THE EDUCATION AND TRAINING PROVIDED TO CHILD DAY CARE HEALTH CONSULTANTS ON MILITARY BASES IN OKLAHOMA

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CHAPTER I

INTRODUCTION

This qualitative study was designed to explore the types of education and training provided to child day care health consultants on four military bases in Oklahoma. Child day care was provided on four military bases throughout the state, and these were regulated by the military system.

Child day care was also provided in various public and private child care centers and family day care homes located throughout the state. According to *Oklahoma Kids Count Factbook* (1999), there were 226,094 children under the age of five in Oklahoma and 239,474 ages five to nine in 1997. Oklahoma had 1,945 licensed child day care centers and 4,268 licensed day care homes, with space available for 134,485 children (Oklahoma Department of Human Services, Office of Child Care, 1999 Annual Report).

As more women were entering the work force than ever before, more children were in need of care outside the home. Approximately 60% of American women with children less than six years of age worked outside the home (United States Bureau of Census, 1990). Seventy-three percent of mothers with school age children were employed (Crowley, 1990). It was predicted by the end of the year 2000 that 75% of the women in the work force would have children in group care settings (Chira, as cited in Schneider, 1996).

Parents sought care for their children from a variety of sources. These included licensed and unlicensed facilities, private home care, private child care centers, child day care facilities located on military bases, public child care centers, Head Start programs, government institutions, and schools. With approximately 70% of the children in the United States enrolled in supplemental child care sites on a daily basis, health and safety issues increased for the children in care as well as for the caregivers (National Association for the Education of Young Children, 1997).

On a national level, some research had been conducted in the field of health and safety issues in child care to determine the best resource for assistance with ongoing health and safety issues related to child day care facilities. The term child day care health consultant was being used to describe the professionals who were available to child day care personnel to address these health issues (U.S. Department of Health and Human Services, *Child Care Bureau,* 1995).

The U.S. Department of Health and Human Services Healthy Child Care American Campaign recommended that each child care program have access to a child day care health consultant. The Oklahoma State Department of Health was awarded a grant to help each child care program in the state of Oklahoma establish access to child day care health consultants. The professionals who were targeted to fill the role of child day care health consultant were generally Public Health Nurses working in local county health departments.

This study focused on determining the education and training provided to child day care health consultants located on Oklahoma military bases. The military served as a

starting point for researching the training provided to child day care health consultants, the health and safety issues addressed by the consultants, and the training that was needed by the consultants. The health and safety consultation provided to the Child Development Centers on the military bases was similar to the type of health and safety consultation that was needed by the child day care centers across the state. Even though the military group was smaller in population than the public health nurses throughout the state, the military had a system in place for the child day care centers on the military bases to access personnel in health-related fields for consultation.

The main role of the public health nurse when interacting with the staff at child care facilities was in the area of disease investigation. A much more expanded role for the public health nurse was needed in order to function in the role of a child day care health consultant. Additional education was needed in the areas of disease prevention, pediatrics, and skills in providing education to child care staff and parents. This same education was needed for those who provided health consultation to aviation-related organizations who provided child care.

Statement of the Problem

The problem was that no formal study had been completed on the education and training provided to child day care health consultants in Oklahoma, including those located on military bases and aviation-related industries. It was important to determine what training was provided and what training was needed in order to establish a baseline for additional training that would be needed for professional development of staff in the

role of a child day care health consultants. The military provided a logical forum to begin to develop an understanding of those training needs.

Purpose of the Study

The purpose of this study was to explore the education and training provided to child day care health consultants at Oklahoma military bases. This model for training child day care health consultants at military bases had the potential of being used as the model for training other child day care health consultants in Oklahoma including those in aviation-related fields associated with child care facilities. The child care programs on military bases responded to the stringent demands of providing child care in non-traditional hours. Aviation-related organizations had this same need for a flexible schedule for child care which in turn impacted those who provided services for the child care including child day care health consultants.

The study was based on the assumption that the persons who had been identified as child day care health consultants had previous education and experience in a health-related field. The findings of this study were especially helpful on a state level as it established a baseline for specific educational needs of those serving in the role of child day care health consultants and provided information for the public as well as private and military child day care programs. The findings of the study could have a particular significance for those health professionals who provided health consultation to child cares in an aviation-related organization.

In Oklahoma, public health nurses were employed by county and state health departments and were often called upon to provide health and safety information to child care facilities in their respective counties. These nurses may have had only a small amount of contact with child day care facilities, except for instances of investigating a disease outbreak. Their role and scope of practice were broad as they generally had a wide range of professional responsibilities. Their work ranged from providing direct care, such as administering immunizations, to representing the health department as members of a task force, or investigating an outbreak of disease.

If information could be obtained to determine what training was provided to staff on military bases who provided health consultation to child care facilities, this information could be utilized to develop training programs for public health nurses and those in aviation-related child care facilities who provided training on health and safety issues to staff in child care facilities in the state of Oklahoma.

Research Questions

The following broad questions were answered by the study:

1. How is the role of the child day care health consultant defined?
2. What training is provided to child day care health consultants?
3. What issues and concerns are identified by child day care health consultants?
4. What additional training is needed for child day care health consultants?

Assumptions

For the purposes of this study, the following assumptions were made:

1. Staff who provided consultation to military child day care facilities had prior experience and education in a health-related field.
2. Military personnel interviewed had background knowledge regarding child day care facilities.
3. The participants who were interviewed in this study did so voluntarily.
4. The participants provided accurate information based on their experiences with child day care health facilities.

Limitations

The limitations of the study were that the findings were specific to the staff who provided child day care health consultation to the child day care facilities and homes on military bases in Oklahoma and may or may not be representative of military bases throughout the United States. Some staff in the health field in the military may have limited contact with child day care facilities. Another limitation of the study was that child day care on military bases did not come under the jurisdiction of the Oklahoma Department of Human Services (DHS) licensing area; however, military Child Development Centers were highly regulated through the military system. The military regulations in some instances were more restrictive than the DHS requirements.

Definitions

The following definitions are provided for a better understanding of the terms as used in this study.

Child Care Center – A facility which provides care for 12 or more children for more than 30 hours per week.

Child Day Care Health Consultant – A person in a health-related field who provides health and safety consultation to child care providers.

Child Development Center – The term used by the military, both Army and Air Force, for a child care facility.

Family Child Care Home – Care provided in a home for seven or fewer children for part of the 24-hour day; the military definition allows a family child care home to care for six or fewer children with no more than two under the age of two.

Health Consultant – The term used by the military when referring to Military Public Health, Safety Office, Medical Consultant, Medical Advisor, and Community Health Nurse.

National Association for the Education of Young Children – National association that focuses on programs which provide care for young children and provides a certification for child care programs.

Part-Time Child Care – A facility which provides care for 12 or more children for 20-30 hours per week.

Scope of the Study

The scope of this study was limited to personnel on Oklahoma military bases who were associated with child day care facilities, including medical personnel who provided health consultation to the child day care facility.

CHAPTER II

REVIEW OF LITERATURE

Introduction

The literature reviewed for this study has been divided into the following subsections: (1) Overview of the field of child care, (2) History of Oklahoma child care (3) Health and safety issues of children and staff in child care facilities, and (4) Health consultation in child day care.

The research available regarding child care associated with military facilities was limited. However, some articles had been written regarding child day care health consultants not related to the military environment. Other studies had been conducted that addressed the child care directors' perception of care given in military bases (Bates, 1983).

In research conducted by Bates (1983), there were approximately 459 day care centers worldwide providing care to children of military families. Bates' study gathered data from 226 full-time day care center directors in the four branches of service, the U.S. Army, U.S. Air Force, U.S. Marine Corps, and the U.S. Navy to assess their perception of the care given in military day care centers. His findings indicated that military day care centers worldwide and in all service branches delivered uniform care. The care was rated

by the directors as adequate or more than adequate in all areas rated except meal planning preparation and promoting good dental care.

Research had been conducted on linking child care and health (Crowley, 1998). Information was written about the psycho-social impact of dependent care prior to school age, and many studies focused on illnesses associated with child care attendance (Lu, 1998), low wages of providers, child development, and educational needs of preschool children (Smith, 1988). All of these studies provided general information that was used as a basis when conducting this study. By reviewing research that had been conducted in child care facilities, including health and safety issues, and by reviewing research linking health and child care, it seemed natural to conduct research that explored the established system developed by the military for health consultation. It was important to review the current literature for health and safety issues related to child care, as this was the main focus of the child day care health consultant.

Overview of the Field of Child Care

Some form of child care has been licensed in the United States (U. S.) for approximately one hundred and fifteen years. The first law licensing child care facilities was passed in 1885 in Pennsylvania. This law was directed to those providers who provided 24-hour care to three or more children under the age of three. Most states had some form of child care regulation by 1920. National associations and federal acts dealing with child care began to emerge in the 1920s and 1930s. In 1926, the National Association for Nursery Education was established to promote the education and well-

being of young children. The provision for child welfare was established in the 1935 Social Security Act. Regulation up to this period focused on care that was provided 24 hours a day (Class as cited in Oklahoma Department of Human Services, Allsup, 1991).

The second world war had a major impact on families, women, and children. One of the strongest effects was the need for the care of children as American women went into the work force. According to the U.S. Bureau of Census, as cited in Cohen (1996), in 1948, approximately 3.2 million mothers were employed who had children under the age of 18. When more women entered the work force, the support from the federal government was through the tax system rather than through direct payment for child care. In 1950, approximately 10% of the women with a child in preschool were in the work force. By 1990, this increased to approximately 60% of women with at least one child in a child care setting (Clifford, 1994).

Child care had become the norm for children in the United States. In the United States in 1995, 13 million or 60% of children from birth to five were enrolled in child care. Eight of ten mothers who were employed used some type of child care arrangements (West, J., et al., 1995 as cited in Hofferth 1996).

The literature search revealed that it was not until the 1970s that the U. S. government was aware of the need for a comprehensive child care policy. It was difficult to develop a national policy regarding issues that related to children, as many consumers had a mistrust of government, especially when it was associated with the regulation of something as personal as the family unit and children. Licensing standards varied from state to state which made national regulation a challenge (Clifford 1994).

Nationally, approximately 13 million preschoolers were in child care, representing three out of five young children (National Center for Health Statistics, 1996). The field of child care had grown rapidly, and child care had become a major part of the life of a family in the United States.

Along with that growth, a number of concerns have surfaced related to child care outside the home both for the parents' and caregivers' perspectives. From the child care center owners'/directors' perspective, it was difficult to hire and maintain qualified staff (Helburn & Howes, 1996).

During the last 20 years research has been conducted on variations of quality in child care. Unfortunately, results of this research found that good child care is rare in the U. S. (Cryer, 2000). Still, other concerns were related to costs. Suzanne Helburn and Carollee Howes (1996) in "Child Care Cost and Quality," revealed that much had been written through the years from the perspectives of education and psychology, but little was written about child care cost. The cost-quality relationship was vital to review, and policy makers must be more aware of the cost-quality issue. It was crucial when one reviewed issues regarding child care to include the cost issues and the impact it had on staff. "As current child care workers leave their jobs, they are being replaced with a less well-educated work force" (p. 71). Several steps were recommended by the authors to improve quality and one was the hiring and retention of trained professionals who were capable of dealing with a variety of health issues and concerns (Helburn & Howes, 1996). When looking to the future, there is a need for nontraditional hours for child care because more families are telecommuting. Globalization leads to the need for 24-hour care to

support the needs of families. With increasing immigration to the U. S., there will be an increased need for understanding families with diverse backgrounds (Friedman, 2000).

Other considerations for the future of quality child care is the impact of funding. Increased funding is needed for the public health infrastructure to adequately monitor group care settings for infectious diseases and other health care issues in day care settings. Even though an individual child is treated by a physician, the physician may not have the information that the child is in day care, and the disease which was diagnosed may have a significant impact on children in a group setting (Goodman, Sacks, Aronson, Addiss, Kendrick, & Osterholm, 1994).

History of Oklahoma Child Care

In 1953, Oklahoma enacted the Oklahoma Children's Agency Licensing Act, Title 10, Chapter 18, which regulated three or more children in full-time care. Because the law included exemptions, many facilities which kept children remained unlicensed. Examples of the types of facilities which remained outside the jurisdiction of this Act were those facilities which kept two or less children, orphanages, and facilities operated by a church or fraternal order. Institutions which did not accept State aid also operated without any State oversight (Class as cited in Oklahoma Department of Human Services, Allsup, 1991).

According to a survey which was conducted in 1963 by the Oklahoma Department of Public Welfare, 203 day care centers were in operation In 1963, Oklahoma enacted the Child Care Facilities Act, Oklahoma Statute 10 O.S., Sec. 401-110, which charged the

Oklahoma Department of Human Services with the responsibility for the development of minimum requirements for the licensure of child care facilities. The members of the Oklahoma Association of Children's Institutions and Agencies were instrumental in the recommendation for establishing standards for the care of children (Class as cited in Oklahoma Department of Human Services, Allsup, 1991).

Child care facilities are licensed in Oklahoma by the Oklahoma Department of Human Services Licensing Division, Office of Child Care. The licensing requirements for child care centers were last revised December 1, 1999 (Department of Human Services, Office of Child Care, 1999).

The purpose of the Oklahoma Child Care Facilities Licensing Act was to ensure minimum standards for the protection and care of children when they were in care outside the home, to "encourage and assist the child care facility in attaining maximum standards," and to "work for the development of sufficient and adequate services to children" (Oklahoma Department of Human Services, Licensing Requirements, p. 2).

Health and Safety Issues of Children and Staff in Child Care Facilities

It was well documented in studies in the literature that with the increased numbers of children attending day care, the risk increased for children acquiring an infectious disease (Lu, 1998). This was considered to be an important public health issue as well as an economic burden for parents. Parents with children in day care missed an average of one to four weeks of work per year to care for their ill children (Thacker 1992). In

addition, many times, the parents became ill themselves, which increased the number of days that they missed work.

Relevant health issues for children enrolled in day care settings are those health issues which affect any child, whether they are cared for at home or in out-of-home settings and those health issues that are associated with being cared for in group settings by someone other than a parent. Exposure to infectious disease is the most common problem associated with children who are cared for in group settings. The child care program provides an excellent access point for health screening and education (Gaines, 1996).

In 1990, the Panel on Child Care Policy of the National Research Council was convened and the "panel's greatest concern was the large number of children who are cared for in settings that neither protect health and safety nor provide appropriate development stimulation" (Novello, 1994, p. 1115).

When children were grouped together, there were more opportunities for the transmission of disease. Generally, preschool-aged children were very susceptible to every virus and bacteria. Since preschool children did not always demonstrate the ideal hygiene habits, diseases spread quickly (Hendley, 1996).

Most infectious diseases that occurred among young children toddler and preschool-age did not severely limit their activity, but since many of these illnesses were contagious, they posed a health threat for other children in group care. The spread of diseases was common in child care settings because of the close personal contact and inadequate hygiene (Hawks, Ascheim, Giebink, Graville, & Solnit, 1994).

Uhari & Mottonen (1999) concluded in a 15-month study involving 20 day care centers that it was possible to prevent infectious diseases in group care settings when infection prevention programs were implemented. The programs were cost effective even if they were implemented by a nurse specialist.

Staff risks for exposure to certain communicable diseases was increased in child-care settings (Hawks, et al., 1994). Working with children was not only stressful but also exposed them to communicable diseases. Inadequate hygiene issues among staff contributed to even further issues with disease prevention. Many times, adults who developed childhood illnesses had severe symptoms (Swanson, Piotrkowski, Curbos, Graville, Kushnir, & Owen, 1994).

A study conducted in North Carolina showed little improvement in the hygienic practices of the staff after training on hygienic issues was conducted. It was important to look at other physical barriers and limitations when training, such as the distance between the diapering area and the hand wash sink. Center staff were encouraged to modify these barriers for increased effectiveness for infection control (Kotch, et al., 1996).

With increased numbers of children in out-of-home care, there were also increased numbers of children with special needs and chronic health conditions who needed care. This provided another opportunity to utilize the services of the health consultant. In a study conducted in Massachusetts with physicians and families of children with chronic health conditions, families identified unmet needs they experienced. The study reported that pediatricians underestimated the families needs for information (Perrin, Lewkowicz, & Young, 2000). When families were better informed, they were

more likely to provide accurate information to caregivers. The involvement of the parent with the health care professional is crucial when children are participating in group care.

When children are in group care outside the home, an increased risk for injuries existed. The U.S. Consumer Product Safety Commission conducted a study of federal, for-profit, nonprofit, and in-home child care settings and found that two-thirds of these facilities had a minimum of one safety hazard. The study reported that at least 56 deaths occurred in children in child care settings since 1990. In 1997, 31,000 children ages four and younger who received injuries in child care centers or schools were treated in emergency rooms (Dateline Child Care, 1999).

In a 1990 nationwide study by Briss, Sacks, Addiss, Kresnow, and O'Neil (1994), 1797 directors of day care centers were interviewed regarding the types of injuries children sustained while in care. The outcomes indicated that the injuries that occurred were relatively minor, but a reduction in the height of playground equipment could further reduce the injury risks in day care centers.

In a Case Study by Strauman-Raymond, Lie, and Kempf-Berketh (1993), it was pointed out that the environment in child care settings was used by children for exploring and developing skills. Caregivers needed to remain alert to potential hazards because young children do not understand how to be safe. Caregivers needed to become aware of interventions to prevent injuries and reference local licensing standards to create a safe and healthy environment. A health consultant had conducted a safety check of the environment. However, the safety check lists did not reflect the structural safety of the center or the varied behaviors including supervision of staff or inadequate staff which

affect safety. Some of the recommendations of this particular study were: inservice child care staff on documentation of injuries on an injury log; analyze the injury data; create safety check lists; examine behavior management techniques, such as aggressive behavior; and follow state regulations for child care.

The goal was to provide a safe and healthy environment by minimizing the spread of disease. Novello (1994) stated that collaboration with local and state health departments, social services, education, and those from the private sector was needed to ensure safe environments for children. Novella believed that day-care centers were the places where children had the opportunity to have a healthy start. In the future, the day-care center would be viewed as "a point to access health in the broadest sense" and safety practices could be taught and regulated (p. 1115).

Gensheimer (1994) stated that child-care setting must be made a public health concern and recognized that it is unique with large numbers of children in a group-care setting. When children who attend the child care become ill, there was a potential for disease to spread to the community. There were no easy solutions to the management of ill children in group care.

Staff at child-care settings may not receive adequate preparation or training to deal with the health aspects of providing care. The level of training in other health settings, such as hospitals and nursing homes, is critical to the quality of care. In Maine, a physician consultant is required for all licensed child-care facilities (Gensheimer, 1994). Control of outbreaks of infectious diseases in day care settings was facilitated when public health agencies were involved, especially when they used specific protocols and

policies that addressed disease prevention. At times, day care providers may not have been receptive to the requests of public health for disease prevention since the requests involved documentation and at times disrupted the routine of the facility (Davis, Mac Kensie, Addiss, 1994).

"Promotion of health and safety standards enhances the quality of child care" (Kuhns and Fiene, 1995, p. 3). The book, *Caring for Our Children: National Health and Safety Performance Standards - Guidelines for Out-of-Home Child Care,* was developed by the American Public Health Association (APHA) and the American Academy of Pediatrics (AAP) as a comprehensive resource to be used as a standard of quality. These standards were developed as supported by objective research data and were written to be specific and to be utilized when updating local standards and requirements. This document "provides a national consensus on approaches to reducing diseases and injury and promoting prevention among children and providers in group-care settings" (Aronson, 1994, p. 1101). These standards provided a thorough guide for recommendations that could be utilized routinely by staff in the child care facility. These standards also provided an excellent reference for health professionals when dealing with health and safety issues when children were in group care.

Health Consultation in Child Day Care

Various disciplines in health related fields have historically provided consultation services. One of the more common avenues for providing consultation was the school

setting. Teams of professionals often discussed recommendations and provided interventions for specified children (Conoley & Conoley, 1992).

What was the purpose of consultation? "Consultation is a voluntary, non-supervisory relationship between professionals from differing fields designed to aid professional functioning" (Conoley & Conoley, 1992, p. 3). As the consultants worked, they usually did not provide direct service to clients, but they did coordinate and evaluate health issues on an ongoing basis. The consultant should be aware that, to be effective, a comprehensive list of skills and attitudes was needed for effective consultation. Consultation was efficient as an indirect mode of delivery of service (Parsons & Meyers 1985). Consultation involved trust, respect, and the development of relationships (p. 82).

Erchul and Martens (1997) in the book, *School Consultation,* had a definite approach to school consultation. They believed that good consultation involved a combination of social influence and professional support. They believed this was the best approach for external consultants. The same information can be applied to those health professionals who provide health consultation to children in child care settings.

The significance of day care in children's lives must be recognized and steps taken to protect the well-being of children in this environment. "Support for the development and education of our children may be our most important legacy to them" (Roper, Thacker, & Teutsch, 1994, p. 1113) and must begin with the youngest children. "To achieve our vision of healthy people in a healthy world able to achieve a quality life, we must act today. The child day-care setting is a place to begin" (p. 1113).

According to the World Health Organization, "health comprises physical (which includes oral and nutritional) and socio-emotional domains" (Randolph, 1994, p. 1050), and the child care facility can assist in promoting healthy habits for children, parents, and staff.

The medical community has a significant role in collaboration with child care facilities. Lombardi (1993) encouraged the participation of the medical community in child care. She stated that the role of the medical community in child care is with parents, with providers, and with policy makers.

Crowley (1990) concluded that nurses with experience in primary care and health promotion were prepared to serve children in group care. However, it was important that the staff in child care understand the scope of nursing practice in order for the health consultant to be utilized fully. Crowley believed that as more children were enrolled in group care, health issues would gain increased attention, citing Peters' and Willis' recommendations from a 1980 study which recommended that nurses expand their role in day care settings.

Gaines (1996) recommended that child care settings could be utilized to provide clinical experiences for nursing students. It was important to teach students about the linkages between health and child care. One way to assist nursing students in learning about health and child care was to teach students about the role of the health consultant. Clinical experiences in nursing schools include pediatrics and the child care setting could provide a natural setting for this partnership.

Nurses and nurse practitioners are well suited to the child care environment to serve as child care health consultants. A nurse consultant can be called by the child care professional for a range of issues from state licensing requirements to specific health and safety issues. Providing consultation to the child care facilities is well within the nurse's scope of practice which includes, assessment and providing education about health care, child development and safety. Some nurses who function in the role of a child care health consultant say their role is much like that of a public health nurse or occupational health nurse (Ulione & Crowley, 1997).

Health consultants for child day care have many opportunities to provide training to caregivers and parents. In the study, "The Children of the Cost, Quality, and Outcomes Study go to School," recommendations were given for improved quality of care for children included that opportunities for training caregivers and stronger requirements were needed to maintain qualified people in the field of childcare. Health professionals have an opportunity to provide this training.

The benefit of collaboration between public health and child care programs is significant. In Nassau county in New York, a program was established by the Child Care Council to assist child care centers in improving hygienic practices. Since 1985, public health nurses have implemented the program by visiting the child care centers who desired to participate. The diaper changing and hand-washing procedures were reviewed, the center's policies evaluated, and recommendations made regarding observed problems. Between 1985 and 1994, an average of 20 centers were visited per year and there have been "no reported outbreaks of fecally transmitted illnesses attributed to improper

hygienic practices at the centers that have participated in the program" (Esernio-Jensses, 1995, p. 1710).

Training of staff in child care facilities is an ongoing process. Assistance can be offered to the child care facilities by the health consultant in the area of providing needed training. Child care professionals may spend time training staff, especially with the rate of turnover that exists in staff who work in child care programs. Alexander (1999) encourages those persons who provide training to base it on the adult learning principles.

In a study by Reder, Gale, and Taylor (1999) evaluating the training needs of public health professionals, communication skills were listed as the area most needed. The four topics rated by respondents were interpersonal communication, cross-cultural and cross-age communication, electronic communication, and participatory teaching/training skills. The preference of more than half of those surveyed preferred on-site training with a trainer.

Health professionals who provide consultation to child care facilities have the opportunity to educate the caregivers on the importance of complying with standards for quality care. A conclusion from a 1998 report entitled, "Child Outcomes When Child Care Center Classes Meet Recommended Standards for Quality Care," determined the outcomes for children were better when they were in classes which met the child-staff ratio and when caregivers had received the levels of recommended training (National Institute of Child Health and Human Development).

Those who provide health care consultation to child day care centers need access to publications, such as *Model Child Care Health Policies,* (1997) that provide health and

safety information for out-of-home care (Aronson, Bradley, Louchheim, Mancuso, & Ungvary, 1997). Monitoring is a regulatory oversight as well as an effective tool for self improvement. Training in pediatric CPR, first aid, immunizations, emergency plans, and proper handwashing are indicators of quality programs (Kuhns & Fiene, 1993).

Another resource was developed by the Healthy Child Care Montana Curriculum Committee for child care health consultation. It included a guide for site visits, a fact sheet describing consultation services, and an outline for orientation for new child care providers (Eckerson, Evans, Ita, Hansen, Stout, & Warford, 1998).

Kendrick (1994) stated that "training in child care assumes a number of forms" (p. 1108). She further elaborated that training had a direct impact on quality, but trainers, in order to be effective, needed to be aware of the context in which care givers worked. In order to effectively deliver training to those in the field of child care, one needed to visit the facilities to encounter the dilemmas that the care giver faced.

Health departments and licensing agencies supported training in the child-care setting and offered consultation, technical assistance, and training. In order to fully benefit from teaching, the health professional needed to recognize that they could learn from child-care experiences. Kendrick challenged health professionals to "become partners with child-care professional in training efforts. Together, we can train other trainers to disseminate our vital child-care health messages throughout the world" (p. 1110).

The staff in child day care facilities were encouraged to establish relationships with their local public health department and physicians (Yamauchi, 1996). It was

essential that child care workers develop good observational skills and were trained to work with parents to assist them in becoming proactive with the delivery of health services to their children (Randolph, 1994).

Infection control policies and guidelines were developed based on the research which was conducted for investigations of communicable disease outbreaks in day care centers. There was much better understanding, now more than ever, of the transmission, risk factors for infection, and effectiveness of the intervention (Davis, et al., 1994). It was very important that state and local health agencies become familiar with the recent research and trends of communicable diseases and health events in the day care setting (Davis, et al., 1994).

When working with the staff in day care settings with regard to disease outbreak investigation, it is important to be consistent. Standardized forms had to be created for the collection of information as well as a standard list of signs and symptoms of illnesses. There were several issues for consideration when an outbreak of communicable disease was worked. These issues were hygiene practices of the staff, child to staff ratio, toileting procedures, sanitation, food handling, group size, physical space and ill-child exclusion policies (Davis, et al., 1994).

It was very important to be aware of the physical layout and design of the facility, as children who are ill needed to be cared for in separate rooms. The staff in the infant and toddler rooms who changed diapers must remember that they must not prepare food at all. The staff required frequent training on the significance of staff ratios and illness as well as the physical layout and design of the facility (Yamauchi, 1996).

The daytime routine in child care created other opportunities for education of the staff regarding adequate hygiene, the importance of separation of food preparation from toileting, diapering, and interventions. This education helped to reduce stress among staff. Ergonomics was an area often overlooked when staff were trained and it was a vital area to include in training in health and safety issues (Swanson, et al., 1994).

Taras (1994) in *Pediatrics* expressed the need for the collaboration between physicians and the child care community. Increased physician involvement had the potential to do more than just be a collaborative piece. The need was expressed for additional health professionals to be willing to serve in the role of child day care health consultant. The availability of child day care health consultants remained an issue for those in need of care. Health professionals needed training as health care consultants.

Child day care facilities who kept children with special needs needed to stay current on these training issues. The United States Public Health system was not funded to provide full-time health consultation to child day care facilities (Taras, 1994). When a physician was acting as a consultant, he/she had to remember that the focus was not on the individual child, but rather the whole facility. The health consultant also had to keep this in mind (Taras, 1994).

The American Public Health Association (APHA) and the American Academy of Pediatrics (AAP) in a joint effort wrote the *National Health and Safety Performance Standards.* This was distributed and made available to health professionals and childcare providers throughout the nation. "Its success depends partly on whether health

professionals will be available, willing and trained to serve as health consultants" (Taras, 1994, p. 1062).

In Maine, the physician consultant worked with parents, staff from child-care, and public health professionals to develop recommendations specific for facilities (Gensheimer, 1994).

The APHA/AAP guidelines stressed that every child-care facility should utilize a health consultant. Health consultants were defined by these guidelines as a physician, a nurse practitioner who was certified in pediatrics, or a registered nurse who had pediatric experience or experience in out-of home child care. These guidelines made recommendations for the activities of the health consultant: (a) develop policies, practices, and procedures which address prevention and control of communicable diseases, child abuse, injuries, integration of children with special needs, and education for children, staff and parents; (b) make visits to the facilities monthly; (c) give advice regarding the health components of the facilities; (d) define the aspects of care to prevent and manage illness and injury and to enhance child development; (e) contact the child care's administration to review health recommendations; and (f) give advice as problems arise.

Hawks wrote that the APHA/AAP guidelines recognized that obtaining health consultants was often difficult and suggested that local or state public health agencies or private consultants be considered (Hawks, et al., 1994).

In response to the national recommendations by APHA and AAP, The National Training Institute for Child Care Health Consultants located at the University of North

Carolina School of Public Health was established. A pilot group was enrolled in 1999, with the group designed at the cohort group for the project beginning in 2000. This training was established to provide training to those who provided health and safety consultation to child care programs. This training was in partnership with the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services, and the Frank Porter Graham Child Development Center of The University of North Carolina at Chapel Hill.

CHAPTER III

METHODOLOGY

Research Design

A qualitative design was selected for this project, and the procedures used to answer the research questions were based on the purpose of the study.

Purpose of the Study

The purpose of the study was to explore the types of education and training provided to child day care health consultants on four military bases in Oklahoma. It was based on the assumption that findings in the personal interviews with directors, staff, and health consultants associated with child day care facilities on military bases, when compared to the review of literature regarding health and safety issues in child day care facilities, would identify training provided and needed for child day care health consultants. This same type of training provided to child day care health consultants on military bases could be a valuable resource to aviation-related organizations who also provide child care. The military environment was similar to an aviation environment with established standards and protocols, the need to maintain flexible schedules, and had a health system in place which could be accessed.

Rationale for Qualitative Research

This particular study was motivated by a personal interest by the researcher in the area of child care, more specifically health consultants and staff associated with child care facilities on military bases. Maxwell (1996) encouraged researchers to distinguish between three kinds of purposes for conducting a study: personal, practical, and research. The personal purpose which motivated the researcher to conduct the study included 14 years experience as a public health nurse in a large metropolitan health department. Thirteen years of this experience involved working with the child care facilities in Oklahoma County. During this time, the researcher had the opportunity to interface with other regulatory and child advocacy agencies, including health professionals in the military. The researcher's awareness of the benefits of collaboration between health professionals and child care professionals increased when observing the military model of the child care facilities access to health professionals.

Qualitative research opened the door and was the foundation for other inquiries and additional studies. Other studies need to have the basic information which can be accomplished through a qualitative study before conducting a quantitative study. As the research continued, it was essential that the researcher was aware of additional purposes which emerged during the study. It was important to begin to recognize the needs of health professionals for additional training related to child care and obtain a better understanding of their education and background.

Gay's (1996) approach to comparing and contrasting qualitative and quantitative research was that they were complementary components of the scientific method since

inductive reasoning was used for qualitative, and deductive reasoning was used for quantitative. The qualitative researcher was attempting to derive and describe findings that further greater understanding of why and how people behave in the manner they do. Gay reminded researchers that qualitative research was grounded theory, that is "theory based on data collected in real-world settings which reflect what naturally occurred over an extended period of time" (p. 212).

Research Questions

The first step in the study was to develop broad questions that were designed to gain insight into the training provided to health consultants associated with child care facilities in the military. The broad questions also identified issues referred to the child day care health consultant by child day care facility staff. Twenty-two interview questions were developed based on the four broad research questions.

Gay (1996) stated that interview questions formulated for qualitative studies were more general than those formulated for quantitative studies (see Appendix A). Therefore, these questions were developed based on research regarding qualitative studies as suggested by Rubin and Rubin (1995). The four broad research questions were:

1. How is the role of the child day care health consultant defined?
2. What training is provided to child day care health consultants?
3. What issues and concerns regarding health and safety are identified by child day care health consultants?
4. What additional training is needed for child day care health consultants?

The study was not restricted to the four broad questions, but was structured to expand on issues as they arose during the interviews and focus groups. Wiersma (2000) referred to this as the "funnel approach" (pp. 207-208), which began with general questions to initiate the research. In this way, the qualitative research was focused. Since the questions were open-ended, it was easy to explore other variables as they arose.

Population

The four military bases in Oklahoma which were selected had Child Development Centers located on their respective military bases. The researcher depended on the Public Information Officer at each base to identify the person designated as the child day care health consultant. The Public Information Officers were also asked to identify a contact at the Child Development Centers.

The Public Information Officers identified the contacts at the Child Development Centers for each respective base. There were a total of 24 persons in the roles identified by the researcher as possible interviewees. The Child Development Center at each military base visited had a Director, an Assistant Director, and a Training and Curriculum Specialist. The Assistant Directors at the Child Development Center also served as the Family Child Care Home Coordinators. A Medical Consultant or Medical Advisor was assigned at each military base as the advisor to the Child Development Center. This was frequently a pediatrician who was located in the medical clinic and who assessed children individually. One base had a Community Health Nurse who was the designated Child Day Care Health Consultant. Three other bases had nurses from Family

Advocacy or the medical clinic who were available as resources to the Child Development Centers.

Selection of the Sample

In the Funnel Approach, after the general research questions were identified, the next step was to select possible sites and subjects (Wiersma, 2000, p. 209). The child care facilities on military bases were deliberately selected and proved to be rich sources of data. The child care facilities on the military bases and their staffing model represented the types of child care facilities located throughout the state of Oklahoma. The military had a system in place for the staff at the child care facility to access information on health-related issues. This same model could also be used for aviation-related organizations who provided child care because of the similarity in structure to the military.

Selection of the sample first required the identification of all military bases in the state of Oklahoma. The sample was then narrowed to include only the specific military bases that had child day care facilities that were open and associated with the base. Once this group was identified, the next step identified staff who were employed at the facilities and staff who provided health consultation to these facilities.

A purposive sample of 11 participants was selected. This was determined by selecting at least one person from each of the roles identified: Nurse, Medical Consultant or Medical Advisor, Coordinator of Programs, Director, Assistant Director, and Training and Curriculum Specialist. These were the contacts given to the researcher by the Public

Information Officer. Not all persons at all bases were available to be interviewed. Purposive sampling was used in order to select child day care facilities whose staff had the possibility of communicating with child day care health and safety consultants on the military base. This study was considered a multi-site study since it involved various military bases in the state of Oklahoma. While the staff at these child day care facilities may have had limited contact with child day care health consultants, they had the possibility of contacts since they were located on the military bases. The selection of the limited sample was consistent with Gay's (1996) comments which stated that the qualitative researcher collected a large amount of data from a limited group and the quantitative researcher generally collected a small amount of data from a large group.

Methods

The interview guide of 22 questions was developed and approved in consultation with the researcher's advisor and committee (Appendix A). Once the instrument was designed, it was submitted to the Institutional Review Board (IRB) for approval (Appendix B). After obtaining the IRB approval, the Public Information Officers at each military base were contacted by phone. The Public Information Officers requested that a written request be submitted to them which included the purpose of the research. A letter was sent to the Public Information Officer at each military base in Oklahoma requesting an interview with the staff who provided consultation to the child day care facilities on the military bases (Appendix C).

Follow-up telephone calls were made to the Public Information Officers to request the names of persons they identified who could be interviewed by the researcher. Once these staff were identified, they were sent letters (Appendix D) requesting an interview to gather information regarding the type of training they received and the consultation issues they addressed with the child day care facilities on the military bases. The Public Information Officer was also asked to select directors from the child day care facilities located on the military bases who were willing to be interviewed regarding their contact with the child day care health consultant on the base. Once this group was identified, they were sent letters requesting permission to be interviewed (Appendix E).

Permission was obtained from the participants to record the interviews with the use of audio tapes (Appendix F) for data collection purposes. Assurance was given verbally and in writing that these audio tapes were confidential, and the tapes and any notes would be destroyed when the data were synthesized and analyzed. After each interview, a thank you letter was sent to each participant (Appendix G).

It was determined that the interviews would be conducted on the military base in the participants' office. A natural setting provides an opportunity for the researcher to observe the participants' daily activities. The decision was made by the researcher to be interactive with subjects in the interview process and noninteractive when the documents were reviewed and the audio tapes transcribed.

Instrumentation

An interview guide was developed based on the review of literature and from The National Training Institute for Child Day Care Health Consultants (Appendix A). The interview guide kept both the researcher and participants focused on the 22 open-ended questions. The interview guide was divided into four categories, which focused on the four research questions.

The interview guide was initially designed for the staff who provided health consultation to the child day care facilities. It was easily adapted for the staff who were interviewed who sought consultation from the child day care health consultant.

The researcher was interested in the face validity and content validity of the Interview Guide, therefore, the instrument was validated by conducting two pilot interviews with public health nurses who were considered experts. One public health nurse in the pilot study had twenty years experience working with the 350 child care facilities in Oklahoma County. This nurse conducted annual inspections of the child care facilities in Oklahoma County, as well as investigated complaints and outbreaks of infectious disease. In addition, this nurse provided consultation visits to the child care facilities upon request, provided phone consultation, and also conducted training for staff in child cares. The second participant in the pilot study, who reviewed the questions, was new in the position as a public health nurse in the child care program health. When feedback was requested regarding the instrument, both nurses in the pilot study stated that the time it took to complete the interview was adequate, and they believed they could expand on their responses and express their opinions freely.

Once the pilot interviews were completed, the order of the questions was changed by the researcher. The sequence of questions seemed to flow more naturally when the questions that dealt with training questions were grouped together.

Data Analysis

The data was obtained from individual interviews of staff on the military bases and from the interviews with the staff at child day care facilities on military bases. The interview data was analyzed with NUD*IST (Non-numerical Unstructured Data Indexing Searching and theorizing) QSR N5, a software for qualitative data analysis. This software system helps to manage the complexity of data. The standards for military child care and forms used for required inspections were also reviewed. Extensive notes were taken during the interviews and these notes included personal comments of the researcher and were coded with a pre-determined alpha code, PC=Personal Comment.

After each interview, the audio tapes were reviewed and transcribed verbatim by a paid transcriptionist. The researcher's notes and comments were injected into the data following the order of the verbal comments. As the audio tapes were reviewed, certain patterns and categories of data began to emerge and were coded. The notes were also transcribed from the personal interviews of the military personnel, and again, as patterns and categories emerged, these too were coded.

The full-text data from all the interviews were downloaded into NUD*IST software by responses to each question. This data analysis system allowed for the storage and retrieval of data.

Each interviewee's response was assigned an alpha code in order to differentiate the responses. The data was analyzed based on each question, as well as coding for themes as they emerged. These themes were coded to determine the frequency of reference. The data was analyzed and synthesized by comparing each military base, comparing the personal interviews, and then further codings were identified to compile an accurate base for the information obtained. Once the coding was complete and the data analyzed, the information identified was used as the basis to determine the type of the training which was provided for the child day care health consultant to develop and increase the skills needed to function in the role of a health consultant for child day care. Areas were identified for additional research which could be conducted in the public health sector.

CHAPTER IV

FINDINGS

Introduction

The findings of the study were taken from the 22 questions asked during interviews with 11 participants selected from four military bases in the state of Oklahoma.

Purpose of the Study

The purpose of this qualitative study was to explore the education and training provided to child day care health consultants at Oklahoma military bases.

Research Questions

The research was conducted to answer the four broad research questions concerning the education and training provided to child day care health consultants on Oklahoma military bases. The four questions were:

1. How is the role of the child day care health consultant defined?
2. What training is provided to child day care health consultants?

3. What issues and concerns are identified by child day care health consultants?

4. What additional training is needed for child day care health consultants?

The persons selected to be interviewed were those who provided and/or coordinated health consultation and training to the child care facilities located on the military bases in the state of Oklahoma. The 11 subjects interviewed for this study were selected from four military bases across the state of Oklahoma which had Child Development Centers located on their respective bases.

The interviewees' roles included: the Superintendent of Youth Programs and the Chief of Family Programs, both of whom coordinated all youth programs and activities on their base, including the oversight for the Child Development Center; two Directors from Child Development Centers; two Assistant Directors from Child Development Centers who also served in the capacity of Family Childcare Coordinators for the family childcare homes; two Training and Curriculum Specialists from the Child Development Centers; two Registered Nurses (RNs) who provided health consultation to the Child Development Centers; and one Pediatrician, designated as the Medical Consultant for the Child Development Center.

Demographics

The participants were either serving in the military, a spouse of someone serving in the military, or employed at the military base. The 11 persons interviewed for this study included ten females and one male. One person was of minority descent. Seven of

the 11 interviewed had bachelors' degrees, one had an Associate Degree, and three had graduate degrees, including a medical degree. All of the participants had been in their positions a minimum of one year, therefore they could draw from their educational experiences as well as daily experiences in the child care setting.

The 11 participants interviewed were associated with the field of child care in a variety of roles on their respective military bases. All participants were involved in providing and/or coordinating health consultation to the Child Development Centers ranging from coordination of health-related training to providing health consultation and making the recommendations for health and safety. This provided a more holistic approach, and a comparison the responses using the duties of the participants. By interviewing staff in varied roles associated with the Child Development Centers, a wealth of information was obtained regarding the issues of health and safety in child care settings and the training that was in place.

Role of Child Day Care Health Consultants Defined

The following narrative paraphrases each of the participants' responses to each of the interview questions. Each of the 11 participants have been assigned a number to ensure confidentiality and to protect their identity. At the conclusion of all 11 paraphrased responses to each question, a brief paragraph provides a summary of the responses to that particular questions. A more detailed summary of each of the 11 paraphrased responses to each particular question is provided in the discussion of the findings.

Perceptions of Health Care Consultants for Child Care

Participant 1. A health care consultant for child care was described as a person who was a professional and a health specialist. A health consultant also needed to be aware of the identification and prevention of disease.

Participant 2. A health care consultant for child care was someone who was available to the Child Development Center to deal with questions from child care staff regarding health issues, such as rashes. A health consultant was also someone who provided recommendations regarding illnesses of the children.

Participant 3. A health care consultant for child care was described as someone who was available to the Child Development Center to answer questions dealing with the health of the children. Health consultants were persons who provided guidance when informing parents of the need to take their sick children home. When children were ill, they did not need to be cared for in a group setting.

Participant 4. When thinking about a health care consultant for child care, this participant stated it was important that the person had a background and training in health. Knowledge of public health and training in the principles of disease transmission for children in group care were also essential for a health care consultant.

Participant 5. A health care consultant for child care was a person who was able to provide education and training for the child care providers. In addition, a health consultant was someone who was familiar with normal growth and development as well

as social, emotional, and intellectual development of children. The health care consultant needed to possess the skills necessary to educate providers about health issues.

Participant 6. A health care consultant for child care was someone who was contacted with questions about a contagious illness that occurred while children were in group care. The medical staff from Military Public Health, military Safety office, and the medical consultant provided consultation to the Child Development Center concerning health issues. The health consultant was generally not contacted about a specific child; that was the parent's prerogative. In the military regulations, there were specific areas that must be approved by the health consultant. A physician on base was assigned as the medical consultant to the Child Development Center. A general concern about safety or health was directed to the Safety Office or Military Public Health.

Participant 7. Examples of health issues in the child care setting for which a health consultant were contacted were given. Examples of requests made to the health consultant or Military Public Health were requests for assistance with immunization issues, recommendations for treatment of head lice, advice on food safety issues, or clarification of a health or safety issue.

Participant 8. A health care consultant for child care was perceived as someone who was available to respond to questions on health and safety issues ranging from illnesses of the children to safety of the equipment.

Participant 9. The health consultant was described as the nurse from Community Health at the base hospital who was available to the Child Development Center in various ways: giving support, answering medication questions, recommending how to deal with illness in a child, inspecting the program, orienting caregivers, providing staff training, and providing classes for parents. Participant 9 also stated the military system designated a nurse from Community Health as the health consultant to the Child Development Center.

Participant 10. A health consultant for the Child Development Center was defined as one who was available to deal with a variety of health and safety issues on a daily basis, for example, responding to questions from caregivers about the treatment for head lice, recommendations on toy safety, and proper storage of toothbrushes. The requests ranged from something specific to environmental issues. An example of a question that was presented to the nurse consultant was whether or not the hot water from the child care rooms could be routed to the kitchen for a repair that was needed. That meant the children would be washing their hands in cold water all day. Since this involved a possible two or three day delay for repair, the physician was consulted, and the decision was made to allow the children to wash their hands in cold water, but continue to use soap.

Participant 11. The health consultant was the Medical Advisor who could be contacted to make recommendations on health issues regarding the Child Development Center. A full-time staff person on the premises at the Child Development Center would

be ideal. It was important that this person understand health issues dealing with children in group care, such as medication policies. Funding issues arise when full-time medical persons were needed for non-medical facilities. Many of the base hospitals have had to downsize because of lack of funding.

Summary of Perceptions of Health Care Consultant for Child Care. All 11 participants perceived a Health Care Consultant as one engaged in a variety of roles, primarily one who responded to health and safety-related questions, made recommendations concerning health issues, and provided education and training to staff.

Frequency of Interactions with Staff at the
Child Development Center

Participant 1. Daily interactions occurred with staff at the Child Development Center by Participant 1 regarding health issues such as staff requesting recommendations on how to deal with an ill child, when to contact the parent, or when to recommend medical care.

Participant 2. Health issues of the children were a daily concern of staff from the Child Development Center and providers of family child care.

Participant 3. A daily interaction that dealt with health and safety issues, as well as other issues which arose during the course of the day, occurred between staff at the Child Development Center on base and Participant 3. There were also occasions to interact with staff from other military bases for monthly video teleconferences and yearly

training which preceded the National Association of Education of Young Children (NAEYC) conference. The monthly video conference allowed interaction among staff from the various participating bases.

Participant 4. The interactions with staff from the Child Development Center were "few and far between." Generally, interactions consisted of questions regarding how to prevent the spread of an infectious disease, such as *Salmonella,* or involved requests to look at a child that had a rash.

Participant 5. The interaction between staff from the Child Development Center and Participant 5 occurred on a regular basis with questions ranging from dealing with rashes to behavioral issues, including abuse and neglect. Interactions also occurred during monthly meetings of an interactive group at the Child Development Center.

Participant 6. The interactions with Military Public Health occurred during their monthly inspections of the center, which included inspections of each classroom and the kitchen. Sometimes the military instructions were not detailed, and the medical consultant was contacted when questions arose about interpreting a health policy or when a letter needed to be sent to parents concerning a health issue at the center. The medical consultant was a full-time physician who generally did not come to the Child Development Center. Daycare homes also had to be inspected by the Fire Department and Safety Office.

Participant 7. Daily interactions occurred between Participant 7 and staff at the Child Development Center regarding training and curriculum issues. A network existed among persons in similar position from other military bases. When assistance was needed about a specific issue, contact was made by phone or email to their counterparts. Sometimes other Training and Curriculum Specialists went to other facilities to validate together for NAEYC accreditation.

Participant 8. The interactions with staff at the Child Development Center and Participant 8 were daily. Interactions occurred two to three times a week with the family child care home providers. Other directors were contacted and problem solving was accomplished together. A training session was a good place to meet other directors. Family day care homes were visited once per month and monthly contact was also made through phone visits.

Participant 9. Regular, daily interactions on health and safety issues occurred between Child Development Center staff and Participant 9. Interactions occurred with other youth and school-age program staff regularly, especially when training was being planned for staff. Currently, the staff from these other facilities are planning training for staff on bloodborne pathogens.

Participant 10. Interactions with family home providers occurred during the yearly inspections as well as when they called with questions. There were approximately 17 certified homes on base. Interactions with staff from the Child Development Center occurred daily regarding health and safety questions. Staff from the Child Development

Center requested that an exception be made to the medication policy. This request was not accommodated because it was against the written policy.

Participant 11. Interactions with staff from the Child Development Center occurred on a daily basis. There were also regular interactions with staff from the Enrichment Program and staff from the 25 family day care homes. Soon, persons who wished to have a family day care home located off base would be able to be certified through the military, although they also needed to meet any local regulations through the Department of Human Services. One main difference in the state regulations and those of the military was that the military required the family day care home provider to have a minimum of $300,000 liability insurance.

Summary of Frequency of Health Care Consultant Interactions with Staff at the Child Development Center. Eight of the 11 participants reported daily interactions with the staff of the Child Development Center. One reported few interactions with staff due to the recent new job assignment. One reported regular interactions as needed, and one reported monthly interactions, mainly during the monthly inspections of the Child Development Center.

Issues Addressed with Child Development Center

Participant 1. Numerous health issues were addressed with staff on an ongoing basis by Participant 1. Common issues addressed with the health consultant were about the exclusion of ill children, requests for information when outbreaks of head lice

occurred, and requests for training or retraining on health-related topics as well as behavioral topics. Issues regarding the curriculum were also addressed and were not necessarily health related.

Participant 2. Childcare staff who were with the children needed assistance in determining if a child was ill or not. In addition, requests were made by the Child Development Center staff for specific training on health-related issues.

Participant 3. A variety of requests from caregivers as well as from parents was received. Issues ranged from the appropriate room temperature for children in care and intervention with staff members, to budget issues.

Participant 4. Requests were received from child development staff when children in care became ill and needed to be evaluated. When an infectious disease, such as *Salmonella,* occurred in the child in care, a letter was written to the Child Development Center with infection control recommendations, and this letter was sent on to parents who had children in care.

Participant 5. Various concerns were addressed with staff at the Child Development Center by Participant 5. Examples of those concerns included reports of abuse, requests to observe certain behaviors of children, such as aggressive behaviors, and abnormalities such as a limp which had been observed in a child.

Participant 6. Numerous concerns were addressed with both staff members and parents, for example, when to exclude sick children and how to deal with children who

had head lice, rashes, fever, and diarrhea. Requests were also received from staff members regarding the explanation of policies.

Participant 7. A variety of issues was addressed with staff members from the Child Development Center. Issues included curriculum, class schedules, and appropriate room arrangement. Requests were also received to coordinate and provide the annual first aid, Cardio-Pulmonary Resuscitation (CPR), Food Handling, and new staff orientation courses. Staff members were required to have annual training, and it was presented in 15 different modules over an 18-month period of time. A written test was given after each module. Once the staff completed the modules, they took a competency test in the caregiver's setting.

Participant 8. Health concerns addressed ranged from questions about food preparation and proper sanitation procedures to safety issues for toys and the environment.

Participant 9. Medication questions were weekly concerns addressed with Child Development Center staff. Medication questions included over-the-counter medications. Written policies and guidelines regarding medications were followed. Additional questions arose weekly, and guidance was requested from health staff.

Participant 10. Head lice, rashes, and immunizations were the topics of concern addressed regularly with Child Development Center staff. Requests were also received when information had to be distributed to parents. An example given was when the

hospital ran out of *Haemophilis influenzae* type b vaccine. If an immunization audit was conducted while the hospital was out of vaccine, there would have been children who were out of compliance with the regulations. A memo was written to the child care facility about the lack of vaccine.

Participant 11. The concerns of parents about the health of their children, medication issues, and issues pertaining to two or more children who had the same illness were the most frequent concerns that were addressed. Communication was key between the child care providers and health consultant because there were times when calls were received from command, asking about a particular child and why a situation was handled in the manner that it was. One issue that had to be addressed was opening the facility during hours when it would normally remain closed. There were situations that arose when child care staff were called to work in order to support the military personnel who were called out on a particular mission.

Summary of Issues Addressed with the Child Development Center. The Child Development Center staff requested the most frequent assistance regarding health and safety issues. Eight of the 11 participants interviewed requested assistance from the health consultant regarding children who were ill and the exclusions of ill children. Four participants also requested assistance on how to effectively respond to outbreaks of disease and reported concerns about environmental safety. Others mentioned that assistance was needed for the provision of training to child care staff. Other concerns given by participants were questions regarding medication administration, immunization

requirements, curriculum, reporting of child abuse, and assistance with policy development.

Frequency of Visits to the Child Development Center

Participant 1. Daily visits were made to the Child Development Center, and monthly visits were made to the providers in family child care homes. Monthly training was provided at the Child Development Center on topics such as appropriate guidance. Responses were made to daily phone calls which, at times, resulted in personal visits to the facility.

Participant 2. A requirement existed for monthly, unannounced inspections to be conducted at the family child care homes. This resulted in an average of two visits per month. When there was a particular concern observed during the inspection, a follow up inspection was conducted within 24 hours.

Participant 3. The interaction with staff at the Child Development Center was constant. This participant's office was located in the Child Development Center.

Participant 4. This participant was new in the position at the base and had not had an occasion to visit the Child Development Center. A nurse could function in the role of a health care consultant and could visit the childcare facility if needed.

Participant 5. Several times a month, visits were made to the Child Development Center. The visits may have been in response to a request, to provide training, or to participate in a monthly interactive group.

Participant 6. This participant's office was located in the Child Development Center and interaction with the staff members at the Child Development Center was on a continual basis.

Participant 7. This participant's office was located in the Child Development Center, and they were in and out of the classrooms on a continual basis.

Participant 8. This participant's office was located in the Child Development Center, and they were in continual contact with staff members at the center.

Participant 9. Inspections of the Child Development Center were made by the Community Health Nurse on a monthly basis to review sanitation, diapering, hand washing, medication administration, and procedures. These inspections were unannounced, and each classroom was inspected. Staff members were observed to make sure procedures were followed and the children's and staffs' records were reviewed. Staff members' records included their health assessments and any training they received.

Participant 10. Monthly unannounced inspections were made to the Child Development Center, and annual inspections were made to the family child care providers. Visits were also made to the Child Development Center in response to requests from staff members. It was not in the scope of practice of the health consultant to deal

with children individually, but rather the consultant looked at the health of the childcare program as a whole. The health consultant participated in the Special Needs Meetings where an individual child was the focus, and an individual plan was made for each special needs child. As a health consultant for the Child Development Center, collaboration was done with preventive medicine and bi-weekly Special Needs Meetings were attended at the facility. Last year, the child care requested consultation on whether or not they could have turtles. They had a bird, but turtles carried more diseases than birds. The request for the turtle was denied.

Participant 11. Actual visits to the facilities were made every week. Visits to the family child care homes were made two to three times per month, generally to accompany someone else who was visiting the home. The directors of the child care programs all had masters' degrees in Early Childhood Education and were well prepared to address issues that arose. Requests were received from the directors to visit their facilities because of a health issue were infrequent.

Summary of Frequency of Visits to the Child Development Center. Five of the 11 participants stated they were at the Child Development Center on a daily basis because their offices were located in the Child Development Center. Three of the 11 participants stated they made monthly visits to the Child Development Center for the purpose of conducting the required inspections. Two participants stated they made a visit when the staff requested their assistance, and one participant was new in the position and had not been to the Child Development Center.

Effective Qualities and Background for Child Day Care Health Consultants

Participant 1. A four-year nursing degree was the background that a person needed to be a health consultant for child day care facilities. A base knowledge of diseases, such as viral infections, and how the spread occurs was important since the health consultant specialized in health-related areas.

Participant 2. It was important for a health consultant to have a very good knowledge of childhood diseases, especially rashes. It was also important to be skilled in providing training to caregivers about hand washing, recognizing diseases, and prevention of the spread of disease.

Participant 3. The first quality of an effective child day care health consultant mentioned was a person who had a good knowledge of child development as well as a medical background, such as a doctor or nurse. It was also important to be personable and to like children.

Participant 4. A background as a nurse or someone with a medical background and who had knowledge of public health practices were qualities believed to be important for a health care consultant for child care.

Participant 5. This participant believed it was important to have a knowledge of family nursing, a strong pediatric background, a background in early childhood education, and be able to teach and demonstrate positive interactions with children.

Participant 6. This participant expressed that he/she had been fortunate to have a pediatrician or family practice physician as the health care consultant to the child care center. Not all bases had pediatricians assigned. Usually if the medical consultant was not a pediatrician, at least he/she was a family practice physician and had experience with children.

Participant 7. Knowledge in public health practices, a background in a health or medical profession, and being accessible were the qualities mentioned as being important when serving in the role of a health care consultant for child care. It was difficult to coordinate the required physical and immunization requirements for children and staff members in a timely manner. A health consultant needed to be aware of these types of requirements and assist staff members in complying.

Participant 8. Effective qualities and background of a health consultant for child care were described as a person who had an educational background with specific training in communicable diseases.

Participant 9. The nurse from Community Health was designated as the health care consultant for the child care program on base. Qualities that made someone in this position effective were described by this participant as someone who was available, personable, had common sense, provided training to staff on health-related issues, provided guidance on regulations, and assisted the Center with compliance with regulations from headquarters, and acted as a resource for child care center staff.

Participant 10. Qualities listed for a health care consultant for child care were as a person with a nursing degree who was flexible, had good resources, had formalized training as a health care consultant, and had public health and pediatric nursing experience.

Participant 11. Health care consultants for child care who were either physicians or physician's assistants with 20-30 hours in early childhood education were the most effective. This participant added that when the health consultants were either parents themselves or had experience in the military system, they were more knowledgeable and understanding of health-related issues that arose when children were in group care.

Summary of Effective Background and Qualities for a Child Day Care Health Consultant. Nine of the 11 participants preferred a child day care health consultant to have a medical background, either a physician who was a pediatrician or in family practice, a Physician's Assistant, or a Registered Nurse. One participant stated that someone who had an educational background with specific training in communicable disease would make an effective child day care health consultant. Seven of the 11 participants mentioned the importance of the knowledge of communicable diseases. Five of the 11 participants believed it was important for the health consultant to have a background in early childhood and child development.

Education and Experience Needed by Child

Day Care Health Consultants

Participant 1. Initially, this participant would not recommend a specific number of years to be employed as a nurse before becoming a health consultant for child care, but believed that both education and prior experience were beneficial. A four-year nursing degree and two to three years experience with children, such as in a pediatric clinic, was beneficial in order to develop a knowledge base about different childhood diseases.

Participant 2. A health consultant for child care should have at least a Registered Nurse (RN) degree with an additional year's experience to become familiar with military child care programs and regulations.

Participant 3. A recent graduate of a nursing school would not have adequate preparation to serve in the role of a health consultant for childcare. This participant continued by saying that a pediatric nurse or a nurse with other experience was better prepared to be the health consultant, so it would be based on the individual, training, and work experience.

Participant 4. Additional training in child development and the spread of disease was needed for a physician or someone with a nursing degree who was the health consultant for child care.

Participant 5. A nurse in the role of a health consultant for child care needed a strong clinical background, with a minimum of one year nursing experience, and maybe even a master's degree or some type of a clinical specialty.

Participant 6. The military regulations determined when a child may or may not attend the Center due to illness. The existing situation was described as "working" with Military Public Health serving as the actual contact on base for health issues. Public Health provided health training for the staff at the Child Development Center.

Participant 7. This question was inadvertently overlooked by the researcher during the interview and was not asked of this participant.

Participant 8. A background in special education with additional courses in early childhood education and health issues would be adequate to work in positions associated with the Child Development Center. Someone who had good experience over a long period of time, and who supplemented that experience with reading and sought to increase their knowledge level were additional qualities listed.

Participant 9. Medical training, with additional training in child development and pediatrics, was an essential component in the background of someone in the role of the health consultant for child care. A mentoring program was important for the health consultant who had no prior experience in settings with children. Regulations existed in the military and were referenced when information was needed on health issues.

Participant 10. It was difficult to identify a certain number of years experience that a nurse would need before becoming a health consultant to the Child Development Center, but ideally, a nurse who had a minimum of three years experience in a childcare setting or elementary school would generally have the knowledge base to serve in the role of a health care consultant for child care.

Participant 11. A nurse who was the health consultant needed a degree in nursing, with a minimum of three years experience in military or civilian day cares, or a school nurse background and experience.

Summary of Education and Experience Needed by Child Day Care Health Consultants. Ten of the 11 participants interviewed believed it was very important for a health consultant to both education and experience in a medical background and child development. The opinions varied regarding the number of years experience needed in a health-related field before becoming a health consultant.

Rapport Between Child Development Center Staff and Child Day Care Health Consultant

Participant 1. The medical advisor at the clinic for the Child Development Center was new, and usually another staff person at the Child Development Center contacted the advisor at the clinic. Participant 1 stated that the rapport experienced between the staff at the Child Development Center and herself/himself was good.

Participant 2. The rapport with the staff at the Child Development Center was described as very good. An open-door policy was maintained, and staff were free to contact Participant 2 as needed.

Participant 3. The relationship with the nurse consultant for the Child Development Center was described "very good." An example given was when the nurse consultant was contacted, the response was prompt and efficient, questions were answered quickly, and calls were returned promptly by the nurse.

Participant 4. The rapport between the staff at the Child Development Center and the health consultant was "pretty good," even though contact had been minimal. When contacted, the staff had been efficient in following through with the recommendations made by the health consultant.

Participant 5. The rapport between staff at the Child Development Center and the health consultant was described as "very good." A mutual attitude of respect was shown.

Participant 6. Both the Medical Consultant and Military Public Health were easy to contact and accessible, and the rapport with them was described as "good."

Participant 7. The rapport with Military Public Health was "good," and they came when called.

Participant 8. The rapport was good and the health consultant was accessible and served as a mentor to the staff members at the Child Development Center.

Participant 9. The rapport between the nurse consultant and the staff at the Child Development Center was described as "good," especially because the nurse had "common sense."

Participant 10. The rapport between the staff at the Child Development Center and the health consultant was "very good." Communication was accomplished through email, the telephone and through personal contact.

Participant 11. The support from the medical unit was described as "very good." Frequent inspections of the Child Development Center helped staff members maintain compliance with health and safety regulations, and medical was described as very supportive. The medical advisor was appointed for the child care facility. The military Child Development Centers were accredited by NAEYC, and the Public Law and Military Childcare Act of 1989 regulates the Child Development Center.

Summary of Rapport Between the Child Development Center Staff and the Child Day Care Health Consultants. Each of the 11 participants' description of their rapport between the Child Development Center Staff and the health consultant ranged from good to very good. Good rapport was described as making time available when consulted, responding promptly to requests, following through with recommendations, giving accurate, dependable information, and assisting the Center with compliance issues.

Health and Safety Issues and/or Concerns Identified at Facilities

Key Problems Addressed at the Child Development Center

Participant 1. There was a strong focus on health and safety at the Child Development Center. Some of the ongoing problems addressed were maintaining a safe environment, the importance of hand washing, dealing with sick children and contacting their parents, disease prevention, labeling bottles, and responding to parents of new enrollees about the frequency of illness experienced when a child first enrolled.

Participant 2. Dealing with children with rashes was a common occurrence. When children came to the center with a rash, the caregiver could not determine the cause of the rash or whether it was contagious. At that point, the Medical Consultant was called. Parents of ill children had to be contacted, and it was sometimes difficult to get in touch with parents. It was frustrating when a child was ill and the parents could not be reached.

Participant 3. One of the main areas dealt with was when to exclude ill children and when to readmit them once improvement was reported by parents.

Participant 4. Some common illnesses that were dealt with regularly in children at the Child Development Center were rash illnesses, pink eye, children with a fever, and diarrhea-type illnesses such as *Salmonella.*

Participant 5. Key areas addressed with staff at the Child Development Center were behavioral problems such as fighting and aggression, and babies who were brought to the Center without adequate formula.

Participant 6. There were ongoing issues regarding ill children and were as follows: determining whether or not children were well enough to participate in the program; dealing with ill children who had symptoms such as vomiting, fever, diarrhea, a rash, runny noses, stomach ache, and headache; and responding to children who did not feel like fully participating in the day's programming. The policies were clear about when to exclude ill children. No child could stay if their temperature was over 100 degrees; however, the challenge was when a child did not have a fever but just did not feel like participating. This was an example of a time when the health consultant was contacted. Articles were also written in the base newsletter which explained to parents the center policies on exclusion of ill children.

Participant 7. Constant training on hand washing was a key area that was addressed with staff according to this participant. Other problems which arose were in the areas of general safety, such as improperly placed cords, playground safety, and completing the daily safety check list. Another key problem was regular screening of the children's hair for head lice in order that prompt treatment could be recommended and the spread could be prevented in the Center.

Participant 8. Participant 8 stated that the common problems that were addressed with providers depended on the provider. For instance, a new provider may not realize

the importance of safety in a family child care home and may need special emphasis on proper storage of potentially hazardous items. Developmental issues and age-appropriate experiences were other areas which were addressed with the providers.

Participant 9. A constant issue dealt with by staff members was sick children who either became ill during the day, or did not feel like participating once they arrived at the facility. Courtesy calls were made to the parents to notify them of anything unusual which was observed in the child. Training staff to evaluate children upon entry to the facility was key when dealing with ill children who had eye infections, head lice, and Hand Foot and Mouth disease. Training staff on the regulations, such as when medication should be administered, was another area mentioned by this participant as a key problem. When children in a particular classroom were sick, parents were notified by a sign posted on the door of the classroom.

Participant 10. Prevention issues were the key areas addressed. Childhood immunizations were considered prevention. The regulations by the military and the state were clear regarding required immunizations for children in group care, but because of the frequent moves made by military families, it was often difficult for children to stay current on their immunizations. There were even some parents who decided not to immunize their children. This presented a problem when there was an outbreak of disease because the children who were not immunized were the first to be excluded from the Child Development Center.

Participant 11. A key issue was encouraging staff members at the Child Development Center to use their common sense and to observe the children, but not react before gathering all the facts. Good parent-caregiver communication was essential when dealing with children, whether it was an issue regarding a medication policy, ways to include challenged children, or problems with babies teething.

Summary of Key Problems Addressed at the Child Development Center. Eight of the 11 participants referenced the problems encountered with parents. Parents brought children to the facility when the children were ill, and parents did not always respond promptly when a request was made to pick up their ill child. Another key problem which was addressed was maintaining training for staff members to keep staff updated on policies.

Methods of Obtaining Consensus with Staff

Participant 1. Several ways that staff were informed about issues that needed correction were as follows: frequent staff training, following up with staff after the areas of correction had been identified, observing staff during the day, using the classroom monitors to ensure that staff were doing things appropriately, and reviewing the video tape from the monitor with staff.

Participant 2. This question was inadvertently overlooked by the researcher and not asked of this participant.

Participant 3. When a caregiver needed to do a task differently, he/she was first informed, follow-up observations were made, and the appropriate action was modeled. If the issue involved several caregivers, it was discussed at a staff meeting, or notes were posted by the time clock as a reminder to staff members. If the issue was serious, the staff person would be counseled individually.

Participant 4. Parents and staff at the Child Development Center had to comply with military regulations. Alternate plans for child care had to be made when children were not well enough to attend child care.

Participant 5. There were several ways to gain consensus with Child Development Center staff on problem issues. Examples listed were observing staff members, conferencing with staff members, and informing the staff members of the appropriate way to address situations or make appropriate referrals for behavioral issues. Participant 5 was contacted by the Child Development Center staff or by parents when a specific observation of a child was needed. If a problem was observed with the child, a referral was made for additional assessment.

Participant 6. Obtaining staff consensus on identified problems was accomplished through monthly staff meetings, individual discussions with staff, referring to the employee handbook regarding center policies, and ensuring that staff can contact supervisors when needed. Phones were placed in each room where care is given so staff could request assistance.

Participant 7. Remaining open to staff suggestions and involving them in the solutions were important ways to obtain consensus with staff members on identified issues. An example of this was given. Staff informed the supervisors that the location of the sandbox was too close to the sidewalk and was a potential safety hazard. This issue was discussed with staff members, and they made recommendations on how to correct the problem. It was important that staff members have input in the problem solving process.

Participant 8. Several techniques were used to obtain consensus from staff and were as follows: modeling the appropriate behavior, explaining the rationale for recommended corrections, and requesting the staff to demonstrate the correct action.

Participant 9. Training was the key to obtaining consensus with staff members. To ensure compliance with regulations, non-compliant issues must be discussed with staff members and clear procedures and check lists created. Staff training needed to include a time for observation and ongoing monitoring of staff members.

Participant 10. Consensus with regulations was obtained with Child Development staff by scheduling a meeting with them, making a visit to the facility, and maintaining current Standard Operating Procedures.

Participant 11. Meeting with the directors of the facilities was a way to get information disseminated. When the information did not get disseminated in this way, meetings were scheduled at the facilities with staff members to discuss the issues.

Summary of Methods of Obtaining Consensus with Staff. Ten of the 11 participants interviewed stated that when a problem was discovered, in order to gain consensus with staff, they met with staff, either individually or in a group. Six of the 11 interviewed stated that training was provided to staff regarding military regulations and standard operating procedures. Training provided staff with the rationale for the importance of following the regulations.

Methods of Determining Compliance with Recommendations

Participant 1. Observation was used to determine staff compliance with regulations. New employee training was also conducted, and new employees spent time working with more experienced staff.

Participant 2. This participant was not asked to respond on this question.

Participant 3. Multiple ways were utilized to determine if staff members were complying with recommendations. Examples given were making return visits, monthly inspections, annual inspections, establishing and disseminating check lists, and conducting a multidisciplinary team inspection.

Participant 4. Participant 4 stated it would be obvious that problems were still occurring if children were continuing to be sick with the same illnesses.

Participant 5. Follow up telephone calls were used to discuss recommendations that were made during a visit.

Participant 6. Military Child Development Centers were highly regulated, and the results of the inspections were documented. Monthly inspections, fire drills, annual safety inspections, daily health checks of children, and the maintenance of children's health records were all ways that compliance with the regulations was monitored.

Participant 7. There were various ways to determine compliance with health and safety regulations. These included a regular review of accident reports, regular observation of new staff in addition to observation of experienced staff, and a review of staff training modules.

Participant 8. Unannounced monthly inspections were conducted to determine compliance with health and safety regulations. During these inspections, questions were asked of staff members, staff members were observed performing routine duties, return visits were made to follow up on non-compliant items, written documentation was given to the providers indicating the corrections needed, and continued education was provided to caregiver on areas which were not compliant with the regulations.

Participant 9. Monitoring the classrooms on a regular basis provided an opportunity to determine noncompliance with regulations. It was also important to stay familiar with the regulations, provide new staff members with training, conduct monthly inspections, discuss identified issues with staff members, and establish a plan of correction.

Participant 10. Monthly inspections were conducted to determine compliance with the regulations.

Participant 11. Monthly inspections with follow up inspections were conducted. Trainers who provided training to staff members were rotated between the Child Development Centers. Staff at the Child Development Center were requested to conduct inspections of their own facilities.

Summary of Methods of Determining Compliance with Recommendations. Eight of the 11 participants stated the ways they determined compliance with the recommendations were by observing staff and inspecting the facilities. One participant stated that when the same illnesses were occurring, then it was obvious that no change had occurred. Another participant stated that follow-up phone calls were made to the Center to determine if any further problems were occurring.

Training Provided to Child Day Care Health Consultants

Role and Responsibilities of Participants

Participant 1. As the Training and Curriculum Specialist, the responsibilities included coordination of mandated training provided to all staff. The mandated training courses included CPR, first aid, child abuse prevention. Other topics which were mandated to be provided annually were: appropriate guidance, safe food preparation, disease control, and an 18-month training program for new staff members. Other

responsibilities were curriculum development and training and maintaining safe, age-appropriate environments.

Participant 2. As the Assistant Director, two main roles included: assisting the director of the Child Development Center and serving as Family Child Care Coordinator with oversight of the Family Child Care Homes on base.

Participant 3. Participant 3 was the Director of the Child Development Center.

Participant 4. Participant 4 was a pediatrician and the medical consultant for the Child Development Center.

Participant 5. As a Registered Nurse Participant 5 was the health consultant for the Child Development Center, and in addition, provided education and support services for young parents in the military.

Participant 6. As the Superintendent for Youth Programs, Participant 6 was responsible for the Child Development Center as well as other youth programs on base.

Participant 7. Participant 7 was the Training and Curriculum Specialist responsible for the coordination of training for the Child Development Center, School Age Program, and Family Child Care Homes on base.

Participant 8. Participant 8 served in a dual role of Assistant Director for the Child Development Center and as the Family Child Care Home Coordinator. In this role,

assistance was given to the Director of the Child Development Center, inspections were conducted, and consultation was provided for the Family Child Care Homes.

Participant 9. Participant 9 served in the capacity as the Director for the Child Development Center, but previously served in the position as the Training and Curriculum Specialist.

Participant 10. As a Registered Nurse, Participant 10 served in the role as the nurse consultant for the Child Development Center and as the case manager for Human Immuno-deficiency virus (HIV) and tuberculosis patients. One of the major functions of this participant was providing education and training to the child development staff, as well as to other staff on base.

Participant 11. As the Chief of Family Programs, Participant 11 had several major responsibilities as follows: oversight of all the children and youth programs on the base, ensured compliance with regulations for these facilities, developed the budgets, and served as an advocate for children.

Summary of Roles and Responsibilities of Participants. Three of the 11 participants interviewed had a medical background, one physician and two Registered Nurses. They served as the health consultants to the Child Development Centers. Four of the 11 interviewed worked in the positions of Director or Assistant Director at the Child Development Centers. They were responsible for the day to day operation of the Child Development Center. The two Assistant Directors were also responsible for the Family

Child Care Homes on base. Two of the 11 interviewed were designated as the Training and Curriculum Specialist for the Child Development Center. They conducted and coordinated the training which was provided at the Child Development Center. Two of the 11 interviewed were responsible for all the youth programs on base, including the Child Development Center.

Prior Health and Safety Training

Participant 1. Participant 1 had received a 40-hour training and certification in Food Safety, a 40-hour training and certification in Playground Safety, as well as an American Heart and American Red Cross First Aid and CPR training.

Participant 2. The health and safety training was provided by the base Safety office pertaining to safety in the classrooms and sanitation issues, such as hand washing.

Participant 3. Participant 3 had received the 40 hours of required annual training which included CPR, first aid, bloodborne pathogens, child abuse prevention, child development, nutrition, safety, and health.

Participant 4. As a physician with a specialty in pediatrics, Participant 4 had attended disease-specific training for continuing education. In addition, currency was maintained with "self training" by using such books as *Caring for our Children.* This publication was written by the American Academy of Pediatrics and the American Public Health Association. It provided excellent guidelines for health and safety in out-of-home care for children.

Participant 5. Participant 5 attended the four-day Child Seat Safety Training course. The remainder of training in safety was self taught by reading, especially updates from the Consumer Product Safety Commission and by participation in the Safe Kids Coalition.

Participant 6. Annual training such as CPR, first aid, and fire safety, was attended as well as task certification through the military base public health staff. The remainder of training on health and safety issues was described as "self-taught," and the military provided numerous updates on issues through newsletters and email.

Participant 7. Participant 7 attended annual supervisions of food handlers and other training as well as annual training that included health and safety topics. Directors, Assistant Directors, and Training and Curriculum Specialists were required to attend training annually and attend core training every five years.

Participant 8. Participant 8 had received certification the past four years in CPR, bloodborne pathogens, and the management of communicable diseases. At a prior base, through attendance at seminars, health and safety training was completed. Also, this participant attended the national Family Child Care Home conference, and health and safety issues were addressed. Continued reading provided a way to stay current on health and safety issues.

Participant 9. Annual training updates on health and safety were received. Video teleconferences, national conferences such as NAEYC and yearly military training provided additional ways to stay current on health and safety areas.

Participant 10. Participant 10 had not attended or received any specific training on health and safety issues or health consultation for children in child care.

Participant 11. Regular training on the administration of medications and children with special needs were a part of the health and safety training received. Health issues were also addressed in annual training and in the yearly communicable disease training.

Summary of Prior Health and Safety Training Received by Participants. The training received by medical staff was primarily through continuing education through conference attendance and by reading current health-related literature. None of the participants who were medical staff had attended a specific course in consultation for child care. The other participants obtained annual training through mandated training provided at their respective child care programs. When attending training at national conferences, participants selected topics that were pertinent to their specific job.

Professional Strengths

Participant 1. A broad knowledge base, good knowledge about children, and a degree in Elementary Education with a minor in Early Childhood Education were professional strengths mentioned.

Participant 2. Professional strengths included a background to deal with children with a degree in Early Childhood Education and a good knowledge base about child development.

Participant 3. Professional strengths listed were being kind hearted, having a love for children, caring about the job, and a bachelor's degree in Elementary and Early Childhood Education.

Participant 4. The dual roles as a parent and the profession as a physician with a background in pediatrics were professional strengths.

Participant 5. The greatest professional strength was being a parent. In this position it was necessary to relate to young military parents, and it was helpful to have experience as a parent. A varied nursing background, which included critical care and head nurse positions at numerous military hospitals, were also listed as professional strengths. Another professional strength was being able to relate well to people.

Participant 6. Professional strengths were good communication skills with staff members and parents and good organizational skills which included maintaining compliance with the regulations and being punctual with reports. It was beneficial to be able to see the big picture yet take care of the details.

Participant 7. A strong knowledge about early childhood, including a graduate degree in Early Childhood Education, was a professional strength. Other strengths listed

were good communication skills and the ability to work with staff versus dictating to them.

Participant 8. Good rapport with providers of childcare was a professional strength as well as being approachable, providing information in a non-intimidating way, and going the extra mile.

Participant 9. Prior experience in varied roles in childcare was considered a professional strength as well as a bachelor's degree in Individual and Family Development with post-graduate work in Early Childhood.

Participant 10. Being a grandparent and a nursing medical surgical background was listed as professional strengths. From a grandparent's perspective, he/she asked the question, "is this a facility where my grandchild could be left in care?"

Participant 11. Because of the number of years in military childcare, experience, knowledge, and being a good problem solver were professional strengths. Other professional strengths were having an awareness of personal limits and knowing when to ask for help.

Summary of Professional Strengths of Participants. Professional strengths of the participants included a background and experience with children. Ten of the 11 participants interviewed had college degrees, and three of the ten had graduate degrees. Three of the 11 participants had a medical background. Eight of the 11 participants interviewed had degrees with an emphasis on Early Childhood Education. Three of the

participants stated that being a parent or grandparent was definitely a professional strength.

Training Provided by Participants

Participant 1. Training was provided four to five times a month for the staff at the Child Development Center, Youth Programs, and Family Child Care. This training courses including first aid and CPR. Other topics included appropriate guidance, food safety, and playground safety. Disease control and child abuse prevention training for staff members were coordinated. In addition, Marazon, a ten-hour training which focused on individualizing a program for children was provided.

Participant 2. All the orientation training for new family child care providers was provided, which included the modules they had to complete on regulations, professionalism, and child development.

Participant 3. Participant 3 did not directly provide training at the present time but served in the role as a mentor and provided assistance to the Training and Curriculum Specialist. In the former position of Training and Curriculum Specialist, varied ongoing training was coordinated and provided to staff at the Child Development Center as well as the Family Child Care homes.

Participant 4. No group training was provided, but this participant reported providing education to patients during their appointments.

Participant 5. Four to five classes a month were provided for those who resided on the military base as well as classes presented in the community on nutrition, child abuse prevention, breast feeding, infant massage.

Participant 6. The role of Participant 6 was to coordinate the training provided to the staff at the Child Development Center and Youth Programs. Training was not provided directly.

Participant 7. No training was provided for the general community, but training was given for new staff on the 18 training modules, topics of child development, and other topics that were requested by staff. Annual mandated training was also provided.

Participant 8. No training was provided for the general community; however, training that was required was provided by the Training and Curriculum Specialist.

Participant 9. The former position of Training and Curriculum Specialist was held by this participant. In the current position of Director, a small amount of training was still provided to staff, but generally he/she coordinated the training for staff. No training was provided in the community.

Participant 10. Training was provided on base and in the community on HIV-AIDS. In addition, classes were provided to persons on base for smoking cessation, and plans were being made to develop a class on Unintended Pregnancy Prevention. Participant 10 was willing to develop training and provide classes based on the requests from the Child Development Center.

Participant 11. Management-related training was provided to staff, and other staff provided health-related training.

Summary of Professional Training Provided by Participants. The two Registered Nurses interviewed provided classes in the community and on the military base on topics including nutrition, child abuse prevention, breast feeding, infant massage, HIV, and smoking cessation. The nurses also provided classes at the Child Development Center. No training was provided presently by two of the 11 interviewed. Seven of the 11 participants provided training directly to staff at the Child Development Center; two of the 11 interviewed coordinated the training which was provided to staff at the Child Development Center. The annual training for staff at the Child Development center included training in CPR, first aid, food safety, child abuse prevention, and bloodborne pathogens, and new staff training on the 18 modules.

Professional Networking

Participant 1. Networking was accomplished with other Training and Curriculum Specialists in the military at annual conferences and by email. A good resource that was consistently used throughout the military system, according to Participant 1, was the book *Caring for our Children.*

Participant 2. The professional network used included staff from the base hospital and Wing Safety.

Participant 3. Networking with other directors in the military was the type of professional network which was helpful. Communication was accomplished by telephone, email, and meetings during the annual conferences.

Participant 4. Networking was done with other professionals in the Family Advocacy Center and the staff who dealt with child abuse issues.

Participant 5. The Internet was beneficial for obtaining information and the web sites established by the military were used for the purpose of networking with other professionals. Child development staff in other parts of the country accessed this web site, and it was a good way to network with one another.

Participant 6. Networking was done through Headquarters groups, and information was disseminated through this system through email and newsletters.

Participant 7. It was beneficial to network with other Training and Curriculum Specialists at the annual conference. Email was also an effective way to contact persons who served in the same position on other bases.

Participant 8. Conferences provided a way to meet other staff in the same position and addresses, phone numbers, and emails could be exchanged.

Participant 9. Other staff in the Child Development Center provided a good professional network. Contacts were made with higher levels and with the nurse consultant on base.

Participant 10. Local resources as well as the consultant for child care located in Washington provided a good network.

Participant 11. The entire Flight was involved in the local network. Active participation was maintained in the organization for early childhood; Oklahoma had a "very active early childhood program" with many knowledgeable people.

Summary of Processional Networking of Participants. All 11 interviewed stated they maintained contact with their peers locally and this provided a strong professional network. Four of the 11 interviewed stated that professional networking was accomplished by attending annual conferences. Seven participants stated that they used email regularly to stay in contact with other professionals.

Methods of Communication with Other Professionals

Participant 1. No preference was expressed when it came to ways to communicate with other professionals. However, if answers were needed to questions, the preference was to meet in person and to follow up with a phone call.

Participant 2. When assistance was needed, phone calls were made and assistance was received.

Participant 3. Face-to-face communication with other professionals was preferred.

Participant 4. When the matter was urgent, a telephone call was the preferred way to communicate. Otherwise, written communication was good so the recipient could have something in writing for reference.

Participant 5. Email was the preferred method to communicate. Email could be retrieved and responded to when phone calls could not always be returned, especially after business hours. Email was a good way to keep in touch with people such as in the staff in the military who were mobile.

Participant 6. Email was "wonderful" and the preferred method for communicating with other professionals. A military web site was also helpful. A forum for Child Development Centers was established on the web site for posting questions and training opportunities.

Participant 7. Email was one way to communicate with other professionals; however, another way to communicate with other professionals occurred when the staff from Behavioral Health, Family Advocacy, and Military Public Health were invited to provide training. This helped to place a name with a face and encouraged interaction among professionals in the same field.

Participant 8. Email was a way to communicate with people in the military system when face to face meetings were sometimes difficult to arrange. If communication was needed with another professional on the same base, such as in the clinic, the preference was for a face-to-face meeting.

Participant 9. Email and the use of a fax machine were much quicker ways to communicate than even the phone.

Participant 10. Email was frequently used as a way to communicate with other professionals across the world.

Participant 11. Email and the telephone were both ways communication occurred. There were numerous links on the military web site that were frequently accessed, and the information was disseminated.

Summary of Methods of Communicating with Other Professionals. Seven of the 11 participants stated they preferred email as a way of communicating with other professionals; one of these seven stated that email was the preferred contact unless they were communicating with someone on the base and they preferred meeting in person. Two of the 11 interviewed preferred meeting in person to communicate with other professionals, while another participant preferred phoning other professionals, especially when training was being requested. One of the 11 participants preferred to communicate in writing offering the rationale that written information could be easily referenced. This same participant stated that when the matter was urgent, a phone call was preferred.

Additional Training Needed for Child Day Care Health Consultants

Additional Training Needed

Participant 1. A health consultant for child care needed additional annual training in order to remain current on such topics as infectious diseases and administering medications.

Participant 2. A health consultant for child care needed training on the rules and regulations for the military and the enforcement of these requirements.

Participant 3. People skills, communications skills, and stress management were mentioned as areas of additional training needed for child day care health consultant.

Participant 4. A nurse consultant for child care needed additional training in public health and the spread of disease in addition to a nursing degree.

Participant 5. Child abuse prevention was a definite area of training needed by a nurse who provided health consultation to child cares. Other training needed was in the areas of presentation skills, teaching parenting classes, legal issues, and state guidelines for child care facilities.

Participant 6. Additional training was needed for a medical person in the area of child development.

Participant 7. In addition to a medical background, a health consultant for child day care needed training in public health which was the current way that health consultation was being provided on base.

Participant 8. More training was needed in early childhood education and on common childhood illness and immunizations.

Participant 9. Definitely training and education in early childhood development was needed. Other training needed was training on the military regulations.

Participant 10. Additional training for the child day care health consultant was needed in the normal development of children, immunizations, the state requirements for child care, train the trainer classes on such topics as parenting. Also, a background in pediatrics and community health should be a prerequisite before becoming a health consultant for child care.

Participant 11. If a position was established for a full time nurse health consultant, it would be important to meet with other military health personnel, such as the medical consultant. Annual training was needed on significant health and safety issues seen in military child care, such as the proper use of child car seats. Coordination was also needed with the other areas that provided training on health and safety issues to minimize duplication.

Summary of Additional Training Needed for Child Day Care Health Consultants. Seven of the 11 participants believed that additional training was needed in the areas of

health and safety, including disease prevention. Additional training in the area of Child Development and soft skills, described as communication and people skills, train the trainer, stress management, and accessing resources was also needed according to participants.

Methods of Obtaining Additional Training

Participant 1. Military Public Health conducted regular inspections and training for the child care providers.

Participant 2. Training was received from the Training and Curriculum Specialist on base, from the hospital on medication administration, and from Wing Safety on health and sanitation issues.

Participant 3. Additional training from military and national conferences, Friends of Early Childhood, and the Oklahoma Association of Early Childhood conferences.

Participant 4. Continuing education units were required and obtained through magazine articles, conferences, and special courses offered.

Participant 5. The annual week-long training from Family Advocacy and the Annual Child Abuse Prevention Conference were attended. Every other year the participant attended the Association for Women's Health Obstetric and Neonatal Nurses conference.

Participant 6. Additional training was received at the annual National Association and Education of Young Children (NAEYC) conference and the two-day training offered by the military prior to this conference.

Participant 7. Attendance at the NAEYC conference provided an opportunity to obtain additional training.

Participant 8. Different training classes were attended on base as well as the Family Child Care Conference, the Child Advocates conference, and the United States Department of Agriculture (USDA) Food Training.

Participant 9. No additional training had been received as a child care health consultant, but if information was needed, the areas on base such as Occupational Health and Community Health and Safety would be contacted.

Participant 10. No specific training as a nurse health consultant to child care had been received. The desire was expressed to attend training.

Participant 11. The Flight Chief Training and the School-Age Conference were attended on an annual basis to obtain additional training in the field of child care.

Summary of Methods of Obtaining Additional Training. Seven of the participants stated they received additional training by attending national conferences annually. Three participants stated they received additional training at the local level through the base Military Public Health, Occupational Health, Community Health, and Wing Safety.

Local conferences were also attended by these participants. One participant expressed the desire to attend training specific for a child day care health consultants.

Method for Obtaining Current Information on Health and Safety Issues

Participant 1. Military Public Health and Behavioral Health provided annual training attended. The topics included were food safety and disease control.

Participant 2. Annual training was received through NAEYC and the Family Child Care Home conference.

Participant 3. Participant 3 kept current on health and safety issues by reading bulletins, consumer product safety information, and professional magazines.

Participant 4. Attending conferences and annual training, as well as reading related literature has kept Participant 4 current on health and safety issues.

Participant 5. The web site and Safety office were the two main sources utilized to stay current on health and safety issues.

Participant 6. Annual training and information disseminated through email were two ways this participant stayed current on health and safety issues.

Participant 7. The annual training provided on health and safety issues provided through the military helped to keep Participant 7 current on health and safety issues.

Participant 8. A desire was expressed to find opportunities where current health and safety information could be obtained. The role of health consultant for child care was a new assignment for this participant.

Participant 9. Both Occupational Health and Community Health provided current health and safety information. The Internet was also utilized.

Participant 10. The military newsletter, the Internet, journals, and information provided through the Oklahoma State Health Department were ways utilized by Participant 10 to stay current on health and safety issues.

Participant 11. Conferences, local meetings, the newsletter, and military web site were utilized to obtain current health and safety information.

Summary of Methods for Obtaining Current Information on Health and Safety Issues. All 11 participants stated that they read bulletins from the military and professional publications in the field of child care for updates on health and safety issues. Seven of the 11 participants stated that they kept current on health and safety issues by attending training, either locally or nationally. Other participants stated that they regularly accessed the military web site to obtain current information.

Preferred Length of Training

Participant 1. When traveling out-of-state for training, one week sessions were selected; two-week training sessions were too long. When local training was conducted

the preference for the length of time was dependent on the qualities of speaker, whether the preference was an hour or several hours in length.

Participant 2. A minimum of one hour was needed for a training session. When attendance for training was out of state, the training was generally two to four days in length.

Participant 3. When the training was on base, the preference was to attend from a minimum of one hour up to four hours. If the training was out of state, the preference was to attend for a minimum of two days up to one week.

Participant 4. The preferred length of time to attend a conference which was from three to five days, with one-half day sessions and the other half day given for free time. Generally, any training that was provided locally for this participant was over lunch and lasted approximately one hour.

Participant 5. When traveling out of state for training, a minimum of one week was preferred. A one week training provided time to review the material before returning home. When training was within the state, generally one day minimum was needed, especially when the travel time was considered.

Participant 6. Most of the training attended was a minimum of one week because the training was in another state. Initially, in this position, a three-week training course conducted by the military was attended. Some training can be obtained through the web site or by using compact discs.

Participant 7. One day was sufficient when training was provided locally, however, a full week was needed when the training was in another state.

Participant 8. A local training, within the state, can be accomplished in a day. However, at least five days were needed if travel was involved to attend training in another state. A recent training attended was six days in length and this was too long by the time the travel time was included.

Participant 9. At least three days was needed for out of state training. When training was conducted locally, it depended on the topic and how much training was needed.

Participant 10. Quarterly training was preferred, and when the training was in another state, the preference was to attend for at least four days.

Participant 11. When traveling to another state for training, the preference for training was at least one day. When the training was conducted locally, no preference on the length of time for the training.

Summary for Preference of Length of Training. Seven participants' preference for the time preferred for local training ranged from one hour to one day. Two participants had no preference, and two participants preferred annual out-of-state training. When training was out-of-state, the responses varied from one day to one week.

Preferred Frequency of Training for the Child Day Care Health Consultant

Participant 1. In order to stay current, training was needed at least once a year.

Participant 2. Quarterly training provided for child day care health consultants was recommended.

Participant 3. Quarterly training was beneficial and permitted child day care health consultants to interact on current issues.

Participant 4. Annual training provided to child day care health consultants was preferred.

Participant 5. The frequency of training needed for a child day care health consultant depended on the "nurse's background." A nurse with a pediatric background might not need training updates as often as someone else. The initial training should be three to four times a year, with annual updates thereafter.

Participant 6. Annual training provided networking opportunities. Quarterly updates could be accomplished through email and newsletters.

Participant 7. General training was needed at least annually. More frequent training would even be better because frequent training was provided by the military.

Participant 8. Monthly updates were preferred on current issues with the general training provided annually.

Participant 9. Annual and quarterly updates including health and safety issues were provided by the military.

Participant 10. Quarterly training was needed because things changed so rapidly.

Participant 11. Annual training for a period of one week was needed.

Summary of Preferred Frequency of Training for Child Day Care Health Consultants. The physician preferred annual training for the Child Day Care Health Consultant. One nurse believed that quarterly training would be beneficial. The other nurse believed that quarterly training should be attended initially and annual training attended thereafter. Two participants from the Child Development Center preferred quarterly training and the remaining six participants preferred annual training for the Child Day Care Health Consultant.

Selection of Training Topics

Participant 1. Topics to provide training were selected from the training that had recently attended.

Participant 2. The training provided followed the guideline from the military regulations which required annual training for staff.

Participant 3. Training topics were selected from information that was provided through newsletters and emails. Occasionally the decision was made to provide a training as a part of a plan of correction after observation of the staff revealed a need.

Participant 4. No group training was provided, but selected training based on what "looked interesting."

Participant 5. Training had to be justified for the budget and was selected based on topics of interest, current trends, and areas identified that increased staff skills.

Participant 6. Annual training was required. Topics were selected that provided new information to staff as well as assisted staff who were identified as needing retraining in a certain area. Training was provided to staff, especially in such areas as immunizations where the military regulations were more strict than the state regulations.

Participant 7. Once the required training was provided, training was provided where weaknesses were observed. Each caregiver had an individual training plan that was developed with input from the directors, and the staff had the opportunity to request training in areas where they believed it was needed.

Participant 8. Mandated training was accomplished first, then specific training topics were selected from recent conferences.

Participant 9. Annual training was conducted first in order to meet the military requirements for mandated training followed by training for the child care staff based on

staff needs and the children's needs. For instance, if there was a child with special needs, a training was provided to staff which addressed a specific child and how to better care for that child.

Participant 10. Training that was selected needed to be pertinent to the job. For example, if there was a need to write a grant, a course in grant writing would be preferred.

Participant 11. Staff members participated in local planning committees, and training topics were selected during this process. Also, the military required training was conducted annually.

Summary of Selection of Training Topics. Topics for training were selected by six of the 11 participants based on the required military training. Five participants selected training to provide based on the needs of staff or themselves. Five participants also stated that training to be presented was selected from the literature and from topics that were new and looked interesting.

Discussion of Findings

In this discussion of findings, a summary is given for each of the four broad research questions by summarizing responses to specific interview questions related to that research question.

A total of 11 persons associated with Child Development Centers located on four military bases across the state of Oklahoma were interviewed.

Table I provides a reference for the titles and responsibilities of the participants associated with the Child Development Centers.

TABLE I

TITLE AND RESPONSIBILITIES OF PARTICIPANTS

Number	Position	Description
2	Registered Nurse	Provided health consultation to the Child Development Center
1	Pediatrician	Designated Medical Consultant for the Child Development Center
1	Superintendent of Youth Programs	Coordinated all programs for the Child Development Center and the school-age programs on base
1	Chief of Family Programs	Coordinated all youth programs on base, including the Child Development Center
2	Director	Director of Child Development Center
2	Assistant Director	Dual role of Assistant Director for the Child Development Center and Family Child Care Coordinator
2	Training and Curriculum Specialist	Provided and/or coordinated the training for staff at the Child Development Center and was responsible for the selection and implementation of the curriculum used by staff at the Child Development Center

By interviewing staff members in various roles associated with the Child Development Centers, a broad perspective was developed on health consultation for child

day cares. Three persons, both the Registered Nurses and the pediatrician, were directly involved in providing health consultation to the Child Development Centers on the military bases. Both the Superintendent of Youth Programs and the Chief of Family Programs were responsible for all youth programs on their respective bases and provided information about the health needs of children in general when in group care. Both Directors of the Child Development Centers who were interviewed knew first hand the daily issues which arose which required the assistance of a health consultant.

Both Assistant Directors from the Child Development Centers served in the role of providing assistance to the Director and as Family Childcare Coordinator, which meant they dealt directly with providers from family day care homes located on the base. These Family Childcare Coordinators were the first to be notified by the home providers about health and safety issues. They, in turn, were the decision makers and made recommendations regarding health and also provided training on health and safety issues to the home providers.

The interviews with the two Training and Curriculum Specialists were significant as they were the persons ultimately responsible for the coordination and implementation of training, including training on health and safety.

Research Question 1: Findings Related to Role of Child Care Health Consultant as Defined by Participants

The first research question was used to determine the participants' perceptions of the term "child day care health consultant." This term was chosen to differentiate it from

the term "child care consultant" which was used in some literature to refer to a professional consultant for children's health issues not necessarily associated with children in group care. Interview questions related to this first research question were designed to establish the general role of the child day care health consultant on military bases; the definition of the term; the qualities, background, experience, and professional strengths needed for the person in the role of the child day care health consultant; and the rapport between staff members at the Child Development Center and those who provided health consultation.

Military Public Health, Public Health, and Community Health were viewed by participants as the health resource for the Child Development Center. Participants described a child day care health consultant as a professional, with a medical background and training, and familiar with public health concepts who could provide support, training, and inspect the program. Knowledge was needed in the following areas: communicable diseases and disease transmission when children were in group care; child development; and the military requirements for Child Development Centers. Nine of the 11 participants preferred a child day care health consultant to have a medical background with additional training in communicable disease prevention and be either a physician who was a pediatrician or in family practice or a Registered Nurse.

Seven of the 11 participants interviewed had a bachelor's degree, and one had an Associate Degree in Nursing. Three of the 11 interviewed had graduate degrees. The three medical staff interviewed stated that in addition to their medical background, they considered being a parent and/or a grandparent to be a professional strength. Both

nurses stated that their background in nursing, which was varied, was also a strength as well as maintaining a good rapport with staff at the Child Development Center. The physician believed that a background in pediatrics was definitely a professional strength. Child Development Center staff persons stated that a broad knowledge base and years of experience with children were professional strengths that made them effective in their jobs. Other attributes that were acknowledged as professional strengths listed by both medical and child development staff were: education and background in early childhood; love of children; being caring and a good communicator; good organizational skills, including paying attention to the details; and experience in the military.

The qualities needed for someone in the position of a child day care health consultant were: a person who was available, flexible, personable, had common sense; someone who liked children and could demonstrate positive interactions with children; a person who had the knowledge and education to provide training; and someone who was a resource person.

The opinions varied greatly as to the specific number of years experience a nurse would need before becoming a child day care health consultant. The range of experience recommended for a Registered Nurse varied from six months to five years before becoming a health consultant for child care, depending on whether or not the nurse had a pediatric or military background or a clinical specialty.

The physician and two nurses interviewed verbalized the necessity of additional training or experience in pediatrics and in disease transmission. The two directors, two assistant directors, and two training and curriculum specialists stressed the importance of

additional education or training in child development and other areas specific to children in addition to having a medical degree or nursing license.

All of the 11 participants described the rapport between the child care staff and the child day care health consultant as good to very good. Staff members at the facilities described good and very good rapport as: the consultant who makes time available to respond to their questions, is accessible and dependable, makes visits to the facility upon request, gives accurate information, responds promptly to requests, and assists the Child Development Center staff to comply with regulatory compliance.

The child day care health consultants described good and very good rapport as: the Child Development Center staff following through with recommendations; staff members being able to recognize when something was not routine; and notifying the child day care health consultant with questions about health issues.

Research Question 2: Findings Related to the Training Provided to the Child Day Care Health Consultants

The second research question was structured to determine the type of training received by the participants and the training they were asked to provide.

The physician and both nurses interviewed stated that they had not received any specific training as child day care health consultants. In their medical and nursing training, there had not been any specific training about health and safety issues for children in group care. One of the nurses interviewed had attended a four-day training course on Child Seat Safety Training. Both the physician and nurses stated they were self

taught in the area of health and safety issues for children in group care, and relied on their medical and nursing backgrounds. They kept current through journal articles written in the literature, attending video-conferences and updates, and by selecting sessions at conferences which dealt with health and safety issues for children in group care. They also expressed a strong desire to obtain specific training that related to health and safety in group child care settings. General conferences and training attended included Association for Women's Health Obstetric and Neonatal Nurses, family advocacy training attended through headquarters, and training offered through the base Occupational or Military Public Health areas.

Training was available for child development staff at the local level through the Base from the Training and Curriculum Specialists, Military Public Health, Occupational Health, Community Health, Safety Office, Wing Safety, Family Childcare conferences, and Oklahoma Association of Early Childhood conference. Annual training courses provided to the child development staff included: first aid, CPR, bloodborne pathogens, and child abuse. Directors, Assistant Directors, and Training and Curriculum Specialists had the option to attend health and safety-related topics when they attend annual conferences at the national level. These included National Association and Education of Young Children (NAEYC), the National Family Childcare Conference, USDA Food Training Course, and the military training that is held in conjunction with the NAEYC conference, such as the Flight Chief Conference.

The military web site and the Internet were accessed to obtain the most current health and safety information. Professional journals, bulletins disseminated from the

military, and newsletters from NAEYC, and publications from the field of childcare and the Oklahoma State Department of Health were other resources utilized regularly.

The length of training preferred according to those interviewed was dependent on several variables: the speaker, the topic, and the location, as listed in Tables II and III.

TABLE II

LOCAL TRAINING PREFERENCES OF PARTICIPANTS

Length of training preferred	Number of participants
One hour	3
One day	3
One to four hours	1
No preference	2
Preferred annual out-of-state	2

Nine of the 11 interviewed had a preference for a length of time for local training. Those preferences were: one hour, one to four hours, and one day. Two participants had no preference, and two others preferred annual out-of-state training. Table III provides a breakout of the length of training preferred by participants when they attended training out of state.

TABLE III

OUT-OF-STATE TRAINING PREFERENCES
OF PARTICIPANTS

Length of training preferred	Number of participants
One day	1
Three days	1
Three to four days	1
Four days	1
Three to five days	3
One week	3
Not answered	1

When asked the preferred length of time for out-of-state training, the responses ranged from a minimum of one day to one week.

Both nurses conducted training that was available to the community and the base population and the classes were: smoking cessation, nutrition, breast feeding, and education regarding HIV-AIDS. These nurses also provided classes for the Child Development Center staff on CPR, first aid, bloodborne pathogens, medication administration, appropriate guidance, nutrition, infant massage education, parenting groups, and child abuse training. The nurses also stated that they were be available to provide training that was requested.

The non-medical participants provided or coordinated a variety of training for the staff at the Child Development Center. Staff members were required to have annual training and this included CPR, first aid, food safety, child abuse prevention, and bloodborne Pathogens. Other ongoing training topics provided by the non-medical participants to staff were: management-related issues, policies and regulations, child development, food safety, and orientation for new providers.

The training that was selected to be presented to staff was based on: mandated training that the military required, staff requests, personal interests of the trainer, current trends and issues identified from the literature, observed needs of the child development staff, recent training attended, and topics pertinent to the individual staff and children, which included a training which was provided for staff regarding caring for a child in a wheelchair.

Research Question 3: Findings Related to the Issues and Concerns Identified by Child Day Care Health Consultants

The third research question was designed to establish some broad categories of priorities and recurring issues that the child day care health consultant addressed and areas in which training needed to be provided.

The interactions between staff at the Child Development Center and the health consultant varied and seemed to naturally fall into four main headings: requests for training, providing recommendations and guidelines for health and safety issues,

assistance in dealing with parental and staff concerns, and reporting of behavioral problems and child abuse.

Requests for training were due to the mandated annual training which was required for CPR, first aid, bloodborne pathogens, food safety, child abuse training, and orientation for new staff. Additional requests for training were related to disease prevention, dealing with appropriate child/staff interactions, child development, curriculum, and budget issues.

Exclusion of ill children was one of the main issues addressed on a regular basis by staff members at the Child Development Center and the health consultants. Children were brought to the Child Development Center and would not feel well enough to participate in the day's scheduled activities. A variety of health-related questions were directed to child day care health consultants on the following topics: medication administration, diseases, rashes, head lice, choking, sanitary storage of items, and proper cleaning and storage of toothbrushes. Assistance was requested by the child development staff about health and safety issues, immunizations, symptoms of illness such as fever, vomiting and diarrhea, and diseases. Safety issues addressed were in the areas of environmental and toy safety.

A significant finding in the data analysis showed that the words "parent or parents" were mentioned 21 times in response to this question. Parents of children at the Child Development Center played a significant part when planning care for the children and establishing policies and training. One of the key issues mentioned by eight of the 11 interviewed was the issue of dealing with parents of children in care. Participants

discussed at length a variety of issues including: parents bringing the child to the center when the child was ill; parents not responding promptly to requests made by staff to pick up ill children; parents not understanding that when their child first attends group care, the child will more than likely be sick more frequently; and parents needing to understand the Center policy on exclusion of ill children.

Four of the 11 interviewed stated that another significant area identified as a key problem was keeping staff current on policies pertaining to immunizations, medications, screening children for illness, and ensuring adequate sanitation measures were in place. Regular monthly inspections, follow-up inspections, and staff observations were the three main methods for determining compliance with the regulations. Visits were also made to the Child Development Center to provide training to staff, especially in areas where deficiencies existed that were noted on the inspections. Frequency of visits made is summarized in Table IV.

TABLE IV

FREQUENCY OF VISITS TO CHILD DEVELOPMENT CENTERS OR FAMILY HOME PROVIDERS BY PARTICIPANTS

Frequency	Number of Participants
Daily	5
Monthly	3
Upon request	2
None	1*

Note: *=Participant new in position

The five participants who stated they had daily interaction with the child development staff had an office at the Child Development Center. These participants were going in and out of the rooms where child care was provided. They also developed and provided training and curriculum for Child Development Center staff. The three participants interviewed who functioned in the role of the health consultant to either the Child Development Center or family home providers stated they made a minimum of one visit per month for the purpose of conducting unannounced inspections and to provide training to staff. Additional visits were made to these facilities when there were areas that were noncompliant with the military regulations. Two participants made visits to the Child Development Center upon request. One of the 11 interviewed was new in the position and had not yet made a visit to the Child Development Center.

These findings appear to be significant due to the fact that the military was highly regulated and recognized the importance of training staff. Staff were trained on the regulations, encouraged to utilize daily checklists for procedures, and encouraged to continually follow up with meetings and observations to determine if further training was needed. When recommendations are made for the Child Development Center, it is important to develop a plan for implementation to ensure compliance.

Behavioral issues addressed to the health consultants included assistance dealing with children who demonstrated behavior problems, such as aggression and the concern of suspected child abuse.

Research Question 4: Findings Related to Additional Training Requested by Child Day Care Health Consultants

The fourth research question was designed to complement and expand on the second research question by inquiring about the additional training that the child day care health professional desired. Information could be gathered to establish the type and frequency of training that was also preferred by the child day care health consultant and recommended by staff from the Child Development Centers. This question also explored the participants' professional networks they accessed and explored preferred ways of communicating with other professionals in the field of child care. It was beneficial to determine the ways professionals in the field of childcare accessed assistance from one another, especially when the consultant had not received training in a specific area. This information could be utilized to develop systems for communication.

The fourth question was broad and designed to include the participants in the study who requested the services of the child day care health consultant. When the requests for the child day care health consultant were compared to the training that the child day care health consultant received, gaps were identified. The child day care health consultant relied on their medical background and experience which provided an excellent base of knowledge. Additional training was needed for the child day care health consultant to be effective as a trainer.

Early Childhood Development was mentioned five times by participants as an area in which additional training for the child day care health consultant was needed. Health and safety issues were referenced 11 times by participants as areas in which they

believed that additional training would be beneficial. Health and safety areas referenced were car seat safety, child abuse training, immunizations, medication administration, and general training on disease prevention. Additional training on legal issues was mentioned once, and training on rules and regulations, which included state requirements, was referenced four times by participants as areas in which additional training would be helpful. Requests for other training for child day care health consultants were defined as soft skills and mentioned six times. These soft skills included the areas of communication and people skills, presentation skills/train the trainer, and stress management and accessing resources (Table V).

TABLE V

CATEGORIES OF TRAINING PREFERRED
BY PARTICIPANTS

Categories of recommended additional training	Number of times referenced
Early Childhood and Child Development	5
Health and Safety issues: Car Seat Safety Child Abuse Immunizations Medication training	11
Public Health/disease prevention and control Legal issues	1
Rules and Regulations, including state requirements	4
Soft Skills: Communication skills People skills Presentation skills/Train the Trainer Stress Management Accessing resources	6

Participants also recommended that a person in the role of a child day care health consultant have background training in one of these areas: Public or Community Health, medical background, pediatric background, health profession, or Child Development.

The physician's preferred for a child day care health consultant was annual; one nurse stated that quarterly training was preferred; the other nurse preferred quarterly training initially, and annually thereafter. Two participants from the field of child development also recommended quarterly training for the health consultant, and the remaining six of the 11 interviewed stated that annual training for the child day care health consultant was preferred. Two of these six preferred quarterly updates, and one of the six preferred monthly updates.

The military had established a network of professionals who are accessible through national conferences; web sites; and locally on each base through the base hospital, Safety Office, Family Advocacy, Behavioral Health, Community Health, and designated Medical Consultants for the Child Development Centers as well as consultants from Washington who were assigned to the programs.

Email was the preferred way of communicating with other professionals by seven of the 11 participants. One participant who preferred email communication stated that when the person was on the same base and communication was needed, that a face-to-face meeting was preferred. Two participants preferred communication directly in person. One participant preferred written communication, unless the matter was urgent, in which a phone call was preferred. One of the benefits of communicating in writing, according to this participant was that written information could be referenced. When

training was being requested or an urgent matter needed attention, one participant preferred to make a phone call (Table VI).

TABLE VI

PREFERRED COMMUNICATION WITH PROFESSIONALS

Type of communication preferred	Number of participants
Email	7*
Person to Person	2
Written	1**
Phone	1

Note: * = If person was on base, a face to face meeting was preferred;
** = Phone communication was preferred for urgent matter.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

During the spring of 1998, when this study first began, the problem statement around which this study centered was that no formalized training existed in Oklahoma for persons who provided health consultation to public child day care facilities in the state of Oklahoma including those on military bases and other aviation-related industries.

Purpose of the Study

The major purpose of this study was to explore the education and training provided to child day care health consultants on four Oklahoma military bases by interviewing staff who were associated with the Child Development Centers located on the four military bases in Oklahoma.

The study was based on the assumption that findings in the personal interviews of staff associated with Child Development Centers on military bases, could provide insights regarding training provided and needed for health care consultants in the state of Oklahoma including those who provided health consultation to aviation-related child care programs. Those findings could be compared to the information obtained through the

personal interviews regarding the type of training that was requested to be provided by health consultants and the health and safety issues that were addressed by staff at the Child Development Center. The findings could be helpful to the public community when training programs are developed for those who provided health consultation to child care centers. The military bases provided an excellent foundation for the study and would serve as a starting point for the review of the educational needs of health consultants who were associated with child care facilities including those in the aviation industry.

Research Questions

The four research questions which guided this study were:

1. How is the role of the child day care health consultant defined?
2. What training is provided to child day care health consultants?
3. What issues and concerns are identified by child day care health consultants?
4. What additional training is needed for child day care health consultants?

Summary of the Findings

The role of the child day care health consultant as described by the health consultants themselves is as varied as the environments in which they operate. Some common threads among all participants were the following terms and phrases used to describe their roles: professional, available, medical background, resource, inspector, Public Health, Military Public Health, Community Health, knowledgeable about disease

concepts, provides guidance, familiar with normal growth and development, and provides training.

Qualities that were considered beneficial for an effective child day care health consultant were as follows: knowledge of the requirements, a person who was flexible and personable, good communicator, and someone who liked children. Both education, including a medical background, and experience with children were strongly recommended.

Training provided to child development staff was as follows: CPR, first aid, child abuse, food safety, playground safety. The training provided specifically for child day care health consultants was limited. Opportunities existed for participants to attend national conferences in which the participants were given the freedom to select topics of interest, which included health and safety topics. Current health and safety information was obtained through reading current professional journals, including regular bulletins produced by the military, accessing the military web sites, and networking with other professionals in the field of child care.

Staff who provided health consultation to child day care facilities were asked to provide regular training on health and safety issues. Training topics included, CPR, first aid, bloodborne pathogens, child abuse, medication administration, disease control, and dealing with children with special needs.

Issues and concerns most frequently addressed by participants were those issues dealing with general health and safety. Dealing with ill children was a frequent area of concern including the exclusion of ill children and parental and staff concerns related to

ill children. Other common issues addressed were behavioral problems, environmental safety, and special needs children. Specific health-related concerns that were addressed were as follows: head lice, rash illnesses, diarrhea, fever, vomiting, runny noses, and pink eye.

Examples of situations for which the child day care health consultant was contacted varied from requests for training to requests for consultation regarding health and safety issues. Child day care health consultants conducted routine inspections of the Child Development Centers in addition to providing consultation and training. Additional training was requested in the areas of health and safety, including disease prevention, Child Development, and interpersonal skills, including train the trainer according to participants.

Networking with other professionals both locally and nationally expanded the resources of the child day care health consultant.

Conclusions

The findings in this qualitative study of training received by child day care health consultants on Oklahoma military bases resulted in the following conclusions as related to the four broad research questions outlined in the first chapter. This study supports the literature review regarding the significant health and safety issues identified when children are in group care and the need for intervention by a health professional.

Research Question 1: Conclusions Regarding the Perception of a Child Day Care Health Consultant

By interviewing staff in various roles associated with the Child Development Centers, a profile emerged regarding the role of a child day care health consultant and the qualities, experiences, and skills needed. Experience requirements includes a medical background, such as a nurse, a pediatrician, or physician in family practice, familiarity with the public health concepts of disease transmission and prevention, and capable of providing consultation and training to staff and parents on health and safety issues. A military background and knowledge of the military requirements for the Child Development Centers were also beneficial for those child day care health consultants who provide consultation to the Child Development Centers on military bases as it provided an opportunity to experience military culture.

Some key personal qualities helpful in this role included interpersonal skills, flexibility, common sense, positive and caring attitude, positive interactions with children, love of children, approachable, and organizational skills. The child day care health consultant was looked to as a professional and a resource person for the staff at the Child Development Centers.

Helpful background for the role of the child day care health consultant included parenting experience as well as strong interpersonal skills to successfully perform in the role of the child day care health consultant.

The number of years prior experience needed varied according to participants and no recommendation could be made as the data varied. Additional training or experience

in pediatrics, disease transmission, child development and interpersonal skills is highly recommended.

Good rapport between staff at the Child Development Center and the child day care health consultant appears to be a key ingredient in establishing an effective working relationship. When child day care health consultants were available and provided information to the Child Development Center staff to improve the overall health of the facility, a healthy and safe environment for children and staff was created.

Research Question 2: Conclusions Regarding Training Provided to Child Day Care Health Consultants

The researcher believed it was not only important to determine what training was provided to the child day care health consultants but what training was requested and provided for others. By determining the training and classes that were conducted by the child day care health consultants as compared to the training they were asked to provide, gaps could be identified

Opportunities for training existed for staff at the Child Development Centers, but child day care health consultants' knowledge about specific training that existed for child day care health consultants was limited. The Internet was accessed regularly by participants, either through the military web sites or other resources to obtain current information on health and safety. Conferences, both local and national, were resources utilized to select current information and to meet training requirements.

Medical professionals need additional training in the area of child development. Child care professionals need ongoing training on health and safety issues. The directors, assistant directors, and training and curriculum specialists interviewed stressed the importance of education or training in child development in addition to having a medical degree of nursing license. This conclusion was significant as it demonstrated that medical persons who served in the role of child day care health consultant recognized the importance of additional training in pediatrics and disease transmission. It was also significant that the staff who worked with children noted the importance of the medical staff having knowledge in child development areas.

The recommended duration of training sessions varied with the location of the training. Three days to five days was generally preferred for out-of-state training. Annual training was recommended for staff in the Child Development Center. The training which was selected to be presented to staff was based on recent training received by the trainer, current issues, and trainer preferences.

The findings pertaining to this research question were significant due to the fact that the military is highly regulated. They also realize the importance of training staff members on the regulations, developing checklists to make it easier to remember procedures, and continually following up with staff meetings and observations to determine if further training is needed to ensure compliance with the regulations.

Research Question 3: Conclusions Regarding Issues and Concerns Identified by Child Day Care Health Consultants

It was important to compare these real-world experiences of the participants' issues and concerns that were addressed to the training that was received and to the related literature. The gaps existed between the training received and the training requested. The child day care health consultants relied on their medical background and experience, but did not have an opportunity for specialized training in the area of a child day care health consultant.

Common issues and concerns included dealing with children who were ill at the center, the exclusion of ill children, informing parents about ill children, and requests for training on health and safety topics for staff and parents. It is crucial that those serving in the capacity of a child day care health consultant realize the significance of the parental role when children are in group care.

Effective mechanisms to ensure compliance are through staff training and monitoring of the Centers with follow-up inspections of military regulations and procedures. The military has an extensive orientation that must be completed in an 18-month period of time and appears to be very thorough and effective for training new staff. The modules include: Child Development Center policies, assessing children's health status upon entry to the facility and how to identify ill children, and communication strategies to assist staff in becoming confident to deal with difficult issues.

Research Question 4: Conclusions Regarding Requests for Additional Training

Participants were aware of the needs for additional training specific for child day care health consultants. Additional training is needed in public health, pediatrics, child development, health and safety issues for children in group care, rules and regulations, soft skills.

Frequently, the child day care health consultants were asked to provide training, but had not received any training in courses such as train the trainer. Additional training in child development is needed for those who provide child day care health consultant services, as their background is primarily in the medical field.

One of the benefits of attending regular training is the opportunity to establish a strong professional network. Contacts can be maintained through email, telephone, and teleconferences. Professionals associated with Child Development Centers are resourceful and access information through a variety of sources: the military web sites; contacts on the base including staff at the base hospital, Safety Office, Family Advocacy Center, Behavioral Health; Medical Consultant; consultants from Washington who were assigned to the programs; and by participating on committees off base with other child care staff. Continued participation in national conferences focusing on child care needs to be maintained. Child day care health consultants have the opportunity to interface with those persons who are actually providing the care for children on a daily basis.

Recommendations

The following recommendations are based on the research study from the 11 interviews conducted from selected participants on four Oklahoma military bases, the review of the literature, and the perceptions of the researcher.

1. The military bases may want to consider designating a specific person or team of persons as the child day care health consultant/consultants and designate specific resource persons or staff who are available to the child day care health consultant, such as Military Public Health, the Safety Office and the Medical Advisor.
2. Health professionals who provide consultation to child day care facilities could benefit from attending the national training course for child care consultants.
3. Additional training could be considered for the child day care health consultant in the areas of communication, interpersonal skills, stress management, and presentation skills/train the trainer.

Implications

These implications might be considered for other agencies who utilized child day care health consultants, such as public health organizations and aviation-related organizations.

1. Annual training should include disease prevention, child development, pediatrics, and health and safety issues with children in group care.

2. Training is important and travel time must be considered for training purposes. The duration of training should vary with the location of the training. For out-of-state training, a minimum of three days should be spent in training. For local training in which no travel was necessary, a minimum of one to four hours is recommended.
3. The frequency of training recommended varies with tenure. Quarterly training may be considered for initial training for a health consultant for child day care with annual training thereafter. Training should be supplemented with monthly or quarterly updates through email, newsletters, on the Internet.
4. Annual assessments could be conducted for those who are providing health consultation to child care programs to determine what additional training they need in order to identify gaps which may exist to ensure that the training the health care consultant receives is adequate.

Recommendations for Additional Research

The following recommendations are based on the 11 interviews conducted with the participants who were staff associated with the Child Development Centers on four military bases in Oklahoma. These recommendations for additional research are offered based on the results of the interviews and the perceptions of the interviewer.

1. This study could be expanded on a national level to include other types of aviation-related organizations who provide child care services.

2. A follow-up study is recommended with Public Health Nurses in the state of Oklahoma to determine their experiences and needs related to providing health consultation to child care centers in their respective counties. The follow-up study could be done using interviews or focus groups.
3. A survey of Department of Human Services licensing workers is recommended to determine frequent health issues about which providers of child care request information. This information could be included in the training that is provided annually to child day care health consultants.
4. It is recommended that a list be compiled of available local and national training which addressees health and safety issues with children in group care.
5. Available training courses and health and safety updates for child day care health consultants could provided through the Internet.

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APPENDIXES

APPENDIX A

INTERVIEW GUIDE RESEARCH QUESTIONS

ROLE OF CHILD DAY CARE HEALTH CONSULTANT

1. When you think about a health consultant for childcare, what do you think about? (Rubin & Rubin, 1995)
2. What occasions do you have to interact with directors and or staff from child day care facilities at the military base and how often do these interactions occur?
3. What types of issues/concerns are addressed by you?
4. When do you make a visit to the child care facility?
5. What qualities and background would make an effective child day care health consultant?
6. How long would a nurse/staff need to be employed before he/she served in the role of a child day care health consultant?
7. What type of rapport do you experience with child care staff/child day care health consultant?

HEALTH AND SAFETY ISSUES/CONCERNS IDENTIFIED AT FACILITIES

1. What are some key problems, including health and safety issues, that you address? (Rubin & Rubin, 1995)
2. How do you obtain consensus with the child care staff regarding the issues addressed and needed corrections?
3. How do you determine compliance with the health and safety recommendations made by you?

AREAS OF TRAINING PROVIDED TO CHILD DAY CARE HEALTH CONSULTANTS

1. What is your role/responsibility at the military institution?
2. Have you ever received any type of training regarding safety and health issues for children in child care and if so, what and how often?

3. What do you consider your professional strengths as a child day care health consultant/director/staff?
4. What types of training do you provide in the community and how often?
5. What type of professional network is helpful to you?
6. What are some effective ways you prefer to communicate with other professionals?

ADDITIONAL AREAS OF TRAINING NEEDED

1. What additional training would be needed for a child day care health consultant?
2. Where do you obtain additional training?
3. How do you keep current on issues regarding health and safety?
4. When you attend a training, what length of time do you prefer to attend?
5. If you were designated as the child day care health consultant for your local county child day care facilities, how often would you like training and inservices to be provided for you?
6. How do you decide to select information for training? (Rubin & Rubin, 1995).

APPENDIX B

INSTITUTIONAL REVIEW BOARD

APPROVAL FORM

Oklahoma State University
Institutional Review Board

Protocol Expires: 8/30/01

Date Thursday, August 31, 2000 IRB Application No ED0118

Proposal Title THE EDUCATION AND TRAINING PROVIDED TO CHILD DAY CARE CONSULTANTS ON MILITARY BASES IN OKLAHOMA

Principal Investigator(s)

Charlene Diane Rudebock
1909 Bella Vista Dr.
Edmond, OK 73013

Steven Marks
308 Cordell North
Stillwater, OK 74078

Reviewed and Processed as Exempt

Approval Status Recommended by Reviewer(s) Approved

Signature Carol Olson

Carol Olson, Director of University Research Compliance

Thursday, August 31, 2000
Date

Approvals are valid for one calendar year, after which time a request for continuation must be submitted. Any modifications to the research project approved by the IRB must be submitted for approval with the advisor's signature. The IRB office MUST be notified in writing when a project is complete. Approved projects are subject to monitoring by the IRB. Expedited and exempt projects may be reviewed by the full Institutional Review Board.

APPENDIX C

PERMISSION REQUEST TO PUBLIC

INFORMATION OFFICER

OKLAHOMA STATE UNIVERSITY

OSU

School of Educational Studies

College of Education
204 Willard
Stillwater, Oklahoma 74078-4045
405-744-6275; Fax 405-744-7758

Date

Public Information Officer
Military Base
Address

Dear Sir:

I am currently working on my doctoral dissertation in the College of Education, Applied Education Studies, at Oklahoma State University, where I am conducting research on the Education and Training provided to child day care health consultants in the state of Oklahoma. I would like to request a meeting with you to describe the research.

I would like to request your permission to interview staff who coordinate the health consultation for the child day care facilities located at the various military sites in the state of Oklahoma. With your permission, I would like to set up a time to interview them as well as interview staff from designated child day care facilities on the base. The participants would be asked to participate in a one-time session where information could be gathered regarding the types of issues they believe are needed to better prepare them to serve as child day care health consultants and the type of issues that the child day care facilities request consultation.

The goal of this process is to establish the type of education and training that is provided to child day care health consultants as they work with the child day care facilities. The benefit to the staff will be that they will have an opportunity to identify the training they receive and identify the areas of requests made by the child care providers. The benefit to the community would be that the model used by the military in this area could be adapted to the public sector.

Attached are samples of questions to which they will be asked to respond. Each interview will last approximately one to one and one-half hours. With your permission, an audio tape will be used to aid in the analysis of the data collected, then it will be destroyed to protect the confidentiality of the participants. Transcriptions on the tape will be identified by number only.

I will contact you by phone to discuss arranging a meeting with you to discuss any questions you might have concerning the project. Thank you in advance for taking the time to review my request, and I look forward to meeting with you. I may be contacted at 405-419-4026.

Sincerely,

Diane Rudebock, R.N., M.S.
Doctoral Student
Oklahoma State University,
College of Education
Stillwater, Oklahoma

APPENDIX D

PARTICIPATION LETTER

OKLAHOMA STATE UNIVERSITY

OSU

School of Educational Studies

College of Education
204 Willard
Stillwater, Oklahoma 74078-4045
405-744-6275; Fax 405-744-7758

Date

Name
Child Day Care Health Consultant
Address

Dear Mr/Ms._____,

I am currently working on my doctoral dissertation in the College of Education, Applied Education Studies, at Oklahoma State University, where I am conducting research on the education and training provided to child day care health consultants in the state of Oklahoma. Since you are the health consultant for the child care facility, I would like to interview you to determine how you select the training you provide to staff and what training you receive as the health care consultant.

Attached are samples of questions to which you will be asked to respond. The interview will last approximately one to one and one-half hours. With your permission, an audio tape will be used to record the data, then it will destroyed once the data has been transcribed. Transcriptions on the tape will be identified by number only.

I will contact you by phone to discuss any questions you might have concerning the project. Thank you in advance for taking the time to review my request, and I look forward to talking with you. I may be contacted at 405-419-4026 (daytime) if you need additional information.

Sincerely,

Diane Rudebock, R.N., M.S.
Doctoral Student
Oklahoma State University
College of Education
Stillwater, Oklahoma

Adult Education
Aviation and Space Education
Higher Education
Human Resource Development
Organization and Leadership
Research and Evaluation
Social Foundations
Student Personnel
Technology

APPENDIX E

MILITARY CHILD DAY CARE DIRECTOR/STAFF

PARTICIPATION LETTER

OKLAHOMA STATE UNIVERSITY

OSU

School of Educational Studies

College of Education
204 Willard
Stillwater, Oklahoma 74078-4045
405-744-6275; Fax 405-744-7758

Date

Name
Military Base
Child Day Care Director/Staff
Address

To Whom It May Concern:

I am currently working on my doctoral dissertation in the College of Education, Applied Educational Studies, at Oklahoma State University, where I am conducting research on the Education and Training provided to child day care health consultants on military bases in the state of Oklahoma. Since you are in charge of the child care facility on the military base, I have been given permission to interview you to determine how you request information and/or training for the staff at your child care facility.

Attached are samples of questions to which you will be asked to respond. The interview will take approximately one to one and one-half hours. With your permission, an audio tape will be used to record the data. Once the data is recorded and transcribed, the audio tape will be destroyed. Transcriptions will be identified by number only.

I will contact you by phone to discuss any questions you might have concerning the project and request a time for an interview. Thank you in advance for taking the time to review my request, and I look forward to talking with you. I may be contacted at 405-419-4026 (daytime).

Sincerely,

Diane Rudebock, R.N., M.S.
Graduate Student
Oklahoma State University
College of Education
Oklahoma State University

APPENDIX F

CONSENT FORM

CONSENT FORM

A. AUTHORIZATION

I, _____ (respondent), hereby authorize or direct Charlene Diane Rudebock (researcher), or associates or assistants of her choosing, to perform the following treatment or procedure.

B. DESCRIPTION

1. The name of the study is "Education and Training Provided to Child Day Care Health Consultants on Military Bases in the State of Oklahoma."

2. The study of the training provided to Child Day Care Health Consultants involves research and is being conducted through Oklahoma State University.

3. The purpose of this study is to explore the types and topics of education and training provided to Child Day Care Health Consultants on Military bases in Oklahoma during the past five years. It was based on the assumption that findings in the personal interviews with personnel on military bases and directors associated with child day care facilities on military bases, when compared to the review of literature regarding health and safety issues in child day care facilities, would identify training topics to be provided for Child Day Care Health Consultants. Interviews will be conducted in one session, approximately one to one and one-half hours duration. The duration of the interview could vary depending upon the length of the response to the 25 open-ended questions.

4. The researcher will conduct oral interviews using the open-ended questions in Appendix A. Audio tapes of the interviews will be made to aid in the analysis of the data. Extensive notes will be taken by the researcher during the interview which will include observations and personal reactions of the person interviewed. The notes and transcriptions will be identified by number and not the name of the subject to ensure the confidentiality of the subject. The tapes will be destroyed once the data is analyzed.

5. There are no experimental procedures associated with the study.

6. A possible risk to those interviewed will be that their identity will be known to the researcher. Efforts will be made to minimize any discomfort to those interviewed by conducting the interview in a place in which they can freely express their ideas and opinions. The audio tape will be located in an area as not to distract either the researcher of those interviewed. These audio tapes will be destroyed once the data is analyzed. Those interviewed will be identified on the audio tape by number only.

7. Information gained from this research will be used as a resource for basic training which will be provided to Child Care Health Consultants throughout the state of Oklahoma.

8. There are no alternative procedures or courses of treatment that might be advantageous to the subject.

9. The interview notes and audio tapes will be destroyed once the data analysis is complete. Those interviewed will be assigned a number and this number will be used as the reference with obtaining information. The researcher will have the control of the audio tapes and interview notes.

10. The study involves no more than minimal risk to the subjects.

11. Subjects may contact Diane Rudebock, R.N., M.S. (researcher) about issues related to the study, research subject's rights, or research-related injury to the subject. Phone: 405-348-9977. An additional contact is Sharon Bacher, IRB Executive Secretary, Oklahoma State University, 203 Whitehurst, Stillwater, OK 74078. Phone: 405-744-5700.

C. VOLUNTARY PARTICIPATION

I understand that participation is voluntary and that I will not be penalized if I choose not to participate. I also understand that I am free to withdraw my consent and end my participation in this project at any time without penalty after I notify the project director.

D. CONSENT

I have read and fully understand the consent form. I sign it freely and voluntarily. A copy has been given to me.

Date: _____ Time: _____ (a.m./p.m.)

Signed: _____

Signature of person authorized to sign for subject, if required

Witness(es) if required: _____

_____

I certify that I have personally explained all elements of this form to the subject or his/her representative before requesting the subject or his/her representative to sign it.

Signed: _____

Project director or authorized representative

APPENDIX G

THANK YOU LETTER

OKLAHOMA STATE UNIVERSITY

OSU

School of Educational Studies

College of Education
204 Willard
Stillwater, Oklahoma 74078-4045
405-744-6275; Fax 405-744-7758

Date

Name
Address

Adult Education
Aviation and Space Education
Higher Education
Human Resource Development
Organization and Leadership
Research and Evaluation
Social Foundations
Student Personnel
Technology

Dear Mr./Mrs._____

Thank you for taking the time out of your day to be interviewed for the research project regarding Child Day Care Health Consultants. It was a pleasure to meet you and hear you share your ideas and experiences.

The information you provided was very valuable to the project. If you have questions, I may be reached at 405-419-4026 (daytime). Again, it was a pleasure to work with you and thank you for your time that you spent with this project.

Sincerely,

Diane Rudebock, R.N., M.S.
Graduate Student
Oklahoma State University
College of Education
Stillwater, Oklahoma

VITA

Charlene Diane Rudebock

Candidate for the Degree of

Doctor of Education

Thesis: THE EDUCATION AND TRAINING PROVIDED TO CHILD DAY CARE HEALTH CONSULTANTS ON MILITARY BASES IN OKLAHOMA

Major Field: Applied Educational Studies

Biographical:

Personal Data: Born in Coffeyville, Kansas, July 11, 1948, the daughter of Lawrence and Ruth Deuson

Education: Graduated from Elgin High School, Elgin, Oklahoma in May 1966; received Bachelor of Science in Nursing degree from the University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma in May, 1971; received Master of Science degree in Natural and Applied Sciences from Oklahoma State University, Stillwater, Oklahoma in December 1997. Completed the requirements for the Doctor of Education degree with a major in Applied Educational Studies at Oklahoma State University in May 2001.

Professional Experience: Program Administrator, Oklahoma City County Health Department, 1986 to present; Adjunct Faculty, Oklahoma State University, School of Educational Studies, 1999-2000; Tuberculosis Program Administrator, Oklahoma City County Health Department, 2000 to present; Interim Guidance Program Administrator, Oklahoma City County Health Department, 1999; Community Health Program Administrator, Oklahoma City County Health Department, 1997-2000; Institutional Health Program Administrator, Oklahoma City County Health Department, 1991-1996; Institutional Health Nurse III, Oklahoma City County Health Department, 1988-1990; Public Health Nurse II,

Oklahoma City County Health Department, 1987; Public Health Nurse I, Oklahoma City County Health Department, 1986; Office Nurse, John M.Brown, M.D., 1978-1984; Registered Nurse, Commanche County Memorial Hospital, Lawton, Oklahoma, 1971.

Professional Memberships: Kappa Delta Pi and Phi Kappa Phi, Oklahoma State University Chapter; Oklahoma Public Health Association, Epidemiology Practitioners of Infection Control; National Association of Tuberculosis Nurses; Nursing Service and Education Administrators.