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Child Caregiver Interaction Scale

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CHILD CAREGIVER INTERACTION SCALE

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ABSTRACT

Research on early brain development and early childhood demonstrates that the experiences children have and the attachments they form early in life have a long-lasting impact on their later development and learning. The link between high quality early childhood experiences and positive child outcomes is well documented. Quality child care is comprised of the combination of classroom environment and caregiver interaction. While there are measurement tools that adequately assess the environment of child care classrooms, the measures to assess caregiver interaction are lacking. Based in developmentally appropriate practice and current research, the Child Caregiver Interaction Scale(CCIS) has a real potential to dramatically understand and improve quality child and caregiver interactions.

The Child Caregiver Interaction Scale was created to assess the quality of child caregiver interaction. This scale was largely based upon the National Association for the Education of Young Children's (NAEYC) Developmentally Appropriate Practice (DAP) position statements (Bredekamp and Copple,, 1997). These statements represent the current best understanding of theory and research about what practices are most supportive and respectful of children's healthy development (p. vi).

The Child Caregiver Interaction Scale is a valid and reliable measure to assess the interactions of child care providers and the children they care for. The CCIS measure demonstrates high internal consistency and strong utility across all age groups, including infant/toddler, preschool and school aged caregiving. The CCIS measure demonstrates strong criterion validity between the Environmental Rating Scale overall and associated "Interaction" and "Space and Furnishings" subscales.

The CCIS is a valuable and much needed measurement tool to assess child caregiver interaction across age groupings and settings. This measure not only provides a scale that can be used for research purposes to compare child care quality, but also serves as a noteworthy tool for training and technical assistance. By helping child caregivers understand their strengths and areas most in need for improvement, the CCIS is a tool that can be used to improve quality child care.

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Chapter One

INTRODUCTION AND BACKGROUND ISSUES

In America, a large number of children spend a good deal of their time in out of home care. The National Association for the Education of Young Children (NAEYC), the nation's largest professional organization of early childhood educators, indicates the following:

- In the United States the majority of mothers with children under age 18 work, including 59% of those with infants and 74% of those with school-aged children.
- Approximately 13 million infants, toddlers, and preschool children are regularly in non-parental care in the United States, including 45% of children younger than one year.
- The Census Bureau reports that approximately 50% of working families rely on child care providers to help them care for their children while they work; 25% rely on relatives for child care; and nearly 25% arrange work schedules so that no child care is needed (e.g. parents work different hours or days; one parent works during school hours and is home after school) (NAEYC, 2005).

Research on early brain development and early childhood demonstrates that the experiences children have and the attachments children form early in life have a decisive, long-lasting impact on their later development and learning (Carnegie Corporation of New York, 1994, p.4). High-quality care beginning in early childhood improves children's school success (Karoly, et al, 1998). Additionally, research indicates that the quality of child care has a lasting impact on children's well-being and ability to learn. Children in poor quality child care have been found to be delayed in language and

reading skills, and display more aggression toward other children and adults. A study released in 1999 found that children in high quality child care demonstrated greater mathematical ability, greater thinking and attention skills, and fewer behavioral problems than children in lower quality care. These differences held true for children from a range of family backgrounds, with particularly significant effects for children at risk (Peisner-Feinberg, et al, 2001).

The increasing demand for childcare, as well as the January, 2001, passage of President George W. Bush's *No Child Left Behind Act*, which places high demands on schools for accountability of results, has caught the attention of politicians in recent years. A review of the 2005 Governor's State of the State addresses reveals that 41 mentioned early care and education and the early grades. Additionally, as of July 2005, 31 states have child care quality improvement initiatives underway (NAEYC, 2005).

In Pennsylvania, for example, the Keystone STARS Child Care Quality Initiative operates to improve the quality of early learning. Started in 2002, this voluntary program became available to all providers regulated by the Pennsylvania Department of Public Welfare. This initiative encourages child care programs to improve quality of care by offering technical assistance, educational scholarships, and retention and merit awards for programs that demonstrate progress in meeting research based quality standards.

The term "high quality" indicates something that meets more than the minimal standards. The first concern in child care is the child's physical health and safety and a child's bodily well being is highly dependent on the adults in their environment (Doherty-Derkowski, 1995). However, programs that only address physical health and

safety are considered custodial, not designed or encouraged to promote the development of a child's skills.

While there are various definitions of quality child care, in general, all renditions share the same major tenets. Quality early childhood programs look at the program in terms of its effect on both the child's physical well being and the child's development. A high quality early childhood program is one that:

- Safely supports and assists the child's physical, emotional, interpersonal, language, and intellectual development; and
- Supports and complements the family in its child-rearing role (Doherty-Derkowski, 1995)

These core elements of quality early care relate to adult/child interaction and have become recognized in the early childhood field as being necessary for positive child development. As defined by Cryer (1999), these elements include the following:

- Safe care, defined as attentive adult supervision that is appropriate for children's ages and abilities; safe toys, equipment and furnishings;
- Healthful care, where children have the opportunities for activity, rest, developing self help skills in cleanliness, and having their nutritional needs met;
- Developmentally appropriate stimulation where children are given choices of play and learning in a variety of areas such as language, art, music, dramatic play, fine and gross motor play;
- Positive adult interactions where children can learn trust, learn from, and enjoy the adults who care for and educate them;

- Promotion of individual emotional growth, defined as encouraging children to operate independently, cooperatively, securely, and competently; and
- Promoting positive peer relationships, allowing children to interact with their peers, with the environmental supports and adult guidance required to help interactions go smoothly (p. 42).

Measures to assess the early care environment are widely used and have repeatedly proven to be both reliable and valid. The Infant Toddler Environmental Rating Scale, Revised (ITERS-R) (Harms, Clifford and Cryer, 2003), assesses the quality of infant and toddler child care environments (infants age 6 weeks through 30 months). The ITERS-R Scale consists of 39 items organized into 7 subscales: Space and furnishings, personal care routines, listening and talking, activities, interaction, program structure, and parents and staff. Inter-rater reliability and internal consistency are reported for a wide variety of 45 day care centers in North Carolina. Inter-rater reliability on the overall scale was .91.65%; the subscales ranged from .79.11% to .97.36% (Spearman's correlation coefficient). Internal consistency was also high (Cronbach's alpha = .93) for the overall scale but subscale scores varied substantially, ranging from 47 (Space and Furnishings) to 80 (Interaction). Because the Space and Furnishings and Personal Care Routine (56) subscales are low, the authors recommend caution with these items (Frank Porter Graham Institute, University of North Carolina, retrieved from the World Wide Web on June 24, 2006).

The Early Childhood Environmental Rating Scale, Revised (ECERS-R) (Harms, Clifford and Cryer, 1998) assesses the quality of preschool aged (2 ½ years through age 5). This measure assesses the space and furnishing, activities, personal care routines,

language reasoning, program structure and parent/staff relationships. Reliability information provided indicates that the percentage of agreement across all indicators is 86%. At the item level, raters agreed within a score of 1 point 71% of the time. Weighted Kappa inter-rater scores for each item vary from .28 through .90, with only one item (Language for Reasoning) being below .5. Inter-rater correlations for the subscales range from .71 through .88, with a total scale internal consistency reliability estimate of .92. This revised measure was field tested in 45 classrooms in 35 different centers and emerged as a sound and versatile tool.

The Family Day Care Rating Scale (FDCRS) is a rating scale for day care homes and is an adaptation of the Early Childhood Environment Rating Scale (ECERS). The FDCRS is designed to provide users with an environmental assessment of health and safety provisions, cognitive and social development opportunities, training opportunities for caregivers, and parent involvement. Individual item median inter-rater reliabilities were all greater than or equal to .90 for two raters observing in 55 family day care homes and for two different observers in 101 family day care homes, all in Los Angeles. Internal consistencies were also high (Cronbach's alpha >.83) on every subscale except the Adult Needs subscale (.70). No test-retest reliability is reported.

The School Age Care Environment Rating Scale (SACERS) (Harms, Jacobs and White, 1996) assesses the quality of nonparental care provided for children of elementary school age (5 to 12 years of age). The SACERS is an adaptation of the ECERS and is designed to provide users with an environmental assessment of space and furnishings, health and safety provisions, activities, interactions, program structure and staff development. Reliability information provided indicates that the percentage of agreement

across all indicators is 83%. Weighted Kappa inter-rater scores for subscales vary from .79 through .91. Inter-rater correlations for the subscales range from .67 through .94, with a total scale internal consistency reliability estimate of .95. This measure was field tested in 24 after-school programs.

Each of these scales does include a few indicators that relates to staff/child interactions, however, the goal and function of these scales is to measure the overall classroom environment, not caregiver interaction. According to Doherty-Derknowski (1995), positive adult interactions may be sufficiently powerful to have positive effects on children whether the early childhood program has a high or low overall rating (Anderson, et al, 1981; Howes, 1990).

A review of research found that measurement tools for assessing caregiver interaction exist. The majority of these measures, however, were generated for specific research purposes. Most of these measures are for gathering research data, rather than for targeting quality improvement across a wider system of child care and development entities. Chapter two includes a discussion highlighting the specific limitations associated with these measures.

Problem Statement

Research supports the notion of the combination of classroom environment and caregiver interaction in defining the quality of childcare. While instruments exist that measure environmental quality, a scientifically sound and research based instrument to assess the global quality of child care staff interactions is lacking. A global measure, as defined by Doherty-Derkowski (1995), examines a number of different characteristics at the same time (p. 16). The Child Caregiver Interaction Scale is comprised of several

research based components. These include elements that Doherty-Derkowski recommends for identifying high or low quality child care programs:

- The development of a composite measure of quality for each program by assigning a score to a number of program characteristics in order to create an overall score. The most common characteristics used for this purpose are: the number of children per adult (staff-to-child ratio), staff training, and number of children per classroom. The CCIS also includes the number of years provider has been caring for this age group, number of total years providing child care, education level and degree major of provider.
- The use of an observational rating scale that provides a score for a number of different characteristics of the program, as well as a total score for it.

As stated previously, there are instruments that assess the environmental ratings of child care classrooms using an observational scale. The primary purpose and function of these scales (ITERS, ECERS-R, FDCRS, SACERS) is to assess the classroom environment. Each of these scales includes a few items relating to caregiver interaction, however, the scales overwhelmingly remain environmentally focused. Given the critical relationship between child development and caregiver interaction, the need exists for a reliable and valid measurement tool for assessing the quality of caregiver interaction.

Purpose and Objectives of the Study

The purpose of this study was to develop and examine the quality of interaction between the care provider and all the children in care. This study explores the reliability and validity of the Child Caregiver Interaction Scale (CCIS), specifically the internal

consistency of the scale, as well as the utility of the scale across four age groups: infant, toddler, preschoolers and school-aged children.

The majority of caregiver interaction measures focus on a caregiver's interaction with an individual child (the targeted unit of analysis for the particular study), rather than the caregiver's interaction with all children in care. Additionally, most measures consist solely on an observational rating scale. Longitudinal research using the global perspective on quality has found a statistically significant relationship between poor quality early childhood programs and children rated as having more behavioral problems than peers enrolled in high quality early childhood programs (Howes, 1988; Vandell et al, 1988). These children exhibited poorer social skills with peers (Vandell et al., 1988) and showed poorer academic progress than their peers who attended high quality programs (Howes, 1988).

Additionally, no one assessment device exists for measuring the interaction between a child care provider and children in multiple age groupings, ranging from infancy through school-age. Most caregiver interaction scales remain limited to specific age groupings and therefore do not cover the age spectrum found in most child care facilities. Given the National and State level focus on child care quality improvement, a need exists for an instrument that can monitor, evaluate and assess the quality of child caregiver interactions at multiple ages, ranging from infancy through school-agel.

The Child Caregiver Interaction Scale was created to assess the quality of child caregiver interaction. This scale will be largely based upon the National Association for the Education of Young Children's (NAEYC) Developmentally Appropriate Practice (DAP) position statements (Bredekamp and Copple, 1997). These statements represent

the current best understanding of theory and research about what practices are most supportive and respectful of children's healthy development (p. vi).

Additionally, in this study I further examine the validity of the CCIS analyzing how it correlates with ECERS-R, ITERS, SACERS, and FDCRS. Data for this study came from child care centers residing throughout Pennsylvania. Infant, toddler, preschool, and school-aged caregivers were assessed to determine the utility of this scale across age groups.

Significance of the Study

Strong documentation exists for linking high quality early childhood experiences with positive child development outcomes. Longitudinal studies demonstrate that children who engage in high quality early care experiences, when compared to peers without this experience:

- Have greater social competency (Anderson, 1992, Howes, 1990, Lamb, 1998; White, 1989);
- Have fewer behavioral problems in elementary school (Howes, 1990);
- Have higher levels of language development (Jacobs et al., 1992; Andersson, 1989, 1992); and
- Perform better in all school subjects (Andersson, 1989, 1992, as cited by Doherty-Derkowski, 1995).

Because of the large number of children in out of home care, the quality of our child care facilities is important. As of March 2006, Pennsylvania had 8,880 regulated child care providers, impacting approximately 337,129 children. As of April 2006, 4,074 of these providers were involved in the Keystone STARS quality improvement initiative.

As of May 2007, 4300 regulated child care providers are participating in Keystone STARS impacting nearly 160,000 children across the Commonwealth (Pennsylvania Department of Public Welfare, n.d, http://www.pakeys.org/Documents/04252006STARSTargets.pdf).

This study has the potential to contribute to knowledge about child caregiver interaction assessment by developing a reliable and valid instrument that has a basis in research and utility in practice. This measurement device being grounded in theory and current research provides both researchers and practitioners with a much needed tool for assessing the quality of child and caregiver interaction.

This measure can assist practitioners and program managers develop targeted training and technical assistance for child care providers, as well as measuring impacts relating to training and technical assistance interventions. Based in developmentally appropriate practice and current research, the CCIS has a real potential to dramatically understand and improve quality child and caregiver interactions.

Research Question(s)

The following questions are addressed in this study.

1. Can a research grounded assessment instrument be developed that adequately incorporates and identifies dimensions associated with the developmentally appropriate practices, and measures the support of cognitive, emotional, and wider social relationship functioning?
2. How reliable is the CCIS instrument? What is the internal consistency of the subscales, which are cognitive, emotional, and wider social relationships?

3. How valid is the CCIS instrument? Does this instrument assess global child caregiver interaction? How does this measure correlate with child care environmental rating scales and the STARS program ratings? Does the CCIS have utility across age the infant, toddler, preschool and school-age age groups?

Assumptions and Definition of Terms

The biggest assumption of this study is that child care quality is an identifiable and measurable construct. However, a definitional challenge does exist. The quality of child care can be "defined from many perspectives and can include a variety of indicators. "any definition is likely to be challenged by those with differing priorities or perspectives" (Cryer, 1999, p. 40).

For example, NAEYC's original 1987, definition of quality, Developmentally Appropriate Practice, was criticized as being less relevant for minority serving programs than for the white middle class. Powell (1994) identified that DAP emphasis on child centered teaching to be in contrast with the more didactic caregiving that is preferred by many lower income, ethnic minority parents. Also, Williams (1994) identified that the child centered approach would not apply well to Native American children, where individual child development is less important as the relationship of the individual to the group and the focus on socially constructed knowledge. It is because of these criticisms that DAP was revised in 1997 to include more of a focus on cultural competency and social connections.

According to Cryer (1999),

> even though criticisms exist, when the arguments are carefully examined, they are usually found to be focused on relatively small components of the larger construct, and not on the core elements. Thus the definition can be sometimes adapted to incorporate changes, but the core, as a whole, does not really change radically (p. 43).

Quality child care is generally defined as experiences that enhance the social, cognitive and emotional development of children (Howes, 1993). Quality care is comprised of two dimensions – structural and process. Structural quality components include group size, adult/child ratio, and teacher education/training. Process quality is identified as the experiences of children while they are in care. These components include the interactions between children and their caregiver, as well as the opportunities present in the environment.

Based upon a review of literature and consideration of the above stated concerns, the underlying assumption of this proposal is that quality child care is "one that provides a safe and nurturing environment that promotes the physical, social, emotional, aesthetic, intellectual, and language development of each child while being sensitive to the needs and preferences of families" (Bredekamp and Copple, 1997, p. 8). This position and supporting theoretical foundation forms the basis for a valid Child Caregiver Interaction Scale.

Using a solid foundation of scale development, developmentally appropriate practice, and current brain research, the CCIS incorporates the constructs of cognitive, emotional and social domains to frame caregiver interaction. In accordance with McCollum, et al (1997), the CCIS rating scale

> … like other measures of personal and interpersonal qualities and characteristics, will be based on a number of important assumptions. First, it is assumed that the items included on the scales represent one or more psychologically meaningful constructs. Second, it is assumed that the scores derived from the ratings distinguish those individuals whose interaction patterns are optimal from those whose patterns are not (p. 495).

The scale items are drawn from inappropriate and appropriate practice as identified by Bredekamp and Copple (1997). This work, the *Developmentally Appropriate Practice, Revised Edition*, identifies specific behaviors that differentiate between optimal and less desired actions and is widely accepted as the standards of quality in the early childhood field.

Operational Definition of Terms

For the purposes of this study, the following operational definitions of terms will be used:

1. Caregiver: One who provides care for other people's children.
2. Early childhood programs: Any part- or full-day group programs in centers, homes, or schools that provide care for children (NAEYC 1987). Also identified as out of home placement, early care and education, and child care centers. Pennsylvania Department of Welfare regulates three types of child care facilities (Pennsylvania Department of Welfare, Public Welfare Code (62 P. S. § § 101—1411). Each type of facility has specific allowable adult:child ratios, dependent upon the ages of children in care.

- Child Care Center - A child care facility in which seven or more children who are not related to the operator receive child care. A child care center must have a certificate of compliance ("license") from the Department of Public Welfare (DPW) in order to legally operate.

Table 1: *Center Based Staff:Child Ratio*

When children are grouped in similar age level, the following maximum child group size and ratios of staff person apply in center based care (PA DPW § 3270.51)

Similar Age Levels	Staff	Children	Maximum Group Size	Total Number of Staff Required for the Maximum Group Size
Infant	1	4	8	2
Young toddler	1	5	10	2
Older toddler	1	6	12	2
Preschool	1	10	20	2
Young School Age	1	12	24	2
Older School Age	1	15	30	2

When children are grouped in mixed age levels, the following child group sizes and ratios of staff persons apply in center based care (PA DPW § 3270.52).

Mixed Age Levels	Staff	Children	Maximum Group Size*	Total Number of Staff Required for the Maximum Group Size
Infant/young or older toddler	1	4	8	2
Infant/preschool	1	4	8	2
Young toddler/preschool	1	5	10	2
Older toddler/preschool	1	6	12	2
Preschool/young or older school-age	1	10	20	2

*No more than 50% of each group may be of the older age level.

- Group Child Care Home - A child care facility in which seven though 12 children of various ages or in which seven though 15 children from 4th grade through 15 years of age who are not related to the operator receive child care. A group child care home must have a certificate of compliance ("license") from the Department of Public Welfare (DPW) in order to legally operate.

Table 2: *Group Child Care Home Staff:Child Ratio*

When children are grouped in similar age level, the following maximum child group size and ratios of staff person apply in center based care (PA DPW § 3280.52)

Similar Age Levels	Staff	Children	Maximum Group Size	Total Number of Staff Required for the Maximum Group Size
Infant	1	4	12	3
Young toddler	1	5	12	3
Older toddler	1	6	12	2
Preschool	1	10	12	2
Young School Age	1	12	24	2
Older School Age	1	15	30	2
When children are grouped in mixed age levels, the following child group sizes and ratios of staff persons apply in center based care (PA DPW § 3280.52).				
Mixed Age Levels	Staff	Children	Maximum Group Size*	Total Number of Staff Required for the Maximum Group Size
Infant/young or older toddler	1	4	12	3
Young toddler/older toddler	1	5	12	3
Older toddler/preschool	1	6	12	2
Preschool/young or older school-age	1	10	12	2

Young school age/older school age	1	12	12	1
*No more than 50% of each group may be of the older age level.				

- Family Child Care Home - A child care facility located in a home in which four, five or six children who are not related to the caregiver receive child care. A family child care home must have a certificate of registration from

Table 3: *Group Family Child Care Home Staff:Child Ratio* The operator may provide care to more no more than five related and unrelated children at any one time. No more than two related or unrelated infants may receive care at any one time. The following numbers of infants and toddlers are permitted in a family day care home (PA DPW § 3290.52)
1). If no infants are in care, five toddlers are permitted.
2). If one infant is in care, four toddlers are permitted.
3). If two infants are in care, three toddlers are permitted.
4). If no infants or toddlers are in care, five preschoolers are permitted.

3. Infant: Child who is between newborn and twelve months of age.
4. Toddler: Child who is between the ages of 12 months and three years of age. This stage can be broken into two sections. Young toddlers, between 13 and 24 months, and older toddlers, between 25 and 36 months.
5. Preschooler: Children between 37 months of age through the date the child enters 1st grade of a public or private school system.
6. Young school age child: A child from the first grade through the 3rd grade of a public or private school system.
7. Older school age child: A child from the 4th grade of a public or private school system through 15 years of age.

Limitations & Delimitations

Data for this study was collected in conjunction with existing data collection efforts. Beginning in April 2006 and continuing through summer 2006, the Pennsylvania Department of Public Welfare, Office of Child Development, conducted an evaluation of the Keystone STARS initiative. This initiative is a system of continuous quality improvement for child care through standards, training/professional development, technical assistance, resources, and support. Keystone STARS works to support the capacity and quality of child care programs through performance standards, financial incentives, and STAR designation awards.

Child care providers are awarded a Start With STARS, STAR One, STAR Two, STAR Three, or STAR Four quality rating based on their achievement of quality performance standards in the areas of staff education, learning environment, and administration. The star rating reflects standards of quality that are research based and linked to improved outcomes for children as related to social and emotional development, learning skills, and school readiness (PA Department of Public Welfare, n.a., Retrieved from http://www.pakeys.org/stars.htm).

A stratified, random sample was selected by research partners at The Office of Child Development, University of Pittsburg. This sample was drawn from all registered child care providers across the Commonwealth. Providers were stratified based on region, STAR level, and type of care provided. Additionally, a representative proportion of regulated child care providers were selected. (Regulated providers are those that are licensed by the Department of Public Welfare but are not participating in the Keystone STARS initiative).

The majority of the sampling frame for this study was drawn from the 545 randomly selected 2006 Keystone STARS Quality Study participants. In addition to myself, two other persons, who were already collecting STARS ECERS-R and FDCRS data, collected CCIS data.

Additional data was collected through observations of caregivers participating in age-specific child development credential (CDA) programs. Infant/toddler assessments were conducted on a random sample of child care providers enrolled in the Infant/Toddler CDA. School aged assessments were conducted on a random sample of child care providers enrolled in the School Aged CDA.

Summary

The link between high quality early childhood experiences and positive child outcomes is well documented. Because of the large number of children in out of home care, the quality of their experiences is important. This study will contribute to knowledge about child caregiver interaction and instrumentation that has a basis in research and utility in practice. The Child Caregiver Interaction Scale (CCIS) is a measure solidly grounded in theory and current research. It provides a much needed tool for assessing the quality of child and caregiver interaction.

The purpose of this study was to develop and examine the quality of interaction between the care provider and all of children in care. This study explores the reliability of the (CCIS), specifically the inter-rater consistency and the internal consistency of the scale. The utility of the scale is assessed across four age groups: infant, toddler, preschooler, and school-aged children. The scale's validity will be measured against the

STARS program ratings and individual SACERS, ECERS-R, ITERS and FDCRS measurement scales.

The following chapters address the study's major goals in several steps. Chapter 2 provides a review of pertinent literature and identifies and defines developmentally appropriate practice for child care environments. This includes presenting the conceptual framework for this study. The limitations of currently available child and caregiver interaction measures are also be addressed. Chapter 3 then describes the sample, procedures, methods, and initial development of CCIS. Components of the CCIS are described in terms of their origin within theory and current research. Chapter 4 presents the results of the study, including exploratory factor analysis, correlations between the subscales and the overall CCIS, measurement variability, internal consistency, and validity of the measure. Finally, Chapter 5 presents the discussion and conclusion of this research project, including recommendations for future study.

Chapter Two:

REVIEW OF RELATED LITERATURE

This chapter summarizes the relevant literature on child care quality. The first section examines the quality child caregiving literature. The second section addresses the characteristics of currently available child and caregiver interaction measures. The third section describes the domains that frame quality caregiver interaction, and introduces variables defined in terms of observed quality interactions. Finally, the fourth section in this chapter provides a review of developmentally appropriate practice and the conceptual framework used to structure this study.

Historical Background

In the United States Approximately 13 million infants, toddlers, and preschool children are regularly in non-parental care in the United States, including 45% of children younger than one year (NAEYC, 2005). Because of these record numbers of children in nonparental care, the question arises: Does the quality of child care matter?

This question is linked to the Belsky and Steinberg's (1978) review of forty child care studies, the existing bulk of literature at the time. Belsky and Steinberg indicated

> Our actual knowledge of day care effects is exceedingly limited. Generally investigations have been conducted within high quality centers which are not representative of most substitute-care environments. (p. 929). The findings from existing research on day care may not be generalizable to the kind and quality of care available to most of the nation's families. (p. 930).

This desire to learn more about the effects of quality child care was the impetus behind much of the research conducted in this area during the past 25 plus years. Studies by Howes (1983), Clarke-Stewart (1987), and Phillips, McCartney, and Scarr (1987) observed children and recorded their experiences. High-quality child care is identified as involving supportive interactions with caregivers, positive peer interaction, and opportunities for cognitively stimulating play. Poor-quality care is conceptualized as aimless wandering and the negative interactions between children and their caregiver and peers. From these and other early studies, the experiences children have with caregivers, peers, and materials became defined as 'process quality.' Child care quality is also assessed by 'structural/caregiver characteristics' such as adult/child ratio and caregiver's training and education (Vandell, 2004).

Concerns about improving the quality of child care are well founded. Research consistently provides evidence for the correlation between quality of care and children's developmental outcomes. Indicators, such as adult-child ratios, consistency of caregiver, and responsive caregiving have been associated with positive developmental outcomes (Howes and Stewart, 1987, Howes & Rubenstein, 1985, and Whitebook, Howes & Phillips, 1990). Consistent findings have emerged across studies (Committee on Family and Work Policies, 2003; Vandell, 2004). In caregiving environments where adult/child ratios are lower, caregivers are more stimulating, warm, responsive and supportive (NICHD Early Child Care Research Network (ECCRN), 2000); and process quality scores are higher (NICHD, ECCRN, 2000; Phillips, Mekow, Scarr, McCartney & Abbott-Shim, 2000), as cited by (Vandell, 2004).

Further, there is increasing evidence that engaging in positive relationships with adults can assist in protecting children from negative early experiences (NICHD ECCRN, 2000). Children who receive continual care by trained caregivers who understand and implement developmentally appropriate curriculum are better equipped for life's academic and social emotional experiences (Peisner-Feinberg, et al., 2001) found that formal training in early childhood education produces higher quality teacher behaviors and can be linked to improved child outcomes (Fontaine, et al, 2006).

Figure 1 graphically demonstrates the interaction between caregiver characteristics, program characteristics, caregiver interaction and child well being outcomes:

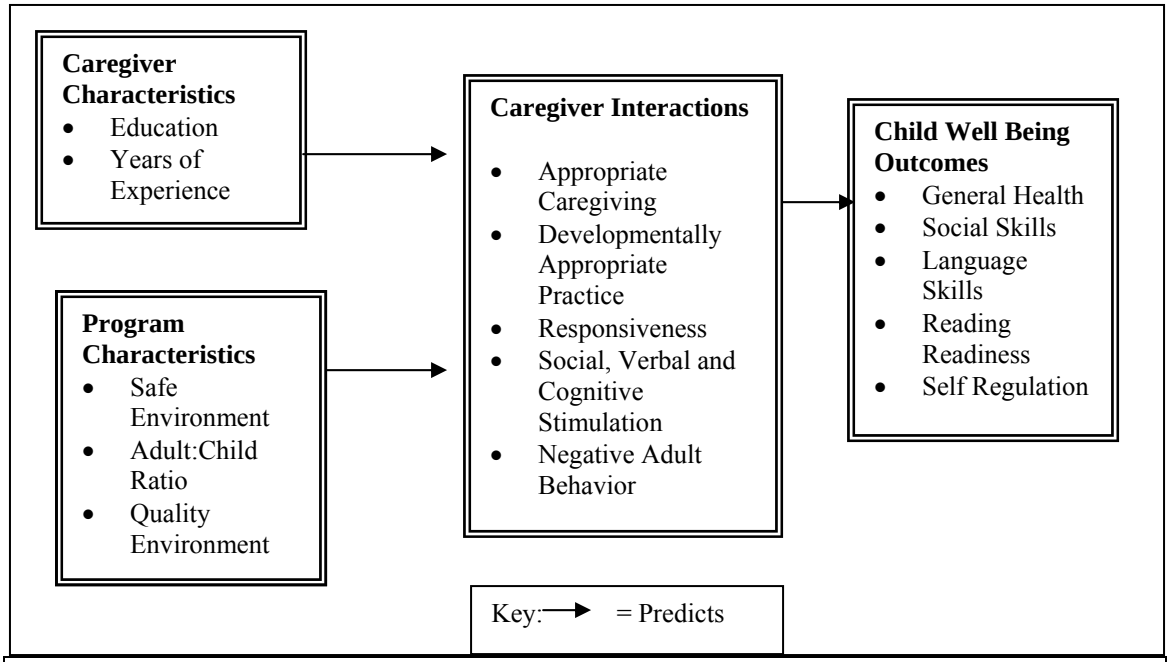


Figure 1: The relationship between caregiver qualifications, program characteristics, caregiver interaction and child well being outcomes (Doherty-Derkowski, 1995, p. 85).

A review by the National Academy of Science (Committee on Family and Work Policies, 2003), reported six studies that identify a correlation between child care process quality and children's behavior. Vandell (2004) summarizes these studies, which

conclude that children appeared happier and more securely attached to caregivers in settings where process quality was higher and adult:child ratios were lower. Children also appeared more prosocial and positively engaged with their peers when caregivers were sensitive and positive to them and when adult:child ratios were lower. Children were rated more cognitively competent during free play in child care environments that provided more opportunities for art, blocks, and dramatic play, and in settings where the caregiver had college degrees and more early childhood training (p. 392).

Research indicates that positive caregiving has long lasting effects. The NICHD Study of Early Child Care (2000) identified that cumulative measures of caregiver behavior as measured by the Observational Record of Caregiving Environments (ORCE) predicted children's performances on standard language and cognitive assessments at 15, 24, 36 and 54 months, controlling for the amount and type of care , as well as an extensive list of family covariants. In the Cost, Quality and Outcomes Study, which included 579 children attending 151 centers, process quality as measured by the ECERS predicted cognitive, language and social development during early elementary school (Peisner-Feinberg, et. al, 2001). Children who had closer relationships with their preschool caregivers were more sociable in kindergarten. Children who had close relationships with their caregivers at age four were reported by their second grade teachers to be more socially competent (Vandell, 2004).

These findings are consistent with Lamb's 1998 *Handbook of Child Psychology* that identifies high-quality child care has positive effects on intellectual, verbal, and cognitive development, and that children receiving high-quality care have better

relationship skills, as opposed to children who receive poor quality care have deficient skills (Vandell, 2004).

The clear link between high quality process indicators, including child and caregiver interaction, to positive outcomes for children, identifies the need for a theoretically and research based assessment measure. The following section explores the existing instruments that are used to assess process indicators in child care settings.

Current State of Practice

Numerous measures to assess the process quality of child care have been developed in the past 25 years. Each measure represents "a version of process quality that is assumed to produce specific child outcomes. Some have been used in research, while many were designed to evaluate and improve program quality" (Cryer, 1999, p. 45). All measures presented here are conducted through direct observation of children and caregivers in child care settings during times of child activity.

A review of the early childhood literature identified various caregiver interaction assessments. The majority of these measures were created for specific studies and for specific outcomes. For example, the Howes Adult Involvement Scale (Howes & Stewart, 1987) and The Observational Record of Caregiving Environment (National Institute of Child Health and Human Development, 2003) focus on a specific child (the unit of analysis of their studies), rather than assessing general caregiver interaction defined as interaction with all children.

The most widely used measure of caregiver interaction is the Arnett Caregiver Interaction Scale (1989). Because of its widespread use, this measure was used as the starting point for the development of the Child Caregiver Interaction Scale and will be

explored most thoroughly. This will be followed by a review of additional process assessments that include caregiver interaction items. Each of these measures has demonstrated varying degrees of statistical reliability.

The Arnett Caregiver Interaction Scale (CIS) (1989)

The Caregiver Interaction Scale (Arnett, 1989) is used frequently and widely as a process indicator of child care quality. Because this measure is used as an assessment of caregiver interaction with all children, an in depth review of this measure is provided. The following is a review of the strengths and limitations of the Arnett Caregiver Interaction Scale (CIS).

Strengths of the CIS

The Arnett CIS is used extensively to assess the quality of caregiver interaction, both in research studies, and in state quality initiatives. Colorado, Kentucky, Maryland, Montana, North Carolina, Oklahoma, Pennsylvania, Tennessee and Vermont have used the Caregiver Interaction Scale to assess child care quality (NAEYC, 2005). There is wide name recognition in the field for this measure, which encourages the need to revisit the measure, rather than to reject it and create something new. Also, this widespread use of the measure may allow for some comparison of caregiver quality across settings and locations.

Limitations of the CIS

Recent research on Developmentally Appropriate Practice in early care and education. While the study of the effect of child care quality on children's behavior and psychological outcomes has long been a tradition in early childhood education (McCain and Mustard, 1999), attempts to operationally define Developmentally Appropriate Practice (DAP) is a relatively new undertaking. The first definitive position on DAP was adapted by the National Association for the Education for Young Children (NAEYC) in 1986 (Gestwicki, 1999).

In 1997, NAEYC further expanded their position on DAP. Several factors attributed to the need for this revision: 1) The need for child care has increased because of the increase in working parents, including those associated with welfare reform; 2) the increased knowledge and research that stresses the importance of the early years in brain development; 3) the changing demographics in the United States, which generates more culturally diverse children and families in care; 4) research that indicates children with disabilities or developmental delays are best served when they are engaged in inclusive classrooms; and 5) the involvement of corporations and public schools in providing early care and education and the desire to provide quality child care (Gestwicki, 1999).

The Arnett CIS is based upon child care studies and literature from 1976 through 1985. Because of the more recent research in the 1990's on child development that stresses brain development, caregiver interaction, and the changing cultural composition of children in care, more current literature, such as DAP, exists that will aide in the development of an updated CIS. This position is in agreement with Moss (1994) who

argues that early childhood program quality is a relative concept, not an objective reality, and that definitions change over time. As such, quality must be continually redefined.

Lack of operational definitions in the CIS. The original Arnett CIS has very limited published or accessible materials relating to validity. In fact, the definitions and explanations of the items are limited only to what is written in the scale. Through the course of using the measure, numerous researchers have added descriptors, which may or may not fit with the original intent of the measure. This lack of standardization makes widespread use of the measure inconsistent and comparison to other studies suspect. Because of this lack of definition, interpretations of the measure can be wide and varied. More closely aligning the definitions and descriptors of this measure with DAP should assist in providing clarity to the instrument.

Adaptations of the CIS. A review of the literature indicates the CIS has been altered to meet specific researcher needs for particular studies. For example, Jaeger & Funk (2001) report the Arnett as a 26-item measure that assesses the quality and content of teacher's interactions with children, organized into four subscales: 1) positive interaction, 2) punitiveness, 3) detachment, and 4) permissiveness. A study by Ghazvini (2002) indicates these same 26 items are organized into three subscales: 1) sensitivity, 2) punitiveness, and 3) detachment. Studies conducted by the Keystone University Research Corporation (2001), utilize 37 items, organized into four subscales: 1) sensitivity, 2) harshness, 3) detachment, and 4) permissiveness. This variation in the measure makes any comparison of data very difficult.

Limited variability of the CIS. The original CIS uses a four point, likert scale (1 = Never, 2 = Few, 3 = Some, 4 = Many). Various attempts were made by Pennsylvania

researchers to operationally define these terms relative to observation, in order to help build consistency into the measure. For example, in the Governor's Pennsylvania Task Force on Early Childhood Care and Education (2002) and the Keystone University Research Corporation TEACH Evaluation (2001), percentages were given to the categories: (1 = 0%, 2 = 1 to 30%, 3 = About 50%, 4 = 60+%).

While this numerical rating may have provided some clearer definition for assessment, it proved unsatisfactory for several reasons. The scaling is arbitrary and not built on a solid research foundation of scale and measurement. Even with the use of percentages, the use of this 4-point scale is very subjective and of limited value. While the measure is effective at assessing either really good, or really poor caregivers, it does not allow for the distinction of caregivers who fall in the mid range of effectiveness. Possibly the categorical definitions are not clear enough to allow raters to identify differentiation among caregiver behaviors.

Both research and technical assistance require an instrument with greater ability to assess the areas of caregiver strength and weakness. For research, a more fine tuned measure would enable us to learn more about the characteristics of caregiver/child interaction that prove critical for quality child care. For technical assistance a more variable scale would allow for greater identification of targeted interventions that relate to specific behaviors.

Review of Other Caregiver Interaction Measures

The following is a review of additional child caregiver interaction measurement tools. The strengths and limitations of each measure are identified. These, coupled with

the theoretical base and principles of DAP provide direction for a clearer understanding of what comprises effective caregiver interaction.

Environmental Rating Scales (Harms, Clifford and Cryer, 1989, 1990, 1998)

This series of rating scales assess process, as well as structural factors in child care environments. These scales include a preschool aged version (Early Childhood Environmental Rating Scale, Revised Edition (ECERS-R) (Harms, Clifford and Cryer, 1998), an infant/toddler version (Infant/Toddler Environment Rating Scale (ITERS) (Harms, Cryer and Clifford, 1990), a school-aged version (School-Age Care Environmental Rating Scale (SACERS) (Harms, Vineberg, and White, 1996), and a version for family child care (Family Day Care Rating Scale (FDCRS) (Harms and Clifford, 1989).

Each of these scales provides a score of overall global process quality. Each scale includes items on personal care routines, furnishings and display for children, language experiences, learning activities, social development, interactions, and adult needs. All three instruments use a seven-point scale with quality descriptors anchoring four points: 1 (inadequate), 3 (minimal), 5 (good), and 7 (excellent) (Cryer, 1999, p. 46).

While each of these measures does include one specific item and several indicators for child and caregiver interaction, they primarily focus on the environment in child care classrooms. Because of this, researchers and practitioners tend to use an additional caregiver interaction measure in conjunction with these scales (Governor's Task Force on Early Childhood Care and Education, 2002; Keystone University Research Corporation, 2001; Whitebook, Howes, and Philips, 1990).

Assessment Profile for Early Childhood Programs (Abbott-Shim and Sibley, 1987)

This measure is similar in scope to the Environmental Rating Scales discussed above. The measure consists of a presence-absence checklist of 150 items, and includes subscales for infant, preschool and school aged children. Process areas assessed include health and safety, learning environment, scheduling curriculum, relationships, and individualized attention to children, as well as structural indicators relating to program structure and administration. While this measure provides a general assessment of the child care classroom, the focus is more on environment than interaction.

ORCE (Observational Record of Caregiving Environments (NICHD, 2005)

While the ORCE can be used for concrete variable definitions, it should be noted that this measure was created for a specific study, with specific research questions. According to the Observation Record of the Caregiving Environment (ORCE): Part l: Behavior Scales, Qualitative Scales, and Observed Structural Variables, Revision 04/28/04,

> This instrument has now evolved so far from the original sources of "inspiration" (Arnett, Abbott-Shim, and ECERS) that it doesn't really make much sense to refer to them any more. In the beginning, we did take some of our scales from these sources. The results of extensive piloting and much input from the Steering Committee as well as members of the child care subcommittee, however, have made this an original and unique assessment instrument specifically designed for our purposes (NICHD, 2005, p. 123).

The variables that relate to caregiver interaction identified in the ORCE consist of sensitivity/responsiveness, detachment/disengagement, intrusiveness/overcontrol, and

cognitive stimulation. Caregiver behaviors are examined in relationship to existing child care standards, which include, child-adult ratios, group size, caregiver's formal education and specialized training, safety of the environment, and years of caregiver experience. This measure consists of several similar scales that assess the same variables, with age specific descriptions. This scale uses a time sampling methodology.

The unit of analysis of this study is the individual study child. As such, this measure does not afford an overall assessment of caregiver quality interaction with all children in care.

Waters Attachment Q-Set (Waters, 1987)

Like the ORCE, this measure focuses on the child and how they relate to the child caregiver. There are five identified subscales: secure base for exploration; avoiding behavior towards caregiver; seeking comfort from caregiver; positive negotiation; and difficult negotiation. This measure consists of 90 items that are sorted to describe how the subject child relates to the caregiver. This measure is for children ages 18-24 months and is assessed by specific, concrete demonstrations of behavior.

Howes Adult Involvement Scale (Howes & Stewart, 1987)

This measure also observes the subject child and their proximity to the adult caregiver. The identified construct behind this assessment is the sensitivity/responsiveness of the caregiver. The latent variables assessed are: sensitivity/insensitivity; acceptance/rejection; cooperation/interference; and accessibility/ignoring. This measure uses a time sampling method and no limitations based on age of observed child.

The Child-Caregiver Observation Scale (C-COS)

(Boller, Sprachman, and the Early Head Start Research Consortium, 1998

This measure was developed from the ORCE (NICHD, 1995) by Head Start to have closer alignment with their performance standards. The main focus of this measure is on language interaction between the caregiver and this child. The focus of this measure is also the subject child. This measure assesses caregiver behavior in the following categories: caregiver characteristics such as understanding of child development, awareness of child's emotional needs, and love and enjoyment of children; caregiver-child interactions including support for language and cognitive development, discipline, and activities; and caregiver-parents interactions, including closeness and communication. A similar version of this measure was created for assessing family, friend, and neighbor care, the Child Care Assessment Tool for Relatives (CCAT-R). There are no age specific recommendations for this measure.

Caregiver Observation Form and Scale (COFAS) (Fiene, 1984)

This measure provides a time sampled measure for assessing caregiver behaviors while interacting with children in a classroom setting. This scale measures caregiver behavior as they interact with children's language, social-emotional, gross motor, cognitive and caregiver behavior, such as routine care and detachment. The strength of this scale is that it uses a time sample method and the focus of study is the caregiver. This measure was created for caregivers providing care for infants through age 8.

The limitation of this measure is that while it might be a valuable research tool, it is cumbersome to administer and is not very user friendly. Additionally, the inclusion and exclusion of specific items, notably gross motor (inclusion) and fine motor (exclusion), is

questionable because there is no solid research foundation used to support the scale.

Emotional Availability Scale (Biringen, et al, 1993)

This is a measure which assesses the emotional availability between a parent and their child. While the published research on this measure relates to parent/child relationships, this measure was reviewed to determine what variables this scale measures. Given the foundation of much of the literature on caregiver/child interactions stems from the parenting literature, this provides a logical exploration.

This scale measures dimensions of emotional availability from the caregiver to the child, and from the child to the caregiver. Variables measured as occurring between the caregiver and child includes: sensitivity, structuring, nonintrusiveness, and nonhostility. Variables relating from the child to parent include the child's responsiveness and involvement with the caregiver. Published use of this measure is limited.

Classroom Assessment Scoring System (CLASS) (Pianta & La Paro, 2003)

This scale describes and measures classroom quality from Pre-k to Grade 3 using a common set of dimensions and rating scales, with grade-specific examples reflecting both instructional and socioemotional aspects of the classroom environment. The CLASS assesses the quality of teachers' implementation and use of a curriculum, the quality of her social and instructional interactions with children, and the intentionality and productivity evident in the classroom setting.

The CLASS assesses 14 constructs within these broad areas, including: (a) positive emotional climate, (b) negative emotional climate, (c) teacher sensitivity, (d) overcontrol, (e) behavior management, (f) productivity, (g) concept development, (h)

instructional learning formats, (i) roteness, and (j) quality of feedback; as well as interactions between teachers and children focused on (k) literacy, (l) mathematics, (m) science, and (n) social studies.

This measure does allow for exploration and assessment of PreK through grade 3 caregiving, this measure is not appropriate for infant and toddler classrooms. Given the importance and need for positive child and caregiver interaction during these early years, it is important to have a theoretically sound and research based instrument to assess these relationships.

Caregiver Interaction as an Emergent Construct and Related Variables

Quality of care has typically been indexed by process features of adult-child interaction that represent good caregiving, whether provided by a parent or someone else. These features include sensitivity and responsiveness to the child's needs and signals, positive affect, frequent verbal and social interaction, and cognitive stimulation (e.g., Friedman & Cocking, 1986; Hart & Risley, 1995).

While other research studies and caregiver assessment scales indicate "constructs" such as respect, sensitivity, positive regard, and warmth, careful review of the literature indicates these should be identified as variables of observed behaviors, rather than constructs. As understood in terms of DeVellis' (2003) framework, these variables are the actual phenomenon we are observing (p. 15).

Table 4 identifies the variables each previously discussed measure is intended to assess. At first glance, it appears that these measures include many variables, however, in actuality, these measures generally measure two distinct constructs: (1)

sensitivity/responsiveness of the caregiver, and (2) cognitive support of the children in care.

The measured variables of the reviewed scales are grouped in Figures 2 and 3. Figure 2 identifies the "variables" that comprise the sensitivity construct. Figure 3 identifies the "variables" that comprise the cognitive support construct.

The aforementioned caregiver interaction measures appear suitable for specific individual studies and purposes, however, there is a definite conceptual disconnect between DAP and the variables and constructs that these measures seek to assess. A review of DAP, supporting theories and other research studies identifies that quality child care can best be assessed through the constructs, or domains, of 1) emotional development, 2) cognitve/physical development, and 3) social support for families/cultural competence.

Only a few of these instruments measure DAP constructs thoroughly. For example, the CLASS effectively measures DAP constructs, however, the measure is intended for preschool and early elementary school aged programs. The measure is not intended to assess infant or toddler caregiver interaction. Given the large number of infants and toddlers in out of home care, as well as the critical developmental stages of young children, there is a strong need for a DAP scale to assess caregiver interaction with young children.

Table 4: *Comparison of Child Caregiver Interaction Measures*

Measurement Name	**Subject Focus/ Child Ages**	**Sensitivity (Warmth, Emotional, Connectivity)**	**Hostility/ Frustration/ Harshness**	**Detachment**	**Cooperation/ Interference**	**Gross Motor**	**Social Emotional Learning**	**Structuring/ Intrusiveness (Set Limits)**	**Cognitive Stimulation**	**Global Assessment**
Assessment Profile for Early Childhood Programs (Abbot-Shim and Sibley, 1987)	Classroom/ Infant Preschool School age	✓		✓	✓	✓		✓	✓	✓
Emotional Availability Scale (Birington, 2000)	Parents	✓	✓					✓		
Observational Record of Caregiving Environments (NICHD, 2004)	Child/ Infant to Pre K (Separate Measures)	✓		✓				✓	✓	
Waters Attachment Q Set (Waters, 1995)	Child/ 18 – 24 Months	✓ Secure Base								
Howes Adult Involvement Scale (Howes & Stewart, 1987)	Child/ Pre K	✓ +Acceptance		✓	✓					

Table 4: *Comparison of Child Caregiver Interaction Measures Continued*

Measurement Name	**Subject Focus/ Child Ages**	**Sensitivity (Warmth, Emotional, Connectivity)**	**Hostility/ Frustration/ Harshness**	**Detachment**	**Cooperation/ Interference**	**Gross Motor**	**Social Emotional Learning**	**Structuring/ Intrusiveness (Set Limits)**	**Cognitive Stimulation**	**Global Assessment**
Caregiver Observation Form (COFAS) Fiene, 1984)	Caregiver/ Infant to Age 8	✓		✓		✓			✓ Language	
Arnett Caregiver Interaction Scale (CIS) Arnett, 1989)	Caregiver/ Infant through Pre K	✓	✓	✓				✓		
Classroom Assessment Scoring System (CLASS) (Pinant & La Paro, 2003)	Caregiver/ Pre K to Grade 3	✓	✓	✓	✓	✓	✓	✓	✓	
Child/Caregiver Observation Scale (CCOS) (Boller, et al, 1998)	Child/ Ages 1 - 5	✓		✓	✓			✓	✓ Language	

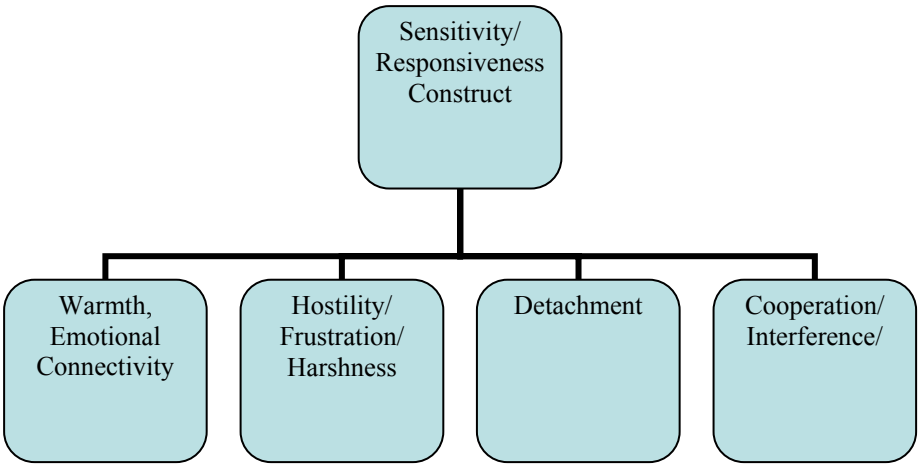


Figure 2: Emotional domain.

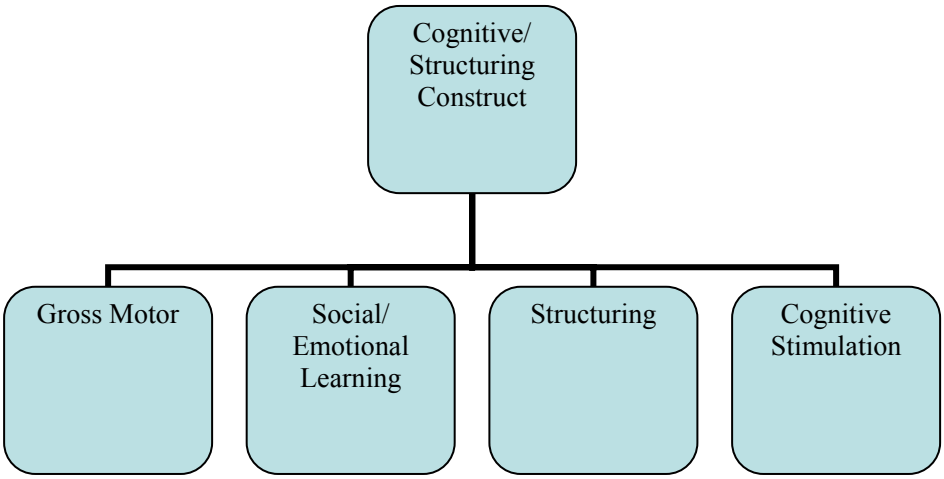


Figure 3: Cognitive domain.

Review of Developmentally Appropriate Practice and Its Theoretical Base

Developmentally Appropriate Practice, or DAP, was built upon knowledge of how children develop and learn. Because development and learning are so complex, no one theory sufficiently explains these events. Instead, NAEYC built DAP around a review of the literature on early childhood education. From this review, a set of twelve empirically based principles were developed to inform early childhood practice (Bredecamp and Copple, 1997, p. 9). These twelve principles are as follows:

1. Domains of children's development – physical, social, emotional, and cognitive – are closely related. Development in one domain influences and is influenced by development in other domains.
2. Development occurs in a relatively orderly sequence, with later abilities, skills, and knowledge building on those already acquired.
3. Development proceeds at varying rates from child to child as well as unevenly within different areas of each child's functioning.
4. Early experiences have both cumulative and delayed effects on individual children's development; optimal periods exist for certain types of development and learning.
5. Development proceeds in predictable directions toward greater complexity, organization, and internalization.
6. Development and learning occur in and are influenced by multiple social and cultural contexts.

7. Children are active learners, drawing on direct physical and social experiences as well as culturally transmitted knowledge to construct their own understanding of the world around them.
8. Development and learning result from interaction of biological maturation and the environment, which includes both the physical and social worlds that children live in.
9. Play is an important vehicle for children's social, emotional, and cognitive development, as well as a reflection of their development.
10. Development advances when children have opportunities to practice newly acquired skills as well as when they experience a challenge just beyond the level of their present mastery.
11. Children demonstrate different modes of knowing and learning and different ways of representing what they know.
12. Children develop and learn best in the context of a community where they are safe and valued, their physical needs are met, and they feel psychologically secure.

DAP is based on the following three kinds of information and knowledge:

1. What is known about child development and learning – knowledge of age-related human characteristics that permit general predictions within an age range about what activities, materials, interactions, or experiences will be safe, healthy, interesting, achievable, and also challenging to children;

2. What is known about the strengths, interests, and needs of each individual child in the group to be able to adapt for and be responsive to inevitable individual variation; and
3. Knowledge of the social and cultural contexts in which children live to ensure that learning experiences are meaningful, relevant, and respectful for participating children and their families (Bredekamp, 1997, p. 9).

The twelve developmentally appropriate practice principles have roots in three main theoretical perspectives: Constructivism (Piaget, 1952, Vgotsky, 1978), Ecological Systems Theory (Brofenbrenner, 1979) and Attachment Theory (Bowlby, 1969; Ainsworth, et al, 1978). An extensive review of the twelve principles and theoretical perspectives found them to be interrelated.

Conceptual Framework

Constructivist Theory

The relationship between quality caregiver interaction and child well being outcomes can best be explained by the constructivist paradigm. The theories of Jean Piaget and Lev Vygotsky provide the foundation for this approach. They theorize that children acquire new knowledge as they interact with their environment and the adults in that environment. Both Vygotsky (1978) and Piaget (1952) theorize that children contribute to their own development and learning as they endeavor to make meaning out of their daily life experiences. From birth, children are actively engaged in constructing understanding from their own experiences and these understandings are mediated by and linked to the sociocultural context.

Children's early learning experiences, whether positive or negative, when occurring on a regular basis, can have an influential effect. Research indicates (Howes & Rubenstein, 1985; Howes and Hamilton, 1993) that infants who received consistent care engage in more social interactions with adults at age 18-24 months. The first three years have been identified as an optimal period for verbal language development (Kuhl, 1994). The preschool years seem to be the optimum time for fundamental motor development (Gallahue, 1995).

Piaget (1972) contends that "social life is a necessary condition for the development of logic" (p. 80). He further argues that when a child has the experience of others who react to what he says, the child begins to feel the truth is important. For Piaget, the social context offers possibilities for children to become aware of differences in perspectives. He stresses the significance of coordinating multiple perspectives as being integral to the moral and social awareness of the individual. This operational reasoning is autonomous in that it is not just a set of truths accepted as given by others, but reflects an internal system of personal and logical conclusions (DeVries & Kohlberg, 1987, p. 123).

DeVries and Kohlberg (1987) define the constructivist caregiver, as one who "tunes in and picks up on children's reactions and ideas rather than trying to impose her own predetermined goals" (p. 84). By observing what the child does, the caregiver is sensitive to the child's needs.

Each child is a unique person with an individual temperament, personality, learning style and family background. All children have their own pattern and timing of growth. While some broad expectations based upon age group can be anticipated, each

child develops at their own pace, depending upon their own characteristics (Piaget, 1972). The sensitive caregiver is aware of this and provides opportunities for learning on an individual basis (Bredekamp and Copple, 1997).

Piaget (1952) asserts that children's ability to understand depends upon their maturational level; therefore, certain cognitive skills must be present before a child can understand certain concepts. Children learn through concrete exploration and manipulation of their environments and have an inborn natural motivation to understand their surroundings and make sense of what they observe and experience.

Children are active constructors of knowledge and development and learning are the result of an interactive process Play gives children the opportunity to understand the word, interact with others in a social way, express and control emotions, and develop their symbolic abilities (Piaget, 1952; Bredekamp & Copple, 1997). Vgotsky (1978) identified that symbolic play that promotes the development of symbolic representation abilities, fosters the growth of oral language, which leads to the development of written language. It is the role and function of the responsive caregiver to provide children with unique and appropriate play opportunities.

Vgotsky's (1978) focus was on the role the social environment plays in children's cognitive growth. He recognized that there is a range, or zone, of tasks that a child cannot yet handle alone but he can accomplish with the help of more skilled partners. This zone of proximal development (ZPD) relates to development that is just outside one's own experience when working alone. ZPD is the difference between what a child can do alone and what they can do with someone's help. Vgotsky contends that children develop their competencies in interactions with others, which encourages them to challenge their

abilities. The sensitive caregiver is intuned to the child's development and provides the balance between assistance and encouragement (DeVries and Kohlberg, 1987).

Within the constructivist paradigm, the focus is on the learner. The learner interacts with the environment and gains understanding of its features and characteristics. The learner constructs his own ideas and finds his own solutions to problems. Learning is the result of individual mental construction where the learner learns by matching new against given information and establishing meaningful connections. Learning is affected by the context and beliefs of the attitude of the learner (Piaget, 1972). The constructivist caregiver encourages and provides guidance for the child to explore and find solutions to their own problems.

Piaget (1972) theorized that there are four primary developmental stages through which a person passes. Stages form an order of increasingly differentiated and integrated structures to fulfill a common function, with higher stages integrating the structures found at lower stages. According to DeVries & Kohlberg (1987), "in the final analysis, it is the quality of the environment the teacher creates, including teacher-child relationships, that either promotes or retards development (p. 84).

Ecological Theory

Bronfenbrenner's (1979) ecological theory conceptualizes the interactions between home and school as they relate to children's development. Within this theoretical framework, the child is in the center of the system, surrounded by the family and encompassed by the school, community, school policies, culture and current political ideology. All the influences that impact on the child, whether they are home or school, are part of the microsystem. The mesosystem consists of interacting microsystems

(Bronfenbrenner, 1979). It is within this structure of the mesosystem that family and school, parents and caregivers, interact to contribute to a child's academic, social, and emotional development.

The mesosystem is classified as a set of inter-relations between two or more settings in which the developing child is an active participant. The developmental potential of both the home and child care experience is enhanced when a supportive link of mutual trust, positive orientation, goal consensus and two-way communication between the settings are established (Bronfenbrenner, 1979). When child caregivers and parents work together to participate in open communication and positive interactions that include the child, the child experiences stronger attachment linkages and benefits (Marty, 2005).

Brofenbrenner (1979) identifies that child outcomes are the result of the complex and reciprocal exchanges that occur between the individual, interconnected ecological contexts and the multiple interactions that occur within and between these contexts. Participation in childcare can be seen as an extension to the complex ecology of family life (York, 1991). Because of the complexity of family systems, participation in child care can be expected to significantly impact the development and/or promotion of a secure parent-child attachment (Marty, 2005).

Bredekamp (1987) suggests that it is especially important for childcare providers and parents discuss basic values and child rearing practices, especially in the care of infants and toddlers. She notes that during these early years, children learn whether or not their environment is supportive and predictable. This communication increases the likelihood that the child will experience a consistent, stable and secure environment.

Attachment Theory

According to Bowlby (1969), when an adult, whether parent or caregiver, is consistently responsive and available when needed, the child develops a secure attachment to the adult. Secure attachment refers to the child's trust that the adult will be responsive and available for support. If the adult ignores or rejects the child's signals for assistance, or response is inconsistent, the child can develop an anxious or insecure attachment. Ainsworth (1978) identified that secure attachment is not a trait of the child, rather it refers to the confidence the child has in the availability and responsiveness of the caregiver.

Attachment is an enduring bond between a child and a caregiver who provides a source of safety in times of stress. The goal of attachment behavior is to locate protection by maintaining closeness to the attachment figure (either parent or caregiver) in response to real or perceived stress or danger (Bowlby, 1969). The quality of children's attachment relationships is dependent on the nature of the interactions with their parents or other caregivers (Cassibba, et al, 2000).

Bowlby (1969) defined that the regulation of attachment behaviors involves mental representations of the attachment figure, the self, and the environment, all of which are largely based on experiences. These representations become the 'internal working model' that allows children to anticipate the future and make plans. It is these 'internal working models' that help to shape how the child will explore the world and organize his/her life experiences (Hill, et al, 1996)

Bowlby (1969) further claims that the inability to form deep relationships with others may result when the succession of substitutes is too frequent. The lack of

consistent caregiving creates a grief and mourning process in children whenever attachment behaviors are activated but the attachment figure continues to be unavailable. For this reason, consistency of caregivers is imperative.

It is on the basis of the quality of relationships with caregivers that young children develop a set of expectations about how people behave towards them (Bowlby, 1969). It is these early relationships that lay the foundation for later personal and social competence. Attachment theory is clearly demonstrated in DAP's twelfth principle, which describes the need for children to be engaged in a safe and secure environment.

This sense of trust develops through many satisfying exchanges between the caregiver and child (Readdick & Walters-Chapman, 1994). Attachment is an important contributing factor to the child's ability to accomplish age-appropriate social, emotional and cognitive tasks in childhood and adulthood (Frankel & Bates, 1990).

Structural Variables that Impact on Quality Caregiver Interaction

As was mentioned previously, a wealth of research indicates that numerous variables impact on the quality of caregiver interaction. These variables include:

1. Education: Adults without education in child development have been found to engage in behaviors that impeded child-well being (Doherty-Derkowski, 1995). This relationship has been found internationally and in the United States, and has consistently been found in all classroom settings (Arnett, 1989, Pence & Goelman, 1991, Whitebook, et al, 1990).
2. Adult:Child Ratio: Research consistently demonstrates that caregivers who are responsible for too many children increases their harsh behavior and detachment (Whitebook, et al, 1990); and is demonstrated with a higher percentage of adult's

time spent in restricting and controlling children's behavior (Kontos and Fiene, 1986).

3. Environmental Safety: Caregivers working in space that is safe for children has been found to be less likely to resist children's activities (Howes, 1983).
4. Quality Environmental Classrooms: Research defines the link between high quality environmental classrooms and quality caregiver interaction. Moore (1986) found quality environments were correlated with larger amounts of positive involvement, and decreased detachment behavior.

The Child Caregiver Interaction Scale

Many caregiver interaction measures exist that appear suitable for specific individual studies and purposes, however, there is a definite conceptual disconnect between (DAP) and the variables and constructs that these measures seek to assess. A review of DAP, supporting theories and other research studies identifies that quality child care can best be assessed through the constructs, or domains, of 1) emotional development, 2) cognitive/physical development, and 3) social support for families/cultural competence.

The Child Caregiver Interaction Scale is a research based assessment measure of child care provider interaction. This measure is based on the Caregiver Interaction Scale (Arnett,1989), Developmentally Appropriate Practice (NAEYC, 1997), NICHD study (2003) and a host of other resource materials. (These sources will be noted and discussed in detail in each individual item and indicator below).

This measure is built on a solid foundation of practice and theory. Table 5 identifies the domains of child's development that are impacted by specific caregiver interactions, as well as the theoretical foundation, and *latent variables that are assessed.*

Table 5: Domains of Child's Development

Domains of Child's Development	Theoretical Foundation	Latent Variable
Emotional	Attachment Theory	Stability Trust
Cognitive and Physical	Constructivist Theory	Sensitivity Responsiveness
Social	Ecological Theory	Fosters Social Development/Mesosystems Cultural Consistency

This foundation is consistent with NAEYC's position statements and identification of appropriate and inappropriate practice. This measure also shares the theoretical underpinnings that are identified by NAEYC in 1997. Each of these theories and domains are discussed in depth below, along with figures that graphically depict items included within each domain.

Emotional Domain

Caring and responsive attention from adults is necessary for young children to form the first important relationships from which so much comes. It is important to consider the various elements that lead to the development of trust, attachment, and emotional responsiveness in children (Gestwicki, 1999, p. 137). Figure 4 depicts the conceptual structure associated with the Emotional Domain.

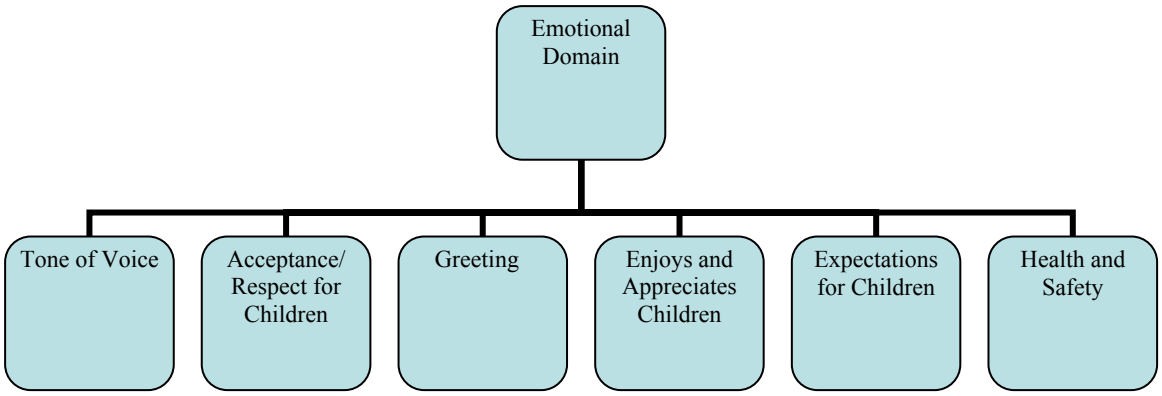


Figure 4: Emotional domain.

Tone of voice. One of the elements of positive caregiving is providing the children in care with plenty of encouragement and taking an active interest in their activities. These include behaviors such as discussing children's activities with them and praising their efforts to master a task (Doherty-Derkowski, 1995, p. 28). Research indicates children who experience high levels of positive caregiver interaction are compared with children experiencing lower level of positive interactions, the children show higher rates of exploratory behavior (Anderson et al., 1981); higher levels of language development (Whitebook et al., 1990); and more advanced cognitive functioning (Carew, 1980).

Reynolds and Jones (1996) identified ways to provide positive attention as a positive reinforcer. One way of doing this is by letting children know their positive actions are recognized, by "catching them being good" and giving appropriate and authentic reinforcement for the desirable behavior. Giving specific positive feedback helps children understand exactly what behaviors earn them positive recognition. By focusing on the positive behaviors, children learn they do not have to misbehave to get the caregiver's attention (Gestwicki, 1999, p. 178).

Acceptance/respect for children. While child development occurs in a relatively orderly sequence, individual children develop at varying rates and unevenly within different areas of each child's functioning (Gestwicki, 1999, p. 9). It is not possible to compare the development of individual children solely based upon chronological ages. Each child has their own pattern and speed of development that is unique to the child. Factors such as heredity, health, individual temperament and personality, learning styles, experiences, and family background influence development.

Greeting. Positive parent involvement in the child care program is one that "supports and complements the family in its child rearing role" (Doherty-Derkowski, 1995, p. 48). Communication between home and the early childhood setting are important because they create an environment of continuity of the child's experiences. Cloutier (1985) stresses the need for meaningful on-going communication between the parent and early childhood program. The underlying assumption is that parents and caregivers share information that provides them with a greater understanding of the child. Without this ongoing communication neither parents nor staff have the whole picture of what is occurring in the child's life.

Research indicates (Galinsky, 1988) the most frequent communication times between parents and caregivers occur when the child is dropped off or picked up. These times are critical because these may be the only time caregivers and parents have the opportunity to share information.

Enjoys and appreciates children. Detachment is defined as an "observable lack of involvement by the adult with the child" (Doherty-Derkowski, 1995, p. 39). Examples of this type of behavior may include lack of interest or involvement with children's

activities, treating children with indifference or lack of any interaction. Research indicates that children who are cared for by detached caregivers demonstrate poor language development (Whitebook et al., 1990); lower levels of developmental play (Whitebook et al., 1990); higher rates of disobedience then their peers (Peterson and Peterson, 1986); and high rates of aimless wandering (Whitebook et al., 1990).

Expectations for children. Child development research indicates fairly predictable patterns of growth and development during early childhood. Development occurs in an orderly sequence, with later skills and abilities building upon those already acquired (Gestwicki, 1999, p. 9). Understanding the behaviors and abilities related to typical development offers a framework for caregivers to know how best to support children's optimum learning. Understanding the sequence of learning abilities of children helps caregivers understand how to engage children in developmentally appropriate activities that build upon those previously learned. Given that it is difficult for development is to continue well without securing the skills of earlier stages, children need the time and patience of caregivers to proceed through the developmental sequence (Gestwicki, 1999).

Health and safety. Because of their immature immune systems, young children are more vulnerable to infections. Children in early childhood programs are exposed to a range of germs and viruses because of their increased contact with other young children. Studies indicate that children in early childhood programs are more vulnerable to diarrhea and hepatitis than their home-reared peers (Hayes et al., 1990).

Research indicates the extent to which diarrhea or hepatitis actually occurs is strongly dependent on the extent to which caregivers are vigilant about handwashing and other sanitary procedures (Black et al., 1981). In a study conducted by Black in four

community child care centers in the United States, a fifty percent decrease in diarrhea occurred when child and adult handwashing was meticulously enforced.

Further, Klein (1986, as cited by Doherty-Derkowski, 1995), from the Department of Pediatrics at Boston University School of Medicine, notes that "handwashing is the single most important technique for prevention of gastrointestinal and many respiratory infections. Compulsory handwashing after handling infants, blowing noses, changing diapers, and using toilet facilities should be expected of every caregiver" (p. 12).

Cognitive/physical Domain

Adults are responsible for ensuring children's learning and healthy development. From birth, children's relationships with adults are critical in determining the child's healthy social and emotional development, and serve as mediators of language and intellectual development. Simultaneously, children are active constructors of their own understanding, who benefit from originating and monitoring their own learning activities and engaging with peers. The quality caregiver is one that strives to balance the need for children's self-directed learning with adult support and guidance (Bredekamp and Copple, 1997, p. 16). Figure 5 depicts the conceptual structure associated with the Cognitive Domain.

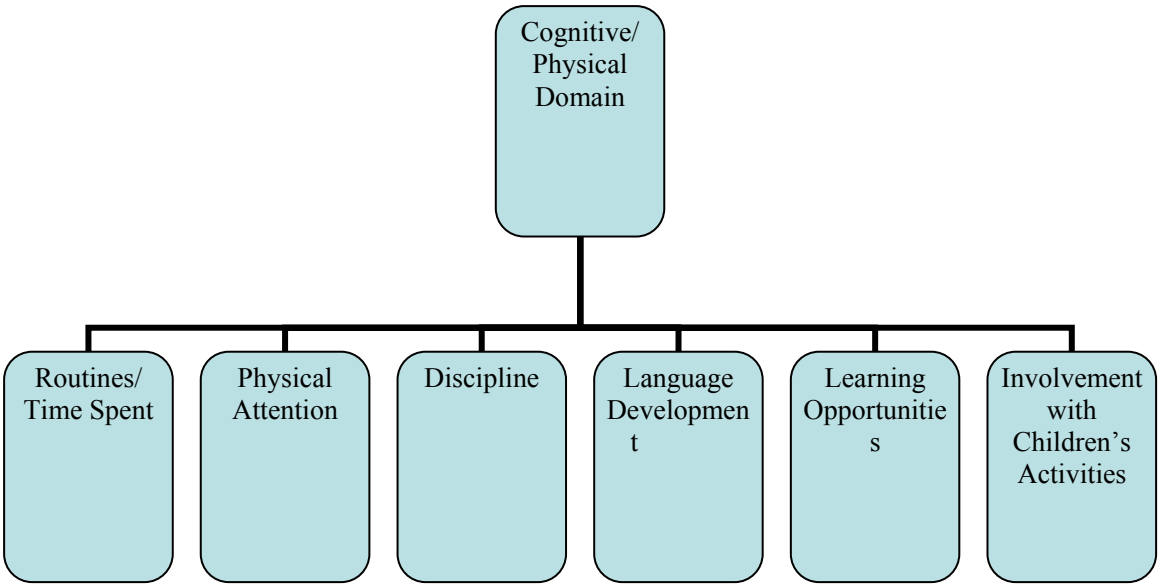


Figure 5: Cognitive/physical domain.

Routines/time spent. The indicators in this item relate to the ways in which the caregiver spends their time, as well as the routines that are established for the children in their care. While there are some definite differences in the needs for routines between the age groups (infants, toddlers, and preschoolers), they all have the same basic need for consistency balanced with flexibility.

A key element of this indicator is what is developmentally appropriate. Infants and younger toddlers should be cared for on an individual basis. A schedule, if defined as a set course of events, does not exist in an infant/young toddler room. Rather, infants should be on a self-demand schedule, one in which infants communicate their own needs and caregivers respond appropriately (Gestwicki, 1999). This sensitivity builds an infant's sense of certainty that their needs will be met by responsive caregivers. In turn, they learn that the world is a safe and trustworthy place. Because younger toddlers still vary greatly in their individual development, they also require flexibility in scheduling.

Older toddlers and preschoolers, on the other hand, are better able to adapt to schedules. Because of their need for routines, they require consistency and stability. This does not mean that their schedules need to be carved in stone. When working with children, flexibility is key. Children's interests should be encouraged, even when it does not fit with the proscribed schedule. The schedule should, however, be predictable for them: They should know that outdoor time comes after circle time, nap comes after lunch, etc (Gestwicki, 1999).

Because so much of caring for children involves *prime times*, this item stresses the importance of these times. Prime Times are identified as the basic of children's needs: food, sleep, toileting, and nurturing. Because these times account for a large part of infants, toddlers, preschoolers and caregivers day, these times can be used as rich learning experiences. These times can be used to focus on quality one-on-one interactions, regardless of the age group (Greenman, J. & Stonehouse, A., 1996).

Physical attention. Children of all ages require interactions that nurtures trust. This includes the capacity to provide consistent responsiveness by the same adults. An environment of trust is a safe, familiar place that is predictable in the patterns of things, people and events (Bredekamp and Copple, 1997, p. 69).

The physical elements of trust development are imperative to infant development. As noted by Gestwicki (1999), physical nurturing that is part of warm caregiver interaction is as critical to healthy growth as the physical essentials of food and sleep. For toddlers, whose stage of development is all about autonomy, paradoxically, one of the most difficult things for them is separation from adults that are important to them. Toddlers feel most secure when their adults (parents and/or caregiver) are nearby. While

toddlers are seeking independence, they need to kow that the caregiver is physically accessible to them when they need comfort (Gestwicki, 1999).

For preschool aged children, physical attention is also important. This stage is marked by the process of identification, where children move from wanting to be near the adults in their lives to being like them. While preschoolers gradually become less dependent o the attention and assistance from adults, they are still connected with them by affection and the desire to please and be like them. (Gestwicki, 1999).

Preschoolers are very physically active beings. For the most part they have mastered many of the large motor activities of toddlerhood. In this stage, preschoolers are working on fine tuning these skills. The physically responsive caregiver is one that assists the preschooler in their attempt to increase their coordination. This can be evidenced, for example, by helping a child peddle a bike or pump on a swing.

In general, the physically responsive caregiver is aware and sensitive to the physical needs of children in his/her care, regardless of their stage of development. This is not to say that the caregiver imposes physical affection on a child who is less physically demonstrative or needy. The key component to this item is being physically available for any child as they need the attention.

Discipline. The term discipline has numerous meanings. For example, the Webster's Dictionary offers several descriptions: to punish; teach obedience or order to; calm, controlled behavior; conscious control over lifestyle; and making people obey the rules. In early childhood literature (and the proposed measure), the term discipline is defined as guidance. In this manner, the purpose of discipline is to assist children learn how to act in socially acceptable, established rules of behavior (Gestwicki, 1999). For

this context, discipline is defined by the ways in which a caregiver helps children manage their behavior.

While it may be clear that it is important for toddlers and preschoolers to learn discipline, the use of discipline with infants can be misleading. Very young infants do not tend to exhibit the same behavioral issues that older children demonstrate. However, if we see discipline as guidance, then it should be clear that all children, regardless of their age, benefit from positive discipline. It should also be noted that this item is closely linked with developmentally age appropriate expectations for children.

Language development. Research indicates the amount of verbal stimulation and opportunities for two-way communication provided by adults has been found to be statistically significant with the child's level of language development (Carew, 1980; Golden et al, 1979; Melhuish et al., 1990), as well as the child's level of social competence (Clarke-Stewart, 1987; Phillips et al., 1987). Additionally, Clarke-Stewart (1987) found that children in home-based child care scored highest on intellectual assessments and social competence when their caregivers consistently had one-to-one conversations with them (as cited by Doherty-Derkowski, 1995).

Learning opportunities. DAP identifies that there are optimal periods for specific types of early childhood learning and development, and that these experiences have both a delayed and additive effect on individual children's development. (Gestwicki, 1999). The repeated experiences of children, both positive and negative, have implications for later development. For example, children who are provided the opportunity to develop social skills through play with peers in preschool tend to develop confidence and competence in their social relations with others. These experiences allow them to develop

familiarity and competence when engaging with their peers as they enter elementary school. They are better able to enter group learning experiences with more ease then children who do not experience these earlier social experiences. As cited by Gestwicki,

> …times of readiness for optimal learning occur in the early years and need to be taken advantage of in planning curricular experiences; for example, growing neurobiological evidence indicates that the social and sensorimotor experiences of the first years affect brain development, with lasting implications for children's learning, (p. 9).

Involvement with children's activities. Children are active learners, drawing from their physical and social experiences, as wall as knowledge that is culturally transmitted. This allows them to construct their own understanding of their world. This intellectual development occurs by the child's constructivist interaction with people, materials, activities and experiences. As children create and test their own hypothesis about how the world works, their thought processes and mental structures undergo constant revisions. Appropriate caregiver interaction and experiences provide the encouragement for these constructions. Positive caregiver interactions and teaching strategies should support children's active learning and rely less on direct communication of knowledge that young children have not created themselves (Gestwicki, 1999, p. 10).

According to Bredekamp and Copple (1997), "child-initiated learning does not occur in the absences of caregiver guidance or input" (p. 118). As noted by Doherty-Derkowski (1995)

> ….it is not sufficient enough to provide a variety of stimulating materials and an environment that encourages exploration and interaction. The adult must select

> and prepare the environment, then observe, guide, and assist the children so that they are challenged and supported in gaining information and an understanding of how things work (p. 58).

Symbolic and literacy interaction. Reading books to children, starting in infancy, is important for several reasons. This activity leads to positive associations of books and reading for pleasure. Children should be exposed to a wide array of reading materials (Barclay et al., 1995). In addition to creating a good beginning for early literacy, language acquisition is "nurtured by hearing the words, watching the adult point to large, clear pictures, going back through the same book and hearing the same words, and making the same visual connections" (Gestwicki, 1999, p. 224).

Whole language is the belief that learning oral and written language is a continual process that takes place at the same time and starts at birth. According to Bird 1987; Pearson, 1990),

> children are motivated to find ways to represent their experiences both through play and action, and through communication. Children learn that communication meets their needs, brings pleasure and friendship, and helps them understand their culture. As they are exposed to literacy, they discover that oral and written language are related and that print is another form of communication. Reading and writing are then viewed as part of a larger system for accomplishing their goals (Gestwicki, 1999, p. 263).

Along with adults providing meaningful literacy materials, activities, and support, this awareness and motivation combine to develop emergent literacy (Sawyer and Sawyer, 1993). Children use continually, experience how print language functions, and

progress to print media experiences (Gestwicki, 1999). There is no start point where children are asked to study language arts. There is an additive continuity between all language experiences, from birth through the early years, not a distinct period of "now it's time to learn to read" (Gestwicki, p. 263).

Social Domain

DAP occurs within a context that supports the development of relationships between caregivers and children, among children, among caregivers, and between caregivers and families. This caring community reflects what is understood about the social construction of knowledge and the importance of establishing an inclusive community where all children can develop and learn (Bredekamp and Copple, 1997, p. 16). Figure 6 depicts the conceptual structure associated with the Social Domain.

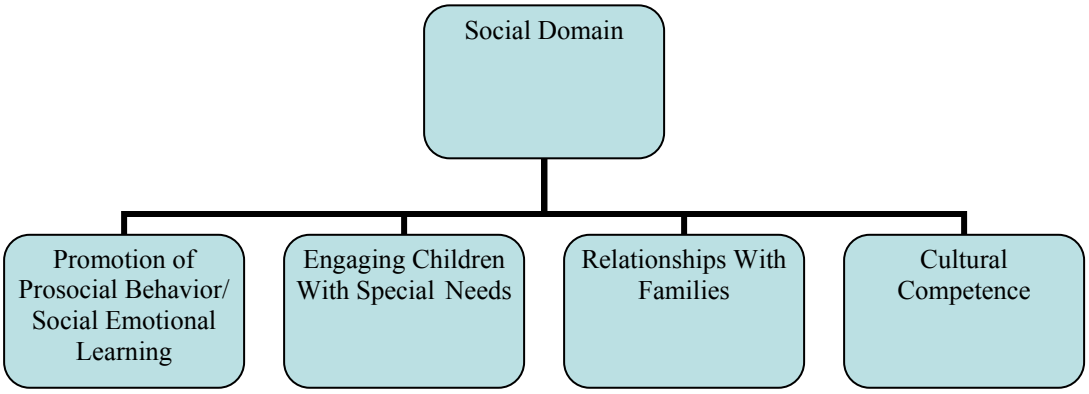


Figure 6: Social domain.

Promotion of prosocial behavior/social emotional learning (SEL). According to Gestwicki (1999), when caregivers verbalize feelings and emotions and the importance of them, children gradually develop and understanding of how others feel and what are the appropriate responses to those feelings. Caregivers help promote prosocial awareness by

seeking out opportunities for children to participate in situations that foster caring and consideration (p. 177).

Engaging children with special needs. A child is considered to have special needs whenever they require help and information beyond what is normally required by a child of the same age in order to assure the best developmental outcome (Canning & Lynn, 1990, as cited by Doherty-Derkowski, 1995, p. 133). Mainstreaming or integration is the term given to the approach of including children with special needs in child care programs with children who do not have special needs. This approach is based on research indicating children with special needs will benefit because:

> The children who do not have special needs will model (demonstrate) age-appropriate behaviors for the children with speicla needs and these children will imitate such behaviors; the mainstreamed setting will provide a more advanced linguistic, social, and cognitive environment than would be provided in a segregated program; and children with disabilities who are in a mainstreamed program will learn to be comfortable with non-disabled peers (Striefel et al., 1991, p. 135)

The caregiver has a large role in providing support and facilitating positive peer interaction between the child with special needs and their normally developing peers. Research indicates that without encouragement, normally developing children interact more frequently with other normally developing peers or with those who have a mild disability than with peers who have a moderate or severe disability. In conclusion, Odom and McEvoy (1988) report that social interaction will generally not occur between

children with moderate or severe disabilities and non-disabled children unless it is specifically encouraged by caregiving staff.

It should be clear that the inclusion of this item is not meant to be viewed as being all that is required when a child with special needs is enrolled in the child care program. The substantial body of research cited for the other items are the same for children with special needs. The inclusion of this item recognizes that a caregiver with a special needs child attending his/her program also has additional requirements to consider.

Relationships with families. Children's development is best understood within the context of their family, then their school community, and the larger community (Gestwicki, 1999). According to Bredekamp and Copple, 1997, "education should be an additive process" (NAEYC, p. 13). Children should be encouraged and supported to add new cultural and language experiences without having to give up on their family of origin contexts. Children's home languages and cultures should be respected and reinforced in early childhood settings (Gestwicki, 1999, p. 10).

Cultural competence. We live in a multicultural society where even children who are born into a homogeneous community are unlikely to live their entire lives in a similarly homogeneous environment. As stated by Doherty-Derkowski (1995),

> Inevitably, almost any child living in North America will be in a situation at one time or another where others have different beliefs and different ways of behaving. Therefore, it is important for children to develop the attitudes and skills required to live and work comfortably with people from various backgrounds. This is best done during the early childhood years when children can learn to view

differences in appearances and ways of doing things as interesting and positive rather than as distressing or threatening (p. 120).

Considerable research indicates a strong link between school success with the extent to which minority children's language and culture are incorporated into the school program (Cummins, 1986). Child care programs can encourage and support all children's identity and the development of a positive self concept by "incorporating materials and activities that respect and affirm children's race or ethnicity, by addressing signs of bias or discrimination, and by promoting collaboration between the program and the home" (Doherty-Derkowski, 1995, p. 122).

Chapter Summary

Multiple factors impact on the quality of care that out of home care children receive. Structural factors, such as adult:child ratio and caregiver's training and education have been linked to positive caregiving. Process factors, including caregiver interaction, are also important measures of quality. Each of these factors has been correlated with positive outcomes for children.

While there is no one firm definition of child care quality, there is a general consensus within the early childhood field regarding what is needed for high quality programs. High quality programs are ones that

> Include safe and healthful care, developmentally appropriate activities and materials, positive interactions with adults, encouragement of individual growth, and the promotion of positive relationships with other children. The various versions of this definition may differ in the details, but few would argue that these

> priorities are not necessary for the positive development of young children. The validity of the definition has been proven in many studies. When higher process quality is provided, all children gain in the development of skills and abilities that are associated with success in school and later in life (Cryer, 1999, p. 52).

While multiple assessment measures of process indicators exist, there is still the need for a valid, reliable, theoretical and research based global measure to assess the quality of child and caregiver interactions. The most widely used caregiver interaction measure, Arnett Caregiver Interaction Scale (1989) provides a good conceptual foundation for subsequent scales. While the CIS does have it's strengths (wide name recognition), it has serious weaknesses as well (lack of operational definitions, minimal attention to recent brain development research, and extensive adaptations in the field). Other caregiver interaction scales, many of which were created for specific research purposes, have their own limitations.

The National Association for the Education of Young Children invested much time, energy and resources into the creation of their eight principles of developmentally appropriate practice. These principles are based on a solid theoretical and research base. It seems logical that any child and caregiver interaction assessment measure should be viewed through the constructs of the cognitive, social/emotional, and family/cultural competence domains. The CCIS is based upon the solid theoretical base of DAP and is structured to incorporate these principles.

Chapter Three: METHODS

The Child Caregiver Interaction Scale (CCIS) was developed to address the limitations of the measures described in the review of caregiver interaction assessments (Chapter 2). The goal of the CCIS is to improve upon existing measures of child and caregiver interaction. This measure is theoretically grounded, research based, and closely aligned with NAEYC's Developmentally Appropriate Practice (DAP).

The following questions are addressed in this study.

1. Can a research grounded assessment instrument be developed that adequately incorporates and identifies dimensions associated with the developmentally appropriate practices, and measures the support of cognitive, emotional, and wider social relationship functioning?
2. How reliable is the CCIS instrument? What is the internal consistency of the subscales, which are cognitive, emotional, and wider social relationships? Does the CCIS have utility across age the infant, toddler and preschool age groups?
3. How valid is the CCIS instrument? Does this instrument assess global child caregiver interaction? How does this measure correlate with child care environmental rating scales and the STARS program ratings?

Scaling of the Child Caregiver Interaction Scale

As previously discussed, the Arnett CIS (1989) is a widely recognized and used measure of caregiver interaction. This project was originally intended to expand and

improve upon the existing measure. Numerous attempts were made to modify the Arnett CIS as follows:

Expanded notes for clarification: Through the course of using the Arnett CIS, it became clear that its very limited operational definitions led to inconsistencies in data collection. A short description (one paragraph) explanation was created to provide further clarification to data collectors. While this allowed for consistency of data collection within specific research studies, there was no way to know if others were interpreting the descriptors in a similar fashion.

5-point scale, versus a 4 point: While this did allow for more variability, it continued to be an arbitrary scaling method (1 = 0%; 2 = 1-25%; 3 = 26-50%; 4 = 51 - 75%; 5 = 76%+), which continued to allow a fair amount of subjectivity, and resulted in ratings that fell into extremes (i.e., caregiver rating of ones and fives).

Time sampling: This method listed each of the 40 Arnett items in a form designed to record each of the specific items. Items were grouped according to subscale (permissiveness, harshness, sensitivity, detachment, cognitive and social). Each subscale was observed for 20 minutes with partial interval data collecting every 2 minutes during an 80-minute period.

While this method allowed for less data collector subjectivity, the length of the scale (40 items) made this approach a cumbersome and lengthy process. It was extremely difficult to observe each of the items during a set time period. The measure was then divided into segments, where the observer focused on a specific number of items for a set period of time. This method led to the data collector missing important interactions that occurred while focusing on other items.

Because modifications to the Arnett CIS proved less than satisfactory, this researcher then decided to incorporate pertinent Arnett CIS descriptors into the new CCIS measure, which resulted in a more sensitive research grounded measure of child caregiver interaction.

The following scoring methodology was chosen for the CCIS. The table below graphically identifies the categories of care:

Table 6: *CCIS Scoring*

Inadequate 1	2	Minimal 3	4	Good 5	6	Excellent 7
Negative or inappropriate behavior		Functionary or custodial care. (Available) Children's basic needs are met Licensing Requirements		Engaging (Accessible) Interactive Child takes the lead		Expanding Caregiver expands on child's interests.

This scoring approach was chosen for several reasons listed below:

- A 7-point scale allows for increased variability in scoring.
- Numerous indicators comprise each CCIS item. Each of these indicators operationally defines specific actions that comprise a score. Either the behavior is present or it is not. This method removes much of the subjectivity in scoring. The proposed CCIS consists of 17 items organized into the three aforementioned domains (emotional, cognitive/physical, and social). Each item is presented as a 7-point scale with detailed criteria at four anchor points: 1 (inadequate), 3 (minimal), 5 (good), and 7 (excellent).

- This type of scoring is familiar to researchers and practitioners alike. It is used in the Infant/Toddler Environmental Rating Scale, Revised Edition (ITERS-R), Early Childhood Environmental Rating Scale, Revised Edition (ECERS-R), the School-Age Care Environment Rating Scale (SACERS) (Harms, Jacobs, and White, 1996), and the Family Day Care Rating Scale (FDCRS), (Harms, T., Clifford, R.M., and Cryer, D. (1998, 2003).

Previous Work on CCIS

Validity

Prior to this study, much work was already accomplished on the development of the CCIS. As previously stated, my original intention was to modify the Arnett CIS, rather than to create a new instrument. It was through the course of modification that the proposed CCIS was born (Carl, B. The Pennsylvania State University, Mind in the Making, IRB #21963, 11/17/05). This measure was developed "in the field" and has strong content validity. During the course of scale development, I observed approximately 85 individual child care providers of varying quality and abilities. It is through these observations, my previous six years experience in the early childhood field, and the theoretical and research base, that the actual items and indicators for the CCIS were developed.

Additionally, various versions of this scale were presented to a group of ten early childhood professionals for review. This group of individuals consisted of the Director of Children's Programming at a medium sized, inclusionary child care facility, a trainer/mentor for child care providers, and eight child care facility assessors. The method used for the process of review followed an approach outlined by DeVillis (2003).

Reviewers were asked to rate how relevant they think each item is to what it is intended to measure (p. 86).

This review was conducted by providing each expert panel member with the measurement tool and detailed descriptors for each indicator. These provided working definitions of the constructs. Reviewers were then asked to evaluate the clarity and conciseness of each item and indicator and to identify awkward or confusing items. Additionally, reviewers were asked to identify other items or indicators that were not previously identified. In these ways, the reviewers helped to maximize the content validity of the CCIS scale as identified by DeVellis (2003, p. 86).

Modifications to the instrument were discussed with reviewers. Blending the expert suggestions with principles of scale construction, the proposed CCIS was created.

Pilot Testing of CCIS

To reduce data collection error and to assure inter-rater reliability, I trained two data collectors to pilot the CCIS. Two simultaneous inter-rater reliability observations were conducted with each data collector. Across all 17 items in the CCIS there are a total of 207 indicators. Each of the reliability observations proved a high percentage of agreement by each observer on each item within one point on the seven-point scale (95%). No items were off by more than one score point.

Data collection for the pilot study was conducted in conjunction with the 2006 Keystone STARS Quality Study, administered through the Office of Child Development (OCD), Pennsylvania Department of Public Welfare. The data collectors gathering the pilot CCIS data simultaneously collected Environmental Rating Scale data for the Quality

Study. The sampling frame for this study consisted of child care providers throughout the Commonwealth.

Informed consent of pilot study participation was included in the agreement between child care facilities participating in the Keystone STARS Quality Improvement Initiative and the Department of Public Welfare. One of the stipulations of participation in STARS is agreement to participate in evaluation and assessment activities. The following statement is signed by each STARS participant:

> I understand that DPW has contracted with several established entities to be their partner agents in administering and implementing Keystone STARS. The information I provide to DPW and its agents as a participant in the Keystone STARS program is shared among these partner agents for research purposes and to inform the development of the Keystone STARS program. My provider information is entered into a database that is accessible only to DPW and its Keystone STARS partner agents (http://www.pakeys.org/Documents/SS-07%20Request%20Designation%200506%20_Revised%2010-15-05.pdf#search='DPW%20OCD, retrieved on June 28, 2006).

OCD staff was responsible for contacting pilot study participants using the following protocol:

1. Informational letters were sent to all child care providers in the sampling pool, including potential replacements. This letter informed them of the study and lets them know someone may be contacting them in the future for an observation.

2. Caregivers in the drawn sample were contacted, via telephone and/or email, and an appointment was made to conduct an observation in their facility.

The sampling design used in the 2006 Keystone STARS Quality Study was stratified, with replacement. The sample includes child care providers drawn from all regions of the Commonwealth. The sample was further delineated by "STAR level." The level, ranging from "Start with STARS" to "STAR 4,"indicates where each provider is in the STARS process. Additionally, regulated, non-STARS participating providers were being invited to participate in this study. (Because the non-STARS participating providers did not previously agree to participation in evaluation activities, they were not included in the pilot of the CCIS).

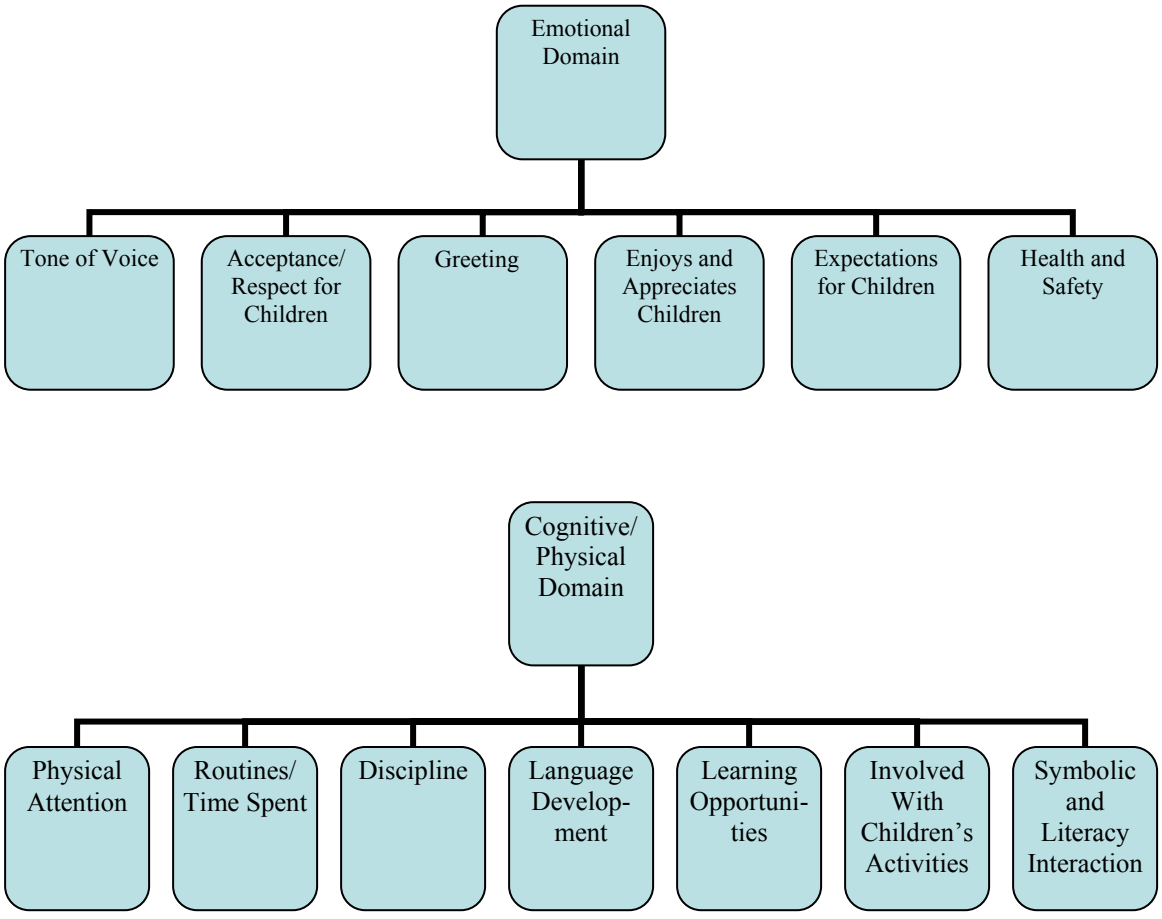
Each case in the pilot study received a unique identifying number. Data from both the Environmental Rating Scales and the CCIS were electronically provided by the two CCIS reliable data collectors in either an Excel or SPSS data file. In addition, structural components, such as caregiver education, current educational activities, number of children in care, and ratios of adult:child was collected. Further, demographic information, such as gender and ethnicity, was gathered and entered into the data file. This data has no identifiers that can be linked to any individual or facility. I did not have access to the identity of pilot study participants.

The CCIS Research Study

Upon approval from the Institutional Review Board (IRB), pilot test data was analyzed using exploratory factor analysis and Cronbach's Alpha. Exploratory factor analysis was the chosen statistic for several reasons. According to Preacher and MacCallum (2003), factor analysis should be used to identify constructs that explain

correlations among multiple variables. The success of a factor is gauged by how well it helps the researcher understand the common variation underlying the observed data.

Figure 7 is a graphic depiction of the predicted exploratory factor analysis for the study. It was anticipated the indicators would fall into three domains and there would be internal consistency within the items.



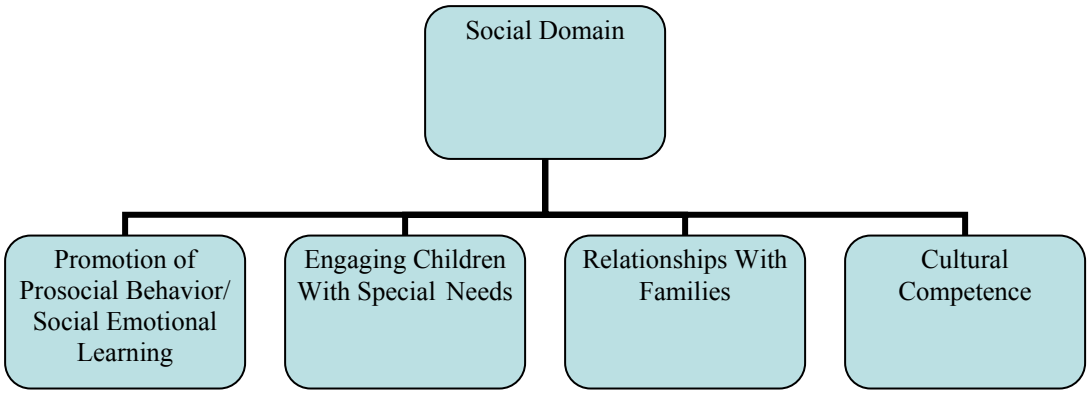


Figure 7: Exploratory factor analysis.

Exploratory factor analysis created a correlation matrix of each possible paring of items, computing an entire matrix of residual correlations (residual matrix), each representing the amount of co-variation between particular items that exists beyond the co-variation that a single latent variable can explain.

There are several methods to determine how many factors to extract. Green and Salkland (2003) suggest using the eigenvalue and scree test as methods of identifying factors. In the eigenvalue rule, each item is given an eigenvalue which is the amount of variance of the variables accounted for by a factor. An eigenvalue for a factor should be greater than or equal to zero and cannot exceed the total variance. According to the eigenvalue rule (Kaiser, 1960, as cited by DeVillis, 2003), factors with less than 1.0 (containing less information than the average item, which is valued at 1.0) should not be retained.

The scree test is based on eigenvalues but uses their relative value rather than absolute values as criterion. This method calls for plotting scores and discarding those that fall in the horizontal part of the plot. According to Green and Salkland (2003) this criterion yields more frequent accurate results than the eigenvalue criterion. It proved to

be beneficial to use both the statistical model, as well as the scree, since the scree provides a visual, rather than just numerical depiction.

Cronbach's coefficient alpha was the statistic calculated on the CCIS as the measurement of internal consistency. This method was used because it is a statistic that measures internal consistency reliability among a group of items that are combined to create a single scale. This statistic reflects the homogeneity of the scale. It is an indication of how well the different items in the scale compliment each other in the measurement of different aspects of the same variable (DeVillis, 2003).

Checking for internal consistency demonstrates the internal consistency between scale items. If the internal consistency is low, the scale can be improved by either adding more items, or reexamining the wording of existing items to add clarity. Reliability testing provides clarity on how well the instrument works on a given population.

The design of this study allowed for assessment of child and caregiver interaction. Classroom observations were conducted using the CCIS and compared to results of the Environmental Ratings Scales (ITERS-R, ECERS-R, SACERS, or FDCRS). The CCIS results were compared to the composite score of the Environmental Rating Scales. This method of concurrent validity allows for the "correlation with other tests that have been validated as measuring the attribute of interest or by means of factor analysis to support the structure of the attribute as it has been designed" (Mertens, 1998, p. 294). Comparison to the multiple Environmental Rating Scales also assessed the utility of the CCIS across age groups and locations. This helped to determine if the indicators in the scale were appropriate for multiple child caregiving age ranges and settings.

Convergent validity was assessed by exploring the relationship between the caregiver interaction subscale of the Environmental Ratings Scales and the CCIS. Similarly, discriminant validity was explored by examining the relationship between the space and furnishings subscale of the Environmental Rating Scales and the CCIS. Finally, construct validity was assessed by conducting regression analysis with the CCIS on a variety of factors that have been linked to higher quality caregiver interaction, including education, STAR level of the facility, years of experience in child care, and adult/child ratio.

Main Study

Sample

Data for this study was collected in conjunction with existing data collection efforts, including the 2006 Keystone STARS Quality Study. Analysis of study participants for this study and those of the larger 2006 Keystone STARS Quality Study reveal a similar sampling pattern. Family child care homes comprise 40.2% of the CCIS study, compared to 37.7% of the Keystone STARS Quality Study. Preschool aged programs in the CCIS study constitute 59.8% of the sample, versus 62.2% of the larger study. Further, exploring the STAR level of participants in each study revealed a similar sampling pattern between high and low STAR levels. These results indicate participants in this study comprise a reasonably representative sample of the larger Keystone STARS Quality Study and also of the total child care facilities population in Pennsylvania, as this study also includes other specific groups (infant/toddler care and school aged care) that are not included in the larger 2006 study.

This researcher strove to administer the measure to as close to 200 caregivers as possible. This number of administrations is suggested by Nunnally (1978) as a method to "concentrate on the adequacy of the items to eliminate subject variance as a significant concern" (DeVillis, 2003, p. 88).

This large study pool was important for several reasons. According to DeVillis (2003), using too few subjects may present concerns about the covariance of items. An item may appear to increase internal consistency, when in fact it does not. If the scale is then administered to a larger sample, these items may no longer obtain alpha.

The second reason for increasing the sample size is that the development sample may not be representative of the population for which the scale is intended. While this may also happen when using a larger sample, a small sample is more likely to exclude certain types of individuals (DeVillis, 2003, p. 89).

Ethical Considerations

According to Bickman and Rog (1998), "ethical research practice entails skillful planning and management of communication, reduction of risk, and creation of benefits, as these issues pertain to the stakeholders in the research" (p. 128). Stakeholders are not just those who fund the research, but also include study participants. This consideration of the interests of all stakeholders betters the chances for successful completion of the research.

Study participants were all involved with the Keystone STARS initiative and thus previously signed a contract indicating they agree to participate in research and evaluation studies. Additionally, data collected for the CCIS was kept in a locked secure

location that was accessible only by the Principal Investigator. This was IRB approved and followed the IRB protocol created for the protection of human subjects.

Summary

The goal of this study and the CCIS was to improve upon existing measures of child and caregiver interaction, with the express purpose of creating a global assessment of the quality of caregiver interactions with children. This measure is theoretically grounded and research based, and closely aligned with NAEYC's Developmentally Appropriate Practice.

The CCIS consists of 17 items, 207 indicators, representing three domains: Emotional, cognitive/physical, and mesosystem support. Each item is comprised of numerous indicators. Each of these indicators operationally defines specific actions that comprise that score. Either the behavior is present or it is not. This method removes much of the subjectivity in scoring. Each item is presented as a 7 point scale with detailed criteria at four anchor points: 1 (inadequate), 3 (minimal), 5 (good), and 7 (excellent).

The study coincided with data collection efforts conducted by the Office of Child Development, Pennsylvania Department of Public Welfare in their 2006 Keystone STARS Quality Study. The sampling design used in the 2006 Keystone STARS Quality Study was stratified, with replacement. The sample included child care providers drawn from all regions of the Commonwealth. The sample was further delineated by "STAR level". The level, ranging from "Start with STARS" to "STAR 4", indicate where each provider is in the STARS process. Additionally, regulated, non-STARS participating STARS providers were invited to participate in this study. Data was both primary (CCIS) and secondary (Environmental Rating Scales).

Data was analyzed using SPSS and included exploratory factor analysis and Cronbach's alpha. Convergent validity was assessed by exploring the correlation between the CCIS average and the "Interaction" subscales of the ERS. Concurrent validity was assessed by comparing CCIS ratings to the Environmental Rating Scales. Discriminant validity was explored by assessing the correlation between the CCIS average and the "Space and Furnishings" subscale of the ERS. Construct validity was further assessed by exploring the relationship between the CCIS average and the STAR rating and education level of the caregiver.

Chapter Four: RESULTS

The link between high quality early childhood experiences and positive child outcomes is well documented. Because of the large number of children in out of home care, the quality of their experiences is important. Research supports the notion of the combination of classroom environment and caregiver interaction in defining the quality of childcare. While instruments that measure environmental quality exist, a scientifically sound and research based instrument to assess the global quality of child care staff interactions is lacking.

A global measure, as defined by Doherty-Derkowski (1995), "focuses on a number of different characteristics at the same time" (p. 16). These include elements that Doherty-Derkowski recommends for identifying high or low quality child care programs:

- The development of a composite measure of quality for each program by assigning a score to a number of program characteristics in order to create an overall score. The most common characteristics used for this purpose are: the number of children per adult (staff-to-child ratio), staff training, and number of children per classroom.
- The use of an observational rating scale that provides a score for a number of different characteristics of the program, as well as a total score for it.

Quality child care is generally defined as experiences that enhance the social, cognitive and emotional development of children (Howes, 1997). Quality care is comprised of two dimensions – structural and process. Structural quality components include group size, adult/child ratio, and teacher education/training. Process quality is

identified as the experiences of children while they are in care. These components include the interactions between children and their caregiver, as well as the opportunities present in the environment (Cryer, 1999). Much research has been conducted over the last 25 years to examine the components of quality child care (Galinsky, et al. 1994, Whitebook, Howes, and Phillips 1990, for example).

Numerous measures to assess the process quality of child care have been developed in the past 25 years. Each measure represents "a version of process quality that is assumed to produce specific child outcomes. Some have been used in research, while many were designed to evaluate and improve program quality" (Cryer, 1999, p. 45). A review of the early childhood literature indicated that most measures were created for specific studies and for specific outcomes. For example, the Howes Adult Involvement Scale (Howes & Stewart, 1987) and The Observational Record of Caregiving Environment (National Institute of Child Health and Human Development, 2003) focus on a specific child (the unit of analysis of their studies), rather than assessing general caregiver interaction defined as interaction with all children.

The most widely used measure of caregiver interaction is the Arnett Caregiver Interaction Scale (CIS) (1989). Because of its widespread use, this measure was used as the starting point for the current development of the Child Caregiver Interaction Scale (CCIS). As outlined in Chapter Two, the CIS does have strengths; however, it also has severe limitations. These limitations include not incorporating current research on developmentally appropriate practice and brain research; the lack of operational definition; multiple versions; and limited variability within its item scales.

The Child Caregiver Interaction Scale (CCIS)

The CCIS, which I have developed, is a comprehensive observational measure that assesses the quality of caregiver interaction with all the children in care. Seventeen items were constructed based upon the National Association for the Education of Young Children's (NAEYC) Developmentally Appropriate Practice (DAP) position statements (Bredekamp and Copple, 1997). These statements represent the current best understanding of theory and research about what practices are most supportive and respectful of children's healthy development (p. vi). Items were developed to assess the child caregiver's demonstrated abilities related to supporting the emotional, cognitive and social needs of the children in care.

Objectives and Hypothesis of the Current Study

1. Can a research grounded assessment instrument be developed that adequately incorporates and identifies dimensions associated with the developmentally appropriate practices, and measures the support of cognitive, emotional, and wider social relationship functioning?
2. How reliable is the CCIS instrument? What is the internal consistency of the subscales, which are cognitive, emotional, and wider social relationships? Does the CCIS have utility across age groups (i.e., infant, toddler, preschool and school-age).
3. How valid is the CCIS instrument? Does this instrument assess global child caregiver interaction? How does this measure correlate with child care environmental rating scales and established quality improvement program ratings?

Procedures

A university Intuitional Review Board approved all procedures for this study. The data for this study was collected in conjunction with existing data collection efforts. Beginning in April 2006 and continuing through summer 2006, the Pennsylvania Department of Public Welfare, Office of Child Development, conducted an evaluation of the Keystone STARS initiative. This initiative is a system of continuous quality improvement for child care through standards, training/professional development, technical assistance, resources, and support. Keystone STARS works to support the capacity and quality of child care programs through performance standards, financial incentives, and STAR designation awards.

Additional data were collected from child care providers who participated in training programs, including Mind in the Making (social/emotional training for the care provider) and Child Development Credential (targeted child education) Programs. Care was taken to only include providers who are enrolled in the Keystone STARS Quality Initiative as they previously consented to participation in research projects.

Each child caregiver included in this study was observed by one of three data collectors for one approximately three-hour period of time. The overall number of caregivers observed was 223. Each of these data collectors was trained on both the age appropriate environmental rating scale, as well as the CCIS.

Inter-rater Reliability

Three data collectors (including myself) who previously demonstrated reliability on the Environmental Rating Scales were trained on the CCIS measure. I conducted a four hour workshop on the CCIS and also conducted onsite reliability observations with

two data collectors. Four separate data collector reliability observations occurred during the course of this data collection effort. These observations consisted of me and two other data collectors observing the same caregiver at the same time, scoring the measure independently, and then reviewing our scores for agreement. I conducted two reliability observations with each data collector during the course of this study.

In Mid-March, 2006, two data collector reliability observations occurred within two days of one another. Approximately two months after the start of this data collection effort a second set of inter-rater reliability observations was conducted. Table 1 reflects the high level of agreement between observers on the CCIS measure. The Intraclass Correlation (ICC) statistic was computed. According to Shrout and Fleiss (1979), the ICC is used to measure inter-rater reliability for two or more raters. According to Garson (2007),

> ICC will approach 1.0 when there is no variance within targets, (ex., subjects) indicating total variation in measurements on the Likert scale is due solely to the target variable. That is, ICC will be high when any given row tends to have the same score across the columns (which are the raters). For instance, one may find all raters rate an item the same way for a given target, indicating total variation in the measure of a variable depends solely on the values of the variable being measured -- that is, there is perfect inter-rater reliability (Retrieved from http://www2.chass.ncsu.edu/garson/pa765/index.htm on April 8, 2007).

The mixed model and a single measure version of the ICC was the chosen procedure for several reasons. This model considers the sites to be random, while the raters are considered fixed. This model allowed for generalizing to future site ratings. The

single measure reliability option was chosen for analysis because future data collection will be conducted by a single rater, versus using multiple raters and averaging their scores. Each of the independent observations produced high interclass correlations, indicating the CCIS measure demonstrates high reliability. Additionally, each individual item demonstrated high reliability, with no item being off by more than one score point.

Table 7: *Inter-rater Agreement As Measured by Single Measure Interclass Correlation*

Reliability Observation	Interclass Correlation Overall CCIS
1	.885
2	.925
3	.879
4	.898

Some of the data collection was incomplete and the original set of 17 items was decreased to 15. Item #3, "Greeting," was omitted because of incomplete data (n = 121). Item #15, "Engaging With Special Needs Children," was also omitted because of the low number of cases (n = 24) where a special needs child was enrolled in the program.

At the end of the data collection phase, variation among the three raters was again investigated along with the dispersion of each measure across observations. Figure 8 presents box plots highlighting the medians, interquartile ranges, and distributional tails of the overall CCIS average score by data collector. Please note that the data plotted do not include common sites across the three observers. Accordingly, differences in means and variances for the three observers may reflect actual differences in the sites they observed.

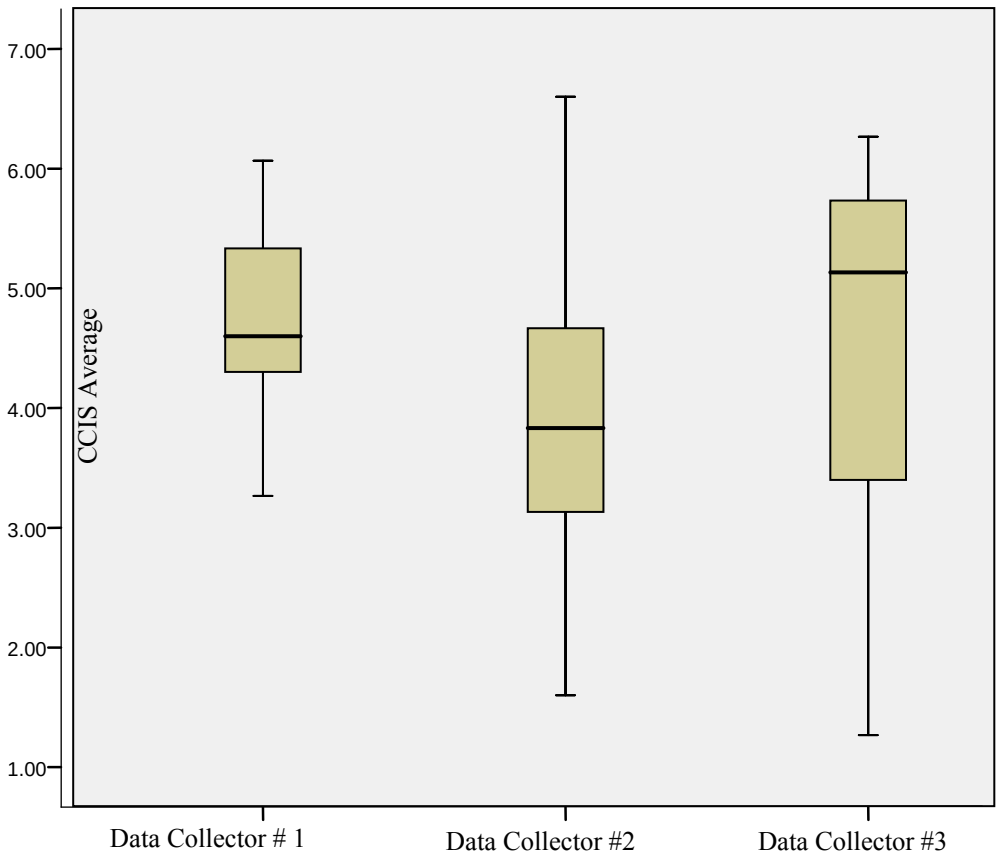


Figure 8: Overall CCIS average by data collector.

Note: These plots represent the medians, interquartile ranges, and upper and lower tails of the distribution.

Results revealed that Data Collector #1 produced data of limited dispersion. Data Collector #2 produced data that was more symmetrical and was reasonably dispersed. Data Collector #3 was somewhat negatively skewed, yet also produced results with adequate dispersion. While the median of Data Collector #3 is quite different from that of Data Collector #2, the mean of Data Collector #3 is closer to Data Collector #2 than to that of Data Collector #1

The means and standard deviations of the overall CCIS average score for each assessor are presented in Figure 2. An Analysis of Variance (ANOVA) was conducted to determine if there were any statistically significant differences in the mean ratings of the assessor (n = 181). The ANOVA was significant, $F(2, 178) = 6.738$, $p = .002$. Follow up tests were conducted to evaluate pair wise differences among the means of each data collector. Because the Levene's test statistic was significant, $F(2,178) = 8.209$, $p < .001$, the assumption of equal variance was not met. As a result, post hoc comparisons were conducted using the Dunnett's C test. This test does not assume equal variances among the three data collectors. This statistic revealed there was a significant difference in the means between Data Collector #1 and that of Data Collector #2 and #3. There was no significant difference between collectors #2 and #3.

Table 8
95% Confidence Intervals of Lower and Upper Bound Pairwise Differences in Mean CCIS Averages By Data Collector

Data Collector	*M*	*SD*	Data Collector #1	Data Collector #2
Data Collector #1	4.755	.705		
Data Collector # 2	3.975	1.155	.376 to 1.187*	
Data Collector #3	4.559	1.525	-7.081 to 1.100	-2.907 to 1.459

Note: An asterisk indicates that the 95% confidence interval does not contain zero, and therefore the difference in means is significant at the .05 significance using Dunnet's C procedure.

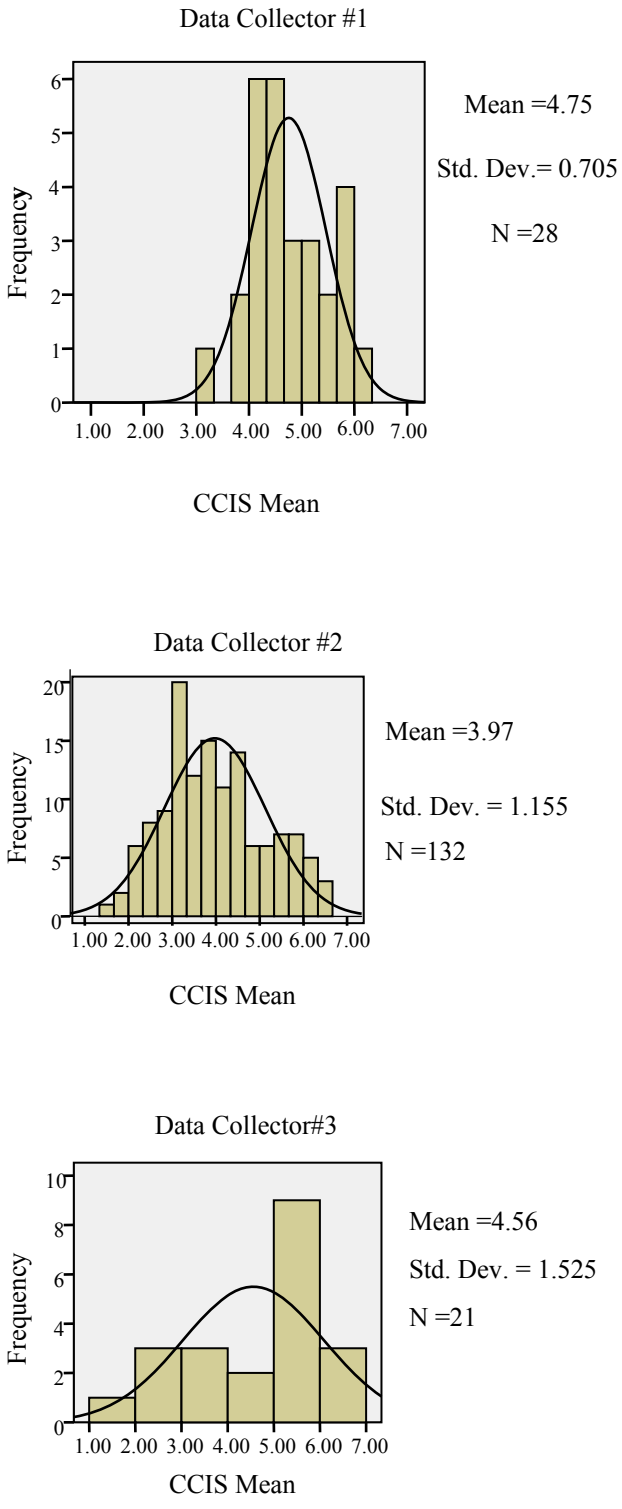


Figure 9: CCIS means and standard deviations by data collector.

Data Collector #1 presented limited dispersion (range = 3.00 to 6.88). Because data associated with Collector #1 was far more leptokurtic and did not produce observation scores that varied sufficiently across the range of the item scales, and because the mean of the average CCIS scores was significantly different than the other data collectors, these data were dropped from further analysis. While the data from Collector #3 demonstrated a positive skew, it also indicated reasonable variation across observations. Also, the mean scores were not statistically significantly different from that of Data Collector #2. The data were therefore retained for further analysis.

To explore the robust nature of CCIS assessments, analyses of data from all three data collectors (n = 181), data from Data Collector #2 only (n = 132), as well as the combination of data from Data Collector #2 and #3 (n =153) were conducted. A comparison of the separate analyses revealed no substantively important differences in the results thereby supporting the notion that the CCIS yields a fairly robust measure that can handle a degree of differentiation among raters. However, in an effort to be conservative, the remaining results include observations from Data Collector #2 and #3 combined.

Exploratory Factor Analysis

Subscale Identification

Exploratory factor analysis was conducted in order to determine if the CCIS scale is comprised of the three theoretically proposed constructs of "Emotional," "Cognitive," and "Social" As discussed in previous chapters, Developmentally Appropriate Practice, supporting child care theories and other research studies identify that quality child care can best be assessed through in terms of three constructs or domains: 1) emotional

development, 2) cognitive/physical development, and 3) social support for families/cultural competence.

Three criteria were used to determine the number of factors to retain: the null hypothesis that the measure was unidimensinal, the use of a scree plot, and the interpretability of the factor solution. The scree plot (Figure 10) indicated that my original hypothesis of three distinct factors was incorrect. Based on the plot, it is clear that only one factor exists. As presented in Table 9, Factor One accounted for 51.4% of the item variance and the Factor Two, "Cultural Competence" only accounted for an additional 4.1% of the item variance, combining to account for a total of 55.4% of item variance. While the "Cultural Competence" item does score high on the second factor, it scores equally high with the first factor. Because these results, in conjunction with the scree plot clearly indicate retaining only one factor, "Child Caregiver Interaction," no additional factor analytic procedures were conducted.

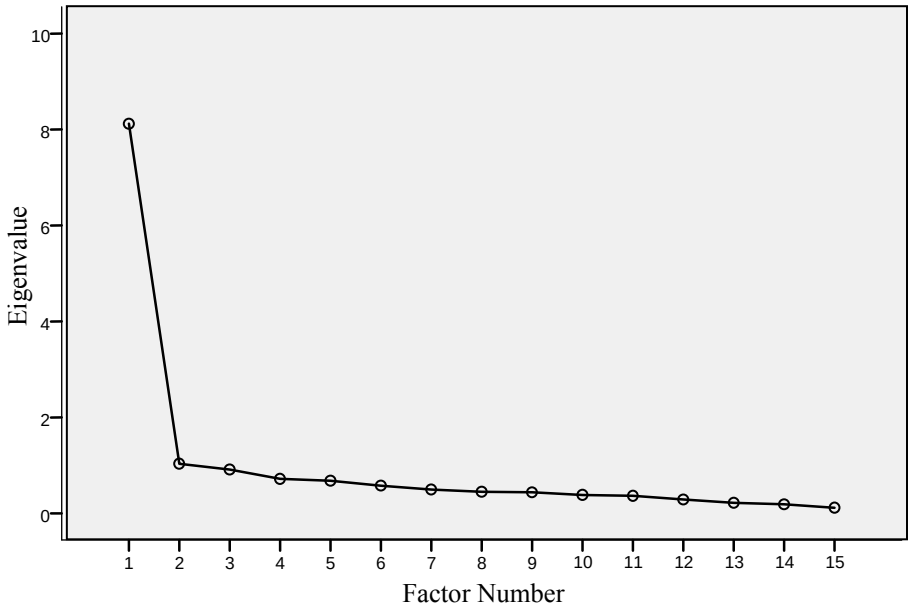


Figure 10: Factor analysis scree plot.

Table 9: *Factor Matrix of CCIS Items*

	Factor	
	1	2
Tone of Voice	.763	-.146
Acceptance/Respect for Children	.864	-.198
Enjoys and Appreciates Children	.821	-.140
Expectations for Children	.828	-.113
Health and Safety	.460	.049
Routines/Time Spent	.687	-.030
Physical Attention	.686	-.044
Discipline	.841	-.182
Language Development	.709	-.007
Learning Opportunities	.766	-.045
Involvement with Children's Activities	.715	.064
Symbolic and Literacy Involvement	.567	.389
Promotion of SEL	.698	.112
Relationships with Families	.658	.085
Cultural Competence	**.560**	**.553**

Extraction Method: Principal Axis Factoring.
Two factors extracted. 21 iterations required.

The originally proposed factors (emotional, cognitive and social support) have a strong theoretical overlap suggesting some plausibility for these results. It seems understandable that a caregiver high on one factor would perform high on the others. According to Bredekamp and Copple (1997, p. 8)),

> Developmentally appropriate practices result from the process of professionals making decisions about the well-being and education of children based on at least three important kinds of information or knowledge:
>
> 1. what is known about child development and learning – knowledge of age-related human characteristics that permits general predictions within an age range about what activities, materials, interactions or

experiences will be safe, healthy, interesting, achievable, and also challenging to children.

2. what is known about the strengths, interests, and needs of each individual child in the group to be able to adapt for and be responsive to inevitable individual variation; and
3. knowledge of the social and cultural contexts in which children live to ensure that learning experiences are meaningful, relevant, and respectful for the participating children and their families.

While these areas of information tend to overlap and complement each other, the literature and research used in formulating DAP present a strong theoretical base for the existence of the subscales previously anticipated as factors, even though this analysis revealed that they statistically fall within a single dimension, "Child Caregiver Interaction." Hence, given the theory and the child care research previously presented, it is important to view these three constructs as distinct dimensions of the "Child Caregiver Interaction" factor. While this factor analytic procedure provided an inductive analysis of the data, the available theory and current body of research strongly supports a deductive decision to consider the existence of all three subscales or domains. This is especially true from a training and technical assistance standpoint.

To further explore the relationship between the three domains, Pearson Correlations (r) were conducted to see if good caregivers scored high on all three subscales while poorer caregivers scored lower on all three subscales. Table 10 presents the results of this analysis and shows each of the three subscales correlating positively with each other. The correlations were greater than or equal to .699 and each correlation

was statistically significant. A caregiver scoring high on one subscale tended to score high on the others and visa versa.

Table 10: *Correlations Between Subscales and Overall CCIS*

	Emotional	Cognitive	Social
Overall CCIS	.950*	.966*	.830*
Emotional		.868*	.699*
Cognitive			.753*

Note: An asterisk indicates the correlation is significant at the 0.01 level (2-tailed).

Measurement Variability

One of the motivations for the development of the CCIS was the lack of an existing measure that adequately assesses child caregiver interactions. A major limitation of the existing CIS (Arnett, 1989) was the limited variability of the measure. The original CIS used a four point scale, which was arbitrarily derived and not built on accepted research foundations used for scale and measurement development. While the CIS measure was effective at assessing the extremes in terms of really good, or really poor caregivers, it could not adequately distinguish caregivers that fall in the mid range of effectiveness. The CCIS was created using a 7-point interval-like scale to offer an instrument with greater ability to assess the areas of caregiver strength and areas for improvement. In addition, the CCIS was carefully constructed in terms of the current DAP body of knowledge. It was anticipated that this dual approach to construction would yield assessment measures more normally spread, versus the polarized or bimodal results realized through the Arnett.

Figures 11 through 14 depict histograms with normal curve overlays for the CCIS and its subscales. Each of the subscales and the CCIS overall depict fairly normal looking distributions, in terms of symmetry, and spread which supports the notion that the CCIS

does a good job of measuring the full breadth of observed caregiver interactions under assessment. In terms of variability, the improvement achieved using the CCIS measure over the polarized Arnett measure is noteworthy.

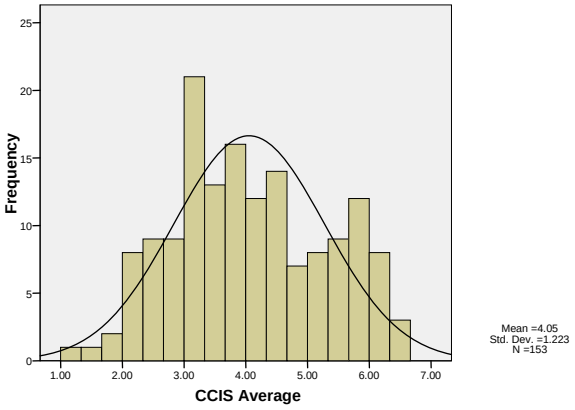


Figure 11: CCIS overall average.

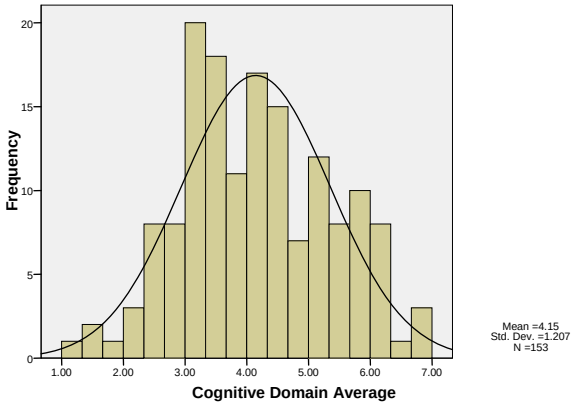


Figure 13: Cognitive domain average.

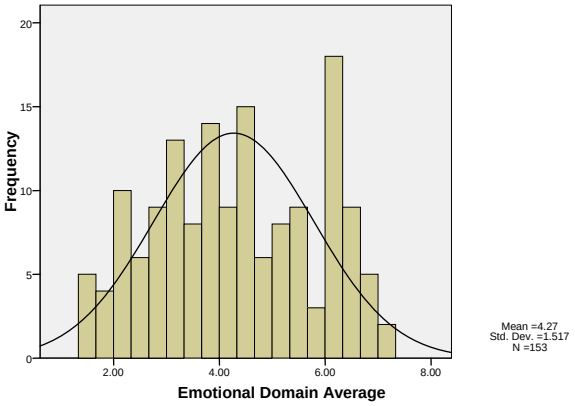


Figure 12: Emotional domain average.

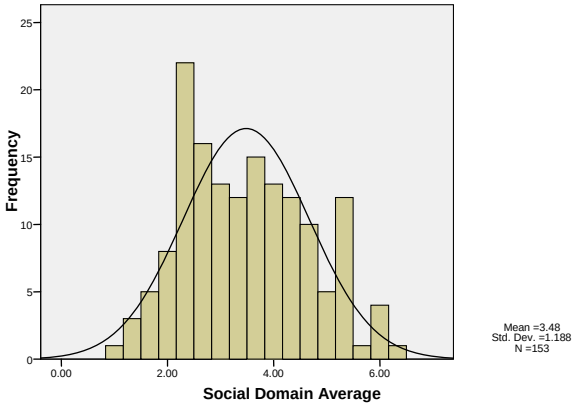


Figure 14: Social domain average.

Internal Consistency

Analysis of CCIS for All Age Groups and Settings

Cronbach's alpha was conducted to determine the internal consistency estimate of reliability for the Child Caregiver Interaction Scale. Given the high correlation between the items on the CCIS we would expect to see a strong coefficient alpha. Analysis revealed a substantially high alpha of .938, which indicates very good reliability. This coefficient meets the criterion for scales outlined by DeVillis (2003, p. 96), which states that scales intended for individual diagnostic purposes should have high reliabilities, preferably in the mid-.90s.

Item analysis was conducted on all 15 retained items hypothesized to assess Child Caregiver Interaction. The corrected item-total correlation was used to examine the correlation between each item and the rest of the scale, without that item being considered part of the scale. Without this correction, the correlation would be inflated, since the item would count twice in the calculation of the correlation (Green and Salkind, 2003). As Table 12 reports, the corrected item-total correlations were all higher than .50 except for the "Health and Safety" item (.447).

The "Health and Safety" item does differ in context from the other 14 items in that it clearly relates to specific environmental hazards potentially present in the classroom. While this item somewhat differs from the other items, based upon child care research that stresses the importance of this indicator; and given that Cronbach's Alpha is only minimally impacted by this item's exclusion, this item was maintained in the final scale.

Table 11: *CCIS Item Analysis, All Age Groups*

Cronbach's Alpha = .938		
	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Tone of Voice	.737	.932
Acceptance/Respect for Children	.834	.930
Enjoys and Appreciates Children	.794	.930
Expectations for Children	.799	.930
Health and Safety	**.447**	**.939**
Routines/Time Spent	.663	.934
Physical Attention	.665	.934
Discipline	.809	.930
Language Development	.686	.934
Learning Opportunities	.743	.932
Involvement with Children's Activities	.694	.933
Symbolic and Literacy Involvement	.546	.937
Promotion of SEL	.680	.934
Relationships with Families	.643	.935
Cultural Competence	.522	.937

Analyses of the theoretically derived subscales each revealed a moderately high Cronbach's Alpha with relatively high corrected item-total correlations (Tables 12 through 14). Considering the unequal number of items in each domain, these results are not surprising. The Emotional subscale is comprised of 5 items (alpha = .87), the Cognitive subscale consists of 7 items (alpha = .88), and the Social subscale consists of only three items (alpha = .72). Based upon child care research, which stresses the importance and relevancy of these subscales, and given that the Cronbach's Alpha coefficients reveal moderately high internal consistency, the subscales appear to be reliable measures. Although the specific subscale coefficients should be considered when

interpreting subscale results, the results suggest that evaluators and researchers can use the entire scale and/or each subscale separately.

Table 12: *Emotional Subscale Analysis, for All Age Groups*

Cronbach's Alpha -= .869		
	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Tone of Voice	.726	.834
Acceptance/Respect for Children	.842	.811
Enjoys and Appreciates Children	.751	.827
Expectations for Children	.730	.833
Health and Safety	.452	.892

Table 13: *Cognitive Subscale Analysis, for All Age Groups*

Cronbach's Alpha = .875		
	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Routines/Time Spent	.651	.858
Physical Attention	.634	.860
Discipline	.734	.847
Language Development	.697	.854
Learning Opportunities	.683	.854
Involvement with Children's Activities	.692	.853
Symbolic and Literacy Involvement	.512	.874

Table 14: *Social Subscale Analysis, for All Age Groups*

Cronbach's Alpha = .716		
	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Promotion of SEL	.564	.590
Relationships with Families	.538	.624
Cultural Competence	.505	.662

Validity

The CCIS proved reliable in terms of high internal consistency as evidenced by the Cronbach's alpha statistic. In order to demonstrate validity of the scale, further analysis was conducted. Aspects of content, concurrent, convergent, discriminant, construct and external validity were investigated. As was discussed and detailed in Chapter 2, the CCIS was systematically constructed to yield a content valid instrument based upon a solid foundation of child care theory and research. Additional validity issues were explored in terms of the same theoretical and research base. These include the following:

- Concurrent validity was explored by correlating the CCIS average and the overall Environmental Rating Scale (ERS) average, which were collected at the same time. This correlation was chosen because each of the ERS scales have been established as reliable and valid measures of quality in the early childhood field.
- Convergent validity was assessed by exploring the correlation between the CCIS average and the "Interaction" subscales of the ERS. This subscale was chosen for comparison because of its theoretical association with the CCIS in terms of caregiver interaction, versus a purer measure of the physical environment.

- Discriminant validity was explored by assessing the correlation between the CCIS average and the "Space and Furnishings" subscale of the ERS. This was chosen for analysis because the "Space and Furnishings" subscale provides a stronger focus on the classroom environment versus that of the caregiver interaction.
- Construct validity was assessed by exploring the relationship between the CCIS and the STARS rating. The STARS rating was chosen for assessing construct validity because other research studies indicate a positive correlation between the STARS ranking and quality of care (Fiene, et al, 2002, Fiene, 2006). Construct validity was also assessed by exploring the relationship between scores on the CCIS and various caregiver characteristics including the education level of the child care provider, training hours completed, and years of caregiver experience, in addition to the adult/child ratio. This analysis was conducted because previous research indicates these variables impact on the quality of care provided.
- External validity was investigated by exploring if the CCIS could adequately measure across multiple age groups and settings. The CCIS was used on infant/toddler, preschool, school-age, and home based child care.

Concurrent, Convergent, and Discriminant Validity

The correlation between the CCIS and the overall ERS ratings average was significant (.740, $p<.001$). According to Hamilton (1996, p. 318), this represents a moderate to strong positive linear relationship between the two assessment measures. The correlation between the CCIS and the "Interactions" subscale of the ERS scale was also significant, (.745, $p<.001$). Again, this indicates a moderate to strong positive linear relationship between the two assessment scales. However, while the correlation between

the CCIS and the "Space and Furnishings" subscale of the ERS was significant, it was also lower than the other two correlations (.667, $p<.001$).

These results were expected. Good caregivers provide for a safe and healthy environment and a positive relationship with the CCIS was therefore anticipated. Similarly, both the ERS and the CCIS contain specific health and safety related measurement items also yielding an expected positive relationship. The ERS "Space and Furnishings" subscale, however, focuses more on the physical environment than the caregiver environment and a lower correlation was expected. While good caregivers operate to ensure a good physical environment, as measured by the ERS "Space and Furnishings" subscale, the CCIS more specifically measures the caregiver interaction.

Construct Validity

Clearly, child caregiver interactions are affected by a variety of factors. For purposes of this analysis, the factors of education, STAR level, years of experience in child care, and the adult/child relationship were explored using multiple regression. Multiple regression is a *technique that allows additional factors to enter the analysis separately so that the effect of each can be estimated. It is valuable for quantifying the impact of various simultaneous influences upon a single dependent variable* (Skyes, 2005, p. 8).

Taking DAP into consideration, one would hypothesize that a positive relationship exists between the CCIS and the STAR levels. One would also expect to find a positive relationship between care giver education levels and the CCIS, but no relationship between years of experience and the CCIS. Research has indicated that education more than experience has a positive relationship with quality care giving.

Research also suggests that the adult/child ratio may potentially have a significant negative effect on the quality of care giving and it was therefore necessary to include this variable in the analysis.

Table 15: *Multiple Regression Analysis*

F (4, 146) = 4.85, p = .001
R Squared = 0.1172

CCIS Average	Coefficient	Std. Regression Coefficient	*t*	*p*	1/VIF (Tolerance)
Education	.1205559	.181	2.31	0.022*	0.971212
Total Years Experience	-.0039845	.006	-0.04	0.965	0.982710
Star Level	.1951514	.258	3.35	0.001*	0.923812
Adult/Child Ratio	.0026994	.0005	0.08	0.933	0.935129
Constant	2.937148	.	7.03	0.000	

* Statistically Significant at >.05 level

The multiple regression analysis revealed the linear combination of caregiver characteristics were significantly related to the CCIS score, F (4, 146) = 4.85, p <.001. Table 15 presents statistically significant relationships between the education of the provider and the CCIS score irrespective of the other variables. It also indicates that after controlling for the other variables a statistically significant relationship exists between the STAR level of the child care facility and the CCIS score.

The variance inflation factor was examined to determine the existence of multicollinearity, and the residuals were compared to the predicted values to further criticize the regression model. In both cases the results indicated that OLS regression was generally an appropriate statistical technique. Partial regression leverage plots were also created to explore if there were any cases that were exerting undue influence on the model. These results are presented in Figures 15 through 18.

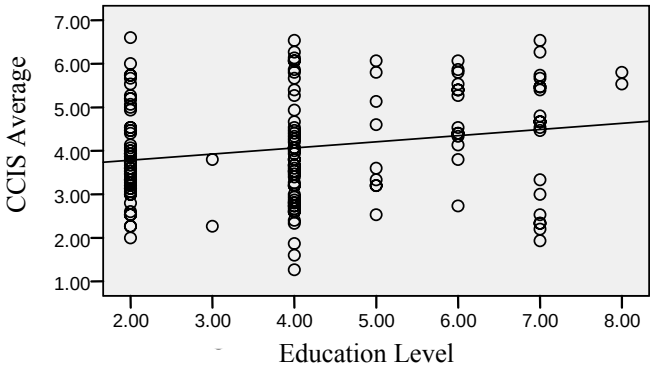


Table 15 Legend:

2 = High School Degree
3 = GED
4 = Some College
5 = CDA
6 = AA Degree
7 = Bachelor's Degree
8 = Master's Degree

Figure 15: Scatterplot of CCIS average and education.

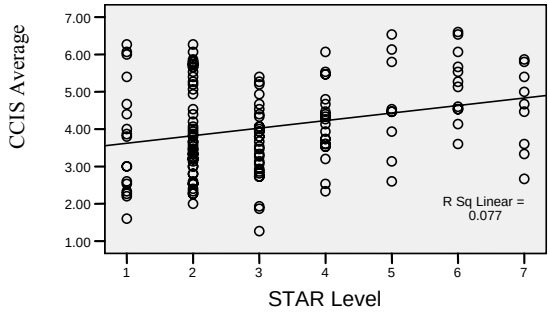


Table 16 Legend:

1 = No STAR
2 = Start With STARS
3 = STAR 1
4 = STAR 2
5 = STAR 3
6 = STAR 4
7 = STAR 4 Accredited

Figure 16: Scatterplot of CCIS average and STAR level.

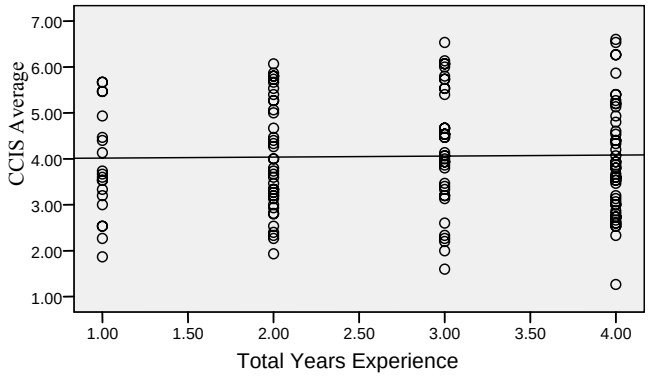


Table 17 Legend:

1 = Up to 2 Years
2 = 3 – 5 Years
3 = 6 – 10 Years
4 = 10 Plus Years

Figure 17: Scatterplot of CCIS average and years of experience.

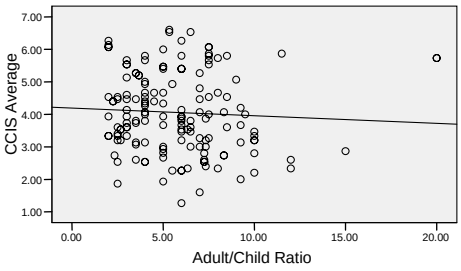


Figure 18: Scatterplot of CCIS average and adult/child ratio.

Even though outliers appear in both the "Education" and the "Adult/Child Ratio" leverage plots, an analysis with them included and then excluded indicated that these cases had no substantial impact on the results. These leverage plots also graphically depict the significant relationship between the CCIS score and the education of the child caregiver and the CCIS score and the facility's STAR level. In summary, this pattern of results shows strong support for the construct validity of the CCIS.

External Validity Analysis of CCIS for Specific Age Groups

A review of established child care interaction measures revealed that no one assessment device exists for measuring the interaction between a child care provider and children in multiple age groupings and settings, ranging from infancy through school age and including family child care homes. Most caregiver interaction scales remain limited to specific age groupings and therefore do not cover the age spectrum found in most child care facilities. Given the National and State level focus on child care quality improvement, a need exists for an instrument that can monitor, evaluate, and assess the quality of child caregiver interactions at multiple age groupings and settings, ranging

from infancy through school age, as well as family child care homes. Analyses of each age grouping and setting are presented below. Care should be taken, however, when reviewing these results. Please note the low number of cases in each age grouping and setting. While these results indicate the need for further study with larger samples, they also preliminarily point to the potential use of the CCIS across age groups and settings. Because of the small sample in each age grouping, Pearson *r* correlations between the CCIS and ERS scores are not reported.

Analysis of study participants for this study and those of the larger 2006 Keystone STARS Quality Study, however, reveal a similar sampling pattern. Family child care homes comprise 40.2% of the CCIS study, compared to 37.7% of the Keystone STARS Quality Study. Preschool aged programs in the CCIS study constitute 59.8% of the sample, versus 62.2% of the larger study. Further, exploring the STAR level of participants in each study, revealed a similar sampling pattern between high and low STAR levels. These results indicate participants in this study comprise a reasonably representative sample of the larger Keystone STARS Quality Study and also of the total child care facilities population in Pennsylvania. Additionally, this study also includes other specific groups (infant/toddler care and school aged care) that are not included in the larger 2006 study.

Analysis of CCIS for preschool age groups. The CCIS for the preschool age group providers revealed a mean of 4.15, with a range of 3.14 to 4.51, and a standard deviation of.1.35. The mean ECERS-R average for preschool age group providers was 4.33. As seen in Figure 19, the measure assessments yielded good variability. Coefficient alpha was computed for the CCIS looking solely at those programs involving preschool aged

children (n = 52). The value for coefficient alpha was .953 indicating high reliability with regard to internal consistency.

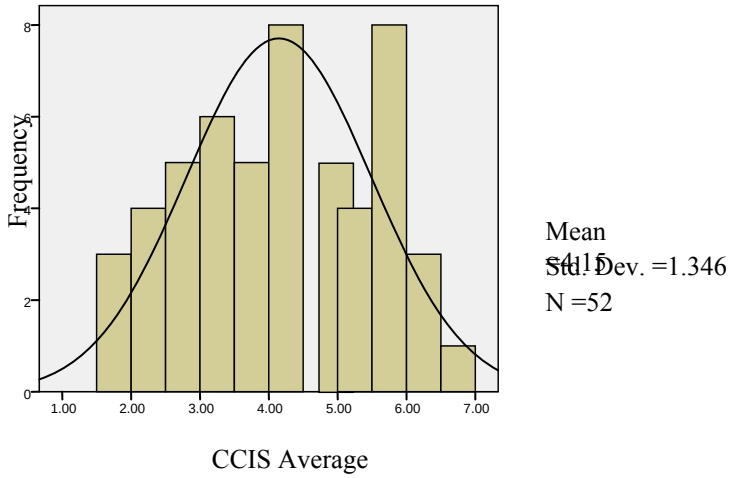


Figure 19: CCIS for preschool aged child caregivers.

Item analysis was conducted on all 15 items hypothesized to assess Child Caregiver Interaction. As presented in Table 16, all correlations were higher than .60 except for the "Health and Safety" item (.46).

These analyses support the conclusion that the CCIS is a reliable, unidimensional instrument that can be used for assessing the quality of preschool aged child caregivers.

Table 16: *CCIS for Preschool Age Group*

Cronbach's Alpha = .953		
	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Tone of Voice	.805	.949
Acceptance/Respect for Children	.880	.947
Enjoys and Appreciates Children	.861	.947
Expectations for Children	.891	.947
Health and Safety	**.455**	**.956**
Routines/Time Spent	.720	.951
Physical Attention	.754	.950
Discipline	.785	.949
Language Development	.803	.950
Learning Opportunities	.810	.949
Involvement with Children's Activities	.778	.949
Symbolic and Literacy Involvement	.600	.953
Promotion of SEL	.640	.952
Relationships with Families	.748	.950
Cultural Competence	.605	.953

Analysis of CCIS for infant/toddler programs. The CCIS for infant/toddler age group providers revealed a mean of 3.83, with a range of 2.5 to 5.31, and a standard deviation of 1.01. The mean ITERS average for infant/toddler age group providers was 4.19. As seen in Figure 11, the instrument assessments yielded good variability. Coefficient alpha was computed for the CCIS looking solely at those programs involving infant/toddler providers (n = 32). The value for coefficient alpha was .911 indicating high reliability or internal consistency.

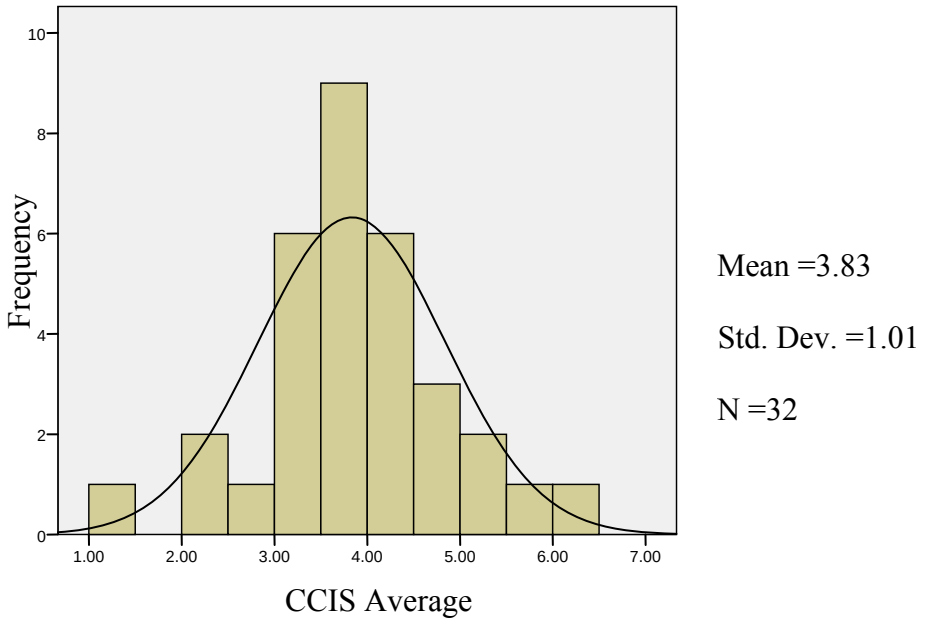


Figure 20: CCIS for infant/toddler aged child caregivers.

Item analysis was conducted on all 15 items hypothesized to assess Child Caregiver Interaction and is presented in Table 17. All correlations were higher than .455, with the exception of the "Health and Safety" item, which produced a correlation of .368.

All in all, this analysis provides evidence to conclude that the CCIS is a good instrument for assessing the quality of infant/toddler aged child care providers.

Table 17: *CCIS for Infant/Toddler Age Group*

Cronbach's Alpha = .911		
	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Tone of Voice	.680	.903
Acceptance/Respect for Children	.875	.895
Enjoys and Appreciates Children	.660	.904
Expectations for Children	.654	.905
Health and Safety	**.368**	**.915**
Routines/Time Spent	.701	.904
Physical Attention	.783	.899
Discipline	.748	.901
Language Development	.668	.904
Learning Opportunities	.574	.907
Involvement with Children's Activities	.450	.911
Symbolic and Literacy Involvement	.580	.907
Promotion of SEL	.525	.909
Relationships with Families	.517	.908
Cultural Competence	.455	.910

Analysis of CCIS for family home providers. The CCIS for family home providers revealed a mean of 4.24, with a range of 2.77 to 5.20 and a standard deviation of 1.10. The mean FDCRS average for family child care providers was 3.99. As seen in Figure 21, the measure assessments yielded good variability, although rectilinear. Coefficient alpha was computed for the CCIS looking solely at those programs involving family home providers (n = 35). The value for coefficient alpha was .926 indicating high reliability and internal consistency.

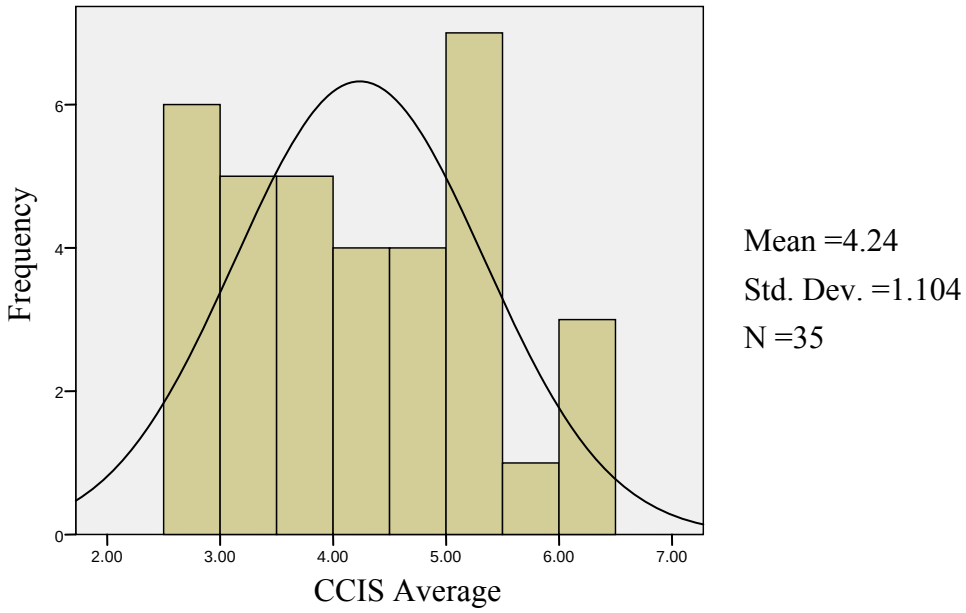


Figure 21 CCIS for home based child caregivers.

Item analysis was conducted on all 15 items hypothesized to assess Child Caregiver Interaction. All correlations were higher than .57 except for the "Routines/Time Spent" item (.381), the "Physical Attention" item (.433), the "Language Development" item (.304), the "Relationship with Families" item (.409), and the

"Cultural Competence" item (.415). These results are presented in Table 18 below and indicate that these items should be examined further to determine their ability to reliably assesses the quality of family child care providers.

Table 18: *CCIS for Family Child Care Providers*

Cronbach's Alpha = .926		
	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Tone of Voice	.778	.917
Acceptance/Respect for Children	.925	.913
Enjoys and Appreciates Children	.812	.916
Expectations for Children	.843	.915
Health and Safety	.567	.924
Routines/Time Spent	**.381**	**.928**
Physical Attention	**.433**	**.928**
Discipline	.871	.915
Language Development	**.304**	**.929**
Learning Opportunities	.763	.917
Involvement with Children's Activities	.752	.918
Symbolic and Literacy Involvement	.621	.922
Promotion of SEL	.817	.917
Relationships with Families	**.409**	**.927**
Cultural Competence	**.415**	**.927**

Analysis of CCIS for school aged programs. The CCIS for school age providers revealed a mean of 3.94, with a range of 2.32 to 5.35, and a standard deviation of 1.33. The mean SACERS average for school age child care providers was 3.87. As seen in Figure 22, the measure assessments yielded good variability. Coefficient alpha computed for the CCIS looking solely at those programs involving school aged providers (n = 34).

The value for coefficient alpha was .948 indicating high reliability or internal consistency. The histogram, however, reveals the data are negatively skewed, with a high proportion of the cases rating on the lower level of the scale. These results indicate the descriptors for the items may require further review to determine more appropriate wording for the school age group provider.

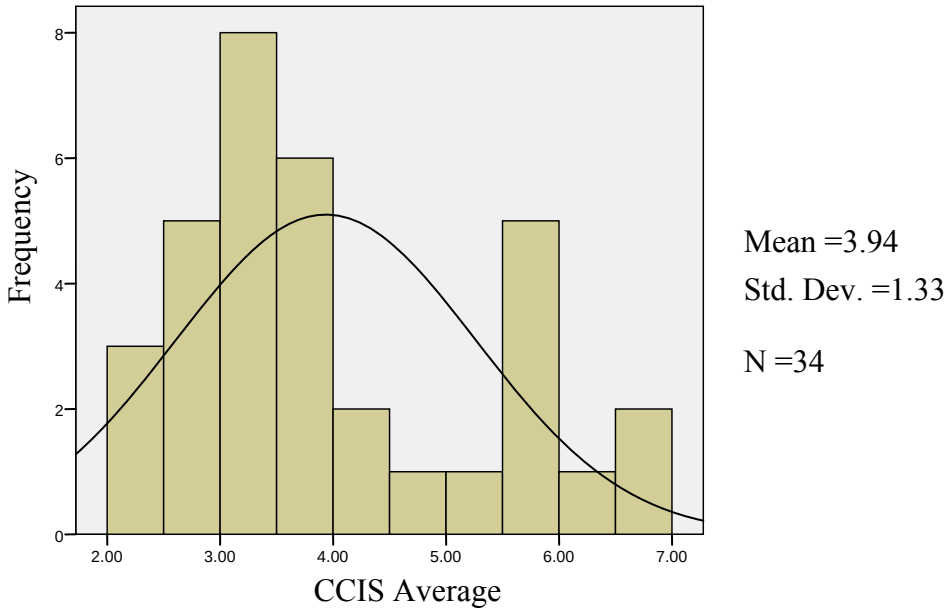


Figure 22: CCIS For School Aged Child Caregivers.

Item analysis was conducted on all 15 items hypothesized to assess Child Caregiver Interaction. All correlations were higher than .55 except for the "Symbolic and Literacy" item (.431). These results are presented in Table 19. Despite the negative skew, the high level of internal consistency supports the tentative use of the CCIS to assess the quality of school aged child caregivers.

Table 19: *CCIS for School Aged Child Caregivers*

Cronbach's Alpha = .948		
	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
Tone of Voice	.721	.945
Acceptance/Respect for Children	.728	.945
Enjoys and Appreciates Children	.757	.944
Expectations for Children	.807	.943
Health and Safety	.634	.947
Routines/Time Spent	.776	.943
Physical Attention	.761	.944
Discipline	.906	.940
Language Development	.868	.942
Learning Opportunities	.730	.945
Involvement with Children's Activities	.703	.945
Symbolic and Literacy Involvement	**.431**	**.950**
Promotion of SEL	.719	.945
Relationships with Families	.782	.943
Cultural Competence	.554	.948

Chapter Summary

The results of the pilot testing of the CCIS indicate the measure will be an asset to the field of early childhood research. While Factor Analysis indicates one clear factor of "Child Caregiver Interaction", correlational analysis reveals the proposed subscales "Emotional", "Cognitive" and "Social" to be internally reliable and highly correlated to one another. While statistically one factor, it may be wise to further explore these subscales from a training and technical support standpoint. Additionally, the new CCIS scale proved to produce variability in assessment scores, something that was lacking with the existing CIS (Arnett, 1989).

The CCIS has high reliability, both overall, and for age-specific/settings. Validity was assessed by comparing the CCIS to the Environmental Rating Scales (ERS), the "Interaction" subscale of the ERS, and the "Space and Furnishings" subscale of the ERS. The results of this analysis demonstrated moderate to strong positive correlations between the CCIS and each of the chosen variables. Also as expected, the relationship between the CCIS and the ERS "Space and Furnishings" subscale was noticeably lower than the other relationships. Therefore, there was strong evidence of convergent, concurrent and discriminant validity

Finally, construct validity was assessed by exploring the relationship between the CCIS score and caregiver characteristics, including the education level of the provider, years of experience in early childhood, and the adult/child ratio . The STAR level of the child care site was also included. These results revealed that both the STAR level and the education of the provider were predictive of the CCIS score when controlling for other care giver variables. The results, therefore, provided strong evidence of the construct validity of the CCIS.

A discussion of these findings is presented in the following chapter. Limitations and identification of future research will also be presented.

Chapter Five: DISCUSSION AND CONCLUSION

The primary aim of the present study was to establish reliability and validity for a newly developed child caregiver interaction scale. These efforts resulted in the Child Caregiver Interaction Scale (CCIS), which provides a theoretically driven assessment of child caregiver interaction across age groupings and settings. Research supports the notion of the combination of classroom environment and caregiver interaction in defining the quality of child care (Cryer, 1999; Doherty-Derkowski, 1995; Howes and Rubenstein, 1985; Howes and Stewart, 1987; Whitebook, Howes and Phillips, 1990). While reliable and valid measures for assessing the early care environment exist, the industry lacks a scientifically sound and research based instrument for assessing the global quality of child care staff interactions.

The CCIS is a comprehensive observational measure that assesses the quality of child caregiver interaction with all the children in care. Seventeen items were constructed based upon the National Association for the Education of Young Children's (NAEYC) Developmentally Appropriate Practice (DAP) position statements (Bredekamp and Copple, 1997). These statements embody the current best knowledge of theory and research about what practices are most supportive and encouraging to children's healthy development (p. vi). These twelve principles are as follows:

1. Domains of children's development – physical, social, emotional, and cognitive – are closely related. Development in one domain influences and is influenced by development in other domains.

2. Development occurs in a relatively orderly sequence, with later abilities, skills, and knowledge building on those already acquired.
3. Development proceeds at varying rates from child to child as well as unevenly within different areas of each child's functioning.
4. Early experiences have both cumulative and delayed effects on individual children's development; optimal periods exist for certain types of development and learning.
5. Development proceeds in predictable directions toward greater complexity, organization, and internalization.
6. Development and learning occur in and are influenced by multiple social and cultural contexts.
7. Children are active learners, drawing on direct physical and social experiences as well as culturally transmitted knowledge to construct their own understanding of the world around them.
8. Development and learning result from interaction of biological maturation and the environment, which includes both the physical and social worlds that children live in.
9. Play is an important vehicle for children's social, emotional, and cognitive development, as well as a reflection of their development.
10. Development advances when children have opportunities to practice newly acquired skills as well as when they experience a challenge just beyond the level of their present mastery.

11. Children demonstrate different modes of knowing and learning and different ways of representing what they know.
12. Children develop and learn best in the context of a community where they are safe and valued, their physical needs are met, and they feel psychologically secure.

The CCIS is based upon the solid theoretical base of DAP and is structured to incorporate these principles. To ensure consistency between DAP and the CCIS, many item indicators of the CCIS include specific examples drawn from DAP. Further, the training materials for data collectors are directly drawn from DAP. (See Appendix A for training materials). This attention to coordination between the DAP and data collection documents ensured the CCIS was built upon both research and theory, and ensured strong content validity.

CCIS Training and Inter-rater Reliability

Training data collectors on the CCIS was conducted using examples of both appropriate and inappropriate practices contained in *Developmentally Appropriate Practice in Early Childhood Programs, Revised Edition* (Bredekamp and Copple, 1997). These materials present specific actions that are present in appropriate and inappropriate caregiving. Two inter-rater reliability observations were conducted with each data collector to ensure inter-rater reliability. Due to time constraints, follow-up inter-rater reliability observations did not occur past the initial two months of data collection. This led to drift, which resulted in some data needing to be discarded from analysis. It is clear that practitioners using the CCIS will require initial and follow up training. Future studies must include a plan for follow up training and inter-rater reliability observations. While

one strength of the CCIS involves a deep tie to the DAP, this same characteristic lead to the development of a sophisticated instrument that requires careful attention to training thereby ensuring reliable data collection and valid results interpretation.

Exploratory Factor Analysis

Subscale Identification

Based upon the original theoretical hypothesis that child caregiver interaction is comprised of three factors, emotional, cognitive, and social, exploratory factor analysis was conducted. Results of this analysis concluded that each of the indicators loaded highly on only one factor, which accounted for 50.3% of the item variance. The only item that loaded highly on the second factor was "Cultural Competence," which accounted for only 3.9% of the item variance. The "Cultural Competence" item also loaded equally high on Factor One. Based upon this analysis, as well as the scree plot results, it was determined that the CCIS inductively consists of one major factor, that of Child Caregiver Interaction.

In contrast, theory suggests the existence of three factors that influence the quality of child care (emotional, cognitive, and social). Data analysis from the current study did not confirm that premise, but rather indicated the existence of one general factor, "Child Caregiver Interaction" that is comprised of aspects of the three theoretical components. While the analysis did suggest a statistical difference in some of the indicators, there was not enough to warrant retaining separate factors. According to Preacher and MacCallum,

> In factor analysis, a latent variable that influences only one indicator is not a common factor; it is a specific factor. Because common factors are defined as influencing at least two manifest variables, there must be at least two (and

preferably more) indicators per factor. Otherwise, the latent variable merely accounts for a portion of the unique variance, that variability which is not accounted for by common factors (2003, p. 27).

Pearson Correlations of the proposed subscales indicated significant relationships among the three domains. These results clearly indicate that a person who scores high in one domain scores high on the other two domains as well. Given the strong theoretical overlap between the original proposed factors, these results are not surprising. According to Bredekamp and Copple (1997),

> Domains of children's development – physical, social, emotional, and cognitive – are closely related. Development in one domain influences and is influenced by development in other domains. What is occurring in development in one domain can both limit and facilitate development in others. A program that strives to nurture development optimally supports all domains as having equal importance. All learning experiences are recognized as integrated opportunities for growth, instead of separate skill or content entities (p. 9).

While these areas of child development are closely related and tend to overlap each other, the literature and research presents a strong theoretical justification for the existence of the subscales previously anticipated as factors. In addition, the Alpha Coefficients for each of the subscales were sufficiently high ranging from .699 to .966 thereby indicating high internal consistency for each. While the factor analytic procedure provided an inductive analysis of the data, the available theory and current body of research strongly supports a deductive decision to consider the existence of all three

subscales or domains. This is especially true from a training and technical assistance standpoint. As stated by Doherty-Derkowski (1995),

….studies, as a group, have demonstrated that high quality early childhood programs require adults who have specific training in child development and early childhood education. This increases the likelihood that the program will encourage the child's development and that the adult interactions with the child are appropriate for the child's age, responsive to the child's needs, and are warm (p. 13).

In summary, the factor analysis, reliability analysis, and correlational analysis described above supports the recommendation that the CCIS can be used as an overall scale (omitting two items), or that the subscales could be used separately, depending upon the needs of the research or evaluation.

Measurement Variability

One of the difficulties experienced by practitioners and program managers was the lack of variability in existing child caregiver interaction assessment inventories. The original and most widely employed Caregiver Interaction Scale (CIS) (Arnett, 1989), which served as a starting point for the CCIS, uses a four point, Likert scale (1 = Never, 2 = Few, 3 = Some, 4 = Many). However, in practice this scaling tended to result in a polarized assessment indicating either high or low scores. Attempts were made by Pennsylvania researchers to operationally define the CIS terms relative to observation, in order to help build consistency and scale into the measure. For example, in the Governor's Pennsylvania Task Force on Early Childhood Care and Education (2002) and

the Keystone University Research Corporation TEACH Evaluation (2001), percentages were given to the categories: (1 = 0%, 2 = 1 to 30%, 3 = About 50%, 4 = 60+%).

While this numerical rating may have provided some clearer definition for assessment, it proved unsatisfactory for several reasons. The scaling is arbitrary and not built on a solid research foundation of scale and measurement. Even with the use of percentages, the use of this 4-point scale remained very subjective and limited in value to program managers and researchers alike. While the measure was effective at assessing either really good, or really poor caregivers, it did not allow for the distinction of caregivers who fell in the mid range of effectiveness.

The CCIS was created using a 7-point interval-like scale to offer an instrument with greater ability precision and to assess the areas of caregiver strength and areas of improvement. Additionally, the CCIS was carefully constructed in terms of the current DAP body of knowledge. This dual approach to construction yielded an assessment measure that was normally spread, versus the polarized or bimodal results realized through the CIS.

Each of the subscales and the CCIS overall scores followed bell shaped distributions thereby providing support that the CCIS does a good job of measuring the full spectrum of observed caregiver interactions under assessment. The results from the CCIS demonstrated measurement variability, which is a noteworthy improvement over the polarized CCIS.

Both research and technical assistance require an instrument with greater ability to assess the areas of caregiver strength and weakness. For researching characteristics critical for quality child care, a more sensitive measure will enable us to learn more about

the attributes associated with caregiver/child interaction. From a technical assistance perspective a more sensitive measure will allow for greater identification of targeted interventions and behavioral considerations. Helping caregivers understand their strengths and areas of improvement can help assess practice. Because the CCIS is built on DAP caregivers can have specific examples of how best they can provide for the children in their care.

Internal Consistency

Utility Across Age Groups and Settings

As was expected, the CCIS proved to have high internal consistency across age groups and settings. According to J.C. Nunnelly (1978),

> the alpha of a scale should be greater than .70 for items to be used together as a scale. The alpha for the total scale is also computed assuming that the item under examination is deleted. If the alpha increases over the current total scale alpha when an item is deleted, then the rule of thumb is to delete the item unless it is theoretically necessary for the analysis (p. 146).

Cronbach's alpha for the CCIS measure, across all age groups and settings was extremely high, at .938. Cronbach's alpha for preschool age caregivers only was .953, for infant/toddler caregivers was .911, for home based caregivers was .926, and for school aged caregivers, was .948. These coefficients indicate strong utility of the CCIS measure across these settings and age groupings of child care.

Validity

Concurrent, Convergent and Discriminant Validity

It is important to understand how the CCIS relates to and differs from other related caregiver measures. Results of the criterion validity assessments between the CCIS and ERS rating averages were as predicted ($r = .740$, $p<.001$). The high correlations with these scores were expected, given the strong theoretical link between these measures. As also was expected, the correlation between the "Interactions" subscale of the ERS was significant ($r = .745$, $p<.001$). Similarly, the correlation between the "Space and Furnishings" subscale of the ERS was significant but noticeably lower than the overall ERS average and the "Interactions" subscale ($r = .667$, $p<.001$).

These results were expected. Providing for a safe and healthy environment is part of good caregiving. Further, both the ERS and CCIS contain specific health and safety related measurement items which yielded an expected positive relationship. The lower correlation between the ERS "Space and Furnishings" subscale and the CCIS was also to be expected. While good caregivers strive to provide a good physical environment, as measured by the "Space and Furnishings" ERS subscale, clearly the CCIS more specifically measures caregiver interaction.

Construct Validity

Child caregiver interactions are affected by a variety of factors. These factors include: the education of the child caregiver, years of experience in child care, and the adult/child ratio. The Pennsylvania Keystone STARS program represents a system of continuous quality improvement for child care through standards, training/professional development, technical assistance, resources, and support. For the purposes of this

analysis, the STAR level of the child care facility was also included since other research studies indicate a positive correlation between the STARS ranking and quality of care

Multiple regression analysis revealed a significant relationship between the STAR level of the child care facility and the CCIS score of the caregiver. The education level of the caregiver was also significantly related to the CCIS score. These results were expected. Previous research has shown that the education level of the caregiver has a positive relationship with quality care (Galinsky et al., 1994; Howes, 1983; Pence and Goelman, 1991; Whitebook et al., 1990). This study supports this finding while controlling for the other variables discussed above.

Because the STARS designation is based upon numerous criteria, including administrative structure, the lower CCIS scores in the lower STARS designations is understandable. Specific quality improvements, as demonstrated by the Environmental Rating Scale scores, are not a requirement for STARS in the lower designations. It is only at the STAR 2 level that a self evaluation is required and an objective assessor observation does not occur until STAR 3. It is clear from this study that the STARS child care quality improvement standards are actually reflected in improved child caregiver interactions.

Limitations and Directions for Future Study

Several limitations of this study warrant discussion. Because this study was conducted in coordination with other research projects, the sample size for each age group and setting could not be controlled. Analysis of study participants for this study and those of the larger 2006 Keystone STARS Quality Study did reveal a similar sampling pattern. Family child care homes comprise 40.2% of the CCIS study, compared

to 37.7% of the Keystone STARS Quality Study. Preschool aged programs in the CCIS study constitute 59.8% of the sample, versus 62.2% of the larger study. Further, exploring the STAR level of participants in each study, revealed a similar sampling pattern between high and low STAR levels. These results indicate study participants in this study to be a reasonably representative sample of the larger Keystone STARS Quality Study and of the total child care facilities population in Pennsylvania. Additionally, this study also includes other specific groups (infant/toddler care and school aged care) that are not included in the larger 2006 study. Future study should include targeted inclusion of each specific age group and setting to determine if the results are consistent with the present findings.

Because of the lack of child caregivers providing care for special needs children, targeted inclusion of caregivers providing care to children of special needs should also be attained so the "Engaging With Special Needs Children" can be included in the analysis. Further, future study should also ensure that data for the "Greetings" item is incorporated on all observations. This item was dropped from this analysis due to missing data. Instruction to data collectors should emphasize the importance and need to collect these data.

The sample for this study included a disproportionate percentage of Caucasian females, which prohibited testing whether this measure would have similar results when assessing other ethnicities and males. There are distinct cultural differences between the Western European culture and others concerning aspects surrounding the socialization of children. These include expressions of feelings, discipline, power and authority, and physical punishment (Gonzalez-Mena, 1997). Research findings suggest that child

caregiving may be influenced by race and ethnicity therefore it is important to examine whether the CCIS is generalizable across such populations.

Using DAP as the foundation of the CCIS, however, provided that special care was taken to ensure the measure was culturally competent and adaptive to various populations and ethnicities. In 1997, NAEYC reviewed their position statements and recognized that child care programs increasingly serve children and families from diverse populations, requiring that child care providers demonstrate understanding of and responsiveness to these diverse populations. Given that culture and language are significant components of children's development, practices cannot be developmentally appropriate unless they are responsive to both cultural and linguistic diversity (Bredekamp and Copple, 1997, p. 4). Given the focused attention to ensure cultural competence in this measure, future study targeting non-Western European and male caregivers would provide important knowledge.

An additional limitation of this study was the lack of a solid training plan and extensive inter-rater reliability follow-up. Analysis of Variance (ANOVA) was conducted on each of the 15 retained items on the CCIS, the overall CCIS average, and the ERS average. It was determined there were statistically significant differences between the data collectors. The mean results on all CCIS items and ERS averages from data collector 1 ($n = 28$) were negatively skewed and did not present a normal distribution. There is no way of knowing if this small number of cases were due to actual differences in observed caregivers or if the data was actually skewed. In an effort to be conservative in data analysis, the negatively skewed data from data collector 1 were omitted from this analysis.

While inter-rater reliability was conducted early on in the course of this study, drift occurred as the study progressed. As stated by the American Educational Research Association, procedures "for scoring and, if relevant, scoring criteria should be presented by the test developer in sufficient detail and clarity to maximize the accuracy of scoring" (1999, p. 47). Additionally," scorer reliability and potential drift over time in raters' scoring standards should be evaluated" (p. 48).

Because this study was done in coordination with other research projects, inter-rater reliability follow-up beyond the initial two month time frame was not possible. Future studies need to incorporate monthly follow up reliability observations to guard against drift.

Data from collector 1 was dropped because of negative skew. While data from collector 3 indicated negative skew, it was not statistically significantly different from that of data collector 2 (myself). Data of collector 2 was analyzed with and without data from collector 3. These analyses indicated no substantive difference in the results suggesting that the CCIS has a positive degree of robustness associated with using data across multiple raters.

While the CCIS demonstrates a robust nature that can accommodate some variability of data collection, researchers and practitioners alike must be cautioned on the potential misuse of the CCIS. As is stated above, thorough training on this instrument is critical prior to data collection. Additionally, follow-up inter-rater reliability checks are necessary to ensure accurate data collection.

The underlying assumption of the CCIS is that quality child care is "one that provides a safe and nurturing environment that promotes the physical, social, emotional,

aesthetic, intellectual, and language development of each child while being sensitive to the needs and preferences of families" (Bredekamp and Copple, 1997, p. 8). While the environmental rating scales do a reliable and valid job of assessing the environment, their focus is mainly on the structure and child care environment. The CCIS, whose focus is on the process components necessary for quality child care, is an important contribution to the early childhood field.

Care should also be taken in the interpretation of the results of the CCIS. Feedback results on individual item responses are not advised. Because each of the items is combined with others to create a subscale for the cognitive, emotional and social domains, it is recommended that the lowest level of feedback provided to caregivers be on the domain level.

Practitioners also need to be clear on how each of the subscales combines to create an overall caregiver interaction score. Because of the interconnected nature of these domains, research from this study indicate that caregivers who scored high on one subscale also tended to score high on the others. Using the CCIS to help caregivers identify and target desired behavior can be a useful tool in increasing the quality of child caregiver interactions.

Conclusion

The data and analysis presented in this dissertation indicates the Child Caregiver Interaction Scale is a valid and reliable measure to assess the interactions of child care providers and the children they care for. The CCIS measure demonstrates high internal consistency and strong utility across age groups. The CCIS measure demonstrates strong

criterion validity between the Environmental Rating Scale overall and associated "Interaction" and "Space and Furnishings" subscales. Care should be given when using this measure to assess home based child caregivers until further validation of the indicators is made with this setting.

Both education level of the child care provider and the STAR designation were correlated with a higher CCIS average score. Results of this study are consistent with those of the 2006 Evaluation of Pennsylvania's Keystone STARS Quality Rating System in Child Care Settings (Fiene, 2006) which found similar results. Further, the education of the child care provider and the STAR designation were predictive of the CCIS average.

Future research includes the development of a solid training plan for each age grouping and setting, as well as ongoing inter-rater reliability observations. Inclusion of diverse ethnicity and gender, as well as caregivers of special needs children will ensure the CCIS adequately measures the quality of child caregiver interaction across diverse populations.

While the CCIS demonstrates a robust nature that can accommodate some variability of data collection, researchers and practitioners alike must be aware that solid training of the instrument is necessary for the collection of accurate data. The factor analytic procedures conducted for this study produced one major factor of "child caregiver interaction," however; both research and available theory indicate support for the three proposed subscales. Because of the strong link with DAP, when properly administered and interpreted, this scale can be tremendously beneficial in helping caregivers identify their areas of strength, as well as improvement.

The CCIS is a valuable and much needed measurement tool to assess child caregiver interaction across age groupings and settings. This measure not only provides a scale that can be used for research purposes to compare child care quality, but also serves as a noteworthy tool for training and technical assistance. By helping child caregivers understand their strengths and areas most in need for improvement, the CCIS is a tool that can be used to improve quality child care.

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Appendix A:

Child Caregiver Interaction Scale

Child Caregiver Interaction Scale (V6)
(Carl, 2006)

Caregiver Name:_____ _____
(First) (Last)

Center Name: _____

Class Name: _____

Date of Observation: _ _ / _ _ /

Center ID: _____
Class ID: _____
CID: _____
Obs ID: _____

Age Group:
- ❑ Infants _____
- ❑ Toddlers _____
- ❑ Preschool _____
- ❑ School Age _____

Staff Present: _____

Volunteers Present: _____

of years experience in child care (total): _____

# of years experience with this age level: _____

Education level and major: _____

Current professional development activities: (college courses, etc.) _____

# of children allowed (ratio) _____

# of children enrolled _____

# of children present _____

Special needs children? _____

Ethnicity:
- ❑ White
- ❑ African American
- ❑ Hispanic
- ❑ Other _____

Gender:
- ❑ Female
- ❑ Male

Child Caregiver Interaction Scale (Carl, 2006)

Emotional Domain
- #1 Tone of Voice
- #2 Acceptance/Respect for Children
- #3 Greeting
- #4 Enjoys and Appreciates Children
- #5 Expectations for children
- #6 Health and Safety

Cognitive/Physical Domain
- #7 Routines/Time Spent
- #8 Physical Attention
- #9 Discipline
- #10 Language Development
- #11 Learning Opportunities
- #12 Involvement with Children's Activities
- #13 Symbolic and Literacy Interaction

Connection with a Wider World
- #14 Promotion of Prosocial Behavior/Social Emotional Learning (SEL)
- #15 Engaging Children With Special Needs
- #16 Relationship With Families
- #17 Cultural Competence

Emotional Domain
#1 Tone of Voice

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Speaks with irritation (sharp tone, raised voice) or harshness. 1.2 Tone of voice and manner are insincere (Caregiver may say one thing and mean another). Uses sarcasm. 1.3 Depressive or flat affect. .		3.1 Speaks warmly to children (tone and words). 3.2 Children are praised for their efforts (Good job!) 3.3 Caregiver's tone and manner match.		5.1 Verbally demonstrates enjoyment of children (Hi! Welcome to school today! I'm glad you are here!) 5.2 Tone expresses acceptance and patience to children, even in difficult situations. 5.3 Emotion/tone appears to be genuine.		7.1 Caregiver consistently seeks out opportunities to positively acknowledge children ('Catch them being good') 7.2 Caregiver's tone is happy and conveys to children that they are delightful and respected.

#2 Acceptance/Respect for Children

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Constantly says "No!" or engages in power struggles over issues that do not relate to the child's health or well-being. 1.2 Punishes children for asserting themselves or saying "No". 1.3 Makes negative comments or statements directed toward any child (shows obvious favoritism).		3.1 Demonstrates acceptance of children, both personally and generally. 3.2 Demonstrates knowledge of child development and child's abilities.		5.1 Expresses acceptance of children. 5.2 Caregiver demonstrates understanding of child development. 5.3 Limits saying "No" to situations that relate to children's safety or emotional well being. 5.4 Directions are positively worded ("Feet belong on the floor"), not just restrictions ("Don't climb on the table").		7.1 Provides opportunities for children to be successful so they can be praised. 7.2 Conveys to children they are valued. 7.3 Plans experiences that engage children's interests, resulting in less opportunity for off task behavior (N/A Option for Infants & Toddlers)

#3 Greeting

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Children are expected to begin their day and no adult interaction. 1.2 Arrival of child not acknowledged. 1.3 Arrival of parent not acknowledged.		3.1 Children and parents are greeted and acknowledged by name upon arrival. 3.2 Children are accepted into the classroom with minimal adult interaction. ✋ 3.3 Caregiver verbally asks parents about child's well being upon arrival		5.1 Caregivers help children settle into the group upon their arrival by reading books or quietly playing with them. 5.2 Problems with separation from parent handled sensitively. 5.3 Caregiver provides written communication to parents on individual children*.		7.1 Parents are encouraged to be involved with daily activities. 7.2 Program is set up to encourage face to face communication between parents and caregiver. 7.3 Children's separation patterns are known and respected by caregiver (i.e., some children want to be held, others allowed "alone time".

*5.3 Most likely you will need to ask to see proof of this.

✋ To move further up the scale, this should be "No".

#4 Enjoys and Appreciates Children

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Seems to dislike children. 1.2 Quiet children are ignored. 1.3 Children are treated with indifference (act like they have no feelings); disrespected. 1.4 Takes little interest in children's activities or accomplishments. 1.5 Attention only given during routine care or for negative behavior.		3.1 Interaction with children is done mainly during routine care; little playing with children. ✋ 3.2 Maintains eye contact with children when they speak or babble. 3.3 Quiet children are engaged with and given attention even while being good. 3.4 Children who are playing well and quietly are acknowledged for their positive behavior.		5.1 Caregiver knows the children well and is able to respond to their temperament and cues, anticipating their needs. 5.2 Children are treated with respect. 5.3 States appreciation for child's efforts. 5.4 Praises children for their accomplishments.		7.1 Caregiver engages all children in conversations, asking of their interests and preferences. 7.2 Expresses delight in children's activities (claps hands, cheers.) 7.3 Conversations regularly include references to child's individual lives (siblings, parents, pets referenced; previous experiences, etc.)

✋ To move further up the scale, this should be "No".

#5 Expectations for children

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Expectations for children are not age appropriate (either expect too much or too little of them). 1.2 Lack of child development knowledge is evident.		3.1 Expectations for children are generally appropriate. 3.2 Caregiver uses appropriate learning techniques with children. 3.3 Caregiver demonstrates knowledge of child development by exposing children to age appropriate materials.		5.1 Caregiver demonstrates knowledge of child development by engaging children with age appropriate materials/activities. 5.2 Activities/materials selected incorporate age-typical behaviors		7.1 Caregiver is tuned into the needs of children in his/her care. 7.2 Activities encourage children to expand their skills.

#6 Health and Safety

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Health and safety procedures routinely overlooked. 1.2 Supervision of children is inadequate (ratios not maintained). 1.3 Formal record of medication and health information is not maintained. 1.4 Daily records are not kept or not complete. 1.5 Children are visibly dirty/need noses wiped.		3.1 Some attention to health practices are generally met– by caregiver AND children. 3.2 No lapses in supervision. 3.3 Formal procedures for administration of medication are in place and implemented. 3.4 Mechanisms are used for parents and staff to share health information daily.		5.1 Health practices are consistently met by caregiver and children (ex., handwashing, etc). 5.2 Caregivers do safety checks, both indoors and out, several times a day. 5.3 Emergency evacuation plans are posted and practiced. 5.4 Extra clothes for indoors and out are available and used as necessary.		7.1 Caregiver consciously stresses good nutrition and health. 7.2 Children are taught proper handwashing techniques. 7.3 Caregiver explains health and safety rules to children.

Cognitive/Physical Domain

#7 Routines/Time Spent

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1.Places high value on obedience/compliance 1.2. Primarily does adult tasks while children are in care. 1.3 Routine times are not used as bonding/learning times.		3.1 A general schedule is adhered to*. 3.2 Majority of time spent conducting routine child care tasks.* ✋		5.1 Daily events are handled with flexibility. 5.2 Time spent is child driven, rather than caregiver driven (only occur when children are interested). 5.3 Uses routine times for learning experiences (Prime Times). 5.4 Caregiver spends majority of time engaging with children. 5.5 Uses appropriate curriculum (i.e., Creative Curriculum) N/A Option		7.1 Caregiver plans for transitions and these are handled with minimal stress on children (no long periods of waiting). 7.2 Allows for change in daily schedule based upon children's needs/interests.

* Read explanation of descriptors carefully for these items. ✋ To move further up the scale, this should be "No".

#8 Physical Attention

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Negative physical contact (rough or abrupt handling). 1.2 Children are shifted from group to group or cared for by whatever adult is available at the moment. 1.3 Children's attempts to initiate physical contact discouraged/rejected.		3.1 Positive physical contact (hug, sit, pat, hold child) during routines. 3.2 Children are cared for by familiar adults, but adults may vary from day to day. 3.3 Children's attempts to initiate physical contact are welcomed.		5.1 Sits on child's level so they can crawl in caregiver's lap. 5.2 Gently, physically redirects child when necessary. 5.3 Children are cared for by one or two primary caregivers who are familiar with their routines.		7.1 Physically demonstrates affection for children throughout the day (hugs, hand holding, kisses). 7.2 Physically assists child in developmental milestones.

#9 Discipline

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 When children misbehave, they are handled abruptly or harshly. 1.2 Caregiver speaks with irritation or lectures when children misbehave. 1.3 Rules are not explained ("No, stop that!" with no reason why). 1.4 Children excluded from group – contained or restrained.		3.1 Children are redirected appropriately when they misbehave. (Consistently) 3.2 Expectations are generally age appropriate. 3.3 Rules are explained to children on a basic level.		5.1 A variety of options are used for children (i.e, duplicate toys, activities used to engage children when they misbehave). 5.2 Caregiver engages with children to prevent misbehavior before it occurs (is aware of the children's cues of frustration).		7.1 Caregiver actively and consciously stresses prosocial behavior and behavioral safety through books, actions and activities. 7.2 Caregiver helps children take the viewpoint of others when they misbehave (discusses consequences, explains how actions affect others). 7.3 Children involved in establishing rules.* (N/A for infants & toddlers).

#10 Language Development

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Ignores children's attempts at communication. 1.2 Talks over children as they talk. 1.3 Uses terms that are unfamiliar to children. 1.4 Calls all children the same name so they are not sure who is being addressed).		3.1 Acknowledges children's attempts at communication. Nods, makes eye contact, attempts to decipher child's needs and vocalizations. 3.2 Verbally responds to child's cues of distress. 3.3 Uses individual child's names when speaking with them. 3.4 Uses terms that are familiar to children.		5.1 Listens attentively when children speak. Rephrases their conversations. 5.2 Dialogues with children. Conversation is interactive. 5.3 Checks for clarification when talking to children. Make sure they understand what is being said. 5.4 Uses clear, one step directions. 5.5 Models appropriate use of language (tense, vocabulary, etc.).		7.1 Adds to children's attempts to dialogue; adds words and explanations to talk. 7.2 Helps children understand their feelings and emotions by labeling communication. 7.3 Encourages verbal communication. 7.4 Fosters conversations between children.

#11 Learning Opportunities

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Does not provide children with learning activities. 1.2 Minimal learning opportunities are available for children.		3.1 Offers child play opportunities. 3.2 Less involved children are drawn in to play. 3.3 Caregiver uses materials to spark interest of children.		5.1 Facilitates children's use of play materials. 5.2 Provides encouragement and praise for successful accomplishments in play. 5.3 Sets up environment /activities to foster development		7.1 Explains the reason for things. 7.2 Encourages children to think for themselves 7.3 Is aware of child's skill level and engages them with materials that expand their skills.

#12 Involvement with Children's Activities

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Is disinterested in child's activities and playtime. 1.2 Interaction with children occurs only during routine care: Feeding, toileting, napping. 1.3 Allows children to become frustrated by tasks they cannot do.		3.1 Verbally acknowledges children's activities. 3.2 Provides a variety of materials for children's play.		5.1 Actively engages in child's play. 5.2 Provides/creates play experiences for children. 5.3 Models appropriate play. .		7.1 Provides additional play experiences to expand on child's interests. 7.2 Talks to children to extend conversation when playing together.

#13 Symbolic and Literacy Interaction

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Any materials are inappropriate for children; materials are scary or violent. 1.2 Children are forced to participate, even when they are no longer interested. 1.3 No literacy materials present. 1.4 Materials are in poor repair.		3.1 Materials are generally appropriate for children. 3.2 Children are engaged only as long as they are interested 3.3 Materials are present but caregiver does not encourage or facilitate use. ✋ .		5.1 Caregiver provides a wide range of literacy and symbolic materials which children have access to during freeplay. All age appropriate. 5.2 Caregiver reads to children throughout the day. 5.3 Caregiver talks about pictures or mobiles.		7.1 Caregiver uses literacy and symbolic materials regularly (daily) that expands on themes or activities in the classroom. 7.2 Children are encouraged to bring materials from home that add to the themes (i.e., books, stuffed animals, etc.). 7.3 Caregiver relates print to verbal communication (N/A option for infants).

✋ To move further up the scale, this should be "No".

Connection with a Wider World
#14 Promotion of Prosocial Behavior/Social Emotional Learning (SEL)

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 No evidence of promotion of SEL (no pictures, books or activities). 1.2 Negative peer interaction is ignored.		3.1 Evidence of SEL in the classroom. 3.2 Caregiver verbally reminds children of positive SEL. 3.3 Environment is set up so there are few instances of aggressive behavior.		5.1 Children are helped to acknowledge the viewpoint of others. 5.2 Encouragement of verbal behavior for conflict resolution. 5.3 Children are praised for prosocial behavior.		7.1 Everyday experiences are used as SEL learning. Caregiver looks for teachable moments. 7.2 Use of SEL curriculum used effectively (First Step, Preschool PATHS).

#15 Engaging Children With Special Needs
(NA Option)

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Children with special needs kept separate from group. 1.2 Caregiver seems uncomfortable interacting with, or caring for, children with special needs. 1.3 No adaptive equiptment/ methods used even when warranted (ie., bracing, seating adaptations, etc). 1.4 The rest of the group is penalized because of perceived limitations.		3.1 Children with special needs included in the group. 3.2 Some adaptations made to help include child in activities (i.e., seat in circle for child who is unstable). 3.3 Adaptations are adequate, but make child with special needs "different"		5.1 Children with special needs are not immediately recognizable to outside observer. 5.2 Activities are planned so that all children can be successful/ participate. 5.3 Caregivers are comfortable interacting with/caring for children with special needs. 5.4 Caregivers seek info from parents /therapists on proper techniques.		7.1 Children with special needs are active /equal members of the group. 7.2 Adaptive materials blend into classroom materials (i.e., all chairs match, some have belts /positioners). 7.3 Caregivers are included as part of IFSP /IEP team. 7.4 Caregivers involved in implementing objectives of IFSP /IEP.

#16 Relationship With Families

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Interaction with families occurs mainly when a problem arises. 1.2 Caregiver is patronizing or disrespectful towards families. 1.3 Cultural and other individual preferences of families are discouraged or ignore.		3.1 Some positive interactions with families occur daily. 3.2 Parent's preferences are treated with respect. 3.3 Families are encouraged to participate in children's program.		5.1 Caregiver's work in partnership with families to assist in child's development. 5.2 Caregiver's stress that they view parent's as the primary source of love and care. 5.3 Parents are always welcome in the child care center.		7.1 The diversity of families is celebrated and used as a basis of learning. 7.2 Caregiver plans curriculum that is culturally responsive. 7.3 Caregiver's use parent's knowledge of children in planning, evaluation and assessment

#17 Cultural Competence

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 No evidence of cultural diversity observed. 1.2 Materials present only sterotypes of races, cultures, ages, abilities and gender. 1.3 Staff demonstrate prejudice against others (Ex. Against child or other adult from difference race or cultural group, against person with disability)		3.1 Some racial materials that show cultural diversity (multi-racial or multi-cultural dolls, books, pictures or music tapes from other countries). 3.2 Multicultural materials presented in a "tourist" approach (themes, specific cultural weeks, etc.). ✋		5.1 Many books and pictures accessible showing people of different races, cultures, ages, abilities, and gender in non-stereotyping roles. 5.2 Many props representing various cultures included for use in dramatic play (Ex. dolls of different races, ethnic clothing, cooking and eating utensils from various cultural groups).		7.1 Caregiver consciously stresses diversity as part of daily routines and play (dancing to music from different cultures, demonstrates it is okay to be different, etc.) 7.2 Activities included to promote understanding and acceptance of diversity (meals planned that include ethnic foods, inclusion of many cultures in holiday celebration).

✋ To move further up the scale, this should be "No".

Appendix B:

Child Caregiver Interaction Scale Scoresheet

SCORE SHEET
Child Caregiver Interaction Scale (V6)
(Carl, 2006)

Observer: _____ Observer Code: __ __ __

Center/School: _____ Center Code: __ __ __

Room: _____ Room Code: __ __

Age Group: □ Infants _____
□ Toddlers _____
□ Preschool _____

Teacher(s): _____ Teacher Code: __ __

Gender: □ Female □ Male

Ethnicity: □ White □ Hispanic
□ African American □ Other _____

Time observation began: __ __ : __ __ □ AM □ PM

Time observation ended: __ __ : __ __ □ AM □ PM

# of years experience in child care (total): _____

# of years experience with this age level: _____

Education level and major: _____

Date of Observation: __ __ / __ __ / __ __
m m d d y y

Birthdates of children enrolled: youngest __ __ / __ __ / __ __
m m d d y y
oldest __ __ / __ __ / __ __
m m d d y y

Number of staff present: __ __

Number of children enrolled: __ __

Highest number center allows in class at one time: __ __

Highest number of children present during observation: __ __

Number of children with identified disabilities: __ __

Check type(s) of disability: □ physical/sensory □ social/emotional
□ cognitive/language □ other: _____

Current professional development activities:
(college courses, etc.) _____
_____

EMOTIONAL DOMAIN

1. Tone of Voice **1 2 3 4 5 6 7**

	Y	N		Y	N		Y	N		Y	N
1.1	□	□	3.1	□	□	5.1	□	□	7.1	□	□
1.2	□	□	3.2	□	□	5.2	□	□	7.2	□	□
1.3	□	□	3.3	□	□	5.3	□	□			

Notes: 5.1 List 1 example of verbal enjoyment of children:
1)

7.1 Caregiver's tone is conveyed happily, List 2 examples
1)

2)

2. Acceptance/Respect for Children **1 2 3 4 5 6 7**

	Y	N		Y	N		Y	N		Y	N	NA
1.1	□	□	3.1	□	□	5.1	□	□	7.1	□	□	
1.2	□	□	3.2	□	□	5.2	□	□	7.2	□	□	
1.3	□	□				5.3	□	□	7.3	□	□	□
						5.4	□	□				

5.4 List 1 example where directions are positively worded:

1)

7.1 List 1 example where opportunities are provided for children to be successful:

1)

7.3 List 1 example of planned experiences that was observed:

1)

3. Greeting **1 2 3 4 5 6 7**

	Y	N		Y	N		Y	N		Y	N
1.1	□	□	3.1	□	□	5.1	□	□	7.1	□	□
1.2	□	□	3.2	□	□	5.2	□	□	7.2	□	□
1.3	□	□	3.3	□	□	*5.3	□	□	7.3	□	□

*5.3 Most likely you will need to ask to see proof of this.

3.1 Greeting Observed: √ = yes x = no w = warm

	Child	Parent	Exchange
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

4. Enjoys and Appreciates Children **1 2 3 4 5 6 7**

	Y	N		Y	N		Y	N		Y	N
1.1	□	□	*3.1	□	□	5.1	□	□	7.1	□	□
1.2	□	□	3.2	□	□	5.2	□	□	7.2	□	□
1.3	□	□	3.3	□	□	5.3	□	□	7.3	□	□
1.4	□	□	3.4	□	□	5.4	□	□			
1.5	□	□									

*3.1 Should answer as NO to move forward

3.3 List examples observed:

3.4 List examples observed:

5.4 List examples observed:

7.3 List at least 3 examples:

1)

2)

3)

5. Expectations for Children **1 2 3 4 5 6 7**

	Y	N		Y	N		Y	N		Y	N
1.1	□	□	3.1	□	□	5.1	□	□	7.1	□	□
1.2	□	□	3.2	□	□	5.2	□	□	7.2	□	□
			3.3	□	□						

3.2 Q: Use of worksheets {y or n}?

7.2 Identify at least 2 examples:

1)

2)

6. Health and Safety **1 2 3 4 5 6 7**

	Y	N		Y	N		Y	N		Y	N
1.1	□	□	3.1	□	□	5.1	□	□	7.1	□	□
1.2	□	□	3.2	□	□	5.2	□	□	7.2	□	□
1.3	□	□	3.3	□	□	5.3	□	□	7.3	□	□
1.4	□	□	3.4	□	□	5.4	□	□			
1.5	□	□									

Hand washing Observed:

C																								
A																								

5.3 Date of last fire drill: __ __ / __ __ / __ __
m m d d y y

7.3 Examples observed:

A. Subscale (Item 1-6) Score ___ ___

B. Number of items scored ___ ___

EMOTIONAL DOMAIN Average Score (A ÷ B) ___.___ ___

COGNITIVE/PHYSICAL DOMAIN

7. Routines/Time Spent **1 2 3 4 5 6 7**

*3.1 Read explanation of descriptors carefully for these items.

*3.2 Should answer as NO to move forward

5.3 Uses routine times for learning times, provide 2 examples:

1)

2)

7.1 Children wait 3+ minutes between activities? {y or n}

8. Physical Attention **1 2 3 4 5 6 7**

7.2 Physically assists child in developmental milestones, list 1 example observed:

	Y	N		Y	N		Y	N		Y	N
1.1	□	□	3.1	□	□	5.1	□	□	7.1	□	□
1.2	□	□	3.2	□	□	5.2	□	□	7.2	□	□
1.3	□	□	3.3	□	□	5.3	□	□			

9. Discipline **1 2 3 4 5 6 7**

5.1 List 1 example of redirection:

7.2 Viewpoints of others considered, List 1 example:

	Y	N		Y	N		Y	N		Y	N	NA
1.1	□	□	3.1	□	□	5.1	□	□	7.1	□	□	
1.2	□	□	3.2	□	□	5.2	□	□	7.2	□	□	
1.3	□	□	3.3	□	□				7.3	□	□	□
1.4	□	□										

7.1 Stresses prosocial behavior, List 2 examples:

1)

2)

7.3 Provide evidence from the teacher(s) that the children assisted in establishing rules:

10. Language Development **1 2 3 4 5 6 7**

	Y	N		Y	N		Y	N		Y	N
1.1	□	□	3.1	□	□	5.1	□	□	7.1	□	□
1.2	□	□	3.2	□	□	5.2	□	□	7.2	□	□
1.3	□	□	3.3	□	□	5.3	□	□	7.3	□	□
1.4	□	□	3.4	□	□	5.4	□	□	7.4	□	□
						5.5	□	□			

5.1 Rephrases conversations with children, List 2 examples:

1)

2)

5.1 Conversation is interactive, list 2 examples:

1)

2)

7.1 Adds words to child's dialogue, List 2 examples:

1)

2)

7.2 Labeling communication, Provide 1 example:

1)

11. Learning Opportunities **1 2 3 4 5 6 7**

	Y	N		Y	N		Y	N		Y	N
1.1	□	□	3.1	□	□	5.1	□	□	7.1	□	□
1.2	□	□	3.2	□	□	5.2	□	□	7.2	□	□
			3.3	□	□	5.3	□	□	7.3	□	□

3.2 Less involved children are drawn to play, List 1 example:

5.2 Encouragement and praise observed, Example:

7.1 Provide 1 example of this:

7.2 Encourages thinking for themselves, Example:

7.3 Provide an example of this:

12. Involvement with Children's Activities

1 2 3 4 5 6 7

	Y	N		Y	N		Y	N		Y	N
1.1	□	□	3.1	□	□	5.1	□	□	7.1	□	□
1.2	□	□	3.2	□	□	5.2	□	□	7.2	□	□
						5.3	□	□			

7.1 Provide 1 example of this:

13. Symbolic and Literacy Interaction

1 2 3 4 5 6 7

	Y	N		Y	N		Y	N		Y	N
1.1	□	□	3.1	□	□	5.1	□	□	7.1	□	□
1.2	□	□	3.2	□	□	5.2	□	□	7.2	□	□
1.3	□	□	*3.3	□	□	5.3	□	□	7.3	□	□
1.4	□	□									

*3.3 Should answer as NO to move forward

5.1 Identify type and number-
Must be at least 2 per child and variety

____ nature ____ people

____ fantasy ____ animals

5.2 Provide at least 2 incidences that were observed:
(Can be both formal or informal)

1)

2)

5.3 Discussion of pictures/mobiles, provide 1 example:

7.1 Literacy used daily, provide an example:

7.2 Bring materials from home? Ask. Provide at least 1 example:

A. Subscale (Items 7 - 13) Score __ __

B. Number of Items scored __ __

COGNITIVE/PHYSICAL DOMAIN Average Score (A ÷ B) __.__ __

CONNECTION WITH A WIDER WORLD

14. Promotion of Prosocial Behavior/Social Emotional Learning (SEL)

1 2 3 4 5 6 7

	Y	N		Y	N		Y	N		Y	N
1.1	□	□	3.1	□	□	5.1	□	□	7.1	□	□
1.2	□	□	3.2	□	□	5.2	□	□	7.2	□	□
			3.3	□	□	5.3	□	□			

3.1 List one example:

3.2 Verbally reminded, provide one example:

5.1 Provide one example:

5.2 Promotes verbal behavior during conflict resolution
List one example:

5.3 Children praised for prosocial behavior, provide one example:

7.1 Everyday experiences used, provide an example observed:

15. Engaging Children With Special Needs

1 2 3 4 5 6 7 NA

	Y	N		Y	N		Y	N		Y	N
1.1	□	□	3.1	□	□	5.1	□	□	7.1	□	□
1.2	□	□	3.2	□	□	5.2	□	□	7.2	□	□
1.3	□	□	3.3	□	□	5.3	□	□	7.3	□	□
1.4	□	□				5.4	□	□	7.4	□	□

16. Relationship with Families

1 2 3 4 5 6 7

	Y	N		Y	N		Y	N		Y	N
1.1	□	□	3.1	□	□	5.1	□	□	7.1	□	□
1.2	□	□	3.2	□	□	5.2	□	□	7.2	□	□
1.3	□	□	3.3	□	□	5.3	□	□	7.3	□	□

3.3 Families encouraged to participate in children's program, provide one example:

17. Cultural Competence **1 2 3 4 5 6 7**

	Y	N		Y	N		Y	N		Y	N
1.1	□	□	3.1	□	□	5.1	□	□	7.1	□	□
1.2	□	□	3.2	□	□	5.2	□	□	7.2	□	□
1.3	□	□									

A. Subscale (Items 14 – 17) Score __ __

B. Number of Items scored __ __

CONNECTION WITH A WIDER WORLD Average Score (A ÷ B) __.__ __

Total and Average Score

	Score	# of Items Scored	Average Score
Emotional Domain	_____	_____	_____
Cognitive/Physical Domain	_____	_____	_____
Connection with a Wider World	_____	_____	_____
TOTAL	_____	_____	_____

Appendix C:

Child Caregiver Interaction Scale Training Manual

Child Caregiver Interaction Scale (CCIS)

Table of Contents

Infant Age Caregiving

Toddler Age Caregiving

Emotional Domain

#1 Tone of Voice

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Speaks with irritation (sharp tone, raised voice) or harshness. 1.2 Tone of voice and manner are insincere (Caregiver may say one thing and mean another). Uses sarcasm. 1.3 Depressive or flat affect. .		3.1 Speaks warmly to children (tone and words). 3.2 Children are praised for their efforts (Good job!) 3.3 Caregiver's tone and manner match.		5.1 Verbally demonstrates enjoyment of children (Hi! Welcome to school today! I'm glad you are here!) 5.2 Tone expresses acceptance and patience to children, even in difficult situations. 5.3 Emotion/tone appears to be genuine.		7.1 Caregiver consistently seeks out opportunities to positively acknowledge children ('Catch them being good') 7.2 Caregiver's tone is happy and conveys to children that they are delightful and respected.

#1 Tone of Voice

General notes about this item:

One of the elements of positive caregiving is providing the children in care with plenty of encouragement and taking an active interest in their activities. These include behaviors such as discussing children's activities with them and praising their efforts to master a task (Doherty-Derkowski, 1995, p. 28). Research indicates children who experience high levels of positive caregiver interaction are compared with children experiencing lower level of positive interactions, the children show higher rates of exploratory behavior (Anderson et al., 1981); higher levels of language development (Whitebook et al., 1990); and more advanced cognitive functioning (Carew, 1980).

Reynolds and Jones (1996) identified ways to provide positive attention as a positive reinforcer. One way of doing this is by letting children know their positive actions are recognized, by "catching them being good" and giving appropriate and authentic reinforcement for the desirable behavior. Giving specific positive feedback helps children understand exactly what behaviors earn them positive recognition. By focusing on the positive behaviors, children learn they do not have to misbehave to get the caregiver's attention (Gestwicki, 1999, p. 178).

Infants Detailed Description of Indicators

1.1 Speaks with irritation (sharp tone, raised voice), or harshness.	Caregiver expresses irritation with babies through tone of voice. This can be heard in a sharp tone, raised voice, or by being verbally abrupt with children. Does the caregiver seem generally irritated with babies?
1.2 Tone of voice and manner are insincere (caregiver may say one thing and mean another). Uses sarcasm.	Caregiver uses an insincere tone. Does he/she say "nice things" in a negative manner? For example, "Oh joy, another messy diaper!" Or does caregiver say mean things in a nice way: "Gee, thanks so much for helping", when what is really meant is "Gosh, you are making more of a mess than a help. I wish you would stop!"
1.3 Depressive or flat affect.	Caregiver demonstrates either depressed demeanor or flat emotions. Does the caregiver seem depressed or withdrawn from the children? Caregiver's tone seems sad or expresses no emotion when engaging with the babies. The distinction between this indicator and 1.1 is the key word irritation, which may or may not be depressive.

3.1 Speaks warmly to children (tone and words)	Caregiver's tone of voice should be warm and demonstrate acceptance of children. This should be evident throughout the day – during play, routines and transitions. Caregiver does not have to be excessively warm or demonstrative to receive credit for this indicator. However, there should be no evidence of sharp tones or harshness in their interactions with babies. Note this is in the minimal category. Care should be given to not be culturally biased in this item. Look at the reactions of the children in care; do they respond favorably to the caregiver? Is the caregiver just not an overly demonstrative individual? If you have any question on the scoring of this item, take 15 minutes to focus on the children as they interact with the caregiver. Is the tone of voice part of the entire culture? Are the interactions with the caregiver received as caring by the children?
3.2 Children are praised for their efforts (Good job!)	Caregiver acknowledges babies efforts. He/she should verbally praise babies as they make attempts at basic skills, such as walking, eating with a spoon, drinking with a sippy cup. Caregiver should also praise babies in their attempts at play. For example, offering encouragement as babies play with busy box. Encouragement should be offered for the attempt, whether successful or not. The intention is that babies should receive recognition for trying.

3.3 Caregiver's tone and manner match.	This indicator means that no sarcasm is used. Words and tones should match. The intention of this item is authenticity. The caregiver doesn't need to be consistently happy or overjoyed – but whatever words are being said need to be expressed in an authentic tone. This should not be confused with good natured joking. When in doubt, look at the children's reaction. Are they laughing? Remember, sarcasm is a "nice nasty", not funny.

5.1 Verbally demonstrates enjoyment of children.	With this indicator, the caregiver needs to demonstrate enjoyment of children. She/he should verbally express warmth and caring towards all children.
5.2 Tone expresses acceptance and patience to children, even in difficult situations.	Adults cope with stress and model the type of interactions they want children to develop. Does the caregiver maintain a calm tone of voice even when stressed? Observe this item during feeding times. What happens when multiple infants want to eat at the same time? Does the caregiver keep calm without being abrupt with babies? Also be aware of this item if there are any discipline issues during the observation. Does the caregiver express acceptance of the child, while discouraging the negative behavior? Does he/she make a clear distinction between the child and the behavior?

5.3 Emotion/tone appears genuine.	The intention of this item is sincerity. Does the caregiver express genuine caring for the children? Do the positive feelings seem to flow effortlessly? Or does the caregiver seem to be pushing him/herself to engage with the children in a responsive manner?

7.1 Caregiver consistently seeks out opportunities to positively acknowledge children (Catch them being good).	Caregiver should 'catch children being good'. This means he/she seeks out times when babies are being good and compliments them. The intention of this indicator is that the caregiver should be aware of and in tune with the children in her care and verbally acknowledge them for positive behavior. For example 1 Caregiver acknowledges when an older infant gives "nice touches" to younger babies – instead of grabbing. 2 Caregiver praises babies who offer to "share" their toys with one another.
7.2 Caregiver's tone is happy and conveys to children that they are delightful and respected.	The difference between this indicator and 5.1 is the level of enthusiasm. The previous indicator describes a caregiver who expresses warmth and enjoyment of children. For this indicator, the caregiver's tone of voice not only expresses warmth, but also happiness and delight in the children. For example 5 Caregiver cheers and applauds infant who is successful with the busy box. 6 "Good morning honey! Did you have a good nap? It's so nice to see your beautiful eyes!" 7 "Good boy! I'm so proud of you!"

#2 Acceptance/Respect for Children

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Constantly says "No!" or engages in power struggles over issues that do not relate to the child's health or well-being. 1.2 Punishes children for asserting themselves or saying "No". 1.3 Makes negative comments or statements directed toward any child (shows obvious favoritism).		3.1 Demonstrates acceptance of children, both personally and generally. 3.2 Demonstrates knowledge of child development and child's abilities.		5.1 Expresses acceptance of children. 5.2 Caregiver demonstrates understanding of child development. 5.3 Limits saying "No" to situations that relate to children's safety or emotional well being. 5.4 Directions are positively worded ("Feet belong on the floor"), not just restrictions ("Don't climb on the table").		7.1 Provides opportunities for children to be successful so they can be praised. 7.2 Conveys to children they are valued. 7.3 Plans experiences that engage children's interests, resulting in less opportunity for off task behavior. (N/A option for Infants and Toddlers)

#2 Acceptance/Respect for Children

General notes about this item:

While child development occurs in a relatively orderly sequence, individual children develop at varying rates and unevenly within different areas of each child's functioning (Gestwicki, 1999, p. 9). It is not possible to compare the development of individual children solely based upon chronological ages. Each child has their own pattern and speed of development that is unique to the child. Factors such as heredity, health, individual temperament and personality, learning styles, experiences, and family background influence development. *Rigid expectations for age-related group norms conflict with principles that demand individual support of particular strengths, needs and interests* (Gestwicki, p. 9).

When children who experience high levels of positive adult interaction are compared to those experiencing lower levels of quality interaction, the children demonstrate higher levels of language development (Howes, 1990; Whitebook et al., 1990) and more advanced cognitive development (Carew, 1980).

Infants Detailed Description of Indicators

1.1 Constantly says "No!" or engages in power struggles over issues that do not relate to the child's health or well-being	Caregiver is constantly saying "No!" to babies or becoming involved in power struggles over issues that do not relate to the child's health or well-being. Caregivers punish babies for asserting themselves and their preferences. With nonverbal infants, this can be seen in the reaction caregiver has when attempting to put baby down for a nap. Does caregiver insist baby is hungry or tired, while baby is obviously not interested in food or rest? Care should be give when scoring this item. The concern is not whether caregiver is trying to comfort baby. The issue is whether this is a power struggle or not. Is caregiver attempting to sooth a fussy baby? Or does he/she just want to get the baby in bed so they can have some respite?
1.2 Punishes children for asserting themselves or saying "No".	Even nonverbal infants can assert themselves. For example, infants can spit out food they don't like or drop finger foods off the high chair in an effort to express they don't like it. Caregiver expresses frustration and punishes babies for this type of behavior. For example, does the caregiver withhold all food because of this? Is the baby still hungry because food was taken away?
1.3 Makes negative comments or statements directed toward any child (show obvious favoritism).	Infants are criticized or laughed at for what they cannot do or for their struggle to master a skill. They are made to feel inadequate and as if they have no effect on others[i]. Adults show favoritism and give most of their attention to certain children[ii].

3.1 Demonstrates acceptance of children, both personally and generally.	Adults are especially attentive to infants during caregiving routines, such as diaper changing, feeding, and changing clothes. The caregiver explains what will happen next, asking and waiting for the infant's cooperation and participation.
3.2 Demonstrates knowledge of child development and child's abilities.	Caregiver offers activities and provides interactions that are age and developmentally appropriate. This item is also evidence by the materials that are present and activities that are offered. Are they developmentally appropriate? For example, infants are provided soft blocks, busy boxes, given tummy time, etc. In this indicator, the caregiver doesn't necessarily need to be actively engaged with the baby as they play; it is enough that they are present and provide baby with the opportunities.

5.1 Expresses acceptance of children.	Caregiver respects infants' individual abilities and respond positively as each baby develops new abilities. Experiencing caregivers' pleasure in their achievements, infants feel competent and enjoy mastering new skills[iii]. Adults ensure that all infant receives nurturing, responsive care. Warm, responsive interactions with infants occur throughout the day. Observing the infant's cues, the caregiver is able to judge when the baby would like to be held, carried to a new place, or shifted to a new position.

5.2 Caregiver demonstrates understanding of child development.	To receive credit for this item, not only does the caregiver need to provide developmentally appropriate activities and materials to babies, he/she also needs to be actively engaged with their play. Examples of this include: 1 Helping infant with busy box. 2 Encouraging infant as they develop new skills (rolling over, crawling, walking). 3
5.3 Limits saying "No" to situations that relate to children's safety or emotional well being.	Caregivers try to limit their saying "No!" to situations that relate to children's safety or emotional well-being. When adults repeatedly use the word "No", children tune out the words so they have no impact over time.
5.4 Directions are positively worded.	Adults give positively worded directions (Feet belong on the floor"), not just restrictions (" Don't climb on the table").

7.1 Provides opportunities for children to be successful so they can be praised.	Caregiver consciously creates opportunities for infants to be successful. For example: 7 Put a busy box within their reach so they can make it work. 8 Encourages newly crawling baby to crawl towards a favored object. 9

7.2 Conveys to children they are valued.	This is evident in the ways caregiver responds to infants. For example: 7 Maintains focus and eye contact with babbling infant. 8 Protects less mobile infants from intrusion by older babies. 9
7.3 Plans experiences that engage children's interests, resulting in less opportunity for off task behavior.	N/A Option for Infants. While this may not be an item that is observed in an infant room, the intention of this item is that the caregiver engages children so they are involved, as opposed to being left to their own devices. This indicator goes beyond just interacting with children; the caregiver knows the needs of children in care and plans experiences so they are occupied. Look carefully at transitions.

#3 Greeting

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Children are expected to begin their day and no adult interaction. 1.2 Arrival of child not acknowledged. 1.3 Arrival of parent not acknowledged.		3.1 Children and parents are greeted and acknowledged by name upon arrival. 3.2 Children are accepted into the classroom with minimal adult interaction. 3.3 Caregiver verbally asks parents about child's well being upon arrival		5.1 Caregivers help children settle into the group upon their arrival by reading books or quietly playing with them. 5.2 Problems with separation from parent handled sensitively. 5.3 Caregiver provides written communication to parents on individual children*.		7.1 Parents are encouraged to be involved with daily activities. 7.2 Program is set up to encourage face to face communication between parents and caregiver. 7.3 Children's separation patterns are known and respected by caregiver (i.e., some children want to be held, others allowed "alone time".

*5.3 Most likely you will need to ask to see proof of this.

#3 Greetings

General notes about this item:

Positive parent involvement in the child care program is one that *supports and complements the family in its child rearing role* (Doherty-Derkowski, 1995, p. 48). Communication between home and the early childhood setting are important because they create an environment of continuity of the child's experiences. Cloutier (1985) stresses the need for meaningful on-going communication between the parent and early childhood program. The underlying assumption is that *parents and staff members share information and are able to agree on consistent approaches with the child* (Doherty-Derkowski, 1995, p. 49). Without this ongoing communication neither parents or staff have the whole picture of what is occurring in the child's life.

Research indicates (Galinsky, 1988) the most frequent communication times between parents and caregivers occur when the child is dropped off or picked up. These times are critical because these may be the only time caregivers and parents have the opportunity to share information.

Infant Detailed Description of Indicators

1.1 Children are expected to begin their day with free play and no adult interaction.	Adults receive babies hurriedly and without individual attention. Babies are placed in a crib or seat with no caregiver interaction[iv].
1.2 Arrival of child not acknowledged.	Parents bring baby into the room but the baby is not acknowledged. Parents either leave baby in infant seat or put into swing or on the floor; baby is not physically exchanged with caregiver.
1.3 Arrival of parent not acknowledged.	Parents bring baby into the room but their arrival is not acknowledged. Caregiver may recognize baby but doesn't pay any attention to the parent; parents are not greeted.

3.1 Children and parents are greeted and acknowledged by name upon arrival.	Baby is physically exchanged from parent to caregiver. Parents are acknowledged. Eye contact is made with baby and they are acknowledged by name upon arrival.
3.2 Children begin their day with free play and minimal adult interaction.	Caregiver physically receives baby but then places baby on their own, in chair, swing, infant seat, or on the floor. Caregiver then physically removes themselves from the baby and goes on to other tasks.
3.3 Caregiver verbally asks parents about child's well being upon arrival	Caregiver asks parents about the previous evening and about baby's well being this morning. Caregiver asks about baby's eating, sleeping and diapering schedule.

5.1 Caregivers help children settle into the group upon their arrival by reading books or quietly playing with them.	Infants and their parents are greeted warmly each morning. The caregiver is available to the infant upon arrival and helps the baby settle into the group setting as needed. A peaceful transition time for parents and child is part of the daily routine[v].
5.3 Problems with separation from parent handled sensitively.	Infants who are having a stressful transition time are given extra attention. Caregiver engages baby with various activities to ease the transition; rocking, reads a story, talking with peers.
5.4 Caregiver provides written communication to parents on individual children.	Caregiver provides written documentation about the infant's activities while in care, including feeding, diapering, napping activities. Also includes updates on daily activities and notes on behavior.

7.1 Parents are encouraged to be involved with daily activities.	Caregiver encourages parental participation, making a welcoming environment for parents. Program is set up to encourage participation. For example: • Extra adult size, comfortable chairs are provided to encourage parents to linger as baby transitions into daily care. • Open houses are offered so parents can get to know staff. • A variety of volunteer opportunities are clearly expressed so parents can participate. This can be both physical opportunities (field trip help) or material offerings (toilet paper rolls for a craft).

7.2 Program is set up to encourage face to face communication between parents and caregiver.	Extra caregivers are brought in to allow primary caregiver to engage with parents and babies upon arrival. Rather than being a rushed drop off time, caregiver is able to talk to parents about baby's evening, as well as any concerns either may have. With the extra caregiver, this can be accomplished without slighting other babies in care.
5.1 Children's separation patterns are known and respected by caregiver (i.e., some children want to be held, others allowed "alone time".	Caregiver has is aware and sensitive to each child's separation needs. Caregiver is respectful of babies' needs and accommodates them. For example, does baby need individual attention from caregiver upon arrival? Does caregiver provide that?

#4 Enjoys and Appreciates Children

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Seems to dislike children. 1.2 Quiet children are ignored. 1.3 Children are treated with indifference (act like they have no feelings); disrespected. 1.4 Takes little interest in children's activities or accomplishments. 1.5 Attention only given during routine care or for negative behavior.		3.1 Interaction with children is done mainly during routine care; little playing with children. 5.2 Maintains eye contact with children when they speak or babble. 3.3 Quiet children are engaged with and given attention even while being good. 3.4 Children who are playing well and quietly are acknowledged for their positive behavior.		5.3 Caregiver knows the children well and is able to respond to their temperament and cues, anticipating their needs. 5.4 Children are treated with respect. 5.5 States appreciation for child's efforts. 5.6 Praises children for their accomplishments.		7.1 Caregiver engages all children in conversations, asking of their interests and preferences. 7.2 Expresses delight in children's activities (claps hands, cheers.) 7.3 Conversations regularly include references to child's individual lives (siblings, parents, pets referenced; previous experiences, etc.)

#4 Enjoys and Appreciates Children

General notes about this item:

Detachment is defined as an *observable lack of involvement by the adult with the child* (Doherty-Derkowski, 1995, p. 39). Examples of this type of behavior may include lack of interest or involvement with children's activities, treating children with indifference or lack of any interaction. Research indicates that children who are cared for by detached caregivers demonstrate poor language development (Whitebook et al., 1990); lower levels of developmental play (Whitebook et al., 1990); higher rates of disobedience then their peers (Peterson and Peterson, 1986); and high rates of aimless wandering (Whitebook et al., 1990).

> As stated by Doherty-Derkowski,(1995) caregiver detachment and harshness impede the child's wellbeing in one of two ways. First, it may give the child the implicit message that the adult does not really care about him or her. Secondly, it results in the possibility that the adult may not be available when needed. Experiences such as this make it difficult for the child to feel confident about the adult's availability (p. 45).

Infant Detailed Description of Indicators

1.1 Seems to dislike children.	Adults are unpredictable and/or unresponsive. They act as if babaies are a bother or cute, doll-like objects[vi]. Caregiver interacts with infants in a harsh, impersonal manner. Consistently demonstrates irritation and annoyance at any baby in care. This can be observed in the caregiver's tone of voice, comments or actions.
1.2 Quiet children are ignored.	Infants are left for long periods of time in cribs, playpens, or seats, without adult's attention[vii]. Awake, quiet babies are not interacted with for periods of 15 minutes or longer. Just because the baby seems content, or the caregiver busy, does not excuse the lack of interaction. Interaction with ALL babies is necessary.
1.3 Children are treated with indifference (act like they have no feelings); disrespected.	Infants are interrupted, toys dangled, put into their hands, or whisked away. Caregivers impose their own ideas or play with toys themselves, without regard to the child's interests. Does the caregiver abruptly pick up an infant to change their diaper, or wipe their face with no warning? In order for babies to learn the world is a safe and predictable place, they need to be treated with respect.

1.4 Takes little interest in children's activities or accomplishments.	Babies are put on the floor, in swings, playpens, etc., and receive minimal interaction from caregiver. Caregiver does not engage with infants activities and does not acknowledge their accomplishments.
1.5 Attention only given during routine care or for negative behavior.	Caregiver only interacts with babies to diaper, feed, or put to bed. In addition, caregiver does not provide any positive engagement with infants; attention is only given when they behave negatively. This item is really looking at the detachment of the caregiver. Does caregiver seem as if they are just "going through the motions"? If there seems to be some genuine warmth in the interaction, give credit for this indicator. (But look closely at indicator 3.1).

3.1 Interaction with children is done mainly during routine care; little playing with children.	In this indicator, while the caregiver interaction mainly occurs during routine care, the interaction is positive and caring. While the caregiver may not engage with play activities with baby, she does provide this functional or custodial care in a positive manner. For example: • Caregiver smiles at baby when changing their diaper. • Caregiver asks baby if their bottle is tasty. Keep in mind, for this item, #3 indicates providing babies with generally basic care.

3.2 Maintains eye contact with children when they speak or babble.	Adults engage in many one-to-one, face to face interactions with infants. Adults talk in pleasant, calm voice, using simple language and frequent eye contact while being responsive to the child's cues[viii].
3.3 Quiet children are engaged with and given attention even while being good.	Quiet babies are not forgotten in the rush of more vocal needs of other babies. Caregiver moves the quiet baby from activity to activity, for example, from the bouncy chair, to the swing, to the floor, to give them a change in stimulation. Quiet babies are either acknowledged or drawn into group activities (as opposed to being ignored in their contendness). All infants receive some sort of adult interaction at no longer than 15 minute time spans.
3.4 Children who are playing well and quietly are acknowledged for their positive behavior.	Similar to the previous indicator, 3.4's focus is on ALL children (not just the quiet ones)[ix]. Caregiver positively reinforces baby's positive behavior by commenting on it. For example: • "Timothy, I like how you are playing with that rattle." • "DeAndre, you are playing so nicely in that bouncy seat". •

5.1 Caregiver knows the children well and is able to respond to their temperament and cues, anticipating their needs.	Caregivers consistently respond to infants' needs for food and comfort, thus enabling the infant to develop trust in the adults who care for them. In this environment, they learn that the world is a secure place for them. As the caregiver comes to know infants very well, they are able to respond to their temperament, needs, and cues of each baby to develop a mutually satisfying pattern of communication with each child and their family[x].

5.2 Children are treated with respect.	Playful interactions with babies are done in ways that are sensitive to child's interests and level of tolerance for physical movement, loud sounds, or other changes. Caregiver warns baby before picking up for diaper change, or warns them prior to washing their face. Infant's feelings are acknowledged and respected.

5.3 States appreciation for child's efforts.	Caregivers show their respect for infant's play by observing the child's activities, complementing on it verbally, and providing a safe environment. The caring, supportive adult encourages the baby's active engagement in play[xi]. The intention of this item is that the caregiver is appreciative of the baby's efforts, whether they are successful or not.
5.4 Praises children for their accomplishments.	Caregiver provides praise for children as they are successful in their efforts. For example: • Cheers and claps for baby who has learned to roll over • Praises baby for successfully playing with shape sorter. •

7.1 Caregiver engages all children in conversations, asking of their interests and preferences.	Caregiver has time structured so they can provide individual, focused time on each baby in care. Babies are engaged, with solid eye contact and attention, and talked to about their choices and preferences. For example: • "Would you like to swing or have tummy time?" • "You like the sunshine, don't you? How about we sit you by the window." Even nonverbal infants can be spoken to in this manner. The intention of this indicator is not that the infant should or will verbally respond. The intention is that the caregiver is demonstrating appreciation and respect for all babies, regardless of their communication skill level.
7.2 Expresses delight in children's activities (claps hands, cheers.)	Authentic enthusiasm expressed at child's activities, accomplishments or behavior. This can be done throughout the day; not just during planned, interactive activities.
7.4 Conversations regularly include references to child's individual lives (siblings, parents, pets referenced; previous experiences, etc.)	Caregiver demonstrates interest and knowledge of babies lives outside of the classroom. Listen for conversations relating to children's siblings, grandparents, or pets, as well as conversations about children's evening or weekend activities

#5 Expectations for children

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Expectations for children are not age appropriate (either expect too much or too little of them). 1.2 Lack of child development knowledge is evident.		3.1 Expectations for children are generally appropriate. 3.2 Caregiver uses appropriate learning techniques with children. 3.3 Caregiver demonstrates knowledge of child development by exposing children to age appropriate materials.		5.1 Caregiver demonstrates knowledge of child development by engaging children with age appropriate materials/activities. 5.2 Activities/materials selected incorporate age-typical behaviors		7.1 Caregiver is tuned into the needs of children in her care. 7.2 Activities encourage children to expand their skills.

#5 Expectations for Children

General notes about this item:

Child development research indicates fairly predictable patterns of growth and development during early childhood. Development occurs in an orderly sequence, with later skills and abilities building upon those already acquired (Gestwicki, 1999, p. 9). Understanding the behaviors and abilities related to typical development offers a framework for caregivers to know how best to support children's optimum learning. Understanding the sequence of learning abilities of children helps caregivers understand how to engage children in appropriate activities and *to resist the pressure to provide less appropriate experiences before the learning foundations have been laid. It is impossible for development to continue well when children are pushed to skip or hurry through earlier stages. Children need the time and patience to proceed through the sequence* (Gestwicki, 1999, p. 9).

Infant Detailed Description of Indicator

1.1 Expectations for children are not age appropriate (either expect too much or too little of them).	Caregivers view work with infants as a chore and as custodial in nature. They have unrealistic expectations for this age group, and/or they project their own perceptions onto the needs of the child[xii]. This item is closely related to indicator 1.2, however, caregiver could have knowledge of child development and still have unrealistic expectations. Look at the behavior the caregiver expects from children. Do they overdo for baby, interceding when baby can do for themselves? This overdependence creates uncertainty and leads to baby questioning their own abilities.
1.2 Lack of child development knowledge is evident.	Staff have little or no training specific to infant development. This is evident by the way they interact with babies, as well as the materials and activities they offer. They are unaware of what to look for that might signal problems in development. Caregivers do not know baby milestones so they don't know if baby is developing on target or not[xiii].

3.1 Expectations for children are generally appropriate.	Caregiver's expectation of babies' behavior is appropriate. These expectations shape the manner in which they engage with baby. Caregiver understands that babies are not "mini-preschoolers" and they cannot be expected to behave as such. Staff enjoys working with infants and are warmly responsive to their communications and needs[xiv].
3.2 Caregiver uses appropriate learning techniques with children.	Caregivers understand that babies learn by exploring their world in a safe environment. Caregiver offers baby materials which they can play with at their own pace[xv]. Caregiver does not use any type of structured "learning time" with babies. For example, flash cards, forced story time (babies set in infant seats and made to listen to a group story).
3.3 Caregiver demonstrates knowledge of child development by exposing children to age appropriate materials.	Staff have had training specifically related to infant development and caregiving. They know what skills and behaviors emerge during the first few months and support children as they become increasingly competent and knowledgeable[xvi]. Caregivers offer age appropriate materials to babies. When in doubt, ask the caregiver about previous trainings that are infant development related.

5.1 Caregiver demonstrates knowledge of child development by engaging children with age appropriate materials/activities.	To receive credit for this indicator, not only does the caregiver provide babies with age appropriate materials, but they also engage in play with them. For example: 1 Caregiver provides age appropriate books for babies, and reads to them informally throughout the day. 2 Mobile babies are encouraged to crawl through tunnel to reach caregiver shaking rattle on the other side. Caregiver plans activities that are age appropriate for babies. These can include, for example: 3 Art, using non-toxic finger paints. 4 Outdoor time to play in the grass on a blanket. 5
5.2 Activities/materials selected incorporate age-typical behaviors.	Caregiver plans activities that are age appropriate for infants. These can include, for example: 6 Toys provided that are responsive to the child's actions: A variety of grasping toys on different skill levels; nesting and stacking materials; activity boxes; variety of balls and rattles. 7 Nonbreakable household items, such as measuring cups and spoons; safe, nonbreakable bowls, and cardboard boxes. 8 Toys such as clutch balls, rattles, teethers and soft, washable dolls and animals, that are scaled to a size that allows infants to manipulate them.[xvii]

7.1 Caregiver is tuned into the needs of children in her care.	A tuned in caregiver can "read" the babies in her care and meet their needs prior to their becoming distressed. For example: 5 She/he is aware of baby's routines and schedule and makes bottle so it is ready prior to baby crying for it. 6 Understands that a fussy baby is tired and wants to be rocked to sleep.
7.2 Activities encourage children to expand their skills.	It is important for child's development that they be provided and encouraged to work slightly above their skill development. This "push" helps them to expand their abilities and gain confidence in themselves[xviii]. With this indicator, please note that not all activities should be beyond baby's abilities. There should be a combination of "old" and "new" activities. If all new activities are offered, baby will get frustrated and uncertain.

#6 Health and Safety

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Health and safety procedures routinely overlooked. 1.2 Supervision of children is inadequate (ratios not maintained). 1.3 Formal record of medication and health information is not maintained. 1.4 Daily records are not kept or not complete. 1.5 Children are visibly dirty/need noses wiped.		3.1 Some attention to health practices are generally met– by caregiver AND children. 3.2 No lapses in supervision. 3.3 Formal procedures for administration of medication are in place and implemented. 3.4 Mechanisms are used for parents and staff to share health information daily.		5.1 Health practices are consistently met by caregiver and children (ex., handwashing, etc). 5.2 Caregivers do safety checks, both indoors and out, several times a day. 5.3 Emergency evacuation plans are posted and practiced. 5.4 Extra clothes for indoors and out are available and used as necessary.		7.1 Caregiver consciously stresses good nutrition and health. 7.2 Children are taught proper handwashing techniques. 7.3 Caregiver explains health and safety rules to children.

#6 Health and Safety

General notes about this item:

Because of their immature immune systems, young children are more vulnerable to infections. Children in early childhood programs are exposed to a range of germs and viruses because of their increased contact with other young children. Studies indicate that children in early childhood programs are more vulnerable to diarrhea and hepatitis than their home-reared peers (Hayes et al., 1990).

Research indicates the extent to which diarrhea or hepatitis actually occurs is strongly dependent on the extent to which caregivers are vigilant about handwashing and other sanitary procedures (Black et al., 1981). In a study conducted by Black in four community child care centers in the United States, a fifty percent decrease in diarrhea occurred when child and adult handwashing was meticulously enforced.

Further, Klein (1986, as cited by Doherty-Derkowski, 1995), from the Department of Pediatrics at Boston University School of Medicine, notes that *handwashing is the single most important technique for prevention of gastrointestinal and many respiratory infections. Compulsory handwashing after handling infants, blowing noses, changing diapers, and using toilet facilities should be expected of every caregiver* (p. 12).

Infant Detailed Description of Indicator

1.1 Health and safety procedures routinely overlooked.	Policies and procedures to ensure a sanitary environment have not been clearly thought through and are not written and displayed. Adults forget hand washing or other essential steps in diapering, cleaning cribs and play areas, handling food, and cleaning of food preparation areas. A disinfectant solution is not prepared daily, and diaper-changing areas are not disinfected after each change. Disinfectants are left out- not stored in any special place; they are difficult for adults to find quickly when cleanup is needed for spills, diaper areas, or bodily fluids. Toys are scattered on the floor and cleaned occasionally, not at all, or improperly[xix].
1.2 Supervision of children is inadequate.	Children are left unattended. Caregivers leave the area when babies are playing quietly or sleeping. ANY lapses in immediate supervision of babies receives a score of "1"[xx].
1.3 Formal record of medication and health information is not maintained.	Formal records of medications are not required of parents. Caregivers are likely to make mistakes, giving medicines incorrectly or to the wrong infant because there is no visual reminder of the needs of each child. Health records are incomplete or outdated.[xxi]

1.4 Daily records are not kept or not complete.	Daily records are not kept or are incomplete. Caregivers and families have no regular effective mechanism for sharing information. Adults leave notes on the refrigerator or in the infant's diaper bag where parents may miss them. Caregivers may fail to communicate vital information to families.[xxii]
1.5 Children are visibly dirty/need noses wiped.	Check for the frequency and duration of this occurrence. If you notice a child needs their nose wiped and it is overlooked by the caregiver for 5 minutes, this indicator would receive a "Yes".

3.1 Some attention to health practices are generally met– by caregiver AND children. **.**	To limit the spread of infectious disease, adults follow health and safety procedures, including proper hand washing methods and overall precautions. There are clearly written sanitation procedures specific to each area. Instructions on the proper diapering and hand washing sequence (including use of protective gloves), cleaning cribs and play areas, and food storage/preparation (including dish washing) are displayed on the walls as visual reminders to adults. Adults daily prepare AND USE a solution of ¼ cup of liquid bleach to 1 gallon of water (or 1 tablespoon to 1 quart of water in a spray bottle) and store it in a place out of reach of children. Toys that are mouthed are removed when a child has finished playing with them so that they can be cleaned and disinfected before use by another child[xxiii].

3.2 No lapses in supervision.	Caregivers directly supervise toddlers by sight and sound, even when they are sleeping[xxiv].
3.3 Formal procedures for administration of medication are in place and implemented. Health records are on file.	Families bring in a signed permission form to administrator nonprescription or prescription medication, including a physician's written instruction for giving the medicine to that particular child. Health records, including immunizations and particular health problems (e.g., allergies) are filled separately and confidentially for every infant.[xxv]
3.4 Mechanisms are used for parents and staff to share health information daily.	A labeled daily record book or clipboard for each child is available for caregivers and parents to check and use. Caregiver's record time, date, and amount of medication administered. Caregivers and family members can also record vital information (bowel movements, feedings, arrival/departure times, and notes about the infant's activities and moods). Adults are aware of the symptoms of common illnesses and alert to changes in children's behavior that may signal illness or allergies. Caregivers conduct daily health checks, recording any signs of illness on each baby's daily record form[xxvi].
5.1 Health practices are consistently met by caregiver and children (handwashing, etc).	Caregiver and children consistently wash their hands with very few lapses. This should be calculated separately for caregiver and babies. Pay close attention to hand washing after wiping of noses. BOTH caregiver AND infant's hands should be washed SUFFICIENTLY. (Review appropriate handwashing techniques for details).

5.2 Caregivers do safety checks, both indoors and out, several times a day	Adults do safety checks of all areas, both indoors and outside, several times a day to ensure that they are safe (e.g., that electric outlets are covered, no objects are on the floor that a baby could choke on, no splinters or nails are exposed on furnishings and equipment)[xxvii]. Additionally, caregiver constantly scans the room, counting children, so all children are accounted for.
5.3 Emergency evacuation plans are posted and practiced.	Emergency evacuation plans are posted on the wall near the daily record charts. A bag of emergency supplies and child emergency forms are immediately accessible. Evacuation drills are practiced on a regular basis[xxviii].
5.4 Extra clothes for indoors and out are available and used as necessary	Extra clothes for both indoors and outdoors are available. Caregivers dress babies so they are comfortable, given the temperature, and can move freely[xxix]. This should be done even if parents bring baby in wearing clothes that are clearly uncomfortable for baby. Does caregiver recognize that baby is unable to move unencumbered? Wet and messy clothes are changed as necessary.

7.1 Caregiver consciously stresses good nutrition and health.	Caregiver demonstrates the value of nutrition and health. This can be evidenced in a multiple of ways: • Explains to baby the value of going outside. • Points out how good tasting AND good for you healthy foods are (like green beans, carrots, etc.). Makes no negative comments about food, such as "Oh, you like beets? I think they are yuckie!" • Sings songs, plays games, reads books or talks about pictures that relate to healthy lifestyle, such as healthy eating, exercise, etc.
7.2 Children are taught proper handwashing techniques.	Even young babies can be taught proper handwashing techniques. Does the caregiver educate baby how to wash hands and for the proper length of time? The intention of this is the caregiver explains why proper handwashing is important (i.e., cut down on spread of germs).
7.3 Caregiver explains health and safety rules to children.	Explains the health and safety reasons behind undesirable behavior. The intention of this indicator is that safety infractions are used as a learning, teachable moment. For example: 1 "We don't climb on chairs because they can fall over. Then we would be hurt." 2 "We don't put our friend's pacifier in our mouth. That is how we spread germs."

Cognitive Domain

#7 Routines/Time Spent

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1.Places high value on obedience/compliance 1.2. Primarily does adult tasks while children are in care. 1.3 Routine times are not used as bonding/learning times.		3.1 A general schedule is adhered to*. 3.2 Majority of time spent conducting routine child care tasks.*		5.1 Daily events are handled with flexibility. 5.2 Time spent is child driven, rather than caregiver driven (only occur when children are interested). 5.3 Uses routine times for learning experiences (Prime Times). 5.4 Caregiver spends majority of time engaging with children. 5.5 Uses appropriate curriculum (i.e., Creative Curriculum) N/A Option		7.1 Caregiver plans for transitions and these are handled with minimal stress on children (no long periods of waiting). 7.2 Allows for change in daily schedule based upon children's needs/interests.

*Read explanation of descriptors carefully for these items.

#7 Routines/Time Spent

General notes about this item:

The indicators in this item relate to the ways in which the caregiver spends their time, as well as the routines that are established for the children in their care. While there are some definite differences in the needs for routines between the age groups (infants, toddlers, and preschoolers), they all have the same basic need for consistency balanced with flexibility.

A key element of this indicator is what is developmentally appropriate. Infants and younger toddlers should be cared for on an individual basis. A schedule, if defined as a set course of events, does not exist in an infant/young toddler room.[xxx] Rather, infants should be on a *self-demand schedule*, one in which infants communicate their own needs and caregivers respond appropriately (Gestwicki, 1999). This sensitivity builds an infant's sense of certainty that their needs will be met by responsive caregivers. In turn, they learn that the world is a safe and trustworthy place. Because younger toddlers still vary greatly in their individual development, still require flexibility in scheduling.

Older toddlers and preschoolers, on the other hand, are better able to adapt to schedules. Because of their need for routines, they require consistency and stability. This does not mean that their schedules need to be carved in stone. When working with children, flexibility is key. Children's interests should be encouraged, even when it does not fit with the proscribed schedule. The

schedule should, however, be predictable for them: They should know that outdoor time comes after circle time, nap comes after lunch, etc..

Because so much of caring for children involves "Prime Times"[xxxi], this item stresses the importance of these times. Prime Times are identified as the basic of children's needs: food, sleep, toileting, and nurturing. Because these times account for a large part of infants, toddlers, preschoolers and caregivers day, these times can be used as rich learning experiences. These times can be used to focus on quality one-on-one interactions, regardless of the age group.

Infant Detailed Description of Indicator

1.1 Places high value on obedience/compliance	Schedules are rigid and based on adult's rather than children's needs. A rigid schedule is one that does not allow for a child's needs to be met individually. Some examples of placing high value on obedience/compliance are as follows: 7 Infants are expected to eat in a group, at a time when is convenient to caregiver. If several babies are crying because they are hungry and the caregiver is not feeding them because it's not "lunch" time, they would receive a score of "1" for this item). 8 All babies must nap at the same time, whether they are tired or not. 9 Food is used to pacify or reward (or is withheld as punishment).
1.2. Primarily does adult tasks while children are in care.	Please note the "primarily" notation in this item. Indicator of this would include: • Talking on the telephone • Doing routine tasks, such as bleaching toys, that can wait • Chatting with a coworker. • Completing paperwork and not interacting with babies. While some of this activity is acceptable and unavoidable, it should be kept to a minimum (3 minutes). Take note of the children in care: Are their needs being met? Physically? Emotionally? Caregivers do not help children make good use of choice time.

	They rarely intervene when children do the same things over and over or become disruptive. Rather than assisting children in developing decision making skills, caregivers overuse time-out or use punishment to control disruptive children. During children's play and choice activities, caregivers assume a passive role, contributing little or nothing to children's play and learning activities.
• **Routine times are not used as bonding/learning times.**	Routines are dealt with hurriedly and indifferently, with efficiency as the priority. Examples of this include: • Not holding infants who can hold their own bottle. Feeding is an important time for connecting to infants. Bottle fed babies deserve the same consideration as breast fed or less able babies. • Diapering is not used as a time to provide individualized, one-on-one time with baby. • Caregiver does not use meal times as time to devote to the child on an individual basis. • Routines are swiftly accomplished without involving the infant in play or communication. • Little or no warm interaction takes place during routines[xxxii].

3.1 A general schedule is adhered to. • **NOTE: This is different for infants versus toddlers and preschoolers.**	Infants should be on a self directed schedule, rather than a group feeding time. While a general schedule that provides structure to caregivers and infants is acceptable and desired, please note that infants should be the ones to direct this schedule. For example, the general schedule may provide for outdoor time to occur during the morning. That activity doesn't have to occur at the same specific time each day, but it generally occurs between 10 and 11 a.m. Please note that the intention of this item is that adults provide a consistency of routine, while adjusting to infants' individual feeding and sleeping schedules.
3.2 Majority of time spent conducting routine child care tasks.	**NOTE: In order to move forward on this item, the response for this item should be "No".** The intention of this indicator is that the caregiver spends most of their time interacting with children in routine tasks, such as feeding, diapering, and napping. <u>This indicator is describing more functionary or custodial care.</u> Infant's basic needs are met, with minimal amount of stress. The difference between this indicator and those at a higher level are that the focus of the caregiver is on these basic care routines, rather than engaging or expanding on child's learning.

5.1 Daily routines are handled with flexibility	Babies must be able to have a schedule based on their own individual needs, temperaments and natural rhythms[xxxiii]. While babies and staff in an infant room should have a general schedule for routines, the schedule needs to be flexible so that the individual needs of babies are met. For example, it may be a general rule of thumb that a specific infant is changed, given a bottle, and then laid down for a nap. Flexibility of the schedule would allow the baby to play after their bottle, should they not be tired.
5.2 Time spent is child driven, rather than caregiver driven.	Caregiver should be aware of baby's interest and expand upon them. For example: • The caregiver receives the book baby is holding and reads it to them. • Helps baby with busy box. • Stops doing finger plays because babies are no longer interested. The intention of this item is twofold: 5 The caregiver does not try and force infant to be engaged when they are no longer interested. 6 The caregiver is tuned into the baby's interests and let's them take the lead.

5.3 Uses routine times for learning experiences.	Diaper changing, feeding, and other routines are viewed as vital learning experiences for both babies and caregivers. These are Prime Times to be used engaging infants one-on-one. The caregiver should use these times to focus on the baby, maintaining eye contact, and engaging them on an individual basis. Examples of this include: 5 Using diapering times to learn body parts. 6 Using meal times to talk about different foods, textures, temperatures. 7 Using a walk in the stroller to talk about the weather, seasons, etc.
5.4 Caregiver spends majority of time <u>engaging with</u> children.	Caregiver not only actively engages babies in routine tasks but also engages them with play and learning activities. Caregiver understands play is child's work and engages with them. The key to this indicator is the idea of <u>engaging with</u> the child. This implies an active, interactive, reciprocal involvement between caregiver and infant. Examples of this would include: • Reading books to baby • Actively helping baby play with busy box • Help infant set up block tower Does the caregiver make eye contact with the infant? Are they truly present with the child (focused) or are they just going through the motions? To receive credit for this item, caregivers need to consistently demonstrate this active engagement.
5.5 Uses appropriate curriculum.	NA Option for Infants

7.1 Caregiver plans for transitions and these are handled with minimal stress on children (no long periods of waiting).	Transitions are times when babies move from one activity to another. Because these transition times can be stressful on children, the caregiver needs to give some thought as to how they will move from one situation to the next. For example, transitioning an infant from diapering to feeding would mean the caregiver is preparing for eating as they are completing the diapering procedure. While the infant will need to be placed somewhere (infant seat, swing, play area) while the caregiver is completing sanitary procedures, the caregiver provides them with some activity and interaction during this time. For example, they can talk with the infant, explaining that a bottle will be coming soon. The key to this item is that infants are not left for long periods of time with nothing to do and no interaction. A long period of waiting between daily events is considered 3 minutes[xxxiv]. To receive credit for this item there should be NO long periods of waiting for any children.
1.1 **Allows for changes in daily schedule based upon children's needs/interests.**	The focus of Item 5.1 is on the individual needs of infants in care. To receive credit for the 7.2 indicator, further flexibility of the caregiver needs to be demonstrated. Examples of this would include: • Extending time outside when all babies are enjoying a ride in the carriage. • Engaging a non-mobile infant with additional play materials before they become bored with those at hand. • Allowing for an extended lunch period for those infants who are learning to finger feed.

#8 Physical Attention

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Negative physical contact (rough or abrupt handling). 1.2 Children are shifted from group to group or cared for by whatever adult is available at the moment. 1.3 Children's attempts to initiate physical contact discouraged/ rejected.		3.1 Positive physical contact (hug, sit, pat, hold child) during routines. 3.2 Children are cared for by familiar adults, but adults may vary from day to day. 3.3 Children's attempts to initiate physical contact are welcomed.		5.1 Sits on child's level so they can crawl in caregiver's lap. 5.2 Gently, physically redirects child when necessary. 5.3 Children are cared for by one or two primary caregivers who are familiar with their routines.		7.1 Physically demonstrates affection for children throughout the day (hugs, hand holding, kisses). 7.2 Physically assists child in developmental milestones.

#8 Physical Attention

General notes about this item:

Children of all ages require interactions that nurtures trust. This includes the capacity to provide consistent responsiveness by the same adults. An environment of trust is a safe, familiar place that is predictable in the patterns of things, people and events (Bredekamp and Copple, 1997, p. 69).

The physical elements of trust development are imperative to infant development. As noted by Gestwicki (1999), *the holding, nuzzling, and belly kisses that are a part of warm caregiving interaction are as crucial as the physical elements of food and sleep to healthy growth* (p. 140). For toddlers, whose stage of development is all about autonomy, paradoxically, one of the most difficult things for them is separation from adults that are important to them. Toddlers feel most secure when their adults (parents and/or caregiver) are nearby. While toddlers are seeking independence, they need to kow that the caregiver is physically accessible to them when they need comfort (Gestwicki, 1999).

For preschool aged children, physical attention is also important. This stage is marked by the process of identification, where children move from wanting to be *near* the adults in their lives to being *like* them. Preschoolers *gradually depend less on attentions and constant assistance from adults, although they are still bound to them by affection, and thus a desire to please and be like them* (Gestwicki, 1999, p. 96).

Preschoolers are very physically active beings. For the most part they have mastered many of the large motor activities of toddlerhood. In this stage, preschoolers are working on fine tuning these skills. The physically responsive caregiver is one that assists the preschooler in their attempt to increase their coordination. This can be evidenced, for example, by helping a child peddle a bike or pump on a swing.

In general, the physically responsive caregiver is aware and sensitive to the physical needs of children in his/her care, regardless of their stage of development. This is not to say that the caregiver imposes physical affection on a child who is less physically demonstrative or needy. The key component to this item is being physically available for any child as they need the attention.

Infant Detailed Description of Indicator

1.1 Negative physical contact (rough or abrupt handling), OR there is no physical contact.	Caregiver is rough and inattentive, ignoring the infant's limitations and responses. Infants are wordlessly and sometimes abruptly moved about at the caregiver's convenience[xxxv]. Given the amount of physical care that is required by infants, it is highly unlikely that a caregiver would not have some sort of physical contact with a baby. Please note this is an "OR" indicator.
1.2 Infants are shifted from group to group or cared for by whatever adult is available at the moment.	The staffing pattern shifts caregivers around from infant to infant, or group to group, not supporting and the formation and maintenance of the infant/caregiving relationship. High staff turnover results in low continuity and frequent disruption of infant's budding attachment to caregivers[xxxvi]. Ask how long caregivers have been in this room. If they have been there for shorter than a year, ask about the previous caregiver's length of stay in this room. You need to understand if this is a pattern of behavior for this room (and center) or is this just a new caregiver?
1.3 Children's attempts to initiate physical contact discouraged/rejected.	Caregiver discourages physical contact initiated by baby. For example, caregiver pushes baby away as they try to crawl into lap. Caregiver physically shirks away from babies attempts at touch.

3.1 Positive physical contact (hug, sit, pat, hold child) during routines.	Caregiver provides physical contact and comfort to babies during routine care. Do they hold infants when feeding, even when they can hold the bottle themselves? Do they snuggle and hug babies who are distressed?
3.3 Children are cared for by familiar adults, but adults may vary from day to day.	Children are cared for by a primary caregiver, however, additional adults also provide care on a regular basis. For example, the caregiver may arrive for work at 9 a.m. Between the opening of the center and that time, a floater or several other staff may provide care. This person does not have to be the same one everyday, however, as long as the child is familiar with the caregivers.
3.3 Children's attempts to initiate physical contact are welcomed.	Caregiver responds to children's efforts at making physical contact. Caregiver recognizes child's attempts by reciprocating the touch, smiling or patting the baby.

5.1 Sits on child's level so they can crawl in caregiver's lap.	Caregiver not only provides physical comfort during routine care, but also purposely sits on children's level so infants can crawl in her lap or cuddle when they need it. Caregiver comforts babies and let them know they are appreciated through warm responsive touches, such as giving pats on the back or hugs and holding babies in their laps. Caregivers are sensitive to ensuring that their touches are welcomed by the children.[xxxvii] The intention of this item is that, when not engaging in routine care, the caregiver is physically accessible to babies.

5.2 Gently, physically redirects child when necessary. **N/A Option If Not Observed.**	Rather than redirecting child with words, which they may or may not understand, caregiver gently redirects babies when necessary. For example, if a more mobile baby is trying to crawl over a less mobile infant, caregiver gently steers the mobile baby to a place that is safer for both children.
5.3 Children are cared for by one or two primary caregivers who are familiar with their routines.	There is sufficient continuity of care to ensure that every infant (and family) is able to form a relationship with a primary caregiver. The staffing pattern is designed to make sure there is continuity over time for each infant's relationship with a primary caregiver. It is a priority to keep each infant in the same group, preferably year to year, to ensure that the child and a primary caregiver form and maintain a reciprocal relationship[xxxviii]? When in doubt, ask.

7.1 Physically demonstrates affection for children throughout the day (hugs, hand holding, kisses).	Caregiver physically demonstrates her affection for children through physical and emotional attention. Does she offer kisses and hugs to babies? Does he/she return a babies hug with a pat on the back?
7.2 Physically assists child in development.	Caregiver provides physical assistance as infants develop new skills. For example: 7 Physically helps non-rolling baby to roll. 8 Places baby in an upright position by propping pillows so they can strengthen their back and stomach muscles.

#8 Physical Attention

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Negative physical contact (rough or abrupt handling). 1.2 Children are shifted from group to group or cared for by whatever adult is available at the moment. 1.3 Children's attempts to initiate physical contact discouraged/ rejected.		3.1 Positive physical contact (hug, sit, pat, hold child) during routines. 3.2 Children are cared for by familiar adults, but adults may vary from day to day. 3.3 Children's attempts to initiate physical contact are welcomed.		5.1 Sits on child's level so they can crawl in caregiver's lap. 5.2 Gently, physically redirects child when necessary. 5.3 Children are cared for by one or two primary caregivers who are familiar with their routines.		7.1 Physically demonstrates affection for children throughout the day (hugs, hand holding, kisses). 7.2 Physically assists child in developmental milestones.

#8 Physical Attention

General notes about this item:

Children of all ages require interactions that nurtures trust. This includes the capacity to provide consistent responsiveness by the same adults. An environment of trust is a safe, familiar place that is predictable in the patterns of things, people and events (Bredekamp and Copple, 1997, p. 69).

The physical elements of trust development are imperative to infant development. As noted by Gestwicki (1999), *the holding, nuzzling, and belly kisses that are a part of warm caregiving interaction are as crucial as the physical elements of food and sleep to healthy growth* (p. 140). For toddlers, whose stage of development is all about autonomy, paradoxically, one of the most difficult things for them is separation from adults that are important to them. Toddlers feel most secure when their adults (parents and/or caregiver) are nearby. While toddlers are seeking independence, they need to kow that the caregiver is physically accessible to them when they need comfort (Gestwicki, 1999).

For preschool aged children, physical attention is also important. This stage is marked by the process of identification, where children move from wanting to be *near* the adults in their lives to being *like* them. Preschoolers *gradually depend less on attentions and constant assistance from adults, although they are still bound to them by affection, and thus a desire to please and be like them* (Gestwicki, 1999, p. 96).

Preschoolers are very physically active beings. For the most part they have mastered many of the large motor activities of toddlerhood. In this stage, preschoolers are working on fine tuning these skills. The physically responsive caregiver is one that assists the preschooler in their attempt to increase their coordination. This can be evidenced, for example, by helping a child peddle a bike or pump on a swing.

In general, the physically responsive caregiver is aware and sensitive to the physical needs of children in his/her care, regardless of their stage of development. This is not to say that the caregiver imposes physical affection on a child who is less physically demonstrative or needy. The key component to this item is being physically available for any child as they need the attention.

Infant Detailed Description of Indicator

1.1 Negative physical contact (rough or abrupt handling), OR there is no physical contact.	Caregiver is rough and inattentive, ignoring the infant's limitations and responses. Infants are wordlessly and sometimes abruptly moved about at the caregiver's convenience[xxxix]. Given the amount of physical care that is required by infants, it is highly unlikely that a caregiver would not have some sort of physical contact with a baby. Please note this is an "OR" indicator.
1.2 Infants are shifted from group to group or cared for by whatever adult is available at the moment.	The staffing pattern shifts caregivers around from infant to infant, or group to group, not supporting and the formation and maintenance of the infant/caregiving relationship. High staff turnover results in low continuity and frequent disruption of infant's budding attachment to caregivers[xl]. Ask how long caregivers have been in this room. If they have been there for shorter than a year, ask about the previous caregiver's length of stay in this room. You need to understand if this is a pattern of behavior for this room (and center) or is this just a new caregiver?
1.3 Children's attempts to initiate physical contact discouraged/rejected.	Caregiver discourages physical contact initiated by baby. For example, caregiver pushes baby away as they try to crawl into lap. Caregiver physically shirks away from babies attempts at touch.

3.1 Positive physical contact (hug, sit, pat, hold child) during routines.	Caregiver provides physical contact and comfort to babies during routine care. Do they hold infants when feeding, even when they can hold the bottle themselves? Do they snuggle and hug babies who are distressed?
3.2 Children are cared for by familiar adults, but adults may vary from day to day.	Children are cared for by a primary caregiver, however, additional adults also provide care on a regular basis. For example, the caregiver may arrive for work at 9 a.m. Between the opening of the center and that time, a floater or several other staff may provide care. This person does not have to be the same one everyday, however, as long as the child is familiar with the caregivers.
3.3 Children's attempts to initiate physical contact are welcomed.	Caregiver responds to children's efforts at making physical contact. Caregiver recognizes child's attempts by reciprocating the touch, smiling or patting the baby.

5.1 Sits on child's level so they can crawl in caregiver's lap.	Caregiver not only provides physical comfort during routine care, but also purposely sits on children's level so infants can crawl in her lap or cuddle when they need it. Caregiver comforts babies and let them know they are appreciated through warm responsive touches, such as giving pats on the back or hugs and holding babies in their laps. Caregivers are sensitive to ensuring that their touches are welcomed by the children.[xli] The intention of this item is that, when not engaging in routine care, the caregiver is physically accessible to babies.

5.2 Gently, physically redirects child when necessary. **N/A Option If Not Observed.**	Rather than redirecting child with words, which they may or may not understand, caregiver gently redirects babies when necessary. For example, if a more mobile baby is trying to crawl over a less mobile infant, caregiver gently steers the mobile baby to a place that is safer for both children.
5.3 Children are cared for by one or two primary caregivers who are familiar with their routines.	There is sufficient continuity of care to ensure that every infant (and family) is able to form a relationship with a primary caregiver. The staffing pattern is designed to make sure there is continuity over time for each infant's relationship with a primary caregiver. It is a priority to keep each infant in the same group, preferably year to year, to ensure that the child and a primary caregiver form and maintain a reciprocal relationship[xlii]? When in doubt, ask.

7.1 Physically demonstrates affection for children throughout the day (hugs, hand holding, kisses).	Caregiver physically demonstrates her affection for children through physical and emotional attention. Does she offer kisses and hugs to babies? Does he/she return a babies hug with a pat on the back?
7.2 Physically assists child in development.	Caregiver provides physical assistance as infants develop new skills. For example: • Physically helps non-rolling baby to roll. 9 Places baby in an upright position by propping pillows so they can strengthen their back and stomach muscles.

#8 Physical Attention

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For preschool aged children, physical attention is also important. This stage is marked by the process of identification, where children move from wanting to be *near* the adults in their lives to being *like* them. Preschoolers *gradually depend less on attentions and constant assistance from adults, although they are still bound to them by affection, and thus a desire to please and be like them* (Gestwicki, 1999, p. 96).

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In general, the physically responsive caregiver is aware and sensitive to the physical needs of children in his/her care, regardless of their stage of development. This is not to say that the caregiver imposes physical affection on a child who is less physically demonstrative or needy. The key component to this item is being physically available for any child as they need the attention.

Infant Detailed Description of Indicator

1.1 Negative physical contact (rough or abrupt handling), OR there is no physical contact.	Caregiver is rough and inattentive, ignoring the infant's limitations and responses. Infants are wordlessly and sometimes abruptly moved about at the caregiver's convenience[xliii]. Given the amount of physical care that is required by infants, it is highly unlikely that a caregiver would not have some sort of physical contact with a baby. Please note this is an "OR" indicator.
1.1 Infants are shifted from group to group or cared for by whatever adult is available at the moment.	The staffing pattern shifts caregivers around from infant to infant, or group to group, not supporting and the formation and maintenance of the infant/caregiving relationship. High staff turnover results in low continuity and frequent disruption of infant's budding attachment to caregivers[xliv]. Ask how long caregivers have been in this room. If they have been there for shorter than a year, ask about the previous caregiver's length of stay in this room. You need to understand if this is a pattern of behavior for this room (and center) or is this just a new caregiver?
1.2 Children's attempts to initiate physical contact discouraged/rejected.	Caregiver discourages physical contact initiated by baby. For example, caregiver pushes baby away as they try to crawl into lap. Caregiver physically shirks away from babies attempts at touch.

3.1 Positive physical contact (hug, sit, pat, hold child) during routines.	Caregiver provides physical contact and comfort to babies during routine care. Do they hold infants when feeding, even when they can hold the bottle themselves? Do they snuggle and hug babies who are distressed?
3.2 Children are cared for by familiar adults, but adults may vary from day to day.	Children are cared for by a primary caregiver, however, additional adults also provide care on a regular basis. For example, the caregiver may arrive for work at 9 a.m. Between the opening of the center and that time, a floater or several other staff may provide care. This person does not have to be the same one everyday, however, as long as the child is familiar with the caregivers.
3.3 Children's attempts to initiate physical contact are welcomed.	Caregiver responds to children's efforts at making physical contact. Caregiver recognizes child's attempts by reciprocating the touch, smiling or patting the baby.

1.3 Sits on child's level so they can crawl in caregiver's lap.	Caregiver not only provides physical comfort during routine care, but also purposely sits on children's level so infants can crawl in her lap or cuddle when they need it. Caregiver comforts babies and let them know they are appreciated through warm responsive touches, such as giving pats on the back or hugs and holding babies in their laps. Caregivers are sensitive to ensuring that their touches are welcomed by the children.[xlv] The intention of this item is that, when not engaging in routine care, the caregiver is physically accessible to babies.

5.2 Gently, physically redirects child when necessary. **N/A Option If Not Observed.**	Rather than redirecting child with words, which they may or may not understand, caregiver gently redirects babies when necessary. For example, if a more mobile baby is trying to crawl over a less mobile infant, caregiver gently steers the mobile baby to a place that is safer for both children.
5.3 Children are cared for by one or two primary caregivers who are familiar with their routines.	There is sufficient continuity of care to ensure that every infant (and family) is able to form a relationship with a primary caregiver. The staffing pattern is designed to make sure there is continuity over time for each infant's relationship with a primary caregiver. It is a priority to keep each infant in the same group, preferably year to year, to ensure that the child and a primary caregiver form and maintain a reciprocal relationship[xlvi]? When in doubt, ask.

7.1 Physically demonstrates affection for children throughout the day (hugs, hand holding, kisses).	Caregiver physically demonstrates her affection for children through physical and emotional attention. Does she offer kisses and hugs to babies? Does he/she return a babies hug with a pat on the back?
7.2 Physically assists child in development.	Caregiver provides physical assistance as infants develop new skills. For example: • Physically helps non-rolling baby to roll. • Places baby in an upright position by propping pillows so they can strengthen their back and stomach muscles.

#9 Discipline

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 When children misbehave, they are handled abruptly or harshly. 1.2 Caregiver speaks with irritation or lectures when children misbehave. 1.3 Rules are not explained ("No, stop that!" with no reason why). 1.4 Children excluded from group – contained or restrained.		3.1 Children are redirected appropriately when they misbehave. 3.2 Expectations are generally age appropriate. 3.3 Rules are explained to children on a basic level.		5.1 A variety of options are used for children (i.e, duplicate toys, activities used to engage children when they misbehave). 5.2 Caregiver engages with children to prevent misbehavior before it occurs (is aware of the children's cues of frustration).		7.1 Caregiver actively and consciously stresses prosocial behavior and behavioral safety through books, actions and activities. 7.2 Caregiver helps children take the viewpoint of others when they misbehave (discusses consequences, explains how actions affect others). 7.3 Children involved in establishing rules. (N/A option for infants and toddlers).

9 Discipline

General notes about this item:

The term discipline has numerous meanings. For example, the Webster's Dictionary offers several descriptions: to punish; teach obedience or order to; calm, controlled behavior; conscious control over lifestyle; and making people obey the rules. In early childhood literature (and this measure), the term discipline is defined as guidance. In this manner, the purpose of discipline is to assist children learn how to act in socially acceptable, established rules of behavior. For this context, discipline is defined by the ways in which a caregiver helps children manage their behavior.

While it may be clear that it is important for toddlers and preschoolers to learn discipline, the use of discipline with infants can be misleading. Very young infants do not tend to exhibit the same behavioral issues that older children demonstrate. However, if we see discipline as guidance, then it should be clear that all children, regardless of their age, benefit from positive discipline.

It should also be noted that this item is closely linked with developmentally age appropriate expectations for children. Again, young infants do not have the same understanding of their behavior that older children do. For the caregiver to identify a young infant is "misbehaving" is not appropriate. For example, a young baby who cannot fall asleep when the caregiver feels it should is not

misbehaving (no matter what the caregiver feels their motives are). There is a major difference between a child not being able to settle into sleep and one who is consciously demonstrating challenging behavior.

Please keep in mind that the term "misbehavior" for infants is not the same as for older toddlers and preschoolers. Misbehavior for infants should be thought of as less than desirable behavior, rather than behavior that is intentionally defiant.

Infant Detailed Description of Indicator

1.4 When babies misbehave, they are handled abruptly or harshly.	Caregiver reacts harshly to baby's 'misbehavior'. Obvious frustration is exhibited in response to infant's non-compliant behavior? For example, babies are handled brusquely, picked up rough manner. Does the caregiver view baby's challenging behavior as misbehavior? Are the expectations realistic?
1.5 Caregiver speaks with irritation or lectures when children misbehave	Caregiver expresses that baby has purposefully misbehaved and is obviously irritated and frustrated. Caregiver raises voice, speaks with annoyance to babies. Caregiver lectures baby, unleashing a monologue of displeasure. Caregiver punishes perceived infractions harshly, frightening and humiliating babies.
1.6 Rules are not explained ("No, stop that!" with no reason why).	Clear purposes for rules of behavior are not explained. Instead, caregiver says "No!" or "Stop That!" without explaining why or what to do instead.

1.4 Children excluded from group – contained or restrained.	Infants who are "misbehaving" are excluded from group activities in an attempt to control their behavior. For example, more mobile infant place in play pen or high chair to keep them contained. Please keep in mind this is a discipline item – the intention is not that children are physically in locations apart from the group. The question is, are they separated from the group as a form of discipline? Or is it because of their individual interest? Is this punishment?

3.1 Children are redirected appropriately when they misbehave.	Caregiver uses age appropriate redirection techniques. For this item, think of misbehavior to mean behavior that is undesirable. For example: • Caregiver shows older baby how to give gentle touches to younger baby (as opposed to slapping). • Caregiver removes book from baby's mouth, redirecting them to hold it rather than eat it. Gives another toy to mouth.
3.2 Expectations are generally age appropriate.	Realistic expectations are based on the age and developmental stage of the infants in care. For example: • Adults know that infants are curious about each other. At the same time, caregivers help ensure that children treat each other gently[xlvii]. • Caregivers know that babies require their special objects, such as "binkies" or "woobies" and protect them when in use.

3.3 Rules are explained to children on a basic level.	Caregiver provides clear, concise explanation of the rules to infants. For example: • "We don't hit. That hurts". • "We don't climb on chairs. They can fall over and you can get hurt." These explanations should not be long; using a few words for explanation is better than lengthy speeches (See indicator 1.2).

5.1 A variety of options are used to engage children when they misbehave.	Caregiver uses a variety of options to engage babies when they act in non-desirable ways. For example: • Offers duplicate toys so babies don't have to share. • Gently, physically redirects more aggressive baby. Does the caregiver have a range of discipline strategies to use?

5.2 Caregiver engages with children to prevent misbehavior before it occurs (is aware of the children's cues of frustration).	Caregiver is aware of baby's cues of frustration and helps redirect or alleviate prior to misbehavior. Watches babies closely and knows when to step in. For example: • Caregiver allows older infant to give "gentle touches" to younger baby but knows the older infant will evolve to grabbing. Redirects older infant before he/she gets grabby. • Knowing that two older infants like the same toy, caregiver brings out a duplicate toy before they can escalate to aggression. Note that misbehavior for infants should be thought of as less than desirable behavior, rather than behavior that is intentionally defiant. The intention of this item is that the caregiver knows the baby's in her care well and intercedes prior to them becoming frustrated and lashing out at one another.

7.1 Caregiver actively and consciously stresses prosocial behavior and behavioral safety through books, words and activities.	Caregiver uses books, pictures, songs, games to reinforce positive, prosocial behavior. For example: • Reads books to baby about being kind to others. • Caregiver actively and appropriately models positive social reactions with baby, using "please" and "thank you". •

7.2 Caregiver helps children take the viewpoint of others when they misbehave (discusses consequences, explains how actions affect others).	When babies 'misbehave', caregiver helps them take the perspective of others. For example: • Points out that climbing on non-mobile infant can hurt baby. • Explains that hitting hurts others. Again, please be clear that young infants do not "misbehave" in the context that older children do. Misbehavior for infants should be thought of as less than desirable behavior, rather than behavior that is intentionally defiant. The intention of this item is that the caregiver uses these times as a learning opportunity for baby.
7.3 Children involved in establishing rules.	N/A for Infants.

#10 Language Development

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Ignores children's attempts at communication. 1.2 Talks over children as they talk. 1.3 Uses terms that are unfamiliar to children. 1.4 Calls all children the same name so they are not sure who is being addressed).		3.1 Acknowledges children's attempts at communication. Nods, makes eye contact, attempts to decipher child's needs and vocalizations. 3.2 Verbally responds to child's cues of distress. 3.3 Uses individual child's names when speaking with them. 3.4 Uses terms that are familiar to children.		5.1 Listens attentively when children speak. Rephrases their conversations. 5.2 Dialogues with children. Conversation is interactive. 5.3 Checks for clarification when talking to children. Make sure they understand what is being said. 5.4 Uses clear, one step directions. 5.5 Models appropriate use of language (tense, vocabulary, etc.).		7.1 Adds to children's attempts to dialogue; adds words and explanations to talk. 7.2 Helps children understand their feelings and emotions by labeling communication. 7.3 Encourages verbal communication. 7.4 Fosters conversations between children.

#10 Language Development

General notes about this item:

Young children develop their language skills through interactions with more accomplished speakers of the language, such as parents, family members, and teachers, as well as other children. Research indicates the amount of verbal stimulation and opportunities for two-way communication provided by adults has been found to be statistically significant with the child's level of language development (Carew, 1980; Golden et al, 1979; Melhuish et al., 1990), as well as the child's level of social competence (Clarke-Stewart, 1987; Phillips et al., 1987). Additionally, Clarke-Stewart (1987) found that children in home-based child care scored highest on intellectual assessments and social competence when their caregivers consistently had one-to-one conversations with them (as cited by Doherty-Derkowski, 1995). According to Snow, Burns and Griffin (1998),

> Early childhood teachers need to know the value of one-to-one, extended, cognitively challenging conversations and how to engage in such communication, even with reluctant talkers. They need to know how the lexicon is acquired and what instructional practices support vocabulary acquisition. They also need to know how to conduct story reading and other early literacy experiences that promote phonological awareness and prepare children for later success in reading.

Infant Detailed Description of Indicator

1.1 Ignores children's attempts at communication.	Crying is ignored or responded to irregularly at the convenience of the adult. Crying is treated as a nuisance. Language is used discriminately, either too much or too little, and caregivers use a very limited range of words. Caregiver is unable to read children's attempts at communicating.
1.2 Talks over infants as they talk.	Adults do not wait for infants to finish vocalizing before beginning to talk; that is, they "talk over" babies vocalizing.
1.3 Uses terms that are unfamiliar to children.	Caregiver makes no attempt to "teach" baby words by repetition. Caregiver does not facilitate language development in young children by using the same words ("bottle" or "blanket") to help them label familiar objects. Additionally, caregiver speaks in long winded monologues that do not tie their conversation into objects or actions that are present in the environment. In this manner, babies are talked "at" rather than "to" or "with" and baby is not assisted in language development.

1.4 Calls all children the same name so they are not sure who is being addressed).	Caregiver does not call children by their individual name. Instead, uses "cutsie" terms, such as hon, rosebud, or sweetie so babies are unsure who is being addressed. This is not to say it is inappropriate for caregiver to use terms of endearment. The key is looking at how the babies respond. Do they seem confused? Do they know they are the sweetie that is being addressed?

3.1 Acknowledges child's attempts at communication	All interactions are characterized by gentle, supportive responses. Caregivers observe, listen and respond to sounds that infants make, imitate their vocalizations, and appreciate infant's sounds as the beginning of communication. Caregiver nods, makes eye contact, attempts to decipher baby's needs and vocalizations.
3.2 Verbally responds to children's cries of distress.	Caregiver recognizes that crying and body movements are the infants' ways to communicate. Responses to infants' cries or calls of distress are calm, tender and respectful. For example: • "Okay Payton, your bottle is coming. I know you are hungry". • "I know, you don't like the cold wipes on your bottom."

3.3 Uses individual child's names when speaking with them.	Caregivers recognize and support each child's individuation by using their name when speaking to them. Using each person's name also ensures that babies know they are being addressed and can respond appropriately.
3.4 Uses terms that are familiar to children.	Caregiver speaks to the children in a way that they know what is asked of them or what they are being told. They understand the words caregiver uses. For infant care, the caregiver uses speech that helps to facilitate language. For example, naming things, like spoon, bottle, ball, etc., so infants can become familiar with their labels.

5.3 Listens attentively when children speak. Rephrases their conversations.	Caregiver pays close attention to each baby when he/she speaks. Does not ignore, tune out or interrupt babies as they attempt to communicate. This is reflected by caregiver's appropriate responses to the babies beginning talk? Does he/she try to decipher what is being communicated? Does caregiver attempt to put words to babies babble?
5.4 Dialogues with children. Conversation is interactive.	Adults often talk to babies, especially older infants, about what is going on ("Let's go for a little walk. Would you like that?"). Caregiver takes care not to talk "at" babies, rather talks "with" them. They recognize that language is taught as conversation, and they demonstrate turn-taking skills of communication.

5.3 Checks for clarification when talking to children. Make sure they understand what is being said.	Caregiver demonstrates their respect for baby by making sure baby understands what is being said and seeking confirmation. For example: Caregiver asks baby if they want a bottle. After the caregiver speaks, they pause and look to infants for response, which may be verbal or nonverbal. They look infants in the eye, direct words to them physically.[xlviii] This labeling and clarification expands baby's language and increases their knowledge of the world around them.
5.4 Uses clear, one step directions.	Babies who are learning the link between language and actions, need clear, one step directions to follow. For example: • "Logan, please hand me your shoe". • "Let's put on your coat". • "It's time to go outside." As opposed to: "Logan, please hand me your shoe. Let's put on your coat". It's time to go outside."
5.5 Models appropriate use of language (tense, vocabulary, etc.).	Caregiver uses correct and appropriate grammar, vocabulary, etc. Caregiver does not necessarily need to constantly correct the child's use of words; rather they need to demonstrate the appropriate use of language themselves. (For example, not using words like "ain't").

7.1 Adds to children's attempts to dialogue; adds words and explanations to talk.	While babies cannot "talk", they certainly babble and coo. Caregiver provides descriptive words and explanations to babies' attempts at talking. For example: • "Yes, that is a red ball". • "That was a loud noise!" • "This baby has yellow hair."
7.2 Helps children understand their feelings and emotions by labeling communication.	Caregiver assists in baby's budding social/emotional awareness by labeling their feelings and emotions. For example? • "Are you feeling grumpy because you are tired?" • "It makes you happy when we blow bubbles!"
7.3 Encourages verbal communication.	While young infants may not have the actual words to provide their own descriptors or labels, caregiver encourages them to verbally communicate. For example, "Can you tell me what the doggie says? Can you say ruff?" "What color is this? Is it red?"
7.4 Fosters conversations between children.	Caregiver encourages dialogue between children. This can even be done with young infants. While young babies are not verbally capable of engaging in interactive conversations, the caregiver can model that behavior and offer words from one infant to another.

#11 Learning Opportunities

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Does not provide children with learning activities. 1.2 Minimal learning opportunities are available for children.		3.1 Offers child play opportunities. 3.2 Less involved children are drawn in to play. 3.3 Caregiver uses materials to spark interest of children.		5.1 Facilitates children's use of play materials. 5.2 Provides encouragement and praise for successful accomplishments in play. 5.3 Sets up environment /activities to foster development		7.1 Explains the reason for things. 7.2 Encourages children to think for themselves 7.3 Is aware of child's skill level and engages them with materials that expand their skills.

11 Learning Opportunities

General notes about this item:

DAP identifies that *early experiences have both a cumulative and delayed effect on individual children's development; optimal periods exist for certain types of development and learning* (Gestwicki, 1999, p. 9). The repeated experiences of children, both positive and negative, have implications for later development. For example, children who are provided the opportunity to develop social skills through play with peers in preschool tend to develop confidence and competence in their social relations with others. These experiences allow them to develop familiarity and competence when engaging with their peers as they enter elementary school. They are better able to enter group learning experiences with more ease then children who do not experience these earlier social experiences. As cited by Gestwicki, *times of readiness for optimal learning occur in the early years and need to be taken advantage of in planning curricular experiences; for example, growing neurobiological evidence indicates that the social and sensorimotor experiences of the first years affect brain development, with lasting implications for children's learning,* (p. 9).

Infant Detailed Description of Indicator

1.1 Does not provide children with learning activities.	Babies are confined to cribs, infant seats, playpens, or the floor with minimal interaction. Make sure to look at ALL children. If any one child is ignored, give a score of "1".
1.2 Minimal learning opportunities are available for children.	There are very few learning opportunities, including materials, available for baby. Materials do not need to be accessible (within reach) but do need to be present in the room for caregiver to access. In this indicator, caregiver provides no or very few materials to infants.

3.1 Offers child play opportunities.	Offers play equipment to babies (crib gyms, stacking cups, etc.). For this item, caregiver does not have to actively engage with baby in play. Merely placing materials in the proximity of babies where they can reach is sufficient.

3.2 Less involved children are drawn in to play.	Less mobile babies are moved so they have access to different sites and sounds. For example, a nonmobile infant is moved from a bouncy seat to a cradle gym. Adults periodically move infants to a different spot (from floor to infant seat, from seat to a stroller, etc.) to give babies different perspectives and reasonable variety in what they are able to look at and explore
3.3 Caregiver uses materials to spark interest of children.	Caregiver uses materials to spark baby's interest and attention. For example, shakes a rattle, points to a mirror, or hands baby a book. To receive credit for this item, caregiver does not have to continue to engage in play after drawing baby to this item.

5.1 Facilitates children's use of play materials.	Caregiver helps babies use play materials. For example: • "Let's try to put this puzzle piece in that hole". • "This cup fits inside that."
5.2 Provides encouragement and praise for successful accomplishments in play.	Provides praise for baby's successful accomplishments. For example, successfully grabbing a rattle or hitting a ball. In addition, praise is given when baby's accomplish newly acquired physical accomplishments, such as rolling over, sitting up, walking, etc.

5.3 Sets up environment /activities to foster development.	Caregiver creates opportunities, through activities or environment that encourage baby's exploration and development. For example, creates a tunnel and encourages new crawlers to explore.

7.1 Explains the reason for things:	Even for young babies, the caregiver can explain the reason for things. This should be done in simple ways. The intention is to encourage babies to think about cause and effect, no matter how simply. For example: • "This block is bigger that that so it should go on the bottom to hold the others up". • "You are cold because you don't have socks on."
7.2 Encourages children to think for themselves.	Again, even young babies can be encouraged to think for themselves. For example: • "This is a duck. What sound does it make?" • "Are you thirsty? Would you like a drink?"

7.3 Is aware of child's skill level and engages them with materials that expand their skills.	It is important to encourage children to expand their skill level by engaging them with activities and materials. This item is closely related to the clear understanding of child development, as well as clear knowledge of the abilities of the children in care. While higher skill level materials are desirable, materials should not be so far beyond baby's abilities that they cause frustration or apathy. For example, • Engaging a reaching infant with a busy box. • Helping a mobile baby crawl through a tunnel.

#12 Involvement with Children's Activities

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Is disinterested in child's activities and playtime. 1.2 Interaction with children occurs only during routine care: Feeding, toileting, napping. 1.3 Allows children to become frustrated by tasks they cannot do.		3.1 Verbally acknowledges children's activities. 3.2 Provides a variety of materials for children's play.		5.1 Actively engages in child's play. 5.2 Provides/creates play experiences for children. 5.3 Models appropriate play. .		7.1 Provides additional play experiences to expand on child's interests. 7.2 Talks to children to extend conversation when playing together.

#12 Involvement with Children's Activities

General notes about this item:

Children are active learners, drawing from their physical and social experiences, as wall as knowledge that is culturally transmitted. This allows them to construct their own understanding of their world. This intellectual development occurs by the child's constructivist interaction with people, materials, activities and experiences. As children create and test their own hypothesis about how the world works, their thought processes and mental structures undergo constant revisions. Appropriate caregiver interaction and experiences provide the encouragement for these constructions. Positive caregiver interactions and teaching strategies should support children's active learning and rely less on direct communication of knowledge that young children have not created themselves (Gestwicki, 1999, p. 10).

According to Bredekamp and Copple (1997), *child-initiated learning does not occur in the absences of caregiver guidance or input* (p. 118). As noted by Doherty-Derkowski (1995)

> *it is not sufficient enough to provide a variety of stimulating materials and an environment that encourages exploration and interaction. The adult must select and prepare the environment, then observe, guide, and assist the children so that they are challenged and supported in gaining information and an understanding of how things work* (p. 58).

Infant Detailed Description of Indicator

1.1 Is disinterested in child's activities and playtime.	Caregiver has little interest in infant's activities. Does not engage with babies at play. Seems emotionally detached or distant from babies; does not touch them or make conversation, outside of routine care.
1.2 Interaction with children occurs only during routine care: Feeding, toileting.	Caregiver provides attention and interaction to babies only during routine care activities, such as diapering, feeding, and naptime. This interaction is done swiftly and with little caring interaction.
1.3 Allows children to become frustrated by tasks they cannot do.	Because caregiver is disinterested and removed from babies, children become frustrated by tasks they cannot do. Caregiver is so uninvolved with infant's play; they are left to play on their own, with no adult interaction or facilitation. For example: • Baby drops pacifier and gets frustrated and upset because they cannot reach it (and no one gets it for them).

3.1 Verbally acknowledges children's activities.	Caregiver acknowledges babies as they play. He/she does not need to be actively physically involved with baby to receive credit for this item. For example, caregiver may acknowledge baby's play activities ("Are you cuddling the bunny?"), as they feed another infant. The intention of this item is that the caregiver provides recognition and awareness of all babies' activities.

3.2 Provides a variety of materials for children's play.	Materials are provided for infants so they have options and choices. To receive credit for this item, caregiver does not have to actively play with babies. They must, however, make sure babies can access the materials on their own. For example: • Nonmobile infant is placed under a floor gym, within their reach. • Infants are provided a variety of age appropriate materials, such as balls, sturdy books, and stuffed toys.

5.1 Actively engages in child's play .	Caregiver not only provides materials and activities for infants, but is also actively engaged with infant's play. For example: • Talks on play telephone with baby. • Plays 'hidie-peekie', and other finger plays.
5.2 Provides play experiences for children.	Caregiver helps babies understand the use of play equipment. For example: • Demonstrates to baby how a shape sorter works. Shows baby how to stack circles on the ring.
5.3 Models appropriate play.	Caregiver demonstrates appropriate play. For example, caregiver shows baby how to use a busy box or shape sorter.

7.1 Provides additional play experiences to expand on child's interests.	Caregiver routinely provides additional play experiences for babies. These are activities that require adult intervention to engage. For example: • Blows bubbles for baby • Tickles baby with feathers
7.2 Talks to children to extend conversation when playing together.	Offers a language rich environment. Continuously talks with baby to expand their conversations and language. Labels actions, items and events. For example: • "Are you going to the store? What are you going to get there? I'd like some oranges." • "See this bird? What color is it? It is blue."

#13 Symbolic and Literacy Interaction

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Any materials are inappropriate for children; materials are scary or violent. 1.2 Children are forced to participate, even when they are no longer interested. 1.3 No literacy materials present. 1.4 Materials are in poor repair.		3.1 Materials are generally appropriate for children. 3.2 Children are engaged only as long as they are interested 3.3 Materials are present but caregiver does not encourage or facilitate use. .		5.1 Caregiver provides a wide range of literacy and symbolic materials which children have access to during freeplay. All age appropriate. 5.2 Caregiver reads to children throughout the day. 5.3 Caregiver talks about pictures or mobiles.		7.1 Caregiver uses literacy and symbolic materials regularly (daily) that expands on themes or activities in the classroom. 7.2 Children are encouraged to bring materials from home that add to the themes (i.e., books, stuffed animals, etc.). 7.3 Caregiver relates print to verbal communication (N/A Option for Infants).

#13 Symbolic and Literacy Interaction

General notes about this item:

Reading books to children, starting in infancy, is important for several reasons. This activity leads to positive associations of books and reading for pleasure. Children should be exposed to a wide array of reading materials (Barclay et al., 1995) In addition to creating a good beginning for early literacy, language acquisition is *nurtured by hearing the words, watching the adult point to large, clear pictures, going back through the same book and hearing the same words, and making the same visual connections* (Gestwicki, 1999, p. 224).

Whole language is the belief that learning oral and written language is a continual process that takes place at the same time and starts at birth. According to Bird 1987; Pearson, 1990),

> *children are motivated to find ways to represent their experiences both through play and action, and through communication. Children learn that communication meets their needs, brings pleasure and friendship, and helps them understand their culture. As they are exposed to literacy, they discover that oral and written language are related and that print is another form of communication. Reading and writing are then viewed as part of a larger system for accomplishing their goals* (Gestwicki, 1999, p. 263).

Along with adults providing meaningful literacy materials, activities, and support, this awareness and motivation combine to develop emergent literacy (Sawyer and Sawyer, 1993). Children use continually, experience how print language functions, and move themselves *into print media experiences* (Gestwicki, 1999, p. 263). There is no start point where children are asked to study language

arts. *There is continuity between all language experiences, from birth through the primary years, not a discontinuity of "now it's time to learn to read"* (Gestwicki, p. 263).

Infant Detailed Description of Indicator

1.1 Any materials are inappropriate for children; materials are scary or violent.	Any books or pictures that are inappropriate to children. These can include materials that are scary, violent, or disturbing. For example, while pictures that promote emotional awareness are desired, ones that depict children crying are not acceptable. This seems to be most of an issue in centers that share space with churches. Are there any pictures that depict Noah's Ark and the flood? This material can be quite frightening to small infants.
1.2 Children are forced to participate, even when they are no longer interested.	Caregiver insists on reading to babies even when they are not interested. Caregiver is more interested in getting through the story than the child's attention.
1.3 No literacy materials present.	Books are not available to infants. Caregivers feel literacy materials are not necessary for infants because they get torn or soiled. There are no pictures or mobiles available for baby to look at.
1.4 Materials are in poor repair.	Torn, pages missing, out of date, dirty.

3.1 Materials are generally appropriate for children.	All literacy materials and pictures are appropriate for infants. These include cardboard, vinyl, or cloth books. Books are specifically for infants.
3.2 Children are engaged only as long as they are interested	Caregiver "reads" books and points out pictures to babies depending upon their interest. Babies are not forced to sit and listen to a story. Caregiver points out pictures to baby but only engages while baby is interested.
3.3 Materials are present but caregiver does not encourage or facilitate use.	Infant books are present and provided to infants to play with as they wish. To receive credit for this item, caregiver does not have to read to baby. Merely having literacy materials (books and picture) present is sufficient.

5.1 Caregiver provides a wide range of literacy and symbolic materials which children have access to during freeplay). All age appropriate.	Caregiver provides a wide range of books and pictures for infants. Sturdy picture books are provided. Content should include a wide variety; ABC's, numbers, drawings, photographs, rhyming, etc. Pictures represent people of different ages, racial and cultural groups, family types, occupations, and abilities/disabilities[xlix].
5.2 Caregiver reads to children throughout the day.	Caregiver reads informally to babies throughout the day. Caregiver consciously encourages the use of literacy materials. This is done in large group, small group or on individual basis.
5.3 Caregiver talks about pictures or mobiles.	Caregiver points out pictures and mobiles to infants. Encourages them to look at the materials and uses to facilitate talk.

7.1 Caregiver uses literacy and symbolic materials regularly (daily) that expands on themes or activities in the classroom.	Uses books and pictures to expand on themes. For example, uses books about apples in the fall, or snow in the winter. The intention of this item is that caregiver exposes babies to the fact that literacy materials can be used to expand knowledge.
7.2 Children are encouraged to bring materials from home that adds to the themes (i.e., books, stuffed animals, etc.)	Babies are encouraged to bring in books or materials from home to add to classroom themes. For example, baby brings in a book about cats from home during the week of "animals" theme. For infants, this item can receive a NA score. While this item is favorable, it may be rather unrealistic in an infant room with all young babies.
7.3 Caregiver relates print to verbal communication.	N/A Option for infants.

Connection with a Wider World

#14 Promotion of Prosocial Behavior/SEL

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 No evidence of promotion of SEL (no pictures, books or activities). 1.2 Negative peer interaction is ignored.		3.1 Evidence of SEL in the classroom. 3.2 Caregiver verbally reminds children of positive SEL. 3.3 Environment is set up so there are few instances of aggressive behavior.		5.1 Children are helped to acknowledge the viewpoint of others. 5.2 Encouragement of verbal behavior for conflict resolution. 5.3 Children are praised for prosocial behavior.		7.1 Everyday experiences are used as SEL learning. Caregiver looks for teachable moments. 7.2 Use of SEL curriculum used effectively (First Step, Preschool PATHS).

#14 Promotion of Prosocial Behavior/SEL

General notes about this item:

According to Gestwicki, 1999, when caregivers *verbalize others' feelings, and their concern for them, children are gradually led toward understanding how others feel and what responses are appropriate to those feelings. Caregivers help promote prosocial awareness and learning by deliberately devising opportunities for children to participate in situations that foster kindness* (p. 177).

As stated by Howes and Ritchie (2002),

> Adults who act as coaches for children's expression and modulation of emotion and focus on social content are linked to children who are more successful at effortful control and emotional regulation. Adult emotional coaching includes responding to emotional displays, labeling the emotions, and in a supportive manner helping children with strategies to modulate their emotional displays. When adults coach children, the children are helped to develop their ability to inhibit negative affect, to self sooth, and to focus their attention on the social context (p. 42).

Infant Detailed Description of Indicator

1.1 No evidence of promotion of SEL.	Caregiver is detached from infants. They clearly do not value or promote positive social and emotional connections. For administrative reasons, such as to maintain required staff-child ratios, the composition of the group changes many times in the course of a day or week, making it difficult for caregivers to get to know the children and for babies to establish relationships with adults or each other[l].
1.2 Negative peer interaction is ignored.	Caregiver does not intercede to protect babies from more aggressive infants. More mobile babies are allowed to crawl all over less mobile babies. Adults push infants to play together when they have no interest in doing so. If one child is very rough with another, adults take no action to protect the child who is being hurt.[li]

3.1 Evidence of SEL in the classroom.	Social/emotional awareness is evident in the room. This can be seen in various ways: • Through the caregiver's actions (saying "please" and "thank you" to baby, modeling the appropriate behavior, using kind words and tone. • The display of pictures that depict emotional learning (pictures with faces of varying emotions - but none that are frightening or disturbing). • Books that focus on emotions and social skills.
3.2 Caregiver verbally reminds children of positive SEL.	Caregiver gives baby the appropriate words to accompany actions. For example: • Thanks baby for handing over a rattle. • Prompts baby to "thank" another baby who "shares" a toy.
3.3 Environment is set up so there are few instances of aggressive behavior.	Caregiver engages children and the environment so there are few instances of aggressive behavior. For example, • Less mobile babies are protected from more aggressive babies. • Provide enough materials so babies do not "fight" over toys.

5.1 Children are helped to acknowleged the viewpoint of others.	Caregiver uses a variety of methods to encourage infants to acknowledge the view of others. For example: • Points out the reaction of a child who is upset. • Identifies facial emotions of characters in a book. • Caregiver talks about their own feelings. ("It is such a beautiful day today, I feel happy.")
5.2 Encouragement of verbal behavior for conflict resolution. **This can be a N/A item if no conflict is observed.**	Caregiver gives even non-verbal infants words to resolve conflicts. For example, When one infant takes a toy from another, caregiver prompts the offended child, "Say, please do not take my block. I was playing with that."
5.3 Children are praised for prosocial behavior **This can be a N/A item if not observed**	Caregiver values prosocial behavior and praises babies for their actions. For example: • One infant picks up the other's pacifier and hands to baby. Caregiver calls attention to the behavior and applauds the positive caring behavior.

7.1 Everyday experiences are used as SEL learning. Caregiver looks for teachable moments.	Caregiver consciously seeks out everyday experiences to be used as teachable SEL moments. Any opportunity is used to promote positive social engagement. For example: When a mobile infant gently touches a less mobile baby, caregiver acknowledges, and positively reinforces the behavior.
7.2 Use of SEL curriculum used effectively (First Step, Preschool PATHS).	N/A for Infants

#15 Engaging Children With Special Needs

(NA Option)

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Children with special needs kept separate from group. 1.2 Caregiver seems uncomfortable interacting with, or caring for, children with special needs. 1.3 No adaptive equiptment/ methods used even when warranted (ie., bracing, seating adaptations, etc). 1.4 The rest of the group is penalized because of perceived limitations.		3.1 Children with special needs included in the group. 3.2 Some adaptations made to help include child in activities (i.e., seat in circle for child who is unstable). 3.3 Adaptations are adequate, but make child with special needs "different"		5.1 Children with special needs are not immediately recognizable to outside observer. 5.2 Activities are planned so that all children can be successful/ participate. 5.3 Caregivers are comfortable interacting with/caring for children with special needs. 5.4 Caregivers seek info from parents /therapists on proper techniques.		7.1 Children with special needs are active /equal members of the group. 7.2 Adaptive materials blend into classroom materials (i.e., all chairs match, some have belts /positioners). 7.3 Caregivers are included as part of IFSP /IEP team. 7.4 Caregivers involved in implementing objectives of IFSP /IEP.

#15 Engaging With Special Needs Children

General notes about this item:

A child is considered to have special needs whenever they require help and information beyond what is *normally required by a child of the same age in order to assure the best developmental outcome* (Canning & Lynn, 1990, as cited by Doherty-Derkowski, 1995, p. 133). Mainstreaming or integration is the term given to the approach of including children with special needs in child care programs with children who do not have special needs. This approach is based on research indicating children with special needs will benefit because:

> The children who do not have special needs will model (demonstrate) age-appropriate behaviors for the children with speicla needs and these children will imitate such behaviors; the mainstreamed setting will provide a more advanced linguistic, social, and cognitive environment than would be provided in a segregated program; and children with disabilities who are in a mainstreamed program will learn to be comfortable with non-disabled peers (Striefel et al., 1991, p. 135)

The caregiver has a large role in providing support and facilitating positive peer interaction between the child with special needs and their normally developing peers. Research indicates that without encouragement, normally developing children interact more frequently with other normally developing peers or with those who have a mild disability than with peers who have a moderate

or severe disability. In conclusion, Odom and McEvoy (1988) report that social interaction will generally not occur between children with moderate or severe disabilities and non-disabled children unless it is specifically encouraged by caregiving staff.

It should be clear that the inclusion of this item is not meant to be viewed as being all that is required when a child with special needs is enrolled in the child care program. The substantial body of research cited for the other items are the same for children with special needs. The inclusion of this item recognizes that a caregiver with a special needs child attending his/her program also has additional requirements to consider.

Infant Detailed Description of Indicators

1.1 Children with special needs kept separate from group.	Is baby with special needs kept contained in an adaptive seat, play pen, etc., not interacting with the rest of the group? Is special needs baby separated from group "for their own good", for most of the day? This is not to say that babies whether special needs or not, cannot be placed in these types of apparatus. The question you should ask is why. If the baby is content, that is one thing. If the caregiver contains baby to keep them away from the group, that is another.
1.2 Caregiver seems uncomfortable interacting with, or caring for, children with special needs.	Look at caregiver's reactions to the baby with special needs. Does he/she seem awkward with the baby?
1.3 No adaptive equipment /methods used even when warranted (i.e., bracing, seating adaptations, etc.).	N/A if this does not pertain to the infants in the observed room. If needed, is the necessary equipment available to provide adequate care? For example, is there a seat that provides straps/braces for the infant who needs additional support? Please note, caregiver can be creative in developing materials – for example, using rolled blankets/towels to provide additional support for baby's head.

1.4 Rest of group is penalized based on perceived limitations.	Listen to the words the caregiver uses? For example, does she express that she'd like to take the group outside for a walk but cannot because of the limitations of the child with special needs?

3.1 Children with special needs included with group.	Babies with special needs are placed in close proximity to the other children in the group.
3.2 Some adaptations made to help include child in activities (i.e., seat in circle for child who is unstable.	Caregiver makes adaptations so children with special needs can actively engage with any group activities. This includes placing cushions around baby who is unsteady in sitting up so they can be around the cluster of other infants.
3.3 Adaptations are adequate, but make child with special needs "different".	These would include awkward or bulky equipment that is used to engage the child in the group.

5.1 Children with special needs are not immediately recognizable to outside observer.	A special needs child should be included in most play activities, just like every other child is, with modifications being carried out as smoothly and inconspicuously as possible. Keep in mind that most interventions are implemented as part of the regular classroom activities that include both the special needs child and their typically developing peers.[lii]	

5.2 Activities are planned so that all children can be successful/participate.	This may require modifications to the schedule and the environment, including: • Arrangement of classroom to provide wider pathways. • Providing special accessible playgrounds. • Providing additional staff to provide extra attention. • Providing more or less structured individual and group activities so all children can participate.[liii] •
5.3 Caregivers are comfortable interacting with/caring for children with special needs.	Caregivers provide care to the special needs infant with the same effortlessness as demonstrated with other infants.
5.4 Caregivers seek information from parents/therapists on proper techniques.	To give credit for this item, caregiver must either be observed using special activities or interactions with the child, or during the interview, staff must describe proper techniques used with the child and how they are carried out. Do not give credit if caregiver obviously does not know about appropriate techniques.

7.1 Children with special needs are active/equal members of the group.	To receive credit for this indicator, the special needs child should be included in most all activities and routines, just as every other child is, with special modifications being implemented as smoothly as possible.[liv]
7.2 Adaptative materials blend into classroom materials (i.e., all chairs match, some have belts, positioners).	While some adaptive furniture may be necessary for the special needs child, do the materials blend in with the others? Do the chairs all match? Or is the adaptive chair radically different than the others, calling attention to the special needs child?
7.3 Caregivers are included as part of IFSP/IEP team.	You will need to ask about this item. Ask if caregivers are members of the IFSP/IEP team. Do they have input on the goal setting of the child? Or do they just receive the recommendations with little participation in the planning process?
7.4 Caregivers involved in implementing objectives of IFSP /IEP.	This indicator is similar to that of 7.4. Ask how the implementation of the IFSP/IEP are accomplished. Are the goals implemented solely by additional professionals or is the caregiver actively involved with implementing interventions within the classroom setting?

#16 Relationship With Families

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Interaction with families occurs mainly when a problem arises. 1.2 Caregiver is patronizing or disrespectful towards families. 1.3 Cultural and other individual preferences of families are discouraged or ignore.		3.1 Some positive interactions with families occur daily. 3.2 Parent's preferences are treated with respect. 3.3 Families are encouraged to participate in children's program.		5.1 Caregiver's work in partnership with families to assist in child's development. 5.2 Caregiver's stress that they view parent's as the primary source of love and care. 5.3 Parents are always welcome in the child care center.		7.1 The diversity of families is celebrated and used as a basis of learning. 7.2 Caregiver plans curriculum that is culturally responsive. 7.3 Caregiver's use parent's knowledge of children in planning, evaluation and assessment.

#16 Relationship With Families

General notes about this item:

Children's development is best understood within the context of their family, then their school community, and the larger community (Gestwicki, 1999). According to Bredekamp and Copple, 1997, *education should be an additive process* (p. 13). Children should be encouraged and supported to add new cultural and language experiences without having to give up on their family of origin contexts. Children's home languages and cultures should be respected and reinforced in early childhood settings (Gestwicki, 1999, p. 10).

As identified by Bredekamp (1987) it is particularly important that parents and staff discuss basic values and childrearing practices. She identifies that during these early years, children learn whether or not their environment is supportive and predictable. Parents and staff who share information about the child's routines and daily experiences increase the likelihood that the child will experience a consistent environment.

Infant Detailed Description of Indicator

1.1 Interaction with families occurs mainly when a problem arises.	Caregivers communicate with parents only about problems or conflicts, ignore parents' concerns, or avoid difficult issues rather than resolving them with parents[lv].
1.2 Caregiver is patronizing or disrespectful towards families.	Caregivers communicate a competitive or patronizing attitude to parents or they make parents feel in the way. Parents view caregivers as the only expert and feel isolated from their child's experience[lvi].
1.3 Cultural and other individual preferences of families are discouraged.	Children's cultural and linguistic backgrounds and other individual differences are ignored or treated as deficits to be overcome. Multicultural curriculum reflects a "tourist approach" in which the artifacts, food, or other particulars of different cultures are presented without meaningful connections to the children's own experiences. Some children's cultural traditions are noted in ways that convey that they are exotic or deviations from the "normal" majority culture.[lvii]

3.1 Some positive interactions with families occur daily.	Caregiver helps parents feel good about their children and their parenting by sharing with them some of the positive and interesting things that happened with their children during the day. Parents always are made to feel welcome in the child's care setting[lviii].
3.2 Parent's preferences are treated with respect.	Does caregiver follow through with parent's choices? For example, does the parent identify food restrictions and the caregiver follows through? Does the parent request certain napping rituals that are carried through by the caregiver?
3.3 Families are encouraged to participate in children's program.	Does the center offer holiday celebrations that families are invited to attend? Are parents invited/encouraged to serve as "room parents" or "room helpers"?

5.1 Caregiver's work in partnership with families to assist in child's development.	Caregivers work in partnership with parents, communicating daily to build mutual understanding and trust and to ensure the welfare and optimal development of the baby. Caregivers listen carefully to what parents say about their children, seek to understand parents' goals and preferences and are respectful of cultural and family differences.

5.2 Caregiver's stress that they view parent's as the primary source of love and care.	Caregiver communicates that they view parents as the child's primary source of affection and care. Caregivers demonstrate that parent's preferences are respected. You do not want to hear: • "I'm just glad she has me in her life because her mom just doesn't have time for her." • "I don't care that mom says to put him to nap with his binky. I don't think he needs it."
5.3 Parents are always welcome in the child care center.	Parents are always welcome in the program. Opportunities for parent participation are arranged to accommodate parents' schedules. Parents have opportunities to be involved in ways that are comfortable for them, such as observing, reading to children, or sharing a skill or hobby.

7.1 The diversity of families is celebrated and used as a basis of learning. .	Caregiver bring each child's home culture and language into the shared culture of the school so that children feel accepted and gain a sense of belonging. The contributions of each child's family and cultural group are recognized and valued by others. Children learn to respect and appreciate similarities and differences among people[lix].

7.2 Caregiver plans curriculum that is culturally responsive	**N/A for Infants Where No Curriculum Is Used** Caregiver plans curriculum that is responsive to the specific context of children's experiences. Culturally diverse and nonsexist activities and materials are provided to help individual children develop positive self-identity, to construct understanding of new concepts by building on prior knowledge and creating shared meaning, and to enrich the lives of all children with respectful acceptance and appreciation of differences and similarities. Books and pictures include people of different races, ages, and abilities, and of both genders in various roles.
7.3 Caregiver's use parent's knowledge of children in planning, evaluation and assessment.	Caregivers and parents work together to make decisions about how best to support children's developmental and learning or to handle problems or differences of opinion as they arise. Teachers solicit and incorporate parents' knowledge about their children into ongoing assessment, evaluation, and planning procedures[lx].

#17 Cultural Competence

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 No evidence of cultural diversity observed. 1.2 Materials present only sterotypes of races, cultures, ages, abilities and gender. 1.3 Staff demonstrate prejudice against others (Ex. Against child or other adult from difference race or cultural group, against person with disability)		3.1 Some racial and cultural diversity visible in materials (Ex. multi-racial or multi-cultural dolls, books, or bulletin boards, music tapes from many cultures; in bilingual areas some materials accessible in children's primary language 3.2 Materials show diversity (Ex. different races, cultures, ages, abilities, or gender) in a positive way. 3.3 Staff intervene appropriately to counteract prejudice shown by children or other adults (Ex. discuss similarities and differences; establish rules for fair treatmend of others), *or* no prejudice is shown.		5.1 Many books, pictures and materials accessible showing people of different races, cultures, ages, abilities, and gender in non-stereotyping roles (Ex. both historical and current images; males and females shown doing many different types of work including traditional and non-traditional roles). 5.2 Some props representing various cultures included for use in dramatic play (Ex. dolls of different races, ethnic clothing, cooking and eating utensils from various cultural groups).		7.3 Inclusion of diversity is part of daily routines and play activities (Ex. ethnic foods are a regular part of meals/snacks; music tapes and songs from different cultures included at music time). 7.4 Activities included to promote understanding and acceptance of diversity (Ex. parents encouraged to share family customs with children; many cultures represented in holiday celebration).

#17 Cultural Competence

General notes about this item:

We live in a multicultural society where even children who are born into a homogeneous community are unlikely to live their entire lives in a similarly homogeneous environment. As stated by Doherty-Derkowski (1995),

> Inevitably, almost any child living in North America will be in a situation at one time or another where others have different beliefs and different ways of behaving. Therefore, it is important for children to develop the attitudes and skills required to live and work comfortably with people from various backgrounds. This is best done during the early childhood years when children can learn to view differences in appearances and ways of doing things as interesting and positive rather than as distressing or threatening (p. 120).

Considerable research indicates a strong link between school success with the extent to which minority children's language and culture are incorporated into the school program (Cummins, 1986). Child care programs can encourage and support all children's identity and the development of a positive self concept by *incorporating materials and activities that respect and affirm children's race or ethnicity, by addressing signs of bias or discrimination, and by promoting collaboration between the program and the home* (Doherty-Derkowski, 1995, p. 122). Being a culturally competent caregiver requires conscious effort. Caregivers not only demonstrate this competence by their actions, but also by the materials they offer the children in their care.

The indicators in this item closely correspond with those in the Early Childhood Environment Rating Scales, Revised Edition (Harms, T., Clifford, R.M., and Cryer, D. (1998) and the Infant/Toddler Environment Rating Scale, Revised Edition (Harms, T., Clifford, R.M., and Cryer, D. (2003). For detailed discussion of these indicators please refer to *All About ITERS-R* (Cryer, Harms and Riley, 2004) and *All About ECERS-R* (Cryer, Harms, and Riley, 2003).

Infant Detailed Description of Indicator

1.1 No evidence of cultural diversity observed.	All pictures and materials represent only one ethnicity or culture. Look for evidence of diversity in dolls, play materials, pictures, and books. Examples of diversity include dolls with various skin tones, doll sized wheelchairs, as well as books and pictures of varying abilities, including people wearing glasses.
1.2 Materials present only sterotypes of races, cultures, ages, abilities and gender.	Books and pictures reflect women and men in traditional roles only.
1.3 Staff demonstrate prejudice against others (Ex. against child or other adult from difference race or cultural group, against person with disability)	Look at caregiver's reactions to all children and staff. Is there a child that is "picked on" by the caregiver? Is there a baby that is neglected or criticized because they are different? This can be particularly evident if there is a baby with special needs. Does the caregiver seem uncomfortable with the baby because of their handicap?

3.1 Some racial and cultural diversity visible in materials (Ex. multi-racial or multi-cultural dolls, books, or bulletin boards, music tapes from many cultures; in bilingual areas some materials accessible in children's primary language	At least three examples of racial and cultural diversity should be observed. Look for examples in dolls, pictures, books and music tapes/cds.
3.2 Materials show diversity (Ex. different races, cultures, ages, abilities, or gender) in a positive way.	This indicator requires that all people are presented as caring and capable individuals and do not stereotype members of any group.

3.3 Staff intervene appropriately to counteract prejudice shown by children or other adults (Ex. discuss similarities and differences; establish rules for fair treatment of others), *or* no prejudice is shown.	To receive credit for this indicator, caregivers must take immediate action when they observe prejudiced behavior, by either adults or children, and make it clear that this is not acceptable. It is doubtful that very young infants and toddlers will demonstrate prejudicial behavior. If this type of behavior is observed, it will most likely be seen in the behavior of other staff present in the classroom. Be aware of other staff's responses to the children in care. If there is any evidence of prejudicial comments or behavior, does the targeted caregiver address them in a constructive way? If there is no evidence of prejudice observed, score this indicator a "Yes".

5.1 Many books, pictures and materials accessible showing people of different races, cultures, ages, abilities, and gender in non-stereotyping roles (Ex. both historical and current images; males and females shown doing many different types of work including traditional and non-traditional roles).	As is stated in the ITERS-R, many means that there are at least 10 examples of diversity. These should include the following: Races, cultures, ages, abilities and gender.
5.2 Some props representing various cultures included for use in dramatic play (Ex. dolls of different races, ethnic clothing, cooking and eating utensils from various cultural groups).	Look for dolls of different skin tones, ethnically diverse food toys (tacos, sushi, etc).

7.1 Inclusion of diversity is part of daily routines and play activities (Ex. ethnic foods are a regular part of meals/snacks; music tapes and songs from different cultures included at music time).	To receive credit for this indicator requires the caregiver make a solid and conscious effort to stress diversity in the classroom. Does the caregiver speak to the infants in different languages (i.e., saying "Hola" or counting to 10 in Spanish)? Are infants exposed to music and books of different cultures?
7.2 Activities included to promote understanding and acceptance of diversity (Ex. parents encouraged to share family customs with children; many cultures represented in holiday celebration).	You will most likely need to ask about this indicator. While infants may be too young to experience these activities directly, ask if the center overall encourages families to share customs and/or holiday celebrations. Only give credit for this indicator if infants are included in these activities.

Child Caregiver Interaction Scale (CCIS)
Toddler Version

Emotional Domain

#1 Tone of Voice

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Speaks with irritation (sharp tone, raised voice) or harshness. 1.2 Tone of voice and manner are insincere (Caregiver may say one thing and mean another). Uses sarcasm. 1.3 Depressive or flat affect. .		3.1 Speaks warmly to children (tone and words). 3.2 Children are praised for their efforts (Good job!) 3.3 Caregiver's tone and manner match.		5.1 Verbally demonstrates enjoyment of children (Hi! Welcome to school today! I'm glad you are here!) 5.2 Tone expresses acceptance and patience to children, even in difficult situations. 5.3 Emotion/tone appears to be genuine.		7.1 Caregiver consistentl y seeks out opportunit ies to positively acknowled ge children ('Catch them being good') 7.2 Caregiver's tone is happy and conveys to children that they are delightful and respected.

#1 Tone of Voice

General notes about this item:

One of the elements of positive caregiving is providing the children in care with plenty of encouragement and taking an active interest in their activities. These include behaviors such as discussing children's activities with them and praising their efforts to master a task (Doherty-Derkowski, 1995, p. 28). Research indicates children who experience high levels of positive caregiver interaction are compared with children experiencing lower level of positive interactions, the children show higher rates of exploratory behavior (Anderson et al., 1981); higher levels of language development (Whitebook et al., 1990); and more advanced cognitive functioning (Carew, 1980).

Reynolds and Jones (1996) identified ways to provide positive attention as a positive reinforcer. One way of doing this is by letting children know their positive actions are recognized, by "catching them being good" and giving appropriate and authentic reinforcement for the desirable behavior. Giving specific positive feedback helps children understand exactly what behaviors earn them positive recognition. By focusing on the positive behaviors, children learn they do not have to misbehave to get the caregiver's attention (Gestwicki, 1999, p. 178).

Toddler Detailed Description of Indicators

1.1 Speaks with irritation (sharp tone, raised voice), or harshness.	Caregiver expresses irritation with children through tone of voice. This can be heard in a sharp tone, raised voice, or by being verbally abrupt with children. Does the caregiver seem generally irritated with children?
1.2 Tone of voice and manner are insincere (caregiver may say one thing and mean another). Uses sarcasm.	Caregiver uses an insincere tone. Does he/she say "nice things" in a negative manner? For example, "Oh great, you dumped the toys again!" Or does caregiver say mean things in a nice way: "Gee, thanks so much for helping", when what is really meant is "Gosh, you are making more of a mess than a help. I wish you would stop!"
1.3 Depressive or flat affect.	Caregiver demonstrates either depressed demeanor or flat emotions. Does the caregiver seem depressed or withdrawn from the children? Caregiver's tone seems sad or expresses no emotion when engaging with the children. The distinction between this indicator and 1.1 is the key word of irritation, which may or may not be depressive.

3.1 Speaks warmly to children (tone and words)	Caregiver's tone of voice should be warm and demonstrate acceptance of children. This should be evident throughout the day – during play, routines and transitions. Caregiver does not have to be excessively warm or demonstrative to receive credit for this indicator. However, there should be no evidence of sharp tones or harshness in their interactions with babies. Note this is in the minimal category. Care should be given to not be culturally biased in this item. Look at the reactions of the children in care; do they respond favorably to the caregiver? Is the caregiver just not an overly demonstrative individual? If you have any question on the scoring of this item, take 15 minutes to focus on the children as they interact with the caregiver. Is the tone of voice part of the entire culture? Are the interactions with the caregiver received as caring by the children?
3.2 Children are praised for their efforts (Good job!)	Caregiver acknowledges toddler efforts. He/she should verbally praise children as they make attempts at basic skills, such as eating with a fork, drinking with a sippy cup, or potty training. Caregiver should also praise toddlers in their attempts at play. For example, offering encouragement as children try to build block tower. Encouragement should be offered for the attempt, whether successful or not. The intention is that toddlers should receive recognition for trying.

3.3 Caregiver's tone and manner match.	This indicator means that no sarcasm is used. Words and tones should match. The intention of this item is sincerity. The caregiver doesn't need to be consistently happy or overjoyed – but whatever words are being said need to be expressed in an authentic tone. This should not be confused with good natured joking. When in doubt, look at the children's reaction. Are they laughing? Remember, sarcasm is a "nice nasty", not funny.
5.1 Verbally demonstrates enjoyment of children.	With this indicator, the caregiver needs to demonstrate enjoyment of children. She/he should verbally express warmth and caring towards all children.
5.2 Tone expresses acceptance and patience to children, even in difficult situations.	Does the caregiver maintain a calm tone of voice even when stressed? Observe this item during transition times. What happens when multiple toddlers are being moved from one activity to another? Does the caregiver keep calm without being abrupt with children? Also be aware of this item if there are any discipline issues during the observation. Does the caregiver express acceptance of the child, even when discouraging the negative behavior? Does he/she make a clear distinction between the child from the behavior? Caregiver models the type of interactions that they want children to develop. Caregivers help toddlers resolve their differences by using words to express what is happening and what the toddler is feeling.("You want to play with the baby? Max is playing with the baby. Let's see if we can find another baby on the shelf").

5.3 Emotion/tone appears genuine.	The intention of this item is sincerity. Does the caregiver express genuine caring for the children? Do the positive feelings seem to flow effortlessly? Or does the caregiver seem to be pushing him/herself to engage with the children in a responsive manner?

7.1 Caregiver consistently seeks out opportunities to positively acknowledge children (Catch them being good).	Caregiver 'catches children being good'. This means he/she seeks out times when children are being good and compliments them. The intention of this indicator is that the caregiver should be aware of and in tune with the children in her care and verbally acknowledge them for positive behavior. For example • Children who are playing nice in the block area are recognized for their positive behavior. • Caregiver praises toddlers who offer to "share" their toys with one another.
7.2 Caregiver's tone is happy and conveys to children that they are enjoyed and respected.	The difference between this indicator and 5.1 is the level of enthusiasm. The previous indicator describes a caregiver who expresses warmth and enjoyment of children. For this indicator, the caregiver's tone of voice not only expresses warmth, but also happiness and delight in the children. For example • Caregiver cheers and applauds toddler who is successful building a block tower. • "Wow! Good job eating all your carrots!" • "Good boy! I'm so proud of you!"

#2 Acceptance/Respect for Children

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Constantly says "No!" or engages in power struggles over issues that do not relate to the child's health or well-being. 1.2 Punishes children for asserting themselves or saying "No". 1.3 Makes negative comments or statements directed toward any child (shows obvious favoritism).		3.1 Demonstrates acceptance of children, both personally and generally. 3.2 Demonstrates knowledge of child development and child's abilities.		5.1 Expresses acceptance of children. 5.2 Caregiver demonstrates understanding of child development. 5.3 Limits saying "No" to situations that relate to children's safety or emotional well being. 5.4 Directions are positively worded ("Feet belong on the floor"), not just restrictions ("Don't climb on the table").		7.1 Provides opportunities for children to be successful so they can be praised. 7.2 Conveys to children they are valued. 7.3 Plans experiences that engage children's interests, resulting in less opportunity for off task behavior. (N/A option for Infants and Young Toddlers)

#2 Acceptance/Respect for Children

General notes about this item:

While child development occurs in a relatively orderly sequence, individual children develop at varying rates and unevenly within different areas of each child's functioning (Gestwicki, 1999, p. 9). It is not possible to compare the development of individual children solely based upon chronological ages. Each child has their own pattern and speed of development that is unique to the child. Factors such as heredity, health, individual temperament and personality, learning styles, experiences, and family background influence development. *Rigid expectations for age-related group norms conflict with principles that demand individual support of particular strengths, needs and interests* (Gestwicki, p. 9).

When children who experience high levels of positive adult interaction are compared to those experiencing lower levels of quality interaction, the children demonstrate higher levels of language development (Howes, 1990; Whitebook et al., 1990) and more advanced cognitive development (Carew, 1980).

Toddler Detailed Description of Indicators

1.1 Constantly says "No!" or engages in power struggles over issues that do not relate to the child's health or well-being.	Adults are constantly saying "No!" to toddlers or becoming involved in power struggles over issues that do not relate to the child's health or well-being. Caregivers punish children for asserting themselves or saying "No."
1.2 Punishes children for asserting themselves or saying "No".	Caregiver does not recognize that constantly testing limits and expressing opposition ("No!") to adults is part of a child developing a healthy sense of self as a separate, autonomous individual[lxi].
1.3 Makes negative comments or statements directed toward any child (show obvious favoritism).	Caregiver criticizes toddlers for what they cannot do or for their clumsy struggle to master a skill[lxii]. For example: • "I don't know why you insist on trying to eat with a spoon. You know you can't do it" OR: Adults foster overdependency; children are overprotected and made to feel inadequate. For example: • "Here, let me do that for you. You know you can't button your coat". Children are made to feel ashamed of their bodies and to think their bodily functions are disgusting[3.] For example: • "Oh my gosh, did you poop again?!" • "You are such a messy eater!" Be aware of favoritism. Are some children allowed privileges while others are not?

3.1 Demonstrates acceptance of children, both personally and generally.	Children are acknowledged for their accomplishments and helped to feel increasingly competent and in control of themselves[lxiii]. Caregiver does not arbitrarily take favored toys away from children or expect them to share with other children. Children are given choices, and preferences are encouraged. Children are not all expected to do the same thing[lxiv].
3.2 Demonstrates knowledge of child development and child's abilities.	This item is evidenced by the materials that are present and activities that are offered. Are they developmentally appropriate? For example, toddlers are provided blocks, family living materials, small people, to play with. In this indicator, the caregiver doesn't necessarily need to be actively engaged with the children as they play; it is enough that they are present and they are offered to toddlers.

5.1 Expresses acceptance of children.	Adults respect children's developing preferences for familiar objects, food, and people. Adults permit children to keep their own favorite objects and provide limited options from which children may choose what they prefer to eat or wear. Children's preferences are seen as a healthy indication of a developing self-concept[lxv]. Healthy, accepting attitudes about children's bodies and their functions are expressed. For example: "Did you go poop on the potty? Good job!"

5.2 Caregiver demonstrates understanding of child development.	To receive credit for this item, not only does the caregiver need to provide developmentally appropriate materials and activities to children, he/she also needs to be actively engaged with their play. Examples of this include: • Helping toddlers build a block tower. • Engaging in family living activities with children. • Caregivers respect toddlers' desires to carry favored objects around with them, to move the objects from one place to another, and to roam around or sit and parallel play with toys and objects.
5.3 Limits saying "No" to situations that relate to children's safety or emotional well being.	Adults recognize that constantly testing limits and expressing opposition ("No!") to adults is part of a child developing a healthy sense of self as a separate, autonomous individual. Caregivers try to limit their saying "No!" to situations that relate to children's safety or emotional well-being.[lxvi]
5.4 Directions are positively worded.	Adults give positively worded directions (Feet belong on the floor"), not just restrictions (" Don't climb on the table").

7.1 Provides opportunities for children to be successful so they can be praised.	Caregiver consciously creates opportunities for toddlers to be successful. For example: • Sets up tunnel and praises children when they come out the other side. • Sings interactive songs where children supply the words.

7.2 Conveys to children they are valued.	This is evident in the ways caregiver responds to toddlers. For example: • Maintains focus and eye contact while children are talking. • Protects more sensitive toddlers from intrusion by more aggressive children. • Doesn't allow children to interrupt one another. • Appreciates that children have a unique and valuable perspective.
7.3 Plans experiences that engage children's interests, resulting in less opportunity for off task behavior.	N/A Option for Young Toddlers. While this may not be an item that is observed in a young toddler room, the intention of this item is that the caregiver engages children so they are involved, as opposed to being left to their own devices. This indicator goes beyond just interacting with children; the caregiver knows the needs of children in care and plans experiences so they are occupied. Look carefully at transitions.

#3 Greeting

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Children are expected to begin their day and no adult interaction. 1.2 Arrival of child not acknowledged. 1.3 Arrival of parent not acknowledged.		3.1 Children and parents are greeted and acknowledged by name upon arrival. 3.2 Children are accepted into the classroom with minimal adult interaction. 3.3 Caregiver verbally asks parents about child's well being upon arrival		5.1 Caregivers help children settle into the group upon their arrival by reading books or quietly playing with them. 5.2 Problems with separation from parent handled sensitively. 5.3 Caregiver provides written communication to parents on individual children*.		7.1 Parents are encouraged to be involved with daily activities. 7.2 Program is set up to encourage face to face communication between parents and caregiver. 7.3 Children's separation patterns are known and respected by caregiver (i.e., some children want to be held, others allowed "alone time".

*5.3 Most likely you will need to ask to see proof of this.

#3 Greetings

General notes about this item:

Positive parent involvement in the child care program is one that *supports and complements the family in its child rearing role* (Doherty-Derkowski, 1995, p. 48). Communication between home and the early childhood setting are important because they create an environment of continuity of the child's experiences. Cloutier (1985) stresses the need for meaningful on-going communication between the parent and early childhood program. The underlying assumption is that *parents and staff members share information and are able to agree on consistent approaches with the child* (Doherty-Derkowski, 1995, p. 49). Without this ongoing communication neither parents or staff have the whole picture of what is occurring in the child's life.

Research indicates (Galinsky, 1988) the most frequent communication times between parents and caregivers occur when the child is dropped off or picked up. These times are critical because these may be the only time caregivers and parents have the opportunity to share information.

Toddler Detailed Description of Indicators

1.1 Children are expected to begin their day with free play and no adult interaction.	Children are received hurriedly and given no individual attention. Toddlers are expected to begin the day with free play and little adult interaction[lxvii]. There is no predictable routine to the daily entry transition of entering group care.
1.2 Arrival of child not acknowledged.	Parents bring toddlers into the room but the child is not acknowledged. Parents leave child; but child is not acknowledged by caregiver.
1.3 Arrival of parent not acknowledged.	Parents bring child into the room but their arrival is not acknowledged. Caregiver may recognize baby but doesn't pay any attention to the parent; parents are not greeted.

3.1 Children and parents are greeted and acknowledged by name upon arrival.	Parents and children are acknowledged. Eye contact is made with toddler and they are acknowledged by name upon arrival.
3.2 Children begin their day with free play and minimal adult interaction.	Caregiver verbally acknowledges toddler but does not actively engage with them. Caregiver recognizes that child is there but goes on to other duties.
3.3 Caregiver verbally asks parents about child's well being upon arrival	Caregiver asks parents about the previous evening and about child's well being this morning. Caregiver asks about child's eating, sleeping and diapering/toileting schedule

5.1 Caregivers help children settle into the group upon their arrival by reading books or quietly playing with them.	Adults warmly greet toddlers and their parents by name when they arrive. The day begins with a great deal of adult-child interaction[1]. Caregivers help toddlers settle into the group setting by engaging with them, for example, reading, puzzle play, etc.
5.2 Problems with separation from parent handled sensitively.	Toddlers who are having a stressful transition time are given extra attention. Caregiver engages child with various activities to ease the transition; rocking, reads a story, talking with peers.
5.3 Caregiver provides written communication to parents on individual children.	Caregiver provides written documentation about the child's activities while in care, including feeding, diapering, napping activities. Also includes updates on daily activities and notes on behavior.

7.1 Parents are encouraged to be involved with daily activities.	Caregiver encourages parental participation, making a welcoming environment for parents. Program is set up to encourage participation. For example: • Extra adult size, comfortable chairs are provided to encourage parents to linger as children transitions into daily care. • Open houses are offered so parents can plan get to know staff. • A variety of volunteer opportunities are clearly expressed so parents can participate. This can be both physical opportunities (field trip help) or material offerings (toilet paper rolls for a craft).

7.2 Program is set up to encourage face to face communication between parents and caregiver.	Extra caregivers are brought in to allow primary caregiver to engage with parents and toddlers upon arrival and departure. Rather than being a rushed drop off time, caregiver is able to talk to parents about child's evening, as well as any concerns either may have. With the extra caregiver, this can be accomplished without slighting other children in care.
7.3 Children's separation patterns are known and respected by caregiver (i.e., some children want to be held, others allowed "alone time".	Caregiver has is aware and sensitive to each child's separation needs. Caregiver is respectful of child's needs and accommodates them. For example, does toddler need individual attention from caregiver upon arrival? Is that provided? Does child need to be held up to the window to watch parent leave? Does caregiver accommodate that?

#4 Enjoys and Appreciates Children

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Seems to dislike children. 1.2 Quiet children are ignored. 1.3 Children are treated with indifference (act like they have no feelings); disrespected. 1.4 Takes little interest in children's activities or accomplishments. 1.5 Attention only given during routine care or for negative behavior.		3.1 Interaction with children is done mainly during routine care; little playing with children. 3.2 Maintains eye contact with children when they speak or babble. 3.3 Quiet children are engaged with and given attention even while being good. 3.4 Children who are playing well and quietly are acknowledged for their positive behavior.		5.1 Caregiver knows the children well and is able to respond to their temperament and cues, anticipating their needs. 5.2 Children are treated with respect. 5.3 States appreciation for child's efforts. 5.4 Praises children for their accomplishments.		7.1 Caregiver engages all children in conversations, asking of their interests and preferences. 7.2 Expresses delight in children's activities (claps hands, cheers.) 7.3 Conversations regularly include references to child's individual lives (siblings, parents, pets referenced; previous experiences, etc.)

#4 Enjoys and Appreciates Children

General notes about this item:

Detachment is defined as an *observable lack of involvement by the adult with the child* (Doherty-Derkowski, 1995, p. 39). Examples of this type of behavior may include lack of interest or involvement with children's activities, treating children with indifference or lack of any interaction. Research indicates that children who are cared for by detached caregivers demonstrate poor language development (Whitebook et al., 1990); lower levels of developmental play (Whitebook et al., 1990); higher rates of disobedience then their peers (Peterson and Peterson, 1986); and high rates of aimless wandering (Whitebook et al., 1990).

> As stated by Doherty-Derkowski,(1995) caregiver detachment and harshness impede the child's wellbeing in one of two ways. First, it may give the child the implicit message that the adult does not really care about him or her. Secondly, it results in the possibility that the adult may not be available when needed. Experiences such as this make it difficult for the child to feel confident about the adult's availability (p. 45).

Toddler Detailed Description of Indicators

1.1 Seems to dislike children.	Adults are unpredictable and/or unresponsive. They act as if children are a bother or cute, doll-like objects[lxviii]. Caregiver interacts with toddlers in a harsh, impersonal manner. Consistently demonstrates irritation and annoyance at any child in care. This can be observed in the caregiver's tone of voice, comments or actions.
1.2 Quiet children are ignored.	Toddlers are left for long periods of time in cribs, playpens, seats, or in free play, without adult's attention[lxix]. Awake, quiet toddlers are not interacted with for periods of 15 minutes or longer. Just because the child seems content, or the caregiver busy, does not excuse the lack of interaction. Interaction with ALL children is necessary.
1.3 Children are treated with indifference (act like they have no feelings); disrespected.	Children are interrupted, toys dangled, put into their hands, or whisked away. Caregivers impose their own ideas or play with toys themselves, without regard to the child's interests. Does the caregiver abruptly pick up a child to change their diaper, or wipe their face with no warning? In order for toddlers to learn the world is a safe and predictable place, they need to be treated with respect.

1.4 Takes little interest in children's activities or accomplishments.	Toddlers are expected to engage in free play and receive minimal interaction from caregiver. Caregiver does not engage with toddlers activities and does not acknowledge their accomplishments.
1.5 Attention only given during routine care or for negative behavior.	Caregiver only interacts with children to diaper, feed, or put to bed. In addition, caregiver does not provide any positive engagement with toddlers; attention is only given when they behave negatively. This item is really looking at the detachment of the caregiver. Does caregiver seem as if they are just "going through the motions"? If there seems to be some genuine warmth in the interaction, give credit for this indicator. (But focus on 3.1).

3.1 Interaction with children is done mainly during routine care; little playing with children.	In this indicator, while the caregiver interaction mainly occurs during routine care, the interaction is positive and caring. While the caregiver may not engage with play activities with toddlers, she does provide this functional or custodial care in a positive manner. For example: • Caregiver smiles and talks to toddler when changing their diaper. • Caregiver asks toddler if their lunch is good. Keep in mind, for this item, #3 indicates providing toddlers with generally basic care.

3.1 Maintains eye contact with children when they speak or babble.	Adults engage in many one-to-one, face to face interactions with toddlers. Adults talk in pleasant, calm voice, using simple language and frequent eye contact while being responsive to the child's cues[lxx].
3.2 Quiet children are engaged with and given attention even while being good.	Quiet children are not forgotten in the rush of more vocal or aggressive needs of other toddlers. Caregiver provides the quiet toddler various activities, such as blocks or family living. The intention of this item is that quiet toddlers are acknowledged or drawn into group activities (as opposed to being ignored in their contendness). All toddlers receive some sort of adult interaction at no longer than 15 minute time spans.
3.4 Children who are playing well and quietly are acknowledged for their positive behavior.	Similar to the previous indicator, 3.4's focus is on ALL children (not just the quiet ones)[lxxi]. Caregiver positively reinforces toddler's positive behavior by commenting on it. For example: • "Kylie, I like how you are feeding your baby doll." • "Conner, that is a really nice tower you made."

5.1 Caregiver knows the children well and is able to respond to their temperament and cues, anticipating their needs.	Caregivers consistently respond to toddlers' needs for food and comfort, thus enabling the child to develop trust in the adults who care for them. In this environment, they learn that the world is a secure place for them. As the caregiver comes to know the toddlers very well, they are able to respond to their temperament, needs, and cues of each child to develop a mutually satisfying pattern of communication with each child and their family[lxxii].

5.2. Children are treated with respect.	Playful interactions with toddlers are done in ways that are sensitive to child's interests and level of tolerance for physical movement, loud sounds, or other changes. Caregiver warns child before picking up for diaper change, or warns them prior to washing their face. Toddler's feelings are acknowledged and respected.
5.3. States appreciation for child's efforts.	Caregivers show their respect for toddler's play by observing the child's activities, complementing on it verbally, and providing a safe environment. The caring, supportive adult encourages the toddler's active engagement in play. The intention of this item is that the caregiver is appreciative of the toddler's efforts, whether they are successful or not.
5.4 Praises children for their accomplishments.	Caregiver provides praise for children as they are successful in their efforts. For example: • Cheers and claps for toddler who has learned to snap their fingers. • Praises toddler for successfully completing a puzzle. •

7.1 Caregiver engages all children in conversations, asking of their interests and preferences.	Caregiver has time structured so they can provide individual, focused time on each toddler in care. Toddlers are engaged, with solid eye contact and attention, and talked to about their choices and preferences. For example: • "Would you like to play with puzzles or blocks?" • "This is your favorite story, isn't it? What do you like about it?" The intention is that the caregiver is demonstrating appreciation and respect for all children, regardless of their communication skill level.
7.2 Expresses delight in children's activities (claps hands, cheers.)	Authentic enthusiasm expressed at child's activities, behavior or accomplishments. This is to be done throughout the day; not just during planned, interactive activities. For example: • Caregiver scans the room during free play, providing praise, interest and encouragement as children engage in self directed play.
7.3 Conversations regularly include references to child's individual lives (siblings, parents, pets referenced; previous experiences, etc.)	Caregiver demonstrates interest and knowledge of toddlers lives outside of the classroom. Listen for conversations relating to children's siblings, grandparents, or pets, as well as conversations about children's evening or weekend activities

#5 Expectations for children

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Expectations for children are not age appropriate (either expect too much or too little of them). 1.2 Lack of child development knowledge is evident.		3.1 Expectations for children are generally appropriate. 3.2 Caregiver uses appropriate learning techniques with children. 3.3 Caregiver demonstrates knowledge of child development by exposing children to age appropriate materials.		5.1 Caregiver demonstrates knowledge of child development by engaging children with age appropriate materials/activities. 5.2 Activities/materials selected incorporate age-typical behaviors		7.1 Caregiver is tuned into the needs of children in her care. 7.2 Activities encourage children to expand their skills.

#5 Expectations for Children

General notes about this item:

Child development research indicates fairly predictable patterns of growth and development during early childhood. Development occurs in an orderly sequence, with later skills and abilities building upon those already acquired (Gestwicki, 1999, p. 9). Understanding the behaviors and abilities related to typical development offers a framework for caregivers to know how best to support children's optimum learning. Understanding the sequence of learning abilities of children helps caregivers understand how to engage children in appropriate activities and *to resist the pressure to provide less appropriate experiences before the learning foundations have been laid. It is impossible for development to continue well when children are pushed to skip or hurry through earlier stages. Children need the time and patience to proceed through the sequence* (Gestwicki, 1999, p. 9).

Toddler Detailed Description of Indicators

1.1 Expectations for children are not age appropriate (either expect too much or too little of them).	Adults expect too much or too little of toddlers. Caregivers are impatient with toddlers who are learning new skill. Because it is faster, adults do tasks for toddlers that they can do themselves. Adults allow children to become frustrated by tasks they cannot do[lxxiii].
1.2 Lack of child development knowledge is evident.	Adults do not understand the value of solitary and parallel play and try to force children to play together. Adults arbitrarily expect children to share. Popular toys are not provided in duplicate and are fought over constantly, while other toys are seldom used[lxxiv].

3.1 Expectations for children are generally appropriate.	Adults have appropriate expectations for toddlers and are supportive of toddlers as they acquire skills. Caregivers watch to see what the child is trying to do and provide the necessary support to help the child accomplish the task, allowing children to do what they are capable of doing and assisting with tasks that are frustrating[lxxv].

3.2 Caregiver uses age appropriate learning techniques.	Caregivers understand that toddlers learn by exploring their world in a safe environment. Caregiver offers children materials which they can play with at their own pace. Caregiver keeps structured "learning time" with toddlers to a minimum. For example, while caregiver may attempt to conduct circle time, this is done with flexibility and only while toddlers are interested. Caregivers don't use flash cards or primary school grade techniques (forced to sit).
3.3 Caregiver demonstrates knowledge of child development by exposing children to age appropriate materials.	Adults respect toddlers' solitary and parallel play. Caregivers provide several of the same popular toys for children to play with alone or near another child. Caregivers realize that having three or four of the same sought-after toy is better than having one each of many different toys[lxxvi].

5.1 Caregiver demonstrates knowledge of child development by engaging children with age appropriate materials/activities.	To receive credit for this indicator, not only does the caregiver provide toddlers with age appropriate materials, but they also engage in play with them. For example: • Caregiver provides age appropriate books for toddlers, and reads to them informally throughout the day. • Caregiver sets up climbing activities for toddlers. Caregiver plans activities that are age appropriate for toddlers. These can include, for example: • Art, using non-toxic finger paints. • Dancing to music, with instruments.
5.2 Activities/materials selected incorporate age-typical behaviors.	Caregiver plans activities that are age appropriate for toddlers. These can include, for example: • Schedules and activities are adapted to meet individual child's needs within the group setting. Recognizing toddler's need to repeat tasks until they master the steps and skills involved, caregivers allow toddlers to go at their own pace. • Caregivers engage in reciprocal play with toddlers, modeling for them how to play imaginatively, such as playing "doctor's office" and "grocery store". • Caregivers support toddler play so children stay interested in an object or activity for longer periods of time and their play becomes more complex.

7.1 Caregiver is tuned into the needs of children in her care.	A tuned in caregiver can "read" the children in her care and meet their needs prior to their becoming distressed. For example: • Knows that a favored toy is going to be guarded. Has a duplicate available prior to children fighting over it. • Engages toddlers to run around when she senses they are becoming restless.
7.2 Activities encourage children to expand their skills.	It is important for child's development that they be provided and encouraged to work slightly above their skill development. This "push" helps them to expand their abilities and gain confidence in themselves[lxxvii]. With this indicator, please not that not all activities should be beyond toddler's abilities. There should be a combination of "old" and "new" activities. If all new activities are offered, children will get frustrated and become uncertain.

#6 Health and Safety

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Health and safety procedures routinely overlooked. 1.2 Supervision of children is inadequate (ratios not maintained). 1.3 Formal record of medication and health information is not maintained. 1.4 Daily records are not kept or not complete. 1.5 Children are visibly dirty/need noses wiped.		3.1 Some attention to health practices are generally met– by caregiver AND children. 3.2 No lapses in supervision. 3.3 Formal procedures for administration of medication are in place and implemented. 3.4 Mechanisms are used for parents and staff to share health information daily.		5.1 Health practices are consistently met by caregiver and children (ex., handwashing, etc). 5.2 Caregivers do safety checks, both indoors and out, several times a day. 5.3 Emergency evacuation plans are posted and practiced. 5.4 Extra clothes for indoors and out are available and used as necessary.		7.1 Caregiver consciously stresses good nutrition and health. 7.2 Children are taught proper handwashing techniques. 7.3 Caregiver explains health and safety rules to children.

#6 Health and Safety

General notes about this item:

Because of their immature immune systems, young children are more vulnerable to infections. Children in early childhood programs are exposed to a range of germs and viruses because of their increased contact with other young children. Studies indicate that children in early childhood programs are more vulnerable to diarrhea and hepatitis than their home-reared peers (Hayes et al., 1990).

Research indicates the extent to which diarrhea or hepatitis actually occurs is strongly dependent on the extent to which caregivers are vigilant about handwashing and other sanitary procedures (Black et al., 1981). In a study conducted by Black in four community child care centers in the United States, a fifty percent decrease in diarrhea occurred when child and adult handwashing was meticulously enforced.

Further, Klein (1986, as cited by Doherty-Derkowski, 1995), from the Department of Pediatrics at Boston University School of Medicine, notes that *handwashing is the single most important technique for prevention of gastrointestinal and many respiratory infections. Compulsory handwashing after handling infants, blowing noses, changing diapers, and using toilet facilities should be expected of every caregiver* (p. 12).

Toddler Detailed Description of Indicators

1.1 Health and safety procedures routinely overlooked.	Policies and procedures to ensure a sanitary environment have not been clearly thought through and are not written and displayed. Adults forget hand washing or other essential steps in toileting, cleaning nap and play areas, handling food, and cleaning of food preparation areas. A disinfectant solution is not prepared daily, and toileting areas are not disinfected. Disinfectants are left out- not stored in any special place; they are difficult for adults to find quickly when cleanup is needed for spills, diaper areas, or bodily fluids. Toys are scattered on the floor and cleaned occasionally, not at all, or improperly[lxxviii].
1.2 Supervision of children is inadequate.	Children are left unattended. Caregivers leave the area when children are playing quietly or sleeping[lxxix]. Ratios are not maintained.
1.3 Formal record of medication and health information is not maintained. .	Formal records of medications are not required of parents. Caregivers are likely to make mistakes, giving medicines incorrectly or to the wrong child because there is no visual reminder of the needs of each child. Health records are incomplete or outdated.[lxxx]

1.4 Daily records are not kept or not complete.	Daily records are not kept or are incomplete. Caregivers and families have no regular effective mechanism for sharing information. Adults leave notes on the refrigerator or in the infant's diaper bag where parents may miss them. Caregivers may fail to communicate vital information to families.[lxxxi]
1.5 Children are visibly dirty/need noses wiped.	Check for the frequency and duration of this occurrence. If you notice a child needs their nose wiped and it is overlooked by the caregiver for 5 minutes, this indicator would receive a "Yes".

3.1 Some attention to health practices are generally met– by caregiver AND children.	To limit the spread of infectious disease, adults follow health and safety procedures, including proper hand washing methods and universal precautions. There are clearly written sanitation procedures specific to each area. Instructions on the proper diapering and hand washing sequence (including use of protective gloves), cleaning nap and play areas, and food storage/preparation (including dish washing) are displayed on the walls as visual reminders to adults. Adults daily prepare AND USE a solution of ¼ cup of liquid bleach to 1 gallon of water (or 1 tablespoon to 1 quart of water in a spray bottle) and store it in a place out of reach of children. Any toys that are mouthed are removed when a child has finished playing with them so that they can be cleaned and disinfected before use by another child[lxxxii].

3.2 No lapses in supervision.	Caregivers directly supervise toddlers by sight and sound, even when they are sleeping[lxxxiii].
3.3 Formal procedures for administration of medication are in place and implemented.	Families bring in a signed permission form to administrator nonprescription or prescription medication, including a physician's written instruction for giving the medicine to that particular child. Health records, including immunizations and particular health problems (e.g., allergies) are filled separately and confidentially for every infant.[lxxxiv]
3.4 Mechanisms are used for parents and staff to share health information daily.	A labeled daily record book or clipboard for each child is available for caregivers and parents to check and use. Caregiver's record time, date, and amount of medication administered. Caregivers and family members can also record vital information (bowel movements, feedings, arrival/departure times, and notes about the child's activities and moods). Adults are aware of the symptoms of common illnesses and alert to changes in children's behavior that may signal illness or allergies. Caregivers conduct daily health checks, recording any signs of illness on each child's daily record form[lxxxv].

5.1 Health practices are consistently met by caregiver and children (handwashing, etc).	Caregiver and children consistently wash their hands with very few lapses. This should be calculated separately for caregiver and babies. Pay close attention to hand washing after wiping of noses. BOTH caregiver AND toddler's hands should be washed SUFFICIENTLY. (Review appropriate handwashing techniques for details).
5.2 Caregivers do safety checks, both indoors and out, several times a day	Adults do safety checks of all areas, both indoors and outside, several times a day to ensure that they are safe (e.g., that electric outlets are covered, no objects are on the floor that a child could choke on, no splinters or nails are exposed on furnishings and equipment)[lxxxvi]. Caregiver constantly scans the room, counting children, so that all children are accounted for.
5.3 Emergency evacuation plans are posted and practiced.	Emergency evacuation plans are posted on the wall near the daily record charts. A bag of emergency supplies and child emergency forms are immediately accessible. Evacuation drills are practiced on a regular basis[lxxxvii].
5.4 Extra clothes for indoors and out are available and used as necessary	Extra clothes for both indoors and outdoors are available. Caregivers dress toddlers so they are comfortable, given the temperature, and can move freely[lxxxviii]. Wet and messy clothes are changed as necessary,

7.1 Caregiver consciously stresses good nutrition and health.	Caregiver demonstrates the value of nutrition and health. This can be evidenced in a multiple of ways: • Explains to toddler the value of physical exercise. • Points out how good tasting AND good for you healthy foods are (like green beans, carrots, etc.). Makes no negative comments about food, such as "Oh, you like beets? I think they are yuckie!" • Sings songs, plays games, reads books or talks about pictures that relate to healthy lifestyle, such as healthy eating, exercise, etc.
7.2 Children are taught proper handwashing techniques.	Even young children can be taught proper handwashing techniques. Does the caregiver educate the child how to wash hands and for the proper length of time? The intention of this is the caregiver explains why proper handwashing is important (i.e., cut down on spread of germs).
7.3 Caregiver explains health and safety rules to children.	Explains the safety reasons behind undesirable behavior. The intention of this indicator is that safety infractions are used as a learning, teachable moment. For example: • "We don't climb on chairs because they can fall over. Then we would be hurt." • "We don't put toys in our mouth. We must wash it because it has our germs on it."

Cognitive Domain

#7 Routines/Time Spent

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1.Places high value on obedience/compliance 1.2. Primarily does adult tasks while children are in care. 1.3 Routine times are not used as bonding/learning times.		3.1 A general schedule is adhered to*. 3.2 Majority of time spent conducting routine child care tasks.*		5.1 Daily events are handled with flexibility. 5.2 Time spent is child driven, rather than caregiver driven (only occur when children are interested). 5.3 Uses routine times for learning experiences (Prime Times). 5.4 Caregiver spends majority of time engaging with children. 5.5 Uses appropriate curriculum (i.e., Creative Curriculum) N/A Option		7.1 Caregiver plans for transitions and these are handled with minimal stress on children (no long periods of waiting). 7.2 Allows for change in daily schedule based upon children's needs/interests.

* Read explanation of descriptors carefully for these items.

#7 Routines/Time Spent

General notes about this item:

The indicators in this item relate to the ways in which the caregiver spends their time, as well as the routines that are established for the children in their care. While there are some definite differences in the needs for routines between the age groups (infants, toddlers, and preschoolers), they all have the same basic need for consistency balanced with flexibility.

A key element of this indicator is what is developmentally appropriate. Infants and younger toddlers should be cared for on an individual basis. A schedule, if defined as a set course of events, does not exist in an infant/young toddler room.[lxxxix] Rather, infants should be on a *self-demand schedule*, one in which infants communicate their own needs and caregivers respond appropriately (Gestwicki, 1999). This sensitivity builds an infant's sense of certainty that their needs will be met by responsive caregivers. In turn, they learn that the world is a safe and trustworthy place. Because younger toddlers still vary greatly in their individual development, still require flexibility in scheduling.

Older toddlers and preschoolers, on the other hand, are better able to adapt to schedules. Because of their need for routines, they require consistency and stability. This does not mean that their schedules need to be carved in stone. When working with children, flexibility is key. Children's interests should be encouraged, even when it does not fit with the proscribed schedule. The

schedule should, however, be predictable for them: They should know that outdoor time comes after circle time, nap comes after lunch, etc..

Because so much of caring for children involves "Prime Times"[xc], this item stresses the importance of these times. Prime Times are identified as the basic of children's needs: food, sleep, toileting, and nurturing. Because these times account for a large part of infants, toddlers, preschoolers and caregivers day, these times can be used as rich learning experiences. These times can be used to focus on quality one-on-one interactions, regardless of the age group.

Toddler Detailed Description of Indicators

1.1 Places high value on obedience/compliance **.**	Schedules are rigid and based on adult's rather than children's needs. Food is used for reward or withheld as punishment. For example, children are allowed to become fussy or cranky, waiting for food that is served on a rigid schedule. Toddlers must either do things in groups according to the caregivers' plan or follow adult demands that they spend a certain amount of time at an activity. Adults impose "group time" on toddler forcing a large group to listen or watch an activity without providing opportunity for children to participate.
1.2. Primarily does adult tasks while children are in care.	Please note the "primarily" notation in this item. Indicator of this would include: • Talking on the telephone • Doing routine tasks, such as bleaching toys, that can wait • Chatting with a coworker. While some of this activity is acceptable and unavoidable, it should be kept to a minimum (3 minutes). Take note of the children in care: Are their needs being met? Physically? Emotionally? Caregivers do not help children make good use of choice time. They rarely intervene when children do the same things over and over or become disruptive. Rather than assisting children in developing decision making skills, caregivers overuse time-out or

	use punishment to control disruptive children. During children's play and choice activities, caregivers assume a passive role, contributing little or nothing to children's play and learning activities.
1.3 Routine times are not used as bonding/learning times.	Routines are dealt with hurriedly and indifferently, with efficiency as the priority. Examples of this include: • Diapering and toileting are not used as a time to provide individualized, one-on-one time with the child. • Caregiver does not use meal times as time to engage with children (i.e., does not sit with children, does not talk about what they are eating, engage in conversation).

3.1 A general schedule is adhered to. *** NOTE: This is different for infants versus toddlers and preschoolers.**	The environment and schedule should have enough predictability and repetition to allow toddlers to form expectations, repeatedly practice emerging skills, and feel the security of a familiar routine. While concrete, inflexible schedules are inappropriate, there should b e some continuity of routines throughout the day so toddlers know the general course of daily events. For example, toddlers should know that outside time comes after snack, or nap comes after lunch.

3.2 Majority of time spent conducting routine child care tasks.	**NOTE: In order to move forward on this item, the response for this item should be "No".** The intention of this indicator is that the caregiver spends most of their time interacting with children in routine tasks, such as feeding, diapering, and napping. This indicator is describing more functionary or custodial care. Toddler's basic needs are met, with minimal amount of stress. The difference between this indicator and those at a higher level are that the focus of the caregiver is on these basic care routines, rather than engaging or expanding on child's learning.

5.1 Daily events are handled with flexibility.	Time schedules are flexible and smooth, dictated more by children's needs than by adults'. There is a relatively predictable sequence to the day to help children feel secure. Caregivers should adapt schedules and activities to meet individual children's needs within the group setting. Recognizing toddlers' need to repeat tasks until they master the steps and skills involved, caregivers allow toddlers to go at their own pace.

5.2 Time spent is child driven, rather than caregiver driven.	Caregiver engages children only as long as they are interested. The intention of this item is that the caregiver allows the children's interests take the lead, rather than a set agenda. For example, caregiver reads to a small group of toddlers, only so long as they are interested. Caregiver should never force toddlers to engage in activity when they clearly would rather be doing something else.
5.3 Uses routine times for learning experiences.	Caregivers recognizes that routine tasks of living, such as eating, toileting, and dressing, are important opportunities to help children learn about their world, acquire skills, and regulate their own behavior. Meals and snacks include finger food or utensils that are easier for toddlers to use, such as bowls, spoons, and graduated versions of drinking containers from bottles to cups. Children's attempts to dress themselves and put on shoes are supported and positively encouraged[xci].
5.4 Caregiver spends majority of time engaging with children.	Caregiver not only actively engages toddlers in routine tasks but also engages them with play and learning activities. Caregiver understands play is child's work and engages with them. The key to this indicator is the idea of engaging with the child. This implies an active, interactive, reciprocal involvement between caregiver and infant. Examples of this would include: • Reading books to interested toddlers • Actively helping toddlers set up a block tower • Engages in pretend play activities with children Does the caregiver make eye contact with the children? Are they truly present with the child (focused) or are they just going through the motions?

5.5 Uses appropriate curriculum. **N/A Option**	Examples of appropriate curriculum would be Creative Curriculum, Ages and Stages, etc. The intention of this item is not necessarily does an age appropriate curriculum exist, but if it is in place, is it used in an appropriate fashion? The key word here is uses – are the lesson plans followed? Or are they just posted?

7.1 Caregiver plans for transitions and these are handled with minimal stress on children (no long periods of waiting).	Transitions are times when children move from one activity to another. Because these transition times can be stressful on children, the caregiver needs to give some thought as to how they will move from one situation to the next. For example, transitioning toddlers from playing to feeding time requires planning on the part of the caregiver. Does the caregiver have meals prepared and set out for toddlers prior to calling them over to the table? Are children engaged with songs or finger plays so they are not focusing on the transition. The key to this item is that toddlers are not left for long periods of time with nothing to do and no interaction. A long period of waiting between daily events is considered 3 minutes[xcii]. To receive credit for this item there should be NO long periods of waiting for any children.

7.2 Allows for changes in daily schedule based upon children's needs/interests.	The focus of Item 5.1 is on the individual needs of toddlers in care. To receive credit for the 7.2 indicator, further flexibility of the caregiver needs to be demonstrated. Examples of this would include: • Extending time outside when all toddlers are enjoying themselves. • Engaging a less involved toddler with additional play materials before they become bored with those at hand. • Allowing for an extended lunch period for those toddlers who are learning to use utensils and enjoying the activity.

#8 Physical Attention

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Negative physical contact (rough or abrupt handling). 1.2 Children are shifted from group to group or cared for by whatever adult is available at the moment. 1.3 Children's attempts to initiate physical contact discouraged/ rejected.		3.1 Positive physical contact (hug, sit, pat, hold child) during routines. 3.2 Children are cared for by familiar adults, but adults may vary from day to day. 3.3 Children's attempts to initiate physical contact are welcomed.		5.1 Sits on child's level so they can crawl in caregiver's lap. 5.2 Gently, physically redirects child when necessary. 5.3 Children are cared for by one or two primary caregivers who are familiar with their routines.		7.1 Physically demonstrates affection for children throughout the day (hugs, hand holding, kisses). 7.2 Physically assists child in developmental milestones.

#8 Physical Attention

General notes about this item:

Children of all ages require interactions that nurtures trust. This includes the capacity to provide consistent responsiveness by the same adults. An environment of trust is a safe, familiar place that is predictable in the patterns of things, people and events (Bredekamp and Copple, 1997, p. 69).

The physical elements of trust development are imperative to infant development. As noted by Gestwicki (1999), *the holding, nuzzling, and belly kisses that are a part of warm caregiving interaction are as crucial as the physical elements of food and sleep to healthy growth* (p. 140). For toddlers, whose stage of development is all about autonomy, paradoxically, one of the most difficult things for them is separation from adults that are important to them. Toddlers feel most secure when their adults (parents and/or caregiver) are nearby. While toddlers are seeking independence, they need to kow that the caregiver is physically accessible to them when they need comfort (Gestwicki, 1999).

For preschool aged children, physical attention is also important. This stage is marked by the process of identification, where children move from wanting to be *near* the adults in their lives to being *like* them. Preschoolers *gradually depend less on attentions*

and constant assistance from adults, although they are still bound to them by affection, and thus a desire to please and be like them (Gestwicki, 1999, p. 96).

Preschoolers are very physically active beings. For the most part they have mastered many of the large motor activities of toddlerhood. In this stage, preschoolers are working on fine tuning these skills. The physically responsive caregiver is one that assists the preschooler in their attempt to increase their coordination. This can be evidenced, for example, by helping a child peddle a bike or pump on a swing.

In general, the physically responsive caregiver is aware and sensitive to the physical needs of children in his/her care, regardless of their stage of development. This is not to say that the caregiver imposes physical affection on a child who is less physically demonstrative or needy. The key component to this item is being physically available for any child as they need the attention.

Toddler Detailed Description of Indicators

1.1 Negative physical contact (rough or abrupt handling) OR there is no physical contact.	Adults are rough and inattentive, ignoring the child's limitations and responses. Toddlers are wordlessly and sometimes abruptly moved about at the caregiver's convenience. OR: Adults follow "no-touch policies" and do not recognize the importance of touch to children's healthy development[xciii].
1.2 Children are shifted from group to group or cared for by whatever adult is available at the moment.	Development and maintenance of one-to-one relationships are not given top priority. Children are shifted from group to group or cared for by whatever caregiver is available at the moment and thus are not able to form a relationship with one or two caregivers over time. High staff turnover results in low continuity and frequent disruption of toddler's attachment to caregivers[xciv]. Ask how long caregivers have been in this room. If they have been there for shorter than a year, ask about the previous caregiver's length of stay in this room. You need to understand if this is a pattern of behavior for this room (and center) or is this just a new caregiver?
1.3 Children's attempts to initiate physical contact discouraged/rejected.	Caregiver discourages physical contact initiated by child. For example, caregiver pushes child away as they try to crawl into lap. Caregiver physically shirks away from toddlers attempts at touch.

3.1 Positive physical contact (hug, sit, pat, hold child) during routines.	Caregiver provides physical contact and comfort to toddlers during routine care. Do they snuggle and hug toddlers who are distressed?
3.2 Children are cared for by familiar adults, but adults may vary from day to day.	Children are cared for by a primary caregiver, however, additional adults also provide care on a regular basis. For example, the caregiver may arrive for work at 9 a.m. Between the opening of the center and that time, a floater or several other staff may provide care. This person does not have to be the same one everyday, however, as long as the child is familiar with the caregivers.
3.3 Children's attempts to initiate physical contact are welcomed.	Caregiver responds to children's efforts at making physical contact. Caregiver recognizes child's attempts by reciprocating the touch, smiling or patting the child.

5.1 Sits on child's level so they can crawl in caregiver's lap.	Caregiver not only provides physical comfort during routine care, but also purposely sits on children's level so toddlers can crawl in her lap or cuddle when they need it. Caregiver comforts toddlers and let them know they are appreciated through warm responsive touches, such as giving pats on the back or hugs and holding toddlers in their laps. Caregivers are sensitive to ensuring that their touches are welcomed by the children.[xcv] The intention of this item is that, when not engaging in routine care, the caregiver is physically accessible to toddlers.

5.2 Gently, physically redirects child when necessary. **N/A Option If Not Observed.**	Adults patiently redirect toddlers to help guide them toward controlling their own impulses and behavior. When children fight over the same toy, the adult provides another like it or removes the toy. If neither of these strategies is effective, the caregiver may gently redirect the children's attention by initiating play in another area.
5.3 Children are cared for by one or two primary caregivers who are familiar with their routines.	There is sufficient continuity of care to ensure that every toddler (and family) is able to form a relationship with a primary caregiver. The staffing pattern is designed to make sure there is continuity over time for each toddler's relationship with a primary caregiver. It is a priority to keep each toddler in the same group, preferably year to year, to ensure that the child and a primary caregiver form and maintain a reciprocal relationship[xcvi]? When in doubt, ask.

7.1 Physically demonstrates affection for children throughout the day (hugs, hand holding, kisses).	Caregiver physically demonstrates his/her affection for children through physical and emotional attention. Does he/she offer kisses and hugs to children? Does he/she return a toddler's hug with a pat on the back?
7.2 Physically assists child in development.	Caregiver provides physical assistance as toddlers develop new skills. For example: • Physically helps toddlers learn to peddle a bike. • Shows toddler how to climb through a tunnel.

#9 Discipline

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 When children misbehave, they are handled abruptly or harshly. 1.2 Caregiver speaks with irritation or lectures when children misbehave. 1.3 Rules are not explained ("No, stop that!" with no reason why). 1.4 Children excluded from group – contained or restrained.		3.1 Children are redirected appropriately when they misbehave. 3.2 Expectations are generally age appropriate. 3.3 Rules are explained to children on a basic level.		5.1 A variety of options are used for children (i.e, duplicate toys, activities used to engage children when they misbehave). 5.2 Caregiver engages with children to prevent misbehavior before it occurs (is aware of the children's cues of frustration).		7.1 Caregiver actively and consciously stresses prosocial behavior and behavioral safety through books, actions and activities. 7.2 Caregiver helps children take the viewpoint of others when they misbehave (discusses consequences, explains how actions affect others). 7.3 Children involved in establishing rules. (N/A option for infants and toddlers).

9 Discipline

General notes about this item:

The term discipline has numerous meanings. For example, the Webster's Dictionary offers several descriptions: to punish; teach obedience or order to; calm, controlled behavior; conscious control over lifestyle; and making people obey the rules. In early childhood literature (and this measure), the term discipline is defined as guidance. In this manner, the purpose of discipline is to assist children learn how to act in socially acceptable, established rules of behavior. For this context, discipline is defined by the ways in which a caregiver helps children manage their behavior.

While it may be clear that it is important for toddlers and preschoolers to learn discipline, the use of discipline with infants can be misleading. Very young infants do not tend to exhibit the same behavioral issues that older children demonstrate. However, if we see discipline as guidance, then it should be clear that all children, regardless of their age, benefit from positive discipline.

It should also be noted that this item is closely linked with developmentally age appropriate expectations for children. Again, young infants do not have the same understanding of their behavior that older children do. For the caregiver to identify a young infant is "misbehaving" is not appropriate. For example, a young baby who cannot fall asleep when the caregiver feels it should is not

misbehaving (no matter what the caregiver feels their motives are). There is a major difference between a child not being able to settle into sleep and one who is consciously demonstrating challenging behavior.

Please keep in mind that the term "misbehavior" for infants is not the same as for older toddlers and preschoolers. Misbehavior for infants should be thought of as less than desirable behavior, rather than behavior that is intentionally defiant.

Toddler Detailed Description of Indicators

1.1 When children misbehave, they are handled abruptly or harshly.	Caregiver reacts harshly to children's misbehavior. Obvious frustration is exhibited in response to toddler's non-compliant behavior? For example: • Noncompliant children are grabbed to redirect when issues of immediate safety are not a concern. • Any form of physical punishment is used with toddlers. Does the caregiver view toddler's exploring behavior as misbehavior? Are the expectations realistic?
1.2 Caregiver speaks with irritation or lectures when children misbehave	Caregiver expresses that toddler has purposefully misbehaved and is obviously irritated and frustrated. Caregiver raises voice, speaks with annoyance to children. Caregiver lectures children, unleashing a monologue of displeasure. Caregiver punishes perceived infractions harshly, frightening and humiliating children.
1.3 Rules are not explained ("No, stop that!" with no reason why).	Clear purposes for rules of behavior are not explained. Instead, caregiver says "No!" or "Stop That!" without explaining why or what to do instead. OR: Caregiver ignores disputes and other problematic behaviors, leading to a chaotic atmosphere. Children obviously do not know what the rules and expectations are for their behavior.

1.4 Children excluded from group – contained or restrained.	Toddlers who are "misbehaving" are excluded from group activities in an attempt to control their behavior. For example, more children are placed in play pen or high chair to keep them contained. Please keep in mind this is a discipline item – the intention is not that children are physically in locations apart from the group. The question is, are they separated from the group as a form of punishment? Or is it because of their individual interest? Separating more aggressive children from the group may be appropriate (i.e., Time Out). However, the children should not be restrained or physically confined as a way of disengaging them from the group.

3.1 Children are redirected appropriately when they misbehave.	Caregiver patiently redirects toddlers to help guide them toward controlling their own impulses and behavior. Children are steered towards other play materials rather than allowing crowding around one toy.
3.2 Expectations are generally age appropriate.	Realistic expectations are based on the age and developmental stage of the children in care. For example: • Caregiver understands that toddlers do not like to share and does not expect them to. • Does not expect toddlers to sit for long periods of time.

3.3 Rules are explained to children on a basic level.	Caregiver provides clear, concise explanation of the rules to toddlers. For example: • "We don't hit. That hurts". • "We don't climb on chairs. They can fall over and you can get hurt." • These explanations should not be long; using a few words for explanation is better than lengthy speeches (See indicator 1.2). Caregivers give clear sanctions for overtly dangerous behavior.

5.1 A variety of options are used for children (i.e, duplicate toys, activities used to engage children when they misbehave).	Caregiver uses a variety of options when undesirable behavior occurs. For example: • When children fight over the same toy, the adult provides another like it or removes the toy. If neither of these strategies is effective, the caregiver may gently redirect the children's attention by initiating play in another area[xcvii].
5.2 Caregiver engages with children to prevent misbehavior before it occurs (is aware of the children's cues of frustration).	Caregiver is aware of toddler's cues of frustration and helps redirect or alleviate prior to misbehavior. Watches children closely and knows when to step in. For example: • Knowing that two toddlers like the same toy, caregiver brings out a duplicate toy before they can escalate to aggression. • When reading a story to a group of toddlers, caregiver notices several toddlers fidgeting. This energy is redirected to some physical activity.

7.1 Caregiver actively and consciously stresses prosocial behavior and behavioral safety through books, actions and activities.	Caregiver uses books, pictures, songs, games to reinforce positive, prosocial behavior. For example: • Reads books to children about being kind to others. • Caregiver actively and appropriately models positive social reactions with children, using "please" and "thank you". • Proactively introduces alternatives for behavior through activities and games.
7.2 Caregiver helps children take the viewpoint of others when they misbehave (discusses consequences, explains how actions affect others).	When children misbehave, caregiver helps them take the perspective of others. For example: • Explains that hitting hurts others. • Directs toddler to look at sad face of offended child. Engages children in understanding why the child is sad.
7.3 Children involved in establishing rules.	N/A Option for Toddlers.

#10 Language Development

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Ignores children's attempts at communication. 1.2 Talks over children as they talk. 1.3 Uses terms that are unfamiliar to children. 1.4 Calls all children the same name so they are not sure who is being addressed).		3.1 Acknowledges children's attempts at communication. Nods, makes eye contact, attempts to decipher child's needs and vocalizations. 3.2 Verbally responds to child's cues of distress. 3.3 Uses individual child's names when speaking with them. 3.4 Uses terms that are familiar to children.		5.1 Listens attentively when children speak. Rephrases their conversations. 5.2 Dialogues with children. Conversation is interactive. 5.3 Checks for clarification when talking to children. Make sure they understand what is being said. 5.4 Uses clear, one step directions. 5.5 Models appropriate use of language (tense, vocabulary, etc.).		7.1 Adds to children's attempts to dialogue; adds words and explanations to talk. 7.2 Helps children understand their feelings and emotions by labeling communication. 7.3 Encourages verbal communication. 7.4 Fosters conversations between children.

#10 Language Development

General notes about this item:

Young children develop their language skills through interactions with more accomplished speakers of the language, such as parents, family members, and teachers, as well as other children. Research indicates the amount of verbal stimulation and opportunities for two-way communication provided by adults has been found to be statistically significant with the child's level of language development (Carew, 1980; Golden et al, 1979; Melhuish et al., 1990), as well as the child's level of social competence (Clarke-Stewart, 1987; Phillips et al., 1987). Additionally, Clarke-Stewart (1987) found that children in home-based child care scored highest on intellectual assessments and social competence when their caregivers consistently had one-to-one conversations with them (as cited by Doherty-Derkowski, 1995). According to Snow, Burns and Griffin (1998),

> Early childhood teachers need to know the value of one-to-one, extended, cognitively challenging conversations and how to engage in such communication, even with reluctant talkers. They need to know how the lexicon is acquired and what instructional practices support vocabulary acquisition. They also need to know how to conduct story reading and other early literacy experiences that promote phonological awareness and prepare children for later success in reading.

Toddler Detailed Description of Indicators

1.1 Ignores children's attempts at communication.	Language is used discriminately, either too much or too little, and caregivers use a very limited range of words. Crying is ignored or responded to irregularly or at the caregiver's convenience. Unable to read children's attempts at communication.
1.2 Talks over toddlers as they talk.	Adults talk at toddlers and do not wait for a response, Adult voices dominate or caregivers do not speak to children because they think they are too young to respond.
1.3 Uses terms that are unfamiliar to children.	Caregivers either talk "baby talk" or use language that is too complex for toddlers to understand. When caregiver speaks to children, they are unsure what is being asked of them or what is being told. They do not understand the words the caregiver uses. Look to see if the children are able to respond to the caregiver appropriately. For example, caregiver speaks in long winded monologues that do not tie their conversation into objects or actions that are present in the environment. In this manner, toddlers are talked "at" rather than "to" or "with" and child is not assisted in language development.

1.4. Calls all children the same name so they are not sure who is being addressed).	Caregiver does not call children by their individual name. Instead, uses "cutsie" terms, such as hon, rosebud, or sweetie so babies are unsure who is being addressed. This is not to say it is inappropriate for caregiver to use terms of endearment. The key is looking at how the children respond. Do they seem confused? Do they know they are the sweetie that is being addressed?

3.1 Acknowledges child's attempts at communication.	All interactions are characterized by gentle, supportive responses. Caregivers observe, listen and respond to sounds that toddlers make, imitate their vocalizations, and appreciate child's budding language as the beginning of communication. Caregiver nods, makes eye contact, attempts to decipher child's needs and vocalizations.
3.2 Verbally responds to infants cries of distress.	Adults respond quickly to toddlers' cries or other signs of distress, recognizing that toddlers have limited language with which to communicate their needs.
3.3 Uses individual child's names when speaking with them.	Caregivers recognize and support each child's individuation by using their name when speaking to them. Uses each person's name also ensures that babies know they are being addressed and can respond appropriately.

3.4 Uses terms that are familiar to children.	Caregiver speaks to the children in a way that they know what is asked of them or what they are being told. They understand the words caregiver uses. The caregiver uses speech that helps to facilitate language. For example, labeling things, so toddlers can expand their vocabulary.

5.1 Listens attentively when children speak. Rephrases their conversations.	Caregiver initiates a conversation with a toddler and gives the child ample time to respond. Caregivers also listen attentively for children's verbal initiations and respond to these. Adult's label or name objects, describe events, and reflect feelings to help children to learn new words[xcviii].
5.2 Dialogues with children. Conversation is interactive.	Adults often talk to children, about what is going on. For example: • "Let's go for a little walk. Would you like that?" • "Are you hot? Would you like to take off your sweater?" Caregiver takes care not to talk "at" toddlers, rather talks "with" them. They recognize that language is taught as conversation, and they demonstrate turn-taking skills of communication.

5.3 Checks for clarification when talking to children. Make sure they understand what is being said.	Caregiver demonstrates their respect for toddler by making sure they understand what is being said and seeking confirmation. For example: "Jacob, are you hungry?" (Waits for response). "Would you like some cheerios?" "Please hand me that block by your foot. Do you see it?" This clarification expands toddler's language and increases their knowledge of the world around them. It also helps to cut down on discipline challenges because children are clear of what is expected of them.
5.4 Uses clear, one step directions.	Caregivers simplify their language for toddlers who are just beginning to talk, saying,"Let's wash our hands, or "Snacktime!" instead of: "Its time to wash our hands and have a snack."
5.5 Models appropriate use of language (tense, vocabulary, etc.)	Caregiver uses correct and appropriate grammar, vocabulary, etc. Caregiver does not necessarily need to constantly correct the child's use of words; rather they need to demonstrate the appropriate use of language themselves. (For example, not using words like "ain't").

7.1 Adds to children's attempts to dialogue; adds words and explanations to communication.	As children acquire their own words, caregivers expand on the toddler's language. For example: • Child: " Cindy's sock." Adult: "Oh, that's Cindy's missing sock , and you found it". • Child: "Cookie". Adult: "Would you like anther cookie?"
7.2 Helps children understand their feelings and emotions by labeling communication.	Caregiver assists in toddler's budding social/emotional awareness by labeling their feelings and emotions. For example? • "This song makes you happy!" • "It makes you sad when your friend takes your toy."
7.3 Encourages verbal communication.	Caregiver encourages toddlers to expand their verbal communication. For example, • "Can you tell me what the doggie says? Can you say ruff?" • "What color is this? Is it red?"
7.4 Fosters conversations between children.	Caregiver encourages dialogue between children. The caregiver can model that behavior and offer words from one toddler to another.

#11 Learning Opportunities

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Does not provide children with learning activities. 1.2 Minimal learning opportunities are available for children.		3.1 Offers child play opportunities. 3.2 Less involved children are drawn in to play. 3.3 Caregiver uses materials to spark interest of children.		5.1 Facilitates children's use of play materials. 5.2 Provides encouragement and praise for successful accomplishments in play. 5.3 Sets up environment /activities to foster development		7.1 Explains the reason for things. 7.2 Encourages children to think for themselves 7.3 Is aware of child's skill level and engages them with materials that expand their skills.

11 Learning Opportunities

General notes about this item:

DAP identifies that *early experiences have both a cumulative and delayed effect on individual children's development; optimal periods exist for certain types of development and learning* (Gestwicki, 1999, p. 9). The repeated experiences of children, both positive and negative, have implications for later development. For example, children who are provided the opportunity to develop social skills through play with peers in preschool tend to develop confidence and competence in their social relations with others. These experiences allow them to develop familiarity and competence when engaging with their peers as they enter elementary school. They are better able to enter group learning experiences with more ease then children who do not experience these earlier social experiences. As cited by Gestwicki, *times of readiness for optimal learning occur in the early years and need to be taken advantage of in planning curricular experiences; for example, growing neurobiological evidence indicates that the social and sensorimotor experiences of the first years affect brain development, with lasting implications for children's learning,* (p. 9).

Toddler Detailed Description of Indicators

1.1 Does not provide children with learning activities.	Toddlers are confined to high chairs or playpens with minimal interaction. If children are allowed to move freely around the room, caregiver has little interaction with them, aside from routine care. Make sure to look at ALL children. If any one child is ignored, give a score of "1".
1.2 Minimal learning opportunities are available for children.	There are very few learning activities or materials available for toddlers. Materials do not need to be accessible (within reach) but do need to be present in the room for caregiver to access. In this indicator, caregiver provides no or very few materials to children. Caregiver is more interested in keeping the room clean than allowing toddlers to play with materials.

3.1 Offers child play opportunities.	Caregiver offers children play materials (books, dolls, etc.). For this item, caregiver does not have to actively engage with toddlers in play. Merely placing materials in the proximity of toddlers where they can access is sufficient.

3.2 Less involved children are drawn in to play.	All children are drawn in to play. Children who are roaming are encouraged to play activities or materials. Toddlers who are sitting by themselves are offered options. Care should be given when this item. The intention is not that children are pressured into play. Rather, intent is that the caregiver is aware of the children and provides them opportunities. If a toddler is contentedly reading a book, they do not need to be given other opportunities; they already are involved. However, the toddler that is just sitting on the floor, staring off in space, should be engaged.
3.3 Caregiver uses materials to spark interest of children.	Caregiver uses materials to spark toddler's interest and attention. For example, hands child a book, hugs stuffed animal, or stacks blocks on one another. To receive credit for this item, caregiver does not have to continue to engage in play after drawing toddler to this item.

5.1 Facilitates children's use of play materials.	Caregiver helps toddlers use play materials. For example: • Helps toddlers make tower of blocks. • Shows child how to make a riding toy work.
5.2 Provides encouragement and praise for successful accomplishments in play.	Provides praise for toddler's successful accomplishments. For example, successfully throwing a ball, building a block tower, etc. In addition, praise is given when toddler is successful with newly acquired physical accomplishments, such as hopping, riding a bike, etc.

5.3 Sets up environment /activities to foster development	Caregiver creates opportunities, through activities or environment that encourage toddler's exploration and development.

7.1 Explains the reason for things:	Explanations should be given in simple ways. The intention is to encourage children to think about cause and effect, no matter how basic. For example: • "We put on our coat to go outside to keep us warm." • "This circle is round. It goes in the round hole. They are the same shape."
7.2 Encourages children to think for themselves.	Caregivers stimulate and support children's engagement in play and child-chosen activities. Adults extend the child's thinking and learning within these child-initiated activities by posing problems, asking questions making suggestions, adding complexity to tasks, and providing information, materials, and assistance as needed to enable a child to consolidate learning and to move to the next level of functioning[xcix].

7.3 Is aware of child's skill level and engages them with materials that expand their skills.	It is important to encourage children to expand their skill level by engaging them with activities and materials. This item is closely related to the clear understanding of child development, as well as clear knowledge of the abilities of the children in care. While higher skill level materials are desirable, materials should not be so far beyond baby's abilities that they cause frustration or apathy. For example: • Engaging a toddler with more complex puzzles. • Assisting toddlers with peg boards. • Helping toddlers learn the concepts of counting by doing so informally

#12 Involvement with Children's Activities

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Is disinterested in child's activities and playtime. 1.2 Interaction with children occurs only during routine care: Feeding, toileting, napping. 1.3 Allows children to become frustrated by tasks they cannot do.		3.1 Verbally acknowledges children's activities. 3.2 Provides a variety of materials for children's play.		5.1 Actively engages in child's play. 5.2 Provides/creates play experiences for children. 5.3 Models appropriate play. .		7.1 Provides additional play experiences to expand on child's interests. 7.2 Talks to children to extend conversation when playing together.

#12 Involvement with Children's Activities

General notes about this item:

Children are active learners, drawing from their physical and social experiences, as wall as knowledge that is culturally transmitted. This allows them to construct their own understanding of their world. This intellectual development occurs by the child's constructivist interaction with people, materials, activities and experiences. As children create and test their own hypothesis about how the world works, their thought processes and mental structures undergo constant revisions. Appropriate caregiver interaction and experiences provide the encouragement for these constructions. Positive caregiver interactions and teaching strategies should support children's active learning and rely less on direct communication of knowledge that young children have not created themselves (Gestwicki, 1999, p. 10).

According to Bredekamp and Copple (1997), *child-initiated learning does not occur in the absences of caregiver guidance or input* (p. 118). As noted by Doherty-Derkowski (1995)

> *it is not sufficient enough to provide a variety of stimulating materials and an environment that encourages exploration and interaction. The adult must select and prepare the environment, then observe, guide, and assist the children so that they are challenged and supported in gaining information and an understanding of how things work* (p. 58).

Toddler Detailed Description of Indicator

1.1 Is disinterested in child's activities and playtime.	Caregiver has little interest in toddler's activities. Does not engage with children at play. Seems emotionally detached or distant from children; does not touch them or make conversation.
1.2 Interaction with children occurs only during routine care: Feeding, toileting, napping).	Caregiver provides attention and interaction to toddlers only during routine care activities, such as toileting, feeding, and naptime. This interaction is done swiftly and with little caring interaction.
1.3 Allows children to become frustrated by tasks they cannot do.	Because caregiver is disinterested and removed from toddlers, children become frustrated by tasks they cannot do. Caregiver is so uninvolved with child's play that they are left to play on their own, with no adult interaction or facilitation. For example: • Toddler gets frustrated trying to build a block tower. Because there is no adult interaction, he quickly escalates to a screaming fit.

3.1 Verbally acknowledges children's activities.	Caregiver acknowledges children as they play. He/she does not need to be actively physically involved with toddlers to receive credit for this item. For example, caregiver may acknowledge child's play activities ("Are you cuddling the bear?"), as they help another child with art. The intention of this item is that the caregiver provides recognition and awareness of all children's activities.
3.2 Provides a variety of play materials.	Materials are provided for children so they have options and choices. To receive credit for this item, caregiver does not have to actively play with toddlers. They must, however, make sure children can access the materials on their own. For example: • Children are provided a variety of age appropriate materials, such as balls, sturdy books, and stuffed toys. • Family living materials are present so toddlers can use for free play.

5.1 Actively engages in child's play.	Caregivers engage in reciprocal play with toddlers, modeling for children how to play imaginatively, such as playing "tea party." Caregivers also support toddlers' play so that children stay interested in an objector activity for longer periods of time and their play becomes more complex, moving from simple awareness and exploration of objects to more complicated pretending.[c]

5.2 Provides play experiences for children.	Caregiver provides play opportunities for toddlers. For example, engages children with sand or water play, art activities, etc. The intention of this item is the caregiver is actively engaged with the child in their play experiences.
5.3 Models appropriate play.	Caregiver demonstrates appropriate play. Caregiver helps toddlers understand the use of play equipment. For example: • Demonstrates to baby how to pour water from a pitcher. Shows toddler how to hold crayons when drawing.
7.1 Provides additional play experiences to expand on child's interests.	Caregiver routinely provides additional play experiences for babies. These are activities that require adult intervention to engage. For example: • Uses scarves and other dance props when playing music. • Uses prop boxes for additional dramatic play.
7.2 Talks to children to extend conversation when playing together.	Offers a language rich environment. Continuously talks with toddlers to expand their conversations and language. Labels actions, items and events. For example: • "Who are you talking to on the phone? Is it mommy? Is she at work?" • "I like your shirt. What color is it? It is blue. Blue is my favorite color. Do you have a favorite color?"

#13 Symbolic and Literacy Interaction

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Any materials are inappropriate for children; materials are scary or violent. 1.2 Children are forced to participate, even when they are no longer interested. 1.3 No literacy materials present. 1.4 Materials are in poor repair.		3.1 Materials are generally appropriate for children. 3.2 Children are engaged only as long as they are interested 3.3 Materials are present but caregiver does not encourage or facilitate use. .		5.1 Caregiver provides a wide range of literacy and symbolic materials which children have access to during freeplay. All age appropriate. 5.2 Caregiver reads to children throughout the day. 5.3 Caregiver talks about pictures or mobiles.		7.1 Caregiver uses literacy and symbolic materials regularly (daily) that expands on themes or activities in the classroom. 7.2 Children are encouraged to bring materials from home that add to the themes (i.e., books, stuffed animals, etc.). 7.3 Caregiver relates print to verbal communication (N/A Option for Infants).

#13 Symbolic and Literacy Interaction

General notes about this item:

Reading books to children, starting in infancy, is important for several reasons. This activity leads to positive associations of books and reading for pleasure. Children should be exposed to a wide array of reading materials (Barclay et al., 1995) In addition to creating a good beginning for early literacy, language acquisition is *nurtured by hearing the words, watching the adult point to large, clear pictures, going back through the same book and hearing the same words, and making the same visual connections* (Gestwicki, 1999, p. 224).

Whole language is the belief that learning oral and written language is a continual process that takes place at the same time and starts at birth. According to Bird 1987; Pearson, 1990),

> *children are motivated to find ways to represent their experiences both through play and action, and through communication. Children learn that communication meets their needs, brings pleasure and friendship, and helps them understand their culture. As they are exposed to literacy, they discover that oral and written language are related and that print is another form of communication. Reading and writing are then viewed as part of a larger system for accomplishing their goals* (Gestwicki, 1999, p. 263).

Along with adults providing meaningful literacy materials, activities, and support, this awareness and motivation combine to develop emergent literacy (Sawyer and Sawyer, 1993). Children use continually, experience how print language functions, and move themselves *into print media experiences* (Gestwicki, 1999, p. 263). There is no start point where children are asked to study language

arts. *There is continuity between all language experiences, from birth through the primary years, not a discontinuity of "now it's time to learn to read"* (Gestwicki, p. 263).

Toddler Detailed Description of Indicator

1.1 Any materials are inappropriate for children; materials are scary or violent.	Any books or pictures that are inappropriate to children. These can include materials that are scary, violent, or disturbing. For example, while pictures that promote emotional awareness are desired, ones that depict children crying are not acceptable. This seems to be an issue mostly in centers that share space with churches. Are there any pictures that depict Noah's Ark and the flood? This material can be quite frightening to small children.
1.2 Children are forced to participate, even when they are no longer interested.	Caregiver insists on reading to toddlers even when they are not interested. Caregiver is more interested in getting through the story than the child's attention. Toddlers are set in high chairs or feeding table during "story time", unable to disengage.
1.3 No literacy materials present.	Books are not available to toddlers. Caregivers feel literacy materials are not necessary for children because they get torn or soiled. If there are no books present, do not give credit for this item. If caregiver tells you there are usually books but, for whatever reason, they aren't there, do not give credit for this item. There are no pictures or mobiles available for children to look at.
1.4 Materials are in poor repair.	Books are torn, pages missing, out of date, dirty.

3.1 Materials are generally appropriate for children.	All literacy materials and pictures are appropriate for toddlers. These can include cardboard, vinyl, or cloth books, but also other "paper" books. Toddlers can also have access to magazines and catalogues. Look at the age and development of children in care. Do they treat the materials appropriately? It is realistic to expect that toddlers will tear apart magazines – but do they eat the pages? If yes, these materials are not age appropriate!
3.2 Children are engaged only as long as they are interested	Caregiver reads books and points out pictures to children depending upon their interest. Children are not forced to sit and listen to a story. Caregiver points out pictures to toddlers but only engages while child is interested.
3.3 Materials are present but caregiver does not encourage or facilitate use.	Children's books are present and provided to toddlers to play with as they wish. To receive credit for this item, caregiver does not have to read to the children. Merely having literacy materials (books and picture) present is sufficient.

5.1 Caregiver provides a wide range of literacy and symbolic materials which children have access to during freeplay (Need # and type). All age appropriate.	Caregiver provides a wide range of books and pictures for children. Sturdy picture books and child materials are provided. Content should include a wide variety; ABC's, numbers, drawings, photographs, rhyming, etc. Pictures represent people of different ages, racial and cultural groups, family types, occupations, and abilities/disabilities[ci].
5.2 Caregiver reads to children throughout the day.	Caregiver reads informally to toddlers throughout the day. Caregiver consciously encourages the use of literacy materials. Caregiver reads in large and small groups, as well as to individuals.
5.3 Caregiver talks about pictures or mobiles.	Caregiver points out pictures and mobiles to children. Encourages them to look at the materials and uses to facilitate talk.
7.1 Caregiver uses literacy and symbolic materials regularly (daily) that expands on themes or activities in the classroom.	Caregiver uses books and pictures to expand on themes. For example, uses books about apples in the fall, or snow in the winter. The intention of this item is that caregiver exposes toddlers to the fact that literacy materials can be used to expand knowledge.
7.2 Children are encouraged to bring materials from home that add to the themes (i.e., books, stuffed animals, etc.)	Toddlers are encouraged to bring in books or materials from home to add to classroom themes. For example, child brings in a book about cats from home during the week of "animals" theme.

7.3 Caregiver relates print to verbal communication.	This can occur in a variety of ways. For example, caregiver asks children about their drawings and communicates this on their pictures. Caregiver can also ask children about their preferences, such as taking a classroom poll, and write up the results. To receive credit for this item, you must see at least one instance in the classroom.

Connection with a Wider World

#14 Promotion of Prosocial Behavior/SEL

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 No evidence of promotion of SEL (no pictures, books or activities). 1.2 Negative peer interaction is ignored.		3.1 Evidence of SEL in the classroom. 3.2 Caregiver verbally reminds children of positive SEL. 3.3 Environment is set up so there are few instances of aggressive behavior.		5.1 Children are helped to acknowledge the viewpoint of others. 5.2 Encouragement of verbal behavior for conflict resolution. 5.3 Children are praised for prosocial behavior.		7.1 Everyday experiences are used as SEL learning. Caregiver looks for teachable moments. 7.2 Use of SEL curriculum used effectively (First Step, Preschool PATHS).

#14 Promotion of Prosocial Behavior/SEL

General notes about this item:

According to Gestwicki, 1999, when caregivers *verbalize others' feelings, and their concern for them, children are gradually led toward understanding how others feel and what responses are appropriate to those feelings. Caregivers help promote prosocial awareness and learning by deliberately devising opportunities for children to participate in situations that foster kindness* (p. 177).

As stated by Howes and Ritchie (2002),

> Adults who act as coaches for children's expression and modulation of emotion and focus on social content are linked to children who are more successful at effortful control and emotional regulation. Adult emotional coaching includes responding to emotional displays, labeling the emotions, and in a supportive manner helping children with strategies to modulate their emotional displays. When adults coach children, the children are helped to develop their ability to inhibit negative affect, to self sooth, and to focus their attention on the social context (p. 42).

Toddler Detailed Description of Indicator

1.1 No evidence of promotion of SEL.	Caregivers are detached from toddlers. They clearly do not value or promote positive social and emotional connections. Adults show aggression, shout, or exhibit a lack of coping behaviors under stress. Adult attempts to punish or control the assertive toddler escalate the hostility.
1.2 Negative peer interaction is ignored.	Caregiver does not anticipate actions of toddlers to prevent children from getting hurt or hurting others nor do they model for toddlers the words to say. The sense of community is undermined by adult behaviors and techniques- for example, encouraging or allowing chronic tattling, scapegoating, teasing, or other practices that turn children against each other; or setting up games or situations in which the same children are always chosen and less-popular children are left out.[cii]

3.1 Evidence of SEL in the classroom.	Social/emotional awareness is evident in the room. This can be seen in various ways: • Through the caregiver's actions (saying "please" and "thank you" to baby, modeling the appropriate behavior, using kind words and tone. • The display of pictures that depict emotional learning (pictures with faces of varying emotions). • Books that focus on emotions and social skills.
3.2 Caregiver verbally reminds children of positive SEL.	Caregiver reminds toddlers the appropriate words to accompany actions. For example: • Prompts toddler to thank another child who "shares" a toy. • Children are expected to use "please" and "thank you" in all interactions
3.3 Environment is set up so there are few instances of aggressive behavior.	Caregiver engages children and the environment so there are few instances of aggressive behavior. For example, • Understands that toddlers do not like to share and does not expect them to. • Provide enough materials so toddlers do not fight over toys.

5.1 Children are helped to acknowledge the viewpoint of others.	Caregiver uses a variety of methods to encourage toddlers to acknowledge the view of others. For example: • Points out the reaction of a child who is upset. • Identifies facial emotions of characters in a book. • Caregiver talks about their own feelings. ("It is such a beautiful day today, I feel happy.")
5.2 Encouragement of verbal behavior for conflict resolution. **This can be a N/A item if no conflict is observed**	Caregiver reminds toddlers to use words to resolve conflicts. Caregiver models this behavior for children. For example: • When one toddler takes a toy from another, caregiver prompts the offended child, "Say, please do not take my block. I was playing with that."
5.3 Children are praised for prosocial behavior (i.e., taking turns).	Caregiver values prosocial behavior and praises toddlers for their actions. For example: • One toddler picks up a puzzle piece that was dropped by another, handing it to the child. Caregiver takes note of this and praises the behavior. • A child gives another a welcome hug. Caregiver identifies this as nice gesture.

7.1 Everyday experiences are used as SEL learning. Caregiver looks for teachable moments.	Caregiver uses a variety of methods to encourage toddlers to take the view of others. For example: • Points out the reaction of a child who is upset. • Identifies facial emotions of characters in a book. • Caregiver talks about their own feelings. ("It is such a beautiful day today, I feel happy.") • Asks children to identify their own feelings. Helps put words to their actions.
7.2 Use of SEL curriculum used effectively (First Step, Preschool PATHS). **N/A if not used.**	The key with this indicator is not whether the curriculum is used, rather it is used effectively. You do not need to know a great deal about the curriculum to score this item. To determine this, first, identify if the curriculum is used. Then, note the caregiver's tone of voice (#1), acceptance/respect for children (#2), and discipline (#10). If either of these curriculums is being used, the caregiver will speak respectfully towards children and positive discipline will be used.

#15 Engaging Children With Special Needs

(NA Option)

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Children with special needs kept separate from group. 1.2 Caregiver seems uncomfortable interacting with, or caring for, children with special needs. 1.3 No adaptive equiptment/ methods used even when warranted (ie., bracing, seating adaptations, etc). 1.4 The rest of the group is penalized because of perceived limitations.		3.1 Children with special needs included in the group. 3.2 Some adaptations made to help include child in activities (i.e., seat in circle for child who is unstable). 3.3 Adaptations are adequate, but make child with special needs "different"		5.1 Children with special needs are not immediately recognizable to outside observer. 5.2 Activities are planned so that all children can be successful/ participate. 5.3 Caregivers are comfortable interacting with/caring for children with special needs. 5.4 Caregivers seek info from parents /therapists on proper techniques.		7.1 Children with special needs are active /equal members of the group. 7.2 Adaptive materials blend into classroom materials (i.e., all chairs match, some have belts /positioners). 7.3 Caregivers are included as part of IFSP /IEP team. 7.4 Caregivers involved in implementing objectives of IFSP /IEP.

#15 Engaging With Special Needs Children

General notes about this item:

A child is considered to have special needs whenever they require help and information beyond what is *normally required by a child of the same age in order to assure the best developmental outcome* (Canning & Lynn, 1990, as cited by Doherty-Derkowski, 1995, p. 133). Mainstreaming or integration is the term given to the approach of including children with special needs in child care programs with children who do not have special needs. This approach is based on research indicating children with special needs will benefit because:

> The children who do not have special needs will model (demonstrate) age-appropriate behaviors for the children with speicla needs and these children will imitate such behaviors; the mainstreamed setting will provide a more advanced linguistic, social, and cognitive environment than would be provided in a segregated program; and children with disabilities who are in a mainstreamed program will learn to be comfortable with non-disabled peers (Striefel et al., 1991, p. 135)

The caregiver has a large role in providing support and facilitating positive peer interaction between the child with special needs and their normally developing peers. Research indicates that without encouragement, normally developing children interact more frequently with other normally developing peers or with those who have a mild disability than with peers who have a moderate

or severe disability. In conclusion, Odom and McEvoy (1988) report that social interaction will generally not occur between children with moderate or severe disabilities and non-disabled children unless it is specifically encouraged by caregiving staff.

It should be clear that the inclusion of this item is not meant to be viewed as being all that is required when a child with special needs is enrolled in the child care program. The substantial body of research cited for the other items are the same for children with special needs. The inclusion of this item recognizes that a caregiver with a special needs child attending his/her program also has additional requirements to consider.

Toddler Detailed Description of Indicators

1.1 Children with special needs kept separate from group.	Is the child with special needs kept contained in an adaptive seat, etc., not interacting with the rest of the group? Is special needs child separated from group "for their own good", for most of the day? This is not to say that children cannot be placed in these types of apparatus. The question you should ask is why. If the child is content, that is one thing. If the caregiver contains the child to keep them away from the group, that is another.
1.2 Caregiver seems uncomfortable interacting with, or caring for, children with special needs.	Look at caregiver's reactions to the child with special needs. Does he/she seem awkward with the child?
1.3 No adaptive equipment /methods used even when warranted (i.e., bracing, seating adaptations, etc.).	N/A if this does not pertain to the children in the observed room. If needed, is the necessary equipment available to provide adequate care? For example, is there a seat that provides straps/braces for the child who needs additional support? Please note, caregiver can be creative in developing materials – for example, using rolled blankets/towels to provide additional support for child's head.
1.4 Rest of group is penalized based on perceived limitations.	Listen to the words the caregiver uses. For example, does she express that she'd like to take the group outside for a walk but cannot because of the limitations of the child with special needs?

3.1 Children with special needs included with group.	Children with special needs are placed in close proximity to the other children in the group and participate in activities.
3.2 Some adaptations made to help include child in activities (i.e., seat in circle for child who is unstable. **.**	Caregiver makes adaptations so children with special needs can actively engage with any group activities. This includes placing cushions around the child who is unsteady in sitting up so they can be around the cluster of other preschoolers.
3.3 Adaptations are adequate, but make child with special needs "different".	These would include awkward or bulky equipment that is used to engage the child in the group. For example, does the special needs child sit in a clunky wooden chair rather than a typical chair that has been modified?

5.1 Children with special needs are not immediately recognizable to outside observer.	A special needs child should be included in most play activities, just like every other child is, with modifications being carried out as smoothly and inconspicuously as possible. Keep in mind that most interventions are implemented as part of the regular classroom activities that include both the special needs child and their typically developing peers.[ciii]
5.2 Activities are planned so that all children can be successful/participate.	This may require modifications to the schedule and the environment, including: • Arrangement of classroom to provide wider pathways. • Providing special accessible playgrounds. • Providing additional staff to provide extra attention. • Providing more or less structured individual and group activities so all children can participate.[civ]

5.3 Caregivers are comfortable interacting with/caring for children with special needs.	Caregivers provide care to the special needs child with the same effortlessness as demonstrated with other children.
5.4 Caregivers seek information from parents/therapists on proper techniques.	To give credit for this item, caregiver must either be observed using special activities or interactions with the child, or during the interview, staff must describe proper techniques used with the child and how they are carried out. Do not give credit if caregiver obviously does not know about appropriate techniques.
7.1 Children with special needs are active/equal members of the group.	To receive credit for this indicator, the special needs child should be included in most all activities and routines, just as every other child is, with special modifications being implemented as smoothly as possible.[cv]
7.2 Adaptative materials blend into classroom materials (i.e., all chairs match, some have belts, positioners).	While some adaptive furniture may be necessary for the special needs child, do the materials blend in with the others? Do the chairs all match? Or is the adaptive chair radically different than the others, calling attention to the special needs child?
7.3 Caregivers are included as part of IFSP/IEP team.	You will need to ask about this item. Ask if caregivers are members of the IFSP/IEP team. Do they have input on the goal setting of the child? Or do they just receive the recommendations with little participation in the planning process?
7.4 Caregivers involved in implementing objectives of IFSP /IEP.	This indicator is similar to that of 7.4. Ask how the implementation of the IFSP/IEP are accomplished. Are the goals implemented solely by additional professionals or is the caregiver actively involved with implementing interventions within the classroom setting?

#16 Relationship With Families

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Interaction with families occurs mainly when a problem arises. 1.2 Caregiver is patronizing or disrespectful towards families. 1.3 Cultural and other individual preferences of families are discouraged or ignore.		3.1 Some positive interactions with families occur daily. 3.2 Parent's preferences are treated with respect. 3.3 Families are encouraged to participate in children's program.		5.1 Caregiver's work in partnership with families to assist in child's development. 5.2 Caregiver's stress that they view parent's as the primary source of love and care. 5.3 Parents are always welcome in the child care center.		7.1 The diversity of families is celebrated and used as a basis of learning. 7.2 Caregiver plans curriculum that is culturally responsive. 7.3 Caregiver's use parent's knowledge of children in planning, evaluation and assessment.

#16 Relationship With Families

General notes about this item:

Children's development is best understood within the context of their family, then their school community, and the larger community (Gestwicki, 1999). According to Bredekamp and Copple, 1997, *education should be an additive process* (p. 13). Children should be encouraged and supported to add new cultural and language experiences without having to give up on their family of origin contexts. Children's home languages and cultures should be respected and reinforced in early childhood settings (Gestwicki, 1999, p. 10).

As identified by Bredekamp (1987) it is particularly important that parents and staff discuss basic values and childrearing practices. She identifies that during these early years, children learn whether or not their environment is supportive and predictable. Parents and staff who share information about the child's routines and daily experiences increase the likelihood that the child will experience a consistent environment.

Toddler Detailed Description of Indicator

1.1 Interaction with families occurs mainly when a problem arises.	Caregivers communicate with parents only about problems or conflicts, ignore parents' concerns, or avoid difficult issues rather than resolving them with parents[cvi].
1.2 Caregiver is patronizing or disrespectful towards families.	Caregivers communicate a competitive or patronizing attitude to parents or they make parents feel in the way. Parents view caregivers as the only expert and feel isolated from their child's experience[cvii].
1.3 Cultural and other individual preferences of families are discouraged.	Children's cultural and linguistic backgrounds and other individual differences are ignored or treated as deficits to be overcome. Multicultural curriculum reflects a "tourist approach" in which the artifacts, food, or other particulars of different cultures are presented without meaningful connections to the children's own experiences. Some children's cultural traditions are noted in ways that convey that they are exotic or deviations from the "normal" majority culture. Caregivers do not talk with the parents about the toddler's speech patterns or home language and they cannot understand what the toddler is trying to say, which causes the child to be frustrated in her efforts to communicate. [cviii]

3.1 Some positive interactions with families occur daily.	Caregiver helps parents feel good about their children and their parenting by sharing with them some of the positive and interesting things that happened with their children during the day. Parents always are made to feel welcome in the child's care setting[cix].
3.2 Parent's preferences s are treated with respect.	Caregivers ask parents what sounds and words their toddlers uses so that the caregiver will understand what the child is saying when she uses beginning speech or a home language that is not understood by the caregivers. Adults work cooperatively with families in encouraging children to learn to use the toilet. When toddlers reach an age when they feel confident and unafraid to sit on a toilet seat, caregivers invite them to use the toilet, help them as needed, provide manageable clothing, and positively reinforce them. The toilet, with a step stool, is in a well-lit, inviting, relatively private space. Children are taken to the toilet frequently and regularly in response to their own biological needs[2].
3.3 Families are encouraged to participate in children's program. .	Does the center offer holiday celebrations that families are invited to attend? Are parents invited/encouraged to serve as "room parents" or "room helpers"?

5.1 Caregiver's work in partnership with families to assist in child's development.	Caregivers work in partnership with parents, communicating daily to build mutual understanding and trust and to ensure the welfare and optimal development of the baby. Caregivers listen carefully to what parents say about their children, seek to understand parents' goals and preferences and are respectful of cultural and family differences.
5.2 Caregiver's stress that they view parent's as the primary source of love and care.	Caregiver communicates that they view parents as the child's primary source of affection and care. Caregivers demonstrate that parent's preferences are respected. You do not want to hear: • "I'm just glad she has me in her life because her mom just doesn't have time for her." • "I don't care that mom says to put him to nap with his binky. I don't think he needs it."
5.3 Parents are always welcome in the child care center.	Parents are always welcome in the program. Opportunities for parent participation are arranged to accommodate parents' schedules. Parents have opportunities to be involved in ways that are comfortable for them, such as observing, reading to children, or sharing a skill or hobby.

7.1 The diversity of families is celebrated and used as a basis of learning. .	Caregiver brings each child's home culture and language into the shared culture of the school so that children feel accepted and gain a sense of belonging. The contributions of each child's family and cultural group are recognized and valued by others. Children learn to respect and appreciate similarities and differences among people[cx].
7.2 Caregiver plans curriculum that is culturally responsive	**N/A for Young Toddlers Where No Curriculum Is Used** Caregiver plans curriculum that is responsive to the specific context of children's experiences. Culturally diverse and nonsexist activities and materials are provided to help individual children develop positive self-identity, to construct understanding of new concepts by building on prior knowledge and creating shared meaning, and to enrich the lives of all children with respectful acceptance and appreciation of differences and similarities. Books and pictures include people of different races, ages, and abilities, and of both genders in various roles.
7.3 Caregiver's use parent's knowledge of children in planning, evaluation and assessment.	Caregivers and parents work together to make decisions about how best to support children's developmental and learning or to handle problems or differences of opinion as they arise. Teachers solicit and incorporate parents' knowledge about their children into ongoing assessment, evaluation, and planning procedures[cxi].

#17 Cultural Competence

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 No evidence of cultural diversity observed. 1.2 Materials present only sterotypes of races, cultures, ages, abilities and gender. 1.3 Staff demonstrate prejudice against others (Ex. Against child or other adult from difference race or cultural group, against person with disability)		3.1 Some racial and cultural diversity visible in materials (Ex. multi-racial or multi-cultural dolls, books, or bulletin boards, music tapes from many cultures; in bilingual areas some materials accessible in children's primary language 3.2 Materials show diversity (Ex. different races, cultures, ages, abilities, or gender) in a positive way. 3.3 Staff intervene appropriately to counteract prejudice shown by children or other adults (Ex. discuss similarities and differences; establish rules for fair treatmend of others), *or* no prejudice is shown.		5.1 Many books, pictures and materials accessible showing people of different races, cultures, ages, abilities, and gender in non-stereotyping roles (Ex. both historical and current images; males and females shown doing many different types of work including traditional and non-traditional roles). 5.2 Some props representing various cultures included for use in dramatic play (Ex. dolls of different races, ethnic clothing, cooking and eating utensils from various cultural groups).		7.5 Inclusion of diversity is part of daily routines and play activities (Ex. ethnic foods are a regular part of meals/snacks; music tapes and songs from different cultures included at music time). 7.6 Activities included to promote understanding and acceptance of diversity (Ex. parents encouraged to share family customs with children; many cultures represented in holiday celebration).

#17 Cultural Competence

General notes about this item:

We live in a multicultural society where even children who are born into a homogeneous community are unlikely to live their entire lives in a similarly homogeneous environment. As stated by Doherty-Derkowski (1995),

> Inevitably, almost any child living in North America will be in a situation at one time or another where others have different beliefs and different ways of behaving. Therefore, it is important for children to develop the attitudes and skills required to live and work comfortably with people from various backgrounds. This is best done during the early childhood years when children can learn to view differences in appearances and ways of doing things as interesting and positive rather than as distressing or threatening (p. 120).

Considerable research indicates a strong link between school success with the extent to which minority children's language and culture are incorporated into the school program (Cummins, 1986). Child care programs can encourage and support all children's identity and the development of a positive self concept by *incorporating materials and activities that respect and affirm children's race or ethnicity, by addressing signs of bias or discrimination, and by promoting collaboration between the program and the home* (Doherty-Derkowski, 1995, p. 122). Being a culturally competent caregiver requires conscious effort. Caregivers not only demonstrate this competence by their actions, but also by the materials they offer the children in their care.

The indicators in this item closely correspond with those in the Early Childhood Environment Rating Scales, Revised Edition (Harms, T., Clifford, R.M., and Cryer, D. (1998) and the Infant/Toddler Environment Rating Scale, Revised Edition (Harms, T., Clifford, R.M., and Cryer, D. (2003). For detailed discussion of these indicators please refer to *All About ITERS-R* (Cryer, Harms and Riley, 2004) and *All About ECERS-R* (Cryer, Harms, and Riley, 2003).

Toddler Detailed Description of Indicator

1.1 No evidence of cultural diversity observed.	All pictures and materials represent only one ethnicity or culture. Look for evidence of diversity in dolls, play materials, pictures, and books. Examples of diversity include dolls with various skin tones, doll sized wheelchairs, as well as books and pictures of varying abilities, including people wearing glasses.
1.2 Materials present only sterotypes of races, cultures, ages, abilities and gender.	Books and pictures reflect women and men in traditional roles only.
1.3 Staff demonstrate prejudice against others (Ex. against child or other adult from difference race or cultural group, against person with disability)	Look at caregiver's reactions to all children and staff. Is there a child that is "picked on" by the caregiver? Is there a toddler that is neglected or criticized because they are different? This can be particularly evident if there is a child with special needs. Does the caregiver seem uncomfortable with the child because of their handicap?

3.1 Some racial and cultural diversity visible in materials (Ex. multi-racial or multi-cultural dolls, books, or bulletin boards, music tapes from many cultures; in bilingual areas some materials accessible in children's primary language	At least three examples of racial and cultural diversity should be observed. Look for examples in dolls, pictures, books and music tapes/cds.
3.2 Materials show diversity (Ex. different races, cultures, ages, abilities, or gender) in a positive way.	This indicator requires that all people are presented as caring and capable individuals and do not stereotype members of any group.

3.3 Staff intervene appropriately to counteract prejudice shown by children or other adults (Ex. discuss similarities and differences; establish rules for fair treatment of others), *or* no prejudice is shown.	To receive credit for this indicator, caregivers must take immediate action when they observe prejudiced behavior, by either adults or children, and make it clear that this is not acceptable. It is doubtful that very young toddlers will demonstrate prejudicial behavior. If this type of behavior is observed, it will most likely be seen in the behavior of other staff present in the classroom. Be aware of other staff's responses to the children in care. If there is any evidence of prejudicial comments or behavior, does the targeted caregiver address them in a constructive way? If there is no evidence of prejudice observed, score this indicator a "Yes".

5.1 Many books, pictures and materials accessible showing people of different races, cultures, ages, abilities, and gender in non-stereotyping roles (Ex. both historical and current images; males and females shown doing many different types of work including traditional and non-traditional roles).	As is stated in the ITERS-R, many means that there are at least 10 examples of diversity. These should include the following: Races, cultures, ages, abilities and gender.
5.2 Some props representing various cultures included for use in dramatic play (Ex. dolls of different races, ethnic clothing, cooking and eating utensils from various cultural groups).	Look for dolls of different skin tones, ethnically diverse food toys (tacos, sushi, etc).

7.2 Inclusion of diversity is part of daily routines and play activities (Ex. ethnic foods are a regular part of meals/snacks; music tapes and songs from different cultures included at music time).	To receive credit for this indicator requires the caregiver make a solid and conscious effort to stress diversity in the classroom. Does the caregiver speak to the infants in different languages (i.e., saying "Hola" or counting to 10 in Spanish)? Are toddlers exposed to music and books of different cultures?
7.2 Activities included to promote understanding and acceptance of diversity (Ex. parents encouraged to share family customs with children; many cultures represented in holiday celebration).	You will most likely need to ask about this indicator. While young toddlers may be too young to experience these activities directly, ask if the center overall encourages families to share customs and/or holiday celebrations. Only give credit for this indicator if toddlers are included in these activities.

Child Caregiver Interaction Scale (CCIS)

Preschool Version

Emotional Domain

#1 Tone of Voice

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Speaks with irritation (sharp tone, raised voice) or harshness. 1.2 Tone of voice and manner are insincere (Caregiver may say one thing and mean another). Uses sarcasm. 1.3 Depressive or flat affect. .		3.1 Speaks warmly to children (tone and words). 3.2 Children are praised for their efforts (Good job!) 3.3 Caregiver's tone and manner match.		5.1 Verbally demonstrates enjoyment of children (Hi! Welcome to school today! I'm glad you are here!) 5.2 Tone expresses acceptance and patience to children, even in difficult situations. 5.3 Emotion/tone appears to be genuine.		7.1 Caregiver consistently seeks out opportunities to positively acknowledge children ('Catch them being good') 7.2 Caregiver's tone is happy and conveys to children that they are delightful and respected.

#1 Tone of Voice

General notes about this item

One of the elements of positive caregiving is providing the children in care with plenty of encouragement and taking an active interest in their activities. These include behaviors such as discussing children's activities with them and praising their efforts to master a task (Doherty-Derkowski, 1995, p. 28). Research indicates children who experience high levels of positive caregiver interaction are compared with children experiencing lower level of positive interactions, the children show higher rates of exploratory behavior (Anderson et al., 1981); higher levels of language development (Whitebook et al., 1990); and more advanced cognitive functioning (Carew, 1980).

Reynolds and Jones (1996) identified ways to provide positive attention as a positive reinforcer. One way of doing this is by letting children know their positive actions are recognized, by "catching them being good" and giving appropriate and authentic reinforcement for the desirable behavior. Giving specific positive feedback helps children understand exactly what behaviors earn them positive recognition. By focusing on the positive behaviors, children learn they do not have to misbehave to get the caregiver's attention (Gestwicki, 1999, p. 178).

Preschoolers Detailed Description of Indicators

1.1 Speaks with irritation (sharp tone, raised voice), or harshness.	Caregiver expresses irritation with children through tone of voice. This can be heard in a sharp tone, raised voice, or by being verbally abrupt with children. Does the caregiver seem generally irritated with children?
1.2 Tone of voice and manner are insincere (caregiver may say one thing and mean another). Uses sarcasm.	Caregiver uses an insincere tone. Does he/she say "nice things" in a negative manner? For example, "It sure is a delight when you ask questions nonstop". Or does caregiver say mean things in a nice way: "Gee, thanks so much for helping", when what is really meant is "Gosh, you are making more of a mess than a help. I wish you would stop!"
1.3 Depressive or flat affect.	Caregiver demonstrates either depressed demeanor or flat emotions. Does the caregiver seem depressed or withdrawn from the children? Caregiver's tone seems sad or expresses no emotion when engaging with the children. The distinction between this indicator and 1.1 is the key word irritation, which may or may not be depressive.

3.1 Speaks warmly to children (tone and words)	Caregiver's tone of voice should be warm and demonstrate acceptance of children. This should be evident throughout the day – during play, routines and transitions. Caregiver does not have to be excessively warm or demonstrative to receive credit for this indicator. However, there should be no evidence of sharp tones or harshness in their interactions with children. Note this is in the minimal category. Care should be given to not be culturally biased in this item. Look at the reactions of the children in care; do they respond favorably to the caregiver? Is the caregiver just not an overly demonstrative individual? If you have any question on the scoring of this item, take 15 minutes to focus on the children as they interact with the caregiver. Is the tone of voice part of the entire culture? Are the interactions with the caregiver received as caring by the children?
3.2 Children are praised for their efforts (Good job!)	Caregiver acknowledges child's efforts. He/she should verbally praise children as they make attempts at basic skills, such as cutting with scissors, writing letters, pouring from a pitcher. For example, • "Good job picking up the toys!" • "Good listening." Caregiver should also praise children in their attempts at play. For example, offering encouragement as children try to complete a puzzle. Encouragement should be offered for the attempt, whether successful or not. The intention is that children should receive recognition for trying.

3.3 Caregiver's tone and manner match.	This indicator means that no sarcasm is used. Words and tones should match. The intention of this item is sincerity. The caregiver doesn't need to be consistently happy or overjoyed – but whatever words that are being said need to be expressed in an authentic tone. This should not be confused with good natured joking. When in doubt, look at the children's reaction. Are they laughing? Remember, sarcasm is a "nice nasty", not funny.

5.1 Verbally demonstrates enjoyment of children.	With this indicator, the caregiver needs to demonstrate enjoyment of children. She/he should verbally express warmth and caring towards all children.
5.2 Tone expresses acceptance and patience to children, even in difficult situations.	Does the caregiver maintain a calm tone of voice even when stressed? Also be aware of this item if there are any discipline issues during the observation. Does the caregiver express acceptance of the child, even when discouraging the negative behavior? Does he/she make a clear distinction between the child from the behavior? Caregivers should also model the type of interactions with others that they want children to develop[112]. Caregivers help children resolve their differences by using words to express what is happening and what the child is feeling.("You want to play with

	the ball? Jennifer is playing with the ball. Let's see if we can find another ball in the box").
5.3 Emotion/tone appears genuine.	The intention of this item is sincerity. Does the caregiver express genuine caring for the children? Do the positive feelings seem to flow effortlessly? Or does the caregiver seem to be pushing him/herself to engage with the children in a responsive manner?

7.1 Caregiver consistently seeks out opportunities to positively acknowledge children (Catch them being good).	Caregiver "catches children being good". This means he/she seeks out times when children are being good and compliments them. The intention of this indicator is that the caregiver should be aware of and in tune with the children in her care and verbally acknowledge them for positive behavior. For example: • Children who are playing nice in the block area are recognized for their positive behavior. • Caregiver acknowledges when a child helps another on the playground.
7.2 Caregiver's tone is happy and conveys to children that they are enjoyed and respected.	The difference between this indicator and 5.1 is the level of enthusiasm. The previous indicator describes a caregiver who expresses warmth and enjoyment of children. For this indicator, the caregiver's tone of voice not only expresses warmth, but also happiness and delight in the children. For example • "Wow! That is an awesome tower you made!" • "Fantastic job cleaning up! You are a great helper"

Emotional Domain

#2 Acceptance/Respect for Children

Inadequate 1	**2**	**Minimal 3**	**4**	**Good 5**	**6**	**Excellent 7**
1.1 Constantly says "No!" or engages in power struggles over issues that do not relate to the child's health or well-being. 1.2 Punishes children for asserting themselves or saying "No". 1.3 Makes negative comments or statements directed toward any child (shows obvious favoritism).		3.1 Demonstrates acceptance of children, both personally and generally. 3.2 Demonstrates knowledge of child development and child's abilities.		5.1 Expresses acceptance of children. 5.2 Caregiver demonstrates understanding of child development. 5.3 Limits saying "No" to situations that relate to children's safety or emotional well being. 5.4 Directions are positively worded ("Feet belong on the floor"), not just restrictions ("Don't climb on the table").		7.1 Provides opportunities for children to be successful so they can be praised. 7.2 Conveys to children they are valued. 7.3 Plans experiences that engage children's interests, resulting in less opportunity for off task behavior. (N/A option for Infants and Toddlers)

#2 Acceptance/Respect for Children

General notes about this item

While child development occurs in a relatively orderly sequence, individual children develop at varying rates and unevenly within different areas of each child's functioning (Gestwicki, 1999, p. 9). It is not possible to compare the development of individual children solely based upon chronological ages. Each child has their own pattern and speed of development that is unique to the child. Factors such as heredity, health, individual temperament and personality, learning styles, experiences, and family background influence development. *Rigid expectations for age-related group norms conflict with principles that demand individual support of particular strengths, needs and interests* (Gestwicki, p. 9).

When children who experience high levels of positive adult interaction are compared to those experiencing lower levels of quality interaction, the children demonstrate higher levels of language development (Howes, 1990; Whitebook et al., 1990) and more advanced cognitive development (Carew, 1980).

Preschoolers Detailed Description of Indicators

1.4 Constantly says "No!" or engages in power struggles over issues that do not relate to the child's health or well-being	Adults are constantly saying "No!" to children or becoming involved in power struggles over issues that do not relate to the child's health or well-being.
1.5 Punishes children for asserting themselves or saying "No".	Caregiver does not recognize that constantly testing limits and expressing opposition ("No!") to adults is part of a child developing a healthy sense of self as a separate, autonomous individual[113].
1.6 Makes negative comments or statements directed toward any child (show obvious favoritism).	Caregiver criticizes children for what they cannot do or for their clumsy struggle to master a skill[114]. For example: • "I don't know why you insist on trying to eat with a fork. You know you can't do it" OR: Adults foster overdependency; children are overprotected and made to feel inadequate. For example: • "Here, let me do that for you. You know you can't button your coat". Children are made to feel ashamed of their bodies and to think their bodily functions are disgusting[115]. For example: • "Oh my gosh, did you poop again?!" • "You are such a messy eater!" Be aware of favoritism. Are some children allowed privileges while others are not?

5.1 Demonstrates acceptance of children, both personally and generally.	Children are acknowledged for their accomplishments and helped to feel increasingly competent and in control of themselves[116]. Caregiver does not arbitrarily take favored toys away from children OR expect them to share with other children. Children are given choices, and preferences are encouraged. Children are not all expected to do the same thing[117].
5.2 Demonstrates knowledge of child development and child's abilities.	This item is evidenced by the materials that are present and activities that are offered. Are they developmentally appropriate? For example: • Preschoolers are provided puzzles, family living materials, blocks and accessories (small people, cars, etc.), to play with. In this indicator, the caregiver doesn't necessarily need to be actively engaged with the children as they play; it is enough that they are present and they are offered to preschoolers.

5.1 Expresses acceptance of children.	Adults respect children's developing preferences for familiar objects, food, and people. Adults permit children to keep their own favorite objects and provide options and opportunities from which children may self choose. Children's preferences are seen as a healthy indication of a developing self-concept[118].
5.2 Caregiver demonstrates understanding of child development.	To receive credit for this item, not only does the caregiver need to provide developmentally appropriate materials to children, he/she also needs to be actively engaged with their play. Examples of

	this include: • Helping preschoolers with puzzles. • Engaging in family living activities with children.
5.3 Limits saying "No" to situations that relate to children's safety or emotional well being.	Caregivers recognize that testing limits and expressing opposition ("No!") to adults is part of a child developing a healthy sense of self as a separate, autonomous individual. Caregivers try to limit their saying "No!" to situations that relate to children's safety or emotional well-being.
5.4 Directions are positively worded ("Feet belong on the floor"), not just restrictions ("Don't climb on the table").	Caregivers give positively worded directions (Bang on the floor"), not just restrictions (" Don't bang on the table").

7.1 Provides opportunities for children to be successful so they can be praised.	Caregiver consciously creates opportunities for preschoolers to be successful. For example: • Chooses noncompetitive games where everyone is a winner. • Assigns tasks so everyone has the chance to be "leader" or "kid of the day". • Sings interactive songs where children supply the words. Caregiver should also stress that it is okay to "mess up" and that children are not expected to be perfect. Children are taught that mistakes are our way to learn.

5.4 Conveys to children they are valued.	This is evident in the ways caregiver responds to children. For example: • Maintains focus and eye contact while children are talking. • Encourages more sensitive children to engage in play. • Doesn't allow children to interrupt one another. • Appreciates that children have a unique and valuable perspective.
5.5 Plans experiences that engage children's interests, resulting in less opportunity for off task behavior.	The intention of this item is that the caregiver engages children so they are involved, as opposed to being left to their own devices. This indicator goes beyond just interacting with children; the caregiver knows the needs of children in care and plans experiences so they are occupied. Look carefully at transitions. For example, does the caregiver lead the children in song as they move from one situation to another?

Emotional Domain

#3 Greeting

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Children are expected to begin their day and no adult interaction. 1.2 Arrival of child not acknowledged. 1.3 Arrival of parent not acknowledged.		3.1 Children and parents are greeted and acknowledged by name upon arrival. 3.2 Children are accepted into the classroom with minimal adult interaction. ✋ 3.3 Caregiver verbally asks parents about child's well being upon arrival		5.6 Caregivers help children settle into the group upon their arrival by reading books or quietly playing with them. 5.7 Problems with separation from parent handled sensitively. 5.8 Caregiver provides written communication to parents on individual children*.		7.1 Parents are encouraged to be involved with daily activities. 7.2 Program is set up to encourage face to face communication between parents and caregiver. 7.3 Children's separation patterns are known and respected by caregiver (i.e., some children want to be held, others allowed "alone time".

✋ To move further up the scale, this should be "No".

*5.3 Most likely you will need to ask to see proof of this.

#3 Greetings

General notes about this item

Positive parent involvement in the child care program is one that *supports and complements the family in its child rearing role* (Doherty-Derkowski, 1995, p. 48). Communication between home and the early childhood setting are important because they create an environment of continuity of the child's experiences. Cloutier (1985) stresses the need for meaningful on-going communication between the parent and early childhood program. The underlying assumption is that *parents and staff members share information and are able to agree on consistent approaches with the child* (Doherty-Derkowski, 1995, p. 49). Without this ongoing communication neither parents or staff have the whole picture of what is occurring in the child's life.

Research indicates (Galinsky, 1988) the most frequent communication times between parents and caregivers occur when the child is dropped off or picked up. These times are critical because these may be the only time caregivers and parents have the opportunity to share information.

Preschoolers Detailed Description of Indicators

5.9 Children are expected to begin their day with free play and no adult interaction.	Children are received hurriedly and given no individual attention. Children are expected to begin the day with free play and little adult interaction[119]. AND/OR: There is no predictable routine to the daily entry transition.
5.10 Arrival of child not acknowledged.	Parents bring children into the room but the child's arrival is not acknowledged. Parents leave child; but child is not acknowledged by caregiver.
1.3 Arrival of parent not acknowledged.	Parents bring child into the room but their arrival is not acknowledged. Caregiver may recognize and greet the child but doesn't pay any attention to the parent; parents are not greeted.

5.11 Children and parents are greeted and acknowledged by name upon arrival.	Parents and children are acknowledged. Eye contact is made with child and they are acknowledged by name upon arrival.
3.3 Children begin their day with free play and minimal adult interaction. **✋ To move further up the scale, this should be "No".**	Caregiver verbally acknowledges child but does not actively engage with them. Caregiver recognizes that child is there but goes on to other duties.

5.12 Caregiver verbally asks parents about child's well being upon arrival	Caregiver asks parents about the previous evening and about child's well being this morning. Caregiver asks about child's eating, sleeping and toileting schedule.

5.13 Caregivers help children settle into the group upon their arrival by reading books or quietly playing with them.	Adults warmly greet children and their parents by name when they arrive. The day begins with a great deal of adult-child interaction[9]. Caregivers help children settle into the group by engaging with them, for example, reading, puzzle play, etc.
5.14 Problems with separation from parent handled sensitively.	Children who are having a stressful transition time are given extra attention. Caregiver engages child with various activities to ease the transition; reads a story, talking with peers, or play materials.
5.15 Caregiver provides written communication to parents on individual children.	Caregiver provides written documentation about the child's activities while in care, including eating, toileting, napping activities. Also includes updates on daily activities and notes on behavior.

7.1 Parents are encouraged to be involved with daily activities.	Caregiver encourages parental participation, making a welcoming environment for parents. Program is set up to encourage participation. For example: • Extra adult size, comfortable chairs are provided to encourage parents to linger as children transitions into daily care. • Open houses are offered so parents can plan get to know staff. • A variety of volunteer opportunities are clearly expressed so parents can participate. This can be either physical

	opportunities (field trip help) or material offerings (toilet paper rolls for a craft).
7.2 Program is set up to encourage face to face communication between parents and caregiver.	Extra caregivers are brought in to allow primary caregiver to engage with parents and children upon arrival and departure. Rather than being a rushed drop off time, caregiver is able to talk to parents about child's evening, as well as any concerns either may have. With the extra caregiver, this can be accomplished without slighting other children in care.
3.3 **Children's separation patterns are known and respected by caregiver (i.e., some children want to be held, others allowed "alone time".**	Caregiver is aware and sensitive to each child's separation needs. Caregiver is respectful of child's needs and accommodates them. For example, does child need individual attention from caregiver upon arrival? Is that provided? Does child need to be held up to the window to watch parent leave? Does caregiver accommodate that?

Emotional Domain

#4 Enjoys and Appreciates Children

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Seems to dislike children. 1.2 Quiet children are ignored. 1.3 Children are treated with indifference (act like they have no feelings); disrespected. 1.4 Takes little interest in children's activities or accomplishments. 1.5 Attention only given during routine care or for negative behavior.		3.1 Interaction with children is done mainly during routine care; little playing with children.  3.2 Maintains eye contact with children when they speak or babble. 3.3 Quiet children are engaged with and given attention even while being good. 3.4 Children who are playing well and quietly are acknowledged for their positive behavior.		5.1 Caregiver knows the children well and is able to respond to their temperament and cues, anticipating their needs. 5.2 Children are treated with respect. 5.3 States appreciation for child's efforts. 5.4 Praises children for their accomplishments.		7.1 Caregiver engages all children in conversations, asking of their interests and preferences. 7.2 Expresses delight in children's activities (claps hands, cheers.) 7.3 Conversations regularly include references to child's individual lives (siblings, parents, pets referenced; previous experiences, etc.)

 To move further up the scale, this should be "No".

#4 Enjoys and Appreciates Children

General notes about this item

Detachment is defined as an *observable lack of involvement by the adult with the child* (Doherty-Derkowski, 1995, p. 39). Examples of this type of behavior may include lack of interest or involvement with children's activities, treating children with indifference or lack of any interaction. Research indicates that children who are cared for by detached caregivers demonstrate poor language development (Whitebook et al., 1990); lower levels of developmental play (Whitebook et al., 1990); higher rates of disobedience then their peers (Peterson and Peterson, 1986); and high rates of aimless wandering (Whitebook et al., 1990).

As stated by Doherty-Derkowski,(1995) caregiver detachment and harshness impede the child's wellbeing in one of two ways. First, it may give the child the implicit message that the adult does not really care about him or her. Secondly, it results in the possibility that the adult may not be available when needed. Experiences such as this make it difficult for the child to feel confident about the adult's availability (p. 45).

Preschoolers Detailed Description of Indicators

1.1 Seems to dislike children.	Adults are unpredictable and/or unresponsive. They act as if children are a bother. Caregiver interacts with children in a harsh, impersonal manner. Consistently demonstrates irritation and annoyance at any child in care. This can be observed in the caregiver's tone of voice, comments or actions.
1.2 Quiet children are ignored.	Children are left for long periods of time engaging in free play without adult's attention[120]. Just because the child seems content, or the caregiver busy, does not excuse the lack of interaction. Interaction with ALL children is necessary.
1.3 Children are treated with indifference (act like they have no feelings); disrespected.	Children are interrupted, children's preferences ignored or discounted. Caregivers impose their own ideas or play with toys themselves, without regard to the child's interests. Does the caregiver abruptly wipe the child's face with no warning? Does the caregiver change the schedule abruptly, to suit her/his own needs?

1.4 Takes little interest in children's activities or accomplishments.	Caregivers are uninvolved in children's play, exploration, and activities, viewing their role as mere supervision. Caregivers fail to take an active role in promoting children's learning, assuming that children will develop skills and knowledge on their own without adult assistance[121]. For example, children do much paper-and-pencil seatwork of the type in which there are only right or wrong answers. As a result, caregivers have little idea about the process of children's problem-solving or their specific areas of difficulty and competence. Adults do not know how to help children who do not understand and are frustrated on how to further challenge children who get the problem "right."
1.5 Attention only given during routine care or for negative behavior.	Caregiver only interacts with children to toilet, feed, or put to nap. In addition, caregiver does not provide any positive engagement with preschoolers; attention is only given when they behave negatively. This item is really looking at the detachment of the caregiver. Does caregiver seem as if they are just "going through the motions"? If there seems to be some genuine warmth in the interaction, give credit for this indicator. (But pay close attention to indicator 3.1).

3.1 Interaction with children is done mainly during routine care; little playing with children. **To move further up the scale, this should be "No".**	In this indicator, while the caregiver interaction mainly occurs during routine care, the interaction is positive and caring. The caregiver may not actively engage in play activities with preschoolers, she does provide this functional or custodial care in a positive manner. For example: • Caregiver smiles and talks to children during circle time. • Caregiver asks preschooler if their lunch is good. Keep in mind, for this item, #3 indicates providing children with generally basic care.
3.2 Maintains eye contact with children when they speak or babble.	Adults engage in many one-to-one, face to face interactions with children. Adults talk in pleasant, calm voice, using simple language and frequent eye contact while being responsive to the child's cues[122].
3.3 Quiet children are engaged with and given attention even while being good.	Quiet children are not forgotten in the rush of more vocal or aggressive needs of other preschoolers. Caregiver provides the quiet preschooler various activities, such as Legos or family living. The intention of this item is that quiet children are not ignored and are either drawn into group activities or acknowledged in some way. All children receive some sort of adult interaction at no longer than 15 minute time spans.

3.4 Children who are playing well and quietly are acknowledged for their positive behavior.	Similar to the previous indicator, 3.4's focus is on ALL children (not just the quiet ones)[123]. Caregiver positively reinforces preschooler's positive behavior by commenting on it. For example: • "Jasmine, did you made a nice dinner for your friends?" • "Anthony, you are doing a good job on that puzzle." •

5.1 Caregiver knows the children well and is able to respond to their temperament and cues, anticipating their needs.	Caregivers consistently respond to children's' needs for food and comfort, thus enabling the child to develop trust in the adults who care for them. In this environment, they learn that the world is a secure place for them[124]. As the caregiver comes to know the children very well, they are able to respond to their temperment, needs, and cues of each child to develop a mutually satisfying pattern of communication with each child and their family[125].
5.2. Children are treated with respect.	Playful interactions with preschoolers are done in ways that are sensitive to child's interests and level of tolerance for physical movement, loud sounds, or other changes. For example: • Children are warned when it's 5 minutes to clean up. • Caregiver engages with children in an interactive manner so they can provide suggestions and input.

5.3. States appreciation for child's efforts.	Caregivers show their respect for child's play by observing the child's activities, complementing on it verbally, and providing a safe environment. The caring, supportive adult encourages the child's active engagement in play. The intention of this item is that the caregiver is appreciative of the preschooler's efforts, whether they are successful or not.
5.4. Praises children for their accomplishments	Caregiver provides praise for children as they are successful in their efforts. For example: • Cheers and claps when child catches a ball. • Praises preschooler for successfully completing a puzzle.

7.1 Caregiver engages all children in conversations, asking of their interests and preferences.	Caregiver has time structured so they can provide focused individual time, with the children in care. Children are engaged, with solid eye contact and attention, and talked to about their choices and preferences. For example: • "Logan, what center would you like to play in today?" • "This is your favorite story, isn't it? Tell me what you like about it." The intention is that the caregiver is demonstrating appreciation and respect for all children, regardless of their communication skill level.

7.2 Expresses delight in children's activities (claps hands, cheers.)	Authentic enthusiasm expressed at child's activities, accomplishments or behavior. This is done throughout the day; not just during planned, interactive activities. For example: • Caregiver scans the room during free play, providing praise, interest and encouragement as children engage in self directed play.
7.3 Conversations regularly include references to child's individual lives (siblings, parents, pets referenced; previous experiences, etc.)	Caregiver demonstrates interest and knowledge of children's lives outside of the classroom. Listen for conversations relating to children's siblings, grandparents, or pets, as well as conversations about children's evening or weekend activities.

5 Expectations for children

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Expectations for children are not age appropriate (either expect too much or too little of them). 1.2 Lack of child development knowledge is evident.		3.1 Expectations for children are generally appropriate. 3.2 Caregiver uses appropriate learning techniques with children. 3.3 Caregiver demonstrates knowledge of child development by exposing children to age appropriate materials.		5.1 Caregiver demonstrates knowledge of child development by engaging children with age appropriate materials/activities. 5.2 Activities/materials selected incorporate age-typical behaviors		7.1 Caregiver is tuned into the needs of children in her care. 7.2 Activities encourage children to expand their skills.

#5 Expectations for Children

General notes about this item

Child development research indicates fairly predictable patterns of growth and development during early childhood. Development occurs in an orderly sequence, with later skills and abilities building upon those already acquired (Gestwicki, 1999, p. 9). Understanding the behaviors and abilities related to typical development offers a framework for caregivers to know how best to support children's optimum learning. Understanding the sequence of learning abilities of children helps caregivers understand how to engage children in appropriate activities and *to resist the pressure to provide less appropriate experiences before the learning foundations have been laid. It is impossible for development to continue well when children are pushed to skip or hurry through earlier stages. Children need the time and patience to proceed through the sequence* (Gestwicki, 1999, p. 9).

Preschoolers Detailed Description of Indicators

1.1 Expectations for children are not age appropriate (either expect too much or too little of them).	Caregivers expect children to respond with one right answer most of the time. Adults treat children's naïve hypotheses as simply wrong answers rather than clues to how they think. Not realizing how much learning young children are capable of, caregivers do not engage them in dialogues in which they take children's ideas seriously, nor do they encourage children to express ideas through other (nonverbal) modes of representation. Underestimating children's intellectual ability, caregivers do not provide time and support for children to develop concepts and skills[126].
1.2 Lack of child development knowledge is evident.	Staff have little or no training specific to preschool child development. This is evident by the way they interact with the children, as well as the materials and activities they offer. They are unaware of what to look for that might signal problems in development. Caregivers do not know child milestones so they don't know if child is developing on target or not. In addition: • Caregivers do things for children that they could do themselves, because it is faster or less messy. • Adults display anger or shame children for toileting accidents or spills[127].

3.1 Expectations for children are generally appropriate.	Children have opportunities and teachers' support to demonstrate and practice developing self-help skills, such as putting on their coat toileting, serving and feeding themselves, brushing teeth, washing hands, and helping pick up toys. Caregivers are patient when there are occasional toileting accidents, spilled food, and unfinished jobs[128].
3.2 Caregiver does not use inappropriate learning techniques.	Caregivers understand that preschoolers learn by exploring their world in a safe environment. Caregiver offers children materials which they can play with at their own pace[129]. While some group time is acceptable for this age group, it is kept to a minimum and only while children are interested. Caregiver does not use ditto sheets or rote (memorization) techniques.
3.3 Caregiver demonstrates knowledge of child development by exposing children to age appropriate materials.	Caregiver offers age appropriate materials to children. For example: • Fine motor materials, such as puzzles, legos and lacing cards. • Block play and accessories. • Family living materials, including dress up clothing. • Books

5.1 Caregiver demonstrates knowledge of child development by engaging children with age appropriate materials/activities.	To receive credit for this indicator, not only does the caregiver provide preschoolers with age appropriate materials, but they also engage in play with them. For example: • Caregiver provides age appropriate books for preschoolers, and reads to them informally throughout the day. • Caregiver engages children in art activities..
5.2 Activities/materials selected incorporate age-typical behaviors.	Caregiver plans activities that are age appropriate for preschoolers. These can include, for example: • Art, using a variety of non-toxic materials. • Dancing to music, with instruments and dance materials

7.1 Caregiver is tuned into the needs of children in her care.	Caregiver knows the children well enough to know when they are getting bored with the current activities. Understanding that, she shifts gears to another activity which is more appealing to them.
7.2 Activities encourage children to expand their skills.	Caregiver provides many opportunities for children to plan, think about, reflect on, and revisit their own experiences. Staff engages children in discussion and representation activities (such as dictating, writing, drawing, or modeling in clay), which help children refine their own concepts and understanding and help the caregiver understand what children know and think[130]. For example: • Caregiver uses children's own hypotheses about how the world works to engage them in problem solving and experimentation.

#6 Health and Safety

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Health and safety procedures routinely overlooked. 1.2 Supervision of children is inadequate (ratios not maintained). 1.3 Formal record of medication and health information is not maintained. 1.4 Daily records are not kept or not complete. 1.5 Children are visibly dirty/need noses wiped.		3.1 Some attention to health practices are generally met– by caregiver AND children. 3.2 No lapses in supervision. 3.3 Formal procedures for administration of medication are in place and implemented. 3.4 Mechanisms are used for parents and staff to share health information daily.		5.1 Health practices are consistently met by caregiver and children (ex., handwashing, etc). 5.2 Caregivers do safety checks, both indoors and out, several times a day. 5.3 Emergency evacuation plans are posted and practiced. 5.4 Extra clothes for indoors and out are available and used as necessary.		7.1 Caregiver consciously stresses good nutrition and health. 7.2 Children are taught proper handwashing techniques. 7.3 Caregiver explains health and safety rules to children.

#6 Health and Safety

General notes about this item

Because of their immature immune systems, young children are more vulnerable to infections. Children in early childhood programs are exposed to a range of germs and viruses because of their increased contact with other young children. Studies indicate that children in early childhood programs are more vulnerable to diarrhea and hepatitis than their home-reared peers (Hayes et al., 1990).

Research indicates the extent to which diarrhea or hepatitis actually occurs is strongly dependent on the extent to which caregivers are vigilant about handwashing and other sanitary procedures (Black et al., 1981). In a study conducted by Black in four community child care centers in the United States, a fifty percent decrease in diarrhea occurred when child and adult handwashing was meticulously enforced.

Further, Klein (1986, as cited by Doherty-Derkowski, 1995), from the Department of Pediatrics at Boston University School of Medicine, notes that *handwashing is the single most important technique for prevention of gastrointestinal and many respiratory infections. Compulsory handwashing after handling infants, blowing noses, changing diapers, and using toilet facilities should be expected of every caregiver* (p. 12).

Preschoolers Detailed Description of Indicators

1.1 Health and safety procedures routinely overlooked.	Policies and procedures to ensure a sanitary environment have not been clearly thought through and are not written and displayed. Adults forget hand washing or other essential steps in cleaning play areas, handling food, and cleaning of food preparation areas. A disinfectant solution is not prepared daily, and used appropriately. Disinfectants are left out and not stored in any special place; they are difficult for adults to find quickly when cleanup is needed for spills, diaper areas, or bodily fluids. Toys are scattered on the floor and cleaned occasionally, not at all, or improperly[131].
1.2 Supervision of children is inadequate.	Children are left unattended. Caregivers leave the area when children are playing quietly or sleeping.[132] Ratios are not maintained.
1.3 Formal record of medication and health information is not maintained.	Formal records of medications are not required of parents. Caregivers are likely to make mistakes, giving medicines incorrectly or to the wrong infant because there is no visual reminder of the needs of each child. Health records are incomplete or outdated.[133] If there is no visible medication log posted, ask caregiver about how medicines are administered.

1.4 Daily records are not kept or not complete.	Daily records are not kept or are incomplete. Caregivers and families have no regular effective mechanism for sharing information. Adults leave notes on the refrigerator or in the child's coat pocket where parents may miss them. Caregivers may fail to communicate vital information to families.[134]
1.5 Children are visibly dirty/need noses wiped.	Check for the frequency and duration of this occurrence. If you notice a child needs their nose wiped and it is overlooked by the caregiver for 5 minutes, this indicator would receive a "Yes".

3.1 Some attention to health practices are generally met– by caregiver AND children.	To limit the spread of infectious disease, caregiver follows health and safety procedures, including proper hand washing methods and universal precautions. There are clearly written sanitation procedures specific to each area. Instructions on the proper diapering and hand washing sequence (including use of protective gloves), cleaning play areas, and food storage/preparation (including dish washing) are displayed on the walls as visual reminders to adults. Adults daily prepare AND USE a solution of ¼ cup of liquid bleach to 1 gallon of water (or 1 tablespoon to 1 quart of water in a spray bottle) and store it in a place out of reach of children. Any toys that are mouthed are removed when a child has finished playing with them so that they can be cleaned and disinfected before use by another child[135].

3.2 No lapses in supervision.	Caregivers supervise children by sight and sound, even when they are sleeping[136].
3.3 Formal procedures for administration of medication are in place and implemented.	Families bring in a signed permission form to administrator nonprescription or prescription medication, including a physician's written instruction for giving the medicine to that particular child. Health records, including immunizations and particular health problems (e.g., allergies) are filled separately and confidentially for every infant.[137]
3.4 Mechanisms are used for parents and staff to share health information daily.	A labeled daily record book or clipboard for each child is available for caregivers and parents to check and use. Caregiver's record time, date, and amount of medication administered. Caregivers and family members can also record vital information (bowel movements, feedings, arrival/departure times, and notes about the child's activities and moods). Adults are aware of the symptoms of common illnesses and alert to changes in children's behavior that may signal illness or allergies. Caregivers conduct daily health checks, recording any signs of illness on each child's daily record form[138].

5.1 Health practices are consistently met by caregiver and children.	Caregiver and children consistently wash their hands with very few lapses. This should be calculated separately for caregiver and babies. Pay close attention to hand washing after wiping of noses. BOTH caregiver AND child's hands should be washed SUFFICIENTLY. Proper handwashing of caregiver and children should occur 75% of the time. (Review appropriate handwashing techniques for details).
5.2 Caregivers do safety checks, both indoors and out, several times a day	Adults do safety checks of all areas, both indoors and outside, several times a day to ensure that they are safe (e.g., that electric outlets are covered, no objects are on the floor that a child could choke on, no splinters or nails are exposed on furnishings and equipment)[139]. Caregiver constantly scans the room, counting children, making sure all children are accounted for.
5.3 Emergency evacuation plans are posted and practiced.	Emergency evacuation plans are posted on the wall near the daily record charts. A bag of emergency supplies and child emergency forms are immediately accessible. Evacuation drills are practiced on a regular basis[140].
5.4 Extra clothes for indoors and out are available and used as necessary	Extra clothes for both indoors and outdoors are available. Caregivers dress children so they are comfortable, given the temperature, and can move freely[141]. Wet and messy clothes are changed as necessary.

7.1 Caregiver consciously stresses good nutrition and health.	Caregiver demonstrates the value of nutrition and health. This can be evidenced in a multiple of ways: • Explains to children the value of exercise. • Points out how good tasting AND good for you healthy foods are (like green beans, carrots, etc.). Makes no negative comments about food, such as "Oh, you like beets? I think they are yuckie!" • Sings songs, plays games, reads books or talks about pictures that relate to healthy lifestyle, such as healthy eating, exercise, etc. • If meals are provided by the program, caregiver offers only healthy and nutritious snacks and meals.
7.2 Children are taught proper handwashing techniques.	Does the caregiver educate children how to wash hands and for the proper length of time? The intention of this is the caregiver explains why proper handwashing is important (i.e., cut down on spread of germs).
7.3 Caregiver explains health and safety rules to children.	Explains the safety reasons behind undesirable behavior. The intention of this indicator is that safety infractions are used as a learning, teachable moment. For example: • "We don't climb on chairs because they can fall over. Then we would be hurt." • "We don't put drink out of our friend's cup. That is how we spread germs."

Cognitive Domain

#7 Routines/Time Spent

Inadequate 1	2	Minimal 3	4	Good 5	6	Excellent 7
1.1.Places high value on obedience/compliance 1.2. Primarily does adult tasks while children are in care. 1.3 Routine times are not used as bonding/learning times.		3.1 A general schedule is adhered to*. 3.2 Majority of time spent conducting routine child care tasks. ✋		5.1 Daily events are handled with flexibility. 5.2 Time spent is child driven, rather than caregiver driven (only occur when children are interested). 5.3 Uses routine times for learning experiences (Prime Times). 5.4 Caregiver spends majority of time engaging with children. 5.5 Uses appropriate curriculum (i.e., Creative Curriculum) N/A Option		7.1 Caregiver plans for transitions and these are handled with minimal stress on children (no long periods of waiting). 7.2 Allows for change in daily schedule based upon children's needs/interests.

* Read explanation of descriptors carefully for these items.

✋ To move further up the scale, this should be "No".

#7 Routines/Time Spent

General notes about this item

The indicators in this item relate to the ways in which the caregiver spends their time, as well as the routines that are established for the children in their care. While there are some definite differences in the needs for routines between the age groups (infants, toddlers, and preschoolers), they all have the same basic need for consistency balanced with flexibility.

A key element of this indicator is what is developmentally appropriate. Infants and younger toddlers should be cared for on an individual basis. A schedule, if defined as a set course of events, does not exist in an infant/young toddler room.[142] Rather, infants should be on a *self-demand schedule*, one in which infants communicate their own needs and caregivers respond appropriately (Gestwicki, 1999). This sensitivity builds an infant's sense of certainty that their needs will be met by responsive caregivers. In turn, they learn that the world is a safe and trustworthy place. Because younger toddlers still vary greatly in their individual development, still require flexibility in scheduling.

Older toddlers and preschoolers, on the other hand, are better able to adapt to schedules. Because of their need for routines, they require consistency and stability. This does not mean that their schedules need to be carved in stone. When working with children, flexibility is key. Children's interests should be encouraged, even when it does not fit with the proscribed schedule. The

schedule should, however, be predictable for them: They should know that outdoor time comes after circle time, nap comes after lunch, etc.

Because so much of caring for children involves "Prime Times"[143], this item stresses the importance of these times. Prime Times are identified as the basic of children's needs: food, sleep, toileting, and nurturing. Because these times account for a large part of infants, toddlers, preschoolers and caregivers day, these times can be used as rich learning experiences. These times can be used to focus on quality one-on-one interactions, regardless of the age group.

Preschoolers Detailed Description of Indicators

1.1 Places high value on obedience/compliance	Caregiver attempt to move all children through the same subskills in the same timeframe, although some children have already mastered them and others are not ready for them yet. Caregivers overschedule activities, so children become overtired from too much activity without respite. The schedule includes many transitions of activity, so children have insufficient time to become involved in a sustained investigation, dramatic-play interaction, or construction activity; children's behavior is restless and frenetic rather than interested and engaged[144].
1.2. Primarily does adult tasks while children are in care.	Please note the "primarily" notation in this item. Indicator of this would include: • Talking on the telephone • Doing routine tasks, such as cutting out shapes for future art activity, or cleaning toys. • Chatting with a coworker. While some of this activity is acceptable and unavoidable, it should be kept to a minimum (3 minutes). Take note of the children in care: Are their needs being met? Physically? Emotionally?

1.3 Routine times are not used as bonding/learning times.	Routines are dealt with hurriedly and indifferently, with efficiency as the priority. Examples of this include: • Caregiver does not use meal times as time to engage with children (i.e., does not sit with children, does not talk about what they are eating, engage in conversation). • Caregiver does not use times, such as putting on coats for outside play, as an opportunity to talk about children's color preferences, call attention to their new shoes, complement child on their polite behavior towards another child, etc..

3.1 A general schedule is adhered to.* **NOTE: This is different for infants versus toddlers and preschoolers.**	The environment and schedule have enough predictability and repetition to allow preschoolers to form expectations, repeatedly practice emerging skills, and feel the security of a familiar routine. While concrete, inflexible schedules are inappropriate, there should be some continuity of routines throughout the day so toddlers know the general course of daily events. For example, preschoolers should know that outside time comes after snack, or nap comes after lunch.
3.2 Majority of time spent conducting routine child care tasks. ✋ **To move further up the scale, this should be "No".**	The intention of this indicator is that the caregiver spends most of their time interacting with children in routine tasks, such as feeding, diapering, and napping. <u>This indicator is describing more functionary or custodial care.</u> Children's basic needs are met, with minimal amount of stress. The difference between this indicator and those at a higher level are that the focus of the caregiver is on these basic care routines, rather than engaging or expanding on child's learning.

5.1 Daily events are handled with flexibility	Time schedules are flexible and smooth, dictated more by children's needs than by adults'. There is a relatively predictable sequence to the day to help children feel secure. Adults adapt schedules and activities to meet individual children's needs within the group setting. Some examples of this include: • Preschoolers are not forced to participate in circle time when it is clear that most children are not interested. • Caregiver engages with children on the playground as they investigate worms in the dirt The intention of this item is that, while the caregiver provides structure to the children's daily routines and environment, she is also willing to "go with the flow" should children express interest in some other, unplanned activity.
5.2 Time spent is child driven, rather than caregiver driven.	Caregiver knows each child well and design activities based on their knowledge of individual children's differing abilities, developmental levels, and approaches to learning. Responsiveness to individual differences in children's abilities and interests is evident in the curriculum, adults' interactions, and the environment. Caregiver does not try and force children to engage in activities they clearly are not interested in, for example, circle or story time.

5.3 Uses routine times for learning experiences.	Adults recognize that routine tasks of living, such as eating, toileting, and dressing, are important opportunities to help children learn about their world, acquire skills, and regulate their own behavior. For example: • Meals and snacks include utensils that are easier for preschoolers to use, such as bowls, spoons, so they can help themselves. • Caregiver sits with children during meal times and uses this time to talk about healthy eating, polite manners, etc. • Caregiver helps children counts the number of steps it takes to get outside.
5.4 Caregiver spends majority of time engaging with children.	Caregiver not only actively engages children in routine tasks but also engages them with play and learning activities. Caregiver understands play is child's work and engages with them. The key to this indicator is the idea of engaging with the child. This implies an active, interactive, reciprocal involvement between caregiver and infant. Examples of this would include: • Reading books with interested children. • Actively helping children set up a block tower • Engages in pretend play activities with children Does the caregiver make eye contact with the children? Are they truly present with the child (focused) or are they just going through the motions?
5.5 Uses appropriate curriculum.	Examples of appropriate curriculum would be Creative Curriculum, Ages and Stages, etc.

N/A Option.	The intention of this item is not necessarily does an age appropriate curriculum exist, but if it is in place, is it used in an appropriate fashion? The key word here is uses – are the lesson plans followed?
7.1 Caregiver plans for transitions and these are handled with minimal stress on children (no long periods of waiting).	Transitions are times when children move from one activity to another. Because these transition times can be stressful on children, the caregiver needs to give some thought as to how they will move from one situation to the next. For example, transitioning preschoolers from toileting to mealtime time requires planning on the part of the caregiver. Does the caregiver have meals prepared and set out for children prior to calling them over to the table? Are children engaged with songs or finger plays so they are not focusing on the transition? The key to this item is that children are not left for long periods of time with nothing to do and no interaction. A long period of waiting between daily events is considered 3 minutes[145]. To receive credit for this item there should be NO long periods of waiting for any children.

7.2 Allows for changes in daily schedule based upon children's needs/interests.	Caregivers organizes the daily schedule to allow for alternating periods of active and quiet time, adequate nutrition, and naptime (for younger children). Adults allocate extended periods of time (at least one hour) for children to engage in play and projects. Children have ample time to explore and learn about the environment, investigate what sparks their curiosity, and experiment with cause-and-effect relationships. In accordance with children's developing capacities, caregivers incorporate experiences to enhance children's ability to actively listen and observe- for example, children listening to a peer describe an event and then having the opportunity to ask questions for clarification or respond with their own ideas[146].

Emotional Domain

#8 Physical Attention

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Negative physical contact (rough or abrupt handling). 1.2 Children are shifted from group to group or cared for by whatever adult is available at the moment. 1.3 Children's attempts to initiate physical contact discouraged/ rejected.		3.1 Positive physical contact (hug, sit, pat, hold child) during routines. 3.2 Children are cared for by familiar adults, but adults may vary from day to day. 3.3 Children's attempts to initiate physical contact are welcomed.		5.1 Sits on child's level so they can crawl in caregiver's lap. 5.2 Gently, physically redirects child when necessary. 5.3 Children are cared for by one or two primary caregivers who are familiar with their routines.		7.1 Physically demonstrates affection for children throughout the day (hugs, hand holding, kisses). 7.2 Physically assists child in developmental milestones.

#8 Physical Attention

General notes about this item

Children of all ages require interactions that nurtures trust. This includes the capacity to provide consistent responsiveness by the same adults. An environment of trust is a safe, familiar place that is predictable in the patterns of things, people and events (Bredekamp and Copple, 1997, p. 69).

The physical elements of trust development are imperative to infant development. As noted by Gestwicki (1999), *the holding, nuzzling, and belly kisses that are a part of warm caregiving interaction are as crucial as the physical elements of food and sleep to healthy growth* (p. 140). For toddlers, whose stage of development is all about autonomy, paradoxically, one of the most difficult things for them is separation from adults that are important to them. Toddlers feel most secure when their adults (parents and/or caregiver) are nearby. While toddlers are seeking independence, they need to kow that the caregiver is physically accessible to them when they need comfort (Gestwicki, 1999).

For preschool aged children, physical attention is also important. This stage is marked by the process of identification, where children move from wanting to be *near* the adults in their lives to being *like* them. Preschoolers *gradually depend less on attentions*

and constant assistance from adults, although they are still bound to them by affection, and thus a desire to please and be like them (Gestwicki, 1999, p. 96).

Preschoolers are very physically active beings. For the most part they have mastered many of the large motor activities of toddlerhood. In this stage, preschoolers are working on fine tuning these skills. The physically responsive caregiver is one that assists the preschooler in their attempt to increase their coordination. This can be evidenced, for example, by helping a child peddle a bike or pump on a swing.

In general, the physically responsive caregiver is aware and sensitive to the physical needs of children in his/her care, regardless of their stage of development. This is not to say that the caregiver imposes physical affection on a child who is less physically demonstrative or needy. The key component to this item is being physically available for any child as they need the attention.

Preschoolers Detailed Description of Indicators

1.1 Negative physical contact (rough or abrupt handling), OR there is no physical contact.	Adults are rough and inattentive, ignoring the child's limitations and responses. Children are abruptly moved about at the caregiver's convenience or irritation. OR Adults follow "no-touch policies" and do not recognize the importance of touch to children's healthy development[147].
1.2 Children are shifted from group to group or cared for by whatever adult is available at the moment.	Development and maintenance of one-to-one relationships are not given top priority. Children are shifted from group to group or cared for by whatever caregiver is available at the moment and thus are not able to form a relationship with one or two caregivers over time. High staff turnover results in low continuity and frequent disruption of children's attachment to caregivers[148]. Ask how long caregivers have been in this room. If they have been there for shorter than a year, ask about the previous caregiver's length of stay in this room. You need to understand if this is a pattern of behavior for this room (and center) or is this just a new caregiver?
1.3 Children's attempts to initiate physical contact discouraged/rejected.	Caregiver discourages physical contact initiated by child. For example, caregiver pushes child away as they try to crawl into lap. Caregiver physically shirks away from child's attempts at touch.

3.1 Positive physical contact (hug, sit, pat, hold child) during routines.	Caregiver provides physical contact and comfort to children during routine care. Do they snuggle and hug preschoolers who are distressed?
3.2 Children are cared for by familiar adults, but adults may vary from day to day.	Children are cared for by a primary caregiver, however, additional adults also provide care on a regular basis. For example, the caregiver may arrive for work at 9 a.m. Between the opening of the center and that time, a floater or several other staff may provide care. This person does not have to be the same one everyday, however, as long as the child is familiar with the caregivers.
3.3 Children's attempts to initiate physical contact are welcomed.	Caregiver responds to children's efforts at making physical contact. Caregiver recognizes child's attempts by reciprocating the touch, smiling or patting the child.

5.1 Sits on child's level so they can crawl in caregiver's lap.	Caregiver not only provides physical comfort during routine care, but also purposely sits on children's level so children can crawl in her lap or cuddle when they need it. Caregiver comforts children and let them know they are appreciated through warm responsive touches, such as giving pats on the back or hugs and holding preschoolers in their laps. Caregivers are sensitive to ensuring that their touches are welcomed by the children.[149] The intention of this item is that, when not engaging in routine care, the caregiver is physically accessible to children.

5.2 Gently, physically redirects child when necessary. **N/A Option If Not Observed.**	Adults patiently redirect children to help guide them toward controlling their own impulses and behavior. When children fight over the same toy, the caregiver provides another like it or removes the toy. If neither of these strategies is effective, the caregiver may gently redirect the children's attention by initiating play in another area[150].
5.3 Children are cared for by one or two primary caregivers who are familiar with their routines.	There is sufficient continuity of care to ensure that every child (and family) is able to form a relationship with a primary caregiver. The staffing pattern is designed to make sure there is continuity over time for each child's relationship with a primary caregiver. It is a priority to keep each preschooler in the same group, preferably year to year, to ensure that the child and a primary caregiver form and maintain a reciprocal relationship[151]? When in doubt, ask.

7.1 Physically demonstrates affection for children throughout the day (hugs, hand holding, kisses).	Caregiver physically demonstrates her affection for children through physical and emotional attention. Does he/she offer kisses and hugs to children? Does he/she return a child's hug with a pat on the back?
7.2 Physically assists child in development.	Caregiver provides physical assistance as children develop new skills. For example: • Physically helps child learn to pump on a swing. Shows child how to hop.

#9 Discipline

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 When children misbehave, they are handled abruptly or harshly. 1.2 Caregiver speaks with irritation or lectures when children misbehave. 1.3 Rules are not explained ("No, stop that!" with no reason why). 1.4 Children excluded from group – contained or restrained.		3.1 Children are redirected appropriately when they misbehave. 3.2 Expectations are generally age appropriate. 3.3 Rules are explained to children on a basic level.		5.1 A variety of options are used for children (i.e, duplicate toys, activities used to engage children when they misbehave). 5.2 Caregiver engages with children to prevent misbehavior before it occurs (is aware of the children's cues of frustration).		7.1 Caregiver actively and consciously stresses prosocial behavior and behavioral safety through books, actions and activities. 7.2 Caregiver helps children take the viewpoint of others when they misbehave (discusses consequences, explains how actions affect others). 7.3 Children involved in establishing rules. (N/A option for infants and toddlers).

9 Discipline

General notes about this item

The term discipline has numerous meanings. For example, the Webster's Dictionary offers several descriptions: to punish; teach obedience or order to; calm, controlled behavior; conscious control over lifestyle; and making people obey the rules. In early childhood literature (and this measure), the term discipline is defined as guidance. In this manner, the purpose of discipline is to assist children learn how to act in socially acceptable, established rules of behavior. For this context, discipline is defined by the ways in which a caregiver helps children manage their behavior.

While it may be clear that it is important for toddlers and preschoolers to learn discipline, the use of discipline with infants can be misleading. Very young infants do not tend to exhibit the same behavioral issues that older children demonstrate. However, if we see discipline as guidance, then it should be clear that all children, regardless of their age, benefit from positive discipline.

It should also be noted that this item is closely linked with developmentally age appropriate expectations for children. Again, young infants do not have the same understanding of their behavior that older children do. For the caregiver to identify a young infant is "misbehaving" is not appropriate. For example, a young baby who cannot fall asleep when the caregiver feels it should is not

misbehaving (no matter what the caregiver feels their motives are). There is a major difference between a child not being able to settle into sleep and one who is consciously demonstrating challenging behavior.

Please keep in mind that the term "misbehavior" for infants is not the same as for older toddlers and preschoolers. Misbehavior for infants should be thought of as less than desirable behavior, rather than behavior that is intentionally defiant.

Preschoolers Detailed Description of Indicators

1.1 When children misbehave, they are handled abruptly or harshly.	Caregiver reacts harshly to preschooler's misbehavior. Obvious frustration is exhibited in response to children's non-compliant behavior? For example, children are handled brusquely, picked up in a rough manner.
1.2 Caregiver speaks with irritation or lectures when children misbehave	Caregiver expresses that child has purposefully misbehaved and is obviously irritated and frustrated. Caregiver raises voice, speaks with annoyance to children. Caregiver lectures children, unleashing a monologue of displeasure. Caregiver punishes perceived infractions harshly, frightening and humiliating children. Caregiver spend a great deal of time punishing unacceptable behavior, demeaning children who misbehave, repeatedly putting the same children who misbehave in time-out or some other punishment unrelated to the action, or refereeing disagreements[152].
1.3 Rules are not explained ("No, stop that!" with no reason why).	Caregivers do not set clear limits and do not hold children accountable to standards of acceptable behavior. The environment is chaotic, and adults do not help children set and learn important rules of group behavior and responsibility.[153] The sense of community is undermined by caregivers' behaviors and techniques- for example, encouraging or allowing chronic tattling, scapegoating, teasing, or other practices that turn children against each other; or setting up games or situations in which the same children are always chosen and less-popular children are left out.[154]

1.4 Children excluded from group – contained or restrained.	Children who are "misbehaving" are excluded from group activities in an attempt to control their behavior. Please keep in mind this is a discipline item – the intention is not that children are physically in locations apart from the group. The question is, are they separated from the group as a form of punishment? Or is it because of their individual interest? Separating more aggressive children from the group may be appropriate (i.e., Time Out). However, the children should not be restrained or physically confined as a way of disengaging them from the group.

3.1 Children are redirected appropriately when they misbehave.	Caregiver patiently redirects preschoolers to help guide them toward controlling their own impulses and behavior. Children are steered towards other play materials rather than allowing crowding around one toy or activity.
3.2 Expectations are generally age appropriate.	Realistic expectations are based on the age and developmental stage of the children in care. For example: • Does not expect preschoolers to sit for long periods of time. • Children are given a variety of options and choices. • Does not expect children to accurately complete ditto sheets.

3.3 Rules are explained to children on a basic level.	Caregiver provides clear, concise explanation of the rules to toddlers. For example: • "We don't hit because it hurts". • "We don't climb up the slide because we may get hurt when our friends are coming down. While these explanations can be more indepth than those offered younger children, they should not be overly long (See indicator 1.2). Caregivers give clear sanctions for overtly dangerous behavior. For example: • Children who are repeatedly physically aggressive are moved to a quiet space where they can compose themselves. •

5.1 A variety of options are used for children (i.e, duplicate toys, activities used to engage children when they misbehave).	Caregiver uses a variety of options when undesirable behavior occurs. For example: • When children fight over the same toy, the adult provides another like it or removes the toy. If neither of these strategies is effective, the caregiver may gently redirect the children's attention by initiating play in another area.

5.2 Caregiver engages with children to prevent misbehavior before it occurs (is aware of the children's cues of frustration).	Caregiver is aware of children's cues of frustration and helps redirect or alleviate prior to misbehavior. Watches children closely and knows when to step in. For example: • Caregiver sees that several children in the block area are becoming increasingly aggressive with the blocks. He/she redirects them to a more positive interaction. • Caregiver notices several children vying for a ball. He/she calls them over and gets enough for them to each have one.

7.1 Caregiver actively and consciously stresses prosocial behavior and behavioral safety through books, actions and activities.	Caregiver uses books, pictures, and activities to stress positive behavior. Caregiver facilitates the development of social skills, self-control, and self-regulation in children by using positive guidance techniques, such as modeling and encouraging expected behavior, redirecting children to more acceptable activities, setting clear limits, and intervening to enforce consequences for unacceptable, harmful behavior. Expectations respect children's developing capabilities. Caregivers are patient, realizing that not every minor infraction warrants a response[155].
7.3 Caregiver helps children take the viewpoint of others when they misbehave (discusses consequences, explains how actions affect others).	When children misbehave, caregiver helps them take the perspective of others. For example: • Explains why we don't shove others. • Encourages the offended child to talk about how the offence made him/her feel.

7.3 Children involved in establishing rules.	Caregiver engages children to create classroom rules of behavior. For example, no hitting, being kind to others, etc. Look around the room for evidence of this. If children help create the rules, there tends to be a list of basic rules displayed. If you see this, ask the caregiver if children helped in creating those rules.

#10 Language Development

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Ignores children's attempts at communication. 1.2 Talks over children as they talk. 1.3 Uses terms that are unfamiliar to children. 1.4 Calls all children the same name so they are not sure who is being addressed).		3.1 Acknowledges children's attempts at communication. Nods, makes eye contact, attempts to decipher child's needs and vocalizations. 3.2 Verbally responds to child's cues of distress. 3.3 Uses individual child's names when speaking with them. 3.4 Uses terms that are familiar to children.		5.1 Listens attentively when children speak. Rephrases their conversations. 5.2 Dialogues with children. Conversation is interactive. 5.3 Checks for clarification when talking to children. Make sure they understand what is being said. 5.4 Uses clear, one step directions. 5.5 Models appropriate use of language (tense, vocabulary, etc.).		7.1 Adds to children's attempts to dialogue; adds words and explanations to talk. 7.2 Helps children understand their feelings and emotions by labeling communication. 7.3 Encourages verbal communication. 7.4 Fosters conversations between children.

#10 Language Development

General notes about this item

Young children develop their language skills through interactions with more accomplished speakers of the language, such as parents, family members, and teachers, as well as other children. Research indicates the amount of verbal stimulation and opportunities for two-way communication provided by adults has been found to be statistically significant with the child's level of language development (Carew, 1980; Golden et al, 1979; Melhuish et al., 1990), as well as the child's level of social competence (Clarke-Stewart, 1987; Phillips et al., 1987). Additionally, Clarke-Stewart (1987) found that children in home-based child care scored highest on intellectual assessments and social competence when their caregivers consistently had one-to-one conversations with them (as cited by Doherty-Derkowski, 1995). According to Snow, Burns and Griffin (1998),

> Early childhood teachers need to know the value of one-to-one, extended, cognitively challenging conversations and how to engage in such communication, even with reluctant talkers. They need to know how the lexicon is acquired and what instructional practices support vocabulary acquisition. They also need to know how to conduct story reading and other early literacy experiences that promote phonological awareness and prepare children for later success in reading.

Preschoolers Detailed Description of Indicators

1.1 Ignores children's attempts at communication.	Adult agendas dominate classroom conversations. Children's responses or reactions are often viewed as interruptions of the adult's talk or work. Caregivers make it a priority to maintain a quiet environment; they ignore, reprimand, or punish children for talking or for not waiting to be called on. OR: For the most part, caregivers address individual children only to reprimand or discipline them. Caregiver unable to read children's attempts to communicate.
1.2 Talks over children as they talk.	Adults do not wait for children to finish speaking before they start to talk. Caregiver's speech is mostly one-way – for instance, much more often telling children what to do than facilitating back-and-forth exchanges -and usually to the group as a whole.
1.3 Uses terms that are unfamiliar to children.	Caregivers "talk down" to children, asking questions children are not really meant to answer or using "baby talk" with preschoolers and kindergartners.

1.4 Calls all children the same name so they are not sure who is being addressed.	Caregiver does not call children by their individual name. Instead, uses "cutsie" terms, such as hon, rosebud, or sweetie so children are unsure who is being addressed. This is not to say it is inappropriate for caregiver to use terms of endearment. The key is looking at how the children respond. Do they seem confused? Do they know they are the sweetie that is being addressed?

3.1 Acknowledges child's attempts at communication.	All interactions are characterized by gentle, supportive responses. Caregivers observe, listen and respond to what the child is saying. Caregiver nods, makes eye contact, attempts to decipher child's needs and vocalizations.
3.2 Verbally responds to child's cries of distress.	Adults respond quickly to children's cries or other signs of distress, recognizing that preschoolers can have limited language with which to communicate their needs and need assistance in sorting out disputes.
3.3 Uses individual child's names when speaking with them.	Caregivers recognize and support each child's individuation by using their name when speaking to them. Using each person's name also ensures that children know they are being addressed and can respond appropriately.

3.4 Uses terms that are familiar to children.	Caregiver speaks to the children in a way that they know what is asked of them or what they are being told. They understand the words caregiver uses. The caregiver uses speech that helps to facilitate language. For example, uses words to expand children's vocabulary. The intention of this item, however, is that caregiver checks with child for clarification and understanding.

5.1 Listens attentively when children speak. Rephrases their conversations.	Caregiver initiates a conversation with a child and gives the child ample time to respond. Caregivers also listen attentively for children's verbal initiations and respond to these. Adult's label or name objects, describe events, and reflect feelings to help children to learn new words.
5.2 Dialogues with children. Conversation is interactive.	Caregiver encourages children's developing language and communication skills by talking with them throughout the day, speaking clearly and listening to their responses, and providing opportunities for them to talk to each other. Caregivers engage individual children and groups in conversations about real experiences, projects, and current events; they encourage children to describe their products or ideas, and they respond attentively to children's verbal initiatives.

5.3 Checks for clarification when talking to children. Make sure they understand what is being said.	Caregiver demonstrates their respect for children by making sure they understand what is being said and seeking confirmation. For example: • "Would you like some more juice?" (Waits for response). • "Kyle, please hand me that green paper." Do you see it?" • "Julie, what color paint would you like?" This clarification expands children's language and increases their knowledge of the world around them. It also helps to cut down on discipline challenges because children are clear of what is expected of them.
5.4 Uses clear, one step directions.	Caregivers simplify their language for children who are easily distracted. For example" • "Let's wash our hands." • "I'll read you this story." • "It's time for lunch". Versus: "Let's wash our hands, then I'll read you this story and then it will be time for lunch."
5.5 Models appropriate use of language (tense, vocabulary, etc.).	Caregiver uses correct and appropriate grammar, vocabulary, etc. Caregiver does not necessarily need to constantly correct the child's use of words; rather they need to demonstrate the appropriate use of language themselves. (For example, not using words like "ain't").

7.1 Adds to children's attempts to dialogue; adds words and explanations to talk.	As children acquire their own words, caregivers expand on the child's language. For example: • "Yes, that is a dinosaur. It is a stegosaurus." • "That fruit is like an orange, only it's called a tangerine."
7.2 Helps children understand their feelings and emotions by labeling communication.	Caregiver assists in children's budding social/emotional awareness by helping to label their feelings and emotions. For example? • "Zach, you seem very frustrated with that toy." • "Did it surprise you when your friend jumped in front of you?"
7.3 Encourages verbal communication.	Caregiver encourages children to expand their verbal communication. For example, • "What did you do when you went to the park?" • "What happened when you played with your cousin?"
7.4 Fosters conversations between children.	Caregiver encourages dialogue between children. The caregiver can model that behavior and offer prompts from one child to another. For example, "Timothy, tell Jon about your visit to the train station."

#11 Learning Opportunities

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Does not provide children with learning activities. 1.2 Minimal learning opportunities are available for children.		3.1 Offers child play opportunities. 3.2 Less involved children are drawn in to play. 3.3 Caregiver uses materials to spark interest of children.		5.1 Facilitates children's use of play materials. 5.2 Provides encouragement and praise for successful accomplishments in play. 5.3 Sets up environment /activities to foster development		7.1 Explains the reason for things. 7.2 Encourages children to think for themselves 7.3 Is aware of child's skill level and engages them with materials that expand their skills.

11 Learning Opportunities

General notes about this item

DAP identifies that *early experiences have both a cumulative and delayed effect on individual children's development; optimal periods exist for certain types of development and learning* (Gestwicki, 1999, p. 9). The repeated experiences of children, both positive and negative, have implications for later development. For example, children who are provided the opportunity to develop social skills through play with peers in preschool tend to develop confidence and competence in their social relations with others. These experiences allow them to develop familiarity and competence when engaging with their peers as they enter elementary school. They are better able to enter group learning experiences with more ease then children who do not experience these earlier social experiences. As cited by Gestwicki, *times of readiness for optimal learning occur in the early years and need to be taken advantage of in planning curricular experiences; for example, growing neurobiological evidence indicates that the social and sensorimotor experiences of the first years affect brain development, with lasting implications for children's learning,* (p. 9).

Preschoolers Detailed Description of Indicators

1.1 Does not provide children with learning activities.	The program provides few or no opportunities for children's choices. The caregiver does much of the activity for the children, such as cutting shapes or performing steps in an experiment. Children's alternative ways of doing things are rejected; copying the adult's model is considered more important. The same materials are available day after day. Children have few new experiences from which to choose, either in terms of materials or the degree of challenge[156].
5.1 **Minimal learning opportunities are available for children.**	The environment is disorderly, with little structure or predictability; children wander aimlessly without purpose or direction. The environment and materials provide too little variety, interest, or choice for children (for instance, puzzles are too easy or are missing pieces). The noise level is stressful for children and adults, impeding conversation and learning. The organization of the environment severely limits children's interaction with other children and their opportunities to pursue engaging learning experiences. For example, children have to stay in their seats throughout most of the day or have to always ask caregiver for materials.[157]

3.1 Offers child play opportunities.	Caregiver offers children age appropriate play materials. For this item, caregiver does not have to actively engage with children in play. Merely placing materials in the proximity of children where they can access is sufficient.
5.1 **Less involved children are drawn in to play.**	All children are drawn in to play. Children who are roaming are encouraged to play activities or materials. Children who are sitting by themselves are offered options. Care should be given when scoring this item. The intention is not that children are pressured into play. Rather, intent is that the caregiver is aware of the children and provides them opportunities. If a child is contentedly reading a book, they do not need to be given other opportunities; they already are involved. However, the child that is just sitting on the floor, staring off in space, should be connected with.
5.1 **Caregiver uses materials to spark interest of children.**	Caregiver uses materials to spark children's interest and attention. For example, hands child a book, hugs stuffed animal, or pretend feeds a baby. To receive credit for this item, caregiver does not have to continue to engage in play after drawing the child to this item.

5.1 Facilitates children's use of play materials.	Caregiver plans a variety of concrete learning experiences with materials and people relevant to children's own life experiences and that promote their interest, engagement in learning, and conceptual development. Materials include, but are not limited to, blocks and other construction materials, books and other language-arts materials, dramatic-play themes and props, art and modeling materials, sand and water with tools for measuring, and tools for simple science activities[158].
5.2 Provides encouragement and praise for successful accomplishments in play.	Provides praise for children's successful accomplishments. For example, successfully building a block tower, completing a puzzle, or conducting science experiment. Caregivers use verbal encouragement in ways that are genuine and related to an actual task or behavior, acknowledging children's work with specific comments like, "I see you drew your older sister bigger than your brother."[159] In addition, praise is given when preschooler is successful with newly acquired physical accomplishments, such as pumping on a swing or riding a bike.

5.3 Sets up environment /activities to foster development	Caregiver creates opportunities, through activities or environment that encourage child's exploration and development.

7.1 Explains the reason for things:	Caregiver's draw on children's curiosity and desire to make sense of their world to motivate them to become involved in interesting learning activities.[160] Explanations should be given in simple ways. The intention is to encourage children to think about cause and effect, without overwhelming them with detail. For example: • "We hold onto the rail when we go downstairs. This is so we don't fall." • "The rock sinks in the water because it is heavy."
7.2 Encourages children to think for themselves.	Caregiver stimulates and supports children's engagement in play and child-chosen activities. Adults extend the child's thinking and learning within these child-initiated activities by posing problems, asking questions making suggestions, adding complexity to tasks, and providing information, materials, and assistance as needed to enable a child to consolidate learning and to move to the next level of functioning. To help children acquire new skills or understanding, caregivers select from a range of strategies, such as asking questions, offering cues or suggestions, demonstrating a skill, adding more complex materials or ideas to a situation, or providing an opportunity for collaborating with peers. Caregivers prepare a learning environment that fosters children's initiative, active exploration of materials, and sustained engagement

	with other children, adults, and activities. In choosing materials and equipment, adults consider children's developmental levels and the social/cultural context, for instance, the geographic location of the program and the backgrounds of the children.[161].
7.3 Is aware of child's skill level and engages them with materials that expand their skills.	To develop children's self-confidence and positive feelings toward learning, caregiver provides opportunities for children to accomplish meaningful tasks and to participate in learning experiences in which they can succeed most of the time and yet be challenged to work on the edge of their developing capabilities. Caregivers observe and interact with individuals and small groups of children in all contexts (including teacher-planned and child-chosen learning experiences) to maximize their knowledge of what children can do and what each child is capable of doing with and without coaching, scaffolding, or other supportive assistance.[162]

#12 Involvement with Children's Activities

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Is disinterested in child's activities and playtime. 1.2 Interaction with children occurs only during routine care: Feeding, toileting, napping. 1.3 Allows children to become frustrated by tasks they cannot do.		3.1 Verbally acknowledges children's activities. 3.2 Provides a variety of materials for children's play.		5.1 Actively engages in child's play. 5.2 Provides/creates play experiences for children. 5.3 Models appropriate play. .		7.1 Provides additional play experiences to expand on child's interests. 7.2 Talks to children to extend conversation when playing together.

#12 Involvement with Children's Activities

General notes about this item

Children are active learners, drawing from their physical and social experiences, as well as knowledge that is culturally transmitted. This allows them to construct their own understanding of their world. This intellectual development occurs by the child's constructivist interaction with people, materials, activities and experiences. As children create and test their own hypothesis about how the world works, their thought processes and mental structures undergo constant revisions. Appropriate caregiver interaction and experiences provide the encouragement for these constructions. Positive caregiver interactions and teaching strategies should support children's active learning and rely less on direct communication of knowledge that young children have not created themselves (Gestwicki, 1999, p. 10).

According to Bredekamp and Copple (1997), *child-initiated learning does not occur in the absences of caregiver guidance or input* (p. 118). As noted by Doherty-Derkowski (1995)

> *it is not sufficient enough to provide a variety of stimulating materials and an environment that encourages exploration and interaction. The adult must select and prepare the environment, then observe, guide, and assist the children so that they are challenged and supported in gaining information and an understanding of how things work* (p. 58).

Preschoolers Detailed Description of Indicators

1.1 Is disinterested in child's activities and playtime.	Caregiver has little interest in children's activities. Does not engage with children at play. Seems emotionally detached or distant from children; does not touch them or make conversation.
1.2 Interaction with children occurs only during routine care: Feeding, diapering.	Caregiver provides attention and interaction to children only during routine care activities, such as toileting, feeding, and naptime. This interaction is done swiftly and with little caring interaction.
1.3 Allows children to become frustrated by tasks they cannot do.	Because caregiver is disinterested and removed from children, the children become frustrated by tasks they cannot do. Caregiver is so uninvolved with child's play that they are left to play on their own, with no adult interaction or facilitation. For example: • Preschooler is trying to do a puzzle that is difficult for him. Because caregiver is not involved or interested, he quickly escalates because of frustration.

3.1 Verbally acknowledges children's activities.	Caregiver acknowledges children as they play. He/she does not need to be actively physically involved with preschoolers to receive credit for this item. For example, caregiver may acknowledge child's play activities ("Are you getting ready for work?") as they are playing with another child. The intention of this item is that the caregiver provides recognition and awareness of all children's activities.

3.2 Provides a variety of play materials.	Materials are provided for children so they have options and choices. To receive credit for this item, caregiver does not have to actively play with children. They must, however, make sure children can access the materials on their own. For example: • Children are provided a variety of age appropriate materials, such as books, fine motor, and family living. • Materials provided are for various skill levels.

5.1 Actively engages in child's play	Caregivers engage in reciprocal play with children, modeling for them how to play imaginatively, such as playing "grocery store." Caregivers also support child's play so that children stay interested in an object or activity for longer periods of time and their play becomes more complex, moving from simple awareness and exploration of objects to more complicated pretending.[163]
5.2 Provides play experiences for children.	Caregiver provides play opportunities for children. For example, engages children with sand or water play, art activities, etc. The intention of this item is the caregiver is actively engaged with the child in their play experiences.
5.3 Models appropriate play.	Caregiver helps children understand the use of play equipment. For example: • Demonstrates how to use magnets. • Explains what a cash register is and how it is used when playing grocery store.

7.1 Provides additional play experiences to expand on child's interests.	Caregiver routinely provides additional play experiences for children. These are activities that require adult intervention to engage. For example: • Plants flowers with children in the spring. • Helps children make a snowman in the winter. • Sets up obstacle course.
7.2 Talks to children to extend conversation when playing together.	Offers a language rich environment. Continuously talks with children to expand their conversations and language. Labels actions, items and events. For example: • "I like your picture. Can you tell me about it?" • "I went to the movies last night. What did you do? Was that fun? What did you like best?"

#13 Symbolic and Literacy Interaction

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Any materials are inappropriate for children; materials are scary or violent. 1.2 Children are forced to participate, even when they are no longer interested. 1.3 No literacy materials present. 1.4 Materials are in poor repair.		3.1 Materials are generally appropriate for children. 3.2 Children are engaged only as long as they are interested 3.3 Materials are present but caregiver does not encourage or facilitate use. ✋ .		5.1 Caregiver provides a wide range of literacy and symbolic materials which children have access to during freeplay. All age appropriate. 5.2 Caregiver reads to children throughout the day. 5.3 Caregiver talks about pictures or mobiles.		7.1 Caregiver uses literacy and symbolic materials regularly (daily) that expands on themes or activities in the classroom. 7.2 Children are encouraged to bring materials from home that add to the themes (i.e., books, stuffed animals, etc.). 7.3 Caregiver relates print to verbal communication (N/A Option for Infants).

✋ To move further up the scale, this should be "No".

#13 Symbolic and Literacy Interaction

General notes about this item

Reading books to children, starting in infancy, is important for several reasons. This activity leads to positive associations of books and reading for pleasure. Children should be exposed to a wide array of reading materials (Barclay et al., 1995) In addition to creating a good beginning for early literacy, language acquisition is *nurtured by hearing the words, watching the adult point to large, clear pictures, going back through the same book and hearing the same words, and making the same visual connections* (Gestwicki, 1999, p. 224).

Whole language is the belief that learning oral and written language is a continual process that takes place at the same time and starts at birth. According to Bird 1987; Pearson, 1990),

> *children are motivated to find ways to represent their experiences both through play and action, and through communication. Children learn that communication meets their needs, brings pleasure and friendship, and helps them understand their culture. As they are exposed to literacy, they discover that oral and written language are related and that print is another form of communication. Reading and writing are then viewed as part of a larger system for accomplishing their goals* (Gestwicki, 1999, p. 263).

Along with adults providing meaningful literacy materials, activities, and support, this awareness and motivation combine to develop emergent literacy (Sawyer and Sawyer, 1993). Children use continually, experience how print language functions, and move themselves *into print media experiences* (Gestwicki, 1999, p. 263). There is no start point where children are asked to study language

arts. *There is continuity between all language experiences, from birth through the primary years, not a discontinuity of "now it's time to learn to read"* (Gestwicki, p. 263).

Preschoolers Detailed Description of Indicators

1.1 Any materials are inappropriate for children; materials are scary or violent.	Any books or pictures that are inappropriate to children. These can include materials that are scary, violent, or disturbing. For example, while pictures that promote emotional awareness are desired, ones that depict children crying are not acceptable. This seems to be an issue in many centers that share space with churches. Are there any pictures that depict Noah's Ark and the flood? This material can be quite frightening to small children.
1.2 Children are forced to participate, even when they are no longer interested.	Caregiver insists on reading to children even when they are not interested. Caregiver is more interested in getting through the story than the child's attention. Children are forced to sit and listen to a story when they clearly are not interested.
1.3 No literacy materials present.	Books are not available to children. Caregivers feel literacy materials are not necessary for children because they get torn or soiled. If there are no books present, do not give credit for this item. If caregiver tells you there are usually books but, for whatever reason, they aren't there, do not give credit for this item. There are no pictures or mobiles available for children to look at.

1.4 Materials are in poor repair.	Books are torn, pages missing, out of date or dirty.

3.1 Materials are generally appropriate for children.	All literacy materials and pictures are appropriate for children. These include books that are appropriate for a wide range of developmental abilities, such as sturdy books, children's story books, or magazines and catalogues. Look at the age and development of children in care. Do they seem satisfied and interested in the level of literacy materials present?
3.2 Children are engaged only as long as they are interested	Caregiver reads books and points out pictures to children depending upon their interest. Children are not forced to sit and listen to a story. Caregiver points out pictures to children but only engages while child is interested. Caregiver reads to large and small groups, as well as individual children.
3.3 Materials are present but caregiver does not encourage or facilitate use. **To move further up the scale, this should be "No".**	Children's books are present and provided to children to play with for freeplay. To receive credit for this item, caregiver does not have to read to children. Merely having literacy materials (books and picture) present is sufficient.

5.1 Caregiver provides a wide range of literacy and symbolic materials which children have access to during freeplay (Need # and type). All age appropriate.	Between the ages of 3 and 5, children learn an average of 50 new words per month[164]. Because of this, children should be exposed to a wide range of books and pictures for children. Content should include a wide variety, including: • Nature/Science • Cultural Diversity • Animals • Work Pictures represent people of different ages, racial and cultural groups, family types, occupations, and abilities/disabilities[165].
5.2 Caregiver reads to children throughout the day.	Caregiver reads informally to children throughout the day. Caregiver consciously encourages the use of literacy materials to aid in the expansion of child's language. Caregiver reads to children in both large and small groups, as well as to individual children.
5.3 Caregiver talks about pictures or mobiles.	Caregiver points out pictures and mobiles to children. Encourages them to look at the materials and uses to facilitate talk.

7.1 Caregiver uses literacy and symbolic materials regularly (daily) that expands on themes or activities in the classroom.	Caregiver uses books, pictures, and music to expand on themes. For example, uses books about different jobs when talking about work, or songs when talking about different cultures.

7.2 Children are encouraged to bring materials from home that add to the themes (i.e., books, stuffed animals, etc.)	Children are encouraged to bring in books or materials from home to add to classroom themes. For example, child brings in a book about fish from home during the week of "ocean" theme.
7.3 Caregiver relates print to verbal communication.	This can occur in a variety of ways. For example, caregiver asks children about their drawings and communicates this on their pictures. Caregiver can also ask children about their preferences, such as taking a classroom poll, and write up the results. To receive credit for this item, you must see at least one instance in the classroom.

Connection with a Wider World

#14 Promotion of Prosocial Behavior/SEL

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 No evidence of promotion of SEL (no pictures, books or activities). 1.2 Negative peer interaction is ignored.		3.1 Evidence of SEL in the classroom. 3.2 Caregiver verbally reminds children of positive SEL. 3.3 Environment is set up so there are few instances of aggressive behavior.		5.1 Children are helped to acknowledge the viewpoint of others. 5.2 Encouragement of verbal behavior for conflict resolution. 5.3 Children are praised for prosocial behavior.		7.1 Everyday experiences are used as SEL learning. Caregiver looks for teachable moments. 7.2 Use of SEL curriculum used effectively (First Step, Preschool PATHS).

#14 Promotion of Prosocial Behavior/SEL

General notes about this item

According to Gestwicki, 1999, when caregivers *verbalize others' feelings, and their concern for them, children are gradually led toward understanding how others feel and what responses are appropriate to those feelings. Caregivers help promote prosocial awareness and learning by deliberately devising opportunities for children to participate in situations that foster kindness* (p. 177).

As stated by Howes and Ritchie (2002),

> Adults who act as coaches for children's expression and modulation of emotion and focus on social content are linked to children who are more successful at effortful control and emotional regulation. Adult emotional coaching includes responding to emotional displays, labeling the emotions, and in a supportive manner helping children with strategies to modulate their emotional displays. When adults coach children, the children are helped to develop their ability to inhibit negative affect, to self sooth, and to focus their attention on the social context (p. 42).

Preschoolers Detailed Description of Indicators

1.1 No evidence of promotion of SEL.	No efforts are made to build a sense of the group as a community. To maintain classroom order, caregivers continually separate children from friends and discourage conversation. Some children who lack social skills are isolated or rejected by peers and receive no help or support from teachers in developing positive relationships with others. Caregivers frequently group children or set up competing teams by age, gender, or other ways that may diminish children's sense of their being part of a whole group. Adults do not help children develop feelings of caring and empathy for each other. Children are expected to work individually at desks or tables most of the time. Caregiver's directions are typically given to the total group, with few opportunities for meaningful social interaction with other children. Adults rarely use children's social relationships as a vehicle to address learning goals. Teaching strategies are not designated to support children's social competence[166].
1.2 Negative peer interaction is ignored.	Adults do not anticipate actions of children to prevent them from getting hurt or hurting others nor do they model for children the words to say. The sense of community is undermined by teachers' behaviors and techniques- for example, encouraging or allowing chronic tattling, scapegoating, teasing, or other practices that turn children against each other; or setting up games or situations in which the same children are always chosen and less-popular children are left out.[167]

3.1 Evidence of SEL in the classroom.	Social/emotional awareness is evident in the room. This can be seen in various ways: • Through the caregiver's actions (saying "please" and "thank you" to children, modeling the appropriate behavior, using kind words and tone. • The display of pictures that depict emotional learning (pictures with faces of varying emotions). • Books that focus on emotions and social skills.
3.2 Caregiver verbally reminds children of positive SEL.	Caregiver reminds children the appropriate words to accompany actions. For example: • Prompts one child to thank another child who shares a toy. • Children are expected to use "please" and "thank you" in all interactions.
3.3 Environment is set up so there are few instances of aggressive behavior.	Caregiver engages children and the environment so there are few instances of aggressive behavior. For example, • Provide enough materials so children do not argue over toys. • Enough options are available so children can have choices.

5.1 Children are helped to acknowledge the viewpoint of others.	Caregiver uses a variety of methods to encourage children to acknowledge the view of others. For example: • Points out the reaction of a child who is upset. • Identifies facial emotions of characters in a book. • Caregiver talks about their own feelings. ("It is such a beautiful day today, I feel happy.") • Caregiver asks children to identify their own feelings. Caregiver ensures that classrooms or groups of young children function as caring communities. They help children learn how to establish positive, constructive relationships with adults and other children. Adult supports children's beginning friendships and provide opportunities for children to learn from each other as well as adults[168].
5.2 Encouragement of verbal behavior for conflict resolution.	Caregiver reminds children to use words to resolve conflicts. Caregiver models this behavior for children. For example: • When one child takes a toy from another, caregiver prompts the offended child, "Say, please do not take my block. I was playing with that."

5.3 Children are praised for prosocial behavior.	Caregiver values prosocial behavior and praises children for their actions. For example: • A child gives another a welcome hug. Caregiver identifies this as nice gesture. • One child lets another go ahead on the slide. Caregiver calls attention to this behavior.

7.1 Everyday experiences are used as SEL learning. Caregiver looks for teachable moments.	Recognizing the value of working and playing collaboratively, caregiver provides many opportunities for children to work in small, flexible groups that children informally create or the teacher organizes. Whole-group time is used as an opportunity to build a sense of community and shared purpose, such as through circle time, storytelling (about children's experiences), problem-solving as a group, or taking attendance by asking the group of children, "Who is absent today?" As each child encounters what others in the group think, say, and create, the child's own knowledge and understanding grow and change. Caregivers use many strategies to help build a sense of the group as a cohesive community. The children sometimes work on group activities that all can identify with, such as creating a mural for the classroom or planning a surprise event for parents. Adults engage children in experiences that demonstrate the explicit valuing of each child, such as sending a "We miss you!" card to a sick classmate[169]. Caregiver provides many opportunities for children to learn to work collaboratively with others and to socially construct knowledge as well as develop social skills, such as cooperating,

	helping, negotiating, and talking with other people to solve problems. Adults foster the development of social skills and group problem solving at all times through modeling, coaching, grouping, and other strategies[170].
7.2 Use of SEL curriculum used effectively (First Step, Preschool PATHS). **N/A if not used**	The key with this indicator is not whether the curriculum is used, rather it is used effectively. You do not need to know a great deal about the curriculum to score this item. To determine this, first, identify if the curriculum is used. Then, note the caregiver's tone of voice (#1), acceptance/respect for children (#2), and discipline (#10). If either of these curriculum are being used, the caregiver will speak respectfully towards children and positive discipline will be used.

#15 Engaging Children With Special Needs

(NA Option)

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Children with special needs kept separate from group. 1.2 Caregiver seems uncomfortable interacting with, or caring for, children with special needs. 1.3 No adaptive equiptment/ methods used even when warranted (ie., bracing, seating adaptations, etc). 1.4 The rest of the group is penalized because of perceived limitations.		3.1 Children with special needs included in the group. 3.2 Some adaptations made to help include child in activities (i.e., seat in circle for child who is unstable). 3.3 Adaptations are adequate, but make child with special needs "different"		5.1 Children with special needs are not immediately recognizable to outside observer. 5.2 Activities are planned so that all children can be successful/ participate. 5.3 Caregivers are comfortable interacting with/caring for children with special needs. 5.4 Caregivers seek info from parents /therapists on proper techniques.		7.1 Children with special needs are active /equal members of the group. 7.2 Adaptive materials blend into classroom materials (i.e., all chairs match, some have belts /positioners). 7.3 Caregivers are included as part of IFSP /IEP team. 7.4 Caregivers involved in implementing objectives of IFSP /IEP.

#15 Engaging With Special Needs Children

General notes about this item

A child is considered to have special needs whenever they require help and information beyond what is *normally required by a child of the same age in order to assure the best developmental outcome* (Canning & Lynn, 1990, as cited by Doherty-Derkowski, 1995, p. 133). Mainstreaming or integration is the term given to the approach of including children with special needs in child care programs with children who do not have special needs. This approach is based on research indicating children with special needs will benefit because:

> The children who do not have special needs will model (demonstrate) age-appropriate behaviors for the children with special needs and these children will imitate such behaviors; the mainstreamed setting will provide a more advanced linguistic, social, and cognitive environment than would be provided in a segregated program; and children with disabilities who are in a mainstreamed program will learn to be comfortable with non-disabled peers (Striefel et al., 1991, p. 135)

The caregiver has a large role in providing support and facilitating positive peer interaction between the child with special needs and their normally developing peers. Research indicates that without encouragement, normally developing children interact more frequently with other normally developing peers or with those who have a mild disability than with peers who have a moderate

or severe disability. In conclusion, Odom and McEvoy (1988) report that social interaction will generally not occur between children with moderate or severe disabilities and non-disabled children unless it is specifically encouraged by caregiving staff.

It should be clear that the inclusion of this item is not meant to be viewed as being all that is required when a child with special needs is enrolled in the child care program. The substantial body of research cited for the other items are the same for children with special needs. The inclusion of this item recognizes that a caregiver with a special needs child attending his/her program also has additional requirements to consider.

Preschoolers Detailed Description of Indicators

1.1 Children with special needs kept separate from group.	Is the child with special needs kept contained in an adaptive seat, etc., not interacting with the rest of the group? Is special needs child separated from group "for their own good", for most of the day? This is not to say that children cannot be placed in these types of apparatus. The question you should ask is why. If the child is content, that is one thing. If the caregiver contains the child to keep them away from the group, that is another.
1.2 Caregiver seems uncomfortable interacting with, or caring for, children with special needs.	Look at caregiver's reactions to the child with special needs. Does he/she seem awkward with the child?
No adaptive equipment /methods used even when warranted (i.e., bracing, seating adaptations, etc.).	N/A if this does not pertain to the children in the observed room. If needed, is the necessary equipment available to provide adequate care? For example, is there a seat that provides straps/braces for the child who needs additional support? Please note, caregiver can be creative in developing materials – for example, using rolled blankets/towels to provide additional support for child's head.
1.4 Rest of group is penalized based on perceived limitations.	Listen to the words the caregiver uses. For example, does she express that she'd like to take the group outside for a walk but cannot because of the limitations of the child with special needs?

3.1 Children with special needs included with group.	Children with special needs are placed in close proximity to the other children in the group and participate in activities.
3.2 Some adaptations made to help include child in activities (i.e., seat in circle for child who is unstable.	Caregiver makes adaptations so children with special needs can actively engage with any group activities. This includes placing cushions around the child who is unsteady in sitting up so they can be around the cluster of other preschoolers.
3.3 Adaptations are adequate, but make child with special needs "different".	These would include awkward or bulky equipment that is used to engage the child in the group. For example, does the special needs child sit in a clunky wooden chair rather than a typical chair that has been modified?

5.1 Children with special needs are not immediately recognizable to outside observer.	A special needs child should be included in most play activities, just like every other child is, with modifications being carried out as smoothly and inconspicuously as possible. Keep in mind that most interventions are implemented as part of the regular classroom activities that include both the special needs child and their typically developing peers.[171]
5.2 Activities are planned so that all children can be successful/participate.	This may require modifications to the schedule and the environment, including: • Arrangement of classroom to provide wider pathways. • Providing special accessible playgrounds. • Providing additional staff to provide extra attention. • Providing more or less structured individual and group activities so all children can participate.[172]

5.3 Caregivers are comfortable interacting with/caring for children with special needs.	Caregivers provide care to the special needs child with the same effortlessness as demonstrated with other children.
5.4 Caregivers seek information from parents/therapists on proper techniques.	To give credit for this item, caregiver must either be observed using special activities or interactions with the child, or during the interview, staff must describe proper techniques used with the child and how they are carried out. Do not give credit if caregiver obviously does not know about appropriate techniques.

Children with special needs are active/equal members of the group.	To receive credit for this indicator, the special needs child should be included in most all activities and routines, just as every other child is, with special modifications being implemented as smoothly as possible.[173]
Adaptative materials blend into classroom materials (i.e., all chairs match, some have belts, positioners).	While some adaptive furniture may be necessary for the special needs child, do the materials blend in with the others? Do the chairs all match? Or is the adaptive chair radically different than the others, calling attention to the special needs child?
7.3 Caregivers are included as part of IFSP/IEP team.	You will need to ask about this item. Ask if caregivers are members of the IFSP/IEP team. Do they have input on the goal setting of the child? Or do they just receive the recommendations with little participation in the planning process?
7.4 Caregivers involved in implementing objectives of IFSP /IEP.	This indicator is similar to that of 7.4. Ask how the implementation of the IFSP/IEP are accomplished. Are the goals implemented solely by additional professionals or is the caregiver actively involved with implementing interventions within the classroom setting?

#16 Relationship With Families

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 Interaction with families occurs mainly when a problem arises. 1.2 Caregiver is patronizing or disrespectful towards families. 1.3 Cultural and other individual preferences of families are discouraged or ignore.		3.1 Some positive interactions with families occur daily. 3.2 Parent's preferences are treated with respect. 3.3 Families are encouraged to participate in children's program.		5.1 Caregiver's work in partnership with families to assist in child's development. 5.2 Caregiver's stress that they view parent's as the primary source of love and care. 5.3 Parents are always welcome in the child care center.		7.1 The diversity of families is celebrated and used as a basis of learning. 7.2 Caregiver plans curriculum that is culturally responsive. 7.3 Caregiver's use parent's knowledge of children in planning, evaluation and assessment.

#16 Relationship With Families

General notes about this item

Children's development is best understood within the context of their family, then their school community, and the larger community (Gestwicki, 1999). According to Bredekamp and Copple, 1997, *education should be an additive process* (p. 13). Children should be encouraged and supported to add new cultural and language experiences without having to give up on their family of origin contexts. Children's home languages and cultures should be respected and reinforced in early childhood settings (Gestwicki, 1999, p. 10).

As identified by Bredekamp (1987) it is particularly important that parents and staff discuss basic values and childrearing practices. She identifies that during these early years, children learn whether or not their environment is supportive and predictable. Parents and staff who share information about the child's routines and daily experiences increase the likelihood that the child will experience a consistent environment.

Preschoolers Detailed Description of Indicators

1.1 Interaction with families occurs mainly when a problem arises.	Caregivers communicate with parents only about problems or conflicts, ignore parents' concerns, or avoid difficult issues rather than resolving them with parents[174].
1.2 Caregiver is patronizing or disrespectful towards families.	Caregivers communicate a competitive or patronizing attitude to parents or they make parents feel in the way. Parents view caregivers as the only expert and feel isolated from their child's experience[175].
1.3 Cultural and other individual preferences of families are discouraged.	Children's cultural and linguistic backgrounds and other individual differences are ignored or treated as deficits to be overcome.

3.1 Some positive interactions with families occur daily.	Caregiver helps parents feel good about their children and their parenting by sharing with them some of the positive and interesting things that happened with their children during the day. Parents always are made to feel welcome in the child's care setting[176].
3.2 Parent's preferences are treated with respect.	Does caregiver follow through with parent's choices? For example, does the parent identify food restrictions and the caregiver follows through? Does the parent request certain napping rituals that are carried through by the caregiver?

3.3 Families are encouraged to participate in children's program.	Does the center offer holiday celebrations that families are invited to attend? Are parents invited/encouraged to serve as "room parents" or "room helpers"?

5.1 Caregiver's work in partnership with families to assist in child's development.	Caregivers work in partnership with parents, communicating daily to build mutual understanding and trust and to ensure the welfare and optimal development of the baby. Caregivers listen carefully to what parents say about their children, seek to understand parents' goals and preferences and are respectful of cultural and family differences. Caregivers and parents confer in making decisions about how best to support children's development or handle problems or differences of opinion as they arise.
5.2 Caregiver's stress that they view parent's as the primary source of love and care.	Caregiver communicates that they view parents as the child's primary source of affection and care. Caregivers demonstrate that parent's preferences are respected. You do not want to hear: • "I'm just glad she has me in her life because her mom just doesn't have time for her." • "I don't care that mom says to put him to nap with his binky. I don't think he needs it."

5.3 Parents are always welcome in the child care center.	Parents are always welcome in the program. Opportunities for parent participation are arranged to accommodate parents' schedules. Parents have opportunities to be involved in ways that are comfortable for them, such as observing, reading to children, or sharing a skill or hobby.

7.1 The diversity of families is celebrated and used as a basis of learning.	Caregiver brings each child's home culture and language into the shared culture of the school so that children feel accepted and gain a sense of belonging. The contributions of each child's family and cultural group are recognized and valued by others. Children learn to respect and appreciate similarities and differences among people[177].
7.2 Caregiver plans curriculum that is culturally responsive	Caregiver plans curriculum that is responsive to the specific context of children's experiences. Culturally diverse and nonsexist activities and materials are provided to help individual children develop positive self-identity, to construct understanding of new concepts by building on prior knowledge and creating shared meaning, and to enrich the lives of all children with respectful acceptance and appreciation of differences and similarities. Books and pictures include people of different races, ages, and abilities, and of both genders in various roles.
7.3 Caregiver uses parent's knowledge of children in planning, evaluation and assessment.	Caregivers and parents work together to make decisions about how best to support children's developmental and learning or to handle problems or differences of opinion as they arise. Caregiver solicits and incorporates parents' knowledge about their children into ongoing assessment, evaluation, and planning procedures[178].

#17 Cultural Competence

Inadequate **1**	**2**	**Minimal** **3**	**4**	**Good** **5**	**6**	**Excellent** **7**
1.1 No evidence of cultural diversity observed. 1.2 Materials present only sterotypes of races, cultures, ages, abilities and gender. 1.3 Staff demonstrate prejudice against others (Ex. Against child or other adult from difference race or cultural group, against person with disability)		3.1 Some racial materials that show cultural diversity (multi-racial or multi-cultural dolls, books, pictures or music tapes from other countries). 3.2 Multicultural materials presented in a "tourist" approach (themes, specific cultural weeks, etc.). ✋		5.1 Many books and pictures accessible showing people of different races, cultures, ages, abilities, and gender in non-stereotyping roles. 5.2 Many props representing various cultures included for use in dramatic play (Ex. dolls of different races, ethnic clothing, cooking and eating utensils from various cultural groups).		7.1 Caregiver consciously stresses diversity as part of daily routines and play (dancing to music from different cultures, demonstrates it is okay to be different, etc.) 7.2 Activities included to promote understanding and acceptance of diversity (meals planned that include ethnic foods, inclusion of many cultures in holiday celebration).

✋ To move further up the scale, this should be "No".

#17 Cultural Competence

General notes about this item

We live in a multicultural society where even children who are born into a homogeneous community are unlikely to live their entire lives in a similarly homogeneous environment. As stated by Doherty-Derkowski (1995),

> Inevitably, almost any child living in North America will be in a situation at one time or another where others have different beliefs and different ways of behaving. Therefore, it is important for children to develop the attitudes and skills required to live and work comfortably with people from various backgrounds. This is best done during the early childhood years when children can learn to view differences in appearances and ways of doing things as interesting and positive rather than as distressing or threatening (p. 120).

Considerable research indicates a strong link between school success with the extent to which minority children's language and culture are incorporated into the school program (Cummins, 1986). Child care programs can encourage and support all children's identity and the development of a positive self concept by *incorporating materials and activities that respect and affirm children's race or ethnicity, by addressing signs of bias or discrimination, and by promoting collaboration between the program and the home* (Doherty-Derkowski, 1995, p. 122). Being a culturally competent caregiver requires conscious effort. Caregivers not only demonstrate this competence by their actions, but also by the materials they offer the children in their care.

The indicators in this item closely correspond with those in the Early Childhood Environment Rating Scales, Revised Edition (Harms, T., Clifford, R.M., and Cryer, D. (1998) and the Infant/Toddler Environment Rating Scale, Revised Edition (Harms, T., Clifford, R.M., and Cryer, D. (2003). For detailed discussion of these indicators please refer to *All About ITERS-R* (Cryer, Harms and Riley, 2004) and *All About ECERS-R* (Cryer, Harms, and Riley, 2003).

Preschoolers Detailed Description of Indicators

1.1 No evidence of cultural diversity observed.	All pictures and materials represent only one ethnicity or culture. Look for evidence of diversity in dolls, play materials, pictures, and books. Examples of diversity include dolls with various skin tones, doll sized wheelchairs, as well as books and pictures of varying abilities, including people wearing glasses.
1.2 Materials present only sterotypes of races, cultures, ages, abilities and gender.	Books and pictures reflect women and men in traditional roles only For example: • Women only doing housework. • Men only as firefighters, police officers, etc.
1.3 Staff demonstrate prejudice against others (ANY demonstration against child or staff from another culture or person with disability).	Look at caregiver's reactions to all children and staff. Is there a child that is "picked on" by the caregiver? Is there a child that is neglected or criticized because they are different? This can be particularly evident if there is a child with special needs. Does the caregiver seem uncomfortable with the child because of their handicap?

3.1 Some racial and cultural diversity visible in materials (Ex. multi-racial or multi-cultural dolls, books, or bulletin boards, music tapes from many cultures; in bilingual areas some materials accessible in children's primary language	At least three examples of racial and cultural diversity should be observed. Look for examples in dolls, pictures, books and music tapes/cds.

3.2 Multicultural materials presented in a "tourist" approach (themes, specific cultural weeks, etc.). **✋ To move further up the scale, this should be "No".**	Multicultural curriculum reflects a "tourist approach" in which the artifacts, food, or other particulars of different cultures are presented without meaningful connections to the children's own experiences. Some children's cultural traditions are noted in ways that convey that they are exotic or deviations from the "normal" majority culture.[179]

5.1 Many books and pictures accessible showing people of different races, cultures, ages, abilities, and gender in non-stereotyping roles.	As is stated in the ECERS-R, many means that there are at least 10 examples of diversity in books and pictures. These should include the following: Races, cultures, ages, abilities and gender.
5.2 Many props representing various cultures included for use in dramatic play (Ex. dolls of different races, ethnic clothing, cooking and eating utensils from various cultural groups).	Look for dolls of different skin tones, ethnically diverse food toys (tacos, sushi, etc). There must be at least 10 props to receive credit for this indicator.

7.1 Caregiver consciously stresses diversity as part of daily routines and play (dancing to music from different cultures, demonstrates it is okay to be different, etc.)	To receive credit for this indicator requires the caregiver make a solid and conscious effort to stress diversity in the classroom. Does the caregiver speak to the children in different languages (i.e., saying "Hola" or counting to 10 in Spanish)? Are children exposed to music and books of different cultures?
7.2 Activities included to promote understanding and acceptance of diversity (meals planned that include ethnic foods, inclusion of many cultures in holiday celebration).	You will most likely need to ask about this indicator. Ask if the center overall encourages families to share customs and/or holiday celebrations. Are ethnic foods offered on a regular basis?

Endnotes

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