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Importance of Caregiver Training and Education in a Chinese Orphanage

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Importance of Caregiver Training and Education in a Chinese Orphanage

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Importance of Caregiver Training and Education in a Chinese Orphanage

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Pacific University

School of Occupational Therapy
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Chapter One:

Background/Significance
Impact of Orphanages on Child Development

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Development of Children in Orphanages

There are over 153 million orphans around the world, and roughly 600,000 orphans in China (Ripley, 2015). Ninety-five percent of all orphans are over the age of 5. While many orphans commonly reside in orphanages, some may reside with a surviving grandparent or family member. A large percentage of orphans are located in Sub-Saharan Africa and Southeast Asia while 1-out-of-9 children in Sub-Saharan Africa die before reaching the age of 5 years (SOS Children’s Villages-USA, Inc., 2015). There are approximately 10 million orphaned children in Latin America. There are 120,000 orphans in the United States of America and 400,000 children who do not have permanent homes or families. Asia has over 60 million orphaned children, which is the largest number of orphaned children in the world. Of those children abandoned in orphanages in China, 98% of the children have a disability, whereas 140,000 children with disabilities live in institutional care in the Russian Federation alone.

Unfortunately, the number of orphans is continually increasing (Walker et al., 2011), which is likely due to economic conditions, education, and access to health care. The negative effects of orphanages on typically developing children are substantial; for children with disabilities, it can be devastating. Negative effects can double or triple the impact of physical, cognitive, and social challenges experienced by the child. It is clearly important to create supports for those who care for these children with disabilities in orphanages; however, caregivers may not always have the education to adequately care for children with disabilities (Groark et al., 2013; Vashchenko, Easterbrooks, & Miller, 2010). Children with disabilities are often given the least amount of attention in an orphanage (St. Petersburg-USA Research Team, 2005).
There are many stigmas associated with having a disability. Grames and Leverentz (2010) found that physical disabilities were perceived more positively than those with psychiatric disabilities. Different parts of the world view disability differently. For example, Chinese have a more negative perception of persons with disabilities than Americans. Children with disabilities around the world are often not receiving the quality of care necessary for a healthy development due to the negative perceptions and stigmatization toward persons with disabilities. Children and adolescents in institutional care often face stigmatization and social judgment, which impacts their self-esteem, confidence, and causes loneliness and other psychological symptoms.

In China the term canfei means handicap or useless (Liu, 2011). Traditionally, it is believed that individuals have a disability as a punishment for his/her parental sins and/or having an unbalanced diet or emotional disturbance during pregnancy. Overall, disability is viewed as shameful and is kept from society – typically resulting in a lack of adequate care. Therefore, it is important to educate carers about disability and important aspects of treatment for these children. There is also a general assumption that there is nothing that can be done to assist in the improvement of development of children with disabilities in low-income countries (Groark et al., 2013). This is likely a result of cultural beliefs and access to education and health care services.

There are different reasons why children are placed in orphanages, such as being affected by natural disasters, armed conflicts, disabilities, or democratic policies (Vashchenko et al., 2010). However, children without disabilities are more likely to be adopted than children with disabilities resulting in longer stays in orphanages (Bakermans-Kranenburg, van
IJzendoorn, & Juffer, 2008). It is thought the longer the children are in the orphanage, the more detriments may be present for a child. These detriments affect both the physical and mental aspects of the child (Escueta, Whetten, Ostermann, O’Donnell, & The Positive Outcomes for Orphans Research Team, 2014; Muhamedrahimov, Palmov, Nikiforova, Groark, & McCall, 2004; Pollak et al., 2010; St. Petersburg-USA Orphanage Research Team, 2005; Wolff & Fesseha, 1998). It is also believed there are no long-term consequences to a child, regardless of the severity of institutional environments, if there is limited exposure during the first few months of life (Groark et al., 2013). Each orphanage should prioritize what is important and be aware of the needs of the population they serve (Ritchie & Howes, 2003).

Inconsistency in the care provided to children in orphanages is common (Daunhauer, Coster, Tickle-Degnen, & Cermak, 2007; Muhamedrahimov et al., 2004). Specifically, during the child’s first 2 years of life in an orphanage, there was little stability and poor consistency in the social-emotional environment (Muhamedrahimov et al., 2004), as children were likely to see 50-100 different caregivers (Muhamedrahimov et al., 2004; St. Petersburg-USA Research Team, 2005). Interactions typically occurred when assistance was needed with self-care needs and feeding. With regard to feeding, literature showed that children fed by caregivers have the spoon touch their mouth approximately 30 times per minute (Muhamedrahimov et al., 2004; St Petersburg-USA Research Team, 2005). This was likely due to the ratio of caregivers to children, which can lead to a rote way of caring for children without providing them with warmth, sensitivity, and child-directed interactions (Groark et al., 2013).

Specifically, with children with disabilities spend a greater amount of time in an environment where movement was prevented (Groark et al., 2013). These children were often
left in cribs, chairs, or awkward or contorted positions for long periods of time (Groark et al., 2013; St. Petersburg-USA Research Team, 2005). Orphanages may also have equipment such as wheelchairs available for children with disabilities, but were often not utilized and may be poorly positioned when seated in an adaptive device.

Staying longer in orphanages appeared to have a negative effect on a child’s cognitive development (Bakermans-Kranenburg et al., 2008). Audet and Le Mare (2010) found increased deprivation prior to adoption resulted in increased inattention and overactivity. Moreover, there were increased symptoms of inattention and overactivity in children who endured durations of deprivation for more than 6 months. Additionally, Cermak (2009a) and colleagues have shown that children in orphanages were subject to sensory processing disorders.

Caregivers play a large part in the development of a child’s emotional needs. From caregivers’ perspectives, they need to notice the children’s emotional needs in order for the children to feel comfortable and trust the caregiver (Bettmann, Moretensen, & Akuoko, 2015; Vashchenko et al., 2010). The caregivers also stated the importance of providing physical comfort through cuddling and holding the children (Bettmann et al., 2015). Caregivers working in orphanages in Ukraine could identify changes that would be ideal, including providing of family-like care, improved physical care for children, and improve working conditions for the carers (Vashchenko et al., 2010).

Displaying positive emotions, sensitivity, and responsivity to the child was shown to improve social-emotional development (Walker et al., 2011). Daunhauer et al. (2007) found that interactions between the caregiver and child showed more competent play of the child than when playing alone. It was also shown participation from a child increased with
individualized care from the caregiver, including caregiver social-emotional support. Increased interactions were also likely to motivate interactions with the environment (Groark et al., 2013). However, play is often object-oriented rather than person-oriented (St. Petersburg-USA Research Team, 2005). Over time children did not expect interactions nor look to the caregivers for assistance.

The result of a distance relationship and interaction with the children may be due to the emotional stress of the caregivers, which can affect their ability to form empathetic relationships with the children (Muhamedrahimov et al., 2004; Vaschenko et al., 2010). Muhamedrahimov et al. (2004) found that caregivers working in orphanages were more likely to have anxiety and depression when working with infants. Continued stress can lead to burnout, internal conflicts, and dissatisfaction with work, thus affecting the quality of care given the children (Curbow et al., 2000).

Providing interventions in orphanages have shown to improve children’s cognitive development (Bakermans-Kranenburg et al., 2008). Specifically, interventions including structural changes and staff training can have an improvement on child development and care given (Baker-Kranenburg et al., 2008; Muhamedrahimov et al., 2004). Structural changes have shown to increase the quality of care given to the child, especially those with a disability, increase caregiver-child relationships, and even increase the social behaviors and attitudes of the caregiver (Muhamedrahimov et al., 2004). By increasing consistency of care through having fewer caregivers for one child has also shown to improve caregiver satisfaction (Rutter, 2008). It was also shown that these interventions had a more positive effect on children if started prior to the first birthday (Baker-Kranenburg et al., 2008).
Providing adequate education and training in orphanages is important in the development of children with disabilities as it may assist children in overcoming barriers children in orphanages may face (Escueta et al., 2014). However, the economic location of the orphanage is a large contributing factor in alternative care arrangements, thus, orphanages will not be eliminated in the foreseeable future (Baker-Kranenburg et al., 2008). It may also be difficult to change practices in orphanages due to rooted beliefs of how children, specifically children with disabilities, should be treated (Groark et al., 2013). St Petersburg-USA Research Team (2005) also found that caregivers received specialized training; however it did not pertain to the developmental stages and needs of children with disabilities.

Often, orphanages have a greater number of children than caregivers can reasonably care for, thus compromising the quality of care given to the child. Berument (2013) found that focusing on caregiver training, program implementation, and environmental enrichment can improve the quality of care provided. This intervention also had an effect on decreasing the language and cognitive developmental gap. Caregivers who received training to provide sensitive, responsive, and respectful interactions with the children also had significance on the behavioral and cognitive development of children with disabilities (Groark et al., 2013).

Sustainability of interventions in an orphanage after implementation does not always occur (McCall et al. 2013). A study by McCall et al. (2013) suggested that a maintenance intervention that included at last the following four factors can assist in sustaining the intervention after implementation. One factor included focusing on overall emphasis of the care provided through warm, sensitive caregiver-child interactions that are individualized. Having increased interactions may also relate to a more secure relationship (Ritchie & Howes,
2003). Other factors included having the older caregivers teach the new caregivers, having the director of the facility committed to the intervention, and having a follow-up period (McCall et al., 2013). These changes showed there was an improvement in children’s behaviors and development.

Overall, it was shown that there were significantly negative effects on the development of children in orphanages. The detriments largely impacted the emotional development of the child which in turn can cause caregiver stress. With continual stress and quality of care being compromised, the children were not receiving adequate care – further inhibiting the children’s well-being. While there were many efforts with several interventions available, further research on how and what information to present in interventions is needed. It is also important to have follow-up to ensure the maintenance of the intervention. The intervention should target both the children and the caregivers. Further research can and should include interventions targeting orphanages for children with disabilities as increased length of stay can cause future detriments in the development of the child.

**Effects of Disabilities on Adolescents in Orphanages**

Children aged 6-to-18 years in institutional care had more emotional, social, attention, and behavioral developmental issues. Children typically have to leave the orphanage when they turn 18 years old and integrate into the community with limited life skills to create a healthy and safe lifestyle. This is often caused by a lack of quality of care from the caregivers and limited opportunities in low socioeconomic orphanages. Children and adolescents are often unable to gain the necessary life skills while living at the orphanage, which affects adolescents
when they reach the age of 18 years. Adolescents in institutional care experienced more externalization and attachment problems than adolescents living with their families.

Adolescents who were institutionalized experience higher levels of depression and loneliness than children who were raised at home, which can then lead to more serious problems in the future (Han & Choi, 2006). Institutionalized children and adolescents often experience a negative attributional disposition due to a lack of quality parental guidance and nourishing environment. During hard times adolescents often experience a negative attributional outcome such as blaming themselves for failures and not taking the credit for their successes; thereby, negatively impacting their self-esteem and creating more distress. It is crucial to get to the root of the problem, which is providing quality care to children who are institutionalized and were more prone to experiencing increased levels of loneliness than child-reared adolescents. This also indicates the impact of having a stable environment so institutionalized children can have a more positive attributional disposition. Poor quality of the relationship between the caregiver and children is a large determinant in children’s mental health (Simsek et al., 2008). Caregiver training is essential in creating confidence, support, and warmth to increase adolescents’ problem solving skills. Training caregivers can help provide an enriched environment for children and/or adolescents with disabilities residing in orphanages by increasing opportunities and providing more quality care.
Research indicates children raised in orphanages often face physical, cognitive, and social-emotional detriments that can be carried into adolescence. This could be due to a lack of caregiver education and training. Poor caregiving is one of the most common faults in orphanages, which caused negative health issues and delays in overall development (Yendork & Somhlaba, 2014). In Ghanaian orphanages, negative caregiver attitudes caused decreased quality of care. The type of care from caregivers impacted children's' development and psychological well-being as they entered into adolescence, thereby potentially affecting their ability to transition and thrive in the community.

One study found that trained caregivers, periodic training, and caregiver supervision improved children's' development and learning process (St. Petersburg-USA Orphanage Research Team, 2008). It also increased their social-emotional abilities and decreased anxiety and depression/withdrawal. This indicates that healthy development for children in orphanages or foster care is largely dependent on the quality of the training and education of the caregivers. Caregivers benefit from training and education to better understand the benefits of creating positive peer relationships such as basic communication and social skills (Yendork & Somhlaba, 2014).

Ninety percent of children born with a disability reach adulthood due to new medical advances (Blomquist, Brown, Peersen, & Presler, 1998). Although medicine has improved the longevity of children with disabilities, it also creates new challenges for caregivers. Children in a Romanian orphanage demonstrated more developmentally competent play when interacting with the caregivers than when playing alone in an environment that provides less than “normal” child-caregiver relationships (Daunhauer, Coster, Tickle-Degnen, and Cermak, 2007).
The caregivers provided social emotional and task support during interactive play with the children causing the children to be more responsive during play.

Groark, Muhamedrahimov, Palmov, Nikiforova, and McCall (2005) found that children with disabilities in an orphanage in Russia experienced social emotional issues due to a lack of quality and unresponsive care from the caregivers. Prior to the caregiver training, the children engaged in self-stimulating behaviors such as rocking back and forth or head banging, kept on toilets for long periods of time as the caregiver attended to other tasks, left in cribs and expected to stay in the crib even if they were not asleep, left unattended lying on the floor or in infant seats with no stimulating activities, received no adaptive positioning by the caregivers, and had an absence or negative peer interactions. The caregivers were detached and had little communication with the children; therefore, the children had poor attachment behaviors such as lacking eye contact with adults and aggressive and impulsive behaviors. Two interventions included caregiver training to promote warm, responsive, and consistent care.

The training was adapted to fit the cultural needs of Russia and provide safe positioning and handling of children with severe physical disabilities. The training promoted caregivers to engage in parental behaviors and interactive play with the children (Groark et al., 2005). Results indicated an increase in the children’s ability to communicate and increased emotional, expressive, and enthusiastic responses. Positive social interactions and consistency among caregivers were seen. The children with disabilities’ physical growth, motor, cognition, language, social, and affect improved after the caregivers received training. The children had increased social-emotional development such as attachment behaviors. Eight orphanages in sub-Saharan Africa collected qualitative data from 92 staff members and also found that
caregiver training is essential in providing children in orphanages attachment and social emotional skills (Bettmann, Mortensen, and Akuoko, 2015). Caregivers who were trained helped the children gain more awareness, sense of competence, and behavioral regulation during play, feeding, bathing, and working routines (Boivin, 2012). One caregiver stated the importance of the relationship between the staff and children; if they work together, then they will succeed.

Children in an orphanage in Latin America were more responsive to caregivers who were trained in providing warm and nourishing care during feeding and bathing/dressing routines (McCall et al., 2010). The caregiver’s training focused on the children’s attention skills, language development, caregiver self-reflection, attachment, brain development, and adapting to the children’s temperament. This led to the children being less depressed. According to Ahl, Johansson, Granat, and Calberg (2005), parents and preschool assistants attended group sessions led by a physician, physiotherapist, special needs teacher, psychologist, and social worker for five months; they were guided, educated, and trained in how to facilitate their children with cerebral palsy (CP) in gross motor capacity and performance in self-care, mobility, and social functioning. The children with CP presented with increased skills in gross motor movement and participation in activities of daily living (ADLs). The amount of caregiver assistance decreased because the children were able to apply their skills acquired from the training sessions and more independently perform certain ADLs. Training the parents and preschool assistants helped increase their knowledge in understanding how to care for children with disabilities; therefore the children had increased ability to participate in ADL and mobility.
Berument (2013) found that quality environments and appropriate caregiver training can lead to increased language and cognitive development in infants and children in Turkish institutional care. Infants and children were cared for primarily by the caregivers, educators, professional staff, and a manager. The primary caregivers were in charge of self-care activities with the children. Children in the control group experienced a developmental decline in cognitive development indicating that institutional care can have negative effects on children; therefore, caregiver training influenced children’s cognitive and social skills by helping create a more conducive environment to the children’s development.

The above literature promotes the importance and impact caregiver training has on the quality of care for children with disabilities. Children with disabilities in these orphanages are able to gain basic attachment behaviors and social emotional and cognitive skills. Environment played a vital role in the early development of a child; therefore caregivers who were providing more structured play and assistance lead to more responsive play from the children (Daunhauer et al., 2007). Training caregivers increased quality of care for children in orphanages and prepared children to grow into adulthood and integrate into their community. No matter a child’s age, caregivers or staff training in orphanages can help create a more nourishing and stable environment (Allen & Vacca, 2011).

**Occupational Participation and Adolescent Transitioning into Adulthood**

Many foster care systems provide short term placements lacking the appropriate transitional education and resources for functioning in society (Allen & Vacca, 2011). The children are supposed to leave foster care systems at the age of 18 years and often have a
difficult time transitioning to independent living. They often lack social support, education, have difficulty finding stable work, and do not have long term relationships due to being abandoned along with their family and society by having to move between different foster homes. Allen and Vacca (2011) mentioned that to get to the root of this issue one must start in the orphanages. A more stable environment over time would be more beneficial to the children, as well as good educational opportunities and providing an atmosphere that is emotionally secure and nurturing. Increasing quality of care in orphanages can also help adolescents transition into living independently in the community. This may then decrease criminal activity and troubled adolescents may be able to find a stable and healthy lifestyle.

Adolescents transitioning into the community and adulthood face challenges; however, adolescents with disabilities also have other, if not more, challenges to face due their impairment and lack of resource availability. Adolescents with disabilities transitioning into the community often find it difficult due to a lack of knowledge of vocational training, education, and self-advocacy skills (Blomquist et al., 1998). Adolescents with physical and/or mental disabilities had fewer opportunities for peer interactions, age appropriate developmental stages, and identity and sexuality issues. Real life experiences can increase children with physical disabilities developmental process and help them gain life skills to increase their participation in ADLs/ instrumental activities of daily living (IADs) (Palisano et al., 2012).

Transitioning to adulthood contains multiple components which include: ADLs, mobility, transportation, health care, living arrangements, housing, recreation and leisure, personal awareness/companionship, community participation, education, employment and job supports, and financial management (Blomquist et al., 1998). Physical and social engagement in activities
can produce psychological, emotional, social, and physical benefits in their developmental process (Palisano et al., 2012). Collaboration between different members of the intervention process can aid in children’s development (Blomquist et al., 1998). Caregivers, nurses, and family can have crucial roles in the transition efforts such as finding community resources, navigating in the community, and gaining independence with life skills. The principle of participation-based therapy is to provide opportunities for children to participate in real life activities (Palisano et al., 2012). There are usually three main barriers such as low expectations, lack of knowledge, and lack of skills. Therefore, training caregivers can help adolescents transition into the community and adulthood and gain life skills by participating in ADLs/IADLs by helping the adolescents with disabilities find appropriate resources, gain knowledge, and self-advocate (Blomquist et al., 1998).

Providing caregivers working with children in orphanages or institutional care with the appropriate knowledge and awareness regarding participation in real life tasks and activities can be beneficial to the development of the children (Palisano et al., 2012). Many orphanages do not provide children with these opportunities; therefore, hindering their developmental process. Literature suggests the importance of participation in real life tasks and ADLs/IADLs provided by caregivers can increase children’s and adolescent’s future success when transitioning into adulthood and into the community. Helping adolescents find the appropriate resources in the community and actively participate in ADLs/IADLs will increase their independence and resilience when faced with challenges living in the community.

Social supports such as families, children, and/or caregivers of children play vital roles in helping children or adolescents with a healthy development and gain life skills necessary for
transitioning into the community (Sunusi, 2012). Informing and educating caregivers about the importance of developing a positive relationship with the children will aid in increasing their coping skills, enhance social interactions, problem solving, resolving conflicts, assertiveness, and manage stress. Adolescents with these skills have an easier time transitioning and living in the community. A community-based approach is beneficial to adolescents transitioning into the community and caregivers aiding in their transition process (Sunusi, 2012). Adolescents thrive more when entering the community after having received support from trained caregivers. Community youth centers provide for psychosocial support and life-preparing programs from the help of trained caregivers. Centers with trained caregivers can help children more smoothly transition into young adulthood. Part of the process is helping to instill more self-confidence in the children, diligence, self-help skills, and cooperation. Caregivers must understand and be educated on the importance of how to provide quality care to then instill a “sense of belonging” and “togetherness” in the children. Children who have a stronger sense of belonging thrive more as they enter into adolescence and the community.

**Summary**

Caregivers can promote self-advocacy for children who are institutionalized and face stigmatization and social judgment. Providing training to caregivers to in turn provide through warm, nourishing care for children with or without disabilities in orphanages/institutionalized care increases their cognitive and social emotional development. Children experienced decreased feelings of loneliness and depression when caregivers were trained. Training caregivers can increase the children’s overall responsiveness and expression in everyday life.
Adolescents with disabilities face even more challenges than their counterparts by having to consider accessible resources, housing, medical funding for their disability, and social support. Literature indicates the importance of caregiver training in helping children and adolescents gain the necessary skills to live as independently as possible in the community.

Implications for further research include studies focused on the impact of caregiver training on the development and quality of life for children with disabilities living in orphanages. Further research is necessary for when children with disabilities enter adolescence and need to begin acquiring basic skills to live as independently as possible in the community. Occupational therapy aids in increasing individuals’ independence and physical, social-emotional, and cognitive ability to participate in meaningful occupations. Therefore, occupational therapy can play a large role in providing caregiver education and training to increase the quality of care for children and adolescents with disabilities residing in orphanages.

Fuling Social Welfare Institute, located in Fuling, China, is an orphanage for children with disabilities between the ages of a few months to 18 years. Pacific University Oregon has a long-standing relationship with the orphanage and a therapy team visits the orphanage annually. After completion of a needs assessment, a few goals have been developed for the orphanage to increase the quality of care for the children. First, education about disability is important as many of the caregivers do not have an education past primary school. Disability is also a topic that is not widely discussed in China; thus, education and knowledge about common disabilities and potential children have to succeed in society is needed. A second goal is training and improving caregivers’ skills on independence and activities of daily living (ADLs). With the caregiver-to-children ratio, efficiency is often seen in many areas such as feeding. Third,
education and training on position and handling. Many of the caregivers do not have knowledge about the common disabilities and are unsure of proper positioning and handling techniques. Fourth, a goal for the therapy team is to understand that these changes will take time and that there is a cultural difference with Western and Eastern views.
Chapter Two:

Methodology
Fuling Kids International (FKI) is a not-for-profit association of families and friends devoted to children who were adopted from Fuling and found their first home in China. Children who lived at the orphanage in Fuling, all have the last or family name Fu. Currently, Fu children live with their families in the United States of America, Canada, Australia, China, Sweden, France, Spain, Ireland, England, the Netherlands, Germany, Belgium, and Iceland. FKI is a grassroots organization devoted to improving the care of children who live at the orphanage. Many of the members of FKI are families who adopted children from the Social Welfare Institute (also known as an orphanage) in Fuling, China. The children at the orphanage range in age from several days old to 18-years old. Many have congenital conditions such as cerebral palsy, cleft palate, Down’s syndrome, and autism spectrum disorder (Fuling Kids International, 2014). Approximately 60 children live at the orphanage while over 100 children are placed in foster homes.

The mission of FKI is to provide the best care for the children who are not adopted and will be living at the orphanage, and to ensure that the children who are eligible for adoption are adopted and cared for while living in the orphanage. The vision of the organization is to have children with disabilities perceived as having the capability to learn and participate in society as valuable individuals (S. Rogers, personal communication, September 3, 2014). A goal set by the staff at FKI is “to treat all children fairly and to provide the best possible environment for a child until she or he has a family” (Fuling Kids International, 2014).
Needs Assessment

April Chu and Constance Liu, occupational therapy students at Pacific University, Oregon showed a keen interest in improving the quality of care for the children with disabilities at FKI. A qualitative approach was taken in collecting data through reviewing the FKI website, which provided general information about the orphanage, and learning what Pacific University faculty and students have completed previously onsite. Further information was gathered from Sandra Rogers and Christine Macfarlane, who are faculty members at Pacific University and FKI board members. A SWOT grid was produced to organize the findings and provide an overview of the strengths and weaknesses of the internal and external factors of this organization (Appendix B).

The internal stakeholders are the caregivers/staff, children, board members, Fuling Social Welfare Institute, and adopting families. The board members and Fuling Social Welfare Institute’s interest is to continually receive funds so they may keep providing a support system for the children without a permanent home. The external stakeholders include the families interested in adopting and health services provided by the physicians who perform surgeries such as repairing cleft palates for the children at the orphanage (S. Rogers, personal communication, September 3, 2014).

Fuling Social Welfare Institute owns a van, which allows the employees to drive into the city on a daily basis. This supports their occupations by allowing the staff to drive and obtain supplies from town and/or stay involved with community members. The employees do not take the children into town with them to obtain supplies, therefore, hindering opportunities for the children to socially interact and learn to function in a larger community (S. Rogers, personal
The orphanage is isolated from the community because it is located at the top of a mountain right outside the city.

Fuling Social Welfare Institute also assists the children with engaging in certain occupations such as education which includes reading and writing. The orphanage has a separate classroom for the children to learn; however, there are social barriers that will be discussed later. The caregivers assist the children with their basic self-care needs such as bathing, feeding, and toileting (S. Rogers, personal communication, September 3, 2014); however, this hinders the children’s opportunity to gain skills in performing these tasks more independently. For example, in the past, the caregivers would feed the children, even if they were physically and cognitively able to self-feed, just to be more efficient. With coaching and encouragement, per involvement of the interprofessional team from Pacific University, carers were shown how helping children feed themselves would reduce caregiver burden and empower the children.

The physical environment of the orphanage contains a classroom that is adequately supplied with desks, chairs, reading materials, white boards, markers, and other school supplies. This benefits the children’s development by giving them the opportunity to learn from a certified teacher. However, the classroom’s desks are not ideal nor built for the functioning needs of children with disabilities (S. Rogers, personal communication, September 30, 2014). The educational and academic curriculum at FKI has shown the most improvement the past few years. Currently, the teacher has good classroom management and is able to engage the children to participate in music, dance, and other various activities. There is playground equipment for the children, which challenges the children’s ability to engage in opportunities
for free and imaginative play, climbing, crawling, and/or sliding. In regards to feeding and meal preparation, there is a kitchen available to prepare all the meals for the children on-site and ensures that the staff knows what is going into the food they prepare.

The social environment involves eight caregivers who are present during the day while only two-to-three caregivers stay overnight at the orphanage (S. Rogers, personal communication, September 3, 2014). The caregivers do not receive a large amount of monetary benefits, thus affecting the quality of care provided to the children. These factors make it difficult for the caregivers to feel motivated and invest more effort towards caring for the children (S. Rogers, personal communication, September 30, 2014). In regards to education, the teacher spends about 5 hours in the classroom with the children, but only 1-out-of-5 hours are spent teaching the children academics, which serve as a barrier to the children’s learning and development. Even with the hour of academics, there is not an established curriculum for the children; and, unlike mainstream China, the children only learn Chinese rather than both Chinese and English. Prior to the current educator, who was previously a teacher at a primary school, there was a high turnover rate within the last 3 years which could be related to the low income and/or lack of experience teaching children with significant disabilities.

Social strengths include the caregivers assisting the children with their basic self-care needs, thus facilitating the children’s engagement in activities of daily living (ADLs) such as feeding, dressing, and personal hygiene (American Occupational Therapy Association, 2014). Students and faculty members from Pacific University, Oregon visit the orphanage annually and provide education to the caregivers about the care given to the children. The location of the orphanage may be isolated from the community, but allows the children to have privacy and
avoid potential situations where others may be verbally and/or physically abusive towards children with disabilities due to cultural stigmas. The location also has better air quality than in the city.

After careful examination, the quality of care provided to the children at FKI needs to be further analyzed as well as the interventions that should focus on the care provided by the caregivers. There are many strengths and barriers regarding the physical and social aspects of Fuling Social Welfare Institute that affect the quality of care given to the children. The large child-to-caregiver ratio makes it difficult to provide the full level of care the children need. Although changes are slowly being implemented to allow the children to be more independent, there is conflict with the caregivers trying to be more efficient with their time. According to the research and evidence gathered, it can be concluded that there are various barriers present hindering the fulfillment of the organization’s mission and goal statements of providing quality care for the children. More awareness addressing caregiver education and quality of care given by the caretakers should be considered.

**Preparation for China Project**

Prior to the Pacific University China Trip 2016, the occupational therapy students had weekly meetings with faculty and community advisors, Sandra Rogers and Christine Macfarlane, to discuss priorities before arriving at Fuling Social Welfare Institute. A daily schedule was developed, which included collecting inventory of supplies/equipment, activities with the caregivers, activities with the children both participating and not participating in school, and daily meetings to debrief about any improvements that could made at FKI. Information was
collected for parts of the Caregiver’s Manual and Resource Guide such as feeding, crib safety, and age-appropriateness. It was decided the therapy team would not bring handouts regarding this information due to the need to understand what supplies were present, current level of skills the caregivers have in caring for children with disabilities, and the level of education for the written handout. It was also understood that all communication with individuals at the orphanage would be through an interpreter as the primary language spoken is Mandarin.

**Interview with Manager of the Orphanage Staff**

The occupational therapy students met with Mrs. HongYa Liu, manager of the orphanage staff, to discuss what she found important for Fuling Social Welfare Institute; an interpreter was used during the meeting. Mrs. Liu showed appreciation for the annual visits from Pacific University’s therapy team. It has been useful to teach and train the caregivers in caring for children with disabilities (H. Liu, personal communication, May 6, 2016). Other institutions have come to the orphanage and provided training in communication with children, cognition, and comforting children. However, there was a lack of carry-over with the training due to the rote ways the caregivers have been caring for the children. She reported that many of the caregivers have not received a formal education and have not completed primary school. There is also an overall lack of knowledge about disability in China. The caregivers working at the orphanage have not received professional training on caring for children with disabilities. Mrs. Liu reported many of the caregivers displayed a lack of optimism and “hope” in caring for children with disabilities at Fuling Social Welfare Institute. Therefore, a way to establish more
formal regulations and guidelines for the caregivers will be beneficial to the quality of care for children with disabilities at Fuling Social Welfare Institute.

Despite Mrs. Liu’s enthusiasm about the Caregiver’s Manual and Resource Guide, she was unable to give personal ideas and/or suggestions for the Caregiver’s Manual and Resource guide despite several prompts. She relayed she wanted the occupational therapy students to provide their own suggestions. However, Mrs. Liu provided a suggestion of a skills checklist to ensure carryover of skills from the manual. A common theme throughout the meeting was the lack of knowledge the caregivers have about disability; thus, it was decided the manual needs to place emphasis on education and knowledge about disability, common disabilities seen at the orphanage, symptoms of these disabilities, and the potential for children with disabilities in the community.

Feeding Workshop at the Orphanage

Christine Macfarlane and Sandra Rogers, with the aid of an occupational therapist and two occupational therapy students, conducted a workshop on May 5, 2016 to educate the caregivers at Fuling Social Welfare Institute on the skills necessary for safely feeding the children at Fuling Social Welfare Institute. An interpreter was used for the entirety of the workshop; thus, it was important to keep the information simple and direct for the ease of translation and varying education levels of the caregivers. The caregivers learned appropriate positioning for feeding, safety precautions for placing food in a child’s mouth, and use of the mobile classroom chair (with lap tray) for appropriate positioning during feeding. Macfarlane used a variety of small snacks for the caregivers to practice positioning of the head as they were
being fed and doing the feeding. Positive responses from the caregivers were observed. Some of the caregivers were later seen integrating the newly learned feeding techniques provided by the workshop when feeding the children. Some of the children were placed in the mobile classroom chair (with lap tray) and were fed from their own bowl and spoon instead of being fed from a communal bowl. Caregivers demonstrated a positive understanding and carryover of information from the feeding workshop.
Chapter Three:

Caregiver’s Manual and Resource Guide
Caregiver’s Manual and Resource Guide

Fuling Kids International

April Chu and Constance Liu

Pacific University Occupational Therapy

Doctoral Internship/Capstone 2016
This manual is to provide you with information about each common disability and what helps children develop and live healthy lives. These are things you can do as the caregiver to help children with disabilities gain skills that will help them throughout the rest of their lives.

We know that children who have access to good health care and early treatment tend to do very well despite their disability. All children need structure, clear expectations, gentle and consistent discipline, and a supportive environment. Children who live in orphanages tend to have poorer outcomes because their caregivers do not understand the importance of these issues. We hope to provide you with training so you can give these children the best care possible, and help you understand how important the simple things you do every day can help the children grow and be healthy.

In this manual we will tell you about some common disabilities and provide you with some common treatment procedures to follow. Hopefully, this will make you more comfortable with caring for children with disabilities. Many of the disabilities found at Fuling Social Welfare Institute and listed in the Caregiver’s Manual and Resource Guide are autism spectrum disorder, cerebral palsy, cleft palate, and intellectual impairment and Down’s syndrome. These disabilities are also the most common conditions found throughout the world, sometimes due to unknown causes. Those listed in the manual are beneficial to know the most about to provide knowledgeable and quality care to children with disabilities.

For more information about the authors, please see Appendix A.
What is Disability

Disability is an overarching term for people with an impairment or health condition that makes it difficult for the person to do everyday activities, interact with others and their environment, and/or affects their daily lives (World Health Organization [WHO], 2011, p. 4). It is unknown and often difficult to understand why a child has a disability. It is often very difficult to understand why a child may be disabled. Often times, people want to believe that the disability was caused by something “wrong” that the parents or the mother did during the pregnancy. We know that this is not true because disabilities tend to be the same throughout the world and medical research shows us that there is often little connection between a disability and parenting. Some kinds of conditions, like loss of an arm/leg, finger/toe development can happen because the mother was exposed to toxic chemicals. Some disabilities like Down syndrome are due to a genetic problem (but not caused by the mother or father). But for most disabilities like Autism, cerebral palsy, and intellectual disability (mental retardation) there is no known cause. Individuals with a disability may experience visual, hearing, speech, physical, intellectual, and/or psychological disabilities; everyone with a disability is different, just as all people are different from one another. It is important not to decide what a child will be able to do, instead expect all children to need love, structure, learning, and abilities.

Environment impacts an individual with a disabilities ability to thrive in the community such as having safe and clean water to drink, clean and healthy food to eat, climate, or accessing health care resources. Negative attitudes, lack of knowledge, and unawareness about disability are often common in societies (WHO, 2011, p. 6). However, those with a disability
with the correct resources and support systems are able to be an important part of the community.
Disability in China

In China prior to 1980, people with disabilities were discriminated against and the common perception was one of handicapped and “useless” to society. In 1991, China enacted the ‘Protection of Disabled Persons’ Law giving individuals with disabilities equal rights in “political, economic, cultural and social fields, in family life and other aspects” (Disabled World, 2016, pg. 1). Views on individuals with disabilities have improved with the enactment of the law; however, there continues to be stigmas against those with disabilities. The degree to which stigmas are present varies depending on the type of disability a person has, socioeconomic status, and region of living (rural vs. city). For example, individuals with a mental illness often face more severe stigmas and ridicule for having a mental illness than individuals with a physical disability (Grames & Leverentz, 2010).

From birth, all children need love and affection from parents/caregivers. Attending to the child’s emotional needs is important to help the child be more comfortable and build trust with others. This can be built through paying attention to when the child is crying as well as holding and cuddling the child while talking to him/her. By giving the child tender love and care, you are providing them with the necessary foundation and tools to better cope with problems in the future. Talking to the child is vital to the development of their communication skills and understanding the world around them such as associating words to an emotion, words to specific actions, or words to identify an object. As the children grow older, they need to feel safe in their environment as they become more independent. The safe and comfortable environment paired with the trust of the caregiver can allow the child to be more willing to
explore the world around them as well as become more independent in self-care skills while having a safe place/person to go back to.

There are 323,000 children with disabilities who have limited access to education, largely due to poverty. There are at least 83 million individuals with a disability in China with 43% of those individuals who are unable to read (Human Rights Watch, 2013). Students with disabilities are able to participate in mainstream or special education schools; however, mainstream schools have a rigorous academic workload. Despite legal obligations for students with disabilities, there are no adequate support systems for educators in mainstream schools for children with disabilities. Low educator-to-student ratios cause class sizes to be difficult to manage (Human Rights Watch, 2013). Lack of accessibility and accommodations is a barrier for children for many children with physical and intellectual disabilities (Disabled World, 2016); and, even more so, when there are limited special education schools throughout the country (Human Rights Watch, 2013). The continued denial and lack of resources for children with disabilities has a negative effect on educational, physical, cognitive, and social development (Shang, Fisher, & Xie, 2009).
What Children with Disabilities are Able to Do

Johanne Hanko (2011) author on disability-related concerns stated, “One should never underestimate the capabilities of children with special needs or their creativity.”

Children with disabilities may require more time and support to complete certain tasks; however they are just as creative, thoughtful, playful, and experience fun and happiness as a child that is typically developing. With good support and access to community resources, and loving care, children with disabilities are able to live fulfilling and meaningful lives.

Children with disabilities are able to:
- Engage in everyday activities that children without disabilities engage in
- Play sports and games with other children
- Complete their own self-care
- Think for themselves (have their own opinions)
- Be happy
- Go to school
- Have a job
Tips to Remember When Working with Children with Disabilities

1. Children with disabilities are PEOPLE first, they are not a DISABILITY. They are a PERSON first; They are NOT their disorder
   - Call the child by their name

2. A child’s disability is NOT anyone’s fault (do not place blame on parents)

3. A child with a disability has feelings even if they do not show them, and their feelings matter

4. Yelling or punishment will NOT make them learn faster
   - e.g. Talk in calm voice when explaining things the children may have done wrong

5. They are NOT doing things to make you mad

6. They are just kids deep down (do not be too hard on them)

7. Be patient, sometimes learning to talk can take years longer than typical children, but that does not make them unable to learn, it just takes much longer to learn

8. Small accomplishments mean a lot
   - i.e. Feeding themselves; cleaning up after playing with toys; sharing toys with other children

9. If you believe in them, then they will believe in themselves too

10. Give reward and praise, even for the small things
    - e.g. Tell them “good job” When they clean up the toys when asked to

11. DO NOT GIVE UP ON THEM
As a caregiver, you will face challenges and difficulties every day when caring for children with disabilities; however it is important to keep in mind that the small changes you make will have a big impact on their life.
Specific Disabilities

Autism Spectrum Disorder

Cerebral Palsy

Cleft Palate

Intellectual Impairment and Down’s Syndrome
Autism Spectrum Disorder

What is Autism Spectrum Disorder?

Autism spectrum disorder (ASD) is a developmental disability. We do not know what causes people to have this disorder. It is not related to bad parenting or a bad pregnancy. A child with ASD will have big problems with social, communication and behavioral challenges. There is often nothing about how people with ASD look that sets them apart from other people, but people with ASD may communicate, interact, behave, and learn in ways that are different from most other people. The learning, thinking, and problem-solving abilities of people with ASD can range from gifted to severely challenged. Some people with ASD need a lot of help in their daily lives; others need less.
Common Problems:

- Difficulty with social communication
  - Upset by change in routine
  - Little eye contact and want to be alone
  - Hard time with conversations
  - Trouble expressing their needs
  - Does not point at objects to show interest
  - Trouble relating to others or show interest in other people
  - Can be very interested in people but do not know how to talk to them
  - Trouble expressing own feelings and understanding other people’s feelings
  - Some are have speech while others do not

- Repetitive & inappropriate behaviors:
  - Repeat words or phrases
  - Overly focused on what is interesting to them
  - May be focused on minor details of a toy and repeat activities over and over beyond what is needed or appropriate
  - May be sensitive to light, noise, clothing, temperature
Intervention:

- Provide a clear routine to everyday life (stick to a schedule)
  - i.e. Have a schedule for the children each morning that they can help cross off when they are done with each activity: wake up, brush teeth, get dressed, eat breakfast
- Be consistent with everything
- Reward good behavior
  - Praise them for good behavior or for learning something new
- Create a safety zone
  - Use visual cues such as colored tape to mark off areas they are not supposed to go, labeling items, using pictures
- Make time for fun
- Pay attention to children’s sensory sensitivities (i.e. light, sound, touch, smells, movements)
  - Children
- Allow children to participate in school
- Able to learn and remember information

Cerebral Palsy

What is cerebral palsy (CP)?

_Cerebral_ means having to do with the brain. _Palsy_ means weakness or problems with using the muscles. CP is caused by abnormal brain development or damage to the developing brain that affects a person’s ability to control his or her muscles. Brain damage does not typically get worse. CP can look different from person to person.

MOST children with CP do NOT have average to above average intelligence, 60% of them have some type of intellectual impairment, BUT those deficits can be mild and 40% of children do have an average to above average intelligence. Cerebral palsy affects the brain causing them to have a hard time controlling how their body moves, how they learn, see the world, and think.

What causes CP?

- Low oxygen during birth
- Born prematurely
- Brain infections
- Head injury
- Infections during the pregnancy
- Severe jaundice
What does CP look like?

- Stiff muscles (Spastic)
  - High muscle tone
  - Awkward movements
- Uncontrollable movements (Dyskinesia)
  - Difficulty controlling movement of hands, arms, feet, and legs
  - Difficulty sitting, walking, writing
  - Muscle tone can change day-to-day (too tight/too loose)
- Poor balance and coordination (Ataxic)
  - Unsteady when walking
  - Hard time with quick movements or movements that need a lot of control (i.e. writing, reaching for an object)
- Can have more than one type

http://www.cepaitkenya.org/cerebral-palsy/types-of-cerebral-palsy
Common Symptoms:

- High tone:
  - Hands in a fisted position
  - Stiff muscles that do not stretch
  - Fluttering or jerky movements of some or all body parts
  - Spasticity affects how they walk and engage in self-care
    - Unable to stay in one position
  - May drool
  - Different walking pattern:
    - Arms tucked to the sides of the body
    - Knees crossed or touching
    - Walks on toes
    - “Scissor” movements of the arms and/or legs (crossing arms and legs)

- Low tone:
  - Floppy muscles
  - Hard time balancing when walking or standing
  - Hard time moving different body parts at the same time
  - Little-to-no head control
  - Little-to-no endurance
Common Problems:

- Intellectual/cognitive impairments (mental retardation)
- Speech
- Hearing
- Vision
- Decreased learning ability
- Seizures
- Pain
- May be sensitive to certain factors in the environment or to touch
- May have a hard time swallowing and sucking
- Vomiting or constipation
Interactions to help children with CP grow and develop:

- Children with CP need to be placed in a variety of different positions every day. They need to experience different movements to learn how to control bodies, even if this movement is difficult for them. The different positions allows their brain to develop skills like spatial relationships, that do not happen if they are in one position all day.
  - e.g. Position children on the floor and in the chair and in standing

- Talk to child at eye level

- Give child time to respond to what you say

- Encourage child to use two hands when playing
  - e.g. Catch and throw with ball

- Encourage child to reach for toy
  - Allow them to use whichever hand they prefer

- Allow child to do as much as possible for self-care activities
  - i.e. Dressing - allow enough time, move slowly, let the child push arm through the hole

- Encourage the child to play and socially interact with others

- Persist in interactions even when the child does not respond, it may take many more repetitions for the child to learn than a typical child
Equipment to Move Around:

- Wheelchairs
- Crutches
- Rolling walkers
- Orthotics/braces
- Devices to help them communicate their needs to others
Cleft Palate

What is Cleft Palate?

Cleft palate is a birth defect when the tissue that make up the roof of the mouth does not join together completely during pregnancy. Sometimes you can see a large opening on one side of the cleft lip/palate or on both sides of the cleft lip/palate.

Babies’ lips and palates develop during the first three months of pregnancy. Normally, the left and right parts of the lip come together, or “fuse,” creating a normal lip. The two vertical lines on the normal upper lip are created when the left and right parts fuse. In a similar way, the left and right parts of the palate come together to create a normal palate. A front-to-back line along the roof of the mouth can usually be seen where the “fusion” occurred.

Physical Features:

- Crooked, poorly shaped, or missing teeth
- Teeth and jaw are not aligned
- Upper jaw deformities
Common Symptoms:

- Feeding problems
  - Milk might come out of the nose when feeding
  - Little to no sucking ability
- Speech problems
- Ear infections
- Hearing problems
- Noisy breathing or hard time breathing
- There is no relationship between mental retardation and cleft lip and palate
How Cleft Lip and Cleft Palate are treated:

- **Surgery**
  - Can improve appearance of face, breathing, hearing, speech and language
    - A cleft lip usually can be repaired during the first few months of life
    - A cleft lip usually can be repaired some months later
    - The exact time of these repairs depends on the baby’s health as determined by the doctor who does the surgery

- **Feeding, some simple guidelines:**

  The feeding goal is to help the baby get the right amount milk in the right amount of time, and avoid talking in too much air.

  1. Place the baby upright, sitting position to prevent the formula from flowing back into the nose area.

  2. Watch for a pattern of sucking and swallowing – listen for swallow, followed by a breath. At first, many babies suck and swallow many times without stopping to rest. Most will figure this process out within a few days, and develop their own rhythm of sucking, swallowing and resting.

  3. Keep the bottle tilted so the nipple is always filled with milk, and pointed down away from the cleft. The infant will move the nipple into the most comfortable position for him/her.

  4. As the baby feeds, some formula escape through the nose
    - Do NOT cut opening of bottle to make hole bigger
    - There are special bottles for babies with cleft palate
5. Babies with a cleft need to be burped more often because they take in more air while feeding. Watching for signs and discomfort; the baby will give you signs when it is time to stop and burp. How will you know it is working? The baby should feed in about 30 minutes or less. Longer feedings can cause exhaustion and burn up too many calories – calories the baby needs to grow.

Instructional feeding videos are located here:

http://www.cleftline.org/who-we-are/what-we-do/feeding-your-baby/
Down’s Syndrome

What is Down’s syndrome (DS)?

Down syndrome is a condition when a person has an extra copy of a chromosome known as chromosome 21. In every cell in the human body there is a nucleus, where genetic material is stored in genes. Genes carry the codes responsible for all of our inherited traits and are grouped along rod-like structures called chromosomes. Typically, the nucleus of each cell contains 23 pairs of chromosomes, half of which are inherited from each parent. Down syndrome occurs when an individual has a full or partial extra copy of chromosome 21.

This additional genetic material alters the course of development and causes the characteristics associated with Down syndrome. A few of the common physical traits of Down syndrome are low muscle tone, small stature, an upward slant to the eyes, and a single deep crease across the center of the palm – although each person with Down syndrome is a unique individual and may possess these characteristics to different degrees, or not at all.
Physical Development:

- Flat-face
- Almond-shaped eyes with upward slant
- Short neck
- Small ears
- Small mouth
- Tongue sticks out of mouth
- Small hands and feet
- Wide short hands with short fingers
- Low muscle tone
- Shorter height

Cognitive and Social Development:

- Impulsive behavior
- Poor judgement
- Short attention span
- Slow learning
Common Symptoms:
- Delayed intellectual development
- Immature behavior
- Limited self-care skills
- Decreased curiosity
- Delayed language development

Other Health Problems:
- Pulmonary hypertension
- Ear infections and hearing loss
- Eye diseases
- Thyroid disease
- Stomach and intestinal
- Seizure disorder
- Difficulty breathing
- Heart defects

http://blog.jonahkessel.com/2011/12/22/save_the_children/
How you can help the child to develop:

- Allow participation in self-care activities
  - Dressing independently
  - Brushing teeth
  - Eat independently

- Provide support for mental abilities, use simple cues to help the child
  - Visual cues; picture schedule
  - Break down activities into small pieces

- Repeat tasks, allow them to practice activities over-and-over again

- Participate in school
  - Provide extra help or attention in school
  - Provide visual cues for activities

- Have child imitate movements
  - i.e. Clapping hands, tapping knees, “high five”

- Talk with child when playing

- Bounce child in air or allow bounce/jump on trampoline

- Have child play with other children
  - i.e. Share toys, play hand games, bounce on trampoline together

How long do they live?

Average life expectancy - 60 year
COMMUNICATION

Communicating and/or understanding the needs of a child with disabilities can be challenging. Children with disabilities may be limited in how they communicate and express themselves and sometimes require you to use different ways of communicating. These are some suggestions for simple communication that make it easier for a child to communicate with you and for you to understand what a child with disability needs.
Tips for Communication

- Eye contact when speaking to child (especially for those with autism)
  - Can use mirrors to see if they can look at you that way if eye contact is too hard
- Talk to children with disabilities the same way as you would with a child without a disability
- BE PATIENT, no matter how rushed you are
- Allow enough or more time for the child to respond
  - May need to wait at least 10 seconds for child to respond
- Be honest if you cannot understand them
  - Ask them to repeat themselves if you could not understand the first time
- Tone of voice helps convey message
  - Deeper tone when saying “Do not touch that” (conveys more serious message)
  - Higher and lighter tone of voice when saying “Good job” (conveys praise and rewarding tone of voice)
- Talk slowly in simple sentences
  - “Pick up toys”
  - “Sit down here (point to where to sit)”
- Be direct (speak in short clear sentences)
  - “Do not touch that toy”
  - “Do not hit”
  - “No yelling”
  - “Sit down”
- Ask questions/explain each step one at a time
- Tell the child each step of the plan
  - Picture of first then chart
  - “First put your arm through the shirt.” - Let the child complete the step. Next, “Put head through the shirt.” - Let child complete the step
- Break the information into smaller chunks
  - “Pick up the toy”, then “Put it away in the toy box”
- Use everyday words (do not use sarcasm)
- Pair your speech with a non-verbal simple cue (for example - give photo of stop)
- Point to or hold the object that they want play with or hold
  - Use a board with pictures of activities or objects the child may want to point to
  - “Do you want the doll (point to the doll)?”
- Watch their gestures and facial expression to see what they are trying to say
  - Smiling when they want something
  - Frowning or crying when they do not want something
- Watch facial expression and body language for signs of pain
  - Body is curled up in pain
  - Face is squeamish, frowning, or looks unhappy
- Body language to respond:
  - Tapping hand in one spot for X and tapping hand in another spot for Y
  - Tapping one finger for X and tapping two fingers for Y
- Make “flash cards” with favorite toys, objects, foods, and more
  - Provide them with at least 2-3 flash card options
- Ask questions with 2 options (e.g. Do you want X or Y?)
  - Do you want to play with the doll or blocks?
  - Do you want to eat or go to sleep?
- Asking questions that require only yes/no answers:
  - Do you have to use the restroom?
  - Are you hungry?
  - Are you sleepy?
- Yes and no techniques to respond:
  - Child can look up for “yes” and down for “no”
  - Blink their eyes once for “yes” and twice for “no”
- Playing with different textures
  - Being messy is GOOD because it can increase their ability to express themselves and communicate
  - Water, sand, foam
- Dance
  - Shaking and turning
- Singing/Music
  - Banging drums, maracas
- Writing
- Drawing/Painting
HYGIENE

Personal Hygiene

Dressing/Clothing Laundry

Hand and Foot Care

Teeth Brushing

Bedding Care
Personal Hygiene

All children need to bathe at least 3-4 times a week to stay clean and reduce the likelihood of body odors and skin problems.

**What causes the bad body odors?**

- Trapped oil, dirt, and germs on the skin

**How do you get rid of those bad odors?**

- Take shower or clean frequently to wash off the dirty germs

**Bathing**

- Use soap and warm water when taking bathing
- Make sure to clean:
  - Arm, hands, and fingers
  - Legs, feet, and between toes
  - Under the arms (armpit)
  - Chest
  - Back
  - Neck and behind the ears
  - Groin and genital area (between the legs)
  - Hair
    - At least once a week or more frequently if hair is oily
Girls’ menstrual period:

- Change a girl’s sanitary napkin often when it becomes dirty and filled with blood
  - Do NOT wait too long to change the dirt sanitary napkin to a CLEAN sanitary napkin.

Washing Hair

- Use shampoo at least two times per week to wash child’s hair (wash with shampoo more often if hair is oily)
- Lather hands with soap and water and massage soap and water into the child’s scalp (make sure to rub all of the child’s head to make sure all dirt gets out of the hair)
- Shampoo child’s hair if they have been sweating a lot
- Bush child’s hair to remove tangles from hair after washing
Dressing/Clothing Laundry

What should you wear?

IMPORTANT: make sure the person is wearing clothes that suit the temperature of the weather.

Humid and hot outside wear?

- Wear light and thin material clothes that fit loosely
- Shorts
- Shirts
- Tank tops
- Sandals
Cold outside

- Wear heavier and warmer clothes
- Layer different pieces of clothing to stay warm
- Sweatshirts
- Pants/jeans
- Long sleeve shirts
- Closed toe shoes to keep feet warm
- Dry socks
When should you change a child’s underwear and socks?

- Change the child’s underwear and socks each day after they bathe and put on clean dry underwear socks

How often should I clean the clothes?

- Clothes should be changed when they look dirty, have stains, or begin to smell bad
  - Example: wash clothes with food on it or sweat stains
- Wash clothes with soap/detergent and water
  - If can, use a washer machine and dryer
  - If hand washing, then wash thoroughly of scrubbing the clothes by hand
- Clothes should be completely dry before being stored away

Diaper Changing

- Wash and dry hands, use baby wipes, or hand sanitizer on hands before changing diaper
- Set up a clean and warm area to change the baby
- Change dirty or soiled diapers immediately and put on a clean diaper
- Lay a clean blanket or towel on the table or bed (changing surface)
- Cloth wipes, washcloths, or disposable wipes to clean the baby
- Optional: Rash cream should be used if the child has diaper rash
Hand and Foot Care

Fingernail and Toenail Care

- Trim fingernails and toenails every two weeks
- Use clean nail clippers
- Gently clean under nail before cutting nails
- Apply lotion to hands and feet where there is dry skin

Fungal infection (most common in feet)

- Causes:
  - Shoes and socks on feet most of the time
  - Shoes and socks are warm, dark, moist
- Symptoms:
  - Dry, peeling, or redness on skin
  - Blisters
  - Itching
- Prevention:
  - Wash feet and toes every day
  - Keep feet clean dry (and between toes)
  - Wear clean, dry socks
  - Do not wear tight shoes
  - Do not wear shoes all the time to let feet have fresh air
Handwashing

When to wash hands:

- Before, during, and after preparing food
- Before and after eating food
- After blowing nose
- After using toilet
- After changing diapers
- Before and after caring for child who is sick
- Before and after putting hands in or near eyes, nose, and mouth

How to wash hands:

- Wet hands with water and put soap in hands
- Rub hands together for at least 20 seconds
  - Front and back of hands, between fingers, and under nails
  - Sing “Happy Birthday” song twice
- Rinse hands in water
- Dry hands (and between fingers)
Teeth Brushing

Why brushing teeth is good?
- Remove germs that can cause diseases or make someone ill
- Sugars from foods and drinks can eat away at parts of the teeth causing the teeth to become weak

When to brush your teeth?
- Brush teeth twice-a-day: morning (after breakfast) and night (before going to bed)
- Before baby starts teething:
  - Use a clean and damp washcloth and gently rub the gums to remove germs

Keep toothbrush clean:
- Rinse toothbrush after brushing
- Keep toothbrush in clean, dry place
- Do not share toothbrushes
- Replace toothbrush every six months
How to brush teeth:

- Brush teeth for 2 minutes
  - Can play a song to make it fun
- Angle toothbrush so it is touching teeth and gums
- Brush back and forth while making small circles with toothbrush
  - Brush both sides of all teeth
- Brush back and forth on top of teeth in the back of the mouth
- Brush the tongue from back to front

Supervision:

- Always supervise children younger than 6 years old so they DO NOT SWALLOW the toothpaste
- Swallowing the toothpaste is BAD for the child
Babies and children under 2 years old:

- Caregivers should brush child’s teeth as soon as the child’s teeth begin to come into the mouth
- Use soft-bristle toothbrush and toothpaste
- Use water and tiny bit (size of grain of rice) of toothpaste

Around age 2:

- Child should only spit while brushing
  - AVOID giving them water to swish in their mouth and spit because the child might swallow the toothpaste

Age 3 and older:

- Use pea-sized amount of toothpaste
Flossing:

- Floss in between each tooth BEFORE brushing teeth each time
Bedding

What can be in our bedding?

- Dust mites (small bugs)
- Sweat - especially during summer
- Body fluids
- These can contribute to respiratory and immune illnesses

How often to wash?

- Once a week
  - Wash pillow covers and bed sheets with water and soap
- Make sure bedding is completely dry before putting back onto bed
Handling and Positioning

Handling/Transfers

Safe Positioning

Feeding Positioning
Handling/Transfers

Getting ready to transfer (setup):

- Caregivers should get as close as they can to the surface they are transferring the child to
- Brakes of the wheelchair should be on when the wheelchair is in one place
- Child or caregiver should help the child to the edge of the seat
- Child’s feet should be flat on the floor before beginning the transfer
- Move the armrest of the chair out of the way of the side the child is transferring

Being safe when lifting

- Lift with your legs
  - Tighten abdominal muscles
  - Bend at the knees and hips while keeping your back straight in upright position
  - Keep the object you are lifting close to your body
- If it is too heavy, ASK FOR HELP
  - Have one person on each side
    - Place one arm on child’s hip and the other arm supporting under the elbow/forearm
- Child’s hand/arms should wrap around caregiver’s waist when being transferred to different surface
How to Transfer

- Tell the child what you are doing at every step of the transfer
- Set up the environment
- Gently scoot child to edge of surface
  - Stay in front of child to make sure the child does not fall
- Keep back straight and bend at the knees
- Place hands on child’s hips
- Lean child forward (bending at the hips)
- Gently rock back and forth three times while counting
- Support the child’s hips and lift using your legs
- Move your whole body to transfer site with keeping your back straight and upright

Transfer from bed to chair

- Child bends elbows and knees and rolls onto his/her side
- Child extends his/her legs over edge of bed
- If possible, child uses forearm and opposite hand to raise up to sit at the edge of the bed
  - Caregiver supports child’s back and shoulders
- Stay in front of the child so they are sitting at the edge of the seat
Safe Positioning

Things to be careful of:

**Pressure ulcers:**

- **Causes:**
  
  - Sitting or lying in one position for a long time with pressure on certain parts of the body causing sores on the skin or soreness

- **How to help:**
  
  - Reposition to relieve pressure every hour
  
  - One hour of sitting or lying in one position = One minute of relief
  
  - Shift body weight onto one side of hip or body and then do the same for the other side
Contractures:

- Causes:
  - Muscles become stiff because not moving the body enough

- How to help:
  - Stretches and good positioning when sitting or lying down
    - Stretch the back of the legs by bending at the waist and bring toes to nose while sitting or lying down OR nose to toes when standing
    - Reach arms by the ears and above the head
    - Touch your hands behind your head
    - Stretch the sides of the body by leaning to one side, then leaning to the other side
  - Repositioning every so often so it stretches muscles in different ways
    - Every 2 hours = at least two minutes
Examples of Stretches:

These stretches can help prevent contractures after being in one position for too long. Show the child how to do this and have the child do the stretches with you. If the child cannot do the stretches, help them by gently moving their body to the position. Look at the child’s face to see if they are in pain; if they look like they are in pain, stop the stretch. The child does not need to do the full stretch, if they can only perform it only half way, it is okay.
Wheelchair/Chair Positioning

- Child should be sitting in upright and tall in the center of the chair
  - Head, shoulder, and hips are stacked in upright position
- Reposition the child every two hours
  - Shift the child’s weight off the hips for at least 1 minute every two hours
Sleeping Positions

Supine:

- Pillows or soft rolled towels may be placed under:
  - Child’s head, shoulder, or small of the back
  - Arms and elbows
  - Child’s thighs
  - Ankles, calves, and knees so heels are slightly lifted off bed
  - Knees so they are slightly bent

Lying on their side:

- Pillows under head and neck
- Bend the knees and place pillow between knees
- Place a pillow under the top arm
- Place a pillow behind their back to help support them on their side
Feeding Positioning

Why is positioning so important during feeding?

- Improper positioning can cause choking, child to be uncomfortable, and ear infections

Bottle Feeding

- Sit in a comfortable position
- Hold the baby in semi-upright position or cradle position
  - Do not feed baby lying down
- Support baby’s head
  - Baby’s head should stay in upright flexed position
  - Keep baby’s head higher than rest of the body
- Rest the baby’s bottom in your lap
- Keep bottle tilted toward baby’s mouth
- Allow baby to bring hands towards the bottle
- Place baby upright and rub/pat his/her back to burp after feeding
- Stop feeding the baby when baby falls asleep
- Baby may need to take breaks while feeding
- Talk with the baby throughout feeding
- Keep eye contact with baby throughout feeding
If you are hard time handling him/her during feeding:

- Hold the top of his/her head to keep him facing forward (keeping his head straight)

Spoon Feeding

- Have the child sit in an upright position so they do not choke
- Make sure the child is supported in upright position
  - Use a highchair or activity chair if child cannot sit by him/herself
- Keep feet on ground
- If convenient, feed the child when sitting facing him/her


http://disabilitycentre.lshtm.ac.uk/files/2013/06/Module-6-Getting-to-know-cerebral-palsy-v1-hires.pdf
Tips to Remember for Positioning for Feeding

4 main things to always remember for safe feeding position (SAFC):

1. Stability
   - Body should be stable during feeding

2. Alignment
   - Head, neck, and body should be lined up

3. Flexed
   - Child’s body should be slightly bent at the hips in upright flexed position

4. Comfort
   - Child should be comfortable
FEEDING

Types of Food

Positioning

Environment

Transitioning off the Bottle

Self-Feeding Skills

Physical Support to Feed with a Utensil (if necessary)

Placement of Food

Swallowing Issues

Feeding and Cleft Palate

Tips for all Babies

Food Allergies
### Types of Food

<table>
<thead>
<tr>
<th>Age</th>
<th>Food Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 month</td>
<td>Liquids only (breast milk and/or formula)</td>
</tr>
<tr>
<td>Under age of 3 months</td>
<td>Water for the formula (boil and cool water before mixing formula)</td>
</tr>
<tr>
<td>3 months</td>
<td>Liquids or pureed foods</td>
</tr>
<tr>
<td></td>
<td>- Water (must be boiled and cooled)</td>
</tr>
<tr>
<td>5 months</td>
<td>Pureed foods</td>
</tr>
<tr>
<td></td>
<td>Formula or breast milk is still very important for baby</td>
</tr>
<tr>
<td>6 months</td>
<td>Liquids and pureed foods</td>
</tr>
<tr>
<td></td>
<td>Recommended foods:</td>
</tr>
<tr>
<td></td>
<td>- Rice porridge (smooth texture and bland taste)</td>
</tr>
<tr>
<td></td>
<td>- Baby rice</td>
</tr>
<tr>
<td></td>
<td>- Pureed vegetables</td>
</tr>
<tr>
<td></td>
<td>- Potato, pumpkin, kumara, marrow</td>
</tr>
<tr>
<td></td>
<td>- Pureed cooked fruit</td>
</tr>
<tr>
<td></td>
<td>- Apple, pear, peach, mashed ripe banana</td>
</tr>
<tr>
<td></td>
<td>Introduce new foods slowly (every 3-4 days)</td>
</tr>
<tr>
<td></td>
<td>- Try again if baby does not want to try new food</td>
</tr>
<tr>
<td></td>
<td>- Homemade food - do NOT add salt, soy sauce, or sugar</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>6-7 months</th>
<th>Small pieces of cooked meat and chicken</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cooked egg yolk</td>
</tr>
<tr>
<td></td>
<td>Cooked mashed vegetables:</td>
</tr>
<tr>
<td></td>
<td>- Bok choy, yams, carrots, taro, cauliflower, peas, courgettes, broccoli</td>
</tr>
<tr>
<td></td>
<td>Mashed cooked/ soft ripe fruit (nectarines, plums - NO SKINS)</td>
</tr>
<tr>
<td></td>
<td>Beef or chicken rice porridge</td>
</tr>
<tr>
<td></td>
<td>Plain/rice noodles with mashed/chopped vegetables and meats</td>
</tr>
<tr>
<td></td>
<td>Strips of toasted bread/ crackers</td>
</tr>
<tr>
<td></td>
<td>Steamed cake (mantou) and steamed buns</td>
</tr>
<tr>
<td></td>
<td>- Do NOT give the child the filling in the steamed bun; ONLY give pieces of the bun to child</td>
</tr>
<tr>
<td></td>
<td>- Constipation:</td>
</tr>
<tr>
<td></td>
<td>- Give water between bites of food</td>
</tr>
<tr>
<td></td>
<td>- Make foods with lumps to increase healthy chewing skills</td>
</tr>
<tr>
<td>Age Range</td>
<td>Foods</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>8-12 months</td>
<td><strong>Vegetables:</strong></td>
</tr>
<tr>
<td></td>
<td>- Gai lan, choy sum, watercress, spinach, beans</td>
</tr>
<tr>
<td></td>
<td><strong>Fruits:</strong></td>
</tr>
<tr>
<td></td>
<td>- Oranges, mandarin oranges, berries, pineapple</td>
</tr>
<tr>
<td></td>
<td><strong>Fish and other seafood</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Yogurt, cottage cheese, grated cheese</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Soy foods (tofu, soy custard)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Grains:</strong></td>
</tr>
<tr>
<td></td>
<td>- White bread, oat cereal, boiled or steamed dumplings</td>
</tr>
<tr>
<td></td>
<td>- Smooth peanut butter</td>
</tr>
<tr>
<td>9 months</td>
<td><strong>Soft foods:</strong></td>
</tr>
<tr>
<td></td>
<td>- Mashed table food</td>
</tr>
<tr>
<td>12 months</td>
<td><strong>Easily chewed foods:</strong></td>
</tr>
<tr>
<td></td>
<td>- Meats, chopped foods</td>
</tr>
<tr>
<td>18 months</td>
<td><strong>Chopped table foods (most meats and raw vegetables)</strong></td>
</tr>
<tr>
<td>24 months</td>
<td>**All table foods (except - tough meat, foods that break into large</td>
</tr>
<tr>
<td></td>
<td>pieces)</td>
</tr>
</tbody>
</table>
Positioning

- Slight chin tuck with body and shoulders supported
  - Children with cleft palate
    - Problem is with sucking, NOT swallowing
    - Upright position or side-lying position
Environment

- Put food and drink in the same spot for every meal
- Put the bowl in front of child and cup at the top right side of the bowl
- Allow more time than usual for the child to eat
- Have a quiet space
- Meals should be eaten away from activities such as hand washing, toileting, diapering, and setting up nap time
- Remove clutter and background noise so the children can focus on eating
- Allow plenty of space for the child to balance food, drink, and eat with utensils
- Allow plenty of space for child to pass, serve, pour, and eat
- Furniture should be placed so child can sit, get up, and walk around the table without bumping into other nearby tables

Swallowing Issues

- Thin liquids (water) is harder to swallow than thicker liquids
- It is harder to swallow with chin tilted up; Tilt chin down to help with swallowing
## Transitioning from the Bottle to Self-Feeding

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-6 months</td>
<td>Offer formula in open cup with caregiver holding. Thicken with baby cereal. Try drinking smooth pureed baby food thinned with water from open cup.</td>
</tr>
<tr>
<td>6-9 months</td>
<td>Continue to practice from open cup using thickened or regular liquid (formula, cold tea, fruit juice mixed with a lot of water). Begin to teach baby to drink from straw. Begin to have baby eat congee, pureed vegetables or fruit.</td>
</tr>
<tr>
<td>9-12 months</td>
<td>Give baby drinks during the day with an open cup, straw, or sippy cup.</td>
</tr>
<tr>
<td>12-15 months</td>
<td>Child should be able to drink from a cup with a straw independently. Offer child cup with handles. Only give baby bottle at night before going to bed with child sitting upright.</td>
</tr>
<tr>
<td>15-18 months</td>
<td>Child should no longer use the bottle. Drink from open cup, straw cup, or sippy cup.</td>
</tr>
</tbody>
</table>
## Self-Feeding Skills

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Feeding Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6 months</td>
<td>Nursing or bottle-fed formula</td>
</tr>
<tr>
<td>5-7 months</td>
<td>Cereal or pureed baby food from spoon</td>
</tr>
<tr>
<td>7-8 months</td>
<td>Holds the bottle but may need help keeping in mouth</td>
</tr>
<tr>
<td></td>
<td>Uses fingers to feed self</td>
</tr>
<tr>
<td>6-9 months</td>
<td>Tries to hold bottle but may not pick it up if it falls (still need to watch baby for safety)</td>
</tr>
<tr>
<td></td>
<td>Grabs spoon but does not use it to scoop food (bangs or sucks on it)</td>
</tr>
<tr>
<td>9-12 months</td>
<td>Continues to use fingers to feed self</td>
</tr>
<tr>
<td></td>
<td>Able to begin using spoon</td>
</tr>
<tr>
<td></td>
<td>Drinks from sippy cup</td>
</tr>
<tr>
<td></td>
<td>Begins to drink from straw</td>
</tr>
<tr>
<td>13-18 months</td>
<td>Holds cup to drink</td>
</tr>
<tr>
<td></td>
<td>Scoops food using a spoon and brings spoon to mouth</td>
</tr>
<tr>
<td>24-30 months</td>
<td>Able to use spoon well</td>
</tr>
<tr>
<td></td>
<td>May stab soft foods with fork</td>
</tr>
</tbody>
</table>
Physical Support to Feed with a Utensil (if necessary)

- Caregiver holds the chin (index finger underneath chin and thumb underneath the lower lip)

- Sit beside the child with one arm around the back of the child’s neck
TIPS FOR ALL BABIES

SELF-FEEDING

- 7-8 months with finger feeding
- 13-18 months can scoop food using spoon and brings spoon to mouth
- Provide other mouth activities for baby such as:
  - Spoon-feeding
  - Taking bites of a toasted bread or cracker
  - Playing with toys that are safe to chew
- Try to work towards skipping evening bottle feedings by replacing them with a bedtime snack
- Bedtime bottles should be the last ones eliminated
- Give an open cup when child is sitting up
- Do not let baby’s head tip back when drinking from a cup
- Hold the jaw when child is learning to drink from a cup to help with coordination
- Cups needs to be narrow enough to fit mouths
- Cups should not be too full or heavy
- Practice drinking in a high chair or at a table so child can rest elbows on flat surface for more support

- Homemade food is healthier for the baby than commercial food

- Do NOT add extra salt or soy sauce to already flavorful foods (use a low salt diet)
  - Too much salt for baby is bad for the kidneys

- CAREFUL with how much sugary foods/drink the baby consumes
  - Too much sugar causes tooth decay

- Finger foods to encourage baby to feed themselves and enjoy food
  - Plain/rice noodles
  - Cooked vegetable pieces
  - Soft fruit
  - Strips of toasted bread
  - Soft cooked chicken

- AVOID small hard foods baby could choke on
  - Pieces of raw carrot
  - Nuts

- Clean/wash yours and baby’s hand before and after feeding
- Nutrients:
  - Baby needs VITAMIN D which can be found in:
    - Milk
    - Meat
    - Egg yolk
    - Fish
    - SUNLIGHT
      - Let the baby play outside in the sun BEFORE 11am and AFTER 4pm for 10-15 minutes 2-3 times a week (with legs and arms UNCOVERED)
  - Baby needs IRON
    - Minced meat or chicken
    - Egg yolk at 6-7 months
    - Dark green leafy vegetables (silver beet, spinach)
FOOD ALLERGIES

Symptoms:

- Diarrhea
- Vomiting
- Difficulty breathing
- Irritated nose and eyes
- Reactions usually occur immediately or within 1 hour of eating or touching food

Most common food allergies:

- Eggs
- Cow’s milk
- Nuts, wheat
- Fish
- Shellfish
- Sesame seeds
- Soy

Sensitivity to foods may disappear within 2-3 years:

- Milk, peanuts, fish, seafood are most severe or last throughout their life
PLAY

Why Play is Important

Typical Development of Play

Effects of Disability on Play

Environment

Types of Toys
Why Play is Important

Play is an essential part of growing up healthy and especially important for a child with a disability. Play helps children’s brain develop. Play causes children to be more creative and use their imaginations, which will help them learn how to solve problems. Children learn how to make decisions and communicate with their peers. Playing allows children to explore their world by understanding different shapes, colors, sizes of toys/ objects, and textures. Children with disabilities tend to have a more difficult time playing; they may even need to be taught certain skills even before they can learn how to play.

The information provided is important to know when playing with children with disabilities because it may take them longer to engage in play or communicate their needs during play. Play is important to their development and ability to explore the world and their surroundings.
Typical Development of Play

Toys are very important for creativity, help the child learn, express their feelings, and gain experience. Children should be engaged when playing with a toy that is age appropriate.

<table>
<thead>
<tr>
<th>Birth-to-6 months</th>
<th>Focuses on attachment and bonding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calms/quiets when picked up</td>
<td></td>
</tr>
<tr>
<td>Uses hands and mouth to explore environment</td>
<td></td>
</tr>
<tr>
<td>Follows moving person with eyes</td>
<td></td>
</tr>
<tr>
<td>Plays with hands in middle of body</td>
<td></td>
</tr>
<tr>
<td>Play when lying on back and stomach</td>
<td></td>
</tr>
<tr>
<td>Smiles and laughs</td>
<td></td>
</tr>
<tr>
<td>Repeat actions</td>
<td></td>
</tr>
</tbody>
</table>

Types of toys:

- Bright colored toys
- Different textures: water, soap, bubbles
- No sharp edges
- Non-breakable
- Examples of toys:
  - Rattles, squeak toys, blocks, stacking toys/rings, stuffed animals or dolls, books, simple picture books, music-making toys, balls
| 6-to-12 months | Enjoys being held up in the air  
Listens to voices without being distracted  
Uses fingers to feed self  
  - Practice skills with picking up small objects while playing (blocks, balls)  
Puts toys in mouth  
Reaches for toys  
Sit independently  
  - Roll ball back and forth between caregiver and/or other children  
Address child by their name  
Child may interact a little with other children  
Plays give and take  
Laughs and makes faces in mirror |
<table>
<thead>
<tr>
<th>12-to-18 months</th>
<th>Enjoys messy activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Example:</td>
</tr>
<tr>
<td></td>
<td>- Paint with paintbrushes or hands on paper</td>
</tr>
<tr>
<td></td>
<td>- Foam bubbles for texture play</td>
</tr>
<tr>
<td>Scribbles with marker/crayon</td>
<td></td>
</tr>
<tr>
<td>Opens and closes box containers</td>
<td></td>
</tr>
<tr>
<td>Tries to play with puzzles</td>
<td></td>
</tr>
<tr>
<td>Pretend play with toys</td>
<td></td>
</tr>
<tr>
<td>- Baby doll</td>
<td></td>
</tr>
<tr>
<td>- Blocks</td>
<td></td>
</tr>
<tr>
<td>- Balls</td>
<td></td>
</tr>
<tr>
<td>- Roll back-and-forth with caregiver or other children</td>
<td></td>
</tr>
<tr>
<td>- Throw ball forward with two hands</td>
<td></td>
</tr>
<tr>
<td>Begins to understand how objects work, cause and effect</td>
<td></td>
</tr>
<tr>
<td>- e.g. Push a button and a toy pops up or plays music</td>
<td></td>
</tr>
<tr>
<td>Responds to facial expressions of others</td>
<td></td>
</tr>
<tr>
<td>18-to-24 months</td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>---</td>
</tr>
<tr>
<td>Enjoys playing by him/herself for a few minutes</td>
<td></td>
</tr>
<tr>
<td>Build tower with blocks</td>
<td></td>
</tr>
<tr>
<td>Books</td>
<td>- Have child try to turn pages in book</td>
</tr>
<tr>
<td>Balls</td>
<td>- Have child kick ball forward</td>
</tr>
<tr>
<td>Expresses affection</td>
<td></td>
</tr>
<tr>
<td>Shows different emotions</td>
<td>- Fear</td>
</tr>
<tr>
<td>- Anger</td>
<td></td>
</tr>
<tr>
<td>- Joy</td>
<td></td>
</tr>
<tr>
<td>Laughs at something silly</td>
<td></td>
</tr>
<tr>
<td>24-to-36 months</td>
<td>Enjoys different textures</td>
</tr>
<tr>
<td>-----------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td></td>
<td>- Water, sand, bubbles, shaving cream, paint</td>
</tr>
</tbody>
</table>

Dress up in costumes and play
- Dress up clothes, cooking toys, construction toys, dolls

Takes turns during play

Enjoys playing with other children

Plays with small group

Types of toys:
- Push-pull toys (toys with short string)
- Trucks/cars
- Bean bags
- Climbing structures
- Puzzles
- Jump rope
- Crayons/markers to color
- Paint
- Musical instruments
<table>
<thead>
<tr>
<th>Age Range</th>
<th>Activities and Behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-to-4 years</td>
<td>Plays with dolls</td>
</tr>
<tr>
<td></td>
<td>Categorizes objects</td>
</tr>
<tr>
<td></td>
<td>- Colored blocks; puzzles</td>
</tr>
<tr>
<td></td>
<td>Attempt hard activities</td>
</tr>
<tr>
<td></td>
<td>- Playdough, coloring, painting</td>
</tr>
<tr>
<td></td>
<td>Prefers to play with other children</td>
</tr>
<tr>
<td></td>
<td>Shows interest in being a friend</td>
</tr>
<tr>
<td>4-to-5 years</td>
<td>Complete up to 10 piece puzzle</td>
</tr>
<tr>
<td></td>
<td>Understands rules to a game</td>
</tr>
<tr>
<td></td>
<td>Makes up stories when playing</td>
</tr>
<tr>
<td></td>
<td>Sing whole songs</td>
</tr>
<tr>
<td></td>
<td>Balls</td>
</tr>
<tr>
<td></td>
<td>- Catch and throw with other children</td>
</tr>
<tr>
<td></td>
<td>- Kick ball back-and-forth with other children</td>
</tr>
<tr>
<td></td>
<td>Blocks</td>
</tr>
<tr>
<td></td>
<td>Bubbles</td>
</tr>
<tr>
<td></td>
<td>- Child can blow bubbles for younger children to pop</td>
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<tr>
<td></td>
<td>Baby doll</td>
</tr>
<tr>
<td></td>
<td>Books</td>
</tr>
<tr>
<td></td>
<td>Musical instruments</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5-to-6 years</th>
<th>Complete up to 20 piece puzzle</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Bases play on real life</td>
</tr>
<tr>
<td></td>
<td>Has friends of the same gender</td>
</tr>
<tr>
<td></td>
<td>Enjoys singing and dancing as a group</td>
</tr>
<tr>
<td>Balls</td>
<td>Catch and throw with other children</td>
</tr>
<tr>
<td></td>
<td>Kick ball back-and-forth with other children</td>
</tr>
<tr>
<td>Blocks</td>
<td></td>
</tr>
<tr>
<td>Bubbles</td>
<td>Child can blow bubbles for younger children to pop</td>
</tr>
<tr>
<td>Baby doll</td>
<td></td>
</tr>
<tr>
<td>Books</td>
<td></td>
</tr>
<tr>
<td>Musical instruments</td>
<td></td>
</tr>
</tbody>
</table>
Effects of Disability on Play Behavior

Physical impairment

- May be limited in movement, strength, and pain
- May have a fear of moving
- Decrease active play
- Preference for sedentary play
- Difficult time getting to or gathering materials for play
- Difficult time moving to certain areas of play
- Difficulty with manipulating materials for play

- Strategies to improve play skills:
  - Place the toys near the child
  - Position the child so he is/she is in a safe position to play in with the toys
  - Use toys that the child can play with while in one place
  - Choose toys that are lightweight and do not break easily
Cognitive impairment

- May show delay in skills
- Difficulty structuring behavior
- Lack of sustained attention
- Decreased curiosity
- Decreased imagination
- Decreased social interaction
- Decreased language
- Increased observation play
- Decreased skills to imitate certain play skills
- Difficult time exploring different parts of play

Strategies to improve their play skills:

- Allow the child more time to process information or listen to instructions
- Only provide 1-2 instructions during play at a time
- Provide toys that are simple
- Place the toys the child will play with near other children to promote social interaction
- Simply demonstrate how to play with certain toys so the child can watch and learn how to use the toy
- Slowly present different toys to the child so they can explore different toys
Visual impairment

- Can have delay in exploring surroundings and objects
- Decreased role play
- Strategies to improve their play skills:
  - Play with toys with different textures
  - Play with toys that have different sounds and music
  - If child is over stimulated from visual information then play in an environment with low lighting or play with toys that do not have bright lights

Hearing impairment

- Decreased social interactions
- Decreased language
- Increased solitary play
- Strategies to improve play skills:
  - Play with toys that have a variety of textures
  - Play with toys that are easy to play with by using their vision to learn how to play with the toy
  - If child is over stimulated from sounds, then play in a quieter environment and choose toys that are quieter
Sensory impairment

- Poor organization of behavior
- Either excessive movement or avoids movement
- Decreased exploration
- Decreased gross motor play
- Increased observation play
- Increased alone play

- Strategies to improve play skills:
  - Have a quiet environment
  - Remove clutter in environment
  - Offer new toys for child to play with
  - Offer choices in toys to play with
Environment

The environment or space a child plays in should be organized, comfortable, and provide chances for a child to play with other children, have enough space to play, and be active.

Playing outside

- Playing outside is VERY IMPORTANT!
- Why is playing outdoors important?
  - Helps children to understand the world through their senses (eyes, ears, touch, smell)
  - Healthier brain development
  - Helps increase social development
  - Helps the children stay physically healthy
- Things to be careful of when playing outdoors:
  - Choking hazards:
    - Children should NOT put anything in their mouths; they might choke
  - Always stay fairly close to the children when playing
  - Children should NOT climb on anything too high
  - Promote walking, crawling, jumping, climbing (not too high) on different textured surfaces (rocks, sand, gravel, dirt)
Providing a safe environment to play includes:

- Large, open space free from obstacles
  - No more than 4-5 children per gym floor mat in a room
- Good lighting in the room (natural light from the windows is the best type of lighting)
- Air ventilation (air should flow throughout the room so it is not stuffy)
- Safe temperature of the room (opening the windows to circulate the air) or using fans to cool the room down

How to help?

- Take the children outside at least one time per day
  - If it is too hot during the day, take children out in the morning or evening
  - Children who need to be in a wheelchair should be taken outside in their wheelchair (Note: one or more people may be needed to help the children in wheelchairs go outside)
  - Recommended: Play for larger blocks of time (30 to 60 minutes or longer) instead of shorter time blocks
Equipment

Managing Equipment

Child Safety with Equipment/Tools/Toys

Cleaning Equipment/Tools/Toys
Managing Equipment (i.e. wheelchairs, desks, handrails)

- Check equipment once a month for loose and broken parts
- Let supervisor know of any loose and broken parts
- Supervisor needs to contact an individual to fix the parts within one week

Child Safety with Equipment/Tools/Toys

- Pick toys that are appropriate for the child’s age
  - Example: 3 year olds still put everything into their mouth so only use toys that are bigger than his/her mouth to stop them from choking
- Do NOT use toys that are broken or have plastic parts that can be easily chewed off
  - Parts on toys should be securely attached, no sharp edges, and paint is not peeling
- Do NOT use toys with a string or cord longer than 12 inches
- Keep small toys away from babies
Cleaning Equipment/Tools/Toys

- Wipe down once every two weeks with clean boiled water and a clean towel
- Wipe down mats and diaper changing surfaces once a week with water and clean towel
- Wipe down the toys being used each day at least 1-2 times a day with a clean towel (especially the toys that children put into their mouths)
- Cleaning materials:
  - Use water and detergents or disinfecting wipes with chlorine and disinfectants; soap
  - Use clean rags, towels, sponges, brushes
- Cover and store equipment not being used to a safe and clean storage area

- Mop the floors at least once a week (especially mop the floors around the eating areas)

- Wipe countertops and tables at least 1-3 times a day depending on how often the table or counter is used
  - e.g. Wipe down before and after meals
CRIBS

Crib Measurement

Crib Maintenance

When to Transition Out of a Crib

Crib Safety

Placing Baby in Crib

Sudden Infant Death Syndrome (SIDS)

Checklist for Cribs
Crib Measurement

- Bars on the crib should be 2 ⅜ inches apart (width of soda can)

- Raised rails - at least 26 inches from top of rail and top of mattress

- Lowered rails - at least 9 inches from top of rail and top of mattress

Crib Maintenance

- Clean sheet/blanket if baby pees/ poops on bed

- Wash sheets at least once a month

- Wipe down crib at least once a month

- Check for broken pieces and loose screws

When to Transition Out of Crib to Bed

- 2 years old or when child is 32-35 inches
Crib Safety

- No pillows, thick blankets, or soft toys in crib
- If using blanket - make sure it is thin
- No space between the mattress and sides of the crib (no more than 2 fingers)
- No cords, ropes, or ties in the crib (may wrap around the baby’s neck)
- Do not tie the children with rope or cloth, for any reason
- If children can climb over the sides of the crib then they are too large or too old to be in a crib
- No missing/ loose/ broken pieces
- Keep crib away from windows and direct sunlight (may get too hot)
- Crib should be stable when you shake it gently, it should not be wobbly
- Mattress should be firm
- Make sure crib is built properly
Placing Baby in Crib

- One baby per crib
  - Under 12 months
    - Place baby on back and face up
    - No lying on side
  - Tuck blanket in securely on sides and at end of bed where infant’s feet are - have the end of the blanket at middle of the chest (do NOT want near face)

Sudden Infant Death Syndrome (SIDS)

- SIDS is the leading cause of death for 1 month to 1 year old babies
- SIDS is when the baby suffocates (stops breathing) or is strangled in bed
  - Suffocation can occur through soft bedding that covers the nose or mouth
  - Suffocation if baby’s head and neck are caught between the crib railings
  - Person rolls on top of baby while they are sleeping
  - Baby is wedged or stuck between two objects (mattress and wall or furniture)

Be careful:

- NEVER place the child face down on their stomachs or sides when sleeping (baby should always sleep on their backs)
- Ensure the baby does not roll onto his/her belly when sleeping
- NO fluffy or loose bedding in the crib so baby does not suffocate on accident
CHECKLISTS

Cribs

Feeding

Handling and Positioning

Hygiene

Managing Equipment

Play
Provided below are checklists with a list of tasks involving different areas of self-care. The list of tasks will help you and the child complete daily tasks. Please refer to the manual for more detailed instructions about each topic. You should complete the tasks on the checklists to promote the child’s independence and provide a safer environment for the children to live in. Go through each item on each of the checklists, then “check off” each item on the checklist after you have completed that task for the day.
CHECKLIST FOR CRIB

CHECK CRIBS EVERY JANUARY AND JUNE

☐ Tighten loose screws

☐ Crib should be stable (not wobbly)

☐ Make sure there are no missing/broken pieces

☐ Wash sheets and blankets at least once a week or when sheets/blankets become soiled

☐ Wipe and clean down all parts of the crib

☐ Continue to tighten sides of blanket under the mattress

☐ Make sure the crib is out of direct sunlight

☐ Make sure rails are at the correct height

☐ Check height of the child (32-35 inches should NOT be in the crib)
CHECKLIST FOR FEEDING

**Bottle Feeding**

- Keep child in semi-upright position
- Support body and head
- Begin giving puree foods around 6 months
- Begin transitioning off bottle around 12 months

**Self-Feeding**

- Let child try to feed themselves with spoon around 9 months
- Amount of food on spoon should be no larger than child’s tip of thumb
- Each child should have their own bowl and spoon
- Begin to drink from straw around 9 months
- Child’s head should not tip back when drinking from a cup
- Eat meals while sitting in a chair at the table
- Drink in upright position
- Use the activity chairs if child needs support to eat and drink in upright position
- Be careful if the child has an allergic food reaction - avoid those foods if allergic
CHECKLIST FOR HANDLING AND POSITIONING

Transfers
- Always use your legs, not back when lifting (bend at the hips and not your back)
- Remember to ask for help when lifting something that is too heavy
- Do not twist your body when transferring
- Always lock the wheels of the wheelchair when the wheelchair is stopped
- Child should scoot to edge of surface as you support the child’s hips and lift using your legs

Wheelchair Positioning
- Check for red spots on body from sitting too long
- Have neck and back supported
- Stretch and reposition child frequently to avoid tight muscles or sores

Sleeping Positioning
- Position the pillows appropriately when child is sleeping on their back or side
Feeding Positioning

Bottle Feeding

☐ Baby should be in a semi-upright position when feeding

☐ Sit in comfortable position when holding baby

☐ Let the baby bring bottle to his/her mouth with hands

☐ Take breaks occasionally when baby is feeding

☐ Maintain eye contact with baby during feeding

Spoon Feeding

☐ Child should be in upright position

☐ Keep feet on floor when eating

☐ Child should eat in an activity chair if they need support for sitting upright
CHECKLIST FOR HYGIENE

Personal Hygiene

☐ Child should bathe frequently

☐ Use soap and water when bathing

☐ Change a girl’s sanitary napkin when it becomes full of blood

Bathing

☐ Always use soap and water when bathing the child

☐ Always watch the child while bathing so he/she does not drown

☐ Bathe at least once a week or more frequently if can

Washing Hair

☐ Wash hair with soap and water at least 2 times per week (shampoo child’s hair every other day or daily if child’s hair appear really oily or if child sweated a lot during the day)

☐ Let hair dry completely before going to bed
Diaper Changing

- Wash and dry hands before changing the baby’s diaper using soap and water or hand sanitizer
- Use a clean and warm changing surface
- Lay a clean blanket or towel on changing surface
- Check the child’s diaper at least once every 1-2 hours to see if the diaper needs to be changed
- Use cloth wipes or clean washcloths to clean the baby’s bottom
- Change dirty or soiled diapers immediately and put on a clean diaper

Dressing

- Child’s clothes and shoes should be appropriate for the temperature of the weather
  - Hot weather - shorts, t-shirt, tank top
  - Cold weather - long sleeve shirt, sweater, long pants, jacket
- Child’s underwear and socks should be changed at least once every day after they bathe
- New underwear and socks should be put on after they bathe
- Clothes should be clean and not have stains or smell bad
- Wash clothes with soap/detergent and water
- Clothes should be clean and dry before being stored away
Hand and Foot Care

☐ Check hands, feet, fingers, and toes for cuts, bruises, and infections every day

☐ Use soap and water when washing hands

☐ Wash hands before and after using bathroom, touching food, touching face

☐ Trim finger and toenails every two weeks

Daily Hand Washing

☐ Child’s hands should be washed with soap and water before, during, and after preparing food

☐ Child washes hands with soap and water before eating

☐ Child washes hands with soap and water after using toilet and blowing nose

☐ Hands are washed for at least 20 seconds with soap and water (sing “Happy Birthday” song twice)
Teeth Brushing

- Always supervise child younger than 6 years old so they do not swallow toothpaste
- Brush child’s teeth twice-a-day in the morning after breakfast and at night before bed
- Keep the toothbrush clean by keeping in clean, dry place
- Do not share toothbrushes
- Replace toothbrush every six months
- Brush teeth for 2 minutes
- Brush the tongue
- Brush back and forth on top of teeth in the front and back of the mouth
- Ensure child does not swallow toothpaste
- Floss in between all teeth after brushing

Bedding

- Wash pillow covers and bed sheets once a week
- Bedding should always be dry
CHECKLIST FOR MANAGING EQUIPMENT

Managing Equipment

☐ Check for loose or broken parts on the wheelchairs, desks, and handrails every 2 weeks
☐ Tell supervisor if there are any loose or broken parts

Cleaning Equipment/Tools/Toys

☐ Clean equipment/tools/toys at least once every two week
☐ Clean mats and diaper changing surfaces at least once a week
☐ Clean countertops and tables at least one to three times a day
☐ Wipe and clean toys that are used each day at least one to two times a day
☐ Use water and detergents or disinfecting wipes to clean
☐ Make sure equipment that is not being used is covered and in a clean area

Child Safety with Equipment/Tools/Toys

☐ Have age appropriate toys
☐ Do not give children toys that are broken or sharp edges
☐ Keep small toys away from babies
CHECKLIST FOR PLAY

Environment

☐ Play space should be in a large, open space free from obstacles

☐ No more than 4-5 children per gym floor mat in a room

☐ Good lighting (natural lighting is best)

☐ Good air flow throughout the room

☐ Room should be at a safe temperature for play

☐ Children should play outside at least one time per day

☐ Stay fairly close to children playing outside so they do not mouth anything

☐ Bring children outside in wheelchair or walker if they use it
Types of Toys

- Have age appropriate toys for the children
- Have a variety and large amount of toys out for the children to play with
- Toys for babies should be brightly colored, washable, and have no sharp edges
- Toys should not be broken
- “B” Toys (types of toys):
  - Blocks & Building toys
  - Bubbles
  - Books
  - Baby dolls
  - Balloon
  - Ball & Bouncing
Grading Rubric

Feeding

Handling and Positioning

Dressing

Hand and Foot Care

Handwashing

Teeth Brushing

Bedding
Provided below are grading rubrics for Mrs. Liu to use to look at and keep track of the skills of the caregivers after reviewing the manual. Mrs. Liu will review the caregivers’ skills at the beginning of every month using the grading rubric. The caregivers can receive a score of “0” or “1” for the skill; if the skill does not apply to the child, no points will be given and “N/A” will be marked. Please review any skill(s) the caregiver received a score of 0 using the manual.
Grading Rubric Feeding

1. Children are sitting in upright position when eating.
   
   0  1  N/A

2. Children are sitting in upright position when drinking.
   
   0  1  N/A

3. Baby head and body are supported when drinking from bottle.
   
   0  1  N/A

4. Children have their own bowl and spoon/bottle.
   
   0  1  N/A

5. Size of food on spoon is small.
   
   0  1  N/A

6. Children's mouth is empty before giving them another bite of food.
   
   0  1  N/A
Grading Rubric for Handling and Positioning

1. Child’s feet are on the floor when transferring out of wheelchair.

   0 1 N/A

2. Put on brakes of the wheelchair when stopped.

   0 1 N/A

3. The wheelchair is positioned next to and as close to the surface the child is being transferred to.

   0 1 N/A

4. Check the children for red marks from sitting in wheelchair.

   0 1 N/A

5. Children are supported and sitting in upright position in the center of their wheelchair (no slouching or leaning in wheelchair).

   0 1 N/A

6. Caregivers bend at their knees and push up with legs when lifting.

   0 1 N/A

7. Caregivers keep back straight and do not twist their backs when lifting.

   0 1 N/A

8. Caregivers gently lift and gently place the child into the wheelchair/bed.

   0 1 N/A
Grading Rubric for Dressing

1. The children’s clothes do not smell and looks clean (no stains).
   0  1  N/A

2. Children are wearing light and thin material clothing when the weather is hot.
   0  1  N/A

3. Children are wearing heavier and warmer clothes when the weather is cold.
   0  1  N/A

4. Child’s underwear and socks should always be dry when the child is wearing them.
   0  1  N/A
Grading Rubric for Hand and Foot Care

1. Check the children’s feet for bruises, blisters, redness, dry skin, peeling, cracked skin, or cuts once a day.

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<tr>
<th>0</th>
<th>1</th>
<th>N/A</th>
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2. Cut children’s fingernails and toenails every 2 weeks.

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<tr>
<th>0</th>
<th>1</th>
<th>N/A</th>
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</thead>
</table>

3. Check that the children’s fingernails and toenails are trimmed at a safe length.

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<thead>
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<th>0</th>
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<th>N/A</th>
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4. Wash children’s feet and toes every day.

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<th>0</th>
<th>1</th>
<th>N/A</th>
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</table>

5. Make sure children’s feet are not worn all the time (feet need fresh air)

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<th>1</th>
<th>N/A</th>
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</thead>
</table>
Grading Rubric for Handwashing

1. Use soap when washing hands.
   
   0  1  N/A

2. Wash hands before and after feeding the children.
   
   0  1  N/A

3. Wash hands before and after changing diaper.
   
   0  1  N/A

4. Children wash hands after using bathroom.
   
   0  1  N/A

5. Wash hands for two minutes.
   
   0  1  N/A

6. Wash top of hands and fingers.
   
   0  1  N/A

7. Wash between fingers.
   
   0  1  N/A

8. Clean under the fingernails.
   
   0  1  N/A
Grading Rubric for Teeth Brushing

1. Teeth are brushed twice-a-day in the morning after breakfast and at night before bed.
   0  1  N/A

2. Toothbrushes are not being shared with others.
   0  1  N/A

3. Toothbrushes are replaced every six months.
   0  1  N/A

4. Brush teeth in the back and front of the mouth, sides of the teeth, and tongue.
   0  1  N/A

5. Caregivers closely watch a child who is younger than 6 years old brush their teeth to make sure no toothpaste is swallowed.
   0  1  N/A

6. Children should always floss before they brush their teeth.
   0  1  N/A
References


CAREGIVER TRAINING AND EDUCATION IN A CHINESE ORPHANAGE


Chapter Four:

Summary and Conclusion
In summary, stigmas against individuals with disabilities all over the world are limiting opportunities for those individuals to live full and meaningful lives. According to research, children with disabilities in orphanages are at an even larger disadvantage by having a disability and being provided inadequate care. This could be due to the lack of knowledge about disability. Therefore, this project, and work completed at Fuling Social Welfare Institute, was to increase quality of care for children with disabilities and enhance understanding of disability in a culture that stigmatizes those with a disability. Knowledge is power and increasing caregiver education will only promote independence and self-sufficiency in children with disabilities who are raised in orphanages throughout China.

This manual was specifically made for the staff at Fuling Social Welfare Institute and should be used to train and educate the caregivers on how to provide quality care to children with disabilities at the orphanage. The purpose of the manual is to provide both new and existing caregivers with clear examples and instructions on how to help the children complete self-care tasks and engage in meaningful activities. Checklists were provided to assist in looking at everyday tasks the caregivers should provide; grading rubrics were also created for the manager of the orphanage staff to assess the skills of the caregivers. The Caregiver’s Manual and Resource Guide has the potential to be used at various orphanages throughout China to increase the quality of life for children with disabilities living in orphanages.

Research indicates that there is sufficient evidence in Russia, Africa, and certain parts of Eastern Europe, which have proven the importance of improving caregiver education to enhance children’s developmental process. There is also evidence proving that more nurturing care and supportive environments improve children’s health and developmental process.
However, there is little research correlating caregiver education and their impact on children with disabilities’ development in Asia. Therefore, this project and its materials are to expand the research into Asian cultures and the impact of caregivers on the children's’ development in orphanages.

Future projects can aid in the carryover of skills provided in the Caregiver’s Manual and Resource Guide. Surveys can help in tracking the trends of the caregiver skills and confidence of the caregivers over time; an example has been provided (Appendix C). The caregivers can use videos and pictures to demonstrate competence and skill to the existing board members of Fuling Kids International. Additional topics could be added to The Caregiver’s Manual and Resource Guide to include community resources for adolescents integrating into the community and strategies to increase independent living for adolescents. This ongoing project will enhance and further research to certain part of Asia, as well as carry over into other parts of the world.
References


Appendices
Appendix A

Biographies

April Chu is third generation born in the United States on both her Japanese and Chinese side of family. Chu received her Bachelor of Science in Interdisciplinary Health and Rehabilitation Sciences-Pre-Physical Therapy with a minor in dance from California State University Fresno. She has prior vocational skills and leadership experience with adolescents and older adults in a variety of movement-based activities. She will receive a Doctorate of Occupational Therapy from Pacific University, Oregon in August 2016 with experience in working with school-aged children, adolescents, and older adults with physical disabilities.

Constance (Connie) Liu comes from a traditional Chinese background and is first generation born in the United States. She is fluent in English and Cantonese. She received a Bachelor of Science in Exercise Science with an emphasis in Motor Behavior and a minor in Psychology from Pacific University, Oregon May 2013, and will receive a Doctorate of Occupational Therapy from Pacific University, Oregon in August 2016. She has experience with working with school-aged children and adolescents in a private pediatric clinic, and older adults in acute rehabilitation.
### Appendix B

**SWOT Analysis**

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
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<tr>
<td>1. There is a separate classroom that is adequately supplied with desks, chairs, reading materials, white boards, markers, and other school supplies and serves as a safe space for learning.</td>
<td>1. The classroom’s desks are antiquated and not built for the functioning needs of children with disabilities.</td>
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<td>2. There is one credentialed and professional special education teacher who spends approximately five hours in the classroom with the children five days a week.</td>
<td>2. The current teacher only one out of the five hours are spent actually teaching the children, and more so when someone is watching.</td>
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<td>3. The caregivers aid in self-care needs of the children.</td>
<td>3. There is no set academic curriculum for the children.</td>
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<td>4. Pacific University students and faculty members visit the orphanage annually, and aid the caregivers on the care given to the children. For example, the caregivers fed the children instead of allowing the children to self-feed, however the caregivers now allow the children to self-feed after Pacific University OT students and faculty explained the importance of independent feeding.</td>
<td>4. Prior to the current teacher, there has been a high rate of teacher turnovers due to the low pay and creates an unstable environment for the children.</td>
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<td>5. There is a kitchen at the orphanage to prepare all the meals on-site and ensure that the staff knows what ingredients are going into the food they prepare. The previous group of occupational therapy students supplied the orphanage with the appropriate baby bottles for children with a cleft palate.</td>
<td>5. There are eight caregivers present during the day and only two-to-three caregivers who stay at the orphanage throughout the night. There is a decrease in quality of care due to the caregiver to child ratio. The stresses can cause the caregivers to look more at efficiency rather than quality of care.</td>
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<td></td>
<td>6. There is a lack of playground equipment outside.</td>
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<td>7. The children are not incorporated into the process of meal preparation.</td>
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</table>
Opportunities

1. Orphanage owns a bus that goes down into the city to get supplies and caregivers can take some of the children with them each time.
2. Having children participate in the simple tasks of meal preparation.
3. Grant for possible certification in OT for future caregivers at the facility.
4. Getting in contact with another orphanage which is successful in obtaining ideas for a caregiver manual.

Threats

1. Lack of funding.
2. Cultural stereotypes and stigma.
3. Location of the orphanage is in the mountain and isolated from society.
4. There is a constant lack of information regarding the transition out of the orphanage after the children turn 18 years of age.
Appendix C

Survey for the Caregivers

Directions: On a scale of 1 to 5 rate the following questions. (1 - Not at all, 3 - Undecided, 5 - Very Much)

1. Has the Caregiver’s Guide helped in caring for the children?
   1  2  3  4  5

2. How often did you refer to the Caregiver’s Guide?
   1  2  3  4  5

3. Has your skill in bathing changed?
   1  2  3  4  5

4. Has your skill in dressing changed?
   1  2  3  4  5

5. How has your skill in feeding changed?
   1  2  3  4  5

6. How has your skill in allowing children to be more independent changed?
   1  2  3  4  5

What area of care do you feel you have improved on the most?

What area of care do you still need improvement on?

What area of care would you like more education on?