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Ask Dr. Sue Your Health and Safety Questions

New Types of Child-Resistant Packaging

by Susan S. Aronson, MD

If a child with a chronic illness needs to receive medication during the child care day, child care providers cannot legally refuse to give it. Under the Americans with Disabilities Act (ADA), giving medicine is considered a necessary accommodation for the child to participate in child care. For medicines that children need for a short time, the child care provider may have more leeway. In either case, when medications come into the child care facility, child care providers must address the risks involved.

For more than 20 years, federal law has required child-resistive packaging for all oral prescription drugs. The only exception is when a purchaser requests that the pharmacist not use the special packaging. Routine use of child-resistive packaging reduces child deaths from unintentional ingestion of medicine by about 45%, but some pharmacists don't follow the law for every prescription.

One of the reasons that medications are not always in child-resistive packaging is that many adults become frustrated trying to open these containers. New, more adult-friendly forms of child-resistive packaging will help this problem. As of January 1998, the U.S. Consumer Product Safety Commission requires that testing of child-resistive packaging follow revised protocols. Already these revised standards have led to new designs for child-resistant caps. For example, new lids may include thumb tabs to help flip open containers once the user lines up arrows on the lid and container. Others have a flip-top lid that the user can open while pushing a tab toward the center of the lid. Another design involves pushing on the side of the container with one hand while unscrewing the lid with the other hand.

No child-resistive design is child-proof. For a container to pass the standard test, 80% of 200 children between 41 and 52 months of age must have been unable to open the package after two five-minute attempts. A second test follows a demonstration by an adult about how to open the package, including an invitation for the children to use their teeth if they wish. The test procedure measures whether the device gives a time delay before children figure out how to get into the container — not whether the device is a perfect barrier. The idea is to give an adult a little longer to stop the child from getting to the medicine.

Use of medication for young children is common. In addition to prescription medicines, parents may ask child care providers to give over-the-counter medications that a doctor may not have recommended. In national surveys, an astounding 30% of parents reported that they had given their children some type of medication for upper respiratory infection within the previous two weeks. Many of these medicines are self-prescribed cold remedies that do nothing to shorten the illness. In fact, many of these cold remedies have undesired side effects.

When parents ask caregivers to give medicine to their child, the first step is to be sure the child needs the medication during the child care day. Giving medication in child care is extra work, and the caregiver should be concerned about the risk of mistakes and unintentional poisoning. Often a doctor can suggest an adjusted schedule for giving medication to avoid the hours when the parent and child are apart.

For common remedies such as fever-reducing medication, a health professional can write a set of general instructions for all children in the facility, called *standing orders*. These

instructions define the circumstances and doses for using the medication in the facility, if parents give their consent. For other medicines, the child's clinician should give specific instructions on what to give and how and when to give it.

Often parents misunderstand or revise the instructions they receive from the child's doctor or nurse clinician. Relying on secondhand communication of the parent's understanding puts the caregiver at risk of making errors. Insist on instructions from a health professional, either by phone or in writing.

Use a written policy to guide the staff about the steps they need to follow in accepting medication for administration in child care. For a model policy, use the third edition of *Model Child Care Health Policies* (June 1997). This newly revised publication from the National Association for the Education of Young Children comes with sample forms to implement the policies. You can also use the Internet to get the text of the model policies that every facility should have. Check the Internet page for ECELS (Early Childhood Education Linkage System) on the web site of the Pennsylvania Chapter of the American Academy of Pediatrics: http://www.paaap.org. You can download the policies onto your own computer and adapt the model text to fit your program.

Insist that all medications come to child care in a labeled container prepared by a pharmacist or by the manufacturer. Parents should ask the pharmacist to split the prescription into two labeled containers or buy two separate containers of a non-prescription medication. When the medicine container comes to child care, be sure staff and parents follow these guidelines:

- Store medications where they are inaccessible to children.
- Accept only medications that have child-resistive packaging.
- Close containers securely after use so that the child-resistive feature works.
- Keep medications in their original containers.
- Check in good light to be sure you have the correct container and measure the right dose.
- Double check the name on the medicine and the child's name so you give the right medicine to the right child.
- Tell the child why you are giving medicine. Don't say that medicine is candy or imply that the medicine will do more than intended.
- Dispose of old medicines by flushing them down the toilet unless the community has another medication disposal procedure.
- When children who are under school age are in care, keep the phone number of a regional poison control center and syrup of ipecac to induce vomiting handy.

Back to Sleep Position Doesn't Delay Development

Putting children down to sleep on their backs significantly reduces the number of deaths from Sudden Infant Death Syndrome. There is no evidence that sleeping on the back is harmful to healthy infants. Infants who are put on their backs to sleep from birth prefer the back position for sleeping. Infants should not sleep on soft surfaces or with pillows or stuffed toys that could cover the infant's airway. When children learn to roll over, they should be allowed to assume whatever position they move into for sleep.

A certain amount of *tummy time* while the baby is awake and observed is a good idea. Children can build their muscles and see the world differently from their tummies while they are awake. Some babies who have no tummy time develop positional head molding (flattening of the back of their heads), and some may take longer to develop motor skills that involve tummy work. However, even these babies don't seem to have any long-term serious problems. The message should be clear — Back to sleep, but some tummy time for play.

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