Coronavirus-2019 (COVID-19) Guidance for Early Care and Education Providers

This document offers updated guidance for operation of early care and education (ECE) sites in a way that will help prevent the spread of novel coronavirus. It reflects an effort to balance increased need for child care as more and more parents return to work outside the home with the critical need to avoid transmission of the virus to children, their families and ECE staff. The document starts with general information about COVID-19, and then moves on to guidance for ECE providers. Note that references to "centers" or "sites" throughout the document apply to all child care providers, including family child care home providers.

A. General Information about COVID-19

COVID-19 is caused by a virus that has never been seen in humans before. In some ways, it is like other viruses we have seen, but there are important factors that set it apart:

- Since it has never infected humans before, none of us are immune to it;
- It can be spread from person to person more easily than some other viruses: any close contact brings risk;
- It can be spread by someone who doesn't have any symptoms and has no idea they are ill;
- While it causes mild or moderate symptoms in most people, it can be very serious, even fatal, for people in high risk groups. These include elderly people, people with chronic conditions, including those that affect heart, lungs or kidneys, people who have weakened immune systems due to disease, people undergoing chemotherapy or other medical treatments or conditions, and people who are pregnant.

Symptoms of COVID-19

People with COVID-19 have had a wide range of symptoms, ranging from mild symptoms to severe illness. Symptoms may include:

- Fever
- Cough
- Shortness of breath/difficulty breathing
- Fatigue
- Chills
- Congestion or Runny Nose
- Muscle or body aches
- Headache
- Sore throat
- Nausea or Vomiting
- Diarrhea
- New loss of taste or smell

How COVID-19 spreads

The virus is spread mainly by close contact from person to person. A "close contact" is any of the following people who were exposed to an "*infected person" while they were infectious:

- An individual who was within 6 feet of the infected person for more than 15 minutes
- An individual who had unprotected contact with the infected person's body fluids and/or secretions, for example, being coughed or sneezed on, sharing utensils/saliva, or providing care for the infected person without wearing appropriate protective equipment.
- An infected person for purposes of this guidance is anyone who has confirmed COVID-19 or who is suspected to have

COVID-19 based on symptoms. These individuals are considered to be infectious from 2 days before their symptoms first appeared until they are no longer required to be isolated (as described in Home Isolation Instructions for People with COVID-19 (Spanish) (Khmer) (Tagalog). A person with a positive COVID-19 test but no symptoms (asymptomatic) is considered to be infectious from two days before their test until 10 days after their test. This means that an early educator who had a long conversation with a colleague on a Friday and then found out that the colleague showed symptoms on Sunday, is considered to have been exposed to the virus.

Further information that may be of interest can be found at http://www.longbeach.gov/covid19

B. Creating a Safe Environment for Children and Caregivers

To avoid preventable spread, ECE sites must comply with these requirements:

1. Classroom configuration

- Childcare activities, indoor and out, must be carried out in stable groups (hereafter "cohorts") of 14 or fewer children with no more than two supervising adults. The cohort of children and supervising adults stay together for all activities (meals, recreation, etc.) and avoid contact with people outside of their cohort in the setting.
- The state recently issued Guidance Related to Cohorts regarding permissible cohort sizes that applies to licensed and license exempt child care settings, which stated that a cohort can include no more than 14 children or youth and no more than two supervising adults, for a total of no more than 16 individuals in the cohort. Requirements for adult to child ratios continue to apply for licensed child care programs. Childcare providers located in Long Beach are under the public health jurisdiction of the Long Beach Department of Health and Human Services (LBDHHS), and our protocol is following the state recommended cohort sizes. Los Angeles County Department of Public Health guidelines apply to providers outside of Long Beach. Please continue to follow the directives found in the LBDHHS Protocols for Day Care for School Aged Children and/or the Early Care and Education Guidance.
- Licensing requirements may mandate stricter child to staff ratios. When possible, children who live in the same household (i.e. siblings) should be placed in the same cohort; if a child must leave the facility and quarantine/test due to exposure, siblings/other children at the facility from the same household will also need to leave the facility to quarantine/test.
- Children do not move from one cohort to another.
- If more than one cohort of children is cared for at a facility, each cohort stays in a separate room. Cohorts do not mix with each other in classrooms, outdoor space or any common space within the facility.
- The same early educator(s) remain(s) solely with one cohort of children.
- If a facility includes any large classrooms, these rooms can be separated into smaller areas, each serving up to 14 children. The following precautions must be taken if rooms are divided:
  - Fire, safety and environmental regulations must be taken into account in placement of dividers.
  - Room dividers must reach from floor to ceiling and be made of non-porous material that can be regularly disinfected.
- Room dividers must be placed in a manner that maximizes ventilation and air flow to permit healthy temperature control and removal of contaminants.
- Room dividers must be secured to the floor in a manner that minimizes the risk of slips, trips, and falls.
- Once divided, each area must leave enough room for physical distancing (that is, a distance of six feet between

children).

- Divided classrooms must be designed so that cohorts of children can enter and exit without passing among a second cohort of up to 14 children. If there are 2 doors into a classroom, it is recommended that each cohort of children have a dedicated door that only they use to enter and exit the space.
- An exit route (means of egress) must be available to children on each side of a divided room. Each area must have a continuous and unobstructed path from any point within the area to a place of safety. Signs should be posted on or near dividers indicating pathways to exits and use of these pathways should be practiced in evacuation drills to assure safety in case of emergency.

2. Additional considerations for physical distancing and infection control

- Due to their elevated risk, it is important to ensure that plans account for the needs of any child with special health care needs and the needs of staff who are over 65 and/or have chronic conditions. Staff who are pregnant should also be vigilant about avoiding infection.
  - Staff should consult with parents of children with special health care needs to identify risks and develop protective strategies. These may include modifications in programming, special training of staff or other steps to ensure appropriate care.
  - If possible, staff with conditions that place them at risk should be offered work that can be done remotely. If that is not possible, these staff should be assigned to work that minimizes contact with other staff, children or visitors.
- Rearrange classrooms to put 6 feet between activity stations, tables, and chairs.
- Eliminate circle time and other activities that bring children close together. Prevent the sharing of toys
- and materials. Instead, use a backpack or a large Ziplock bag for each child's individual materials.
- At naptime, place cribs/cots at least 6 feet apart and alternate them from head to foot. If 6 feet is not feasible, create as much space as possible between children and arrange them from head to foot.
- Develop activities that model and reinforce physical distancing practices. Use classroom materials to help children visualize the required 6-foot distance between people, make and decorate face coverings, play games acting out children reminding each other to stay six feet apart, wear their face coverings, etc.
- Stagger breaks and outdoor activities so no two groups are in the same place at the same time. Do make use of outdoor space, however, to extend the classroom and make more room for activities.
- Discontinue buffet-style food service. Offer pre-packaged foods when possible.
- Have lunch and/or other meals in classrooms and avoid sharing tables whenever possible.
- Use disposable plates and utensils to minimize contamination risks. Remind children never to share or
- touch anyone else's food or drinks.
- Modify daily operations to minimize exposures (e.g. avoid the use of touchscreens for sign-in/out, ask parents to bring their own pens to sign in, implement valet services or have staff meet children as they arrive to avoid parents coming into the childcare center).
- Restrict visitors, including volunteers and parents/caregivers.
- Minimize the risks of congregation and contagion at drop-off and pick-up times.
  - Stagger arrivals and departures if possible.
  - Instruct parents to exit quickly after drop-off and require physical distancing between families as they arrive and

depart.

- Arrange for any prolonged parent-teacher conversations to occur by phone or internet, rather than in the classroom at drop-off or pick-up.

3. Adopt activities that are individualized or permit distancing

Early care and education is often based on group play, but during the COVID-19 outbreak, ECE providers are encouraged to emphasize individualized activities.

- Individualized activities may include coloring, painting, putting together puzzles, using building blocks or other activities children like to do alone.
- If children are seated apart from one another, some group activities that don't involve physical contact
- (clapping games, storytelling) are also possible.
- Use the outdoors. Some activities that are risky indoors, like singing, which can spread droplets that may carry the virus, may be fine outdoors if children are placed (and reminded to stay) more than 6 feet apart.

4. Screening is key

Screening for COVID-19 helps to avert introduction of the virus into settings where there is a high risk of contagion. Screening is simple. It entails 1) asking about cough, difficulty breathing or other respiratory symptoms, and any other symptoms that could be due to COVID19 (see Symptoms of COVID-19 above) 2) a temperature check – using a no-touch thermometer or, if that is not feasible, a verbal check on whether the person feels feverish.

- Staff, children, parents/caregivers, and visitors should be reminded regularly that they should do their own at-home symptom checks and stay home if they are ill, even with mild symptoms.
  - Instruct parents to screen their children and themselves before leaving home. Anyone with symptoms consistent with COVID-19, including the child, should remain at home in isolation for a minimum of 10 days plus at least 24 hours after the resolution of fever (without fever- reducing medication) and improvement in other symptoms.
- Start the day at your site with health screenings for all staff and children on arrival.
  - Ensure that plans to conduct health screenings address the needs of children who are challenged by physical touch and/or significant changes in their daily routine.
- If a staff member or child shows symptoms of COVID-19, they may not remain at the site.
  - Note the list of symptoms on page 1 of this document. The first three symptoms listed (fever, cough and shortness of breath) are the most common signs of COVID-19 infection. But any symptom/s require a child to leave the site.
  - If a child develops any of these symptoms while at your site, they should be separated away from the classroom while waiting for a parent to arrive for pick up. If possible (and age appropriate), keep a face covering on the symptomatic child with as soon as possible after moving them to the sick room. Otherwise, make sure the child has a cloth face covering (if age appropriate) and that any staff member escorting the child has appropriate personal protective equipment (PPE).
  - Note guidelines for site response when a staff person or a child is sick (see Sections B. 8-10 below).

5. Promote good hygiene to limit the spread of COVID-19

- All early care and education staff should wear cloth face coverings at all times while at work (and in public at other times) except when alone in a private office or an enclosed cubicle or when eating.
  - Employees who have been instructed by their medical provider that they should not wear a face covering should

wear a face shield with a drape on the bottom edge, to be in compliance with State directives, as long as their condition permits it. A drape that is form fitting under the chin is preferred.
    - Site must provide face coverings for all staff who have any contact with other employees, with children and/or with visitors to the site.
    - Instruct staff to wash face coverings daily.
    - Staff that care for children under two, and/or children not able to wear a face covering for medical reasons, should be provided with face shields to use over their face coverings.
- Children from birth through two years old should not wear face coverings. Children who are two through eight years old should use face coverings with adult supervision to ensure that the child can breathe safely and avoid choking or suffocation. Children with breathing problems should not wear cloth face coverings.
- Use signage to remind staff, visitors and children to wash hands frequently. Use signs in all bathrooms to instruct on proper handwashing technique.
    - Use age appropriate signs to remind children to wash hands (for example, see https://www.cdc.gov/handwashing/buttons.html).
- Signs should instruct adults to use best practice in hand washing (see for example https://www.cdc.gov/handwashing/when-how-handwashing.html).
- Provide supplies needed for good hygiene, including easy access to clean and functional handwashing stations, soap, paper towels, and alcohol-based hand sanitizer. Make it easy for any adult entering the site or any room in the site to sanitize their hands-on entry.
    - Note, however, that the CDC warns against unsupervised use of hand sanitizer by young children without adult supervision due to risk of alcohol ingestion (see https://www.cdc.gov/handwashing/show-me-the-science-hand-sanitizer.html).
- Incorporate handwashing into daily site routines; teach children how to do a hand wash thoroughly.
    - Handwashing should take place at the beginning of the day, before and after meals, after outside play, after using the restroom, and before and after classroom activities that involve sharing supplies and materials and after coughing and sneezing.
    - Handwashing should be supervised for children under six. Sing the “Happy Birthday Song” twice in a row while children wash their hands to demonstrate 20 seconds.

6. Cleaning and disinfecting at your site

- Cleaning and disinfecting are two separate steps in the clean-up process.
    - Cleaning is aimed at removing germs (including viruses), dirt and impurities from surfaces. Cleaning doesn’t kill germs, but it reduces risk of infection by reducing the number of germs on the surface.
- Disinfecting, on the other hand, doesn’t necessarily make the surface look clean, but it does reduce risk of infection by killing germs on the surface. The stronger the disinfectant and the longer it stays on the surface the more germs it will kill (https://www.cdc.gov/coronavirus/2019-ncov/community/home/cleaning-disinfection.html).
- For cleaning:
    - Warm water and soap are effective for cleaning. They remove germs, dirt, and impurities from surfaces.
    - If you don’t have soap, use another detergent with water.
- For disinfecting:

- Use a commercial EPA-registered disinfectant if one is available. An alternative is a bleach solution: five tablespoons (1/3 cup) bleach per gallon of water or four teaspoons bleach per quart of water.
- Alcohol is an effective alternative when another disinfectant is not available.
- To reduce risk of asthma among children and staff, try to use disinfectant products on the EPA's N list with asthma-safer ingredients (hydrogen peroxide, citric acid or lactic acid) and as opposed to products that include peroxyacetic acid, sodium hypochlorite (bleach) or quaternary ammonium compounds.
- Disinfecting sprays and household bleach solutions should be left to sit and coat surfaces to be disinfected according to label instructions.

- Safe cleaning and disinfecting
  - Ideally, full-scale cleaning and disinfecting are done after hours, when children are not present, giving the site adequate time to air out before children are back.
  - Spot cleaning and disinfecting of frequently touched or soiled areas should be carried out regularly throughout the day, even when children are present. Surfaces of concern may include sink knobs, toilet handles, tables, and door handles.
  - Check the labels on products. Never mix bleach or any product containing bleach with any product containing ammonia, as the gas produced is extremely harmful.
  - Cleaning and disinfecting products should be stored out of reach of children,
  - If at all possible, cleaning and disinfecting should be done with windows and/or doors open, allowing chemicals to dissipate, or when children are outside or otherwise away.
  - Make sure anyone using cleaning products is adequately protected with PPE, including gloves and/or eye protection as required by the product instructions.
- Assure that toys and educational supplies are cleaned and disinfected after each use.
  - Designate a container for toys that need to be cleaned, sanitized, or disinfected before being introduced back into the classroom environment.
  - Have multiple toys and manipulatives accessible that are easy to clean and disinfect throughout the day or provide individually labeled bins with toys and belongings for each child. Toys that may be put in a child's mouth should be cleaned and sanitized often. Ensure toys that are difficult to clean (e.g. soft toys) are either removed from the classroom or carefully monitored for use by individual children only.

7. Action steps when a staff person is sick

- Staff must stay home when they are sick with symptoms of respiratory illness such as fever and cough or other symptoms that could be COVID-19 (see symptoms of COVID-19 above).
  - Staff are strongly recommended to be tested if symptomatic. If staff tests positive, they must remain at home in isolation and not return to the ECE facility for a minimum of 10 days after onset of symptoms AND until their symptoms have improved AND they are free of fever for at least 24 hours without fever-reducing medication.
  - All staff and any children who had close contact with the infected person, should be sent home to self-quarantine as soon as possible. See below for further information regarding self-quarantine.
  - If the staff person is symptomatic but has not been tested for COVID-19, instruct them to seek testing from their own provider, from a free, public test site or from another site of their choosing and to inform the center about the outcome of the test. If the staff person declines testing, then they must remain at home in isolation and not

return to the ECE facility for a minimum of 10 days after onset of symptoms AND until their symptoms have improved AND they are free of fever for at least 24 hours without fever reducing medication. All staff and any children who had close contact with the ill person, (as defined in Section B.2 of this document) should be sent home to self-quarantine as soon as possible. See below for further information regarding self-quarantine.

- If staff person is tested and is negative, they can return to work three days after symptoms resolve.

- All staff and any children who had close contact with the infected person, (as defined in Section B.2 of this document) should be sent home to self-quarantine as soon as possible. The quarantine must be for 14 days following contact with the infected person. If no symptoms arise during the 14 days, the quarantined person may return to work. A negative test during the quarantine period does not shorten the quarantine period; the quarantine period is always for 14 days from date of last exposure.
  - Testing is recommended after day 10 of quarantine. If negative, individual must continue to quarantine at home the entire 14 days.
  - If the infected staff person was at work when symptoms emerged and/or within two days before becoming symptomatic, follow directions below for contacting LBDHHS.
- A health care provider's note is NOT required for employees (or children) who have been sick with acute respiratory illness to stay at home or to return when they have recovered.

8. Action steps when a child is sick

- Remind parents to update their emergency contact information regularly so site staff can get in touch quickly if they need to. When a child does show signs of illness, they will need to be picked up immediately.
- Children who develop symptoms of illness after drop-off at an ECE site should be separated from others right away, preferably in a sick room which others do not enter or pass through. The child should remain in isolation until they can go home.
  - If possible and age appropriate, ensure cloth face covering is on symptomatic child
- Guidelines for isolation of a sick child are the same as those for an adult. The child must stay home in isolation and not return to the ECE facility for a minimum of 10 days after onset of symptoms AND until their symptoms have improved AND they are free of fever for at least 24 hours without fever-reducing medication. Provide families with guidance on home isolation from the LBDHHS website: Home Isolation Instructions for People with Coronavirus-2019 (COVID-19) Infection (Spanish) (Khmer) (Tagalog).
- While the virus is spread when the infected person is clearly ill, many individuals can infect others even when they don't have obvious symptoms or any symptoms at all.
  - Given that risk, children who have been exposed to (meaning within 6ft for greater than 15 minutes) student or staff who have been diagnosed with COVID-19 should remain home for 14 days.
    - Quarantine begins on the date after the last exposure with that person, and lasts 14 days.
    - A negative COVID-19 test during quarantine does **not** mean quarantine can end early. Quarantine must continue for the full 14 days after last date of exposure.

9. Action steps when there has been exposure at the center

- When someone at your site (child, staff person or visitor) has COVID-19 (confirmed by lab test or suspected based on symptoms), contact the Long Beach Health Department at 562.570.INFO and let them know you are a childcare facility reporting a case of COVID-19. Someone from the Communicable Disease Control Program will then follow up

with you.

- Identify adults or children who may have had close contact with the ill individual/s for more than 15 minutes or those who may have had unprotected direct contact with body fluids or secretions of the ill individual starting from two days before symptoms appeared. Body fluids or secretions include saliva, sputum, nasal mucus, vomit, urine or diarrhea. These people should home-quarantine for 14 days from the date of the contact. All individuals in the infected child or staff's cohort should be quarantined.
    - Anyone who has had close contact with an infected person must be sent home to self- quarantine, as described in Sections 2.7 and 2.8 above.
    - If any staff or children develop symptoms while in quarantine, they should follow the guidelines for self-isolation (10 days after symptoms started AND 24 hours after fevers have resolved and symptoms improved.) described above in 2.7 and 2.8.
- Note that while all parents/caregivers and staff should be informed of a confirmed case of COVID-19 in someone connected to the facility, it is not legal to share the name of the infected individual. It may not be hard for children or staff to guess who the person is, but that is different from an intentional release of private medical information about someone.

C. What if it is necessary to close?

When closure might be necessary

- If an individual was present at the center while potentially contagious, LBDHHS may require short- term closure to permit intensive cleaning and disinfecting.
    - This may be required for the whole site or just for one or more specific areas in which the infected person spent time.
- If the site must close, the Child Care Licensing Local Regional Office should be notified immediately.
- If three or more cases occur at a site within a 14-day period among staff, children, or visitors who spent time at the site, a longer-term closure may be required for an investigation to determine the source and pathway of contagion. Contact the Long Beach Health Department at 562.570.INFO and let them know you are a childcare facility reporting several cases of COVID-19.
- Families should be informed immediately about the need for and the likely duration of a site closure. They should also be informed about the nature and extent of risk to their children and whether that risk indicates a need for quarantine and testing.
- Provide guidance to parents, teachers, and staff reminding them of the importance of physical distancing and other preventive measures while the facility is closed. Emphasize the importance of home quarantine and preventive practices to avoid spread among children and their household members in case one or more have contracted COVID-19.
- Consult with the LBDHHS to determine the timing of return for children and staff, and if any additional steps are needed for the childcare facility to reopen.

D. How should ECE providers (and parents) be talking to children about COVID-19?

The Centers for Disease Control and Prevention (CDC) has provided evidence-based recommendations for helping children

cope with emergencies, including the COVID-19 outbreak. Important points include:

- The importance of being honest, but age-appropriate. Children's questions should be answered, but it is not necessary to give information that goes beyond what a child can handle.
- The importance of listening, especially to ascertain if the child has any unfounded fears or worries about COVID-19.
- The need to avoid blaming others for the outbreak or using language that can lead to stigma or bullying of some children by others.
- The value of emphasizing what the child can do to stay healthy, including handwashing, covering coughs and sneezes, staying home, physical distancing, and wearing a cloth face covering (if age appropriate) when outside the home and in the presence of others.
- The need for parents and teachers to model behavior that reduces the spread of the virus, for example, teach children how to sneeze into an elbow or choose a child to role play physical distancing with you.

E. Useful resources

What websites have accurate information on COVID-19?

- Long Beach Department of Health and Human Services www.longbeach.gov/covid19
- Social Media: Facebook, Instagram, Twitter (@LBHealthDept)
- Los Angeles County Department of Mental Health Access Center 24/7 Helpline (800) 854-7771
- California Department of Social Services, Community Care Licensing Division https://www.cdss.ca.gov/inforesources/community-care-licensing
- California Department of Public Health (CDPH, State) https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/nCOV2019.aspx
- Centers for Disease Control and Prevention (CDC, National) http://www.cdc.gov/coronavirus/novel-coronavirus-2019.html
- World Health Organization (WHO, International) https://www.who.int/health-topics/coronavirus

If you have questions and would like to speak to someone, or need help finding medical care, call the Los Angeles County Information line 2-1-1, which is available 24/7.