Virginia Regulatory Town Hall

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Proposed Regulation
Agency Background Document

Agency name	State Board of Social Services
Virginia Administrative Code (VAC) citation	22 VAC 40 –111-10 et seq.
Regulation title	Standards for Licensed Family Day Homes
Action title	New Regulation
Document preparation date	Enter date this form is uploaded on the Town Hall

This information is required for executive review (www.townhall.state.va.us/dpbpages/apaintro.htm#execreview) and the Virginia Registrar of Regulations (legis.state.va.us/codecomm/register/regindex.htm), pursuant to the Virginia Administrative Process Act (www.townhall.state.va.us/dpbpages/dpb_apa.htm), Executive Orders 21 (2002) and 58 (1999) (www.governor.state.va.us/Press_Policy/Executive_Orders/EOHome.html), and the *Virginia Register Form, Style and Procedure Manual* (http://legis.state.va.us/codecomm/register/download/styl8_95.rtf).

Brief summary

In a short paragraph, please summarize all substantive changes that are being proposed in this regulatory action.

The new regulation, Standards for Licensed Family Day Homes, incorporates and replaces Minimum Standards for Licensed Family Day Homes (22 VAC 40-110-10 et seq.). The new regulation establishes education and experience requirements for licensed providers. Orientation to this regulation and licensing procedures is required prior to licensure. The number of hours of ongoing training required annually is increased. In the physical plant, resilient surfacing is required under play equipment with moving parts and climbing apparatus. All heating equipment must be inspected annually. Facilities licensed prior to the effective date of this regulation have one year to install a barrier around outdoor play areas located within 30 feet of hazards. Height limits have been added for platforms and climbing equipment for preschool and school age children. Certain written policies and procedures must be developed and provided to parents at the time of each child's admission. A written plan to provide a competent adult to provide temporary care in a medical emergency is newly required.

Basis

Please identify the state and/or federal source of legal authority to promulgate this proposed regulation, including (1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly bill and chapter numbers, if applicable, and (2) promulgating entity, i.e., the agency, board, or person. Describe the legal authority and the extent to which the authority is mandatory or discretionary.

Sections 63.2-217, 63.2-1701, 63.2-1734, of the *Code of Virginia* provide the legal authority for the State Board of Social Services to promulgate this regulation. The State Board of Social Services is mandated to promulgate regulations for the activities, services, and facilities used by a person required to be licensed as a family day home by the Department of Social Services. The *Code of Virginia* mandates licensure of family day homes serving six through twelve children, exclusive of the provider's own children and any children who reside in the home. Every person who maintains such a family day home, except family day homes that are members of a licensed family day system, is required to obtain a license from the Commissioner of Social Services.

The above-referenced sections of the *Code of Virginia* may be found at http://leg1.state.va.us.

Purpose

Please explain the need for the new or amended regulation by (1) detailing the specific reasons why this regulatory action is essential to protect the health, safety, or welfare of citizens, and (2) discussing the goals of the proposal and the problems the proposal is intended to solve.

The new regulation replaces the current Minimum Standards for Licensed Family Day Homes. The goal of the regulation is to protect the health, safety and well-being of children receiving care in licensed family day homes. The last major revision of the regulation for licensed family day homes occurred in 1993. In addition to incorporating the majority of the provisions from 1993, this new regulation adds requirements that are based on changes in law since that time, findings of research, and changes in practice.

A periodic review of the Minimum Standards for Licensed Family Day Homes was conducted in 1999. The periodic review resulted in a recommendation for repeal and promulgation of a new regulation with requirements that were reworded and reorganized in order to improve readability and clarity. A recommendation was also made that, where feasible, family day home standards be the same as those for child day centers. In April 2002, a notice of intent to develop a new regulation was published, that incorporated and addressed the findings of the periodic review. That notice of intent was subsequently withdrawn due in part to the length of time between initial submission and publication in the Virginia Register, but public comment was received during the notice period. Providers rejected the notion of having, where feasible, the same requirements as child day centers.

Public comment was received a second time during the notice period that ended in June 2003. While there were some differences expressed to proposed changes in some areas, there was clear support during both public comment periods for strengthening other areas of the requirements.

The purpose of this regulatory action is to increase protection of children in care in licensed family day homes through requirements that are clearly written, less burdensome and less intrusive.

Substance

Please briefly identify and explain the new substantive provisions, the substantive changes to existing sections, or both where appropriate. (More detail about these changes is requested in the "Detail of changes" section.)

The following changes in the proposed regulation are mandated by the *Code of Virginia:*

- The added requirement that the family day home provider disclose to parents the percentage of time someone other than the provider will be caring for children;
- The added requirement to secure documentation that establishes a child's age and identity and last day care or school attended; and
- The requirement for compliance with the provisions of the law related to background checks and the current regulation for background checks.

New substantive changes for providers of care include the following:

- The establishment of "entry-level" education and experience requirements for providers wishing to be licensed after the effective date of the new regulation;
- Increased training hours from 6 to 16 hours annually, with a three-year phase-in period after the regulation becomes effective;
- Certification in CPR newly required, in addition to first aid;
- Expanded list of acceptable sources for first aid and CPR training;
- Orientation to licensing standards and procedures prior to issuance of a license;
- First aid and CPR training prior to licensure or employment;
- Based on guidance from the Virginia Department of Health, use of risk assessment as evidence of the absence of symptoms of active tuberculosis infection or disease, in addition to the Tuberculin Skin Test.

In the area of physical plant, the following substantive changes are being proposed:

- A barrier such as a fence or hedge around outdoor play areas located within 30 feet of hazards;
- Prohibition against use of hot tubs, spas and whirlpools by children in care;
- The addition of specific indoor and outdoor space requirements;

- Resilient surfacing under play equipment with moving parts and under climbing apparatus, including in the use zone around equipment;
- Prohibition against use of trampolines during hours children are in care;
- Additional requirements for use of play yards; and
- Annual inspection of all heating equipment.

Requirements for development of the following written policies and procedures are being proposed:

- Discipline policy, including acceptable and unacceptable discipline methods;
- Policies and procedures for termination of care;
- Policies on provision of meals and snacks;
- Policies on medication, including what medication or medical procedures will be administered; and
- A written plan to provide a competent adult to be available to provide temporary care in the event of a medical emergency.

In the area of medication administration, the following requirements are being proposed:

- Authorization for nonprescription medications like antihistamines, non-aspirin fever reducers/pain relievers; diaper ointment and sunscreen that does not exceed 3 months; and
- Authorization for the provider to permit self-administration of medication under certain conditions.

The following requirements are proposed in the area of water safety:

- A water safety instructor must be on duty if a pool, lake, or other swimming area has water depth more than two feet;
- The written permission from parents for swimming or wading activities must include a statement advising of a child's swimming skill level; and
- Revised provisions regarding use of portable wading pools.

In the area of record keeping, the following are proposed:

- Proof of a child's age and identity and the names and addresses of previous child day care and schools attended;
- The establishment of time frames for review and update of a child's emergency contact information; and
- The requirement that immunization records be on file by the first day of a child's attendance in the family day home.

Issues

Please identify the issues associated with the proposed regulatory action, including:

1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;
2) the primary advantages and disadvantages to the agency or the Commonwealth; and
3) other pertinent matters of interest to the regulated community, government officials, and the public.

If the regulatory action poses no disadvantages to the public or the Commonwealth, please so indicate.

Studies indicate that the establishment of baseline educational and experience requirements for providers has positive and long-lasting impacts on children in care. Increasing the number of ongoing hours of training required annually for providers provides the public with some assurance that providers are staying abreast of changes and trends in child care and child development. For these reasons, the new regulation is advantageous to parents choosing a family day home as a day care option.

Increased requirements for care of children with disabilities result in increased protections in family day homes, and may increase availability of spaces in private family residences for children with special needs.

The addition of space requirements may or may not result in reductions in capacity of licensed homes upon implementation of the regulation. Currently the requirement is that providers have "adequate" space. The overall effect might be only a slight reduction in the number of available care spaces, since licensing staff have used 25 square feet as a benchmark for evaluating the adequacy of space. The increase to 30 square feet and ultimately to 35 square feet may affect the number of care spaces available in the future.

Several of the proposed requirements will result in additional costs to providers. A disadvantage is that these costs may be passed on the parents.

The regulation supports providers in their efforts to dispel the view of the care being provided in a home as "custodial" and simply "babysitting," in addition to highlighting the role licensed providers play in the education and development of young children.

The regulation presents no disadvantages to the Commonwealth or the agency. The regulation supports the efforts of the Commonwealth to improve services to children under school age and, in addition, supports the efforts of the Department of Social Services to improve the quality of care provided to children in out-of-home day care settings.

Economic impact

Please identify the anticipated economic impact of the proposed regulation.

Projected cost to the state to implement and enforce the proposed regulation, including (a) fund source / fund detail, and (b) a	Implementation and enforcement of the new regulation will not result in any significant

delineation of one-time versus on-going expenditures	increased cost to the state. Licensing staff with responsibility for implementation and enforcement are currently in place. The size of the regulation will increase, which will result in a slight increase in the cost of printing and distribution, particularly during initial implementation. Slight cost increases can also be anticipated for staff and provider training upon implementation of the new regulation. Licensing offices currently provide orientation sessions to licensing standards and procedures to inquirers and applicants for licensure on a regular basis. Therefore, the orientation requirement prior to licensure will not result in increased staffing costs.
Projected cost of the regulation on localities	Implementation and enforcement of the new regulation will have no cost impact on localities.
Description of the individuals, businesses or other entities likely to be affected by the regulation	Persons providing care to more than six children, excluding their own and resident children, in their home or in the home of one of the children in care, are affected by this regulation. Also, persons caring for more than four children under the age of two years, including their own and resident children under the age of two years, are affected. These persons must be licensed, except that the person caring for infants may be voluntarily registered. The regulation affects children cared for in family day homes subject to the regulation, and their families.
Agency's best estimate of the number of such entities that will be affected	As of April 1, 2003, there were 1,657 licensed family day homes serving a total of 17, 966 children.
Projected cost of the regulation for affected individuals, businesses, or other entities	Costs for family day home providers and families of children in care are described below.

Evidence of compliance with the education requirement

Securing documentation of meeting revised educational requirements (high school transcript) may result in a minimal cost to providers licensed after the effective date of this regulation.

Increased expenditure for ongoing training

The increase in ongoing training hours required from six to 16 hours annually will result in increased costs to providers. The phase-in approach, however, spreads any additional costs over a three year period after the regulation becomes effective. The cost will vary depending on the source of the training and the number of hours of each workshop or class. The fee for a three or four hour workshop sponsored by the department is $10. A six-hour workshop is $20. The total cost to providers to meet the 10 hours of annual training required when the regulation becomes effective is approximately $30 if the provider chooses department-sponsored training; approximately $40 for 12 hours one year after the regulation becomes effective; approximately $50 for 14 hours two years after the effective date of the regulation, and $50 for 16 hours three years after the effective date of the regulation.

Additional cost for CPR

American Red Cross training in CPR costs approximately $50 annually. When CPR certification is combined with first aid certification, which is currently required, the cost for certification through the American Red Cross is approximately $60 annually. Additional acceptable sources have been added, that may offer training at a competitive rate.

Tuberculosis screening for all adult household members

Household members who may have been exempt from the requirement for TB screening based on lack of contact with children, would be newly subject effective with this regulation. The cost of TB screenings varies depending on whether they are obtained from a local health department or a private physician.

Enclosure of yards with fences or hedges, where hazards exist

This requirement could result in substantial cost to providers and would depend on the size of the yard, and the type of barrier erected.

Indoor square footage requirements

Implementation of square footage requirements may reduce the number of children in care for the provider who is operating below the proposed minimum. The result may or may not be a reduction of income for the provider. Providers establish their own fees, and some providers are already in compliance, therefore, the dollar impact of this change cannot be determined. Providers may be affected by the increase in space required after the effective date of the regulation. Public comment will be helpful in determining the impact of this change as providers make projections about how they will be affected in the future.

Resilient surfacing under play equipment

The addition of resilient surfacing under play equipment will result in increased expenditures for providers who have qualifying equipment and who are not already in compliance. The cost will vary depending on the dimensions of the equipment and the surfacing materials used, weather and use pattern. Additional costs may be incurred in order to maintain the surfacing at the required depth. Barriers to contain the resilient surfacing would add to the cost.

Inspection of all heating equipment

Annual inspection of primary home heating equipment may result in increased expenditures for providers who do not routinely conduct these inspections. The cost would vary depending on the source of the inspection. Some local utility companies routinely offer inspections of gas heating equipment at the beginning of heating season free of charge. Prices for inspection by professional heating contractors could begin at $55, which is the hourly rate charged by some contractors for a home visit.

Distribution of written policies and procedures

The requirement that parents receive copies of the home's written policies and procedures in five areas could result in an expense for the provider. At $.10 per page, a complete booklet of polices would cost approximately $.50. Distribution to 12 families would cost approximately $6.00. Because turnover of families is limited in family day homes, this expense may not be a regular one.

Assignment of portable wading pools for individual use by non-potty trained children

Portable inflatable wading pools cost as little as $3.95 each.

Use of baby monitors during overnight care

Baby monitors range in price from $20 to $100. The impact of this requirement would not be widespread, as the majority of family day home providers do not provide overnight care.

Water Safety Instructor

An informal poll of licensing staff found that fewer than 100 licensed providers have pools on site more than 2 feet deep. Compliance may result in the additional cost for Water Safety Instructor Training for those providers who are not already in compliance.

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action.

The *Code of Virginia* requires that the State Board of Social Services adopt regulations for licensed family day homes. In developing this proposal, consideration was given to the necessity, the enforceability, reasonableness and the cost impact of the regulation. Public comment was carefully reviewed and analyzed. Regulations from other states were reviewed. The proposed regulation reflects the least burdensome or intrusive alternative.

Public comment

Please summarize all comments received during public comment period following the publication of the NOIRA, and provide the agency response.

Comments were received on both the changes proposed in the NOIRA and on areas of concern in the current regulation. All of the comments were received via the Internet. Comments were received from eight providers, two organizations- Virginia Association of Family Child Care (VAFCCA) and Voices for Children, staff from one licensing office (Office #1), and two Licensing Inspectors (LI).

Current/NOIRA Language	Commenter	Comment	Agency Response
NOIRA: "Programmatic experience" means time spent working directly with non-related children in a group. Work time shall be computed on the basis of full-time work experience during the period prescribed or equivalent work time over a longer period. Experience settings include but are not limited to: a child day program; family day home; child day center; boys and girls club; field placement; elementary school; or a faith-based organization.	Office #1	"Programmatic experience" (definition) – the last phrase in the paragraph refers to "or a faith-based organization." We would like clarification, if this were Sunday school would like it removed.	Faith-based organizations provide services to the community. Counting relevant experience from these settings increases the pool of providers who may qualify for licensure. Sunday school, Vacation Bible School or weekday Bible study may count toward meeting the experience requirement. Evidence of compliance with both the length of time, and that the group included preschool or school age children, as appropriate, would be needed.

Current/NOIRA Language	Commenter	Comment	Agency Response
NOIRA: "Use zone" means the surface under and around a piece of equipment onto which a child falling from or exiting from equipment would be expected to land.	Office #1	"Use zone" (definition) – needs to be clearer. Is this referring to CPSC requirements?	"Use zone" means the area under and around a piece of equipment where resilient surfacing is required.
NOIRA: Resilient surfacing" means, for *outdoor use,* (1) impact absorbing surfacing material, including loose-fill materials such as wood chips; double shredded bark mulch; engineered wood fibers; fine sand coarse sand; fine gravel; medium gravel; shredded tires; and unitary materials such as rubber mats or unitary materials such as poured in place ones that meet the most recent edition of the Consumer Product Safety Commission's (CPSC) guidelines for safety and/or minimum safety standards when tested in accordance with the procedures described in the most recent edition of the American Society for Testing and Materials (ASTM) standard F 1292; (2) maintained at sufficient depths	Office #1	"Resilient surfacing" – Definition needs to be clearer, feel it needs to state exact inches so it could be understood.	Revise definition to include depths.

Current/NOIRA Language	Commenter	Comment	Agency Response
as described in the CPSC Critical Height Table to reduce the impact of a child's fall and; therefore, lessen the potential for a serious life-threatening head injury; and (3) maintained in the use zone, or area under and around playground equipment where protective surfacing is required, that is also free of obstacles that children could run into or fall on top of and thus be injured. For *indoor use,* means (1) impact absorbing surfacing material specifically designed and tested as playground surfacing such as rubber mats, rubber tiles, or poured-in-place rubber compositions that meet minimum safety standards when tested in accordance with the procedures described in the most recent edition of the American Society for Testing and Materials (ASTM) standard F1292; and (2) has a critical height value equal to or greater than the highest designated			

Current/NOIRA Language	Commenter	Comment	Agency Response
play surface on the equipment.			
	Office #1	The proposed exception to the educational and experience requirement for providers that would allow programmatic experience to be waived by completion of a curriculum approved by the department should be removed.	Delete exception. Option exists for providers to present alternatives to evaluation by the department through the allowable variance process.
NOIRA: Family day home providers licensed after the effective date of these standards and substitute providers shall have a high school diploma, G.E.D. or verification of completion of a home school program approved by the state and three months of programmatic experience.	LI #2	I feel that limiting the qualifications to people who have had three months of experience is cutting out a group of "just Mom's" that I have found to make very good providers. I have no problem with the high school diploma part, but how will we document that for the many providers who attended school in another country?	Revise to require high school diploma or equivalent. Guidance will be provided on what constitutes acceptable documentation. Operating a family day home means operating a business without leaving home. There are very few business endeavors that do not require some prior experience. Nannies are required to have prior experience. Even jobs that do not involve work with people require prior experience, including clerical workers, painters and housekeepers. Family day home providers are more than "just Moms." Family day home providers have the ability to care for other people's children without neglecting their own. They are willing to spend long hours with other people's
	LI #1	I agree with licensee having HS diploma/G.E.D.; however can we accept their verbal statement as verification? Particularly the applicants who have been out of high school a while may have problems verifying graduation via their diploma.	

Current/NOIRA Language	Commenter	Comment	Agency Response
			children and provide the security and protection needed. Licensed providers may care for between six and 12 children not including their own. Providers wishing to become licensed have the option of operating below the licensure threshold (five or fewer children) while gaining the required three months experience.
NOIRA: Prior to granting of an initial license, applicants shall satisfactorily complete a department-sponsored or approved training program on these standards and pertinent licensure requirements unless the department determines the training is not needed or practical.	LI #1	Either really require it or make it a recommendation. The not practical part basically makes the standard unenforceable.	Delete "where practical." The standard requires completion of a department sponsored or approved training. "Department approved" offers several options for providing the content.
	LI # 1	What is the definition of a disability? Standard or definition needs to clarify who this includes i.e., kids with ADD or a school age children with mild motor delay or a child with food allergies, etc. Are they included?	Minor revision made to current definition that includes broad key indicators of which children are included.
NOIRA: For overnight care, adequate drinking water must be made available to children during the	LI #1	Does this mean they should be offered water during evening waking hours or they can have water should they wake up during the nite?	Deleted. Existing standard requires that water be available for drinking and offered on a

Current/NOIRA Language	Commenter	Comment	Agency Response
night.			regular basis to all children in care.
NOIRA: Each caregiver and any other adult household members who come in contact with children or handle food served to children shall: 1. No earlier than six months prior to licensure, employment, or contact with children undergo: a. an assessment for risk of tuberculosis	Office #1	Why not all household members have a TB test/screen, CPS and CRC are required? Why are we not consistent with CDC standards for 2 years prior? What was rationale of going from 90 days to 6 months?	Retain current requirement, but revise to include all adult household members. Current guidance from Virginia Department of Health is that a person could have negative results one day and be ill 3 months later, which suggests that the tests are only good for as the day they are performed. The current time frame of 90 days prior to licensure or employment affords the maximum protection for children in care, the provider and household members. The portion related to “persons handling food served to children” is deleted. The Virginia Department of Health advises that tuberculosis is not transmitted by food.
NOIRA: Whenever the caregiver leaves the home with the child, the caregiver shall have a mechanism for making telephone calls to emergency personnel and	Provider # 1	Cellular phones and the monthly fee is more than some providers can afford	Several options are proposed in addition to cell phones. Additional contact options found in regulations from other states include pagers and two-way radios.

Current/NOIRA Language	Commenter	Comment	Agency Response
parents (e.g., change, calling card, cellular phone) (410 C 3)			
NOIRA: Resilient surfacing shall be under equipment with moving parts or climbing apparatus over 15 ½ inches high. A use zone shall encompass sufficient area to include the child's trajectory in the event of a fall while the equipment is in use.	Provider # 1	I know of one death where a child was instantly killed falling from a swing set. It took place in a center. Mulch was in place and an aide was standing right there. It was a sad situation but accidents happen. I also heard of a center where a child chewed on mulch and the poison control center had to be contacted, as the mulch was coated with pesticide. I particularly am concerned with pea gravel under outside swing sets. I have found children that go out in the morning for preschool come home with gravel in their pockets from the playground. I've found this gravel throughout my house. I have toddler children and crawling children on the floor that I have to worry about putting the gravel in their mouths thus creating a choking hazard. I've calculated the cost for placing mulch around the swing set in the back yard. The set is approximately 20 x 10 feet x 1 foot of mulch = 200 cubic feet of mulch divided by 3 cubic feet per pack = 67 bags, plus railroad ties to place around the swing	Revise minimum height to 36 inches. Add requirements to address indoor equipment height that would require resilient surfacing. Dimensions are added for use zone. A search of the Internet for information on "home playground safety" results in numerous articles on injuries associated with playground equipment, with falls from swings as a primary cause of injuries. Note that "pea" gravel is not used in the definition, based on the finding that products sold as "pea" gravel may actually be larger rocks.

Current/NOIRA Language	Commenter	Comment	Agency Response
		set, and labor would cost approximately $500 by the time this is completed. This does not include mulch under my castle outside. I also worry about the railroad ties or wood that would have to go around the mulch to keep it in place. This to me would be more of a safety hazard. Some home daycare providers are single parent owners and the cost of such an expense would be prohibitive. Therefore, I do believe the state should provide grants to complete such work, should this be passed into law. I have a play set in my recreation room for kids to have exercise inside as well as outside. This set has been in place for seven years with no injuries up to this point. The parents like the idea and the children were using my couch as a jumping box before I put this set in place. Several of the parents bought similar sets for their own homes. Take this away from the inside recreation room and the children will jump and climb on the furniture. They will be falling, if they fall, on the same floor as the exercise set is on now. The age group I care for is physically active. They need an outlet on the inside as well as the outside. Had I thought this set would be	

Current/NOIRA Language	Commenter	Comment	Agency Response
		harmful for the children I would never have purchased it? I utilized the Internet to determine what statistics were available regarding accidents with outside yard equipment. I was surprised that I could find very little on swing set injuries. There was one daycare provider that said there were 200,000 accidents of various types, but did not give her source or any details. There was actually more about the accidents using the wooden beds required by the state of Virginia than swing sets.	
	VAFCCA	"Resilient surfacing shall be under outside equipment with moving parts and climbing apparatus over 36 inches or 3 feet high. [Proposed] measurement is too low for outside equipment. Teeter-totters, chairs, and Little Tykes small slide are higher than 15". Our old rule and current center guidelines for toddlers and preschoolers require outside equipment higher than 36" must have resilient surfacing. Based on playground safety training, the 3 feet met their safety recommendation for climbing apparatus and equipment with moving parts…	
	Office # 1	Resilient surfacing …over 15 ½ inches high	

Current/NOIRA Language	Commenter	Comment	Agency Response
		– Could remove last statement. Be specific – actual depth and perimeter. Use zone shall….. Is there a formula? Not specific enough.	
	Provider # 2	We feel this is too expensive an obligation. This will have to be redone each year. We have had no injuries since we are providers that stay with our children and supervise them. Home care providers have smaller numbers of children and can patrol the play areas better.	
	Provider # 3	I have a problem with requiring "resilient surfacing" under outdoor play equipment. The proposed changes do not list exactly what this entails but I have been to trainings that cover this. It would be very cost prohibitive for me to do this. If this change is passed I would have to remove my swing set. I have talked to the providers in my association and no one has experienced a fall. You need to remember that in a Family Day Home we have a very small group of children and so it is much easier to watch and make sure they are using the equipment as it is meant. I believe that most injuries come from doing things that were not intended.	
	Provider # 4	What is the amount of	

Current/NOIRA Language	Commenter	Comment	Agency Response
		resilient surfacing that will be required under playground equipment? I read about a CPSC Critical Height Table, but have no knowledge of it or its requirements.	
NOIRA: Written parent authorization for the following nonprescription medications shall include a start date and ending date not to exceed one month: Diaper ointments and powders, intended specifically for use in the diaper area of the child	VAFCCA	A parental written authorization for diaper ointments and powders intended specifically for the diaper area of the child, to include the name of the ointments or powders to be used should a diaper rash occur, and kept in the child's file. Caregivers must administer diaper rash ointments on a situational needs basis and [treating] them differently from other nonprescription medications is important. A diaper rash may appear without warning when infants or toddlers change foods or perhaps were given an inappropriate food at home, i.e. a spicy food. The next day a rash appears after a stool. It is very important that a caregiver be able to administer a diaper ointment immediately should this occur to prevent a more serious rash or even an infection from developing. Expecting caregivers to update written authorization monthly for diaper rash medication is not realistic and an undue burden. If they forget, then it could not be used and it is important	Revise to allow authorization to expire after 3 months. Diaper ointment is an over-the-counter nonprescription drug. The Food and Drug Administration defines "drug" as "(A) articles recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, any any supplement to any of them; and (B) articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; and (C) articles (other than food) intended to affect the structure or any function of the body of man or other animals; and (D) articles intended for use as a component of any article specified in (A), (B) or (C). Diaper

Current/NOIRA Language	Commenter	Comment	Agency Response
		that diaper rash medication be administered when needed. Diaper rash medication is of a different category than other nonprescription medications. Perhaps some type of written agreement on what ointment should be administered should a rash develop and then a follow-up report to parent relating the information on the rash and what steps were taken by the caregiver.	ointment is not designed for long-term use. A review of the literature on diaper rash indicates that the child's physician should be contacted if over-the-counter ointments don't result in improvement after a few days. Just as with other medication, providers should not assume responsibility for applying diaper ointment without written permission from parents. Research indicates there are many types of diaper rash, and application of an over-the-counter ointment without written permission could have adverse effects on the health of a child. The American Academy of Pediatrics and other authorities (Centers for Disease Control, Mayo Clinic) say the best way to treat diaper rash is to prevent it from happening in the first place, by keeping babies' skin as clean and dry as possible.
	Office # 1	Why does this need to be specified? Why not just say the first sentences? What about anti-diarrhea meds?	
	Provider # 1	I can understand a prescription for an ointment for a yeast infection on diaper changing, but I can't understand an over the counter ointment needing a signature. It's a rarity that a child has a rash. Most of the ones I've seen have been from yeast resulting from taking an antibiotic. I understand that the centers get around this law by placing in the contract the question of whether a parent wants ointments or powder applied.	
	Provider # 2	We feel that diaper ointment being administered should be done with a verbal permission, such as a phone conversation with	

Current/NOIRA Language	Commenter	Comment	Agency Response
		a parent who may be at work. We further feel than any types of topical ointments that may be required, sunscreens or diaper ointments should be allowed unless they are listed in the items that a child is allergic to or that a parent may deem necessary to exclude as a permissible item in their file.	
	Provider # 3	I have a problem with the authorization for nonprescription medication. The public schools have to only have one authorization signed each year and then they notify parents when any medication is administered. This is how I have been handling this situation. As an example of the problem with the change, I have one 11 year old child who gets migraines. When he feels one coming on he has to take Motrin. He or I have no way to know child day one will start. If he takes it then, he is fine. If he had to wait for his parents to come he would get such a bad headache that he throws up. I know this because this is what happened before the doctor diagnosed him. I also see no need to have an authorization for diaper ointments or sunscreen. I would like to see the requirement written that all nonprescription	

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		medicine must be brought from home. That one authorization is good for the whole year but that a parent must be notified before any medicine is dispensed.	
	LI # 2	Sunscreen and diaper ointment need a longer time frame than 1 month for parental permission.	
	Provider # 4	I feel that the one month expiration date of this permission form is unnecessary as sunscreen is needed over several months time (hopefully the sun will be shining throughout the summer. I currently have a blanket type permission form that the parents must sign before I administer sunscreen to their child. As well as granting me permission to apply a specific sunscreen, it asks the parent if there have been any adverse reactions to it. I feel that a yearly signing of this form is sufficient and creates less paperwork.	
	LI #2	Parental notification needs to add – any injury to the head.	Head injury included.
NOIRA: Small electrical appliances, such as but not limited to, curling irons; toasters; blenders; can openers; and irons, shall be unplugged when not in use.	Provider # 5	Unplugging appliances is senseless when I use everything and the children are supervised.	The agency will continue to require that small electrical appliances, including, but not limited to, those identified in the standard, be unplugged when not in use.
	VAFCCA	Have the standard include exclusion for the microwave oven. By writing the standard like	

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		that, Licensing Specialists (LS) may include the microwave as a small appliance. Clocks on microwaves would have to reset each time they are unplugged; unplugging and re-plugging could reduce the life of a microwave; and plugs are often located behind the microwave. Although they do not name the microwave, they say "but not limited to" which an LS could interpret to include the microwave oven. It is not unusual for LS's to write something up as a violation and make a statement such as "The standard does not say except……, the standard reads ……."	A microwave is not considered a small, electrical appliance.
CURRENT: All alternate heating devices, such as oil stoves, wood burning stoves, and fireplaces, associated chimneys, and ventilating devices shall be inspected annually by a heating and air qualified inspector to verify that the devices are properly installed, maintained and cleaned as needed. Documentation of the completed inspection and cleaning shall be maintained by the licensee.	Provider # 5 VAFCCA	Fireplaces inspected when never used. Add language that specifies that if it is used as an alternate heating device, then it must be inspected. "If an alternate heating device, such as oil stoves, wood burning stoves, and fireplaces, associated chimneys, and ventilating devices are used as an alternate heating device, it shall be inspected annually by a heating and air qualified inspector…." If an alternative heating device exists but is not employed as an alternate heating device, it should not be mandated that it be inspected. It is unnecessary and an	This requirement is replaced for clarity, equity in application, and safety in the family day home. Since its addition in 1993, questions have arisen over the intent of this standard, including what is covered and what is not. What does "alternate" mean? Should fireplaces used "casually" be inspected? Should unvented fireplaces be inspected? A review of available historical documents indicates that in 1992, alternate heating sources included oil and

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		undue financial burden. As it is now written, there are no exceptions.	wood burning stoves. Fireplaces were added by the time the summary of public comments from public hearings conducted in 1993 was compiled. Because instances where use of alternate heating sources could not be predicted, no exceptions to annual inspection of wood burning stoves, oil stoves and fireplaces was intended. Newly added is a requirement that all heating systems be inspected and cleaned at least once a year. Included is a listing of personnel who may conduct the inspection and provide the required written documentation. In addition, the requirement that portable, liquid fuel burning heaters not be used in areas accessible to children while children are in care is revised. Use of unvented fuel burning heaters is prohibited while children are in care. Vented heaters, according to the Environmental Protection Agency, are used with a

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			duct, chimney, pipe or other device that carries the combustion pollutants outside the home. Unvented heaters do not vent to the outside. The National Fire Prevention Association, the Environmental Protection Agency, and the Consumer Product Safety Commission are among the authorities that support annual inspection of all heating equipment. Fires caused by heating equipment typically occurred because the equipment was not cleaned regularly, were placed too close to combustible materials, had basic flaws in construction or design or were improperly fueled.
	Provider # 5	Why does there always have to be so many regulations and paperwork? I left working in a day care center because the paperwork took away from the kids. Instead of planning fun activities we were burdened with this and that.	
	Provider # 5	Most of us in family daycare like the fact that we can have less children, a more relaxed	

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		atmosphere and more time to make it a quality learning experience.	
	Provider # 1	It has been my privilege over the years to know quite a few home child care providers. For the most part, the providers left professional careers to be home with their own children, and decided they could provide a service to their community by providing quality day care. I have noticed that many of the center providers are aged 19 and slightly above. There is a steady turnover in the centers. Children need to have a loving, maternal, constant environment to survive and become whole and productive beings. Home daycare with experienced mothers for the most part fulfills this objective.	
	Provider # 6	I am noticing a trend with the notion of children being raised in a home setting changing into the notion of the home becoming a center setting. Please stay sensitive to the differences between a center and home setting. There are situations where a child needs to be in a home setting and some where a child needs to be in a center. It is important to give parents the choice of both.	
NOIRA: In addition to first aid and CPR training,	Provider # 1	I normally take 25-30 hours of training annually. So far this	Language has been added to specify “clock”

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caregivers shall obtain a minimum of twelve (instead of the current six) hours of training annually.		year, I have taken 23 hours. One county charges for its classes and you still can't get in. One county's classes are full with a portion of home daycare and mostly center trainees. Please figure out how the increased education is going to be accomplished before the law is put in place. I normally take more than the required number of hours required annually to remain licensed and have taken college coursed in day care as well as pre-education.	hours, for clarity. Ten (10) hours of annual training is proposed when the regulation becomes effective. The hours will increase to 12 one year after the effective date; to 14 two years after the effective date; and to 16 three years after the effective date of the regulation. The department, through its provider training series, offers between 20 and 30 training topics per year. Each topic is offered between 6 and 16 times. Based on a maximum of 50 or 60 per class, the department has the capability to serve approximately 14,000 providers annually. Because the workshops are interactive, the maximum size is 50 or 60, which is a relatively large group for this type of training. Because of "no shows", the department actually trains approximately 8000 providers yearly. A child care training needs
	Provider # 6	Raising the hours of training is the way to raise the standard of care in Virginia. I got my CDA and it gave me confidence through knowledge.	
	VAFCCA	Caregivers shall obtain a minimum of ten hours of training annually. Twelve hours of training may be very challenging, if not impossible, for people in more remote areas where training is not readily available. It may put an undue burden on some caregivers traveling to outside areas to achieve this training. It is more realistic to increase it to 8 or at the very most, 10 hours of training. This would also leave room for caregivers to exceed standards by attaining additional training hours.	

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	Office # 1	We agree with this, however, we do foresee problems. Recommend more training offered and bigger groups allowed.	survey is mailed to providers every 18 months, in order to assess needs and interests. Other opportunities for training are available through child care organizations, other state and local agencies, and colleges and universities.
	Provider # 2	The system may be better served by requiring child care providers with fewer years experience taking more hours of continuing education, however, those with more than 3-5 years of experience and having taken the continuing education find much of the classes repetitive. Those more seasoned child care providers will be sufficiently educated with 6 hours of continuing education.	
	Provider # 3	I like that you are increasing the training hours. I have averaged 14 hours of training over the last 8 years that I have been licensed. I was voluntary register before that. The only problem I am having is I am running out of classes. I have had to take duplicates. I think more classes need to be offered for veteran providers.	
NOIRA: Providers and substitute providers shall obtain certification in first aid and CPR as appropriate to the ages of children in care prior to licensure or employment and shall maintain a	Provider # 6	It is wonderful that CPR is going to be required. This will raise the standard for the whole state. Since most counties already require it, the rest of the state should have little problem adjusting. All providers should have CPR.	Agency agrees.

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current first aid and CPR certificate….			
NOIRA: If a pool, lake, or other swimming area has a water depth of more than 2 feet, a lifeguard holding a current certificate must be on duty supervising children at all times when one or more children are in the water.	Provider # 6	It is too extreme a measure to require providers to be lifeguard certified. I question and cannot believe that a child care provider was watching any of the "*163 children that drowned in Virginia between January 1, 1989 and December 31, 1994."* Any child care provider, who is successful enough to own a pool, is very vigilant and attentive in the water. Providers with a pool will often say they feel so strict at the pool, that they wonder how children are having any fun while following all the rules. I spoke with the American Red Cross in my town and was told, "The Red Cross is not prepared to teach child care providers the lifeguard classes." I spoke with a Red Cross lifeguard instructor. She informed me that the lifeguard class is 80% first aid and CPR. The rest is swim skills. She said if providers have first aid and CPR, they should be able to care for a water accident until EMS arrives. The American Red Cross has a class just for this. It is called **Community Water Safety**. Its' purpose is to present information about various aquatic	Revise standard to require water safety instructor. Either a caregiver or some other qualified person must be present. The required staffing ratios must also be met.

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		environments and their potential hazards and to inform the general public on how to safely participate in aquatic activities. The learning objectives are: • Learn to recognize and prevent aquatic emergencies • Understand what to do in an aquatic emergency • Understand self-help skills for aquatic emergencies Most providers who have pools do not allow diving and do not have a deep end. Older children and adults can stand up in the water. Most backyard pools are about 20 feet by 30 feet. Where does the need to swim 500 yards (20 lengths of a 25 meter pool, about 65-75 feet) come in? A provider can take about 5-7 steps around the deck or just jump in before needing to swim at all. I have this kind of pool. I do not get in the water when watching children. This enables me to see the whole pool and all the children at the same time. I also have at least one other adult. Most parents will stay and watch their children swim in the pool before they go home. Sometimes I have all the parents at the same time. If someone needs me, I can jump in and be next	

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		to them. I don't need to swim to get to them. All of the 12 children in my care have had at least 2 seasons of American Red Cross swim lessons. When they could not swim, I had an approved life vest for each child. The amount of money in taking classes should not be considered when the safety of children is involved. Even though the Community Water Safety class is considerably less expensive, I truly believe it is the better way to cover "Water Safety" in the Minimum Standards. Requiring lifeguard certificates may set precedence where, in the future, providers may be asked to become an RN to administer medication or a teaching degree to do curriculum. It is requiring providers to have two professions. Use of lakes and streams should be prohibited. There is no way to protect children. There is no way to know depths or what animals may be residing in these waters. You can't see through the water so you can't see where to go to get the body.	
	VAFCCA	Providers with pools only take children with access to pools at home. If Moms are afraid for the children's safety, providers do not	

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		accept these children for care. Remove pools; rewrite "If a lake or other undefined swimming are has …." This new regulation would make it necessary for a provider to go through Life Guard Certification Training in order to use her own back yard pool for swimming activities. The design of Life Guard certification is for use in much larger, public pools and lakes, where there can be several dozens of children needing supervision at one time. The training is usually quite strenuous and covers much more than a provider needs for the safe operation of her own pool. Most back yard pools are small and many do not exceed 4 feet deep. Life Guard training is not appropriate for back yard pools. However, if the intention of this new regulation is training, Water Safety training would be much more appropriate for providers who desire to use their back yard swimming pools.	
	Office #1	Who in a family day home will have a lifeguard certificate?	
	Provider # 7	Concerning swimming pools deeper than 2 feet: This new regulation would make it	

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		necessary for a provider to go through Life Guard Training in order to use her back yard pool. I believe this is inappropriate training for the situation. Life Guard training is very vigorous and covers much more than a provider needs to experience for the safe operation of her pool. Water Safety training, on the other hand, would be very appropriate. It covers very practical training and information that a provider would need to safely operate her pool.	
NOIRA: Use of hot tubs, spas and whirlpools is prohibited.	Provider # 6	Hot tubs should never be used by children. The water temperature is too hot for children and can cause serious health problems.	Agency agrees.
NOIRA: Portable wading pools shall not be used.	Provider # 6	Portable wading pools should be allowed. Children spend more awake hours of the day with providers than parents. Every child remembers the hot days in the little pool. It is easy to take proper care of these pools. The little pools are used by schools everyday. Schools use them for beach day. Non-potty-trained children should have their own pool (one pool, one child), since they are so inexpensive. If soiled, take the child out, change the child and sanitize the pool.	Revise standard to allow wading pools. Add requirement for one pool per child for non-potty trained children. Require cleaning and sanitizing before re-use. Restore repealed language regarding emptying and storage when not in use.
	VAFCCA	"Wading pools may only be used for activities that do not allow	

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		children to sit in the water." Caregivers use wading pools for dramatic play or science activities such as duck ponds (magnetic fishing), sink or float, etc. Eliminating them will unnecessarily eliminate dramatic play activities. Or preferably, "Wading pools must be cleaned and sanitized prior to each use; children not potty taught must wear "swimmer" pull-ups when in wading pools. A caregiver must be within sight AND sound of children when wading pools are in use. Justification for keeping wading pools for wading activities as well: Sprinklers often frighten young toddlers under two because they do not like water in their face and some dwellings are not conducive to sprinklers. Swimming pull-ups are available to reduce the risk of contamination and caregivers can sanitize wading pools.	
	LI # 1	I'm not certain how I feel about this. My personal preference is for fdh's to use the sprinkler, on the other hand, particularly for older children, the wading pools are a good way to cool off. Why not just prohibit these for younger children? Maybe only allow 4 y/o & above?	

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		The “slip & slides” that people use are pretty dangerous. I would like to comment on the prohibition of portable wading pools. I only provide care for children that are potty trained and although I understand the concern about sanitation, I feel that older, potty trained children will be missing out. Can an addition be made that states portable wading pools must be cleaned out and sanitized daily and may only be used by children that are potty trained.	
NOIRA language: Toddler means a child from 16 months to 24 months. Issue: A recommendation has been made to change the definition of infant from “birth to 16 months” to “birth to 12 months.” A toddler would be from 12 months to two years.	VAFCCA	Change definition of “infant” from “birth to 16 months” to “birth through to 12 month”; and “toddler” from 16 months to 24 months to “12 months to 24 months.” The current definition does not correspond to the developmental stages of children in these age groups in licensed child care environments. Because children are in child care environments, the states of development move quicker as they tend to develop at a faster pace. A child 1 year of age, most likely, is walking unassisted or walking by holding a caregiver’s hand. They are eating at the table or in highchairs with the assistance only in assuring food is presented in a safe	Ratios currently in effect provide the maximum protection for children. The agency will continue to research and explore the issues associated with revision in ratios.

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		form. Exposure to storytelling, music, and older children increases language development; they are using words by age one and language is often well developed by 16 months. Thus, the staffing level needed to assure the supervision and protection during the first 24 months has also changed. The staffing level necessary to assure appropriate supervision and protection necessary for an 8 week old and that of a 12 month old is very different. Changing the definition of an infant to "birth through 12 months" would not place toddlers at risk as their needs have changed. It would still limit homes to 4 infants during the younger, developmental stages that require the greater assistance and it would continue to assure the supervision and protection needed during the first 2 years of development, while assisting parents in finding more available, quality child care for children over 12 months.	
	Provider # 1	In regard to your changing the toddler from 16 months to 12 months, it is unclear whether the number of points assigned to the child would go down to 3 points at months versus 3 points at 16 months that is currently the law. This needs to	

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		be worded very carefully if this is your intention.	
	Provider # 2	If the point system is changed to infants being 0-12 months and the toddlers 12 months to 3 years, how will that change the point system? We feel that is a good thing to make that change, provided the change is not detrimental to the over-all point system. 0-12 months should count as 4 points and 12-24 months should count as 3 points.	
	Provider # 3	I am very much in favor of changing the classification of infants to birth through 12 months. Another point not covered in these changes is the points for each age group. I would like to see the following assignments: Birth through 12 months – 4 points 13 months through 23 months – 3 points 24 months through 4 years – 2 points	
NOIRA: "Serious injury" means a wound or other specific damage to the body such as but not limited to: unconsciousness; broken bones; dislocation; deep cut requiring stitches; concussion; or foreign object	VAFCCA	Rewrite definition changing the wording from "foreign object lodged" to "foreign object protruding from eye, nose, ear, or other body orifice. " The way it reads, if a child put a pebble, bean, acorn, etc, in the nose, ear, or other body orifice, it would be considered a "serious injury" which	Retain proposed definition. Use of the term "lodged" suggests that foreign objects are positioned in a manner that would require medical attention.

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lodged in eye, nose, ear, or other body orifice.		would really be a "medical emergency." This occurs frequently and it has not been considered a "serious injury in the past. Sand in a child's eyes also happens frequently and is not a serious injury but it is a lodged foreign object. Is it the intention to elevate these types of occurrences? National Safety Council does not define these as "serious injuries." The object would need to be "protruding" to be considered a "serious injury."	
NOIRA: Toys and toy parts accessible to children under three years of age shall be large enough that they cannot be swallowed or inhaled.	VAFCCA	Be specific in the size of a choking hazard. "Toys and toy parts accessible to children under age three must not fit into the mouth of a toilet paper roll." Does the LS plan to see if the object fits inside of a child's mouth? The standard needs to be more exact in the size of the toys. National Safety Council and American Heart use the standard toilet paper roll as a measuring device. Every home has them. They say "anything small enough to fit in a toilet paper roll" is a choking risk to children under 3.	Revise standard to require that objects less than 1 1/4 inches in diameter, or that would fit through a toilet tissue roll be kept out of reach of children under age 3.
NOIRA: Catch points, shearing points, crush points and protrusions shall be eliminated to prevent entrapment, entanglement, or strangulation	VAFCCA	Rewrite the standard with a specific hazard or delete it. It leaves too much open to interpretation. What all exactly are they referring to here? What meets the definition of a "catch" point or a "crush" point, and so	Proposed standard rewritten as follows: "Ropes, loops or any hanging apparatus that might entrap, close, or tighten upon a child shall not be used."

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hazards that could injure children or catch their clothing.		on? This standard is too vague and open to an individual's interpretation. Currently, caregivers make every attempt to eliminate all playground hazards because they do not want children injured.	"Equipment with moving parts that might pinch or crush children's hands or fingers shall not be used unless they have guards or covers." A protrusion can be defined as two threads beyond the face of a nut. A sharp point is an accessible point that can puncture or cut the skin. A shearing point is the place where at least two moving parts meet which could cause the child to suffer a bruise, cut, scrape, amputation, or fracture during use of the equipment. A pinch point is the place were at lest two moving parts meet which could cause a part of the child's body to be squeezed or bound, causing pain.
NOIRA: Infants and toddlers must spend no more than ½ hour of consecutive time during waking hours confined in a crib, play yard, high chair or other confining structure or piece of equipment. The intervening time periods between periods of confinement in a crib, play yard, high chair or other	VAFCCA	Rewrite as "Infants and toddlers must be offered several opportunities throughout the day to experience a diversity of play spaces as well as the opportunity to creep, toddle and walk. When in a crib, high chair or other confining structure or piece of equipment is in use, activities must be ongoing or available to stimulate the child." Although the intent of the regulation is certainly	The intent of this requirement is to assure that children spend a significant time outside of a confined space if not sleeping or eating. An exception added for mealtime. The second sentence is shortened to read, "The intervening time period between confinement must be at least one

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confining structure or piece of equipment must be at least 1 hour.		understandable and admirable, placing specific time-restraints on how we work with children is not the solution. The only way to be sure a caregiver is not breaking the ½ hour rule and thus be in violation of the standard, is to set timers to go off so we know when to rotate children? This is not the appropriate way to insure a variety of play to enhance the development of children. Often, especially in the summer, outside play is an hour or longer for older children, depending on the weather. When weather allows, crafts, science activities and story time are frequently set up outside. When toddlers and infants are awake, they should be outside as well. Depending on the time and length of the nap, this could mean outside play for more than ½ hour. Not all family childcare homes have assistants; therefore, it is not possible to separate the children, sending the non-walking toddlers inside for 1 hour at the end of a ½ hour, which is what this standard would mean. Since it is not realistic to expect outside play to be scheduled around sleeping infants, this standard would result in restricting outside play to ½ hour and then	hour." Strict adherence to the established times may not be possible, however, the times should trigger movement of infants and toddlers in order to assure a diversity of play spaces and experiences. Opportunities for stimulation, interaction and play are covered elsewhere in the regulation.

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		everyone would need to come inside for 1 hour because “the intervening time periods between periods of confinement is at least 1 hour.” This means floor time without restrictions around them for 1 hour. Our schedules cannot always allow this. Play yards offer outside floor time for creeping, crawling, toddling. In addition, we can place walk-around toys in the play yards. These outside experiences and the fresh air are important for their development as well; placing time restrictions are not appropriate and place unrealistic expectations on caregivers. Children often take more than ½ hour to eat, especially children with reflux issues. It typically takes longer than ½ hour to feed (holding is confining) an infant and then they would need to be in a chair or something confining while they ate the cereal or other prepared foods. In addition, infants who hold their own bottle often spend longer than ½ hour drinking and then it is still necessary to feed them. This means time in a confining piece of equipment. Toddlers are often at the table in a confining chair or high chair for longer than ½ hour to eat. What should we do at the end	

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		of this ½ hour – take the food away? Slow eaters often take as much as an hour to complete the meal. Infants and toddlers do need to receive adequate stimulation allowing opportunities to experience a diversity of ply spaces and the opportunity to creep, crawl, toddle and walk but WITHOUT placing time restraints on caregivers as to when to offer these opportunities.	
	Office # 1	Disagree. Wording is difficult. Needs to word like CDC standard 461.4.e	
	Provider # 2	We feel this will cause more providers not to take infants and we already have a problem placing infants. An infant playing on the floor with older children in a family child care is not safer than an infant in a play yard. Possibly an infant being taken out of the confined area every hour or two for 30 minutes or moving them from one environment to another would be a more appropriate solution.	
	Provider # 3	There is a major safety problem with the section on confinement time. Most providers that keep infants also have older children. I would not want my newborn on the floor with 2 or 3 year olds playing nearby. Since I work	

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		alone I have to keep the children together to adequately watch all of them. I always moved my infants around from say carrier to swing to play pen. I made sure they had things to do while they were confined. I also made sure that they got some floor time. This was usually during the bigger children's lunch or when they were napping. But when they were approximately 6 months they got more floor time and by the time they were mobile they were hardly ever confined. I think this needs to be rewritten to allow for different ages of infants.	
	Provider # 8	I agree with all regulations except the feeding time allowed for children.	
NOIRA: No milk except breast milk or iron-fortified formula shall be given to infants, unless otherwise instructed by a child's physician in writing.	VAFCCA	No milk except breast milk or iron-fortified formula shall be given to children under 12 months of age, unless otherwise instructed by a child's physician in writing. USDA says 12 months of age can go from formula to milk.	Proposed requirement withdrawn. Already included is the requirement that infant formula be prepared according to the manufacturer's or physician's instructions.
	Office # 1	Don't agree with. Taking decision making from parents. If parent calls doctor and is advised to try another formula she then has to go to the doctor and get it in writing?	
	Provider # 3	The rule on milk for infants may need to be rewritten depending on	

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		what ages you decide to use for infants. This rule is fine if infants are birth to 12 months but needs to be modified if it includes children from 13 months to 16 months. Agree with rest of changes.	
NOIRA: A one-day's emergency supply of disposable bottles, nipples, and commercial formulas appropriate for the children in care shall be maintained in the family day home.	VAFCCA	Take out the word disposable. A one day's emergency supply of bottles, nipples and commercial formulas or breast milk appropriate for the children in care shall be maintained in the family day home. Not all infants will drink from disposable bottles and nipples. They are attached to their own and do not want to change. Children on breast milk may not be willing to drink commercial formulas. As long as you have a sufficient supply of bottles, nipples and formula or breast milk for one day, why would they need to be disposable or commercial formula?	Proposed requirement withdrawn. Unnecessary. Has potential to raise other issues, including adequate and appropriate storage, identification, return to parents when no longer needed.
CURRENT: Protective barriers including but not limited to safety gates shall be installed securely at the top or bottom of open stairways on the floors where the stairways are accessible to children under two years of age and children over two years of age who are not developmentally ready to climb or	VAFCCA	Delete the wording "installed securely at the top or bottom of open stairways" and change the word "where" to "when." Rewrite as: "Protective barriers including but not limited to safety gates shall be installed securely to prevent access to open stairways on the floor when the stairways are accessible to children under two years of age and children over two years of age that are not developmentally ready to climb or	Protective barriers are necessary to the protection of children in care. Procedures are in place for requesting a waiver if this requirement presents a hardship.

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descend stairs without supervision….		descend stairs without supervision." A caregiver may have found it necessary to use gates that fit to doorways instead of at the top or bottom of the steps since not all stairways allow for the installation of gates (may not be able to install at steps due to type of railing or the wall structure). The standard states "installed securely at the tip or bottom of open stairways…." This might be interpreted by LS as not meeting the standard as written. The gate placed in the doorways means stepping over the gates to move from room to room. The toddler or infant may be in a swing, a safety chair, stationary exercisers, or high chair eating. During this period, the steps would not be accessible and therefore the gates not necessary. The LS may interpret the standard to mean "at all times", write it up as out of compliance stating, "The standard does not say except when…., it says ……." Yet the children are safe from harm, which is the intent of our standards – not to make caregiver's days more difficult. The standards states "under two years of age" which would include a new born or	

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		infant that is not crawling yet. Again, a LS may write it up as out of compliance stating, "The standard does not say except for….., it says ……."	
CURRENT: Soiled disposable diapers and wipes shall be discarded in a lined container, with a tight fitting lid, operated by a foot pedal (step can).	VAFCCA	Eliminate the "operated by a foot pedal (step can). Rewrite as: "Soiled disposable diapers and wipes shall be discarded in a lined container, with a tight fitting lid. If the lid is handled, it shall be disinfected by lightly spraying with a germicidal or water and chlorine bleach solution each time it is used." The Diaper Genie® is a bacterially safe alternate diaper receptacle with the addition to the standard that the lid is sterilized with a bleach solution, each time it is used. This system does not allow the diapers to fall out of the container when tilted or dumped, this contaminating the surrounding area. You can sanitize the lid and the diaper-changing surface at the same time. Many of the foot pedal cans have locks on them and if the mechanism is used, the surface becomes contaminated just like the Diaper Genie®.	The risk of transmission of infectious organisms is high in the diapering process. Diapering practices that require increased manipulation of diapers and paraphernalia present increased opportunities for contamination of the caregiver's hands, the child, the diapering surface and surrounding objects. Not only must the Diaper Genie® be opened by hand, an inner rim must be twisted in order to seal the soiled diaper into the plastic barrier. The tip-proof feature is a benefit, but the number of hand contacts required to operated the system, including emptying it, increase the likelihood of contamination, even with the best intentions and planning on the part of providers. Lined containers, with tight fitting lids, operated by foot pedals, will

Current/NOIRA Language	Commenter	Comment	Agency Response
			continue to be required.
CURRENT: Prepared infant formula shall be labeled with the individual child's name and kept in the refrigerator when not in use.	VAFCCA Office # 1	Either add the words "when not in use" at the beginning or add when more than one child is using formula. "When not being used, prepared infant formula shall be labeled with the individual child's name and kept in the refrigerator when more than one child is using formula." If there is only one child in the home using formula, it should not be necessary to label the bottle. Many caregivers receive violations because they do not realize with one infant, the LS will still require them to label the bottle because the standard does not say "if more than one child is in care." Would like it to read "bottles."	Standard reworded to read as follows: "Bottles shall be refrigerated and labeled with the child's name, if more than one infant is in care."
NOIRA language: Hanging items, including but not limited to ….tablecloths shall be out of reach of children under five years of age	Office # 1	What is the rationale?	Hanging tablecloths can be as hazardous as other hanging objects. The potential exists for them to yanked by infants, toddlers and preschool children, to access what might be hot objects or harmful substances on the table. Children could be scalded or otherwise injured.
NOIRA: A barrier at least four feet high such as, but not limited to, a	Office # 1	Would like to know what other regions are doing. Take out the 30 feet and let us continue to	The determination of whether a hazard exists will continue to be

Current/NOIRA Language	Commenter	Comment	Agency Response
fence or hedge shall surround outdoor play areas located within 30 feet of hazards such as, but not limited to traffic, open bodies of water, or railroad tracks. Facilities licensed prior to the effective date of these standards must comply fully within one year.		make the decision if not going to put fence on all of playgrounds.	made by licensing inspectors. This standard does not require that all outdoor play areas be fenced; only those located within 30 feet of hazards.
	Provider # 2	These areas should be judged hazards by our local licensing specialist. An area that might be construed hazardous in one area may not be so by another. We understand the need for uniformity in the code, however, some locals may need to be judged according to the neighborhood that housed the family child care home. Again, we generally have smaller numbers of children to police and have better control. A home that is on a dead end street and the play area is within 30 feet of the cul-de-sac is much less likely to be a hazard than a child care facility on a main thoroughfare within 30 feet of the busy street.	
	Provider # 3	I have a major problem with the barrier. I have a large front yard and driveway. There is no way I would put a four-foot high barrier 30 feet from the road across my driveway or front yard. The driveway is the only hard surface that the children have to play on. They would lose the basketball goal and the place where they learn to ride first push toys, then tricycles and finally bikes. The children know how far they can go toward the road. The preschoolers	

Current/NOIRA Language	Commenter	Comment	Agency Response
		are allowed to go only more than 35' from the road. I also have school-agers and they are allowed a little closer depending on their age (most of mine are 10 to 12 years old). I think you need to keep in mind that this business is run from our homes – homes that one day may have to be sold. I think it would be very hard to sell a home with a barrier 30' from the road. Once again, please remember I am not running a center. I have a small group and very little turnover. The children quickly learn the rules and I have no problem with the children following them. (I only average 1 to 2 new children a year. The first month or so I watch the new ones very carefully to make sure they learn the rules and are acting safely. The other children also help with this. They know what is allowed and what isn't and will let their new friend know when they are breaking rules.)	
NOIRA: Usable floor space of 25 square feet per child (a total of 300 square feet for a home caring for the maximum of 12 children) shall be available for children's activities, exclusive of halls, unless the halls	Office # 1 Provider # 2	What is considered usable? Is this the same as if using personal beds to sleep -- is that area considered usable, or do we count open floor space? So we measure the entire kitchen because they sit at the table to eat? I have been a child care	Usable floor space of 25 square feet per child is proposed when the regulation becomes effective. This requirement will increase to 30 square feet two years after the effective date of the regulation, and to 35 square feet

Current/NOIRA Language	Commenter	Comment	Agency Response
are regularly used as play spaces, bathrooms, office space or storage areas. Providers licensed prior to the effective date of these standards shall comply within one year of expiration of the current license.		provider for 7 years and have not had 25 square feet of usable space for each child and no one has developed any respiratory problems, however, I am not disputing the "experts" opinion. I have approximately 22 square feet per child and we have extra room. There is plenty of room to move and play. It may be better evaluated by the usable area of a room as to the square feet of a space. You can have a small amount of square footage that is better situated for play than a lot of square footage that is "chopped up" and unable to be utilized that well. I think that halls should definitely be included in the usable floor space. This business is in a home and the halls make great places to play. It is not like in a center or business where halls are mainly for getting from one place to the next. My entry hall is the only floor without carpet so it makes a great raceway for cars, etc. The downstairs hall dead-ends into the nap room so it is a great place to hide or just to get away from other people. I have some concern about the 25 square feet per child. This is not a problem in my house but I worry about people who live in the	five years after the effective date of the regulation. Usable space is all space identified by providers as space used by children. Hallways are not routinely included in usable space. However, the agency has a process in place where a waiver may be considered when it is determined that compliance creates an undue hardship. The agency will survey providers to assess the impact of the proposed requirement, and will also evaluate responses received during public comment.
	Provider # 3		

Current/NOIRA Language	Commenter	Comment	Agency Response
		city. Their houses may not be as large and I would hate to see people get out of licensed childcare because of a space problem. A survey of providers to see how many this is a problem for might be a good idea.	
NOIRA: Swings shall have lightweight seats of…plastic….	Office # 1	Why can they have plastic? Not allowed in CDC standards.	A standard is added that allows use of non-flexible molded swing seats when a staff member stays within arm's length of any hard molded swing in use and is positioned to see and protect other children who might walk into the path of the swing.
NOIRA: Play yards or playpens, where used : (g) must not be occupied by more than one child; and (h) must be cleaned and sanitized each day of use or more often as needed	VAFCCA	Recommendation: (g) Clean play yards weekly or more often if needed; and (h) follow the 25 sq. ft. space requirement as stated in the standards for occupancy in play yards. This may make sense for **playpens** due to the size and structure. The **play yards**, on the other hand, are much larger and can be set up to allow 30 sq. ft. of play. This structure allows ample space for the child as well as age and developmentally appropriate toys; you can construct different geometric shapes with play yards. A play yard is a "safe" play area, and not a confining structure, when used outside. In addition,	Play yards as used in this context are defined by ASTM as framed enclosures *with a floor* made for the purpose of containing a child who is (1) unable to climb out; (2) is 35 inches tall or less, or (3) weighs no more than 30 pounds.

Current/NOIRA Language	Commenter	Comment	Agency Response
		more than one play yard can be joined together to create an even larger playground. Two play yards can create as much as 75 sq. ft. of space. These are necessary to allow us to take young children, who are not walking outside to take advantage of fresh air and sunshine. Play yards have no bottom and the sides are of a honeycomb type structure. Daily cleaning and sanitizing is not necessary, and would be an undue burden due to the honeycomb structure. Weekly cleaning, as needed, would be more appropriate.	
	Office # 1	Play yards…. Clarify.	
NOIRA: When overnight care is provider, caregivers shall remain awake until all children are asleep and shall sleep on the same floor level as the children in care.	Office # 1 Provider # 3	Some type of monitor. Needs to include the T/A about this. For overnight care I think you need to add the caregiver shall sleep on the same floor OR have a baby monitor. Many homes are not designed with all bedrooms on the same floor.	The proposed standard provides reasonable protection for children in overnight care. In addition, a baby monitor is required, in order to assure the provider is awakened.
NOIRA: The provider may permit self-administration of a medication by a child in care if:…..	Office # 1	Feel this should be removed. Will open up Pandora's box. Parents will come in with a three-year old and a statement allowing them to administer.	The intent of this standard is to build protections into a practice that occurs, whether regulated or not. Children often come into care accustomed to using care inhalers, epi-pens, sunscreen on their own. In addition to

Current/NOIRA Language	Commenter	Comment	Agency Response
			written instructions from parents, providers have the option of requesting a physician's written statement.
NOIRA: The provider must have a written plan to provide a competent adult to be available to provide temporary child care in case of a medical emergency. The plan must include the name, address, and telephone number of the emergency caregiver.	Office # 1	If a provider has to use this person do they have to have the background checks on this person? Technically, we feel the standards say 21 days to get info. Does this emergency person have to have TB too? Could their plan be that parents are called to come pick up children?	The emergency caregiver is not required to have background checks or a TB screening. This person does not have to meet education and experience requirements. This person must be a "competent adult." The department will provide guidance in the development of the written plan, which is intended to maintain supervision and care of children, for a short period of time, in case of a medical emergency.
	Provider # 3	I love the addition of the "Emergency Preparedness and Procedures." That is one thing I had never thought of. Great idea.	
	LI # 1	I assume this person must meet all the other fdh requirements – including annual training?	
	Provider # 4	I would like to seek some clarification as to the new requirement in "Emergency Preparedness and Procedures." Would the emergency caregiver be required to meet the same requirements of a substitute provider including the background checks, TB test, and the educational minimums that are proposed to be changed?	

Current/NOIRA Language	Commenter	Comment	Agency Response
NOIRA: When permanent swimming or wading pools are located on the premises….	Office # 1	What is a permanent wading pool? Standards currently say wading pools are emptied each day. 4.38	A permanent wading pool is one that is not portable. (See requirements for portable wading pools)
NOIRA: Outdoor swimming pools must be enclosed by safety fences and gates that are in compliance with Virginia USBC for private swimming pools. Gates must be kept locked when the pool is not in use.	Office # 1	Does this apply if the pool is not used by the day care children? If not how far do we have to go? Some locations may not have a USBC to follow? How do they access this?	Pools must be enclosed, whether they are used or not. They pose a safety hazard for children in care, if not all children. The requirement has been revised to add a fence that is at least 5 feet high around the pool.
NOIRA: Each child's record will include information on … (b) written instructions signed and dated by a physician on actions to take in an emergency related to the allergy or intolerance….	Office # 1	Why do we have to have doctor's instructions? Is this not up to the parents, too?	Requirement for a physician's signature and date on written instructions is deleted.
NOIRA: The provider shall obtain by the first day of attendance and maintain documentation that each child is up-to-date for all immunizations required by the State Board of Health.	Office # 1 LI # 1	Can we accept a copy of the immunization card? Standards say immunizations must be signed and dated. This infers to me that we will have to check the specific immunizations. Hope not—we should continue to check for immunization information that is signed/dated by the MD, nurse designee, etc., but we don't check the specific "shots" and should not be doing the	This change aligns immunization requirements for Family Day Homes with those required by child day centers and public schools. This change does not mean a change in how compliance is determined.

Current/NOIRA Language	Commenter	Comment	Agency Response
		job of the health dept or the MD. If a child is behind on shots, for any number of reasons, it is the MD, or whoever the child sees for medical care, who takes action. The health department does their audit and it should be kept that way. So why not change the language to "current documentation of immunizations…" and that would clear up any question about this standard.	
	Provider # 4	I am curious as to why there is the need to make the change that documentation of immunization be provided by the first day of attendance. If a child is transferring from another center or provider, this is less of an issue than if it is the first time a child is in care. From experience I know that it is not always practical for these records to be immediately available. Some doctors offices cannot readily produce this file for a family, often a doctors visit is required and that may not always be able to be scheduled immediately (most often due to the doctors office rather than the family's schedule).	
CURRENT: In determining the need for an assistant, the following fixed	Office # 1	Would like to see it removed. All of the FDHs we have do mixed age grouping.	No change will be made at this time.

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adult to child ratios shall be maintained….			
CURRENT: …. Child Protective Services Central Registry clearance conducted no later than January 31, 1994.	Office # 1	Remove. No longer applies	Requirement deleted.
CURRENT: Cleaning agents. Disinfectants… stored in areas inaccessible to children or in a cabinet or drawer with child-resistant locks.	Office # 1	Is it going to remain inaccessible or will you put "locked up" only? Currently this is left up to the L.I.	Licensing Inspectors will continue to have discretion in determining when hazardous substances should be locked or if inaccessible provides the required protection.
CURRENT: Operable fire extinguisher and smoke detector	Office # 1	We are not supposed to cite. Will they be taken out?	Requirement is deleted.
CURRENT: Sharp kitchen utensils inaccessible or in a cabinet or drawer with child-resistant latches…..	Office # 1	Inaccessible? What is it?	Inaccessible means out of reach of children.
CURRENT: Each child shall be provided with a designated…rest mat…. Clean linen suitable to the season, and assigned for individual use….	Office # 1	Do rest mats need to have linens?	Yes.
CURRENT: The diaper changing surface shall be cleaned with soap and water, and disinfected by lightly spraying with a germicidal or water and chlorine bleach	Office # 1	Why soap and water and disinfecting by light spraying?	This standard has been revised as follows: "the diapering surface shall be cleaned and sanitized after each use with a solution consisting of one tablespoon

Current/NOIRA Language	Commenter	Comment	Agency Response
solution.			of bleach to one quart of water. "Cleaning and disinfecting are separate processes. Definitions have been added for "cleaned" and "sanitized." According to the Centers for Disease Control, "Routine cleaning with soap and water is the most useful method of removing germs from surfaces in the child care setting."… "However, some items and surfaces should receive an additional step, disinfection, to kill germs after cleaning with soap and rinsing." Various bacteria respond differently to cleaning and sanitizing agents. (Research: American Public Health Association (APHA; American Academy of Pediatrics (AAP); National Health and Safety Performance Standards: Guidelines for Out-Of-Home Child Care Programs.
CURRENT: Children shall not be allowed to eat or drink while walking, running, playing, lying down, or riding in vehicles	Office # 1	Can infants hold their own bottles while lying down?	No. The current standard prohibits drinking or eating while lying down.

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	Voices for Virginia's Children	We recommend child to staff ratios be decreased so that for infants the ratio would be 3:1, for toddlers the ratio would be 4:1, etc… We recommend that there be increased education and training required for providers and the establishment of limits on group size.	
	Provider # 2	First of all, the very first time we were contacted about the NOIRA (maybe a year ago?) I could not find it on the computer. The directions for finding it were not complete at all. I made several calls and finally found someone that had the rest of the directions to get to the document…. I have friends that don't have computers in which to find these documents. Some of my provider friends could get to the site (after we got the purple sheet of paper this time), but their computer could not produce it to be printed. We believe it would be better if like in previous years this document (as important as it is that all of us be able to read it) would be mailed to us.	
	Provider # 3	I would first like to comment on the way the proposed changes were made accessible to providers. I received my letter of notification about mid-way through the comment period. I know another provider who got hers at the	

Current/NOIRA Language	Commenter	Comment	Agency Response
		beginning. I'm not sure why mine was so late. Then when I tried to download the changes I could get all the way to the downloading but my computer could not read the file. I tried several times. I finally asked my specialist for a copy. I have talked to numerous people and not one was able to download it. And that was after about 4 phone calls. Also not all providers have access to the Internet. I was a provider when the revisions were done in 1993. I remember receiving hard copies of proposed changes. I feel with this major of a revision that a hard copy should be sent to all providers and the comment period should be extended. Some of these changes could have significant impact on providers and may even force some to quit or start doing childcare under the table. This is something I would hate to see. There is not enough quality childcare as it is and I would hate to lose what there is.	
NOIRA: Every six months, the provider shall review emergency contact information with the parent to ensure the information is correct.	Provider # 2	A family child care provider has closer contact with the parent than a child care center for the most part. We know the changes that our parents make as part of their career changes and we have an update sheet that they complete for that	Requirement changed to "annually."

Current/NOIRA Language	Commenter	Comment	Agency Response
		purpose.	
	Provider # 3	I already have the parents review the emergency contacts each year. I tie this to their tax information. I give out the "daycare information check" in January and when it is returned they get their tax receipt. I have had great success with this. I tried the first year with no incentive and hardly got any back. I feel that every six months is too much. I feel once a year is fine.	
	Provider # 2	FINAL COMMENTS: We want to provide care as excellent for our children as you would like us to provide. You want us to be regulated and the majority of us welcome those regulations and more for our own family child care facilities. We feel that some of these regulations you are proposing will be putting family child care providers out of business. We also feel that you may be losing sight of the fact that this is "HOME" child care. We do not have the large numbers of children that are present on a daily basis in a child care center nor do we have the amount of turnover or accidents that a child care center may have.	
	Provider # 3	As final comment I would like to state that I want to provide excellent care for my	

Current/NOIRA Language	Commenter	Comment	Agency Response
		daycare children but I don't want to be so regulated that it puts me out of business. I am very happy about a lot of the changes but feel that some will cause a hardship for many others and me. I am in my 11th year of being a childcare provider and am very proud of both my profession and how I perform. I feel that many times a family day home is looked at as a small center. This is not the case. When I had my first child I used daycare. My son was in both family day homes and centers during his birth to school age years. From these experiences I know there are many differences between a family day home and a center. The first difference is that a family day home is a "home." We not only provide great care for the daycare children but we live there. Second, in family day homes the main caregiver never changes. And from the ones I know there is very little turnover with assistants. This is a major difference with centers where the turnover is much higher. Third, in family day homes there is very little turnover of children. Thus the children see me as a second mom and my house as a	

Current/NOIRA Language	Commenter	Comment	Agency Response
		second home. I don't think you will find many children who feel that way about centers because even if they love the center they will have different caregivers at different ages. My day care children always have me.	
	LI # 2	In general, I think that parts of these standards have taken the home out of Family Day Home and turned them into mini centers. Has anyone though of 2 types of Licenses/Standards like some other states do (Delaware?)? There could be one set /license for a large FDH (9-12 children) and another for Small FDH (6-8).	
	Provider # 4	I feel many of the proposed changes will help create a higher level of safety for caregivers to follow.	
NOIRA: Infants shall be placed to sleep on a firm, tight fitting mattress in a crib that meets current safety standards. To reduce the risk of suffocation, soft bedding of any kind shall not be used under or on top of the baby including but not limited to pillows, quilts, comforters, sheepskins, or stuffed toys.	Provider # 3	I need clarification. Can a blanket be placed over a baby?	A blanket can be placed over a baby. The infant should be place at the foot of the crib with a thin blanket tucked around the crib mattress, reaching only as far as the infant's chest.

Family impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability.

This regulation has no adverse impact on family stability or the institution of the family. The regulation recognizes and supports the family by establishing regulations that provide a level of out-of-home care that is safe, healthy and conducive to the needs of children.

Detail of changes

Please detail all changes that are being proposed and the consequences of the proposed changes. Detail all new provisions and/or all changes to existing sections.

If the proposed regulation is intended to replace an emergency regulation, please list separately (1) all changes between the pre-emergency regulation and the proposed regulation, and (2) only changes made since the publication of the emergency regulation.

For changes to existing regulations, use this chart:

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
22 VAC 40-110 - 10 Definitions	22 VAC 40-111-10 Definitions		The following new terms and their meanings are added in order to clarify their use in the body of the regulation: "Cleaned" means treated in such a way as to remove dirt and debris by scrubbing and washing with soap and water or detergent solution and rinsing with water. "Medical emergency" means an unforeseen event that results in a caregiver, a child in care, or a household member needing immediate medical care. "Overnight care" means care provided after 7 p.m. and through the night.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
			"Preschool" means children from two years up to the age of eligibility to attend public school, five years by September 30. "Programmatic experience" means time spent working directly with non-related children in a group. Work time shall be computed on the basis of full-time work experience during the period prescribed or equivalent work time over a longer period. Experience settings may include but not be limited to a child day program, family day home, child day center, boys and girls club, field placement, elementary school, or a faith-based organization. "Residence" means principal legal dwelling or abode; a dwelling that is occupied for living purposes by the provider and contains the facilities necessary for sleeping, eating, cooking and family living. "Resilient surfacing" means, (i) for outdoor use under and surrounding equipment: • at least nine inches of loose-fill, impact absorbing surfacing material such as wood chips, double shredded bark mulch, engineered wood fibers, fine or course sand, and rounded, fine or medium

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
			gravel; • at least six inches of shredded rubber or tires; or • unitary, impact absorbing material such as rubber mats and poured in place compositions that meet minimum safety standards when tested in accordance with procedures described in the American Society for Testing and Materials standard F 1292 and has a critical height value (less than 200G's and less than 1,000 HIC or Head Injury Criteria) equal to or greater than the highest designated play surface on the equipment, and (ii) for indoor use under and surrounding equipment, impact absorbing surfacing material specifically designed and tested as playground surfacing such as rubber mats and rubber tiles that meet minimum safety standards when tested in accordance with the procedures described in the American Society for Testing and Materials standard F 1292 and has a critical height value (less than 200 G's and less than 1,000 HIC or Head Injury Criteria) equal to or greater than the highest designated play surface on the equipment.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
			Hard surfaces such as asphalt, concrete, dirt, grass or flooring covered by carpet or gym mats do not qualify as resilient surfacing. "Sanitized" means treated in such a way as to remove bacteria and viruses from inanimate surfaces through first cleaning and secondly using a disinfectant solution (i.e., bleach solution or commercial disinfectant) or physical agent (e.g., heat). The surface of the item is sprayed or dipped into the disinfectant solution and allowed to air dry between uses. "Serious injury" means a wound or other specific damage to the body such as, but not limited to: unconsciousness; broken bones; dislocation; deep cut requiring stitches; concussion; foreign object lodged in eye, nose, ear, or other body orifice. "Toddler" means a child 16 months to 24 months. "Use zone" means the area under and round a piece of equipment where resilient surfacing is required. The following words and terms and their definitions are deleted: "Child Protective Services Central Registry," "Cooling device," "Family day home standards," "Major accident" or "Major injury," "Minor

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
			accident" or "Minor injury," "Ventilating device." Definitions are changed for clarity for the following terms: "Age appropriate" – "developmental characteristics" changed to "individual needs." "Child" – means individual under 18 years of age instead of 13 years of age for purpose of child day programs. "Child with special needs" has been replaced with "child with a disability." The term "diagnosed" has been replaced with "evaluated." "Commissioner" – "also known as the Director of the Virginia Department of Social Services" is deleted. "Department's representative"- "in carrying out the responsibilities and duties specified in Chapter 10 (§63.1-195 et seq.) of Title 63.1 of the Code of Virginia" is deleted. "Family day home" – the portion of the definition referencing requirements in effect from July 1, 1993, until July 1, 1996 is deleted. "Family day home assistant" or "assistant" – added is "under the direct supervision of the family day home provider or substitute provider."

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
			"Infant" – changed from "birth through 15 months" to "birth to 16 months." This wording makes the language consistent with the child day center definition. "Parent" – "legal" added to describe custody. "Physician" – "in any of the fifty states or the District of Columbia" added.
Article 2. Legal Base			This section is deleted. Included was the statutory basis for licensure, the requirement that the license be posted, and a repeat of the definition of a family day home. Also included was an exception that said when 13 or more children are in care in a family day home that is subject to licensure, Child Day Center Standards apply. General information about the statutory basis for the standards will be included in a "Forward" to the regulation, along with information about when a child day center license is required. The requirement for posting of a license is included in another regulation, General Procedures and Information for Licensure.
PART II. PERSONNEL	PART II. THE DAY CARE PROVIDER AND OTHER DAY CARE PERSONNEL		Title changed to be more descriptive.
	22 VAC 40-111-		Providers are newly required to

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
	20.A General requirements and qualifications of the licensee		have a high school diploma or equivalent, or evidence of having met the requirements for admission to an accredited college or university, and three months of programmatic experience. The requirement is broadly written to allow several qualification options for providers licensed after the effective date of the regulation. Providers who may not be able to locate copies of a diploma may provide other documentation, including, but not limited to, a statement from the school district where the high school attended is located. In addition, providers who have not completed high school may be enrolled in an accredited college or university after having completed tests that assess ability to function at the college level. Providers using the Virginia Scholarship Program or a similar program to defray the cost of college-level courses may submit documentation of having been admitted in lieu of a high school diploma or equivalent. The new requirement establishes the expectation that family day home providers will meet certain basic literacy and experience requirements prior to being licensed to provide care.
	22 VAC 40-111-20 B		A requirement is added that defines where care is to be provided. In the past, providers have purchased or leased homes that are not their primary residence for the purpose of

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
			providing day care. Care in locations other than the primary, legal residence of the provider is subject to licensure as a child day center.
	22 VAC 40-111-20 C		Several requirements are added that spell out the duties and expectations of the provider as the licensee or license holder, to include: ensuring compliance with the standards and terms of the license; being responsible for the day-to-day operation of the home and for the health, safety and welfare of the children; providing direct care for the majority of the time that the home is in operation; ensuring that any advertising is not misleading or deceptive; and complying with the regulation, General Procedures and Information for Licensure. These requirements are added for clarity.
22 VAC 40-110-40-60. Behavior	22 VAC 40-111-30. Caregivers		Caregiver attributes are incorporated under the new number.
PART III. HOUSEHOLD	PART III. HOUSEHOLD MEMBERS		Change in section title for clarity.
22 VAC 40-110-160-180. Clearances	22 VAC 40-111-50. Background clearances		Providers are required to comply with the statute and the current regulation for background clearances. This change combines several requirements into one. Eliminates duplication of the requirements from another regulation.
22 VAC 40-110-1090-1110	22 VAC 40-111-60-70	Requires maintenance of health information on caregivers and any other adult	All caregivers and adult household members are required to provide evidence of freedom from tuberculosis in a communicable form. This

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
		household members who come in contact with children or handle food served to children. Any individual who comes in contact with a known case of tuberculosis or develops chronic respiratory symptoms must obtain an evaluation within 30 days of exposure.	requirement is newly applicable to *all* household members, rather than those who have direct contact with children or who handle food. In 1999, the Virginia Health Department issued new guidance that allows for assessment of the risk factors for tuberculosis by health personnel, in lieu of a tuberculin skin test. The Health Department also advised that tuberculosis is not transmitted through contact with food; therefore this portion of the requirement is deleted. The time frame for securing the TB screening within 90 days prior to licensure remains the same for licensed family day home providers. The proposal to expand the time to 6 months prior to licensure was abandoned, based on information from the Health Department that indicated the screening only provided assurance that a person was free from tuberculosis at the time the test was read. The 90-day time frame currently in effect provides the maximum possible assurance. The Health Department also recommended decreasing the exposure time from 30 to 14 days for removal from contact with children of a person with symptoms of active tuberculosis.
	PART IV. ORIENTATION AND TRAINING		New Part added for ease of location of pertinent information.
22 VAC 40-110-80. First aid certification	22 VAC 40-111-80. First aid and CPR certification	Providers and substitute providers required to obtain pediatric first aid certification,	CPR is newly required. Both first aid and CPR are required prior to licensure or employment, rather within 6 months *after* employment or licensure as

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		including rescue breathing and first aid for choking, within six months of licensure or employment. Three sources provided, or completion of a course equivalent to the curriculum approved by the State Board of Health. Exception made for provider who is an RN or LPN with a current license.	previously required for first aid. This change equips providers with the skills necessary to act in an emergency prior to having a number of children in care that would require licensure. In addition, the first aid and CPR training must be appropriate to the ages of children and may be obtained from an increased number of sources. The consequence is that the number of options available for obtaining first aid and CPR are expanded. Exception for LPN or RN deleted, since nurses may not have this training.
	22 VAC 40-111-90. Orientation		Orientation to licensing standards and procedures prior to issuance of a license is a new requirement that mirrors the statutory requirement for orientation prior to licensure for assisted living facilities. Most of the licensing offices around the state provide orientation sessions on a monthly basis. Pre-licensure orientation allows the provider to make an informed decision about becoming licensed and familiarizes the provider with the role of the department and expectations of licensed providers. Licensed providers are newly required to provide orientation to assistants and substitute providers prior to employment. Orientation topics include job responsibilities, the parental notifications and protections outlined in the regulation, emergency evacuation

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			procedures, confidential treatment of information about children and their families, location of emergency numbers and the first aid kit, and child abuse and neglect reporting requirements. The consequence is that other care giving staff is familiar with their duties and expectations *prior to* beginning to provide care to children.
22 VAC 40-110-90. Additional training	22 VAC 40-111-100. Ongoing training	Six (6) hours of training annually in addition to first aid training.	Annual training hours are increased from 6 to 16 clock hours annually, beginning with 10 hours when the regulation becomes effective. One year after the regulation becomes effective, required annual training hours will increase to 12; two years after the effective date, the number will increase to 14; and three years after the effective date, the number will increase to 16 hours annually. Research, including the National Health and Safety Performance Standards, indicates that better trained providers are better able to prevent, recognize, and correct health and safety problems. They are also able to provide activities appropriate to the developmental needs of the children in care. Highly trained providers, according to the research, behave more sensitively, engage in more positive interactions, display less detachment, are less punitive, encourage children more, engage in less restrictive behavior, and promote the development of

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			children's verbal skills. Children cared for by these providers are more compliant and socially competent, and score higher on tests that measure intellectual ability. A review of the regulations for family child care and group family child care from 29 states that have requirements for ongoing provider training indicates of range of from six to 30 hours of training annually. The average number of hours across all of these states is approximately 12 hours annually.
PART IV. PHYSICAL ENVIRONMENT AND EQUIPMENT	PART V. THE HOME AND YARD		Part title simplified. Separate part added for equipment.
	22 VAC 40-111-110 C		A protective barrier, including but not limited to, fencing or hedges, to form a 4 foot high barrier around outdoor play areas located within 30 feet of hazards is newly required. Hazards include, but are not limited to, traffic, open bodies of water or railroad tracks. Facilities licensed prior to the effective date of the standard have one year to fully comply. The intent is to prevent access to hazardous conditions and to protect children from harm.
	22 VAC 40-111-110 D, E, F		Bathtubs, buckets, and other containers of liquid that are accessible to children must be emptied immediately after use in order to eliminate the danger of drowning, particularly for a small child whose head is heavier than

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			his body. Other newly added requirements intended to prevent drowning include a prohibition against the use of hot tubs, spas and whirlpools, and the requirement that covers on hot tubs be securely bolted and locked.
22 VAC 40-110-230. Firearms	22 VAC 40-111-110 G, H, I	Requires storage of firearms unloaded and apart from ammunition. Firearms and ammunition must be stored in a locked area with keys out of reach of children.	Requirements related to storage of firearms and ammunition have been revised to require storage in a locked container, compartment or cabinet, rather than in a locked area. This change addresses the issue that arose when *area* was considered to be a locked room that was reported to be off limits to children in care. Firearms were stored in bedside tables or chests that made them potentially accessible to children in the event the room was left unlocked in error. Newly added is the requirement that all other sporting equipment and devices be stored in locked areas with keys out of reach of children.
22 VAC 40-110-370. Alternate heating sources	22 VAC 40-111-120 F	Requires all alternate heating devices such as oil stoves, wood burning stoves, fireplaces and associated chimneys, and ventilating devices to be inspected annually.	Qualified heating personnel must inspect all heating equipment annually. This change responds to confusion over which heating equipment requires inspection under the current standard. In some areas of the state, all fireplaces are inspected. In others, only fireplaces that are unvented are inspected. There is no requirement to inspect the home's primary heating systems. Caring For Our Children – National Health and Performance Standards states, "Heating equipment is the second leading cause of ignition in fatal home

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			fires. Heating equipment that is kept in good repair is less likely to cause fires." In addition, according to the Consumer Product Safety Commission, seasonal inspection of all fuel-burning heating systems is the first line of defense against carbon monoxide poisoning. Fuels include kerosene, oil, coal, natural and liquid petroleum gas, and wood. Yearly inspections are recommended for chimneys, flues and vents for leakage and blockage by debris. Birds, other animals and insects sometimes nest in vents and block exhaust gases, causing the gas to enter the home. Equipment should also be inspected for gas leaks and adequate ventilation. According to CPSC, fresh air is important to help carry pollutants up the chimney, stovepipe or flue, and is necessary to complete combustion of any fuel.
22 VAC 40-110-390. Liquid fuel heaters	22 VAC 40-111-120 H	This standard prohibits use of portable liquid fuel burning heaters in areas accessible to children when children are in care.	This standard is revised for clarity. Use of unvented fuel burning heaters is prohibited when children are in care. Unvented fuel burning heaters are identified, to include portable electric space heaters, portable oil-burning (kerosene) heaters, portable gas fueled heater, unvented fireplaces. Space heaters, according to The Hartford Insurance Company, if used as a primary heat source in the home, are three times more likely to cause a heating fire than a home where a central system is the primary heating source. Portable kerosene heaters,

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			according to the National Fire Prevention Association have the highest rate of deaths per household. Fifteen states prohibit use of unvented portable and fixed heaters during child care. The standard preventing use of these items while children are in care in Virginia has been strengthened.
22 VAC 40-110-400 and 410. Fire extinguishers and smoke detectors.			The requirements for smoke detectors and fire extinguishers are deleted, based on an Attorney General's opinion that the Department of Social Services has no authority to enforce these requirements.
22 VAC 40-110-470. Fire hazards	22 VAC 40-111-120 K	This standard allows contact with local fire prevention officials if there are open and obvious fire hazards.	This standard, which states that local fire prevention officials may be contacted if open and obvious fire hazards are observed, has been revised to include the option of reporting the absence of fire extinguishers and smoke detectors.
22 VAC 40-110-510. Spaces	22 VAC 40-111-140. Spaces	The home shall provide adequate space for each child to allow free movement and active play indoors and outdoors.	Square footage requirements are added for space indoors and outdoors (75 square feet per child), in order to allow sufficient space for children's movement. Indoors, 25 square feet is required when the regulation becomes effective. Two years after the effective date, 30 square feet will be required. Five years after the effective date of the regulation, 35 square feet of indoor space per child will be required. According to the National Health and Safety Performance Standards, crowding has been shown to be associated with increased risk of developing upper respiratory

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			infections. Sufficient space also reduces the risk of injuries. The National Health and Safety Performance Standards recommend 35 square feet per child. In addition, most states currently require 35 square feet per child for family child care and group family child care homes. These requirements quantify what has previously been a judgment call (adequate space) on the part of licensing staff.
	22 VAC 40-111-180. Decks and porches		Protective barriers or guardrails are newly required for decks, porches and balconies more than 15 ½ inches above the ground or floor level, with openings no greater than 3 ½ inches. The consequence is that the risk of injuries due to falls or head entrapment is reduced.
22 VAC 40-110-190. Smoke-free environment	22 VAC 40-111-200. Smoking and prohibited substances	A smoke-free environment must be provided in rooms accessible to children while children are in care.	In addition to a smoke-free environment, a requirement is added that prohibits caregivers from being under the influence of alcohol, illegal drugs or medication that would impair functioning while children are in care. The consequence is that children are protected from exposure to second-hand smoke, which can trigger asthma and allergies in children. Non-smoking providers also serve as models of healthy behavior.
PART IV. PHYSICAL ENVIRONMENT AND EQUIPMENT	PART VI. EQUIPMENT		Section separated for clarity.
	22 VAC 40-111-		Newly added is the requirement

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	230. Play materials and equipment		that toys and toy parts less than 1 1/4 inches in diameter or that would fit through a toilet tissue roll be kept out of reach of children under 3 years of age. Any part smaller than this, according to the federal government's small parts standard, is a potential choking hazard.
	22 VAC 40-111-230 D		Access by infants, toddlers and preschool children to uninflated or underinflated balloons is prohibited as a choking hazard. The U.S. Consumer Product Safety Commission reported at least 4 deaths from balloon aspiration with choking in 1998.
	22 VAC 40-111-230 E		Newly added is the requirement that toys or mobiles strung across a crib or play pen be removed when a child begins to push up on hands and knees or is five months old, whichever occurs first. The consequence is that children who are able to lift their heads above the crib surface are at risk of strangulation if they fall across the mobile and are not able to remove themselves from that position. In addition, infants could accidentally swallow or choke on small parts that fall within their grasp.
	22 VAC 40-111-230 F - M		Newly added are requirements for resilient surfacing under indoor and outdoor climbing equipment and equipment with moving parts. Height limits are established for climbing rungs or platforms or the top of a slide for preschool and school age children. These equipment heights (6 feet for school age

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			children; 4 feet for preschool children) when placed over resilient surfacing at the depths shown in the definition and including the use zone specified, help protect children from serious injury in the event of a fall from the equipment. Requirements are added that provide protections against injury on outdoor play equipment that include: tightly closed "S" hooks; swings seats made of lightweight rubber, canvas or nylon; openings no smaller than 3 1/2 inches and no larger than 9 inches; prohibition of use of ropes, loops or any hanging apparatus that might entrap, close, or tighten upon a child; and prohibition of equipment with uncovered or unguarded moving parts that might pinch or crush children's hands or fingers. Because infants or children with disabilities may require non-flexible molded swing seats in order to provide the required support, a newly added standard requires supervision within arm's length, in order to protect children who might walk into the path of the swing.
	22 VAC 40-111-230 N		Newly added is the requirement that sandboxes with bottoms that prevent drainage be covered when not in use, in order to protect against contamination by cats, birds other objects that could be hazardous to the health and safety of children in care.
	22 VAC 40-111-230 O		Trampolines may not be used during the hours that children are

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			in care. The Consumer Product Safety Commission has documented injuries to children under the age of 15 associated with trampolines, including six deaths since 1990.
	22 VAC 40-111-270. Play yards		Play yards, play pens and portable cribs, according to the CPSC, have evolved into identical products. Requirements are added for safe use of play yards. Height and weight maximums are included. Play yards may not be used for sleeping. Use of pillows and comforters in play yards is prohibited. They must be cleaned and sanitized each day of use. The Consumer Product Safety Commission reports that over 200 children have died in similar products since 1988, and therefore has established these standards for their use.
	PART VII. POLICIES AND PROCEDURES		New part added for ease of use.
	22 VAC 40-111-280. Written policies and procedures.		In order to reduce misunderstanding between parents and the provider, a requirement has been added that written policies and procedures relating to discipline, termination of care, food service and medication administration be provided to the parents of each child at the time of admission.
	22 VAC 40-111-300 D		In accordance with the requirement of the *Code of Virginia*, the provider must notify the parent of the percentage of time when someone other than the provider will be caring for the children.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
	22 VAC 40-111-320 D		Newly adds the requirement that children under the age of five years or over age five who lack the motor strength or skill not be left unattended in the bathtub. The purpose is to protect children from accidental drowning, falling or scalding while bathing.
	22 VAC 40-111-320 E		Newly adds the requirement that sleeping children be checked every 15-20 minutes. Children who are presumed to be sleeping might be awake and in need of adult attention.
	22 VAC 40-111-320 G		When overnight care is provided, the provider must remain awake until all children are asleep. If the provider does sleep, it must be on the same floor level as the children, and a baby monitor must be used. These additions assure supervision and the availability of an adult in the event of an emergency. Use of the baby monitor provides added sound supervision, and may assist in awakening a sleeping provider.
	22 VAC 40-111-340 E		Newly added is the requirement that infants and toddlers spend no more than ½ hour of consecutive time during waking hours, except during mealtime, confined in a crib, play yard, high chair or other confining structure or piece of equipment. The intervening time period between confinements must be at least one hour. The consequence is that infants will have the opportunity to experience a diversity of play spaces and opportunities to creep, crawl, toddle and walk.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
	22 VAC 40-111-370 A and B		The following requirements have been added related to infant sleeping positions: infants shall be placed on their backs when sleeping or napping, and no soft bedding of any kind shall be used under or on top of infants. The consequence is a reduction in the risk of Sudden Infant Death Syndrome associated with children sleeping on their stomachs. Infants have been found dead on their stomachs with their faces, noses, and mouths covered by soft bedding.
22 VAC 40-110-690. Movement of sleeping infants	22 VAC 40-111-370. Sleeping or napping infants, toddlers and preschool children.	An infant who falls asleep in a play space other than his own sleeping space shall be moved promptly to his own designated sleeping space if the safety or comfort of the infant is in question.	In addition to infants, toddlers and preschool children who fall asleep in a play other than their own sleeping space must be moved promptly if their safety or comfort is in question. The consequence is equal protection of toddlers and preschool children.
	22 VAC 40-111-390. Care of children with disabilities		Requirements have been added that provide increased protection for children with disabilities. Caregivers must provide the care and activities recommended in writing by a physician, psychologist or other professional who has evaluated or treated the child. In addition, the environment must be appropriate for the child based on the written plan of care. The provider must instruct other caregivers in the proper techniques of care, and the home shall only perform those procedures and treatments for which the caregivers have the necessary training, experience,

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
			credentials or license to perform. In addition, if a child above the age of three with disabilities requires assistance with diapering, dressing or other personal care procedures, a separate area with privacy must be provided for these activities.
	22 VAC 40-111-410- 7		In the area of behavior management, and in response to reports of children's mouths being washed out with soap and other unpleasant substances as a disciplinary measure, a requirement is added that prohibits punishment by applying unpleasant or harmful substances. The consequence is protection of children from unreasonable, inappropriate and potentially hazardous discipline methods.
22 VAC 40-110-890. Food groups; lunch and dinner	22 VAC 40-111-420 A	Foods served to children for lunch and dinner shall consist of a variety of items selected from each of the following food groups: 1.Meat or meat alternates; 2. Fruits and vegetables; 3. Bread or bread alternates, e.g., pasta, rice, noodles and cereal; and 4. Milk unless a child is allergic to milk or milk products.	Newly adds the requirement that meals and snacks served to children meet the requirements of a recognized authority such as the Child and Adult Care Food Program of the United States Department of Agriculture (USDA). The consequence is that food service and nutrition are guided by expert scientific knowledge of the nutritional needs of children.
	22 VAC 40-111-420 W and X		Newly added are requirements related to food service for children with disabilities that assure that their special needs are

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			met, to include the requirement that any necessary equipment and adaptive feeding techniques be used as necessary, and that the consistency of food provided be appropriate to any special feeding needs identified for the child.
	22 VAC 40-111-430 E		The requirement is added that no milk except breast milk or iron-fortified milk be served to children under 12 months without written instructions from the child's physician. Infants need iron-fortified milk or human milk to grow. This addition assures that infants' nutritional needs are met and that transitions to other liquids are not made before the infant is developmentally ready.
22 VAC 40-110-1000. Formula labeling	22 VAC 40-111-430 F	Prepared infant formula shall be labeled with the individual child's name and kept in the refrigerator when not in use.	This requirement is changed to require labeling of bottles with the child's name if more than one infant is care.
22 VAC 40-110-1010. Formula preparation	22 VAC 40-111-430 H	If infant formula is heated in a microwave oven, precautions shall be taken to prevent scalding. Only refrigerated formula shall be heated. When formula is heated in the bottles, the bottles shall be upright and uncovered. Heating time shall be no more than 30 seconds for four	Newly added is the requirement that bottles not be heated in the microwave. According to the National Health and Safety Performance Standards, studies have documented the dangers of using microwave ovens for heating human milk, formula, or food fed to infants.

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		ounce bottles and no more than 45 seconds for eight ounce. After heating and replacing nipples, bottles shall be turned up and down 10 times and the temperature tested by dropping milk on the top of the hand. The temperature shall be cool on the hand.	
	22 VAC 40-111-430- J		A requirement has been added that allows a child's mother access to a private area for breast-feeding.
	22 VAC 40-111-450- A		Newly adds the requirement that the family day home's policy may be that medications are not given, unless a child has a medically recognized special need requiring medication. This addition establishes in regulation an option that is not often used by providers. Medication administration is a responsibility that carries with it certain risks if instructions are not followed and records are not maintained and permissions secured.
	22 VAC 40-111-450 C and E		Newly added is a requirement that parents provide written authorization for nonprescription drugs including sunscreen, diaper ointment, antihistamines, non-aspirin fever reducer/pain relievers, non-narcotic cough suppressants and decongestants. In addition these nonprescription drugs must be given only at the dose, duration and method of

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			administration specified on the manufacturer's label for the age or weight of the child needing the medication. The consequence of these additions is that common, over-the-counter substances are appropriately identified as nonprescription drugs that require written permission in the same manner as prescription drugs. Written permission provides liability protection for providers. The authorization must be renewed after three months. Also added is a requirement that builds protections around the common practice of self-administration of certain medications by children, to include a written statement from the child's physician or parent indicating the child's capacity to take medication without assistance.
	22 VAC 40-111-450 N		Adds the requirement that long-term medications may be used with written authorization from the child's parent and physician, and allows the written authorization to be reviewed and updated annually. This addition eliminates the need for parents to submit repeated written authorizations, while establishing a time-frame for review and update.
	22 VAC 40-111-460 C 3, E 4 and 5		Requirements are added that increase protection to children during transportation by the provider and assure systems are in place to handle emergencies that include having on-hand a

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			mechanism for making telephone calls to emergency personnel and parents (e.g., change, calling card, cellular phone), and the requirement that the vehicle being used is manufactured for the purpose of transporting people seated in an enclosed area and that the vehicle has seats.
	22 VAC 40-111-460 F 2 - 6		Newly added is the requirement that children remain seated, with arms, legs and head inside the vehicle, the requirement that doors are closed and properly locked, and that at least one caregiver is always in the vehicle when children are present. Added also are requirements that children not occupy the front seat of a vehicle that has an operational passenger side air bag and that children board and leave vehicles from the curb side of the street. These requirements provide additional protection during transportation of children.
	PART XIII. EMERGENCY PREPAREDNESS AND PROCEDURES		New part added for ease of use.
	22 VAC 40-111-470. Medical emergency plan		For continuity of care in a medical emergency, a written plan is newly required to ensure the availability of a competent adult to provide temporary care in case of a medical emergency involving a caregiver or a child in care.
	22 VAC 40-111-510 6		The name of the emergency contact provider must be posted with other emergency numbers in an area visible and close to the telephone. This addition assures

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			that needed information is readily available in the event of an emergency.
	22 VAC 40-111-530 12		Newly adds activated charcoal to the first aid kit, along with syrup of ipecac, to be used only when instructed by the regional poison control center or child's physician and before the expiration date (of the syrup of ipecac). Recent articles on syrup of ipecac and information received from a regional poison control center indicate a move underway to limit the use of syrup of ipecac as a poison remedy. Doctors and hospitals are moving away from vomiting as a treatment for poisoning to other methods, including use of activated charcoal, which absorbs certain toxins before they reach the bloodstream. The addition of activated charcoal to the first aid kit assures providers are prepared in the event the poison control center provides instructions for its use in the event of a poisoning.
	PART XIV. WATER SAFETY		New part added for ease of use.
	22 VAC 40-111-550 B		A water safety instructor is newly required to be on duty when children are participating in swimming or wading activities in a pool, lake or other swimming area with water more than two feet deep. According to the National Health and Safety Performance Standards, most drownings happen in fresh water, often in home pools. Most children drown within a

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change and rationale
			few feet of safety and in the presence of a supervising adult. This requirement, together with the requirement for maintenance of applicable staff child ratios based on the ages of children in care reduces the risk of injury and drowning.
22 VAC 40-110-570. Swimming pools	22 VAC 40-111-570. Requirements for swimming pools.	Outdoor swimming pools shall be enclosed by safety gates with child resistant locks….	Outdoor swimming pools must be enclosed by a safety fence that is at least 5 feet high, when not enclosed by fences and gates that meet the Uniform Statewide Building Code for private pool and gates. The added protection of a fence at a height that prohibits children from gaining access to pools provides a layer of protection for a child who may wander away from supervision. Also added is the requirement that entrances to indoor swimming pools be locked when the pool is not in use.
22 VAC 40-110-570. Swimming pools	22 VAC 40-111-580 A and B	...wading pools shall be emptied and stored away when not in use during normal family day home hours of operation.	Portable wading pools, when used by children who are not potty trained, must be individually assigned. The consequence is that non-potty trained children will continue to enjoy water play in wading pools without the risk of spreading disease. Newly added is the requirement that portable wading pools are emptied, cleaned and sanitized after use by each child or group of children, and filled with fresh water before being re-used, in order to reduce the risk of spread of disease.
	22 VAC 40-111-590 D		A record retention requirement of two years after termination of services or employment has been

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			added. This requirement is consistent with the retention requirement for child day centers.
	22 VAC 40-111-620. Proof of age and identity; record of child care and schools		Requirements are added, as required by law for verification of child's age and identity, and previous child care and schools attended.
22 VAC 40-110-1120. Timing and frequency of medical reports	22 VAC 40-111-630. Immunizations for children	Requires that both physical examination reports and immunization records be on file in the home either prior to enrollment or within 30 days after enrollment.	Immunization records are newly required to be available by the first day of a child's attendance. This is consistent with requirements for day care centers and public schools.