, including during transitions. Programs should develop these policies and procedures with input from staff and families. They should also consider how to communicate these policies and procedures to all adults in the program, including substitute staff, contractors, and volunteers. *Model Child Care Health Policies* has a sample supervision policy that programs can adapt to fit site-specific requirements.

Using an active supervision checklist, such as the *Supervision and Ratio Best Practices Checklist* from the *Virtual Lab School* or the *Tool for Supervisors* from the Zoning to Maximize Learning *in-service suite* can help adults observe active supervision strategies and identify strengths and areas for improvement. The Virtual Lab School's lesson on *Ensuring Staff-to-Child Ratios and Appropriate Supervision Practices Are Followed at All Times* describes best practices to ensure that staff provide appropriate supervision indoors and outdoors. In home-based settings, home visitors support parents or other caregivers to incorporate safety and supervision practices into their daily routines.

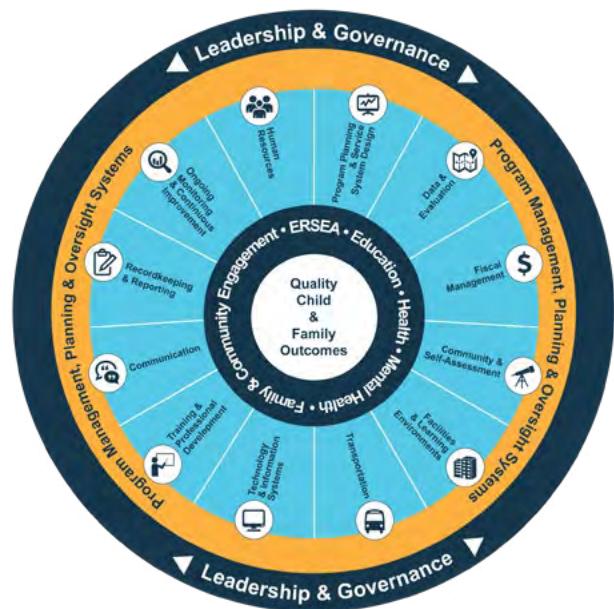


Figure 1. Head Start Management Systems Wheel

The Role of Head Start Program Leadership

Head Start program leadership (governing body/tribal council, Policy Council, and key management staff) set the stage for developing a culture of safety. Policy Council parents, in their role as leaders and advocates, play a critical role in informing supervision strategies.

Head Start leadership use the Head Start management systems to implement consistent and effective safety practices throughout the program. The *Head Start Management Systems Wheel* is a visual representation of the 12 program management, planning, and oversight systems that



are critical to sound program infrastructure and high-quality service delivery. [*Head Start Management Systems: Guiding Questions for Active Supervision and Child Safety*](#) is a resource to help management staff evaluate each of the management systems that support the implementation of active supervision.

In Head Start programs, an effective governing body/tribal council and Policy Council work with management staff to ensure the safety of all children. They exercise their oversight responsibility by asking programs to share information about their safety practices, including active supervision. Policy Council parents share this information with other families so that everyone can work together to keep children safe. Management staff and governing bodies work together to promptly address safety concerns and correct quality and compliance issues.

Head Start programs can use [*Foundation II: Leadership, Systems, and Service*](#) to build and sustain a culture of safety that includes active supervision. The [*Learning for New Leaders: Head Start A to Z*](#) series helps directors and other key management staff examine their leadership style, reflect on organizational change, and link systems and services to improve programming for children and families.

Planning is critical in creating a culture of safety in programs. Head Start programs can use [*Foundations for Excellence: A Guide for Five-Year Planning and Continuous Improvement, 2nd Edition*](#) to set goals, objectives, and expected outcomes and use data to measure their progress.

Two-Way Communication with Families

Communicating regularly with families is key to developing nurturing relationships with children. All programs should have a comprehensive plan for communicating their policies and procedures related to child supervision. This includes:

- Supervision plans and procedures that support pick-up and drop-off conversations with families, since children require close supervision during transitions



- The program's expectations about
 - Who is responsible for supervising children in a home-based socialization or on a field trip when the parent/guardian is present
 - Who is responsible for supervising a child at pick-up and drop-off times and after the parent/guardian has signed their child out but is still on Head Start property

Ongoing communication with families, including checking in daily with each family, can help staff plan for supervision. Families can help staff learn about their child's interests, abilities, and needs, which helps staff anticipate when to engage and redirect the children in their care. Supervision strategies should be informed by parents' knowledge and reports—for example, about a child who is very tired, recovering from an illness, has had an emotionally challenging experience, or is working on a new skill. Strong relationships with families help programs tailor their approaches and create partnerships that ensure children are safe at home and in their ECE program.



Active Supervision Resource Guide

General Active Supervision Resources

Active Supervision

<https://eclkc.ohs.acf.hhs.gov/safety-practices/article/active-supervision>

Active Supervision on Buses

<https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/no-search/active-supervision-on-buses.pdf>

Caring for Our Children: National Health and Safety Performance Standards, Guidelines for Early Care and Education, Standard 2.2.0.1: Methods of Supervision of Children

<http://nrckids.org/CFOC/Database/2.2.0.1>

Keep Children Safe Using Active Supervision

<https://eclkc.ohs.acf.hhs.gov/safety-practices/article/keep-children-safe-using-active-supervision>

Tips for Keeping Children Safe: A Developmental Guide

<https://eclkc.ohs.acf.hhs.gov/safety-practices/article/tips-keeping-children-safe-developmental-guide>

Infant and Toddler Active Supervision Resources

EHS TA Paper No. 14: Supporting Outdoor Play and Exploration for Infants and Toddlers

<https://eclkc.ohs.acf.hhs.gov/learning-environments/article/supporting-outdoor-play-exploration-infants-toddlers>

Individualizing Care for Infants and Toddlers

<https://eclkc.ohs.acf.hhs.gov/teaching-practices/article/individualizing-care-infants-toddlers>

Infant/Toddler Teacher Time Episode 2

<https://eclkc.ohs.acf.hhs.gov/video/infanttoddler-teacher-time-episode-2>

News You Can Use: Environment as Curriculum for Infants and Toddlers

<https://eclkc.ohs.acf.hhs.gov/learning-environments/article/news-you-can-use-environment-curriculum-infants-toddlers>

News You Can Use: Transitions

<https://eclkc.ohs.acf.hhs.gov/transitions/article/news-you-can-use-transitions>

Tips for Keeping Infants and Toddlers Safe:

A Developmental Guide for Home Visitors

<https://eclkc.ohs.acf.hhs.gov/safety-practices/article/tips-keeping-infants-toddlers-safe-developmental-guide-home-visitors>

Professional Development In-Service Suites and Tools and Worksheets to Support Active Supervision

Behavior Guidance:

Problem Solving in the Moment

<https://eclkc.ohs.acf.hhs.gov/video/problem-solving-moment>

- *Anticipating Problem Situations: Problem Solving in the Moment*
<https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/no-search/iss/behavior-guidance/problemsolving-la-anticipate.pdf>
- *Observation Form, Tools for Supervisors: Problem Solving in the Moment*
<https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/no-search/iss/behavior-guidance/problemsolving-supervisortools.pdf>

Behavior Guidance: Redirecting Behavior

<https://eclkc.ohs.acf.hhs.gov/video/redirecting-behavior>

Building Relationships:

Being Aware of Children's Needs

<https://eclkc.ohs.acf.hhs.gov/video/being-aware-childrens-needs>

Managing the Classroom: Classroom Transitions

<https://eclkc.ohs.acf.hhs.gov/video/classroom-transitions>

- *Planning for Transitions: Classroom Transitions (Transition Planning Chart)*
<https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/no-search/iss/managing-the-classroom/classroom-transitions-planning.pdf>
- *Tips for Teachers: Classroom Transitions*
<https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/no-search/iss/managing-the-classroom/classroom-transitions-teacher-tips.pdf>

- **Tools for Supervisors: Classroom Transitions, Supporting Positive Behaviors During Classroom Transitions: Observation Form**
<https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/no-search/iss/managing-the-classroom/classroom-transitions-supervisor-tools.pdf>

Managing the Classroom: Designing Environments
<https://eclkc.ohs.acf.hhs.gov/video/designing-environments>

Staffing: Zoning to Maximize Learning
<https://eclkc.ohs.acf.hhs.gov/video/zoning-maximize-learning>

- **Classroom Map with Zoning Areas: Zoning to Maximize Learning**
<https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/no-search/iss/staffing/zoning-areas.pdf>
- **Staff Zoning Chart: Zoning to Maximize Learning**
<https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/no-search/iss/staffing/zoning-staff-chart.pdf>
- **Tips for Teachers: Zoning to Maximize Learning**
<https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/no-search/iss/staffing/zoning-teacher-tips-rev.pdf>
- **Tools for Supervisors: Zoning to Maximize Learning (Observation Checklist)**
<https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/no-search/iss/staffing/zoning-supervisor-tools-rev.pdf>

Teacher-to-Teacher Talk
<https://eclkc.ohs.acf.hhs.gov/video/teacher-teacher-talk>

Head Start Leadership Resources

Foundations for Excellence: A Guide for Five-Year Planning and Continuous Improvement, 2nd Edition
<https://eclkc.ohs.acf.hhs.gov/publication/foundations-excellence-guide-five-year-planning-continuous-improvement-2nd-edition>

Guiding Questions for Active Supervision and Safety: Using the Head Start Management Systems Wheel
<https://eclkc.ohs.acf.hhs.gov/publication/guiding-questions-active-supervision-safety>

Program Governance
<https://eclkc.ohs.acf.hhs.gov/organizational-leadership/article/program-governance>

Family Engagement Resources

Building Partnerships: Guide to Developing Relationships with Families
<https://eclkc.ohs.acf.hhs.gov/family-engagement/developing-relationships-families/building-partnerships-guide-developing>

Families as Advocates & Leaders
<https://eclkc.ohs.acf.hhs.gov/family-engagement/article/understanding-family-engagement-outcomes-research-practice-series>



Active Supervision on Buses

Head Start transportation teams have an important job. They not only have to make sure buses are safe and routes run on time but also must supervise children on their bus.^[1] Each driver, monitor, and transportation manager has an important role. Together, they make sure that children get to and from programs safely. Children are safer when teams work together and communicate well. This fact sheet explores many of the issues teams are likely to face and active supervision strategies to keep children safe on the bus.

How Can Active Supervision Help You Supervise Children on Buses?

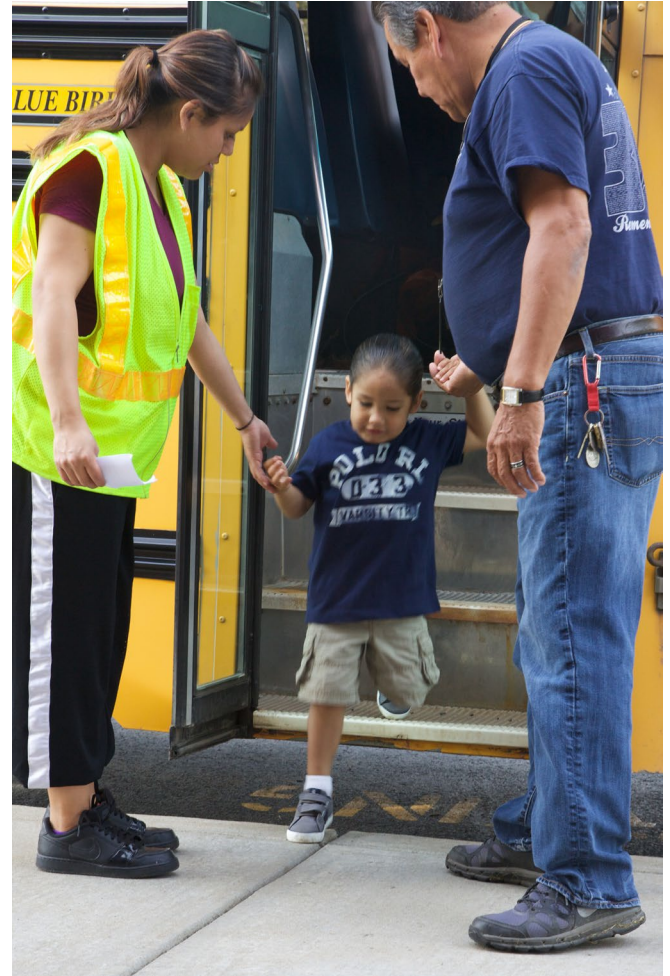
Active supervision is the most effective strategy for creating a safe environment and preventing injuries in young children. It transforms supervision from a passive approach to an active skill. Transportation teams use active supervision when children are boarding, exiting, and riding the bus.^[2]

What Are the Key Strategies for Actively Supervising Children on Buses?

The key strategies for actively supervising children on buses are as follows:

Set Up the Environment

Drivers and monitors set up daily routines that include reminders to help them keep track of who is on the bus. They check and double-check each seat on the bus so they always know which children are on the bus. For example,



- A small object, such as a token, is stuck underneath the last seat on the bus. The monitor or driver must collect it after finishing each route.
- A bus alarm system is used so that the bus driver has to walk to the back of the bus to turn it off.

1 Subpart I—Human Resources Management. 1302.90 Personnel policies. (c)(1)(v) Standards of conduct.

2 Subpart D—Health Program Services. 1302.47 Safety practices. (b)(5) (iii) Safety practices.

Position Staff

If possible, the ratio of bus monitors to children on the bus is the same as the ratio of teachers to children in the classroom. Bus monitors stay with the bus until an authorized adult picks up each child.^[3] Monitors carefully plan where they will sit on the bus during the trip. They choose a seat that allows them to see and hear children and respond when needed. For example,

- Bus monitors sit in the front or the back of the bus.
- If only one bus monitor is on the bus, he or she is seated in the middle.

Scan and Count

Bus monitors always know where all children are on the bus and what they are doing. They are always scanning and counting. For example,

- Bus monitors record attendance as children board and leave the bus, ideally using name-to-face checks to make sure they release children to the right adult. They may use paper logs or tablets with a photo of each child to log children in and out as they enter or exit the bus.
- An authorized adult signs off once all children are in his or her care at the program. This person could be the center director, a teacher, or another staff member. Family members or other authorized adults also sign the attendance record when their child is dropped off.
- Bus monitors and drivers scan the bus to make sure all children have left the bus. They then check each seat on the bus at the end of every trip.
- Whenever possible, someone other than the driver or monitor checks the bus at the end of each shift.
- Transportation supervisors frequently spot-check. Other program managers or families sometimes check the bus after the route is finished. This is part of a program's ongoing monitoring system and continuous improvement.



Listen

Bus monitors are always listening to children. They know which sounds are signs of danger. For example,

- Bus monitors are alert to unusual sounds or silence while riding the bus.
- Bus monitors can identify the causes of a wide range of sounds and recognize which sounds indicate an immediate need for attention.

Anticipate Children's Behavior

Because children are seated in a Child Safety Restraint System (CSRS) and cannot move around the bus freely, bus monitors must be able to recognize children's needs and respond quickly. They get to know the children on their bus, including their interests and needs, which helps predict what children will do. For example,

- Bus monitors build relationships with the children and their families. As much as possible, bus drivers and monitors have the same routes every day.
- Bus monitors quickly check in with the adult dropping the child off. Understanding each child helps monitors know what to expect when a child is not feeling well or gets upset on the bus.

3 Subpart F—Transportation. 1303.72 Vehicle operation. (a)(3) Safety.

Engage and Redirect

Families and staff let the bus monitor know when children may need extra attention on a bus trip. Bus monitors help children who need support. They offer reminders and soothe children when they become upset and need help calming down. They also distract or refocus children when necessary. For example,

- When a child seems upset, bus monitors and adults responsible for picking up the child work together to help the child manage his or her feelings.
- Bus monitors observe and react quickly to children who need extra support on the bus. When possible, these children are seated close to the monitor.

In summary, when transportation teams use these strategies, children are more likely to ride the bus and arrive at their destination safely. Programs that use active supervision never leave children unattended.



What Does Supervising on Buses Look Like?

The following story shows how one transportation team uses these strategies:

Monday morning, Marguerite and Ahmed begin their day by boarding bus 31 in the bus lot behind 1, 2, 3 Head Start. Before they depart, Ahmed goes to the back of the bus and places white tokens on a Velcro spot underneath the last 2 seats. Then he moves to the middle rows and places tokens underneath those seats as well. These tokens will help remind him that he needs to check every seat at the end of each route.

When the team agrees that the bus is safe and ready to go, Ahmed grabs his clipboard with attendance sheets. There is a sheet for each route with the name of every child who rides the bus. It is arranged by the scheduled time for each bus stop.

Ahmed sits in a seat in the middle of the bus. He will seat the children from the front to the back so he can observe the children safely and be close to them. When he is seated, Marguerite starts the bus and begins their first route of the day.

At each stop, Ahmed gets off the bus and greets each parent and child. The parent or another authorized adult initials the list next to his or her child's name. Then Ahmed seats the children so he can see and hear them. He fastens their belts and straps them securely in every CSRS to protect them during the trip.

As the bus is moving, Ahmed constantly scans the bus to see and listen to how the children are doing. Some children sleep on the bus, while others sing songs and chatter with Ahmed. One child drops his mitten and starts to cry, but Ahmed reassures him that he will get it at the next stop. He sometimes moves to sit near a child who needs encouragement.

Ahmed knows that one child, Rosa, has just learned how to unbuckle herself. He seats her next to him and distracts her by chatting with her about what she did at home that morning. If necessary, he reminds her that all children have to keep the buckles fastened.

When the bus arrives at the program, the children's teachers come out to greet them. Ahmed and Marguerite conduct a last head count together, and they give the clipboard to a teacher who is waiting outside. As each child exits, a teacher initials next to the child's name on the clipboard. This provides a written check that each child has been released to an authorized adult. The teachers then walk the children to their classrooms.

When all the children have exited, Marguerite and Ahmed inspect the bus to make sure that all children got off and no one got back on. While they conduct this check, the center supervisor counts the children as they enter the building with their teachers. This is a way of double-checking the information on the clipboard to make sure they can account for all the children.

When Marguerite and Ahmed are done with their inspection, Ahmed removes the tokens from the middle and back seats. He reviews the clipboard and he and Marguerite sign off at the bottom of the attendance sheet. The center supervisor takes the sign-in sheet for program files. Ahmed then conducts a final check of the bus before the next route, replacing the tokens in the middle and back seats.

At the end of their daily runs, Marguerite and Ahmed park the bus in the yard. They walk through the bus one last time from front to back, checking each seat. They collect and put the tokens away before leaving the yard. The Look Before You Lock symbol posted on the door reminds them to do this as well.

Marguerite and Ahmed are a team. They work together to actively supervise children on the bus. They also double- and triple-check counts to make sure children are where they should be. They have a plan and follow through with their plan for how to keep children safe.



Active Supervision on Buses Self-Reflection Tool

Questions to Help Your Team Assess Your Active Supervision Practices

How do we set up the bus to easily observe children?

How do we make sure bus monitors safely position themselves to see children on the bus at all times?

How do we make sure we scan and count continually during and at the end of each route?

How do we listen to determine whether children are safe?

How do we anticipate child behaviors so we know when to engage and redirect children?

To understand how this approach will work for you, consider using the following tool:

Active Supervision on Buses Implementation Plan		
Key Strategy	Current Practice	Action Steps
Set up the environment.		
Position staff.		
Scan and count.		
Listen.		
Anticipate children's behavior.		
Engage and redirect.		

Resources to Learn More

Administration for Children and Families, US Department of Health and Human Services. *Caring for Our Children Basics: Health and Safety Foundations for Early Care and Education*. Washington, DC: US Dept of Health and Human Services; 2015. https://www.acf.hhs.gov/sites/default/files/ece/caring_for_our_children_basics.pdf. Published June 25, 2015. Accessed May 10, 2017

Standard 2.2.0.1 Methods of Supervision of Children

American Academy of Pediatrics, American Public Health Association, National Resource Center for Health and Safety in Child Care and Early Education. *Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs*. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2011. <http://cfoc.nrckids.org/>. Accessed May 12, 2017

Standard 1.1.1.4: Ratios and Supervision During Transportation <http://cfoc.nrckids.org/StandardView/1.1.1.4>

Standard 2.2.0.1: Methods of Supervision of Children <http://cfoc.nrckids.org/StandardView/2.2.0.1>

National Center on Early Childhood Health and Wellness. Keep children safe using active supervision. Head Start Web site. <https://eclkc.ohs.acf.hhs.gov/safety-practices/article/keep-children-safe-using-active-supervision>. Updated December 1, 2016. Accessed May 12, 2017

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Northern Health. Supervision of children. Northern Health Web site. http://www.northernhealth.ca/Portals/0/Your_Health/Programs/Community%20Care%20Licensing/Supervision%20of%20Children%2010-410-6024.pdf. Published 2011. Accessed May 12, 2017

Tanah Merah Child Care Centre (Australia). Supervision policy. Tanah Merah Child Care Centre Web site. http://www.tanahmerahchildcare.com.au/uploads/supervision_policy.pdf. Reviewed May 2011. Accessed May 12, 2017



NATIONAL CENTER ON

Early Childhood Health and Wellness

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Hazard Mapping for Early Care and Education Programs

Hazard Mapping is a process that Head Start programs can use after an injury occurs. It helps to: 1) identify location(s) for high risk of injury; 2) pinpoint systems and services that need to be strengthened; 3) develop a corrective action plan; and 4) incorporate safety and injury prevention into ongoing-monitoring activities. Hazard mapping is employed effectively in emergency preparedness planning related to natural disasters. It also is used to isolate locations of disease outbreaks and determine where prevention efforts are most needed.

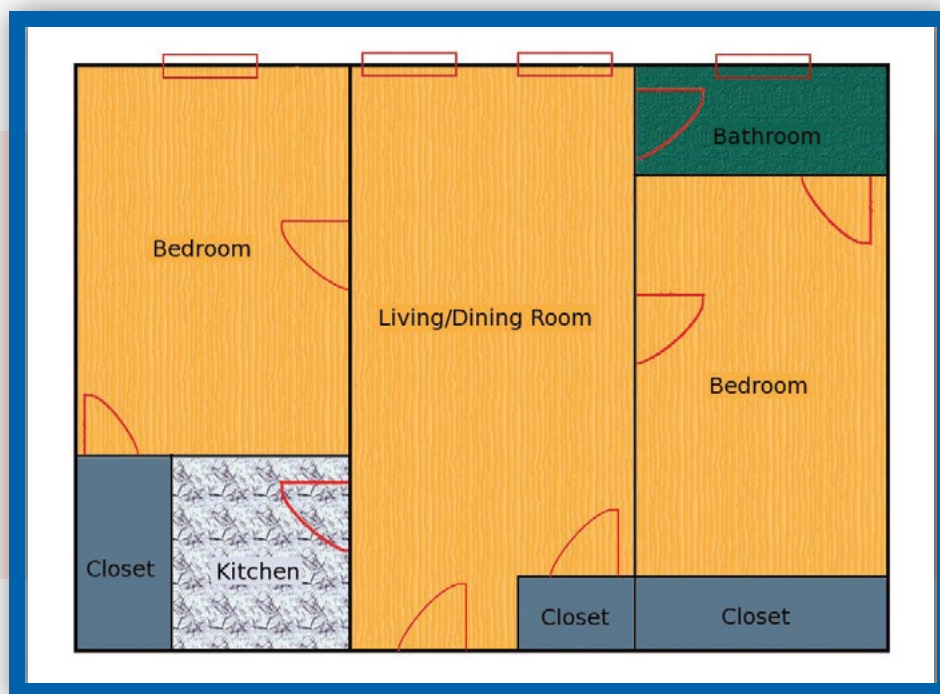
Goals and Benefits of Hazard Mapping

Hazard mapping provides:

- An easy method for ongoing, systematic data collection and analysis about where injuries occur in Head Start programs
- A way to identify the “how”, “what”, “when”, “who”, etc. by building on injury and incident reports
- A strategic approach to safety and injury prevention problems by studying patterns of injury rather than isolated incidents
- Compelling visual data for decision makers, staff, and families to make informed decisions about solutions



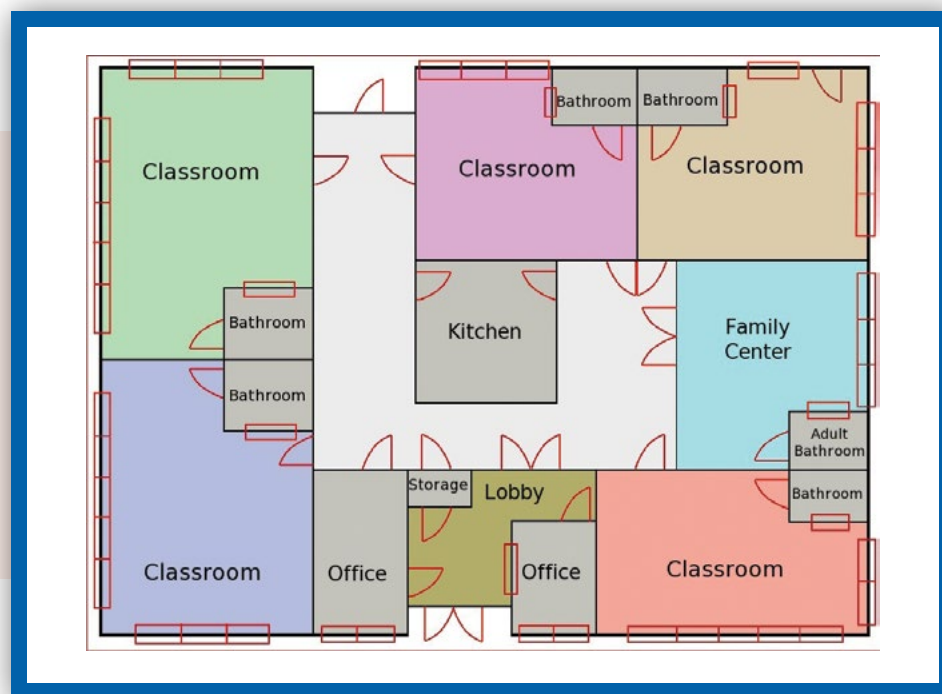
School readiness begins with health!



Instructions for Hazard Mapping Step One—Identify high risk injury locations

1. Create a map of the home, classroom, center, family child care home, Head Start bus or playground area. Label the various places and/or equipment in the location(s) that is being mapped. Make the map as accurate as possible.
2. Have staff, administrators, or anyone who observed the incident place a “dot” or “marker” on the map to indicate where the specific incident and/or injury occurred.
3. Depending on the size of the program and number of injuries reported, use data from injury/incident reports for the past 3-6 months. Add more “dots” or “markers” to identify additional locations where injuries occurred.
4. Establish a safety and injury prevention committee to review and analyze incident data. The committee may include administrators, staff, Head Start parents/families and community partners. Programs may use their Health Services Advisory Committee or some of its members as their Safety and Injury Prevention Committee.
5. Analyze and chart the findings. To do this, count the number of incidents in each location.
6. Count how many of the incidents resulted in an injury and the level of severity of each injury. Use incident and/or injury reports to collect this additional data.
7. Determine where most incidents occur and where to focus initial efforts for a corrective action plan.

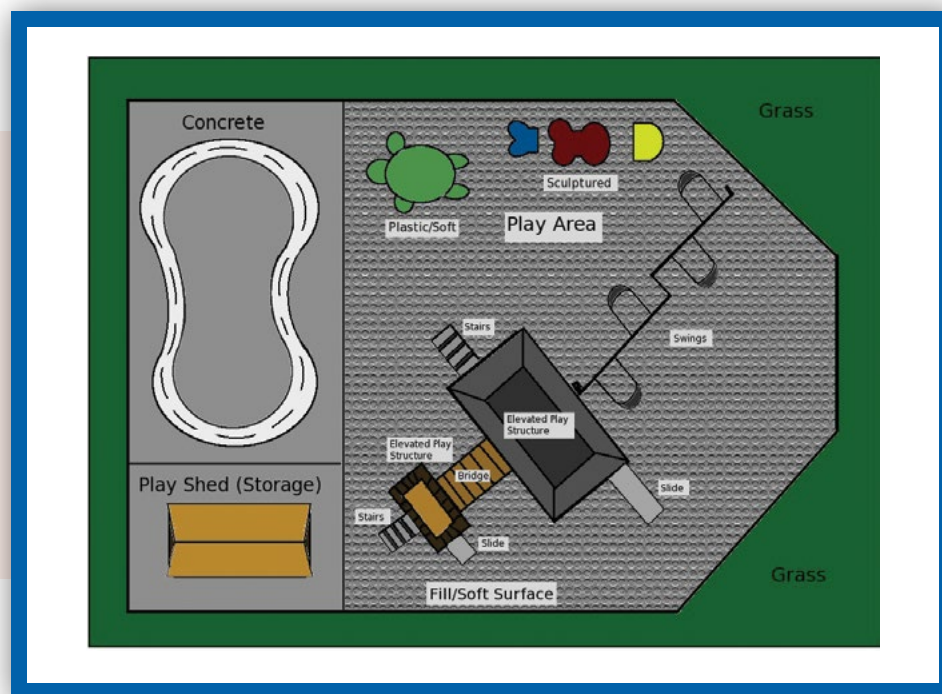
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Instructions for Hazard Mapping Step Two—Pinpoint systems and services that need to be strengthened

1. To identify and understand patterns of injuries at locations throughout the program, review additional information from injury and/or incident reports.
 - **Who** was involved in each injury? (child/children; staff, volunteers, parents)
 - **Where** did the injury occur?
 - **What** happened? (What was the cause?)
 - **What** was the severity of each injury?
 - **When** did each injury occur?
 - **Who** – e.g., what staff were present and where were they at the time of each injury?
 - **How** could each injury have been prevented?
2. Using your/the program plan, determine areas where systems and services affect these findings.
3. Translate these findings into recommendations that strengthen systems and services.

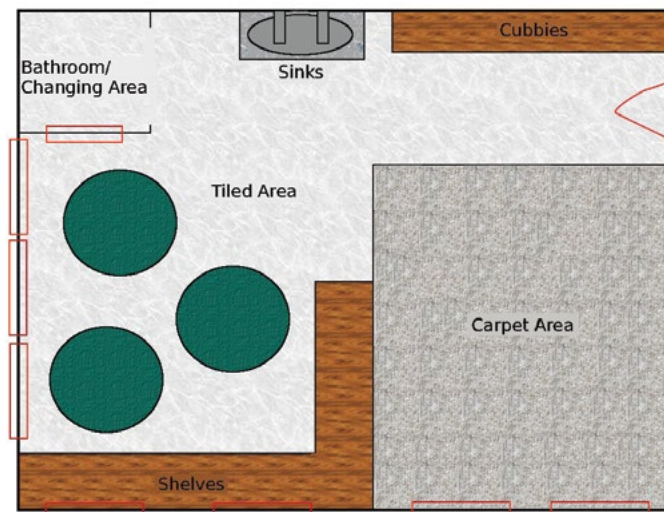
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Instructions for Hazard Mapping Step Three—Developing a Corrective Action Plan

1. Review all of the findings and recommendations regarding injuries and incidents.
2. Prioritize and select specific activities/strategies to resolve problem areas. These should focus on the everyday service delivery level and the higher systemic level.
3. Develop an action plan to correct the problem areas you identified. Include each of the activities/strategies selected in this corrective action plan. Identify the steps, the individuals responsible, and the dates for completion.
4. Create a plan for sharing the corrective action plan with management, staff, and families to get buy in for injury and/or incident responses.

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Instructions for Hazard Mapping Step Four—Incorporating Hazard Mapping in Ongoing-Monitoring Activities

- Based on an analysis of these data, determine what action(s) needs to be taken to avoid future injuries in the location(s) identified. Determine if any additional questions should be added to injury/incident report forms to obtain this missing information.
- When developing corrective action plans, consider prioritizing more serious injuries, even if they have occurred less often.
- A reduction in injuries and/or incidents happens over time if the correct set of interventions is selected based on analysis of the data about patterns of injuries.
- Continuously review incident and/or injury data to make sure that interventions are reducing the number of incidents and the severity of injuries. They may include:
 - Educational opportunities about safety and injury prevention for staff
 - Environmental modifications
 - Procedures to monitor compliance with program policies, and/or
 - Other necessary corrective actions.
- Discuss how to share injury data from ongoing monitoring activities and the self-assessment process with staff, families, the Health Services Advisory Committee, and Governing Board and Policy Council. Determine:
 - How will managers share the results of hazard mapping activities with all staff to advise them of risks or hazards that may exist at their center or location?
 - How will managers share the hazard mapping and incident and/or injury report results with the program's Health Services Advisory Committee (HSAC) (when it is not the same as the Safety and Injury Prevention Committee) to problem-solve the issues that are identified?
 - How will managers use hazard mapping as part of ongoing-monitoring activities to (1) develop and maintain corrective action plans, (2) assure continuous program improvement, and (3) reduce the incidence of future injuries to enrolled children?

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Resources to Learn More

National Council for Occupational Safety and Health. (2012).

"Mapping" Health and Safety Problems. Los Angeles, CA:

National Council for Occupational Safety and Health. Retrieved August 13, 2012 from: <http://www.coshnetwork.org/sites/default/files/Mapping%20NLC.pdf>

Injury Prevention Program Division. (2012). *UCLA Injury and Illness Prevention Program (IIPP)*. Los Angeles, CA: University of California, Los Angeles. Retrieved August 13, 2012 from: http://ora.research.ucla.edu/OBFS/Documents/VC_Research_IIPP.pdf

Health and Safety Checklist for Early Care and Education Programs:

Based on *Caring for Our Children*
National Health and Safety Performance Standards



*Developed by the California Childcare Health Program
Funded by the UCSF School of Nursing
2014; Updated January, 2019*

Health and Safety Checklist for Early Care and Education Programs: Based on *Caring for Our Children National Health and Safety Performance Standards*

Developed by the California Childcare Health Program (CCHP)
University of California San Francisco (UCSF) School of Nursing
2014

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PILOT STUDY

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GRAPHIC DESIGN: Mara Gendell, California Childcare Health Program

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Health and Safety Checklist for Early Care and Education Programs:

Based on *Caring for Our Children* National Health and Safety Performance Standards

Child Care Center: _____

Classroom: _____

Classroom type (infant/toddler, preschool): _____

Date: (month/day/year) ____/____/____

Observer Name: _____

Time Begin: ____:____AM/PM

Time End: ____:____AM/PM

Ratings:

Code	Meaning	Definition
1	Never	None of the components of the item are met.
2	Sometimes	Less than or 50% ($\leq 50\%$) of the components in the item are met.
3	Usually	More than 50% ($> 50\%$) but less than 100% of the components in the item are met.
4	Always	Every component in the item is met (100%).
NA	Not Applicable	The item is not applicable (NA) to the classroom/program. Explain why it is rated NA in the 'notes' section.
N Op	No Opportunity to Observe	There was no opportunity (N Op) to observe this item. Explain why it is rated N Op in the 'notes' section.

Notes:

- An asterisk (*) means you may need to talk to the director or a staff member to ask where to find an item or product.
- At the end of each subscale there is a space to list and rate other related standards and/or regulations that may apply.
- When a field/box is shaded grey, the rating choice is not an option.

This checklist does not cover all health and safety concerns or replace each child care program's responsibility to meet local, state, and federal health and safety requirements.

FACILITIES: Emergencies, Medications, Equipment and Furnishings

Emergencies

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
1. A sign-in/sign-out system tracks who (other than children) enters and exits the facility. It includes name, contact number, purpose of visit (for example, parent/guardian, vendor, guest, consultant) and time in and out. (Std. 9.2.4.7)	1	2	3	4		
NOTES						
2. Phone numbers to report child abuse and neglect (Child Protective Services) are clearly posted where any adult can easily see them. (Std. 3.4.4.1)	1	2	3	4		
NOTES						
3. Phone number for the Poison Center is posted where it can be seen in an emergency (for example, next to the phone). (Std. 5.2.9.1 , 5.2.9.2)	1	2	3	4		
NOTES						
4. Fire extinguishers are inspected annually. Check date on fire extinguisher tag. (Std. 5.1.1.3)	1	2	3	4		
NOTES						
5. Each building or structure has at least two unobstructed exits leading to an open space at the ground floor. (Std. 5.1.4.1)	1	2	3	4		
NOTES						
6. A smoke detector system or alarm in working order is in each room or place where children spend time. (Std. 5.2.5.1)	1	2	3	4		
NOTES						
7. *Carbon monoxide detectors are outside of sleeping areas. (Std. 5.2.9.5)	1	2	3	4	NA	
NOTES						
8. *First aid supplies are well-stocked in each location where children spend time. (Std. 5.6.0.1)	1	2	3	4		
NOTES						
9. *First aid supplies are kept in a closed container, cabinet or drawer that is labeled. They are stored out of children's reach and within easy reach of staff. (Std. 5.6.0.1)	1	2	3	4		
NOTES						
10. *A well-stocked first aid kit is ready for staff to take along when they leave the facility with children (for example, when going on a walk, a field trip or to another location). (Std. 5.6.0.1)	1	2	3	4	NA	
NOTES						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
NOTES						

Medications

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
11. *Medications are stored in an organized fashion and are not expired. They are stored at the proper temperature, (for example, in the refrigerator or at room temperature according to instructions) out of children's reach and separated from food. (Std. 3.6.3.2)	1	2	3	4	NA	
NOTES						
12. *Over-the-counter medications are in the original containers. They are labeled with the child's name. Clear written instructions from the child's health care provider are with the medication. (Stds. 3.6.3.1, 3.6.3.2)	1	2	3	4	NA	N Op
NOTES						
13. *Prescription medications are in their original, child resistant container, labeled with child's name, date filled, prescribing health care provider's name, pharmacy name and phone number, dosage, instructions and warnings. (Stds. 3.6.3.1, 3.6.3.2)	1	2	3	4	NA	N Op
NOTES						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
NOTES						

Equipment and Furnishings — Indoors and Outdoors

14. There is fresh air provided by windows or a ventilation system. There are no odors or fumes (for example, mold, urine, excrement, air fresheners, chemicals, pesticides.) (Stds. 5.2.1.1, 3.3.0.1, 5.2.8.1)	1	2	3	4		
NOTES						
15. Windows accessible to children open less than 4 inches or have window guards so that children cannot climb out. (Std. 5.1.3.2)	1	2	3	4	NA	
NOTES						
16. There are no unvented gas or oil heaters or portable kerosene space heaters. (Std. 5.2.1.10)	1			4		
NOTES						
17. Gas cooking appliances are not used for heating purposes. Charcoal grills are not used indoors. (Std. 5.2.1.10)	1			4	NA	
NOTES						
18. Portable electric space heaters are not used with an extension cord and are not left on when unattended. They are placed on the floor at least three feet from curtains, papers, furniture and/or any flammable object and are out of children's reach. (Std. 5.2.1.11)	1	2	3	4	NA	N Op
NOTES						
19. All electrical outlets within children's reach are tamper resistant or have safety covers attached by a screw or other means that cannot be removed by a child. (Std. 5.2.4.2)	1	2	3	4	NA	
NOTES						
20. All cords from electrical devices or appliances are out of children's reach. (Stds. 4.5.0.9, 5.2.4.4)	1	2	3	4		
NOTES						

Equipment and Furnishings — Indoors and Outdoors — *Continued*

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
21. There are no firearms, pellet or BB guns, darts, bows and arrows, cap pistols, stun guns, paint ball guns or objects manufactured for play as toy guns visible. (Std. 5.5.0.8)	1			4		
NOTES						
22. Plastic bags, matches, candles and lighters are stored out of children's reach. (Stds. 5.5.0.7 , 5.5.0.6)	1	2	3	4		
NOTES						
23. There are no latex balloons (inflated, underinflated, or not inflated) or inflated objects that are treated as balloons (for example, inflated latex gloves) on site. (Stds. 6.4.1.5 , 6.4.1.2)	1			4		
NOTES						
24. Bathtubs, buckets, diaper pails and other open containers of water are emptied immediately after use. (Std. 6.3.5.2)	1	2	3	4	NA	
NOTES						
25. Children do not play in areas where there is a body of water unless a caregiver/teacher is within an arm's length providing "touch supervision". Bodies of water include tubs, pails, sinks, toilets, swimming pools, ponds, irrigation ditches and built-in wading pools. (Std. 2.2.0.4)	1			4	NA	N Op
NOTES						
26. Hot liquids and food (more than 120°F) are kept out of children's reach. Adults do not consume hot liquids in child care areas. (Std. 4.5.0.9)	1	2	3	4		
NOTES						
27. Equipment and play areas (including water play areas) do not have sharp points or corners, splinters, glass, protrusions that may catch a child's clothing (for example, nails, pipes, wood ends, long bolts), flaking paint, loose or rusty parts, small parts that may become detached or present a choking, aspiration, or ingestion hazard, strangulation hazards (for example, straps or strings), or components that can snag skin, pinch, or shear or crush body tissues. (Stds. 5.3.1.1 , 6.2.1.9 , 6.3.1.1)	1	2	3	4		
NOTES						
28. All openings in play or other equipment are smaller than 3.5 inches or larger than 9 inches. There are no rings on long chains. (Stds. 6.2.1.9 , 5.3.1.1)	1	2	3	4		
NOTES						
29. All openings in play or other equipment are smaller than 3/8 of an inch or larger than 1 inch. (Std. 6.2.1.9)	1	2	3	4		
NOTES						
30. Climbing equipment is placed over and surrounded by a shock-absorbing surface. Loose fill materials (for example, sand, wood chips) are raked to maintain proper depth/distribution. Unitary shock-absorbing surfaces meet current ASTM International standards and/or CPSC Standards. http://www.astm.org/Standards/F2223.htm http://www.cpsc.gov/PageFiles/122149/325.pdf (Std. 6.2.3.1 , Appendix Z)	1	2	3	4	NA	N Op
NOTES						
31. Fall zones extend at least six feet beyond the perimeter of stationary climbing equipment. (Std. 6.2.3.1)	1	2	3	4	NA	N Op
NOTES						
32. Equipment and furnishings are sturdy and in good repair. There are no tip-over or tripping hazards. (Std. 5.3.1.1)	1	2	3	4		
NOTES						

Equipment and Furnishings — Indoors and Outdoors — *Continued*

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
33. There is no hazardous equipment (for example, broken equipment, lawn mowers, tools, tractors, trampolines) accessible to children. (Std. 5.7.0.4 , 6.2.4.4)	1			4		
NOTES						
34. Open sides of stairs, ramps, porches, balconies and other walking surfaces, with more than 30 inches to fall, have guardrails or protective barriers. The guardrails are at least 36 inches high. (Std. 5.1.6.6)	1	2	3	4	NA	
NOTES						
35. Children one year of age and older wear helmets when riding toys with wheels (for example, tricycles, bikes) or using any wheeled equipment (for example, rollerblades, skateboards). Helmets fit properly and meet CPSC standards. Children take off helmets after riding or using wheeled toys or equipment. (Std. 6.4.2.2)	1	2	3	4	NA	N Op
NOTES						

Equipment and Furnishings — Outdoors Only

36. Children play outdoors each day. Children stay inside only if weather poses a health risk (for example, wind chill factor at or below minus 15°F, heat index at or above 90°F). (Std. 3.1.3.2)	1	2	3	4		N Op
NOTES						
37. Outdoor play areas are enclosed with a fence or natural barriers that allow caregivers/teachers to see children. Openings in fences and gates are no larger than 3.5 inches. (Std. 6.1.0.8)	1	2	3	4	NA	N Op
NOTES						
38. Enclosures outside have at least two exits, one being remote from the building. (Std. 6.1.0.8)	1	2	3	4	NA	N Op
NOTES						
39. Each gate has a latch that cannot be opened by children. Outdoor exit gates are equipped with self-closing, positive latching closure mechanisms that cannot be opened by children. (Std. 6.1.0.8)	1	2	3	4	NA	N Op
NOTES						
40. Shade is provided outside (for example, trees, tarps, umbrellas). Children wear hats or caps with a brim to protect their faces from the sun if they are not in a shaded area. (Std. 3.4.5.1)	1	2	3	4	NA	N Op
NOTES						
41. Broad spectrum sun screen with SPF of 15 or higher is available for use. (Std. 3.4.5.1)	1			4		
NOTES						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
NOTES						

SUPERVISION: Interaction, Physical Activity, and Nutrition (Eating and Drinking)

Interaction and Physical Activity

Age	Maximum Child: Staff Ratio	Maximum Group Size	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
≤12 months	3:1	6						
13-35 months	4:1	8						
3-year-olds	7:1	14						
4-year-olds	8:1	16						
5-year-olds	8:1	16						

42. Ratios: Indoors: Time (hour/min): ____ / ____
Ages of children observed: (check all that apply)
≤12 months 13-35 mo 3 years 4 years 5 years
of children ____ # of staff ____ child/staff ratio: ____:____ (Std. 1.1.1.2) For Family
Child Care Programs, see CFOC3 Stds. [1.1.1.1](#), [1.1.1.2](#)

NOTES

43. Ratios: Outdoors: Time (hour/min): ____ / ____
Ages of children observed: (check all that apply)
≤12 months 13-35 mo 3 years 4 years 5 years
of children ____ # of staff ____ child/staff ratio: ____:____ (Std. 1.1.1.2)
For Family Child Care Programs, see CFOC3 Stds. [1.1.1.1](#), [1.1.1.2](#)

NOTES

44. Caregivers/Teachers directly supervise children by sight and hearing at all times. This includes indoors, outdoors and when children are sleeping, going to sleep or waking up. (Std. 2.2.0.1)

NOTES

45. Caregivers/Teachers encourage positive behavior and guide children to develop self-control. Caregivers/Teachers model desired behavior. "Time out" is only used for persistent, unacceptable behavior. (Std. 2.2.0.1)

NOTES

46. Caregivers/Teachers support children to learn appropriate social skills and emotional responses. There are daily routines and schedules. (Std. 2.2.0.6)

NOTES

47. There is no physical or emotional abuse or maltreatment of a child. There is no physical punishment or threat of physical punishment of a child. (Std. 2.2.0.9)

NOTES

48. Caregivers/Teachers do not use threats or humiliation (public or private). There is no profane or sarcastic language. There are no derogatory remarks made about a child or a child's family. (Std. 2.2.0.9)

NOTES

49. Children are not physically restrained unless their safety or that of others is at risk. (Std. 2.2.0.10)

NOTES

50. Physical activity/outdoor time are not taken away as punishment. (Std. 2.2.0.9)

NOTES

51. Children engage in moderate to vigorous physical activities such as running, climbing, dancing, skipping and jumping. All children (including infants) have opportunities to develop and practice gross motor and movement skills. (Std. 3.1.3.1)

NOTES

Interaction and Physical Activity — *Continued*

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
52. There are structured or adult-led physical activities and games that promote movement for children. (Std. 3.1.3.1)	1	2	3	4		
NOTES						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
NOTES						

Nutrition: Eating and Drinking

53. Individual children's food allergies are posted where they can be seen in the classroom and wherever food is served. (Std. 4.2.0.10)	1	2	3	4	NA	
NOTES						
54. Children two years of age and older are served skim or 1% milk. (Std. 4.9.0.3)	1	2	3	4	NA	N Op
NOTES						
55. Drinking water is available, indoors and outdoors, throughout the day for children over six months of age. (Std. 4.2.0.6)	1	2	3	4		
NOTES						
56. A variety of nourishing foods is served at meals and snacks. Nourishing foods include fruits, vegetables, whole and enriched grains, protein and dairy. (Std. 4.2.0.3)	1	2	3	4	NA	N Op
NOTES						
57. Foods that are choking hazards are not served to children under four years of age. This includes hot dogs and other meat sticks (whole or sliced into rounds), raw carrot rounds, whole grapes, hard candy, nuts, seeds, raw peas, hard pretzels, chips, peanuts, popcorn, rice cakes, marshmallows, spoonfuls of peanut butter or chunks of meat larger than can be swallowed whole. (Std. 4.5.0.10)	1			4		
NOTES						
58. Children are always seated while eating. (Std. 4.5.0.10)	1	2	3	4		
NOTES						
59. Food is not used or withheld as a bribe, reward or punishment. (Std. 2.2.0.9)	1			4		
NOTES						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
NOTES						

SANITATION: Personal Hygiene, Food Safety/Food Handling, Environmental Health

Personal Hygiene — Handwashing

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
60. Situations or times that children and staff should perform hand hygiene are posted in all food preparation, hand hygiene, diapering and toileting areas. (Std.3.2.2.1)	1	2	3	4		
NOTES						
61. Handwashing Procedures — <i>Staff</i> <ul style="list-style-type: none"> - Moisten hands with water and apply soap (not antibacterial). - Rub hands together into a soapy lather for 20 seconds. - All hand surfaces are washed including fronts and backs and between fingers from wrists to finger tips. - Hands are rinsed with running water and dried with a paper or single use cloth towel. (Std. 3.2.2.2)	1	2	3	4		
NOTES						
62. Handwashing Procedures — <i>Children</i> Children wash their hands or have their hands washed. <ul style="list-style-type: none"> - Moisten hands with water and apply soap (not antibacterial). - Rub hands together into a soapy lather for 10 to 20 seconds. - All hand surfaces are washed including fronts and backs and between fingers from wrists to finger tips. - Hands are rinsed with running water and dried with a paper or single use cloth towel. (Std. 3.2.2.2)	1	2	3	4		
NOTES						
63. Caregivers/Teachers help children wash their hands when children can stand but cannot wash their hands by themselves. Children's hands hang freely under the running water either at a child level sink or at a sink with a safety step. (Std. 3.2.2.3)	1	2	3	4		
NOTES						
64. Adults and children only use alcohol-based hand sanitizers as an alternative to handwashing with soap and water if hands are not visibly soiled. Hand sanitizers are only used for children over 24 months with adult supervision. (Stds. 3.2.2.2, 3.2.2.3)	1	2	3	4	NA	N Op
NOTES						

Personal Hygiene — Toothbrushing

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
65. When toothbrushes are present, they are not worn or frayed. Fluoride toothpaste is present. (Std. 3.1.5.1)	1	2	3	4	NA	
NOTES						
66. *Except in the case of children who are known to brush their teeth twice a day at home, caregivers/teachers brush children's teeth or monitor tooth brushing activities at least once during the hours that the child is in child care. (Std. 3.1.5.1)	1	2	3	4	NA	N Op
NOTES						

Food Safety/Food Handling

67. The food preparation area of the kitchen is separate from eating, play, laundry, toilet, bathroom and diapering areas. No animals are allowed in the food preparation area. (Std. 4.8.0.1)	1	2	3	4	NA	
NOTES						
68. The food preparation area is separated from child care areas by a door, gate, counter or room divider. (Std. 4.8.0.1)	1			4	NA	
NOTES						
69. There is no home-canned food or food in cans without labels. Food from dented, rusted, bulging or leaking cans is not used. (Std. 4.9.0.3)	1	2	3	4	NA	
NOTES						
70. Meat, fish, poultry, milk and egg products are refrigerated or frozen before use. Refrigerators have a thermometer and are kept at 41°F or lower. (Std. 4.9.0.3)	1	2	3	4	NA	
NOTES						
71. Meat product labels state they are from government-inspected sources and/or dairy product labels state that they are pasteurized. (Std. 4.9.0.3)	1	2	3	4	NA	N Op
NOTES						
72. All fruits and vegetables are washed thoroughly with water prior to use. (Std. 4.9.0.3)	1	2	3	4	NA	N Op
NOTES						
73. Store bought fruit juice labels state the juice is pasteurized. Fruit and vegetable juices squeezed on-site are squeezed just prior to serving. (Std. 4.9.0.3)	1	2	3	4	NA	
NOTES						
74. Food surfaces (for example, dishes, utensils, dining tables, high chair trays, cutting boards) and/or objects intended for the mouth (for example, pacifiers and teething toys) are sanitized. A dishwasher is used or an EPA registered sanitizer is used according to label instructions for sanitizing. (Std. 3.3.0.1)	1	2	3	4		
NOTES						

Environmental Health

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
75. Kitchen equipment is clean and in working order. Food surfaces are in good repair and free of cracks and crevices. Food surfaces are made of non-porous, smooth material and are kept clean and sanitized. (Std. 4.8.0.3)	1	2	3	4	NA	N Op
NOTES						
76. There are no cracks or holes in walls, ceilings, floors or screens. (Std. 5.2.8.1)	1	2	3	4		
NOTES						
77. There is no clutter, trash, water damage or standing water. Leaking pipes and pest breeding areas are not on site. (Std. 5.2.8.1)	1	2	3	4		
NOTES						
78. Objects and surfaces are kept clean of dirt, debris and sticky films. (Std. 3.3.0.1)	1	2	3	4		
NOTES						
79. Hard, non-porous surfaces soiled with potentially infectious body fluid (for example, toilets, diaper changing tables, blood spills) are disinfected. An EPA registered disinfectant is used according to label instructions. (Std. 3.3.0.1)	1	2	3	4		N Op
NOTES						
80. There are disposable gloves available for handling blood and blood containing body fluids. (Std. 3.2.3.4)	1			4		
NOTES						
81. *Infectious waste (for example soiled diapers, blood) and toxic waste (for example, used batteries, fluorescent light bulbs) are stored separately from other waste. (Std. 5.2.7.6 , 5.2.9.1)	1	2	3	4		N Op
NOTES						
82. Sanitizing and disinfecting are not done when children are nearby. (Std. 3.3.0.1)	1	2	3	4		N Op
NOTES						
83.*Pesticides are not applied when children are present. (Std. 5.2.8.1)	1	2	3	4		
NOTES						
84. *Toxic substances are stored in the original, labeled containers. Safety Data Sheets (SDS) are on site for each toxic substance/chemical. (Std. 5.2.9.1)	1	2	3	4	NA	N Op
NOTES						
85. *Toxic substances are inaccessible to children and in a locked room or cabinet. Bleach solutions are labeled with contents and date mixed. (Std. 5.2.9.1 , 5.2.8.1 , 3.2.3.4 , Appendix J)	1	2	3	4		
NOTES						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
NOTES						

POOLS, SPAS and HOT TUBS

Does this program have a pool, spa or hot tub or other water hazard?

Yes: If yes, complete the items below. No: If no, go to the Infants and Toddlers Section.

This facility has the following water hazards: (check all that apply)

Swimming Pool Hot Tub Stationary Wading Pool Pond Other_____

Developmental Levels		Child: Staff Ratios	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
Infants		1:1						
Toddlers		1:1						
Preschoolers		4:1						
School-age Children		6:1						

86. Ratios: Ages of children observed: (check all that apply)
 ≤12 months 13-36 mo 3 years 4 years 5 years 5+ years
 Location_____ Time of Day (hour/min): ____/____
 # of children ____ # of staff ____ child/staff ratio: ____:____ (Std. 1.1.1.5)

NOTES

87. All outdoor water hazards are enclosed with a fence at least 4-6 feet high that comes within 3½ inches from the ground. Exits and entrances around bodies of water have self-closing, positive latching gates or doors. The locking devices are a minimum of 55 inches from the ground or floor. (Stds. 6.1.0.6, 6.3.1.1)

NOTES

88. When not in use, in-ground and above-ground swimming pools, spas, hot tubs or wading pools are covered with a safety cover. The cover meets the ASTM International standards. (Std. 6.3.1.4)

NOTES

List and rate other federal, state, local and/or accreditation standards/regulations that may apply:

NOTES

INFANTS and TODDLERS: Personal Relationships, Diapering, Injury Prevention

Are there children under 36 months of age in this program?

Yes: If yes, complete the items below. No: If no, you have completed the Checklist.

Infants and Toddlers — Personal Relationships

89. Caregivers/Teachers smile, talk, touch, hold, sing and/or play with children during daily routines, such as diapering, feeding and eating. (Std. 2.1.2.1)	1	2	3	4		
NOTES						
90. Caregivers/Teachers comfort children who are upset. Caregivers/Teachers are aware of and respond to children's feelings. (Std. 2.1.2.1)	1	2	3	4		
NOTES						

Infants and Toddlers — Diapering

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
91. Caregivers/Teachers follow diaper changing procedures below: <ul style="list-style-type: none"> - Caregiver/Teacher has one hand on the child at all times. - Non-absorbent paper liner, large enough to cover the changing surface from the child's shoulders to beyond the child's feet, is used. - Clothing is removed or otherwise kept from contact with the contents of the diaper during the change. - Child is cleaned of stool and urine, front to back, with a fresh wipe for each swipe. - Soiled diapers are placed in a plastic-lined, covered, hands-free can. - If reusable cloth diapers are used, soiled diaper is put in a plastic bag or into a plastic-lined, hands-free covered can. - A fresh wipe is used to clean the hands of the caregiver and another fresh wipe to clean the hands of the child before putting on a new diaper and dressing the child. - The child's hands are washed according to the procedure in item #62 before returning the child to a supervised area. - Diaper changing surface is cleaned and disinfected with an EPA registered disinfectant after each diaper change. - Disinfectant is put away, out of children's reach. - Caregivers'/Teachers' hands are washed after diapering procedure is complete according to the procedure in item #61. (Std. 3.2.1.4, 3.2.3.4) 	1	2	3	4	NA	N Op
NOTES						
92. Current diaper changing procedures as listed in item #91 are posted in the diaper changing area(s). (Std. 3.2.1.4)	1	2	3	4	NA	N Op
NOTES						

Infants and/or Toddlers — Injury Prevention

93. Strings, cords, ribbons, ties and straps long enough to encircle a child's neck are out of children's reach. (Std. 3.4.6.1)	1	2	3	4		
NOTES						
94. The following are not within children's reach: small objects, toys, and toy parts that have a diameter less than 1¼ inch and a length between 1 inch and 2¼ inches; balls and toys with spherical, egg shaped, or elliptical parts that are smaller than 1¾ inches in diameter; toys with sharp points and edges; plastic bags; Styrofoam® objects; coins; rubber or latex balloons; safety pins; marbles; magnets; foam blocks, books, or objects; latex gloves; bulletin board tacks or glitter. (Std. 6.4.1.2)	1	2	3	4		
NOTES						
95. Securely installed guards (for example, gates) are at the top and bottom of each open stairway where infants and toddlers are in care. (Std. 5.1.5.4)	1	2	3	4	NA	
NOTES						
96. Children over 12 months of age who can feed themselves are actively supervised by a caregiver/teacher. The caregiver/teacher is within arm's reach of the child's high chair or feeding table or is seated at the same table. (Std. 4.5.0.6)	1	2	3	4	NA	
NOTES						
97. Foods that are choking hazards are not served to toddlers. Food for toddlers is served in pieces ½ inch or smaller. (Std. 4.5.0.10)	1	2	3	4	NA	
NOTES						

Infants and/or Toddlers — Injury Prevention — *Continued*

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
NOTES						

INFANTS ONLY: Activity, Sleep, Safety, Nutrition

Are there infants under 12 months of age in this program?

Yes: If yes, complete items below No: If no, you have completed the Checklist.

Infants Only — Activity, Sleep, Safety

98. Sunscreen is not applied to infants younger than six months. Infants younger than six months are not in direct sunlight. (Std. 3.4.5.1)	1	2	3	4	NA	N Op
NOTES						
99. Infants have supervised tummy time while awake at least once each day. (Std. 3.1.3.1)	1	2	3	4		N Op
NOTES						
100. Infants are not seated more than 15 minutes at a time except during meals. (Std. 3.1.3.1)	1	2	3	4		
NOTES						
101. All infants are placed to sleep on their backs, in a crib, on a firm mattress, with a tightly fitting sheet. Only one infant is placed in each crib. (Std. 3.1.4.1)	1	2	3	4		N Op
NOTES						
102. Soft or loose bedding and other objects are kept away from sleeping infants and are not in safe sleep environments (for example, not in cribs). This includes bumpers, pillows, positioners, blankets, quilts, bibs, diapers, flat sheets, sheepskins, toys and stuffed animals. One-piece blanket sleepers may be used for warmth. (Std. 3.1.4.1)	1	2	3	4		
NOTES						
103. The room temperature where infants sleep is comfortable for a lightly clothed adult. (Std. 3.1.4.1)	1			4		
NOTES						
104. Infants who fall asleep any place that is not a crib are moved and placed to sleep on their backs in a crib. Examples of places where infants may not be left to sleep are car seats, high chairs, swings, infant seats, beanbag chairs and futons. (Std. 3.1.4.1)	1			4		N Op
NOTES						
105. *Cribs meet the current guidelines approved by CPSC and ASTM International standards. Crib slats are spaced no more than 2 3/8 inches apart. The crib has a firm mattress that is fitted so that no more than two fingers can fit between the mattress and the crib side in the lowest position. Cribs with drop sides are not used. Cribs are placed away from window blinds or draperies. (Std. 5.4.5.2)	1	2	3	4	NA	
NOTES						
106. Infants mobile enough to potentially climb out of a crib sleep on cots or mats. (Std. 5.4.5.2)	1	2	3	4	NA	N Op
NOTES						

Infants Only — Nutrition

	Never	Sometimes	Usually	Always	Not Applicable	No Opportunity
107. Bottles or containers with mother's milk are labeled with the infant's full name, date and time the milk was expressed. Mother's milk is stored in the refrigerator or freezer. (Std. 4.3.1.3)	1	2	3	4	NA	
NOTES						
108. Bottles of formula prepared from powder or concentrate or ready-to-feed formula are labeled with the child's full name and the time and date of preparation. (Std. 4.3.1.5)	1	2	3	4	NA	
NOTES						
109. If caregivers/teachers warm bottles and infant foods, bottles are warmed under running warm tap water or by placing in a container of water no warmer than 120°F. Bottles and infant foods are not thawed or warmed in microwave ovens. The temperature of warmed milk does not exceed 98.6 F. (Stds. 4.3.1.3, 4.3.1.9)	1	2	3	4		
NOTES						
110. Infants are not fed solid foods sooner than four months of age (preferably six months of age). Introductory foods are single ingredient. (Std. 4.3.1.11)	1			4	NA	N Op
NOTES						
111. Infants who are learning to feed themselves are actively supervised by a caregiver/teacher. Infants are seated within arm's reach of caregiver/teacher at all times while being fed or eating. (Std. 4.5.0.6)	1	2	3	4		N Op
NOTES						
112. Foods that are choking hazards are not served to infants. Food for infants is served in pieces ¼ inch or smaller. (Std. 4.5.0.10)	1			4		N Op
NOTES						
List and rate other federal, state, local and/or accreditation standards/regulations that may apply:						
	1	2	3	4		N Op
NOTES						

Health and Safety Checklist for Early Care and Education Programs:

Based on *Caring for Our Children*
National Health and Safety Performance Standards

User Manual



*Developed by the California Childcare Health Program
Funded by the UCSF School of Nursing
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User Manual
Health and Safety Checklist for Early Care and Education Programs: Based on *Caring for Our Children*
National Health and Safety Performance Standards

This User Manual provides information about the development and use of the Health and Safety Checklist for Early Care and Education Programs: Based on *Caring for Our Children National Health and Safety Performance Standards* (CFOC) (referred to as the Checklist). The manual explains how to complete the Checklist and how to rate the items on the Checklist.

I. Background and Methodology of the Checklist

The Checklist uses CFOC standards from *Stepping Stones, 3rd Edition (SS3)*. It is a compilation of selected CFOC standards, which if followed, are most likely to prevent adverse outcomes for children/staff in early care and education (ECE) settings. CFOC standards are updated periodically and can be found on the National Resource Center website: nrckids.org

Of the 138 SS3 standards, 72 standards were determined to be observable. These 72 standards were used to establish the 112 items in the Checklist. Many of the items in the Checklist include several observable components of a standard. In addition, some standards are represented by more than one item.

For this Checklist, observable is defined as the following:

1. Requires interaction with the staff or director only to ask where to find an item or identify products. For example, ask permission to open first aid kits, cabinets, etc.
2. Able to observe when walking through a program over a two-hour period of time.
3. The standard/item can be seen and evaluated in an objective way.
4. Observation may include opening windows, taking measurements (for example, measuring the depth of an impact surface or height of equipment), smelling for odors and reading labels (for example, checking dates on medication labels).
5. Does not require checking records or documents, such as child immunizations, professional development records or written program policies.

The Checklist was designed to assess the key observable health and safety standards in ECE programs. The observer uses the Checklist to assess the space, equipment and function in a specific classroom and in overall facility. Anyone may use the Checklist to assess the health and safety of an ECE program, including Child Care Health Consultants, ECE Directors and Staff Members and Quality Improvement Coaches.

II. Organization of the Checklist

The Checklist includes 5 main sections: (1) Facilities, which includes Emergencies, Medications, Equipment and Furnishings, (2) Supervision, which includes Interaction and Physical Activity, Nutrition, (3) Sanitation, which includes Personal Hygiene, Food Safety/Food Handling, Environmental Health, (4) Pools, Spas, and Hot Tubs, and (5) Infants and Toddlers. The sections are broken down into subscales as follows.

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III. Equipment Needed to Complete the Checklist

Tape measure (at least 60 inches long)
 Rigid measuring stick to measure the depth of loose fill impact surfacing (at least 9 inches long)
 Refrigerator thermometer
 Stop watch or timer
 Clipboard and pen or electronic tablet
 No-Choke Testing Tube (optional)
 Fanny pack or back pack to carry equipment

IV. Planning Your Visit

1. The items are organized in an order to facilitate making observations and rating items as you walk through a facility.
2. For the following items noted by an asterisk, *7-13, *66, *81 *83, *84, *85, *105, you may need to ask the director or a staff member questions about the item (for example, where toxic substances are stored).
3. Inform the director that you will need to open cabinets, read labels, open windows and measure heights of equipment and depths of impact surfaces.
4. Bring your own equipment to complete the Checklist. Start your visit by putting the thermometer in the refrigerator as it takes at least one hour to accurately read the temperature (#70; Std. 4.9.0.3).

5. Pick a classroom to observe indoors and outdoors. When the children mix with other classes, observe the overall environment in the program and rate what you observe in the overall program.
6. Items #4, #6, #7 relate to the full program and not one classroom.

V. Rating Scale

The 112 items objectively describe key observable components of 72 CFOC3 standards. Each item is rated on the following scale:

1 = **Never**. None of the components of the item are met.

2 = **Sometimes**. Less than or 50% ($\leq 50\%$) of the components in the item are met.

3 = **Usually**. More than 50% ($>50\%$) but less than 100% of the components in the item are met.

4 = **Always**. Every component in the item is met (100%).

NA = The item is not applicable (N/A) to the classroom/program. Explain why it is rated N/A in the 'notes' section.

N Op = There was no opportunity (N Op) to observe this item. Explain why it is rated N Op in the 'notes' section.

When a rating area is shaded grey, the rating choice is not an option.

Notes:

After each item, there is a space for notes and/or comments. Use this space to document why the classroom/program does not meet 100% of the components of the item or why the item was not applicable or not observed. Also, write notes about issues needing follow-up or discussion with program staff.

At the end of each subscale, there is space to list and rate other federal, state, local and/or accreditation standards/regulations that may apply.

Citation:

The Checklist and User Manual were written by the UCSF California Childcare Health Program (CCHP) staff. The development and psychometrics of the Health and Safety Checklist are discussed in the article: Alkon, A, Rose, R, Wolff, M, Kotch, JB, Aronson, SS. Development of a health and safety checklist to assess key, observable national health and safety standards in early care and education programs. *Maternal and Child Health Journal*. 2016, 20(1):114-127.

The Checklist includes the national standards published in: American Academy of Pediatrics, American Public Health Association, & National Resource Center for Health and Safety in Child Care and Early Education. (2011). *Caring For Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs* (3rd ed.). American Academy of Pediatrics, American Public Health Association, National Resource Center, Elk Grove Village, IL; Washington, DC.

Item-By-Item Specifications

FACILITIES: Emergencies, Medications, Equipment and Furnishings

Emergencies

1. A sign-in/sign-out system tracks who (other than children) enters and exits the facility. It includes name, contact number, purpose of visit (for example, parent/guardian, vendor, guest, consultant) and time in and out. (Std. 9.2.4.7)

Note: If the sign-in/sign-out log is not easily visible, ask to see it. The sign-in/sign-out system is for all persons other than children entering and exiting the facility.

1 = There is no sign-in/sign-out system.

2 = There is a sign-in/sign-out system that meets $\leq 50\%$ of the components of the item. For example, the sign-in/sign-out system includes name and contact number, but not the relationship to facility nor the recorded time in and out.

3 = There is a sign-in/sign-out system that meets $> 50\%$ of the components of the item. For example, the sign-in/sign-out system includes name and contact number and the relationship to facility, but not the recorded time in and out.

4 = There is a sign-in/sign-out system that tracks who (other than children) enters and exits the facility. The system includes name, contact number, relationship to facility (for example, parent/guardian, vendor, guest, consultant) and recorded time in and out.

2. Phone numbers to report child abuse and neglect (Child Protective Services) are clearly posted where any adult can easily see them. (Std. 3.4.4.1)

1 = No phone numbers to report child abuse and neglect are posted.

2 = Phone numbers to report child abuse and neglect are available on site, but not posted.

3 = Phone numbers to report child abuse and neglect are posted but not easily seen.

4 = Phone numbers to report child abuse and neglect are clearly posted where any adult can easily see them.

3. Phone number for the Poison Center is posted where it can be seen in an emergency (for example, next to the phone). (Std. 5.2.9.1, 5.2.9.2)

Note: The National help line for the poison center is 1-800-222-1222. The number should be clearly visible to the rater and is either posted near the phones or in a convenient location.

1 = The Poison Control number is not posted where it can be seen in an emergency, and not available on-site.

2 = The Poison Control number is available on site but not posted.

3 = The Poison Control number is posted on site but not easily seen.

4 = The Poison Center number is posted and can be easily seen in an emergency.

4. Fire extinguishers are inspected annually. Check date on fire extinguisher tag. (Std. 5.1.1.3)

Note: Check that the center complies with state-approved or nationally recognized fire prevention code. Inspect all fire extinguishers in the facility for written documentation of annual inspections.

1 = There are no fire extinguishers. Or none of the fire extinguishers have a date of last inspection within one year.

2 = $\leq 50\%$ of the fire extinguishers have a date of last inspection within one year.

3 = $> 50\%$ of the fire extinguishers have a date of last inspection within one year.

4 = All of the fire extinguishers have a date of last inspection within one year.

5. Each building or structure has at least two unobstructed exits leading to an open space at the ground floor. (Std. 5.1.4.1)

Note: Assess each exit on each floor in the facility (above or below ground level) that is used for child care.

- 1 = There are no unobstructed exits leading to an open space at the ground level.*
- 2 = $\leq 50\%$ of the exits are unobstructed and lead to an open space at the ground level.*
- 3 = $> 50\%$ of the exits are unobstructed and lead to an open space at the ground level.*
- 4 = Every building or structure has two or more unobstructed exits leading to an open space at the ground floor.*

6. A Smoke detector system or alarm is in working order in each room or place where children spend time. (Std. 5.2.5.1)

- 1 = There are no working smoke detector systems in the facility.*
- 2 = $\leq 50\%$ of the rooms where children spend time have a working smoke detector system.*
- 3 = $> 50\%$ of the rooms where children spend time have a working smoke detector system*
- 4 = There is a working smoke detector system in each room or palce where children spend time.*

7. * Carbon monoxide detectors are outside of sleeping areas. (Std. 5.2.9.5)

Note: Carbon monoxide detectors may be found placed on the walls or ceiling and/or may be combined with smoke detectors. You may need to ask the director or a staff member about carbon monoxide detectors.

- 1 = There are no carbon monoxide detectors outside of sleeping areas.*
- 2 = Carbon monoxide detectors are present outside of $\leq 50\%$ of sleeping areas.*
- 3= Carbon monoxide detectors are present outside of $> 50\%$ of sleeping areas.*
- 4 = Carbon monoxide detectors are present outside of all sleeping areas.*
- NA = The center does not have any children that sleep or nap on site.*

8. *First aid supplies are well-stocked in each location where children spend time. (Std. 5.6.0.1)

Note: Ask where the first aid kit is kept. Examine the contents of the kit(s). Each kit must be fully equipped and the supplies should not be stored separately. The kit(s) must be in the location where children spend time and/or immediately accessible.

For the rater's reference the National Health and Safety Performance Standards recommend that the first aid kit contain at least these 23 supplies:

- a. Disposable nonporous, latex free or non-powdered latex gloves (latex-free recommended);
- b. Scissors;
- c. Tweezers;
- d. Non-glass, non-mercury thermometer;
- e. Bandage tape;
- f. Sterile gauze pads;
- g. Flexible roller gauze;
- h. Triangular bandages;
- i. Safety pins;
- j. Eye patch or dressing;
- k. Pen/pencil and note pad;
- l. Cold pack;

- m. Current American Academy of Pediatrics (AAP) standard first aid chart or equivalent first aid guide such as the AAP Pediatric First Aid For Caregivers and Teachers (PedFACTS) Manual;
- n. Coins for use in a pay phone and cell phone;
- o. Water (two liters of sterile water for cleaning wounds or eyes);
- p. Liquid soap to wash injury and hand sanitizer;
- q. Tissues;
- r. Wipes;
- s. Individually wrapped sanitary pads to contain bleeding of injuries;
- t. Adhesive strip bandages, plastic bags for cloths, gauze, and other materials used in handling blood;
- u. Flashlight;
- v. Whistle;
- w. Battery powered radio

1 = None of the supplies listed above are in the first aid kit.

2 = $\leq 50\%$ (less than or equal to 11) of the supplies are in the first aid kit.

3 = $> 50\%$ (12 or more) of the supplies are in the first aid kit.

4 = 100% (23) of all the supplies are in the first aid kit.

9. * First aid supplies are kept in a closed container, cabinet or drawer that is labeled. They are stored out of children's reach and within easy reach of staff. (Std. 5.6.0.1)

1 = None of the first aid supplies are kept in a closed container, cabinet or drawer that is labeled and inaccessible to children or there are no first aid supplies present at the facility.

2 = $\leq 50\%$ of the components in this item are met.

3 = $> 50\%$ of the components in this item are met.

4 = All first aid supplies are kept in a closed container, cabinet or drawer that is labeled and inaccessible to children.

10. * A well-stocked first aid kit is ready for staff to take along when they leave the facility with children (for example, when going on a walk, a field trip or to another location). (Std. 5.6.0.1)

Note: The first aid kit is used when children leave the facility for a walk or by vehicle to another location. The transportable first aid kit should include ALL items listed above (# 8) AND the following emergency information/items:

- a. List of children in attendance (organized by caregiver/teacher they are assigned to) and their emergency contact information (for example, parents/guardian/emergency contact with home, work, and cell phone numbers);
- b. Special care plans for children who have them;
- c. Emergency medications or supplies as specified in the special care plans;
- d. List of emergency contacts (for example, location information and phone numbers for the Poison Center, nearby hospitals or other emergency care clinics, and other community resource agencies);
- e. Maps;
- f. Written transportation policy and contingency plans.

1 = There is no transportable first aid kit available.

2 = There is a transportable first aid kit that is readily available with $\leq 50\%$ with the required first aid supplies.

3 = *There is a transportable first aid kit that is readily available with > 50% of the required first aid supplies.*

4 = *There is a transportable first aid kit that is readily available that has all of the required first aid supplies.*

NA = *Children do not go on walks, field trips or otherwise leave the facility with staff.*

Medications

Ask where medications are stored. If no medications are stored on site, mark "NA" for these items.

11. * Medications are stored in an organized fashion and are not expired. They are stored at the proper temperature, (for example, in the refrigerator or at room temperature according to instructions) out of children's reach and separated from food. (Std. 3.6.3.2)

Note: Adult belongings, such as purses and backpacks, are out of children's reach.

1 = *Medications are not organized and not stored at the proper temperature, out of children's reach and separated from food.*

2 = *≤ 50% of the components in this item are met.*

3 = *> 50% of the components in this item are met.*

4 = *All medications are organized and stored at the proper temperature, out of children's reach and separated from food.*

NA = *There are no medications stored on site.*

12. *Over-the-counter medications are in the original containers. They are labeled with the child's name. Clear written instructions from the child's health care provider are with the medication. (Std. 3.6.3.1, 3.6.3.2)

Note: Written instructions from the child's health care provider can be by note, email or fax.
Sunscreen, insect repellent and diaper cream only require parental consent.

1 = *Over-the-counter medications are not appropriately stored, labeled, and accompanied by instructions.*

2 = *≤ 50% (only one) of the components are met.*

3 = *> 50% (2 out of 3) of the components in this item are met.*

4 = *All over-the-counter medications are in the original containers, are appropriately labeled, and have clear written instructions from the child's health care provider.*

NA = *There are no over-the-counter medications stored on site.*

N Op = *There was no opportunity to observe over-the-counter medications.*

13. *Prescription medications are in their original, child resistant container, labeled with child's name, date filled, prescribing health care provider's name, pharmacy name and phone number, dosage, instructions and warnings. (Std. 3.6.3.1, 3.6.3.2)

1 = *Prescription medications are not in their original, child resistant container, labeled with child's name, date filled, prescribing health care provider's name, pharmacy name and phone number, dosage/instructions and warnings.*

2 = *≤ 50% (5 or less) of the components are met.*

3 = *> 50% (6 or more) of the components are met.*

4 = *All prescription medications are in their original, child resistant container, labeled with child's name, date filled, prescribing health care provider's name, pharmacy name and phone number, dosage, instructions and warnings.*

NA = *There are no prescription medications on site.*

N Op = *There was no opportunity to observe over-the-counter medications.*

Equipment and Furnishings - Indoors and Outdoors

14. There is fresh air provided by windows or a ventilation system. There are no odors or fumes (for example, mold, urine, excrement, air fresheners, chemicals, pesticides.) (Std. 5.2.1.1, 3.3.0.1, 5.2.8.1)

Note: The ventilation system must supply fresh outdoor air or clean the air by filtration. Fans that only move the air around do not meet this standard.

1 = Fresh air is not provided by windows or a ventilation system. There are odors or fumes.

2 = ≤50% of the child care areas have fresh air provided by windows or ventilation system and have no odors or fumes.

3 = >50% of the child care areas have fresh air provided by windows or ventilation system and have no odors or fumes.

4 = Fresh air is provided by windows or ventilation system and there are no odors or fumes.

15. Windows accessible to children open less than 4 inches or have window guards so that children cannot climb out. (Std. 5.1.3.2)

Note: Use a tape measure to measure openings of windows. Check the windows to see how far (<4 inches) they can be opened.

1 = All open windows are open more than 4 inches or don't have window guards.

2 = ≤50% of the open windows are open less than 4 inches or have window guards.

3 = >50% of the open windows are open less than 4 inches or have window guards.

4 = All open windows are open less than 4 inches or have window guards.

NA = None of the windows in the facility open.

16. There are no unvented gas or oil heaters or portable kerosene space heaters. (Std. 5.2.1.10)

1 = There are unvented gas or oil heaters or portable kerosene space heaters in the facility.

4 = There are no unvented gas or oil heaters or portable kerosene space heaters in the facility.

17. Gas cooking appliances are not used for heating purposes. Charcoal grills are not used indoors. (Std. 5.2.1.10)

Note: "Gas cooking appliances" include gas grills. Gas grills should never be used for heating purposes.

1 = Gas cooking appliances are used for heating purposes and/or charcoal grills are used indoors.

4 = Gas cooking appliances are not used for heating purposes and charcoal grills are not used indoors.

NA = There are no gas cooking appliances or charcoal grills on site.

18. Portable electric space heaters are not used with an extension cord and are not left on when unattended. They are placed on the floor at least three feet from curtains, papers, furniture, and/or any flammable object and are out of children's reach. (Std. 5.2.1.11)

1 = Portable space heaters are left on when unattended, are accessible to children, are used with an extension cord and are placed on the floor within three feet of flammable objects.

2 = ≤50% (1 or 2) of the components in this item are met.

3 = > 50% (3+) of the components in this item are met.

4 = Portable electric space heaters are not left on when unattended, are out of children's reach, are not used with an extension cord, and are placed on the floor at least three feet from curtains, papers, furniture, and any flammable object.

NA = There are no portable electric space heaters on site.

N Op = The facility has portable electrical space heaters but there was no opportunity to observe them being used.

19. All electrical outlets within children's reach are tamper resistant or have safety covers attached by a screw or other means that cannot be removed by a child. (Std. 5.2.4.2)

Note: Tamper resistant electrical outlets with an internal shutter mechanism or safety covers attached by screw are acceptable. Safety plugs are not acceptable.

1 = None of the electrical outlets accessible to children are tamper resistant or have safety covers attached by a screw or other means that cannot be removed by a child.

2 = $\leq 50\%$ of the electrical outlets accessible to children are tamper resistant or have safety covers that are attached by a screw or other means that cannot be removed by a child.

3 = $> 50\%$ of the electrical outlets accessible to children are tamper resistant or have safety covers that are attached by a screw or other means that cannot be removed by a child.

4 = All electrical outlets accessible to children are tamper resistant or have safety covers that are attached by a screw or other means that cannot be removed by a child.

NA= There are no electrical outlets within children's reach.

20. All cords from electrical devices or appliances are out of children's reach. (Std. 4.5.0.9, 5.2.4.4)

1 = No cords from electrical devices or appliances are out of children's reach.

2 = $\leq 50\%$ of the electrical cords from appliances are out of children's reach.

3 = $> 50\%$ of cords from electrical appliances are out of children's reach.

4 = All cords from electrical devices or appliances are out of children's reach.

21. There are no firearms, pellet or BB guns, darts, bows and arrows, cap pistols, stun guns, paint ball guns or objects manufactured for play as toy guns visible. (Std. 5.5.0.8)

1 = One or more of the devices listed in the item is/are visible.

4 = None of the devices is visible.

22. Plastic bags, matches, candles and lighters are stored out of children's reach. (Std. 5.5.0.7, 5.5.0.6)

1 = All of these objects are stored within children's reach.

2 = $\leq 50\%$ (1 or 2) of these objects (plastic bags, matches, candles and lighters) are stored out of children's reach.

3 = $> 50\%$ (3 to 4) of these objects (plastic bags, matches, candles and lighters) are stored out of children's reach.

4 = All 4 of the objects in this item are stored out of children's reach.

23. There are no latex balloons (inflated, underinflated or not inflated) or inflated objects that are treated as balloons (for example, inflated latex gloves) on site. (Std. 6.4.1.5, 6.4.1.2)

1 = Balloons or inflated objects that are treated as balloons are on site.

4 = There are no balloons or inflated objects that are treated as balloons are on site.

24. Bathtubs, buckets, diaper pails and other open containers of water are emptied immediately after use. (Std. 6.3.5.2)

Note: Water tables should be emptied immediately after use.

1 = No open water containers are emptied after use.

2 = $\leq 50\%$ of open water containers are emptied after use.

3 = $> 50\%$ of open water containers are emptied after use.

4 = All open water containers are emptied after use.

NA = There are no water containers on site.

25. Children do not play in areas where there is a body of water unless a caregiver/teacher is within an arm's length providing "touch supervision". Bodies of water include tubs, pails, sinks, toilets, swimming pools, ponds, irrigation ditches and built-in wading pools. (Std. 2.2.0.4)

Note: Small children can drown within thirty seconds, in as little as two inches of liquid.

1 = Children play in or around water without touch supervision.

4 = Touch supervision is provided for all children playing in or around water.

NA= Children do not play in or around water.

N Op =There are bodies of water on site, but there was no opportunity to observe them during this observation.

26. Hot liquids and food (more than 120°F) are kept out of children's reach. Adults do not consume hot liquids in child care areas. (Std. 4.5.0.9)

1 = Hot food and liquids are within children's reach, and adults consume hot liquids in child care areas.

2= Hot food and liquids are sometimes (<=50%) kept out of children's reach, and adults frequently consume hot liquids in child care areas.

3=Hot food and liquids are usually (>50%) kept out of children's reach, and adults usually do not consume hot liquids in child care areas.

4 = Hot liquids and foods are out of children's reach, and adults do not consume hot liquids in child care areas.

27. Equipment and play areas (including water play areas) do not have sharp points or corners, splinters, glass, protrusions that may catch a child's clothing (for example, nails, pipes, wood ends, long bolts), flaking paint, loose or rusty parts, small parts that may become detached or present a choking, aspiration, or ingestion hazard, strangulation hazards (for example, straps or strings), or components that can snag skin, pinch, or sheer or crush body tissues. (Std. 5.3.1.1, 6.2.1.9, 6.3.11)

1 = All equipment and/or play areas have hazards listed in this item.

2 = ≤ 50% of the equipment and/or play areas are free from the hazards listed in this item.

3 = > 50% of the equipment and/or play areas are free from the hazards listed in this item.

4 = All of the equipment and/or play areas are free from the hazards listed in this item.

28. All openings in play or other equipment are smaller than 3.5 inches or larger than 9 inches. There are no rings on long chains. (Std. 6.2.1.9, 5.3.1.1)

Note: This item is to prevent entrapment of children's heads and limbs or strangulation.

A tape measure is needed to complete this item.

1 = None of the openings on play equipment are sized to prevent entrapment of a child's head or limbs or strangulation.

2 ≤ 50% of the openings on play equipment are sized to prevent entrapment of a child's head or limbs or strangulation.

3 = > 50 % of the openings on play equipment are sized to prevent entrapment of a child's head or limbs or strangulation.

4 = All openings on play equipment are the correct size to prevent entrapment of a child's head or limbs or strangulation.

29. All openings in play or other equipment are smaller than 3/8 of an inch or larger than 1 inch. (Std. 6.2.1.9)

Note: This item is to prevent entrapment of a child's fingers. Use a tape measure to measure the openings to assess entrapment hazards.

- 1 = None of the openings on play equipment are smaller than 3/8 of an inch or larger than 1 inch.
 2 = ≤ 50% of the openings on play equipment are smaller than 3/8 of an inch or larger than 1 inch.
 3 = > 50% of the openings on play equipment are smaller than 3/8 of an inch or larger than 1 inch.
 4 = All openings on play equipment are smaller than 3/8 of an inch or larger than 1 inch.

30. Climbing equipment is placed over and surrounded by a shock-absorbing surface. Loose fill materials (for example, sand, wood chips) are raked to maintain proper depth/distribution. Unitary shock-absorbing surfaces meet current ASTM International standards and/or CPSC Standards.

www.astm.org/Standards/F2223.htm www.cpsc.gov/PageFiles/122149/325.pdf

CFOC3: Appendix Z

Inches	Loose fill material	Fall height (feet)
6	Shredded recycled rubber	10
9	Sand	4
9	Pea Gravel	5
9	Wood mulch (non CCA)	7
9	Wood chips	10

Note: Any equipment that a child can use to climb above ground level should be considered climbing equipment, whether it was manufactured for climbing or not. For example, play castles that children can climb on should be surrounded by a shock-absorbing surfacing. Shredded rubber loose fill surfacing does not compress in the same manner as other loose-fill materials.

However, care should be taken to maintain a constant depth as displacement may still occur.

- 1 = None of the climbing equipment is placed over and surrounded by a shock-absorbing surface as described.
 2 = ≤ 50% of the climbing equipment is placed over and surrounded by a shock-absorbing surface as described.
 3 = > 50% of the climbing equipment is placed over and surrounded by a shock-absorbing surface as described.
 4 = All climbing equipment is placed over and surrounded by a shock-absorbing surface as described.
 NA = There is no climbing equipment that requires shock-absorbing surfaces on site.
 N Op = There was no opportunity to observe climbing equipment.

31. Fall zones extend at least six feet beyond the perimeter of stationary climbing equipment. (Std. 6.2.3.1)

Note: Use a tape measure to measure fall zones both outdoors and indoors. Fall zones are the areas that surround equipment that children can use to get above ground level.

- 1 = No shock-absorbing surfaces extend six feet beyond the perimeter of stationary climbing equipment.
 2 = ≤ 50% of the shock-absorbing surfaces extend six feet beyond the perimeter of stationary climbing equipment.
 3 = > 50% of the shock-absorbing surfaces extend six feet beyond the perimeter of stationary climbing equipment.
 4 = All shock-absorbing surfaces extend six feet beyond the perimeter of stationary climbing equipment.
 NA = There is no stationary climbing equipment on the premises.
 N Op = There was no opportunity to observe fall zones.

32. Equipment and furnishings are sturdy and in good repair. There are no tip-over or tripping hazards. (Std. 5.3.1.1)

Note: Tripping hazards include objects on the floor, uneven pavement, protrusions or pieces of equipment that may cause a person to fall. Tip-over hazards include unsecured televisions, book shelves, chests of drawers and/or indoor or outdoor equipment that children can climb on, whether or not the equipment was intended to be used for climbing.

1 = No equipment is sturdy and in good repair, there are tip over or tripping hazards in child care areas.

2 = $\leq 50\%$ equipment and furnishings are sturdy and in good repair. $\leq 50\%$ of the child care areas have no tip-over or tripping hazards.

3 = $> 50\%$ equipment and furnishings are sturdy and in good repair. $> 50\%$ of the child care areas have no tip-over or tripping hazards.

4 = All equipment is sturdy and in good repair and there are no tip-over or tripping hazards.

33. There is no hazardous equipment (for example, broken equipment, lawn mowers, tools, tractors, trampolines) accessible to children. (Std. 5.7.0.4, 6.2.4.4)

1 = One or more types of hazardous equipment is accessible to children.

4 = Hazardous equipment is not present or is inaccessible to children by a non-hazardous barrier.

34. Open sides of stairs, ramps, porches, balconies and other walking surfaces, with more than 30 inches to fall, have guardrails or protective barriers. The guardrails are at least 36 inches high. (Std. 5.1.6.6)

Note: Use a tape measure to measure the height of the barriers. (For specific details of guardrails and protective barriers see Std. 5.1.6.6)

1 = No walking surfaces with more than 30 inches to fall have guardrails at least 36 inches high.

2 = $\leq 50\%$ of the walking surfaces with more than 30 inches to fall have guardrails at least 36 inches high.

3 = $> 50\%$ of the walking surfaces with more than 30 inches to fall have guardrails at least 36 inches high.

4 = All walking surfaces with more than 30 inches to fall have guardrails at least 36 inches high.

NA = There are no walking surfaces with over 30 inches vertical distance to fall.

35. Children one year of age and older wear helmets when riding toys with wheels (for example, tricycles, bikes) or using any wheeled equipment (for example, rollerblades, skateboards). Helmets fit properly and meet CPSC standards. Children take off helmets after riding or using wheeled toys or equipment. (Std. 6.4.2.2)

1 = None of the children (one year of age and older) riding wheeled toys wear and remove helmets when appropriate.

2 = $\leq 50\%$ of children (one year of age and older) riding wheeled toys wear and remove helmets when appropriate.

3 = $> 50\%$ of children (one year of age and older) riding wheeled toys wear and remove helmets when appropriate.

4 = All children (one year of age and older) riding wheeled toys wear and remove helmets when appropriate.

NA = There are no wheeled toys on the premises.

N Op = There was no opportunity to observe children riding wheeled toys.

Equipment and Furnishings - Outdoors Only

36. Children play outdoors each day. Children stay inside only if weather poses a health risk (for example, wind chill factor at or below minus 15°F, heat index at or above 90°F). (Std. 3.1.3.2)

1 = Children do not play outdoors when weather does not pose a health risk.

2 = ≤ 50% of the children play outdoors each day unless weather poses a health risk.

3 = > 50% of the children play outdoors each day unless weather poses a health risk.

4 = All children play outdoors each day unless weather poses a health risk.

N Op = There was no opportunity to observe children playing outdoors at the time of the visit.

37. Outdoor play areas are enclosed with a fence or natural barriers that allow caregivers/teachers to see children. Openings in fences and gates are no larger than 3.5 inches. (Std. 6.1.0.8)

1 = None of the outdoor play areas are enclosed with fences or natural barriers that allow for observation of children. Fences or natural barriers have openings in fences and gates larger than 3.5 inches.

2 = ≤ 50% of the outdoor play areas are enclosed with fences or natural barriers that allow for observation of children. ≤ 50% of the fences or natural barriers have openings no larger than 3.5 inches.

3 = > 50% of the outdoor play areas are enclosed with fences or natural barriers that allow for observation of children. > 50% of the fences or natural barriers have openings no larger than 3.5 inches.

4 = All outdoor fences or natural barriers allow for observation of children and openings in fences and gates are no larger than 3.5 inches.

NA=There are no outdoor play areas.

N Op = There was no opportunity to observe outdoor play areas.

38. Enclosures outside have at least two exits, one being remote from the building. (Std. 6.1.0.8)

1 = Enclosures outside have no exits.

2 = There is one exit outside and it is not remote from the building.

3 = There is one exit and it is remote from the building. OR There are two exits and neither is remote from the building.

4 = All enclosures have at least two exits and one is remote from the building.

NA=There are no outside enclosures.

N Op = There was no opportunity to observe outside enclosures.

39. Each gate has a latch that cannot be opened by children. Outdoor exit gates are equipped with self-closing, positive latching closure mechanisms that cannot be opened by children. (Std. 6.1.0.8)

1 = No outdoor gates have a latch that cannot be opened by children. No outdoor gates are equipped with self-closing, positive latching closure mechanisms.

2 = ≤ 50% of the outdoor gates have a latch that cannot be opened by children. ≤ 50% of the outdoor gates are equipped with self-closing, positive latching closure mechanisms.

3 = > 50% of the outdoor gates have a latch that cannot be opened by children. > 50% of the outdoor gates are equipped with self-closing, positive latching closure mechanisms.

4 = All outdoor gates have a latch that cannot be opened by children. All outdoor gates are equipped with self-closing, positive latching closure mechanisms.

NA= There are no outdoor gates.

N Op = There was no opportunity to observe outdoor gates.

40. Shade is provided outside (for example, trees, tarps, umbrellas). Children wear hats or caps with a brim to protect their faces from the sun if they are not in a shaded area. (Std. 3.4.5.1)

1 = None of the areas open to direct sun have shade and children do not wear protective hats or caps if they are not in a shaded area.

2 = $\leq 50\%$ of the areas open to direct sun have shade or $\leq 50\%$ of children wear protective hats or caps in the sun.

3 = $> 50\%$ of the areas open to direct sun have shade or $> 50\%$ of children wear protective hats or caps in the sun.

4 = All areas open to direct sun have shade or all children wear protective hats or caps in the sun.

NA = There are no areas accessible to children open to direct sun.

N Op = There was no opportunity to observe outdoor areas.

41. Broad spectrum sun screen with SPF of 15 or higher is available for use. (Std. 3.4.5.1)

Note: If sunscreen is not easily visible, ask to see it.

1 = Broad-spectrum sunscreen with SPF of 15 or higher is not available for use.

4 = Broad-spectrum sunscreen with SPF of 15 or higher is available for use.

SUPERVISION: Interaction, Physical Activity and Nutrition (Eating and Drinking)

42. Ratios: Indoors: Time (hour/min): ____/ ____ Ages of children observed:

(circle all that apply) ≤ 12 months, 13-35 mo., 3 years, 4 years, 5 years

of children ____ # of staff ____ child: staff ratio: ____:____ (Std. 1.1.1.2)

Note: At the end of the observation calculate the ratio and assign a rating. The recommended staff/child ratios for child care centers are listed in the table below from Std. 1.1.1.2. For details for recommended staff/child ratios in other settings such as Small Family Child Care Homes and Large Family Child Care Homes or other special circumstances see Standards: 1.1.1.1 – 1.1.1.5.

Age	Maximum Child: Staff Ratio	Maximum Group Size
≤ 12 months	3:1	6
13-35 months	4:1	8
3-year-olds	7:1	14
4-year-olds	8:1	16
5-year-olds	8:1	16

1 = The child: staff ratio does not meet the Standard.

4 = The child: staff ratio meets the Standard.

43. Ratios: Outdoors: Time (hour/min): ____/ ____ Ages of children observed:

(circle all that apply) ≤ 12 months, 13-35 mo., 3 years, 4 years, 5 years

of children ____ # of staff ____ child: staff ratio : ____:____ (Std. 1.1.1.2)

1 = The child: staff ratio does not meet the Standard.

4 = The child: staff ratio meets the Standard.

N Op = There was no opportunity to observe children outdoors.

44. Caregivers/teachers directly supervise children by sight and hearing at all times. This includes indoors, outdoors and when children are sleeping, going to sleep or waking up. (Std. 2.2.0.1)

1 = None of the observed children are supervised by sight and hearing at all times.

2 = $\leq 50\%$ of the observed children are supervised by sight and hearing at all times.

3 = $> 50\%$ of the observed children are supervised by sight and hearing at all times.

4 = All observed children are supervised by sight and hearing at all times.

45. Caregivers/Teachers encourage positive behavior and guide children to develop self-control.

Caregivers/Teachers model desired behavior. "Time out" is only used for persistent, unacceptable behavior. (Std. 2.2.0.6)

Note: The caregiver/teacher should tell the child what to do rather than what not to do and provide an example of the desired behavior. An example of an inappropriate "time out" is for a toddler who grabs a toy from another child. Instead of a "time out" the child needs to learn the words to ask for a toy or how to wait for a turn.

1 = Caregivers/Teachers do not encourage positive behavior, do not promote self-control and do not model desired behavior. They use "time out" when behaviors are not persistent or unacceptable.

2 = $\leq 50\%$ (1 to 2) of the behaviors (positive behavior, promote self-control, model desired behavior, not using "time outs" inappropriately) are observed.

3 = $> 50\%$ (3 to 4) of the behaviors (positive behavior, promote self-control, model desired behavior, not using "time outs" inappropriately) are observed.

4 = Caregivers/Teachers always encourage positive behavior, promote self-control, and model desired behavior. They only use "time out" for persistent, unacceptable behavior.

46. Caregivers/Teachers support children to learn appropriate social skills and emotional responses. There are daily routines and schedules. (Std. 2.2.0.6)

1 = Caregivers/Teachers do not support children to learn appropriate social skills and emotional responses. There are no daily routines or schedules.

2 = $\leq 50\%$ Caregivers/Teachers support children to learn appropriate social skills and emotional responses and have daily routines and schedules.

3 = $> 50\%$ Caregivers/Teachers support children to learn appropriate social skills and emotional responses and have daily routines and schedules.

4 = All Caregivers/Teachers support children to learn appropriate social skills and emotional responses. There are daily routines and schedules.

47. There is no physical or emotional abuse or maltreatment of a child. There is no physical punishment or threat of physical punishment of a child. (Std. 2.2.0.9)

1 = One child or more is observed being physically or emotionally abused, maltreated or threatened.

4 = None of the children are observed to be physically or emotionally abused, maltreated or threatened.

48. Caregivers/Teachers do not use threats or humiliation (public or private). There is no profane or sarcastic language. There are no derogatory remarks made about a child or a child's family. (Std. 2.2.0.9)

1 = All caregivers/teachers were observed using threats, humiliation, profane, sarcastic or derogatory language.

2 = $\leq 50\%$ of the caregivers/teachers observed do not use threats, humiliation, profane, sarcastic or derogatory language.

3 = $> 50\%$ of the caregivers/teachers observed do not use threats, humiliation, profane, sarcastic or derogatory language.

4 = Caregivers/Teachers do not use threats or humiliation (public or private). There is no profane or sarcastic language. There are no derogatory remarks made about a child or a child's family.

49. Children are not physically restrained unless their safety or that of others is at risk. (Std. 2.2.0.10)

1 = Children are observed being inappropriately physically restrained.

4 = No children are inappropriately physically restrained.

50. Physical activity/outdoor time are not taken away as punishment.

1 = Physical activity/outdoor time is observed being taken away as punishment for one or more children.

4 = Physical activity/outdoor time is not taken away as punishment for any child.

51. Children engage in moderate to vigorous physical activities such as running, climbing, dancing, skipping and jumping. All children (including infants) have opportunities to develop and practice gross motor and movement skills. (Std.3.1.3.1)

Note: Vigorous activity for infants includes movement of limbs, crawling, cruising, pulling-up.

1 = No children have opportunities to engage in moderate to vigorous activities.

2 = ≤ 50% of the children have opportunities to engage in moderate to vigorous activities.

3 = > 50% of the children have opportunities to engage in moderate to vigorous activities.

4 = All children have opportunities to engage in moderate to vigorous activities.

52. There are structured or adult-led physical activities and games that promote movement for children. (Std. 3.1.3.1)

1 = There are no structured activities or adult-led activities and games that promote movement for children.

2 = ≤ 50% of the time there are structured or adult-led activities and games that promote movement for the children

3 = > 50% of the time there are structured or adult-led activities and games that promote movement for the children

4 = There are always structured or adult-led physical activities and games that promote movement for the children.

NUTRITION: Eating and Drinking

53. Individual children's food allergies are posted where they can be seen in the classroom and wherever food is served. (Std. 4.2.0.10)

1 = Children's food allergies are not posted where they can be seen in the classroom and wherever food is served.

2 = Children's food allergies are not posted where they can be seen in the classroom and in ≤ 50% of places where food is served.

3 = Children's food allergies are posted in the classroom where they can be seen and in > 50% of places where food is served.

4 = Children's food allergies are posted where they can be seen in the classroom and wherever food is served.

NA = There are no children with food allergies on site, or food is not served on site.

54. Children two years of age and older are served skim or 1% milk. (Std. 4.9.0.3)

Note: Children between the ages of one and two years of age should be served whole milk unless there is a note from the child's health care provider that says the child should have reduced fat milk.

1 = None of the milk served to children two years of age and older is either skim or 1% milk.

2 = ≤ 50% of the children two years of age and older are served milk that is either skim or 1%.

3 = > 50% of the children two years of age and older are served milk that is skim or 1% milk.

4 = All of the children two years of age or older are served either skim or 1% milk.

NA = Milk is not served on site.

N Op = There was no opportunity to observe children ages two-years or older drinking beverages.

55. Drinking water is available, indoors and outdoors, throughout the day for children over six months of age. (Std. 4.2.0.6)

1 = Drinking water is not available indoors and outdoors throughout the day for children over six months of age.

2 = For $\leq 50\%$ of the time drinking water is available indoors and outdoors for children over six months of age.

3 = For $> 50\%$ of the time drinking water is available indoors and outdoors for children over six months of age.

4 = Drinking water is always available, in indoor and outdoor areas, throughout the day for children over six months of age.

56. A variety of nourishing foods is served at meals and snacks. Nourishing foods include fruits, vegetables, whole and enriched grains, protein and dairy. (Std. 4.2.0.3)

Note: All meals and snacks should meet the requirements of the USDA Child and Adult Care Food Program (CACFP). (For more details see related Stds: 4.2.0.4, 4.2.0.5)

1 = No nourishing foods, such as fruits, vegetables, whole and enriched grains, protein and dairy, are served at meals and snacks.

2 = $\leq 50\%$ of the foods served at meals and snacks are nourishing.

3 = $> 50\%$ of the foods served at meals and snacks are nourishing.

4 = A variety of nourishing foods is served at meals and snacks, including fruits, vegetables, whole and enriched grains, protein and dairy.

NA = There is no food served at the program.

N Op = There was no opportunity to observe food being served.

57. Foods that are choking hazards are not served to children under four years of age. This includes hot dogs and other meat sticks (whole or sliced into rounds), raw carrot rounds, whole grapes, hard candy, nuts, seeds, raw peas, hard pretzels, chips, peanuts, popcorn, rice cakes, marshmallows, spoonfuls of peanut butter or chunks of meat larger than can be swallowed whole. (Std. 4.5.0.10)

Note: This includes food brought from home in “bag lunches”.

1 = One or more foods offered to children under age four years of age are choking hazards.

4 = Children under four years of age are not offered foods that are choking hazards.

58. Children are always seated while eating. (Std. 4.5.0.10)

1 = None of the children are seated while eating.

2 = $\leq 50\%$ of the children are seated while eating.

3 = $> 50\%$ of the children are seated while eating.

4 = All children are seated while eating.

59. Food is not used or withheld as a bribe, reward or punishment. (Std.2.2.0.9)

1 = Food is used or withheld as a bribe, reward or punishment.

4 = Food is not used or withheld as a bribe, reward or punishment.

SANITATION: Personal Hygiene, Food Safety/Food Handling, Environmental Health

Personal Hygiene - Handwashing

60. Situations or times that children and staff should perform hand hygiene are posted in all food preparation, hand hygiene, diapering and toileting areas. (Std.3.2.2.1)

1 = Procedures for hand hygiene are not posted.

2 = Procedures for hand hygiene are posted in $\leq 50\%$ of the appropriate areas.

3 = Procedures for hand hygiene are posted in $> 50\%$ of the appropriate areas.

4 = Procedures for hand hygiene are posted in all appropriate areas.

61. Handwashing Procedures-Staff

- **Moisten hands with water and apply soap (not antibacterial).**
- **Rub hands together into a soapy lather for 20 seconds.**
- **All hand surfaces are washed including fronts and backs and between fingers from wrists to finger tips.**
- **Hands are rinsed with running water and dried with a paper or single use cloth towel. (Std. 3.2.2.2)**

Note: If soap is used from a dispenser, check the original container to assess if antibacterial is being used. See Standard 3.2.2.2 for more details about handwashing procedures.

1 = No staff members are observed following the handwashing procedures stated above.

2 = $\leq 50\%$ of the time, staff members are observed using the handwashing procedures as stated above or $\leq 50\%$ of the staff members are observed using the handwashing procedures as stated above.

3 = $> 50\%$ of the time, staff members are observed using the handwashing procedures as stated above or $> 50\%$ of the staff members are observed using the handwashing procedures as stated above.

4 = All staff members always demonstrate handwashing procedures as stated above.

62. Handwashing Procedures- Children

Children wash their hands or have their hands washed.

- **Moisten hands with water and apply soap (not antibacterial).**
- **Rub hands together into a soapy lather for 10 to 20 seconds.**
- **All hand surfaces are washed including fronts and backs and between fingers from wrists to finger tips.**
- **Hands are rinsed with running water and dried with a paper or single use cloth towel. (Std. 3.2.2.2)**

Note: If soap is used from a dispenser, check the original container to assess if antibacterial is being used.

1 = No children wash their hands according to the procedures stated above.

2 = $\leq 50\%$ of the time children are observed using the handwashing procedures as stated above or $\leq 50\%$ of the children are observed using the handwashing procedures as stated above.

3 = $> 50\%$ of the time children are observed using the handwashing procedures as stated above or $> 50\%$ of the children are observed using the handwashing procedures as stated above.

4 = All children always wash their hands according to the handwashing procedures stated above.

63. Caregivers/Teachers help children wash their hands when children can stand but cannot wash their hands by themselves. Children's hands hang freely under the running water either at a child level sink or at a sink with a safety step. (Std. 3.2.2.3)

1 = Children who can stand but cannot wash their hands by themselves are not assisted by a caregiver/teacher. Children do not use a child level sink or a safety step so their hands can hang freely.

2 = ≤ 50% of the children who can stand but cannot wash their hands by themselves are assisted by the caregiver/teacher. ≤ 50% use a child level sink or a safety step so their hands can hang freely.

3 = > 50% of the children who can stand but cannot wash their hands by themselves are assisted by the caregivers/teachers. > 50% use a child level sink or a safety step so their hands can hang freely.

4 = Children who can stand but cannot wash their hands by themselves are assisted by a caregiver/teacher. A child level sink or a safety step is used so children's hands can hang freely.

64. Adults and children only use alcohol-based hand sanitizers as an alternative to handwashing with soap and water, if hands are not visibly soiled. Hand sanitizers are only used by children over 24 months with adult supervision. (Stds. 3.2.2.2, 3.2.2.3)

1 = Alcohol-based hand sanitizers are used by adults and children as an alternative to handwashing with soap and water when hands are visibly soiled. Hand sanitizers are used for children under 24 months.

2 = ≤ 50% of the components in this item are met.

3 = > 50% of the components in this item are met.

4 = Alcohol-based hand sanitizers are used by adults and children as an alternative to handwashing if hands are not visibly soiled. Hand sanitizers are only used for children over 24 months with adult supervision.

NA = Alcohol-based hand sanitizers are not used on site.

N Op = Alcohol-based hand sanitizers were not observed being used.

Personal Hygiene - Toothbrushing

65. When toothbrushes are present, they are not worn or frayed. Fluoride toothpaste is present. (Std. 3.1.5.1)

1 = All of the toothbrushes are worn or frayed, and fluoride toothpaste is not present.

2 = ≤ 50% of the toothbrushes are not worn or frayed and/or fluoride toothpaste is not present.

3 = > 50% of the toothbrushes are not worn or frayed. Fluoride toothpaste is present.

4 = No toothbrushes are worn or frayed, and fluoride toothpaste is present.

NA = There are no toothbrushes on site.

66. *Except in the case of children who are known to brush their teeth twice a day at home, caregivers/teachers brush children's teeth or monitor toothbrushing activities at least once during the hours that the child is in child care. (Std. 3.1.5.1)

1 = Staff do not monitor or assist any of the children brushing their teeth.

2 = Staff monitor and/or assist ≤ 50% of children brushing their teeth.

3 = Staff monitor and/or assist > 50% of children brushing their teeth.

4 = Staff monitor and/or assist all children brushing their teeth.

NA = Children are known to brush their teeth twice a day at home.

N Op = Children were not observed brushing their teeth.

Food Safety/Food Handling

67. The food preparation area of the kitchen is separate from eating, play, laundry, toilet, bathroom and diapering areas. No animals are allowed in the food preparation area. (Std. 4.8.0.1)

1 = The food preparation area is not separate from eating, play, laundry, toilet, bathroom and diapering areas. Animals are allowed in the food preparation area.

2 = $\leq 50\%$ of the food preparation area is separate from eating, play, laundry, toilet, bathroom and diapering areas. Animals are not allowed in the food preparation area.

3 = $> 50\%$ of the food preparation area is separate from eating, play, laundry, toilet, bathroom and diapering areas. Animals are not allowed in the food preparation area.

4 = The food preparation area of the kitchen is separate from eating, play, laundry, toilet, bathroom and diapering areas. Animals are not allowed in the food preparation area.

NA = There is no food preparation area on site.

68. The food preparation area is separated from child care areas by a door, gate, counter or room divider. (Std. 4.8.0.1)

Note: This item does not apply to Family Child Care Homes where supervision may be an issue.

1 = The food preparation of the kitchen is not separated by a door, gate, counter or room divider.

4 = The food preparation area of the kitchen is separated by a door, gate, counter or room divider.

NA = Food is not prepared on site.

69. There is no home-canned food or food in cans without labels. Food from dented, rusted, bulging or leaking cans is not used. (Std. 4.9.0.3)

1 = Home canned food or food in cans without labels is present. Canned foods have dents, rust, leaks or bulges.

2 = $\leq 50\%$ of the cans have labels. Some of the canned foods have dents, rust, leaks or bulges. There is home canned food present.

3 = $> 50\%$ of the cans have labels. Only one of the canned foods has dents, rust, leaks or bulges. There is home canned food present.

4 = All of the canned foods are stored in labeled cans that are free from dents, rust, leaks or bulges. There is no home canned food present.

NA = There are no canned foods on-site.

70. Meat, fish, poultry, milk and egg products are refrigerated or frozen before use. Refrigerators have a thermometer and are kept at 41°F or lower. (Std. 4.9.0.3)

Note: Put your thermometer in the refrigerator at the beginning of your visit. Compare the reading on your thermometer with the thermometer in the refrigerator.

1 = Meat, fish, poultry, milk and egg products are either not refrigerated, or not kept frozen until immediately before use. Refrigerators do not have a thermometer or it reads higher than 41° F.

2 = $\leq 50\%$ of the meat, fish, poultry, milk and egg products is refrigerated or kept frozen until immediately before use. Refrigerators have a thermometer. Thermometer reads higher than 41° F.

3 = $> 50\%$ of the meat, fish, poultry, milk and egg products are refrigerated or kept frozen until immediately before use. Refrigerators have a thermometer. Thermometer reads 41° F or lower.

4 = Meat, fish, poultry, milk and egg products are refrigerated or frozen until immediately before use. Refrigerators have a thermometer and reads 41°F or lower.

NA = There is no food stored on site, or there is no refrigerated food on site.

71. Meat product labels state they are from government-inspected sources and/or dairy product labels state that they are pasteurized. (Std. 4.9.0.3)

1 = None of the meat or dairy products are labeled as specified in the item.

2 = ≤ 50% of the meat or dairy products are labeled as specified in the item.

3 = > 50% of the meat or dairy products are labeled as specified in the item.

4 = All meat and dairy are labeled as specified in the item.

NA = Food is not served on site.

N Op = There was no opportunity to observe meat and/or dairy products.

72. All fruits and vegetables are washed thoroughly with water prior to use. (Std. 4.9.0.3)

1 = No fruits and vegetables are washed thoroughly prior to use.

2 = ≤ 50% of fruits and vegetables are washed thoroughly prior to use.

3 = > 50% of fruits and vegetables are washed thoroughly prior to use.

4 = All fruits and vegetables are washed thoroughly prior to use.

NA = Food is not prepared on site.

N Op = Fruits and vegetables were not observed being prepared.

73. Store bought fruit juice labels state that juice is pasteurized. Fruit and vegetable juices squeezed on site are squeezed just prior to serving. (Std. 4.9.0.3)

1 = None of the store bought fruit juice has a label stating the juice is pasteurized, and fresh squeezed fruit and vegetable juices are not squeezed just prior to serving.

2 = ≤ 50% of the juice served to children either has a label stating the juice is pasteurized or was squeezed just prior to serving.

3 = > 50% of the juice served to children either has a label stating the juice is pasteurized or was squeezed just prior to serving.

4 = All juice served to children has a label stating the juice is pasteurized or was squeezed just prior to serving.

NA = Fruit and vegetable juice is not served.

74. Food surfaces (for example, dishes, utensils, dining tables, high chair trays, cutting boards) and/or objects intended for the mouth (for example, pacifiers, teething toys) are sanitized. A dishwasher is used or an EPA registered sanitizer is used according to label instructions for sanitizing. (Std. 3.3.0.1)

Note: Dishwashers must be used at the appropriate settings to sanitize.

1 = Food surfaces and objects intended for the mouth are not sanitized using a dishwasher or an EPA registered sanitizer.

2 = ≤ 50% of the food surfaces and objects intended for the mouth are sanitized in a dishwasher or by using an EPA registered sanitizer.

3 = > 50% of the food surfaces and objects intended for the mouth are sanitized in a dishwasher or by using an EPA registered sanitizer.

4 = Food surfaces and objects intended for the mouth are always sanitized in a dishwasher or by using an EPA registered sanitizer.

Environmental Health

75. Kitchen equipment is clean and in working order. Food surfaces are in good repair and free of cracks and crevices. Food surfaces are made of non-porous, smooth material and are kept clean and sanitized. (Std. 4.8.0.3)

Note: Sanitizing procedures reduce germs on inanimate surfaces to levels considered safe by public health codes or regulations. Only Environmental Protection Agency (EPA)-registered products that have an EPA registration number on the label, when used according to label instructions, can make public health claims that can be relied on for reducing or destroying germs.

1 = Kitchen equipment is not clean and operable. Food surfaces are not made of non-porous, smooth material and are not in good repair, clean or sanitized.

2 = $\leq 50\%$ of the components in this item are met.

3 = $> 50\%$ of the components in this item are met.

4 = All kitchen equipment are clean and operable. Food surfaces are made of smooth, non-porous material and are in good repair, clean and sanitized.

NA= Food is not prepared on site or there is no kitchen on site.

N Op = There was no opportunity to observe the kitchen and food surfaces.

76. There are no cracks or holes in walls, ceilings, floors or screens. (Std. 5.2.8.1)

1 = All walls, ceilings, floors and screens have cracks and holes.

2 = $\leq 50\%$ walls, ceilings, floors and screens are free of cracks and holes.

3 = $> 50\%$ of walls, ceilings, floors and screens are free of cracks and holes.

4 = All walls, ceilings, floors and screens are free of cracks and holes.

77. There is no clutter, trash, water damage, standing water. Leaking pipes and pest breeding areas are not on site. (Std. 5.2.8.1)

1= Clutter, trash, water damage, standing water, leaking pipes and pest breeding areas are observed.

2 = $\leq 50\%$ (1 to 3) of the components in this item are met. The 6 components are: no clutter, trash, water damage, standing water, leaking pipes, pest breeding areas are not on site.

3 = $> 50\%$ (4 or more) of the components in this item are met. For example, there is no clutter and trash, or water damage but there is standing water on the premises.

4 = There is no clutter or trash or water damage or standing water, or pest breeding areas on the premises.

78. Objects and surfaces are kept clean of dirt, debris and sticky films. (Std. 3.3.0.1)

1 = None of the objects and surfaces are kept clean.

2 = $\leq 50\%$ of objects and surfaces are kept clean.

3 = $> 50\%$ of objects and surfaces are kept clean.

4 = All of the objects and surfaces are kept clean.

79. Hard, non-porous surfaces soiled with potentially infectious body fluid (for example, toilets, diaper changing tables, blood spills) are disinfected. An EPA registered disinfectant is used according to label instructions. (Std.3.3.0.1)

Note: See Std. 3.2.3.4 for information on Standard Precautions.

1 = None of the hard, non-porous surfaces contaminated with potentially infectious body fluid are disinfected using an EPA registered disinfectant.

2 = ≤ 50% of the hard, non-porous surfaces contaminated with potentially infectious body fluid are disinfected using an EPA registered disinfectant.

3 = > 50% of the hard, non-porous surfaces contaminated with potentially infectious body fluid are disinfected using an EPA registered disinfectant.

4 = Hard, non-porous surfaces contaminated with potentially infectious body fluid are always disinfected using an EPA registered disinfectant.

N Op = There was no opportunity to observe disinfecting of non-porous surfaces with potentially infectious body fluids.

80. There are disposable gloves available for handling blood and blood containing body fluids. (Std. 3.2.3.4)

Note: Body fluids include urine, feces, blood, saliva, nasal discharge, eye discharge, injury and tissue discharges.

1 = Disposable gloves are not available for cleaning blood and bodily fluids.

4 = Disposable gloves are available for cleaning blood and bodily fluids.

81. * Infectious waste (for example soiled diapers, blood) and toxic waste (for example, used batteries, fluorescent light bulbs) are stored separately from other waste. (Std. 5.2.7.6, 5.2.9.1)

Note: Ask where the infectious and toxic waste is stored.

1 = Infectious and toxic waste is not stored separately from other waste.

2 = ≤ 50% of the infectious and toxic waste is stored separately from other waste.

3 = > 50% of the infectious and toxic waste is stored separately from other waste.

4 = Infectious and toxic waste is always stored separately from other waste.

N Op = There was no opportunity to observe infectious or toxic waste on the premises.

82. Sanitizing and disinfecting are not done when children are nearby. (3.3.0.1)

Note: Children should be in a supervised area away from areas where sanitizers and/or disinfecting products are used. For example, a caregiver/teacher should not be holding a child while disinfecting the diapering surface. Only EPA registered products, used according to label instructions, should be used to sanitize or disinfect.

1 = All children are nearby during sanitizing and disinfecting procedures.

2 = ≤ 50% of the children are not nearby during sanitizing and disinfecting procedures.

3 = > 50% of the children are not nearby during sanitizing and disinfecting procedures.

4 = All children are not nearby during sanitizing and disinfecting procedures.

N Op = There was no opportunity to observe sanitizing and disinfecting.

83. * Pesticides are not applied when children are present. (Std. 5.2.8.1)

Note: Ask about practices for pesticide use.

1 = Children are present when pesticides are applied.

2 = ≤ 50% of the time children are not present when pesticides are used.

3 = > 50% of the time children are not present when pesticides are used.

4 = Pesticides are never applied when children are present.

84. * Toxic substances are stored in the original, labeled containers. Safety Data Sheets (SDS) are on site for each toxic substance/chemical. (Std. 5.2.9.1)

1 = Toxic substances are not stored in the original labeled containers. SDS are not on site for each toxic substance/chemical on site.

2 = $\leq 50\%$ of the toxic substances are stored in the original, labeled containers and/or $\leq 50\%$ of the SDS sheets are present for each toxic substance/chemical on site.

3 = $> 50\%$ of the toxic substances are stored in the original, labeled containers and $> 50\%$ of the SDS sheets are present for each toxic substance/chemical on site.

4 = All toxic substances are stored in the original, labeled containers. SDS are on site for each toxic substance/chemical on site.

N/A = Toxic substances are not stored on site.

N Op = No opportunity to observe toxic substances or SDS.

85. * Toxic substances are inaccessible to children and in a locked room or cabinet. Bleach solutions are labeled with contents and date mixed. (Std. 5.2.9.1, 5.2.8.1, 3.2.3.4, Appendix J)

1 = Toxic substances are accessible to children and/or they are not kept in a locked cabinet or room. Bleach solutions do not have a label with contents and date mixed.

2 = $\leq 50\%$ of the 4 components in this item are met. Toxic substances are inaccessible to children and in a locked room or cabinet, bleach solutions are labeled with contents and date mixed.

3 = $> 50\%$ of the 4 components in this item are met.

4 = Toxic substances are inaccessible to children and in a locked room or cabinet. Bleach solutions are labeled with contents and date mixed.

POOLS, SPAS AND HOT TUBS

Does this program have a pool, spa or hot tub or other water hazard?

Yes: ☐ If yes, complete the items below.

No: ☐ If no, go to the Infants and Toddlers Section.

POOLS, SPAS AND HOT TUBS

This facility has the following water hazards: (circle all that apply)

Swimming Pool Hot Tub Stationary Wading Pool Pond Other _____

86. Ratios: Ages of children observed: (circle all that apply)

≤ 12 months, 13-36 mo, 3 years, 4 years, 5 years, 5+ years

Location _____ Time of Day (hour/min): ____/ ____

of children _____ # of staff _____ child: staff ratio: ____:____

(Std. 1.1.1.5)

Note: Ratios for water supervision are different than for other child care areas and activities. At the time of the observation document the time (hour/minute), location, and the number of children and staff present.

Developmental Levels	Child: Staff Ratios
Infants	1:1
Toddlers	1:1
Preschoolers	4:1
School-age Children	6:1

1 = Child: staff ratio standard is not met.

4 = Child: staff ratio standard is met.

N Op= There was no opportunity to observe children in or around a water hazard.

87. All outdoor water hazards are enclosed with a fence at least 4-6 feet high that comes within 3½ inches from the ground. Exits and entrances around bodies of water have self-closing, positive latching gates or doors. The locking devices are a minimum of 55 inches from the ground or floor. (Std. 6.1.0.6, 6.3.1.1)

Note: Use a tape measure to measure the height of the locking devices. If bodies of water are present in outside play areas, check enclosure entry/exit points and measure the height.

1 = Outdoor water hazards are not enclosed with a fence at least 4-6 feet high that comes within 3 ½ inches from the ground. The exit and entrance points around bodies of water do not have self-closing, positive latching gates or doors with locking devices that are a minimum of 55 inches from the ground or floor.

2 = ≤ 50% of the components in this item are met.

3 = > 50% of the components in this item are met.

4 = All outdoor water hazards are enclosed with a fence at least 4-6 feet high that comes within 3 ½ inches from the ground. The exit and entrance points around bodies of water have self-closing, positive latching gates or doors with locking devices that are a minimum of 55 inches from the ground or floor.

N Op = There was no opportunity to observe water hazards.

88. When not in use, in-ground and above-ground swimming pools, spas, hot tubs or wading pools are covered with a safety cover. The cover meets the ASTM International standards. (Std. 6.3.1.4)

Note: The ASTM standard defines a safety cover “as a barrier (intended to be completely removed before water use) for swimming pools, spas, hot tubs, or wading pools. The cover should have an anchoring mechanism and be used according to manufacturer instructions.” See ASTM standard F1346-03.

1 = Swimming pools, spas, hot tubs or wading pools are not covered when not in use.

4 = Swimming pools, spas, hot tubs or wading pools are all correctly covered when not in use.

NA = There are no swimming pools, spas, hot tubs or wading pools on site OR the bodies of water are in use.

N Op = There was no opportunity to observe the swimming pool, spas, hot tubs or wading pools when not in use.

INFANTS AND TODDLERS: Personal Relationships, Diapering, Injury Prevention

Are there children under 36 months of age in this program?

Yes: ☐ If yes, complete the items below.

No: ☐ If no, you have completed the Checklist.

Infants and Toddlers - Personal Relationships

89. Caregivers/Teachers smile, talk, touch, hold, sing and/or play with children during daily routines, such as diapering, feeding and eating. (Std. 2.1.2.1)

1 = Caregivers/Teachers do not interact (talk, smile, touch, hold, sing and/or play) with children during daily routines such as diapering, feeding and eating.

2 = ≤ 50% of the time caregivers/teachers interact with infants/toddlers during daily routine activities.

3 = > 50% of the time caregivers/teachers interact with infants/toddlers during daily routine activities.

4 = Caregivers/Teachers always interact with infants and toddlers during daily routine activities.

90. Caregivers/Teachers comfort children who are upset. Caregivers/Teachers are aware of and responsive to children's feelings. (Std. 2.1.2.1)

1 = Caregivers/Teachers do not comfort children who are upset and are not aware of and responsive to children's feelings.

2 = $\leq 50\%$ of the time caregivers/teachers comfort children who are upset and are aware of and responsive to children's feelings .

3 = $> 50\%$ of the time caregivers/teachers comfort children who are upset and are aware of and responsive to children's feelings.

4 = Caregivers/Teachers always comfort children who are upset and are aware of and responsive to children's feelings.

Infants and Toddlers – Diapering

91. Caregivers/Teachers follow diaper changing procedures below:

- Caregiver/Teacher has one hand on the child at all times.
- Non-absorbent paper liner, large enough to cover the changing surface from the child's shoulders to beyond the child's feet, is used.
- Clothing is removed or otherwise kept from contact with the contents of the diaper during the change.
- Child is cleaned of stool and urine, front to back, with a fresh wipe for each swipe.
- Soiled diapers are placed in a plastic-lined, covered, hands-free can.
- If reusable cloth diapers are used, soiled diaper is put in a plastic bag or into a plastic-lined, hands-free covered can.
- A fresh wipe is used to clean the hands of the caregiver and another fresh wipe to clean the hands of the child before putting on a new diaper and dressing the child.
- The child's hands are washed according to the procedure in item #62 before returning the child to a supervised area.
- Diaper changing surface is cleaned and disinfected with an EPA registered disinfectant after each diaper change.
- Disinfectant is put away, out of children's reach.
- Caregivers'/Teachers' hands are washed after diapering procedure is complete according to the procedure in item #61. (Stds. 3.2.1.4, 3.2.3.4)

1 = The 11 diaper changing procedures above are not followed for any diaper changes.

2 = The diaper changing procedures are followed in $\leq 50\%$ of the diaper changes or $\leq 50\%$ of the 11 procedures are followed.

3 = The diaper changing procedures are followed in $> 50\%$ of the diaper changes or $> 50\%$ of the 11 procedures are followed.

4 = All of the 11 diaper changing procedures are followed for every diaper change.

NA = There are no children requiring diaper changing on site.

N Op = There was no opportunity to observe diaper changing.

92. Current diaper changing procedures, as listed in item #91, are posted in the diaper changing area(s). (Std. 3.2.1.4)

1 = Diaper changing procedures are not posted in any diaper changing areas.

2 = Diaper changing procedures are posted in $\leq 50\%$ of the diaper changing areas or five or fewer diaper changing procedures are posted.

3 = Diaper changing procedures are posted in $> 50\%$ of the diaper changing areas or six or more of the diaper changing procedures are posted.

4 = The 11 diaper changing procedures are posted in all diaper changing areas.

NA = There are no diaper changing areas on site.

N Op = There was no opportunity to observe the diaper changing area/s.

Infants and Toddlers - Injury Prevention

93. Strings, cords, ribbons, ties and straps long enough to encircle a child's neck are out of children's reach. (Std.3.4.6.1)

1 = Strings, cords, ribbons, ties and straps long enough to encircle a child's neck are accessible to all children under 3 years of age.

2 = $\leq 50\%$ of the time strings, cords, ribbons, ties and straps long enough to encircle a child's neck are not accessible to children under 3 years of age.

3 = $> 50\%$ of the time strings, cords, ribbons, ties and straps long enough to encircle a child's neck are not accessible to children under 3 years of age.

4 = Strings, cords, ribbons, ties and straps long enough to encircle a child's neck are never accessible to any children under 3 years of age.

94. The following are out of children's reach: small objects, toys, and toy parts that have a diameter less than $1\frac{1}{4}$ inch and a length between 1 inch and $2\frac{1}{4}$ inches; balls and toys with spherical, egg shaped, or elliptical parts that are smaller than $1\frac{1}{4}$ inches in diameter; toys with sharp points and edges; plastic bags; Styrofoam® objects; coins; rubber or latex balloons; safety pins; marbles; magnets; foam blocks, books, or objects; latex gloves; bulletin board tacks or glitter. (Std. 6.4.1.2)

1 = The objects listed in the item are accessible to children under three years of age.

2 = $\leq 50\%$ of the objects listed in the item are not accessible to children under three years of age.

3 = $> 50\%$ of the objects listed in the item are not accessible to children under three years of age.

4 = None of the objects listed in the item are not accessible to children under three years of age.

95. Securely installed guards (for example, gates) are at the top and bottom of each open stairway where infants and toddlers are in care. (Std. 5.1.5.4)

1 = None of the stairways have security guards installed at both the top and bottom of the stairs.

2 = $\leq 50\%$ of the stairways have security guards installed at both the top and bottom of the stairs.

3 = $> 50\%$ of the stairways have security guards installed at both the top and bottom of the stairs.

4 = All stairways have security guards installed at both the top and bottom of the stairs.

NA = There are no stairs in the facility.

96. Children over 12 months of age who can feed themselves are actively supervised by a caregiver/teacher. The caregiver/teacher is within arm's reach of the child's high chair or feeding table or is seated at the same table. (Std. 4.5.0.6)

1 = No toddlers over age 12 months are actively supervised by a caregiver/teacher and are not within arm's reach of a caregiver/teacher while feeding themselves.

2 = \leq 50% of the toddlers are actively supervised and within arm's reach of a caregiver/teacher while feeding themselves.

3 = $>$ 50% of the toddlers are actively supervised and within arm's reach of a caregiver/teacher while feeding themselves.

4 = All toddlers over age 12 months are actively supervised by a caregiver/teacher and are within arm's reach while feeding themselves.

NA = There are no children over 12 months of age. There are only infants younger than 12 months of age.

97. Foods that are choking hazards are not served to toddlers. Food for toddlers is served in pieces $\frac{1}{2}$ inch or smaller. (Std. 4.5.0.10)

1 = Foods that are choking hazards are served to toddlers. Food for toddlers is served in pieces larger than $\frac{1}{2}$ inch.

2 = \leq 50% of the foods served to toddlers are not choking hazards (served in pieces $\frac{1}{2}$ inch or smaller).

3 = $>$ 50% of the foods served to toddlers are not choking hazards (served in pieces $\frac{1}{2}$ inch or smaller).

4 = Foods that are choking hazards are never served to toddlers. Food for toddlers is served in pieces $\frac{1}{2}$ inch or smaller.

NA = There are no toddlers in the classroom.

INFANTS: Are there infants under 12 months of age in this program?

Yes: ☐ If yes, complete the items below.

No: ☐ If no, you have completed the Checklist.

Infants – Activity, Sleep, Safety

98. Sunscreen is not applied to infants younger than six months. Infants younger than six months are not in direct sunlight. (3.4.5.1)

1 = All of the infants younger than six months were observed in direct sunlight and/or had sunscreen applied.

2 = \leq 50% of the infants younger than six months are not in direct sunlight and/or don't have sunscreen applied.

3 = $>$ 50% of the infants younger than six months are not in direct sunlight and/or don't have sunscreen applied.

4 = No infants younger than six months are in direct sunlight or have sunscreen applied.

NA = There are no infants younger than six months on site.

N Op = There was no opportunity to observe infants younger than six months outside.

99. Infants have supervised tummy time while awake at least once each day. (Std. 3.1.3.1)

Note: It should be possible to observe an infant having tummy time during a two hour Checklist visit.

1 = None of the infants have supervised tummy time while awake at least once per day.

2 = \leq 50% of the infants have supervised tummy time while awake at least once per day.

3 = $>$ 50% of the infants have supervised tummy time while awake at least once per day.

4 = All infants have supervised tummy time while awake at least once per day.

N Op = There was no opportunity to observe Infants having tummy time during this visit.

100. Infants are not seated more than 15 minutes at a time except during meals. (Std. 3.1.3.1)

Note: Record of the number of minutes infants are seated except during meals.

1 = All the infants are seated more than 15 minutes at a time, excluding meals.

2 = \leq 50% of the infants are not seated for more than 15 minutes at a time, excluding meals

3 = $>$ 50% of the infants are not seated for more than 15 minutes at a time, excluding meals

4 = No infants are seated for more than 15 minutes at a time except during meals.

101. All infants are placed to sleep on their backs, in a crib, on a firm mattress, with a tightly fitting sheet. Only one infant is placed in each crib. (Std. 3.1.4.1)

Note: Bedding should be changed between infants when crib assignments change.

1 = No infants up to 12 months of age are placed to sleep on their backs, on a firm mattress, with a tightly fitting sheet and there is more than one infant in a crib.

2 = \leq 50% of the components in this item are met.

3 = $>$ 50% of the components in this item are met.

4 = All infants up to 12 months of age are placed to sleep on their backs, on a firm mattress, with a tightly fitting sheet. Only one infant is placed in each crib.

N Op = Infants were not observed sleeping.

102. Soft or loose bedding and other objects are kept away from sleeping infants and are not in safe sleep environments (for example, not in cribs). This includes bumpers, pillows, positioners, blankets, quilts, bibs, diapers, flat sheets, sheepskins, toys and stuffed animals. One-piece blanket sleepers may be used for warmth. (Std. 3.1.4.1)

Note: This item is assessing sleep environments by observing the cribs; infants do not have to be in the crib to complete this item. *Swaddling is not recommended.*

1 = All cribs have soft or loose bedding or objects including bumpers, pillows, positioners, blankets, quilts, diapers, flat sheets, sheepskins, toys or stuffed animals.

2 = \leq 50% of the cribs have no soft or loose bedding or objects including bumpers, pillows, positioners, blankets, quilts, diapers, flat sheets, sheepskins, toys and stuffed animals.

3 = $>$ 50%, of the cribs have no loose bedding or objects including bumpers, pillows, positioners, blankets, quilts, diapers, flat sheets, sheepskins, toys and stuffed animals.

4 = No soft or loose bedding or objects are in cribs including bumpers, pillows, positioners, blankets, quilts, diapers, flat sheets, sheepskins, toys and stuffed animals.

103. Room temperature where infants sleep is comfortable for a lightly clothed adult. (Std. 3.1.4.1)

Note: Sleeping infants should not be overheated or sweaty.

1 = The room temperature is not comfortable.

4 = The room temperature is comfortable (not too hot or too cold).

104. Infants who fall asleep any place that is not a crib are moved and placed to sleep on their backs in a crib. Examples of places where infants may not be left to sleep are car seats, high chairs, swings, infant seats, beanbag chairs and futons. (Std. 3.1.4.1)

1 = None of the children who fall asleep in an unsafe environment are moved to sleep on their backs in a crib.

4 = All children who fall asleep in an unsafe environment are moved to sleep on their backs in a crib.

N Op=No infants observed falling asleep in any place other than a crib.

105. * Cribs meet the current guidelines approved by CPSC and ASTM International standards. Crib slats are spaced no more than 2 3/8 inches apart. The crib has a firm mattress that is fitted so that no more than two fingers can fit between the mattress and the crib side in the lowest position. Cribs with drop sides are not used. Cribs are placed away from window blinds or draperies. (Std. 5.4.5.2)

Note: Ask for paper work that demonstrates that all the cribs meet the current CPSC guidelines. CPSC Standards for cribs: <http://www.cpsc.gov/en/Safety-Education/Safety-Education-Centers/cribs/>

1 = None of the cribs meet current guidelines.

2 = ≤ 50% of the cribs meet current guidelines.

3 = > 50% of the cribs meet current guidelines.

4 = All cribs meet current guidelines.

NA = There are no cribs on-site.

106. Infants mobile enough to potentially climb out of a crib sleep on cots or mats. (Std. 5.4.5.2)

Note: If infants are observed sleeping on cots or mats, ask about their mobility.

1 = None of the infants that can potentially climb out of a crib are placed to sleep on a cot or mat.

2 = ≤ 50% of the infants that can potentially climb out of a crib are placed to sleep on a cot or mat.

3 = > 50% of the infants that can potentially climb out of a crib are placed to sleep on a cot or mat.

4 = All infants that can potentially climb out of a crib are placed to sleep on a cot or mat.

NA = There are no infants that can potentially climb out of a crib.

N Op = There was no opportunity to observe the mobility of infants.

Infant - Nutrition

107. Bottles or containers with mother's milk are labeled with the infant's full name, date and time the milk was expressed. Mother's milk is stored in the refrigerator or freezer. (Std. 4.3.1.3)

1 = Bottles or containers with mother's milk are not labeled with infant's full name, date and time the milk was expressed. Mother's milk is not stored in the refrigerator or freezer.

2 = ≤ 50% of the components in this item are met.

3 = > 50% of the components in this item are met.

4 = Bottles or containers with mother's milk are labeled with infant's full name, date and time the milk was expressed. Mother's milk is stored in the refrigerator or freezer.

NA= There are no bottles or containers of mother's milk on-site.

108. Bottles of formula prepared from powder or concentrate or ready-to-feed formula are labeled with the child's full name and the time and date of preparation. (Std. 4.3.1.5)

1 = Bottles of formula prepared from powder or concentrate or ready-to-feed formula are not labeled with the child's full name and the time and date of preparation.

2 = ≤ 50% of the components in this item are met.

3 = > 50% of the components in this item are met.

4 = All bottles of formula prepared from powder or concentrate or ready-to-feed formula are labeled with the child's full name and the time and date of preparation.

NA = There are no bottles of formula on-site.

109. If caregivers/teachers warm bottles and infant foods, bottles are warmed under running warm tap water or by placing in a container of water no warmer than 120°F. Bottles and infant foods are not thawed or warmed in microwave ovens. The temperature of warmed milk does not exceed 98.6 F. (Std. 4.3.1.3, 4.3.1.9)

Note: Warmed milk should not feel hot to touch.

1 = If bottles are warmed, they are not warmed under running warm tap water or they are placed in a container of water that is warmer than 120° F. Bottles and infant foods are thawed or warmed in microwaves. The temperature of warmed milk exceeds 98.6 F.

2 = ≤ 50% of the components in this item are met.

3 = > 50% of the components in this item are met.

4 = If bottles are warmed, they are warmed under running warm tap water or by placing in a container of water no warmer than 120° F. Bottles and infant foods are not thawed or warmed in microwaves. The temperature of warmed milk does not exceed 98.6 F.

110. Infants are not fed solid foods sooner than four of age months (preferably six months).

Introductory foods are single ingredient. (Std. 4.3.1.11)

1 = All of the infants younger than four months of age are fed solid foods. Introductory foods have more than one ingredient.

4 = Infants younger than four months of age are not fed solid foods. Introductory foods are single ingredient.

NA = There are no infants younger than four months of age.

N Op = Infants were not observed eating solid foods.

111. Infants who are learning to feed themselves are actively supervised by a caregiver/teacher.

Infants are seated within arm's reach of caregiver/teacher at all times while being fed or eating. (Std. 4.5.0.6)

1 = Infants who are learning to feed themselves are not actively supervised by a caregiver/teacher. Infants are not seated within arm's reach of caregiver/teacher at all times while being fed or eating.

2 = ≤ 50% of infants who are learning to feed themselves are not actively supervised by a caregiver/teacher and ≤ 50% of the infants are not seated within arm's reach of caregiver/teacher at all times while being fed or eating.

3 = > 50% if the infants who are learning to feed themselves are actively supervised by a caregiver/teacher and >50% of the infants are seated within arm's reach of caregiver/teacher at all times while being fed or eating

4 = All infants who are learning to feed themselves are actively supervised by a caregiver/teacher. Infants are seated within arm's reach of caregiver/teacher at all times while being fed or eating.

N Op = Infants were not observed feeding themselves or being fed.

112. Foods that are choking hazards are not served to infants. Food for infants is served in pieces ¼ inch or smaller (Std. 4.5.0.10)

1 = Foods that are choking hazards are served to infants. Food for infants is served in pieces larger than ¼ inch.

4 = Foods that are choking hazards are not served to infants. All foods for infants are served in pieces ¼ inch or smaller.

N Op = Infants were not observed eating solid food.



Health and Safety Checklist Summary: Section and Subscales

Early Care and Education Site _____

Assessment Completed by: _____ Date: ____/____/____

Section 1: Facilities: Emergencies, Medications, Equipment and Furnishings			
Subscale	# Items Met National Standards	# Items Did Not Meet National Standards	Action Steps
Emergencies			
Medications			
Equipment and Furnishings – Indoors and Outdoors			
Equipment and Furnishings – Outdoors Only			
Section 2: Supervision, Interaction, and Activity			
Subscale	# Items Met National Standards	# Items Did Not Meet National Standards	Action Steps
Interaction and Physical Activity			
Nutrition: Eating and Drinking			
Section 3: Sanitation: Personal Hygiene, Environmental Health			
Subscale	# Items Met National Standards	# Items Did Not Meet National Standards	Action Steps
Personal Hygiene - Handwashing			
Personal Hygiene - Toothbrushing			
Food Safety/ Food Handling			
Environmental Health			

Section 4: Pools, Spas, and Hot Tubs			
Subscale	# Items Met National Standards	# Items Did Not Meet National Standards	Action Steps
Pools, Spas, and Hot Tubs			
Section 5: Infants and Toddlers			
Subscale	# Items Met National Standardss	# Items Did Not Meet National Standards	Action Steps
Infants and Toddlers: Personal Relationships			
Infants and Toddlers: Diapering			
Infants and Toddlers: Injury Prevention			
Infants Only: Activity, Sleep, Safety			
Infants Only: Nutrition			
Overall Health and Safety Score	Total # Items Met National Standards (Sum)	Total # Items Did Not Meet National Standards (Sum)	Overall Action
Notes and Recommendations (Short and Long Term Goals): 			
Date of Next Review: 			



NATIONAL CENTER ON

Early Childhood Health and Wellness

KEEPING CHILDREN SAFE IN VEHICLES

A Guide for Families and Caregivers



WHY IT'S IMPORTANT

- Motor vehicle injuries are a leading cause of death among children in the United States ([Centers for Disease Control and Prevention](#) [CDC], WISQARS, 2016).
- Most of these deaths occur when children are passengers in a motor vehicle ([Insurance Institute for Highway Safety](#), [IIHS] 2016).
- Many child deaths and serious injuries could be prevented through the proper use of car seats, booster seats, and seat belts, also known as a child passenger restraint system.
- Using a car seat reduces the risk of death in passenger vehicles by 71% for infants younger than age 1 and by 54% for toddlers ages 1–4 (Durbin, [Technical Report-Child Passenger Safety](#)).
- Of children ages 12 years and younger who died in a crash in 2015, 35% were not buckled up ([National Highway Traffic Safety Administration](#) [NHTSA, Traffic Safety Facts 2015], CDC).

TALKING POINTS ABOUT WHY IT'S IMPORTANT

- Every family wants to keep their child safe.
- Many young children are seriously injured or killed in motor vehicle crashes.
- You can protect your child by always using a car seat, booster seat, or seat belt that is right for your child's age, height and weight, and developmental needs.
- All 50 states, the territories, the District of Columbia, and most tribes have child passenger safety laws because car seats save lives!
- Many resources can help you find the right seat for your child and install it properly.

WHY IT'S IMPORTANT

Car Seats Save Lives!



Secure his future.

Always seat him in the correct car seat.

STAFF NOTES

BE A GOOD ROLE MODEL. ALWAYS BUCKLE UP!

WHY IS THIS IMPORTANT?

- Drivers who buckle up are more likely to use a car seat, booster seat, or seat belt for children riding in their vehicle.
- Drivers who wear a lap and shoulder belt buckle up children 92% of the time. Drivers who don't wear a lap and shoulder belt only buckle up children 70% of the time ([Controlled Intersection Study](#), 2015).

TALKING POINTS ABOUT BEING A GOOD ROLE MODEL

- You are your child's first and best teacher. When you protect yourself by buckling up, you are also protecting the children in your vehicle. Teach children the habits that you want them to use to stay safe and healthy.
- Did you know that drivers who buckle up are more likely to use a car seat, booster seat, or seat belt for children riding in their vehicle? We know that drivers who wear a lap and shoulder belt buckle up children 92% of the time. Drivers who don't wear a lap and shoulder belt buckle up children only 70% of the time.
- A younger child may be more willing to ride in a car seat when you wear your lap and shoulder belt. An older child is more likely to buckle up because you do.
- Always wear a lap and shoulder belt on every trip, even if you aren't going far. Most crashes happen close to home.
- If you buckle up, you have a better chance of surviving a crash. So do the children in your vehicle, because you can get them out quickly if there is a crash.
- If you aren't buckled up, you could be thrown out of the car. You could also be thrown around the car, hurting yourself and your passengers.
- Make sure you adjust your headrest so it supports your head. This can protect your head and neck from injury.

**BE A GOOD ROLE MODEL.
ALWAYS BUCKLE UP!**



DRIVE SAFELY. KEEP YOUR EYES ON THE ROAD.

WHY IS THIS IMPORTANT?

- Driving safely requires your full attention.
- Anything that takes your attention away from driving safely increases your risk of being in a motor vehicle crash.
- Distracted driving—such as talking on the phone or texting while you drive—causes many crashes. In 2015, almost 3,500 people were killed and 400,000 injured in crashes due to distracted driving ([Distracted Driving](#), NHTSA).
- Drivers who stay focused protect themselves and the children in their vehicle.

TALKING POINTS ABOUT KEEPING YOUR EYES ON THE ROAD

- Driving safely requires your full attention.
- Distracted driving is any activity that takes your attention away from driving safely.
- Don't text or talk on the phone while you are driving. You are more likely to be in a motor vehicle crash.
- Protect yourself and the children in your vehicle by focusing on driving safely.

**DRIVE SAFELY.
KEEP YOUR EYES ON THE ROAD.**



MAKE SURE CHILDREN YOUNGER THAN AGE 13 RIDE IN THE BACK SEAT.

WHY IS THIS IMPORTANT?

- In 2016, 55% of passenger vehicle deaths were the result of a crash to the front of the car ([Insurance Institute for Highway Safety \[IIHS\]](#)).
- Riding in the back seat keeps a child farther away from the location of a frontal crash.
- It also keeps a child away from front passenger side airbags, which have caused deaths or serious injuries to children.
- These airbags inflate at speeds up to 200 miles per hour!
- Placing children in the rear seat instead of the front seat reduces their risk of fatal injury by about 75% for children up to age 3 and almost 50% for children ages 4 to 8 (Durbin et al, 2015. [Rear seat safety: variation in protection by occupant, crash and vehicle characteristics](#). *Accid Analysis Prev*.80:185-192; [[IIHS](#)]).

TALKING POINTS ABOUT RIDING IN THE BACK SEAT

- In 2016, more than half of passenger vehicle deaths were the result of a crash to the front of the car.
- Studies show that the back seat provides better protection for young children. One study showed that placing children in the back seat instead of the front seat reduced their risk of fatal injury by about 75% for children up to age 3, and almost 50% for children ages 4 to 8.
- It also keeps a child away from front passenger side airbags, which have caused deaths or serious injuries to children. In a crash, these airbags can inflate at speeds up to 200 miles per hour!
- It's amazing how fast children grow! Your child may look big enough to ride in the front seat, but the back seat is the safest place for children under age 13 to sit, regardless of their size.
- Don't let a child under age 13 sit in the front seat, even as a special privilege or reward.
- Make sure everyone who drives your child knows how to properly buckle children up in the back seat.

**MAKE SURE CHILDREN YOUNGER
THAN AGE 13 RIDE IN THE BACK SEAT.**



CHOOSE THE RIGHT SEAT FOR YOUR CHILD.

WHY IS THIS IMPORTANT?

- Car seat manufacturers design their products to meet federal safety standards.
- [Federal motor vehicle safety standard 213](#) mandates how car seats and booster seats should perform to decrease the severity of injuries and increase the chance of survival in motor vehicle crashes.
- Car seats are designed to keep children safe by spreading the force of a crash across the stronger parts of a child's body, shoulder and hips.
- For the best protection, a child needs a car seat designed for their size (height and weight), age, and developmental needs.
- Child passenger restraint systems offer different levels of protection. Rear-facing car seats are considered the most protective since they distribute crash forces over a child's back; forward-facing car seats distribute forces over a child's shoulders and hips using a 5-point harness; and seat belts distribute forces over the shoulder and hips, but only by 3-points.

TALKING POINTS ABOUT THE RIGHT SEAT

- A car seat is designed to keep your child as safe as possible in the event of a crash. The right seat can save your child's life.
- All U.S. car seat manufacturers meet the same federal safety standards. But with over 200 different models, it can be confusing to know how to choose the right seat for your child.
- We don't recommend a particular brand. Choosing a seat based on your child's size (height and weight), age, and developmental needs provides the best protection.
- As children grow, they will need different types of car or booster seats.
- Don't be in a hurry to move your child into the next type of seat. Keep your child in their car seat until they have reached the seat's maximum height or weight requirement. Car seats label the minimum and maximum height and weight requirements on their packaging, on their instruction booklet, and on the seat itself.
- Rear-facing car seats are considered the most protective since they distribute crash forces over a child's back; forward-facing car seats that use a 5-point harness distribute forces over a child's shoulders and hips; and seat belts distribute crash forces over the shoulder and hips, but only by 3 points. Let's look at the different types of car seats so you know how to choose the right seat.

CHOOSE THE RIGHT SEAT FOR YOUR CHILD.



USE REAR-FACING CAR SEATS FOR INFANTS & TODDLERS.

WHY IS THIS IMPORTANT?

- A young child's bones, muscles, and ligaments are not strong enough to withstand the force of a crash—even a minor one. A rear-facing seat provides the best protection.
- A young child's head is larger and heavier in proportion to their body than that of an older child.
- In a frontal crash, the head of a child who is riding forward-facing moves forward abruptly, placing increased force on the neck.
- A rear-facing car seat supports the entire head, neck, and back of a child in a frontal crash. The shell of the car seat absorbs the force of the crash. When a child sits in a rear-facing car seat, the head moves with the seat, reducing the risk of injuries to a child's head, neck, and spine.
- The American Academy of Pediatrics recommends that children ride rear-facing until at least age 2 or until they outgrow the rear-facing height or weight limits of the car seat.

TALKING POINTS ABOUT REAR-FACING CAR SEATS

- Rear-facing reduces the risk of neck and spine injuries. It is the safest way for infants and toddlers to ride in a motor vehicle.
- There are different types of rear-facing car seats.
- Rear-facing-only car seats have carrying handles and usually have detachable bases. Most are for children who weigh up to 30-35 pounds. A few are available for children who weigh up to 22 pounds.
- Convertible and all-in-one car seats change from rear-facing to forward-facing car seats. Most rear-face for children who weigh up to 40 pounds.
- It's okay if your child's feet touch the back of the vehicle seat. It may look uncomfortable to us, but a child's legs bend easily, and leg injuries are rare.
- Keep your child rear-facing until your child outgrows the rear-facing height or weight limits of the car seat. Most convertible seats have limits that will permit children to ride rear-facing for 2 years or more.

USE REAR-FACING CAR SEATS FOR INFANTS & TODDLERS.



**REAR-FACING
ONLY CAR SEAT**



**REAR-FACING
CONVERTIBLE CAR SEAT**

USE FORWARD-FACING CAR SEATS FOR TODDLERS & PRESCHOOLERS.

WHY IS THIS IMPORTANT?

- Once a child has outgrown a rear-facing car seat, they should move into a forward-facing car seat and continue using the harness straps until they reach the manufacturer's height or weight limit.
- Most car seat manufacturers design the harness straps for children who weigh up to 65 pounds, although some set other limits ranging from 40 to 90 pounds. Check the instructions for your child's seat.
- A car seat with a 5-point harness protects a child better than a booster seat. A 5-point harness has straps over both shoulders, both hips, and between the legs. A booster seat has a lap and shoulder seat belt that only provide 3 points of protection.

TALKING POINTS ABOUT FORWARD-FACING CAR SEATS

- Move your child to a forward-facing car seat with a 5-point harness when your child outgrows their rear-facing car seat.
- A 5-point harness provides better protection than a booster seat by spreading the force of a crash across more parts of the body.
- Most car seat manufacturers design the harness straps for children who weigh up to 65 pounds, although some set other limits ranging from 40 to 90 pounds. Check the instructions for your child's seat.
- Some forward-facing seats change into rear-facing seats. Others change into booster seats. Make sure you are using the seat the right way for your child's age and size. You can find this information on the seat or in the instruction booklet.
- Keep your child in a forward-facing car seat and continue using the harness straps until your child reaches the manufacturer's height and weight limits. This usually happens when a child is between the ages of 4 and 7, depending on their height and weight.
- When your child outgrows their forward-facing car seat, move them into a booster seat.

**USE FORWARD-FACING CAR SEATS
FOR TODDLERS & PRESCHOOLERS.**



USE BOOSTER SEATS FOR SCHOOL-AGE CHILDREN.

WHY IS THIS IMPORTANT?

- Booster seats reduce the risk of serious injury by 45% for children ages 4–8 compared to seat belts alone (Durbin, [Technical Report-Child Passenger Safety](#)).
- The bones in a child's hips aren't fully developed until ages 12–13. This can cause the lap part of the seat belt to ride up on the abdomen instead of staying low on the hips. The hip bone is strong and can tolerate crash forces better than soft abdominal tissue. If the lap belt isn't positioned low on the hips, it can cause serious injuries to a child's abdominal organs or spine in a crash.
- A child in a booster seat can also be thrown around or even thrown from a vehicle when a seat belt does not fit properly.

TALKING POINTS ABOUT BOOSTER SEATS

- After your child outgrows a forward-facing car seat with a harness, your child should use a booster seat. This is usually somewhere between ages 4 and 7.
- A booster seat lifts your child up so the adult seat belt fits correctly.
- Use a lap and shoulder belt with a booster. NEVER use just a lap belt.
- When used the right way, the lap belt fits snugly on the upper thighs or low on the hips. The shoulder belt fits snugly across the middle of the shoulder and chest. A properly positioned shoulder and lap belt can spread the force of the crash across the stronger parts of a child's body, shoulder and hips.
- Without a booster seat, a seat belt can ride up on a child's stomach or across the neck. This can cause serious injuries to the stomach or spine in a crash.
- There are two types of booster seats, backless and highback. The backless model is a small platform. The highback model has head and neck support. It is best to use the highback type of booster seat if your vehicle does not have headrests or a high vehicle seat back.
- If your child puts the shoulder belt under their arm or behind their back, check the seat belt fit. This is not a safe way to ride. Your child may not be ready for a booster seat and may still need a car seat with a harness.

USE BOOSTER SEATS FOR SCHOOL-AGE CHILDREN.



HIGHBACK BOOSTER



BACKLESS BOOSTER

USE SEAT BELTS FOR OLDER CHILDREN AND ADULTS.

WHY IS THIS IMPORTANT?

- For older children and adults, seat belt use reduces the risk of serious injury and death by about half (Source: NHTSA, Traffic Safety Facts, 2017, 2015 data) <https://crashstats.nhtsa.dot.gov/Api/Public/ViewPublication/812374>.
- Proper use of a seat belt will prevent an older child from being ejected or thrown around the car.
- A seat belt spreads the forces of a crash over stronger parts of the body, the shoulders and hips.

TALKING POINTS ABOUT SEAT BELTS

- Use a lap and shoulder belt, not just a lap belt, so your child has upper body protection.
- When used correctly, the lap seat belt fits low on the hips, and the shoulder belt lies across the middle of the shoulder and chest. This spreads the forces of a crash over stronger parts of the body, the shoulders and hips.
- Your child is ready to use a seat belt when
 - Your child can sit all the way back on the vehicle seat without slouching.
 - Your child's knees hang over the edge of the vehicle seat with feet on the floor.
 - The seat belt fits the right way—with the shoulder belt across the middle of the shoulder and chest and the lap belt flat across the hips.
- This is usually when a child is about 4'9" tall and between ages 8 and 12.
- Make sure your child has support behind their head.
- If your child puts the shoulder belt under their arm or behind their back, check the seat belt fit. This is not a safe way to ride. Your child may still need a booster seat.
- Remember that the back seat is the safest place in a vehicle for a child to sit until age 13.
- Use your seat belt every time you're in the car.

**USE SEAT BELTS FOR
OLDER CHILDREN AND ADULTS.**



INSTALL CAR SEATS CORRECTLY.

WHY IS THIS IMPORTANT?

- If a car seat isn't installed or is installed incorrectly, it can move around in the vehicle and injure your child. In some cases, both the car seat and your child could be thrown out of the vehicle.
- Use either the vehicle seat belt or the LATCH (lower anchors and tethers for children) system to secure the seat tightly. To use the LATCH system, the vehicle must have lower anchors.
- Rear-facing car seats must be installed tilted back, according to the manufacturers' instructions. Some infants have breathing problems if they ride too upright. Rear-facing seats have a feature, such as leveling bubbles or leveling lines, that show when the seat is at the correct angle.

TALKING POINTS ABOUT INSTALLING CAR SEATS

- Even if you have the right car seat, it has to be installed correctly to protect your child. Test the seat once you install it. It should not move more than 1 inch side to side and back to front when grabbed where the seatbelt goes through the car seat (seat belt path).
- If it moves too much, your child could be seriously injured or thrown out of the vehicle in a crash.
- A car seat is installed with either a vehicle seat belt or lower anchors. You only need to use one.
- If you use a seat belt, make sure the seat belt is locked at all times and does not loosen.
- Lower anchors are attached to a car seat. They can be used instead of seat belts to install car seats. To use lower anchors, the vehicle must have anchor connectors. All vehicles model year 2002 and later are required to have anchor connectors.
- Read your vehicle owner's manual to learn how to install a car seat in your vehicle. It explains how to lock your seat belts and find the lower anchor connectors.
- Never install a rear-facing car seat in front of an airbag. The force of an airbag hitting the back of a rear-facing car seat can seriously injure or kill a child.
- Rear-facing car seats must be installed tilted back, at an angle determined by the manufacturer. If the seat is at the wrong angle, an infant's head can flop over and affect how they breathe. Rear-facing seats have a feature, such as leveling bubbles or leveling lines, that show when the seat is at the correct angle.
- Car seats that can be used rear-facing and forward-facing have different seat belt paths for each direction. It's important to use the correct belt path labeled on the seat or in the manufacturer's guide.

INSTALL CAR SEATS CORRECTLY.



**LATCH CONNECTOR BEING SNAPPED
ONTO LOWER ANCHOR**



**SEAT BELT THROUGH
FORWARD-FACING BELT PATH**

POSITION CHILDREN IN CAR SEATS PROPERLY.

WHY IS THIS IMPORTANT?

- Proper positioning in a car seat is essential to protecting a child in a crash.
- In a rear-facing car seat, the harness holds the child down low in the seat so they do not slide up and out of the seat. The crotch strap keeps the child from moving forward. If the crotch strap is too far forward, it can cause a small child to slump. This can affect their breathing.
- The harness straps in a forward-facing car seat keep the child in the seat and help to distribute crash forces to stronger parts of the child's body, the shoulders and hips.
- If a harness is too loose, the child could be thrown out of the seat.
- The 5-point harness straps need to be positioned snugly over a child's shoulders and across the child's hips and buckled at the crotch strap.
- A snug harness should pass the "pinch test." This means you cannot pinch excess webbing on the harness at the shoulders and hips when buckled.
- The chest clip helps keep the harness over the child's shoulders. It needs to be mid-chest or in line with the child's armpits.

TALKING POINTS ABOUT POSITIONING CHILDREN

- Even if you choose the right car seat, and install it correctly, it won't protect your child completely unless you position your child in the seat correctly.
- Place your child's back and bottom flat against the car seat.
- Position the harness straps at or slightly **below** the shoulders of your rear-facing child.
- Position the harness straps at or slightly **above** the shoulders of your forward-facing child.
- Tighten the harness until you can no longer pinch any webbing at the shoulders and hips.
- Fasten and move the chest clip to the middle of the chest or armpit level.
- Never add positioning pillows, cushions, or inserts that do not come with the car seat.
- Avoid having your child wear bulky coats. They can interfere with proper harness fit. Put the bulky coat on backwards, over your child's arms and chest, after you buckle the harness. You can also place blankets over your child after you buckle the harness.

POSITION CHILDREN IN CAR SEATS PROPERLY.



**REAR FACING: HARNESS STRAPS
AT OR BELOW SHOULDER LEVEL**



**FORWARD FACING:
HARNESS STRAPS AT OR ABOVE
SHOULDER LEVEL**



**HARNESS "PINCH" TO TEST
FOR SNUG FIT**



**CHEST CLIP MID-CHEST OR
ARMPIT LEVEL**

KNOW WHEN TO USE TETHERS.

WHY IS THIS IMPORTANT?

- A tether is a strap that is attached to the top of a car seat. It has a hook on one end that connects to a tether anchor in a vehicle.
- A tether holds the back of a forward-facing car seat against the vehicle seat. It can decrease the distance a child's head moves forward in a crash by as much as 4–6 inches, reducing the risk of head injuries.
- Tethers are only used with forward-facing car seats, not rear-facing car seats.
- Tethers can be used with either lower anchors or seat belt installations.

TALKING POINTS ABOUT TETHERS AND FORWARD-FACING CAR SEATS

- A tether is a strap that is attached to the top of your car seat. It has a hook on one end that connects to a tether anchor in your vehicle.
- Tethers are only used with forward-facing car seats, not rear-facing car seats.
- A tether holds the back of a forward-facing car seat against the vehicle seat. It can decrease the distance your child's head moves forward in a crash by as much as 4–6 inches.
- Using a tether reduces the risk of a head injury in the event of a crash. Check your vehicle's owner's manual to learn where to find the tether anchors. They may be on the rear window shelf, the floor, the ceiling, or the back of the vehicle seat.
- First, install your car seat with either a seat belt or lower anchors. Then attach the tether and tighten it.

KNOW WHEN TO USE TETHERS.



TETHER STRAP ON CAR SEAT



TETHER ANCHOR ON REAR WINDOW SHELF



TETHER ANCHOR ON SEAT BACK



**TETHER SYMBOL FOUND IN
SOME VEHICLES**

IMPORTANT QUESTIONS ABOUT CAR SEATS

**THESE PAGES PROVIDE ADDITIONAL INFORMATION THAT
CAN HELP YOU ANSWER QUESTIONS FROM FAMILIES.**

Did you register your car seat?

Families should send in the registration card that is attached to new car seats so they can be notified if their seat is recalled. They can also call the manufacturer's customer service number to register their car seat. Or, they can use this link to find out how to register a car seat: <https://www.nhtsa.gov/equipment/car-seats-and-booster-seats#car-seat-registration>.

Did you sign up to receive car seat recall notices?

Car seats are recalled for a variety of reasons, ranging from crashworthiness to missing labels. Use this link to find out how to sign up for car seat recall notices: <https://www-odi.nhtsa.dot.gov/nhtsa/subscriptions>.

Is your car seat used or secondhand?

Using a secondhand seat can be risky, especially if you don't know the history of the seat. Families need to know if the seat meets federal safety standards, is expired, is on recall, has been in a crash, or is missing parts or instructions. If you don't know the history of the seat, the safest thing to do is to get a different seat.

TALKING POINTS ABOUT IMPORTANT QUESTIONS

There are some important questions to ask yourself before you use your car seat.

- Did you send in the registration card attached to your car seat? If so, the car seat manufacturer will notify you about any recalls on your seat. You can also contact the car seat manufacturer directly to find out how to register your seat. Or contact the National Highway Traffic Safety Administration at <https://www.nhtsa.gov/equipment/car-seats-and-booster-seats#car-seat-registration>. They will provide the information to the manufacturer for you. Recalls happen for different reasons. These range from how a car seat performs in a crash to missing labels. The car seat manufacturer will fix the problem.
- Are you the original owner of your car seat? Using a secondhand car seat can be risky if you don't know the history of the seat. The safest thing to do is to get a different seat.
- A certified child passenger safety technician can help you determine if your car seat is safe for your child. You can find a technician by going to <https://www.nhtsa.gov/equipment/car-seats-and-booster-seats#installation-help-inspection>.

IMPORTANT QUESTIONS ABOUT CAR SEATS

ARE YOU THE ORIGINAL OWNER
OF YOUR CAR SEAT?

For Your Child's Continued Safety

Please take a few moments to promptly fill out and return the attached card.

Although child restraint systems undergo testing and evaluation, it is possible that a child restraint could be recalled.

In case of recall, we can reach you only if we have your name and address, so please send in the card or register online to be on our recall list.

Please fill this card out and mail it now, or register online at www.djgusa.com/registration/carseat/us while you are thinking about it.

It's already addressed and we've paid the postage.

Tear Off and Mail This Part or Register Online

4348-00818

Consumer: Just fill in your name, address and email. Please print (use dark ink).

Your Name

Your Street Address

City

State

Zip Code

Email Address (optional)

BC062 BVC

Safety 1st BoostApak

DID YOU REGISTER
YOUR CAR SEAT?

IMPORTANT QUESTIONS ABOUT CAR SEATS

**THESE PAGES PROVIDE ADDITIONAL INFORMATION
THAT CAN HELP YOU ANSWER QUESTIONS FROM FAMILIES**

Has your car seat expired?

Car seats have expiration dates that vary by manufacturer and can range from 6 to 10 years. These dates account for possible deterioration of the plastic shell, lost or broken parts, and failure of older seats to meet updated safety standards. Expiration dates can be found on a label embedded in the shell of the seat or in the owner's manual.

Has your car seat been in a motor vehicle crash?

Car seats are designed to protect a child during one crash, not multiple crashes, and usually have to be replaced after a crash. Families should check with the manufacturer to learn if the seat needs to be replaced after all types of crashes, including minor ones.

Is it safe to let infants sleep in a car seat when you aren't driving?

No. Infants, especially those younger than age 4 months, can get into a position that creates a risk of suffocation or airway obstruction. Once you are no longer driving, move them to a crib or other appropriate flat surface as soon as possible (American Academy of Pediatrics, [Pediatrics](#), 2016).

TALKING POINTS ABOUT IMPORTANT QUESTIONS

- Car seats have an expiration date. Has your car seat expired? Check for the expiration date on a label on the shell of the seat or in the owner's manual. An expired car seat is not safe to use.
- Car seats are meant to protect your child during one crash. Has your car seat been in a crash? If so, check the car seat owner's manual or call the manufacturer to learn if you should replace it.
- A certified child passenger safety technician can help you determine if your car seat is safe for your child. You can find a technician by going to <https://www.nhtsa.gov/equipment/car-seats-and-booster-seats#installation-help-inspection>.
- Car seats are not safe for routine sleeping. Infants, especially those younger than age 4 months, can get into a position that creates a risk of suffocation or airway obstruction. Once you are no longer driving, move them to a crib or other appropriate flat surface as soon as possible.

IMPORTANT QUESTIONS ABOUT CAR SEATS

HAS YOUR CAR SEAT EXPIRED?



**HAS YOUR CAR SEAT
BEEN IN A CRASH?**



STAFF NOTES

WANT TO LEARN MORE?

- Child restraint systems are often used incorrectly. An estimated 46% of car seats and booster seats (59% of car seats and 20% of booster seats) are misused in a way that could reduce their effectiveness. ([National Child Restraint Use Special Study](#), June 2015)
- Car seat manufacturers have specific instructions for their products, based on how the seats performed in crash tests.
- If a car seat is not used correctly, it cannot protect a child as well as it should.

TALKING POINTS ABOUT THE RIGHT CAR SEAT

- There are many resources to help you learn how to properly use and install your car seat or booster seat, such as
 - The owner's manual for your car seat and your vehicle
 - The labels on the side of the seat
 - Car seat manufacturers' websites
 - Certified child passenger safety technicians
- Certified child passenger safety technicians have in-depth training about the best way to protect children in a motor vehicle. They offer their services at car seat check-up events such as child safety seat inspection stations and car seat clinics.
- You can find a technician by going to <https://www.nhtsa.gov/equipment/car-seats-and-booster-seats#installation-help-inspection>.
- Enter your city and state or zip code where it asks you to enter your location.

WANT TO LEARN MORE?

CERTIFIED CHILD PASSENGER SAFETY



INFORMATION ABOUT THE FLIP CHART AND TIPS FOR SPEAKERS

The purpose of this flip chart is to share information with families about child passenger safety.

- Each page has information on the front and back side.
 - The front side of each page is for parents. It has photos that illustrate some of the talking points.
 - The back side has speaker notes and talking points. The talking points are the key points to discuss with parents.
- Ask parents what type of vehicle they drive. Then, as you review each page of the flip chart, you can talk about what they can do to keep their child safe in their car or truck.
- Please stay as close as possible to these talking points.

TALKING POINTS FOR SPEAKERS

Before using this flip chart, know:

- The child passenger safety law in your state, territory, the District of Columbia, or tribe. You can find basic information about the laws for states and territories at <https://www.ghsa.org/state-laws/issues/Child-Passenger-Safety>. Check with local officials for information about the laws for tribes.
- Local child passenger safety resources to share with families and caregivers.

Learn more by visiting one or more of the following websites:

- www.healthychildren.org/carseatguide
American Academy of Pediatrics website for families
- <https://www.nhtsa.gov/equipment/car-seats-and-booster-seats>
National Highway Traffic Safety Administration's website for families
- www.safekids.org
Worldwide organization with injury prevention information for the general public
- www.cdc.gov/motorvehiclesafety/native/best_practices_guide.html
Information for tribes on car seat safety from the Centers for Disease Control and Prevention

The content of this flip chart was originally developed by the Automotive Safety Program, Indiana University School of Medicine, with funding from the Indiana Criminal Justice Institute, and adapted with permission by the National Center on Early Childhood Health and Wellness. Select images downloaded from the NHTSA image Library.



NATIONAL CENTER ON Early Childhood Health and Wellness

School readiness begins with health!

Although the National Center on Early Childhood Health and Wellness is not a testing or standard-setting organization, this document sets forth some of the factors that parents should consider before selecting and using a car seat based on guidance from the National Highway Traffic Safety Administration and recommendations from peer-reviewed literature available at the time of its publication. For specific recommendations regarding the selection and installation of a car seat for your child and vehicle type, you may want to consult a Certified Passenger Safety Technician (CPST). You can find a CPST at: https://ssl06.cyzap.net/dzapps/dbzap.bin/apps/assess/webmembers/tool?pToolCode=TAB9&pCategory1=TAB9_CERTSEARCH&Webid=SAFEKIDSCERTSQL.

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Leading a Culture of Safety: A Blueprint for Success



American College of
Healthcare Executives
for leaders who care®

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Leading a Culture of Safety: A Blueprint for Success



American College of Healthcare Executives

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For more information, visit www.ache.org.

The IHI/NPSF Lucian Leape Institute

Established in 2007, the IHI/NPSF Lucian Leape Institute is charged with defining strategic paths and calls to action for the field of patient safety, offering vision and context for the many efforts under way within healthcare, and providing the leverage necessary for system-level change. Its members are national thought leaders with a common interest in patient safety. Their expertise and influence are brought to bear as the Institute calls for the innovation necessary to create significant, sustainable improvements in culture, process, and outcomes that are critical to safer healthcare.

For more information, visit www.npsf.org/LLI.



The Institute for Healthcare Improvement / National Patient Safety Foundation

The Institute for Healthcare Improvement (IHI) and the National Patient Safety Foundation (NPSF) began working together as one organization in May 2017. The newly formed entity is committed to using its combined knowledge and resources to focus and energize the patient safety agenda in order to build systems of safety across the continuum of care. To learn more about our trainings, resources, and practical applications, visit ihi.org/PatientSafety.

Letter from the Project Co-chairs

Dear Colleagues:

Healthcare is one of the most complex industries in our world. Amid all of the pressing priorities, we must remember that the elimination of harm to our patients and workforce is our foremost moral and ethical obligation. In our roles as healthcare leaders, we have numerous responsibilities for ensuring the quality of care provided within our organizations, including patient and family experience, improving the health status of our communities, and maintaining the financial sustainability of our organizations. However, one of the most critical roles we must fulfill is ensuring the safety of patients who entrust their lives to our care, as well as ensuring the safety of a workforce—both clinical and non-clinical—that entrusts their livelihoods to our organizations. It is the ultimate duty of leaders to ensure the safety and prevention of unnecessary harm to these individuals and their loved ones. Healthcare executives must address the need to create sustainable cultures of safety throughout a healthcare system full of daunting challenges.

As our organizations aim to continually improve the reliability and safety of care, we can look to resources and successful practices to assist us, our Boards, our executive colleagues, our healthcare professionals, and the entirety of our workforce. The American College of Healthcare Executives (ACHE) and the Lucian Leape Institute have partnered to collaborate with some of the most progressive healthcare organizations and globally renowned experts in leadership, safety, and culture to develop *Leading a Culture of Safety: A Blueprint for Success*. This document is an evidence-based, practical resource with tools and proven strategies to assist you in creating a culture of safety—an essential foundation for achieving zero harm. It is our hope that this guide will inspire and motivate, while providing approaches and tactics leaders can implement in driving cultural change, with the goal of elevating healthcare into the realm of recognized industries that have succeeded in reducing error and harm.

ACHE and the IHI/NPSF Lucian Leape Institute stand ready to assist you on this journey. We invite you to use this guide in both a strategic and tactical manner to direct your efforts in creating and sustaining a culture of safety, and to evaluate your success along your journey to zero harm.

Sincerely,



Gary S. Kaplan, MD, FACMPE
Co-chair



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Acknowledgments

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The Culture of Safety Imperative

Harm to Patients and the Workforce

In 1999, the Institute of Medicine (IOM) Committee on Quality of Health Care in America estimated that between 44,000 and 98,000 Americans die each year as a result of medical errors (IOM 1999). More recent estimates place this number closer to 200,000 deaths per year (James 2013). Though deaths due to medical error are notoriously difficult to measure, if this number is accurate within 100,000 deaths, medical error kills four times more Americans each year than motor vehicle accidents. It is important to note that these statistics, while disconcerting on their own, do not account for serious temporary or permanent physical and psychological harm caused by medical error, and they do not include harm to the healthcare workforce. Regardless of the measurement or estimation used, the rate of error and harm in healthcare is astounding, and sweeping, system-wide changes are imperative.

Moreover, when patients experience harm, clinicians find themselves negatively impacted as well. Being involved in an error that results in the harm or death of a patient is devastating for an individual who is committed to serving those who are sick. At its worst, this devastation can lead to self-harm, depression, isolation, and even suicide. The desolation that often results from causing harm is compounded for clinicians who work in organizations without supportive systems. Based on the 2016 Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture's hospital comparative database, only 64% of staff respondents felt that reported mistakes led to positive changes in their organization. Even fewer members of the workforce, only 45%, responded positively to questions related to their organization's non-punitive response to error (AHRQ 2016).

Considering the impact described above, every healthcare executive should prioritize enhancing the safety of patients and the workforce. As an industry, healthcare has taken steps in improving quality and patient safety. However, these small-scale, incremental improvements are not enough. Our immediate work requires a focus on safety not just as a key improvement initiative but as a core value that is fully embedded throughout our organizations and our industry.

In every healthcare organization, the ultimate responsibility for system-based errors and their resulting costs rests with the CEO and Board of Directors. CEOs and Boards will be held increasingly responsible for harm and death caused by error. In the long run, patient and workforce safety will not only be a moral imperative but will likely be critical to sustainability and essential to delivering on value.

Based on data from James and the American Hospital Association, an average, 100-bed hospital committed errors in care that caused the death of 23 patients in 2013. Such statistics indicate that each organization contributed to the preventable death of almost one patient every other week (AHA 2014, James 2013).

The Business Case for Safety

While the business case for patient safety continues to expand and to change with new regulatory and reimbursement requirements, the general consensus within the healthcare research community is that organizational costs for error and harm are high and will likely increase in the coming years. In addition to the increase in direct cost of care for the impacted patient and family following an error, organizations must also consider personnel costs, regulatory costs, and resource costs including investigation of errors, pursuit of legal defense, and payment of settlements. Perhaps most important to consider are the potentially immense costs related to repairing reputation after a catastrophic event has occurred and been publically reported (Weeks and Bagian 2003). When each of these costs is considered on top of the direct cost of patient care, the business case for improving safety becomes abundantly compelling.

A Case Study in Culture:

Mr. Jones is a previously healthy 55-year-old man, with a recent history of shortness of breath that is related to exercise. He has been referred by his primary care physician for a cardiology consultation, at which a stress test is ordered. The results of the stress test indicate a positive finding for potential heart disease. These results are not communicated back to his primary care provider, and although they are sent to the referring cardiologist, he is away at a conference. Mr. Jones receives no communications about the results of his test. One week later, Mr. Jones presents to the emergency department with chest pain and is diagnosed with an acute myocardial infarction. Upon further review of his medical records, the care team reviews his past test results and learns about the positive stress test. Mr. Jones requires placement of a stent to open his coronary artery, and requires rehabilitation prior to discharge to his home due to reduced cardiac function. One week after discharge from inpatient rehabilitation, Mr. Jones returns to his primary care physician, who realizes that Mr. Jones is not taking one of the new cardiac medications that was ordered by his inpatient team.

A Tale of Two Organizations: Which is more like yours?

ORGANIZATION A:

The inpatient team notifies the patient safety department about the missed test result, and a root cause analysis is performed to determine why Mr. Jones' critical test result was not communicated to either him or his cardiologist. Action steps from the root cause analysis focus on re-educating the stress test department about the policy for communication of abnormal test results.

The lessons from the root cause analysis are not shared beyond the safety team. The action plan is not presented to the leadership team or the Board for approval, and does not include metrics for sustainability. The CEO and Board hear about the event only as a statistic presented quickly at the end of a quarterly Board meeting.

Mr. Jones is not informed about either the missed stress test result or the root cause analysis.

The primary care provider writes a new prescription for the cardiac medication. Mr. Jones ultimately misses several weeks of work.

ORGANIZATION B:

The inpatient team notifies the patient safety department about the missed test result, and a root cause analysis is performed. Action steps include designing a new process for communication of test results that includes an escalation policy when it is not immediately possible to communicate critical test results to the ordering provider and/or the patient.

The primary care provider ensures that Mr. Jones begins taking the cardiac medication and also notifies the risk management/patient safety department about the delay in medication use. An additional root cause analysis is conducted, with a clear tracing of the breakdown during transition from hospital to rehabilitation and rehabilitation to home, and how and why it may have occurred.

The results of both RCAs, including strong action plans for improvement and metrics for sustainability, are presented to the organization's leadership team for review and approval. The CEO presents the case and action plan at the next quality and safety meeting.

Mr. Jones' care team informs him about these breakdowns in communication, and how they may have contributed to his myocardial infarction and could cause future health issues. His care team extends an apology, as well as an offer for early resolution and compensation that helps Mr. Jones pay for his medical bills, his time away from work, and the additional costs associated with the need for his family to care for him.

Six months later, an assigned member of the leadership team follows up with the frontline care team involved in the event to evaluate and reassess the action plan and review improvement metrics. These results are presented at the next Board meeting.

DEBRIEF

Many organizations report that their response to handling Mr. Jones' situation is more similar to Organization A than to Organization B. This example is but one of many that illustrate why healthcare must create and improve systems that are committed to zero harm to patients and our workforce.

Introduction

Dr. Lucian Leape, widely regarded as the father of the modern patient safety movement, has repeatedly stated that “the single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes.” By prioritizing, developing, and sustaining an organizational culture focused on safety, we can drive the future of healthcare to a place where patients and those who care for them are free from harm. It is not only one of many priorities, but is the overriding ethical imperative for all leaders.

AHRQ defines a culture of safety as one “in which healthcare professionals are held accountable for unprofessional conduct, yet not punished for human mistakes; errors are identified and mitigated before harm occurs; and systems are in place to enable staff to learn from errors and near-misses and prevent recurrence” (AHRQ PSNet Safety Culture 2014). The leaders of organizations must set and, more importantly, demonstrate the behaviors and expectations essential to a safe and transparent culture.

To help healthcare leaders achieve their mission of total system safety, ACHE and the Lucian Leape Institute have partnered to develop this guide, which is intended to assist leaders in creating, shaping, and sustaining the type of culture needed to advance patient and workforce safety efforts. It is designed to inspire, motivate, and inform you as you lead your organization on its journey to zero harm.

The information in this guide comes from industry leaders and experts who have had success in transforming their organizations into system-wide cultures of safety. It is designed for you and your team members to adapt to your organization, wherever you may be on your journey.

Cultures of Safety Across the Continuum

Because error and harm happen across the continuum, it is imperative that all improvement initiatives also encompass all care settings. While some of the tactics and recommendations throughout this document will be more relevant in certain environments than others, the key principles developed throughout the six domains are applicable to all who oversee the delivery of care—not just hospital settings. This work is intended to be adapted as needed to enhance applicability for all organizations. However, the key concepts—building trust, respect, and enthusiasm for improvement through behaviors and principles that focus on ameliorating systems issues while requiring fair and inclusive practices—are critical to safe care in all settings.

Leading a Culture of Safety: A Blueprint for Success

This resource is organized into six leadership domains that require CEO focus and dedication to develop and sustain a culture of safety:



Establish a compelling vision for safety. An organization's vision reflects priorities that, when aligned with its mission, establish a strong foundation for the work of the organization. By embedding a vision for total patient and workforce safety within the organization, healthcare leaders demonstrate that safety is a core value.



Build trust, respect, and inclusion. Establishing trust, showing respect, and promoting inclusion — and demonstrating these principles throughout the organization and with patients and families — is essential to a leader's ability to create and sustain a culture of safety. In order to achieve zero harm, leaders must ensure that their actions are consistent at all times and across all levels of the organization. Trust, respect, and inclusion are non-negotiable standards that must encompass the Board room, the C-suite, clinical departments, and the entire workforce.



Select, develop, and engage your Board. Governing Boards play a vital role in creating and maintaining safety cultures. CEOs are responsible for ensuring the education of their Board members on foundational safety science, including the importance of and processes for keeping patients and the workforce safe. Boards must ensure that metrics that meaningfully assess organizational safety and a culture of safety are in place and systematically reviewed, analyzed, and the results acted upon.



Prioritize safety in the selection and development of leaders. It is the responsibility of the CEO, in collaboration with the Board, to include accountability for safety as part of the leadership development strategy for the organization. In addition, identifying physicians, nurses, and other clinical leaders as safety champions is key to closing the gap between administrative and clinical leadership development. Expectations for the design and delivery of relevant safety training for all executive and clinical leaders must be set by the CEO and subsequently spread throughout the organization.



Lead and reward a just culture. Leaders must possess a thorough understanding of the principles and behaviors of a just culture, and be committed to teaching and modeling them. Human error is and always will be a reality. In a just culture framework, the focus is on addressing systems issues that contribute to errors and harm. While clinicians and the workforce are held accountable for actively disregarding protocols and procedures, the reporting of errors, lapses, near-misses, and adverse events is encouraged. The workforce is supported when systems break down and errors occur. In a true just culture, all workforce members—both clinical and non-clinical—are empowered and unafraid to voice concerns about threats to patient and workforce safety.



Establish organizational behavior expectations. Senior leaders are responsible for establishing safety-mindfulness for all clinicians and the workforce and, perhaps even more importantly, modeling these behaviors and actions. These behaviors include, but are not limited to, transparency, effective teamwork, active communication, civility, and direct and timely feedback. These cultural commitments must be universally understood and apply equally to the entire workforce, regardless of rank, role, or department.

The journey toward patient and workforce safety requires vigilance and the highest level of dedication. Safety cannot be merely a strategic priority, but must be a core value that is woven into the fabric of our organizations. A culture of safety demands the involvement and commitment of the full healthcare team, from patients to clinicians to the rest of the workforce. However, an organization cannot be what its leader is not. It is both the obligation and the privilege of every healthcare CEO to create and represent a compelling vision for a culture of safety: a culture in which mistakes are acknowledged and lead to sustainable, positive change; respectful and inclusive behaviors are instinctive and serve as the behavioral norms for the organization; and the physical and psychological safety of patients and the workforce is both highly valued and ardently protected.

A Note about Disparities in Care

Across the United States, individuals experience great differences in life expectancy and other health outcomes based on social determinants that may include ethnicity, religion, socioeconomic status, geographic location, sexual orientation, and gender identity, among others. It is impossible to envision an organization driving toward zero harm that is not also consciously focused on addressing these disparities.

Professor Margaret Whitehead, head of the World Health Organization (WHO) Collaborating Centre for Policy Research on the Social Determinants of Health, defines equity in health this way: “Ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, no one should be disadvantaged from achieving this potential, if it can be avoided” (Whitehead and Dahlgren 2006). The reality of healthcare today is that quality and safety cannot be achieved without equity. Healthcare organizations have the power to address disparities at the point of care and to make an impact on many of the determinants that create these disparities (Institute for Healthcare Improvement 2016). Because equity in health is essential to quality and safety, mitigation of health disparities must be prioritized across the six domains for developing a culture of safety. Not only is creating health equity part of the safety imperative, but it requires many of the same mechanisms recommended throughout this document.

A Note about Learning Systems

The IOM describes a learning healthcare system as one in which “science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the care process, patients and families are active participants in all elements, and new knowledge captured as an integral by-product of the care experience” (IOM 2013).

While this guide focuses on developing and sustaining a culture that drives patient and workforce safety outcomes, a CEO’s accountability for developing and supporting a learning system is equally important. Change implementation is a vast interdisciplinary undertaking that requires all aspects of a safety culture, from safety science knowledge, to trust, respect, and visionary leadership (Friedman 2015). The design of learning systems may vary—from high reliability to Six Sigma™ to the Toyota Production System and other Lean methodologies—but the key characteristics are the same. Zero harm to patients and the workforce is only possible with both a robust culture of safety and an embedded organizational learning system.

Recommendations for Use of This Guide

This guide was developed for CEOs and other executive leaders in order to provide a useful tool for assessing and advancing an organization's culture of safety. It can be used to help determine the current state of your organization's journey, inform dialogue with your Board and leadership team, and help you set priorities. The six domains are intended to be discussed with your Board, your leadership team, your workforce, and your community. These domains are interdependent, and each domain is an essential element that must be addressed along your journey. This guide contains recommendations for developing and evaluating plans to flourish in each of the six domains, and resources for helping you move forward and make measurable progress in your journey.

The high-level strategies and practical tactics in this guide are divided into two levels: foundational and sustaining. The foundational level provides basic tactics and strategies essential for the implementation of each domain. The sustaining level provides strategies for spreading and embedding a culture of safety throughout the organization. However, it is important to note that the journey to zero harm is more complex than this simple two-level structure. Each organization will be at a different place on the spectrum from developing the foundation of a culture of safety to embedding and sustaining these principles. An organization may work on strategies and tactics across the two levels, or may be at various levels of progress across each of the domains. In organizations that lack an empowering vision statement or trust and respect among leadership, clinicians, and the workforce, it may be most effective to begin improvement initiatives in these two domains. The keys to developing and sustaining a culture of safety are honest and transparent evaluation of your organization's current state, identification of gaps and goals, and an action plan that engages all members of the Board, leadership team, and workforce.

Whether an organization is just beginning the journey to a culture of safety or is working to sustain its safe culture, the following steps are recommended:

- ✓ Share this document with your Board Chair and leadership team.
- ✓ Complete the self-assessment with input from your Board, leadership team, clinicians and the frontline workforce, and patient and family representatives, as appropriate.
- ✓ Develop action plans based on an understanding of the current state of your organization. Use assessment results to frame discussions with your leadership team and the Board that focus on identifying ways to close gaps and aligning the direction of your organization with key safety and culture initiatives.
- ✓ Share the outcomes of the assessment, action plans, and progress with your senior leadership team, the Board, your workforce, and your patients and families, as appropriate and helpful.
- ✓ Ask for periodic feedback from your Board, your leadership team, and the workforce.
- ✓ Refer to this guide as a resource for systematic check-ins and adjustments, as needed.

A Culture of Safety: The Six Domains



Vision



Establish a Compelling Vision for Safety

GOAL: COMMIT TO DEVELOP, COMMUNICATE, AND EXECUTE ON AN ORGANIZATIONAL VISION OF ZERO HARM TO PATIENTS, FAMILIES, AND THE WORKFORCE.

To engage and inspire all clinical and non-clinical healthcare professionals and the public, an organization's vision should reflect long-term, aspirational goals. This vision must be clearly aligned with the organization's mission, which establishes the foundation of what an organization does.

A compelling vision enhances performance, promotes change, motivates individuals, and provides context for decision making (Lipton 1996). Clearly articulated, a strong vision addresses the why, the how, and the when of the aspirational goal (Lipton 2003). Many CEOs of healthcare organizations strive to include safety among their top strategic priorities, and this objective must be clearly reflected as a core value in the vision and mission statements. The CEO is responsible for launching the critical first step of establishing safety as the most important part of what everyone does, every day.

	Foundational	Sustaining
Strategies <i>Overarching strategies for implementation at the CEO level</i>	<ul style="list-style-type: none"> ✓ CEO takes responsibility for educating himself/herself on how to develop vision and lead a culture of safety ✓ CEO communicates and models a shared vision of zero harm to patients, families, the community, and the workforce ✓ CEO communicates genuine, clear messages about vision, conveying purpose of safety culture to everyone, in all settings, repeatedly and for the long term ✓ CEO communicates how vision is critical to organizational success ✓ CEO prioritizes measurement, gap analysis, and improvement of culture of safety as foundational for vision ✓ CEO gains additional understanding of safety by participating in full harm investigation, including disclosure and apology and root cause analysis 	<ul style="list-style-type: none"> ✓ CEO and leadership team provide consistent, personalized messaging about the importance of safety and zero harm ✓ CEO relays importance and urgency of safety vision to both internal and external audiences ✓ CEO practices transparency and shared accountability between Board and leadership team regarding vision and relevant measurement and reporting

Vision



Establish a Compelling Vision for Safety

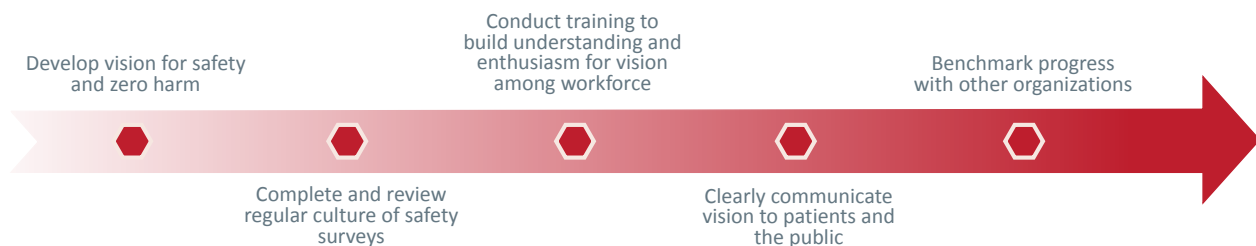
A compelling vision with patient and workforce safety as a core value is essential to achieving safe care. Zero harm is the aspirational “North Star.” Healthcare CEOs demonstrate their belief that safety is a primary, non-negotiable goal by working with their Board, clinical leadership, and workforce to develop such a vision, to embed it in their organization, and to demonstrate their commitment and energize frontline workers through direct involvement in safety activities (NPSF 2015).

The first step for a CEO in creating this vision is to understand, acknowledge, and communicate the current state of their organization. A successful vision statement may be developed by top management and shared with the organization, or created in partnership with the workforce. The key is that the vision statement must encompass all organizational interests and engage the entire workforce. Visions that offer long-term perspective and include a degree of difficulty or stretch are often the most powerful. Finally, a vision statement should be clear and concise, allowing it to be easily remembered, repeated, and communicated (Kantabutra and Avery 2010).

Leaders must work with their teams, in direct partnership with physicians, nurses, and other clinical and non-clinical leaders, to assess the internal and external landscape of their organization. They must consider safety metrics, clinicians’ attitudes and perceptions, patient and family experiences, and current practices, as well as trends and events that affect or might affect the healthcare industry. Landscape analysis is often accomplished through tactics including focus groups, safety culture surveys, safety rounds, analysis of safety metrics and reporting, and other diagnostic approaches. As one team of management researchers tell us, “The best way to lead people into the future is to connect with them deeply in the present” (Kouzes and Posner 2009). Understanding and communicating the current state enables leaders to connect and work with their teams and clinical experts to create a shared vision that can inspire everyone within the organization and the community.

While it is important to get input and buy-in from all levels when developing a vision, CEOs must be the ones to define and model the vision. Leaders at every level need to be visible in their commitment to patient and workforce safety and vocal about supporting actions that align with the organizational vision.

A clear and aspirational vision inspires the workforce and the public. The CEO works with the Board, leadership team, clinicians, and workforce to develop and embed this vision.



Vision



Establish a Compelling Vision for Safety

Organizational Readiness Level	Foundational	Sustaining
Tactics <i>Examples of tactics that may be implemented to create change at each of these levels</i>	To engage your organization: <ul style="list-style-type: none"> ✓ Work with select individuals throughout the organization to develop understanding of key organizational interests and goals ✓ Work with leadership team to develop aspirational end state (e.g., zero harm) that will be incorporated into vision ✓ Communicate the definition and importance of a culture of safety ✓ Build awareness of current state through culture surveys, observations, and focus groups, and communicate this throughout the organization ✓ Include zero harm vision in all communications from leaders at all levels, and keep this communication simple, consistent, and repetitive ✓ Include equity of care as part of vision statement and communicate the definition and importance of health equity ✓ Conduct training and information sessions for all employees to build understanding and enthusiasm for the vision ✓ Spend time on all floors and units communicating the connection of culture of safety and vision to the work of the frontline 	To engage your organization: <ul style="list-style-type: none"> ✓ Clearly articulate your vision to the workforce and the public ✓ Benchmark culture progress and best practices with other similar organizations (e.g., participate in collaboratives) ✓ Develop and implement a recognition program for leaders, clinicians, and the workforce based on growth and adherence to vision ✓ Establish organizational goals that address safety and disparities in care To engage clinical leaders: <ul style="list-style-type: none"> ✓ Include physician, nursing and other clinical leaders in development of vision statement and strategic plan To engage patients and families: <ul style="list-style-type: none"> ✓ Clearly communicate the vision statement and values to patients ✓ Incorporate patient and family stories, along with statistics, when discussing vision at the Board level ✓ Include patient feedback in the development of vision statement
Assessing Execution <i>List of questions that should be asked to further assess and measure progress</i>	YES / NO <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Are the CEO and leadership team able to clearly communicate the vision to all parties, in both internal and external interactions? <input type="checkbox"/> <input type="checkbox"/> Can all members of the organization articulate the vision for safety and how it relates to their individual work? <input type="checkbox"/> <input type="checkbox"/> Is a patient safety and quality dashboard (which includes safety culture metrics) utilized and regularly reviewed in the context of organizational vision? 	

Trust, Respect, and Inclusion



Value Trust, Respect, and Inclusion

GOAL: ESTABLISH ORGANIZATIONAL BEHAVIORS THAT LEAD TO TRUST IN LEADERSHIP AND RESPECT AND INCLUSION THROUGHOUT THE ORGANIZATION REGARDLESS OF RANK, ROLE, OR DISCIPLINE.

Trust, respect for others, and inclusion are essential to creating environments that are both physically and psychologically safe. Building trust involves managing conflict and making the environment safe for communicating bad news. It also involves practicing honesty, inclusion, transparency, and respect with everyone. Each member of the workforce must feel compelled and empowered to uphold mutual accountability and speak up for safety. Healthcare leaders develop trust within their organizations by having authentic relationships and conversations. For example, undertaking humble inquiry, asking questions to which you do not already know the answer, and building relationships based on genuine curiosity and interest all help leaders find information that might otherwise elude them (Schein 2013).

	Foundational	Sustaining
Strategies <i>Overarching strategies for implementation at the CEO level</i>	<ul style="list-style-type: none"> ✓ CEO recognizes the critical importance of trust, respect, and inclusion in shaping organizational culture ✓ CEO creates expectation for trust, respect, and inclusion, and models these through his or her interactions with every individual at every level of the organization ✓ CEO holds the leadership team accountable for modeling trust, respect and inclusion ✓ CEO directs policies that empower the workforce to first and foremost act within the guidelines of trust, respect, and inclusion when making decisions ✓ CEO establishes the expectation that learning from failures and improving systems is a part of daily organizational activity 	<ul style="list-style-type: none"> ✓ CEO establishes expectations and accountability for formal program focusing on trust, respect, and inclusion that includes patients and is implemented across the organization ✓ CEO and organization have clear, visible expectations of acceptable behavior and consequences for behaviors that do not meet standards of trust, respect, and/or inclusion ✓ CEO establishes transparent practices with the Board, senior leadership, workforce and community, as appropriate ✓ CEO takes ownership of partnering with similar organizations, through Patient Safety Organizations (PSOs) or other collaboratives, to share learning and best practices

Trust, Respect, and Inclusion



Value Trust, Respect, and Inclusion

The actions of leaders must be consistent over time and throughout the organization. Behavioral standards and expectations should apply to everyone, without exception. Respect for others—be they patients, family members, peers, or subordinates—is essential for creating and sustaining trust. Developing and holding all leaders and the workforce accountable to codes of conduct or code of ethics can help to solidify the practices and behaviors that encourage trust and respect (Chassin and Loeb 2013).

Beyond modeling behaviors of respect themselves, leaders may need to institute ongoing education for volunteers, students, clinicians, and the workforce about appropriate behavior, and continue to actively encourage changes designed to increase fairness, transparency, collaboration, inclusion, and individual responsibility (Leape et al., 2012).

In pursuing safety as a core value, trust, respect, and inclusion are fostered by CEOs who make and keep commitments to the workforce, who communicate when a problem cannot be fixed immediately, who consistently display a sense of fairness, and who engage in and encourage reciprocal, helping behavior throughout the organization.

CEOs must also display their trust in others. Creating a strong team enables leaders to have confidence in delegating decisions and authority, though trust does not mean believing nothing will ever go wrong. Leaders can expect to continually work on building, sustaining, or repairing trust.

Cultural Diversity and Respect in the Workplace

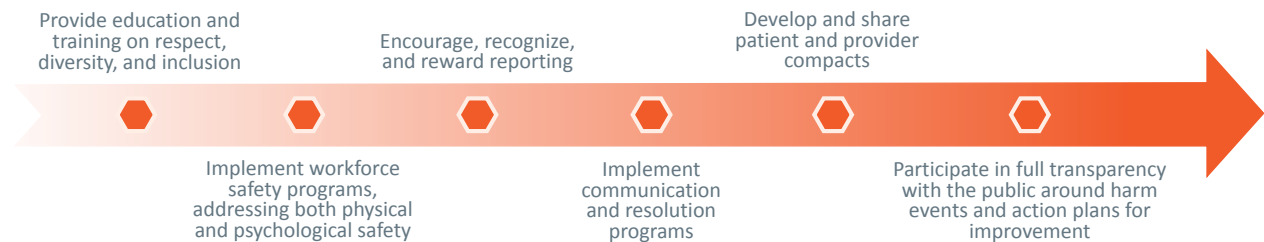
It is imperative that CEOs understand the cultural makeup of both the community and the organization in which they serve. Implementing and modeling behaviors that reflect a respectful and inclusive environment is essential to a culture of safety. This should include placing a high value on the positive impact of greater diversity and inclusion among leadership as well as the workforce. It should also include efforts to evaluate and eliminate disparities in patient care. Unleashing the potential of workforce diversity depends on the establishment of inclusion, the building of trust and respect, and training in skills and behaviors that support an inclusive and respectful organization. With this approach, cultural diversity can be an effective resource for creative problem solving and organizational learning, and can help to identify and ameliorate disparities of care. (EU-OSHA 2013)

Trust, Respect, and Inclusion



Value Trust, Respect, and Inclusion

Trust, respect, and inclusion are the foundation of a culture of safety. The CEO develops trust and respect with individuals at all levels of the organization, and, with the Board, holds leaders, clinicians, and the workforce accountable for policies and behaviors that reflect these values.



Organizational Readiness Level	Foundational	Sustaining
Tactics <i>Examples of tactics that may be implemented to create change at each of these levels</i>	To engage your organization: <ul style="list-style-type: none"> ✓ Commit to implementing and holding all leaders and the work force accountable for processes and policies related to respect for people, just culture, and managing disruptive behavior ✓ Encourage and promote open discussion of safety issues via leadership rounds and reporting systems, and ensure follow-up and feedback ✓ Ensure that the workforce has dedicated time to devote to patient safety and safety culture work ✓ Implement workforce safety programs to reduce physical and psychological harm to the workforce ✓ Clearly define and encourage behaviors that show deference to expertise rather than hierarchy or title 	To engage your organization: <ul style="list-style-type: none"> ✓ Aim for total transparency, but explain situations in which the organization is unable to be completely transparent ✓ Publicly share available information about events of harm, and plans for managing associated risks ✓ Ensure follow-up and feedback on identified safety issues, and be transparent if an issue cannot be resolved promptly ✓ Create compacts for leaders that clearly define expected behaviors in trust and transparency as they relate to other leaders, peers, and subordinates ✓ Build metrics for respect and trust (e.g., workforce psychological safety, error reporting) into the evaluation process for all leaders

Trust, Respect, and Inclusion



Value Trust, Respect, and Inclusion

Organizational Readiness Level	Foundational	Sustaining
Tactics <i>Examples of tactics that may be implemented to create change at each of these levels</i>	To engage your organization (cont): <ul style="list-style-type: none"> ✓ Recognize and reward reporting with the goal of reducing and eventually eliminating anonymous reporting ✓ Provide education and training on diversity and inclusion at every level of the organization ✓ Track employee engagement and turnover as a metric to evaluate trust, inclusion, and respect ✓ Include care disparity metrics on regularly reviewed patient safety dashboards ✓ Translate tools and resources for both patients and the workforce into a variety of languages, keeping in mind cultural context and linguistic idiosyncrasies ✓ Adopt communication and resolution/reconciliation programs for patients and families after events of preventable harm ✓ Establish patient and family advisory councils 	To engage clinical leaders: <ul style="list-style-type: none"> ✓ Provide training for physicians, nurses, and other clinical leaders around patient engagement and communication ✓ Provide cultural competency training for all clinical leaders that is relevant to the patient populations they serve To engage patients and families: <ul style="list-style-type: none"> ✓ Encourage and enable patients and families to speak up if they notice a risk to safety ✓ Ensure that crisis plans address how to communicate with patients and families in the event of an error, regardless of degree of harm ✓ Commit to shared decision making and consider patient preferences in all treatment plans ✓ Engage patients and families in creating and disseminating patient compacts that include what patients can expect from the organization, their care providers, and the workforce
Assessing Execution <i>List of questions that should be asked to further assess and measure progress</i>	YES / NO <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Are all clinicians and workforce members provided with training in communicating with patients, including disclosure and apology? <input type="checkbox"/> <input type="checkbox"/> Are measures of respect included in all performance assessment tools? <input type="checkbox"/> <input type="checkbox"/> Is a formal program for respect and trust in place and evaluated regularly? <input type="checkbox"/> <input type="checkbox"/> Is there systematic training on diversity and inclusion for both the clinical and non-clinical workforce? <input type="checkbox"/> <input type="checkbox"/> Do the Board and leadership team regularly create and evaluate improvement plans for addressing disparities in patient care? 	

Board Engagement



Select, Develop, and Engage Your Board

GOAL: SELECT AND DEVELOP YOUR BOARD SO THAT IT HAS CLEAR COMPETENCIES, FOCUS, AND ACCOUNTABILITY REGARDING SAFETY CULTURE.

Boards of healthcare organizations oversee the fiduciary performance, reputation, and key performance outcomes of an organization, including those related to quality, safety, and culture. The accountability for safety is shared between the CEO and the Board. The CEO is responsible for guaranteeing Board education on the importance of safety, ensuring that the Board understands quality and safety metrics, and recommending the appropriate representation of safety expertise on the Board, which could mean a safety expert from another field. In line with the CEO's responsibilities, the Board is responsible for making sure the correct oversight is in place, that quality and safety data are systematically reviewed, and that safety receives appropriate attention as a standing agenda item at all meetings. It is imperative that safety be a foundational factor in how healthcare Boards make decisions, so that patient and workforce safety culture is a sustainable focus for the organization.

	Foundational	Sustaining
Strategies <i>Overarching strategies for implementation at the CEO level</i>	<ul style="list-style-type: none"> ✓ CEO guarantees Board education on importance of safety, the meaning of quality and safety metrics, and safety culture principles and behaviors ✓ CEO ensures Board membership includes clinical, safety, and patient/family representation ✓ CEO provides adequate agenda time for review and discussion of safety culture metrics and issues ✓ CEO sets up quality and safety committee(s) with Board representation ✓ CEO ensures each Board agenda includes time designated for Chief Medical Officer or Chair of Quality and Safety Committee to present safety and quality data ✓ CEO develops a robust Board-level patient and workforce safety dashboard that includes culture of safety metrics 	<ul style="list-style-type: none"> ✓ CEO works with the Board to set direction, goals, metrics, and systems of mutual accountability for zero harm to both patients and the workforce ✓ CEO provides for the appropriate level of oversight of the credentialing and re-credentialing process, including elements of quality and safety ✓ CEO works with the Board and/or compensation committee to align executive compensation with patient and workforce safety and culture metrics ✓ CEO leverages patient stories and presentations to educate the Board ✓ CEO provides opportunities for Board member representation on appropriate safety committees

Board Engagement



Select, Develop, and Engage Your Board

In recruiting new Board members, considerable thought should be given to the competencies, skills, experiences, and diversity needed to create and sustain a culture of safety. These skills may include specific competencies related to leading culture improvement efforts, as well as clinical and safety competencies. Ensuring that there is robust clinical expertise in the Board room is critical to incorporating frontline perspective into all conversations and initiatives, and allows for collaborative leadership in safety efforts throughout the organization (Goeshel et al. 2010). These decisions should also include measures of diversity that ensure the board is representative of the community and workforce it serves. Finally, leaders may encourage Boards or relevant committees to include a patient and family representative and safety experts from relevant industries. These recommendations should be made at the appropriate level based on each unique organization's needs.

A well-rounded and diverse Board empowers and supports the work of the CEO in creating and sustaining a culture of safety. The importance of Board education and training in safety science fundamentals, including just culture, human factors, and systems engineering cannot be overemphasized (NPSF 2015). There is real power in support for the CEO from the Board regarding issues of safety, allowing this focus to cascade to leadership and, ultimately, throughout all levels of the organization.

Effective Patient and Family Representation on Boards and Committees:

CEOs should consider the following characteristics of effective representation, while keeping in mind the appropriate voice and level of representation of patient/family member(s) to meet the needs of their organization and community:

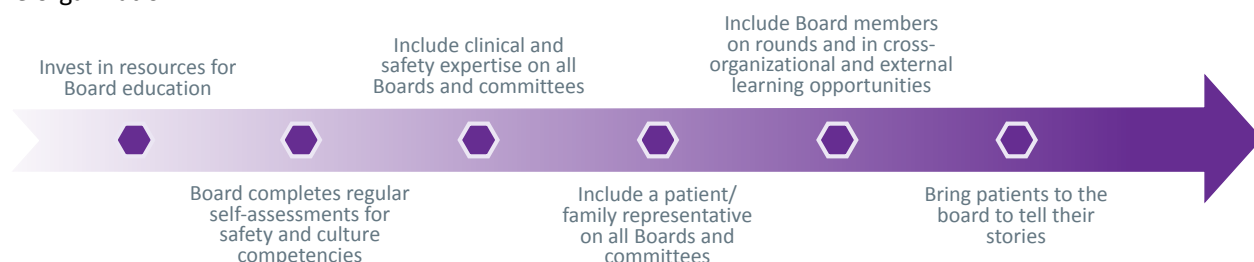
- 1 Culture of the Board encourages total engagement and involvement of patient/family member(s)
- 2 Patient/family member(s) are representative of the community the organization serves
- 3 Patient/family member(s) have representation on quality and safety committee(s) and other committees, as appropriate
- 4 Patient/family representative is provided with ongoing learning opportunities in safety science and safety culture

Board Engagement



Select, Develop, and Engage Your Board

An engaged Board plays a key role in organizational culture and safety. The CEO encourages Board competencies and commitment regarding safety, while providing a transparent line of sight between the Board and the rest of the organization.



Organizational Readiness Level	Foundational	Sustaining
Tactics <i>Examples of tactics that may be implemented to create change at each of these levels</i>	To engage your organization: <ul style="list-style-type: none"> ✓ Establish Board Quality and Safety Committee with oversight responsibility for culture change, safety, and performance improvement ✓ Include an individual with safety and culture expertise on Board and appropriate committees, or ensure an advisor with these skills is available to the CEO and the Board ✓ Begin each Board meeting with a slide detailing the number and names of patients and staff who experienced harm since last meeting, and include a story about at least one of these individuals ✓ Regularly share and discuss a dashboard that includes patient and workforce safety and culture metrics ✓ Utilize a Board self-assessment that includes inquiry on safety culture knowledge to determine educational opportunities ✓ Identify a list of required Board competencies specific to leading culture improvement 	To engage your organization: <ul style="list-style-type: none"> ✓ Encourage the Board to link executive compensation to safety outcomes, while ensuring metrics chosen do not discourage safety efforts ✓ Include Board members on guided leadership rounds ✓ Align Board dashboards to show safety and quality metrics as segmented by categories related to disparities in care ✓ Ask Board members to participate in events to show their support during Patient Safety Awareness Week and to be present at major quality, safety, and culture-related events ✓ Bring frontline teams to Board meetings to share their success stories and receive recognition ✓ Consider a rotating position on the Board or Quality and Safety Committee reserved for the frontline workforce ✓ Request that Board members spend time on all floors and units communicating and supporting the safety agenda

Board Engagement



Select, Develop, and Engage Your Board

Organizational Readiness Level	Foundational	Sustaining
Tactics <i>Examples of tactics that may be implemented to create change at each of these levels</i>	To engage your organization (cont): <ul style="list-style-type: none"> ✓ Discuss whether Board reflects the community your organization serves and implement action plan to address any gaps ✓ Invest in resources for Board education, including patient safety science and quality ✓ Create a matrix of Board competency needs and seek candidates with those skills in mind ✓ Regularly review accreditation survey results with the Board ✓ Encourage ample clinical expertise, including physicians and nurses on the Board and/or on Board committees ✓ Include a presentation on a current organizational safety culture issue by an expert in safety and quality at each Board meeting ✓ Educate Board members on issues of disparities in care 	To engage your organization (cont): <ul style="list-style-type: none"> ✓ Provide Board members with opportunities to learn from Boards and leaders of outside organizations and industries ✓ Require Board approval on resolutions to all serious safety events To engage clinical leaders: <ul style="list-style-type: none"> ✓ Involve physicians, nurses, and other clinical leaders to present clinical and quality improvement efforts regularly to the Board ✓ Bring clinical leaders dedicated to culture to Board meetings to share their experience and receive recognition To engage patients and families: <ul style="list-style-type: none"> ✓ Create positions for patient/family representatives on your Board and on your quality/safety committee(s) ✓ Present patient stories at Board and appropriate committee meetings ✓ Invite patients to attend Board meetings and personally share their stories and experiences (both positive and negative)
Assessing Execution <i>List of questions that should be asked to further assess and measure progress</i>	YES / NO <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Does the Board conduct regular self-assessments related to knowledge and understanding of culture of safety? <input type="checkbox"/> <input type="checkbox"/> Are programs in place to build competencies in culture improvement for Board members? <input type="checkbox"/> <input type="checkbox"/> Is the amount of time spent on quality and safety during each Board meeting tracked and at least comparable to time spent on finance and other items? <input type="checkbox"/> <input type="checkbox"/> Do performance assessments for the CEO include the organization's safety activities and measures of culture? <input type="checkbox"/> <input type="checkbox"/> Do patient safety and quality leaders participate in at least a portion of all Board meetings? <input type="checkbox"/> <input type="checkbox"/> Is a patient and/or workforce story presented at each Board meeting? 	

Leadership Development



Prioritize Safety in Selection and Development of Leaders

GOAL: EDUCATE AND DEVELOP LEADERS AT ALL LEVELS OF THE ORGANIZATION WHO EMBODY ORGANIZATIONAL PRINCIPLES AND VALUES OF SAFETY CULTURE.

Healthcare CEOs, in collaboration with the Board, are responsible for establishing the direction and accountability for the design and delivery of their organization-wide leadership development strategy. Within this strategy, it is imperative that safety is part of the education for both current and emerging leaders. It is the responsibility of the CEO to establish the priority for safety and culture in the development of leaders at all levels and in all departments across the organization.

Emphasis on safety education can also help close the gap between administrative and clinical leadership, providing all leaders with the shared goal of driving toward a culture of safety for the betterment of the organization and the patients they serve. Identifying and developing physician, nursing, and other clinical leaders as champions for safety is a key responsibility of the CEO. Numerous studies indicate the positive impact clinical leaders can have on culture and safety, particularly in an era when healthcare leaders are often in a position to make decisions that affect care at the frontlines. Clinical leaders have extensive understanding of healthcare's "core business" of patient care, and are therefore in a unique position to connect administration with the clinical workforce, and to garner support for safety and culture initiatives. In addition to safety education, CEOs can commit to developing effective physician, nursing, and other clinical leaders by providing and encouraging training in non-clinical skills, including professionalism, emotional intelligence, team building and communication, and basic business principles (Angood 2014).

	Foundational	Sustaining
Strategies <i>Overarching strategies for implementation at the CEO level</i>	<ul style="list-style-type: none"> ✓ CEO sets expectations and accountability for the design and delivery of the organization's leadership development strategy ✓ CEO ensures he/she and the leadership team receive necessary safety education, and provides the appropriate level of safety education throughout the rest of the organization ✓ CEO identifies physicians, nurses, and other clinical leaders as champions for safety 	<ul style="list-style-type: none"> ✓ CEO serves as a mentor for other C-Suite executives ✓ CEO establishes expectation that quality and safety performance and competence are required elements for evaluating current and potential leaders for promotion and succession planning ✓ CEO assigns accountability for measurable outcomes of safety education as part of leadership development strategy ✓ CEO ensures patient and workforce safety are key parts of the organization's reward and recognition system

Leadership Development



Prioritize Safety in Selection and Development of Leaders

The selection process for both current and emerging leaders should be predicated on their understanding of, dedication to, and alignment with the organization's vision for patient and workforce safety, communication skills, and modeling of expected safety behaviors. Safety can be a topic for individual professional development as well as organization-wide succession planning to ensure that the commitment to safety is sustainable throughout all levels and functional areas. Many organizations already have a process in place for identifying individuals with high potential to succeed as leaders, into which a safety and culture program can be integrated (Garman and Anderson 2014).

Finally, it is critically important to provide regular feedback to both current and developing leaders that is valuable to them, whether that is a 360-degree review model or another structured review (Garman and Anderson 2014). Feedback should clearly define, communicate, and embody required leadership competencies in safety culture, and safety development plans should be reviewed at regularly scheduled check-ins. CEOs are responsible for not only setting this direction, but also participating in these reviews from the perspective of gathering feedback about their own competence in safety culture and behaviors, and sharing input for members of their leadership team.

A well-developed leadership team that is dedicated to a culture of safety provides a catalyst for the evolution of the organization. The CEO, in collaboration with the Board, is responsible for establishing the direction and accountability for the design and delivery of an organization-wide leadership development strategy.



Leadership Development



Prioritize Safety in Selection and Development of Leaders

Organizational Readiness Level	Foundational	Sustaining
Tactics <i>Examples of tactics that may be implemented to create change at each of these levels</i>	To engage your organization: <ul style="list-style-type: none"> ✓ Define and develop organizational leadership competencies in safety culture and safety behaviors and ensure that all current and future leaders and the frontline workforce receive education in selected competencies ✓ Define cultural roles and expectations for all leaders within the organization, including clinical leaders ✓ Create systems to support leaders in culture work at all levels of the organization through training, coaching, and mentoring ✓ Consider safety expertise and credentialing along with leadership potential when considering emerging leaders ✓ Discuss whether leadership team reflects the community the organization serves and develop plan to address any gaps ✓ Create systems that ensure regular reporting on leadership development measures ✓ Develop and employ a talent review process that is candid and transparent ✓ Conduct gap analysis of CEO and leadership for knowledge, skills, and attitudes around patient safety and culture 	To engage your organization: <ul style="list-style-type: none"> ✓ Build an incentive program into leadership reviews that is focused on reporting performance on key culture of safety metrics ✓ Provide continuing learning opportunities in safety and culture, with a focus on experiential learning ✓ Tie measures and performance on safety and culture to leadership development priorities, talent management reviews, and succession planning ✓ Provide opportunities and expectations for leaders to learn outside of the organization, both with similar organizations and outside industries ✓ Build a guiding coalition of champions, including clinicians and frontline workforce members, that provides candid and honest feedback to the CEO ✓ Incorporate leadership development into organizational people strategy ✓ Define talent as an organizational resource and allow for interdepartmental training and mobility ✓ Ensure leaders are trained to teach and coach their employees ✓ Recommend that each senior executive participate in communication and apology to patients and families who have experienced harm

Leadership Development



Prioritize Safety in Selection and Development of Leaders

Organizational Readiness Level	Foundational	Sustaining
Tactics <i>Examples of tactics that may be implemented to create change at each of these levels</i>	To engage your organization (cont): <ul style="list-style-type: none"> ✓ Ensure all executives can clearly articulate how a culture of safety applies in their department, and that all leaders can do the same ✓ Develop systems that encourage deference to expertise rather than hierarchy or title in issues of safety 	To engage clinical leadership: <ul style="list-style-type: none"> ✓ In leadership development programs, incorporate opportunities for clinical leader advancement To engage patients and families: <ul style="list-style-type: none"> ✓ Ensure leaders have competencies in how to partner effectively with patients at all levels of care ✓ Include patient and family representatives in leadership recruitment and hiring process
Assessing Execution <i>List of questions that should be asked to further assess and measure progress</i>	YES / NO <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Do all leaders receive training in patient safety science and safety culture? <input type="checkbox"/> <input type="checkbox"/> Is at least one member of the executive leadership team a Certified Professional in Patient Safety or a safety expert? <input type="checkbox"/> <input type="checkbox"/> Are leadership development plans reviewed annually? Do they include measures of key safety culture competencies? <input type="checkbox"/> <input type="checkbox"/> Do leadership development programs include cultivation of a robust skill set in communication, engagement, listening, performance improvement, and emotional intelligence, as well as business acumen? 	

Just Culture



Lead and Reward a Just Culture

GOAL: BUILD A CULTURE IN WHICH ALL LEADERS AND THE WORKFORCE UNDERSTAND BASIC PRINCIPLES OF PATIENT SAFETY SCIENCE, AND RECOGNIZE ONE SET OF DEFINED AND ENFORCED BEHAVIORAL STANDARDS FOR ALL INDIVIDUALS IN THE ORGANIZATION.

Healthcare organizations that are successful in improving safety and eliminating harm have leaders who understand and commit to the principles of just culture. A just culture “focuses on identifying and addressing systems issues that lead individuals to engage in unsafe behaviors, while maintaining individual accountability by establishing zero tolerance for reckless behavior. Just organizations focus on identifying and correcting system imperfections, and pinpoint these defects as the most common cause of adverse events. Just culture distinguishes between human error (e.g., slips), at-risk behavior (e.g., taking shortcuts), and reckless behavior (e.g., ignoring required safety steps), in contrast to an overarching ‘no-blame’ approach” (AHRQ PSNet 2016).

	Foundational	Sustaining
Strategies <i>Overarching strategies for implementation at the CEO level</i>	<ul style="list-style-type: none"> ✓ CEO encourages commitment to just culture framework as an essential business philosophy ✓ CEO communicates and models the use of just culture principles in all decisions and actions as part of daily responsibilities and interactions, including root cause analysis ✓ CEO educates Board and leadership team on principles of just culture and role models these principles 	<ul style="list-style-type: none"> ✓ CEO employs just culture principles throughout organization and communicates that rules apply to all, regardless of rank, role and discipline ✓ CEO sets expectations for accountability for anyone interacting with the healthcare organization to commit to utilizing just culture principles in every day practice and decisions ✓ CEO ensures just culture principles are implemented in all interactions

A just culture is not a blame-free environment; clinicians and the workforce are still held accountable for following protocols and procedures. The vast majority of errors are not a result of individual failures, but are the result of systems that are inherently flawed and create environments of risk. A just culture acknowledges that punishing people for mistakes discourages reporting, fails to correct problems in the system, and sets up the likelihood of recurrence. Just culture also emphasizes the importance of the affected workforce after events occur, and focuses on support and peer-to-peer counseling for affected clinicians and the workforce.

When clearly defined, articulated, and implemented by leadership, a just culture approach encourages the reporting of errors, lapses, near-misses, and adverse events. It is through reporting and event analysis that the organization learns what went wrong, or could have gone wrong, and how to prevent it from happening again.

Just Culture



Lead and Reward a Just Culture

The hard work of establishing a just culture, however, goes well beyond agreeing to the concept itself. It involves incorporation of expertise in human factors engineering and systems design, full support and resources from the CEO and all leadership, and full engagement of departments such as Human Resources and Organizational Development. It also requires robust reporting systems with mechanisms in place to provide timely feedback to the workforce about not only what went wrong, but why it went wrong. This feedback also includes strong action plans to prevent future occurrence. Developing a just culture policy is just the first step, and organization-wide, systemic implementation is key.

While training of leaders and the patient safety workforce on just culture is vital, everyone at all levels of the organization must consistently integrate just culture principles as an organizational norm. The CEO's role in ensuring that just culture principles are understood and implemented across the organization is fundamental to success. If one individual within the organization is punished for a system flaw, just culture efforts can be severely undermined. Leaders must be transparent with the Board, physicians, the workforce, and the public about the organization's approach, so that when something does go wrong, the response is expected, practiced, and applied uniformly throughout the organization.

Just Culture Principles

Human behaviors within a just culture can be described as follows:

- **HUMAN ERROR** = An inadvertent slip or lapse. Human error is expected, so systems should be designed to help people do the right thing and avoid doing the wrong thing.
Response: Support the person who made the error. Investigate how the system can be altered to prevent the error from happening again.
- **AT-RISK BEHAVIOR** = Consciously choosing an action without realizing the level of risk of an unintended outcome.
Response: Counsel the person as to why the behavior is risky; investigate the reasons they chose this behavior, and enact system improvements if necessary.
- **RECKLESS BEHAVIOR (NEGLIGENCE)** = Choosing an action with knowledge and conscious disregard of the risk of harm.
Response: Disciplinary action.

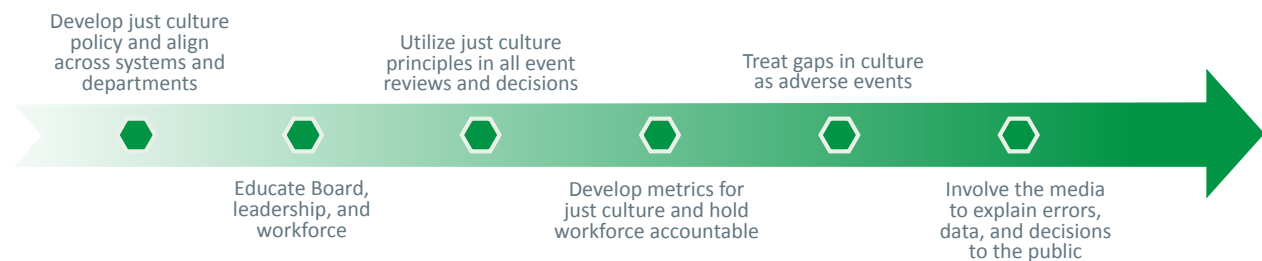
(AHRO PSNet 2016)

Just Culture



Lead and Reward a Just Culture

A just culture that focuses on identification and resolution of systems issues supports clinicians and the workforce when these systems break down. CEOs ensure that the principles of a just culture are implemented organization-wide and that they inform every action and decision.



Organizational Readiness Level	Foundational	Sustaining
Tactics <i>Examples of tactics that may be implemented to create change at each of these levels</i>	To engage your organization: <ul style="list-style-type: none"> ✓ Educate Board, leadership, and workforce about just culture through integrated training programs ✓ Develop and implement a decision-making process and application of just culture that is behavior-based, rather than harm-based ✓ Ensure organization-wide leadership commitment to frameworks of just culture and accountability that are aligned across all departments ✓ Create an interdisciplinary just culture champion team to review organizational policies, provide training, and ensure policies are being followed at all levels ✓ Identify metrics to track performance on just culture implementation 	To engage your organization: <ul style="list-style-type: none"> ✓ Educate organization to be responsive to and transparent about actions related to professional discipline ✓ Implement a peer support program ✓ Hold workforce accountable for implementing just culture principles in daily practice and decision-making ✓ Include actual and mock scenarios on meeting agendas that demonstrate application of just culture principles ✓ Involve the media as a way to explain errors, decisions, and data to the public ✓ Treat and respond to gaps in culture and expected safety behaviors as adverse events ✓ Expect that leaders utilize just culture tools in all situations, even those not significant or punishable, to ingrain principles and use into organizational norms

Just Culture



Lead and Reward a Just Culture

Organizational Readiness Level	Foundational	Sustaining
Tactics <i>Examples of tactics that may be implemented to create change at each of these levels</i>	To engage your organization (cont): <ul style="list-style-type: none"> ✓ Align systems and standards for just culture across all organizational departments, including Human Resources ✓ Ensure employees are well-trained in just culture algorithm and tools and utilize them in daily activities and decisions ✓ Publicly reward positive examples of just culture 	To engage clinical leadership: <ul style="list-style-type: none"> ✓ Include clinical leaders in the development of just culture policies ✓ Provide training for physicians, nurses, and other clinical leaders in just culture to build understanding and enthusiasm To engage patients and families: <ul style="list-style-type: none"> ✓ Ensure that patients and family members who serve on Board and committees are educated on just culture principles ✓ Include patients and families in mediation committees/tribunals to assist in resolving conflicts between departments
Assessing Execution <i>List of questions that should be asked to further assess and measure progress</i>	YES / NO <ul style="list-style-type: none"> <input type="checkbox"/> <input type="checkbox"/> Do Board, leadership, and workforce development programs include training on just culture? <input type="checkbox"/> <input type="checkbox"/> Is there one set of defined behavioral standards for all individuals within the organization, including leadership, physicians, and the workforce? <input type="checkbox"/> <input type="checkbox"/> Is compliance with the established just culture framework part of regularly reviewed performance reviews, including career development plans, for leaders and the workforce? <input type="checkbox"/> <input type="checkbox"/> Does the organization use, evaluate, and define action plans related to measures of just culture on employee surveys? <input type="checkbox"/> <input type="checkbox"/> Is there an existing measure that is regularly evaluated for assessing frontline knowledge of just culture algorithm? 	

Behavior Expectations



Establish Organizational Behavior Expectations

GOAL: CREATE ONE SET OF BEHAVIOR EXPECTATIONS THAT APPLY TO EVERY INDIVIDUAL IN THE ORGANIZATION AND ENCOMPASS THE MISSION, VISION, AND VALUES OF THE ORGANIZATION.

Much of the work involved in creating a culture of safety in healthcare is intrinsically linked to the everyday behaviors that characterize an organization (PSNet Patient Safety Primer: Safety Culture 2016). In fact, culture is often defined as “the way we do things around here.” CEOs set the tone and have the power and responsibility to establish behaviors, set expectations, and promote accountability for these behavioral norms for everyone, including both employed and non-employed individuals. It is essential for Board members, the CEO, and leaders at every level to model the behaviors they aim to cultivate throughout the organization.

	Foundational	Sustaining
Strategies <i>Overarching strategies for implementation at the CEO level</i>	<ul style="list-style-type: none"> ✓ CEO creates, communicates, and models an organizational climate of personal and professional accountability for behavior ✓ CEO establishes systems to recognize and reward desirable behaviors ✓ CEO activates organization to develop, implement, and evaluate programs that address and improve personal, professional, and organizational behavior and accountability ✓ CEO engages Board by sharing metrics and dashboards related to organizational behavior ✓ CEO engages and holds all leaders and workforce accountable for defined behaviors 	<ul style="list-style-type: none"> ✓ CEO prioritizes resources for professional accountability framework and programs to ensure and sustain behavioral excellence ✓ CEO ensures that succession planning and talent management programs prepare future leaders with competencies in organizational behavior and accountability ✓ CEO works with licensing bodies and medical executive committees, where applicable, to ensure behavioral expectations and accountability practices are consistent ✓ CEO and leaders at all levels of the organization encourage questions, increasing the likelihood that the right question will be asked at a critical time

Behavior Expectations



Establish Organizational Behavior Expectations

Chief among the behaviors that contribute to an environment of physical and psychological safety are transparency, effective teamwork, active communication, just culture, respect, and direct and timely feedback. Each of these can be learned, and the workforce should be educated about what is expected and why. For example, educating health professionals in effective communication with patients and families, whether disclosing an error, seeking informed consent, or practicing shared decision making, is a key part of cultivating teamwork, communication, and respect.

One of the first responsibilities of a CEO is to understand the current accepted behaviors within the organization. One way to achieve this understanding is through use of validated surveys of patient safety culture, which can help identify areas of strength as well as areas for improvement at organizational, departmental, and unit levels. Surveys can also reveal the strength or weaknesses of organizational culture and “subcultures,” and provide leaders a better sense of where they may need to focus attention. In this manner, leaders are able to better connect with the frontline workforce on a regular basis, whether through leadership rounding, safety huddles, briefings/debriefings, or other tactics, so they can hear about challenges firsthand. A Board, leadership, physician and other clinical professional, and workforce “credo” or compact also helps to communicate behavioral expectations. Such a compact can frame discussions and maintain accountability when someone violates the standard behavioral code (Webb et al. 2016).

It is also important to have a mechanism for escalating concerns when behavioral codes are violated and for dealing with disruptive and unsafe behaviors. Everyone within the organization should understand what that procedure is, and that it will be applied consistently across the organization, regardless of rank, department, revenue, or other considerations. It is essential to remember that the process of changing behavioral norms across an organization or system can be a long and challenging one. That is why it is equally important to ensure that there is also a system to reward individuals who are identified as modeling desired behavior. True progress can be accomplished with the dedication of a highly engaged, unwavering, and courageous CEO.

Importance of Physical and Psychological Safety of the Workforce

An environment that protects the physical and psychological safety of the workforce is fundamental to a culture of safety. Yet many healthcare workers suffer from harm, including bullying, burnout, and physical injury and assault, during the course of providing care. Under these conditions, it is difficult for care providers to find joy and purpose in their work, and patient safety is jeopardized. The prioritization of safety behaviors including respect, transparency, and teamwork is at the foundation of safety for the workforce, and therefore for patients. The workforce needs to know that their safety is an enduring, non-negotiable priority for the CEO and Board. This commitment is demonstrated when action plans are developed and implemented to ensure the workforce feels valued, safe from harm, and part of the solution for change (NPSF LLI 2013).

Behavior Expectations



Establish Organizational Behavior Expectations

Organizational safety behavior expectations are the daily demonstration of a true culture of safety. CEOs work with leaders and the workforce to develop these expectations and to personally demonstrate expected behaviors, while holding the leadership team accountable for doing the same.



Organizational Readiness Level	Foundational	Sustaining
Tactics <i>Examples of tactics that may be implemented to create change at each of these levels</i>	To engage your organization: <ul style="list-style-type: none"> ✓ Complete culture of safety surveys every 12-18 months and review with Board, leadership team, and workforce; set targets for improvement and take deliberate action to achieve them ✓ Stratify and track culture and safety metrics by sociodemographic variables that are important to the organization's community and develop plans to address any gaps ✓ Develop required processes for teamwork, communication, and handoffs among the workforce and with patients, using tools like SBAR, read back, "stop the line," briefings, and de-briefings ✓ Require, participate in, and give context for existing safety processes, including safety huddles and operational briefings, and use these opportunities as forums to build better teamwork and safety culture 	To engage your organization: <ul style="list-style-type: none"> ✓ Require annual signatures on compacts for Board members, leaders, and the workforce that clearly define expected professional accountability behaviors ✓ Educate and explain to your organization and the public what you will be transparent about, and what limits may exist on transparency ✓ Design and implement a crisis communications policy and plan for both internal and external audiences ✓ Align and integrate organizational safety and respectful behaviors with all departments across the organization ✓ Provide feedback to employees when they report a safety issue, closing the loop and demonstrating how frontline callouts improve safety ✓ Recognize and reward individuals and teams for demonstrating positive safety behaviors and reporting

Behavior Expectations



Establish Organizational Behavior Expectations

Organizational Readiness Level	Foundational	Sustaining
Tactics <i>Examples of tactics that may be implemented to create change at each of these levels</i>	To engage your organization (cont): <ul style="list-style-type: none"> ✓ Define organizational safety behavior expectations and respectful behaviors, as well as the organizational response to disrespectful behavior and conflict ✓ Proactively promote and encourage teamwork by implementing a formal team training program ✓ Break down hierarchical policies and systems for reporting, and encourage reporting without fear of punishment or retribution ✓ Break down power gradients by communicating and rewarding a policy that requires all staff to speak up for safety concerns ✓ Develop and abide by leadership behaviors, including appreciative or humble inquiry ✓ Celebrate and recognize individuals and teams who excel at key safety behaviors ✓ Work with key stakeholders to clearly communicate and enforce the same behavioral standards for both employed and non-employed practitioners and staff 	To engage your organization (cont): <ul style="list-style-type: none"> ✓ Ensure the existence of measurement tools and/or report cards for individual performance ✓ CEO requires and accepts notification of any serious safety events within 24 hours, without exception ✓ SBAR for all serious safety events is shared with full administrative and clinical leadership teams and with the Board ✓ Leadership distributes awards for teams and organizations based on culture of safety metrics To engage clinical leaders: <ul style="list-style-type: none"> ✓ Recognize and reward physicians, nurses, and other clinical leaders who actively participate in teamwork and communication initiatives ✓ Create (and require signatures on) physician and leadership compacts that clearly define behavioral expectations ✓ Commit to and train the workforce on communication and resolution programs To engage patients and families: <ul style="list-style-type: none"> ✓ Include patients in the development of required processes for communication with patients, using tools like AskMe3® and shared decision making ✓ Encourage and enable patients and families to report safety concerns, and follow up with families who have reported ✓ Ensure that safety behavior expectations are centered around the patient, and involve patients in setting these expectations ✓ Create, supply, and use understandable tools for patient involvement and shared decision making ✓ Invite patients to utilize versions of communication and reporting tools (e.g., SBAR) and to participate in team processes ✓ Have a designated team available to provide support to patients, families, and the workforce when an error has occurred

Behavior Expectations



Establish Organizational Behavior Expectations

Organizational Readiness Level	Foundational	Sustaining
Assessing Execution <i>List of questions that should be asked to further assess and measure progress</i>	YES / NO <input type="checkbox"/> <input type="checkbox"/> Does the organization have a clearly defined reporting system and measure utilization of this system (including follow-up and feedback processes)? <input type="checkbox"/> <input type="checkbox"/> Are organizational behavior expectations, such as use of huddles and briefings, with follow-up plans and identified owners of action items, implemented and reviewed regularly? <input type="checkbox"/> <input type="checkbox"/> Are professional accountability standards (e.g., a process to address disruptive behaviors) in place, used, and regularly evaluated? <input type="checkbox"/> <input type="checkbox"/> Are specific tools to encourage teamwork and clear communication in place, used, and regularly evaluated? <input type="checkbox"/> <input type="checkbox"/> Are communication and resolution/reconciliation programs in place, utilized, and regularly evaluated?	

Appendix

Key Terms Related to Patient Safety and a Culture of Safety

Based on AHRQ PSNet Glossary [nd], Runciman et al. 2009, and others as noted.

Adverse Event: Any injury caused by medical care. An undesirable clinical outcome that has resulted from some aspect of diagnosis or therapy, not an underlying disease process. Preventable adverse events are the subset that are caused by error.

Clinician: A health professional qualified in the clinical practice of medicine, such as a physician, nurse, pharmacist, or psychologist who is directly involved in patient care, as distinguished from one specializing in laboratory or research techniques or in theory.

Error: An act of commission (doing something wrong) or omission (failing to do the right thing) that leads to an undesirable outcome or significant potential for such an outcome.

Harm: An impairment of structure or function of the body and/or any deleterious effect arising therefrom, including disease, injury, suffering, disability, and death. Harm may be physical, social, or psychological, and either temporary or permanent.

Inclusion: Positively striving to meet the needs of different people and taking deliberate action to create environments where everyone feels respected and able to achieve their full potential (INVOLVE, NIHR 2012).

Just Culture: A culture that recognizes that individual practitioners should not be held accountable for system failings over which they have no control. A just culture also recognizes that many individual or “active” errors represent predictable interactions between human operators and the systems in which they work. However, in contrast to a culture that touts “no blame” as its governing principle, a just culture does not tolerate blameworthy behavior such as conscious disregard of clear risks to patients or gross misconduct (e.g., falsifying a record, performing professional duties while intoxicated).

Patient Safety: Patient safety refers to freedom from accidental or preventable injuries produced by medical care. Thus, practices or interventions that improve patient safety are those that reduce the occurrence of preventable adverse events.

Psychological Safety: Individuals’ perceptions about the consequences of interpersonal risks in their work environment. These perceptions include taken-for-granted beliefs about acceptable interactions with co-workers, superiors, and subordinates, and how others will respond when one puts oneself on the line, such as by asking a question, seeking feedback, reporting a mistake, or proposing a new idea (Edmondson 2011).

Respect: The treatment of others with deference in daily interactions, weighing their values, views, opinions and preferences (Sergen’s Medical Dictionary 2012).

Safety Culture/Culture of Safety: The safety culture of an organization is the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the characteristics of the organization’s health and safety management. Organizations with a positive safety culture are characterized by communications based on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures (Health and Safety Commission 1993).

Total Systems Safety: Safety that is systematic and uniformly applied (across the total process) (Pronovost et al. 2013). A systems approach can help with the design and integration of people, processes, policies, and organizations to promote better health at lower cost.

Trust: The collective expectations by the public and other clinicians that health care providers will demonstrate knowledge, skill, and competence, and will act in the best interest of both patients and colleagues with beneficence, fairness, and integrity (Calnan 2008).

Workforce: Health professionals and all other workers employed in health service or other settings, including but not limited to clinicians, administrators, medical records personnel, and laboratory assistants.

Workforce Safety: Healthcare workforce safety refers to freedom from both physical and psychological harm for all those who work with patients as well as those who oversee or provide non-clinical support for those who work with patients.

Zero Harm/Free from Harm: The total absence of physical and psychological injury to patients and the workforce.

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Self-Assessment Tool

Culture of Safety Organizational Self-Assessment

Please Note: The questions in this self-assessment represent a selection of elements from the report, “Leading a Culture of Safety: A Blueprint for Success.” This brief assessment may not accurately represent the full environment or state of each organization. It is recommended that teams review all strategies, tactics, and information in the full document for additional clarity and guidance.

Instructions:

- 1 **Select** a diverse team to lead the safety culture review and improvement process. It is recommended that this team include key C-Suite executives, clinical leadership, patient safety leadership, and a patient and family representative.
- 2 **Share** the guide, *Leading a Culture of Safety: A Blueprint for Success* with your team. Review the full document as a team or independently.
- 3 **Ask** each team member to complete this self-assessment independently. Conduct a series of meetings to:
 - A) Review self-assessment responses and scoring for each category as a team, and finalize your organizational score.
 - B) Develop action plans, metrics/dashboard, for assessment, and follow-up plans for low scoring domains (Refer back to *Leading a Culture of Safety: A Blueprint for Success* for assistance)
Note: if your team records low scores in Establish a Compelling Vision for Safety or Value Trust, Respect, and Inclusion, it is recommended that you begin with action plans for improvement in these domains.
 - C) Review improvement metrics, revisit action plans, and make adjustments as necessary. You should include additional team members and/or consultants where applicable.

Notes on Scoring:

Each statement should be scored on a scale of 1-5 based on the following:

- 1 – **Never** true for my organization
- 2 – **Rarely** true for my organization
- 3 – **Sometimes** true for my organization
- 4 – **Almost always** true for my organization
- 5 – **Always** true for my organization

If you are **unsure** of the response, please check the box titled unsure. When adding responses for a total score, this box should be recorded as a **0**. For any item where a member of the leadership team is unsure of the response, it is recommended that he or she spend time speaking with frontline staff and other appropriate individuals in the organization to determine the best answer.

Reviewing Responses:

The **total score** is the sum of the response for each of the three questions. The total score will correlate with one of the three ranges in the boxes below, 0 – 4, 5 – 9, or 10 – 15. Confirm that the **organizational state** box accurately describes the current state of your organization. If it does not, you may need to reevaluate your responses, or speak with additional individuals to better understand the current state of your organization.

Use the **recommended next steps** box in the column that correlates with your total score as a quick reference when developing action plans for improvement. For additional information and recommendations, refer to *Leading a Culture of Safety: A Blueprint for Success*.

Scoring:

- 1 – **Never** true for my organization
 2 – **Rarely** true for my organization
 3 – **Sometimes** true for my organization

- 4 – **Almost always** true for my organization
 5 – **Always** true for my organization
 0 – **Unsure** of the response

Establish a compelling vision for safety

MEASURABLE ELEMENTS	SCORE						OBSERVATIONS
<i>Key questions to ask about your organization's capabilities and processes.</i>	1	2	3	4	5	Unsure 0	<i>Please provide a brief description of why you chose this score, considering all parts of each question.</i>
1. My organization's safety vision statement and aspirational end state are clear and consistently communicated.							
2. My organization completes and reviews culture of safety surveys every 12 – 18 months with evidence of improvement.							
3. My organization's CEO and leadership team effectively build enthusiasm for and understanding of my organization's safety vision statement.							

Total Score = _____

	Score: 0 – 4	Score: 5 – 9	Score: 10 – 15
Organizational State <i>Brief description of current state of the organization</i>	Organization's vision statement does not reflect an end state of zero harm and is not regularly communicated to the workforce. Leaders and staff may have a difficult time understanding or communicating how their daily work contributes to advancement of the vision statement.	Organization has a defined vision with a clear, aspirational end state. Leaders communicate this vision consistently to the workforce, and understand how their work fits into the organizational vision statement. All members of the workforce are able to effectively communicate the vision statement.	Leaders and the workforce effectively communication the organization's vision to patients, families, and the public. The workforce is motivated by the vision statement and can clearly tie their daily work to the advancement of this vision. Metrics to benchmark progress toward vision are in place and regularly evaluated.
Recommended Next Steps <i>Recommended next steps for improvement and implementation are based on domain and included in Leading a Culture of Safety: A Blueprint for Success</i>	<i>Begin with review of Foundational tactics</i> Develop a vision statement with a clear end goal; Educate leaders and the workforce on the meaning of safety culture and zero harm; Host information sessions to build understanding and enthusiasm for the vision	<i>Review Foundational and Sustaining tactics</i> Encourage leader visibility on front lines and communication about how daily work advances vision; Hold leaders accountable for regularly and consistently communicating vision to all units and departments	<i>Review Foundational and Sustaining tactics</i> Share vision and action plans for change transparently with patients, families, and the public; Benchmark progress towards zero harm and share goals and strategies with similar organizations; Develop and support programs that recognize growth and adherence to vision

Scoring:

- 1 – **Never** true for my organization
 2 – **Rarely** true for my organization
 3 – **Sometimes** true for my organization

- 4 – **Almost always** true for my organization
 5 – **Always** true for my organization
 0 – **Unsure** of the response

Value trust, respect, and inclusion

MEASURABLE ELEMENTS	SCORE						OBSERVATIONS
<i>Key questions to ask about your organization's capabilities and processes.</i>	1	2	3	4	5	Unsure 0	<i>Please provide a brief description of why you chose this score, considering all parts of each question.</i>
1. My organization uses and regularly evaluates formal respect programs that provide education and support to patients and the workforce.							
2. My organization implements workforce safety programs to reduce physical and psychological harm to the workforce.							
3. My organization transparently shares information and metrics around harm events and action plans for improvement across our organization.							

Total Score = _____

	Score: 0 – 4	Score: 5 – 9	Score: 10 – 15
Organizational State <i>Brief description of current state of the organization</i>	CEO and organizational leaders understand the criticality of trust, inclusion, and respect, but may not model these values in all situations. The workforce fears punishment from reporting and disclosing errors to patients. Hierarchies based on rank and role exist throughout the organization.	Formal respect and teamwork programs are in place across the organization, and all staff participate in regular trainings. The workforce reports errors and close calls anonymously and without fear of retribution. Leaders across the organization embody behaviors that focus on trust, respect, and inclusion in all interactions.	Open and honest reporting is standard across the organization and includes defined feedback cycles. Both patients and the workforce are empowered to speak up about safety concerns. Robust communication and support programs are in place for patients, families, and the workforce.
Recommended Next Steps <i>Recommended next steps for improvement and implementation are based on domain and included in Leading a Culture of Safety: A Blueprint for Success</i>	<i>Begin with review of Foundational tactics</i> Develop organization-wide respect for people programs; Train all leaders, staff, and clinicians on respect program; Develop, implement, and train on anonymous reporting systems; Establish a patient and family advisory council	<i>Review Foundational and Sustaining tactics</i> Educate leaders and workforce on inclusion, diversity, and communication with both patients and co-workers; Develop and implement disclosure and apology program; Include metrics for trust, respect, and inclusion as part of annual review process for all leaders	<i>Review Foundational and Sustaining tactics</i> Publically share information about harm events and plans to prevent recurrence; Enable and encourage patients and families to speak up for safety through available tools and education programs; Provide cultural competency training for leaders and workforce; Regularly evaluate metrics on disparities in patient care

Scoring:

- 1 – **Never** true for my organization
 2 – **Rarely** true for my organization
 3 – **Sometimes** true for my organization

- 4 – **Almost always** true for my organization
 5 – **Always** true for my organization
 0 – **Unsure** of the response

Select, develop and engage your Board

MEASURABLE ELEMENTS	SCORE						OBSERVATIONS
<i>Key questions to ask about your organization's capabilities and processes.</i>	1	2	3	4	5	Unsure 0	<i>Please provide a brief description of why you chose this score, considering all parts of each question.</i>
1. At all Board meetings in my organization, the amount of time spent reviewing and discussing a transparent dashboard on safety and culture is equal to or greater than time spent reviewing financial performance.							
2. My organization's Board members are required to complete regular self-assessments and education related to safety culture and quality principles.							
3. Performance assessments and incentives for my organization's leadership are inclusive of safety culture metrics and performance.							

Total Score = _____

	Score: 0 – 4	Score: 5 – 9	Score: 10 – 15
Organizational State <i>Brief description of current state of the organization</i>	Organization's Board members have strong financial backgrounds, but lack quality and safety expertise. Safety metrics are presented briefly at each Board meeting, and few questions are asked. The majority of the meeting focuses on financial review.	Organization has a quality and safety committee that reviews all serious harm events, but these are rarely presented to the full Board. Time spent on safety during Board meetings includes a story of harm told by the safety/quality manager, and some questions are asked about the event. Board meetings prioritize financial review over safety review.	Organization's Board and committees include experts in safety, clinicians, and a patient and family representative. Patients are invited to meetings to present their experiences directly to the Board. Safety is a top priority and Board members understand how safety impacts the bottom line and feel empowered to ask questions.
Recommended Next Steps <i>Recommended next steps for improvement and implementation are based on domain and included in Leading a Culture of Safety: A Blueprint for Success</i>	<i>Begin with review of Foundational tactics</i> Provide educational opportunities in safety science and culture for all Board members; Include a safety expert on the Board; Develop a patient and workforce safety dashboard for regular review; Establish a quality and safety committee	<i>Review Foundational and Sustaining tactics</i> Consider including a patient/family representative on Board and all committees; Provide opportunities for all Board members to participate on guided leadership rounds; Share all serious safety events and action plans with the full Board	<i>Review Foundational and Sustaining tactics</i> Link CEO compensation and bonuses to performance on safety and culture metrics; Provide opportunities for Board members to learn from other organizations and industries; Bring frontline teams to Board meetings to tell their stories and be recognized for exemplary performance

Scoring:

- 1 – **Never** true for my organization
 2 – **Rarely** true for my organization
 3 – **Sometimes** true for my organization

- 4 – **Almost always** true for my organization
 5 – **Always** true for my organization
 0 – **Unsure** of the response

Prioritize safety in the selection and development of leaders

MEASURABLE ELEMENTS	SCORE						OBSERVATIONS
<i>Key questions to ask about your organization's capabilities and processes.</i>	1	2	3	4	5	Unsure 0	<i>Please provide a brief description of why you chose this score, considering all parts of each question.</i>
1. All leaders in my organization receive education and review opportunities in safety science and safety culture.							
2. My organization has defined roles, safety competencies, and development programs for leaders at all levels.							
3. My organization allows leaders opportunities for learning across departments and from outside organizations and industries.							

Total Score = _____

	Score: 0 – 4	Score: 5 – 9	Score: 10 – 15
Organizational State <i>Brief description of current state of the organization</i>	Organization's leaders are considered for development opportunities and promotion based on business and financial competencies. Leader development programs focus on executive leadership. All leaders have semi-regular reviews that focus on financial performance.	Organization's executive leaders are provided basic safety science and culture educational opportunities. Leadership development programs are in place at all levels and throughout the organization. Both current and emerging leaders have access to peer coaching and mentoring programs.	Leaders at all levels of the organization are required to complete safety culture training. Regular reviews for all leaders include safety and culture metrics. Leaders are provided opportunities to learn from outside organizations and industries and are able to transfer among departments and units based on interest and organizational needs.
Recommended Next Steps <i>Recommended next steps for improvement and implementation are based on domain and included in Leading a Culture of Safety: A Blueprint for Success</i>	<i>Begin with review of Foundational tactics</i> Define required leadership competencies in culture and safety; Conduct regular gap analyses for CEO and senior leader competencies in safety culture; Develop and implement an organization-wide leadership development program	<i>Review Foundational and Sustaining tactics</i> Provide continuing education opportunities in safety and culture for both new and emerging leaders; Develop systems that support leaders at all levels, including opportunities for cross-departmental training	<i>Review Foundational and Sustaining tactics</i> Provide leaders at all levels opportunities for learning outside the organization; Define talent as an organizational resource; Tie performance on safety culture to leadership development priorities and promotional opportunities

Scoring:

- 1 – **Never** true for my organization
 2 – **Rarely** true for my organization
 3 – **Sometimes** true for my organization

- 4 – **Almost always** true for my organization
 5 – **Always** true for my organization
 0 – **Unsure** of the response

Lead and reward a just culture

MEASURABLE ELEMENTS	SCORE						OBSERVATIONS
<i>Key questions to ask about your organization's capabilities and processes.</i>	1	2	3	4	5	Unsure 0	<i>Please provide a brief description of why you chose this score, considering all parts of each question.</i>
1. My organization uses a defined just culture policy during all review processes and decisions (e.g. not just harm event review).							
2. My organization regularly reviews metrics for just culture education and understanding and defines improvement opportunities.							
3. My organization has one set of defined and employed behavior standards and accountability guidelines in place for all individuals, regardless of department, rank, or role.							

Total Score = _____

	Score: 0 – 4	Score: 5 – 9	Score: 10 – 15
Organizational State <i>Brief description of current state of the organization</i>	Organization may have just culture policy but it is not robust or embedded in decisions and processes across the organization. Patient safety and risk management professionals are systematically trained in just culture principles.	Organization has a robust just culture policy that is well-communicated internally and utilized in processes and departments across the organization and/or system. All staff are trained on just culture principles and use of just culture algorithm.	Just culture algorithm is embedded in all reviews and decisions across all departments. The Board, leaders, and the workforce are held accountable for utilizing the just culture policy. Patients and the public are educated on just culture and transparency around events through their providers and use of the media.
Recommended Next Steps <i>Recommended next steps for improvement and implementation are based on domain and included in Leading a Culture of Safety: A Blueprint for Success</i>	<i>Begin with review of Foundational tactics</i> Develop a robust just culture policy; Educate the Board, leadership team, and workforce on just culture principles and the daily use of the just culture algorithm; Ensure utilization of just culture principles in all event reviews	<i>Review Foundational and Sustaining tactics</i> Work with the Board and organizational leaders to align just culture policies across all professions and departments; Develop and review metrics for just culture; Hold workforce accountable for the utilization of just culture algorithm	<i>Review Foundational and Sustaining tactics</i> Treat gaps in culture as adverse events requiring review with the just culture algorithm; Educate providers on transparent communication of errors; Work with the media to educate and inform the public about just culture and plans for improvement

Scoring:

- 1 – **Never** true for my organization
 2 – **Rarely** true for my organization
 3 – **Sometimes** true for my organization

- 4 – **Almost always** true for my organization
 5 – **Always** true for my organization
 0 – **Unsure** of the response

Establish organizational behavior expectations

MEASURABLE ELEMENTS	SCORE						OBSERVATIONS
<i>Key questions to ask about your organization's capabilities and processes.</i>	1	2	3	4	5	Unsure 0	<i>Please provide a brief description of why you chose this score, considering all parts of each question.</i>
1. My organization uses and regularly reviews a formal training program and defined processes for teamwork and communication.							
2. Professional accountability standards, including processes to address disruptive behavior and disrespect, are implemented uniformly across my organization.							
3. My organization has a program for recognition and celebration when individuals or teams excel at key safety behaviors and culture metrics.							

Total Score = _____

	Score: 0 – 4	Score: 5 – 9	Score: 10 – 15
Organizational State <i>Brief description of current state of the organization</i>	Behavior expectations vary across the organization, often based on department, unit, or role. Leaders and the workforce are not aware of defined standards of respectful behavior or consequences for disrespectful behavior. Best practices and standard processes also vary.	Behavior expectations are consistent across care providers, but organizational response to disruptive behavior may vary. Non-clinical departments, including finance and human resources, may not utilize common behavioral standards. Leaders are held accountable for modeling expected behaviors.	All members of the organization are held accountable for the same behavior expectations and have the same consequences for disrespectful behavior. Organization provides transparency of these expectations through patient/provider compacts. Leaders and the workforce are rewarded for exceptional teamwork and communication.
Recommended Next Steps <i>Recommended next steps for improvement and implementation are based on domain and included in Leading a Culture of Safety: A Blueprint for Success</i>	<i>Begin with review of Foundational tactics</i> Implement a formal team training program; Develop and communicate organization-wide behavioral expectations; Develop and implement standard processes for teamwork and communication	<i>Review Foundational and Sustaining tactics</i> Measure implementation and compliance of teamwork and communication programs; Develop compacts detailing behavior expectations for signature by leaders and the workforce; Ensure measurement tools and report cards for individual performance exist and are utilized	<i>Review Foundational and Sustaining tactics</i> Work with key stakeholders to ensure identical processes for employed and non-employed clinicians and staff; Develop required processes for communication and teamwork with patients and families; Develop standard tools for patient and family involvement in teamwork and communication processes

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STATE STATUTES

Current Through
August 2015

Mandatory Reporters of Child Abuse and Neglect

All States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands have statutes identifying persons who are required to report suspected child maltreatment to an appropriate agency, such as child protective services, a law enforcement agency, or a State's toll-free child abuse reporting hotline.

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Summaries of State laws

To find statute information for a particular State, go to

<https://www.childwelfare.gov/topics/systemwide/laws-policies/state/>



**Child Welfare
Information Gateway**

Children's Bureau/ACYF/ACF/HHS
800.394.3366 | Email: info@childwelfare.gov | <https://www.childwelfare.gov>



**Children's
Bureau**

Professionals Required to Report

Approximately 48 States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands designate professions whose members are mandated by law to report child maltreatment.¹ Individuals designated as mandatory reporters typically have frequent contact with children. Such individuals may include:

- Social workers
- Teachers, principals, and other school personnel
- Physicians, nurses, and other health-care workers
- Counselors, therapists, and other mental health professionals
- Child care providers
- Medical examiners or coroners
- Law enforcement officers

Some other professions frequently mandated across the States include commercial film or photograph processors (in 12 States, Guam, and Puerto Rico) and computer technicians (in 6 States).² Substance abuse counselors are required to report in 14 States, and probation or parole officers are mandatory reporters in 17 States.³ Directors, employees, and volunteers at entities that provide organized activities for children, such as camps, day camps, youth centers, and recreation centers, are required to report in 13 States.⁴ Six States and the District of Columbia include domestic violence workers on the list of mandated reporters, while six other States and the

District of Columbia include animal control or humane officers.⁵ Illinois includes both domestic violence workers and animal control or humane officers as mandatory reporters. Court-appointed special advocates are mandatory reporters in 11 States.⁶ Members of the clergy now are required to report in 27 States and Guam.⁷

Eleven States now have faculty, administrators, athletics staff, and other employees and volunteers at institutions of higher learning, including public and private colleges and universities and vocational and technical schools, designated as mandatory reporters.⁸

Reporting by Other Persons

In approximately 18 States and Puerto Rico, any person who suspects child abuse or neglect is required to report. Of these 18 States, 16 States and Puerto Rico specify certain professionals who must report, but also require all persons to report suspected abuse or neglect, regardless of profession.⁹ New Jersey and Wyoming require all persons to report without specifying any professions. In all other States, territories, and the District of Columbia, any person is permitted to report. These voluntary reporters of abuse are often referred to as “permissive reporters.”

¹ The word “approximately” is used to stress the fact that States frequently amend their laws. This information is current only through August 2015. At that time, New Jersey and Wyoming were the only two States that did not enumerate specific professional groups as mandated reporters but required all persons to report.

² Film processors are mandated reporters in Alaska, California, Colorado, Georgia, Illinois, Iowa, Louisiana, Maine, Missouri, Oklahoma, South Carolina, and West Virginia. Computer technicians are required to report in Alaska, California, Illinois, Missouri, Oklahoma, and South Carolina.

³ Substance abuse counselors are required to report in Alaska, California, Connecticut, Illinois, Iowa, Kansas, Massachusetts, Nevada, New York, North Dakota, Oregon, South Carolina, South Dakota, and Wisconsin. Probation or parole officers are mandated reporters in Arkansas, California, Colorado, Connecticut, Hawaii, Illinois, Louisiana, Massachusetts, Minnesota, Missouri, Nevada, North Dakota, South Dakota, Texas, Vermont, Virginia, and Washington.

⁴ California, Hawaii, Illinois, Louisiana, Maine, Nevada, New York, Ohio, Oregon, Pennsylvania, Vermont, Virginia, and West Virginia.

⁵ Domestic violence workers are mandated reporters in Alaska, Arizona, Arkansas, Connecticut, Maine, and South Dakota. Humane officers are mandated reporters in California, Colorado, Maine, Ohio, Virginia, and West Virginia.

⁶ Arkansas, California, Louisiana, Maine, Montana, Ohio, Oregon, South Carolina, Virginia, Washington, and Wisconsin.

⁷ Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Georgia, Illinois, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, Vermont, West Virginia, and Wisconsin. For more information, see Child Welfare Information Gateway’s *Clergy as Mandatory Reporters of Child Abuse and Neglect* at <https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/clergymandated/>.

⁸ Alabama, Arkansas, California, Georgia, Illinois, Iowa (includes only instructors at community colleges), Louisiana, Oregon, Pennsylvania, Virginia, and Washington.

⁹ Delaware, Florida, Idaho, Indiana, Kentucky, Maryland, Mississippi, Nebraska, New Hampshire, New Mexico, North Carolina, Oklahoma, Rhode Island, Tennessee, Texas, and Utah.

Institutional Responsibility to Report

The term “institutional reporting” refers to those situations in which the mandated reporter is working (or volunteering) as a staff member of an institution, such as a school or hospital, at the time he or she gains the knowledge that leads him or her to suspect that abuse or neglect has occurred. Many institutions have internal policies and procedures for handling reports of abuse, and these usually require the person who suspects abuse to notify the head of the institution that abuse has been discovered or is suspected and needs to be reported to child protective services or other appropriate authorities. Statutes in 33 States, the District of Columbia, and the Virgin Islands provide procedures that must be followed in those cases.¹⁰ In 18 States, the District of Columbia, and the Virgin Islands, any staff member who suspects abuse must notify the head of the institution when the staff member feels that abuse or possible abuse should be reported to an appropriate authority.¹¹ In nine States, the District of Columbia, and the Virgin Islands, the staff member who suspects abuse notifies the head of the institution first, and then the head or his or her designee is required to make the report.¹² In nine States, the individual reporter must make the report to the appropriate authority first and then notify the institution that a report has been made.¹³

Laws in 15 States make clear that, regardless of any policies within the organization, the mandatory reporter is not relieved of his or her responsibility to report.¹⁴ In 17 States, an employer is expressly prohibited from taking any action to prevent or discourage an employee from making a report.¹⁵

¹⁰ Alaska, Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Texas, Vermont, Virginia, West Virginia, Wisconsin, and Wyoming.

¹¹ California, Connecticut, Georgia, Hawaii, Idaho, Illinois, Indiana, Maine, Maryland, Massachusetts, Michigan, New York, Pennsylvania, South Dakota, Tennessee, Virginia, West Virginia, and Wyoming.

¹² Georgia, Idaho, Indiana, Kentucky, Maine, Massachusetts, South Dakota, Virginia, and Wyoming.

¹³ California, Connecticut (the Commissioner of Children and Families makes the notification), Hawaii, Illinois, Michigan, New York, Pennsylvania, Tennessee, and West Virginia.

¹⁴ Alaska, California, Florida, Indiana, Iowa, Kentucky, Maine, Michigan, Missouri, North Dakota, Oklahoma, Oregon, Tennessee, Texas, and Wyoming.

¹⁵ Alabama, Arkansas, California, Connecticut, Georgia, Illinois, Iowa, Massachusetts, Michigan, Missouri, New York, North Dakota, Oklahoma, Tennessee, Texas, Vermont, and Wisconsin.

Standards for Making a Report

The circumstances under which a mandatory reporter must make a report vary from State to State. Typically, a report must be made when the reporter, in his or her official capacity, *suspects* or *has reason to believe* that a child has been abused or neglected. Another standard frequently used is in situations in which the reporter has knowledge of, or observes a child being subjected to, conditions that would reasonably result in harm to the child. In Maine, a mandatory reporter must report when he or she has reasonable cause to suspect that a child is not living with the child’s family.

Mandatory reporters are required to report the facts and circumstances that led them to suspect that a child has been abused or neglected. They do not have the burden of providing proof that abuse or neglect has occurred. Permissive reporters follow the same standards when electing to make a report.

Privileged Communications

Mandatory reporting statutes also may specify when a communication is privileged. “Privileged communications” is the statutory recognition of the right to maintain confidential communications between professionals and their clients, patients, or congregants. To enable States to provide protection to maltreated children, the reporting laws in most States and territories restrict this privilege for mandated reporters. All but three States and Puerto Rico currently address the issue of privileged communications within their reporting laws, either affirming the privilege or denying it (i.e., not allowing privilege to be grounds for failing to report).¹⁶ For instance:

- The physician-patient and husband-wife privileges are the most common to be denied by States.
- The attorney-client privilege is most commonly affirmed.

¹⁶ Connecticut, Mississippi, and New Jersey do not currently address the issue of privileged communications within their reporting laws. The issue of privilege may be addressed elsewhere in the statutes of these States, such as rules of evidence.

- The clergy-penitent privilege is also widely affirmed, although that privilege usually is limited to confessional communications and, in some States, denied altogether.¹⁷

In Louisiana, a mental health or social services practitioner is not required to report if the practitioner is engaged by an attorney to assist in the provision of legal services to a child.

Inclusion of the Reporter's Name in the Report

Most States maintain toll-free telephone numbers for receiving reports of abuse or neglect.¹⁸ Reports may be made anonymously to most of these reporting numbers, but States find it helpful to their investigations to know the identity of reporters. Approximately 19 States, the District of Columbia, American Samoa, Guam, and the Virgin Islands currently require mandatory reporters to provide their names and contact information, either at the time of the initial oral report or as part of a written report.¹⁹ The laws in Connecticut, Delaware, and Washington allow child protection workers to request the name of the reporter. In Wyoming, the reporter does not have to provide his or her identity as part of the written report, but if the person takes and submits photographs or x-rays of the child, his or her name must be provided.

¹⁷ New Hampshire, North Carolina, Oklahoma, Rhode Island, Texas, West Virginia, and Guam disallow the use of the clergy-penitent privilege as grounds for failing to report suspected child abuse or neglect. For a more complete discussion of the requirement for clergy to report child abuse and neglect, see Information Gateway's *Clergy as Mandatory Reporters of Child Abuse and Neglect* at <https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/clergymandated/>.

¹⁸ For State-specific information about these hotlines, see Information Gateway's *State Child Abuse Reporting Numbers* at https://www.childwelfare.gov/organizations/?CWIGFunctionsaction=rols:main.dsprol&rolType=Custom&RS_ID=5.

¹⁹ Arizona, California, Colorado, Florida, Illinois, Indiana, Iowa, Louisiana, Maine, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, New Mexico, New York, North Carolina, Pennsylvania, and Vermont have this requirement.

Disclosure of the Reporter's Identity

All jurisdictions have provisions in statute to maintain the confidentiality of abuse and neglect records. The identity of the reporter is specifically protected from disclosure to the alleged perpetrator in 41 States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, and Puerto Rico.²⁰ This protection is maintained even when other information from the report may be disclosed.

Release of the reporter's identity is allowed in some jurisdictions under specific circumstances or to specific departments or officials, for example, when information is needed for conducting an investigation or family assessment or upon a finding that the reporter knowingly made a false report (in Alabama, Arkansas, Connecticut, Kentucky, Louisiana, Minnesota, Nevada, South Dakota, Vermont, and Virginia). In some jurisdictions (California, Florida, Minnesota, Tennessee, Texas, Vermont, the District of Columbia, and Guam), the reporter can waive confidentiality and give consent to the release of his or her name.

This publication is a product of the State Statutes Series prepared by Child Welfare Information Gateway. While every attempt has been made to be complete, additional information on these topics may be in other sections of a State's code as well as agency regulations, case law, and informal practices and procedures.

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²⁰ The statutes in Alaska, Delaware, Idaho, Maryland, Massachusetts, New Hampshire, Rhode Island, West Virginia, Wyoming, and the Virgin Islands do not specifically protect reporter identity but do provide for confidentiality of records in general.

Alabama

Professionals Required to Report

Ala. Code § 26-14-3

Reports are required from all of the following:

- Hospitals, clinics, sanitariums, doctors, physicians, surgeons, medical examiners, coroners, dentists, osteopaths, optometrists, chiropractors, podiatrists, pharmacists, physical therapists, and nurses
- Public and private K–12 employees, teachers, and school officials
- Peace officers and law enforcement officials
- Social workers
- Daycare workers or employees
- Mental health professionals
- Employees of public and private institutions of postsecondary and higher education
- Members of the clergy
- Any other person called upon to render aid or medical assistance to a child

Reporting by Other Persons

Ala. Code § 26-14-4

Any other person who has reasonable cause to suspect that a child is being abused or neglected may report.

Institutional Responsibility to Report

Ala. Code § 26-14-3

A public or private employer who discharges, suspends, disciplines, or penalizes an employee solely for reporting suspected child abuse or neglect pursuant to this section shall be guilty of a Class C misdemeanor.

Standards for Making a Report

Ala. Code § 26-14-3

A report must be made when the child is known or suspected of being a victim of abuse or neglect.

Privileged Communications

Ala. Code §§ 26-14-3; 26-14-10

Only clergy-penitent and attorney-client privileges are permitted.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity

Ala. Code § 26-14-8

The department will not release the identity of the reporter except under court order when the court has determined that the reporter knowingly made a false report.

Alaska

Professionals Required to Report

Alaska Stat. §§ 47.17.020; 47.17.023

The following persons are required to report:

- Health practitioners or administrative officers of institutions
- Teachers and school administrators, including athletic coaches, of public and private schools
- Child care providers
- Paid employees of domestic violence and sexual assault programs, crisis intervention and prevention programs, or organizations that provide counseling or treatment to individuals seeking to control their use of drugs or alcohol
- Peace officers or officers of the Department of Corrections
- Persons who process or produce visual or printed matter, either privately or commercially
- Members of a child fatality review team or the multidisciplinary child protection team
- Volunteers who interact with children in a public or private school for more than 4 hours a week

Reporting by Other Persons**Alaska Stat. § 47.17.020**

Mandated reporters may report cases that come to their attention in their nonoccupational capacities. Any other person who has reasonable cause to suspect that a child has been harmed may report.

Institutional Responsibility to Report**Alaska Stat. § 47.17.020(g)**

A person required to report child abuse or neglect who makes the report to the person's job supervisor or to another individual working for the entity that employs the person is not relieved of the obligation to make the report to the department as required by law.

Standards for Making a Report**Alaska Stat. §§ 47.17.020; 47.17.023**

A report must be made when, in the performance of his or her occupational or appointed duties, a reporter has reasonable cause to suspect that a child has suffered harm as a result of abuse or neglect.

A person providing—either privately or commercially—film, photo, visual, printed matter processing, production, or finishing services; or computer installation, repair, or other services; or Internet or cellular telephone services; who in the process of providing those services observes a film, photo, picture, computer file, image, or other matter and has reasonable cause to suspect that the film, photo, picture, computer file, image, or other matter visually depicts a child engaged in conduct described in § 11.41.455(a) [sexual exploitation of a minor or child pornography], shall immediately report the observation to the nearest law enforcement agency.

Privileged Communications**Alaska Stat. § 47.17.060**

Neither the physician-patient nor the husband-wife privilege is recognized.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity

This issue is not addressed in the statutes reviewed.

American Samoa**Professionals Required to Report****Ann. Code § 45.2002**

The following persons are required to report:

- Physicians or surgeons, including physicians in training, osteopaths, optometrists, chiropractors, podiatrists, child health associates, medical examiners or coroners, dentists, nurses, or hospital personnel
- Christian Science practitioners
- School officials or employees
- Social workers or workers in family care homes or child care centers
- Mental health professionals

Reporting by Other Persons**Ann. Code § 45.2002**

All other persons are urged and authorized to report.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report**Ann. Code § 45.2002**

A report is required when:

- A reporter has reasonable cause to know or suspect that a child has been subjected to abuse or neglect.
- A reporter has observed the child being subjected to circumstances or conditions that would result in abuse or neglect.

Privileged Communications**Ann. Code § 45.2016**

The physician-patient privilege and the husband-wife privilege are not recognized as grounds for excluding evidence.

Inclusion of Reporter's Name in Report**Ann. Code § 45.2010**

The name, address, and occupation of the person making the report must be included in the report.

Disclosure of Reporter Identity**Ann. Code § 45.2027**

The identity of the reporter is not released to the subject of the report if that release would be detrimental to the safety or interests of the reporter.

Arizona**Professionals Required to Report****Rev. Stat. § 13-3620**

The following persons are required to report:

- Physicians, physician's assistants, optometrists, dentists, behavioral health professionals, nurses, psychologists, counselors, or social workers
- Peace officers, child welfare investigators, or child protective services workers
- Members of the clergy, priests, or Christian Science practitioners
- Parents, stepparents, or guardians
- School personnel or domestic violence victim advocates
- Any other person who has responsibility for the care or treatment of minors

Reporting by Other Persons**Rev. Stat. § 13-3620**

Any other person who reasonably believes that a minor is a victim of abuse or neglect may report.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report**Rev. Stat. § 13-3620**

A report is required when a person reasonably believes that a minor is or has been the victim of physical injury, abuse, child abuse, a reportable offense, or neglect that appears to have been inflicted on the minor by other than accidental means or that is not explained by the available medical history as being accidental in nature.

A 'reportable offense' means any of the following:

- Any offense listed in chapters 14 and 35.1 of this title or § 13-3506.01
- Surreptitious photographing, videotaping, filming, or digitally recording or viewing a minor pursuant to § 13-3019
- Child prostitution pursuant to § 13-3212
- Incest pursuant to § 13-3608
- Unlawful mutilation pursuant to § 13-1214

Privileged Communications**Rev. Stat. § 13-3620**

Only the attorney-client and the clergy-penitent privileges are recognized.

Inclusion of Reporter's Name in Report**Rev. Stat. § 8-455**

A report made to the child abuse hotline that is maintained by the Department of Child Safety must include the name and address or contact information for the person making the report.

Disclosure of Reporter Identity**Rev. Stat. § 8-807**

Before it releases records pertaining to child maltreatment investigations, the department shall take whatever precautions it determines are reasonably necessary to protect the identity and safety of a person who reports child abuse or neglect.

Arkansas**Professionals Required to Report****Ann. Code § 12-18-402**

The following individuals are mandated reporters:

- Child care, daycare, or foster care workers
- Coroners
- Dentists and dental hygienists
- Domestic abuse advocates and domestic violence shelter employees or volunteers
- Employees of the Department of Human Services
- Employees working under contract for the Division of Youth Services of the Department of Human Services
- Foster parents
- Judges, law enforcement officials, peace officers, and prosecuting attorneys
- Licensed nurses, physicians, mental health professionals or paraprofessionals, surgeons, resident interns, osteopaths, and medical personnel who may be engaged in the admission, examination, care, or treatment of persons
- Public or private school counselors; school officials, including without limitation institutions of higher education; and teachers
- Social workers and juvenile intake or probation officers
- Court-appointed special advocate program staff members or volunteers
- Attorneys ad litem
- Clergy members, which include ministers, priests, rabbis, accredited Christian Science practitioners, or other similar functionary of a religious organization
- Employees of a child advocacy center or a child safety center
- Sexual abuse advocates or volunteers who work with victims of sexual abuse
- Child abuse advocates or volunteers who work with child victims of abuse or maltreatment as employees of a community-based victim service or a mental health agency
- Victim/witness coordinators
- Victim assistance professionals or volunteers
- Employees of the Crimes Against Children Division of the Department of Arkansas State Police
- Employees or volunteers at reproductive health-care facilities
- An individual not otherwise identified in this subsection who is engaged in performing his or her employment duties with a nonprofit charitable organization other than a nonprofit hospital

Reporting by Other Persons**Ann. Code § 12-18-401**

Any person who has reasonable cause to suspect child maltreatment may report.

Institutional Responsibility to Report**Ann. Code §§ 12-18-402(c); 12-18-204**

An employer or supervisor of an employee identified as a mandated reporter shall not prohibit an employee or a volunteer from directly reporting child maltreatment to the Child Abuse Hotline.

An employer or supervisor of an employee identified as a mandated reporter shall not require an employee or a volunteer to obtain permission or notify any person, including an employee or a supervisor, before reporting child maltreatment to the Child Abuse Hotline.

Nothing in the reporting laws shall prohibit any person or institution from requiring an employee or volunteer who is a mandatory reporter to inform a representative of that person or institution that the reporter has made a report to the Child Abuse Hotline.

Standards for Making a Report**Ann. Code § 12-18-402**

An individual listed as a mandatory reporter shall immediately notify the Child Abuse Hotline if he or she:

- Has reasonable cause to suspect that a child has been subjected to maltreatment, has died as a result of maltreatment, or died suddenly and unexpectedly
- Observes a child being subjected to conditions or circumstances that would reasonably result in maltreatment

Privileged Communications**Ann. Code §§ 12-18-402(c); 12-18-803**

A privilege or contract shall not prevent a person from reporting child maltreatment when he or she is a mandated reporter and required to report under this section.

No privilege, except that between a lawyer and a client and between a minister, including a Christian Science practitioner, and a person confessing to or being counseled by a minister, shall prevent anyone from testifying concerning child maltreatment.

When a physician, psychologist, psychiatrist, counselor, or therapist conducts interviews with or provides therapy to a subject of a report of suspected child maltreatment for purposes related to child maltreatment, the physician, psychologist, psychiatrist, licensed counselor, or therapist is deemed to be performing services on behalf of the child.

An adult subject of a report of suspected child maltreatment cannot invoke privilege on the child's behalf.

Inclusion of Reporter's Name in Report**Ann. Code § 12-18-302**

A mandated reporter may report child maltreatment or suspected child maltreatment by telephone call, facsimile transmission, or online reporting.

Facsimile transmission and online reporting may be used in nonemergency situations by an identified mandated reporter who provides the following contact information:

- Name and phone number
- In the case of online reporting, his or her email address

A mandated reporter who wishes to remain anonymous shall make a report through the toll-free Child Abuse Hotline telephone system.

Disclosure of Reporter Identity**Ann. Code § 12-18-909**

The identity of the reporter shall not be disclosed unless a court determines that the reporter knowingly made a false report.

California**Professionals Required to Report****Penal Code § 11165.7**

Mandated reporters include the following:

- Teachers, teacher's aides, administrators, and employees of public or private schools
- Administrators or employees of day camps, youth centers, or youth recreation programs
- Administrators or employees of licensed community care or child daycare facilities; Head Start program teachers

- Public assistance workers
- Foster parents, group home personnel, and personnel of residential care facilities
- Social workers, probation officers, and parole officers
- Employees of school district police or security departments
- District attorney investigators, inspectors, or local child support agency caseworkers
- Peace officers and firefighters, except for volunteer firefighters
- Physicians, surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, optometrists, marriage and family therapists, or social workers
- State or county public health employees who treat minors for venereal diseases or other conditions
- Coroners and medical examiners
- Commercial film and photographic print or image processors; computer technicians
- Child visitation monitors
- Animal control or humane society officers
- Clergy members and custodians of records of clergy members
- Employees of police departments, county sheriff's departments, county probation departments, or county welfare departments
- Employees or volunteers of a court-appointed special advocate program
- Alcohol and drug counselors
- Employees or administrators of public or private postsecondary institutions
- Athletic coaches, athletic administrators, or athletic directors employed by any public or private schools
- Athletic coaches, including, but not limited to, assistant coaches or graduate assistants involved in coaching at public or private postsecondary institutions

Reporting by Other Persons

Penal Code §§ 11165.7; 11166

Volunteers of public or private organizations whose duties require direct contact with and supervision of children are not mandated reporters but are encouraged to obtain training in the identification and reporting of child abuse and neglect and are further encouraged to report known or suspected instances of child abuse or neglect.

Any other person who reasonably suspects that a child is a victim of abuse or neglect may report.

For the purposes of this section, 'any other person' includes a mandated reporter who acts in his or her private capacity and not in his or her professional capacity or within the scope of his or her employment.

Institutional Responsibility to Report

Penal Code § 11166(h)-(i)

When two or more persons, who are required to report have joint knowledge of a known or suspected instance of child abuse or neglect, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member who was originally designated to report has failed to do so shall thereafter make the report.

The reporting duties under this section are individual; no supervisor or administrator may impede or inhibit the reporting duties, and no person making a report shall be subject to any sanction for making the report. However, internal procedures to facilitate reporting and apprise supervisors and administrators of reports may be established, provided that they are not inconsistent with this article. The internal procedures shall not require any employee required to make reports to disclose his or her identity to the employer.

Reporting the information regarding a case of possible child abuse or neglect to an employer, supervisor, school principal, school counselor, coworker, or other person shall not be a substitute for making a mandated report to an agency specified in § 11165.9.

Standards for Making a Report

Penal Code §§ 11166; 11165.7

A report is required when:

- A mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the reporter knows or reasonably suspects is the victim of abuse or neglect.
- Commercial film and photographic print processors have knowledge of or observe any film, photograph, videotape, negative, or slide depicting a child under age 16 engaged in an act of sexual conduct.

- Commercial computer technicians have knowledge of or observe, within the scope of their professional capacity or employment, any representation of information, data, or an image, including, but not limited to, any computer hardware, software, file, floppy disk, data storage medium, CD-ROM, computer-generated equipment, or computer-generated image, that is retrievable in perceivable form and that is intentionally saved, transmitted, or organized on an electronic medium, depicting a child under age 16 engaged in an act of sexual conduct.

For the purposes of this article, 'reasonable suspicion' means that it is objectively reasonable for a person to entertain a suspicion based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect. 'Reasonable suspicion' does not require certainty that child abuse or neglect has occurred nor does it require a specific medical indication of child abuse or neglect; any 'reasonable suspicion' is sufficient. For the purposes of this article, the pregnancy of a minor does not, in and of itself, constitute a basis for a reasonable suspicion of sexual abuse.

Privileged Communications Penal Code § 11166

The clergy-penitent privilege is permitted for penitential communications. This does not modify or limit a clergy member's duty to report known or suspected child abuse or neglect when the clergy member is acting in some other capacity that would otherwise make the clergy member a mandated reporter.

Inclusion of Reporter's Name in Report Penal Code § 11167

Reports of mandated reporters shall include:

- The name, business address, and telephone number of the mandated reporter
- The capacity that makes the person a mandated reporter

Reports of other persons do not require the reporter's name.

Disclosure of Reporter Identity Penal Code § 11167

The identity of the reporter shall be confidential and disclosed only:

- Among agencies receiving or investigating mandated reports
- To the prosecutor in a criminal prosecution or in an action initiated under § 602 of the Welfare and Institutions Code arising from alleged child abuse
- To counsel appointed pursuant to § 317(c) of the Welfare and Institutions Code
- To the county counsel or prosecutor in a proceeding under Part 4 (commencing with Section 7800) of Division 12 of the Family Code or § 300 of the Welfare and Institutions Code
- To a licensing agency when abuse or neglect in out-of-home care is reasonably suspected
- When the reporter waives confidentiality
- By court order

Colorado

Professionals Required to Report Rev. Stat. § 19-3-304

Persons required to report include:

- Physicians, surgeons, physicians in training, child health associates, medical examiners, coroners, dentists, osteopaths, optometrists, chiropractors, podiatrists, nurses, hospital personnel, dental hygienists, physical therapists, pharmacists, or registered dietitians
- Public or private school officials or employees
- Social workers, Christian Science practitioners, mental health professionals, psychologists, professional counselors, and marriage and family therapists
- Veterinarians, peace officers, firefighters, or victim's advocates
- Commercial film and photographic print processors
- Counselors, marriage and family therapists, or psychotherapists

- Clergy members, including priests; rabbis; duly ordained, commissioned, or licensed ministers of a church; members of religious orders; or recognized leaders of any religious bodies
- Workers in the State Department of Human Services
- Juvenile parole and probation officers
- Child and family investigators
- Officers and agents of the State Bureau of Animal Protection and animal control officers
- The child protection ombudsman
- Educators providing services through a Federal special supplemental nutrition program for women, infants, and children, as provided for in 42 U.S.C. § 1786
- Directors, coaches, assistant coaches, or athletic program personnel employed by private sports organizations or programs
- Persons registered as psychologist candidates, marriage and family therapist candidates or licensed professional counselor candidates
- Emergency medical service providers

Reporting by Other Persons**Rev. Stat. § 19-3-304**

Any other person may report known or suspected child abuse or neglect.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report**Rev. Stat. § 19-3-304**

A report is required when:

- A mandated reporter has reasonable cause to know or suspect child abuse or neglect.
- A reporter has observed a child being subjected to circumstances or conditions that would reasonably result in abuse or neglect.
- Commercial film and photographic print processors have knowledge of or observe any film, photograph, videotape, negative, or slide depicting a child engaged in an act of sexual conduct.

Privileged Communications**Rev. Stat. §§ 19-3-304; 19-3-311**

The clergy-penitent privilege is permitted. The physician-patient, psychologist-client, and husband-wife privileges are not allowed as grounds for failing to report.

Inclusion of Reporter's Name in Report**Rev. Stat. § 19-3-307**

The report shall include the name, address, and occupation of the person making the report.

Disclosure of Reporter Identity**Rev. Stat. § 19-1-307**

The identity of the reporter shall be protected.

Connecticut**Professionals Required to Report****Gen. Stat. §§ 17a-101; 53a-65**

The following persons are required to report:

- Physicians, surgeons, residents, interns, nurses, medical examiners, dentists, dental hygienists, optometrists, chiropractors, podiatrists, physician assistants, pharmacists, or physical therapists
- Psychologists or other mental health professionals
- School employees, as defined by § 53a-65
- Social workers

- Police officers, juvenile or adult probation officers, or parole officers
- Members of the clergy
- Alcohol and drug counselors, marital and family therapists, professional counselors, sexual assault counselors, or domestic violence counselors
- Licensed foster parents
- Emergency medical services providers
- Any person paid to care for a child in any public or private facility, child daycare center, group daycare home, or family daycare home that is licensed by the State
- Employees of the Department of Children and Families, the Department of Public Health, and the Office of Early Childhood who are responsible for the licensing of child daycare centers, group daycare homes, family daycare homes, or youth camps
- The Child Advocate and any employee of the Office of Child Advocate
- Family relations counselor trainees or family services supervisors employed by the Judicial Department

The term 'school employee' includes teachers, substitute teachers, school administrators, school superintendents, guidance counselors, psychologists, social workers, nurses, physicians, school paraprofessionals, or coaches employed by a local or regional board of education or a private elementary, middle, or high school or any other person who, in the performance of his or her duties, has regular contact with students.

Reporting by Other Persons

Gen. Stat. § 17a-103

Any mandated reporter acting outside his or her professional capacity, or any other person having reasonable cause to suspect that a child is being abused or neglected, may report.

Institutional Responsibility to Report

Gen. Stat. §§ 17a-101b(d); 17a-101e(a)

Whenever a mandated reporter has reasonable cause to suspect or believe that any child has been abused or neglected by a member of the staff of a public or private institution or facility that provides care for such child or a public or private school, the mandated reporter shall report as required by law. The Commissioner of Children and Families or the commissioner's designee shall notify the principal, headmaster, executive director, or other person in charge of the institution, facility, or school, or that person's designee, unless that person is the alleged perpetrator of the abuse or neglect of the child. In the case of a public school, the commissioner also shall notify the person's employing superintendent. The person in charge or the person's designee then shall immediately notify the child's parent or other person responsible for the child's care that a report has been made.

No employer shall:

- Discharge or in any manner discriminate or retaliate against any employee who in good faith makes a report of child abuse or neglect, testifies, or is about to testify in any proceeding involving child abuse or neglect
- Hinder, prevent, or attempt to hinder or prevent any employee from making a report as required or testifying in any proceeding involving child abuse or neglect

Standards for Making a Report

Gen. Stat. § 17a-101a

A report is required when, in the ordinary course of his or her employment or profession, a reporter has reasonable cause to suspect or believe that any child under age 18:

- Has been abused or neglected
- Has had a nonaccidental physical injury or an injury that is at variance with the history given of the injury
- Is placed at imminent risk of serious harm

Any school employee shall report when, in the ordinary course of his or her employment or profession, he or she has reasonable cause to suspect or believe that any person who is being educated by the technical high school system or a local or regional board of education, other than as part of an adult education program, is a victim of abuse and the perpetrator is a school employee.

A mandated reporter's suspicion or belief may be based on factors, including, but not limited to, observations, allegations, facts, or statements by a child, victim, or a third party. Such suspicion or belief does not require certainty or probable cause.

Privileged Communications

This issue is not addressed in the statutes reviewed.

Inclusion of Reporter's Name in Report**Gen. Stat. §§ 17a-101d; 17a-103**

The reporter is not specifically required by statute to include his or her name in the report. The Commissioner of Children and Families shall use his or her best efforts to obtain the name and address of the reporter.

Disclosure of Reporter Identity**Gen. Stat. § 17a-28(f)**

The name of an individual reporting suspected child abuse or neglect or cooperating with an investigation of child abuse or neglect shall be kept confidential upon request or upon determination by the department that disclosure of such information may be detrimental to the safety or interests of the individual.

When there is reasonable cause to believe that the reporter knowingly made a false report, however, the name of any such individual shall be disclosed to:

- An employee of the department for reasons reasonably related to the business of the department
- A law enforcement officer for purposes of investigating:
 - » Abuse or neglect of a child or youth
 - » An allegation that the individual falsely reported the suspected abuse or neglect of a child or youth
- A State's attorney for purposes of investigating or prosecuting:
 - » Abuse or neglect of a child or youth
 - » An allegation that the individual falsely reported the suspected abuse or neglect of a child or youth
- An assistant attorney general or other legal counsel representing the department
- A judge of the Superior Court and all necessary parties in a court proceeding pursuant to § 17a-112 or 46b-129, or a criminal prosecution involving child abuse or neglect
- A State child care licensing agency
- The executive director of any institution, school, or facility or superintendent of schools pursuant to § 17a-101i

Delaware**Professionals Required to Report****Ann. Code Tit. 16, § 903**

Any person, agency, organization, or entity that knows or in good faith suspects child abuse or neglect shall make a report. For purposes of this section, 'person' shall include, but not be limited to:

- Physicians, interns, residents, nurses, or medical examiners
- Other persons in the healing arts, including persons licensed to render services in medicine, osteopathy, or dentistry
- School employees, social workers, or psychologists
- Hospitals or health-care institutions
- The Medical Society of Delaware
- Law enforcement agencies

Reporting by Other Persons**Ann. Code Tit. 16, § 903**

Any person who knows or in good faith suspects child abuse or neglect shall make a report.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report**Ann. Code Tit. 16, § 903**

A report is required when the reporter knows or in good faith suspects child abuse or neglect.

Privileged Communications**Ann. Code Tit. 16, § 909**

Only attorney-client and clergy-penitent privileges are recognized.

Inclusion of Reporter's Name in Report**Ann. Code Tit. 16, § 905**

Although reports may be made anonymously, the Division of Family Services shall request the name and address of any person making a report.

Disclosure of Reporter Identity

This issue is not addressed in the statutes reviewed.

District of Columbia**Professionals Required to Report****Ann. Code § 4-1321.02**

Persons required to report include:

- Child and Family Services Agency employees, agents, and contractors
- Physicians, psychologists, medical examiners, dentists, chiropractors, registered nurses, licensed practical nurses, or persons involved in the care and treatment of patients
- Law enforcement officers or humane officers of any agency charged with the enforcement of animal cruelty laws
- School officials, teachers, or athletic coaches
- Department of Parks and Recreation employees, public housing resident managers, social service workers, or daycare workers
- Human trafficking counselors
- Domestic violence counselors or mental health professionals

Reporting by Other Persons**Ann. Code § 4-1321.02**

Any other person who knows or has reason to suspect that a child is being abused or neglected may report.

Institutional Responsibility to Report**Ann. Code § 4-1321.02**

Whenever a person is required to report in his or her capacity as a member of the staff of a hospital, school, social agency, or similar institution, he or she shall immediately notify the person in charge of the institution or his or her designated agent who shall then be required to make the report. The fact that such a notification has been made does not relieve the person who was originally required to report from his or her duty to report.

Standards for Making a Report**Ann. Code § 4-1321.02**

A report is required when:

- A mandated reporter knows or has reasonable cause to suspect that a child known to him or her in his or her professional or official capacity has been or is in immediate danger of being a mentally or physically abused or neglected child.
- A health professional, law enforcement officer, or humane officer, except an undercover officer whose identity or investigation might be jeopardized, has reasonable cause to believe that a child is abused as a result of inadequate care, control, or subsistence in the home environment due to exposure to drug-related activity.
- A mandated reporter knows or has reasonable cause to suspect that a child known to him or her in his or her professional or official capacity has been, or is in immediate danger of being, the victim of sexual abuse or attempted sexual abuse; the child was assisted, supported, caused, encouraged, commanded, enabled, induced, facilitated, or permitted to become a prostitute; the child has an injury caused by a bullet; or the child has an injury caused by a knife or other sharp object that was caused by other than accidental means.
- A licensed health professional who in his or her own professional or official capacity knows that a child under 12 months of age is diagnosed as having a Fetal Alcohol Spectrum Disorder.

Privileged Communications**Ann. Code §§ 4-1321.02(b); 4-1321.05**

A mandated reporter is not required to report when employed by a lawyer who is providing representation in a criminal, civil (including family law), or delinquency matter, and the basis for the suspicion arises solely in the course of that representation.

Neither the husband-wife nor the physician-patient privilege is permitted.

Inclusion of Reporter's Name in Report**Ann. Code § 4-1321.03**

Mandated reporters are required to provide their names, occupations, and contact information.

Disclosure of Reporter Identity**Ann. Code § 4-1302.03**

The Child Protection Register staff shall not release any information that identifies the source of a report or the witnesses to the incident referred to in a report to the alleged perpetrator of the abuse, the child's parent or guardian, or a child-placing agency investigating a foster or adoptive placement, unless said staff first obtains permission from the source of the report or from the witnesses named in the report.

Florida**Professionals Required to Report****Ann. Stat. § 39.201**

The following persons are mandated reporters:

- Physicians, osteopaths, medical examiners, chiropractors, nurses, or hospital personnel
- Other health or mental health professionals
- Practitioners who rely solely on spiritual means for healing
- Teachers or other school officials or personnel
- Social workers, daycare center workers, or other professional child care, foster care, residential, or institutional workers
- Law enforcement officers or judges

Reporting by Other Persons**Ann. Stat. § 39.201**

Any person who knows or has reasonable cause to suspect that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare or that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care shall report such knowledge or suspicion to the department.

Any person who knows or who has reasonable cause to suspect that a child is abused by an adult other than a parent, legal custodian, caregiver, or other person responsible for the child's welfare shall report such knowledge or suspicion to the department.

Any person who knows or has reasonable cause to suspect that a child is the victim of childhood sexual abuse or the victim of a known or suspected juvenile sexual offender shall report such knowledge or suspicion to the department.

Institutional Responsibility to Report**Ann. Stat. § 39.201**

Nothing in this chapter or in the contracting with community-based care providers for foster care and related services as specified in § 409.1671 shall be construed to remove or reduce the duty and responsibility of any person, including any employee of the community-based care provider, to report a suspected or actual case of child abuse, abandonment, or neglect or the sexual abuse of a child to the central abuse hotline.

Standards for Making a Report**Ann. Stat. § 39.201**

A report is required when:

- A person knows or has reasonable cause to suspect that a child is abused, abandoned, or neglected.
- A person knows that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care.

Privileged Communications**Ann. Stat. § 39.204**

Only attorney-client and clergy-penitent privileges are permitted.

Inclusion of Reporter's Name in Report**Ann. Stat. § 39.201**

Professionals who are mandated reporters are required to provide their names to hotline staff.

Disclosure of Reporter Identity**Ann. Stat. §§ 39.201; 39.202**

The names of reporters shall be entered into the record of the report but shall be held confidential. The name of the reporter may not be released to any person other than employees of the Department of Children and Family Services responsible for child protective services, the central abuse hotline, law enforcement, the child protection team, or the appropriate State attorney, without the written consent of the person reporting.

This does not prohibit the serving of a subpoena to a person reporting child abuse, abandonment, or neglect when deemed necessary by the court, the State attorney, or the department, provided the fact that such person made the report is not disclosed.

Georgia**Professionals Required to Report****Ann. Code §§ 19-7-5; 16-12-100**

The following persons are required to report:

- Physicians, physician assistants, residents, interns, hospital and medical personnel, podiatrists, dentists, or nurses
- Teachers, school administrators, school counselors, visiting teachers, school social workers, or school psychologists
- Psychologists, counselors, social workers, or marriage and family therapists
- Child welfare agency personnel (as that agency is defined by § 49-5-12) or child-counseling personnel
- Child service organization personnel (includes any organization—whether public, private, for-profit, not-for-profit, or voluntary—that provides care, treatment, education, training, supervision, coaching, counseling, recreational programs, or shelter to children)
- Law enforcement personnel
- Reproductive health-care facility or pregnancy resource center personnel and volunteers
- Persons who process or produce visual or printed matter

The term 'school' means any public or private prekindergarten, elementary school, secondary school, technical school, vocational school, college, university, or institution of postsecondary education.

Reporting by Other Persons**Ann. Code § 19-7-5**

Any other person who has reasonable cause to believe that a child has been abused may report.

Institutional Responsibility to Report**Ann. Code § 19-7-5**

If a person is required to report child abuse because that person attends to a child as part of the person's duties as an employee of or volunteer at a hospital, school, social agency, or similar facility, that person shall notify the person in charge of the facility, or the designated delegate thereof, and the person so notified shall report or cause a report to be made in accordance with this section. An employee or volunteer who makes a report to the person designated shall be deemed to have fully complied with this subsection. Under no circumstances shall any person in charge of such hospital, school, agency, or facility, or the designated delegate thereof to whom such notification has been made exercise any control, restraint, modification, or make other change to the information provided by the reporter, although each of the aforementioned persons may be consulted prior to the making of a report and may provide any additional, relevant, and necessary information when making the report.

Standards for Making a Report**Ann. Code §§ 19-7-5; 16-12-100**

A report is required when:

- A reporter has reasonable cause to believe that child abuse has occurred.
- A person who processes or produces visual or printed matter has reasonable cause to believe that the visual or printed matter submitted for processing or producing depicts a minor engaged in sexually explicit conduct.

Privileged Communications**Ann. Code § 19-7-5(g)**

A mandated reporter must report regardless of whether the reasonable cause to believe that abuse has occurred or is occurring is based in whole or in part upon any communication to that person that is otherwise made privileged or confidential by law. However, a member of the clergy shall not be required to report child abuse reported solely within the context of confession or other similar communication required to be kept confidential under church doctrine or practice. When a clergy member receives information about child abuse from any other source, the clergy member shall comply with the reporting requirements of this section, even though the clergy member may have also received a report of child abuse from the confession of the perpetrator.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity**Ann. Code § 49-5-41**

Any release of records shall protect the identity of any person reporting child abuse.

Guam**Professionals Required to Report****Ann. Code Tit. 19, § 13201**

Persons required to report suspected child abuse include, but are not limited to:

- Physicians, medical examiners, dentists, osteopaths, optometrists, chiropractors, podiatrists, interns, nurses, hospital personnel, or Christian Science practitioners
- Clergy members
- School administrators, teachers, nurses, or counselors
- Social services workers, daycare center workers, or any other child care or foster care workers
- Mental health professionals, peace officers, or law enforcement officials
- Commercial film and photographic print processors

Reporting by Other Persons**Ann. Code Tit. 19, § 13202**

Any person may make a report if that person has reasonable cause to suspect that a child is an abused or neglected child.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report**Ann. Code Tit. 19, § 13201**

A report is required when:

- A reporter, who in the course of his or her employment, occupation, or professional practice comes into contact with children, has reason to suspect on the basis of his or her medical, professional, or other training and experience that a child is an abused or neglected child.
- Any commercial film and photographic print processor has knowledge of or observes any film, photograph, videotape, negative, or slide depicting a child under age 18 engaged in an act of sexual conduct.

Privileged Communications**Ann. Code Tit. 19, § 13201**

No person may claim privileged communications as a basis for his or her refusal or failure to report suspected child abuse or neglect or to provide Child Protective Services or the Guam Police Department with required information. Such privileges are specifically abrogated with respect to reporting suspected child abuse or neglect or of providing information to the agency.

Inclusion of Reporter's Name in Report**Ann. Code Tit. 19, § 13203**

Every report should include the name of the person making the report. Persons who are required by law to report shall be required to reveal their names.

Disclosure of Reporter Identity**Ann. Code Tit. 19, § 13203**

The identity of the reporter shall be confidential and may be disclosed only:

- Among child protective agencies
- To counsel representing a child protective agency
- To the attorney general's office in a criminal prosecution or family court action
- To a licensing agency when abuse in licensed out-of-home care is reasonably suspected
- When the reporter waives confidentiality
- By court order

Hawaii**Professionals Required to Report****Rev. Stat. § 350-1.1**

The following persons are required to report:

- Physicians, physicians in training, psychologists, dentists, nurses, osteopathic physicians and surgeons, optometrists, chiropractors, podiatrists, pharmacists, and other health-related professionals
- Medical examiners or coroners
- Employees or officers of any public or private school
- Child care employees or employees or officers of any licensed or registered child care facility, foster home, or similar institution
- Employees or officers of any public or private agency or institution, or other individuals, providing social, medical, hospital, or mental health services, including financial assistance
- Employees or officers of any law enforcement agency, including, but not limited to, the courts, police departments, departments of public safety, correctional institutions, and parole or probation offices
- Employees of any public or private agency providing recreational or sports activities

Reporting by Other Persons**Rev. Stat. § 350-1.3**

Any other person who becomes aware of facts or circumstances that cause the person to believe that child abuse or neglect has occurred may report.

Institutional Responsibility to Report**Rev. Stat. § 350-1.1**

Whenever a person designated as a mandatory reporter is a member of the staff of any public or private school, agency, or institution, that staff member shall immediately report the known or suspected child abuse or neglect directly to the department or to the police department and also shall immediately notify the person in charge or a designated delegate of the report made in accordance with this chapter.

Standards for Making a Report**Rev. Stat. § 350-1.1**

A report is required when, in his or her professional or official capacity, a reporter has reason to believe that child abuse or neglect has occurred or that there exists a substantial risk that child abuse or neglect may occur in the reasonably foreseeable future.

Privileged Communications**Rev. Stat. § 350-5**

The physician-patient, psychologist-client, husband-wife, and victim-counselor privileges are not grounds for failing to report.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity**Rev. Stat. § 350-1.4**

Every reasonable good-faith effort shall be made by the department to maintain the confidentiality of the name of a reporter who requests that his or her name be confidential.

Idaho

Professionals Required to Report Idaho Code § 16-1605

The following persons are required to report:

- Physicians, residents on hospital staffs, interns, nurses, or coroners
- Teachers or daycare personnel
- Social workers or law enforcement personnel
- Other persons

Reporting by Other Persons Idaho Code § 16-1605

Any person who has reason to believe that a child has been abused, abandoned, or neglected is required to report.

Institutional Responsibility to Report Idaho Code § 16-1605

When the attendance of a physician, resident, intern, nurse, daycare worker, or social worker is pursuant to the performance of services as a member of the staff of a hospital or similar institution, he or she shall notify the person in charge of the institution, or his or her designated delegate, who shall make the necessary reports.

Standards for Making a Report Idaho Code § 16-1605

A report is required when:

- A person has reason to believe that a child has been abused, abandoned, or neglected.
- A person observes a child being subjected to conditions or circumstances that would reasonably result in abuse, abandonment, or neglect.

Privileged Communications Idaho Code §§ 16-1605; 16-1606

Any privilege between a husband and wife and any professional and client, except for the clergy-penitent or attorney-client privilege, shall not be grounds for failure to report.

Any privilege between husband and wife, or between any professional person—except the lawyer-client privilege and including, but not limited to, physicians, counselors, hospitals, clinics, daycare centers, and schools—and their clients shall not be grounds for excluding evidence at any proceeding regarding the abuse, abandonment, or neglect of the child or the cause thereof.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity

This issue is not addressed in the statutes reviewed.

Illinois

Professionals Required to Report Comp. Stat. Ch. 325, § 5/4; Ch. 720, § 5/11-20.2

The following persons are required to report:

- Physicians, residents, interns, hospital administrators and personnel, surgeons, dentists, dental hygienists, osteopaths, chiropractors, podiatric physicians, physician assistants, or substance abuse treatment personnel
- Funeral home directors or employees, coroners, or medical examiners
- Emergency medical technicians, acupuncturists, or crisis line or hotline personnel
- School personnel, including administrators and employees, educational advocates, or truant officers
- Personnel of institutions of higher education
- Members of a school board or the Chicago Board of Education

- Members of the governing body of a private school
- Social workers, social services administrators, or domestic violence program personnel
- Nurses, genetic counselors, respiratory care practitioners, advanced practice nurses, or home health aides
- Directors or staff assistants of nursery schools or child care centers, or recreational or athletic program or facility personnel
- Early intervention providers, as defined in the Early Intervention Services System Act
- Law enforcement officers or probation officers
- Licensed professional counselors, psychologists, psychiatrists, or their assistants
- Field personnel of the Department of Healthcare and Family Services, Juvenile Justice, Public Health, Human Services, Corrections, Human Rights, or Children and Family Services
- Supervisors and administrators of general assistance under the Illinois Public Aid Code
- Animal control officers or Department of Agriculture Bureau of Animal Health and Welfare field investigators
- Foster parents, homemakers, or child care workers
- Members of the clergy
- Commercial film and photographic print processors or computer technicians

Reporting by Other Persons**Comp. Stat. Ch. 325, § 5/4**

Any other person who has reasonable cause to believe that a child is abused or neglected may report.

Institutional Responsibility to Report**Comp. Stat. Ch. 325, § 5/4**

Whenever such person is required to report in his or her capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, or as a member of the clergy, he or she shall make a report immediately to the Department of Children and Family Services and also may notify the person in charge of such institution, school, facility, or agency; or church, synagogue, temple, mosque, or other religious institution; or his or her designated agent that a report has been made. Under no circumstances shall any person in charge of such institution, school, facility, or agency; or church, synagogue, temple, mosque, or other religious institution; or his or her designated agent to whom such notification has been made exercise any control, restraint, modification, or other change in the report or the forwarding of the report to the department.

Standards for Making a Report**Comp. Stat. Ch. 325, § 5/4; Ch. 720, § 5/11-20.2**

A report is required when:

- A reporter has reasonable cause to believe that a child known to him or her in his or her professional capacity may be abused or neglected.
- A physician, physician's assistant, registered nurse, licensed practical nurse, medical technician, certified nursing assistant, social worker, or licensed professional counselor of any office, clinic, or any other physical location that provides abortions, abortion referrals, or contraceptives has reasonable cause to believe a child known to him or her in his or her professional or official capacity may be an abused child or a neglected child.
- Commercial film and photographic print processors or computer technicians have knowledge of or observe any film, photograph, videotape, negative, slide, computer hard drive, or any other magnetic or optical media that depicts a child engaged in any actual or simulated sexual conduct.

Privileged Communications**Comp. Stat. Ch. 325, § 5/4; Ch. 735, § 5/8-803**

The privileged quality of communication between any professional person required to report and his or her patient or client shall not apply to situations involving abused or neglected children and shall not constitute grounds for failure to report.

A member of the clergy shall not be compelled to disclose a confession or admission made to him or her as part of the discipline of the religion.

The reporting requirements shall not apply to the contents of a privileged communication between an attorney and his or her client or to confidential information within the meaning of Rule 1.6 of the Illinois Rules of Professional Conduct relating to the legal representation of an individual client.

Inclusion of Reporter's Name in Report**Comp. Stat. Ch. 325, § 5/7.9**

The report shall include the name, occupation, and contact information of the person making the report.

Disclosure of Reporter Identity**Comp. Stat. Ch. 325, § 5/11.1a**

Any disclosure of information shall not identify the person making the report.

Indiana**Professionals Required to Report****Ann. Code § 31-33-5-2**

Mandatory reporters include any staff member of a medical or other public or private institution, school, facility, or agency.

Reporting by Other Persons**Ann. Code § 31-33-5-1**

Any person who has reason to believe that a child is a victim of abuse or neglect must report.

Institutional Responsibility to Report**Ann. Code §§ 31-33-5-2; 31-33-5-3**

If an individual is required to make a report under this article in the individual's capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, the individual shall immediately notify the individual in charge of the institution, school, facility, or agency or the designated agent of the individual in charge of the institution, school, facility, or agency.

An individual notified as required above shall report or cause a report to be made.

This chapter does not relieve an individual of the obligation to report on the individual's own behalf, unless a report has already been made to the best of the individual's belief.

Standards for Making a Report**Ann. Code §§ 31-33-5-1; 31-33-5-2**

A report is required when any person has reason to believe that a child is a victim of abuse or neglect.

Privileged Communications**Ann. Code § 31-32-11-1**

Privileged communications between any of the following shall not be grounds for failing to report:

- A husband and wife
- A health-care provider and the provider's patient
- A licensed social worker, clinical social worker, marriage and family therapist, mental health counselor, addiction counselor, or clinical addiction counselor and a client of any of these professionals
- A school counselor or psychologist and a student

Inclusion of Reporter's Name in Report**Ann. Code § 31-33-7-4**

The written report must include the name and contact information for the person making the report.

Disclosure of Reporter Identity**Ann. Code § 31-33-18-2**

The report shall be made available to the person about whom a report has been made, with protection for the identity of:

- Any person reporting known or suspected child abuse or neglect
- Any other person if the person or agency making the information available finds that disclosure of the information would be likely to endanger the life or safety of the person

The report also may be made available to each parent, guardian, custodian, or other person responsible for the welfare of a child named in a report and an attorney of any of these individuals, with protection for the identity of reporters and other appropriate individuals.

Iowa

Professionals Required to Report

Ann. Stat. §§ 232.69; 728.14

The following persons are required to report:

- Health practitioners
- Social workers or psychologists
- School employees, certified paraeducators, coaches, or instructors employed by community colleges
- Employees or operators of health-care facilities, child care centers, Head Start programs, family development and self-sufficiency grant programs, substance abuse programs or facilities, juvenile detention or juvenile shelter care facilities, foster care facilities, or mental health centers
- Employees of Department of Human Services institutions
- Peace officers, counselors, or mental health professionals
- Commercial film and photographic print processors

Reporting by Other Persons

Ann. Stat. § 232.69

Any other person who believes that a child has been abused may report.

Institutional Responsibility to Report

Ann. Stat. § 232.70

The employer or supervisor of a person who is a mandatory or permissive reporter shall not apply a policy, work rule, or other requirement that interferes with the person making a report of child abuse.

Standards for Making a Report

Ann. Stat. §§ 232.69; 728.14

A report is required when:

- A reporter, in the scope of his or her professional practice or employment responsibilities, reasonably believes that a child has been abused.
- A commercial film and photographic print processor has knowledge of or observes a visual depiction of a minor engaged in a prohibited sexual act or in the simulation of a prohibited sexual act.

Privileged Communications

Ann. Stat. § 232.74

The husband-wife or health practitioner-patient privilege does not apply to evidence regarding abuse to a child.

Inclusion of Reporter's Name in Report

Ann. Stat. § 232.70

The report shall contain the name and address of the person making the report.

Disclosure of Reporter Identity

Ann. Stat. § 232.71B

The department shall not reveal the identity of the reporter to the subject of the report.

Kansas

Professionals Required to Report

Ann. Stat. § 38-2223

The following persons are required to report:

- Persons providing medical care or treatment, including persons licensed to practice the healing arts, dentistry, and optometry; persons engaged in postgraduate training programs approved by the State Board of Healing Arts; licensed professional or practical nurses; and chief administrative officers of medical care facilities

- Persons licensed by the State to provide mental health services, including psychologists, clinical psychotherapists, social workers, marriage and family therapists, professional counselors, and registered alcohol and drug abuse counselors
- Teachers, school administrators, or other employees of an educational institution that the child is attending
- Licensed child care providers or their employees at the place where the child care services are being provided to the child
- Firefighters, emergency medical services personnel, law enforcement officers, juvenile intake and assessment workers, court services officers, community corrections officers, case managers, and mediators
- Employees or volunteers for any organization, whether for profit or not-for-profit, that provides social services to pregnant teenagers, including, but not limited to, counseling, adoption services, and pregnancy education and maintenance

Reporting by Other Persons**Ann. Stat. § 38-2223**

Any person who has reason to suspect that a child may be a child in need of care may report.

Institutional Responsibility to Report**Ann. Stat. § 38-2223**

Reports of child abuse or neglect occurring in an institution operated by the Department of Social and Rehabilitation Services or the Department of Juvenile Justice shall be made to the attorney general. All other reports of child abuse or neglect by persons employed by or of children of persons employed by the Department of Social and Rehabilitation Services shall be made to the appropriate law enforcement agency.

Standards for Making a Report**Ann. Stat. § 38-2223**

A report is required when a reporter has reason to suspect that a child has been harmed as a result of physical, mental, or emotional abuse or neglect or sexual abuse.

Privileged Communications**Ann. Stat. § 38-2249**

In all proceedings under this code, the rules of evidence of the code of civil procedure shall apply, except that no evidence relating to the condition of a child shall be excluded solely on the ground that the matter is or may be the subject of a physician-patient privilege, psychologist-client privilege, or social worker-client privilege.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity**Ann. Stat. § 38-2213**

Information authorized to be disclosed in this subsection shall not contain information that identifies a reporter of a child alleged or adjudicated to be a child in need of care.

Kentucky**Professionals Required to Report****Rev. Stat. § 620.030**

All persons are required to report, including, but not limited to:

- Physicians, osteopathic physicians, nurses, coroners, medical examiners, residents, interns, chiropractors, dentists, optometrists, emergency medical technicians, paramedics, or health professionals
- Teachers, school personnel, or child care personnel
- Social workers or mental health professionals
- Peace officers

Reporting by Other Persons**Rev. Stat. § 620.030**

Any person who knows or has reasonable cause to believe that a child is dependent, neglected, or abused shall immediately report.

Any person who knows or has reasonable cause to believe that a child is a victim of human trafficking as defined in § 529.010 immediately shall cause an oral or written report to be made to a local law enforcement agency or the State police, the cabinet or its designated representative, the Commonwealth's attorney, or the county attorney by telephone or otherwise. This subsection shall apply regardless of whether the person believed to have caused the human trafficking of the child is a parent, guardian, or person exercising custodial control or supervision.

Institutional Responsibility to Report
Rev. Stat. § 620.030(1)

Any supervisor who receives from an employee a report of suspected dependency, neglect, or abuse shall promptly make a report to the proper authorities for investigation. Nothing in this section shall relieve individuals of their obligations to report.

Standards for Making a Report
Rev. Stat. § 620.030

A report is required when a person knows or has reasonable cause to believe that a child is dependent, neglected, or abused.

Privileged Communications
Rev. Stat. § 620.030(3)

Neither the husband-wife nor any professional-client/patient privilege, except the attorney-client and clergy-penitent privilege, shall be a ground for refusing to report.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity
Rev. Stat. § 620.050

The identity of the reporter shall not be disclosed except:

- To law enforcement officials, the agency investigating or assessing the report, or to a multidisciplinary team
- Under court order, after a court has found reason to believe the reporter knowingly made a false report
- To the external child fatality and near fatality review panel established by § 620.055

Louisiana**Professionals Required to Report**
Children's Code Art. 603(17)

Mandatory reporters include any of the following individuals:

- Health practitioners, including physicians, surgeons, physical therapists, dentists, residents, interns, hospital staff, podiatrists, chiropractors, nurses, nursing aides, dental hygienists, emergency medical technicians, paramedics, optometrists, medical examiners, or coroners
- Mental health/social service practitioners, including psychiatrists, psychologists, marriage or family counselors, social workers, members of the clergy, or aides
- Members of the clergy, including priests, rabbis, duly ordained clerical deacons or ministers, Christian Science practitioners, or other similarly situated functionaries of a religious organization
- Teaching or child care providers, including public or private teachers, teacher's aides, instructional aides, school principals, school staff members, bus drivers, coaches, professors, technical or vocational instructors, technical or vocational school staff members, college or university administrators, college or university staff members, social workers, probation officers, foster home parents, group home or other child care institutional staff members, personnel of residential home facilities, daycare providers, or any individual who provides such services to a child in a voluntary or professional capacity
- Police officers or law enforcement officials
- Commercial film and photographic print processors
- Mediators
- Parenting coordinators
- Court-appointed special advocates

- Organizational or youth activity providers, including administrators, employees, or volunteers of any day camp, summer camp, youth center, or youth recreation programs or any other organization that provides organized activities for children
- School coaches, including, but not limited to, public technical or vocational school, community college, college, or university coaches and coaches of intramural or interscholastic athletics

Reporting by Other Persons**Children's Code Art. 609**

Any other person who has cause to believe that a child's health is endangered as a result of abuse or neglect may report.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report**Children's Code Art. 609; 610**

A report is required when:

- A reporter has cause to believe that a child's physical or mental health or welfare is endangered as a result of abuse or neglect.
- A commercial film or photographic print processor has knowledge of or observes any film, photograph, videotape, negative, or slide depicting a child, whom he or she knows or should know is under age 17, that constitutes child pornography.
- A physician has cause to believe that a newborn was exposed in utero to an unlawfully used controlled dangerous substance, as determined by a toxicology test upon the newborn, without the consent of the newborn's parents or guardian. Positive test results shall not be admissible in a criminal prosecution.
- A physician observes symptoms of withdrawal in a newborn or other observable and harmful effects in his or her physical appearance or functioning that the physician has cause to believe are due to the chronic or severe use of alcohol by the mother during pregnancy.

Privileged Communications**Children's Code Art. 603(17); 609**

A clergy member is not required to report a confidential communication from a person to a member of the clergy who, in the course of the discipline or practice of that church, denomination, or organization, is authorized or accustomed to hearing confidential communications and, under the discipline or tenets of the church, denomination, or organization, has a duty to keep such communications confidential.

Notwithstanding any other provision of law to the contrary, when representing a child in a case arising out of this code, a mental health or social service practitioner shall not be considered a mandatory reporter under the following limited circumstances:

- When the practitioner is engaged by an attorney to assist in the rendition of professional legal services to that child
- When the information that would serve as the basis for reporting arises in furtherance of facilitating the rendition of those professional legal services to that child
- When the information that would serve as the basis for reporting is documented by the mental health/social service practitioner

The documentation shall be retained by the mental health/social service practitioner until 1 year after the child has reached the age of majority.

Notwithstanding any claim of privileged communication, any mandatory reporter who has cause to believe that a child's physical or mental health or welfare is endangered as a result of abuse or neglect, or that abuse or neglect was a contributing factor in a child's death, shall report.

Inclusion of Reporter's Name in Report**Children's Code Art. 610**

The report must include the name and address of the reporter.

Disclosure of Reporter Identity**Rev. Stat. § 46:56(F)(8)(b)**

The identity of the reporter shall not be released unless a court finds that the reporter knowingly made a false report.

Maine

Professionals Required to Report

Rev. Stat. Tit. 22, § 4011-A

Mandatory reporters include:

- The following persons, when acting in a professional capacity:
 - » Allopathic or osteopathic physicians, residents, interns, emergency medical services persons, medical examiners, physician's assistants, dentists, dental hygienists, dental assistants, chiropractors, podiatrists, or registered or licensed practical nurses
 - » Teachers, guidance counselors, school officials, youth camp administrators or counselors, or social workers
 - » Court-appointed special advocates or guardians ad litem
 - » Homemakers, home health aides, medical or social service workers, psychologists, child care personnel, or mental health professionals
 - » Law enforcement officials, State or municipal fire inspectors, or municipal code enforcement officials
 - » Commercial film and photographic print processors
 - » Clergy members
 - » Chairs of professional licensing boards that have jurisdiction over mandated reporters
 - » Humane agents employed by the Department of Agriculture, Food and Rural Resources
 - » Sexual assault counselors or family or domestic violence victim advocates
 - » School bus drivers or attendants
- Any person who has assumed full, intermittent, or occasional responsibility for the care or custody of the child, regardless of whether the person receives compensation
- Any person affiliated with a church or religious institution who serves in an administrative capacity or has otherwise assumed a position of trust or responsibility to the members of that church or religious institution, while acting in that capacity, regardless of whether the person receives compensation

Reporting by Other Persons

Rev. Stat. Tit. 22, § 4011-A

Any person may make a report if that person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected or that there has been a suspicious child death.

An animal control officer may report to the State Department of Health and Human Services when that person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected.

Institutional Responsibility to Report

Rev. Stat. Tit. 22, § 4011-A

Whenever a person is required to report in a capacity as a member of the staff of a medical or public or private institution, agency, or facility, that person immediately shall notify either the person in charge of the institution, agency, or facility or a designated agent who then shall cause a report to be made. The staff also may make a report directly to the department.

If a person required to report notifies either the person in charge of the institution, agency, or facility, or the designated agent, the notifying person shall acknowledge in writing that the institution, agency, or facility has provided confirmation to the notifying person that another individual from the institution, agency, or facility has made a report to the department. The confirmation must include, at a minimum, the name of the individual making the report to the department, the date and time of the report, and a summary of the information conveyed. If the notifying person does not receive the confirmation from the institution, agency, or facility within 24 hours of the notification, the notifying person immediately shall make a report directly to the department.

An employer may not take any action to prevent or discourage an employee from making a report.

Standards for Making a Report

Rev. Stat. Tit. 22, §§ 4011-A; 4011-B

A report is required when:

- The person knows or has reasonable cause to suspect that a child is or is likely to be abused or neglected or that a suspicious death has occurred.

- When a child who is under 6 months of age or otherwise nonambulatory exhibits evidence of the following:
 - » Fracture of a bone
 - » Substantial bruising or multiple bruises
 - » Subdural hematoma
 - » Burns
 - » Poisoning
 - » Injury resulting in substantial bleeding, soft tissue swelling, or impairment of an organ
- A health-care provider involved in the delivery or care of an infant knows or has reasonable cause to suspect that the infant has been born affected by illegal substance abuse or is demonstrating withdrawal symptoms that have resulted from or have likely resulted from prenatal drug exposure that require medical monitoring or care beyond standard newborn care, whether the prenatal exposure was to legal or illegal drugs, or has fetal alcohol spectrum disorders.

A mandatory reporter shall report to the department if the person knows or has reasonable cause to suspect that a child is not living with the child's family. Although a report may be made at any time, a report must be made immediately if there is reason to suspect that a child has been living with someone other than the child's family for more than 6 months or if there is reason to suspect that a child has been living with someone other than the child's family for more than 12 months pursuant to a power of attorney or other nonjudicial authorization.

Privileged Communications**Rev. Stat. Tit. 22, §§ 4011-A; 4015**

A member of the clergy may claim privilege when information is received during a confidential communication. The husband-wife and physician- and psychotherapist-patient privileges cannot be invoked as a reason not to report.

Inclusion of Reporter's Name in Report**Rev. Stat. Tit. 22, § 4012**

The report shall include the name, occupation, and contact information for the person making the report.

Disclosure of Reporter Identity**Rev. Stat. Tit. 22, § 4008**

The department will protect the identity of reporters and other persons as appropriate when disclosing information in the records to a child named in a report, the child's parent, custodian, or caregiver, or a party to a child protection proceeding.

Maryland**Professionals Required to Report****Fam. Law § 5-704**

Persons required to report include:

- Health practitioners
- Educators or human service workers
- Police officers

Reporting by Other Persons**Fam. Law §§ 5-705; 5-704.1**

Any other person who has reason to believe that a child has been subjected to abuse or neglect must report.

An individual may notify the local department or the appropriate law enforcement agency if the individual has reason to believe that a parent, guardian, or caregiver of a child allows the child to reside with or be in the regular presence of an individual, other than the child's parent or guardian, who is registered as a child sex offender and, based on additional information, poses a substantial risk of sexual abuse to the child.

Institutional Responsibility to Report**Fam. Law § 5-704**

A mandated reporter who is acting as a staff member of a hospital, public health agency, child care institution, juvenile detention center, school, or similar institution immediately shall notify and give all information required by this section to the head of the institution or the designee of the head.

Standards for Making a Report**Fam. Law §§ 5-704; 5-705**

A mandatory reporter is required to report when, acting in a professional capacity, the person has reason to believe that a child has been subjected to abuse or neglect. Other persons shall report when they have reason to believe that a child has been subjected to abuse or neglect.

Privileged Communications**Fam. Law §§ 5-704; 5-705**

Mandatory reporters are required to report regardless of any other provision of law, including any law on privileged communications. Only attorney-client and clergy-penitent privileges are permitted.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity

This issue is not addressed in the statutes reviewed.

Massachusetts**Professionals Required to Report****Gen. Laws Ch. 119, § 21**

Mandatory reporters include:

- Physicians, medical interns, hospital personnel, medical examiners, psychologists, emergency medical technicians, dentists, nurses, chiropractors, podiatrists, optometrists, osteopaths, allied mental health and human services professionals, drug and alcoholism counselors, psychiatrists, or clinical social workers
- Public or private schoolteachers, educational administrators, guidance or family counselors, or child care workers
- Persons paid to care for or work with a child in any public or private facility, home, or program that provides child care or residential services to children
- Persons who provide the services of child care resource and referral agencies, voucher management agencies, family child care systems, or child care food programs
- Licensors of the Department of Early Education and Care or school attendance officers
- Probation officers, clerk-magistrates of a district court, parole officers, social workers, foster parents, firefighters, or police officers
- Priests, rabbis, clergy members, ordained or licensed ministers, leaders of any church or religious body, or accredited Christian Science practitioners
- Persons performing official duties on behalf of a church or religious body that are recognized as the duties of a priest, rabbi, clergy, ordained or licensed minister, leader of any church or religious body, or accredited Christian Science practitioner
- Persons employed by a church or religious body to supervise, educate, coach, train, or counsel a child on a regular basis
- Persons in charge of a medical or other public or private institution, school, or facility or that person's designated agent
- The child advocate

Reporting by Other Persons**Gen. Laws Ch. 119, § 51A**

Any other person who has reasonable cause to believe that a child is suffering from or has died as a result of abuse or neglect may file a report.

Institutional Responsibility to Report**Gen. Laws Ch. 119, § 51A(a), (h)**

If a mandated reporter is a member of the staff of a medical or other public or private institution, school, or facility, the mandated reporter may instead notify the person or designated agent in charge of such institution, school, or facility, who shall become responsible for notifying the department in the manner required by this section.

No employer shall discharge, discriminate, or retaliate against a mandated reporter who, in good faith, files a report, testifies, or is about to testify in any proceeding involving child abuse or neglect. Any employer who discharges, discriminates, or retaliates against that mandated reporter shall be liable to the mandated reporter for treble damages, costs, and attorney's fees.

Standards for Making a Report**Gen. Laws Ch. 119, § 51A**

A mandated reporter must report when, in his or her professional capacity, he or she has reasonable cause to believe that a child is suffering physical or emotional injury resulting from:

- Abuse inflicted upon the child that causes harm or substantial risk of harm to the child's health or welfare, including sexual abuse
- Neglect, including malnutrition
- Physical dependence upon an addictive drug at birth
- Being a sexually exploited child
- Being a human trafficking victim as defined by chapter 233, § 20M

Privileged Communications**Gen. Laws Ch. 119, § 51A**

Any privilege relating to confidential communications, established by §§ 135 to 135B, inclusive, of chapter 112 [pertaining to social worker-client privilege] or by §§ 20A [clergy-penitent privilege] and 20B [psychotherapist-patient privilege] of chapter 233, shall not prohibit the filing of a report under this section or a care and protection petition under § 24, except that a priest, rabbi, clergy, member, ordained or licensed minister, leader of a church or religious body, or accredited Christian Science practitioner need not report information solely gained in a confession or similarly confidential communication in other religious faiths. Nothing in the general laws shall modify or limit the duty of a priest, rabbi, clergy member, ordained or licensed minister, leader of a church or religious body, or accredited Christian Science practitioner to report suspected child abuse or neglect under this section when the priest, rabbi, clergy member, ordained or licensed minister, leader of a church or religious body, or accredited Christian Science practitioner is acting in some other capacity that would otherwise make him or her a mandated reporter.

Inclusion of Reporter's Name in Report**Gen. Laws Ch. 119, § 51A**

A report shall include the name of the person making the report.

Disclosure of Reporter Identity

This issue is not addressed in the statutes reviewed.

Michigan**Professionals Required to Report****Comp. Laws § 722.623**

Mandatory reporters include:

- Physicians, physician assistants, dentists, dental hygienists, medical examiners, nurses, persons licensed to provide emergency medical care, or audiologists
- School administrators, counselors, or teachers
- Regulated child care providers
- Psychologists, marriage and family therapists, licensed professional counselors, social workers, or social work technicians
- Persons employed in a professional capacity in any office of the friend of the court
- Law enforcement officers
- Members of the clergy
- Department of Human Services employees, including eligibility specialists, family independence managers, family independence specialists, social services specialists, social work specialists, social work specialist managers, or welfare services specialists
- Any employee of an organization or entity that, as a result of Federal funding statutes, regulations, or contracts, would be prohibited from reporting in the absence of a State mandate or court order

Reporting by Other Persons**Comp. Laws § 722.624**

Any other person, including a child, who has reasonable cause to suspect child abuse or neglect may report.

Institutional Responsibility to Report**Comp. Laws § 722.623**

If the reporting person is a member of the staff of a hospital, agency, or school, the reporting person shall notify the person in charge of the hospital, agency, or school of his or her finding and that the report has been made, and shall make a copy of the written report available to the person in charge. A notification to the person in charge of a hospital, agency, or school does not relieve the member of the staff of the hospital, agency, or school of the obligation of reporting to the department as required by this section. One report from a hospital, agency, or school is adequate to meet the reporting requirement. A member of the staff of a hospital, agency, or school shall not be dismissed or otherwise penalized for making a report required by this act or for cooperating in an investigation.

Standards for Making a Report**Comp. Laws § 722.623**

A report is required when a reporter has reasonable cause to suspect child abuse or neglect.

Privileged Communications**Comp. Laws § 722.631**

Only the attorney-client or clergy-penitent privilege can be grounds for not reporting.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity**Comp. Laws §§ 722.625; 722.627**

The identity of a reporting person is confidential and subject to disclosure only with the consent of that person or by judicial process. The identity of the reporter is protected in any release of information to the subject of the report.

Minnesota**Professionals Required to Report****Ann. Stat. § 626.556, Subd. 3**

Mandatory reporters include:

- A professional or professional's delegate who is engaged in the practice of the healing arts, hospital administration, psychological or psychiatric treatment, child care, education, social services, correctional supervision, probation or correctional services, or law enforcement
- A member of the clergy who received the information while engaged in ministerial duties

Reporting by Other Persons**Ann. Stat. § 626.556, Subd. 3**

Any person may voluntarily report to the local welfare agency, agency responsible for assessing or investigating the report, police department, county sheriff, Tribal social services agency, or Tribal police department if the person knows, has reason to believe, or suspects a child is being or has been neglected or subjected to physical or sexual abuse.

Institutional Responsibility to Report**Ann. Stat. § 626.556, Subd. 3(c)**

A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the agency responsible for licensing the facility or a nonlicensed personal care provider organization. A health or corrections agency receiving a report may request the local child welfare agency to provide assistance. A board or other entity whose licensees perform work within a school facility, upon receiving a complaint of alleged maltreatment, shall provide information about the circumstances of the alleged maltreatment to the Commissioner of Education.

Standards for Making a Report**Ann. Stat. § 626.556, Subd. 3**

A report is required when a reporter knows or has reason to believe that a child is being neglected or sexually or physically abused, or has been neglected or physically or sexually abused within the preceding 3 years.

Privileged Communications**Ann. Stat. § 626.556, Subd. 3 & 8**

A member of the clergy is not required by this subdivision to report information that is otherwise privileged under § 595.02, subdivision 1, paragraph (c).

No evidence relating to the neglect or abuse of a child, or to any prior incidents of neglect or abuse involving any of the same persons accused of neglect or abuse, shall be excluded in any proceeding on the grounds of privilege set forth in § 595.02, subdivision 1, paragraph (a) [husband-wife], (d) [medical practitioner-patient], or (g) [mental health professional-client].

Inclusion of Reporter's Name in Report**Ann. Stat. § 626.556, Subd. 7**

The written report from a mandatory reporter must include the name and address of the reporter.

Disclosure of Reporter Identity**Ann. Stat. § 626.556, Subd. 11**

Any person conducting an investigation or assessment under this section who intentionally discloses the identity of a reporter prior to the completion of the investigation or assessment is guilty of a misdemeanor. After the assessment or investigation is completed, the name of the reporter shall be confidential. The subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by the court that the report was false and that there is evidence that the report was made in bad faith.

Mississippi**Professionals Required to Report****Ann. Code § 43-21-353**

The following professionals are required to report:

- Physicians, dentists, interns, residents, or nurses
- Public or private school employees or child care givers
- Psychologists, social workers, family protection workers, or family protection specialists
- Attorneys, ministers, or law enforcement officers

Reporting by Other Persons**Ann. Code § 43-21-353**

All other persons who have reasonable cause to suspect that a child is abused or neglected must report.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report**Ann. Code § 43-21-353**

A report is required when a person has reasonable cause to suspect that a child is abused or neglected.

Privileged Communications

This issue is not addressed in the statutes reviewed.

Inclusion of Reporter's Name in Report**Ann. Code § 43-21-353**

The department's report shall include the name and address of all witnesses, including the reporter if he or she is a material witness to the abuse.

Disclosure of Reporter Identity**Ann. Code § 43-21-353**

The identity of the reporting party shall not be disclosed to anyone other than law enforcement officers or prosecutors without an order from the appropriate youth court. The identity of the reporter shall not be disclosed to an individual under investigation.

Missouri**Professionals Required to Report****Rev. Stat. §§ 210.115; 352.400; 568.110**

Professionals required to report include:

- Physicians, medical examiners, coroners, dentists, chiropractors, optometrists, podiatrists, residents, interns, nurses, hospital and clinic personnel, or other health practitioners
- Daycare center workers or other child care workers, teachers, principals, or other school officials
- Psychologists, mental health professionals, or social workers
- Ministers, including clergypersons, priests, rabbis, Christian Science practitioners, or other persons serving in a similar capacity for any religious organization
- Juvenile officers, probation or parole officers, peace officers, law enforcement officials, or jail or detention center personnel
- Other persons with responsibility for the care of children
- Commercial film and photographic print processors; computer providers, installers, or repair persons; or Internet service providers

Reporting by Other Persons**Rev. Stat. § 210.115**

Any other person who has reasonable cause to suspect that a child has been subjected to abuse or neglect may report.

Institutional Responsibility to Report**Rev. Stat. § 210.115**

If two or more members of a medical institution who are required to report jointly have knowledge of a known or suspected instance of child abuse or neglect, a single report may be made by a designated member of that medical team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter immediately make the report. Nothing in this section, however, is meant to preclude any person from reporting abuse or neglect.

The reporting requirements under this section are individual, and no supervisor or administrator may impede or inhibit any reporting under this section. No person making a report shall be subject to any sanction, including any adverse employment action, for making such report. Every employer shall ensure that any employee required to report has immediate and unrestricted access to the communications technology necessary to make an immediate report and is temporarily relieved of other work duties for such time as is required to make any report required by this section.

Standards for Making a Report**Rev. Stat. §§ 210.115; 568.110**

A report is required when:

- A reporter has reasonable cause to suspect that a child has been subjected to abuse or neglect.
- A reporter observes a child being subjected to conditions or circumstances that would reasonably result in abuse or neglect.
- A commercial film and photographic print processor has knowledge of or observes any film, photograph, videotape, negative, slide, or computer-generated image or picture depicting a child engaged in an act of sexual conduct.

Privileged Communications**Rev. Stat. § 210.140**

Only the attorney-client or clergy-penitent privilege may be grounds for failure to report.

Inclusion of Reporter's Name in Report**Rev. Stat. § 210.130**

The report must include the name, address, occupation, and contact information for the person making the report.

Disclosure of Reporter Identity**Rev. Stat. § 210.150**

The names or other identifying information of reporters shall not be furnished to any child, parent, guardian, or alleged perpetrator named in the report.

Montana**Professionals Required to Report****Ann. Code §§ 41-3-201; 15-6-201(2)(b)**

Professionals required to report include:

- Physicians, residents, interns, members of hospital staffs, nurses, osteopaths, chiropractors, podiatrists, medical examiners, coroners, dentists, optometrists, or any other health professionals
- Teachers, school officials, or school employees who work during regular school hours
- Operators or employees of any registered or licensed daycare or substitute care facility, or operators or employees of child care facilities
- Mental health professionals or social workers
- Religious healers
- Foster care, residential, or institutional workers
- Members of the clergy, as defined in § 15-6-201(2)(b)
- Guardians ad litem or court-appointed advocates authorized to investigate a report
- Peace officers or other law enforcement officials

The term 'clergy' means:

- An ordained minister, priest, or rabbi
- A commissioned or licensed minister of a church or church denomination that ordains ministers if the person has the authority to perform substantially all the religious duties of the church or denomination
- A member of a religious order who has taken a vow of poverty
- A Christian Science practitioner

Reporting by Other Persons**Ann. Code § 41-3-201**

Any other person who knows or has reasonable cause to suspect that a child is abused or neglected may report.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report**Ann. Code § 41-3-201**

A report is required when:

- A reporter knows or has reasonable cause to suspect, as a result of information received in his or her professional or official capacity, that a child is abused or neglected.
- A health-care professional involved in the delivery or care of an infant knows that the infant is affected by a dangerous drug.

Privileged Communications**Ann. Code § 41-3-201**

A person listed as a mandated reporter may not refuse to make a report as required in this section on the grounds of a physician-patient or similar privilege.

A member of the clergy or a priest is not required to make a report under this section if the communication is required to be confidential by canon law, church doctrine, or established church practice.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity**Ann. Code § 41-3-205**

The identity of the reporter shall not be disclosed in any release of information to the subject of the report.

Nebraska**Professionals Required to Report****Rev. Stat. § 28-711**

Professionals required to report include:

- Physicians, medical institutions, or nurses
- School employees
- Social workers
- The Inspector General appointed under § 43-4317

The office of Inspector General of Nebraska Child Welfare was created within the office of Public Counsel for the purpose of conducting investigations, audits, inspections, and other reviews of the Nebraska child welfare system. The Inspector General shall be appointed by the Public Counsel with approval from the chairperson of the Executive Board of the Legislative Council and the chairperson of the Health and Human Services Committee of the Legislature.

Reporting by Other Persons**Rev. Stat. § 28-711**

All other persons who have reasonable cause to believe that a child has been subjected to abuse or neglect must report.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report**Rev. Stat. § 28-711**

A report is required when:

- A reporter has reasonable cause to believe that a child has been subjected to abuse or neglect.
- A reporter observes a child being subjected to conditions or circumstances that reasonably would result in abuse or neglect.

Privileged Communications**Rev. Stat. § 28-714**

The physician-patient, counselor-client, and husband-wife privileges shall not be grounds for failing to report.

Inclusion of Reporter's Name in Report**Rev. Stat. § 28-711**

The initial oral report shall include the reporter's name and address.

Disclosure of Reporter Identity**Rev. Stat. § 28-719**

The name and address of the reporter shall not be included in any release of information.

Nevada**Professionals Required to Report****Rev. Stat. § 432B.220**

Mandatory reporters include:

- Persons providing services licensed or certified in this State pursuant to, without limitation, hospitals, physicians and other medical personnel, psychologists, therapists, social workers, and counselors, as described in chapters 450B, 630, 630A, 631, 632, 633, 634, 634A, 635, 636, 637, 637B, 639, 640, 640A, 640B, 640C, 640D, 640E, 641, 641A, 641B, and 641C
 - Any personnel of a licensed medical facility engaged in the admission, examination, care, or treatment of persons or an administrator, manager, or other person in charge of the medical facility upon notification of suspected abuse or neglect of a child by a member of the staff of the medical facility
-

- Coroners
- Members of the clergy, Christian Science practitioners, or religious healers
- Persons working in schools
- Persons who maintain or are employed by facilities that provide care for children, children's camps, or other public or private facilities, institutions, or agencies furnishing care to children
- Persons licensed to conduct foster homes
- Officers or employees of law enforcement agencies or adult or juvenile probation officers
- Except as otherwise provided below, attorneys
- Person who maintain, are employed by, or serve as volunteers for agencies or services that advise persons regarding abuse or neglect of a child and refer them to persons and agencies where their requests and needs can be met
- Persons who are employed by or serve as volunteers for a youth shelter
- Any adult person who is employed by an entity that provides organized activities for children

Reporting by Other Persons**Rev. Stat. § 432B.220**

Any other person may report.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report**Rev. Stat. § 432B.220**

A report is required when:

- A reporter, in his or her professional capacity, knows or has reason to believe that a child is abused or neglected.
- A reporter has reasonable cause to believe that a child has died as a result of abuse or neglect.
- A medical services provider who delivers or provides medical services to a newborn infant, in his or her professional or occupational capacity, knows or has reasonable cause to believe that the newborn infant has been affected by prenatal illegal substance abuse or has withdrawal symptoms resulting from prenatal drug exposure.

Privileged Communications**Rev. Stat. §§ 432B.220; 432B.225; 432B.250**

The clergy-penitent privilege applies when the knowledge is gained during religious confession.

Notwithstanding the provisions of § 432B.220, an attorney shall not make a report of the abuse or neglect of a child if the attorney acquired knowledge of the abuse or neglect from a client during a privileged communication if the client:

- Has been or may be accused of committing the abuse or neglect
- Is the victim of the abuse or neglect, is in foster care, and did not give consent to the attorney to report the abuse or neglect

Nothing in this section shall be construed as relieving an attorney from:

- The duty to report the abuse or neglect of a child, except as otherwise provided above
- Complying with any ethical duties of attorneys, including, without limitation, any duty to take reasonably necessary actions to protect his or her client if the client is not capable of making adequately considered decisions because of age, mental impairment, or any other reason

Any other person who is required to report may not invoke privilege for failure to make a report.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity**Rev. Stat. § 432B.290**

Information maintained by a child welfare agency may be made available to the persons listed below, as long as the identity of the person making the report is kept confidential:

- The proposed guardian or proposed successor guardian of a child
- A parent or legal guardian of the child and his or her attorney

- A child age 14 or older over whom a guardianship is sought
- Upon written consent of the parent, any officer of this State or a city or county or legislator, to investigate the activities or programs of a child welfare agency

An agency investigating a report of the abuse or neglect of a child shall, upon request, provide to a person named in the report as allegedly causing the abuse or neglect of the child a written summary of the allegations made against the person who is named in the report as allegedly causing the abuse or neglect of the child. The summary must not identify the person responsible for reporting the alleged abuse or neglect or any collateral sources and reporting parties.

Except as provided below, before releasing any information an agency shall take whatever precautions it determines are reasonably necessary to protect the identity and safety of any person who reports child abuse or neglect.

A person who is the subject of an unsubstantiated report of child abuse or neglect who believes that the report was made in bad faith or with malicious intent may petition a district court to order the agency that provides child welfare services to release information maintained by the agency. If the court finds that there is a reasonable cause to believe that the report was made in bad faith or with malicious intent and that the disclosure of the identity of the person who made the report would not be likely to endanger the life or safety of the person who made the report, the court shall provide a copy of the information to the petitioner.

New Hampshire

Professionals Required to Report

Rev. Stat. § 169-C:29

The following professionals are required to report:

- Physicians, surgeons, county medical examiners, psychiatrists, residents, interns, dentists, osteopaths, optometrists, chiropractors, nurses, hospital personnel, or Christian Science practitioners
- Teachers, school officials, nurses, or counselors
- Daycare workers or any other child or foster care workers
- Social workers
- Psychologists or therapists
- Priests, ministers, or rabbis
- Law enforcement officials

Reporting by Other Persons

Rev. Stat. § 169-C:29

All other persons who have reason to suspect that a child has been abused or neglected must report.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report

Rev. Stat. § 169-C:29

A report is required when a person has reason to suspect that a child has been abused or neglected.

Privileged Communications

Rev. Stat. § 169-C:32

Only the attorney-client privilege is permitted.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity

This issue is not addressed in the statutes reviewed.

New Jersey

Professionals Required to Report

No professional groups are specified in statute; all persons are required to report.

Reporting by Other Persons**Ann. Stat. § 9:6-8.10**

Any person having reasonable cause to believe that a child has been subjected to child abuse, neglect, or acts of child abuse shall report.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report**Ann. Stat. § 9:6-8.10**

A report is required when a person has reasonable cause to believe that a child has been subjected to abuse or neglect.

Privileged Communications

This issue is not addressed in the statutes reviewed.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity**Ann. Stat. § 9:6-8.10a**

The identity of the reporter shall not be made public. Any information that could endanger any person shall not be released.

New Mexico**Professionals Required to Report****Ann. Stat. § 32A-4-3**

Professionals required to report include:

- Physicians, residents, or interns
- Law enforcement officers or judges
- Nurses
- Teachers or school officials
- Social workers
- Members of the clergy

Reporting by Other Persons**Ann. Stat. § 32A-4-3**

Every person who knows or has a reasonable suspicion that a child is an abused or a neglected child shall report the matter immediately.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report**Ann. Stat. § 32A-4-3**

A report is required when a person knows or has a reasonable suspicion that a child is abused or neglected.

Privileged Communications**Ann. Stat. §§ 32A-4-3; 32A-4-5**

A clergy member need not report any information that is privileged.

The report or its contents or any other facts related thereto or to the condition of the child who is the subject of the report shall not be excluded on the ground that the matter is or may be the subject of a physician-patient privilege or similar privilege or rule against disclosure.

Inclusion of Reporter's Name in Report**Ann. Stat. § 32A-4-5**

The identity of the mandated reporter will be verified before any investigation is initiated.

Disclosure of Reporter Identity**Ann. Stat. § 32A-4-33**

Any release of information to a parent, guardian, or legal custodian shall not include identifying information about the reporter.

New York**Professionals Required to Report****Soc. Serv. Law § 413**

The following persons and officials are required to report:

- Physicians, physician assistants, surgeons, medical examiners, coroners, dentists, dental hygienists, osteopaths, optometrists, chiropractors, podiatrists, residents, interns, psychologists, registered nurses, social workers, or emergency medical technicians
- Licensed creative arts therapists, marriage and family therapists, mental health counselors, or psychoanalysts
- Hospital personnel or Christian Science practitioners
- School officials, including but not limited to, teachers, guidance counselors, school psychologists, school social workers, school nurses, or administrators
- Full- or part-time compensated school employees required to hold temporary coaching licenses or professional coaching certificates
- Social services workers, daycare center workers, providers of family or group family daycare, or any other child care or foster care worker
- Directors of children's overnight camps, summer day camps, or traveling summer day camps
- Employees or volunteers in residential care facilities for children that are licensed, certified, or operated by the Office of Children and Family Services
- Mental health professionals, substance abuse counselors, alcoholism counselors, or all persons credentialed by the Office of Alcoholism and Substance Abuse Services
- Peace officers, police officers, district attorneys or assistant district attorneys, investigators employed in the office of a district attorney, or other law enforcement officials

Reporting by Other Persons**Soc. Serv. Law § 414**

Any other person who has reasonable cause to suspect that a child is abused or maltreated may report.

Institutional Responsibility to Report**Soc. Serv. Law § 413**

Whenever a person is required to report in his or her capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, he or she shall make the report as required and immediately notify the person in charge of such institution, school, facility, or agency, or his or her designated agent. The person in charge, or the designated agent of such person, shall be responsible for all subsequent administration necessitated by the report. Any report shall include the name, title, and contact information for every staff person of the institution who is believed to have direct knowledge of the allegations in the report. Nothing in this section or title is intended to require more than one report from any such institution, school, or agency.

A medical or other public or private institution, school, facility, or agency shall not take any retaliatory personnel action against an employee because such employee believes that he or she has reasonable cause to suspect that a child is an abused or maltreated child and that employee therefore makes a report in accordance with this title. No school, school official, child care provider, foster care provider, residential care facility provider, hospital, medical institution provider, or mental health facility provider shall impose any conditions, including prior approval or prior notification, upon a member of their staff specifically required to report under this title.

Standards for Making a Report**Soc. Serv. Law § 413**

A report is required when the reporter has reasonable cause to suspect:

- A child coming before him or her in his or her professional or official capacity is an abused or maltreated child.
- The parent, guardian, custodian, or other person legally responsible for the child comes before the reporter and states from personal knowledge facts, conditions, or circumstances that, if correct, would render the child an abused or maltreated child.

Privileged Communications**Soc. Serv. Law § 415**

Notwithstanding the privileges set forth in article 45 of the civil practice law and rules, and any other provision of law to the contrary, mandated reporters who make a report that initiates an investigation of an allegation of child abuse or maltreatment are required to comply with all requests for records made by a child protective service relating to the report.

Inclusion of Reporter's Name in Report**Soc. Serv. Law § 415**

The report shall include the name and contact information for the reporter.

Disclosure of Reporter Identity**Soc. Serv. Law § 422-a**

Any disclosure of information shall not identify the source of the report.

North Carolina**Professionals Required to Report****Gen. Stat. § 7B-301**

Any person or institution that has cause to suspect abuse or neglect shall report.

Reporting by Other Persons**Gen. Stat. § 7B-301**

All persons who have cause to suspect that any juvenile is abused, neglected, or dependent, or has died as the result of maltreatment, shall report.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report**Gen. Stat. § 7B-301**

A report is required when a reporter has cause to suspect that any juvenile is abused, neglected, or dependent, or has died as the result of maltreatment.

Privileged Communications**Gen. Stat. § 7B-310**

No privilege shall be grounds for failing to report, even if the knowledge or suspicion is acquired in an official professional capacity, except when the knowledge or suspicion is gained by an attorney from that attorney's client during representation only in the abuse, neglect, or dependency case. No privilege, except the attorney-client privilege, shall be grounds for excluding evidence of abuse, neglect, or dependency.

Inclusion of Reporter's Name in Report**Gen. Stat. § 7B-301**

The report must include the name, address, and telephone number of the reporter.

Disclosure of Reporter Identity**Gen. Stat. § 7B-302**

The Department of Social Services shall hold the identity of the reporter in strictest confidence, except that the department shall disclose confidential information regarding the identity of the reporter to any Federal, State, or local government entity or its agent with a court order. The department may only disclose confidential information regarding the identity of the reporter to a Federal, State, or local government entity or its agent without a court order when the entity demonstrates a need for the reporter's name to carry out the entity's mandated responsibilities.

North Dakota**Professionals Required to Report****Cent. Code § 50-25.1-03**

The following professionals are required to report:

- Physicians, nurses, dentists, dental hygienists, optometrists, medical examiners or coroners, or any other medical or mental health professionals
- Religious practitioners of the healing arts
- Schoolteachers, administrators, or school counselors
- Addiction counselors, social workers, child care workers, or foster parents
- Police or law enforcement officers, juvenile court personnel, probation officers, division of juvenile services employees
- Members of the clergy

Reporting by Other Persons**Cent. Code § 50-25.1-03**

Any other person who has reasonable cause to suspect that a child is abused or neglected may report.

Institutional Responsibility to Report**Cent. Code §§ 50-25.1-04; 50-25.1-09.1**

Reports involving known or suspected institutional child abuse or neglect must be made and received in the same manner as all other reports made under this chapter.

An employer is prohibited from retaliating against an employee solely because the employee in good faith reported having reasonable cause to suspect that a child was abused or neglected, or died as a result of abuse or neglect, or because the employee is a child with respect to whom a report was made.

There is a rebuttable presumption that any adverse action within 90 days of a report is retaliatory. For purposes of this subsection, an 'adverse action' is action taken by an employer against the person making the report or the child with respect to whom a report was made, including:

- Discharge, suspension, termination, or transfer from any facility, institution, school, agency, or other place of employment
- Discharge from or termination of employment
- Demotion or reduction in remuneration for services
- Restriction or prohibition of access to any facility, institution, school, agency, or other place of employment or persons affiliated with it

Standards for Making a Report**Cent. Code § 50-25.1-03**

A report is required when a reporter has knowledge of or reasonable cause to suspect that a child is abused or neglected, if the knowledge or suspicion is derived from information received by that person in that person's official or professional capacity.

A person who has knowledge of or reasonable cause to suspect that a child is abused or neglected based on images of sexual conduct by a child discovered on a workplace computer shall report the circumstances to the department.

Privileged Communications**Cent. Code §§ 50-25.1-03; 50-25.1-10**

A member of the clergy is not required to report such circumstances if the knowledge or suspicion is derived from information received in the capacity of spiritual adviser.

Any privilege of communication between husband and wife or between any professional person and the person's patient or client, except between attorney and client, cannot be used as grounds for failing to report.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity**Cent. Code § 50-25.1-11**

All reports are confidential and must be made available to a parent, the child's guardian, and any person who is the subject of a report; provided, however, that the identity of persons reporting or supplying information is protected.

Northern Mariana Islands**Professionals Required to Report****Commonwealth Code Tit. 6, § 5313**

Reports are required from the following:

- Any health-care worker, including anesthesiologists, acupuncturists, chiropractors, dentists, health aides, hypnotists, massage therapists, mental health counselors, midwives, nurses, nurse practitioners, osteopaths, naturopaths, physical therapists, physicians, physician's assistants, psychiatrists, psychologists, radiologists, religious healing practitioners, surgeons, or x-ray technicians
- Teachers or other school officials
- Daycare providers, nannies, au pair workers, or any other person who is entrusted with the temporary care of a minor child in return for compensation, except babysitters who are themselves minor children
- Counselors or social workers
- Peace officers or other law enforcement officials

Reporting by Other Persons**Commonwealth Code Tit. 6, § 5313**

Any other person may at any time report known or suspected instances of child abuse or neglect.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report**Commonwealth Code Tit. 6, § 5313**

A report is required when a mandated reporter comes into contact in a professional capacity with a child who the person knows or has reasonable cause to suspect is abused or neglected.

Privileged Communications**Commonwealth Code Tit. 6, § 5317**

Common law and statutory privileges as to communications between husband and wife and a professional person and his or her patient or client, except for that between attorney and client, do not apply to communications relating to the reporting of child abuse offenses.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity**Commonwealth Code Tit. 6, § 5325**

The release of data that would identify the person who made a report of suspected child abuse or the person who cooperated in a subsequent investigation is prohibited.

Ohio

Professionals Required to Report

Rev. Code § 2151.421

Mandatory reporters include:

- Attorneys
- Physicians, interns, residents, dentists, podiatrists, nurses, or other health-care professionals
- Licensed psychologists, school psychologists, or marriage and family therapists
- Speech pathologists or audiologists
- Coroners
- Administrators or employees of child daycare centers, residential camps, child day camps, certified child care agencies, other public or private children services, or private, nonprofit therapeutic wilderness camps agencies
- Teachers, school employees, or school authorities
- Persons engaged in social work or the practice of professional counseling
- Agents of county humane societies
- Persons, other than clerics, rendering spiritual treatment through prayer in accordance with the tenets of a well-recognized religion
- Professional employees of a county Department of Job and Family Services who works with children and families
- Superintendents or regional administrators employed by the Department of Youth Services
- Superintendents, board members, or employees of county boards of developmental disabilities; investigative agents contracted with by a county board of developmental disabilities; employees of the Department of Developmental Disabilities; employees of a facility or home that provides respite care; employees of a home health agency; employees of an entity that provides homemaker services
- Persons performing the duties of an assessor or third party employed by a public children's services agency to assist in providing child- or family-related services
- Court-appointed special advocates or guardians ad litem

Reporting by Other Persons

Rev. Code § 2151.421

Any other person who suspects that a child has suffered or faces a threat of suffering from abuse or neglect may report.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report

Rev. Code § 2151.421

A report is required when a mandated person is acting in an official or professional capacity and knows or suspects that a child has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child.

Privileged Communications

Rev. Code § 2151.421

An attorney, physician, or cleric is not required to make a report concerning any communication the attorney, physician, or cleric receives from a client, patient, or penitent in a professional relationship, if, in accordance with § 2317.02, the attorney, physician, or cleric could not testify with respect to that communication in a civil or criminal proceeding.

The client, patient, or penitent in the relationship is deemed to have waived any testimonial privilege with respect to any communication the attorney, physician, or cleric receives, and the attorney, physician, or cleric shall make a report with respect to that communication if all of the following apply:

- The client, patient, or penitent, at the time of the communication, is either a child under age 18 or a mentally retarded, developmentally disabled, or physically impaired person under age 21.
- The attorney, physician, or cleric knows, or has reasonable cause to suspect based on facts that would cause a reasonable person in similar position to suspect, as a result of the communication or any observations made during that communication, that the client, patient, or penitent has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the person.

- The abuse or neglect does not arise out of the person's attempt to have an abortion without the notification of her parents, guardian, or custodian in accordance with § 2151.85.

Inclusion of Reporter's Name in Report**Rev. Code § 2151.421**

The reporter is not required to provide his or her name in the report, but if he or she wants to receive information on the outcome of the investigation, he or she must provide his or her name, address, and telephone number to the person who receives the report.

Disclosure of Reporter Identity**Rev. Code § 2151.421**

The information provided in a report made pursuant to this section and the name of the person who made the report shall not be released for use and shall not be used as evidence in any civil action or proceeding brought against the person who made the report.

Oklahoma**Professionals Required to Report****Ann. Stat. Tit. 10A, § 1-2-101; Tit. 21, § 1021.4**

Mandatory reporters include:

- All persons
- Commercial film and photographic print processors or computer technicians

Reporting by Other Persons**Ann. Stat. Tit. 10A, § 1-2-101**

Every person who has reason to believe that a child is a victim of abuse or neglect must report.

Institutional Responsibility to Report**Ann. Stat. Tit. 10A, § 1-2-101**

The reporting obligations under this section are individual, and no employer, supervisor, or administrator shall interfere with the reporting obligations of any employee or other person or in any manner discriminate or retaliate against the employee or other person who in good faith reports suspected child abuse or neglect, or who provides testimony in any proceeding involving child abuse or neglect.

Standards for Making a Report**Ann. Stat. Tit. 10A, § 1-2-101; Tit. 21, § 1021.4**

A report is required when:

- Any person has reason to believe that a child under age 18 is a victim of abuse or neglect.
- A physician, surgeon, or other health-care professional, including doctors of medicine, licensed osteopathic physicians, residents, and interns, attends the birth of a child who tests positive for alcohol or a controlled dangerous substance.
- A commercial film and photographic print processor or computer technician has knowledge of or observes any film, photograph, videotape, negative, or slide depicting a child engaged in an act of sexual conduct.

Privileged Communications**Ann. Stat. Tit. 10A, § 1-2-101**

No privilege shall relieve any person from the requirement to report.

Inclusion of Reporter's Name in Report

This issue is not addressed in the statutes reviewed.

Disclosure of Reporter Identity**Ann. Stat. Tit. 10A, § 1-2-101**

The Department of Human Services shall electronically record each referral received by the statewide centralized child abuse reporting hotline and establish a secure means of retaining the recordings for 12 months. The recordings shall be confidential and subject to disclosure only if a court orders the disclosure of the referral. The department shall redact any information identifying the reporting party unless otherwise ordered by the court.

Oregon

Professionals Required to Report

Rev. Stat. §§ 419B.005; 419B.010

A public or private official is mandated to report. Public or private officials include:

- Physicians, physician assistants, naturopathic physicians, interns, residents, optometrists, chiropractors, dentists, nurses, nurse practitioners, pharmacists, nurse's aides, home health aides, or employees of in-home health services
- School employees, including employees of higher education institutions (such as community colleges and public and private universities)
- Employees of the Department of Human Services, Oregon Health Authority, Early Learning Division, Youth Development Council, Office of Child Care, the Oregon Youth Authority, a local health department, a community mental health program, a community developmental disabilities program, a county juvenile department, a licensed child-caring agency, or an alcohol and drug treatment program
- Peace officers
- Members of the clergy
- Psychologists, social workers, professional counselors, marriage and family therapists
- Certified foster care or child care providers
- Attorneys or court-appointed special advocates
- Firefighters or emergency medical technicians
- Members of the Legislative Assembly
- Physical, speech, or occupational therapists
- Audiologists or speech-language pathologists
- Employees of the Teacher Standards and Practices Commission directly involved in investigations or discipline by the commission
- Operators of preschool or school-age recorded programs
- Employees or a private agency or organization facilitating the provision of respite services for parents pursuant to a properly executed power of attorney
- Employees of organizations providing child-related services or activities, including youth groups or centers, scout groups or camps, or summer or day camps
- Coaches, assistant coaches, or trainers of athletes, if compensated and if the athlete is a child
- Personal support and home care workers

Reporting by Other Persons

Rev. Stat. § 419B.015

Any person may voluntarily make a report.

Institutional Responsibility to Report

Rev. Stat. § 419B.010

The duty to report under this section is personal to the public or private official alone, regardless of whether the official is employed by, a volunteer of, or a representative or agent for any type of entity or organization that employs persons or uses persons as volunteers who are public or private officials in its operations.

The duty to report under this section exists regardless of whether the entity or organization that employs the public or private official or uses the official as a volunteer has its own procedures or policies for reporting abuse internally within the entity or organization.

Standards for Making a Report

Rev. Stat. § 419B.010

A report is required when any public or private official has reasonable cause to believe that any child with whom the official comes in contact has suffered abuse.

The duty to report under this section is personal to the public or private official alone, regardless of whether the official is employed by, a volunteer of, or a representative or agent for any type of entity or organization that employs persons or uses persons as volunteers who are public or private officials in its operations.

The duty to report under this section exists regardless of whether the entity or organization that employs the public or private official or uses the official as a volunteer has its own procedures or policies for reporting abuse internally within the entity or organization.

Privileged Communications**Rev. Stat. § 419B.010**

A psychiatrist, psychologist, member of the clergy, or attorney shall not be required to report if such communication is privileged under law. An attorney is not required to make a report of information communicated to the attorney in the course of representing a client if disclosure of the information would be detrimental to the client.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity**Rev. Stat. § 419B.015**

The name, address, and other identifying information about the person who made the report may not be disclosed.

Pennsylvania**Professionals Required to Report****Cons. Stat. Tit. 23, § 6311**

The following adults are required to report:

- Persons licensed or certified to practice in any health-related field
- Medical examiners, coroners, or funeral directors
- Employees of licensed health-care facilities who are engaged in the admission, examination, care, or treatment of individuals
- School employees
- Employees of a child care service or public library
- A clergyman, priest, rabbi, minister, Christian Science practitioner, religious healer, or spiritual leader of any regularly established church or other religious organization
- Any person, paid or unpaid, who, on the basis of the person's role in a program, activity, or service, is a person responsible for the child's welfare or has direct contact with children
- Employees of a social services agency
- A peace officer or law enforcement official
- An emergency medical services provider
- An individual supervised or managed by a person listed above who has direct contact with children
- An independent contractor
- An attorney affiliated with an agency, institution, or other entity, including a school or established religious organization that is responsible for the care, supervision, guidance, or control of children
- A foster parent
- An adult family member who is a person responsible for the child's welfare and provides services to a child in a family living home, community home for individuals with an intellectual disability, or licensed host home for children

A 'school employee' is an individual who is employed by a school or who provides an activity or service sponsored by a school. The term does not apply to administrative personnel unless that person has direct contact with children. A school is a facility providing elementary, secondary, or postsecondary educational services, including public and nonpublic schools, vocational-technical schools, and institutions of higher education.

Reporting by Other Persons**Cons. Stat. Tit. 23, § 6312**

Any person may make an oral or written report of suspected child abuse, which may be submitted electronically, if that person has reasonable cause to suspect that a child is a victim of child abuse.

Institutional Responsibility to Report
Cons. Stat. Tit. 23, § 6311

Whenever a person is required to report in the capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, that person shall report immediately in accordance with § 6313 and shall immediately thereafter notify the person in charge of the institution, school, facility, or agency, or the designated agent of the person in charge. Upon notification, the person in charge or the designated agent, if any, shall facilitate the cooperation of the institution, school, facility, or agency with the investigation of the report. Any intimidation, retaliation, or obstruction in the investigation of the report is subject to the provisions of title 18, § 4958 (relating to intimidation, retaliation, or obstruction in child abuse cases). This chapter does not require more than one report from any such institution, school, facility, or agency.

Standards for Making a Report
Cons. Stat. Tit. 23, § 6311

A mandated reporter shall make a report of suspected child abuse if he or she has reasonable cause to suspect that a child is a victim of child abuse under any of the following circumstances:

- The mandated reporter comes into contact with the child in the course of employment, occupation, and practice of a profession or through a regularly scheduled program, activity, or service.
- The mandated reporter is directly responsible for the care, supervision, guidance, or training of the child, or is affiliated with an agency, institution, organization, school, regularly established church or religious organization, or other entity that is directly responsible for the care, supervision, guidance, or training of the child.
- A person makes a specific disclosure to the mandated reporter that an identifiable child is the victim of child abuse.
- An individual age 14 or older makes a specific disclosure to the mandated reporter that the individual has committed child abuse.

Nothing in this section shall require a child to come before the mandated reporter in order for the mandated reporter to make a report of suspected child abuse. Nothing in this section shall require the mandated reporter to identify the person responsible for the child abuse to make a report of suspected child abuse.

Privileged Communications
Cons. Stat. Tit. 23, § 6311.1

The privileged communications between a mandated reporter and a patient or client of the mandated reporter shall not:

- Apply to a situation involving child abuse
- Relieve the mandated reporter of the duty to make a report of suspected child abuse

The following protections shall apply:

- Confidential communications made to a member of the clergy are protected under title 42, § 5943 (relating to confidential communications to clergymen).
- Confidential communications made to an attorney are protected so long as they are within the scope of title 42, § 5916 (relating to confidential communications to attorney) and § 5928 (relating to confidential communications to attorney), the attorney work product doctrine, or the rules of professional conduct for attorneys.

Inclusion of Reporter's Name in Report
Cons. Stat. Tit. 23, § 6313

A written report of suspected child abuse, which may be submitted electronically, shall include the name, telephone number, and email address of the person making the report.

Disclosure of Reporter Identity
Cons. Stat. Tit. 23, § 6340

Upon a written request, a subject of a report may receive a copy of all information, except for the identity of the person who made the report.

Except for reports released to law enforcement officials and the district attorney's office, and in response to a law enforcement official investigating allegations of false reports under title 18, § 4906.1 (relating to false reports of child abuse), the release of data that would identify the person who made a report of suspected child abuse or who cooperated in a subsequent investigation is prohibited. Law enforcement officials shall treat all reporting sources as confidential informants.

Puerto Rico

Professionals Required to Report

Ann. Laws Tit. 8, § 446

The following individuals and entities are required to report:

- Professionals or public officials
- Public, private, and privatized entities
- Professionals in the fields of health, justice, education, social work, or public order
- Persons who administer or work in caregiving institutions or centers, rehabilitation institutions, centers for minors, or foster homes
- Processors of film or photographs

Reporting by Other Persons

Ann. Laws Tit. 8, § 446

Any person who has knowledge of or suspects that a minor is a victim of abuse or neglect must report.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report

Ann. Laws Tit. 8, § 446

A report is required when:

- A person, in his or her professional capacity and in the performance of his or her functions, learns or comes to suspect that a minor is, has been, or is at risk of becoming a victim of abuse.
- A film processor has knowledge of or observes any motion picture, photograph, videotape, negative, or slide that depicts a minor involved in a sexual activity.

Privileged Communications

This issue is not addressed in the statutes reviewed.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity

Ann. Laws Tit. 8, § 446

The identity of the person who made the report shall be kept in strict confidence.

Rhode Island

Professionals Required to Report

Gen. Laws § 40-11-6

Any physician or duly certified registered nurse practitioner is required to report.

Reporting by Other Persons

Gen. Laws § 40-11-3(a)

Any person who has reasonable cause to know or suspect that a child has been abused or neglected must report.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report

Gen. Laws §§ 40-11-3(a); 40-11-6

A report is required when:

- A person has reasonable cause to know or suspect that a child has been abused or neglected.
- A physician or nurse practitioner has cause to suspect that a child brought to them for treatment is an abused or neglected child, or he or she determines that a child under age 12 is suffering from any sexually transmitted disease.

Privileged Communications**Gen. Laws § 40-11-11**

The privileged quality of communication between husband and wife and any professional person and his or her patient or client, except that between attorney and client, shall not constitute grounds for failure to report.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity

This issue is not addressed in the statutes reviewed.

South Carolina**Professionals Required to Report****Ann. Code § 63-7-310**

The following professionals are required to report:

- Physicians, nurses, dentists, optometrists, medical examiners, or coroners
- Employees of county medical examiner's or coroner's offices
- Any other medical, emergency medical services, mental health, or allied health professionals
- Members of the clergy, including Christian Science practitioners or religious healers
- School teachers, counselors, principals, assistant principals, or school attendance officers
- Social or public assistance workers, substance abuse treatment staff, or child care workers in a child care center or foster care facility
- Foster parents
- Police or law enforcement officers or juvenile justice workers
- Undertakers, funeral home directors, or employees of a funeral home
- Persons responsible for processing films or computer technicians
- Judges
- Volunteer nonattorney guardians ad litem serving on behalf of the South Carolina Guardian Ad Litem Program or the Richland County Court-Appointed Special Advocates (CASA) program

Reporting by Other Persons**Ann. Code § 63-7-310**

Except as provided above, a person, including, but not limited to, a volunteer nonattorney guardian ad litem serving on behalf of the South Carolina Guardian Ad Litem Program or the Richland County CASA, who has reason to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse and neglect may report, and is encouraged to report, in accordance with this section.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report**Ann. Code § 63-7-310**

A report is required when a reporter, in his or her professional capacity, receives information that gives him or her reason to believe that a child has been or may be abused or neglected.

Privileged Communications**Ann. Code § 63-7-420**

The privileged quality of communication between husband and wife and any professional person and his or her patient or client, except that between attorney and client or clergy member, including a Christian Science practitioner or religious healer, and penitent, does not constitute grounds for failure to report. However, a clergy member, including a Christian Science practitioner or religious healer, must report in accordance with this subarticle except when information is received from the alleged perpetrator of the abuse and neglect during a communication that is protected by the clergy and penitent privilege as provided for in § 19-11-90.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity**Ann. Code § 63-7-330**

The identity of the person making a report pursuant to this section must be kept confidential by the agency or department receiving the report and must not be disclosed, except as specifically provided for in statute.

South Dakota**Professionals Required to Report****Codified Laws § 26-8A-3**

Mandatory reporters include:

- Physicians, dentists, osteopaths, chiropractors, optometrists, podiatrists, hospital interns or residents, nurses, or coroners
- Teachers, school counselors or officials, or licensed or registered child welfare providers
- Mental health professionals or counselors, psychologists, social workers, chemical dependency counselors, employees or volunteers of domestic abuse shelters, or religious healing practitioners
- Employees or volunteers of child advocacy organizations or child welfare service providers
- Parole or court services officers or law enforcement officers
- Any safety-sensitive position (as defined in § 23-3-64), including any law enforcement officer authorized to carry firearms and any custody staff employed by any agency responsible for the rehabilitation or treatment of any adjudicated adult or juvenile

Reporting by Other Persons**Codified Laws § 26-8A-3**

Any person who knows or has reasonable cause to suspect that a child younger than age 18 has been abused or neglected may report.

Institutional Responsibility to Report**Codified Laws §§ 26-8A-6; 26-8A-7**

Any person who has contact with a child through the performance of services as a member of a staff of a hospital or similar institution shall immediately notify the person in charge of the institution or his designee of suspected abuse or neglect. The person in charge shall report the information in accordance with the provisions of § 26-8A-8.

Any person who has contact with a child through the performance of services in any public or private school, whether accredited or unaccredited, as a teacher, school nurse, school counselor, school official, or administrator, or any person providing services pursuant to § 13-27-3 shall notify the school principal or school superintendent or designee of suspected abuse or neglect. The school principal or superintendent shall report the information in accordance with the provisions of § 26-8A-8. Each school district shall have a written policy on reporting of child abuse and neglect.

Standards for Making a Report**Codified Laws § 26-8A-3**

A report is required when a reporter has reasonable cause to suspect that a child has been abused or neglected.

Privileged Communications**Codified Laws § 26-8A-15**

The following privileges may not be claimed as a reason for not reporting:

- Physician-patient
- Husband-wife
- School counselor-student
- Social worker-client

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity

Codified Laws § 26-8A-11.1

The name of the reporter is not disclosed unless:

- The report is determined to be unsubstantiated.
- Within 30 days, the subject of the report requests disclosure of the reporter's identity.
- A hearing is held to determine whether the report was made with malice and without reasonable foundation and that release of the name will not endanger the life or safety of the reporter.

Tennessee

Professionals Required to Report

Ann. Code §§ 37-1-403; 37-1-605

Persons required to report include:

- Physicians, osteopaths, medical examiners, chiropractors, nurses, hospital personnel, or other health or mental health professionals
- Teachers, other school officials or personnel, daycare center workers
- Other professional child care, foster care, residential, or institutional workers
- Social workers
- Practitioners who rely solely on spiritual means for healing
- Judges or law enforcement officers
- Neighbors, relatives, or friends
- Authority figures at community facilities, including any facility used for recreation or social assemblies or for educational, religious, social, health, or welfare purposes, including, but not limited to, facilities operated by schools, the Boy or Girl Scouts, the YMCA or YWCA, the Boys and Girls Club, or church or religious organizations
- Other persons

Reporting by Other Persons

Ann. Code §§ 37-1-403; 37-1-605

Any person who has knowledge that a child has been harmed by abuse or neglect must report.

Institutional Responsibility to Report

Ann. Code § 37-1-403

Nothing in this section shall be construed to prohibit any hospital, clinic, school, or other organization responsible for the care of children from developing a specific procedure for internally tracking, reporting, or otherwise monitoring a report made by a member of the organization's staff, including requiring a member of the organization's staff who makes a report to provide a copy of or notice concerning the report to the organization, so long as the procedure does not inhibit, interfere with, or otherwise affect the duty of a person to make a report as required by law.

Nothing in this section shall prevent staff of a hospital or clinic from gathering sufficient information, as determined by the hospital or clinic, in order to make an appropriate medical diagnosis or to provide and document care that is medically indicated and is needed to determine whether to report an incident as defined in this part. Those activities shall not interfere with nor serve as a substitute for any investigation by law enforcement officials or the department. However, if any hospital, clinic, school, or other organization responsible for the care of children develops a procedure for internally tracking, reporting, or otherwise monitoring a report, the identity of the person who made a report of harm shall be kept confidential.

Standards for Making a Report

Ann. Code §§ 37-1-403; 37-1-605

A report is required when:

- A person has knowledge that a child has been harmed by abuse or neglect.
- A person is called upon to render aid to any child who is suffering from an injury that reasonably appears to have been caused by abuse.
- A person knows or has reasonable cause to suspect that a child has been sexually abused.
- A physician diagnoses or treats any sexually transmitted disease in a child age 13 or younger or diagnoses pregnancy in an unemancipated minor.

Any school official, personnel, employee, or member of the board of education who is aware of a report or investigation of employee misconduct on the part of any employee of the school system that in any way involves known or alleged child abuse, including, but not limited to, child physical or sexual abuse or neglect, shall immediately upon knowledge of such information notify the Department of Children's Services or law enforcement official of the abuse or alleged abuse.

Privileged Communications**Ann. Code § 37-1-411**

The following privileges may not be claimed:

- Husband-wife
- Psychiatrist-patient or psychologist-patient

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity**Ann. Code § 37-1-409**

Except as may be ordered by the juvenile court, the name of any person reporting child abuse or neglect shall not be released to any person, other than employees of the department or other child protection team members responsible for child protective services, the abuse registry, or the appropriate district attorney general upon subpoena of the Tennessee Bureau of Investigation, without the written consent of the person reporting.

The reporter's identity shall be irrelevant to any civil proceeding and shall, therefore, not be subject to disclosure by order of any court. This shall not prohibit the issuance of a subpoena to a person reporting child abuse when deemed necessary by the district attorney general or the department to protect a child who is the subject of a report, provided that the fact that the person made the report is not disclosed.

Texas**Professionals Required to Report****Fam. Code § 261.101**

Persons required to report include professionals, for purposes of the reporting laws, who are licensed or certified by the State or who are an employees of facilities licensed, certified, or operated by the State and who, in the normal course of official duties or duties for which licensure or certification is required, have direct contact with children. Professionals include:

- Teachers or daycare employees
- Nurses, doctors, or employees of a clinic or health-care facility that provides reproductive services
- Juvenile probation officers or juvenile detention or correctional officers

Reporting by Other Persons**Fam. Code § 261.101**

A person who has cause to believe that a child has been adversely affected by abuse or neglect shall immediately make a report.

Institutional Responsibility to Report**Fam. Code §§ 261.101; 261.110**

A professional may not delegate to or rely on another person to make the report.

An employer may not suspend or terminate the employment of, or otherwise discriminate against, a person who is a professional and who in good faith:

- Reports child abuse or neglect to the person's supervisor, an administrator of the facility where the person is employed, a State regulatory agency, or a law enforcement agency
- Initiates or cooperates with an investigation or proceeding by a governmental entity relating to an allegation of child abuse or neglect

A person whose employment is suspended or terminated or who is otherwise discriminated against in violation of this section may sue for injunctive relief, damages, or both.

Standards for Making a Report

Fam. Code § 261.101

A report is required when a person has cause to believe that a child has been adversely affected by abuse or neglect.

In addition, a person or professional shall make a report if the person or professional has cause to believe that an adult was a victim of abuse or neglect as a child, and the person or professional determines in good faith that disclosure of the information is necessary to protect the health and safety of another child, an elderly person, or person with a disability.

Privileged Communications

Fam. Code §§ 261.101; 261.202

The requirement to report applies without exception to an individual whose personal communications may otherwise be privileged, including an attorney, a member of the clergy, a medical practitioner, a social worker, a mental health professional, an employee or member of a board that licenses or certifies a professional, and an employee of a clinic or health-care facility that provides reproductive services.

In a proceeding regarding the abuse or neglect of a child, evidence may not be excluded on the ground of privileged communication except in the case of communication between an attorney and client.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity

Fam. Code §§ 261.101; 261.201

Unless waived in writing by the person making the report, the identity of an individual making a report is confidential and may be disclosed only:

- As provided by § 261.201
- To a law enforcement officer for the purposes of conducting a criminal investigation of the report

A report of alleged or suspected abuse or neglect and the identity of the person making the report are confidential. A court may order the disclosure of such confidential information, if after a hearing and an in camera review of the requested information, the court determines that the disclosure is:

- Essential to the administration of justice
- Not likely to endanger the life or safety of a child who is the subject of the report, a person who made the report, or any other person who participates in an investigation of reported abuse or neglect or who provides care for the child

The Texas Youth Commission shall release a report of alleged or suspected abuse if the report relates to abuse or neglect involving a child committed to the commission. The commission shall edit any report disclosed under this section to protect the identity of:

- A child who is the subject of the report
- The person who made the report
- Any other person whose life or safety may be endangered by the disclosure

Utah

Professionals Required to Report

Ann. Code § 62A-4a-403

Any person licensed under the Medical Practice Act or the Nurse Practice Act is required to report.

Reporting by Other Persons

Ann. Code § 62A-4a-403

Any person who has reason to believe that a child has been subjected to abuse or neglect must report.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report**Ann. Code § 62A-4a-403**

A report is required when:

- A person has reason to believe that a child has been subjected to abuse or neglect.
- A person observes a child being subjected to conditions or circumstances that would reasonably result in sexual abuse, physical abuse, or neglect.

Privileged Communications**Ann. Code §§ 62A-4a-403; 62A-4a-412(5)**

The requirement to report does not apply to a clergy member or priest without the consent of the person making the confession, with regard to any confession made to the clergy member or priest in his or her professional character in the course of discipline enjoined by the church.

The physician-patient privilege is not a ground for excluding evidence regarding a child's injuries or the cause of those injuries in any proceeding resulting from a report made in good faith pursuant to this part.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity**Ann. Code § 62A-4a-412(3)(b)**

The name and contact information of the reporter shall be deleted prior to any release of records to the subject of the report.

Vermont**Professionals Required to Report****Ann. Stat. Tit. 33, § 4913**

Mandatory reporters include:

- Health-care providers, including physicians, surgeons, osteopaths, chiropractors, physician assistants, resident physicians, interns, hospital administrators, nurses, medical examiners, emergency medical personnel, dentists, psychologists, and pharmacists
- Individual who are employed or contracted and paid by a school district or an approved or recognized independent school, including school superintendents, headmasters, teachers, student teachers, school librarians, school principals, and school guidance counselors
- Child care workers
- Mental health professionals and social workers
- Police officers and probation officers
- Employees, contractors, and grantees of the Agency of Human Services who have contact with clients
- Camp owners, camp administrators, and camp counselors
- Members of the clergy

Reporting by Other Persons**Ann. Stat. Tit. 33, § 4913**

Any other concerned person who has reasonable cause to believe that a child has been abused or neglected may report.

Institutional Responsibility to Report**Ann. Stat. Tit. 33, § 4913**

An employer or supervisor shall not discharge; demote; transfer; reduce pay, benefits, or work privileges; prepare a negative work performance evaluation; or take any other action detrimental to any employee because that employee filed a good-faith report in accordance with the provisions of this subchapter. Any person making a report under this subchapter shall have a civil cause of action for appropriate compensatory and punitive damages against any person who causes detrimental changes in the employment status of the reporting party by reason of his or her making a report.

Standards for Making a Report**Ann. Stat. Tit. 33, § 4913**

A report is required when a mandated reporter reasonably suspects abuse or neglect of a child.

Privileged Communications**Ann. Stat. Tit. 33, § 4913**

A person may not refuse to make a report required by this section on the grounds that making the report would violate a privilege or disclose a confidential communication, except that a member of the clergy is not required to report if the knowledge comes from a communication that is required to be kept confidential by religious doctrine.

Inclusion of Reporter's Name in Report**Ann. Stat. Tit. 33, § 4914**

Reports shall contain the name and address or other contact information of the reporter.

Disclosure of Reporter Identity**Ann. Stat. Tit. 33, § 4913**

The name of and any identifying information about either the person making the report or any person mentioned in the report shall be confidential unless:

- The person making the report specifically allows disclosure.
- A Human Services Board proceeding or judicial proceeding results from the report.
- A court, after a hearing, finds probable cause to believe that the report was not made in good faith and orders the department to make the name of the reporter available.
- A review has been requested pursuant to § 4916a of this title, and the department has determined that identifying information can be provided without compromising the safety of the reporter or the persons mentioned in the report.

Virgin Islands**Professionals Required to Report****Ann. Code Tit. 5, § 2533**

The following professionals are required to report:

- Physicians, hospital personnel, nurses, dentists, or any other medical or mental health professionals
- Teachers or other school personnel, social service workers, daycare workers, or other child care or foster care workers
- Peace officers or law enforcement officials

Reporting by Other Persons**Ann. Code Tit. 5, § 2533**

Any other person who has reasonable cause to suspect that a child has been abused or neglected may report.

Institutional Responsibility to Report**Ann. Code Tit. 5, § 2533**

Whenever any person is required to report in his or her capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, he or she shall immediately notify the person in charge of such institution, school, facility, or agency, or his or her designated agent, who then also shall become responsible to report or cause reports to be made. Nothing in this subchapter is intended to require more than one report from any such institution, school, or agency; but neither is it intended to prevent individuals from reporting on their own behalf.

Standards for Making a Report**Ann. Code Tit. 5, § 2533**

A report is required when:

- A reporter has reasonable cause to suspect that a child has been subjected to abuse, sexual abuse, or neglect.
- A reporter observes the child being subjected to conditions or circumstances that would reasonably result in abuse or neglect.

Privileged Communications**Ann. Code Tit. 5, § 2538**

The privileged quality of communications between husband and wife and between any professional person and his or her patient or client, except that between attorney and client, shall not constitute grounds for failure to report.

Inclusion of Reporter's Name in Report**Ann. Code Tit. 5, § 2534**

The report shall include the name, address, and occupation of the reporter.

Disclosure of Reporter Identity

This issue is not addressed in the statutes reviewed.

Virginia**Professionals Required to Report****Ann. Code § 63.2-1509**

The following professionals are required to report:

- Persons licensed to practice medicine or any of the healing arts
- Hospital residents or interns, and nurses
- Social workers, family-services specialists, or probation officers
- Teachers or other employees at public or private schools, kindergartens, or nursery schools
- Persons providing full-time or part-time child care for pay on a regular basis
- Mental health professionals
- Law enforcement officers, animal control officers, or mediators
- Professional staff employed by private or State-operated hospitals, institutions, or facilities to which children have been placed for care and treatment
- Persons age 18 or older associated with or employed by any public or private organization responsible for the care, custody, or control of children
- Court-appointed special advocates
- Persons age 18 or older who have received training approved by the Department of Social Services for the purposes of recognizing and reporting child abuse and neglect
- Persons employed by a local department who determine eligibility for public assistance
- Emergency medical services providers, unless such providers immediately report the matter directly to the attending physician at the hospital to which the child is transported
- Persons employed by public or private institutions of higher education, other than an attorney who is employed by a public or private institution of higher education as it relates to information gained in the course of providing legal representation to a client
- Athletic coaches, directors, or other persons age 18 or older employed by or volunteering with private sports organizations or teams
- Administrators or employees age 18 or older of public or private day camps, youth centers, and youth recreation programs

Reporting by Other Persons**Ann. Code § 63.2-1510**

Any person who suspects that a child is abused or neglected may report.

Institutional Responsibility to Report**Ann. Code § 63.2-1509**

If the information is received by a teacher, staff member, resident, intern, or nurse in the course of professional services in a hospital, school, or similar institution, such person may, in place of making a report, immediately notify the person in charge of the institution or department, or his or her designee, who shall make the report forthwith. If the initial report of suspected abuse or neglect is made to the person in charge of the institution or department or his or her designee, such person shall notify the teacher, staff member, resident, intern, or nurse who made the initial report when the report of suspected child abuse or neglect is made to the local department or to the toll-free child abuse and neglect hotline, and of the name of the individual receiving the report, and shall forward any communication resulting from the report, including any information about any actions taken regarding the report.

Standards for Making a Report**Ann. Code § 63.2-1509**

A report is required when, in his or her professional or official capacity, a reporter has reason to suspect that a child is abused or neglected. For purposes of this section, 'reason to suspect that a child is abused or neglected' shall include:

- A finding made by a health-care provider within 6 weeks of the birth of a child that the results of toxicology studies of the child indicate the presence of a controlled substance not prescribed for the mother by a physician
- A finding made by a health-care provider within 6 weeks of the birth of a child that the child was born dependent on a controlled substance that was not prescribed by a physician for the mother and has demonstrated withdrawal symptoms
- A diagnosis made by a health-care provider at any time following a child's birth that the child has an illness, disease, or condition that, to a reasonable degree of medical certainty, is attributable to in utero exposure to a controlled substance that was not prescribed by a physician for the mother or the child
- A diagnosis made by a health-care provider at any time following a child's birth that the child has a fetal alcohol spectrum disorder attributable to in utero exposure to alcohol

When 'reason to suspect' is based upon this subsection, that fact shall be included in the report along with the facts relied upon by the person making the report.

Privileged Communications**Ann. Code §§ 63.2-1509; 63.2-1519**

The requirement to report shall not apply to any regular minister, priest, rabbi, imam, or duly accredited practitioner of any religious organization or denomination usually referred to as a church as it relates to information required by the doctrine of the religious organization or denomination to be kept in a confidential manner.

The physician-patient or husband-wife privilege is not permitted.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity**Ann. Code § 63.2-1514**

Any person who is the subject of an unfounded report who believes that the report was made in bad faith or with malicious intent may petition the court for the release of the records of the investigation or family assessment. If the court determines that there is a reasonable question of fact as to whether the report was made in bad faith or with malicious intent and that disclosure of the identity of the reporter would not be likely to endanger the life or safety of the reporter, it shall provide to the petitioner a copy of the records of the investigation or family assessment.

Washington**Professionals Required to Report****Rev. Code § 26.44.030**

The following persons are required to report:

- Practitioners, county coroners, or medical examiners
- Law enforcement officers
- Professional school personnel
- Registered or licensed nurses, social service counselors, psychologists, or pharmacists
- Employees of the Department of Early Learning
- Licensed or certified child care providers or their employees
- Employees of the Department of Social and Health Services
- Juvenile probation officers
- Placement and liaison specialists, responsible living skills program staff, or HOPE center staff
- State family and children's ombudsman or any volunteer in the ombudsman's office
- Persons who supervise employees or volunteers who train, educate, coach, or counsel children or have regular unsupervised access to children
- Department of Corrections personnel
- Any adult with whom a child resides
- Guardians ad litem and court-appointed special advocates

The reporting requirement also applies to administrative and academic or athletic department employees, including student employees, of public and private institutions of higher education.

Reporting by Other Persons**Rev. Code § 26.44.030**

Any person who has reasonable cause to believe that a child has suffered abuse or neglect may report.

Institutional Responsibility to Report

This issue is not addressed in the statutes reviewed.

Standards for Making a Report**Rev. Code § 26.44.030**

A report is required when:

- A reporter has reasonable cause to believe that a child has suffered abuse or neglect.
- Any person, in his or her official supervisory capacity with a nonprofit or for-profit organization, has reasonable cause to believe that a child has suffered abuse or neglect caused by a person over whom he or she regularly exercises supervisory authority.
- Department of Corrections personnel observe offenders or the children with whom the offenders are in contact, and as a result of these observations have reasonable cause to believe that a child has suffered abuse or neglect.
- Any adult has reasonable cause to believe that a child who resides with them has suffered severe abuse.

Privileged Communications**Rev. Code §§ 26.44.030; 26.44.060**

No one shall be required to report when he or she obtains the information solely as a result of a privileged communication.

Information considered privileged by statute and not directly related to reports required by this section must not be divulged without a valid written waiver of the privilege.

Conduct conforming with reporting requirements shall not be deemed a violation of the confidential communication privilege of §§ 5.60.060 (3) and (4) [pertaining to clergy-penitent and physician-patient privilege], 18.53.200 [pertaining to optometrist-patient privilege], and 18.83.110 [pertaining to psychologist-client privilege].

Inclusion of Reporter's Name in Report**Rev. Code § 26.44.030**

The department shall make reasonable efforts to learn the name, address, and telephone number of the reporter.

Disclosure of Reporter Identity**Rev. Code § 26.44.030**

The department shall provide assurances of appropriate confidentiality of the identification of persons reporting under this section.

West Virginia**Professionals Required to Report****Ann. Code § 49-2-803**

The following professionals are required to report:

- Medical, dental, or mental health professionals
- Christian Science practitioners or religious healers
- Teachers or other school personnel
- Social service, child care, or foster care workers
- Emergency medical services personnel
- Peace officers, law enforcement officials, or humane officers
- Members of the clergy
- Circuit court judges, family court judges, employees of the Division of Juvenile Services, or magistrates
- Youth camp administrators, counselors, employees, coaches, or volunteers of entities that provide organized activities for children
- Commercial film or photographic print processors

Reporting by Other Persons**Ann. Code § 49-2-803**

Nothing in this article is intended to prevent individuals from reporting suspected abuse or neglect on their own behalf. In addition to those persons and officials specifically required to report situations involving suspected abuse or neglect of children, any other person may make a report if that person has reasonable cause to suspect that a child has been abused or neglected in a home or institution or observes the child being subjected to conditions or circumstances that would reasonably result in abuse or neglect.

Institutional Responsibility to Report**Ann. Code § 49-2-803**

Any person required to report who is a member of the staff or volunteer of a public or private institution, school, entity that provides organized activities for children, facility, or agency also shall immediately notify the person in charge of the institution, school, entity that provides organized activities for children, facility, or agency, or a designated agent thereof, who may supplement the report or cause an additional report to be made.

Standards for Making a Report**Ann. Code § 49-2-803**

Any mandatory reporter who has reasonable cause to suspect that a child is neglected or abused or observes the child being subjected to conditions that are likely to result in abuse or neglect shall report the circumstances or cause a report to be made to the Department of Health and Human Resources. In any case where the reporter believes that the child suffered serious physical abuse or sexual abuse or sexual assault, the reporter shall also immediately report, or cause a report to be made, to the State Police and any law-enforcement agency having jurisdiction to investigate the complaint.

Privileged Communications**Ann. Code § 49-2-811**

The privileged quality of communications between husband and wife and between any professional person and his or her patient or client, except that between attorney and client, cannot be invoked in situations involving suspected or known child abuse or neglect.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity

This issue is not addressed in the statutes reviewed.

Wisconsin**Professionals Required to Report****Ann. Stat. § 48.981**

The following professionals are required to report:

- Physicians, coroners, medical examiners, nurses, dentists, chiropractors, optometrists, acupuncturists, other medical or mental health professionals, physical therapists, physical therapist assistants, dietitians, occupational therapists, speech-language pathologists, audiologists, or emergency medical technicians
- Schoolteachers, administrators, or counselors
- School employees not otherwise specified above
- Child care workers in child care centers, group homes, or residential care centers, or child care providers
- Alcohol or other drug abuse counselors, marriage and family therapists, professional counselors, or members of the treatment staff employed by or working under contract with a county department or a residential care center for children and youth
- Social workers, public assistance workers, first responders, police or law enforcement officers, mediators, or court-appointed special advocates
- Members of the clergy or a religious order, including brothers, ministers, monks, nuns, priests, rabbis, or sisters

Reporting by Other Persons**Ann. Stat. § 48.981**

Any person, including an attorney, who has reason to suspect that a child has been abused or neglected or who has reason to believe that a child has been threatened with abuse or neglect and that abuse or neglect of the child will occur may report.

Institutional Responsibility to Report**Ann. Stat. § 48.981**

No person making a report in good faith may be discharged from employment, disciplined, or otherwise discriminated against in regard to employment or threatened with any such treatment for so doing.

Standards for Making a Report**Ann. Stat. § 48.981**

A report is required when:

- A reporter, in the course of his or her professional duties, has reasonable cause to suspect that a child has been abused or neglected.
- A reporter, in the course of his or her professional duties, has reason to believe that a child has been threatened with abuse or neglect or that abuse or neglect will occur.

Privileged Communications**Ann. Stat. § 48.981**

A member of the clergy is not required to report child abuse information that he or she receives solely through confidential communications made to him or her privately or in a confessional setting if he or she is authorized to hear or is accustomed to hearing such communications and, under the disciplines, tenets, or traditions of his or her religion, has a duty or is expected to keep those communications secret. Those disciplines, tenets, or traditions need not be in writing.

A person delegated care and custody of a child under § 48.979, including a court-appointed special advocate, is not required to report any suspected or threatened abuse or neglect of the child. Such a person who has reason to suspect that the child has been abused or neglected or who has reason to believe that the child has been threatened with abuse or neglect and that the abuse or neglect of the child will occur may report.

Inclusion of Reporter's Name in Report

The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity**Ann. Stat. § 48.981**

The identity of the reporter shall not be disclosed to the subject of the report.

Wyoming**Professionals Required to Report**

No professional groups are specified in statute; all persons are required to report.

Reporting by Other Persons**Ann. Stat. § 14-3-205**

All persons must report.

Institutional Responsibility to Report**Ann. Stat. § 14-3-205(b)**

If a person reporting child abuse or neglect is a member of the staff of a medical or other public or private institution, school, facility, or agency, he or she shall notify the person in charge or his or her designated agent as soon as possible, who is thereupon also responsible to make the report or cause the report to be made. Nothing in this subsection is intended to relieve individuals of their obligation to report on their own behalf, unless a report has already been made or will be made.

Standards for Making a Report**Ann. Stat. § 14-3-205**

A report is required when:

- A person knows or has reasonable cause to believe or suspect that a child has been abused or neglected.
- A person observes any child being subjected to conditions or circumstances that would reasonably result in abuse or neglect.

Privileged Communications**Ann. Stat. § 14-3-210**

Evidence regarding a child in any judicial proceeding resulting from a report made pursuant to the reporting laws shall not be excluded on the ground it constitutes a privileged communication:

- Between husband and wife
- Claimed under any provision of law other than § 1-12-101(a)(i) [regarding attorney-client or physician-patient privilege] and § 1-12-101(a)(ii) [regarding privilege of a clergy member or priest as it relates to a confession made to him or her in his or her professional character if enjoined by the church to which he or she belongs]
- Claimed pursuant to § 1-12-116 [regarding the confidential communication between a family violence and sexual assault advocate and victim]

Inclusion of Reporter's Name in Report**Ann. Stat. § 14-3-206**

The report must include any available photographs, videos, and x-rays with the identification of the person who created the evidence and the date the evidence was created.

Disclosure of Reporter Identity

This issue is not addressed in the statutes reviewed.



U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau





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Disponible en español

[https://www.childwelfare.gov/
pubs/factsheets/ques.cfm](https://www.childwelfare.gov/pubs/factsheets/ques.cfm)

What Is Child Abuse and Neglect? Recognizing the Signs and Symptoms



The first step in helping abused or neglected children is learning to recognize the signs of child abuse and neglect. The presence of a single sign does not mean that child maltreatment is occurring in a family, but a closer look at the situation may be warranted when these signs appear repeatedly or in combination. This factsheet is intended to help you better understand the legal definition of child abuse and neglect, learn about the different types

What's Inside:

- How is child abuse and neglect defined in Federal law?
- What are the major types of child abuse and neglect?
- Recognizing signs of abuse and neglect
- Resources



Use your smartphone to
access this factsheet online.



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of abuse and neglect, and recognize the signs and symptoms of abuse and neglect. Resources about the impact of trauma on well-being also are included in this factsheet.

How Is Child Abuse and Neglect Defined in Federal Law?

Federal legislation lays the groundwork for State laws on child maltreatment by identifying a minimum set of acts or behaviors that define child abuse and neglect. The Federal Child Abuse Prevention and Treatment Act (CAPTA), (42 U.S.C.A. §5106g), as amended and reauthorized by the CAPTA Reauthorization Act of 2010, defines child abuse and neglect as, at minimum:

“Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act which presents an imminent risk of serious harm.”

Most Federal and State child protection laws primarily refer to cases of harm to a child caused by parents or other caregivers; they generally do not include harm caused by other people, such as acquaintances or strangers. Some State laws also include a child’s witnessing of domestic violence as a form of abuse or neglect.

CHILD ABUSE AND NEGLECT STATISTICS

- **Child Maltreatment**
This report summarizes annual child abuse statistics submitted by States to the National Child Abuse and Neglect Data System (NCANDS). It includes information about child maltreatment reports, victims, fatalities, perpetrators, services, and additional research:
<http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>
- **Child Welfare Outcomes Report Data**
This website provides information on the performance of States in seven outcome categories related to the safety, permanency, and well-being of children involved in the child welfare system. Data, which are made available on the website prior to the release of the annual report, include the number of child victims of maltreatment:
<http://cwoutcomes.acf.hhs.gov/data/overview>

What Are the Major Types of Child Abuse and Neglect?

Within the minimum standards set by CAPTA, each State is responsible for providing its own definitions of child abuse and neglect. Most States recognize the four major types of maltreatment: physical abuse, neglect, sexual abuse, and emotional abuse. Signs and symptoms for each type of maltreatment are listed below. Additionally, many States identify abandonment and parental substance abuse as abuse or neglect. While these types of maltreatment may be found separately, they often occur in combination. For State-specific laws pertaining to child abuse and neglect, see Child Welfare Information Gateway's State Statutes Search page:

https://www.childwelfare.gov/systemwide/laws_policies/state/

Information Gateway's *Definitions of Child Abuse and Neglect* provides civil definitions that determine the grounds for intervention by State child protective agencies:

https://www.childwelfare.gov/systemwide/laws_policies/statutes/define.pdf

Physical abuse is nonaccidental physical injury (ranging from minor bruises to severe fractures or death) as a result of punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or otherwise harming a child, that is inflicted by a parent, caregiver, or other person who

has responsibility for the child.¹ Such injury is considered abuse regardless of whether the caregiver intended to hurt the child. Physical discipline, such as spanking or paddling, is not considered abuse as long as it is reasonable and causes no bodily injury to the child.

Neglect is the failure of a parent, guardian, or other caregiver to provide for a child's basic needs. Neglect may be:

- Physical (e.g., failure to provide necessary food or shelter, or lack of appropriate supervision)
- Medical (e.g., failure to provide necessary medical or mental health treatment)²
- Educational (e.g., failure to educate a child or attend to special education needs)
- Emotional (e.g., inattention to a child's emotional needs, failure to provide psychological care, or permitting the child to use alcohol or other drugs)

Sometimes cultural values, the standards of care in the community, and poverty may contribute to maltreatment, indicating

¹ Nonaccidental injury that is inflicted by someone other than a parent, guardian, relative, or other caregiver (i.e., a stranger), is considered a criminal act that is not addressed by child protective services.

² *Withholding of medically indicated treatment* is a specific form of medical neglect that is defined by CAPTA as "the failure to respond to the infant's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which, in the treating physician's or physicians' reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions..." CAPTA does note a few exceptions, including infants who are "chronically and irreversibly comatose"; situations when providing treatment would not save the infant's life but merely prolong dying; or when "the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane."

the family is in need of information or assistance. When a family fails to use information and resources, and the child's health or safety is at risk, then child welfare intervention may be required. In addition, many States provide an exception to the definition of neglect for parents who choose not to seek medical care for their children due to religious beliefs.³

Sexual abuse includes activities by a parent or caregiver such as fondling a child's genitals, penetration, incest, rape, sodomy, indecent exposure, and exploitation through prostitution or the production of pornographic materials.

Sexual abuse is defined by CAPTA as "the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children."

Emotional abuse (or psychological abuse) is a pattern of behavior that impairs a child's emotional development or sense of self-worth. This may include constant criticism, threats, or rejection, as well as withholding love, support, or guidance. Emotional abuse is often difficult to prove, and therefore, child protective services may not be able to intervene without evidence of harm or

³ The CAPTA amendments of 1996 (42 U.S.C.A. § 5106i) added new provisions specifying that nothing in the act be construed as establishing a Federal requirement that a parent or legal guardian provide any medical service or treatment that is against the religious beliefs of the parent or legal guardian.

mental injury to the child. Emotional abuse is almost always present when other types of maltreatment are identified.

Abandonment is now defined in many States as a form of neglect. In general, a child is considered to be abandoned when the parent's identity or whereabouts are unknown, the child has been left alone in circumstances where the child suffers serious harm, or the parent has failed to maintain contact with the child or provide reasonable support for a specified period of time. Some States have enacted laws—often called safe haven laws—that provide safe places for parents to relinquish newborn infants. Child Welfare Information Gateway produced a publication as part of its State Statute series that summarizes such State laws. *Infant Safe Haven Laws* is available on the Information Gateway website: https://www.childwelfare.gov/systemwide/laws_policies/statutes/safehaven.cfm

Substance abuse is an element of the definition of child abuse or neglect in many States. Circumstances that are considered abuse or neglect in some States include the following:

- Prenatal exposure of a child to harm due to the mother's use of an illegal drug or other substance
- Manufacture of methamphetamine in the presence of a child
- Selling, distributing, or giving illegal drugs or alcohol to a child
- Use of a controlled substance by a caregiver that impairs the caregiver's ability to adequately care for the child

For more information about this issue, see Child Welfare Information Gateway's *Parental Drug Use as Child Abuse* at https://www.childwelfare.gov/systemwide/laws_policies/statutes/drugexposed.cfm

Recognizing Signs of Abuse and Neglect

In addition to working to prevent a child from experiencing abuse or neglect, it is important to recognize high-risk situations and the signs and symptoms of maltreatment. If you do suspect a child is being harmed, reporting your suspicions may protect him or her and get help for the family. Any concerned person can report suspicions of child abuse or neglect. Reporting your concerns is not making an accusation; rather, it is a request for an investigation and assessment to determine if help is needed.

Some people (typically certain types of professionals, such as teachers or physicians) are required by State law to make a report of child maltreatment under specific circumstances—these are called mandatory reporters. Some States require all adults to report suspicions of child abuse or neglect. Child Welfare Information Gateway's publication *Mandatory Reporters of Child Abuse and Neglect* discusses the laws that designate groups of professionals as mandatory reporters: https://www.childwelfare.gov/systemwide/laws_policies/statutes/manda.cfm

For information about where and how to file a report, contact your local child protective services agency or police department.

Childhelp National Child Abuse Hotline (800.4.A.CHILD) and its website offer crisis intervention, information, resources, and referrals to support services and provide assistance in 170 languages: <http://www.childhelp.org/pages/hotline-home>

For information on what happens when suspected abuse or neglect is reported, read Information Gateway's *How the Child Welfare System Works*: <https://www.childwelfare.gov/pubs/factsheets/cpswork.pdf>

Some children may directly disclose that they have experienced abuse or neglect. The factsheet *How to Handle Child Abuse Disclosures*, produced by the "Childhelp Speak Up Be Safe" child abuse prevention campaign, offers tips. The factsheet defines direct and indirect disclosure, as well as tips for supporting the child: <http://www.speakupbesafe.org/parents/disclosures-for-parents.pdf>

The following signs may signal the presence of child abuse or neglect.

The Child:

- Shows sudden changes in behavior or school performance
- Has not received help for physical or medical problems brought to the parents' attention
- Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes
- Is always watchful, as though preparing for something bad to happen
- Lacks adult supervision

- Is overly compliant, passive, or withdrawn
- Comes to school or other activities early, stays late, and does not want to go home
- Is reluctant to be around a particular person
- Discloses maltreatment

The Parent:

- Denies the existence of—or blames the child for—the child’s problems in school or at home
- Asks teachers or other caregivers to use harsh physical discipline if the child misbehaves
- Sees the child as entirely bad, worthless, or burdensome
- Demands a level of physical or academic performance the child cannot achieve
- Looks primarily to the child for care, attention, and satisfaction of the parent’s emotional needs
- Shows little concern for the child

The Parent and Child:

- Rarely touch or look at each other
- Consider their relationship entirely negative
- State that they do not like each other

The above list may not be *all* the signs of abuse or neglect. It is important to pay attention to other behaviors that may seem unusual or concerning. In addition to these signs and symptoms, Child Welfare Information Gateway provides information on the risk factors and perpetrators of child abuse and neglect fatalities: https://www.childwelfare.gov/can/risk_perpetrators.cfm

Signs of Physical Abuse

Consider the possibility of physical abuse when the **child**:

- Has unexplained burns, bites, bruises, broken bones, or black eyes
- Has fading bruises or other marks noticeable after an absence from school
- Seems frightened of the parents and protests or cries when it is time to go home
- Shrinks at the approach of adults
- Reports injury by a parent or another adult caregiver
- Abuses animals or pets

Consider the possibility of physical abuse when the **parent or other adult caregiver**:

- Offers conflicting, unconvincing, or no explanation for the child’s injury, or provides an explanation that is not consistent with the injury
- Describes the child as “evil” or in some other very negative way
- Uses harsh physical discipline with the child
- Has a history of abuse as a child
- Has a history of abusing animals or pets

Signs of Neglect

Consider the possibility of neglect when the **child**:

- Is frequently absent from school
- Begs or steals food or money

- Lacks needed medical or dental care, immunizations, or glasses
- Is consistently dirty and has severe body odor
- Lacks sufficient clothing for the weather
- Abuses alcohol or other drugs
- States that there is no one at home to provide care

Consider the possibility of neglect when the **parent or other adult caregiver:**

- Appears to be indifferent to the child
- Seems apathetic or depressed
- Behaves irrationally or in a bizarre manner
- Is abusing alcohol or other drugs

Signs of Sexual Abuse

Consider the possibility of sexual abuse when the **child:**

- Has difficulty walking or sitting
- Suddenly refuses to change for gym or to participate in physical activities
- Reports nightmares or bedwetting
- Experiences a sudden change in appetite
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
- Becomes pregnant or contracts a venereal disease, particularly if under age 14
- Runs away
- Reports sexual abuse by a parent or another adult caregiver
- Attaches very quickly to strangers or new adults in their environment

Consider the possibility of sexual abuse when the **parent or other adult caregiver:**

- Is unduly protective of the child or severely limits the child's contact with other children, especially of the opposite sex
- Is secretive and isolated
- Is jealous or controlling with family members

Signs of Emotional Maltreatment

Consider the possibility of emotional maltreatment when the **child:**

- Shows extremes in behavior, such as overly compliant or demanding behavior, extreme passivity, or aggression
- Is either inappropriately adult (parenting other children, for example) or inappropriately infantile (frequently rocking or head-banging, for example)
- Is delayed in physical or emotional development
- Has attempted suicide
- Reports a lack of attachment to the parent

Consider the possibility of emotional maltreatment when the **parent or other adult caregiver:**

- Constantly blames, belittles, or berates the child
- Is unconcerned about the child and refuses to consider offers of help for the child's problems
- Overtly rejects the child

THE IMPACT OF CHILDHOOD TRAUMA ON WELL-BEING

Child abuse and neglect can have lifelong implications for victims, including on their well-being. While the physical wounds heal, there are several long-term consequences of experiencing the trauma of abuse or neglect. A child or youth's ability to cope and even thrive after trauma is called "resilience," and with help, many of these children can work through and overcome their past experiences.

Children who are maltreated often are at risk of experiencing cognitive delays and emotional difficulties, among other issues. Childhood trauma also negatively affects nervous system and immune system development, putting children who have been maltreated at a higher risk for health problems as adults. For more information on the lasting effects of child abuse and neglect, read Child Welfare Information Gateway's factsheet *Long-Term Consequences of Child Abuse and Neglect*: https://www.childwelfare.gov/pubs/factsheets/long_term_consequences.cfm

The National Child Traumatic Stress Network's webpage *What Is Child Traumatic Stress* offers definitions, materials on understanding child traumatic stress, and several Q&A documents: <http://www.nctsn.org/resources/audiences/parents-caregivers/what-is-cts>

The Monique Burr Foundation for Children's brief *Speak Up Be Safe: The Impact of Child Abuse and Neglect* explains the immediate and long-term consequences of child abuse and neglect to child, family, school, and community well-being: http://www.moniqueburrfoundation.org/SUBS/Resources/Impact_of_Abuse_and_Neglect.pdf

The National Council for Adoption's article "Supporting Maltreated Children: Countering the Effects of Neglect and Abuse" explains several issues common to children that have experienced abuse or neglect and offers suggestions for parents and caregivers on talking with children and helping them overcome past traumas: https://www.adoptioncouncil.org/images/stories/documents/NCFA_ADOPTION_ADVOCATE_NO48.pdf

ZERO TO THREE produced *Building Resilience: The Power to Cope With Adversity*, which presents tips and strategies for helping families and children build resilience after trauma: <http://www.zerotothree.org/maltreatment/31-1-prac-tips-beardslee.pdf>

Resources

Child Welfare Information Gateway's web section on child abuse and neglect provides information on identifying abuse, statistics, risk and protective factors, and more:

<https://www.childwelfare.gov/can/>

The Information Gateway Reporting Child Abuse and Neglect webpage provides information about mandatory reporting and how to report suspected abuse:

<https://www.childwelfare.gov/responding/reporting.cfm>

The National Child Abuse Prevention Month web section provides tip sheets for parents and caregivers, available in English and Spanish, that focus on concrete strategies for taking care of children and strengthening families:

<https://www.childwelfare.gov/preventing/preventionmonth/tipsheets.cfm>

Information Gateway also has produced a number of publications about child abuse and neglect:

- *Child Maltreatment: Past, Present, and Future:*
https://www.childwelfare.gov/pubs/issue_briefs/cm_prevention.pdf
- *Long-Term Consequences of Child Abuse and Neglect:*
https://www.childwelfare.gov/pubs/factsheets/long_term_consequences.pdf
- *Preventing Child Abuse and Neglect:*
<https://www.childwelfare.gov/pubs/factsheets/preventingcan.pdf>
- *Understanding the Effects of Maltreatment on Brain Development:*
https://www.childwelfare.gov/pubs/issue_briefs/brain_development/brain_development.pdf

The Centers for Disease Control and Prevention (CDC) produced *Understanding Child Maltreatment*, which defines the many types of maltreatment and the CDC's approach to prevention, in addition to providing additional resources:

http://www.cdc.gov/violenceprevention/pdf/cm_factsheet2012-a.pdf

Prevent Child Abuse America is a national organization dedicated to providing information on child maltreatment and its prevention:

<http://www.preventchildabuse.org/index.shtml>

The National Child Traumatic Stress Network strives to raise the standard of care and improve access to services for traumatized children, their families, and communities:

<http://www.nctsn.org/>

Stand for Children advocates for improvements to, and funding for, programs that give every child a fair chance in life: <http://stand.org/>

A list of organizations focused on child maltreatment prevention is available in Information Gateway's National Child Abuse Prevention Partner Organizations page:

https://www.childwelfare.gov/pubs/reslist/rl_dsp.cfm?rs_id=21&rate_chno=19-00044

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U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau



Public Playground Safety Handbook



U.S. Consumer Product Safety Commission
Saving Lives and Keeping Families Safe



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1. INTRODUCTION

In recent years, it is estimated that there were more than 200,000 injuries annually on public playgrounds across the country that required emergency room treatment. By following the recommended guidelines in this handbook, you and your community can create a safer playground environment for all children and contribute to the reduction of playground-related deaths and injuries.

1.1 Scope

This handbook presents safety information for public playground equipment in the form of guidelines. Publication of this handbook is expected to promote greater safety awareness among those who purchase, install, and maintain public playground equipment. Because many factors may affect playground safety, the U.S. Consumer Product Safety Commission (CPSC) staff believes that guidelines, rather than a mandatory rule, are appropriate. These guidelines are not being issued as the sole method to minimize injuries associated with playground equipment. However, the Commission believes that the recommendations in this handbook along with the technical information in the ASTM standards for public playgrounds will contribute to greater playground safety.

Some states and local jurisdictions may require compliance with this handbook and/or ASTM voluntary standards. Additionally, risk managers, insurance companies, or others may require compliance at a particular site; check with state/local jurisdictions and insurance companies for specific requirements.

1.2 Intended Audience

This handbook is intended for use by childcare personnel, school officials, parks and recreation personnel, equipment purchasers and installers, playground designers, and any other members of the general public (e.g., parents and school groups) concerned with public playground safety and interested in evaluating their respective playgrounds. Due to the wide range of possible users, some information provided may be more appropriate for certain users than others. The voluntary standards listed in 1.4.1 contain more technical requirements than this handbook and are primarily intended for use by equipment manufacturers, architects, designers, and any others requiring more technical information.

1.3 What is a Public Playground?

“Public” playground equipment refers to equipment for use by children ages 6 months through 12 years in the playground areas of:

- Commercial (non-residential) child care facilities
- Institutions
- Multiple family dwellings, such as apartment and condominium buildings
- Parks, such as city, state, and community maintained parks
- Restaurants
- Resorts and recreational developments
- Schools
- Other areas of public use

These guidelines are not intended for amusement park equipment, sports or fitness equipment normally intended for users over the age of 12 years, soft contained play equipment, constant air inflatable play devices for home use, art and museum sculptures (not otherwise designed, intended and installed as playground equipment), equipment found in water play facilities, or home playground equipment. Equipment components intended solely for children with disabilities and modified to accommodate such users also are not covered by these guidelines. Child care facilities, especially indoor, should refer to ASTM F2373 — *Standard Consumer Safety Performance Specification for Public Use Play Equipment for Children 6 Months Through 23 Months*, for more guidance on areas unique to their facilities.

1.4 Public Playground Safety Voluntary Standards and CPSC Handbook History

- 1981 – First CPSC *Handbook for Public Playground Safety* was published, a two-volume set.
- 1991 – *Standard Specification for Impact Attenuation of Surface Systems Under and Around Playground Equipment*, ASTM F1292, was first published.
- 1991 – Two-volume set was replaced by a single-volume handbook, which contained recommendations based on a COMSIS Corporation report to the CPSC (*Development of Human Factors Criteria for Playground Equipment Safety*).

- 1993 – First version of voluntary standard for public playground equipment, ASTM F1487 — *Standard Consumer Safety Performance Specification for Playground Equipment for Public Use*, was published (revisions occur every 3 to 4 years).
- 1994 – Minor revisions to the *Handbook*.
- 1997 – *Handbook* was updated based on (1) staff review of ASTM F1487, (2) playground safety roundtable meeting held October 1996, and (3) public comment received to a May 1997 CPSC staff request.
- 2005 – First version of voluntary standard for playground equipment intended for children under two years old, ASTM F2373 — *Standard Consumer Safety Performance Specification for Public Use Play Equipment for Children 6 Months Through 23 Months*, was published.
- 2008 – *Handbook* was updated based on comments received from members of the ASTM F15 Playground Committees in response to a CPSC staff request for suggested revisions. Significant revisions are listed below.

1.4.1 ASTM playground standards

Below is a list of ASTM technical performance standards that relate to playgrounds.

- **F1487** *Standard Consumer Safety Performance Specification for Playground Equipment for Public Use*.
- **F2373** *Standard Consumer Safety Performance Specification for Public Use Play Equipment for Children 6 Months through 23 Months*.
- **F1292** *Standard Specification for Impact Attenuation of Surface Systems Under and Around Playground Equipment*.
- **F2075** *Standard Specification for Engineered Wood Fiber for Use as a Playground Safety Surface Under and Around Playground Equipment*.
- **F2223** *Standard Guide for ASTM Standards on Playground Surfacing*.
- **F2479** *Standard Guide for Specification, Purchase, Installation and Maintenance of Poured-In-Place Playground Surfacing*.
- **F1951** *Standard Specification for Determination of Accessibility of Surface Systems Under and Around Playground Equipment*.
- **F1816** *Standard Safety Specification for Drawstrings on Children's Upper Outerwear*.

- **F2049** *Standard Guide for Fences/Barriers for Public, Commercial, and Multi-Family Residential Use Outdoor Play Areas*.
- **F1148** *Standard Consumer Safety Performance Specification for Home Playground Equipment*.
- **F1918** *Standard Safety Performance Specification for Soft Contained Play Equipment*.

1.5 Significant Revisions for 2008

1.5.1 Equipment guidelines

- Age ranges expanded to include children as young as 6 months based on ASTM F2373
- Guidelines for track rides and log rolls added
- Exit zone requirements for slides harmonized with ASTM F1487

1.5.2 Surfacing guidelines

- Critical height table revised
- Suggestions for surfacing over asphalt added

1.5.3 General guidelines

- Suggestions on sun exposure added

1.5.4 Other revisions

- Editorial changes to make the *Handbook* easier to understand and use

1.6 Background

The safety of each individual piece of playground equipment as well as the layout of the entire play area should be considered when designing or evaluating a playground for safety. Since falls are a very common playground hazard pattern, the installation and maintenance of protective surfacing under and around all equipment is crucial to protect children from severe head injuries.

Because all playgrounds present some challenge and because children can be expected to use equipment in unintended and unanticipated ways, adult supervision is highly recommended. The handbook provides some guidance on supervisory practices that adults should follow. Appropriate equipment design, layout, and maintenance, as discussed in this

handbook, are also essential for increasing public playground safety.

A playground should allow children to develop gradually and test their skills by providing a series of graduated challenges. The challenges presented should be appropriate for age-related abilities and should be ones that children can perceive and choose to undertake. Toddlers, preschool- and school-age children differ dramatically, not only in physical size and ability, but also in their intellectual and social skills. Therefore, age-appropriate playground designs should accommodate these differences with regard to the type, scale, and the layout of equipment. Recommendations throughout this handbook address the different needs of toddlers, preschool-age, and school-age children; “toddlers” refers to children ages 6 months through 2 years of age, “preschool-age” refers to children 2 through 5 years, and “school-age” refers to children 5 through 12 years. The overlap between these groups is anticipated in terms of playground equipment use and provides for a margin of safety.

Playground designers, installers and operators should be aware that the Americans with Disabilities Act of 1990 (ADA) is a comprehensive civil rights law which prohibits discrimination on the basis of disability. Titles II and III of the ADA require, among other things, that newly constructed and altered State and local government facilities, places of public accommodation, and commercial facilities be readily accessible to and usable by individuals with disabilities. Recreation facilities, including play areas, are among the types of facilities covered by titles II and III of the ADA.

The Architectural and Transportation Barriers Compliance Boards – also referred to as the “Access Board” – has developed accessibility guidelines for newly constructed and altered play areas that were published October 2000. The play area guidelines are a supplement to the Americans with Disabilities Act Accessibility Guidelines (ADAAG). Once these guidelines are adopted as enforceable standards by the Department of Justice, all newly constructed and altered play areas covered by the ADA will be required to comply. These guidelines also apply to play areas covered by the Architectural Barriers Act (ABA).

Copies of the play area accessibility guidelines and further technical assistance can be obtained from the U.S. Access Board, 1331 F Street, NW, Suite 1000, Washington, DC 20004-1111; 800-872-2253, 800-993-2822 (TTY), www.access-board.gov.

1.7 Playground Injuries

The U. S. Consumer Product Safety Commission has long recognized the potential hazards that exist with the use of playground equipment, with over 200,000 estimated emergency room-treated injuries annually. The most recent study of 2,691 playground equipment-related incidents reported to the CPSC from 2001-2008 indicated that falls are the most common hazard pattern (44% of injuries) followed by equipment-related hazards, such as breakage, tip over, design, and assembly (23%).¹ Other hazard patterns involved entrapment and colliding other children or stationary equipment. Playground-related deaths reported to the Commission involved entanglement of ropes, leashes, or clothing; falls; and impact from equipment tip over or structural failure.

The recommendations in this handbook have been developed to address the hazards that resulted in playground-related injuries and deaths. The recommendations include those that address:

- The potential for falls from and impact with equipment
- The need for impact attenuating protective surfacing under and around equipment
- Openings with the potential for head entrapment
- The scale of equipment and other design features related to user age and layout of equipment on a playground
- Installation and maintenance procedures
- General hazards presented by protrusions, sharp edges, and crush or shear points

1.8 Definitions

Barrier — An enclosing device around an elevated platform that is intended to prevent both inadvertent and deliberate attempts to pass through the device.

Composite Structure — Two or more play structures attached or functionally linked, to create one integral unit that provides more than one play activity.

Critical Height — The fall height below which a life-threatening head injury would not be expected to occur.

¹O'Brien, Craig W.; Injuries and Investigated Deaths Associated with Playground Equipment, 2001–2008. U.S. Consumer Product Safety Commission: Washington DC, October, 2009.

Designated Play Surface — Any elevated surface for standing, walking, crawling, sitting or climbing, or a flat surface greater than 2 inches wide by 2 inches long having an angle less than 30° from horizontal.

Embankment Slide — A slide that follows the contour of the ground and at no point is the bottom of the chute greater than 12 inches above the surrounding ground.

Entanglement — A condition in which the user's clothes or something around the user's neck becomes caught or entwined on a component of playground equipment.

Entrapment — Any condition that impedes withdrawal of a body or body part that has penetrated an opening.

Fall Height — The vertical distance between the highest designated play surface on a piece of equipment and the protective surfacing beneath it.

Footing — A means for anchoring playground equipment to the ground.

Full Bucket Seat Swing — A swing generally appropriate for children under 4 years of age that provides support on all sides and between the legs of the occupant and cannot be entered or exited without adult assistance.

Geotextile (filter) Cloth — A fabric that retains its relative structure during handling, placement, and long-term service to enhance water movement, retard soil movement, and to add reinforcement and separation between the soil and the surfacing and/or sub-base.

Guardrail — An enclosing device around an elevated platform that is intended to prevent inadvertent falls from the elevated surface.

Infill — Material(s) used in a protective barrier or between decks to prevent a user from passing through the barrier (e.g., vertical bars, lattice, solid panel, etc.).

Loose-Fill Surfacing Material — A material used for protective surfacing in the use zone that consists of loose particles such as sand, gravel, engineered wood fibers, or shredded rubber.

Preschool-Age Children — Children 2 years of age through 5 years of age.

Projection — Anything that extends outward from a surface of the playground equipment and must be tested to determine whether it is a protrusion or entanglement hazard, or both.

Protective Barrier — See Barrier.

Protective Surfacing — Shock absorbing (i.e., impact attenuating) surfacing material in the use zone that conforms to the recommendations in §2.4 of this handbook.

Protrusion — A projection which, when tested, is found to be a hazard having the potential to cause bodily injury to a user who impacts it.

Roller Slide — A slide that has a chute consisting of a series of individual rollers over which the user travels.

School-Age Children — Children 5 years of age through 12 years of age.

Slide Chute — The inclined sliding surface of a slide.

Stationary Play Equipment — Any play structure that has a fixed base and does not move.

Supervisor — Any person tasked with watching children on a playground. Supervisors may be paid professionals (e.g., childcare, elementary school or park and recreation personnel), paid seasonal workers (e.g., college or high school students), volunteers (e.g., PTA members), or unpaid caregivers (e.g., parents) of the children playing in the playground.

Toddlers — Children 6 months through 23 months of age.

Tube Slide — A slide in which the chute consists of a totally enclosed tube or tunnel.

Unitary Surfacing Material — A manufactured material used for protective surfacing in the use zone that may be rubber tiles, mats, or a combination of energy absorbing materials held in place by a binder that may be poured in place at the playground site and cures to form a unitary shock absorbing surface.

Upper Body Equipment — Equipment designed to support a child by the hands only (e.g., horizontal ladder, overhead swinging rings).

Use Zone — The surface under and around a piece of equipment onto which a child falling from or exiting from the equipment would be expected to land. These areas are also designated for unrestricted circulation around the equipment.

2. GENERAL PLAYGROUND CONSIDERATIONS

2.1 Selecting a Site

The following factors are important when selecting a site for a new playground:

Site Factor	Questions to Ask	If yes, then...Mitigation
Travel patterns of children to and from the playground	Are there hazards in the way?	Clear hazards.
Nearby accessible hazards such as roads with traffic, lakes, ponds, streams, drop-offs/cliffs, etc.	<p>Could a child inadvertently run into a nearby hazard?</p> <p>Could younger children easily wander off toward the hazard?</p>	Provide a method to contain children within the playground. For example, a dense hedge or a fence. The method should allow for observation by supervisors. If fences are used, they should conform to local building codes and/or ASTM F-2049.
Sun exposure	Is sun exposure sufficient to heat exposed bare metal slides, platforms, steps, & surfacing enough to burn children?	<p>Bare metal slides, platforms, and steps should be shaded or located out of direct sun.</p> <p>Provide warnings that equipment and surfacing exposed to intense sun can burn.</p>
	Will children be exposed to the sun during the most intense part of the day?	Consider shading the playground or providing shaded areas nearby.
Slope and drainage	Will loose fill materials wash away during periods of heavy rain?	Consider proper drainage re-grading to prevent wash outs.

2.1.1 Shading considerations

According to the American Academy of Dermatology, research indicates that one in five Americans will develop some form of skin cancer during their lifetime, and five or more sunburns double the risk of developing skin cancer. Utilizing existing shade (e.g., trees), designing play structures as a means for providing shading (e.g., elevated platforms with shaded space below), or creating more shade (e.g., man-made structures) are potential ways to design a playground to help protect children's skin from the sun. When trees are used for shade, additional maintenance issues arise, such as the need for cleaning up debris and trimming limbs.

2.2 Playground Layout

There are several key factors to keep in mind when laying out a playground:

- Accessibility
- Age separation
- Conflicting activities
- Sight lines
- Signage and/or labeling
- Supervision

2.2.1 Accessibility

Special consideration should be given to providing accessible surfaces in a play area that meets the *ASTM Standard Specification for Determination of Accessibility of Surface Systems Under and Around Playground Equipment*, ASTM F1951.

Equipment selection and location along with the type of protective surfacing are key components to ensuring the opportunity for children with disabilities to play on the playground.

2.2.2 Age separation

For playgrounds intended to serve children of all ages, the layout of pathways and the landscaping of the playground should show the distinct areas for the different age groups. The areas should be separated at least by a buffer zone, which could be an area with shrubs or benches. This separation and buffer zone will reduce the chance of injury from older, more active children running through areas filled with younger children with generally slower movement and reaction times.

2.2.3 Age group

In areas where access to the playground is unlimited or enforced only by signage, the playground designer should recognize that since child development is fluid, parents and caregivers may select a playground slightly above or slightly below their child's abilities, especially for children at or near a cut-off age (e.g., 2-years old and 5-years old). This could be for ease of supervising multiple children, misperceptions about the hazards a playground may pose to children of a different age, advanced development of a child, or other reasons. For this reason, there is an overlap at age 5.

Developmentally a similar overlap also exists around age 2; however, due to the differences in ASTM standards and entrapment testing tools, this overlap is not reflected in the handbook. Playgrounds used primarily by children under the supervision of paid, trained professionals (e.g., child-care centers and schools) may wish to consider separating playgrounds by the facility's age groupings. For example, a child-care facility may wish to limit a playground to toddlers under 2 exclusively and can draw information from this guide and ASTM F2373. A school, on the other hand, may have no children under 4 attending, and can likewise plan appropriately. Those who inspect playgrounds should use the intended age group of the playground.

2.2.4 Conflicting activities

The play area should be organized into different sections to prevent injuries caused by conflicting activities and children running between activities. Active, physical activities should be separate from more passive or quiet activities. Areas for playground equipment, open fields, and sand boxes should be located in different sections of the playground. In addition, popular, heavy-use pieces of equipment or activities should be dispersed to avoid crowding in any one area.

Different types of equipment have different use zones that must be maintained. The following are general recommendations for locating equipment within the playground site. Specific use zones for equipment are given in §5.3.

- Moving equipment, such as swings and merry-go-rounds, should be located toward a corner, side, or edge of the play area while ensuring that the appropriate use zones around the equipment are maintained.
- Slide exits should be located in an uncongested area of the playground.
- Composite play structures have become increasingly popular on public playgrounds. Adjacent components on composite structures should be complementary. For example, an access component should not be located in a slide exit zone.

2.2.5 Sight lines

Playgrounds that are designed, installed, and maintained in accordance with safety guidelines and standards can still present hazards to children. Playgrounds should be laid out to allow parents or caregivers to keep track of children as they move throughout the playground environment. Visual barriers should be minimized as much as possible. For example, in a park situation, playground equipment should be as visible as possible from park benches. In playgrounds with areas for different ages, the older children's area should be visible from the younger children's area to ensure that caregivers of multiple children can see older children while they are engaged in interactive play with younger ones.

2.2.6 Signage and/or labeling

Although the intended user group should be obvious from the design and scale of equipment, signs and/or labels posted in the playground area or on the equipment should give some guidance to supervisors as to the age appropriateness of the equipment.

2.2.7 Supervision

The quality of the supervision depends on the quality of the supervisor's knowledge of safe play behavior. Playground designers should be aware of the type of supervision most likely for their given playground. Depending on the location and nature of the playground, the supervisors may be paid professionals (e.g., childcare, elementary school or park and recreation personnel), paid seasonal workers (e.g., college or high school students), volunteers (e.g., PTA members), or unpaid caregivers (e.g., parents) of the children playing in the playground.

Parents and playground supervisors should be aware that not all playground equipment is appropriate for all children who may use the playground. Supervisors should look for posted






signs indicating the appropriate age of the users and direct children to equipment appropriate for their age. Supervisors may also use the information in Table 1 to determine the suitability of the equipment for the children they are supervising. Toddlers and preschool-age children require more attentive supervision than older children; however, one should not rely on supervision alone to prevent injuries.

Supervisors should understand the basics of playground safety such as:

- Checking for broken equipment and making sure children don't play on it.
- Checking for and removing unsafe modifications, especially ropes tied to equipment, before letting children play.
- Checking for properly maintained protective surfacing.
- Making sure children are wearing foot wear.

TABLE 1. EXAMPLES OF AGE APPROPRIATE EQUIPMENT

 <p>Toddler — Ages 6-23 months</p> <ul style="list-style-type: none"> • Climbing equipment under 32" high • Ramps • Single file step ladders • Slides* • Spiral slides less than 360° • Spring rockers • Stairways • Swings with full bucket seats 	 <p>Preschool — Ages 2-5 years</p> <ul style="list-style-type: none"> • Certain climbers** • Horizontal ladders less than or equal to 60" high for ages 4 and 5 • Merry-go-rounds • Ramps • Rung ladders • Single file step ladders • Slides* • Spiral slides up to 360° • Spring rockers • Stairways • Swings – belt, full bucket seats (2-4 years) & rotating tire 	 <p>Grade School — Ages 5-12 years</p> <ul style="list-style-type: none"> • Arch climbers • Chain or cable walks • Free standing climbing events with flexible parts • Fulcrum seesaws • Ladders – Horizontal, Rung, & Step • Overhead rings*** • Merry-go-rounds • Ramps • Ring treks • Slides* • Spiral slides more than one 360° turn • Stairways • Swings – belt & rotating tire • Track rides • Vertical sliding poles
<p>* See §5.3.6</p>	<p>** See §5.3.2</p>	<p>*** See §5.3.2.5</p>

- Watching and stopping dangerous horseplay, such as children throwing protective surfacing materials, jumping from heights, etc.
- Watching for and stopping children from wandering away from the play area.

2.3 Selecting Equipment

When selecting playground equipment, it is important to know the age range of the children who will be using the playground. Children at different ages and stages of development have different needs and abilities. Playgrounds should be designed to stimulate children and encourage them to develop new skills, but should be in scale with their sizes, abilities, and developmental levels. Consideration should also be given to providing play equipment that is accessible to children with disabilities and encourages integration within the playground.

Table 1 shows the appropriate age range for various pieces of playground equipment. This is not an all-comprehensive list and, therefore, should not limit inclusion of current or newly designed equipment that is not specifically mentioned. For equipment listed in more than one group, there may be some modifications or restrictions based on age, so consult the specific recommendations in §5.3.

2.3.1 Equipment not recommended

Some playground equipment is not recommended for use on public playgrounds, including:

- Trampolines
- Swinging gates
- Giant strides
- Climbing ropes that are not secured at both ends.
- Heavy metal swings (e.g., animal figures) – These are not recommended because their heavy rigid metal framework presents a risk of impact injury.
- Multiple occupancy swings – With the exception of tire swings, swings that are intended for more than one user are not recommended because their greater mass, as compared to single occupancy swings, presents a risk of impact injury.
- Rope swings – Free-swinging ropes that may fray or otherwise form a loop are not recommended because they present a potential strangulation hazard.
- Swinging dual exercise rings and trapeze bars – These are rings and trapeze bars on long chains that are generally considered to be items of athletic equipment and are not recommended for public playgrounds. *NOTE: The recommendation against the use of exercise rings does not apply to overhead hanging rings such as those used in a ring trek or ring ladder (see Figure 7).*



2.4 Surfacing

The surfacing under and around playground equipment is one of the most important factors in reducing the likelihood of life-threatening head injuries. A fall onto a shock absorbing surface is less likely to cause a

serious head injury than a fall onto a hard surface. However, some injuries from falls, including broken limbs, may occur no matter what playground surfacing material is used.

The most widely used test method for evaluating the shock absorbing properties of a playground surfacing material is to drop an instrumented metal headform onto a sample of the material and record the acceleration/time pulse during the impact. Field and laboratory test methods are described in ASTM F1292 *Standard Specification for Impact Attenuation of Surface Systems Under and Around Playground Equipment*.

Testing using the methods described in ASTM F1292 will provide a “critical height” rating of the surface. This height can be considered as an approximation of the fall height below which a life-threatening head injury would not be expected to occur. Manufacturers and installers of playground protective surfacing should provide the critical height rating of their materials. This rating should be greater than or equal to the fall height of the highest piece of equipment on the playground. The fall height of a piece of equipment is the distance between the highest designated play surface on a piece of equipment and the protective surface beneath it. Details for determining the highest designated play surface and fall height on some types of equipment are included in §5 Parts of the Playground.

2.4.1 Equipment not covered by protective surfacing recommendations

The recommendations for protective surfacing do not apply to equipment that requires a child to be standing or sitting at ground level. Examples of such equipment are:



Appropriate Surfacing

- Any material tested to ASTM F1292, including unitary surfaces, engineered wood fiber, etc.
- Pea gravel
- Sand
- Shredded/recycled rubber mulch
- Wood mulch (not CCA-treated)
- Wood chips



Inappropriate Surfacing

- Asphalt
- Carpet not tested to ASTM F1292
- Concrete
- Dirt
- Grass
- CCA treated wood mulch

- Sand boxes
- Activity walls at ground level
- Play houses
- Any other equipment that children use when their feet remain in contact with the ground surface

2.4.2 Selecting a surfacing material

There are two options available for surfacing public playgrounds: unitary and loose-fill materials. A playground should never be installed without protective surfacing of some type. Concrete, asphalt, or other hard surfaces should never be directly under playground equipment. Grass and dirt are not considered protective surfacing because wear and environmental factors can reduce their shock absorbing effectiveness. Carpeting and mats are also not appropriate unless they are tested to and comply with ASTM F1292. Loose-fill should be avoided for playgrounds intended for toddlers.

2.4.2.1 Unitary surfacing materials

Unitary materials are generally rubber mats and tiles or a combination of energy-absorbing materials held in place by a

binder that may be poured in place at the playground site and then cured to form a unitary shock absorbing surface. Unitary materials are available from a number of different manufacturers, many of whom have a range of materials with differing shock absorbing properties. New surfacing materials, such as bonded wood fiber and combinations of loose-fill and unitary, are being developed that may also be tested to ASTM F1292 and fall into the unitary materials category. When deciding on the best surfacing materials keep in mind that some dark colored surfacing materials exposed to the intense sun have caused blistering on bare feet. Check with the manufacturer if light colored materials are available or provide shading to reduce direct sun exposure.

Persons wishing to install a unitary material as a playground surface should request ASTM F1292 test data from the manufacturer identifying the critical height rating of the desired surface. In addition, site requirements should be obtained from the manufacturer because some unitary materials require installation over a hard surface while others do not. Manufacturer's instructions should be followed closely, as some unitary systems require professional installation. Testing should be conducted in accordance with the ASTM F1292 standard.

2.4.2.2 Loose-fill surfacing materials

Engineered wood fiber (EWF) is a wood product that may look similar in appearance to landscaping mulch, but EWF products are designed specifically for use as a playground safety surface under and around playground equipment. EWF products should meet the specifications in ASTM F2075: *Standard Specification for Engineered Wood Fiber* and be tested to and comply with ASTM F1292.

There are also rubber mulch products that are designed specifically for use as playground surfacing. Make sure they have been tested to and comply with ASTM F1292.

When installing these products, tips 1-9 listed below should be followed. Each manufacturer of engineered wood fiber and rubber mulch should provide maintenance requirements for and test data on:

- Critical height based on ASTM F1292 impact attenuation testing.
- Minimum fill-depth data.
- Toxicity.
- ADA/ABA accessibility guidelines for firmness and stability based on ASTM F1951.

Other loose-fill materials are generally landscaping-type materials that can be layered to a certain depth and resist compacting. Some examples include wood mulch, wood chips, sand, pea gravel, and shredded/recycled rubber mulch.

Important tips when considering loose-fill materials:

1. Loose-fill materials will compress at least 25% over time due to use and weathering. This must be considered when planning the playground. For example, if the playground will require 9 inches of wood chips, then the initial fill level should be 12 inches. See Table 2 below.
2. Loose-fill surfacing requires frequent maintenance to ensure surfacing levels never drop below the minimum depth. Areas under swings and at slide exits are more susceptible to displacement; special attention must be paid to maintenance in these areas. Additionally, wear mats can be installed in these areas to reduce displacement.
3. The perimeter of the playground should provide a method of containing the loose-fill materials.
4. Consider marking equipment supports with a minimum fill level to aid in maintaining the original depth of material.

5. Good drainage is essential to maintaining loose-fill surfacing. Standing water with surfacing material reduces effectiveness and leads to material compaction and decomposition.
6. Critical height may be reduced during winter in areas where the ground freezes.
7. Never use less than 9 inches of loose-fill material except for shredded/recycled rubber (6 inches recommended). Shallower depths are too easily displaced and compacted.
8. Some loose-fill materials may not meet ADA/ABA accessibility guidelines. For more information, contact the Access Board (see §1.6) or refer to ASTM F1951.
9. Wood mulch containing chromated copper arsenate (CCA)-treated wood products should not be used; mulch where the CCA-content is unknown should be avoided (see §2.5.5.1).

Table 2 shows the minimum required depths of loose-fill material needed based on material type and fall height. The depths shown assume the materials have been compressed due to use and weathering and are properly maintained to the given level.

2.4.2.3 Installing loose-fill over hard surface

CPSC staff strongly recommends against installing playgrounds over hard surfaces, such as asphalt, concrete, or hard packed earth, unless the installation adds the following layers of protection. Immediately over the hard surface there should be a 3- to 6-inch base layer of loose-fill (e.g., gravel for drainage). The next layer should be a Geotextile cloth. On top of that should be a loose-fill layer meeting the specifications addressed in §2.4.2.2 and Table 2. Embedded in the loose-fill layer should be impact attenuating mats under high traffic areas, such as under swings, at slide exits, and other places where displacement is likely. Figure 1 provides a visual representation of this information. Older playgrounds that still exist on hard surfacing should be modified to provide appropriate surfacing.

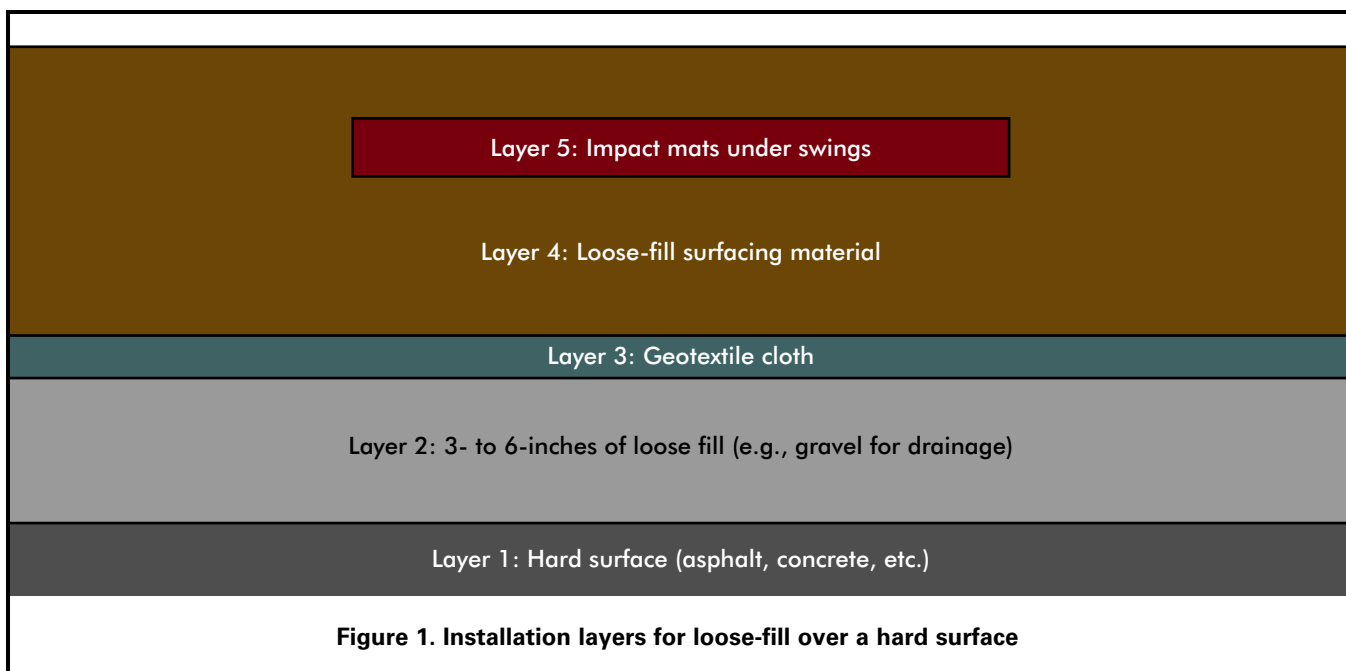
2.5 Equipment Materials

2.5.1 Durability and finish

- Use equipment that is manufactured and constructed only of materials that have a demonstrated record of durability in a playground or similar setting.

Table 2. Minimum compressed loose-fill surfacing depths

Inches	Of	(Loose-Fill Material)	Protects to	Fall Height (feet)
6*		Shredded/recycled rubber		10
9		Sand		4
9		Pea Gravel		5
9		Wood mulch (non-CCA)		7
9		Wood chips		10
* Shredded/recycled rubber loose-fill surfacing does not compress in the same manner as other loose-fill materials. However, care should be taken to maintain a constant depth as displacement may still occur.				



- Finishes, treatments, and preservatives should be selected carefully so that they do not present a health hazard to users.
 - All fasteners, connectors, and covering devices that are exposed to the user should be smooth and should not be likely to cause laceration, penetration, or present a clothing entanglement hazard (see also §3.2 and Appendix B).
- ### 2.5.2 Hardware
- When installed and maintained in accordance with the manufacturer's instructions:
- All fasteners, connectors, and covering devices should not loosen or be removable without the use of tools.
 - Lock washers, self-locking nuts, or other locking means should be provided for all nuts and bolts to protect them from detachment.
 - Hardware in moving joints should also be secured against unintentional or unauthorized loosening.

- All fasteners should be corrosion resistant and be selected to minimize corrosion of the materials they connect. This is particularly important when using wood treated with ACQ/CBA/CA-B² as the chemicals in the wood preservative corrode certain metals faster than others.
- Bearings or bushings used in moving joints should be easy to lubricate or be self-lubricating.
- All hooks, such as S-hooks and C-hooks, should be closed (see also §5.3.8.1). A hook is considered closed if there is no gap or space greater than 0.04 inches, about the thickness of a dime.

2.5.3 Metals

- Avoid using bare metal for platforms, slides, or steps. When exposed to direct sunlight they may reach temperatures high enough to cause serious contact burn injuries in a matter of seconds. Use other materials that may reduce the surface temperature, such as but not limited to wood, plastic, or coated metal (see also Slides in §5.3.6).
- If bare or painted metal surfaces are used on platforms, steps, and slide beds, they should be oriented so that the surface is not exposed to direct sun year round.

2.5.4 Paints and finishes

- Metals not inherently corrosion resistant should be painted, galvanized, or otherwise treated to prevent rust.
- The manufacturer should ensure that the users cannot ingest, inhale, or absorb potentially hazardous amounts of preservative chemicals or other treatments applied to the equipment as a result of contact with playground equipment.
- All paints and other similar finishes must meet the current CPSC regulation for lead in paint.
- Painted surfaces should be maintained to prevent corrosion and deterioration.
- Paint and other finishes should be maintained to prevent rusting of exposed metals and to minimize children playing with peeling paint and paint flakes.

- Older playgrounds with lead based paints should be identified and a strategy to control lead paint exposure should be developed. Playground managers should consult the October 1996 report, CPSC Staff Recommendations for Identifying and Controlling Lead Paint on Public Playground Equipment, while ensuring that all paints and other similar finishes meet the current CPSC regulation.³

2.5.5 Wood

- Wood should be either naturally rot- and insect-resistant (e.g., cedar or redwood) or should be treated to avoid such deterioration.
- Creosote-treated wood (e.g., railroad ties, telephone poles, etc) and coatings that contain pesticides should not be used.

2.5.5.1 Pressure-treated wood

A significant amount of older playground wood was pressure-treated with chemicals to prevent damage from insects and fungi. Chromated copper arsenate (CCA) was a chemical used for decades in structures (including playgrounds). Since December 31, 2003, CCA-treated wood is no longer processed for use in playground applications. Other rot- and insect-resistant pressure treatments are available that do not contain arsenic; however, when using any of the new treated wood products, be sure to use hardware that is compatible with the wood treatment chemicals. These chemicals are known to corrode certain materials faster than others.

Existing playgrounds with CCA-treated wood

Various groups have made suggestions concerning the application of surface coatings to CCA-treated wood (e.g., stains and sealants) to reduce a child's potential exposure to arsenic from the wood surface. Data from CPSC staff and EPA studies suggest that regular (at least once a year) use of an oil- or water-based, penetrating sealant or stain can reduce arsenic migration from CCA-treated wood. Installers, builders, and consumers who perform woodworking operations, such as sanding, sawing, or sawdust disposal, on pressure-treated wood should read the consumer information sheet available at the point of sale. This sheet contains important health precautions and disposal information.

² Ammoniacal copper quat (ACQ), copper boron azole (CBA), copper azole type B (CA-B), etc.

³ CPSC Staff Recommendations for Identifying and Controlling Lead Paint on Public Playground Equipment; U.S. Consumer Product Safety Commission: Washington, DC, October 1996.

When selecting wood products and finishes for public playgrounds, CPSC staff recommends:

- Avoid “film-forming” or non-penetrating stains (latex semi-transparent, latex opaque and oil-based opaque stains) on outdoor surfaces because peeling and flaking may occur later, which will ultimately have an impact on durability as well as exposure to the preservatives in the wood.
- Creosote, pentachlorophenol, and tributyl tin oxide are too toxic or irritating and should not be used as preservatives for playground equipment wood.
- Pesticide-containing finishes should not be used.
- CCA-treated wood should not be used as playground mulch.

2.6 Assembly and Installation

- Strictly follow *all* instructions from the manufacturer when assembling and installing equipment.
- After assembly and before its first use, equipment should be thoroughly inspected by a person qualified to inspect playgrounds for safety.
- The manufacturer’s assembly and installation instructions, and all other materials collected concerning the equipment, should be kept in a permanent file.
- Secure anchoring is a key factor to stable installation, and the anchoring process should be completed in *strict* accordance with the manufacturer’s specifications.

3. PLAYGROUND HAZARDS

This section provides a broad overview of general hazards that should be avoided on playgrounds. It is intended to raise awareness of the risks posed by each of these hazards. Many of these hazards have technical specifications and tests for compliance with ASTM F1487 and F2373. Some of these tests are also detailed in Appendix B.

3.1 Crush and Shearing Points

Anything that could crush or shear limbs should not be accessible to children on a playground. Crush and shear points can be caused by parts moving relative to each other or to a fixed part during a normal use cycle, such as a seesaw.

To determine if there is a possible crush or shear point, consider:

- The likelihood a child could get a body part inside the point, and
- The closing force around the point.

Potential crush/shear hazards specific to certain pieces of equipment are identified in §5.3 Major Types of Playground Equipment.

3.2 Entanglement and Impalement

Projections on playground equipment should not be able to entangle children's clothing nor should they be large enough to impale. To avoid this risk:

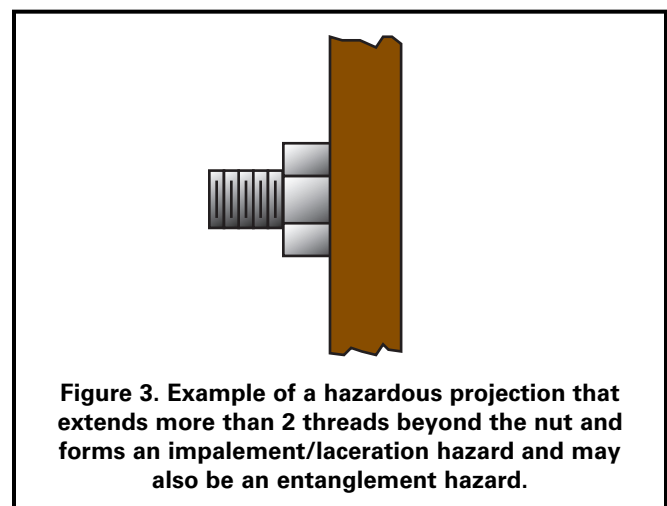
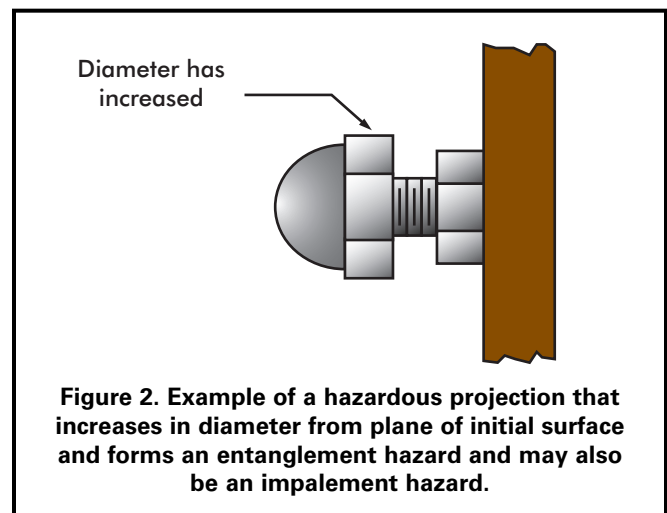
- The diameter of a projection should not increase in the direction away from the surrounding surface toward the exposed end (see Figure 2).
- Bolts should not expose more than two threads beyond the end of the nut (see Figure 3).
- All hooks, such as S-hooks and C-hooks, should be closed (see also §5.3.8.1). A hook is considered closed if there is no gap or space greater than 0.04 inches, about the thickness of a dime.
 - Any connecting device containing an in-fill that completely fills the interior space preventing entry of clothing items into the interior of the device is exempt from this requirement.

- Swings and slides have additional recommendations for projections detailed in §5.3.
- See Appendix B for testing recommendations.

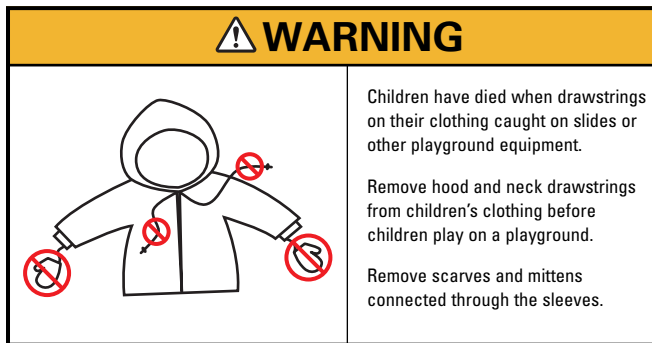
3.2.1 Strings and ropes

Drawstrings on the hoods of jackets, sweatshirts, and other upper body clothing can become entangled in playground equipment, and can cause death by strangulation. To avoid this risk:

- Children should not wear jewelry, jackets or sweatshirts with drawstring hoods, mittens connected by strings through the arms, or other upper body clothing with drawstrings.
- Remove any ropes, dog leashes, or similar objects that have been attached to playground equipment. Children can become entangled in them and strangle to death.



- Avoid equipment with ropes that are not secured at both ends.
- The following label, or a similar sign or label, can be placed on or near slides or other equipment where potential entanglements may occur.



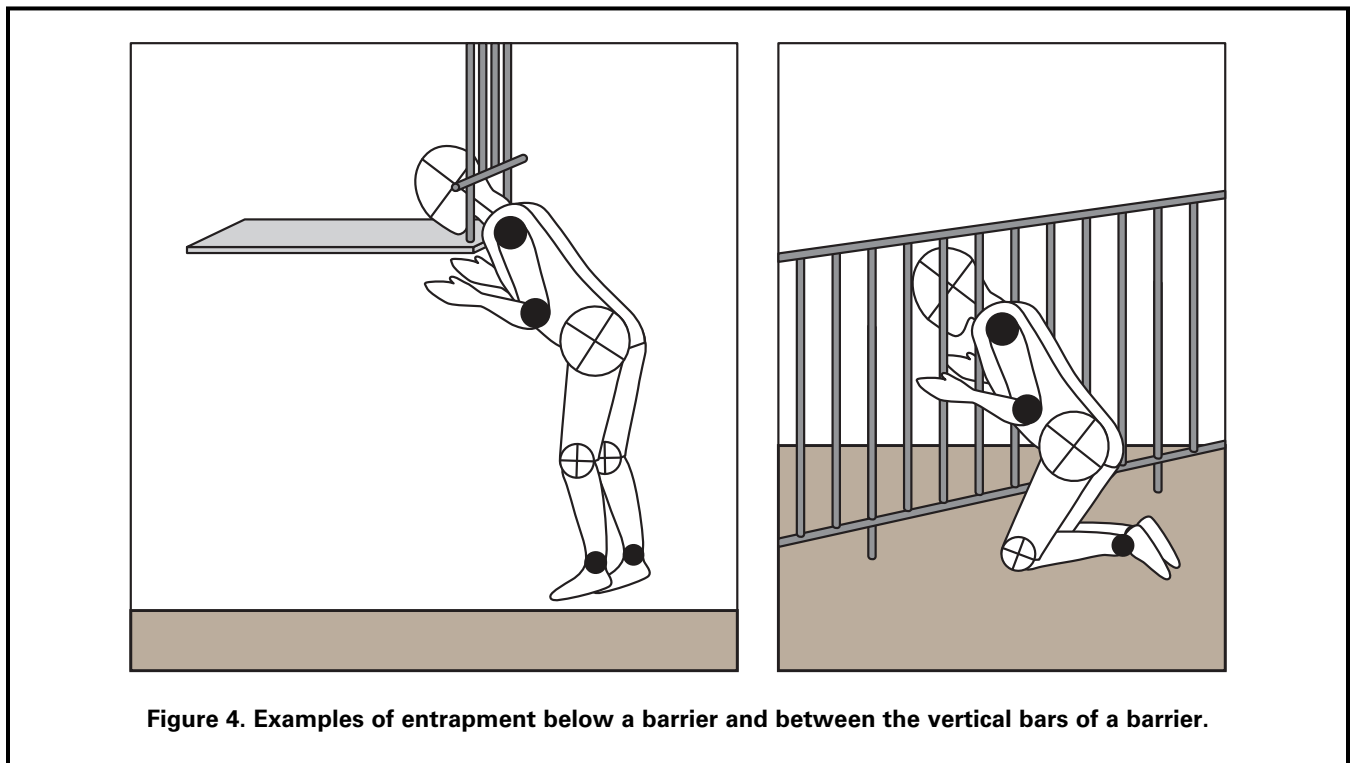
3.3 Entrapment

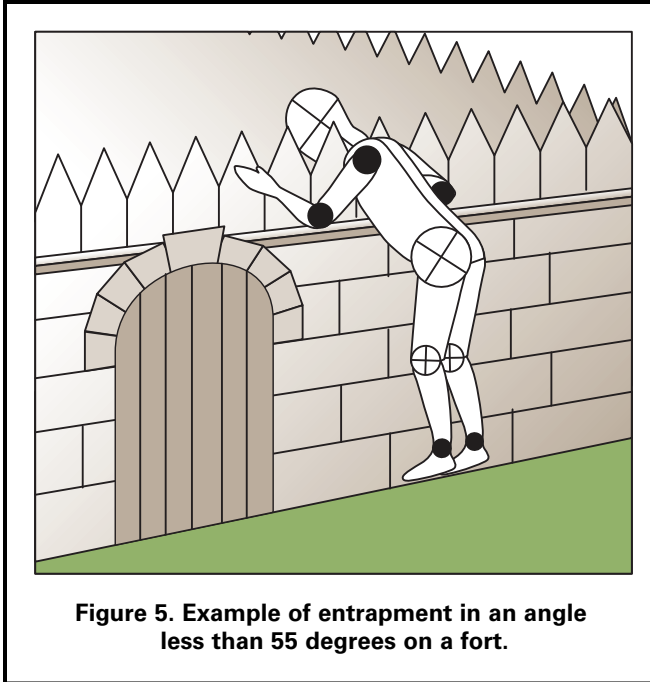
3.3.1 Head entrapment

Head entrapment is a serious concern on playgrounds, since it could lead to strangulation and death. A child's head may become entrapped if the child enters an opening either feet first or head first. Head entrapment by head-first entry generally occurs when children place their heads through an

opening in one orientation, turn their heads to a different orientation, then are unable to get themselves out. Head entrapment by feet first entry involves children who generally sit or lie down and slide their feet into an opening that is large enough to permit their bodies to go through but is not large enough to permit their heads to go through. A part or a group of parts should not form openings that could trap a child's head. Also, children should not wear their bicycle helmets while on playground equipment. There have been recent head entrapment incidents in which children wearing their bicycle helmets became entrapped in spaces that would not normally be considered a head entrapment.

Certain openings could present an entrapment hazard if the distance between any interior opposing surfaces is greater than 3.5 inches and less than 9 inches. These spaces should be tested as recommended in Appendix B. When one dimension of an opening is within this range, all dimensions of the opening should be considered together to evaluate the possibility of entrapment. Even openings that are low enough for children's feet to touch the ground can present a risk of strangulation for an entrapped child. (See Figure 4). Younger children may not have the necessary intellectual ability or motor skills to reverse the process that caused their heads to become trapped, especially if they become scared or panicked.





3.3.2 Partially bound openings and angles

Children can become entrapped by partially bound openings, such as those formed by two or more playground parts.

- Angles formed by two accessible adjacent parts should be greater than 55 degrees unless the lowest leg is horizontal or below horizontal.
- Use the partially-bound opening test in Appendix B to identify hazardous angles and other partially-bound openings.

3.4 Sharp Points, Corners, and Edges

Sharp points, corners, or edges on any part of the playground or playground equipment may cut or puncture a child's skin. Sharp edges can cause serious lacerations if protective measures are not taken. To avoid the risk of injury from sharp points, corners and edges:

- Exposed open ends of all tubing not resting on the ground or otherwise covered should be covered by caps or plugs that cannot be removed without the use of tools.
- Wood parts should be smooth and free from splinters.
- All corners, metal and wood, should be rounded.
- All metal edges should be rolled or have rounded capping.

- There should be no sharp edges on slides. Pay special attention to metal edges of slides along the sides and at the exit (see also §5.3.6.4).
- If steel-belted radials are used as playground equipment, they should be closely examined regularly to ensure that there are no exposed steel belts/wires.
- Conduct frequent inspections to help prevent injuries caused by splintered wood, sharp points, corners, or edges that may develop as a result of wear and tear on the equipment.

3.5 Suspended Hazards

Children using a playground may be injured if they run into or trip over suspended components (such as cables, wires, ropes, or other flexible parts) connected from one piece of the playground equipment to another or hanging to the ground. These suspended components can become hazards when they are within 45 degrees of horizontal and are less than 7 feet above the protective surfacing. To avoid a suspended hazard, suspended components:

- Should be located away from high traffic areas.
- Should either be brightly colored or contrast with the surrounding equipment and surfacing.
- Should not be able to be looped back on themselves or other ropes, cables, or chains to create a circle with a 5 inch or greater perimeter.
- Should be fastened at both ends unless they are 7 inches or less long or attached to a swing seat.

These recommendations do not apply to swings, climbing nets, or if the suspended component is more than 7 feet above the protective surfacing and is a minimum of one inch at its widest cross-section dimension.

3.6 Tripping Hazards

Play areas should be free of tripping hazards (i.e., sudden change in elevations) to children who are using a playground. Two common causes of tripping are anchoring devices for playground equipment and containment walls for loose-fill surfacing materials.

- All anchoring devices for playground equipment, such as concrete footings or horizontal bars at the bottom of flexible climbers, should be installed below ground level

and beneath the base of the protective surfacing material. This will also prevent children from sustaining additional injuries from impact if they fall on exposed footings.

- Contrasting the color of the surfacing with the equipment color can contribute to better visibility.
- Surfacing containment walls should be highly visible.
- Any change of elevation should be obvious.
- Contrasting the color of the containment barrier with the surfacing color can contribute to better visibility.

3.7 Used Tires

Used automobile and truck tires are often recycled as playground equipment, such as tire swings or flexible climbers, or as a safety product such as cushioning under a seesaw or shredded as protective surfacing. When recycling tires for playground use:

- Steel-belted radials should be closely examined regularly to ensure that there are no exposed steel belts/wires.
- Care should be taken so that the tire does not collect water and debris; for example, providing drainage holes on the underside of the tire would reduce water collection.
- Recycled tire rubber mulch products should be inspected before installation to ensure that all metal has been removed.

In some situations, plastic materials can be used as an alternative to simulate actual automobile tires.

4. MAINTAINING A PLAYGROUND

Inadequate maintenance of equipment has resulted in injuries on playgrounds. Because the safety of playground equipment and its suitability for use depend on good inspection and maintenance, the manufacturer's maintenance instructions and recommended inspection schedules should be strictly followed. If manufacturer's recommendations are not available, a maintenance schedule should be developed based on actual or anticipated playground use. Frequently used playgrounds will require more frequent inspections and maintenance.

4.1 Maintenance Inspections

A comprehensive maintenance program should be developed for each playground. All playground areas and equipment should be inspected for excessive wear, deterioration, and any potential hazards, such as those shown in Table 3. One possible procedure is the use of checklists. Some manufacturers supply checklists for general or detailed inspections with their maintenance instructions. These can be used to ensure that inspections are in compliance with the manufacturer's specifications. If manufacturer-provided inspection guidelines are not available, a general checklist that may be used as a guide for frequent routine inspections of public playgrounds is included at Appendix A. This is intended to address only general maintenance concerns. Detailed inspections should give special attention to moving parts and other parts that can be expected to wear. Maintenance inspections should be carried out in a systematic manner by personnel familiar with the playground, such as maintenance workers, playground supervisors, etc.

4.2 Repairs

Inspections alone do not constitute a comprehensive maintenance program. Any problems found during the inspection should be noted and fixed as soon as possible.

- All repairs and replacements of equipment parts should be completed following the manufacturer's instructions.
- User modifications, such as loose-ended ropes tied to elevated parts, should be removed immediately.
- For each piece of equipment, the frequency of thorough

Table 3. Routine inspection and maintenance issues

- | | |
|--------------------------|--|
| <input type="checkbox"/> | Broken equipment such as loose bolts, missing end caps, cracks, etc. |
| <input type="checkbox"/> | Broken glass & other trash |
| <input type="checkbox"/> | Cracks in plastics |
| <input type="checkbox"/> | Loose anchoring |
| <input type="checkbox"/> | Hazardous or dangerous debris |
| <input type="checkbox"/> | Insect damage |
| <input type="checkbox"/> | Problems with surfacing |
| <input type="checkbox"/> | Displaced loose-fill surfacing (see Section 4.3) |
| <input type="checkbox"/> | Holes, flakes, and/or buckling of unitary surfacing |
| <input type="checkbox"/> | User modifications (such as ropes tied to parts or equipment rearranged) |
| <input type="checkbox"/> | Vandalism |
| <input type="checkbox"/> | Worn, loose, damaged, or missing parts |
| <input type="checkbox"/> | Wood splitting |
| <input type="checkbox"/> | Rusted or corroded metals |
| <input type="checkbox"/> | Rot |

inspections will depend on the type and age of equipment, the amount of use, and the local climate.

- Consult the manufacturer for maintenance schedules for each piece of equipment. Based on these schedules, a maintenance schedule for the entire playground can be created. This routine maintenance schedule should not replace regular inspections.

4.3 Maintaining Loose-Fill Surfacing

Loose-fill surfacing materials require special maintenance. High-use public playgrounds, such as child care centers and schools, should be checked frequently to ensure surfacing has not displaced significantly, particularly in areas of the playground most subject to displacement (e.g., under swings and slide exits). This can be facilitated by marking ideal surfacing depths on equipment posts. Displaced loose-fill

surfacing should be raked back into proper place so that a constant depth is maintained throughout the playground. Impact attenuating mats placed in high traffic areas, such as under swings and at slide exits, can significantly reduce displacement. They should be installed below or level with surfacing so as not to be a tripping hazard.

The following are key points to look for during regular checks of surfacing:

- Areas under swings and at slide exits. Activity in these areas tends to displace surfacing quickly. Rake loose-fill back into place.
- Pooling water on mulch surfacing. For example, wet mulch compacts faster than dry, fluffy mulch. If puddles are noticed regularly, consider addressing larger drainage issues.
- Frozen surfacing. Most loose-fill surfacing that freezes

solid no longer functions as protective surfacing. Even if the first few inches may be loose, the base layer may be frozen and the impact attenuation of the surfacing may be significantly reduced. It is recommended that children not play on the equipment under these conditions.

4.4 Recordkeeping

Records of all maintenance inspections and repairs should be retained, including the manufacturer's maintenance instructions and any checklists used. When any inspection is performed, the person performing it should sign and date the form used. A record of any accident and injury reported to have occurred on the playground should also be retained. This will help identify potential hazards or dangerous design features that should be corrected.

5. PARTS OF THE PLAYGROUND

5.1 Platforms, Guardrails and Protective Barriers

5.1.1 Platforms

- Platforms should be generally flat (i.e., within $\pm 2^\circ$ of horizontal).
- Openings in platforms should be provided to allow for drainage.
- Platforms should minimize the collection of debris.
- Platforms intended for toddlers should be no more than 32 inches from the ground.

5.1.2 Stepped platforms

On some composite structures, platforms are layered or tiered so that a child may access the higher platform without steps or ladders. Unless there is an alternate means of access/egress, the maximum difference in height between stepped platforms should be:

- Toddlers: 7 inches.
- Preschool-age: 12 inches.
- School-age: 18 inches.

An access component (such as a rung) is needed if the difference in height is more than 12 inches for preschool-age and 18 inches for school-age children.

The space between the stepped platforms should follow the recommendations to minimize entrapment hazards in enclosed openings:

- Toddlers: if the space is less than 7 inches, infill should be used to reduce the space to less than 3.0 inches.
- Preschool-age: if the space exceeds 9 inches and the height of the lower platform above the protective surfacing exceeds 30 inches, infill should be used to reduce the space to less than 3.5 inches.
- School-age: if the space exceeds 9 inches and the height of the lower platform above the protective surfacing exceeds 48 inches, infill should be used to reduce the space to less than 3.5 inches.

5.1.2.1 Fall height

- The fall height of a platform is the distance between the top of the platform and the protective surfacing beneath it.

5.1.3 Guardrails and protective barriers

Guardrails and protective barriers are used to minimize the likelihood of accidental falls from elevated platforms. Protective barriers provide greater protection than guardrails and should be designed to discourage children from climbing over or through the barrier. Guardrails and barriers should:

- Completely surround any elevated platform.
- Except for entrance and exit openings, the maximum clearance opening without a top horizontal guardrail should be 15 inches.
- Prevent unintentional falls from the platform.
- Prevent the possibility of entrapment.
- Facilitate supervision.

For example:

- Guardrails may have a horizontal top rail with infill consisting of vertical bars having openings that are greater than 9 inches. These openings do not present an entrapment hazard but do not prevent a child from climbing through the openings.
- A barrier should minimize the likelihood of passage of a child during deliberate attempts to defeat the barrier. Any openings between uprights or between the platform surface and lower edge of a protective barrier should prevent passage of the small torso template (see test in B.2.5).

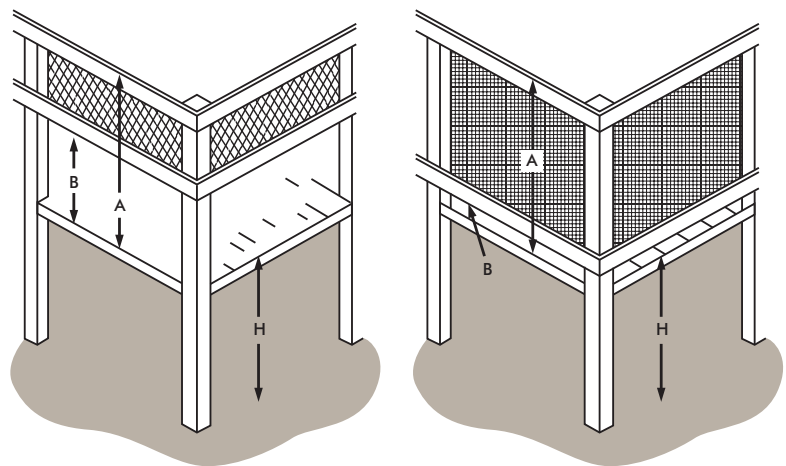
Guardrails or protective barriers should be provided on elevated platforms, walkways, landings, stairways, and transitional surfaces. In general, the younger the child, the less coordination and balance they have, therefore the more vulnerable they are to unintentional falls. Toddlers are the most vulnerable, and equipment intended for this age should use barriers on all elevated walking surfaces above 18 inches. Physical skills develop further in preschool-age children and then more with school-age children; therefore, minimum elevation recommendations for guardrails and barriers increase with each age group.

Guardrails and barriers should be high enough to prevent the tallest children from falling over the top. For guardrails, the lower edge should be low enough so that the smallest children cannot walk under it. Barriers should be low enough to prevent the smallest child from getting under the barrier in any way. This is generally done by designing the barrier so that the small torso probe (see test methods in Appendix B) cannot pass under or through the barrier. Vertical infill for protective barriers may be preferable for younger children because the vertical components can be grasped at whatever height a child chooses as a handhold.

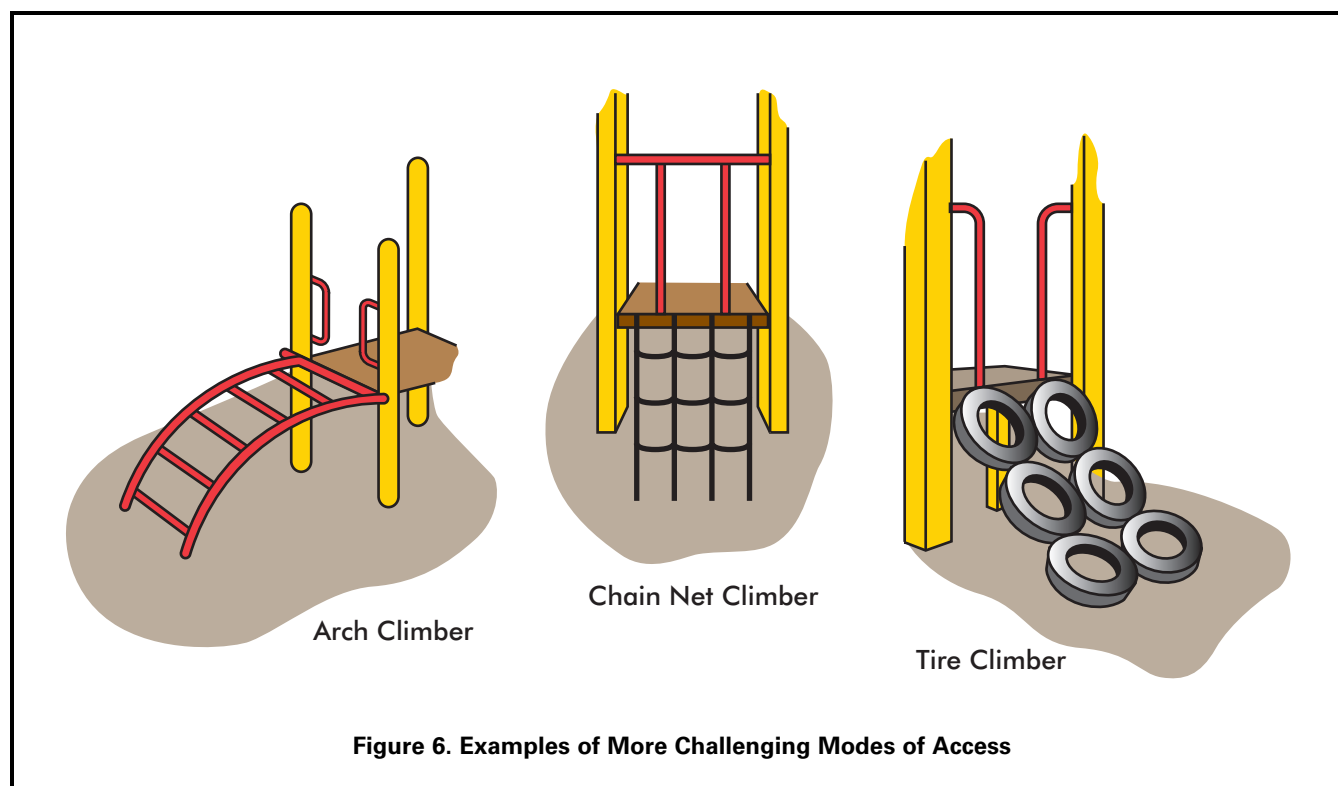
Guardrail and barrier recommendations are shown in Table 4. However, the recommendations do not apply if the guardrail or barrier would interfere with the intended use of the equipment, such as:

- Climbing equipment
- Platforms layered so that the fall height is:
 - Toddlers: 7 inches or less.
 - Preschool-age: 20 inches or less.
 - School-age: 30 inches or less.

Table 4. Guardrails and Barriers



	Guardrail	Barrier
Protects against accidental falls from platform	Yes	Yes
Discourages climbing over	No	Yes
Protects against climbing through	No	Yes
Toddlers		
A Top edge distance from platform	Not recommended	A = 24" or higher
B Bottom edge distance from platform	Not recommended	B < 3"
H Recommended when platform fall height is:	Not recommended	H = 18" or higher
Preschool-age		
A Top edge distance from platform	A = 29" or higher	A = 29" or higher
B Bottom edge distance from platform	9" < B ≤ 23"	B < 3.5"
H Recommended when platform fall height is:	20" < H ≤ 30"	H > 30"
School-age		
A Top edge distance from platform	A = 38" or higher	A = 38" or higher
B Bottom edge distance from platform	9" < B ≤ 28"	B < 3.5"
H Recommended when platform fall height is:	30" < H ≤ 48"	H > 48"



5.2 Access Methods to Play Equipment

Access to playground equipment can take many forms, such as conventional ramps, stairways with steps, and ladders with steps or rungs. Access may also be by means of climbing components, such as arch climbers, climbing nets, and tire climbers (see Figure 6).

As children develop, they gain better balance and coordination, so it is important to pick appropriate access methods based on the age group. Table 5 shows the most common methods of access and the youngest appropriate age group.

Access to platforms over 6 feet high (except for free-standing slides) should provide an intermediate standing surface so that the child can pause and make a decision to keep going up or find another way down. Children generally master access before egress, that is, they can go up before they can get back down a difficult component. Therefore, if there are more difficult access methods, it is important to have easier components for egress.

Table 5. Methods of access and egress

Method of Access	Challenge Level	Appropriate for
Ramps	Easiest	Toddlers +
Straight stairways	Easy	Toddlers +
Spiral stairways	Moderate	Toddlers* +
Step ladders	Moderate	15 months* +
Rung ladders	Moderate	Preschool* +
Arch climbers	Difficult	Preschool* +
Flexible climbers (nets, tires)	Difficult	Preschool* +
* only if an easy egress method is also provided		

5.2.1 Ramps, stairways, rung ladders, and step ladders

Ramps, stairways, rung ladders, and step ladders each have different recommendations for slope and tread dimension, but the steps or rungs always should be evenly spaced - even the spacing between the top step or rung and the surface of the platform. Table 6 contains recommended dimensions for: access slope; tread or rung width; tread depth; rung diameter; and vertical rise for rung ladders, step ladders, and stairways. Table 6 also contains slope and width recommendations for ramps. However, these recommendations are not intended to address ramps designed for access by wheelchairs.

- Openings between steps or rungs and between the top step or rung and underside of a platform should prevent entrapment.
- When risers are closed, treads on stairways and ladders should prevent the accumulation of sand, water, or other materials on or between steps.
- Climbing equipment should allow children to descend as easily as they ascend. One way of implementing this recommendation is to provide an easier, alternate means of descent, such as another mode of egress, a platform, or another piece of equipment. For example, a stairway can be added to provide a less challenging mode of descent than a vertical rung ladder or flexible climbing device (see Table 5).
- For toddlers and preschool-age children, offering an easy way out is particularly important since their ability to descend climbing components develops later than their ability to climb up the same components.

Table 6. Recommended dimensions for access ladders, stairs, and ramps*

AGE OF INTENDED USER			
Type of Access	Toddler	Preschool-age	School-age
<i>Ramps (not intended to meet ADA/ABA specifications)</i>			
Slope (vertical:horizontal)	< 1:8	≤ 1:8	≤ 1:8
Width (single)	≥ 19"	≥ 12"	≥ 16"
Width (double)	≥ 30"	≥ 30"	≥ 36"
<i>Stairways</i>			
Slope	≤ 35°	< 50°	< 50°
Tread width (single)	12-21"	≥ 12"	≥ 16"
Tread width (double)	≥ 30"	≥ 30"	≥ 36"
Tread depth (open riser)	Not appropriate	≥ 7"	≥ 8"
Tread depth (closed riser)	≥ 8"	≥ 7"	≥ 8"
Vertical rise	≤ 7"	≤ 9"	≤ 12"
<i>Step ladders</i>			
Slope	35≤65°	50-75°	50-75°
Tread width (single)	12-21"	12-21"	≥ 16"
Tread width (double)	Not appropriate	Not appropriate	≥ 36"
Tread depth (open riser)	Not appropriate	≥ 7"	≥ 3"
Tread depth (closed riser)	8"	≥ 7"	≥ 6"
Vertical rise	> 5" and ≤ 7"	≤ 9"	≤ 12"
<i>Rung ladders</i>			
Slope	Not appropriate	75-90°	75-90°
Rung width	Not appropriate	≥ 12"	≥ 16"
Vertical rise	Not appropriate	≤ 12"	≤ 12"
Rung diameter	Not appropriate	0.95-1.55"	0.95-1.55"
* entrapment recommendations apply to all openings in access components			

5.2.2 Rungs and other hand gripping components

Unlike steps of stairways and step ladders that are primarily for foot support, rungs can be used for both foot and hand support.

- Rungs with round shapes are easiest for children to grip.
- All hand grips should be secured in a manner that prevents them from turning.
- Toddlers:
 - Handrails or other means of hand support should have a diameter or maximum cross-section between 0.60 and 1.20 inches.
 - A diameter or maximum cross-section of 0.90 inches is preferred to achieve maximal grip strength and benefit the weakest children.
- Preschool- and school-age:
 - Rungs, handrails, climbing bars, or other means of hand support intended for holding should have a diameter or maximum cross-section between 0.95 and 1.55 inches.
 - A diameter or maximum cross-section of 1.25 inches is preferred to achieve maximal grip strength and benefit the weakest children.

5.2.3 Handrails

Handrails on stairways and step ladders are intended to provide hand support and to steady the user. Continuous handrails extending over the full length of the access should be provided on both sides of all stairways and step ladders, regardless of the height of the access. Rung ladders do not require handrails since rungs or side supports provide hand support on these more steeply inclined accesses.

5.2.3.1 Handrail height

Handrails should be available for use at the appropriate height, beginning with the first step. The vertical distance between the top front edge of a step or ramp surface and the top surface of the handrail above it should be as follows:

- Toddlers: between 15 and 20 inches.
- Preschool-age: between 22 and 26 inches.
- School-age: between 22 and 38 inches.

5.2.4 Transition from access to platform

Handrails or handholds are recommended at all transition points (the point where the child must move from the access component to the play structure platform).

- The handhold should provide support from the access component until the child has fully achieved the desired posture on the platform.
- Any opening between a handrail and an adjacent vertical structure (e.g., vertical support post for a platform or vertical slat of a protective barrier) should not pose an entrapment hazard.
- Access methods that do not have handrails, such as rung ladders, flexible climbers, arch climbers, and tire climbers, should provide hand supports for the transition between the top of the access and the platform.

5.3 Major Types of Playground Equipment

5.3.1 Balance beams

- Balance beams should be no higher than:
 - Toddlers: not recommended.
 - Preschool-age: 12 inches.
 - School-age: 16 inches.

5.3.1.1 Fall height

The fall height of a balance beam is the distance between the top of the walking surface and the protective surfacing beneath it.

5.3.2 Climbing and upper body equipment

Climbing equipment is generally designed to present a greater degree of physical challenge than other equipment on public playgrounds. This type of equipment requires the use of the hands to navigate up or across the equipment. “Climbers” refers to a wide variety of equipment, such as but not limited to:

- Arch climbers
- Dome climbers
- Flexible climbers (usually chain or net)
- Parallel bars
- Sliding poles



Simple Arch Climber



Geodesic Dome Climber



Overhead Horizontal Ladder



Overhead Loop Ladder

Figure 7. Examples of climbers

- Spiral climbers
- Upper body equipment (horizontal overhead ladders, overhead rings, track ride).

School-age children tend to use climbing and upper body equipment more frequently and more proficiently than preschool children. Young preschool children may have difficulty using some climbers because they have not yet developed some of the physical skills necessary for certain climbing activities (balance, coordination, and upper body strength). Older preschool children (i.e., 4- and 5-year-olds) are beginning to use flexible climbers, arch climbers, and upper body devices.

5.3.2.1 Design considerations

5.3.2.1.1 Layout of climbing components

When climbing components are part of a composite structure, their level of challenge and method of use should be compatible with the traffic flow from nearby components. Upper body devices should be placed so that the swinging movement generated by children on this equipment cannot interfere with the movement of children on adjacent structures, particularly children descending on slides. The design of adjacent play structures should not facilitate climbing to the top support bars of upper body equipment.

5.3.2.1.2 Fall Height

Climbers:

- Unless otherwise specified in this section, the fall height for climbers is the distance between the highest part of the climbing component and the protective surfacing beneath it.
- If the climber is part of a composite structure, the fall height is the distance between the highest part of the climber intended for foot support and the protective surfacing beneath it.
 - Toddlers: The maximum fall height for free standing and composite climbing structures should be 32 inches.

Upper Body Equipment:

- The fall height of upper body equipment is the distance between the highest part of the equipment and the protective surface below.

5.3.2.1.3 Climbing rungs

Some of the access methods discussed in §5.2 are also considered climbing devices; therefore, the recommendations for the size of climbing rungs are similar.

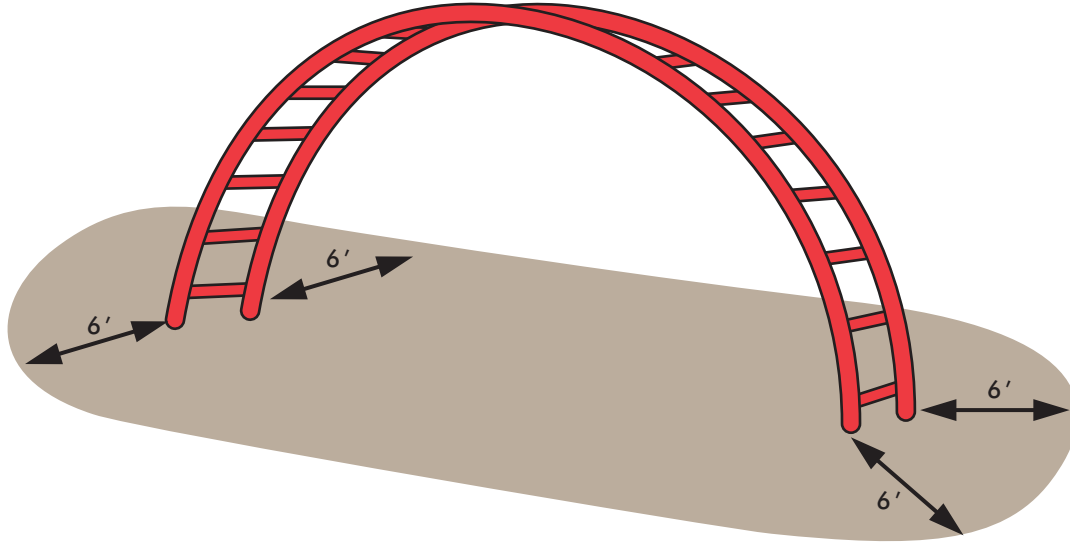


Figure 8. Use zone surrounding a freestanding arch climber

- Rungs should be generally round.
- All rungs should be secured in a manner that prevents them from turning.
- Climbing rungs should follow the same diameter recommendations as in §5.2.2.

5.3.2.1.4 Use zone

- The use zone should extend a minimum of 6 feet in all directions from the perimeter of the stand alone climber. See Figure 8.
- The use zone of a climber may overlap with neighboring equipment if the other piece of equipment allows overlapping use zones and
 - There is at least 6 feet between equipment when adjacent designated play surfaces are no more than 30 inches high; or
 - There is at least 9 feet between equipment when adjacent designated play surfaces are more than 30 inches high.

5.3.2.1.5 Other considerations

- Climbers should not have climbing bars or other rigid structural components in the interior of the climber onto

which a child may fall from a height of greater than 18 inches. See Figure 9 for an example of a climber that **DOES NOT** follow this consideration.



Figure 9: Climber with rigid structural components that DOES NOT meet 5.3.2.1.5

5.3.2.2 Arch climbers

Arch climbers consist of rungs attached to convex side supports. They may be free standing (Figure 10) or be provided as a more challenging means of access to other equipment (Figure 11).

- Arch climbers should not be used as the sole means of access to other equipment for preschoolers.
- Free standing arch climbers are not recommended for toddlers or preschool-age children.
- The rung diameter and spacing of rungs on arch climbers should follow the recommendations for rung ladders in Table 6.

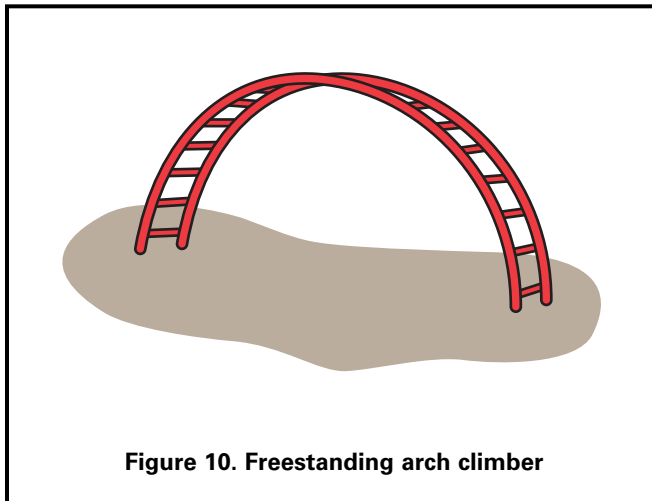


Figure 10. Freestanding arch climber

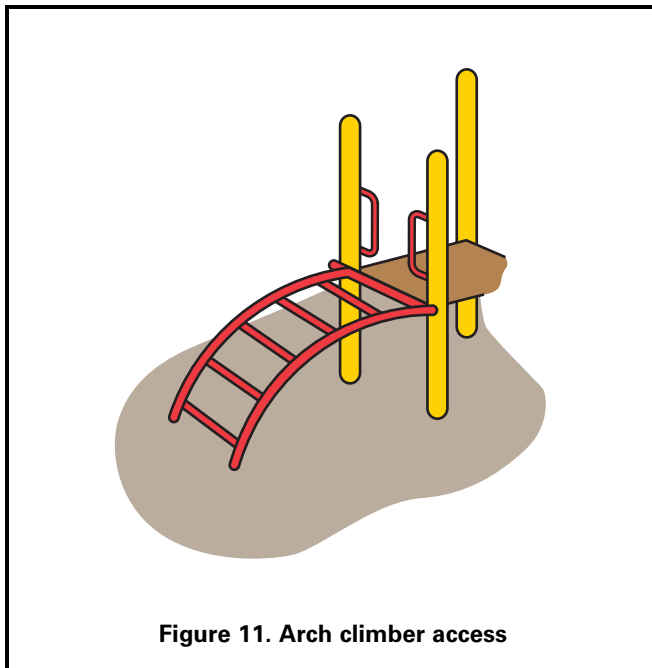


Figure 11. Arch climber access

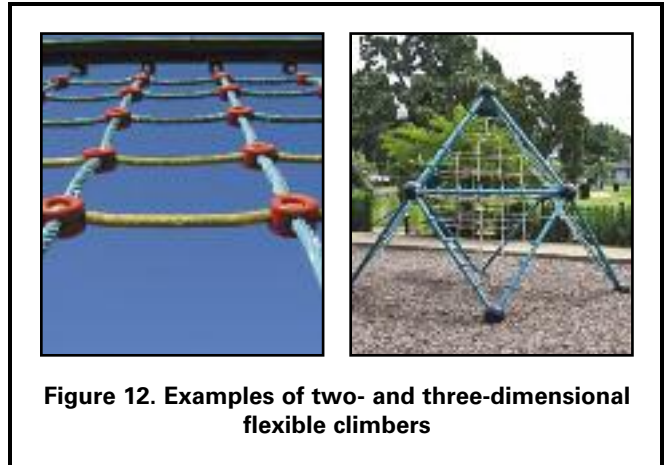


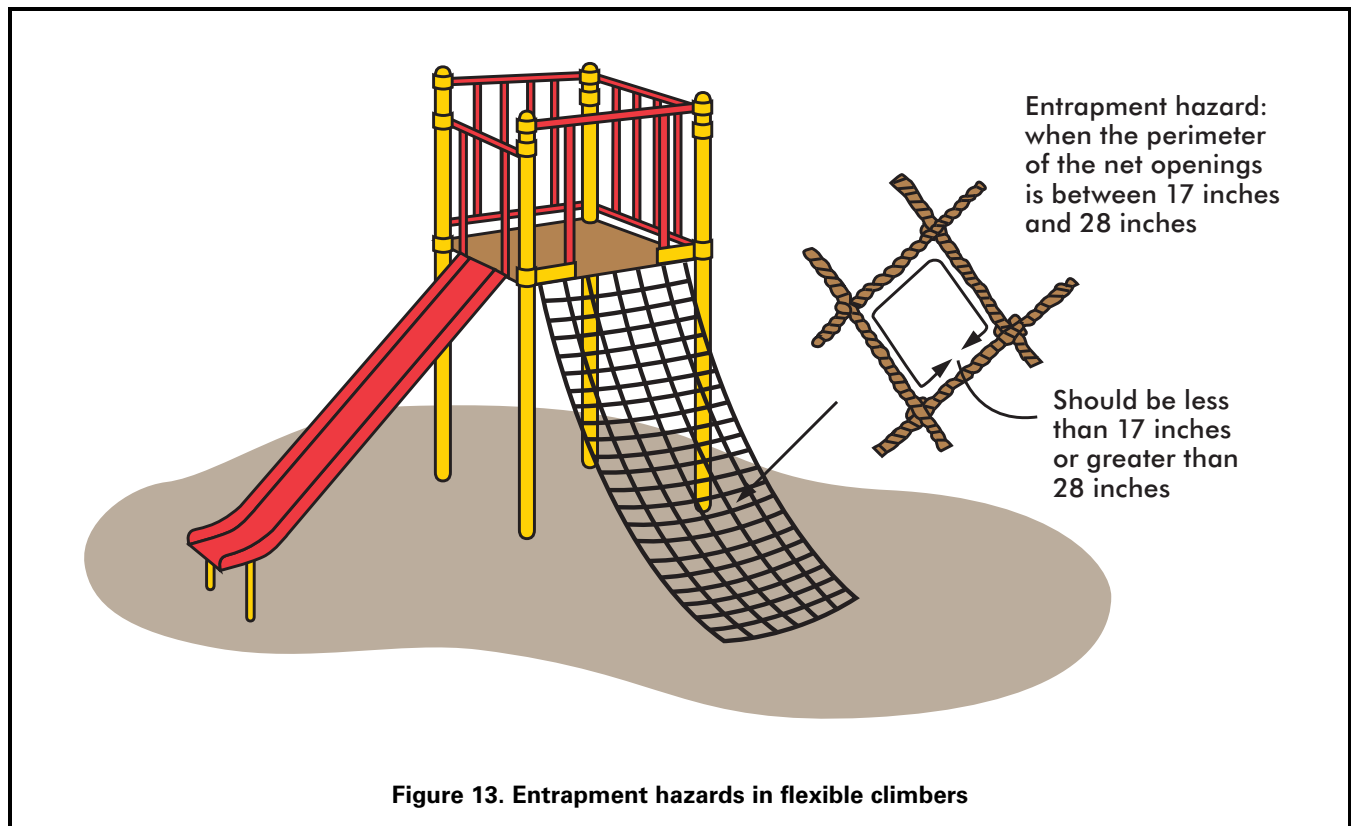
Figure 12. Examples of two- and three-dimensional flexible climbers

5.3.2.3 Flexible climbers

Flexible climbers use a grid of ropes, chains, cables, or tires for climbing. Since the flexible parts do not provide a steady means of support, flexible climbers require more advanced balance abilities than rigid climbers.

Rope, chain, and cable generally form a net-like structure that may be either two or three dimensional. See Figure 12. Tire climbers may have the tires secured tread-to-tread to form a sloping grid, or the tires may be suspended individually by chains or other means.

- Flexible climbers that provide access to platforms should be securely anchored at both ends.
- When connected to the ground, the anchoring devices should be installed below ground level and beneath the base of the protective surfacing material.
- Connections between ropes, cables, chains, or between tires should be securely fixed.
- Flexible climbers are not recommended as the sole means of access to equipment intended for toddlers and preschool-age children.
- Free-standing flexible climbers are not recommended on playgrounds intended for toddlers and preschool children.
- Spacing between the horizontal and vertical components of a climbing grid should not form entrapment hazards.
- The perimeter of any opening in a net structure should be less than 17 inches or greater than 28 inches (see Figure 13).



5.3.2.4 Horizontal (overhead) ladders

Horizontal (overhead) ladders are a type of climber designed to build upper body strength. They are designed to allow children to move across the ladder from end to end using only their hands.

Four-year-olds are generally the youngest children able to use upper body devices like these; therefore, horizontal ladders should not be used on playgrounds intended for toddlers and 3-year-olds. The recommendations below are designed to accommodate children ages 4 through 12 years.

- The first handhold on either end of upper body equipment should not be placed directly above the platform or climbing rung used for mount or dismount. This minimizes the risk of children impacting rigid access structures if they fall from the first handhold during mount or dismount.
- The horizontal distance out to the first handhold should be:
 - No greater than 10 inches but not directly above the platform when access is from a platform.
 - At least 8 inches but no greater than 10 inches when access is from climbing rungs.
- The space between adjacent rungs of overhead ladders should be greater than 9 inches to prevent entrapment.
- Horizontal ladders intended for preschool-age children should have rungs that are parallel to one another and evenly spaced.
- The maximum height of a horizontal ladder (i.e., measured from the center of the grasping device to the top of the protective surfacing below) should be:
 - Preschool-age (4 and 5 years): no more than 60 inches.
 - School-age: no more than 84 inches.
- The center-to-center spacing of horizontal ladder rungs should be as follows:
 - Preschool-age (4 and 5 years): no more than 12 inches.
 - School-age: no more than 15 inches.
- The maximum height of the take-off/landing platform above the protective surfacing should be:
 - Preschool-age (4 and 5 years): no more than 18 inches.
 - School-age: no more than 36 inches.

5.3.2.5 Overhead rings

Overhead rings are similar to horizontal ladders in terms of the complexity of use. Therefore, overhead rings should not be used on playgrounds intended for toddlers and 3-year-olds. The recommendations below are designed to accommodate children 4 through 12 years of age.

Overhead rings differ from horizontal ladders because, during use, the gripped ring swings through an arc and reduces the distance to the gripping surface of the next ring; therefore, the spacing distance recommendations for horizontal ladders do not apply.

- The first handhold on either end of upper body equipment should not be placed directly above the platform or climbing rung used for mount or dismount. This minimizes the risk of children hitting rigid access structures if they fall from the first handhold during mount or dismount.
- The horizontal distance out to the first handhold should be:
 - No greater than 10 inches but not directly above the platform when access is from a platform.
 - At least 8 inches but no greater than 10 inches when access is from climbing rungs.
- The maximum height of overhead rings measured from the center of the grasping device to the protective surfacing should be:
 - Preschool-age (4 and 5 years): 60 inches.
 - School-age: 84 inches.
- If overhead swinging rings are suspended by chains, the maximum length of the chains should be 7 inches.
- The maximum height of the take-off/landing platform above the protective surfacing should be:
 - Preschool-age (4 and 5 years): no more than 18 inches.
 - School-age: no more than 36 inches.

5.3.2.6 Sliding poles

Vertical sliding poles are more challenging than some other types of climbing equipment. They require upper body strength and coordination to successfully slide down the pole. Unlike other egress methods, there is no reverse or stop, so a child cannot change his or her mind. Children who start a sliding pole must have the strength to slide the whole way or they will fall.

- Sliding poles are not recommended for toddlers or preschool-age children since they generally don't have the upper body and/or hand strength to slide.

- Sliding poles should be continuous with no protruding welds or seams along the sliding surface.
- The pole should not change direction along the sliding portion.
- The horizontal distance between a sliding pole and any structure used for access to the sliding pole should be between 18 inches and 20 inches.
- The pole should extend at least 60 inches above the level of the platform or structure used for access to the sliding pole.
- The diameter of sliding poles should be no greater than 1.9 inches.
- Sliding poles and their access structures should be located so that traffic from other events will not interfere with the users during descent.
- Upper access should be on one level only.
- The upper access area through the guardrail or barrier should be 15 inches wide at most.

5.3.2.6.1 Fall height

- For sliding poles accessed from platforms, the fall height is the distance between the platform and the protective surfacing beneath it.
- For sliding poles not accessed from platforms, the fall height is the distance between a point 60 inches below the highest point of the pole and the protective surfacing beneath it.
- The top of the sliding pole's support structure should not be a designated play surface.

5.3.2.7 Track rides

Track rides are a form of upper body equipment where the child holds on to a handle or other device that slides along a track above his or her head. The child then lifts his or her feet and is carried along the length of the track. Track rides require significant upper body strength and the judgment to know when it is safe to let go. These are skills not developed until children are at least school-age; therefore, CPSC staff recommends:

- Track rides should not be used on playgrounds for toddlers and preschool-age children.
- Track rides should not have any obstacles along the path of the ride, including anything that would interfere in the take-off or landing areas.

- Two track rides next to each other should be at least 4 feet apart.
- The handle should be between 64 inches and 78 inches from the surfacing and follow the gripping recommendations in §5.2.2.
- Nothing should ever be tied or attached to any moving part of a track ride.
- Rolling parts should be enclosed to prevent crush hazards.

5.3.2.7.1 Fall height

- The fall height of track ride equipment is the distance between the maximum height of the equipment and the protective surface beneath it.
- Equipment support posts with no designated play surfaces are exempt from this requirement.

5.3.3 Log rolls

Log rolls help older children master balance skills and increase strength. Children must balance on top of the log as they spin it with their feet. See Figure 14.

- Log rolls are not recommended for toddlers and preschool-age children. These children generally do not possess the balance, coordination, and strength to use a log roll safely.
- Log rolls should have handholds to assist with balance.
- The handholds should follow the guidelines in §5.2.2.
- The highest point of the rolling log should be a maximum of 18 inches above the protective surface below.
- When not part of a composite structure, the use zone may overlap with neighboring equipment if the other piece of equipment allows overlapping use zones (see §5.3.9) and
 - There is at least 6 feet between equipment when adjacent designated play surfaces are no more than 30 inches high; or
 - There is at least 9 feet between equipment when adjacent designated play surfaces are more than 30 inches high.

5.3.3.1.1 Fall height

The fall height of a log roll is the distance between the highest portion of the rolling log and the protective surfacing beneath it.



Figure 14. Log roll

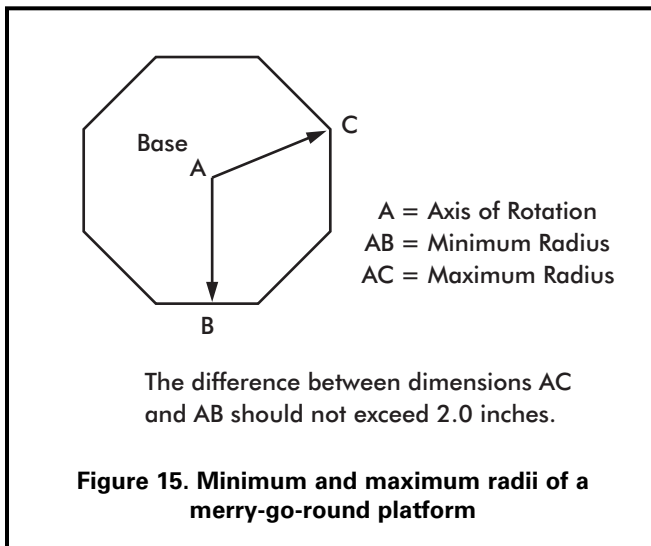
5.3.4 Merry-go-rounds

Merry-go-rounds are the most common rotating equipment found on public playgrounds. Children usually sit or stand on the platform while other children or adults push the merry-go-round to make it rotate. In addition, children often get on and off the merry-go-round while it is in motion. Merry-go-rounds may present a physical hazard to preschool-age children who have little or no control over such products once they are in motion. Therefore, children in this age group should always be supervised when using merry-go-rounds.

The following recommendations apply when the merry-go-round is at least 20 inches in diameter.

- Merry-go-rounds should not be used on playgrounds intended for toddlers.
- The standing/sitting surface of the platform should have a maximum height of:
 - Preschool: 14 inches above the protective surface.
 - School-age: 18 inches above the protective surface.
- The rotating platform should be continuous and approximately circular.
- The surface of the platform should not have any openings between the axis and the periphery that permit a rod having a diameter of 5/16 inch to penetrate completely through the surface.

- The difference between the minimum and maximum radii of a non-circular platform should not exceed 2.0 inches (Figure 15).



- The underside of the perimeter of the platform should be no less than 9 inches above the level of the protective surfacing beneath it.
- There should not be any accessible shearing or crushing mechanisms in the undercarriage of the equipment.
- Children should be provided with a secure means of holding on. Where handgrips are provided, they should conform to the general recommendations for hand gripping components in §5.2.2.
- No components of the apparatus, including handgrips, should extend beyond the perimeter of the platform.
- The rotating platform of a merry-go-round should not have any sharp edges.
- A means should be provided to limit the peripheral speed of rotation to a maximum of 13 ft/sec.
- Merry-go-round platforms should not have any up and down (oscillatory) motion.

5.3.4.1 Use zone

- The use zone should extend a minimum of 6 feet beyond the perimeter of the platform.
- The use zone may not overlap other use zones, unless the rotating equipment is less than 20 inches in diameter and the adjacent equipment allows overlap.

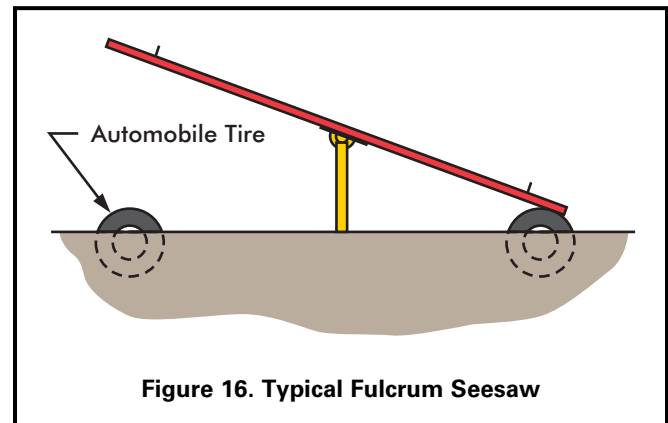
5.3.4.2 Fall height

The fall height for a merry-go-round is the distance between the perimeter of the platform where a child could sit or stand and the protective surfacing beneath it.

5.3.5 Seesaws

5.3.5.1 Fulcrum seesaws

The typical seesaw (also known as a “teeter totter”) consists of a board or pole with a seat at each end supported at the center by a fulcrum. See Figure 16. Because of the complex way children are required to cooperate and combine their actions, fulcrum seesaws are not recommended for toddlers or preschool-age children.



- The fulcrum should not present a crush hazard.
- Partial car tires, or some other shock-absorbing material, should be embedded in the ground underneath the seats, or secured on the underside of the seats. This will help prevent limbs from being crushed between the seat and the ground, as well as cushion the impact.
- The maximum attainable angle between a line connecting the seats and the horizontal is 25°.
- There should not be any footrests.

5.3.5.2 Spring-centered seesaws

Preschool-age children are capable of using spring-centered seesaws because the centering device prevents abrupt contact with the ground if one child dismounts suddenly. Spring-centered seesaws also have the advantage of not requiring two children to coordinate their actions in order to play safely. Spring-centered seesaws should follow the recommendations for spring rockers including the use of footrests (§5.3.7).

5.3.5.3 Use zone for fulcrum and spring-centered seesaws

- The use zone should extend a minimum of 6 feet from each outside edge of the seesaw.
- The use zone may overlap with neighboring equipment if the other piece of equipment allows overlapping use zones and
 - There is at least 6 feet between equipment when adjacent designated play surfaces are no more than 30 inches high; or
 - There is at least 9 feet between equipment when adjacent designated play surfaces are more than 30 inches high.

5.3.5.4 Handholds

- Handholds should be provided at each seating position for gripping with both hands and should not turn when grasped.
- Handholds should not protrude beyond the sides of the seat.

5.3.5.5 Fall height

The fall height for a seesaw is the distance between the highest point any part of the seesaw can reach and the protective surfacing beneath it.

5.3.6 Slides

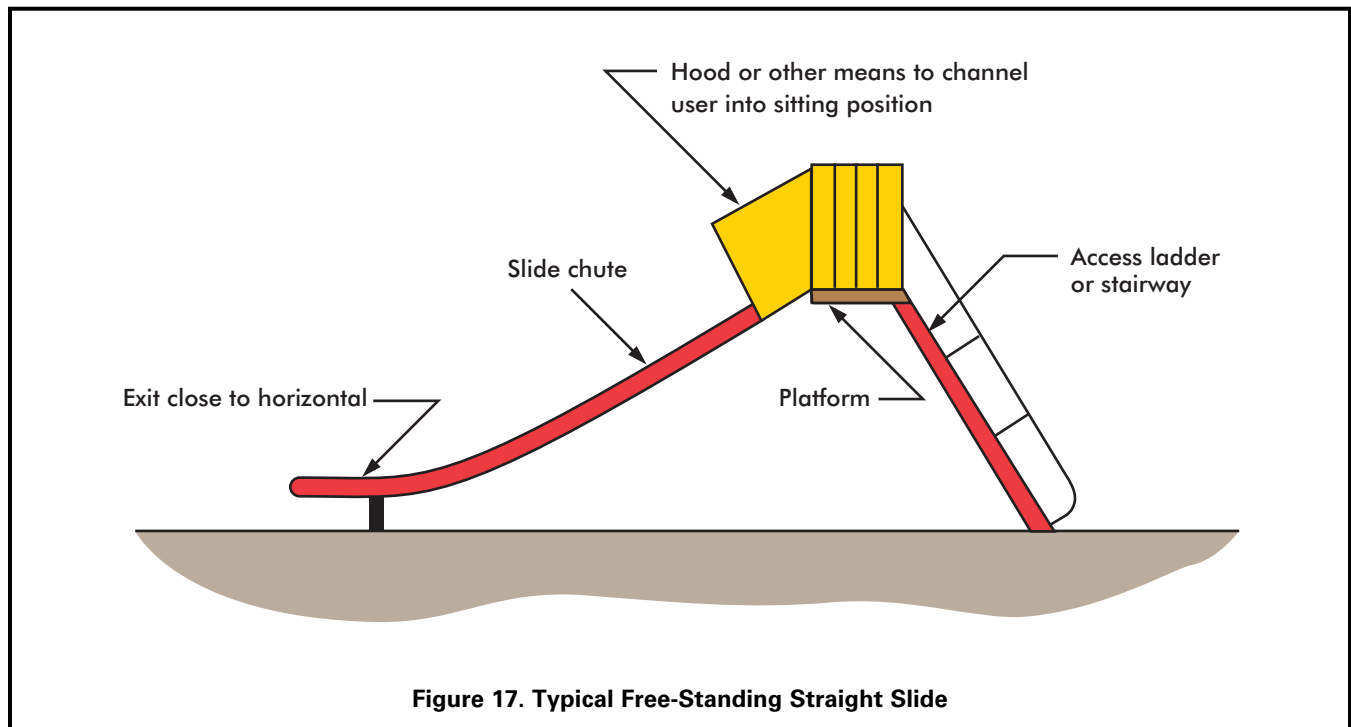
Children can be expected to descend slide chutes in many different positions, rather than always sitting and facing forward as they slide. These other positions should be discouraged at all times to minimize injuries.



Slides may provide a straight, wavy, or spiral descent either by means of a tube or an open slide chute. They may be either free-standing (Figure 17), part of a composite structure, or built on the grade of a natural or man-made slope (embankment slide). Regardless of the type of slide, avoid using bare metals on the platforms, chutes, and steps. When exposed to direct sunlight the bare metal may reach temperatures high enough to cause serious contact burn injuries in a matter of seconds. Provide shade for bare metal slides or use other materials that may reduce the surface temperature such as, but not limited to, plastic or coated metal.

5.3.6.1 Slide access

Access to a stand-alone slide generally is by means of a ladder with rungs, steps, or a stairway with steps. Slides may also be part of a composite play structure, so children will gain access from other parts of the structure. Embankment slides use the ground for access.



5.3.6.2 Slide platform

All slides should be provided with a platform with sufficient length to facilitate the transition from standing to sitting at the top of the inclined sliding surface. Embankment slides are exempt from platform requirements because they are on ground level; however, they should not have any spaces or gaps as noted below.

The platform should:

- Be at least 19 inches deep for toddlers.
- Be at least 14 inches deep for preschool-age and school-age children.
- Be horizontal.
- Be at least as wide as the slide chute.
- Be surrounded by guardrails or barriers.
- Conform to the same recommendations as general platforms given in §5.1.1.
- Not have any spaces or gaps that could trap strings, clothing, body parts, etc. between the platform and the start of the slide chute.
- Provide handholds to facilitate the transition from standing to sitting and decrease the risk of falls (except tube slides where the tube perimeter provides hand support). These should extend high enough to provide hand support for the largest child in a standing position, and low enough to provide hand support for the smallest child in a sitting position.
- Provide a means to channel a user into a sitting position at the entrance to the chute, such as a guardrail, hood, or other device that discourages climbing.

5.3.6.3 Slide chutes

5.3.6.3.1 Embankment slides

- The slide chute of an embankment slide should have a maximum height of 12 inches above the underlying ground surface. This design basically eliminates the hazard of falls from elevated heights.
- Embankment slides should follow all of the recommendations given for straight slides where applicable (e.g., side height, slope, use zone at exit, etc.).
- There should be some means provided at the slide chute entrance to minimize the use of embankment slides by children on skates, skateboards, or bicycles.

5.3.6.3.2 Roller slides

- Roller slides should meet applicable recommendations for other slides (e.g., side height, slope, use zone at exit, etc.).
- The space between adjacent rollers and between the ends of the rollers and the stationary structure should be less than 3/16 inch.
- Frequent inspections are recommended to insure that there are no missing rollers or broken bearings and that the rollers roll.

5.3.6.3.3 Spiral slides

- Spiral slides should follow the recommendations for straight slides where applicable (e.g., side height, slope, use zone at exit, etc.).
- Special attention should be given to design features which may present problems unique to spiral slides, such as lateral discharge of the user.
- Toddlers and preschool-age children have less ability to maintain balance and postural control, so only short spiral slides (one 360° turn or less) are recommended for these age groups.

5.3.6.3.4 Straight slides

- Flat open chutes should have sides at least 4 inches high extending along both sides of the chute for the entire length of the inclined sliding surface.
- The sides should be an integral part of the chute, without any gaps between the sides and the sliding surface. (This does not apply to roller slides).
- Slides may have an open chute with a circular, semicircular or curved cross section provided that:
 - A. The vertical height of the sides is no less than 4 inches when measured at right angles to a horizontal line that is 8 inches long when the slide is intended for toddlers, 12 inches long when the slide is intended for preschool-age children, and 16 inches long when the slide is intended for school-age children (Figure 18); or
 - B. For any age group, the vertical height of the sides is no less than 4 inches minus two times the width of the slide chute divided by the radius of the slide chute curvature (Figure 19).

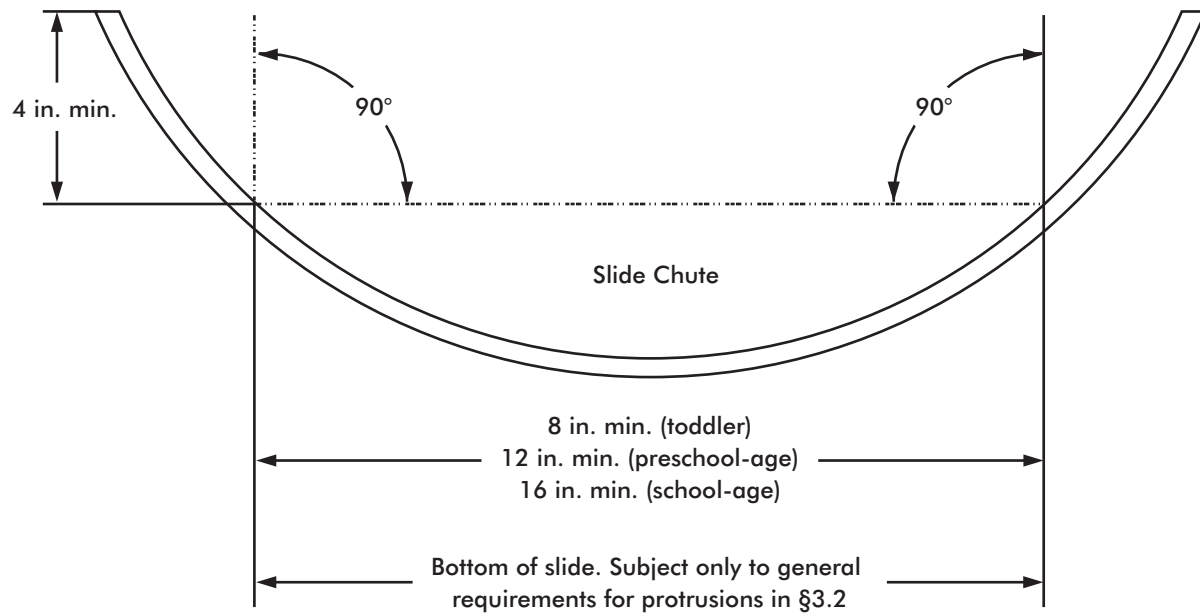


Figure 18. Minimum Side Height for Slide with Circular Cross Section

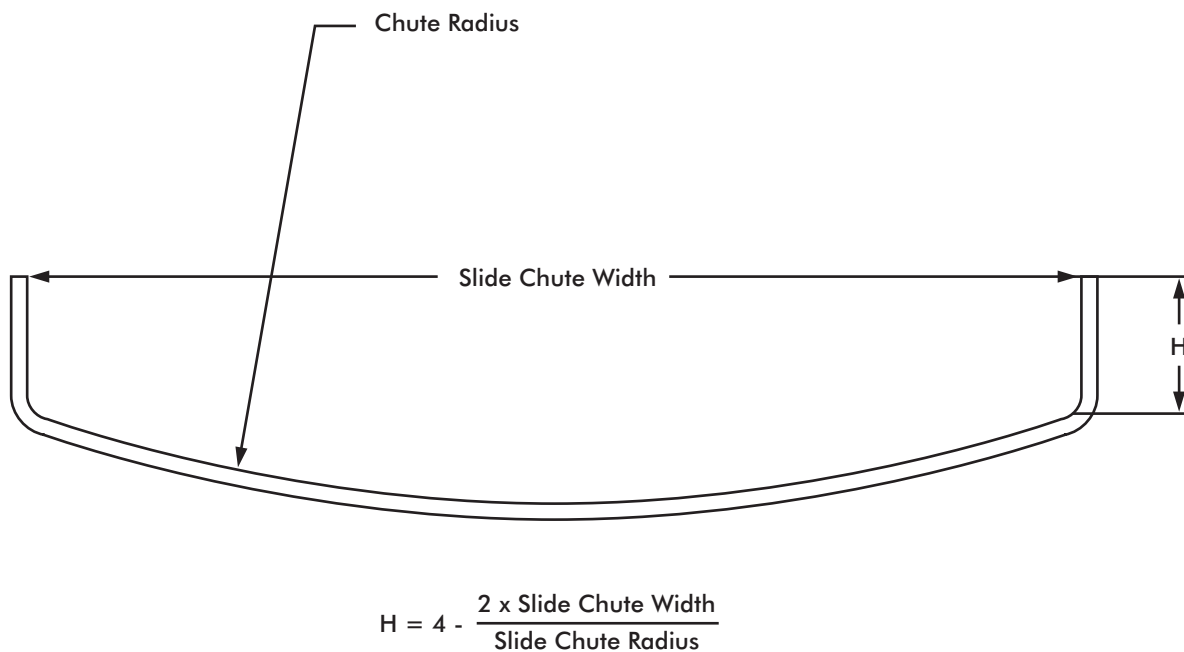


Figure 19. Formula for Minimum Vertical Side Height for Slide with Curved Chute

- For toddlers:
 - The average incline of a slide chute should be no more than 24° (that is, the height to horizontal length ratio shown in Figure 20 does not exceed 0.445).
 - No section of the slide chute should have a slope greater than 30° .
 - The slide chute should be between 8 and 12 inches wide.
- For preschool- and school-age children:
 - The average incline of a slide chute should be no more than 30° (that is, the height to horizontal length ratio shown in Figure 20 does not exceed 0.577).
 - No section of the slide chute should have a slope greater than 50° .

5.3.6.3.5 Tube slides

- Tube slides should meet all the applicable recommendations for other slides (e.g., side height, slope, use zone at exit, etc.).
- Means, such as barriers or textured surfaces, should be provided to prevent sliding or climbing on the top (outside) of the tube.
- The minimum internal diameter of the tube should be no less than 23 inches.
- Supervisors should be aware of children using tube slides since the children are not always visible.

5.3.6.4 Chute exit region

All slides should have an exit region to help children maintain their balance and facilitate a smooth transition from sitting to standing when exiting. The chute exit region should:

- Be between 0 and -4° as measured from a plane parallel to the ground.
- Have edges that are rounded or curved to prevent lacerations or other injuries that could result from impact with a sharp or straight edge.
- For toddlers the chute exit region should:
 - Be between 7 and 10 inches long if any portion of the chute exceeds a 24° slope.
 - Be no more than 6 inches above the protective surfacing.
 - Have a transition from the sliding portion to the exit region with a radius of curvature of at least 18 inches.
- For preschool- and school-age the chute exit region should:
 - Be at least 11 inches long.
 - Be no more than 11 inches above the protective surfacing if the slide is no greater than 4 feet high.
 - Be at least 7 inches but not more than 15 inches above the protective surfacing if the slide is over 4 feet high.

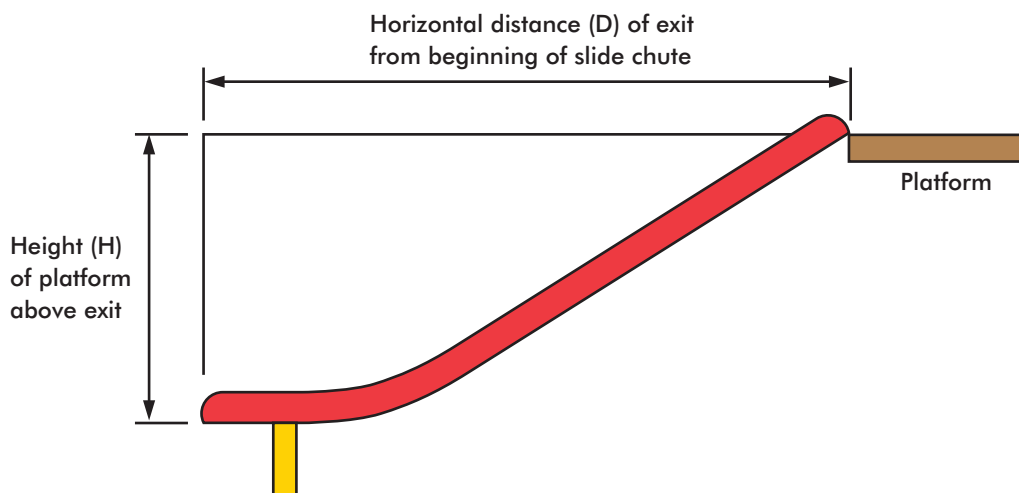


Figure 20. Slide Slope

5.3.6.5 Slide use zone

Toddlers:

- In a limited access environment
 - The use zone should be at least 3 feet around the perimeter of the slide.
 - The area at the end of the slide should not overlap with the use zone for any other equipment.
- In public areas with unlimited access
 - For a stand-alone slide, the use zone should be at least 6 feet around the perimeter.
 - For slides that are part of a composite structure, the minimum use zone between the access components and the side of the slide chute should be 3 feet.
 - The use zone at the end of the slide should be at least 6 feet from the end of the slide and not overlap with the use zone for any other equipment.

Preschool- and school-age (see Figure 21):

- The use zone in front of the access and to the sides of a slide should extend a minimum of 6 feet from the perimeter of the equipment. This recommendation does not apply to embankment slides or slides that are part of a composite structure (see §5.3.9).
- The use zone in front of the exit of a slide should never overlap the use zone of any other equipment; however, two or more slide use zones may overlap if their sliding paths are parallel.
- For slides less than or equal to 6 feet high, the use zone in front of the exit should be at least 6 feet.
- For slides greater than 6 feet high, the use zone in front of the exit should be at least as long as the slide is high up to a maximum of 8 feet.

5.3.6.6 Fall height

The fall height for slides is the distance between the transition platform and the protective surfacing beneath it.

5.3.6.7 Entanglement hazard

Children have suffered serious injuries and died by getting parts of their clothing tangled on protrusions or gaps on slides.

To reduce the chance of clothing entanglement:

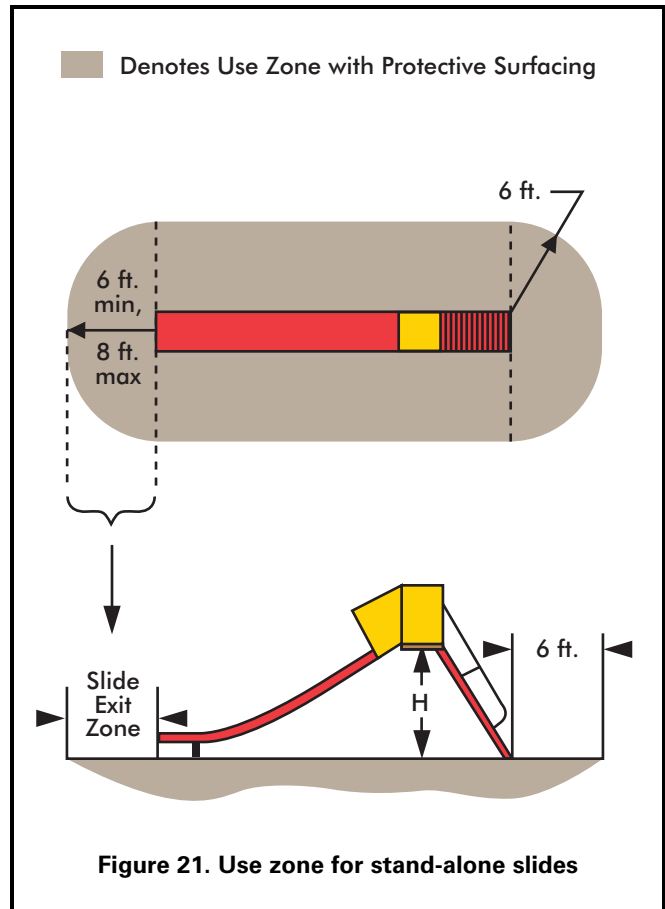


Figure 21. Use zone for stand-alone slides

- Projections up to 3 inches in diameter should not stick up more than 1/8 inch from the slide.
- There should be no gaps at the tops of slides where the slide chute connects with the platform that can entangle clothing or strings.
- See Appendix B for full recommendations and details of the protrusion test procedure.

5.3.6.8 Other sliding equipment

Equipment where it is foreseeable that a primary use of the component is sliding should follow the same guidelines for entanglement that are in 5.3.6.7.

5.3.7 Spring rockers

Toddlers and preschool-age children enjoy the bouncing and rocking activities presented by spring rockers, and they are the primary users of rocking equipment. See Figure 22. Older children may not find it challenging enough.

- Seat design should not allow the rocker to be used by more than the intended number of users.



Figure 22. Example of spring rocker

- For toddlers:
 - The seat should be between 12 and 16 inches high.
 - Spring rockers with opposing seats intended for more than one child should have at least 37 inches between the seat centers.
- For preschoolers:
 - The seat should be between 14 and 28 inches high.
- Each seating position should be equipped with handgrips and footrests. The diameter of handgrips should follow the recommendations for hand gripping components in §5.2.2.
- The springs of rocking equipment should minimize the possibility of children crushing their hands or their feet between coils or between the spring and a part of the rocker.
- The use zone should extend a minimum of 6 feet from the “at rest” perimeter of the equipment.
- The use zone may overlap with neighboring equipment if the other piece of equipment allows overlapping use zones and
 - There is at least 6 feet between equipment when adjacent designated play surfaces are no more than 30 inches high; or

- There is at least 9 feet between equipment when adjacent designated play surfaces are more than 30 inches high; and
- The spring rocker is designed to be used from a seated position.

5.3.7.1 Fall height

The fall height of spring rockers is the distance between either (1) the highest designated playing surface or (2) the seat, whichever is higher, and the protective surfacing beneath it.

5.3.8 Swings

Children of all ages generally enjoy the sensations created while swinging. Mostly they sit on the swings; however, it is common to see children jumping off swings. Younger children also tend to swing on their stomachs, and older children may stand on the seats. To prevent injuries, these behaviors should be discouraged.

Swings may be divided into two distinct types:

- Single axis: Sometimes called a to-fro swing. A single-axis swing is intended to swing back and forth in a single plane and generally consists of a seat supported by at least two suspending members, each of which is connected to a separate pivot on an overhead structure.
- Multi-axis: A multi-axis swing consists of a seat (generally a tire) suspended from a single pivot that permits it to swing in any direction.

5.3.8.1 General swing recommendations

- Hardware used to secure the suspending elements to the swing seat and to the supporting structure should not be removable without the use of tools.
- S-hooks are often part of a swing’s suspension system, either attaching the suspending elements to the overhead support bar or to the swing seat. Open S-hooks can catch a child’s clothing and present a strangulation hazard. S-hooks should be pinched closed. An S-hook is considered closed if there is no gap or space greater than 0.04 inches (about the thickness of a dime).
- Swings should be suspended from support structures that discourage climbing.
- A-frame support structures should not have horizontal cross-bars.

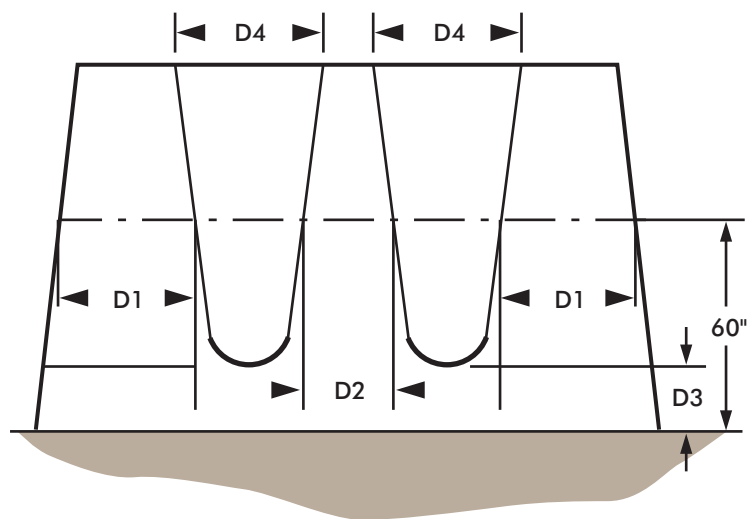


Figure 23. Minimum Clearances for Single-Axis Swings

Table 7. Minimum clearance dimensions for swings

Reason	Dimension	Toddler Full bucket	Preschool-age Belt	School-age Belt
Minimizes collisions between a swing and the supporting structure	D1	20 inches	30 inches	30 inches
Minimizes collisions between swings	D2	20 inches	24 inches	24 inches
Allows access	D3	24 inches	12 inches	12 inches
Reduces side-to-side motion	D4	20 inches	20 inches	20 inches

- Fiber ropes are not recommended as a means of suspending swings since they may degrade over time.
- Swing structures should be located away from other equipment or activities to help prevent young children from inadvertently running into the path of moving swings. Additional protection can be provided by means of a low blockade such as a fence or hedge around the perimeter of the swing area. The blockade should not be an obstacle within the use zone of a swing structure or hamper supervision by blocking visibility.

5.3.8.2 Fall height

The fall height for swings is the vertical distance between the pivot point and the protective surfacing beneath it.

5.3.8.3 Single-axis swings

5.3.8.3.1 Belt seats used without adult assistance

- The use zone to the front and rear of single-axis swings should never overlap the use zone of another piece of equipment.
- To minimize the likelihood of children being struck by a moving swing, it is recommended that no more than two single-axis swings be hung in each bay of the supporting structure.

- Swings should not be attached to composite structures.
- Swing seats should be designed to accommodate no more than one user at any time.
- Lightweight rubber or plastic swing seats are recommended to help reduce the severity of impact injuries. Wood or metal swing seats should be avoided.
- Edges of seats should have smoothly finished or rounded edges and should conform to the protrusion recommendations in 5.3.8.5.
- If loose-fill material is used as a protective surfacing, the height recommendations should be determined after the material has been compressed.
- The full bucket seat materials should not present a strangulation hazard, such as might be presented with a rope or chain used as part of the seat.
- Openings in swing seats should conform to the entrapment criteria in §3.3.
- Full bucket seat swings should be suspended from structures that are separate from those for other swings, or at least suspended from a separate bay of the same structure.
- Full bucket seat swings should not allow the child to enter and exit alone.
- Pivot points should be more than 47 inches but no more than 96 inches above the protective surfacing.

5.3.8.3.2 Full bucket seat swings

Full bucket seat swings are similar to single-axis swings since they move in a to-fro direction. However, full bucket seat swings are intended for children under 4 years of age to use with adult assistance.

- The seats and suspension systems of these swings, including the related hardware, should follow all of the criteria for conventional single axis swings.
- Full bucket seats are recommended to provide support on all sides of a child and between the legs of the occupant (see Figure 24).



Figure 24. Example of full bucket seat swings

5.3.8.3.3 Use zone for single-axis swings – belt and full bucket

The use zone in front of and behind the swing should be greater than to the sides of such a swing since children may deliberately attempt to exit from a single-axis swing while it is in motion. See Figure 25.

- The use zone for a belt swing should extend to the front and rear of a single-axis swing a minimum distance of twice the vertical distance from the pivot point and the top of the protective surface beneath it.
- The use zone for a full bucket swing should extend to the front and rear a minimum of twice the vertical distance from the top of the occupant's sitting surface to the pivot point.
- The use zone in front of and behind swings should never overlap with any other use zone.
- The use zone to the sides of a single-axis swing should extend a minimum of 6 feet from the perimeter of the swing. This 6-foot zone may overlap that of an adjacent swing structure or other playground equipment structure.

5.3.8.4 Multi-axis (tire) swings

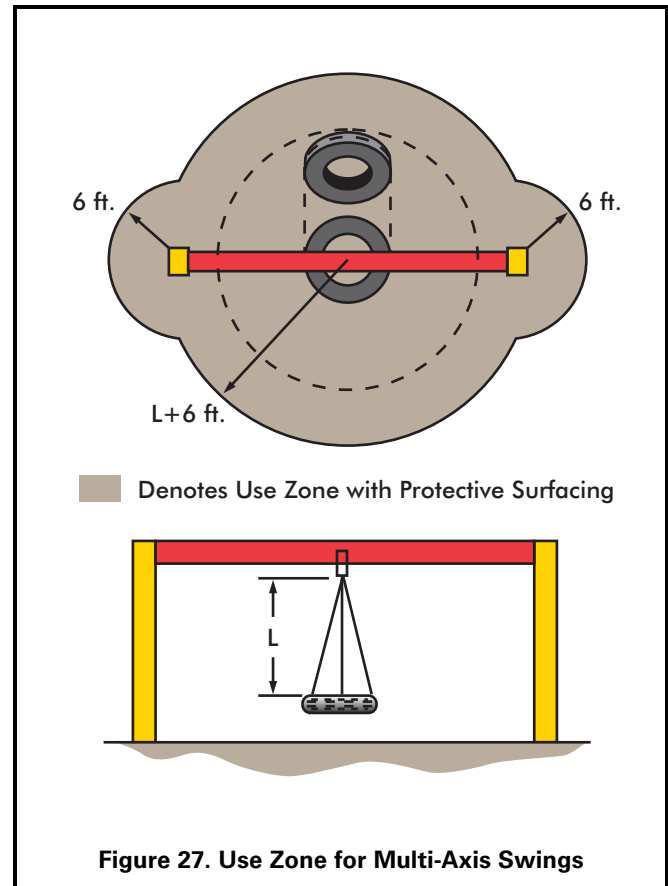
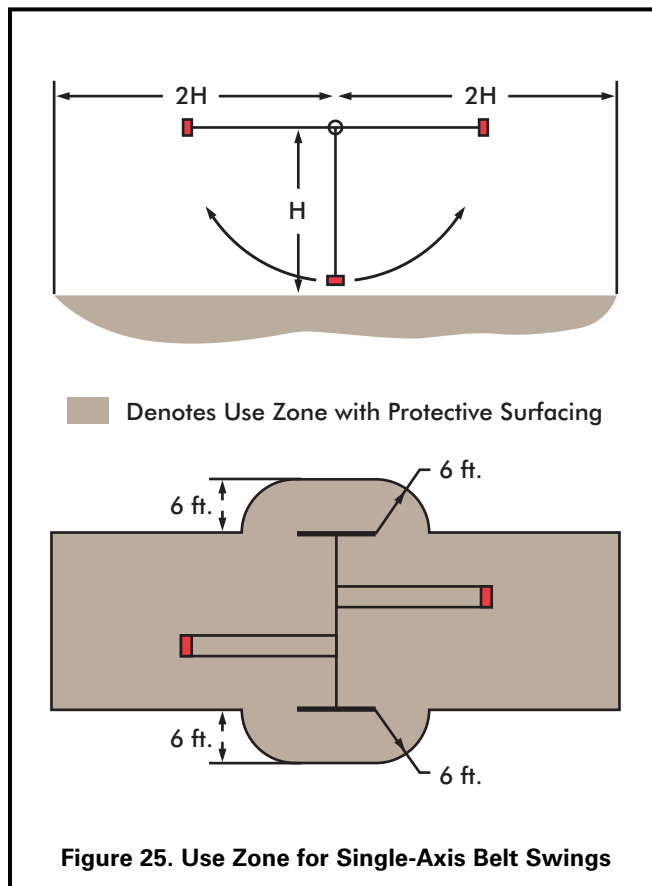
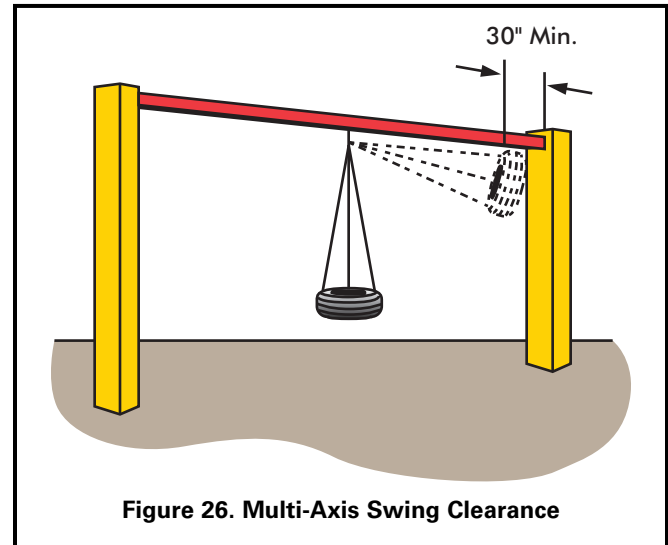
Tire swings are usually suspended in a horizontal orientation using three suspension chains or cables connected to a single swivel mechanism that permits both rotation and swinging motion in any axis.

- A multi-axis tire swing should not be suspended from a structure having other swings in the same bay.
- Attaching multi-axis swings to composite structures is not recommended.

- To minimize the hazard of impact, heavy truck tires should be avoided. Further, if steel-belted radials are used, they should be closely examined to ensure that there are no exposed steel belts or wires that could be a potential protrusion or laceration hazard. Plastic materials can be used as an alternative to simulate actual automobile tires. Drainage holes should be provided in the underside of the tire.
- Pay special attention to maintenance of the hanger mechanism because the likelihood of failure is higher for tire swings due to the added stress of rotational movement and multiple occupants.
- The hanger mechanisms for multi-axis tire swings should not have any accessible crush points.
- The minimum clearance between the seating surface of a tire swing and the uprights of the supporting structure should be 30 inches when the tire is in a position closest to the support structure (Figure 26).
- The minimum clearance between the bottom of the seat and the protective surface should not be less than 12 inches.

5.3.8.4.1 Multi-axis swing use zones

- The use zone should extend in any direction from a point directly beneath the pivot point for a minimum distance of 6 feet plus the length of the suspending members (see Figure 27). This use zone should never overlap the use zone of any other equipment.



- The use zone should extend a minimum of 6 feet from the perimeter of the supporting structure. This 6-foot zone may overlap that of an adjacent swing structure or other playground equipment structure.

5.3.8.5 Protrusions on suspended members of swing assemblies

Protrusions on swings are extremely hazardous because of the potential for impact incidents. Nothing, including bolts or other parts, on the front, back, or underside of a swing should stick out more than 1/8 of an inch. See test procedures in Appendix B.

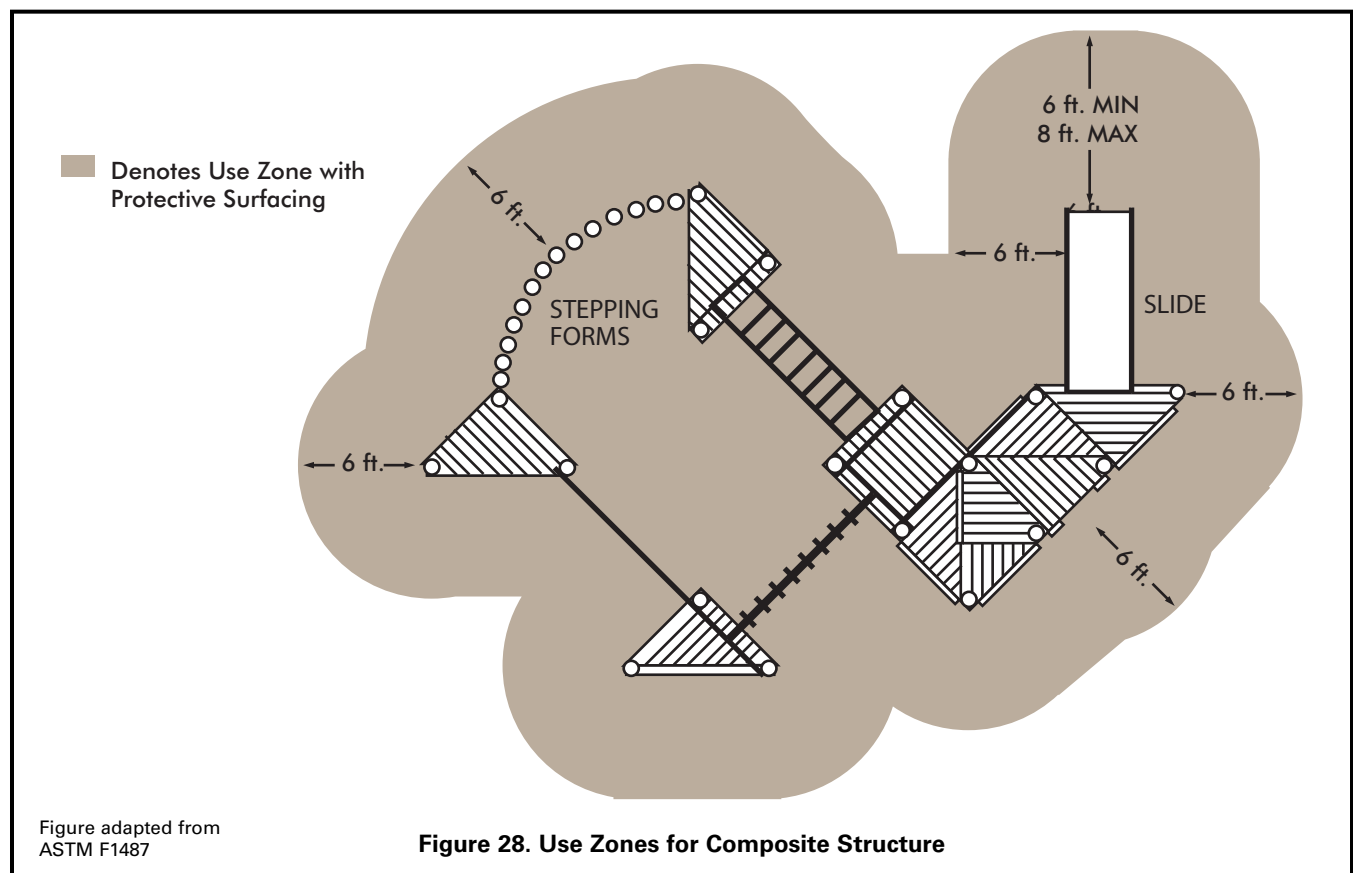
5.3.9 Fall height and use zones for composite structure

When two or more complementary play components are linked together in a composite structure (e.g., combination climber, slide, and horizontal ladder), the use zone should extend a minimum of 6 feet from the external perimeter of the structure (see Figure 28). Where slides are attached to a platform higher than 6 feet from the protective surfacing, the use zone may need to extend further in front of the slide (see §5.3.6.5).

5.3.10 Fall height and use zones not specified elsewhere

Most playground equipment belongs in one of the categories listed above. If it does not, the following general recommendations should be applied:

- The fall height of a piece of playground equipment is the distance between the highest designated playing surface and the protective surface beneath it.
- The use zone should extend a minimum of 6 feet in all directions from the perimeter of the equipment.
- The use zones of two stationary pieces of playground equipment that are positioned adjacent to one another may overlap if the adjacent designated play surfaces of each structure are no more than 30 inches above the protective surface and the equipment is at least 6 feet apart.
- If adjacent designated play surfaces on either structure exceed a height of 30 inches, the minimum distance between the structures should be 9 feet.
- Use zones should be free of obstacles.



APPENDIX A: SUGGESTED GENERAL MAINTENANCE CHECKLISTS

Surfacing (§2.4)

- ☐ Adequate protective surfacing under and around the equipment.
 - ☐ Install/replace surfacing
- ☐ Surfacing materials have not deteriorated.
 - ☐ Replace surfacing
 - ☐ Other maintenance: _____
- ☐ Loose-fill surfacing materials have no foreign objects or debris.
 - ☐ Remove trash and debris
- ☐ Loose-fill surfacing materials are not compacted.
 - ☐ Rake and fluff surfacing
- ☐ Loose-fill surfacing materials have not been displaced under heavy use areas such as under swings or at slide exits.
 - ☐ Rake and fluff surfacing

Drainage (§2.4)

- ☐ The entire play area has satisfactory drainage, especially in heavy use areas such as under swings and at slide exits.
 - ☐ Improve drainage
 - ☐ Other maintenance: _____

General Hazards

- ☐ There are no sharp points, corners or edges on the equipment (§3.4).
- ☐ There are no missing or damaged protective caps or plugs (§3.4).
- ☐ There are no hazardous protrusions (§3.2 and Appendix B).
- ☐ There are no potential clothing entanglement hazards, such as open S-hooks or protruding bolts (§2.5.2, §3.2, §5.3.8.1 and Appendix B).
- ☐ There are no crush and shearing points on exposed moving parts (§3.1).
- ☐ There are no trip hazards, such as exposed footings or anchoring devices and rocks, roots, or any other obstacles in a use zone (§3.6).

Security of Hardware (§2.5)

- ☐ There are no loose fastening devices or worn connections.
 - ☐ Replace fasteners
 - ☐ Other maintenance: _____
- ☐ Moving parts, such as swing hangers, merry-go-round bearings, and track rides, are not worn.
 - ☐ Replace part
 - ☐ Other maintenance: _____

Durability of Equipment (§2.5)

- ☐ There are no rust, rot, cracks, or splinters on any equipment (check carefully where it comes in contact with the ground).
- ☐ There are no broken or missing components on the equipment (e.g., handrails, guardrails, protective barriers, steps, or rungs).
- ☐ There are no damaged fences, benches, or signs on the playground.
- ☐ All equipment is securely anchored.

Leaded Paint (§2.5.4)

- ☐ Paint (especially lead paint) is not peeling, cracking, chipping, or chalking.
- ☐ There are no areas of visible leaded paint chips or accumulation of lead dust.
 - ☐ Mitigate lead paint hazards

General Upkeep of Playgrounds (§4)

- ☐ There are no user modifications to the equipment, such as strings and ropes tied to equipment, swings looped over top rails, etc.
 - ☐ Remove string or rope
 - ☐ Correct other modification
- ☐ The entire playground is free from debris or litter such as tree branches, soda cans, bottles, glass, etc.
 - ☐ Clean playground
- ☐ There are no missing trash receptacles.
 - ☐ Replace trash receptacle
- ☐ Trash receptacles are not full.
 - ☐ Empty trash

NOTES:

DATE OF INSPECTION:

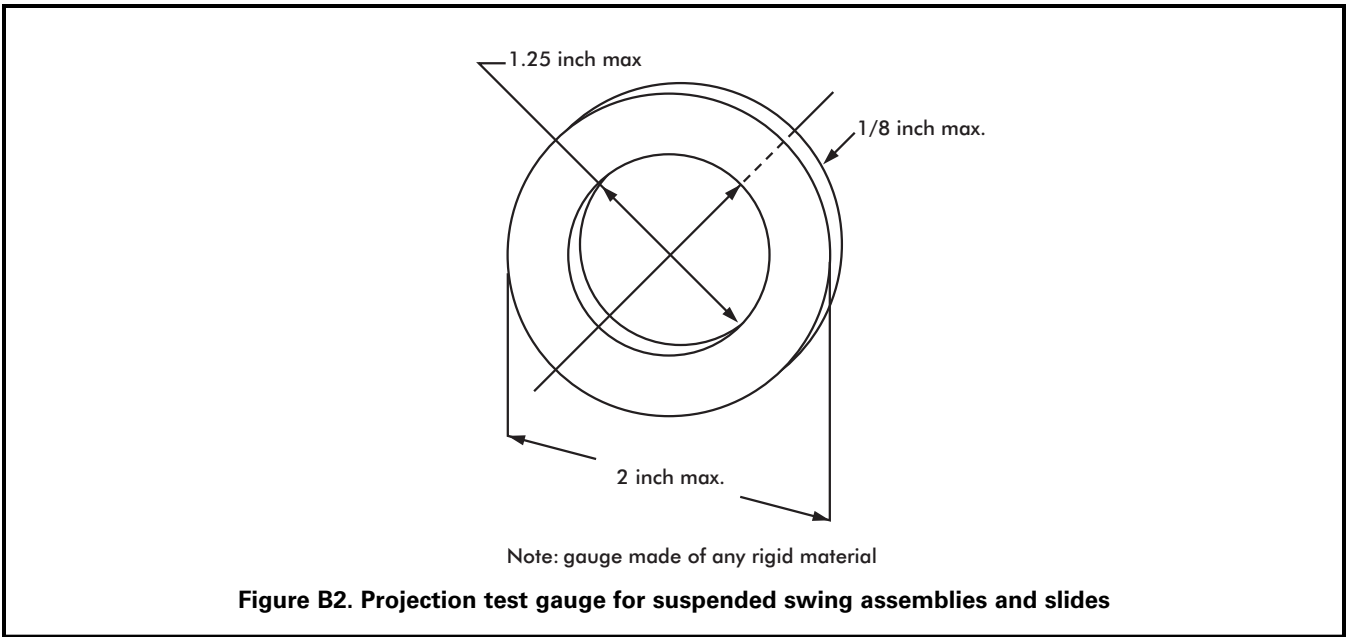
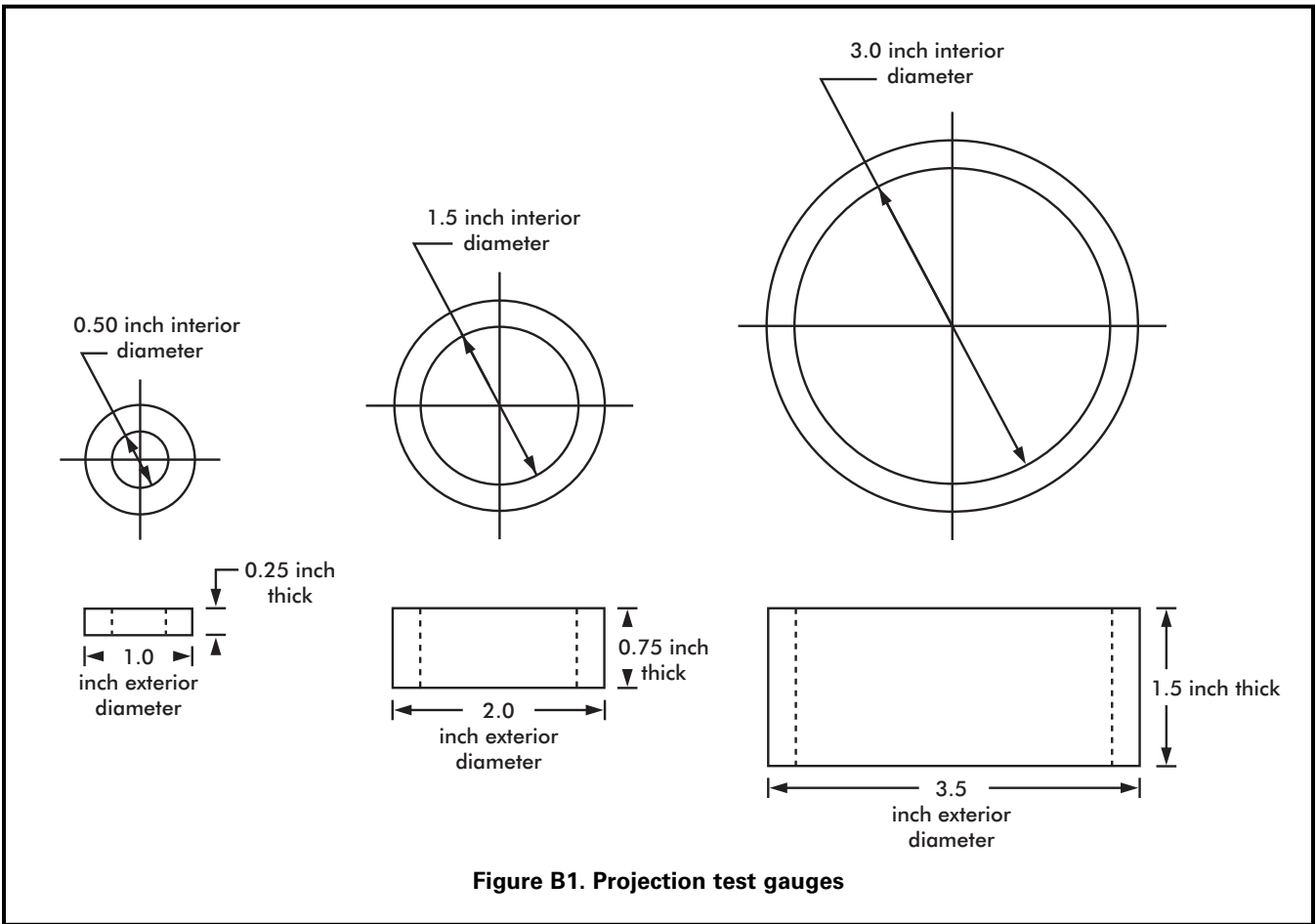
INSPECTION BY:

Routine Inspection and Maintenance Issues

- ☐ Broken equipment such as loose bolts, missing end caps, cracks, etc.
- ☐ Broken glass & other trash
- ☐ Cracks in plastics
- ☐ Loose anchoring
- ☐ Hazardous or dangerous debris
- ☐ Insect damage
- ☐ Problems with surfacing
- ☐ Displaced loose-fill surfacing (see Section 4.3)
- ☐ Holes, flakes, and/or buckling of unitary surfacing
- ☐ User modifications (such as ropes tied to parts or equipment rearranged)
- ☐ Vandalism
- ☐ Worn, loose, damaged, or missing parts
- ☐ Wood splitting
- ☐ Rusted or corroded metals
- ☐ Rot

APPENDIX B: PLAYGROUND TESTING

B.1 Templates, Gauges, and Testing Tools



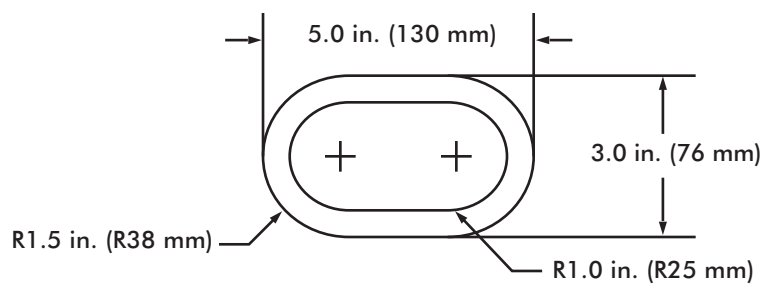


Figure B3. Toddler small torso template

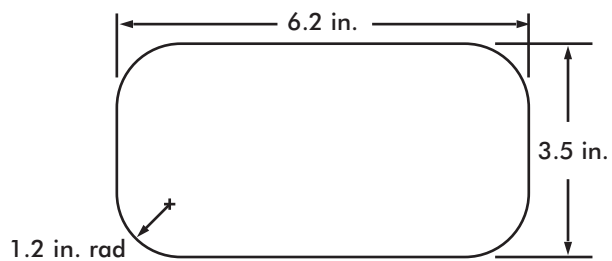


Figure B4. Preschool- and school-age small torso template

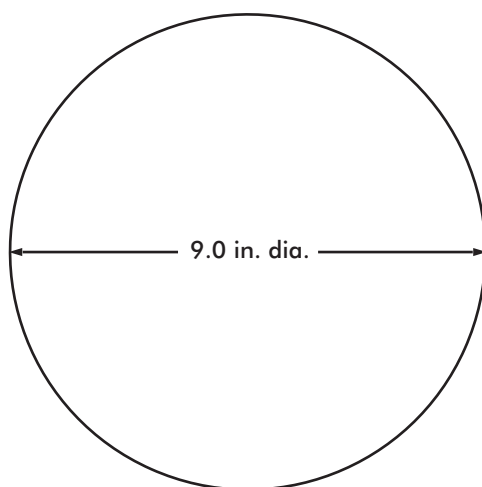
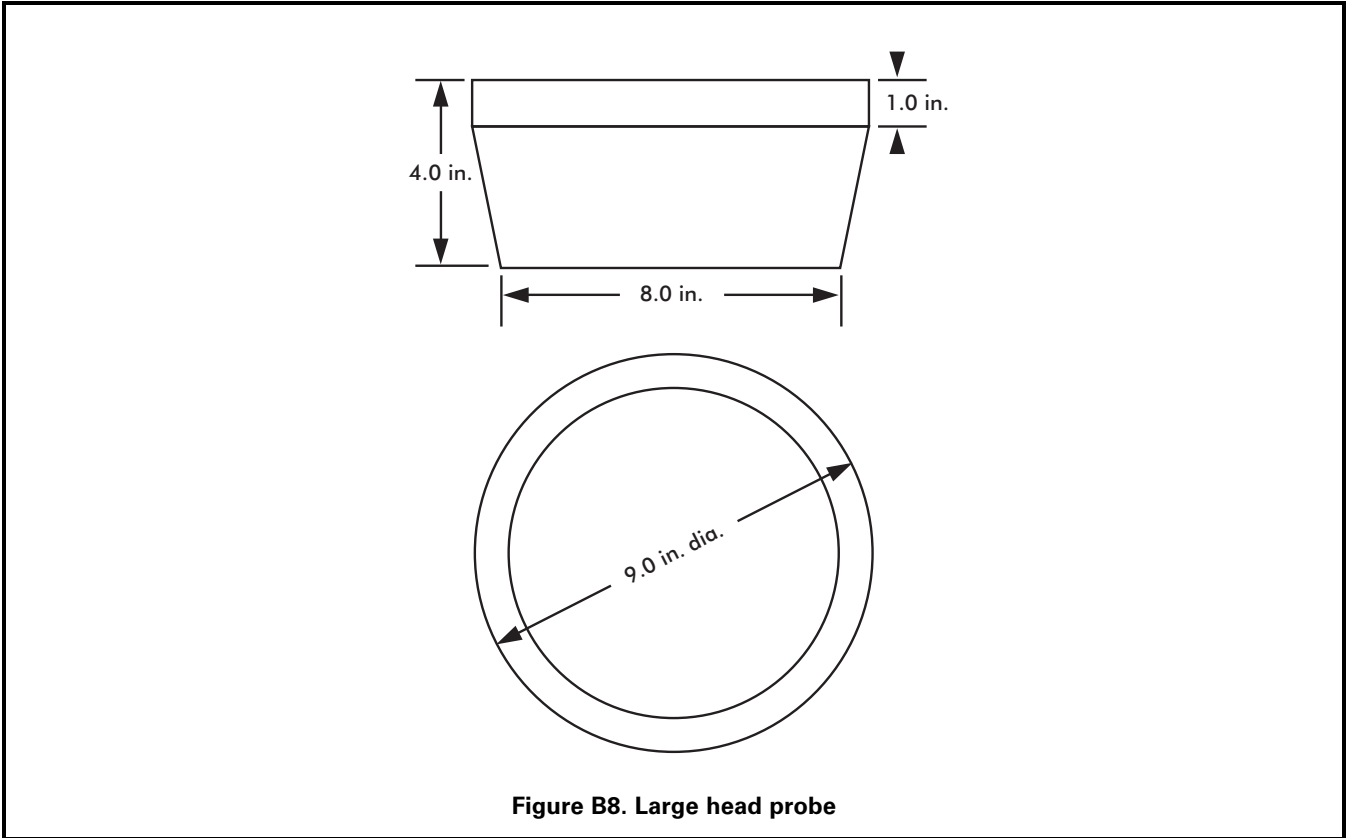
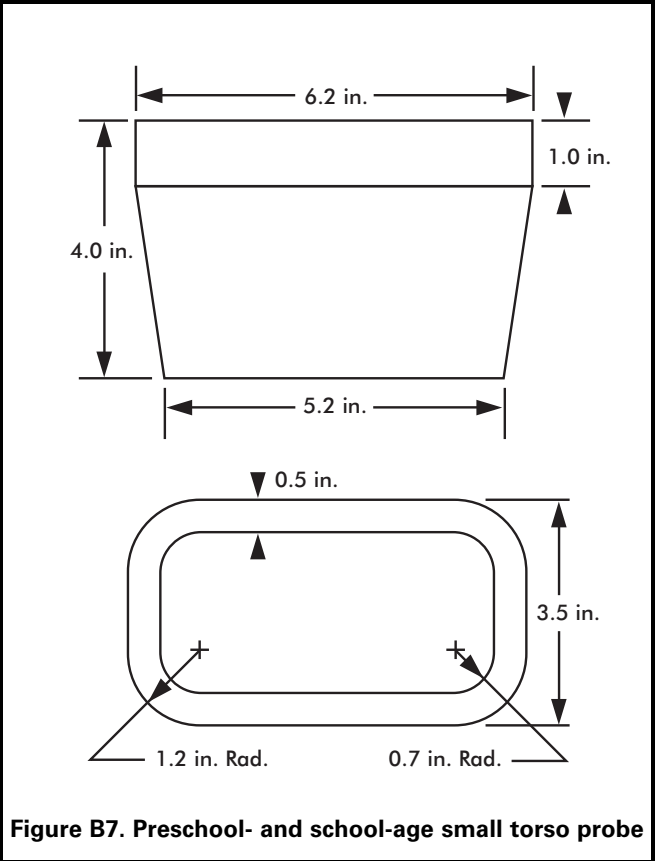
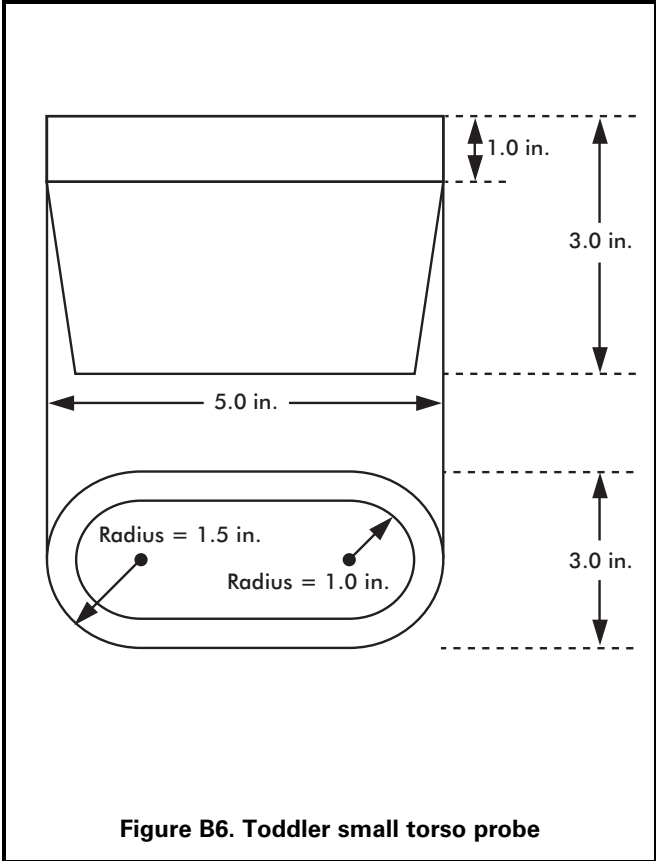


Figure B5. Large head template



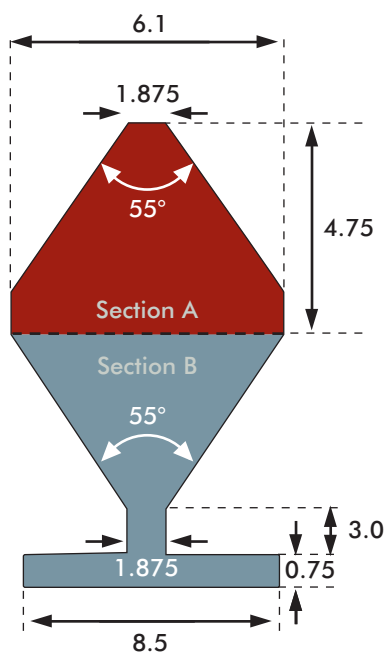


Figure B9. Preschool/School-age partially bound probe (dimensions in inches, template is 0.75 inches thick)

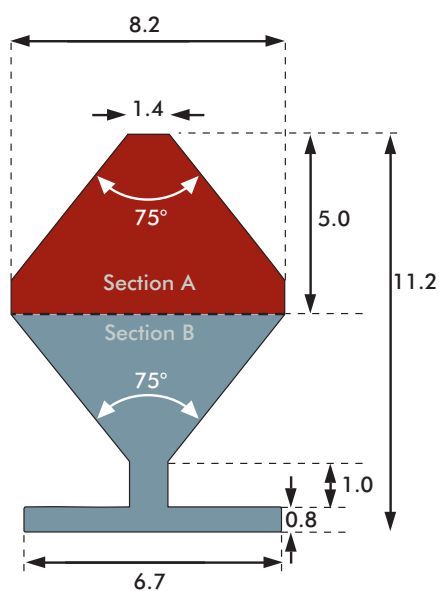


Figure B10. Toddler partially bound probe (dimensions in inches, template is 0.60 inches thick)

APPENDIX B: PLAYGROUND TESTING

B.2 Test Methods

B.2.1 Determining whether a projection is a protrusion

B.2.1.1 Test procedure

- Step 1: Successively place each projection test gauge (see Figure B1) over any projection
- Step 2: Visually determine if the projection penetrates through the hole and beyond the face of the gauge (see Figure B11 below).
- Pass:** A projection that does not extend beyond the face of the gauge passes.
- Fail:** A projection that extends beyond the face of any one of the gauges is considered a hazardous protrusion and should be eliminated.

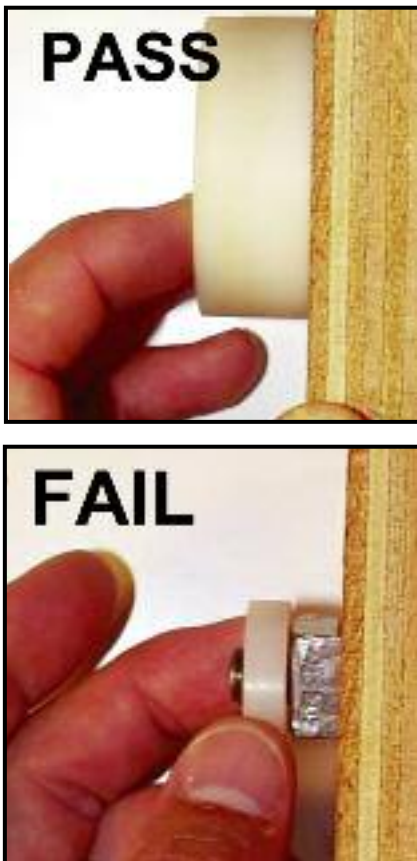


Figure B11. Determining whether a projection is a protrusion

B.2.2 Projections on suspended members of swing assemblies

Given the potential for impact incidents, projections on swings can be extremely hazardous. A special test gauge (see Figure B2) and procedure are recommended. When tested, no bolts or components in the potential impact region on suspended members should extend through the hole beyond the face of the gauge.

B.2.2.1 Test procedure

- Step 1: Hold the gauge (Figure B2) vertically with the axis through the hole parallel to the swing's path of travel.
- Step 2: Place the gauge over any projections that are exposed during the swing's path of travel.
- Step 3: Visually determine if the projection penetrates through the hole and beyond the face of the gauge.

Pass: A projection that does not extend beyond the face of the gauge passes.

Fail: A projection that extends beyond the face of the gauge is considered a hazardous protrusion and should be eliminated.

B.2.3 Projections on slides

To minimize the likelihood of clothing entanglement on slides, projections that (1) fit within any one of the three gauges shown in Figure B1 and (2) have a major axis that projects away from the slide bed should not have projections greater than 1/8 inch perpendicular to the plane of the surrounding surface (Figure B12).

B.2.3.1 Test procedure

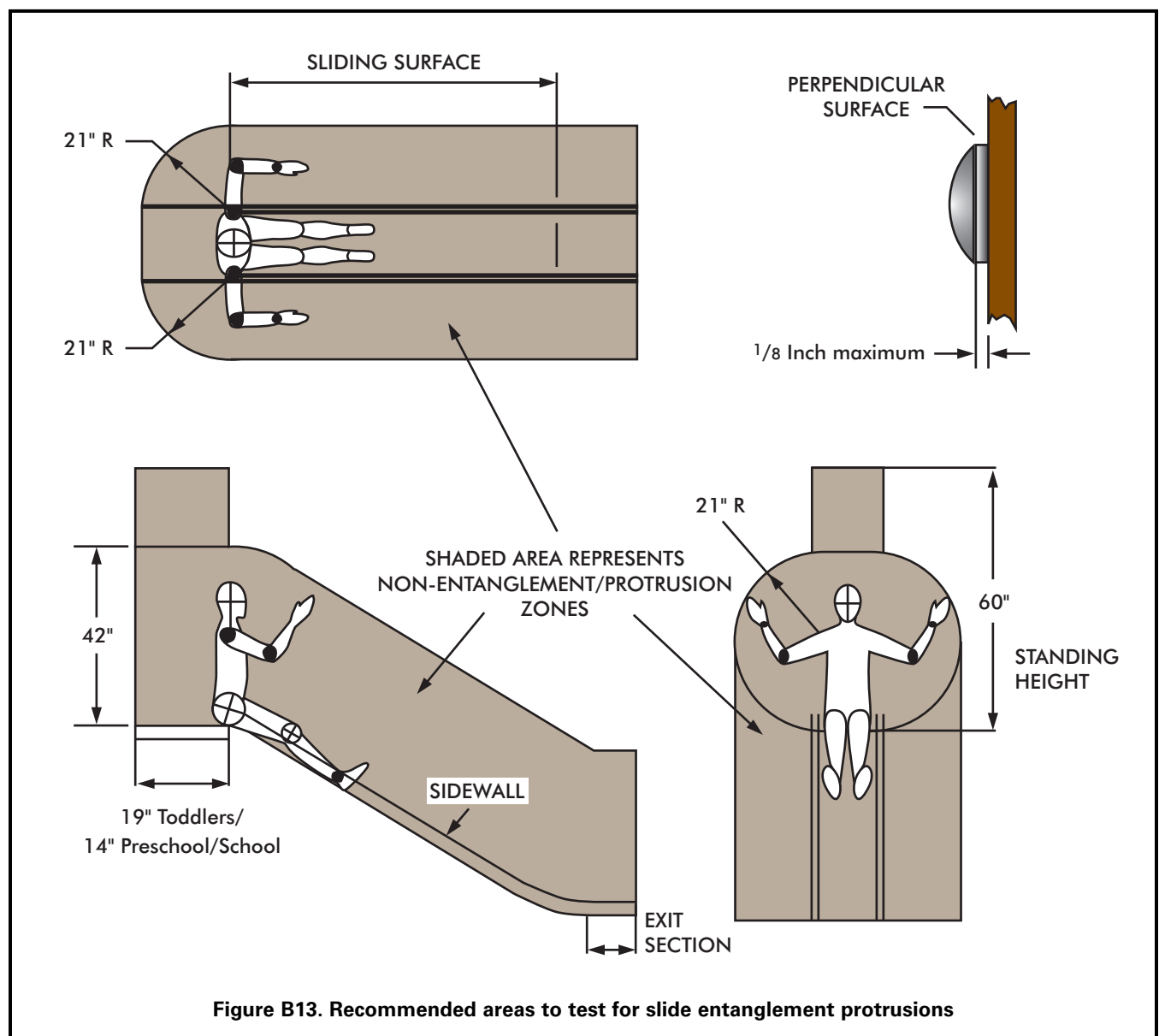
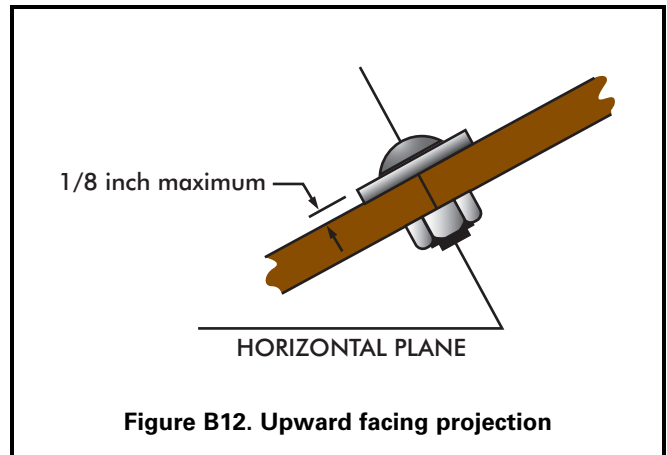
- Step 1: Identify all projections within the shaded area shown in Figure B13.
- Step 2: Determine which, if any, fit inside the projection test gauges (Figure B1).
- Step 3: Place the swing and slide projection gauge (Figure B2) next to the projection to check the height of the projection.

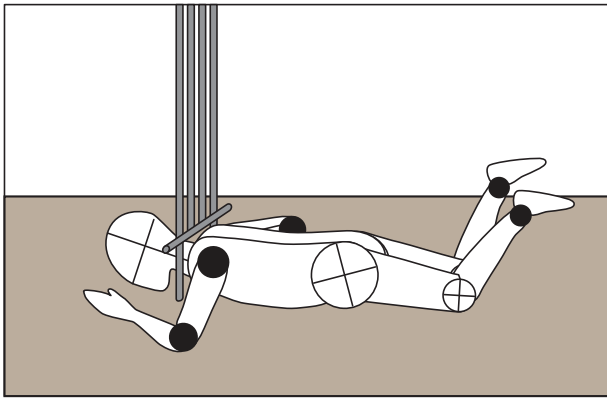
Step 4: Visually determine if the projection extends beyond the face of the slide projection gauge.

Pass: A projection that does not extend beyond the face of the gauge passes.

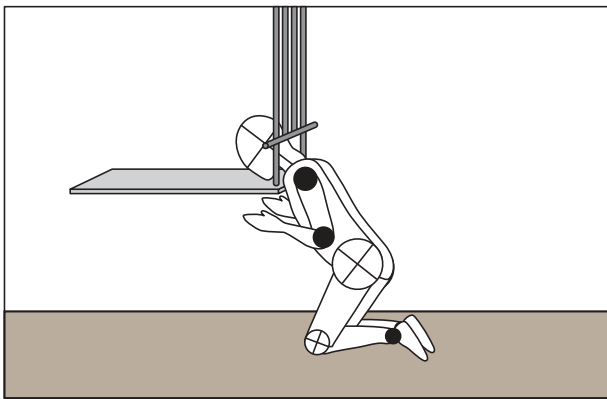
Fail: A projection that extends beyond the face of the gauge is considered a hazardous protrusion and should be eliminated.

NOTE: This test procedure is not applicable to the underside of a slide chute. For a slide chute with a circular cross section, the portion of the underside not subject to this projection recommendation is shown in Figure 18. The general recommendations for projections in §B.2.1 are applicable to the underside of the slide.

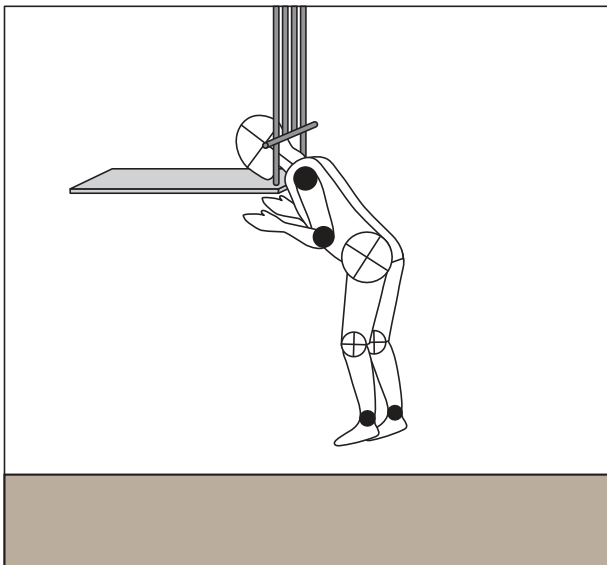




Ground-bounded: Not subject to entrapment recommendations.



Low entrapment



High entrapment

Figure B14. Examples of completely bounded openings

B.2.4 Entrapment

B.2.4.1 General

Any completely-bounded opening (Figure B14) that is not bounded by the ground may be a potential head entrapment hazard. Even those openings which are low enough to permit a child's feet to touch the ground present a risk of strangulation to an entrapped child, because younger children may not have the necessary intellectual ability and motor skills to withdraw their heads, especially if scared or panicked. An opening may present an entrapment hazard if the distance between any interior opposing surfaces is greater than 3.5 inches and less than 9 inches. If one dimension of an opening is within this potentially hazardous range, all dimensions of the opening should be considered together to fully evaluate the possibility of entrapment. The most appropriate method to determine whether an opening is hazardous is to test it using the following fixtures, methods, and performance criteria.

These recommendations apply to all playground equipment, i.e., toddler, preschool-age, and school-age children. Fixed equipment as well as moving equipment (in its stationary position) should be tested for entrapment hazards. There are two special cases for which separate procedures are given: (1) completely-bounded openings where depth of penetration is a critical issue (see Figure B15) and (2) openings formed by flexible climbing components.

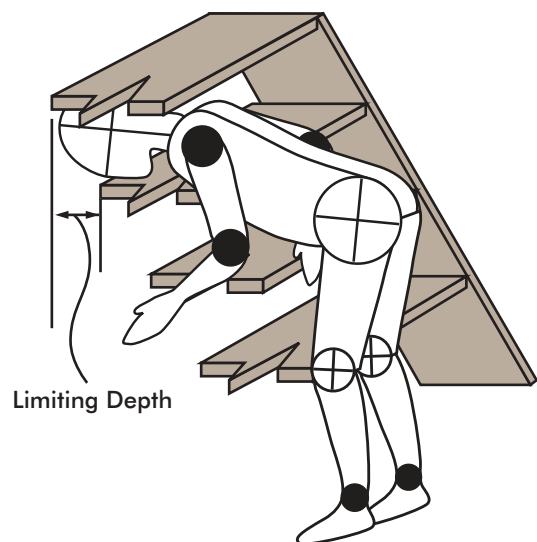


Figure B15. Completely bounded opening with limited depth

B.2.5 Test fixtures

Two templates are required to determine if completely bounded openings in rigid structures present an entrapment hazard. These templates can easily be fabricated from cardboard, plywood, or sheet metal.

B.2.5.1 Small torso template

The dimensions (see Figure B3 and Figure B4) of this template are based on the size of the torso of the smallest user at risk (5th percentile 6-month-old child for Figure B3 and 2-year-old child for Figure B4). If an opening is too small to admit the template, it is also too small to permit feet first entry by a child. Because children's heads are larger than their torsos, an opening that does not admit the small torso template will also prevent head first entry into an opening by a child.

B.2.5.2 Large head template

The dimensions (see Figure B5) of this template are based on the largest dimension on the head of the largest child at risk (95th percentile 5-year-old child). If an opening is large enough to permit free passage of the template, it is large enough to permit free passage of the head of the largest child at risk in any orientation. Openings large enough to permit free passage of the large head template will not entrap the chest of the largest child at risk.

B.2.5.3 Completely bounded openings with unlimited depth

B.2.5.3.1 Test procedure

- Step 1: Select the appropriate small torso template based on the intended users of the playground (Figure B3 for toddler playgrounds, Figure B4 for preschool- and school-age playgrounds).
- Step 2: Identify all completely bounded openings.
- Step 3: Attempt to place the small torso template in the opening with the plane of the template parallel to the plane of the opening. While keeping it parallel to the plane of the opening, the template should be rotated to its most adverse orientation (i.e., major axis of template oriented parallel to the major axis of the opening.)

- Step 4: Determine if the small torso template can freely pass through the opening.

No: **Pass.** Stop

Yes: Continue



- Step 5: Place the large head template in the opening, again with the plane of the template parallel to the plane of the opening, and try to insert it through the opening.

Pass: The large head template can be freely inserted through the opening

Fail: The opening admits the small torso template but does not admit the large head template.



B.2.5.4 Completely bounded openings with limited depth of penetration

The configuration of some openings may be such that the depth of penetration is a critical issue for determining the entrapment potential. For example, consider a vertical wall or some other barrier behind a step ladder. The entrapment potential depends not only on the dimensions of the opening between adjacent steps but also on the horizontal space between the lower boundary of the opening and the barrier. A child may enter the opening between adjacent steps feet first and may proceed to pass through the space between the rear of the lower step and the barrier and become entrapped when the child's head is unable to pass through either of these two openings. In effect, there are openings in two different planes, and each has the potential for head entrapment and should be tested.

Figure B16 illustrates these two planes for a step ladder as well as for a generic opening. Plane A is the plane of the completely bounded opening in question, and Plane B is the plane of the opening encompassing the horizontal space between the lower boundary of the opening in Plane A and the barrier that should also be tested for entrapment hazards.

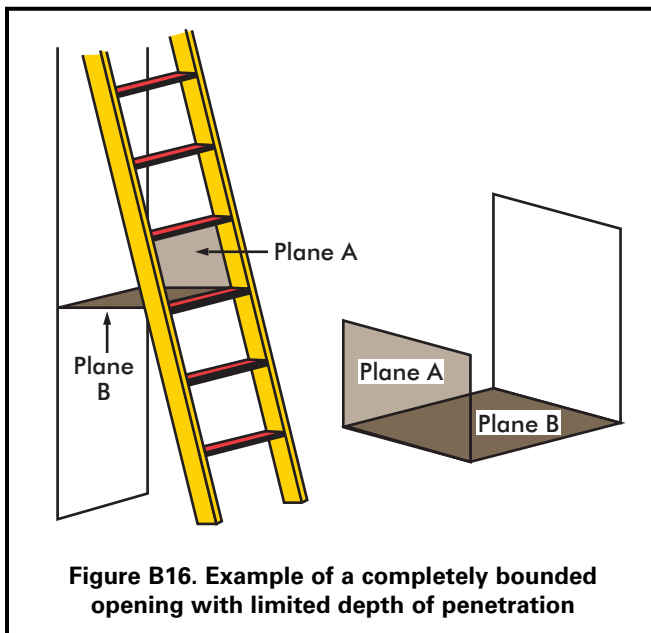


Figure B16. Example of a completely bounded opening with limited depth of penetration

B.2.5.4.1 Test procedure

Step 1: Select the appropriate small torso template based on the intended users of the playground (Figure B3 for toddler playgrounds, Figure B4 for preschool-age and school-age playgrounds).

Step 2: Identify all completely bounded openings with limited depth of penetration.

Step 3: Place the small torso template in the opening in Plane A with its plane parallel to Plane A; rotate the template to its most adverse orientation with respect to the opening while keeping it parallel to Plane A.

Step 4: Determine if the opening in Plane A admits the small torso template in any orientation when rotated about its own axis.

No: Pass. The opening is small enough to prevent either head first or feet first entry by the smallest user at risk and is not an entrapment hazard.

Yes: Continue.

Step 5: Place the small torso template in the opening in Plane B with its plane parallel to Plane B; rotate the template to its most adverse orientation with respect to the opening while keeping it parallel to Plane B.

Step 6: Determine if the opening in Plane B admits the small torso template.

No: Pass. The depth of penetration into the opening in Plane A is insufficient to result in entrapment of the smallest user at risk.

Yes: Continue.

Step 7: Place the large head template (Figure B5) in the opening in Plane A with its plane parallel to Plane A. Determine if the opening in Plane A admits the large head template.

No: Fail. A child, whose torso can enter the opening in Plane A as well as the opening in Plane B, may become entrapped by the head in the opening in Plane A.

Yes: Continue.

Step 8: With the plane of the large head template parallel to the opening in Plane B, determine if the opening in Plane B admits the large head template.

No: Fail. The largest user at risk cannot exit the opening in Plane B.

Yes: Pass. The openings in Plane A and Plane B do not pose an entrapment risk.

B.2.5.5 Flexible openings

Climbing components such as flexible nets are also a special case for the entrapment tests because the size and shape of openings on this equipment can be altered when force is applied, either intentionally or simply when a child climbs on or falls through the openings. Children are then potentially at risk of entrapment in these distorted openings.

The procedure for determining conformance to the entrapment recommendations for flexible openings requires two three-dimensional test probes which are illustrated in Figure B6, Figure B7, and Figure B8 are applied to an opening in a flexible component with a force of up to 50 pounds.

B.2.5.5.1 Test procedure

- Step 1: Select the appropriate small torso template based on the intended users of the playground (Figure B3 for toddler playgrounds, Figure B4 for preschool-age and school-age playgrounds).
- Step 2: Identify all completely bounded openings with flexible sides.
- Step 3: Place the small torso probes (Figures B6 and B7) in the opening, tapered end first, with the plane of its base parallel to the plane of the opening.
- Step 4: Rotate the probe to its most adverse orientation (major axis of probe parallel to major axis of opening) while keeping the base parallel to the plane of the opening.
- Step 5: Determine if the probe can be pushed or pulled completely through the opening by a force no greater than 30 pounds on toddler playgrounds or 50 pounds on preschool-age and school-age playgrounds.

No: Pass. Stop

Yes: Continue.



Step 6: Place the large head probe (Figure B8) in the opening with the plane of its base parallel to the plane of the opening.

Step 7: Determine if the large head probe can be pushed or pulled completely through the opening by a force no greater than 30 pounds on toddler playgrounds or 50 pounds on preschool-age and school-age playgrounds.

Yes: Pass. Stop.



No: Fail.



B.2.5.6 Partially bound openings

A partially bound opening is any opening which has at least one side or portion open, such as a U- or V-shaped opening. These openings can still pose an entrapment hazard by allowing the neck to enter but not allowing the head to slip out. A partially bound opening can be any part of the playground equipment where a child could get his or her neck caught, so it includes not only two- or three-sided openings, but also areas of large openings (large enough for the head template to enter) that have the characteristics that can entrap a child's neck. Several examples outlines of this situation are shown in the figures below. Openings that have an outline similar to these figures are often found when two parts of a playground meet, for example, the top of a slide and the side of a guardrail.

Identifying partially bound openings varies depending on the age range of the playground. Openings that should be tested include any opening where:

For toddlers:

- The perimeter of the opening is not closed
- The lowest leg of the opening is tilted upward (i.e. above horizontal) or 45 degrees below horizontal.

For preschool- and school-age:

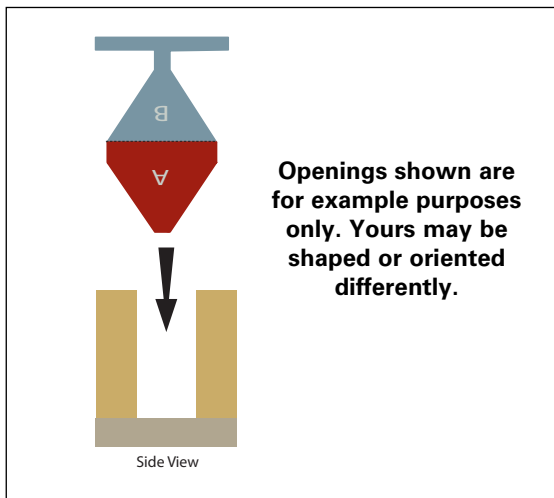
- The perimeter of the opening is not closed
- The lowest leg of the opening is tilted upward (i.e. above horizontal)



Examples of partially bound openings. Note, these examples are intended to illustrate the principle of partially bound openings and may or may not require testing.

B.2.5.6.1 Test procedure

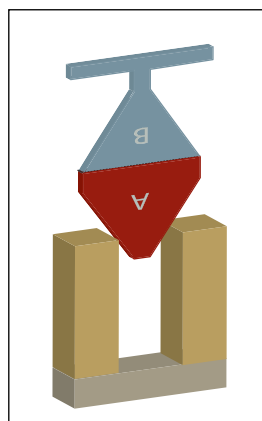
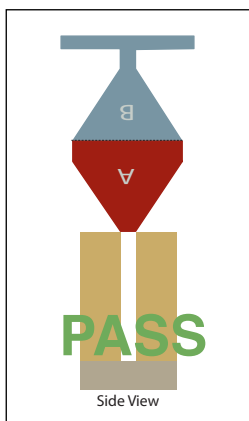
- Step 1: Select the appropriate Partially Bound Template based on the intended users of the playground (Figure B10 for toddler playgrounds, Figure B9 for preschool and school-age playground).
- Step 2: Identify partially bound openings.
- Step 3: Align the template so that the face of the template is parallel to the plane of the opening and the narrow tip of the A section is pointing toward the opening.



- Step 4: Insert the A portion of the template into the opening following the centerline of the opening.
- Step 5: Once inserted as far as possible, determine if there is simultaneous contact between the sides of the opening and both of the top corners at the narrow tip of section A.

Yes: Pass. Stop

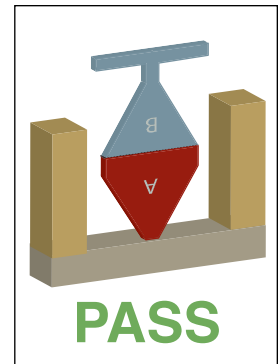
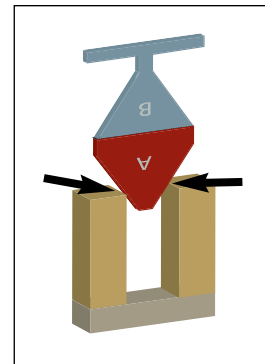
No: continue



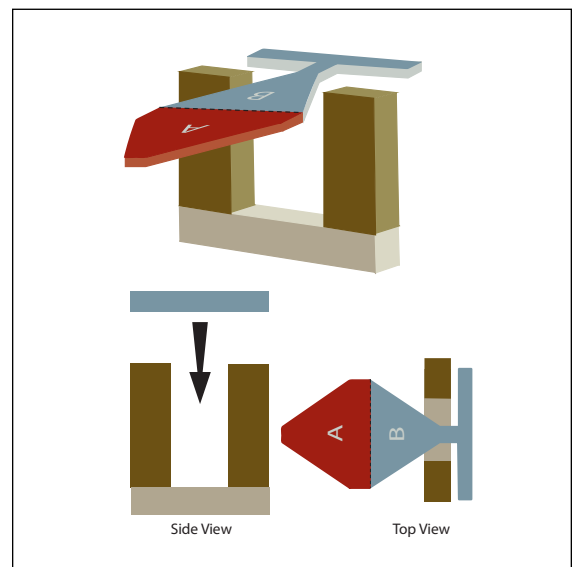
- Step 6: While still inserted as far as possible, determine if there is simultaneous contact between both of the angled sides of section A and the sides of the opening.

Yes: Note the points on the sides of opening where contact was made and continue

No: Pass. The narrow tip should be resting on the lower boundary of the opening with no contact with the sides of the opening. Stop



- Step 7: Remove the template and turn the template so that the face of the template is perpendicular to the opening.
- Step 8: Following the plane of the opening, insert the B portion of the template into the opening so that the narrow part of the B portion is between the sides of the opening.

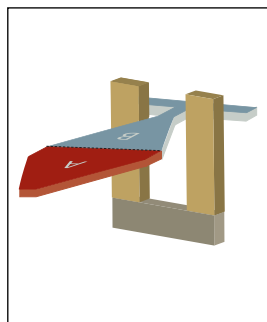
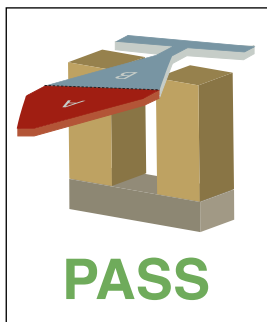


Step 9: Once inserted as far as possible, determine if the B portion is completely past the points where contact was made on the sides of the opening with the A portion.

No: Pass. Stop

Yes: Toddlers:
Fail. Stop

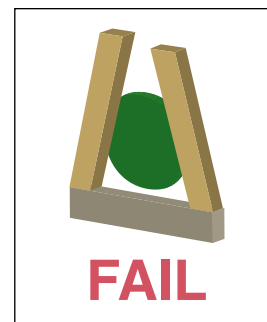
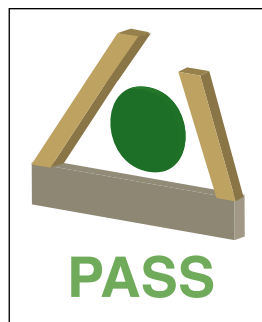
Preschool and
School-age:
Continue



Step 11: Determine if the Large Head Template passes freely through the larger opening.

Yes: Pass

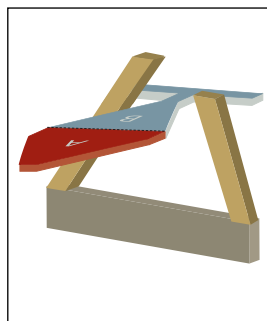
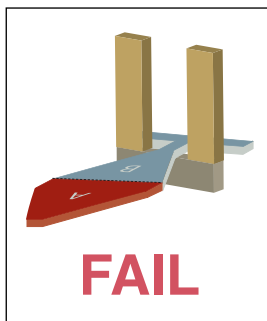
No: Fail



Step 10: Determine if the B portion can reach a point where the opening increases in size.

No: Fail. Stop

Yes: continue



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Manual de Seguridad para Parques Infantiles Públicos



Comisión para la Seguridad de los Productos de Consumo de EE.UU.
Salvando vidas y manteniendo a las familias seguras



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1. INTRODUCCIÓN

Se estima que en años recientes se han registrado anualmente más de 200,000 lesiones en parques infantiles de toda la nación que requirieron tratamiento en salas de urgencia. Siguiendo las recomendaciones incluidas en este manual, usted y su comunidad pueden crear un entorno más seguro para todos los niños en el parque infantil y contribuir a la disminución de muertes y lesiones relacionadas con parques infantiles.

1.1 Alcance

Este manual presenta información sobre la seguridad de los equipos de juegos para parques infantiles en forma de recomendaciones. Con la publicación de este manual se espera promover una mayor concientización de la seguridad entre aquellos que compran, instalan y mantienen los equipos de juego en parques infantiles. Teniendo en cuenta que son muchos los factores que pueden afectar la seguridad de un parque infantil, los miembros del personal de la Comisión para la Seguridad de los Productos de Consumo de EE.UU. (CPSC) opinan que la guía es más apropiada que un reglamento obligatorio. Estas recomendaciones no se hacen públicas como único método para minimizar lesiones asociadas con equipos de parques infantiles. Sin embargo, la Comisión cree que estas recomendaciones junto con la información técnica de las normas ASTM para parques infantiles públicos contribuirán a una mayor seguridad en las áreas de juego.

Puede que algunas jurisdicciones estatales y locales requieran el cumplimiento de este manual y/o las normas voluntarias de ASTM. Además, administradores de riesgo, compañías de seguro u otros pueden requerir su cumplimiento en un lugar particular; contacte las jurisdicciones estatales/locales y compañías de seguro para determinar los requisitos específicos.

1.2 Personas interesadas

Este manual está creado para el uso de personas empleadas en el cuidado infantil, funcionarios escolares, personal de parques y recreación, compradores e instaladores de equipos de juego, diseñadores de parques infantiles y cualesquiera otros miembros del público en general (por ej. padres y grupos de escuelas) preocupados por la seguridad en los parques infantiles e interesados en evaluar sus respectivas áreas de juego. Debido al amplio rango de posibles usuarios, puede que alguna información sea más apropiada para cierto tipo de usuarios que otros. Las normas voluntarias enumeradas en 1.4.1. contienen más requisitos técnicos que este manual y están dirigidas principalmente a fabricantes de equipos, arquitectos, diseñadores y cualquier otra persona

que necesite información más técnica.

1.3 ¿Qué es un parque infantil público?

Con equipos para parques infantiles “públicos” nos referimos a módulos de juego para niños entre las edades de 6 meses a 12 años ubicados en las áreas destinadas para jugar de:

- Instalaciones comerciales (no residenciales) de cuidado infantil
- Instituciones
- Viviendas familiares múltiples, como edificios de apartamentos y condominios
- Parques pertenecientes a ciudades, estados y comunidades
- Restaurantes
- Centros vacacionales y recreacionales
- Escuelas
- Otras áreas de uso público

Esta guía no se refiere a equipos de parques de diversiones, equipos deportivos o de gimnasios, concebidos normalmente para el uso de mayores de 12 años, equipos de juego contenidos de materiales blandos, módulos de juego inflables de aire constante para uso en el hogar, esculturas de arte y museos (no diseñadas para otros fines, dirigidas e instaladas como equipos de juego para zonas de recreo), equipos que se encuentran en instalaciones de juegos acuáticos, o equipos de juego para hogares. Componentes de equipos destinados exclusivamente para el uso de niños con discapacidades y también modificados para acomodar a tales usuarios no se incluyen en esta guía. Instalaciones de cuidado infantil, especialmente en interiores, deberán referirse a las normas ASTM F2373— *Especificación Estándar para la Seguridad del Consumidor con respecto al Funcionamiento Seguro de Equipos de Juego de Uso Público para Niños de 6 hasta 23 meses de edad* (Standard Consumer Safety Performance Specification for Public Use Play Equipment for Children 6 Months Through 23 Months) para más información sobre áreas propias de sus instalaciones.

1.4 Estándares voluntarios para la seguridad en parques infantiles públicos e historia del Manual de la CPSC

- 1981 – Se publica el primer *Manual de Seguridad para Parques Infantiles Públicos* de la CPSC, en dos volúmenes.
- 1991 – Se publica por primera vez la *Especificación Estándar para la Atenuación de Impactos en Sistemas de Revestimiento de Superficies debajo y alrededor de Equipos de Parques Infantiles* (Standard Specification for Impact Attenuation of Surface Systems Under and Around Playground Equipment), ASTM F1292, was first published.
- 1991 – Los dos volúmenes se sustituyen por un manual de un volumen que incluía las recomendaciones basadas en un reporte de la Corporación COMSIS a la CPSC (*Desarrollo de Criterios de Factores Humanos para la Seguridad de*

Equipos de Parques Infantiles [Development of Human Factors Criteria for Playground Equipment Safety]).

- 1993 – Se publica la primera versión de las normas voluntarias para equipos de parques infantiles públicos, ASTM F1487 — Especificación Estándar para la Seguridad del Consumidor con respecto al Funcionamiento Seguro de Equipos de Juego en Parques Infantiles para el Uso Público [Standard Consumer Safety Performance Specification for Playground Equipment for Public Use] (revisiones cada 3 o 4 años).
- 1994 – Revisiones menores al Manual.
- 1997 – Actualización del Manual basada en (1) la revisión de la norma ASTM F1487 por los miembros del personal, (2) mesa redonda con el tema seguridad en parques infantiles que tuvo lugar en octubre de 1996 y (3) comentarios públicos recibidos a una petición de mayo de 1997 del personal de CPSC.
- 2005 – Se publica la primera versión de las normas voluntarias para equipos de parques infantiles para niños menores de dos años, norma ASTM F2373 — Especificación Estándar para la Seguridad del Consumidor con respecto al Funcionamiento Seguro de Equipos de Juego de Uso Público para Niños de 6 hasta 23 meses de edad (Standard Consumer Safety Performance Specification for Public Use Play Equipment for Children 6 Months Through 23 Months).
- 2008 – El manual se actualizó sobre la base de comentarios de miembros de los Comités de Parques Infantiles de la norma ASTM F15 como respuesta a sugerencias de revisiones por parte del personal de la CPSC. Las revisiones más importantes se enumeran a continuación.

1.4.1 Normas ASTM para parques infantiles

A continuación una lista de las normas ASTM de funcionamiento técnico relativas a parques infantiles.

- **F1487** Especificación Estándar para la Seguridad del Consumidor con respecto al Funcionamiento Seguro de Equipos de Juego en Parques Infantiles para el Uso Público (Standard Consumer Safety Performance Specification for Playground Equipment for Public Use).
- **F2373** Especificación Estándar para la Seguridad del Consumidor con respecto al Funcionamiento Seguro de Equipos de Juego de Uso Público para Niños de 6 hasta 23 meses de edad (Standard Consumer Safety Performance Specification for Public Use Play Equipment for Children 6 Months through 23 Months).
- **F1292** Especificación Estándar para la Atenuación de Impactos en Sistemas de Revestimiento de Superficies debajo y alrededor de Equipos en Parques Infantiles (Standard Specification for Impact Attenuation of Surface Systems Under and Around Playground Equipment).
- **F2075** Especificación Estándar de Fibra de Madera Elaborada a ser usada como Superficie de Seguridad debajo y alrededor de Equipos de Juegos en Parques Infantiles (Standard Specification for Engineered Wood Fiber for Use as a Playground Safety Surface Under and Around Playground Equipment).
- **F2223** Guía General para normas ASTM para revestimientos de superficies en parques infantiles (Standard Guide for ASTM Standards on Playground Surfacing).

- **F2479** Guía General para especificación, compra, instalación y mantenimiento de revestimientos de superficie vertidos en parques infantiles (Standard Guide for Specification, Purchase, Installation and Maintenance of Poured-In-Place Playground Surfacing).
- **F1951** (Especificación General para la Determinación de Accesibilidad de sistemas de revestimiento de superficie por debajo y alrededor de los equipos de parques infantiles (Standard Specification for Determination of Accessibility of Surface Systems Under and Around Playground Equipment).
- **F1816** Especificación General de Seguridad para cordones en ropa infantil para la parte superior del cuerpo (Standard Safety Specification for Drawstrings on Children's Upper Outerwear).
- **F2049** Guía Estándar de Cercas/Barreras para Zonas de Juego en Exteriores Públicas, Comerciales y en Residencias Multifamiliares (Standard Guide for Fences/Barriers for Public, Commercial, and Multi-Family Residential Use Outdoor Play Areas).
- **F1148** Especificación Estándar de Seguridad para el Consumidor con respecto al Funcionamiento de Equipos para Parques Infantiles en el Hogar (Standard Consumer Safety Performance Specification for Home Playground Equipment).
- **F1918** Especificación Estándar de Funcionamiento Seguro para Equipos de Juego Contenidos de Materiales Blandos (Standard Safety Performance Specification for Soft Contained Play Equipment).

1.5 Revisiones significativas para el 2008

1.5.1 Recomendaciones para equipos

- Se expanden los rangos de edad para incluir niños de hasta 6 meses de edad basado en la norma ASTM F2373
- Se añaden recomendaciones para tirolinas y troncos rodantes
- Se compatibilizan los requisitos para la zona de salida en toboganes con la norma ASTM F1487

1.5.2 Recomendaciones para revestimientos de superficies

- Se revisa la tabla de altura crítica
- Se añaden sugerencias para revestimientos sobre superficies de asfalto

1.5.3 Orientaciones generales

- Se añaden sugerencias con respecto a la exposición al sol

1.5.4 Otras revisiones

- Cambios editoriales para hacer el Manual más fácil de entender y utilizar

1.6 Antecedentes

La seguridad de cada pieza individual de los equipos del parque infantil tanto como la distribución de toda la zona de juego debe considerarse cuando se diseña o evalúa la seguridad de un parque infantil. Dado que las caídas son un patrón muy común de peligro en parques infantiles, la instalación y mantenimiento de revestimientos de superficies

debajo y alrededor de los equipos son de suma importancia para proteger a los niños de lesiones graves en la cabeza.

Debido a que todos los parques infantiles presentan algún desafío, ya que se puede esperar de los niños un uso imprevisto y ajeno a su propósito la supervisión de adultos es altamente recomendada. El manual proporciona cierta orientación sobre prácticas supervisoras que los adultos deben seguir. El diseño, distribución y mantenimiento apropiados de los equipos como se expone en este manual son también esenciales para aumentar la seguridad en parques infantiles públicos.

Un parque infantil debe permitirles a los niños desarrollarse gradualmente y probar sus capacidades proporcionándoles una serie de retos también graduales. Los retos presentados deben corresponder a las habilidades según las distintas edades y deben ser tales que los niños puedan percibir y elegir superar. Los niños pequeños (6 a 23 meses), de edad preescolar y escolar se diferencian considerablemente no solo en términos de tamaño y habilidades físicas, sino también en cuanto a su capacidad intelectual y social. Por lo tanto, un diseño apropiado según las edades deberá también tener en cuenta estas diferencias en cuanto al tipo, tamaño y distribución de los equipos. Las recomendaciones en este manual explican las distintas necesidades de niños pequeños, en edad preescolar y escolar; “niños pequeños” son los de 6 a 23 meses, en “edad preescolar” son los niños entre 2 y 5 años y niños “edad escolar” son aquellos de 5 a 12 años de edad. La superposición de estos grupos se anticipa de acuerdo al uso de los equipos del parque infantil y proporciona un margen de seguridad.

Diseñadores, instaladores y operadores de parques infantiles deben tener en cuenta que la Ley de Estadounidenses con Discapacidades de 1990 (ADA por sus siglas en inglés) es una ley abarcadora de derechos civiles que prohíbe la discriminación por discapacidad. Los Títulos II y III de la ADA exigen, entre otras cosas, que las instituciones gubernamentales estatales y locales nuevas o remodeladas, lugares de hospedaje público y centros comerciales sean accesibles y utilizables por individuos con discapacidades. Los establecimientos recreativos, entre ellos las áreas de juego, se encuentran entre el tipo de instituciones que se incluyen en los títulos II y III de la ADA.

La Junta para el Cumplimiento de Barreras Arquitectónicas y de Transporte (Architectural and Transportation Barriers Compliance Boards) – también llamado Junta de Acceso – ha desarrollado guías de accesibilidad para áreas de juego de nueva construcción o remodeladas que fue publicada en octubre del 2000. Las guías para áreas juego son un suplemento de la Guía de Acceso de la Ley de Estadounidenses con Discapacidades (ADAAG por sus siglas en inglés). Cuando el Departamento de Justicia adopte esta guía como una norma obligatoria, todas las áreas de juego renovadas o de nueva construcción tendrán que cumplirla. Esta guía también es válida para las áreas de juego que se incluyen en la Ley de Barreras Arquitectónicas (ABA por sus siglas en inglés).

Usted puede obtener copias de la guía de acceso para áreas de juego y más asistencia técnica de la Junta de Acceso de los Estados Unidos, U.S. Access Board, 1331 F Street, NW, Suite 1000, Washington, DC 20004-1111; 800-872-2253, 800-993-2822 (TTY), www.access-board.gov.

1.7 Lesiones en parques infantiles

La Comisión para la Seguridad de los Productos de Consumo de EE.UU. ha reconocido desde hace mucho los peligros potenciales que existen en el uso de equipos de juego en parques infantiles, con un estimado anual de más de 200,000 lesiones que han requerido tratamiento en salas de emergencia. La investigación más reciente de 2,691 incidentes relacionados con equipos en parques infantiles reportada a la CPSC del 2001 al 2008 indica que las caídas son el patrón más común de peligros (44% de las lesiones) seguidas por peligros relacionados con el equipo, como roturas, vuelcos, diseño y ensamblaje (23%).¹ Otros patrones de peligro incluyen atasco y choques entre niños o unidades estacionarias. Las muertes reportadas a la Comisión relacionadas con parques infantiles involucraron enredo de sogas, correas o vestuario; caídas; e impacto debido a vuelcos del equipo o fallos estructurales.

Las recomendaciones en este manual se han desarrollado para prevenir los peligros que resultaron en lesiones y muertes relacionadas con equipos de parques infantiles. Las recomendaciones incluyen aquellas que señalan:

- El potencial para caídas de equipos e impacto con éstos
- La necesidad de un revestimiento de superficie protector que atenúe los impactos debajo y alrededor de los equipos
- Las aberturas con potencial para atasco de cabeza
- El tamaño de los equipos y otras características de diseño relacionadas con la edad del usuario y la distribución de las unidades de juego en el parque infantil
- Procedimientos para instalación y mantenimiento
- Peligros generales presentados por protuberancias, bordes afilados y puntos de aplastamiento o cortaduras

1.8 Definiciones

Altura crítica — La altura de caída por debajo de la cual no se anticipa una lesión en la cabeza con consecuencias mortales.

Altura de caída — La distancia vertical entre la superficie de juego designada más alta en un equipo de módulos de juego y el revestimiento protector de superficie debajo de éste.

Anclaje — Un mecanismo de sujeción para fijar los equipos de juego al suelo.

Atasco — Cualquier condición que impide la salida del cuerpo o parte del cuerpo que ha penetrado en una abertura.

¹O'Brien, Craig W.; Injuries and Investigated Deaths Associated with Playground Equipment (Lesiones y muertes investigadas asociadas con equipos de parques infantiles), 2001–2008. U.S. Consumer Product Safety Commission: Washington DC, Octubre, 2009.

Baranda — Un elemento de cierre alrededor de una plataforma elevada con el fin de prevenir caídas involuntarias de la superficie elevada.

Barrera — Un obstáculo que impide el paso alrededor de una plataforma elevada con el fin de prevenir intentos involuntarios y deliberados de pasar a través de él.

Barrera protectora — Véase Barrera.

Columpio con asiento de seguridad — Un columpio normalmente adecuado para niños menores de 4 años que proporciona apoyo en todos los lados y entre las piernas del niño, del cual no se puede subir ni bajar sin la ayuda de un adulto.

Enredo — Una condición en la que el vestuario o algo alrededor del cuello del usuario se atasca o enreda en un componente del equipo de juego.

Equipos de juego estacionarios — Cualquier estructura de juego que tiene una base fija y no se mueve.

Equipos para la parte superior del cuerpo — Equipos de juego diseñados para el apoyo del niño exclusivamente por las manos (por ej. escalera horizontal, anillas sostenidas por encima de la cabeza).

Estructura compuesta — Dos o más estructuras para juegos unidas o conectadas de manera funcional para crear una unidad integral que proporciona más de una actividad de juego.

Material de relleno suelto para revestimiento — Un material utilizado para revestimiento de superficies en la zona de uso que consiste de partículas sueltas como arena, gravilla, fibra de madera elaborada o caucho triturado.

Material de Revestimiento de Superficie Unitario — Un material utilizado para revestimiento protector de superficies en el área de uso que puede ser losas de caucho, esteras, o una combinación de materiales amortiguadores que se fijan con un aglutinante que puede ser vertido en el área del parque infantil y fragua formando una superficie amortiguadora unitaria.

Niños de edad preescolar — Niños entre 2 y 5 años de edad.

Niños en edad escolar — Niños entre 5 y 12 años de edad.

Niños pequeños — Niños entre 6 y 23 meses de edad.

Protuberancia — Un saliente que, al verificarlo, se determina que es un peligro con probabilidad de causar lesiones físicas a un usuario que la impacta.

Rampa de tobogán — La superficie inclinada para deslizarse en un tobogán.

Relleno — Material(es) utilizados en una barrera protectora o entre módulos para prevenir el paso de un usuario a través de la barrera (por ej. barrotes verticales, entramados, paneles sólidos, etc.).

Revestimiento protector de superficie o superficie protectora — Material para revestimiento de superficie amortiguador (atenuador de impacto) en el área de uso que corresponde a las recomendaciones de §2.4 en este manual.

Saliente — Cualquier elemento que se extiende desde una superficie del equipo de juego y debe ser probado para determinar si constituye una protuberancia, un peligro de enredo o ambos.

Superficie de juego designada — Cualquier superficie elevada para pararse, caminar, gatear, sentarse o escalar, o una superficie plana de más de 2 pulgadas de ancho por 2 pulgadas de largo que forme un ángulo de menos de 30° con la horizontal.

Supervisor — Cualquier persona encargada de vigilar a los niños en un parque infantil. Los supervisores pueden ser profesionales asalariados (por ej. empleados de centros de cuidado infantil, escuelas primarias o parques y centros de recreo), trabajadores temporales asalariados (por ej., estudiantes de colegios universitarios o secundarias), voluntarios (por ej., miembros de PTA), o proveedores de cuidado infantil no asalariados (por ej. padres) de los niños que juegan en el parque infantil.

Tejido Geotextil (filtro) — Una tela que mantiene su estructura relativa durante su manejo, colocación y servicio a largo plazo para mejorar el drenaje del agua, retardar el movimiento del terreno y reforzar y separar el terreno del revestimiento de superficie y/o la subbase.

Tobogán con rodillos — Un tobogán con una rampa que consiste de diversos rodillos individuales sobre los cuales el usuario se desliza.

Tobogán para terraplén — Un tobogán que sigue el contorno del suelo y cuya parte inferior de la rampa nunca se encuentra a más de 12 pulgadas por encima del suelo circundante.

Tobogán tubular — Un tobogán donde la rampa constituye un túnel o tubo completamente cerrado.

Zona de uso — La superficie debajo y alrededor de un equipo de módulos de juego sobre la cual se anticipa pueda caer un niño desde un equipo de juego o la salida del mismo. Estas áreas también están destinadas al tránsito libre alrededor del equipo.

2. CONSIDERACIONES GENERALES RESPECTO A PARQUES INFANTILES

2.1 Selección del lugar

Los siguientes factores son importantes al seleccionar el lugar para un parque infantil nuevo:

Factor del lugar	Preguntas a hacer	Si la respuesta es sí, entonces...
Patrones de movimiento de niños desde y hacia el parque infantil.	¿Hay peligros en el camino?	Elimine los peligros.
Peligros accesibles en los alrededores, como carreteras con tráfico, lagos, estanques, arroyos, despeñaderos/precipicios, etc.	¿Podría un niño toparse con un peligro cercano sin percatarse? ¿Podrían acercarse fácilmente los niños más pequeños al peligro?	Proporcione un método para mantener a los niños dentro del parque infantil. Por ejemplo, un seto denso o una cerca. El método debe permitir la observación por parte de supervisores. Si se usan cercas deben cumplir los códigos de construcción locales y/o la norma ASTM F-2049.
Exposición al sol	¿La exposición al sol es tal que pueda calentar toboganes, plataformas, peldaños y superficies de metal como para quemar a los niños?	Los toboganes, plataformas y peldaños de metal deben tener sombra o no estar ubicados a pleno sol. Proporcione avisos de que los equipos y las superficies expuestas a sol intenso pueden quemar.
	¿Estarán los niños expuestos al sol durante la parte del día de más calentamiento?	Considere proveer sombra al parque infantil o a áreas en los alrededores.
Pendiente y drenaje	¿Se llevará el agua materiales de relleno suelto durante períodos de lluvia intensa?	Considere un drenaje apropiado gradual para prevenir deslaves

2.1.1 Consideraciones en torno a la protección del sol

Según la Academia Norteamericana de Dermatología (American Academy of Dermatology), las investigaciones indican que uno de cada cinco norteamericanos desarrollará algún tipo de cáncer de la piel durante su vida y cinco o más quemaduras de sol duplican el riesgo de desarrollar cáncer de la piel. El uso de sombras existentes (por ej. árboles), el diseño de estructuras de juego como un medio para proporcionar sombra (por ej. plataformas elevadas con espacios sombreados debajo), o crear más sombra (por ej. estructuras artificiales) son formas posibles de diseñar un parque infantil que ayude a proteger del sol la piel de los niños. Cuando los árboles se utilizan para sombra, surgen otras cuestiones de mantenimiento, como la necesidad de limpiar deshechos y podar ramas.

2.2 Trazado del parque infantil

Existen muchos factores importantes a tener en cuenta cuando se traza un parque infantil:

- Accesibilidad
- Separación por edades
- Actividades incompatibles
- Líneas de visibilidad
- Señalizaciones y/o carteles
- Supervisión

2.2.1 Accesibilidad

Se debe prestar especial atención a proporcionar superficies accesibles en áreas de juego que cumplan con la *Especificación Estándar para la Atenuación de Impactos en Sistemas de Revestimiento de Superficies debajo y alrededor de Equipos en Parques Infantiles (Standard Specification for Determination of Accessibility of Surface Systems Under and Around Playground Equipment)*, ASTM F1951. La elección de los equipos y el área, junto con el tipo de revestimiento protector de superficie son elementos claves para garantizar la oportunidad de niños con discapacidades de jugar en el parque infantil.

2.2.2 Separación por edades

En parques infantiles para niños de todas las edades, la distribución de caminos y el diseño del paisaje del parque debe mostrar distintas áreas para los distintos grupos de edades. Las áreas deben estar separadas por al menos una zona neutral, que puede ser un área con arbustos o bancos. Esta zona de separación neutral ayudará a reducir la probabilidad de lesiones causadas por niños mayores que corran en áreas llenas de niños más pequeños con movimientos y tiempo de reacción mucho más lentos.

2.2.3 Grupos de edades

En áreas donde el acceso al parque infantil no es controlado o donde la edad para el cual es apropiado solo se determina por señalizaciones, el diseñador del mismo debe tener en cuenta que dado que el desarrollo de un niño es continuo, los padres y proveedores de cuidado infantil pueden elegir un parque infantil ligeramente por encima o por debajo de las capacidades de sus niños, especialmente en caso de menores en edades de transición (por ej. niños de 2 y 5 años). Esto podría suceder para facilitar la supervisión de varios niños, por desconocimiento sobre los peligros que un parque infantil pueda constituir para niños de diferentes edades, debido al desarrollo avanzado de un niño u otras razones. Por tanto, los grupos de edad se solapan a la edad de 5 años. En cuanto al desarrollo del niño, también existe una superposición similar alrededor de los 2 años; sin embargo, debido a las diferencias en las normas ASTM y herramientas de verificación para atrapamientos, este solape no está reflejado en el manual. Para parques infantiles utilizados principalmente por niños supervisados por profesionales asalariados entrenados (por ej. centros de cuidado infantil y escuelas) tal vez sea sensato considerar separar las zonas de juego de acuerdo a los distintos grupos de edades de los centros. Por ejemplo, un centro de cuidado infantil puede preferir restringir el parque infantil para el uso exclusivo de niños pequeños (6 a 23 meses) de menos de 2 años y puede obtener información de esta guía y la norma ASTM F2373. Por otra parte, puede que una escuela no tenga niños de menos de 4 años entre sus estudiantes y pueda planificar en consecuencia. Aquellas personas que inspeccionen los parques infantiles deben tener en cuenta el grupo de edades para el que está destinado el parque infantil.

2.2.4 Actividades incompatibles

El área de juego debe ser organizada en distintas secciones para prevenir lesiones por actividades incompatibles y niños corriendo entre éstas. Las actividades físicas de mucha actividad deben estar separadas de las pasivas o más tranquilas. El área para equipos de juego, el campo abierto y los cajones de arena deben colocarse en distintas secciones del parque infantil. Además, las piezas de juego o actividades favoritas más utilizadas deben estar dispersas para evitar aglomeración en una sola área.

Distintos tipos de equipos requieren distintas zonas de uso que deben respetarse. A continuación, las recomendaciones generales para colocar equipos dentro del área del parque infantil. Las zonas de uso específicas para equipos de juego se discuten en §5.3.

- Equipos que se mueven, como columpios y tiiovivos (ruedas giratorias) deben colocarse hacia una esquina, lado o borde del área de juego, garantizando que se mantengan las zonas de uso apropiadas alrededor del equipo.
- Las salidas de toboganes deben estar en un área descongestionada del parque infantil.
- Las estructuras de juego mixtas se han vuelto populares en parques infantiles públicos. Los elementos adyacentes a estas estructuras deberán ser complementarios. Por ejemplo, un componente de acceso no debe estar situado en la zona de salida de un tobogán.

2.2.5 Líneas de visibilidad

Los parques infantiles que están diseñados, instalados y cuidados de acuerdo con recomendaciones y estándares de seguridad pueden aún presentar peligros para los niños. Los parques infantiles deben ser diseñados de modo tal que permitan a los padres o proveedores de cuidado infantil vigilar a los niños en todo momento cuando se desplazan por todo el entorno del parque infantil. Las barreras visuales deben reducirse tanto como sea posible. Por ejemplo, en un parque infantil los equipos de juego deben ser lo más visibles posible desde los bancos del parque. En parques infantiles con áreas para distintas edades, el área para niños mayores debe ser visible desde el área para niños pequeños (6 a 23 meses) para garantizar que los proveedores de cuidado infantil de varios niños puedan ver a los mayores mientras juegan de forma interactiva con los más pequeños.

2.2.6 Señalizaciones y/o carteles

Aunque el grupo de usuarios para el que está destinado el equipo debe ser obvio por el diseño y la escala de los módulos, las señalizaciones y/o los carteles en el área del parque infantil o en los equipos deben servir como guía para los supervisores respecto a cuáles equipos son apropiados para cuáles edades.

2.2.7 Supervisión

La calidad de la supervisión depende de la calidad del conocimiento del supervisor sobre comportamientos de juego seguros. Los diseñadores de parques infantiles deben conocer el tipo de supervisión más probable para su parque infantil determinado. Dependiendo del lugar y tipo de parque infantil, los supervisores pueden ser profesionales asalariados (por ej. trabajadores de centros de cuidado infantil, escuelas primarias o parques y centros de recreo), trabajadores temporales asalariados (por ej., estudiantes de colegios universitarios o secundarias), voluntarios (por ej., miembros de PTA), o proveedores de cuidado infantil no asalariados (por ej. padres) de los niños que juegan en el parque infantil.

Los padres y supervisores de parques infantiles deben tener en cuenta que no todos los equipos de juego son apropiados



para todos los niños que pueden utilizar el parque infantil. Los supervisores deben buscar señalizaciones que indiquen la edad apropiada de los usuarios y dirigir a los niños a los equipos apropiados para sus edades. Los supervisores también pueden hacer uso de la información en la Tabla 1 para determinar que equipo es adecuado para los niños que están supervisando. Los niños pequeños (6 a 23 meses) y en edad preescolar necesitan mayor supervisión que otros niños; sin embargo, no se puede confiar exclusivamente en supervisión para prevenir lesiones.

Los supervisores deben comprender los aspectos básicos de la seguridad en parques infantiles, como:

- Verificar si un equipo está roto y asegurarse de que los niños no jueguen en este.
- Verificar si hay modificaciones inseguras y eliminarlas, en especial sogas atadas al equipo, antes de permitir que los niños jueguen.
- Verificar que el revestimiento de la superficie está bien cuidado.
- Asegurarse de que los niños tienen los zapatos puestos.

TABLA 1. EJEMPLOS DE EQUIPOS DE JUEGO APROPIADOS SEGÚN LA EDAD

 <p>Niños pequeños — de 6-23 meses</p> <ul style="list-style-type: none"> • Equipos para escalar de menos de 32" de altura • Rampas • Escaleras simples de un paso • Toboganes* • Toboganes en espiral con vueltas de menos de 360° • Balancines sobre muelles • Escaleras • Columpios con asientos de seguridad 	 <p>Edad preescolar — de 2-5 años</p> <ul style="list-style-type: none"> • Algunos escaladores** • Escaleras horizontales de menos de o iguales a 60" de alto para 4 y 5 años • Tiovivos • Rampas • Escaleras de travesaños • Escaleras simples de un paso • Toboganes* • Toboganes en espiral con vueltas de hasta 360° • Balancines sobre muelles • Escaleras • Columpios – con cinturón, con asientos de seguridad (2-4 años) y de neumáticos que giran 	 <p>Edad escolar — de 5-12 años</p> <ul style="list-style-type: none"> • Escaladores en arco • Pasarelas de cadenas o cables • Construcciones independientes para escalar con partes flexibles • Subibajas con fulcro • Escaleras – horizontales, de travesaños y de peldaños • Anillas suspendidas por encima de la cabeza*** • Tiovivos • Rampas • Anillas en fila • Toboganes* • Toboganes en espiral con más de una vuelta de 360° • Escaleras • Columpios – con cinturón y de neumáticos que giran • Tirolinas • Postes de Deslizamiento Verticales
* Véase §5.3.6	** Véase §5.3.2	*** Véase §5.3.2.5

- Vigilar y prohibir juegos violentos peligrosos, como niños lanzando materiales del revestimiento protector de superficies, saltando desde lo alto, etc.
- Vigilar y prohibir que los niños se alejen del área de juego.

2.3 Selección de módulos de juego

Al seleccionar los módulos de juego para un parque infantil es importante saber el rango de edades de los niños que lo utilizarán. Los niños tienen necesidades y habilidades distintas a diferentes edades y niveles de desarrollo. Los parques infantiles deben estar diseñados de forma tal que estimulen a los niños y los animen a desarrollar nuevas habilidades, pero deben hacerlo de acuerdo a su tamaño, capacidades y niveles de desarrollo. Debe también considerarse el ofrecer equipos de juego que sean accesibles a niños con discapacidades y que promuevan la integración dentro del parque infantil.

La Tabla 1 muestra el rango de edad apropiado para varios equipos de módulos de juego en parques infantiles. Esta no es una lista exhaustiva y por lo tanto no debe limitar la inclusión de equipos actuales o recién diseñados que no se mencionan específicamente. Para aquellos módulos que se citan en más de un grupo, pueden existir modificaciones o restricciones dependiendo de la edad, por lo tanto, consulte las recomendaciones específicas en §5.3.

2.3.1 Equipos no recomendados

Algunos equipos de juego no se recomiendan en parques infantiles públicos, entre ellos:

- Trampolines
- Rejas pivotantes
- “Giant Strides” (este equipo consiste de un poste del cual se extienden varias sogas o cadenas con asas de las cuales los niños se agarran para dar vueltas.)
- Sogas para escalar que no están sujetas en ambos extremos.
- Columpios de metal pesado (por ej. figuras de animales) – Estos no se recomiendan porque su armazón de metal rígido y pesado constituye un riesgo de lesiones por impacto.
- Columpios de varios puestos – Con la excepción de columpios de neumáticos, los columpios que son para el uso de más de un usuario no se recomiendan porque su mayor masa, comparada con los columpios de un solo puesto, constituye un riesgo de lesiones por impacto.
- Columpios de sogas – Las sogas libres para balancearse que puedan deshilacharse o formar un lazo no se recomiendan porque constituyen un peligro potencial de estrangulación.
- Trapecios de ejercicio con anillas dobles o barras – Estas

anillas y barras de trapecio están suspendidos de cadenas largas que generalmente se consideran artículos deportivos y no se recomiendan para parques infantiles públicos. *NOTA: La recomendación contra el uso de anillas de ejercicio no es válida para anillas suspendidas sobre la cabeza como los que se usan en módulos de juego con anillas en fila o una escalera de anillas (véase Figura 7).*

2.4 Revestimiento de superficie



El revestimiento de superficie debajo y alrededor de los equipos es uno de los factores más importantes para disminuir la probabilidad de lesiones mortales en la cabeza. Es menos probable que una caída en una superficie amortiguadora cause una lesión grave en la cabeza que una caída en una superficie

dura. Sin embargo, algunas lesiones de caídas, incluyendo fracturas de extremidades, pueden ocurrir independientemente del material de revestimiento de superficie usado.

El método de verificación más utilizado para evaluar las propiedades amortiguadoras de un material de revestimiento es dejar caer una imitación de cabeza elaborada en metal en una muestra del mismo y anotar el impulso de aceleración/tiempo durante el impacto. La norma ASTM F1292 *Especificación Estándar para la Atenuación de Impactos en Sistemas de Revestimiento de Superficies debajo y alrededor de Equipos de Parques Infantiles (Standard Specification for Impact Attenuation of Surface Systems Under and Around Playground Equipment)* describe métodos de verificación de laboratorio y de campo.

Las pruebas en las que se utilizan los métodos descritos en ASTM F1292 proporcionarán una clasificación de la “altura crítica” para el revestimiento de superficie. Esta altura puede considerarse una aproximación de la altura de la caída por debajo de la cual no se anticipa una lesión en la cabeza con consecuencias mortales. Los fabricantes e instaladores de revestimientos protectores de superficies para parques infantiles deben proporcionar la clasificación de altura crítica de sus materiales. Esta clasificación deberá ser mayor o igual a la altura de caída del equipo más alto entre los módulos de juego en el parque infantil. La altura de caída de un equipo es la distancia entre la superficie de juego establecida en un equipo y el revestimiento protector de superficie debajo de ésta. Más detalles para determinar la superficie de juego establecida más alta y la altura de caída en algunos tipos de módulos se incluyen en §5 Partes del parque infantil.

2.4.1 Equipos no incluidos en las recomendaciones de revestimientos protectores de superficie

Las recomendaciones para revestimientos protectores de superficie no son válidas para módulos de juego que requieran que un niño esté de pie o sentado *al nivel del suelo*. Ejemplos de tales equipos son:



Revestimiento apropiado

- Cualquier material probado de acuerdo a la norma ASTM F1292, incluyendo superficies unitarias, fibra de madera elaborada, etc.
- Gravilla
- Arena
- Caucho triturado/reciclado
- Virutas de madera (sin tratamiento CCA)
- Chips de madera



Revestimiento inapropiado

- Asfalto
- Alfombra no evaluada según ASTM F1292
- Concreto
- Tierra
- Césped
- Virutas de madera con tratamiento CCA

- Cajones de arena
- Paneles de actividades al nivel del suelo
- Casitas de juguete
- Cualquier otro equipo que utilicen los niños mientras sus pies estén en contacto con la superficie del suelo

2.4.2 Selección de materiales de revestimiento

Existen dos opciones disponibles para el revestimiento de superficie en parques infantiles públicos: materiales unitarios y materiales de relleno suelto. Un parque infantil nunca debe ser instalado sin algún tipo de revestimiento protector de superficie. Concreto, asfalto u otras superficies duras no deben encontrarse nunca directamente debajo de equipos de parques infantiles. El césped y la tierra no se consideran revestimientos protectores ya que factores de desgaste y ambiente pueden reducir la efectividad de su amortiguamiento. Las alfombras y esteras tampoco son apropiadas, salvo aquellas sometidas a las pruebas de verificación de las normas ASTM F1292 que cumplan con ellas. El relleno suelto debe evitarse en parques infantiles para niños pequeños (6 a 23 meses).

2.4.2.1 Materiales de revestimiento unitarios

Los materiales unitarios son generalmente esteras y losas de caucho o una combinación de materiales amortiguadores unidos por un aglutinante, que puede ser vertidos en el área

del parque infantil y que luego fragua para formar una superficie amortiguadora unitaria. Los materiales unitarios pueden adquirirse a través de numerosos fabricantes, muchos de los cuales ofrecen una amplia gama de materiales con distintas propiedades amortiguadoras. Los materiales de revestimiento nuevos, como fibra de madera aglomerada y combinaciones de relleno suelto y unitario, que están en desarrollo pueden ser sometidos a pruebas de cumplimiento de las normas ASTM F1292 y caer dentro de la categoría de materiales unitarios. Al decidir cuál es el mejor material para el revestimiento de la superficie, tenga en cuenta que algunos materiales de revestimiento oscuros expuestos a sol intenso han ocasionado ampollas en pies descalzos. Chequee con el fabricante si hay materiales de colores claros disponibles o procure sombra para reducir la exposición directa al sol.

Aquellas personas que deseen instalar un material unitario para revestimiento de superficie de un parque infantil deben pedir información sobre datos de pruebas de ASTM F1292 del fabricante que identifiquen la clasificación de la altura crítica para el revestimiento deseado. También se deben obtener del fabricante los requisitos del lugar porque algunos materiales unitarios exigen ser instalados sobre superficies duras, mientras que otros no. Las instrucciones del fabricante deben seguirse atentamente, ya que algunos sistemas unitarios requieren instalación profesional. Las pruebas deben efectuarse según la norma ASTM F1292.

2.4.2.2 Materiales de relleno suelto

La fibra de madera elaborada (EWF por sus siglas en inglés) es un producto de madera que puede lucir similar a las virutas de madera utilizadas en el diseño de paisajes, pero los productos EWF están diseñados específicamente para el uso en parques infantiles como suelo de seguridad debajo y alrededor de módulos de juego. Los productos EWF deben cumplir con la norma ASTM F2075: *Estándar de Fibra de Madera Elaborada para usar como Superficie Segura debajo y alrededor de Equipos de Juegos en Parques Infantiles (Standard Specification for Engineered Wood Fiber for Use as a Playground Safety Surface Under and Around Playground Equipment)* y haber sido probados y cumplir con la ASTM F1292.

Existen también productos de compuestos de caucho que están diseñados específicamente para su uso como revestimiento de superficies en parques infantiles. Asegúrese de que han sido probados y cumplen con la norma ASTM F1292.

Al instalar estos productos deben seguirse los consejos 1 a 9 a continuación. Cada fabricante de fibra de madera elaborada y compuestos de caucho debe proporcionar los requisitos de mantenimiento y datos de pruebas sobre:

- La altura crítica según la prueba de atenuación de impacto de ASTM F1292.
- Datos sobre profundidad mínima de relleno.
- Toxicidad.
- Guías ADA/ABA de accesibilidad para firmeza y estabilidad según la ASTM F1951.

Otros materiales de relleno suelto son generalmente el tipo de material para diseño de paisajes que puede colocarse en capas hasta cierta profundidad y resistir la compresión. Algunos ejemplos incluyen virutas y chips de madera, arena, gravilla y compuestos de caucho triturado/reciclado.

Consejos importantes para materiales de relleno suelto:

1. Los materiales de relleno suelto se comprimirán al menos un 25% con el tiempo debido al uso e inclemencias del tiempo. Esto debe considerarse cuando se planifique el parque infantil. Por ejemplo, si el parque infantil requerirá 9 pulgadas de chips de madera, el nivel inicial de relleno debe ser de 12 pulgadas. Vea la Tabla 2 abajo.
2. Los materiales de relleno suelto exigen mantenimiento frecuente para garantizar que los niveles de superficie no queden nunca por debajo de la profundidad mínima. Las áreas debajo de columpios y en las salidas de toboganes son más susceptibles a desplazamientos; debe prestarse especial atención al mantenimiento en estas áreas. Adicionalmente se pueden instalar esteras protectoras en estas zonas para reducir el desplazamiento.
3. El perímetro del parque infantil debe proporcionar un método para contener los materiales de relleno suelto.
4. Considere marcar los soportes de los equipos para un nivel de relleno mínimo, lo que ayudará a mantener la profundidad original del material.

5. Un buen drenaje es esencial en el cuidado de revestimientos sueltos de superficies. El agua estancada en los materiales de revestimiento reduce la eficacia y lleva a la compactación y descomposición del material.
6. La altura crítica puede reducirse en los inviernos en áreas donde el suelo se congele.
7. No utilice nunca menos de 9 pulgadas de materiales de relleno suelto salvo para caucho triturado/reciclado (se recomiendan 6 pulgadas). Una capa menos profunda se desplaza y compacta muy fácilmente.
8. Algunos materiales de relleno suelto pueden no cumplir con las normas de accesibilidad de ADA/ABA. Para más información contacte a la Junta de Acceso (véase §1.6) o remítase a la ASTM F1951.
9. Las virutas de madera que contengan productos de madera tratados con arseniato de cobre cromatado (CCA) no deben ser utilizados; las virutas que no especifiquen el contenido de CCA deben evitarse (véase §2.5.5.1).

La Tabla 2 muestra la profundidad mínima requerida para materiales de relleno suelto basada en el tipo de material y la altura de caída. Las profundidades aquí expuestas suponen que los materiales han sido comprimidos debido al uso e inclemencias del tiempo y reciben el mantenimiento adecuado según su nivel.

2.4.2.3 Instalación de relleno suelto sobre superficie dura

El personal de la CPSC recomienda vehementemente no instalar parques infantiles sobre superficies duras como asfalto, concreto o tierra compactada, a no ser que la instalación añada las siguientes capas de protección. Inmediatamente sobre la superficie dura debe haber una capa base de 3 a 6 pulgadas de grosor de material de relleno suelto (por ej. gravilla para el drenaje). La próxima capa debe ser un tejido Geotextil. Encima de este debe existir una capa de relleno suelto que cumpla con las especificaciones discutidas en §2.4.2.2 y la Tabla 2. Debe haber esteras amortiguadoras integradas en la capa de relleno suelto debajo de zonas de mucho tránsito, como debajo de columpios, en las salidas de toboganes y otros sitios donde sea probable un desplazamiento. La Figura 1 muestra una representación visual de esta información. Los parques infantiles más antiguos que aún existen sobre pavimentos duros deben modificarse para proporcionar un revestimiento de superficie adecuado.

2.5 Materiales de los equipos

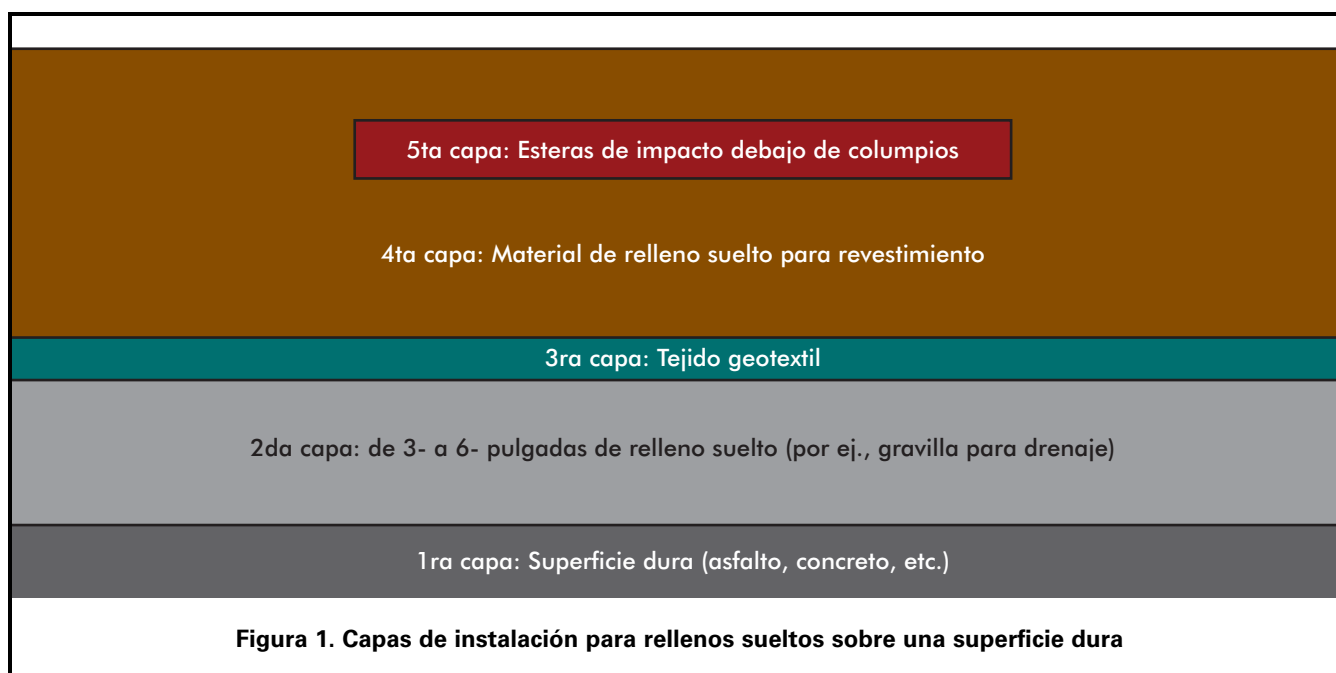
2.5.1 Durabilidad y acabado

- Utilice equipos que sean fabricados y construidos exclusivamente de materiales que posean antecedentes registrados de durabilidad en un parque infantil o una instalación similar.

Tabla 2. Profundidad mínima para revestimientos de relleno suelto comprimidos

Pulgadas	de	(Material de relleno suelto)	Protege hasta	Altura de caída (pies)
6*		Caucho triturado/reciclado		10
9		Arena		4
9		Gravilla		5
9		Virutas de madera (sin tratamiento CCA)		7
9		Chips de madera		10

* Los revestimientos de caucho triturado/reciclado suelto no se comprimen de la misma forma que otros materiales de relleno suelto. Sin embargo, debe prestarse atención en cuanto a mantener una profundidad constante, debido a que aún pueden ocurrir desplazamientos.



- Los revestimientos, tratamientos y preservativos deben ser seleccionados con cuidado para que no constituyan un riesgo para la salud de los usuarios.
- Todos los cerrojos, conectores y dispositivos de cobertura que están expuestos al usuario deben ser lisos y con poca probabilidad de provocar laceraciones, penetraciones o constituir un peligro de enredo con la ropa (véase también §3.2 y el Apéndice B).
- Todos los pernos y roscas deben contar con arandelas de freno, tuercas autoblocantes u otros medios de seguridad para evitar que se desprendan.
- El herraje en juntas móviles también debe estar asegurado contra desprendimientos involuntarios o no autorizados.

2.5.2 Herrajes

Cuando son instalados y reciben mantenimiento según las instrucciones del fabricante:

- Todos los cierres deben ser resistentes a la corrosión y seleccionados con el fin de disminuir la corrosión de los materiales que conectan. Esto es en especial importante al utilizar madera tratada con ACQ/CBA/CA-B2 debido a que los químicos en los preservativos de madera corroen ciertos metales más rápidamente que otros.
- Los cojinetes o casquillos empleados en uniones movibles deben ser fáciles de lubricar o ser autolubrificables.
- Todos los ganchos, como aquellos en forma de S y C, deben estar cerrados (véase también §5.3.8.1). Un gancho se considera cerrado si no hay intervalo o un espacio mayor a 0.04 pulgadas, aproximadamente el grosor de una moneda de diez centavos.

2.5.3 Metales

- Evite el uso de metales no revestidos en plataformas, toboganes o peldaños. Cuando se exponen a la luz directa del sol pueden alcanzar temperaturas tan altas como para causar lesiones graves de quemaduras por contacto en cuestión de segundos. Utilice otros materiales que puedan reducir la temperatura de superficies como, pero no limitado a, madera, plástico o metal recubierto (véase también Toboganes en §5.3.6).
- Si se emplea metal no revestido o pintado en plataformas, peldaños y toboganes, deben orientarse de forma tal que la superficie no esté expuesta directamente al sol durante todo el año.

2.5.4 Pinturas y acabados

- Los metales que no sean inherentemente resistentes a la corrosión deben pintarse, galvanizarse o ser tratados de cualquier otra forma para prevenir el óxido.
- El fabricante debe garantizar que los usuarios no pueden ingerir, inhalar o absorber cantidades potencialmente peligrosas de preservativos químicos u otros tratamientos aplicados a los módulos como resultado del contacto con equipos de juego en un parque infantil.
- Todas las pinturas y acabados similares deben cumplir con la regulación actual CPSC para plomo en pinturas.
- Las superficies pintadas deben recibir mantenimiento para prevenir la corrosión y el deterioro.
- La pintura y otros acabados deben ser mantenidos para prevenir la oxidación de metales expuestos y para minimizar que los niños jueguen con pintura descascarada y pedacitos de pintura.

- Los parques infantiles más antiguos con pintura a base de plomo deben ser identificados y debe desarrollarse una estrategia para controlar la exposición a la pintura con plomo. Los administradores de parques infantiles deben consultar el reporte de octubre de 1996, Recomendaciones del personal de CPSC para la identificación y el control de la pintura con plomo en equipos para parques infantiles públicos⁴

2.5.5 Madera

- La madera debe ser naturalmente resistente a la putrefacción y a insectos (por ej. cedro o secoya) o debe recibir un tratamiento para evitar tal desgaste.
- Las maderas tratadas con creosota (por ej. durmientes, postes de teléfono, etc.) y los recubrimientos que contengan pesticidas no deben ser utilizados.

2.5.5.1 Madera tratada a presión

Una gran cantidad de madera para parques infantiles fue tratada a presión con químicos para prevenir deterioro por insectos u hongos. El arseniato de cobre cromatado (CCA por sus siglas en inglés) fue un químico empleado durante décadas en estructuras (incluyendo parques infantiles). Desde el 31 de diciembre del 2003, la madera tratada con CCA no se procesa para uso en aplicaciones de parques infantiles. Existen otros tratamientos contra el óxido e insectos que no contienen arsénico; sin embargo, cuando emplee cualquiera de los productos de madera con nuevos tratamientos, asegúrese de utilizar herraje que sea compatible con los químicos del tratamiento de la madera. Estos químicos tienden a corroer ciertos materiales más rápido que otros.

Parques infantiles preexistentes con maderas tratadas con CCA

Varios grupos han presentado sugerencias en torno a la aplicación de recubrimiento de superficies en maderas tratadas con CCA (por ej. barnices o selladores) para reducir la exposición potencial de un niño al arsénico en la superficie de la madera. La información del personal de la CPSC y los estudios de la EPA sugieren que el uso regular (al menos una vez al año) de un sellador con base de aceite o agua puede reducir la migración del arsénico de maderas tratadas con CCA. Los instaladores, constructores y consumidores que lleven a cabo operaciones de carpintería con madera tratada a presión, como lijar, serruchar, o botar aserrín, deben leer el documento informativo para el consumidor correspondiente a este producto, disponible en puntos de venta. Esta documentación contiene precauciones importantes para la salud e información sobre su eliminación.

² Cobre amoniacal cuaternario (ACQ por sus siglas en inglés), cobre boro azoleo (CBA por sus siglas en inglés), cobre azoleo tipo B (CA-B por sus siglas en inglés), etc.

³ CPSC Staff Recommendations for Identifying and Controlling Lead Paint on Public Playground Equipment (Recomendaciones del personal de CPSC para la identificación y el control de la pintura con plomo en equipos para parques infantiles públicos); U.S. Consumer Product Safety Commission (Comisión para la seguridad de los productos de consumo de EE. UU.): Washington, DC, Octubre de 1996.

Al seleccionar productos de madera y acabados para parques infantiles públicos, el personal de la CPSC recomienda:

- Evitar barnices que “formen películas” o no penetrantes (látex semitransparente, látex opaco y barnices opacos a base de aceite) en superficies exteriores, ya que posteriormente puede ocurrir desconchado y descascarado, lo cual finalmente tendrá un impacto en la durabilidad, así como exposición a los preservativos en la madera.
- La creosota, el pentaclorofenol y el óxido de tributil estaño son demasiado tóxicos o irritantes y no deben emplearse como preservativos para madera de equipos de parques infantiles.
- No deben utilizarse los acabados que contengan pesticidas.
- No deben utilizarse los acabados que contengan pesticidas.

2.6 Ensamblaje e instalación

- Siga estrictamente todas las instrucciones del fabricante al ensamblar e instalar los módulos.
- Tras el ensamblaje y antes de su primer uso, el equipo debe ser inspeccionado rigurosamente por una persona calificada para inspeccionar la seguridad en parques infantiles.
- Las instrucciones de ensamblaje e instalación del fabricante y otros materiales compilados sobre los módulos deben conservarse en un archivo permanente.
- El anclaje seguro es un factor de suma importancia para una instalación estable, y el proceso de anclaje debe completarse estrictamente según las especificaciones del fabricante.

3. PELIGROS EN EL PARQUE INFANTIL

Esta sección proporciona una vista general de los peligros comunes que deben evitarse en los parques infantiles. Tiene como intención crear conciencia de los riesgos que llevan a cada uno de estos peligros. Muchos de estos peligros son considerados en las especificaciones técnicas y pruebas de cumplimiento de las normas ASTM F1487 y F2373. Algunas de estas pruebas también se explican en el Apéndice B.

3.1 Puntos de aplastamiento y cortaduras

Cualquier cosa que pudiera aplastar o cortar no debe ser accesible a niños en un parque infantil. Los puntos de aplastamiento y corte pueden ser creados por partes que se muevan entre sí o una parte que se mueva hacia otra fija en el ciclo de uso normal, como un subibaja.

Para determinar si hay un posible punto de aplastamiento o corte, tenga en consideración:

- La probabilidad de que un niño pudiera introducir una parte de su cuerpo dentro del punto y
- La fuerza de cierre alrededor del punto.

En §5.3 Principales tipos de equipos para parque infantil se identifican peligros potenciales de aplastamiento/corte propios de ciertas piezas de equipos de juegos.

3.2 Enredo y empalamiento

Salientes en equipos de juego de parques infantiles no deben tener la capacidad de enredar el vestuario de los niños, ni deben ser tan grandes como para empalar. Para evitar este riesgo:

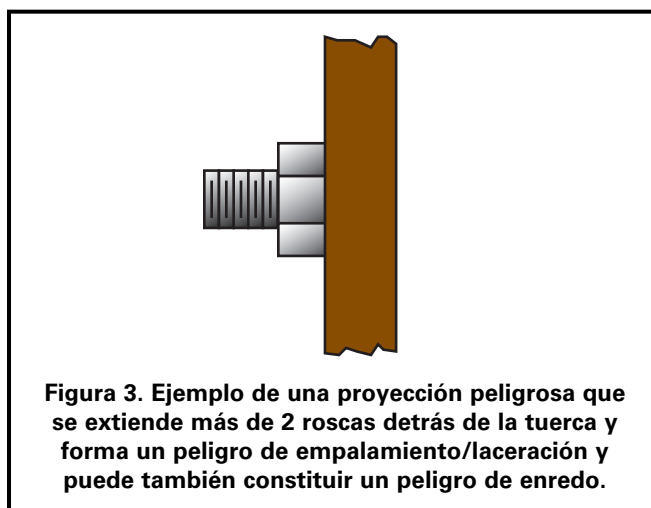
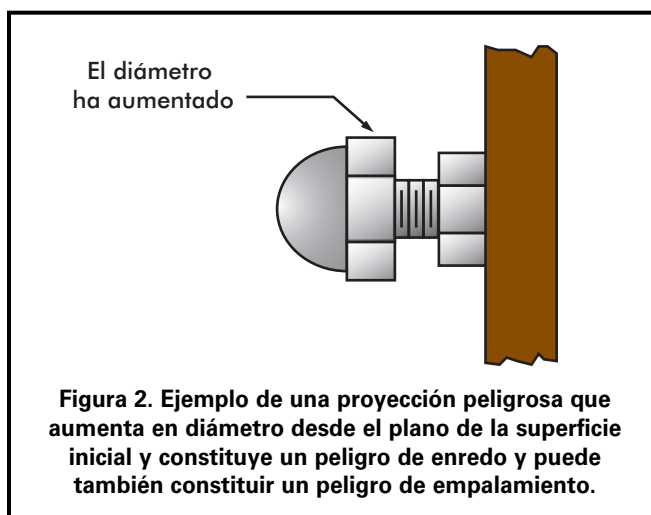
- El diámetro de una proyección no debe prolongarse más allá de la superficie circundante hacia el extremo expuesto.
- Los tornillos no deben sobresalir más de dos roscas después del extremo de la tuerca (Ver Figura 3).
- Todos los ganchos, como aquellos con formas de S o C, deberán cerrarse (véase además §5.3.8.1). Un gancho se considera cerrado si no hay intervalo o un espacio mayor a 0.04 pulgadas, aproximadamente el grosor de una moneda de diez centavos.
 - Cualquier dispositivo de conexión que contenga un relleno que llene completamente el espacio interior previniendo la entrada de artículos de vestuario en el interior del dispositivo está exento de este requisito.

- Los columpios y toboganes tienen recomendaciones adicionales para salientes como se explica en §5.3.
- Vea el Apéndice B para recomendaciones de pruebas.

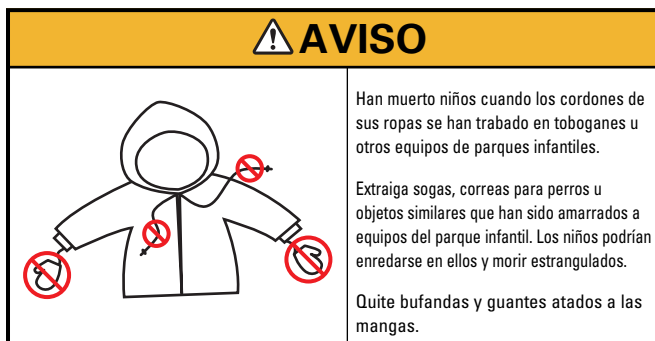
3.2.1 Cordones y sogas

Los cordones en las capuchas de chaquetas, sudaderas y otras prendas para vestir la parte superior del cuerpo pueden enredarse en equipos del parque infantil y causar muerte por estrangulación. Para evitar este riesgo:

- Los niños no deben usar joyas, chaquetas o sudaderas con cordones en capuchas, guantes unidos con cordones a las mangas u otras prendas de vestuario para la parte superior del cuerpo con cordones.
- Extraiga sogas, cuerdas para perros u objetos similares que hayan sido amarrados a equipos del parque infantil. Los niños podrían enredarse en ellos y morir estrangulados.



- Evite equipos con sogas que no estén aseguradas en ambos extremos.
- El siguiente letrero, o un cartel o letrero similar, puede colocarse en o cerca de los toboganes u otros equipos donde puedan ocurrir enredos potenciales.



3.3 Atascos

3.3.1 Atasco de cabeza

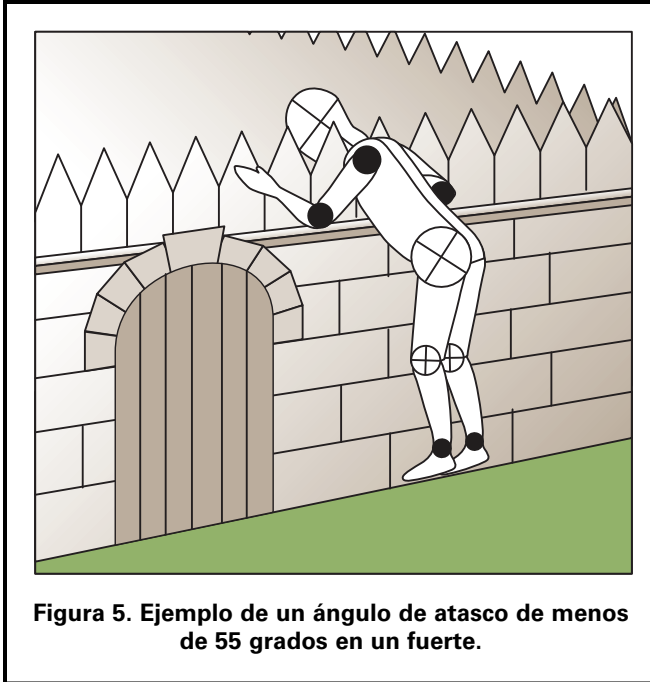
El atasco de cabeza constituye una seria preocupación en los parques infantiles, ya que podría llevar a la muerte por estrangulación. La cabeza de un niño puede verse atrapada si el menor se introduce en una abertura ya sea colocando primero los pies o la cabeza. El atasco de la cabeza por la introducción de ésta primero sucede generalmente cuando los

niños introducen la cabeza en una abertura con una orientación determinada y una vez dentro, la giran en otra dirección y entonces no son capaces de salir. El atasco de la cabeza por introducción de los pies primero ocurre por lo general cuando los niños se sientan o acuestan y deslizan los pies a través de una abertura que es lo suficientemente grande como para permitir que su cuerpo pase, pero no lo suficientemente grande como para permitir que pase la cabeza. Una parte o un grupo de partes no deben formar aberturas que puedan atrapar la cabeza de un niño. Además, los niños no deben usar sus cascos de bicicleta cuando se hallan en un módulo de juegos en el parque infantil. Ha habido incidentes recientes de niños con cascos cuyas cabezas han quedado atrapadas en espacios que normalmente no se considerarían como de posible atasco de cabeza.

Ciertas aberturas podrían constituir un peligro de atasco si la distancia entre superficies interiores opuestas es superior a 3.5 pulgadas e inferior a 9 pulgadas. Estos espacios deberán ser verificados según la recomendación en el Apéndice B. Cuando la dimensión de una abertura se encuentra dentro de este rango, todas las dimensiones de la abertura deben considerarse en conjunto para evaluar la posibilidad de atasco. Incluso aquellas aberturas que sean lo suficientemente bajas como para que los pies del niño toquen el piso pueden presentar un riesgo de estrangulación para un niño atrapado. (Véase Figura 4) Los niños más pequeños pueden no tener la capacidad intelectual o habilidades motoras necesarias para revertir el proceso que causó que sus cabezas se vieran atrapadas, especialmente si se asustan o entran en pánico.



Figura 4. Ejemplos de atascos por debajo de una barrera y entre los barrotes verticales de una barrera.



3.3.2 Aberturas y ángulos parcialmente unidos

Los niños pueden quedar atrapados en aberturas parcialmente unidas, como las que se forman por dos o más partes de un equipo de juegos en un parque infantil.

- Los ángulos formados por dos partes adyacentes accesibles deben ser mayores a 55 grados a no ser que la parte más baja del ángulo sea horizontal o esté por debajo de la horizontal.
- Utilice la prueba para aberturas parcialmente unida en el Apéndice B para identificar ángulos peligrosos y otras aberturas parcialmente unidas.

3.4 Puntas, esquinas y bordes afilados

Las puntas, las esquinas o los bordes afilados en cualquier parte del parque infantil o sus equipos pueden cortar o pinchar la piel de un niño. Los bordes afilados pueden provocar laceraciones serias si no se toman medidas preventivas. Para evitar el riesgo de lesiones por puntas, esquinas o bordes afilados:

- Los extremos abiertos expuestos de todos los tubos que no se apoyen en el piso o estén cubiertos de otra forma deberán cubrirse con tapas o tapones que no puedan ser extraídos sin el uso de herramientas.
- Las partes de madera deben estar lisas y sin astillas.
- Todas las esquinas, ya sean de metal o de madera deberán ser redondeadas.
- Todos los bordes de metal deberán ser enrollados o tener una cubierta redondeada.

- No debe haber bordes afilados en los toboganes. Preste atención en especial a los bordes de metal a lo largo de los laterales y en la salida de toboganes (véase también §5.2.6.4).
- Si se utilizan neumáticos radiales con bandas de acero como parte del equipo de un parque infantil, deberán ser examinadas con cuidado periódicamente para garantizar que no hay bandas/alambres de acero al descubierto.
- Lleve a cabo inspecciones a menudo para prevenir lesiones causadas por madera astillada, o por puntos, esquinas o bordes afilados que pueden desarrollarse como resultado del uso y desgaste del equipo.

3.5 Peligros de elementos que cuelgan

En un parque infantil, los niños pueden lesionarse si se caen sobre elementos colgantes (como cables, alambres, sogas u otras partes flexibles) conectados de una pieza de equipos de juegos a otra, o que están colgando hasta el suelo. Estos elementos que cuelgan pueden convertirse en peligros si se encuentran dentro de un ángulo de 45 grados en la horizontal y están a menos de 7 pies por encima de la superficie protectora. Para evitar el peligro de elementos o componentes que cuelgan, estos:

- Deben colocarse lejos de áreas de mucho tránsito.
- Deben tener colores brillantes o contrastar con los equipos circundantes y con el revestimiento de la superficie.
- No debe poder hacerse un lazo sobre ellos mismos o con otras sogas, cables o cadenas para crear un círculo de un perímetro de 5 pulgadas o más.
- Debe estar atado en ambos extremos a no ser que midan 7 pulgadas o menos de largo, o estén atados a un asiento de columpio.

Estas recomendaciones no son válidas para columpios, redes de escalar o si el componente suspendido mide más de 7 pies sobre el revestimiento protector de la superficie y mide al menos una pulgada en su parte transversal más ancha.

3.6 Peligros de Caídas

Las zonas de juego deben estar libres de peligros de caídas (por ej., un cambio repentino de nivel) para niños que están utilizando un parque infantil. Dos causas muy comunes de caídas son debido a los dispositivos de anclaje de los equipos de juego y las paredes de contención para materiales sueltos del revestimiento de superficie.

- Todos los mecanismos de sujeción para equipos de parques infantiles, como cimientos de concreto o barras

horizontales en la parte inferior de escaladores flexibles deben instalarse por debajo del nivel del suelo y debajo de la base del material de revestimiento protector de la superficie. Esto también servirá para prevenir que los niños sufran lesiones de impactos con el cemento expuesto al caer sobre éste.

- Contrastar el color del revestimiento de la superficie con el color del equipo puede contribuir a una mejor visibilidad.
- Las paredes de contención para la superficie deben ser perfectamente visibles.
- Cualquier cambio de elevación debe ser obvio.
- Contrastar el color de la barrera de contención con el color del revestimiento de la superficie puede contribuir a una mejor visibilidad.

3.7 Neumáticos usados

Los neumáticos usados de automóviles y camiones se reciclan a menudo para ser utilizados como equipamiento de parques

infantiles, como columpios de neumáticos o escaladoras flexibles, o como productos de seguridad tales como un acolchado bajo un subibaja o en trozos como revestimiento protector. Al reciclar neumáticos para usar en los parques infantiles:

- Los neumáticos radiales con bandas de acero deben examinarse con cuidado periódicamente para garantizar que no hay bandas/alambres de acero al descubierto.
- Debe prestarse atención a que el neumático no acumule agua ni desperdicios; por ejemplo, hacer orificios de desagüe en la parte inferior del neumático reduciría el almacenamiento de agua.
- Los productos acolchados hechos de caucho de neumáticos reciclado triturado deben ser inspeccionados antes de la instalación para garantizar que todo el metal ha sido extraído.

En algunas situaciones, los materiales plásticos pueden usarse como alternativa para simular neumáticos reales de automóviles.

4. MANTENIMIENTO DEL PARQUE INFANTIL

El mantenimiento inadecuado de equipos ha causado lesiones en parques infantiles. Dado que la seguridad de los equipos de un parque infantil y su uso adecuado dependen de su debida inspección y mantenimiento, las instrucciones del fabricante acerca del mantenimiento y el programa de inspecciones recomendadas deben cumplirse estrictamente. Si las recomendaciones del fabricante no están a su alcance deberá desarrollarse una guía de mantenimiento sobre la base del uso habitual o anticipado del parque infantil. Los parques infantiles de uso frecuente requerirán inspecciones y mantenimiento con más frecuencia.

4.1 Inspecciones de mantenimiento

Todas las áreas y equipos de un parque infantil deben inspeccionarse para detectar desgaste excesivo, deterioro y cualquier peligro potencial, como aquellos que aparecen en la Tabla 3. Uno de los posibles procedimientos es el uso de listas de verificación. Algunos fabricantes proporcionan listas de verificación para inspecciones generales o detalladas junto con sus instrucciones para mantenimiento. Las mismas pueden usarse para garantizar que las inspecciones cumplan las especificaciones del fabricante. Si las guías de inspección del fabricante no están disponibles, el Apéndice A incluye una lista de verificación general que puede usarse para realizar inspecciones de rutina frecuentes en parques infantiles públicos. Su propósito es resolver solo cuestiones generales de mantenimiento. Las inspecciones detalladas deben prestar especial atención a las partes móviles y otras partes cuyo deterioro puede ser anticipado. Las inspecciones de mantenimiento deben ejecutarse de forma sistemática por personal que esté familiarizado con el parque infantil, como encargados de mantenimiento, supervisores del parque infantil, etc.

4.2 Reparaciones

Un programa completo de mantenimiento no consiste tan solo de inspecciones. Cualquier problema que se detecte durante la inspección debe anotarse y resolverse lo más pronto posible.

- Todas las reparaciones y reemplazos de partes de equipos se deben completar siguiendo las instrucciones del fabricante.
- Las modificaciones del usuario, como sogas con cabos sueltos atadas a partes elevadas, deben retirarse inmediatamente.

Tabla 3. Inspección de rutina y temas de mantenimiento

- | |
|---|
| <input type="checkbox"/> Equipos rotos como tornillos flojos, tapas perdidas, rajaduras, etc. |
| <input type="checkbox"/> Cristales rotos y otros tipos de desperdicios |
| <input type="checkbox"/> Rajaduras en plásticos |
| <input type="checkbox"/> Anclaje suelto |
| <input type="checkbox"/> Escombros peligrosos o dañinos |
| <input type="checkbox"/> Daños provocados por insectos |
| <input type="checkbox"/> Problemas con el revestimiento de la superficie |
| <input type="checkbox"/> Desplazamiento del material de relleno suelto para revestimiento de superficie (ver Sección 4.3) |
| <input type="checkbox"/> Orificios, escamas, y/o deformaciones en la superficie unitaria |
| <input type="checkbox"/> Modificaciones del usuario (como sogas atadas a partes o reubicación del equipo) |
| <input type="checkbox"/> Vandalismo |
| <input type="checkbox"/> Partes desgastadas, flojas, deterioradas o perdidas |
| <input type="checkbox"/> Madera astillada |
| <input type="checkbox"/> Metales oxidados o corroídos |
| <input type="checkbox"/> Putrefacción |

- La frecuencia de inspecciones detalladas para cada equipo dependerá del tipo y edad del mismo, volumen de uso y del clima local.
- Consulte al fabricante para el plan de mantenimiento para cada pieza de los equipos. Según estas guías, se puede crear un plan de mantenimiento para todo el parque infantil. Este plan de rutina para mantenimiento no debe reemplazar las inspecciones habituales.

4.3 Mantenimiento del relleno suelto para revestimiento de superficie

Los materiales de relleno suelto para revestimiento de superficie requieren un mantenimiento especial. Los parques infantiles públicos de mucho uso, como los de las guarderías y escuelas deben inspeccionarse frecuentemente para asegurar que el revestimiento de superficie no se ha desplazado significativamente, particularmente en áreas del parque

infantil más susceptibles al desplazamiento (por ej. debajo de columpios y salidas de toboganes). Esto se facilita marcando la altura ideal del revestimiento de superficie en los postes de los equipos. El relleno suelto de revestimiento de superficie que se ha desplazado debe volver a colocarse en su lugar adecuado para que se mantenga una profundidad constante en todo el parque infantil. Las esteras para amortiguación de impacto dispuestas en las áreas de mucho tráfico como debajo de los columpios y a la salida de los toboganes pueden reducir significativamente el desplazamiento. Dichas esteras deberán instalarse por debajo de la superficie o al mismo nivel de ésta para que no constituyan un peligro de tropiezo.

A continuación los lugares clave que han de revisarse durante los chequeos habituales del revestimiento de superficie:

- Las áreas debajo de los columpios y a la salida de los toboganes. La actividad en estas áreas tiende a desplazar el revestimiento de superficie rápidamente. Con la ayuda de un rastrillo, devuelva el relleno suelto a su sitio.
- Acumulación de agua en revestimientos de superficie de caucho triturado. Por ejemplo, el caucho triturado húmedo se compacta más rápidamente que el seco, más suave. Si se notan charcos con regularidad, considere instalar un sistema de drenaje de mayor capacidad.

- Revestimiento de superficie congelado. La mayoría del relleno suelto para revestimiento de superficie que se congela no puede seguir funcionando como un revestimiento de superficie protector. Aunque las primeras pulgadas estén sueltas, la capa de la base puede estar congelada y la amortiguación del impacto en la superficie de protección puede reducirse en gran medida. Se recomienda que los niños no jueguen en el equipo bajo estas condiciones.

4.4 Conservación de archivos

Se deben conservar registros de todas las inspecciones de mantenimiento y reparaciones, incluyendo las instrucciones de mantenimiento del fabricante y cualquier lista de verificación utilizada. Cuando se realiza una inspección cualquiera, la persona que la hace debe firmar y anotar la fecha en el formulario utilizado. También se deberá mantener un archivo de cualquier accidente y lesiones reportados que hayan ocurrido en el parque infantil. Esto ayudará a identificar peligros potenciales o características peligrosas del diseño que se deben corregir.

5. PARTES DEL PARQUE INFANTIL

5.1 Plataformas, Barandas y Barreras Protectoras

5.1.1 Plataformas

- Las plataformas deben ser generalmente planas (por ejemplo, dentro de $\pm 2^\circ$ de la horizontal).
- En las plataformas deben existir aberturas para que haya drenaje.
- Las plataformas deben minimizar la acumulación de desperdicios.
- Las plataformas para uso de niños pequeños (6 a 23 meses) no deben estar a más de 32 pulgadas del suelo.

5.1.2 Plataformas a diferentes niveles

En algunas estructuras mixtas, las plataformas se suceden a diferentes niveles o gradas para que el niño pueda llegar a la plataforma más alta sin usar peldaños o escaleras. A no ser que exista un modo alternativo de acceso/egreso, la diferencia de altura máxima entre las plataformas escalonadas deberá ser:

- Niños pequeños (6 a 23 meses): 7 pulgadas.
- Edad preescolar: 12 pulgadas.
- Edad escolar: 18 pulgadas.

Se necesita un componente de acceso (como un travesaño) si la altura es mayor que 12 pulgadas para niños de edad preescolar y 18 pulgadas para niños de edad escolar.

El espacio entre las plataformas escalonadas debe seguir las recomendaciones para minimizar el peligro de atasco en las aberturas limitadas:

- Niños pequeños (6 a 23 meses): si el espacio es menor de 7 pulgadas, se debe usar relleno para reducir el espacio a menos de 3.0 pulgadas.
- Edad preescolar: si el espacio excede las 9 pulgadas y la altura de la plataforma más baja por encima de la superficie protectora excede las 30 pulgadas se deberá usar relleno para reducir el espacio a menos de 3.5 pulgadas.
- Edad escolar: si el espacio excede 9 pulgadas y la altura de la plataforma más baja encima de la superficie protectora excede 48 pulgadas el relleno debe usarse para reducir el espacio a menos de 3.5 pulgadas.

5.1.2.1 Altura de caída

- La altura de caída de una plataforma es la distancia entre la parte superior de la plataforma y la superficie protectora debajo de la misma.

5.1.3 Barandas y barreras protectoras

Las barandas y barreras protectoras se usan para reducir la probabilidad de caídas accidentales de plataformas elevadas. Las barreras protectoras brindan mayor protección que las barandas y deben ser diseñadas para disuadir a los niños de subir por encima o a través de la barrera. Las barandas y barreras deben:

- Rodear completamente cualquier plataforma elevada
- Exceptuando aberturas de entrada y salida, las aberturas que no tienen una baranda superior horizontal, no deben medir más de 15 pulgadas.
- Prevenir caídas accidentales de la plataforma
- Prevenir la posibilidad de atasco
- Facilitar la supervisión

Por ejemplo:

- Las barandas pueden constar de una barra superior horizontal y barrotes verticales con espacios mayores de 9 pulgadas. Estas aberturas no presentan un riesgo de atasco pero no impiden a un niño subir a través de las aberturas.
- Una barrera debe minimizar la probabilidad de que un niño pase durante intentos deliberados de franquear la barrera. Cualquier abertura entre elementos verticales o entre la superficie de la plataforma y el borde de una barrera protectora debe evitar el paso de una plantilla de torso infantil utilizada para verificar su adecuación (ver verificación en B.2.5).

Las barandas o barreras protectoras deben colocarse en plataformas elevadas, pasillos, descansos, escaleras y superficies de transición. En general, mientras más pequeño sea el niño menor coordinación y balance tendrá, lo cual lo hace más vulnerable a caídas accidentales. Los niños pequeños (6 a 23 meses) son los más vulnerables y el equipo para esta edad debe contar con barreras en todas las superficies para caminar que estén elevadas por encima de 18 pulgadas. Las habilidades físicas se desarrollan más en niños de edad preescolar y más aun en niños de edad escolar. Por lo tanto, la elevación mínima que se recomienda para las barandas y barreras aumenta según el grupo de edades.

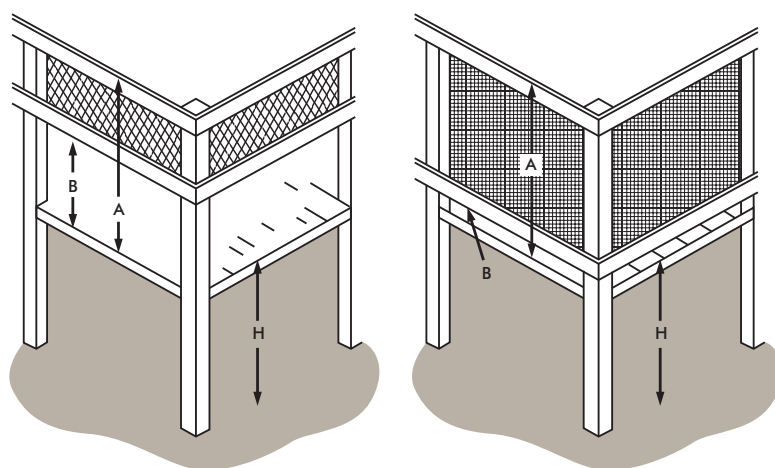
Las barandas y barreras deben ser lo suficientemente altas para evitar que los niños más altos se caigan por encima de ellas. En el caso de las barandas, el borde inferior debe ser lo suficientemente bajo para que los niños más pequeños no caminen por debajo del mismo. Las barreras deben ser lo suficientemente bajas para impedir al niño más diminuto pasar por debajo de ellas en forma alguna. Esto se consigue generalmente diseñando la barrera de manera tal que al efectuar la prueba con la plantilla de un torso de niño pequeño (ver los métodos de prueba en el Apéndice B) no pueda pasar por debajo o a través de la barrera. Los rellenos verticales para las barreras protectoras pueden ser preferibles para los niños más pequeños porque los componentes

verticales pueden ser alcanzados a cualquier altura que el niño escoja para agarrarse.

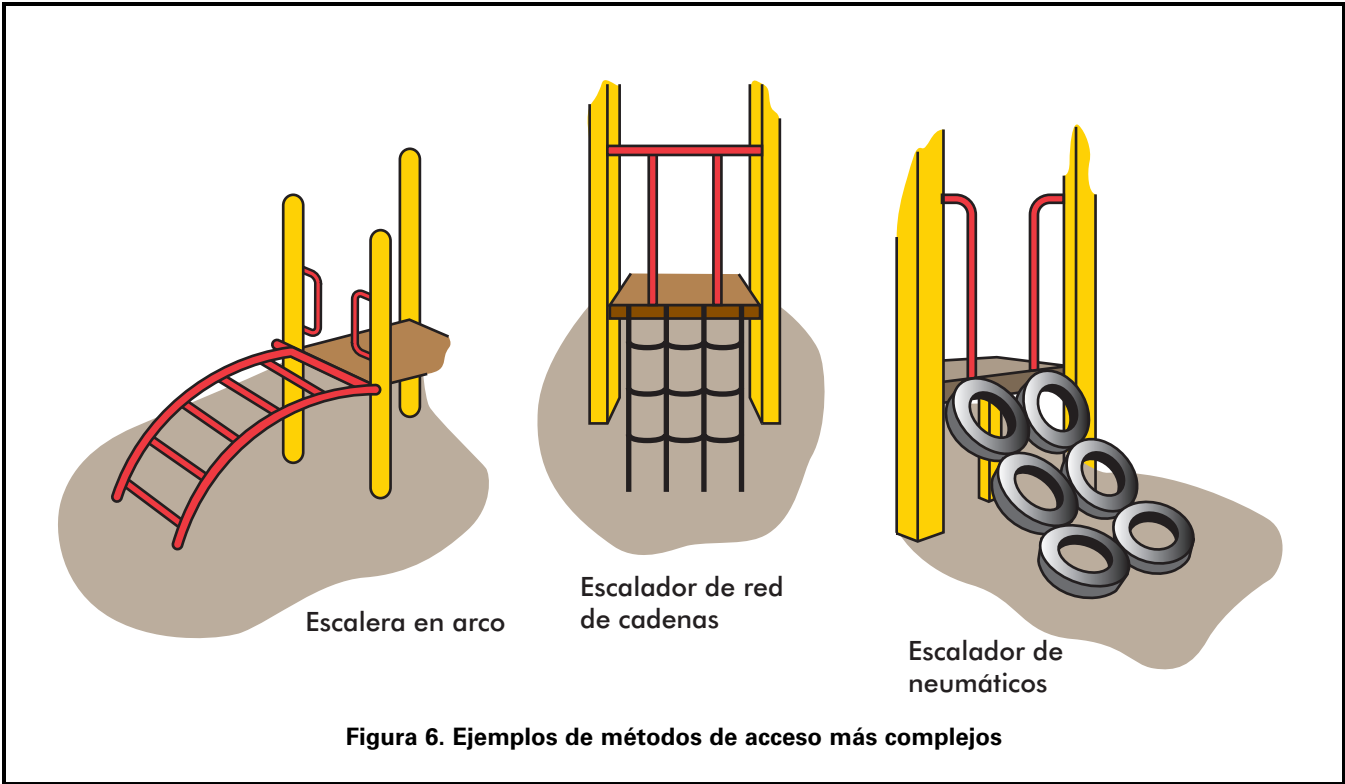
Las recomendaciones para las barandas y barreras aparecen en la Tabla 4. Sin embargo, la recomendación no debe seguirse si la baranda o barrera interfiere con la intención de uso del equipo, como:

- equipos para escalar
- plataformas con secuencia de niveles cuya altura de caída sea:
 - niños pequeños (6 a 23 meses): 7 pulgadas o menos.
 - edad preescolar: 20 pulgadas o menos.
 - edad escolar: 30 pulgadas o menos.

Tabla 4. Barandas y Barreras



	Baranda	Barrera
Protege contra caídas accidentales de la plataforma	Sí	Sí
Disuade el escalamiento	No	Sí
Protege del escalamiento a través de ella	No	Sí
Niños pequeños (6 a 23 meses)		
A Distancia de la plataforma al borde superior	No recomendado	A = 24" o más alta
B Distancia de la plataforma al borde inferior	No recomendado	B < 3"
H Recomendado cuando la altura de caída la plataforma es:	No recomendado	H = 18" o más alta
Niños en edad preescolar		
A Distancia de la plataforma al borde superior	A = 29" o más alta	A = 29" o más alta
B Distancia de la plataforma al borde inferior	9" < B ≤ 23"	B < 3.5"
H Recomendado cuando la altura de caída la plataforma es:	20" < H ≤ 30"	H > 30"
Niños en edad escolar		
A Distancia de la plataforma al borde superior	A = 38" o más alta	A = 38" o más alta
B Distancia de la plataforma al borde inferior	9" < B ≤ 28"	B < 3.5"
H Recomendado cuando la altura de caída la plataforma es:	30" < H ≤ 48"	H > 48"



5.2 Métodos de acceso a equipos de juego

El acceso a los equipos del parque infantil puede presentar varias formas, como rampas convencionales, escaleras con peldaños, y escalerillas con travesaños o peldaños. También puede ocurrir por medio de componentes para escalar como arcos para escalar, redes de escalar y neumáticos (ver figura 6)

A medida que los niños se desarrollan adquieren mayor balance y coordinación, por lo que es importante escoger los métodos de acceso apropiados según la edad del grupo. La Tabla 5 presenta los métodos más comunes de acceso y los grupos de edad apropiados.

El acceso a plataformas de más de 6 pies de alto (excepto para toboganes independientes) debe brindar una superficie intermedia de descanso para que el niño pueda hacer una pausa y tomar la decisión de continuar subiendo o buscar otra manera de descender. En general los niños dominan el acceso antes que la salida, o sea, pueden subir antes de saber bajarse de un componente complejo. Por lo tanto si existen métodos de acceso más difíciles es importante tener componentes de salida más fáciles.

Tabla 5. Métodos de acceso y salida

Método de Acceso	Nivel de Riesgo	Apropiado para
Rampas	El más fácil	Niños Pequeños +
Escaleras rectas	Fácil	Niños Pequeños +
Escaleras en espiral	Moderado	Niños Pequeños* +
Escaleras de peldaños	Moderado	15 meses* +
Escalera de travesaños	Moderado	Preescolar* +
Escalador en arco	Difícil	Preescolar* +
Escaladores flexibles (redes, neumáticos)	Difícil	Preescolar* +

* solo si también se brinda un método fácil de salida

5.2.1 Rampas, escaleras, escaleras de travesaños y escaleras de peldaños

Existen diferentes recomendaciones para las dimensiones de pendientes y peldaños de rampas, escaleras, escaleras de travesaños y escalerillas; pero los escalones o travesaños deben hallarse siempre a la misma distancia, incluso en el caso del peldaño o travesaño superior y la superficie de la plataforma ha de mantenerse igual espacio. La tabla 6 contiene las dimensiones recomendadas para las pendientes de acceso, ancho de peldaños o de travesaños, profundidad de los peldaños, diámetro de los travesaños, y elevación vertical para escalas de travesaños o peldaños y escaleras. La Tabla 6 también incluye recomendaciones para pendientes y anchuras de rampas. Sin embargo, estas recomendaciones no están dirigidas a las rampas diseñadas para el acceso en sillas de ruedas.

- Los espacios entre peldaños o travesaños y entre el peldaño o travesaño superior y la superficie inferior de una plataforma deben prevenir atascos.
- Cuando las contrahuellas están cerradas, los peldaños en las escaleras y escalerillas deben evitar la acumulación de arena, agua u otros materiales en los peldaños o entre ellos.
- El equipo de escalada debe permitir que los niños desciendan tan fácilmente como ascienden. Una manera de implementar esta recomendación es brindar una alternativa más fácil de descenso, como otro método para la salida, una plataforma, u otra pieza del equipo. Por ejemplo, se puede añadir una escalera para ofrecer un método de descenso menos complejo que una escalera vertical de travesaños o un aparato de escalada flexible (ver tabla 5).
- Para los niños pequeños (6 a 23 meses) y los de edad escolar es importante ofrecer una vía de salida fácil pues suelen desarrollar habilidades para descender componentes de escalada más tarde que las necesarias para subirlos.

Tabla 6. Dimensiones recomendadas para escaleras de acceso, escaleras y rampas*

EDAD DEL USUARIO POTENCIAL			
Tipo de Acceso	Niño pequeño	En edad preescolar	En edad escolar
<i>Rampas (no diseñadas para cumplir las especificaciones de ADA/ABA)</i>			
Pendiente (vertical: horizontal)	< 1:8	≤ 1:8	≤ 1:8
Ancho (simple)	≥ 19"	≥ 12"	≥ 16"
Ancho (doble)	≥ 30"	≥ 30"	≥ 36"
<i>Escaleras</i>			
Pendiente	≤ 35°	< 50°	< 50°
Ancho del peldaño (simple)	12-21"	≥ 12"	≥ 16"
Ancho del peldaño (doble)	≥ 30"	≥ 30"	≥ 36"
Profundidad del peldaño (sin contrahuella)	No apropiado	≥ 7"	≥ 8"
Profundidad del peldaño (sin contrahuella)	≥ 8"	≥ 7"	≥ 8"
Elevación Vertical	≤ 7"	≤ 9"	≤ 12"
<i>Escalerillas de peldaños</i>			
Pendiente	35≤65°	50-75°	50-75°
Ancho del peldaño (simple)	12-21"	12-21"	≥ 16"
Ancho del peldaño (doble)	No apropiados	No apropiado	≥ 36"
Profundidad del peldaño (sin contrahuella)	No apropiado	≥ 7"	≥ 3"
Profundidad del peldaño (con contrahuella)	8"	≥ 7"	≥ 6"
Elevación Vertical	> 5 "and ≤ 7"	≤ 9"	≤ 12"
<i>Escaleras de travesaños</i>			
Pendiente	No apropiado	75-90°	75-90°
Ancho del travesaño	No apropiado	≥ 12"	≥ 16"
Elevación	No apropiado	≤ 12"	≤ 12"
Diámetro del travesaño	No apropiado	0.95-1.55"	0.95-1.55"
* las recomendaciones para atasco son válidas para todas las aberturas en elementos de acceso			

5.2.2 Travesaños y otros componentes para agarre de manos.

A diferencia de las escaleras y escalerillas de peldaños que son principalmente para apoyo de pies, los travesaños pueden usarse para apoyo de pies y de manos.

- Los travesaños con formas redondeadas son más fáciles de agarrar para los niños.
- Todos los agarres de mano deben estar asegurados de modo tal que no puedan virarse.
- Niños pequeños (6 a 23 meses):
 - Los pasamanos u otros medios de apoyo de manos deben tener un diámetro o sección transversal máximo entre 0.60 y 1.20 pulgadas.
 - Se prefiere un diámetro o sección transversal máximos de 0.90 para lograr una fuerza de agarre máxima y beneficiar a los niños más débiles.
- Edad preescolar y escolar:
 - Travesaños, pasamanos, barras de escalada u otros medios de apoyo de manos para aguantarse deben tener un diámetro o sección transversal máximos entre 0.95 y 1.55 pulgadas.
 - Se prefiere un diámetro o sección transversal máximos de 1.25 pulgadas para lograr una fuerza de agarre máxima y beneficiar a los niños más débiles.

5.2.3 Pasamanos

Los pasamanos en escaleras y escalerillas de peldaños brindan apoyo de manos para afianzar al que los usa. Los pasamanos continuos que se extienden a todo lo largo del acceso deben proveerse a ambos lados de todas las escaleras y escalerillas de peldaños sin importar la altura del medio de acceso. Las escaleras de travesaños no requieren pasamanos porque los travesaños o apoyos laterales brindan apoyo de mano en estos accesos mucho más inclinados.

5.2.3.1 Altura de pasamanos

Los pasamanos deben ser accesibles para el uso a la altura apropiada, comenzando con el primer peldaño. La distancia vertical entre la parte superior del borde frontal de un peldaño o superficie con rampa y la superficie superior del pasamanos sobre este debe ser la siguiente:

- Niños pequeños (6 a 23 meses): entre 15 y 20 pulgadas.
- Edad preescolar: entre 22 y 26 pulgadas
- Edad escolar: entre 22 y 38 pulgadas.

5.2.4 Transición desde el acceso a la plataforma

Los pasamanos o agarraderas se recomiendan en todos los puntos de transición (los puntos donde el niño debe moverse del componente de acceso a la plataforma de estructura de juego)

- La agarradera debe brindar apoyo desde el componente de acceso hasta que el niño haya adquirido completamente la posición deseada en la plataforma.
- Ningún espacio entre el pasamanos y la estructura vertical adyacente (por ej. poste de apoyo vertical para plataforma o tablilla vertical de una barrera protectora) debe constituir un peligro de atasco.
- Las formas de acceso que no poseen pasamanos, como escaleras de travesaños, escaladores flexibles, escaladores en arco y neumáticos deben brindar apoyo de manos para la transición entre la parte superior del medio de acceso y la plataforma.

5.3 Principales tipos de equipos de parque infantil

5.3.1 Barras de equilibrio

- Las barras de equilibrio no deben ser más altas de:
- Niños pequeños (6 a 23 meses): no se recomienda.
- Edad preescolar: 12 pulgadas
- Edad escolar: 16 pulgadas.

5.3.1.1 Altura de caída

La altura de caída de una barra de equilibrio es la distancia entre la parte superior de la superficie para caminar y la superficie protectora debajo.

5.3.2 Equipos para escalar y para la parte superior del cuerpo

El equipo para escalar está generalmente diseñado para presentar un grado mayor de dificultad física que otros equipos del parque infantil. Este tipo de equipo requiere el uso de las manos para desplazarse hacia arriba o a través del equipo. Por “escaladores” se entiende una amplia variedad de equipos, que incluyen pero no se limitan a:

- Escaladores en arco
- Escaladores de cúpula
- Escaladores flexibles (usualmente cadenas o redes)
- Barras paralelas



Escalador en arco simple



Escalador geodésico de cúpula



Escalera horizontal



Escalera horizontal de lazos

Figura 7. Ejemplos de escaladores

- Postes de deslizamiento
- Escaladores en espiral
- Equipos para la parte superior del cuerpo (escaleras horizontales por encima de la cabeza, anillas suspendidas por encima de la cabeza, tirolinas).

Los niños en edad escolar tienden a usar equipos de escalar y para la parte superior del cuerpo con más habilidad que los niños en edad preescolar. Los niños pequeños (6 a 23 meses) en edad preescolar pueden tener dificultades al usar algunos de los escaladores porque aun no han desarrollado parte de las habilidades físicas necesarias para ciertas actividades de escalada (balance, coordinación y fuerza en la parte superior del cuerpo). Los niños mayores en edad preescolar (por ej. 4 y 5 años) comienzan a usar los escaladores flexibles, de arco y los aparatos para la parte superior del cuerpo.

5.3.2.1 Consideraciones del diseño

5.3.2.1.1 Distribución de los componentes para escalar

Cuando los componentes para escalar son parte de una estructura compuesta su nivel de complejidad y método de uso debe ser compatible con el flujo del tráfico de los componentes cercanos. Los aparatos para la parte superior del cuerpo deben colocarse de manera que el movimiento oscilante generado por los niños en estos equipos no interfiera con el movimiento de los niños en las estructuras adyacentes, particularmente los niños deslizándose por los toboganes. El diseño de las estructuras de juego adyacente no debe facilitar la subida a las barras superiores de apoyo de los equipos para la parte superior del cuerpo.

5.3.2.1.2 Altura de caída

Escaladores

- A no ser que se especifique de otro modo en esta sección, la altura de caída para escaladores es la distancia entre la parte más alta del componente para escalar y la superficie protectora debajo del mismo.
- Si el escalador es parte de una estructura compuesta, la altura de caída es la distancia entre la parte más alta del escalador para apoyar los pies y la superficie protectora debajo del mismo.
 - Si el escalador es parte de una estructura compuesta, la altura de caída es la distancia entre la parte más alta del escalador para apoyar los pies y la superficie protectora debajo del mismo.

Equipo para la parte superior del cuerpo:

- La altura de caída de equipos para la parte superior del cuerpo es la distancia entre la parte más alta del equipo y la superficie protectora debajo.

5.3.2.1.3 Travesaños para escalar

Algunos de los métodos de acceso examinados en 5.2 son también considerados equipos para escalar; por lo tanto, las recomendaciones para el tamaño de los travesaños para escalar son similares.

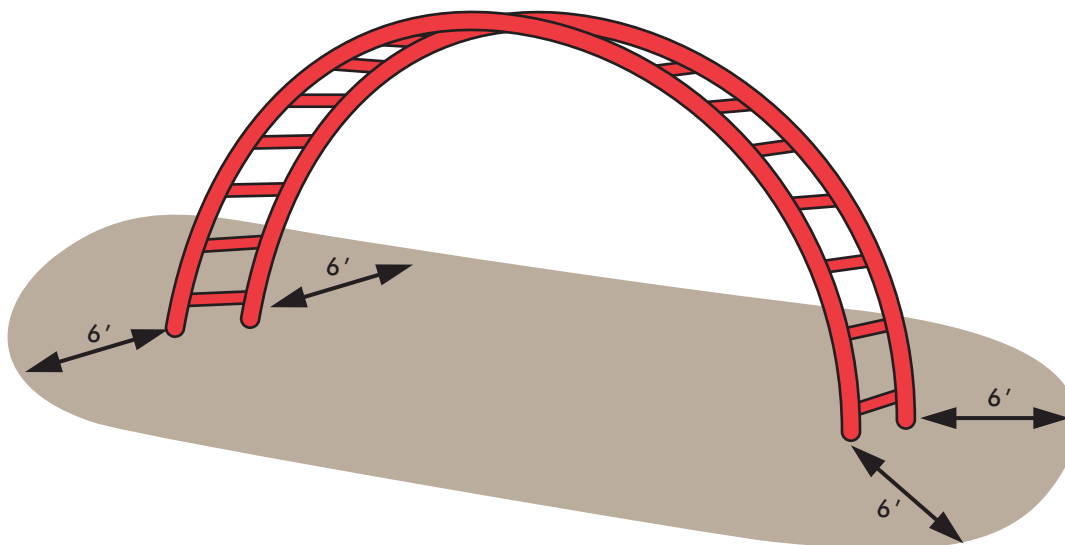


Figura 8. Zona de uso alrededor de un escalador autónomo en arco

- Los travesaños deben ser por lo general redondos.
- Todos los travesaños deben estar asegurados de manera que no puedan virarse.
- Los travesaños para escalar deben seguir las mismas recomendaciones dadas en §5.2.2. para sus diámetros.

5.3.2.1.4 Zona de uso

- La zona de uso debe extenderse un mínimo de 6 pies en todas las direcciones desde el perímetro del escalador autónomo. Ver Figura 8.
- La zona de uso de un escalador puede solaparse con equipos vecinos si la zona de uso de los otros equipos así lo permite y
 - Existe al menos 6 pies entre los equipos cuando las superficies de juego adyacentes no miden más de 30 pulgadas de altura
 - Existen al menos 9 pies entre equipos cuando las superficies de juego designadas adyacentes no miden más de 30 pulgadas de altura

5.3.2.1.5 Otras consideraciones

- Los escaladores no deberán tener barras de escalar u otros componentes de estructura rígida en el interior del

escalador de los que un niño pueda caerse de una altura mayor de 18 pulgadas. Ver Figura 9 para un ejemplo de un escalador que **NO** se atiene a esta consideración.



Figura 9: Escalador con componentes estructurales rígidos que NO cumple con 5.3.2.1.5

5.3.2.2 Escaladores de arco

Los escaladores de arco consisten en travesaños conectados a apoyos laterales convexos. Pueden ser autónomos (Figura 10) o presentarse como un método más complejo de acceso a otros equipos (Figura 11).

- Los escaladores de arco no deben utilizarse como único método de acceso a otros equipos para niños en edad preescolar.
- Los escaladores autónomos no se recomiendan para niños pequeños (6 a 23 meses) o niños en edad preescolar.
- El diámetro de los travesaños y el espacio entre ellos en escaladores de arco deben seguir las recomendaciones para escaleras de travesaños de la Tabla 6.

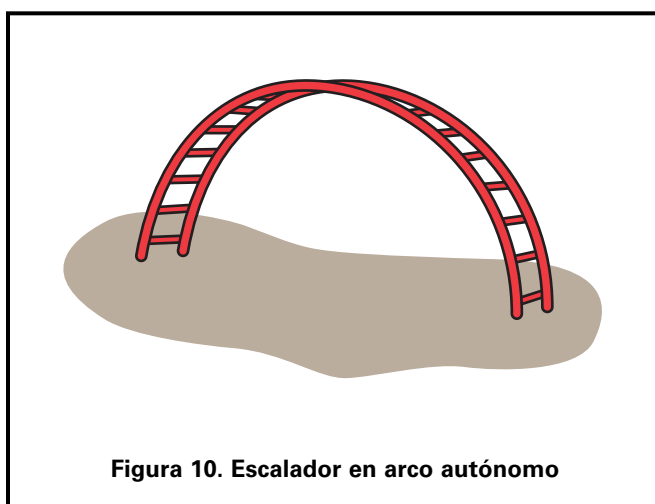


Figura 10. Escalador en arco autónomo

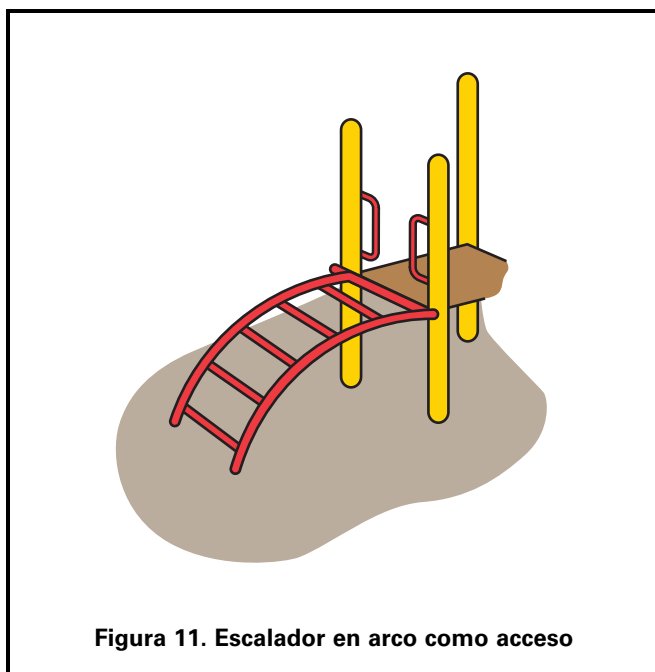


Figura 11. Escalador en arco como acceso



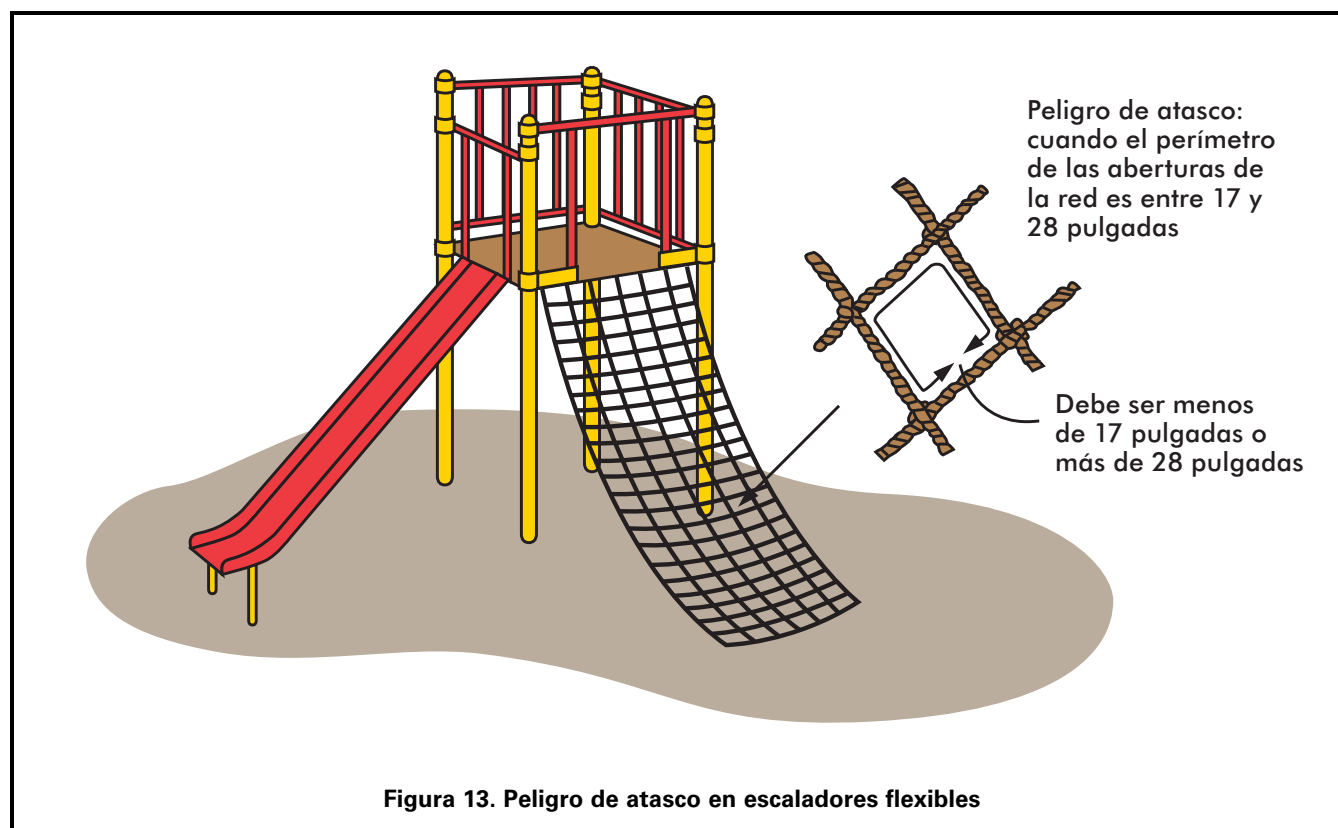
Figura 12. Ejemplos de escaladores flexibles de dos y tres dimensiones

5.3.2.3 Escaladores flexibles

Los escaladores flexibles usan un entramado de sogas, cadenas, cables o neumáticos para escalar. Debido a que las partes flexibles no constituyen un método firme de apoyo, los escaladores flexibles requieren habilidades de balance más desarrolladas que los escaladores rígidos.

Las sogas, cadenas y cables generalmente forman una estructura similar a una red que puede tener dos o tres dimensiones. Ver Figura 12. Los escaladores de neumáticos pueden tener asegurados los neumáticos paso a paso para formar un entramado en pendiente o los neumáticos pueden estar suspendidos individualmente por cadenas u otros medios.

- Los escaladores flexibles que proporcionan acceso a plataformas deben estar anclados con seguridad en ambos extremos.
- Cuando están conectados al suelo los dispositivos de anclaje deben ser instalados por debajo del nivel de la superficie y debajo de la base del material protector de revestimiento de superficie.
- Las conexiones entre sogas, cables, cadenas o entre neumáticos deben ser fijadas de forma segura.
- Los escaladores flexibles no se recomiendan como el único método de acceso al equipo designado para niños pequeños (6 a 23 meses) y niños de edad escolar.
- Los escaladores autónomos y flexibles no se recomiendan en parques infantiles designados para niños pequeños (6 a 23 meses) y niños en edad preescolar.
- El espacio entre los componentes horizontales y verticales de una red para escalar no deben crear peligros de atasco.
- El perímetro de cualquier abertura en una estructura de red debe ser menor que 17 pulgadas o mayor que 28 pulgadas (ver Figura 13).



5.3.2.4 Escaleras horizontales (por encima de la cabeza)

Las escaleras horizontales (por encima de la cabeza) son un tipo de escalador diseñado para fortalecer la parte superior del cuerpo. Están diseñadas para permitir que los niños se muevan de un extremo a otro a través de la escalera usando solo sus manos.

Los niños de cuatro años son generalmente los más pequeños que pueden usar equipos como estos para la parte superior del cuerpo, por lo tanto las escaleras horizontales no deben ser utilizadas en parques para el uso de niños pequeños (6 a 23 meses) y de 3 años. Las recomendaciones que aparecen abajo fueron pensadas para acomodar a niños de 4 a 12 años de edad.

- La primera agarradera en cualquier extremo de un equipo para la parte superior del cuerpo no debe colocarse directamente encima de la plataforma o travesaño para escalar que se use para subir o bajarse. Esto reduce el riesgo de impacto de estructuras de acceso rígidas si los niños se caen de la primera agarradera al subirse o bajarse.
- La distancia horizontal hasta la primera agarradera será:
 - No más de 10 pulgadas pero no debe estar directamente encima de la plataforma cuando el acceso es desde una plataforma.
 - Al menos 8 pulgadas pero no más de 10 cuando el acceso es desde travesaños para escalar.
- El espacio entre travesaños adyacentes de escaleras por encima de la cabeza debe ser de más de 9 pulgadas para prevenir atascos.
- Las escaleras horizontales para uso de niños en edad preescolar deben tener travesaños paralelos entre sí y situados a igual distancia.
- La altura máxima de una escalera horizontal (por ej. medida desde el centro del agarre hasta la parte superior de la superficie protectora debajo) deberá ser:
 - Edad preescolar (4 y 5 años): no más de 60 pulgadas
 - Edad escolar: no más de 84 pulgadas.
- El espacio de centro a centro de los travesaños de las escaleras horizontales debe ser:
 - Edad preescolar (4 y 5 años): no más de 12 pulgadas.
 - Edad escolar: no más de 15 pulgadas.
- La altura máxima de la plataforma de entrada/salida encima de la superficie protectora deberá ser:
 - Edad preescolar (4 y 5 años) no más de 18 pulgadas
 - Edad escolar: no más de 36 pulgadas.

5.3.2.5 Anillas suspendidas por encima de la cabeza

Las anillas suspendidas por encima de la cabeza son similares a las escaleras horizontales en cuanto a complejidad de uso. Por lo tanto, las mismas no deben ser utilizadas en parques infantiles para niños pequeños (6 a 23 meses) ni de 3 años. Las recomendaciones a continuación están concebidas para el uso de niños de 4 a 12 años de edad.

Las anillas suspendidas se diferencian de las escaleras horizontales, pues, durante su uso, la anilla agarrada se balancea en arco y reduce así la distancia hasta el área de agarre de la próxima anilla; por ello no son válidas las recomendaciones para las distancias de espacios en escaleras horizontales.

- El primer agarre en cualquier extremo del módulo para la parte superior del cuerpo no debe colocarse directamente sobre la plataforma o travesaño utilizado para subir y bajar. Esto disminuye el riesgo de que los niños se golpeen con estructuras de acceso rígidas si se caen al sujetarse del primer agarre al subirse o bajarse.
- La distancia horizontal hasta el primer agarre debe medir:
 - No más de 10 pulgadas pero no debe estar directamente sobre la plataforma cuando el acceso es por plataforma.
 - Al menos 8 pulgadas pero no más de 10 pulgadas cuando el acceso es desde travesaños de ascenso.
- La altura máxima de las anillas suspendidas por encima de la cabeza medida desde el centro del dispositivo de agarre hasta el revestimiento protector de superficie debe ser:
 - Niños en edad preescolar (4 y 5 años): 60 pulgadas.
 - Niños en edad escolar: 84 pulgadas.
- Si las anillas que se balancean cuelgan de cadenas, la longitud máxima de las cadenas debe ser de 7 pulgadas.
- La altura máxima de la plataforma de entrada/salida sobre el revestimiento de superficie protector debe ser:
 - Niños en edad preescolar (4 y 5 años): no más de 18 pulgadas.
 - Niños en edad escolar: no más de 36 pulgadas.

5.3.2.6 Postes de deslizamiento

Los postes verticales de deslizamiento presentan un desafío más complejo que otros tipos de equipos para escalar. Requieren fuerza en la parte superior del cuerpo y coordinación para descender por el poste con éxito. A diferencia de otras formas de salida, no hay posibilidad de regreso o interrupción, por lo que un niño no puede cambiar de idea. Los niños que empiezan a deslizarse por el poste deben tener la fuerza para llegar hasta abajo o de lo contrario se caerán.

- Los postes de deslizamiento no se recomiendan para niños pequeños (6 a 23 meses) o en edad preescolar, ya que éstos por lo general no tienen la fuerza necesaria en las manos y/o parte superior del cuerpo para deslizarse.

- Los postes de deslizamiento deben ser continuos y no presentar empalmes o soldaduras que sobresalgan en la superficie de deslizamiento.
- El poste no debe cambiar de dirección en la sección de deslizamiento.
- La distancia horizontal entre un poste de deslizamiento y cualquier otra estructura utilizada para el acceso al poste debe tener entre 18 y 20 pulgadas.
- El poste debe extenderse al menos 60 pulgadas por encima del nivel de la plataforma o estructura de acceso al poste.
- El diámetro de los postes de deslizamiento no debe ser mayor de 1.9 pulgadas.
- Los postes de deslizamiento y sus estructuras de acceso deben estar situados de manera tal que el tránsito procedente de otras actividades no interfiera con los usuarios en el momento del descenso.
- En la parte superior solo se debe acceder desde un solo punto.
- El área de acceso a la parte de arriba a través de la baranda o barrera debe tener a lo sumo 15 pulgadas.

5.3.2.6.1 Altura de caída

- Para postes de deslizamiento que se alcancen desde plataformas, la altura de caída es la distancia entre la plataforma y el revestimiento protector debajo de ésta.
- Para postes de deslizamiento a los que no se acceda desde plataformas, la altura de caída es la distancia entre un punto a 60 pulgadas por debajo del punto más alto del poste y el revestimiento protector debajo de éste.
- La parte superior de la estructura de soporte del poste de deslizamiento no debe ser un área designada de juego.

5.3.2.7 Tirolinas

Las tirolinas son un tipo de equipo para la parte superior del cuerpo donde el niño se sujeta a un asidero u otro dispositivo que se desliza por un carril por encima de su cabeza. El niño alza los pies y es transportado por el carril. Las tirolinas requieren bastante fuerza en la parte superior del cuerpo, y capacidad de discernimiento para saber cuándo es seguro soltarse. Estas capacidades no se desarrollan hasta que los niños estén al menos en edad escolar; por lo tanto, el personal de la CPSC recomienda que:

- Las tirolinas no deben utilizarse en parques infantiles para niños pequeños (6 a 23 meses) o en edad preescolar.
- Las tirolinas no deben presentar obstáculos en el tramo del recorrido, incluyendo cualquier cosa que pudiera interferir en las áreas de entrada o salida.

- Las tirolinas de dos carriles uno al lado del otro deben estar separadas por una distancia de al menos 4 pies.
- El agarre debe estar entre 64 y 78 pulgadas del revestimiento de superficie y atenerse a las recomendaciones para asideros ofrecidas en §5.2.2.
- Nunca se debe atar o adosar algo a ninguna parte movable de una tirolina.
- Los elementos que ruedan deben estar cerrados para prevenir peligros de aplastamiento.

5.3.2.7.1 Altura de caída

- La altura de caída para equipos de tirolinas es la distancia entre la altura máxima del módulo y el revestimiento protector de superficie debajo de ésta.
- Los postes de soporte del equipo que no tienen áreas de juego designadas están libres de este requisito.

5.3.3 Rodillos

Los rodillos permiten a los niños mayores dominar habilidades de equilibrio y aumentar la fuerza. Los niños deben mantener el equilibrio sobre el rodillo mientras lo hacen girar con sus pies. Véase Figura 14.

- Los rodillos no se recomiendan para niños pequeños (6 a 23 meses) o en edad preescolar. Estos niños por lo general no poseen el equilibrio, la coordinación y la fuerza necesarias para el uso seguro de un rodillo.
- Los rodillos deben tener asideros que ayuden a mantener el equilibrio.
- Los asideros deben atenerse a las recomendaciones ofrecidas en §5.2.2.
- El punto más alto del rodillo debe estar a un máximo de 18 pulgadas por encima del revestimiento protector debajo de éste.
- Si no es parte de una estructura compuesta, la zona de uso puede solapar equipos vecinos si el otro equipo permite la coexistencia de zonas de uso (véase §5.3.9) y
 - hay al menos 6 pies entre los equipos cuando la superficie adyacente de juego designada no tiene una altura de más de 30 pulgadas; o
 - hay al menos 9 pies entre los equipos cuando la superficie adyacente de juego designada tienen una altura de más de 30 pulgadas.

5.3.3.1.1 Altura de caída

La altura de caída de un rodillo es la distancia entre la parte más alta del rodillo y el revestimiento protector debajo de éste.

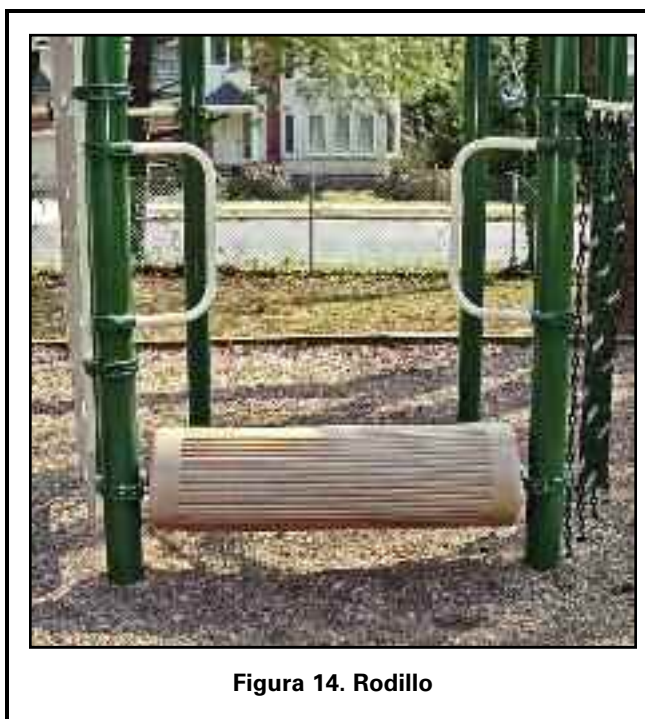


Figura 14. Rodillo

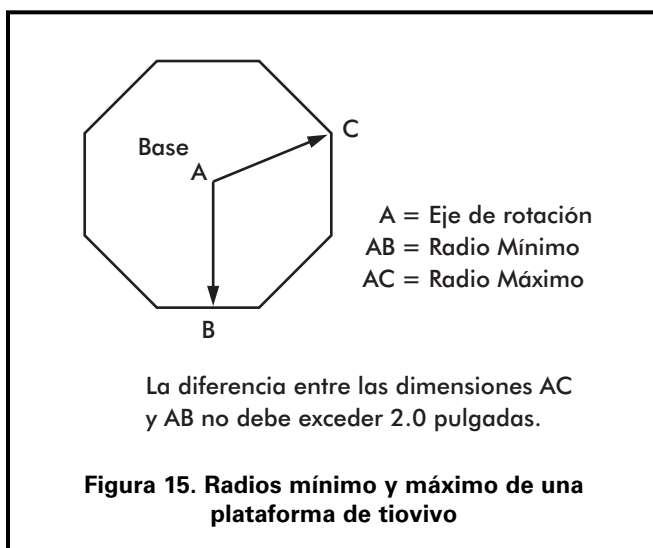
5.3.4 Tiovivos

Los tiiovivos son el equipo de rotación más común que se encuentran en parques infantiles. Los niños por lo general se sientan o paran en la plataforma mientras que otros niños o adultos empujan el tiiovivo para hacerlo girar. Además, los niños suben y bajan a menudo mientras está en movimiento. Los tiiovivos pueden presentar un peligro físico para niños de edad preescolar que tienen poco o ningún control de tales aparatos cuando están en movimiento. Por ello, los niños de este grupo de edad deben estar siempre bajo supervisión cuando utilizan tiiovivos.

A continuación las recomendaciones válidas para tiiovivos con un diámetro de al menos 20 pulgadas.

- Los tiiovivos no deben utilizarse en parques infantiles para niños pequeños (6 a 23 meses).
- El área para pararse o sentarse en la plataforma debe tener una altura máxima de:
 - Edad preescolar: 14 pulgadas por encima del revestimiento protector de superficie.
 - Edad escolar: 18 pulgadas por encima del revestimiento protector de superficie.
- La plataforma que gira debe ser continua y aproximadamente circular.
- La superficie de la plataforma no debe tener aberturas entre el eje y la periferia que permitan penetrar completamente a través de la superficie una barra con un diámetro de 5/16 pulgadas.

- La diferencia entre el radio mínimo y máximo de una plataforma no circular no debe exceder las 2 pulgadas (Figura 15).



- La parte inferior del perímetro de la plataforma no debe estar a menos de 9 pulgadas por encima del nivel del revestimiento protector de superficie bajo ésta.
- No deben existir mecanismos accesibles de corte o aplastamiento en el chasis del equipo.
- Debe proporcionarse una forma de agarre segura para los niños. Donde existan agarraderas, éstas deben cumplir con las recomendaciones generales para elementos de agarre en §5.2.2.
- Ningún elemento del aparato, incluyendo las agarraderas, debe extenderse más allá del perímetro de la plataforma.
- La plataforma giratoria de un tiovivo no debe tener bordes afilados.
- Debe proporcionarse una forma de limitar la velocidad periférica de la rotación a un máximo de 13 pies/segundo.
- Las plataformas de un tiovivo no debe tener movimientos de arriba hacia abajo (oscilatorios).

5.3.4.1 Zona de uso

- La zona de uso debe extenderse un mínimo de 6 pies más allá del perímetro de la plataforma.
- La zona de uso no debe coincidir con otras, salvo cuando el equipo giratorio tiene un diámetro de menos de 20 pulgadas y el equipo adyacente permite la coexistencia.

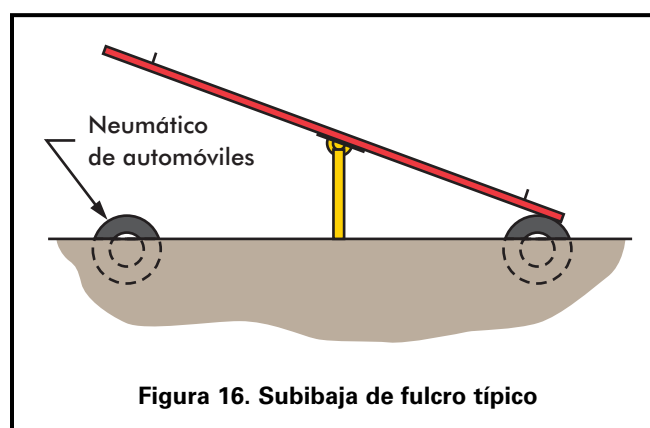
5.3.4.2 Altura de caída

La altura de caída para un tiovivo es la distancia entre el perímetro de la plataforma donde un niño puede sentarse o pararse y el revestimiento protector de la superficie bajo ésta.

5.3.5 Subibajas

5.3.5.1 Subibajas de fulcro

El subibaja típico (también conocido como “balancín”) consiste de un madero o tubo con un asiento en cada extremo apoyado en el centro sobre un fulcro. Ver Figura 16. Debido a la forma compleja en que los niños deben cooperar y combinar sus acciones, los subibajas de fulcro no se recomiendan para niños pequeños (6 a 23 meses) o de edad preescolar.



- El fulcro no debe constituir un peligro de aplastamiento.
- Trozos de neumáticos de autos u otro material amortiguador deben incrustarse en el suelo en el área debajo de los asientos o ser asegurado en la parte inferior de los asientos. Esto ayudará a evitar que las extremidades sean aplastadas debajo del asiento y también amortiguarán el impacto.
- El ángulo máximo posible entre una línea que conecte los asientos y la horizontal es 25°.
- No debe haber apoyapiés.

5.3.5.2 Subibajas con muelles centrales

Los niños en edad preescolar son capaces de utilizar subibajas con muelles porque el dispositivo central previene el contacto abrupto con el suelo si uno de los niños se baja súbitamente. Los subibajas con muelles centrales también tienen la ventaja de que no requieren dos niños que coordinen sus acciones para jugar a salvo. Los subibajas de muelles deben atenerse a las recomendaciones para balancines con resortes, incluyendo el uso de apoyapiés (§5.3.7).

5.3.5.3 Zona de uso para subibajas de fulcro y de resortes

- La zona de uso se debe extender como mínimo 6 pies desde cada borde exterior del subibaja.
- La zona de uso puede solaparse con el equipo cercano si dicho equipo permite zonas de uso que se solapen y
 - Existen al menos 6 pies entre el equipo cuando las zonas de juego designadas adyacente no tienen más de 30 pulgadas de alto; o
 - Hay al menos 9 pies entre equipos cuando las zonas de juego designadas adyacentes tienen más de 30 pulgadas de alto.

5.3.5.4 Agarraderas

- Las agarraderas deben proveerse en cada posición donde se sientan los niños para que puedan agarrarlas con ambas manos y no deben virarse cuando se agarren.
- Las agarraderas no deben sobresalir más allá de los lados del asiento.

5.3.5.5 Altura de caída

La altura de caída para un subibaja es la distancia entre el punto más alto que cualquier parte del subibaja pueda alcanzar y la superficie protectora debajo del mismo.

5.3.6 Toboganes

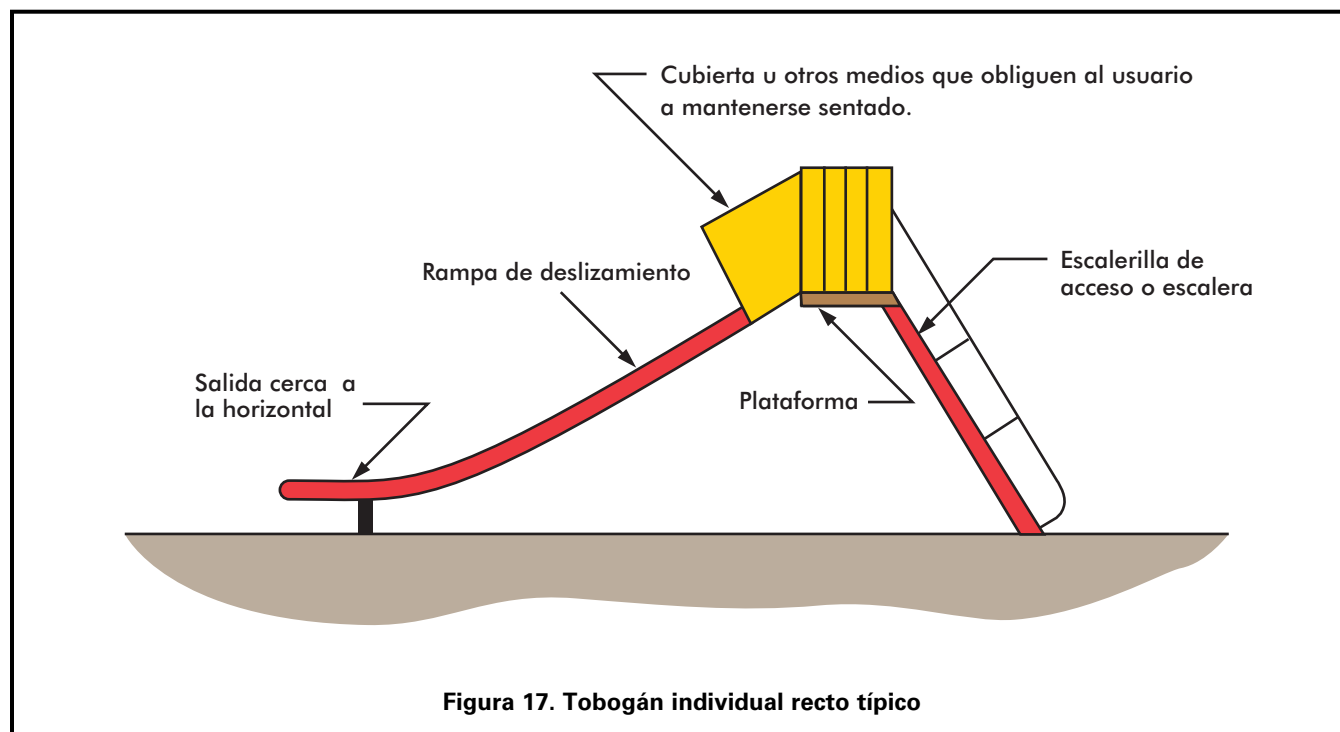
Es de esperarse que los niños se deslicen por las rampas de los toboganes en diferentes posiciones, y no siempre sentados y mirando hacia el frente mientras se deslizan. En todo momento se les debe desanimar a que se deslicen en estas otras posiciones para minimizar lesiones.



Los toboganes pueden ofrecer un descenso recto, ondulado o en espiral ya sea por medio de un tubo o una rampa abierta. Pueden ser individuales (figura 17); parte de una estructura compuesta o contruidos en el gradiente de una pendiente natural o artificial (tobogán de terraplén). Independientemente del tipo de tobogán, evite usar metales no recubiertos en las plataformas, rampas, y peldaños. Cuando está expuesto a luz solar directa el metal no recubierto puede alcanzar temperaturas lo suficientemente altas para causar lesiones de quemaduras por contacto en segundos. Brinde sombra para los toboganes de metal no recubierto o use otros materiales que puedan reducir la temperatura de la superficie como plásticos o metal recubierto, entre otros.

5.3.6.1 Acceso al tobogán

El acceso a un tobogán individual generalmente es a través de una escalerilla con travesaños, peldaños o una escalera con escalones. Los toboganes pueden ser parte de una estructura compuesta de juego para que los niños puedan tener acceso desde otras partes de la estructura. Los toboganes para terraplén utilizan el suelo como medio de acceso.



5.3.6.2 Plataformas en toboganes

Todos los toboganes deben estar equipados con una plataforma suficientemente larga para facilitar la transición de estar de pie a sentarse en la parte superior de la superficie inclinada para deslizamiento. Los toboganes para terraplén están exentos de los requisitos para plataformas porque están al nivel del terreno, sin embargo no deben tener ningún espacio o aberturas como se detalla a continuación:

La plataforma debe:

- tener al menos 19 pulgadas de profundidad para niños pequeños (6 a 23 meses).
- tener al menos 14 pulgadas de profundidad para niños en edad preescolar y niños en edad escolar
- ser horizontal.
- ser al menos tan ancha como su rampa.
- estar rodeada de barandas o barreras.
- atenerse a las mismas recomendaciones para plataformas en general que se indican en §5.1.1.
- carecer de espacios que puedan atrapar cuerdas, ropa, partes del cuerpo, etc. entre la plataforma y el comienzo de la rampa de deslizamiento
- contar con agarraderas para facilitar la transición de estar de pie a sentarse y disminuir el riesgo de caídas (excepto en los toboganes tubulares, donde el perímetro del tubo brinda apoyo para manos). Las mismas deben ser lo suficientemente altas para brindar apoyo de manos para el niño más grande de pie y lo suficientemente bajas para ofrecer apoyo de manos al niño más pequeño sentado.
- ofrecer un medio para obligar a una posición sentada a la entrada de la rampa, como una baranda, una cubierta, u otro dispositivo que disuada de escalar.

5.3.6.3 Rampas de deslizamiento

5.3.6.3.1 Toboganes para terraplenes

- La rampa de deslizamiento de un tobogán emplazado en un terraplén debe tener una altura máxima de 12 pulgadas por encima de la superficie subyacente que le rodea. Este diseño elimina básicamente el peligro de caídas desde alturas elevadas.
- Los toboganes para terraplenes deben seguir todas las recomendaciones para toboganes rectos cuando sea pertinente (por ej. la altura de los lados, pendiente, zona de uso a la salida, etc.)
- En la entrada de la rampa de deslizamiento de los toboganes en terraplenes debe existir alguna forma de minimizar el uso del equipo por parte de niños en patines, patinetas o bicicletas.

5.3.6.3.2 Toboganes de rodillos

- Los rodillos deben cumplir con todas las recomendaciones para otros toboganes (por ej. la altura de los lados, pendiente, zonas de uso a la salida, etc.)
- El espacio entre los rodillos adyacentes y entre sus extremos y la estructura fija deberá ser inferior a 3/16 pulgadas.
- Se recomiendan las inspecciones frecuentes para garantizar que no haya rodillos perdidos o cojinetes rotos y que los rodillos rueden.

5.3.6.3.3 Toboganes en espiral

- Los toboganes en espiral deben seguir las recomendaciones para toboganes rectos cuando sea pertinente (por ej. la altura de los lados, la pendiente, zonas de uso, etc.).
- Se debe prestar especial atención a características de diseño que pueden presentar problemas inherentes a toboganes en espiral, tales como salida lateral del usuario.
- Los niños pequeños (6 a 23 meses) y en edad preescolar tienen menos habilidad para mantener el control de su equilibrio y su postura, por lo que solo se recomiendan toboganes en espiral cortos (una vuelta de 360° o menos) para este grupo de edades.

5.3.6.3.4 Toboganes rectos

- Las rampas abiertas deben tener lados de al menos 4 pulgadas de alto a lo largo de toda la superficie inclinada de deslizamiento.
- Los lados deben ser una parte integral de la rampa, sin ningún espacio entre los lados y la superficie deslizante. (Esto no es válido para toboganes de rodillo).
- Los toboganes pueden tener una rampa abierta con una sección circular, semicircular o curva si:
 - A. La altura vertical de los lados es no menor de 4 pulgadas medida en los ángulos rectos con una línea horizontal de 8 pulgadas de largo cuando el tobogán va a ser usado por niños pequeños (6 a 23 meses); 12 pulgadas de largo si es para niños de edad preescolar y 16 pulgadas de largo cuando el tobogán será usado para niños de edad escolar (Figura 18); o
 - B. Para cualquier grupo de edad la altura vertical de los lados es no menor de 4 pulgadas menos dos veces el ancho de la rampa del tobogán dividido por el radio de la curvatura de la rampa del tobogán (Figura 19).

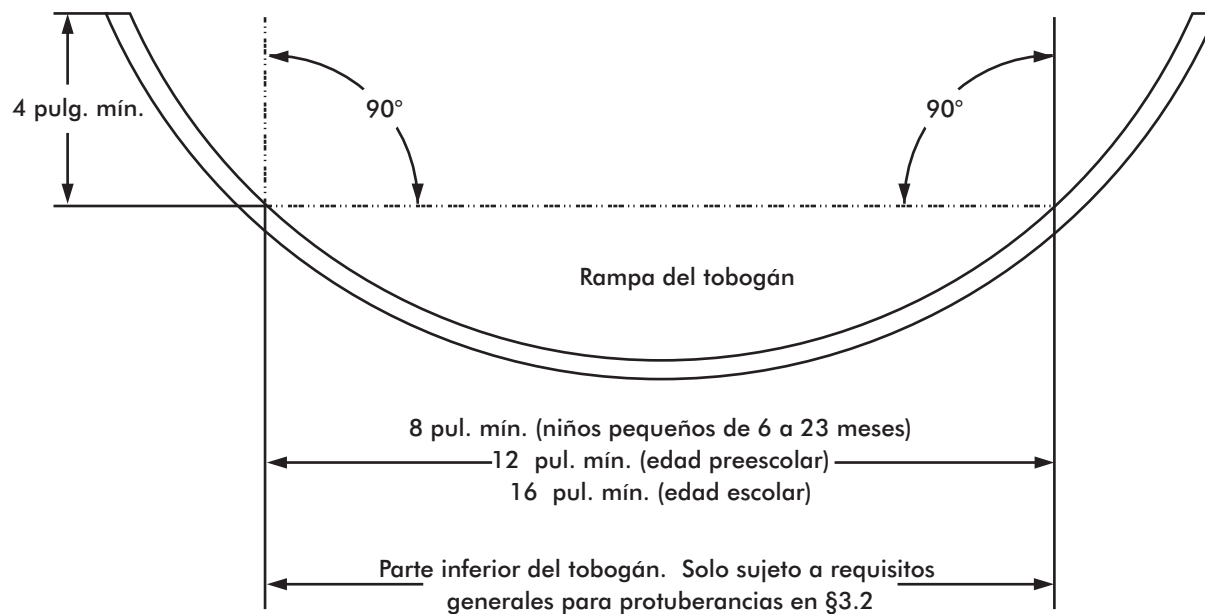


Figura 18. Altura lateral mínima para tobogán con sección circular

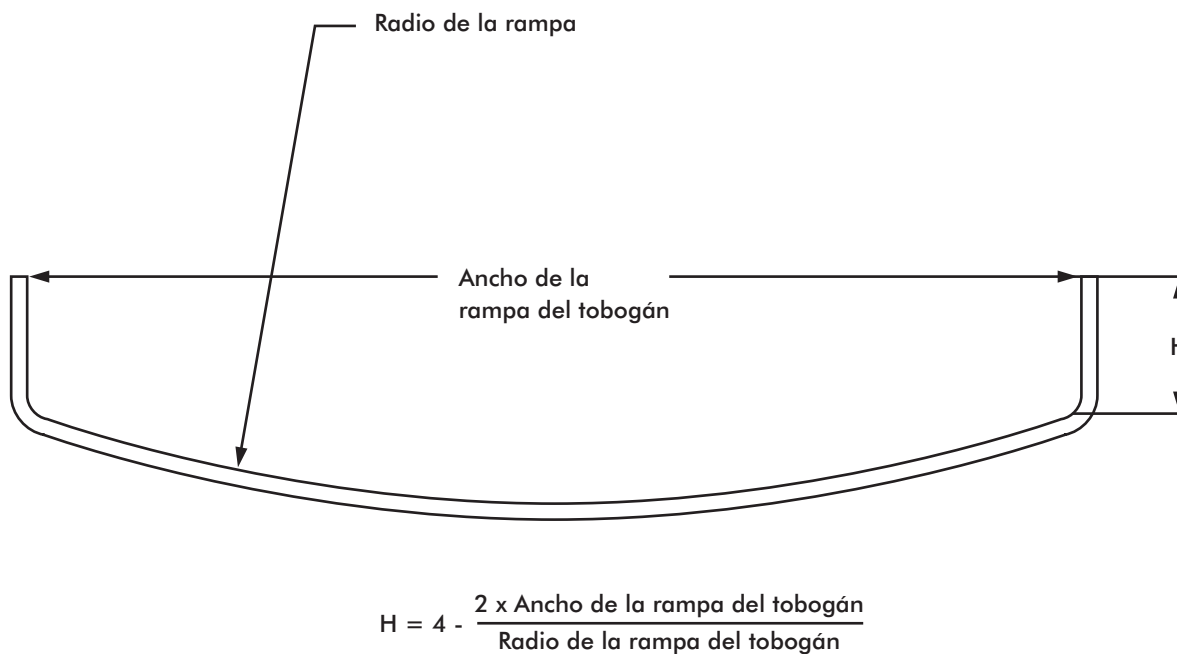


Figura 19. Fórmula para la altura lateral vertical mínima para tobogán con rampa curva

- Para niños pequeños (6 a 23 meses):
 - La inclinación promedio de una rampa de tobogán debe ser no más de 24° (o sea la proporción de altura a longitud horizontal que aparece en la Figura 20 no sobrepasa 0.445).
 - Ninguna sección de la rampa del tobogán deberá tener una pendiente mayor de 30° .
 - La rampa del tobogán debe ser entre 8 y 12 pulgadas de ancho.
- Para niños de edad preescolar y escolar:
 - La inclinación promedio de una rampa de tobogán no debe tener más de 30° (o sea la proporción de altura a longitud horizontal que aparece en la Figura 20 no sobrepasa 0.577).
 - Ninguna sección de la rampa del tobogán deberá tener una pendiente mayor de 50° .

5.3.6.3.5 Toboganes tubulares

- Los toboganes tubulares deben cumplir todas las recomendaciones pertinentes para otros toboganes (por ej. altura vertical, pendiente, zonas de uso a la salida, etc.).
- Debe utilizarse algún medio como barreras o superficies labradas que prevengan el deslizamiento o escalar en la parte superior (afuera) del túnel.
- El diámetro mínimo interior del túnel no debe ser menor de 23 pulgadas.
- Los supervisores deben estar pendientes de los niños cuando usan los toboganes tubulares, ya que no siempre están visibles.

5.3.6.4 Área de salida de la rampa

Todos los toboganes deben tener un área de salida que ayude a los niños a mantener su equilibrio y facilite su transición de estar sentados a pararse para salir. La región de salida de la rampa deberá:

- Estar entre 0° y -4° medidos desde un plano paralelo al suelo.
- Tener bordes redondeados o con curvas para evitar laceraciones u otras lesiones que pueden ocurrir por impacto con un borde afilado o recto.
- Para niños pequeños (6 a 23 meses) la región de salida de la rampa deberá:
 - Tener entre 7 y 10 pulgadas de largo si alguna porción de la rampa excede una pendiente de 24°
 - Estar a no más de 6 pulgadas por encima de la superficie protectora.
 - Tener una transición de la porción deslizante a la región de salida con un radio de curvatura de al menos 18 pulgadas.
- Para niños de edad preescolar y escolar la región de salida de la rampa deberá:
 - Tener al menos 11 pulgadas de largo.
 - Estar a no más de 11 pulgadas por encima de la superficie protectora si el tobogán no mide más de 4 pies de altura.
 - Estar al menos 7 pulgadas pero no más de 15 pulgadas por encima de la superficie protectora si el tobogán mide más de 4 pies de altura.

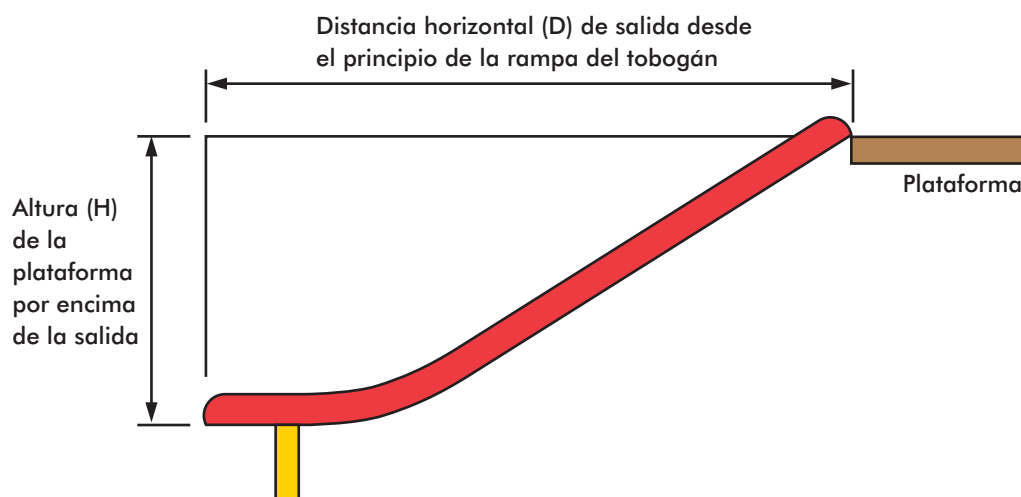


Figura 20. Pendiente del tobogán

5.3.6.5 Zona de uso de tobogán

Niños pequeños (6 a 23 meses):

- En un ambiente de acceso limitado
 - La zona de uso deberá ser al menos 3 pies alrededor del perímetro del tobogán.
 - El área al final del tobogán no debe solaparse con la zona de uso de ningún otro equipo.
- En áreas públicas de acceso ilimitado
 - Para un tobogán individual la zona de uso deberá ser al menos 6 pies alrededor del perímetro.
 - Para toboganes que son parte de una estructura compuesta la zona de uso mínima entre los componentes de acceso y el lado de la rampa de tobogán deberá ser de 3 pies.
 - La zona de uso al final del tobogán deberá ser al menos 6 pies desde el final del tobogán y no solaparse con la zona de uso de ningún otro equipo.

Niños de edad preescolar y escolar (ver Figura 21):

- La zona de uso frente al acceso y a los lados del tobogán debe extenderse un mínimo de 6 pies desde el perímetro del equipo. Esta recomendación no se aplica a los toboganes de terraplén o toboganes que son parte de una estructura compuesta (vea §5.3.9).
- La zona de uso frente a la salida del tobogán nunca debe solaparse con la zona de uso de ningún otro equipo; sin embargo las zonas de uso de dos o más toboganes pueden solaparse si sus direcciones de deslizamiento son paralelas.
- Para los toboganes de 6 pies de altura o menores la zona de uso frente a la salida debe ser de al menos 6 pies.
- Para los toboganes de más de 6 pies de altura la zona de uso frente a la salida deberá ser al menos tan larga como la altura del tobogán con un máximo de 8 pies.

5.3.6.6 Altura de caída

La altura de caída para toboganes es la distancia entre la plataforma de transición y la superficie protectora bajo la misma.

5.3.6.7 Peligro de enredo

Se han registrado casos de niños con lesiones graves e incluso muertes cuando parte de su ropa ha quedado enredada en protuberancias o espacios en los toboganes.

Para reducir la probabilidad de enredos de ropa:

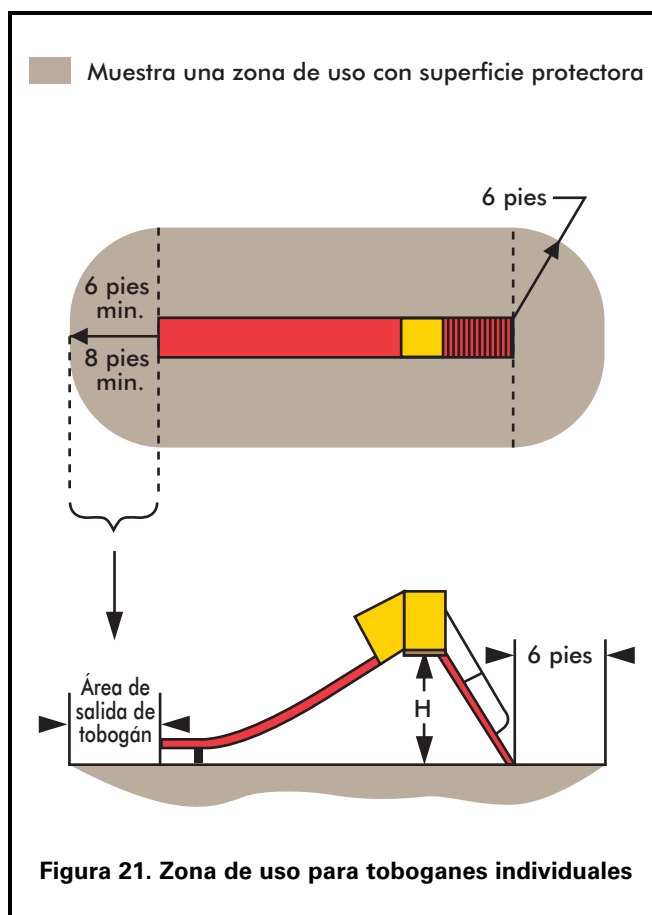


Figura 21. Zona de uso para toboganes individuales

- Los salientes de hasta 3 pulgadas de diámetro no deben sobresalir más de 1/8 pulgadas del tobogán.
- No deben existir espacios en la parte superior de los toboganes donde la rampa de tobogán se conecta con la plataforma que pueda enredar ropa o cuerdas.
- Ver el Apéndice B para las recomendaciones completas y detalles acerca del procedimiento para prueba de salientes

5.3.6.8 Otros equipos de deslizamiento

Los equipos en los que puede preverse que el uso primario de los componentes será el deslizamiento deben seguir las mismas pautas para enredo que aparecen en 5.3.6.7.

5.3.7 Balancines con resortes

Los niños pequeños (6 a 23 meses) y de edad preescolar disfrutan las actividades para brincar y mecerse que ofrecen los balancines con resortes, y ellos son los usuarios primarios de los equipos de balanceo. Ver Figura 22. Los niños mayores pueden hallarlos muy simples.

- Los diseños de asiento no deben permitir que el balancín sea utilizado por un número mayor de usuarios que el planificado.



Figura 22. Ejemplo de un balancín con resortes

- Para niños pequeños (6 a 23 meses):
 - El asiento debe medir entre 12 y 16 pulgadas de alto
 - Balancines con soportes con asientos opuestos para más de un niño deben tener al menos 37 pulgadas entre el centro de los asientos.
- Para edad preescolar:
 - El asiento debe medir entre 14 y 28 pulgadas de alto
- Cada posición para sentarse debe estar equipada con agarre de manos y apoyo para los pies. El diámetro de éste debe atenerse a las recomendaciones para elementos de agarre en §5.2.2.
- Los resortes de equipos de balanceo deben reducir la posibilidad de que los niños se aplasten las manos o sus pies entre los muelles o entre un resorte y una parte del balancín.
- La zona de uso debe extenderse un mínimo de 6 pies desde el perímetro del equipo
- La zona de uso puede solaparse con los equipos cercanos si el otro equipo permite zonas de uso que se solapen y
 - Hay al menos 6 pies entre equipos cuando las superficies de juego designadas adyacentes no tienen más de 30 pulgadas de alto; o
 - Hay al menos 9 pies entre equipos cuando las superficies de juego designadas adyacentes tienen más de 30 pulgadas de alto; y

- El balancín con resortes está diseñado para usarse en una posición sentada.

5.3.7.1 Altura de caída

La altura de caída de un balancín con resortes es la distancia entre (1) la superficie de juego designada más alta o (2) el asiento, según la que sea más alta, y la superficie protectora debajo del mismo.

5.3.8 Columpios

Los niños de todas las edades generalmente disfrutan la sensación de columpiarse. En su mayoría se sientan en el columpio pero es común ver a los niños saltando de los columpios. Los niños más pequeños también tienden a columpiarse en los estómagos y los mayores pueden pararse en los asientos. Para evitar lesiones se debe desanimar este comportamiento.

Los columpios pueden dividirse en dos tipos:

- De eje sencillo: a veces conocido como un columpio de vaivén. Un eje sencillo está diseñado para oscilar al frente y hacia atrás en un solo plano y generalmente consiste en un asiento sujeto por al menos dos partes suspendidas, cada una de las cuales está conectada a un pivote separado en una estructura situada por encima de la cabeza.
- De ejes múltiples: un columpio de ejes múltiples consiste de un asiento (generalmente un neumático) suspendido de un pivote sencillo que le permite oscilar en cualquier dirección.

5.3.8.1 Recomendaciones generales para columpios

- Los herrajes que se usan para asegurar los elementos de suspensión al asiento del columpio y a la estructura de soporte no deben ser removibles sin el uso de herramientas.
- Los ganchos tipo S son a menudo parte del sistema de suspensión del columpio, conectando los elementos de suspensión a la barra de soporte por encima de la cabeza o al asiento del columpio. Los ganchos S abiertos pueden atrapar la ropa de un niño y presentar un peligro de estrangulación. Los ganchos S deben ser apretados para que cierren. Un gancho S se considera cerrado si no existe un espacio o abertura mayor de 0.04 pulgadas (más o menos del grosor de una moneda de 10 centavos).
- Los columpios deben estar suspendidos de estructuras de soporte que desanimen el escalár.
- Las estructuras de soporte en A no deben tener barras horizontales.
- Las sogas de fibra no se recomiendan como métodos de suspensión de columpios porque pueden deteriorarse con el paso del tiempo.

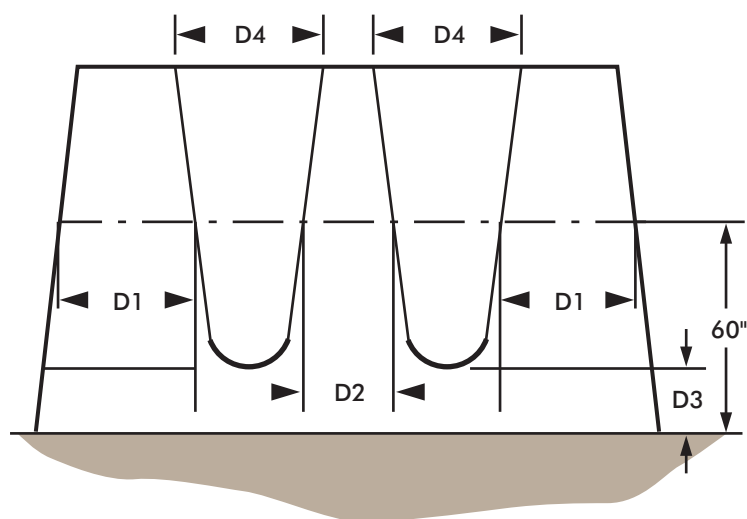


Figura 23. Luces mínimas para columpios de eje sencillo

Tabla 7. Dimensiones mínimas de luz para columpios

Razón	Dimensión	Niño pequeño Asiento de seguridad	Edad preescolar Cinturón	Edad escolar Cinturón
Minimiza choques entre un columpio y la estructura de apoyo	D1	20 pulgadas	30 pulgadas	30 pulgadas
Minimiza choques entre columpios	D2	20 pulgadas	24 pulgadas	24 pulgadas
Permite el acceso	D3	24 pulgadas	12 pulgadas	12 pulgadas
Disminuye el movimiento de lado a lado	D4	20 pulgadas	20 pulgadas	20 pulgadas

- Las estructuras de columpios deben ser ubicadas lejos de otros equipos o actividades para prevenir que los niños pequeños (6 a 23 meses) inadvertidamente puedan correr al paso de los columpios oscilantes. Se puede brindar protección adicional por medio de una barrera baja, como una cerca o arbustos alrededor del perímetro del área del columpio. La barrera no debe ser un obstáculo dentro de la zona de uso de una estructura de columpio o dificultar la supervisión bloqueando la visibilidad.

5.3.8.2 Altura de caída

La altura de caída para columpios es la distancia vertical entre el punto de pivote y la superficie protectora debajo del mismo.

5.3.8.3 Columpios de eje sencillo

5.3.8.3.1 Asientos tipo cinturón usados sin asistencia de adultos

- La zona de uso en el frente y parte posterior de los columpios de eje sencillo nunca deben solapar la zona de uso de otro equipo.
- Para reducir la probabilidad de que los niños sean golpeados por un columpio en movimiento se recomienda que no más de dos columpios de eje sencillo sean colgados en cada zona de la estructura de apoyo.
- Los columpios no deben estar conectados a estructuras mixtas.
- Los asientos de columpios deben ser diseñados para acomodar solo un usuario a la vez.

- Los asientos de columpios plásticos o de goma se recomiendan para ayudar a reducir la severidad de lesiones por impacto. Los asientos de columpios de madera o metal deben evitarse.
- Los bordes de los asientos deben tener acabados lisos o redondeados y deben estar atenerse a las recomendaciones de salientes discutidos en 5.3.8.5.
- Si el material de relleno suelto se usa como superficie protectora la recomendación para su altura debe determinarse después que el material ha sido comprimido.

5.3.8.3.2 Columpios con asientos tipo canasta

Los columpios con asientos tipo canasta son similares a los columpios de eje sencillo porque ambos se mueven de adelante hacia atrás. No obstante, los asientos de columpios tipo canasta son para el uso de niños menores de 4 años con asistencia de adultos.

- Los sistemas de asiento y suspensión de estos columpios incluyendo el herraje correspondiente deben cumplir con todos los requisitos para columpios convencionales de eje sencillo.
- Los asientos tipo canasta se recomiendan para brindar apoyo por todos lados y entre las piernas al niño que lo ocupa (Ver Figura 24).
- Los materiales del asiento tipo canasta no deben presentar un peligro de estrangulación como pudiera presentarlo una soga o cadena usada como parte del mismo.



Figura 24. Ejemplo de columpios con asiento tipo canasta

- Las aberturas en los asientos de columpios deben cumplir con los criterios sobre atascos discutidos en §3.3.
- Los columpios con asientos tipo canasta deben estar suspendidos de estructuras que estén separadas de los otros columpios o al menos suspendidas en una zona separada de la misma estructura.
- Los columpios con asientos tipo canasta no deben permitir que el niño entre y salga solo.
- Los puntos de pivote deben medir más de 47 pulgadas pero no más de 96 pulgadas por encima de la superficie protectora.

5.3.8.3.3 Zona de uso para columpios de eje sencillo-con asientos tipo cinturón o tipo canasta

La zona de uso al frente y parte posterior del columpio debe ser mayor que la zona de uso de los lados del columpio porque los niños pueden deliberadamente intentar salir de un columpio de eje sencillo mientras está en movimiento. Ver Figura 25.

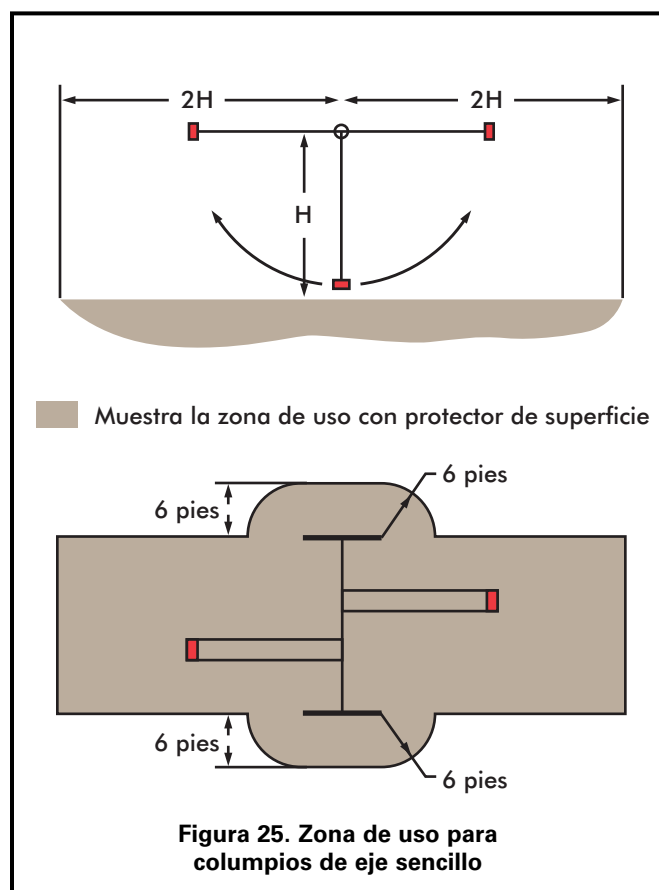
- La zona de uso para un columpio con asientos tipo cinturón deberá extenderse hacia al frente y hacia la parte trasera del columpio de eje sencillo una distancia mínima de dos veces la distancia vertical desde el punto de pivote hasta la parte superior de la superficie protectora debajo de la misma.
- La zona de uso para un columpio con asiento tipo canasta deberá extenderse al frente y parte trasera un mínimo de dos veces la distancia vertical desde la parte superior de la superficie para sentarse el ocupante hasta el punto de pivote.
- La zona de uso al frente y en la parte trasera de los columpios nunca deberá solaparse con cualquier otra zona de uso
- La zona de uso en los lados de un columpio de eje sencillo deberá extenderse un mínimo de 6 pies desde el perímetro del columpio. Esta zona de 6 pies puede solapar la de una estructura de columpio adyacente u otra estructura de equipo de parque infantil.

5.3.8.4 Columpios (neumáticos) de eje múltiple

Los columpios de neumáticos usualmente están suspendidos en una orientación horizontal usando tres cadenas o cables de suspensión conectados a un mecanismo de oscilación sencillo que permite rotación y balanceo en cualquier eje.

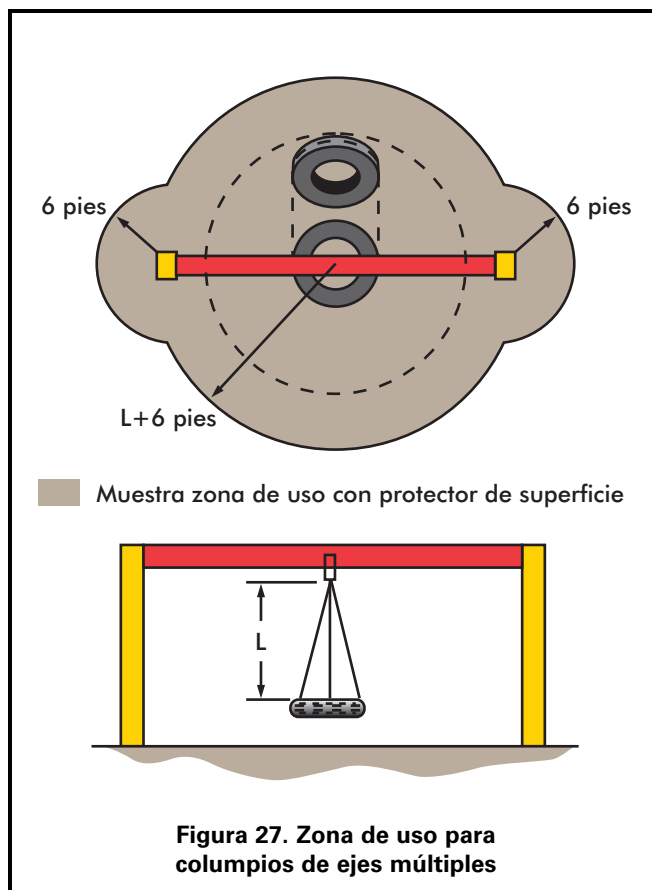
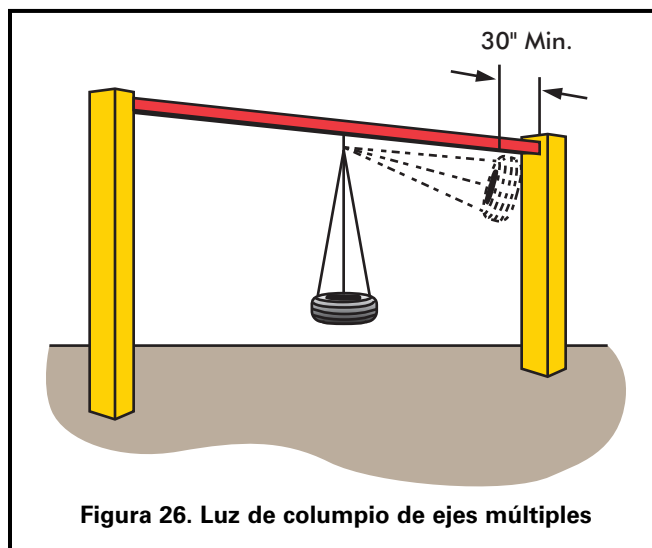
- Un columpio neumático de eje múltiple no debe estar suspendido de una estructura que tenga otros columpios en la misma zona.
- No se recomienda sujetar columpios de ejes múltiples a estructuras mixtas.

- Para reducir el peligro de impacto se deben evitar los neumáticos pesados de camiones. Además, si se usan neumáticos radiales con bandas de metal, estos deben ser examinados cuidadosamente para garantizar que no existen cinturones de metal o alambres expuestos que puedan ser un peligro potencial de protuberancia o laceraciones. Los materiales plásticos pueden usarse como alternativa para simular neumáticos de autos. Se deben proveer orificios para drenaje en la superficie inferior del neumático.
- Preste especial atención al mantenimiento del mecanismo de suspensión porque la probabilidad de fallos es mayor para columpios de neumáticos debido al peso adicional del movimiento rotativo y los múltiples ocupantes.
- Los mecanismos de suspensión de columpios con ejes múltiples no deben tener ningún punto accesible de aplastamiento.
- La luz mínima entre la superficie para sentarse en un columpio de neumático y los postes de la estructura de soporte debe ser 30 pulgadas cuando el neumático está en la posición más próxima a la estructura de soporte (figura 26).
- La luz mínima entre la parte inferior del asiento y la superficie protectora debe ser menor que 12 pulgadas.



5.3.8.4.1 Zonas de uso para columpios de eje múltiple

- La zona de uso deberá extenderse en cualquier dirección desde un punto directamente debajo del punto de pivote por una distancia mínima de 6 pies más la distancia de las partes suspendidas (ver Figura 27). Esta zona de uso nunca debe solaparse con la zona de uso de cualquier otro equipo.



- La zona de uso debe extenderse un mínimo de 6 pies desde el perímetro de la estructura de soporte. Esta zona de 6 pies puede solaparse a la de una estructura de columpios adyacente u otra estructura de equipos del parque infantil.

5.3.8.5 Protuberancias en partes suspendidas de ensamblaje de columpio

Las protuberancias en columpios son extremadamente peligrosas por su potencial para incidentes de impacto. Nada deberá sobresalir más de 18 de una pulgada incluyendo tornillos u otras partes, en el frente, parte posterior, superficie lateral de un columpio. Vea los procedimientos de verificación en el Apéndice B.

5.3.9 Altura de caída y zonas de uso para estructuras mixtas.

Cuando dos o más componentes complementarios de juego están conectados en una estructura compuesta (por ej. escalador combinado, tobogán, y escalera horizontal) la zona de uso deberá extenderse un mínimo de 6 pies del perímetro externo de la estructura (ver Figura 28). Cuando los toboganes están conectados a una plataforma de más de 6 pies de altura de la superficie protectora puede ser necesario extender la zona de uso al frente del tobogán (vea 5.3.6.5).

5.3.10 Altura de caída y zonas de uso no especificadas

La mayoría de los equipos de parques infantiles pertenece a una de las categorías mencionadas más arriba. Si no es así, las recomendaciones generales siguientes se deben poner en práctica:

- La altura de caída de una parte de equipo de parque infantil es la distancia entre la superficie de juego designada más alta y la superficie protectora debajo de la misma.
- La zona de uso deberá extenderse un mínimo de 6 pies en todas las direcciones desde el perímetro del equipo.
- Las zonas de uso de dos partes de un equipo fijo de parque infantil que están ubicadas en posición adyacente pueden solaparse si la superficie de juego designada de cada estructura no están a más de 30 pulgadas por encima de la superficie protectora y los equipos están separados al menos 6 pies.
- Si una superficie de juego designada adyacente a cualquier estructura excede una altura de 30 pulgadas, la distancia mínima entre las estructuras debe ser 9 pies.
- Las zonas de uso deben estar libres de obstáculos.

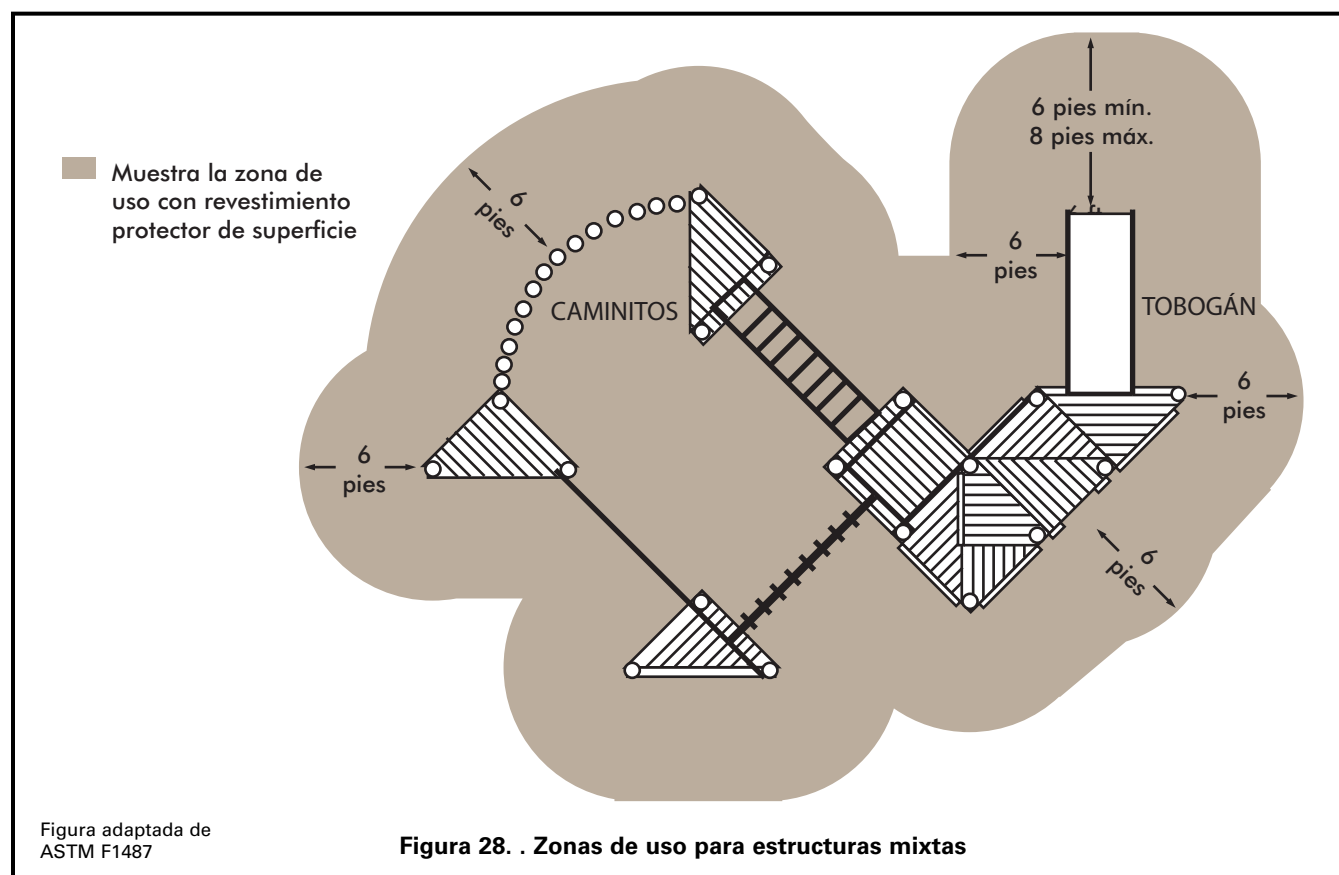


Figura 28. . Zonas de uso para estructuras mixtas

APÉNDICE A: LISTAS DE VERIFICACIÓN SUGERIDAS PARA EL MANTENIMIENTO GENERAL

Revestimiento de superficie (§2.4)

- ☐ Revestimiento protector de superficie adecuado debajo y alrededor del equipo.
 - ☐ Instalar/sustituir el revestimiento de la superficie
- ☐ Los materiales de revestimiento no se han deteriorado.
 - ☐ Sustituir el revestimiento de superficie
 - ☐ Otro mantenimiento: _____
- ☐ Los materiales sueltos para revestimiento de superficie no contienen objetos ajenos o desperdicios.
 - ☐ Elimine la basura y los escombros
- ☐ Los materiales sueltos para acabado de superficie no están compactos.
 - ☐ Rastrillar y mullir el acabado de superficie
- ☐ Los materiales sueltos para revestimiento de superficie no se han desplazado debajo de áreas de mucho uso como columpios o salidas de toboganes.
 - ☐ Rastrillar y mullir el revestimiento de superficie

Drenaje (§2.4)

- ☐ La zona entera de juego tiene drenaje satisfactorio, especialmente en áreas de mucho uso como debajo de columpios o salidas de toboganes.
 - ☐ Mejorar el drenaje
 - ☐ Otro mantenimiento: _____

Peligros generales

- ☐ No hay puntas, esquinas o bordes afilados en los equipos (§3.4).
- ☐ No hay tapas o tapones protectores deteriorados o perdidos (§3.4).
- ☐ No hay salientes peligrosos (§3.2 y Apéndice B).
- ☐ No hay peligros potenciales de enredo de prendas como ganchos en forma de S abiertos o tornillos salidos (§2.5.2, §3.2, §5.3.8.1 y el Apéndice B).
- ☐ No hay puntos de aplastamiento y corte en partes móviles expuestas (§3.1).
- ☐ No hay peligros de caídas, como cimientos o elementos de sujeción expuestos ni piedras, raíces u otros obstáculos en una zona de uso (§3.6).

Seguridad de herrajes

- ☐ No hay elementos de sujeción sueltos o conexiones desgastadas.
 - ☐ Sustituir amarres
 - ☐ Otro mantenimiento: _____
- ☐ Piezas móviles como soportes de columpios, cojinetes de tirovivos y tirolinas no están desgastadas.
 - ☐ Sustituir pieza
 - ☐ Otro mantenimiento: _____

Durabilidad de los equipos (§2.5)

- ☐ No hay óxido, putrefacción, rajaduras o astillas en ningún equipo (chequear con cuidado donde haya contacto con el suelo).
- ☐ No hay elementos rotos o faltantes en el equipo (por ej. pasamanos, barandas, barreras protectoras, peldaños o travesaños).
- ☐ No hay cercas, bancos ni carteles dañados en el parque infantil.
- ☐ Todos los equipos están bien anclados.

Pintura con plomo (§2.5.4)

- ☐ La pintura (en especial la pintura con plomo) no está desconchada, agrietada, cuarteada o descascarada.
- ☐ No hay áreas visibles de pérdida de pintura con plomo o acumulación de partículas de plomo.
 - ☐ Mitigar los peligros de la pintura con plomo.

Cuidado General de Parques Infantiles (§4)

- ☐ No hay modificaciones del usuario en el equipo como cuerdas y sogas atadas amarradas al equipo, columpios enlazados a barras superiores, etc.
 - ☐ Eliminar cuerdas o sogas
 - ☐ Corregir otra modificación
- ☐ Todo el parque infantil está libre de escombros o desperdicios como ramas de árboles, latas de sodas, botellas, cristales, etc.
 - ☐ Limpiar el parque infantil
- ☐ No faltan contenedores de basura.
 - ☐ Sustituir contenedores de basura
- ☐ Los contenedores de basura no están llenos.
 - ☐ Vaciar contenedores de la basura.

NOTAS:

FECHA DE LA INSPECCIÓN:

INSPECCIONADO POR:

Inspección de rutina y problemas de mantenimiento

- ☐ Equipos rotos como tornillos sueltos, tapas perdidas, rajaduras, etc.
- ☐ Cristales rotos y otros desperdicios
- ☐ Rajaduras en plásticos
- ☐ Anclajes sueltos
- ☐ Escombros perjudiciales o peligrosos
- ☐ Daños por insectos
- ☐ Problemas con el revestimiento de la superficie
- ☐ Desplazamiento del revestimiento de superficie suelto (véase Sección 4.3)
- ☐ Orificios, escamas y/o arqueamiento de superficie unitaria
- ☐ Modificaciones del usuario (como sogas atadas a partes o cambios en la ubicación del equipo)
- ☐ Vandalismo
- ☐ Piezas gastadas, sueltas, dañadas o perdidas
- ☐ Astillas
- ☐ Metales oxidados o corroídos
- ☐ Putrefacción

APÉNDICE B: VERIFICACIÓN DEL PARQUE INFANTIL

B.1 Plantillas e instrumentos de medición y verificación

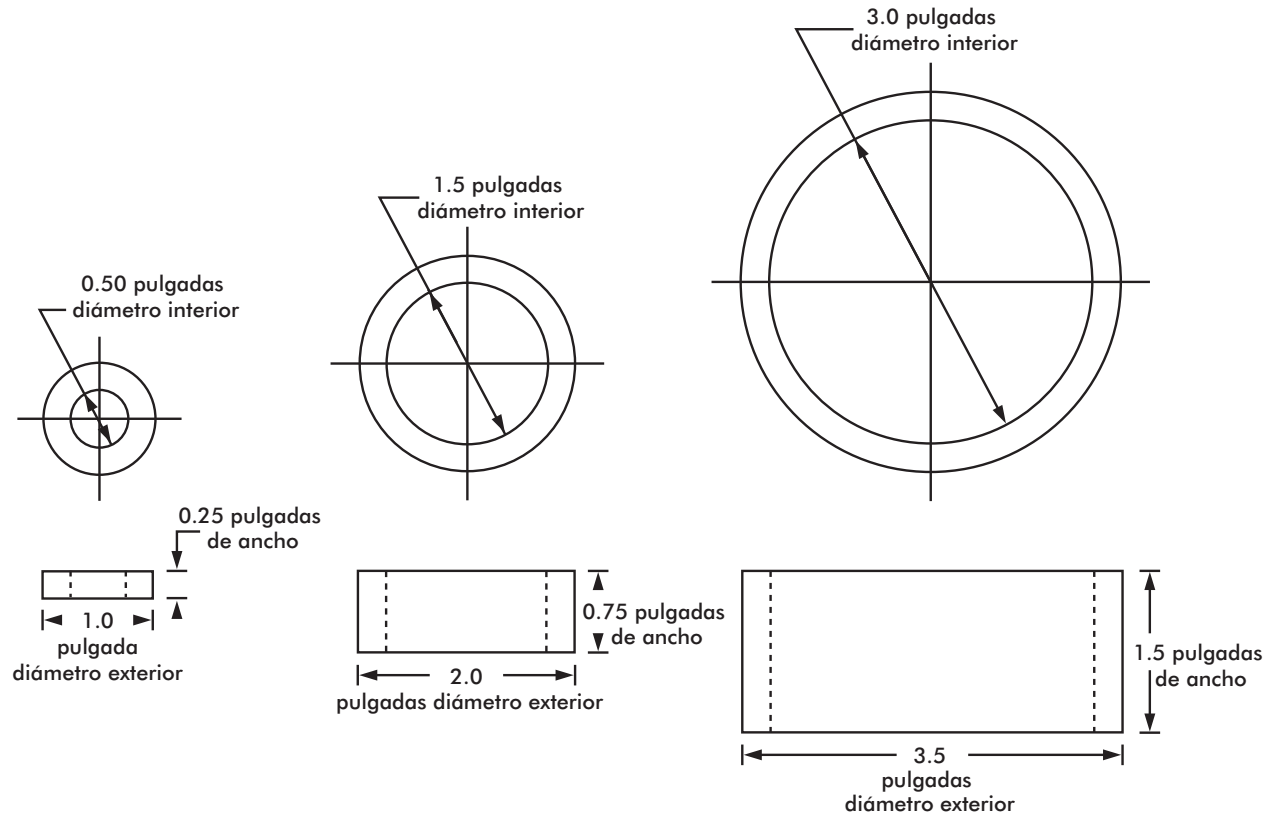
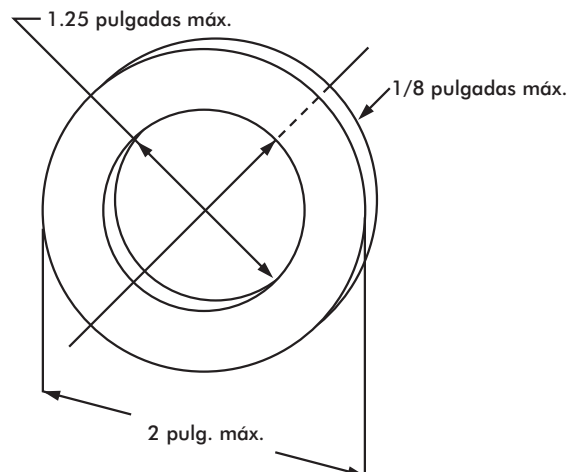


Figura B1. Medidores para verificación de salientes



Nota: instrumento de medición hecho de cualquier material rígido

Figura B2. Medidor para la verificación de salientes de ensamblajes de columpios suspendidos y toboganes

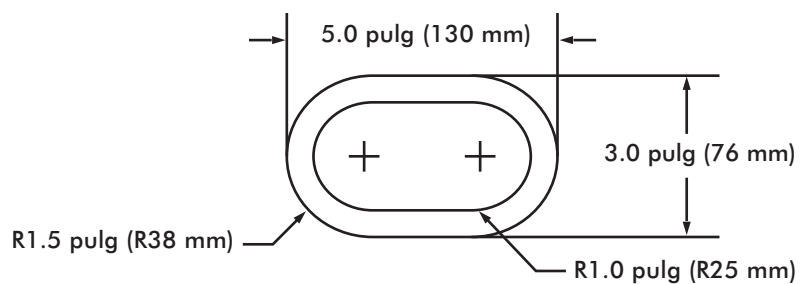


Figura B3. Plantilla del torso de un niño pequeño

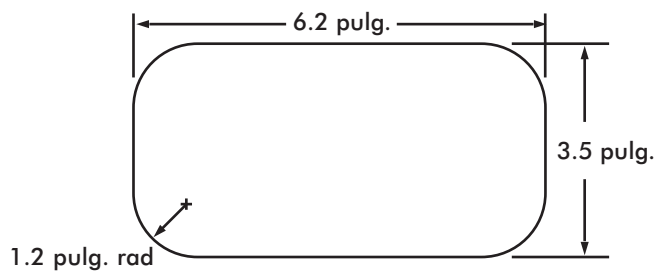


Figura B4. Plantilla de un torso de un niño en edad preescolar o escolar

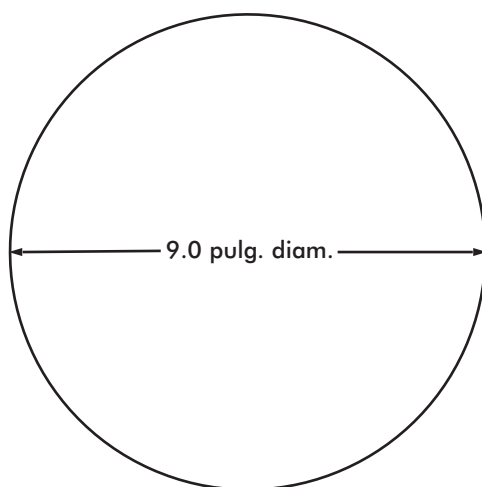


Figura B5. Plantilla de una cabeza

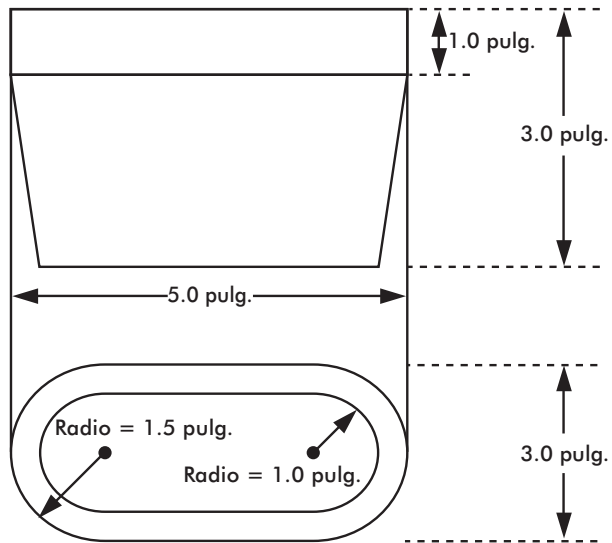


Figura B6. Dispositivo para torso de un niño pequeño

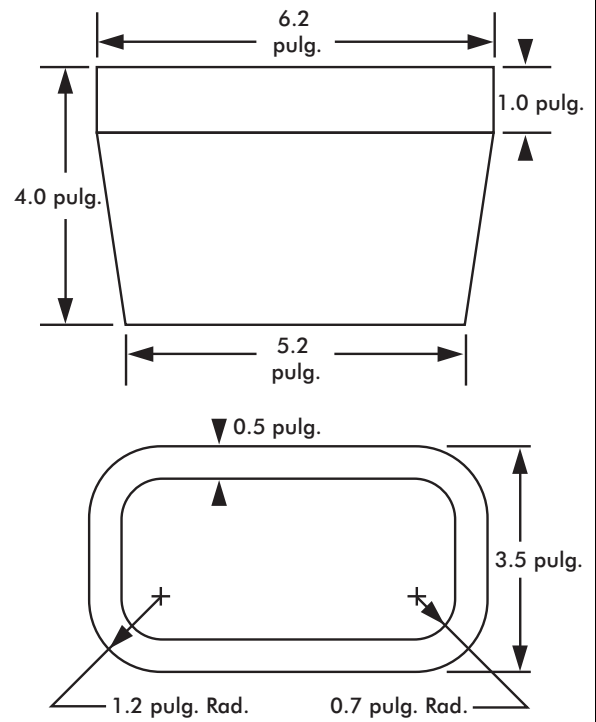


Figura B7. Dispositivo para torso pequeño de un niño en edad preescolar o escolar

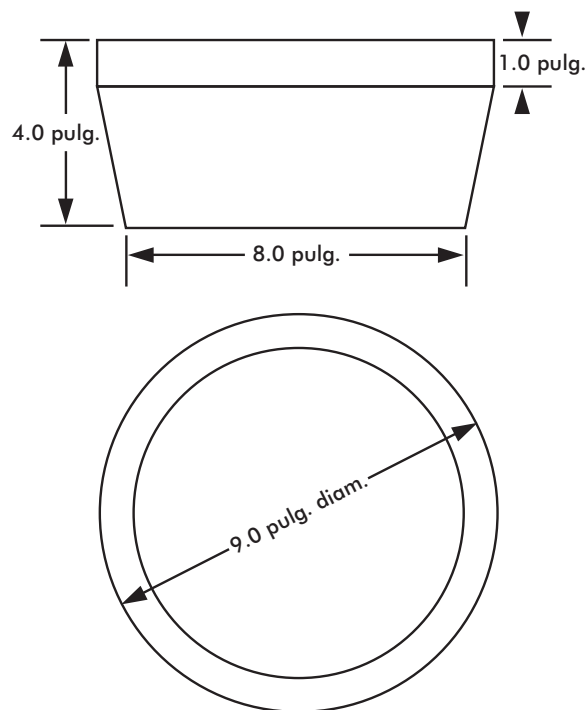


Figura B8. Dispositivo para cabeza grande

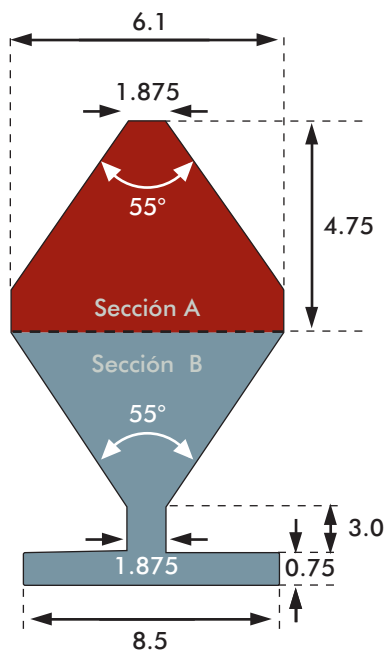


Figura B9. Dispositivo para aberturas parcialmente restringidas para niños en edad preescolar/escolar (dimensiones en pulgadas, la plantilla tiene 0.75 pulgadas de grosor)

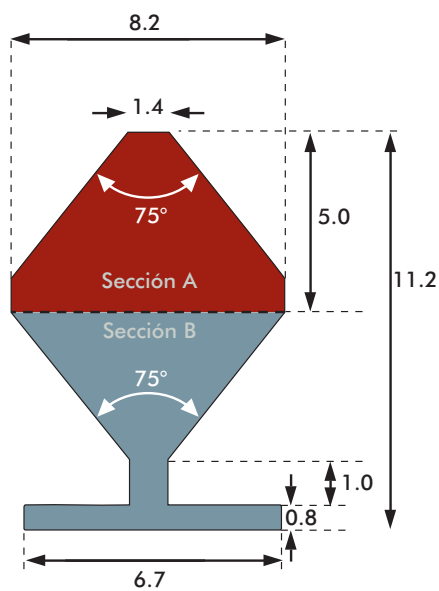


Figura B10. Dispositivo para aberturas parcialmente restringidas para niño pequeño (dimensiones en pulgadas, la plantilla tiene 0.60 pulgadas de grosor)

APÉNDICE B: VERIFICACIÓN DEL PARQUE INFANTIL

B.2 Métodos de verificación

B.2.1 Como determinar cuándo un saliente es una protuberancia

B.2.1.1 Procedimientos para efectuar la verificación

1ro: Coloque cada medidor de verificación de saliente sucesivamente (Ver Figura B1) sobre cualquier saliente.

2do: Determine con la vista si el saliente penetra por el orificio y se prolonga más allá del plano del medidor (Ver Figura B11 debajo).

Pasa: Un saliente que no se prolonga más allá del plano del medidor pasa la prueba.

Falla: Un saliente que se prolonga más allá del plano de cualquiera de los medidores se considera una protuberancia peligrosa y debe ser eliminada.

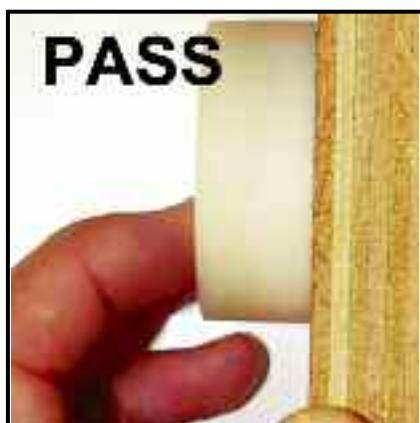


Figura B11. Determinación de cuándo un saliente es una protuberancia (PASA/FALLA)

B.2.2 Salientes en partes suspendidas de ensamblajes de columpios

Dada la posibilidad de incidentes de impacto, las salientes en columpios pueden ser extremadamente peligrosas. Se recomienda el uso de un medidor de verificación especial (Ver Figura B2) y una serie de pasos a seguir. Cuando se realice la verificación, ningún tornillo o componente deberá sobresalir más allá del orificio del plano del medidor.

B.2.2.1 Procedimientos para efectuar la verificación

1ro: Sujete el medidor (Figura B2) verticalmente con el eje atravesando el orificio paralelo al paso del movimiento del columpio.

2do: Coloque el medidor sobre cualquier saliente que este al descubierto durante el paso del movimiento del columpio.

3ro: Determine visualmente si el saliente penetra por el orificio y se prolonga más allá del plano del medidor.

Pasa: Un saliente que no se prolonga más allá del plano del medidor pasa la prueba.

Falla: Un saliente que se prolonga más allá del plano de cualquiera de los medidores se considera una protuberancia peligrosa y debe ser eliminada.

B.2.3 Salientes en toboganes

Para disminuir la probabilidad de enredo de ropas en toboganes, salientes que (1) caben en uno de los tres medidores que se muestran en la Figura B1 y (2) tienen un eje principal que se proyecta en dirección opuesta a la rampa del tobogán no deben tener salientes perpendiculares al plano de la superficie circundante de más de 1/8 pulgadas (Figura B12).

B.2.3.1 Procedimientos para efectuar la verificación

1ro: Identifique todos los salientes dentro del área sombreada en la Figura B13.

2do: Determine cuál, si es que hay alguna, cabe dentro del medidor para verificación de salientes (Figura B1).

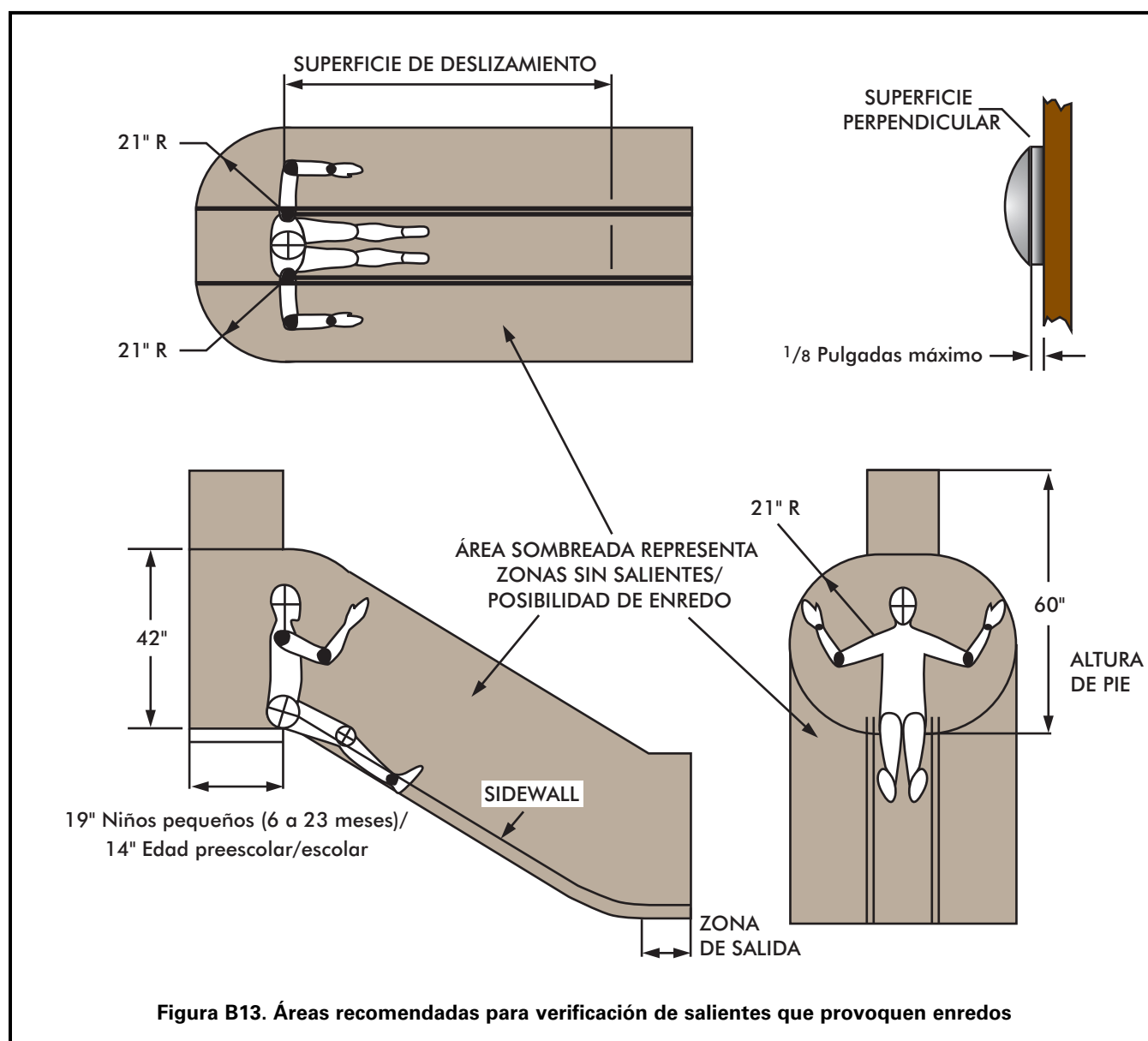
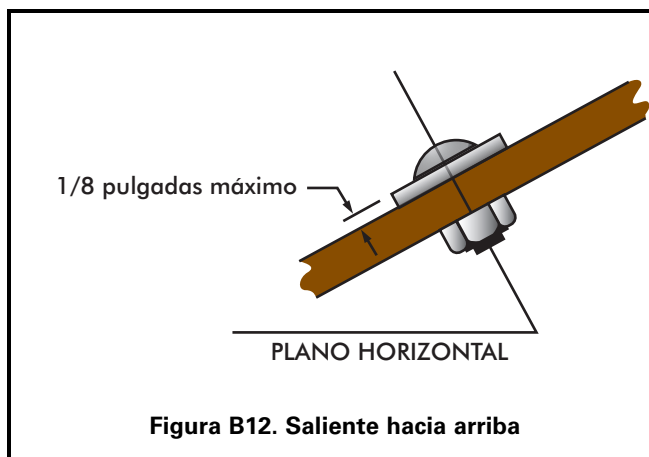
3ro: Coloque el medidor para la verificación de salientes para columpio y tobogán (Figura B2) al lado de la protuberancia para verificar su altura.

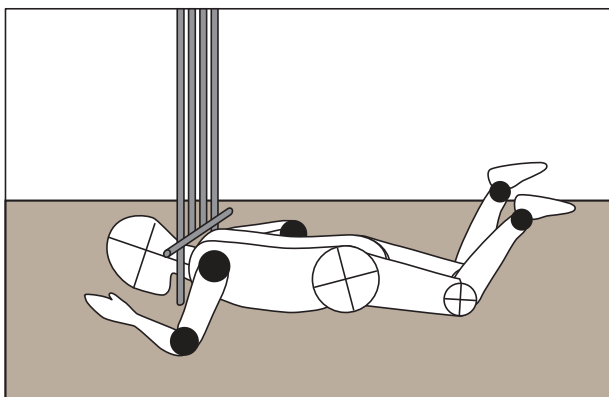
4to: Determine con la vista si el saliente se prolonga más allá del plano del medidor de salientes para toboganes.

Pasa: Un saliente que no se prolonga más allá del plano del medidor está aprobado.

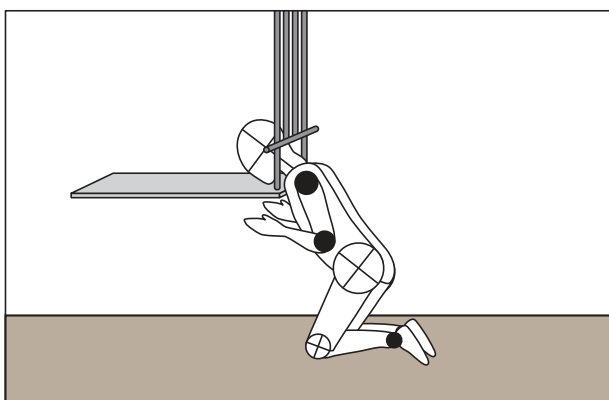
Falla: Un saliente que se prolonga más allá del plano de cualquiera de los medidores se considera una protuberancia peligrosa y debe ser eliminada.

NOTA: Este procedimiento de verificación no es válido para la parte inferior de la rampa de un tobogán. Para la rampa de un tobogán con una sección transversa circular, la parte inferior que no está sujeta a esta recomendación de salientes que se muestra en la Figura 18. Las recomendaciones generales para salientes en §B.2.1 son válidas para la parte inferior de un tobogán.

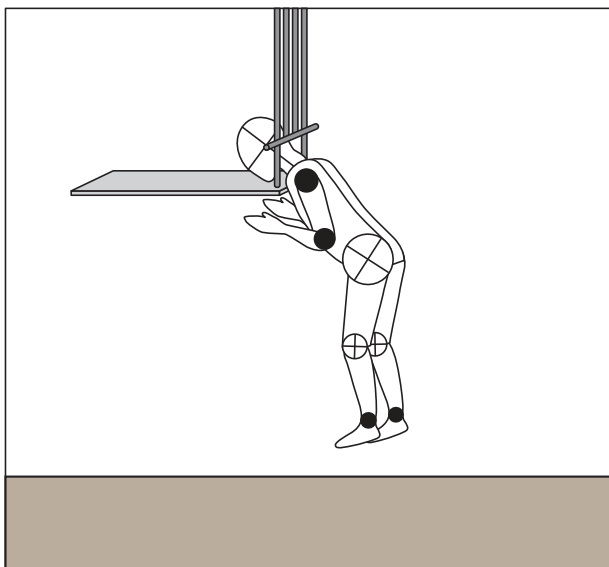




Pegado al suelo: No está sujeto a recomendaciones de atasco.



Atasco a poca altura



Atasco a mayor altura

Figura B14. Ejemplos de aberturas totalmente restringidas

B.2.4 Atasco

B.2.4.1 Generalidades

Cualquier abertura totalmente restringida (Figura B14) que no esté limitada por el piso puede ser un peligro potencial de atasco. Incluso aquellas que se encuentran a poca altura como para permitir que los pies de un niño toquen el suelo pueden constituir un riesgo de estrangulación para un niño atascado, ya que los niños más pequeños pueden no tener la capacidad intelectual o habilidades motoras necesarias para revertir el proceso que causó que sus cabezas se vieran atrapadas, especialmente si se asustan o entran en pánico. Una abertura puede constituir un peligro de atasco si la distancia entre superficies interiores opuestas es superior a 3.5 pulgadas e inferior a 9 pulgadas. Si la dimensión de una abertura se encuentra dentro de este rango potencialmente peligroso, todas las dimensiones de la abertura deben considerarse en conjunto para evaluar la posibilidad de atasco. El método más apropiado para determinar si una abertura es peligrosa es verificarlo utilizando los siguientes dispositivos, métodos y criterios de ejecución.

Estas recomendaciones son válidas para todos los equipos de parques infantiles, es decir, para niños pequeños (6 a 23 meses), en edades preescolar y escolar. Los equipos fijos tanto como aquellos móviles (en sus posiciones estáticas) deben ser sometidos a pruebas para determinar posibles peligros de atasco. Existen dos casos especiales para los cuales hay procedimientos distintos: (1) Aberturas completamente restringidas donde la profundidad de la penetración es de suma importancia (Ver Figura B15) y (2) aberturas formadas por componentes flexibles para escalar.

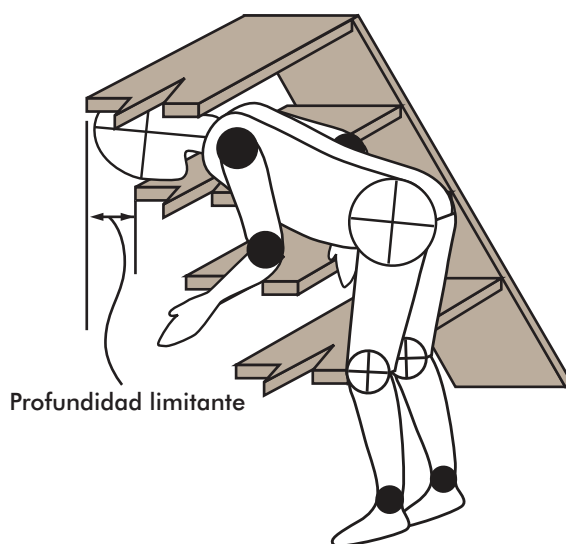


Figura B15. Abertura totalmente restringida con profundidad limitada

B.2.5 Dispositivos para pruebas

Se necesitan dos plantillas para determinar si una abertura totalmente restringida en estructuras rígidas constituye un peligro de atasco. Estas plantillas pueden construirse fácilmente de cartón, contrachapado u hojas de metal.

B.2.5.1 Plantilla de un torso pequeño

Las dimensiones (véase las figuras B3 y B4) de esta plantilla se basan en el tamaño del torso del usuario más pequeño en riesgo (5 percentil de niños de 6 meses de edad en la Figura B3 y niños de 2 años en la Figura B4). Si una abertura es demasiado pequeña para la plantilla, también será demasiado pequeña como para permitir la entrada del niño desde los pies. Como las cabezas de los niños son más grandes que sus torsos, una abertura que no admita la plantilla del torso pequeño también impedirá la entrada del niño por la cabeza en la apertura.

B.2.5.2 Plantilla de cabeza grande

Las dimensiones (Ver Figura B5) de esta plantilla están basadas en las mayores dimensiones de la cabeza del niño más grande en riesgo (95 percentil de niños de 5 años). Si una abertura es lo suficientemente grande como para que pase la plantilla, es lo suficientemente grande para permitir que quepa la cabeza del niño más grande en riesgo en cualquier dirección. Las aberturas que sean lo suficientemente grandes como para permitir el paso libre de la plantilla de la cabeza grande no representarán riesgo de atasco para el torso del niño más grande en riesgo.

B.2.5.3 Abertura completamente restringida con profundidad ilimitada

B.2.5.3.1 Procedimientos para efectuar la prueba

- 1ro: Seleccione la plantilla para torsos pequeños apropiada teniendo en cuenta los usuarios para quienes está diseñado el parque infantil (Figura B3 para parques infantiles para niños pequeños (6 a 23 meses) y Figura B4 para niños en edad preescolar y escolar).
- 2do: Identifique todas las aberturas totalmente restringidas.
- 3ro: Intente colocar la plantilla para torsos pequeños en la abertura con el plano de la plantilla paralelo al plano de la abertura. Mientras la mantiene paralelo al plano de la abertura, la plantilla debe rotarse en su orientación más adversa (es decir, el eje mayor de la plantilla debe estar orientado paralelo al eje mayor de la abertura.)

- 4to: Determine si la plantilla del torso pequeño cabe fácilmente por la abertura.

No: **Pasa.** Deténgase

Sí: Continúe



- 5to: Coloque la plantilla para la cabeza grande en la abertura una vez más con el plano de la plantilla paralelo al plano de la abertura e intente introducirla en la abertura.

Pasa: La plantilla para cabeza grande puede ser fácilmente introducida por la abertura.

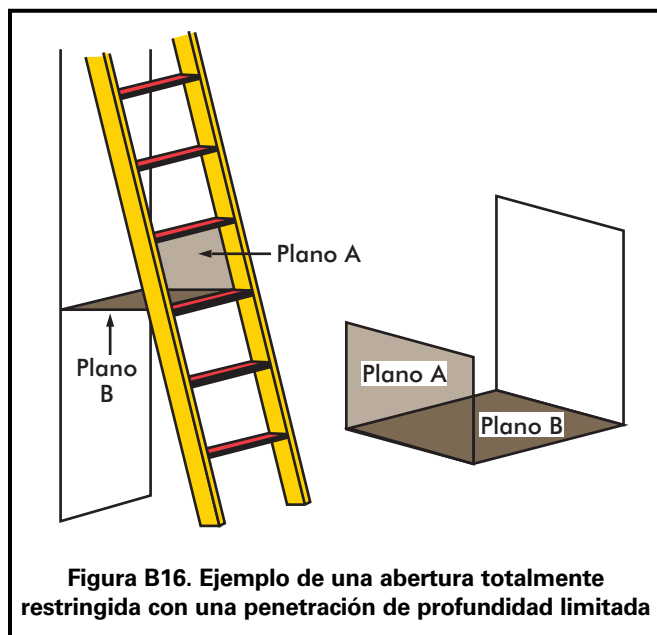
Falla: La abertura deja pasar la plantilla del torso pequeño pero no la de la cabeza grande.



B.2.5.4 Aberturas completamente restringidas con profundidad de penetración limitada

La configuración de algunas aberturas puede ser tal que la profundidad de penetración es de suma importancia para determinar el potencial de atasco. Por ejemplo, considere una pared vertical u otra barrera detrás de una escalera de peldaños. El potencial de atasco depende no solo de las dimensiones de la abertura entre los peldaños adyacentes, pero también en el espacio horizontal entre el límite inferior de la abertura y la barrera. Un niño puede penetrar la abertura entre los peldaños adyacentes primero por los pies y luego pasar por el espacio entre la parte posterior del peldaño inferior y la barrera y verse atascado cuando la cabeza del niño no puede pasar. De hecho, hay aberturas en dos planos distintos y cada una tiene el potencial para atasco de cabeza y debe ser verificada.

Figura B16 muestra estos dos planos en una escalera de peldaños así como en una abertura genérica. El Plano A es el plano de la abertura totalmente restringida en sí y el Plano B es el plano de la abertura incluyendo el espacio horizontal entre el límite inferior de la abertura en el Plano A y la barrera que también debe ser verificada para peligros de atasco.



B.2.5.4.1 Procedimientos para efectuar la prueba

1ro: Seleccione la plantilla para torsos pequeños apropiada teniendo en cuenta los usuarios para quienes está diseñado el parque infantil (Figura B3 para parques infantiles para niños pequeños (6 a 23 meses) y Figura B4 para

2do: Identifique todas las aberturas totalmente restringidas con profundidad de penetración limitada.

3ro: Coloque la plantilla para torsos pequeños en la abertura del Plano A con su plano paralelo al Plano A; gire la plantilla hasta su orientación más adversa con respecto a la abertura mientras lo mantiene paralelo al Plano A.

4to: Determine si la abertura en el Plano A deja pasar la plantilla del torso pequeño en cualquier dirección al rotarlo sobre su propio eje.

No: Pasa. La abertura es lo suficientemente pequeña como para prevenir un atasco ya sea por introducción de cabeza o pies por el usuario en riesgo más pequeño y no constituye un peligro de atasco.

Sí: Continúe.

5to: Coloque la plantilla del torso pequeño en la abertura en el Plano B con su plano paralelo a éste; gire la plantilla hacia su posición más adversa con respecto a la abertura mientras la mantiene paralela al Plano B.

6to: Determine si la abertura en el Plano B deja pasar la plantilla del torso pequeño.

No: Pasa. La profundidad de penetración en la abertura del Plano A no es suficiente para causar un atasco del usuario más pequeño.

Sí: Continúe.

7mo: Coloque la plantilla para cabezas grandes (Figura B5) en la abertura del Plano A con su plano paralelo a éste. Determine si la abertura en el Plano A deja pasar la plantilla de cabeza grande.

No: Falla. Un niño cuyo torso puede pasar por la abertura del Plano A así como la abertura del Plano B puede atascarse de cabeza en la abertura del Plano A.

Sí: Continúe.

8vo: Con el plano de la plantilla para cabezas grandes paralelo a la abertura en el Plano B, determine si la abertura en el Plano B deja pasar la plantilla para cabezas grandes.

No: Falla. El usuario en riesgo de mayor edad no puede salir de la abertura en el Plano B.

Sí: Pasa. La abertura en los planos A y B no constituyen un riesgo de atasco.

B.2.5.5 Aberturas flexibles

Módulos para escalar, tales como redes flexibles, también son un caso especial para pruebas de atasco porque el tamaño y la forma de las aberturas en estos equipos puede ser alterada cuando se aplica fuerza, ya sea intencionalmente o simplemente cuando un niño escala sobre una abertura o se cae por ella. En tales instancias, los niños se encuentran en riesgo potencial de atasco en aberturas distorsionadas.

El procedimiento para determinar el cumplimiento de las recomendaciones de atasco para aberturas flexibles requiere dos dispositivos de prueba tridimensionales ilustrados en las figuras B6, B7, y B8 que se colocan en una abertura del componente flexible con una fuerza de hasta 50 libras.

B.2.5.5.1 Procedimientos para efectuar la verificación

- 1ro: Seleccione la plantilla para torsos pequeños apropiada teniendo en cuenta los usuarios potenciales para quienes está diseñado el parque infantil (Figura B3 para parques infantiles para niños pequeños (6 a 23 meses) y Figura B4 para parques infantiles para niños en edad preescolar y escolar).
- 2do: Identifique todas las aberturas totalmente restringidas con lados flexibles.
- 3ro: Coloque los dispositivos para torso pequeño (Figuras B6 and B7) en la abertura, comenzando por el extremo cónico, con el plano de su base paralelo al plano de la abertura.
- 4to: Gire el dispositivo hacia su posición más adversa (eje mayor del dispositivo paralelo al eje mayor de la abertura) mientras mantiene la base paralela al plano de la abertura.
- 5to: Determine si el dispositivo puede ser empujado o halado completamente a través de la abertura con una fuerza de no más de 30 libras en parques infantiles para niños pequeños (6 a 23 meses) o de no más de 50 libras en parques infantiles para niños de edad preescolar y escolar.

No: Pasa. Deténgase

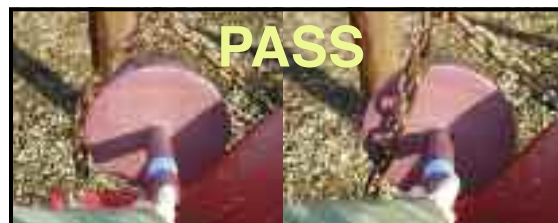
Sí: Continúe.



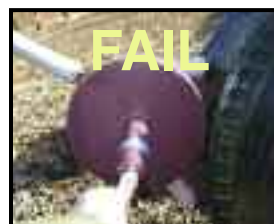
6to: Coloque el dispositivo para cabeza grande (Figura B8) en la abertura con el plano de su base paralelo al plano de la abertura.

7mo: Determine si el dispositivo de prueba para cabeza grande puede empujarse o halarse por una fuerza de no más de 30 libras en parques infantiles para niños pequeños (6 a 23 meses) y no más de 50 libras en parques infantiles para niños en edad preescolar y escolar.

Sí: Pasa. Deténgase.



No: Falla.



B.2.5.6 Aberturas parcialmente restringidas

Una abertura parcialmente restringida es cualquier abertura que tiene al menos un lado o segmento abierto, como una abertura con forma de U o V. Estas aberturas pueden también representar un peligro de atasco al permitir que el cuello pase pero no la cabeza. Una abertura parcialmente restringida puede ser cualquier parte del equipo de juego donde la cabeza o el cuello de un niño pueda atascarse, por lo que incluye no solo aberturas con dos o tres lados, sino también áreas de aberturas amplias (lo suficientemente grandes como para que la plantilla de la cabeza quepa) que tienen las características que puedan atascar el cuello de un niño. Las figuras a continuación muestran varios ejemplos de esta situación. Las aberturas que tienen un esquema similar al de estas figuras se dan a menudo cuando dos partes de un parque infantil se encuentran, por ejemplo, la parte superior de un tobogán y el lado de una baranda protectora.

La identificación de aberturas parcialmente restringidas varía en dependencia del rango de edad para el uso del parque infantil. Las aberturas que deben verificarse incluyen cualquiera donde:

Para niños pequeños (6 a 23 meses)

- El perímetro de la abertura no está cerrado.
- La parte inferior de la abertura está por encima de la horizontal) o 45 grados por debajo de la horizontal.

Para niños en edad preescolar y escolar:

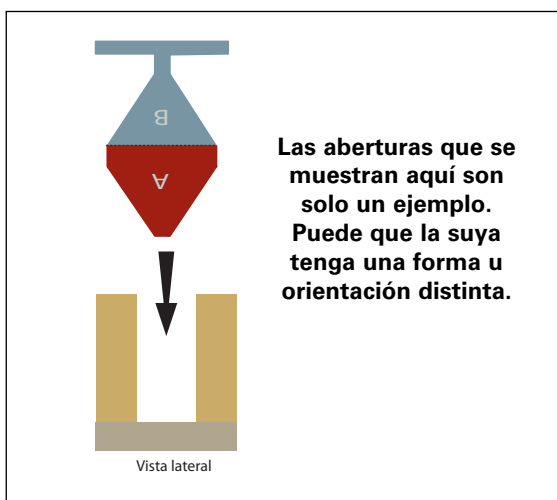
- El perímetro de la abertura no está cerrado.
- La parte inferior de la abertura está por encima de la horizontal)



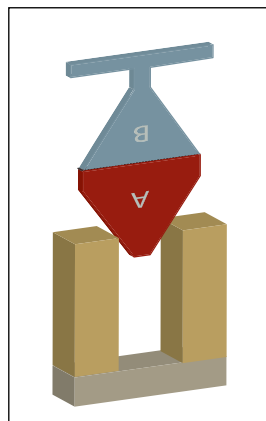
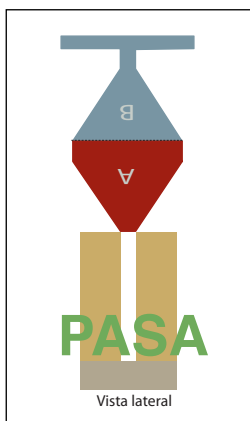
Ejemplos de aberturas parcialmente restringidas. Tenga en cuenta que el fin de estos ejemplos es ilustrar el principio de las aberturas parcialmente restringidas y puede o no requerir verificación.

B.2.5.6.1 Procedimientos para efectuar la prueba

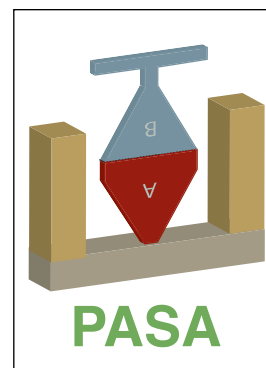
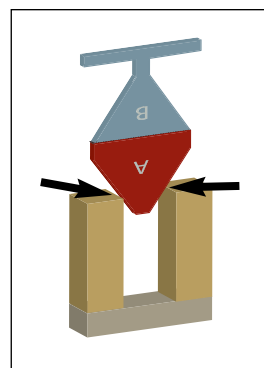
- 1ro: Seleccione la plantilla para aberturas parcialmente restringidas apropiada teniendo en cuenta los usuarios para quienes está diseñado el parque infantil (Figura B10 para parques infantiles para niños pequeños (6 a 23 meses), Figura B9 para parques infantiles para niños en edad preescolar y escolar).
- 2do: Identifique las aberturas parcialmente restringidas.
- 3ro: Alinee la plantilla de manera que el plano de ésta se encuentre paralelo al plano de la abertura y el extremo estrecho de la sección A esté apuntando hacia la abertura.



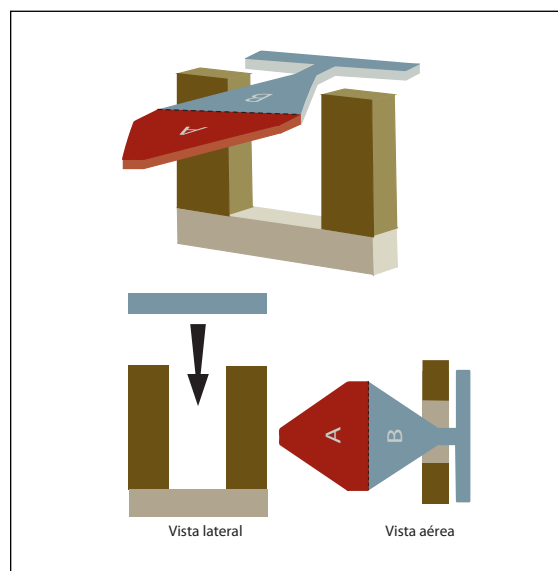
- 4to: Introduzca la parte A de la plantilla en la abertura siguiendo la línea central de la abertura.
- 5to: Una vez introducida lo más posible, determine si hay contacto simultáneo entre los lados de la abertura y las dos esquinas superiores en el extremo estrecho de la sección A.

Sí: Pasa. Deténgase**No:** Continúe

- 6to: Mientras esté introducida lo más posible, determine si hay contacto simultáneo entre ambos lados angulares de la sección A y los lados de la abertura.

Sí: Tenga en cuenta puntos de contacto a los lados de la abertura y continúe**No:** Pasa. El extremo más estrecho debe descansar en el límite inferior de la abertura sin contacto con los lados. Pare

- 7mo: Extraiga la plantilla y gírela de manera que su plano sea perpendicular al plano de la abertura.
- 8vo: Siguiendo el plano de la abertura, introduzca la parte B de la plantilla en la abertura para que el extremo estrecho de la parte B quede entre los lados de la abertura.

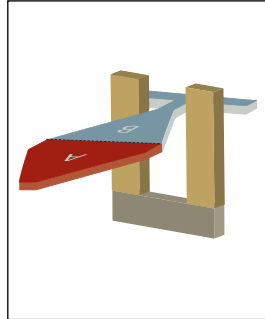
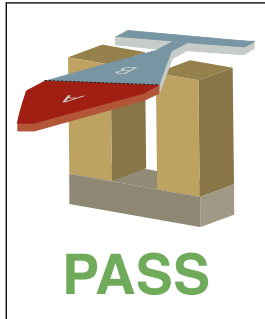


9no: Una vez introducido lo más posible, determine si la parte B está completamente más allá de los puntos donde se hizo contacto en los lados de la abertura con la porción A.

No: Pasa. Deténgase

Sí: Niños pequeños (6 a 23 meses): Falla. Deténgase

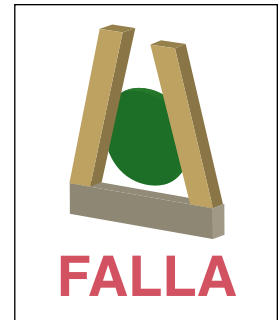
Niños en edad preescolar y escolar: Continúe



11mo: Determine si la plantilla para cabeza grande pasa libremente por la abertura más grande.

Sí: Pasa

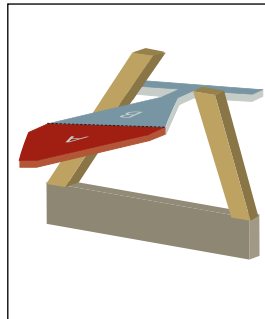
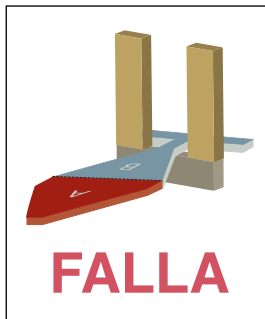
No: Falla



10mo: Determine si la parte B puede alcanzar un punto donde el tamaño de la abertura aumenta.

No: Falla. Deténgase

Sí: Continúe



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