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Enhancing the Quality of Relationships in Infant–Toddler Child Care:

A Developmental Process

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The single most important factor in early education and care is the relationship between the child and the caregiver (Carnegie Corporation of New York, 1994; Zeanah, Larrieu, Heller, & Valliere, 2000). Yet the quality of this relationship is rarely, if ever, adequately emphasized in any global measurement of child care quality. The Environmental Rating Scales (Harms, Cryer, & Clifford, 1998, 2003), probably the most widely used measure of quality care, weights all components equally. As a result, programs can score "inadequate" in "staff–child interaction" and "excellent" on "furnishings and program structure" and still achieve an overall rating of "good." Programs can achieve National Association for the Education of Young Children (NAEYC) accreditation, a widely respected indicator of quality, without implementing continuity of care or training staff in responsive caregiving and other critical social–emotional components of care. Although the Environmental Rating Scales and NAEYC accreditation criteria are extremely valuable, we believe that measures of child care quality must reflect *current* child–care research on the

at a glance

- A relationship-based definition of child–care quality can serve as a framework for continuous improvement.
- The 10 Components of Quality—including primary caregiver and continuity of care, and active and responsive caregiving to support children's development—give prominence to relationships and social–emotional development.
- Front–line caregivers, center directors, and funders need to have a common vision of child–care quality.
- Most child–care programs need several years to integrate all components of quality, including relationship–based care.

Photo Courtesy of Florida State University Center for Prevention & Early Intervention Policy

centrality of the caregiver–child relationship. Moreover, our experience suggests that a relationship-based definition of child–care quality can serve as a framework for continuous improvement.

The 10 Components of Quality Child Care

With support from multiple funders, we developed the 10 Components of Quality Child Care (Florida State University Center for Prevention & Early Intervention Policy, 2003). Based on earlier work at ZERO TO THREE (Lally, Griffin, Fenichel, Segal, Szanton, & Weissbourd, 1995), the new components give appropriate prominence to relationship components of quality child care. Two of the 10 components directly address the quality of relationship components (primary caregiver and continuity of care, and active and responsive caregiving). The remaining eight components support social–emotional development. Information on the research basis and accompanying training on the 10 Components of Quality is available at www.cpeip.fsu.edu.

1. Licensed Programs Following Appropriate Health and Safety Practices

Licensing ensures that a child–care setting meets basic health and safety requirements. In addition, quality child care settings for young children have separate areas for food preparation and diapering/toileting; detailed procedures for emergencies; policies for addressing illnesses; nutritious meals and snacks; collaboration with community health and safety resources; and frequent hand washing by caregivers and children to minimize the transfer of infections. To reduce the risk of SIDS, all healthy infants should be placed on their backs to sleep.

2. Staff Well Trained in Early Childhood Development

The strongest indicators for long-term success tied to early education and care are related to the caregivers' education and level of participation in ongoing training in the field of early childhood development and care. Staff competence is the most important contributing factor to a social environment that facilitates early learning. Caregivers should apply their knowledge of early childhood development and use curricula and materials to plan appropriate activities and provide responsive caregiving. Caregivers should also use routines to promote learning and look for opportunities to have meaningful conversations and interactions with children.

3. Age–Appropriate Environments

Learning is an interactive process that involves continuous opportunities for exploration and interactions. Infants and toddlers should have age-appropriate equipment and spaces, both inside and outside, that are separate from those used by older children. Room arrangements should allow for both quiet and active play, dramatic and messy play, large group activities, and individual care. Multiple sets of the same toys prevent conflicts. Toys and books should be available for access at the child's level to promote independent choice and use. High-quality programs arrange classrooms to facilitate young children's learning, rather than to accommodate the preferences of adult caregivers.

4. Small Groups with Optimal Ratios

Group size and ratios determine the amount of time and attention that each caregiver can devote to each child. Small groups create a sense of intimacy and safety. A rich dialogue between caregivers and infants is possible in small groups because there are fewer people, less noise, and less activity to interfere with a child's ability to learn. Small groups and more staff enable caregivers to build strong relationships with each child and to adapt activities to meet the changing interests and needs of the group.

The recommended group size for infants is six to eight. The best adult-to-child ratio is one adult for every three or four infants.

5. Primary Caregiver and Continuity of Care

Positive relationships between caregivers and children are crucial to quality child care. It is through close relationships with caring adults (including caregivers) that children flourish, discover their world, and learn who they are. Each child enrolled in group care should be assigned a primary caregiver. A primary caregiver has the principal responsibility for that child and helps build a positive, constant, intimate relationship with the child. The primary caregiver also offers family members a consistent contact who knows the child well.

Having one primary caregiver for more than a year (optimally, from entry into child care until the child is 3 years of age or older) is important to a child's emotional development. Each change from one caregiver to another takes a toll on the child. When young children are repeatedly changed from one caregiver to another, the process of grieving the loss of the previous caregiver and learning the new caregiver's ways may slow their overall development and leave them reluctant to form new relationships.

6. Active and Responsive Caregiving to Support Children's Development

The active and responsive caregiver takes cues from each child to know when to expand on the child's initiative, when to guide, when to teach, and when to intervene. Responsive caregivers are alert to signs of stress in each child's behavior and respond with appropriate stress-reducing activities and techniques. The responsive caregiver continuously facilitates the development of self-esteem by respecting and accepting children, regardless of their behavior.

7. Emerging Language and Literacy

The path to literacy begins with interactions between caregivers and young children. Caregivers expand on the vocalizations of infants and toddlers, and add words and ideas to what very young children express, feel, or say. They promote the development of language through the use of simple words and maintain a balance between listening and talking with the child. Songs, nursery rhymes, and finger plays promote the development of language and literacy. Staff create a learning environment that includes books and other print material throughout the child–care setting. Opportunities for shared reading are a part of each day. Children are encouraged to enjoy books independently.

8. Curriculum, Observation, and Individualized Programming

Learning involves activities, materials, and opportunities for exploration and interaction. Staff in quality programs use curricular resources to plan and prepare an environment in which children can choose from a variety of activities. Caregivers also understand the temperaments, moods, and preferences of each child. They adapt sleeping, eating, and play routines to meet individual needs. Children's special abilities, as well as disabilities, are continuously discovered as caregivers routinely observe and assess each child. Based on curriculum and observations, caregivers develop an overall plan for each day, individualizing activities, materials and schedules according to the developmental stage of each child.

Photo Courtesy of Florida State University Center for Prevention & Early Intervention Policy

9. Family Involvement and Cultural Continuity

High-quality programs incorporate practices reflecting the values and beliefs of the families and the cultures of their communities. Using the child's home language, following cultural norms related to daily routines, and celebrating diverse cultures are examples of such practices. Caregivers should communicate each day with families, welcome parents into their child's classroom, and organize special events that include the child's family members.

10. Comprehensive Support Services

High-quality child care serves as a protective environment for the child and a source of support for the child's family. Because child care cannot meet all the varied needs of young children and their families, linkages with community agencies are essential to provide a medical home, mental health and social services, and therapeutic interventions. Ongoing communication can ensure continuity of care across multiple disciplines and promote holistic support services and treatment.

Developmental Progression of Change in Early Care and Education Settings

Communities can use the 10 Components of Quality Child Care, in conjunction with global quality scales, to strengthen relationship-based care in their early care and education programs. Most programs need several years to integrate all the components of quality — facilities, health and safety, group

size, well-trained staff, and relationship-based care. Changing a child–care program or a child–care system involves:

- articulating a common vision of quality,
- translating that vision into a detailed action plan,
- securing the skills and resources needed, and
- implementing the plan to achieve the desired change.

Articulating a Common Vision of Quality

Front-line caregivers, center directors, and funders need to have a common vision of child care quality. The 10 Components of Quality are grounded in both research and practicality. When trainers and consultants present visual examples of the 10 components, all staff can picture what quality looks like in the classroom. Site visits to model programs help directors and caregivers see how continuity of care actually works or how caregivers infuse literacy into daily routines. A common vision of quality helps build a common will for change.

Action Plan

A common vision of quality must be translated into a detailed set of actions that will achieve the vision. The Environmental Rating Scales (Harms et al., 1998, 2003), which rate quality of classroom furnishings, personal care routines, language, learning activities, program structure, and parent–staff needs, provide a baseline measure of the child care environment. In addition to this quantitative perspective, interviews with program administrators and key staff, guided by the 10 Components of Quality, provide a qualitative view of staff perspectives on the care at their center. Both types of information form the basis of a "quality improvement plan" with goals, actions, timelines, and assignments of responsibility. The success of the plan will depend upon the commitment and skills of the center director, the motivation of the direct caregivers, and the availability of training and technical assistance.

Resources

Abundant resources are available in the field to support the social–emotional development of young children. However, few programs are familiar with classic resources such as the Program for Infant-Toddler Caregivers' (West Ed., 1995) videotapes and trainings; the video, *10 Things Every Child Needs* (WTTW Chicago, 1997); or the publications, Web site, and training resources of ZERO TO THREE. To improve quality, child–care programs need to devote resources to the components that directly affect quality. In order for regular hand washing to occur, for example, sinks must be easily accessible. Age-appropriate environments require child-size equipment. Small groups require room partitions or additional space. Curricular activities require age-appropriate learning materials. Comprehensive support services require specialized staff. Many child–care administrators cite "lack of resources" as the explanation for poor facilities, large group size, developmentally inappropriate playgrounds, lack of child-size sinks and toilets and noncompliance with Americans with Disabilities Act requirements. But many other administrators are extraordinarily resourceful about getting civic groups, parents, or grants to help build playgrounds, or sponsor events, or volunteer services. Whether purchased or donated, resources are essential for creating and maintaining quality.

Building Skills

Achieving child–care quality requires the skills of center directors, caregivers, and support staff. The director's leadership skills are needed to identify barriers to quality, assess staff's need for skills, create a plan for achieving skills, and marshal necessary resources. Teachers' skills, as many research studies have found, represent a critical component of quality child care. Multidisciplinary support staff must have content knowledge in their field and skills in addressing the needs of young children and families.

Like developmental progression in children, qualitative changes in early care and education programs typically proceed in a predictable developmental sequence.

Caregivers' Individual Professional Development Plans can be linked to the 10 Components of Quality. Individual and group training, hands-on modeling, and mentoring help staff learn and practice skills along a continuum of complexity. Concrete components of quality are easy for most staff to master — for example, "putting art at child level," arranging the classroom, and making sure there is a designated block area. Some skills — even routine ones such as hand washing — tend to require hands-on modeling and continuous reinforcement. Higher-level skills, such as responsive caregiving, seem to require training, extensive mentoring, and ongoing encouragement within the context of relationships. Intensive, structured training, combined with on-site mentoring for caregivers and consultation for directors, can quicken the pace of skill building. "One-shot" trainings are rarely effective in building skills, but mentors can provide hands-on help to caregivers in applying and practicing concepts from training.

The Developmental Process of Change

Our experience in program development suggests the existence of a phenomenon that we call the "developmental process of change." Like developmental progression in children, qualitative changes in early care and education programs typically proceed in a predictable developmental sequence. Like children's development, improvement in child–care quality proceeds from the concrete to the more abstract, from the general to the specific. Changes in facilities and materials are more easily achieved than changes in behavior. In an early care and education setting, change seems to trickle down from the overall center environment, to the classroom, to the caregivers, until it touches the children.

- ***Basic facilities layout, equipment, and materials***. Improving a child–care facility might include painting, replacing carpet or tile, and landscape or playground improvements. Kelling and Coles' (1996) "broken window" theory suggests that if one window on a block is broken and remains so, residents will become indifferent to more broken windows. Changes that staff and parents can see may inspire more qualitative changes. And a facility that is clean, freshly painted, and well taken care of increases pride in the workplace.

- ***Health and safety, hand washing.*** Caregivers easily understand the importance of health and safety issues. Training that is followed up by regular accountability checks can institutionalize changes in procedures like diaper changing, frequent hand washing (by both caregivers and children), cleaning toys, and dealing with ill children.

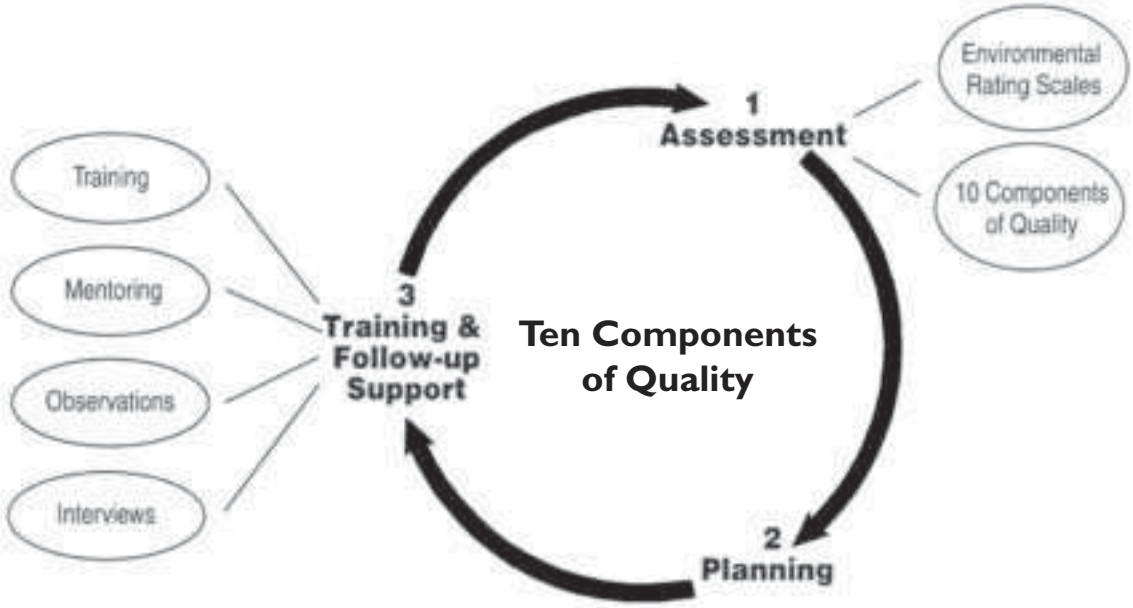
- ***Group size and ratio.*** Caregivers welcome decreases in group size or ratio or both. Although these are often economically challenging for programs, decreases in group size or ratio typically result in immediate positive changes in both staff and child behaviors. Caregivers are less stressed because they are responsible for fewer children. Young children in smaller groups have fewer other children with whom they are competing for their caregiver's attention and as a result tend to exhibit higher levels of play, appear calmer, and display fewer behavior problems. When an early care and education setting can make progress in facility improvement, more rigorous attention to health and safety, and more nearly optimal group size and ratio, overall quality improves.

- ***Well-trained staff.*** When all of the above changes are implemented and the subsequent positive outcomes for both staff and children are evident, caregivers often acknowledge that the program is committed to quality. Staff are typically more enthusiastic about training opportunities and become proud of their accomplishments. As a result, caregivers learn more about the needs of infants and toddlers, and staff competence increases in areas like planning developmentally appropriate activities.

- ***Relationship-based care.*** Relationship-based care is typically much more challenging to implement than other aspects of quality. This change in attunement to the individual needs of the children necessitates change in behaviors. For example, "contraptions" are removed and caregivers are encouraged to get down on the floor interacting with children. Staff are more responsive to children's distress, quickly and appropriately responding to their needs and temperaments.

- ***Quality.*** A child care setting's process of change can be called successful when all 10 components of quality are integrated into the setting's practice — facilities, health and safety, group size, well-trained staff, and relationship-based care. This process of change typically takes years to achieve, however. Small changes should be celebrated and reinforced.

FIGURE 1: MODEL FOR CONTINUOUS IMPROVEMENT OF QUALITY CARE



Measuring Quality Improvement in Child Care

If we accept the 10 Components of Quality as a description of child–care quality and also recognize that child– care settings move toward quality through a developmental progression, how should achievement of and adherence to quality be documented and monitored? We propose a 3-step model for continuous quality improvement, illustrated in Figure 1.

Step 1: Continuous improvement begins with the collection of baseline information about the early care and education environment. The Environmental Rating Scales provide a valuable quantitative measure of classroom furnishings, personal care routines, language, learning activities, interaction, program structure, and parent–staff needs. Using the 10 Components of Quality as a framework for self-evaluation, evaluators ask program administrators and caregiving staff how, in their view, their center addresses each component. Step 1 identifies clearly the center's areas of strengths and needs for improvement.

Staff are typically more enthusiastic about training opportunities and become proud of their accomplishments. As a result, caregivers learn more about the needs of infants and toddlers, and staff competence increases in areas like planning developmentally appropriate activities.

Step 2: The evaluators draft a report and discuss it with the director and mentor, coach, or technical assistance provider who will be working with center staff over time. With concurrence of the director, the mentor drafts the improvement plan for the center. The mentor and director also develop individual quality improvement plans for each classroom and their staff. The mentor meets weekly with staff to prioritize and pace improvements to ensure staff buy-in and reduce resistance to change. This enables the development of a "quality improvement plan" with goals, actions, timelines, and person(s) responsible.

Step 3: Implementation of the quality improvement plan depends on a continuous cycle of assessment, planning, training, and support followed by reassessment, planning, training, and support. Activities might include training workshops, mentoring and professional support for directors and caregiving staff, observation and feedback, and attitude and perception interviews. Trainers remain focused on the common vision of quality and the use of a continuous quality improvement model for change that will remain in place within programs over time. Trainers help staff use reflective practice so that they are likely to remain focused on improving quality long after the "project" is over.

Using the 10 Components of Quality to Build Quality Child Care: A Case Study

The Picower Quality Childcare Initiative (a collaboration among the Picower Foundation, the Children's Services Council of Palm Beach County, and the United Way) provides an instructive case study of the use of a relationship-based definition of child care quality, as well as a quality improvement framework for evaluation. The goal of the Initiative was to improve the quality of six child care centers in two communities in Palm Beach County, Florida, with plans for countywide expansion. The Florida State University (FSU) Center for Prevention and Early Intervention Policy was engaged originally to evaluate the Initiative. FSU expanded its role to help the Initiative use its resources to facilitate implementation of the 10 Components of Quality.

Establishing a common vision of quality was the Initiative's first task. Although everyone from the funder to the frontline caregivers aspired to "quality," stakeholders lacked a common definition. When Board and staff of the Initiative were presented with the 10 Components of Quality, the Components then became a framework for organizing change. The Initiative's resources made it possible for participating centers to:

- upgrade their facilities;
- establish comprehensive services teams to identify and refer children needing health, developmental, behavioral, and social supports; and
- undertake staff development and mentoring by masters-level early childhood experts (one for each participating center).

Improvements in these areas provided a foundation for achieving additional Components of Quality.

In the Initiative's first year, facility upgrades (critical for NAEYC accreditation) provided participating centers with computers, landscaping, playground equipment, teacher lounges, painting, carpeting and tile, and sinks. The second year of the Initiative focused on training. In one of the communities, almost 60% of the staff completed the 15-week High/Scope program; in the other community almost 80% completed the High/Scope or West Ed. training. Any staff member who completed training received a $500 bonus.

Beginning in the second year, a full-time mentor worked with each center. The mentor attended training with staff and then helped caregivers apply the concepts in the classroom, linked to the 10 Components of Quality and each center's quality improvement plan. Year Three is focusing on enhancing relationship-based care.

Evaluation and Continuous Improvement in the Picower Initiative

We believe that the 3-step process for continuous quality improvement — identifying the problem, mapping out an improvement plan, and hands-on mentoring and modeling—facilitated and accelerated improvements in child care centers in the Picower Initiative. The success of individual plans depended upon the commitment and skills of the center director, the motivation of the direct caregivers, and the availability of training and technical assistance.

Early in the Initiative, we assessed each classroom in the six participating centers, using the Environmental Rating Scales. This process gave us standard baseline measures of quality, which provided the rationale for planned improvements. These, in turn, could be measured in re-assessments. Mentors worked with directors and teachers to develop improvement plans. Mentoring and modeling helped to achieve the improvements. Evidence of improvement was noted in the "post" ITERS/ECERS ratings.

We used interviews with front-line caregivers to find out how they perceived changes in quality at their centers and how additional supports provided by the Initiative were affecting them. We asked participants to rate how the Initiative had enhanced each of the 10 Components of Quality at their center. They were asked to identify which components had changed most (health and safety practices, and staff training) and which had changed least. We found that interviewing front-line caregivers individually encouraged them to reflect on their experience with the Components, and, moreover, validated directors' statements that caregivers' views about change were important. The ongoing qualitative information provided by the interviews has not only helped clarify what components are perceived as needing or demonstrating change, but also has helped show how supports such as mentors and service teams can bring about such changes

We attribute improvements in the quality of care at participating centers to a combination of the intensive mentoring relationship and extensive training. Although program developers may have clear ideas about how various activities and supports may specifically enhance quality, the process of relationship-building and communication about roles does not occur automatically. Assigning mentors to a specific center helped mentors "earn the right to influence" and seemed to accelerate positive change. Because mentors attended intensive High/Scope and West Ed. trainings with the caregivers, they were better able to help caregivers apply concepts from the trainings to their daily work. Because mentoring is, itself, a reflective relationship, it can be used as a vehicle for reflection on how to improve all relationships in child care contexts.

In addition to mentors, Comprehensive Services Teams were available to the participating centers to identify and refer children needing health, developmental, behavioral, and social supports. Prior to the Initiative, few caregivers knew about the Individuals with Disabilities Education Act (IDEA) or where to refer children with special needs. During the Initiative, the early identification of children with special needs increased significantly, and referrals were made to address a variety of concerns.

The Picower Initiative has provided significant resources to help early care and education programs implement their vision of quality. Thousands of dollars were spent in equipping classrooms and playgrounds to meet NAEYC accreditation standards. Significant resources were spent in upgrading facilities such as painting, replacing carpet, planting flowers, and landscaping. Substantial human resources were provided including the mentors (now called early learning coaches) and Comprehensive Services Teams. The Initiative also supported High/Scope and West Ed. training for caregivers and mentors.

In Conclusion

The Picower Quality Childcare Initiative illustrates the use of a relationship-based framework for ongoing evaluation to build program quality over several years. Staff, mentors, and evaluators have brought about improvements by translating a common vision of quality into a set of specific actions and using available skills and resources to implement plans for improvement. Evaluation activities can play a crucial role in program development. Relationship-based practices can play a prominent role in early care and education.

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