	Participants' Guide Sudden Unexpected Infant Death and Abusive Head Trauma
This module is part of the Rule 2/Rule 3 training requirements for Child Care providers 2013	**1 hour**

Primary Core Competencies and CDA Content Area

The Primary Core Competencies and CDA Content Area are listed here to help participants understand how these topics meet the child care Rule 3 training requirements.

Core Competencies: Health, Safety, and Nutrition

VI-1 Actively supervises and interacts with children to ensure safety indoors

CDA Content Area: Safe, Healthy, Learning Environment

Learning Objectives:

While no training alone can ensure learning objectives, they can be designed to meet certain goals for each learner. If learners are engaged and participatory they will learn to:

- State the recommendations to reduce Sudden, Unexpected Infant Deaths (SUID) including SIDS, suffocation, and other sleep related infant deaths
- Create a safe sleep environment for infants.
- Be familiar with MN Child Care regulations related to safe infant sleep.
- Identify the consequences of non-compliance with regulations ☐Develop a safe sleep policy

Session Outline

Section	**Overview**
1. Welcome and Introduction	Large group discussion: Who is here?
2. Definitions and Incidence	Large group presentation
3. Strategies to Reduce the Incidence of Sleep Related Sudden Unexpected Infant Death	Larger group presentation Video clip
4. Other Safe Sleep Related Issues	Large group presentation
5. Consequences of Not Following Safe Sleep Regulations	Large group presentation
6. Reflection ad Wrap Up	• Large Group Discussion • Individual Reflection • Evaluation

MINESOTA REGULATIONS AND STATUTE LANGUAGE

Minnesota child care regulation, Minnesota Statutes, section 245A.1435

- When a license holder is placing an infant to sleep, the license holder must place the infant on the infant's back, unless the license holder has documentation from the infant's physician directing an alternative sleeping position for the infant.

The physician directive must be on a form approved by the commissioner and must remain on file at the licensed location. see attachment)

www.dhs.state.mn.us/main/groups/licensing/documents/pub/dhs16_177975.pdf

- An infant who independently rolls onto his stomach after being placed to sleep on his back may be allowed to remain sleeping on his stomach if the infant is at least six months of age or the license holder has a signed statement from the parent indicating that the infant regularly rolls over at home.

Minnesota child care regulation, Minnesota Statutes, section 245A.1435b,c

- The license holder must place the infant in a crib directly on a firm mattress with a fitted sheet that is appropriate to the mattress size that fits tightly on the mattress, and overlaps the underside of the mattress so it cannot be dislodged by pulling on the corner of the sheet with reasonable effort. **Nothing should be placed between the mattress and sheet to soften the surface of the mattress. Infants need to sleep on a firm surface to sleep safely.**

- Licensed child care providers must meet the crib requirements under section 245A.146. (see attachment)

- If an infant falls asleep before being placed in a crib, the license holder must move the infant to a crib as soon as practicable, and must keep the infant within sight of the license holder until the infant is placed in a crib.

- When an infant falls asleep while being held, the license holder must consider the supervision needs of other children in care when determining how long to hold the infant before placing the infant in a crib to sleep. The sleeping infant must not be in a position where the airway may be blocked or with anything covering the infant's face

Minnesota child care regulation, Minnesota Statutes, section 245A.1435

☐ The license holder must not place pillows, quilts, comforters, sheepskin, pillow-like stuffed toys, or other soft products in the crib with the infant.

Minnesota child care regulation, Minnesota Statutes, section 245A.1435b

- The license holder must not place anything in the crib with the infant except for the infant's pacifier, as defined in Code of Federal Regulations, title 16, part 1511. The requirements of this section apply to license holders serving infants younger than one year of age.

Minnesota Statutes, section 144.414 , Subd. 2. Day care premises.

- Smoking is prohibited in a day care center licensed under Minnesota Rules, parts 9503.0005 to 9503.0175, or in a family home or in a group family day care provider home licensed under Minnesota Rules, parts 9502.0300 to 9502.0445, during its hours of operation.

- The proprietor of a family home or group family day care provider must disclose to parents or guardians of children cared for on the premises if the proprietor permits smoking outside of its hours of operation. Disclosure must include posting on the premises a conspicuous written notice and orally informing parents or guardians.

Minnesota Administrative Rule 9503.0145 subpart 7

For Centers: The license holder must ensure that sanitary procedures and practices are used to prepare, handle and store formula, milk, breast milk, solid foods and supplements. These policies and procedures must be approved by the license holder's Health Consultant, and the licensors ensure that those policies are followed and staff persons are trained.

Minnesota Administrative Rule 9502.0445 subpart 3

For Family Child Care: Bottles brought from home must be labeled with the child's name and refrigerated when necessary. Bottles must be washed after use.

Minnesota child care regulation, Minnesota Statutes, section 245A.1435d

- Placing a swaddled infant down to sleep in a licensed setting is not recommended for an infant of any age.

- Is prohibited for any infant who has begun to roll over independently.

- However, with the written consent of a parent or guardian according to this paragraph, a license holder may place the infant who has not yet begun to roll over on its own down to sleep in a onepiece sleeper equipped with an attached system that fastens securely only across the upper

torso, with no constriction of the hips or legs, to create a swaddle. **Ensure that the part that fastens around the infant's torso does not move toward the infant's face. Keep in mind that is the infant rolls while wearing this device, they will be unable to use their arms to lift or position their face away from the mattress.**

- Prior to any use of swaddling for sleep by a provider licensed under this chapter, the license holder must obtain informed written consent for the use of swaddling from the parent or guardian of the infant on a form provided by the Commissioner…

  www.dhs.state.mn.us/main/groups/licensing/documents/pub/dhs16_177973.pdf

For Family Childcare

Minnesota Rules, part 9502.0315 Subp.29a:

"Supervision" means a caregiver being within sight or hearing of an infant, toddler, or preschooler at all times so that the caregiver is capable of intervening to protect the health and safety of the child.

Minnesota Statutes, section 245A.147

Encourages family child care providers to monitor sleeping infants by conducting in-person checks every 30 minutes and every 15 minutes during the first four months of care or if the infant has an upper respiratory infection. In addition to in person checks, providers are encouraged to use an audio or visual monitoring device to monitor each sleeping infant in care during all hours of sleep.

For Child Care Centers

Minnesota Statutes, section 245A.02, Subd. 18

For purposes of child care centers, "supervision" means when a program staff person is within sight and hearing of a child at all times so that the program staff can intervene to protect the health and safety of the child.

When an infant is placed in a crib room to sleep, supervision occurs when a staff person is within sight or hearing of the infant.

When supervision of a crib room is provided by sight or hearing, the center must have a plan to address the other supervision component.

Minnesota Statutes 245A.50 Family Child Care training requirements.

Subd. 1. **Initial training.**

(a) License holders, caregivers, and substitutes must comply with the training requirements in this section.

(b) Helpers who assist with care on a regular basis must complete six hours of training within one year after the date of initial employment.

Subd. 5. **Sudden unexpected infant death … training.**

(a) **License holders must document that before staff persons, caregivers, and helpers assist in the care of infants, they are instructed on the standards in section 245A.1435 and receive training on reducing the risk of sudden unexpected infant death.**

In addition, license holders must document that before staff persons, caregivers, and helpers assist in the care of infants and children under school age, they receive training on reducing the risk of abusive head trauma from shaking infants and young children.

The training in this subdivision may be provided as initial training under subdivision 1 or ongoing annual training under subdivision 7.

(b) Sudden unexpected infant death reduction training required under this subdivision must be at least one-half hour in length and must be completed in person at least once every two years.

- On the years when the license holder is not receiving the in-person training on sudden unexpected infant death reduction, the license holder must receive sudden unexpected infant death reduction training through a video of no more than one hour in length developed or approved by the commissioner.
- At a minimum, the training must address the risk factors related to sudden unexpected infant death, means of reducing the risk of sudden unexpected infant death in child care, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death.

(c) Training for family and group family child care providers must be developed by the commissioner in conjunction with the Minnesota Sudden Infant Death Center and approved by the Minnesota Center for Professional Development.

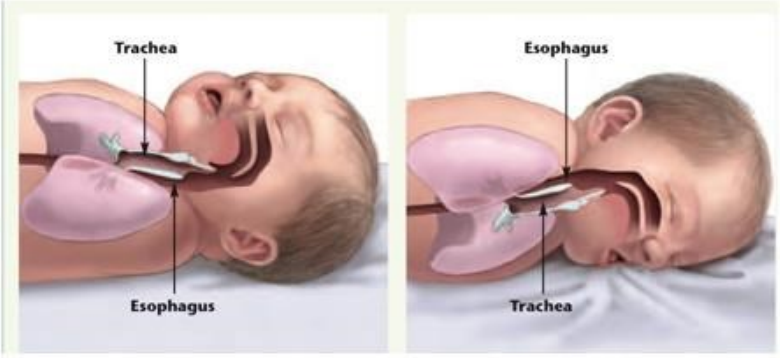
NOTES

Safe Sleep Position

Sleep Clothing

- Alternative to blankets
- Cotton or fleece

Remember the anatomy!



Participant Action Plan

Create a written safe sleep policy incorporating the best practice recommendations.

1) All babies are placed on their backs for every sleep.

2) All babies will be placed in a safety approved crib or mesh-sided play yard (only allowed in family child care).

3) Nothing will be placed in crib with baby other than tight fitting sheet over a firm mattress. If baby accepts a pacifier it will be clean, dry with no strings.

4) If parent requests that baby be swaddled,

- Parent must sign a directive that has been approved by the Commissioner of DHS.
- Only a one-piece sleeper equipped with an attached system that fastens securely only across the upper torso, with no constriction of the hips or legs will be used.
- Swaddling will be discontinued when baby begins to roll on his own.

5) A physician directive on a form approved by the Commissioner of DHS is required for an alternative sleep position to be followed in child care. This directive will be regularly reviewed with parents and physician to determine when baby can be placed on his back for sleep.

6) Discuss safe sleep policy on intake interview so parents are aware of policy.

7) Offer parents brochure, *Safe sleep for your baby,* or information sheet, *What does a safe sleep environment look like* as part of intake and registration process. (Both are available free from the MN SID Center) (see attachments)

Suggestion for discussing ways to handle parental requests for alternate sleep position
If parents make a request for alternate sleep position use this opportunity to educate about safe sleep practices to reduce infant death and positively explain the policy to stress that the safety of their children while in your care is a top priority.

There are many other resources and materials that can be downloaded from the Child Care Aware of MN website: http://childcareawaremn.org/

OR at the following links

Minnesota Child Care Licensing Forms Related to Safe Sleep Regulations Physician

order for an alternate sleep position

www.dhs.state.mn.us/main/groups/licensing/documents/pub/dhs16 177975.pdf

Parent directive regarding swaddling
www.dhs.state.mn.us/main/groups/licensing/documents/pub/dhs16_177973.pdf

Crib inspection form –Family Child Care

www.dhs.state.mn.us/main/groups/licensing/documents/pub/dhs16_178540.pdf Crib inspection form – Center Based Child Care

www.dhs.state.mn.us/main/groups/licensing/documents/pub/dhs16_178568.pdf

Forms for family child care are available on the MN DHS website under **Forms for family child care, child foster care, and adult foster care"**

www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_028228#FS

Forms for child care centers are available on the MN DHS website under "**Forms for child care centers"** www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_028228#FS

NOTES

Learning Log: 3-2-1 Action Plan

Take a few minutes to reflect on what you have learned in these sessions. Use the spaces below

to capture your ideas and plans for action.

3 Important Things I Learned In This Training…

2 Things I Will Implement Into My Program…

1 Action I Will Take Immediately…

(Formerly Shaken Baby Syndrome)	**Participants' Guide** **Abusive Head Trauma**
This module is part of the Rule 2/Rule 3 training requirements for Child Care providers 2013	**1 hour**

Primary Core Competencies and CDA Content Area

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Core Competencies: Health, Safety, and Nutrition

VI-1 Actively supervises and interacts with children to ensure safety indoors

CDA Content Area: Safe, Healthy, Learning Environment

Learning Objectives:

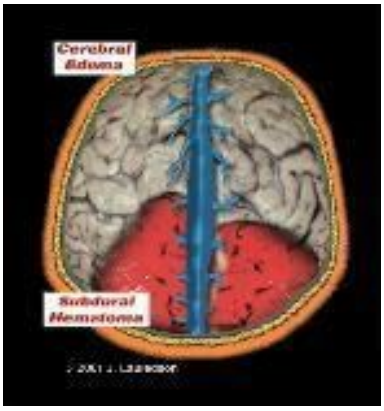
While no training alone can ensure learning objectives, they can be designed to meet certain goals for each learner. If learners are engaged and participatory they will learn to:

- Describe pediatric abusive head trauma.
- Discuss symptoms and consequences of abusive head trauma ☐Identify risk factors for abusive head trauma.
- Identify strategies to use when stressed, angry or frustrated

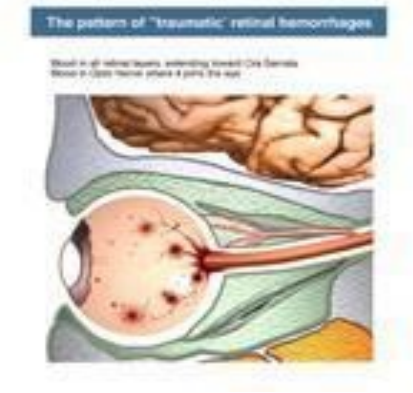
Session Outline

Section	**Overview**
1. Welcome and Introduction	☐Large group discussion: Who is here?
2. Pediatric Abusive Head Trauma (AHT)	• Small group activity • Large group presentation
3. AHT: Symptoms and Consequences	☐Large group presentation
4. Risk factors and the child care provider role	☐Large group presentation
Reflection ad Wrap Up	• Large Group Discussion • Individual Reflection • Evaluation


Infants are believed to be particularly susceptible to abusive head trauma because of their relatively large and heavy head, making up about 25% of their total body weight. Their neck muscles are too weak to support such a disproportionately large head (NCSBS). Infants also have thin, pliable skulls.



- Substantial rotational shearing forces are generated causing the brain to rotate within the skull cavity.
- When shaking occurs, blood vessels feeding the brain can be torn, leading to bleeding around the brain.
- Blood pools within the skull, sometimes creating more pressure within the skull and possibly causing additional brain damage.



Retinal (back of the eye) bleeding is very common

The symptoms of AHT may include but are not limited to: (NCSBS nd, Chiesa & Duhaime, 2009; NIH, 2009)

Immediate Symptoms:

- Breathing may stop or be compromised
- Difficulty breathing
- Pale or bluish skin
- Extreme irritability, or other changes in behavior, especially fussy, and fretful behavior, despite attempts at comforting and soothing
- Seizures
- Limp arms and legs or rigidity/posturing
- Inability to hold head up
- Decreased responsiveness
- Decreased level of consciousness, alertness, lethargy, sleepiness
- Vomiting; poor feeding, poor sucking or swallowing
- Not smiling or vocalizing
- Loss of vision
- Inability to suck or swallow
- Heart may stop
- Death

Long-Term Consequences:

- Learning disabilities
- Physical disabilities
- Visual disabilities or blindness
- Hearing impairment
- Speech disabilities
- Cerebral Palsy
- Seizures
- Behavior disorders
- Cognitive impairment
- Death

What to look for:

It is important to seek medical attention right away if an infant or child is experiencing any of the following symptoms:

- Significant changes in sleeping patterns or inability to be awakened
- Vomiting (more than usual)
- Convulsions or seizures
- Increasing irritability
- Inability to be consoled, and

- Inability to nurse or take to the bottle.

In more severe cases, babies may be:

- Unresponsive or
- Unconscious

Emergency Medical Services (911) should be called and babies should be taken to the emergency department immediately if they are experiencing any of these severe signs and symptoms of AHT listed above

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Parent Education

- Reassure parents that crying is normal for babies:
    a) crying is one way babies communicate.

    b) excessive crying is a normal phase in infant development.

    c) babies cry most between 2 and 4 months.

    d) Prolonged, inconsolable crying generally lessens when babies are around 5 months old.

    e) Most babies who cry a great deal are healthy and stop crying spontaneously.
- Educate parents of babies about the dangers of shaking a baby and what to do if they become angry, frustrated, or upset when their baby has an episode of inconsolable crying or does other things that parents may find annoying, such as interrupting television, video games, sleep time, etc.
- Let parents know that crying can be very frustrating, especially when they're tired and stressed. Reinforce that crying is normal and that it will get better.
- Tell the parent how to leave his or her baby in a safe place while he or she takes a break.
- Be sensitive and supportive in situations when parents are trying to calm a crying baby.

Reflection/Learning Log: 3-2-1 Action Plan

Take a few minutes to reflect on what you have learned in these sessions. Use the spaces below to capture your ideas and plans for action.

3 Important Things I Learned In This Training…

2 Things I Will Implement Into My Program…

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Resources

American Academy of Pediatrics The American Academy of Pediatrics (AAP) and its member pediatricians dedicate their efforts and resources to the health, safety, and well-being of infants, children, adolescents, and young adults. The AAP has approximately 60,000 members in the United states, Canada, and Latin America. The AAP develops guidelines on a variety of pediatric health issues and distributes a wide range of patient education materials. ***www.aap.org***

The National Children's Advocacy Center Child Abuse Library Online The Child abuse library online of the national Children's advocacy Center is one of the largest professional collections of published knowledge, educational materials, and resources related to child maltreatment in the United states. It provides training, online services, and annotated bibliographies to organizations and individuals, and offers resource packages to decision makers and researchers. ***www.nationalcac.org***

National Alliance of Children's Trust and Prevention Funds The National Alliance of Children's Trust and Prevention funds is a membership organization that provides training, technical assistance, and peer consulting opportunities to state Children's Trust and Prevention funds to strengthen efforts to prevent child abuse. ***www.msu.edu/user/nactpf/*****National Center on Shaken Baby Syndrome** The National Center on Shaken Baby Syndrome has a mission to educate and train parents and professionals, and to conduct research that will prevent shaking and abuse of infants in the United states. It provides help to professionals and parents looking for information, ideas, and answers to questions about sbs. ***www.dontshake.org***

National Indian Child Welfare Association The National Indian Child Welfare Association (NICWA) addresses the issues of child abuse and neglect through training, research, public policy, and grassroots community development. NICWA improves the lives of American Indian children and families by helping tribes and other service providers implement activities that are culturally competent, community-based, and focused on the strengths and assets of families. ***www.nicwa.org***

National Scientific Council on the Developing Child The National Scientific Council on the Developing Child is a multi-disciplinary collaboration comprising leading scholars in neuroscience, early childhood development, pediatrics, and economics. ***www.developingchild.net***

Prevent Child Abuse America Prevent Child Abuse America works to prevent abuse and neglect of our nation's children. Through its chapters in 43 states and its voluntary home visitation services provided by Healthy Families America® in more than 400 communities nationwide, Prevent Child Abuse America helps provide healthy, safe, and nurturing experiences for more than 100,000 families every year. ***www.preventchildabuse.org/index.shtml***

Shaken Baby Alliance The shaken baby alliance collaborates with community agencies and professionals to provide support for victim families (including adoptive and foster parents) of sbs to advocate justice for sbs victims, and to increase awareness of the problem. ***www.shakenbaby.com*** **Zero to Three** The mission of Zero to Three is to support the healthy development and well-being of infants, toddlers, and their families. The organization accomplishes this by informing, educating, and supporting adults who influence the lives of infants and toddlers. ***www.zerotothree.org***