

Syracuse University

SURFACE

Child and Family Studies - Dissertations

David B. Falk College of Sport and Human
Dynamics

5-2012

Child Care Center Directors' Perceptions of Continuity of Care: A Qualitative Investigation

Desalyn De-Souza
Syracuse University

Follow this and additional works at: https://surface.syr.edu/cfs_etd



Part of the [Education Commons](#)

Recommended Citation

De-Souza, Desalyn, "Child Care Center Directors' Perceptions of Continuity of Care: A Qualitative Investigation" (2012). *Child and Family Studies - Dissertations*. 64.
https://surface.syr.edu/cfs_etd/64

This Dissertation is brought to you for free and open access by the David B. Falk College of Sport and Human Dynamics at SURFACE. It has been accepted for inclusion in Child and Family Studies - Dissertations by an authorized administrator of SURFACE. For more information, please contact surface@sy.edu.

Abstract

Continuity of care, keeping a primary caregiver and children together throughout the first three years of the infant/toddler period or for the time that the child is enrolled in child care, is assumed to influence infant and toddler development positively. However, strong empirical support is lacking along with wide variation of implementation among early childhood programs. Employing a qualitative design, this study investigated child care center directors' perceptions of continuity of care as a quality indicator and best practice in early care and education programs. Twenty-one child care center directors were interviewed using a list of open-ended questions gauging knowledge of and experience with continuity of care. Interviews were transcribed using Dragon Naturally Speaking voice recognition software and loaded into NVivo 8, a qualitative data analysis software package. Three central themes around directors' understanding of and belief in continuity of care, continuity of care relevant to program operation, and career development emerged from the data. Seventy-one percent of child care center directors defined continuity of care as sameness of caregiving routines, daily schedule, and programmatic rules and policies for parents. Eighty-one percent of directors reported continuity of care as advantageous to the caregiver-child relationship, but were uncertain of the establishment of continuity of care as a policy. Child care center directors encountered an array of administrative challenges on a daily basis and were pressured to make decisions based upon the financial stability of the program. Fifty-two percent of directors did not understand how continuity of care could be implemented into a child care center program and 76 percent of directors did not think continuity of care could be implemented at their particular center due to issues with enrollment, staffing and training. Seventy-six percent of child care center directors reported child care as a critical profession. Child care center directors reported difficulty in hiring and retaining quality

staff due to limited earnings potential and substandard benefits and believed offering a higher rate of pay would improve upon the professionalism of the field.

CHILD CARE CENTER DIRECTORS' PERCEPTIONS OF CONTINUITY OF CARE:

A QUALITATIVE INVESTIGATION

by

Desalyn De-Souza

B.A. Siena College, 1996

MS.Ed. Le Moyne College, 2005

DISSERTATION

Submitted in partial fulfillment of the requirements for the degree of

Doctor of Philosophy in Child and Family Studies

Syracuse University

May 2012

Copyright © Desalyn De-Souza, 2012

All Rights Reserved

TABLE OF CONTENTS

Abstract	i
List of Tables and Figures	vii
Chapter 1 Introduction	1
Theoretical Underpinnings	4
Research and Background on Continuity of Care	11
The Present Study	23
Chapter 2 Methods	30
Research Design	30
Sample	33
Procedures	36
Measures	37
Analysis Approach and Software for Transcription	37
Chapter 3 Results	49
Theme 1: If We Could We Would	49
Theme 2: What We Do Works	62
Theme 3: For the Love of the Children	86
Chapter 4 Conclusions and Implications	100
Conclusions	100
Implications for Practice	103
Limitations of the Study	107
Further Research	108

Appendices	111
Appendix A: Letter Inviting Director To Participate in Study	111
Appendix B: Informed Consent Form	112
Appendix C: Interview Questions	114
Appendix D: Demographic Questionnaire	116
Appendix E: List of Tree Nodes: Parent and Child	118
Appendix F: Memo of Main Ideas	119
Appendix G: NVivo 8 Model of Main Themes	129
Appendix H: Node and Attribute Summary Reports	130
Appendix I: Serious Regulatory Violation History	131
References	133

LIST OF TABLES AND FIGURES

Figure 1: Steps in Data Analysis and Interpretation: A Visual Model	31
Table 1: Summary of Child Care Center Attributes	34
Figure 2: Coding and Memo-ing: A Dynamic Process	41
Table 2: Matrix Coding Query: Best Practice and Director's Education Level	43
Table 3: Infant and Toddler Classroom Arrangements	65

CHILD CARE CENTER DIRECTORS' PERCEPTIONS OF CONTINUITY OF CARE:

A QUALITATIVE INVESTIGATION

CHAPTER 1

Introduction

The utilization of child care services by working families in the United States continues to rise with over 11 million children under the age of 5 in some type of nonmaternal child care arrangement (National Association of Child Care Resource and Referral Agencies [NACCRRA], 2008). Sixty-two percent of married mothers with children under the age of 6 and 53 percent of married mothers with infants under the age of 1 were in the labor force in 2004 (Bureau of Labor Statistics, 2005). The workforce participation rate increases to 77 percent for single mothers with children under the age of 6 (Bureau of Labor Statistics, 2005). On average, children under the age of 5 spend 36 hours a week in child care (NACCRRA, 2008). Concerns over the long-term effects of child care, particularly on young children's development and later functioning, have been the source of debate since child care was first utilized by working families over 40 years ago.

Much has been learned about child care, in particular quality indicators of child care, through the extensive work of the National Institute of Child Health and Human Development Early Child Care Research Network (NICHD ECCRN). Since 1991, the NICHD ECCRN has followed the same children and families in a longitudinal study design with relatively low

attrition rates (Belsky, Burchinal, McCartney, Vandell, Clarke-Stewart, & Owen, 2007). The NICHD ECCRN studies how variations in type, quality and quantity of child care impacts children's outcomes. Typically, previous research involving child care has focused on one dimension at a time and never all three simultaneously, making it difficult to disentangle the effects of different features.

Research has demonstrated that children who experience high quality child care are more likely to engage in more complex play and score higher on measures of cognitive and language development than children who attend poor quality programs (Burchinal, Robert, Nabo, & Bryant, 1996). Child-staff ratios, group size and teacher preparation have all been shown to be indicators of quality child care within a center-based setting. Classrooms with fewer numbers of children in the whole group, fewer children per staff person and more educated teachers have been linked to children receiving more positive caregiving and better child outcomes when assessed on social competence and adjustment (NICHD ECCRN, 1999). Knowledge gained through early childhood education and child development courses and workshops for caregivers has been shown to promote high quality center-based child care (Honig&Hirallal, 1998).

Gender differences are also apparent in the child care environment. In a non-risk sample, Bornstein, Hahn, Gist, and Haynes (2006), found girls scored higher than boys on measures of language and boys exhibited more behavior problems than girls. The child to caregiver ratio was a significant predictor of behavioral adjustment. Girls exhibited fewer behavioral problems with a higher child to caregiver ratio than boys. In contrast, boys exhibited more behavioral problems with hyperactivity, distractibility, hostility, aggression and inattention than girls in a caregiving environment with a higher child to caregiver ratio.

Children from low-income families attending high quality center-based child care display increased cognitive development when their caregivers are more sensitive and responsive and increased social development when their caregivers have increased levels of education beyond high school (Loeb, Fuller, Kagan, & Carrol, 2004). Children from middle class, affluent and low-income families attending a high quality child care program display higher vocabulary scores in fifth grade than children attending a poorer quality child care program (Belsky, Burchinal, McCartney, Vandell, Clarke-Stewart, & Owen, 2007). Child care quality remains a predictor of cognitive and academic achievement for children, regardless of family economic status, well into adolescence (Vandell, Burchinal, Vandergrift, Belsky, & Steinberg, 2010).

As a result of the body of research on quality child care, state regulating agencies have established minimum standards for the operation of early care and education programs. Beyond minimum standards are professional views of “best practice”. Best practice is seen as going above and beyond the minimum standards to offer a higher level of quality child care. A perceived best practice is continuity of care – keeping the primary caregiver and children together throughout the first three years of the infant/toddler period or for the time that the child is enrolled in care, whichever is longer.

Although continuity of care is repeatedly cited as a quality indicator for a high quality child care program, little empirical evidence exists to support such a notion. Continuity of care is repeatedly advocated for in early care and education policies, included as a guideline for programmatic practice, included as an indicator in environmental rating and assessment scales, and taught as a best practice in infant and toddler coursework and training

curriculum. The requirements for such a practice are theoretical in nature and are based on conclusions drawn from child development theory.

Although there exists an understanding that quality child care is associated with child outcomes, there is little evidence available that explains the effects of specific program practices on children's development. Continuity of care is one such practice that is assumed to influence infant and toddler development positively. However, strong empirical support is lacking along with wide variation of implementation among early childhood programs. This study will focus on continuity of care to learn more about child care center directors' perceptions of this concept as a viable quality indicator and best practice in early care and education programs.

Theoretical Underpinnings

Attachment theory is most frequently referenced by investigators as the basis for the study of attachment relationships of infants and toddlers in child care. Bowlby proposed that infants have an inborn ability to emit signals to adults, who are biologically predisposed to respond. Survival of the infant is dependent upon his or her ability to use these signals or attachment behaviors to entice the caregiver to be close in proximity. In the first few months of life, the infant learns that crying is an attachment behavior that encourages caring and protective adults to approach, while smiling is an attachment behavior that encourages those same adults to stay near and continue with interactions. Thus, when attachment behaviors are activated, it is close bodily contact that is required (Lamb & Lewis, 2005).

According to Bowlby, infants do not initially show specific attachment preferences. However, as infants begin to recognize familiar faces and begin to have consistent interactions with familiar adults, they begin to exhibit preferences. It is through these interactions with adults

that infants learn turn-taking and reciprocity, that their behavior affects the behavior of others, and that they develop trust in their caregiver to respond when given a signal. The level of security of their attachment relationship is then determined by their degree of trust in their caregiver and the reliability of responsiveness of that caregiver, particularly when infants are disturbed or stressed.

Once infants have an understanding of reciprocity and become purposeful in their social interactions with familiar adults, they begin another phase revolving around times of separation. The baby now begins to protest separation times by crying and has the ability to move around in the environment. This allows for increased opportunities for exploration and the ability to maintain proximity to the individual to whom they are attached. Stayton, Ainsworth and Main (1973) found that in their home environment, mobile infants followed the mother when she left the room almost two times more than they cried and were more likely to greet their mother with pleasure upon reunion into the room. Mobile infants were more likely to be actively and positively involved in regaining proximity to their mother, than being distressed. Eventually as time goes on and development progresses, children increasingly initiate interactions with adults outside of their attachment relationships and are able to tolerate increasing distances from those to whom they are attached (Lamb & Lewis, 2005).

Attachment is an affectional bond that is long-lasting and built upon the overall history of interactions between two individuals, but never entirely replaceable by another human being (Ainsworth, 1989). Ainsworth (1989) states:

There is, however, one criterion of attachment that is not necessarily present in other affectional bonds. This is the experience of security and comfort obtained from the

relationship with the partner, and yet the ability to move off from the secure base provided by the partner, with confidence to engage in other activities. Because not all attachments are secure, this criterion should be modified to imply a seeking of the closeness that, if found, would result in feeling secure and comfortable in relation to the partner. (p. 711)

It is through this history of early interactions and feedback received from their attachment figures that young children construct “internal working models”, or representations of themselves within the context of relationships with others (Lamb & Lewis, 2005). These internal working models, often unconscious, serve as a guide for behavior in future relationships based upon the level of trust that children have felt with their own caregivers.

What happens to the attachment behaviors of young children when they are exposed to increasing amounts of stress by being in an unfamiliar environment, with an unfamiliar adult, and encountering brief separations from their parent? According to the Strange Situation paradigm, infant behavioral patterns can be classified into different levels of security (secure, anxious/avoidant, anxious/resistant, and disorganized) based upon the influence of sensitive or insensitive maternal caregiving on the infant’s internal working model. An infant who receives sensitive caregiving from an emotionally available and responsive mother, has an increased likelihood of developing a secure attachment relationship and developing a sense of trust. In contrast, an infant who receives insensitive caregiving from an emotionally unavailable and unresponsive mother, has an increased likelihood of developing an insecure attachment relationship and developing a greater sense of mistrust (Belsky&Fearon, 2002). Spangler and Grossmann (1993) found that infants with a secure attachment relationship have lower levels of

cortisol 30 minutes after the last separation than infants with an insecure or disorganized attachment relationship.

Maternal behaviors are critical to the formation of a secure attachment relationship, particularly within the infant's first year of life. Both Bowlby and Ainsworth suggest that a hierarchy of attachment relationships exists for young children, such that mothers become the primary attachment figure after which children may and do form attachment relationships with other caregivers (Lamb & Lewis, 2005). It is under certain circumstances such as illness, fatigue or stress, that babies show a preference for their primary attachment figure, implying that all attachment figures are not equally significant (Ainsworth, 1979).

Theorists working according to attachment theory have been particularly concerned over the early entry of young children into child care, due to routine separations between the mother and child evoking child stress. Ainsworth (1979) asserts that infants who are securely attached to their mother may be able to tolerate brief separations in a relatively stress-free manner; however, these same infants are likely to become distressed when cared for by unfamiliar adults in unfamiliar environments. Huston & Rosenkrantz Aronson (2005) hypothesized that "extended hours of separation may disrupt this process because mothers have fewer opportunities to learn their infants' signals and to develop appropriate reciprocal interactions, and infants may experience their mothers' presence as sporadic and unpredictable" (p. 467). Their findings support the notion that mothers who spend more time with their infants engaged in social interaction, are more sensitive and provide a higher quality home environment, however, there was no indication that time spent increased the infant's ability to engage with his or her mother or contributed to the child's developmental outcomes. Likewise, there was no evidence that time

spent at work by the mother, interfered with the quality of the infant-mother relationship, the quality of the home environment, or the child's development. Ainsworth (1979) states that:

So much depends on the circumstances under which separation takes place, on the degree to which the separation environment can substitute satisfactorily for home and parents, on the child's stage of development and previous experience, and on the nature of his or her relationship with attachment figures. No wonder that the issue of the separations implicit in day care is controversial. (p. 935)

Attachment theory assumes that an adult-child attachment relationship is based upon the quality of interactions between the child and that individual adult. Thus, the child care caregiver-child attachment relationship is independent of the mother-child attachment relationship and that of the father-child attachment relationship (Goossens & van IJzendoorn, 1990). Ahnert et al. (2006) expand upon this finding and suggest that the child-parent and child-child care caregiver attachment relationships are representative of the specific caregiving environment each with their unique qualities.

Interactions experienced early on in a child's life may shape his or her internal working model. Honig (2002) proposes that attachment stems from the quality of caregiving experiences that are nurturing and responsive, as well as through an ongoing relationship with a special caregiver. However, later interactions with other adults and stability of interactions between child and parent influence the internal working model to undergo updates and revisions. Elicker, Englund, and Sroufe (1992) note:

Whereas the security of the attachment relationship in infancy has been shown to be a function of the responsiveness and sensitivity of the caregiver during the first year,

correlates of secure attachment are seen 10 years later in the self-confidence and competent social functioning of the preadolescent child in his or her peer group, away from direct parental influence. (p.99)

The NICHD Early Child Care Research Network (2006) sought to test whether parenting behaviors associated with the development of an attachment relationship early in life predicted continuity of the attachment relationship later in life, or whether children with differing attachment histories respond differently to changing environmental conditions. Results of the study support both viewpoints suggesting “that there may be benefits of early secure attachments in the form of protection from the negative events of declining quality of parental caregiving. At the same time, there is evidence supporting hope for children with histories of insecure or disorganized attachment when their mothers become more sensitive and responsive over time” (NICHD Early Child Care Research Network, 2006, p. 40).

Belsky and Fearon (2002) investigated how combinations of attachment security and maternal sensitivity relate to child functioning at three years old, as well as why some mothers exhibited low sensitivity with a securely attached infant, while other mothers exhibited high sensitivity with insecurely attached infants. Children with a consistent developmental advantage (secure attachment to the mother at 15 months old and high levels of maternal sensitivity at 24 months) demonstrated greater social competence, language skills, school readiness and fewer behavior problems at age 3. Children with inconsistent histories functioned more competently than children with a consistent history of developmental disadvantage (insecure attachment to the mother at 15 months old and low levels of maternal sensitivity at 24 months). Interestingly, children with an insecure attachment history in combination with high levels of maternal

sensitivity, functioned better than children with a secure attachment history in combination with low levels of maternal sensitivity. In addition, children with an early insecure attachment who later received sensitive caregiving had more positive developmental outcomes at three years old, than children with an early secure attachment relationship who later received insensitive caregiving. Although the level of maternal sensitivity relates to maternal stress level, it is unclear how other factors within the social context of the family moderate the relationship between the environment and developmental outcomes. Differential susceptibility hypothesis asserts individuals vary in the degree to which they are affected by environmental experiences, with some individuals more susceptible to both positive and negative influences than others (Belsky, Bakersman-Kranenburg, & van IJzendoorn, 2007).

Critics of attachment theory cite its lack of generalizability due to several concerns: most studies have involved Caucasian, middle-class samples from within the United States. Thus, researchers have limited ability to define expectations for developmental norms and parent-child and child-child care caregiver relationships across various cultures. Socialization processes are not yet fully understood within the diverse populations living in the United States let alone more globally. Cultural implications relevant to validity and reliability of research methodology and measurement tools and the overall lack of research on the father-child attachment relationship relevant to the focus on the mother-child attachment relationship, also complicates our understanding of these phenomena. Researchers employing attachment theory to investigate the attachment relationships of infants and toddlers within the context of child care have more work to do in order to understand the complexities surrounding children's early and later experiences

and the level of stability of interactions, given the broad array of caregivers that children are likely to encounter.

Research and Background on Continuity of Care

Within the past 15 years, the notion of continuity of care for infants and toddlers in center-based child care has surfaced. More recently, continuity of care has gained momentum and notoriety as a best practice in center-based child care and now appears in research, as well as, national and state policy efforts, child care regulations, assessment scales, and curriculum and teaching tools for child care providers.

Research

Research concerning continuity of care is relatively sparse and has focused primarily on three main areas: caregiver stability as a function of the child-caregiver attachment relationship, the impact of caregiver instability on children's distress and problem behaviors, and the extent to which child care programs implement continuity of care and the factors influencing their decisions.

The first area of the research examines the link between caregiver stability and the child-caregiver attachment relationship. Ritchie and Howes (2003) investigated high quality early care and education programs, as reported by professionals in the field, serving low-income and minority children in a therapeutic child care setting. Spending more time with a primary caregiver and caregiver responsiveness during interactions were the most important predictors of child-caregiver attachment security. However, only 11 percent of the children in the study were assigned a primary caregiver and only 15 percent experienced continuity of care for a period of more than 1 year. On average, children spent only 22 percent of their time with their primary

caregiver, while the remaining 78 percent of the time was spent with other caregivers or with no caregiver involvement.

Similarly, Raikes (1993) found that time with caregiver significantly contributed to the attachment security of infants in a full-time child care center setting. Fifty-seven percent of the infants who spent between 5 to 8 months with their caregiver were securely attached; while 67 percent of the infants who spent between 9 to 12 months with their caregiver were securely attached; and 91 percent of the infants who spent over 1 year with their caregiver were securely attached. While it appears in this study that time does have a positive influence on the child-caregiver relationship, it does not provide a complete picture since 86 percent of the variance was unexplained.

Conversely, Howes and Hamilton (1992) found no relationship between length of time with caregiver and children's security scores on the Attachment Q-Set. Caregivers were found to be most sensitive and involved with children in the secure category and least sensitive and involved with children in the avoidant and ambivalent categories. All children included in this study attended child care full-time, either in a family child care setting or child care center, and received care from their primary caregiver for at least four months prior to the first observation. The study attempted to collect data over a three-year period. However, only 47 out of 403 children had data at all collection points.

Interestingly, different child care arrangements were found to predict different adaptive behaviors for boys and girls. In comparison with girls, boys who received group care outside of the home experienced lower levels of overall adaptive functioning and communication, daily living and socialization skills (Bornstein & Hahn, 2007).

In a study by Goosens and van IJzendoorn (1990) infants were with their caregiver for a minimum of 3 months prior to the first observation and were subsequently observed every 3 months from the age of 12 to 18 months old. The researchers found that infants classified as securely attached to their caregiver, spent more hours per week in child care and had caregivers who were somewhat younger and more responsive during free play than infants who were classified as insecurely attached to their caregiver. Child-caregiver ratios, child's gender, and the caregiver's level of experience in child care were not significant predictors of child-caregiver attachment. However, the study fails to measure how much time is needed to promote a secure child-caregiver attachment relationship. Would the findings of the study hold true over a period of three years if a policy of continuity of care were instituted? Would the child care programs encounter turnover during this time preventing continuity of caregiving? Is the child-caregiver attachment relationship only about time as a variable or does the quality of the caregiving within the relationship account for security? This study raises more questions about continuity of caregiving as it relates to the child-caregiver attachment relationship.

A second area of the research examines the link between caregiver instability and children's levels of distress and problem behaviors. A study of caregiver stability in center-based care in the Netherlands found that caregivers report children being more at ease in the caregiving environment when one or more of their consistent caregivers are available (Clasien de Schipper, Van IJzendoorn, & Tavecchio, 2004). However, no significant associations were found between a child's adjustment to child care and caregiver continuity, group stability of peers, stability of the overall program, and attendance stability at the program. In addition, no significant associations were found between a child's social-emotional well-being and problem

behaviors and the following structural aspects of child care: caregiver-child ratio, caregiver education and staff turnover rate.

Cryer, Wagner-Moore, Burchinal, Yazejian, Hurwitz, and Wolery (2005) found that children did exhibit higher levels of distress when moved from a familiar classroom to a new classroom environment. Heightened levels of distress were found to diminish within a month's time so that children's levels of distress returned to the pre-transition levels. Younger infants displayed more distress than older children when transitioned to a new classroom. In addition, children receiving care in a high quality classroom showed more distress after the transition phase than children who received care in a lower quality pre-transition classroom. Interestingly, caregiver-child interaction measures did not significantly relate to the distress levels displayed in the pre and post-transition classrooms. However, about 60 percent of children did not encounter distress due to the transition, suggesting individual differences within children and possible environmental variables. Results also indicate that when children transitioned to a new classroom, negative behaviors diminished initially and then later returned to pre-transition levels.

Field, Vega-Lahr, and Jagadish (1984) found children as young as 15 months old experience stress when separated from peers. Infants that spent 14 months in a familiar classroom who were moved to a new toddler classroom experienced increased inactivity, negative affect, fussiness, irregular naps with more frequent arousals during naptime, and irregular feeding patterns. Similar results were also noted for toddlers 24 months of age who were moved to a new preschool classroom. Transitioning to a new classroom with close peers buffers the stressful effects of separation (Field, Vega-Lahr, & Jagadish, 1984).

Watanabe, Donzella, Alwin, and Gunnar (2003) found increased levels of cortisol for infants and toddlers in child care center settings as compared to cortisol levels in the home environment. Cortisol levels for infants and toddlers increased from morning to afternoon while in group care. Cortisol levels peaked in the toddler period and toddlers who were less involved in play with peers exhibited higher levels of cortisol than toddlers who played with peers frequently. Vermeer and van IJzendoorn (2006) found the effect of attendance at a child care program on cortisol excretion was most notable for children younger than three years of age. Increases in cortisol levels for young children were found in average and high quality child care centers; lower quality child care centers were not included in the sample (Vermeer & van IJzendoorn, 2006). Child care center classrooms with a wide age range and more than fifteen children and four adults present, were also associated with increased cortisol levels (Legendre, 2003).

A third area of the research examines the factors influencing the implementation of continuity of care within early care and education programs. Of 52 children who attended a child care center advertising their program as a continuity of care environment, only 7 children had received care from a single caregiver from the time of entry into the program to either their third birthday or at time of data collection (Aguillard, Pierce, Benedict, & Burts, 2005). The remaining 45 children encountered a cumulative total of 71 caregiver transitions during the infant/toddler period. Caregiver turnover is often cited by child care center directors as the primary barrier to the implementation of continuity of care, however this study found that it is the caregiver's lack of enthusiasm for the idea that is the true barrier. Only 3 transitions (5 percent) in this study were due to caregiver turnover, while 41 transitions (65 percent) were due

to caregiver attitudes and abilities. Similar findings are reported by Cryer, Hurwitz and Wolery (2000) who found the majority of children enrolled in child care in their sample remained in the center until they turned three years of age. Staff longevity was also present in their sample, indicating that continuity of caregiving was possible at least into the second year.

Research efforts concerning continuity of care have been scarce to date. Very little is known about the true impact of continuity of care on the child-caregiver attachment relationship and whether instability of caregivers is directly linked to increased levels of distress and problem behaviors for children. Very few programs across the nation actually implement continuity of care (Lally, 2009) and many children continue to undergo several transitions throughout their enrollment in a child care program. One exception to this is at the Child and Family Research Center of the University of Nevada at Reno, where they have practiced continuity of care for over ten years. Infants and toddlers remain with the same caregiver for the first three years of life and the program reports several benefits of the practice including: close relationships between children and teachers, close relationships between the parents and teachers, and smooth transitions when moving the entire group of children and teachers to a new classroom (Essa, Favre, Thweatt, & Waugh, 1999).

National and State Policy Efforts

Policies regarding quality infant and toddler child care address eight core components: health and safety, small groups with high staff-to-child ratios, primary caregiving assignments, continuity of care, responsive caregiving, cultural and linguistic continuity, individualized curriculum, and the physical environment (Lally, Griffin, Fenichel, Segal, Szanton, & Weissbourd, 1995). More recently, the Florida State University Center for Prevention and

Early Intervention Policy developed the 10 Components of Quality Child Care emphasizing relationship-based caregiving and the importance of social-emotional development for young children. The 10 Components of Quality Child Care expand upon the eight core components and include continuity of care with primary caregiving assignments (component 5), as well as staff well trained in early childhood development (component 2) and comprehensive support services with multidisciplinary teams (component 10) (Graham, Hogan, White, & Chiricos, 2003). Thus, two of the ten components directly address the quality of caregiver-child relationships, while the remaining eight components support children's social and emotional development.

The National Association for the Education of Young Children (NAEYC) reports that there are certain attributes that all high quality, developmentally appropriate early care and education programs have in common. The mission of NAEYC is to promote high quality early care and education programs that are developmentally appropriate and contribute to each individual child's development. According to NAEYC (1997), "a high quality early childhood program is one that provides a safe and nurturing environment that promotes the physical, social, emotional, aesthetic, intellectual, and language development of each child while being sensitive to the needs and preferences of families" (p. 4).

In 1985, NAEYC established a voluntary national accreditation system for early care and education programs serving as a standard of excellence, as opposed to the minimum standards of state child care licensing regulations. More recently, NAEYC fine-tuned the accreditation process and introduced new guidelines in September 2006, which are directly tied to their definition of high quality, developmentally appropriate early care and education programs (NAEYC, 2007).

NAEYC defines quality according to ten standards: relationships, curriculum, teaching, assessment of child progress, health, teachers, families, community relationships, physical environment, and leadership and management. Each standard stands alone as an essential component and together the ten standards comprise a definition of quality for child care programs. Standard ten addresses the accreditation criteria for leadership and management (Ritchie & Willer, 2005). Several criteria under management policies and procedures address continuity of care. Groups of children are assigned a teacher who has primary responsibility for the group's overall well-being including personal contact and ongoing custodial care, learning activities, and supervision. Specific to infants and toddlers, NAEYC encourages that this group of children remain with the same caregiver for at least a period of nine months. Another criteria seeks to minimize the number of transitions among groups, teaching staff, and classrooms for the individual child during the course of a day and throughout the year.

The attempt to maintain continuity of relationships between teaching staff and children and among groups of children is of prime importance in the accreditation process. If programs allow children to intermingle for more than two hours and if the composition of the original group changes by more than 50 percent, then NAEYC views this as a separate group. In order for programs to receive credit for these criteria, a child must not experience more than two transitions during the full-day program, meaning when the composition of the group of children or the composition of the teaching staff changes by more than 50 percent (NAEYC, 2008).

Beginning in 1998 with the development of the Reaching for the Stars program in Oklahoma, a movement towards statewide Quality Rating and Improvement Systems (QRIS) for early care and education programs has surfaced (ZERO TO THREE, 2008). Currently, 17 states

have instituted a QRIS program of which 15 are linked to NAEYC's accreditation process. The intent of QRIS is to promote high quality in child care settings through the establishment of a system for rating children's daily experiences in child care and to support continuous program quality improvement.

The National Infant and Toddler Child Care Initiative (NITCCI), based within the ZERO TO THREE organization, is charged with assisting the Child Care and Development Fund Administrators to improve the quality and supply of child care for infants and toddlers. Upon review of the existing QRIS across the nation, it became apparent that indicators addressing quality specific to infants and toddlers was lacking. In response to this finding, the NITCCI issued recommendations for intentionally including infants and toddlers in QRIS. The promotion of continuity of care as an administrative program policy was one of many recommendations made by NITCCI for inclusion in all statewide QRIS. Policies that support the establishment of continuity of caregivers, caregiving space, and the connection between home and the caregiving setting are all cited as critical to the development of the caregiver-child and caregiver-parent relationship (ZERO TO THREE, 2008).

Recent policy efforts through the work of the Center for Law and Social Policy (CLASP), a national non-profit organization dedicated to improving the lives of low-income families and their children, have centered around infants and toddlers. Through the Charting Progress for Babies in Child Care Project, CLASP developed a policy framework with 4 key principles and 15 recommendations for states to implement policies and practices that support the healthy growth and development of infants and toddlers in child care settings (Center for Law and Social Policy, 2008).

Recommendation three advocates for continuity of care between child and caregiver from the time the child enters child care to the age of three. CLASP outlines the following policies for states to move forwards the implementation of continuity of care in center-based programs: increasing the minimum state licensing requirements to include primary caregiver assignments, requiring centers to implement strategies that allow infants and toddlers to remain with their primary caregiver until age three, and allowing child care centers to mix age groups in order to implement such practices; providing incentives to child care centers that implement continuity of care for low-income children in the form of increased child care subsidies; training for child care providers regarding the implementation of continuity of care; ensuring that continuity of care is addressed and encouraged in state QRIS; and educating parents and the larger community on the importance of consistent relationships for infants and toddlers.

Child Care Regulations

Head Start and Early Head Start recognize continuity of care in the Program Performance Standards, Title 45 of the Code of Federal Regulations. Section 1304.21 (b)(1) entitled Education and Early Childhood Development Approach for Infants and Toddlers states:

grantee and delegate agencies' program of services for infants and toddlers must encourage: (1) the development of secure relationships in out-of-home care settings for infants and toddlers by having a limited number of consistent teachers over an extended period of time. Teachers must demonstrate an understanding of the child's family culture and, whenever possible, speak the child's language; (2) trust and emotional security so that each child can explore the environment according to his or her developmental level; and (3) opportunities for each child

to explore a variety of sensory and motor experiences with support and stimulation from teachers and family members (Head Start Information and Publication Center, 2005, p. 5).

Head Start Program Performance Standards do not specify a time frame for continuity of care. Simply stated, “continuity of care is the practice of keeping young children with the same caregiver for as long as possible” (Head Start Information and Publication Center, 2005, p. 2).

Continuity of care also appears in state regulations for child care centers as a minimum standard. Since 1998, the state of Illinois has required the same infant/toddler staff member to “feed, diaper and play with the child every day to establish interaction and establish continuity in the child’s relationship with as few adults as possible” (National Resource Center for Health and Safety in Child Care and Early Education, 2006). Child care center regulations in Indiana state that “centers shall make a reasonable effort to provide continuity of care for children under 30 months of age”, which was an amendment adopted in August of 2003 (National Resource Center for Health and Safety in Child Care and Early Education, 2003).

Assessment Scale

The Infant Toddler Environment Rating Scale Revised Edition (ITERS-R) (Harms, Cryer& Clifford, 2006) is a widely used assessment tool that measures the quality of a center-based child care environment for children ranging in age from 6 weeks to 36 months. The ITERS-R is comprised of 39 items organized into the following 7 subscales: space and furnishings, personal care routines, listening and talking, activities, interaction, program structure, and parents and staff. Each item is rated on a seven-point scale with one indicating an inadequate level of quality, three indicating minimal levels of quality, five indicating a good

level of quality, and seven indicating an excellent level of quality. Item number 37 on the tool measures staff continuity. In order to score at a minimal level on the item, the caregiving environment must provide one to two stable staff members who lead the group every day and children must not change to a new group or caregiver more than two times within a year. To score at a good level of quality, children must remain with the same caregiver and group of children for at least a year and volunteers and substitutes are limited to the same two to three individuals. To score at an excellent level of quality, the same group of children must be cared for by a designated primary caregiver who carries out the routines and programming for that group with the option for the child to remain with the same caregiver and group of children for more than one year.

Curriculum and Teaching Tools for Child Care Providers

Concerns over the availability of quality child care for infants and toddlers, coupled with the growing numbers of mothers of young children returning to the workforce, led to the creation of the Program for Infant/Toddler Caregivers (PITC) in 1986 (Signer & Wright, 1993). WestEd, a national non-profit educational research agency, in collaboration with the California Department of Education's Child Development Division and members of the National and California Advisory Panels, developed a comprehensive training curriculum focused on responsive, relationship-based caregiving for infants and toddlers.

PITC consists of four training modules: social-emotional growth and socialization, group care, learning and development and culture, family and providers. Six program policies serve as the basis for the training modules and are woven throughout the curriculum. All policies are grounded in relationship-based caregiving and particular emphasis is placed upon continuity of

care and cultural continuity, as well as primary caregiving, small groups, individualized care and inclusion of children with special needs.

PITC is highly regarded by early care and education professionals as one of the most comprehensive training curriculum for caregivers of infants and toddlers. Over 900 early care and education professionals from Early Head Start programs, Head Start Quality Improvement Centers, Head Start Central Office and Regional Offices, and Migrant Head Start have completed the training to become a Certified PITC Trainer (Program for Infant/Toddler Caregivers, 2007). In addition, caregivers who are residents of the state of California are eligible to attend the training without charge through support from the California Department of Education.

The Present Study

With a national trend towards the development of statewide quality rating systems, the field of early care and education is cognizant of moving towards “better practices” for children and families. As it currently stands, continuity of care is a practice based upon theoretical assumptions and limited research. However, early care and education policymakers, state and national organizations, and quality improvement tools and rating systems privilege continuity of care as an indicator of high quality for infants and toddlers in a center-based setting.

Even with the perception of continuity of care as a best practice and as a quality indicator, few early care and education programs actually practice this. Cryer, Hurwitz & Wolery (2000) surveyed nearly 300 accredited and non-accredited child care centers across the United States and found that over 60 percent reported that none of the infants stayed with the same

teacher and more than 70 percent reported that none of the toddlers stayed with the same teacher. Decisions that influenced transitioning from one classroom to another revolved around reaching a developmental milestone or age, space availability in the next classroom and if a younger child had been enrolled into the center requiring an older child to move up. More than half of respondents either agreed or were neutral that children should have the same teacher for the first three years, while less than 20 percent strongly agreed. Despite those who strongly agreed, the connection between belief and implementation of the practice of continuity of care was weak. Overall, the practice of continuity of care for infants and toddlers is rare with no significant differences between accredited and non-accredited child care center programs (Cryer, Hurwitz & Wolery, 2000).

What is the distinction among popular buzzwords that are widely used within the early care and education field such as “developmentally appropriate practice”, “high quality” and “best practice”? The roots of developmentally appropriate practice emerged within the 20th century based upon the pioneers in the field who wrote about such concepts as child-centered education, play as a means of learning, and meaningful curriculum based upon children’s real life experiences and interests (Perry & Duru, 2000). Based upon the theoretical concepts and writings of the early care and education pioneers, the first edition of *Developmentally Appropriate Practice in Early Childhood Programs* was published in 1987 and served as the guidebook for practitioners. In response to the publication, researchers began to investigate the validity of such practices which ultimately led to a revision of the book in 1997 and again in 2009. The most recent edition of *Developmentally Appropriate Practice in Early Childhood Programs* is heavily based upon research findings regarding child development, learning and

effective practices, yet interwoven with experiential learning from practitioners in the field.

Thus, developmentally appropriate practice is continuously evolving and shaped by research as well as caregiving practices.

The evolution of developmentally appropriate practice led to the use of the term and the concept of “high quality” within the field of early care and education. Three years after the publication of the first edition of *Developmentally Appropriate Practice in Early Childhood Programs*, the *Infant/Toddler Environment Rating Scale* was introduced as a valid and reliable tool to measure quality in child care center-based environments for infants and toddlers. A revised version of the tool was published in 2006 with revisions based upon three main sources: research within the field of health, child development, and education; views of best practice from professionals in the field; and experience from practitioners within various child care settings (Harms, Cryer, & Clifford, 2006). Also during this time, the Florida State University Center for Prevention and Early Intervention Policy developed the 10 Components of Quality Child Care. Coincidentally, the publication is based upon the *Developmentally Appropriate Practice in Early Childhood Programs* publication as well as a compilation of research on child development in the early years as presented by Shonkoff and Phillips in *From Neurons to Neighborhoods: The Science of Early Childhood Development*. Thus, the use of the term and the concept of high quality within early care and education results from a combination of research, experiential learning from practitioners, as well as best practices cited by well-known experts in the field.

Who are the experts within early care and education that determine best practice and how do they determine best practice? The experts referred to by NAEYC as contributors to the original concept of developmentally appropriate practice were members of the early care and

education profession from diverse roles, the early childhood educators themselves, NAEYC staff, and members of the NAEYC Developmentally Appropriate Practice, Curriculum, and Assessment Panel (Perry & Duru, 2000). Tracing the roots of concepts such as developmentally appropriate practice and high quality, leads us to the development of best practice. If developmentally appropriate practice is primarily based upon theory and research and high quality is a combination of research, experiential learning and best practices; then best practices are the furthest away from research-based concepts and more heavily influenced by the experiences and ideas of our experts, committees, panels and workgroups in the field.

How are best practices created in disciplines outside of early care and education and are they based upon empirical evidence? The American Society for Training and Development (ASTD), founded in 1943 by a small group of Training Directors, is a professional membership association of practitioners in the field of Human Resource Development. ASTD focuses on workplace learning and performance and provides a variety of services to its membership including online resources and print publications; access to conferences, workshops, and online discussion forums; specialized professional development training programs leading to a variety of certificates; and an organized voice for those working in the profession. ASTD serves as an international membership association for human resource development practitioners and has grown to include over 130 chapter affiliates within the United States alone (American Society for Training and Development, 2008). The evolution and mission of ASTD parallels that of NAEYC, a national professional membership organization geared towards the practice of early care and education with a network of local, state and regional chapter affiliates. Much like the

history of NAEYC, the roots of corporate training and development emerged from the pioneers in the field and the experiential learning from practitioners.

Unlike the field of early care and education, scholars within the discipline of training and human resource development realized that an organized voice through a professional membership association was not convincing enough as a basis for best practices in the field. Fifty years after the founding of ASTD, the Academy of Human Resource Development (AHRD) was created. AHRD emerged from the Professors Network of the American Society of Training and Development and the University Council for Research on Human Resource Development, a group of educational institutions offering doctoral degrees in Human Resource Development (Swanson & Holton, 2009). In order to advance the profession, the importance of the connection between theory, practice, research and scholarship as essential became apparent.

In recent years, AHRD has taken the field of training and human resource development to new heights through research, promotion of the application of research-based practices, and dissemination of scholarly publications. AHRD has evolved as a professional membership organization of scholars and researchers with membership benefits that promote research-based best practices in Human Resource Development. AHRD distributes four scholarly journals to its members each with its own unique focus including putting research into practice, cultural implications, dissemination of research, and theory building (Academy of Human Resource Development, 2009). AHRD promotes scholarly work and the recognition of up and coming scholars in the field through various annual awards for the publication of research articles and books, cutting edge results that contribute new knowledge, and contributions to the field through dissertation projects.

Current best practices within training and human resource development are a result of the evolution of the field from practice-based to empirically-tested. The field of early care and education has traditionally followed a similar path to that of training and human resource development. However, the profession of early care and education does not yet have a national organization of scholars to provide empirical grounding for the work of the national membership organization. Emerging leaders in early care and education are just beginning to voice concerns over the lack of clarity of the purpose, identity, and responsibility of the discipline as a whole. Goffin and Washington (2007) point out that:

despite its many accomplishments, the field largely has been unwilling or unable to develop a coherent definition of itself and its work. It cannot even agree on a name – is it, for example, early care and education or early education and care? – and the differing viewpoints on these and other issues evoke passionate debate. (p. 2)

What then, is the purpose of citing the importance of best practice within the field of early care and education? Are best practices intended to be rules of the trade that promote high quality and optimal outcomes, or techniques that are more effective than others in achieving a desired outcome? Are best practices universal or should they depend upon the situation, much like the concept of individualizing in early childhood education? Best practices in early care and education imply that there is a standard way of doing things that caregivers within differing environments should employ; it is a sense of universality that has a final answer.

Can best practices have a negative impact depending upon the individual, the educational environment, or the context for which the caregiving takes place? Best practices should be field-tested, researched and documented with positive outcomes before they are applied, distributed,

and encouraged. Perhaps within the field of early care and education, best practices are more about current thinking and “better practices” that lead towards adaptation and continuous improvement. Movement towards best practices should involve continuous improvement, involving progression from theory to application and on to research to support the practice. As in the case with the first edition of *Developmentally Appropriate Practice in Early Childhood Programs*, revisions and continuous improvements were made based upon research findings.

The complexity of issues surrounding child care – caregiver turnover, multiple child care arrangements on behalf of parents, consistency in the definitions of continuity and transition, policies that vary by state and national standards - makes measurement of continuity of care difficult. This study utilized a qualitative design in order to provide a detailed picture of child care center directors’ perceptions of continuity of care. I sought to discover the following: How do child care center directors perceive continuity of care as a developmentally appropriate practice for infants and toddlers?; How do child care center directors perceive continuity of care as a quality indicator of high quality child care for infants and toddlers?; How do child care center directors perceive continuity of care as a best practice of early care and education for infants and toddlers?; Do child care center directors perceive there to be a disconnect between best practice policies and implementation of continuity of care into practice; and if so, what are the reasons for this disconnect? What are child care center directors’ feelings about their staff’s caregiving abilities and how does this relate to ongoing professional development?

CHAPTER 2

Methods

Research Design

I chose a qualitative research design for several reasons: limited research base on the practice of continuity of care for infants and toddlers in child care centers, primary reliance upon theoretical assumptions with a disconnect to practice, and difficulty in measuring continuity of care given the complex issues surrounding child care. Lincoln and Guba (1985) note several instances for which a qualitative research design has strengths:

research that delves in depth into complexities and processes; research on little known phenomena or innovative systems; research that seeks to explore where and why policy, local knowledge and practice are at odds; research on real, as opposed to stated, organizational goals; and research for which relevant variables have yet to be identified (p. 91).

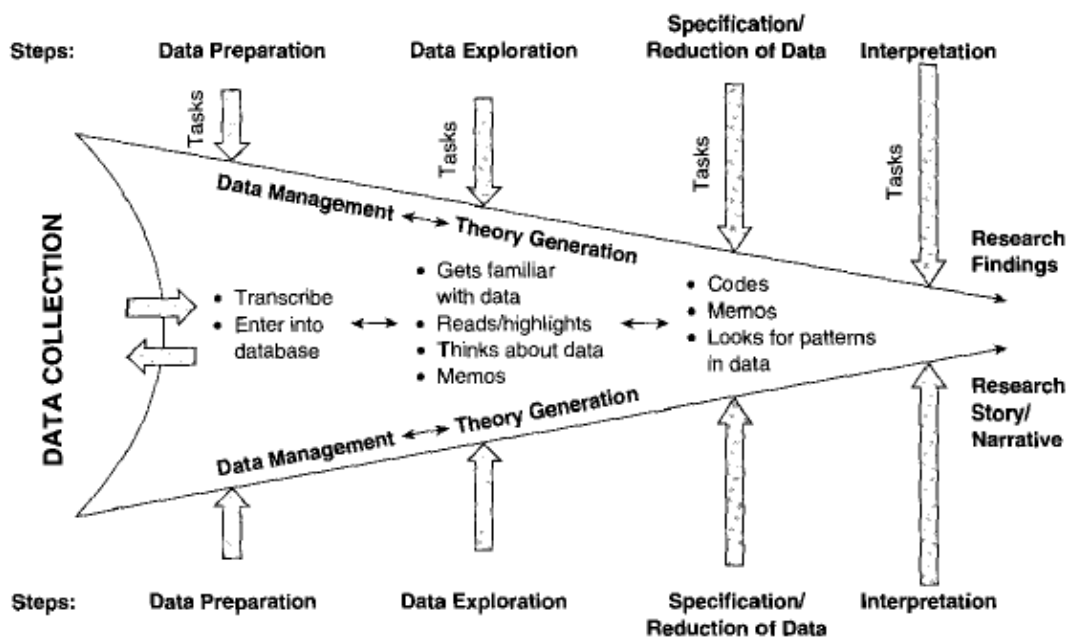
I also chose a qualitative research design because I am attempting to answer “how” questions.

As Denzin and Lincoln (2005) state:

Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry. Such researchers emphasize the value-laden nature of inquiry. They seek answers to questions that stress *how* social experience is created and given meaning (p. 10).

Hesse-Biber and Leavy (2011, p. 317) provide a visual model of the various phases involved in the process of data analysis and interpretation, beginning with the data collection phase and concluding with the research findings or narrative phase. Refer to Figure 1. The design and process of this study closely mirror the model as presented by Hesse-Biber and Leavy (2011).

Figure 1: Steps in data analysis and interpretation: A visual model



Initially, I embarked on this qualitative research journey intending to utilize grounded theory as the method of inquiry for this study. As data collection evolved, the theoretical framework that became evident was Bronfenbrenner's (1989) ecological systems theory.

Ecological systems theory views the environment as a “set of nested structures”... “moving from the innermost level to the outermost level”, each contributing to shaping human development (Bronfenbrenner, 1993, p. 39). These structures, the microsystem, mesosystem, exosystem, and macrosystem; are interconnected and change over time.

The microsystem is characterized by interpersonal relationships encountered by the developing individual. These are face to face interactions occurring within the family, among peers, at the parent’s workplace, and within the neighborhood and early care and education setting. The mesosystem is the interaction between two or more microsystems, which exists within the larger context of the exosystem. Individuals do not directly participate in settings comprising the exosystem, however, these settings indirectly influence the processes impacting the individual. These settings include economic, political, education, government, and religious systems. The microsystem, mesosystem and exosystems operate within the context of the macrosystem; or the overarching societal and cultural beliefs and values (Bronfenbrenner, 1993).

While this study does not specifically focus on child development outcomes, it does investigate the interconnectedness between the relationships experienced by the child within the microsystem nested within the mesosystem, exosystem and macrosystems. More specifically, the ecological systems theoretical framework in this study focuses on the interplay between caregiver-child interactions through the practice of continuity of care within an early care and education setting (microsystem and mesosystem), the state regulations for early education, health and safety, and funding (exosystem); and the beliefs and values around quality early care and education proposed by NAEYC, Environmental Rating Scales, and advocacy efforts of CLASP and Zero To Three (macrosystem).

Sample

Twenty-one directors of child care center programs from upstate New York were recruited using criterion sampling. Including participants according to predetermined criterion is useful for quality assurance and for identifying and understanding cases that are information rich (Patton, 2002). Individuals eligible to participate in the study must have directed a child care center for a period of at least one year and hold a current license from the New York State Office of Children and Family Services (OCFS). Only child care center programs serving infants and toddlers from 6 weeks to 3 years of age and having at least one classroom for infants and one classroom for toddlers were recruited. This was to ensure that children within this age range would transition at least one time between infancy and toddlerhood.

Directors of child care center programs were eligible to participate in the study if they were not practicing continuity of care at the time of data collection and had not participated in an in-depth training seminar on how to institute continuity of care in a child care center. These criteria purposefully eliminated child care programs that were part of Early Head Start. Early Head Start defines and promotes continuity of care within their programmatic standards and guidelines. To obtain the truest sense of the dynamics and practices around continuity of care free from prescribed programmatic mandates, I included directors in the sample that represented the typical community child care center.

A total of 75 child care centers, within a single county focus, held a valid operating license from OCFS and served infants and toddlers from 6 weeks to 3 years of age. Twenty-nine of those centers (39 percent) became ineligible for participation due to the established criteria. Special attention was given to recruiting at least five directors from child care centers serving a

large proportion of children receiving subsidies. My initial goal was to recruit 18 participants, representing approximately 39 percent of all eligible child care centers. Twenty-one directors participated in the study, representing 46 percent of all eligible child care center directors, with 5 (24 percent) from child care centers serving a large proportion of children receiving subsidies.

Thirty-eight percent of individuals in this study have 1 to 5 years of experience as a child care center director. Twenty-four percent of directors have 6 to 10 years experience and nineteen percent of the sample has 11 to 15 or 16 or more years experience directing a child care center. Fifty-seven percent of individuals have been the director of the current child care center for 1 to 3 years, 14 percent for 4 to 6 years, and 19 percent for 7 to 10 years. Only ten percent of the sample has been the director of the current child care center for more than ten years. Sixty-two percent of individuals have experience as a director of another child care center.

Eighty-one percent of directors earned a college degree in early childhood education or a related field, while 19 percent have earned a college degree in an unrelated field. Twenty-four percent of directors earned a master's degree, fifty-two percent earned a bachelor's degree, and 24 percent earned an associate degree. Fifty-two percent of directors in this sample have taken college coursework specific to infants and toddlers. Table 1 displays attributes specific to the child care centers in this study.

Table 1: Summary of Child Care Center Attributes

Attributes of Child Care Centers	Attribute Value (Percent)	
	Yes	No
Accredited center	3 (14)	18 (86)
Director turnover during study	8 (38)	13 (62)
Enforcement action	2 (9.5)	19 (90.5)
Serious violation	20 (95.2)	1 (4.8)
Unresolved violations	3 (14.3)	18 (85.7)

“As time is spent with subjects, the relationship becomes less formal. The researcher’s goal is to increase the subjects’ level of comfort, encouraging them to talk about what they normally talk about and, eventually, to confide in the researcher” (Bogdan&Biklen, 2003, p.73).

I developed a professional working relationship with many of the child care center directors in the region through my prior employment at a child care resource and referral agency. I believe the positive response rate for participation in this study was due, in large part, to the development of these relationships over an eight year period and to the supportive role I played at the agency where I offered training and technical assistance to center staff.

Consequently, I was able to gather rich data through one extensive interview with participants without the typical barriers around gaining access and building rapport that qualitative researchers often encounter. Rich data refers to “data that are detailed and complete enough that they provide a full and revealing picture of what is going on” (Maxwell, 1996, p.95). “Good interviews produce rich data filled with words that reveal the respondents’ perspectives. Transcripts are filled with details and examples” (Bogdan&Biklen, 2003, p.96).

Given the sensitive nature of conducting research involving human subjects, I completed the Collaborative Institutional Training Initiative (CITI) Web-based training program as well as obtained approval through the Institutional Review Board Office at Syracuse University. In order to maintain confidentiality, participant names have been changed and pseudonyms used when referring to each child care center.

Procedures

I obtained a list of all licensed child care center programs within a single county from the New York State OCFS website. The primary purpose of this website is to provide up-to-date information to parents looking for regulated child care. A letter (Appendix A) was sent to all eligible child care programs in a single county in upstate New York inviting the director to participate in the study and offering an incentive of children's books for use in the infant and toddler classrooms. Twenty-one directors responded to the letter and were screened over the telephone to verify eligibility (director of a child care center for at least one year, currently licensed, serving infants and toddlers with at least one classroom for each age group, and not currently practicing continuity of care). Once eligibility was verified and the individual agreed to participate, an appointment for a face-to-face interview was scheduled for a date, time and place convenient for the participant. All individuals chose to participate in the interview at the child care center location where they were employed.

Each participant received an informed consent form (Appendix B) describing the purpose and expectations of the study and highlighting the fact that participation was voluntary and that they could stop at any time without penalty. Participants signed the form, after having time to read the information and ask any questions. The interview was conducted face-to-face, recorded using a handheld digital audio recorder, and lasted no more than two hours in length. The interview was semi-structured and focused on the participant's knowledge of continuity of care and experience with continuity of care. Bogdan and Biklen (2003) note:

In keeping with the qualitative tradition of attempting to capture the subjects' own words and letting the analysis emerge, interview schedules and observation guides generally

allow for open-ended responses and are flexible enough for the observer to note and collect data on unexpected dimensions of the topic (p.71).

Measures

A list of open-ended interview questions gauging knowledge of and experience with continuity of care is provided in Appendix C. The interview was semi-structured using open-ended questions as a guide, however, allowing freedom for the participant to tell his or her own story. Participants also completed a demographic questionnaire as provided in Appendix D.

The New York State Summary of Regulatory Compliance for each of the child care centers included in the study was obtained from the OCFS website and used as an indicator of quality. The Summary of Regulatory Compliance provides information on the number, severity, and nature of any violation within the past 24 months; in addition to the compliance status of each of the recorded violations including those that are unresolved for longer than 24 months. A summary of the regulatory compliance history is included in Appendix H contained within the attribute summary report.

Analysis Approach and Software for Transcription

I transcribed each of the interviews using Dragon Naturally Speaking voice recognition software. Upon completion of the initial transcription I slowed the speed of the interview with the accompanying digital voice recorder software and reviewed the transcript to check for accuracy. Transcripts were then loaded as sources into NVivo 8, a qualitative data analysis software package. I found the process of transcribing the interviews and checking the transcript for accuracy to be an invaluable part of the overall research process in terms of building knowledge of my data. Hesse-Biber and Leavy (2011) note:

Transcribing research data is interactive and engages the researcher in the process of deep listening, analysis, and interpretation. Transcription is not a passive act but instead provides the researcher with a valuable opportunity to actively engage with his or her research material from the beginning of data collection (p. 304).

NVivo 8 is a qualitative data analysis software program that supports researchers in recording, sorting, retrieving and linking various forms of data. Data and ideas can be managed, queried, and graphically modeled; and reports can be generated. “The use of a computer is not intended to supplant time-honored ways of learning from data, but to increase the effectiveness and efficiency of such learning” (Bazeley, 2010, p.2). The software program allows the researcher to organize and manage large amounts of data and sort through the data more completely and efficiently than the traditional paper-based methods of cutting, labeling and sorting. Bazeley (2010) states: “the complexity and detail with which coding was made possible by computers, and the benefit of that in driving a complex and iterative data interrogation process, provided the basis for a radical shift in researchers’ approaches to both coding and analysis” (p.7). The computer by no means takes the place of the methodology involved in the qualitative research approach. “The researcher must integrate their chosen perspective and conceptual framework into their choices regarding what and how to code, and what questions to ask of the data; software cannot do that” (Bazeley, 2010, p. 11). Perhaps, “it can be claimed that the use of a computer for qualitative analysis can contribute to a more rigorous analysis” (Bazeley, 2010, p.3).

For this study, I used NVivo 8 to store and organize field notes and transcribed interviews. I also created a journal, known as a memo in NVivo, with a date and time stamp on

each entry. A memo is essentially a methodological log that documents the research process from the beginning of the project. It provides a detailed account of decisions made along the way, changes in direction, insights gained and ideas as they develop. I chose to keep three separate memos: one devoted to the coding history and reflections on the research process, one devoted to main ideas and questions for continued reflection based upon completion of coding, and one tracking the process involved with the analysis phase.

Coding Within NVivo 8

The purpose of coding is to break up data into categories and to “expand and tease out the data, in order to formulate new questions and levels of interpretation” (Coffey & Atkinson, 1996, p.30). Coding in NVivo 8 involves the use of nodes, a place where you can gather ideas together around a particular topic or idea. There are four main types of nodes: free nodes, tree nodes, case nodes and relationship nodes. Free nodes stand on their own, are used to capture emergent ideas, and do not fit into a hierarchical structure. Tree nodes are hierarchically organized, serve to manage connections between ideas, and are subdivided according to parent nodes and child nodes. Case nodes serve to organize all materials around a specific case and relationship nodes organize materials between two items in the project that have a specific connection (Bazeley, 2010).

Because of a lack of an established knowledge base around continuity of care, as discussed in the literature review, I was unable to develop tree nodes based upon previous research. Therefore, I began the coding process by reading the interview transcript, identifying text and developing free nodes. “Text then can be viewed by category as well as by source, and so, as well as facilitating data management, classification of text using codes assists

conceptualization” (Bazeley, 2010, p. 66). Examples of free nodes that were created during this step are quality and diversity of center.

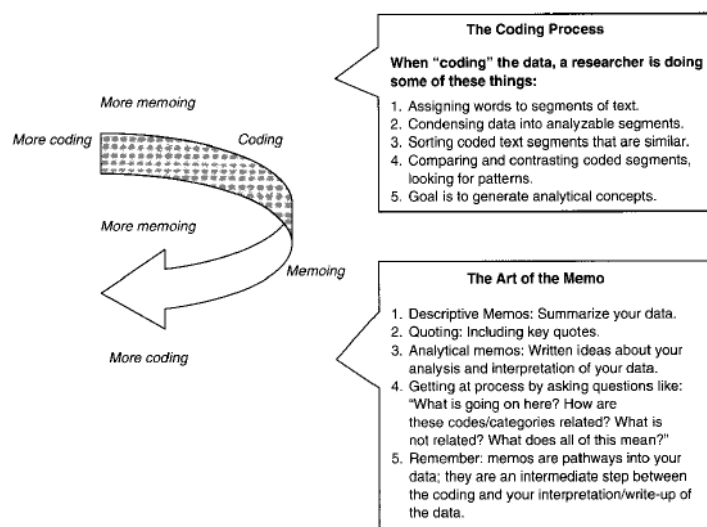
Memos played an important role during the construction of free nodes. I used memos created within NVivo 8 to capture emerging ideas, questions, and patterns about the data; to document thoughts that led to decision making; and to capture the logical progression of the coding process. Hesse-Biber and Leavy (2011) note “as more and more interviews are analyzed and you continue to memo about what is going on in your data, you may come up with several analytical dimensions or subcodes” (p. 312). This is precisely what occurred as I used the memos to refine the free nodes into tree nodes.

With the exception of two nodes, quality and diversity of center, all free nodes became tree nodes; or parent nodes with a minimum of three child nodes as subcategories of the larger concept. For example, best practice was created as a parent node with continuity of care as a best practice, understanding of best practice, and the definition of best practice as child nodes. Appendix E displays the list of nodes in this study.

“Memo writing is an important link between analysis and interpretation” (Hesse-Biber&Leavy, 2011, p. 315). After organizing the data into tree nodes, I took a reflective look at the emerging themes for each of the parent and child nodes. This was also the time when I made decisions to uncode selections and recode at a different node. Figure 2 illustrates that the “qualitative coding process consists of cycles of coding and memoing” (Hesse-Biber&Leavy, 2011, p. 314). Ultimately, I created another memo summarizing the main ideas apparent within each of the tree nodes. Appendix F contains the memo of main ideas in its entirety. “Analysis and interpretation are not necessarily two distinct phases in the qualitative research process...the

process is much more fluid, as the researcher often engages simultaneously in the process of data collection, data analysis, and interpretation of research findings” (Hesse-Biber&Leavy, 2011, p.315).

Figure 2: Coding and memo-ing: A dynamic process



Another feature of NVivo 8 that assisted me in the process of analysis and interpretation of the data was the modeling tool. Modeling is a visual journal or concept map representing an association between nodes and sources that assists the qualitative researcher in clarifying a conceptual framework and theoretical link (Maxwell, 2005). Creating a model helped me visually explore and organize the relationships between and among sources and nodes to obtain a better idea of the overall connectedness of the various aspects of the project. Coding selections of the nodes in the model assisted me in determining central themes of the study. Appendix G displays the model I created in NVivo 8 in order to display three central themes.

Reports and Queries

In addition to various tools for data analysis as mentioned above, I also used NVivo 8 to generate reports and queries. The reports feature generates a summary listing of specific aspects of the study. I generated three reports including a node summary report, an attribute summary report and a coding summary report. Collectively, the reports allowed me to view the following: which themes or ideas are occurring more than others, demographic data, and check the progress of coding. Appendix H contains results from these reports.

The query feature in NVivo 8 allows the researcher to question the data and look for patterns in order to review the project from another perspective. For this study, I utilized three different types of queries: text search, word frequency and matrix coding. The text search query function allowed me to search for key words or phrases within sources and nodes. This feature was useful during the initial coding process and again during the analysis phase when writing memos. The word frequency query was useful for providing a picture of how many times words appear in the data. Both query features allowed me to be sure I did not overlook any data and to check for accuracy within coded nodes. Qualitative data analysis involves both the decontextualization and recontextualization of data where “segments of your data are first looked at in isolation from their particular contexts”... “segments are linked to other decontextualized segments that appear to contain the same meanings and ideas” culminating with like segments being assembled into groups or categories (Hesse-Biber&Leavy, 2011, p. 325). This analysis process “provides a mechanism for discovering larger themes and patterns in your data that reveal a new level of understanding of your data as a whole”... “and this is where a computer software program can help with the coding and retrieval of text segments” (Hesse-Biber&

Leavy, 2011, p. 325). For nodes that outlast the query process, “these are categories that will move you forward in your analysis as you look for ways they, with their dimensions, might link together in a model or theory” (Bazeley, 2010, p. 191).

The matrix coding query allowed me to look for patterns across different groups, by attribute, and/or theme. Rather than running several separate queries, NVivo 8 can run one matrix coding query that displays all of the results in a table with links to the original data source. For example, I built a matrix coding query to examine any patterns between best practice (understanding of best practice, definition of best practice, and continuity of care as a best practice) and director’s education level (earned Associate, Bachelor’s or Master’s degree). Table 2 shows the results generated by this matrix coding query. Seven references of continuity of care as a best practice were identified by individuals with an associate degree. I then reviewed the seven references pulled out of the data to determine any connection to references identified by those individuals with a bachelor's degree and a master's degree. As Bazeley (2010) states: “NVivo’s contribution is to select and sort the data for you, often with a degree of complexity which would simply not be possible working manually” (p. 180).

Table 2: *Matrix Coding Query: Best Practice and Director’s Education Level*

	Highest degree = Associates	Highest degree = Bachelors	Highest degree = Masters
Continuity of Care as Best Practice	7	19	8
Definition of Best Practice	10	23	8
Understanding Of Best Practice	6	21	7

The results of the matrix coding query permit me to take a closer look at the sorted data to further investigate trends in best practice according to director's education level. Matrix coding queries allow for a deeper level of interpretation by the researcher by aiding in a more rigorous analysis (Bazeley, 2010).

Validity and Trustworthiness

Historically, “reliability, validity, objectivity, and generalizability – borrowed from more quantitative approaches – were the criteria against which the soundness of a qualitative study was judged” (Marshall & Rossman, 2011, p. 39). In their influential work, Lincoln and Guba (1985) proposed alternative constructs of credibility, dependability, confirmability, and transferability, for use with a qualitative research approach. Others have built upon the constructs proposed by Lincoln and Guba (1985) to develop a checklist of validity (Maxwell, 1996) and to address the issues of rigor and usefulness (Kvale, 1996; Creswell & Miller, 2000). In this study, I have focused on validity and trustworthiness as identified by Lincoln and Guba (1985).

To achieve credibility, the researcher has appropriately described and identified the sample such that the complexities of the process and interactions are plausible to the reader. As a greater understanding of the topic is obtained through the research process, a researcher gains dependability by accounting for purposeful changes in the design of the study. Confirmability involves transparency of the logic and interpretation behind the study inquiry such that it makes sense to others and the assertions are strengthened. How the study's findings are useful to others in situations that are similar, who have similar research questions or who have questions about

practice, leads to transferability (Lincoln & Guba, 1985). NVivo 8 was instrumental in assisting with issues surrounding validity and trustworthiness for this study.

NVivo 8 was used to manage data records, conduct queries of various levels to explore patterns across the data and inform decisions about the research process, and provide detailed records of methodological decisions. Memos served a crucial role as a methodological log to document the history of coding decisions that were made, at what point in the study they were made, and the rationale behind them. “Audit trails provide a transparent way to show how data were collected and managed – to account for all data and for all design decisions made in the field so that anyone could trace the logic” (Marshall & Rossman, 2011, p. 221). NVivo 8 allowed me to organize information from a variety of data sources and served to track the course of the project and the building of themes and ideas that gained clarity along the journey. The memo was important because it required me to reflect on the various parts of the project, the project as a whole, and document the thought process. “By writing thematic memos, the researcher assembles thoughts about how a story of events, behaviors, or sentiments seems to have meanings, and will use these as building blocks in analysis” (Marshall & Rossman, 2011, p. 214). The memo provides documentation for others to view my research process, decision making, and final conclusions. “Then, those who make policy or design research studies within those same (or sufficiently similar) parameters can determine whether the cases described can be generalized for new research policy and transferred to other settings” (Marshall & Rossman, 2011, p. 252).

In addition to NVivo, I employed several other procedures to further address issues of validity and trustworthiness. As previously mentioned, the premise for this study is based upon

eight years of employment at a child care resource and referral agency and several additional years in various other positions within the field of early care and education. Lincoln and Guba (1985) refer to this as prolonged engagement and urge qualitative researchers to be involved in the field for a long period of time to establish credibility.

Lincoln and Guba (1985) also urge qualitative researchers to discuss interpretations and emergent findings, solicit feedback, and engage in reflective practice with colleagues and peers familiar with the setting to ensure that analysis is grounded in the data. I worked closely with my dissertation committee to obtain feedback throughout this process. I also had a network of colleagues from a variety of backgrounds within the area of education who were familiar with qualitative research methods. Ensuring confidentiality, I delivered a presentation to a local group of professors of adult learners and presented a paper at a national conference of early educators. These opportunities allowed me to share my study design and interpretations as they emerged and to consider alternative ideas and questions proposed by those in attendance. Also, receipt of the NAECTE Foundation Research Award was recognition that this research study, and the methods employed, has relevance for policy and advocacy within early care and education.

To address issues of triangulation three sources of data were collected including a face-to-face semi-structured interview, a Summary of Regulatory Compliance from the New York State OCFS website, and a demographic questionnaire. In addition, memoing, modeling, querying, and the ability to generate reports within NVivo also served to address this issue.

Finally, I have purposefully provided a detailed description within this chapter around the procedures of this study to address the constructs of credibility, dependability, and confirmability

ultimately leading to transferability. In summary, issues surrounding validity and trustworthiness depend upon a “fundamental appreciation of naturalistic inquiry, qualitative methods, inductive analysis, purposeful sampling, and holistic thinking” along with rigorous fieldwork methods and the credibility of the researcher (Patton, 2002, p. 552-553).

Subjectivity

Historically, qualitative research has been viewed as subjective and riddled with researcher bias. “Qualitative research, however, is neither naively subjectivist nor biased” (Marshall & Rossman, 2011, p. 5). In an effort towards transparency I will address the issue of subjectivity as related to my values, beliefs and assumptions for this study. I approached this study with a belief that there is a disconnect between policy and practice within the field of early care and education. I also believe there is a mystification over the terms developmentally appropriate practice, high quality, and best practices. Best practice policies may be good ideas in theory, but may not be absolutely necessary or practical for the existence of a high quality program. For example, to obtain an “excellent” rating on item 39, opportunities for professional growth, on the *Infant/Toddler Environment Rating Scale* requires programs to maintain a professional library of current early childhood materials for staff (Harms, Cryer, & Clifford, 2006). Maintaining a professional resource library for staff is a best practice for child care centers, and may not be practical for programs on a tight budget or indicative of a high quality program. Therefore, I suspect there is a disconnect between what is thought to be a very good idea and what actually occurs in practice.

I believe there are several contributing factors to the variance between policy and practice. Child care center directors face daily operating challenges around caregiver turnover,

caregiver education and training, and state and national standards for regulating programs. There is also a limited body of research that is available on the topic. I suspect child care center directors believe continuity of care for infants and toddlers in a child care center is an important concept in order to promote optimal developmental outcomes for a child; however, I do not think they view continuity of care as an essential practice for their program.

“The researcher’s primary goal is to add to knowledge, not to pass judgment on a setting” (Bogdan&Biklen, 2003, p. 33). Marshall and Rossman (2011) call for a shift in discussion away from questioning the validity of qualitative research towards “a discussion of epistemology and to strategies for ensuring trustworthy and credible studies (p. 5-6). In order to monitor my subjectivity and minimize its impact, I employed several procedures. Reflective memos, peer debriefing, soliciting feedback, and participation in professional presentations and conferences were activities in which I engaged with others outside of my own self. These concepts have been addressed in detail in an earlier section of this document.

CHAPTER 3

Results

Creating a data display through narrative text is the most frequently used form of display for qualitative data (Miles & Huberman, 1984). A theme is a concept, trend, or key distinction that emerges from qualitative data (Bogdan & Biklen, 2003). Common practice for writing a qualitative manuscript is to focus on three emergent themes (Bogdan & Biklen, 2003). As is the nature of qualitative research, all of the data that emerged from these questions did not cluster into a theme (Bogdan & Biklen, 2003). Thus, the results section will focus on the three primary themes that emerged: continuity of care, program operation and career development.

Theme 1: If We Could We Would

This section focuses on the theme of continuity of care that emerged from three research questions presented earlier in this document. How do child care center directors perceive continuity of care: as a developmentally appropriate practice for infants and toddlers?; as a quality indicator of high quality child care for infants and toddlers?; and as a best practice of early care and education for infants and toddlers? Developmentally appropriate practice and best practice did not emerge as significant themes in the data.

In contrast, continuity of care emerged as a significant theme and is the focus of this section in regards to directors' perceptions of continuity of care concerning a definition and understanding of terminology, advantages and disadvantages of this type of caregiving, continuity of staff, and policy issues.

Definition and Understanding of Terminology

As a discipline, early care and education is riddled with jargon. Terminology is used to denote application of theoretical constructs and guiding principles, such as developmentally appropriate practice, best practice, and continuity of care. These commonly used terms, referencing the guiding principles of early care and education, pose a challenge for directors.

Directors defined continuity of care according to sameness of caregiving. Each child receives the same kind of care, is offered the same opportunities on a daily basis, and has similar experiences overall. The child has these experiences within the same classroom. Teacher expectations for acceptable behavior from children are the same and teachers maintain a similar curricular focus when a child transitions to the next classroom. Seventy-one percent of directors viewed continuity of care as consistency of routines and the daily schedule.

Directors also defined continuity of care according to sameness of programmatic rules and policies. Management and staff follow the same rules and regulations for all families and uphold the same policies throughout the building. Continuity of care is a phenomenon that occurs within the building. The children remain in the center from the time of enrollment until they age out and teachers remain employed at the program. Continuity of care is familiarity within the building as a whole and presents a consistent physical environment.

Directors in this study struggled to articulate a definition of continuity of care. One director had never heard of the term and was not familiar with the concept when provided the definition from NAEYC. Only 8 directors (38 percent) defined continuity of care depicting the importance of developing a primary caregiver-child relationship over time. Mandy explains, continuity of care “is when a teacher stays with that child throughout their time at the day care

center. So, from infant to five years they move with that child instead of that child moving to different caregivers” (personal communication, September 11, 2009).

Interestingly, more than half of the directors (55 percent) in this study feel their staff has an understanding of the meaning of continuity of care. Teachers reportedly learned about continuity of care in a variety of ways. As the director, Carol asserts: “I am teaching it to them and they are doing what I am telling them to do” (personal communication, October 9, 2009).

More commonly, directors feel their staff learn about continuity of care through experience in a child care setting. “Once they have worked here a little bit they understand for themselves because of a child’s behavior” (Kathy, personal communication, September 4, 2009). At Nikki’s center, one of the infant teachers called in sick. The co-teacher in that classroom worked her eight-hour shift and asked if she could stay in her classroom until the end of the day “because she did not want her babies with someone who did not know them or the routine” (Nikki, personal communication, November 6, 2009).

Directors also learn about continuity of care through firsthand experience in the classroom. Anna covered a break for the teacher in the infant classroom at her center. Anna explains her experience with one child:

She just looked around and sat there with a sad look on her face no matter what I did. I tried to play with her and she just sat there with this depressed look on her face. I thought, she must be missing the teacher. The teacher came in after her break and the child was a new baby. I thought this is continuity of care; she expected to see her person, her person wasn’t there, and she was mad (personal communication, October 1, 2009).

For the other forty-five percent of directors in this study, they either felt their staff did not understand continuity of care (3 directors) or were confused about continuity of care and only understand the concept somewhat (6 directors). “I am thinking of the staff that we have now and it would be a lot of education and training just to explain the concept” (Sylvie, personal communication, November 24, 2009).

Directors report that teachers have difficulty articulating what is meant by continuity of care and are unable to explain it to parents. According to directors, teachers are not familiar with the term, “but if you explain to them what you mean, then I think they would give the same answers that I have” (Patty, personal communication, October 9, 2009). Other directors hope that the understanding of the concept “just kind of trickles down” (Molly, personal communication, November 12, 2009). Eighty-six percent of directors did not formally talk with staff about the concept as part of a staff meeting or training.

Directors report that teacher understanding of continuity of care is viewed as intrinsic. Carrie asserts:

On a gut level or a personal level, I think most of them get it. I think there is a different understanding of how important those relationships are when you are really connected to a child, as you are when you are a parent. So, on a personal level I think most of them get it, but on a professional level I think they struggle with it (personal communication, October 15, 2009).

Directors also use their own intrinsic feelings to assess teacher understanding of continuity of care. Colleen contends, “they may not understand the extent and all of the reasons for what they do, but they do get it” (personal communication, September 24, 2009).

Directors created their own definition of continuity of care specific to their current practices and beliefs and the literal meaning of the term.

Continuity is that everybody knows everybody. So, it doesn't matter which adult comes into your room or which room you go to. You know who it is, you know who the people are, and you know who is going to take care of you. So, for us, that's our continuity (Sue, personal communication, October 20, 2009).

Directors also used their own definition of continuity of care as a basis for assessing teacher's knowledge. According to directors, consistency with classroom rules, environment and daily routine; sameness in teacher expectations for children; and helping to keep the center running smoothly without a lot of changes during the day was evidence of teacher's understanding of continuity of care. Sue explains:

Probably everyone has a little bit of a different perception of what continuity of care actually is and I think different people could make it mean something different that still might make sense. You could probably come up with 10 different definitions of what continuity of care would be and then you would never be able to do it (personal communication, October 20, 2009).

Defining the terms developmentally appropriate practice and best practice posed a challenge for directors and teachers, similar to that of continuity of care. Directors provided a range of responses including those who were unable to provide a definition and those who viewed such practices synonymously with the state regulations. Similar to continuity of care, teacher knowledge of developmentally appropriate practice and best practice is dependent upon experience in the classroom and training obtained through supervision from the director. Some

directors had difficulty articulating the meaning of these terms, and thus applications of the concepts in the classroom were as varied as the definitions themselves.

Advantages and Disadvantages of Continuity of Care

Directors conveyed both advantages and disadvantages of the practice of continuity of care, with 81 percent of directors viewing continuity of care positively. There are several advantages to continuity of care for children, parents and teachers.

Directors view continuity of care as vital for children to develop a sense of trust, safety, and security with a primary caregiver. Children become “stressed about who is touching them and who is feeding them” (Mary, personal communication, November 6, 2009). Continuity of care is important for children who have a less flexible temperament. Continuity of care provides structure and predictability within the environment. “When you don’t have continuity or sameness it makes for a more chaotic setting and children not feeling safe” (Nikki, personal communication, November 6, 2009). Through continuity of care a child becomes familiar with caregiver expectations, thereby preventing confusion and promoting a sense of safety and self confidence.

Continuity of care is viewed as developmentally important for children because infants and toddlers grow at a rapid rate. Developing a relationship with a primary caregiver is “fundamental for the rest of everything that can grow on top of that and what they can learn” (Kristen, personal communication, November 13, 2009). When children encounter disruptions with caregivers, time is spent developing a relationship with a new caregiver. “It’s very valuable time for children and if they didn’t have to be reestablishing those relationships then they could be doing other things” (Carrie, personal communication, October 15, 2009).

Directors believe continuity of care is beneficial for children lacking a stable home environment. Sylvie recounts a time when she observed a child hitting peers in the classroom. She spoke with his mother about the behavior and learned the child's mother works two jobs. His mother picks him up at the child care center and drops him off at another provider's home where there are upwards of eight other children that are much older. Sylvie explains:

Sometimes we are the safe haven. When he's with us, let this be the one place where he knows that someone really cares about him; where he gets some one-on-one attention if he needs it, and we are looking for all those signs of distress or whatever he might be sending out to us (personal communication, November 24, 2009).

If the same teacher is with a child for a long period of time, the teacher is able to track progress. If the child lacks progress, the teacher is informed about what may be going on with him and is better able to help the child.

Directors also perceive benefits of continuity of care for parents. Parents see the same faces and experience a sense of security knowing the same teacher is taking care of their child every day. Parents leave for the day knowing their child is well taken care of while they are at work. "The more years you spend with a person, the more you are going to get to know about them - their wants, their needs, their expectations; what a better way to serve the family" Amy, personal communication, October 9, 2009).

In some cases, parents requested the teacher move with their child to the next classroom. Due to unplanned circumstances with staffing, Kristen moved a teacher with the group of children to the next classroom. "When we did this our parents were happy that their children would still be with someone that they were familiar with. The teacher was actually happy about

moving too; it was a good experience” (Kristen, personal communication, November 13, 2009). Teachers continue building upon already established parent and child relationships into the next classroom, making the child care experience easier for everyone involved.

Theoretically, directors perceived continuity of care worthy of consideration. However, putting continuity of care into practice is easier said than done. “Continuity of care is great if you have a good relationship, good connection, and everything is positive and great. But, what if that’s not the deal? I get hung up in my head as I think about this and I chew over that quite a bit” (Carrie, personal communication, October, 15, 2009).

Directors mulled over a range of circumstances. Perhaps, what is most important is for a child to stay in the same child care center. Remaining with the same caregiver does not allow a child to experience different teaching styles, personalities and role models. “I think a lot depends on the nature of the child” (Amy, personal communication, October 9, 2009). A child may need different expectations, new classmates and a more challenging learning environment. Gina argues, “what my employees can bring to the table, children can be challenged in different ways; my staff can provide different environments for children to challenge them” (personal communication, October 15, 2009). A change in caregivers may or may not impact a child exhibiting challenging behaviors.

Directors mentioned additional concerns including teacher turnover rates and goodness of fit between a parent and teacher. Transitioning out of the child care center to kindergarten was a more central quandary. Sue explains:

We have kids that have been with us literally their life – from six weeks to when they are ready to go to kindergarten. Some of them have a really tough time because they have

been here that long. They have had different teachers, been in different rooms, and met a lot of different kids, but going to kindergarten is rough. They think one of us is going to be there. They think their class of kids is going to be there. So, I am trying to picture the kid who has been with the same person for all that time. Some kids' personalities handle that and some don't (personal communication, October 20, 2009).

Continuity of Staff

In this study, every child care center director faced a multitude of challenges around staffing. Directors based staffing decisions upon adult-child ratios mandated by state regulations. Attempts are made to minimize change, however, as Colleen notes:

In day care there are days that there is a wrench thrown in somewhere. Sometimes, unfortunately, continuity gets messed up a little bit where we have to put somebody in that is not typically in the classroom. So, we do the best we can in finding the right people to go in there (personal communication, September 24, 2009).

Attwocenters, directors reported moving staff to a different classroom every other week and as often as every day if needed. "Occasionally, you need to put a band-aid on a situation" (Gina, personal communication, October 15, 2009).

Directors are consciously aware of staffing considerations, particularly for infant and toddler classrooms. Efforts are made to staff infant and toddler classrooms with members from the same team, such that the same two teachers are in the classroom with the children and a core group of caregivers is available to cover lunch breaks and occurrences when teachers call in sick.

With the infant room especially, we have adjusted the schedule so that they have four caregivers that these babies interact with throughout the whole week. In the toddler room

I think it's about five. For our 3 and 4-year-old preschoolers it is something like 18 to 20 different adults within a week's time (Nikki, personal communication, November 6, 2009).

Teachers have preferences for working with a particular age group. Maddie recounts a time when she offered one of her infant teachers a new classroom assignment with toddlers:

A fresh room with fresh kids; not a big age difference. At first, she said that would be great; but when it got right down to it she said no. I know my kids and I want to take care of my kids; I don't want to leave my kids. (Maddie, personal communication, September 4, 2009).

Directors accommodate teacher preferences out of fear of turnover. "If I went to them and said next year is your infant year and next year is your toddler year, they would probably go running for the hills"(Amy, personal communication, October 9, 2009). Teachers "like to come in and know that this is their classroom, these are their children; and they take ownership of that" (Anna, personal communication, October 1, 2009).

When directors discussed continuity of care the focus was on continuity within a specific classroom. Continuity of care was not focused on a caregiver remaining with a core group of children for an extended period of time. Directors commonly utilize a traditional school calendar, with the program beginning in September, to determine a child's duration of time in a classroom. In very few instances, children remained in the same classroom for a period of 18 months before transitioning.

Graduating to a new classroom leads to a sense of loss for children, parents and teachers. If children are "expecting to see that same teacher, they have become attached to that teacher,

and then suddenly that teacher is gone; it's hard on the child" (Emma, personal communication, August 31, 2009). Children develop preferences for a specific caregiver and feel more comfortable playing, exploring, and eating in the presence of that special person. Crying increases because "when they get somebody else they are not as relaxed" (Katie, personal communication, September 28, 2009).

Parents also become comfortable with their child's caregiver. "It's hard for parents to leave her, but we have to say, 'these teachers in the next classroom are just as great as she is'" (Emma, personal communication, August 31, 2009). In some cases parents develop a close relationship with a caregiver and request the caregiver move up with the child to the next classroom.

Directors are aware that teachers become attached to their group of children and recognize transition times are difficult. "The infant teacher cries when the babies have to leave; it's hard for her" (Anna, personal communication, October 1, 2009). However, the grieving process is not valued. "The way it works around here is that one leaves and another one comes in, so she doesn't have too much time to worry about it" (Nikki, personal communication, November 6, 2009).

Teachers are viewed as specialists with a particular age group and parents often enroll their child at the center because of the staff member in the infant room. When changes in scheduling or teacher turnover occur, directors receive an influx of phone calls and emails. In some cases, parents request a classroom change to a caregiver they feel they already know somewhat. Stepping outside of her role as director, Margaret recounts her experience as a parent of an infant enrolled at a different center:

I walked in one day and there were two different teachers. I actually ended up calling the director and asking ‘what happened and why did you do this’? ‘Where are the infant teachers’? I didn’t get any formal letter saying anything; just one day it was different (personal communication, November 19, 2009).

Policy Issues

Directors have mixed feelings about instituting a policy promoting continuity of care in early care and education programs. As mentioned earlier, directors overwhelmingly believe continuity of care as a theoretical notion makes sense for infants and toddlers. Lack of caregiver continuity “can’t be good for the babies; it’s too hard to get to know that many people” (Nikki, personal communication, November 6, 2009). The source of apprehension is about mandating continuity of care through development of policy and requiring a specific length of time.

Directors are unsure if continuity of care should be the standard for early care and education programs. There are a number of factors that determine the practice such as, timing of enrollment into the program, developmental readiness, and staff and child turnover. It is great in theory, but not practical. Maddie asserts, “trying to enforce it as a standard; I don’t know if you could do that. I agree with it, but I don’t know if you could make it a regulation” (personal communication, September 4, 2009). Continuity of care is a practice that programs could strive towards; however, “I would not want a licensor coming in and telling me that I have to do that” (Sue, personal communication, October 20, 2009). Directors do not want to be held accountable for what they perceive as a difficult approach to adhere to.

As a group, directors lacked consensus for a specific length of time to define continuity of care. Eighty percent of directors believe nine months is enough time for a caregiver and child to get to know one another, while 20 percent of directors feel nine months is not long enough.

I personally don't think 9 months would be considered continuity of care. But, I don't know, if I would not accept 9 months, what would I accept? I'm not sure. I think the longer you can have the better. I think any break is difficult, but 9 months is not very long. If you have a child who takes longer to create those bonds or a family with irregular attendance, it is going to be harder. It could take 3 or 4 months just to get that established (Carrie, personal communication, October 15, 2009).

Nineteen percent of directors believe eighteen months is the maximum time children should spend in one classroom. Anna explains:

I wouldn't keep them in there longer than that because then they are bored. The big kid on the block turns out to be a bully. They are done with this baby room and there are no more stimulating materials left in there; they are ready to move on (personal communication, October 1, 2009).

Although directors believe 9 months is a minimum standard for continuity of care, in practice, nine programs (43 percent) in this study moved children after only 6 months in one classroom.

Conclusions

A considerable number of challenges confront the director of an early care and education program. On a daily basis, directors must juggle enrollment, scheduling, transitions, relationships and regulations. Regardless of directors' openness to new ideas and approaches,

staffing issues take center stage. The reality of directing an early care and education program overrides aspirations of instituting continuity of care.

Repeatedly during the interview, directors declared “we try to do that” or “if we could we would”. Directors reminisced about the ideal scenario such as, “when I did home day care and I was the one who was there with the baby for one, two, and three years; it was fantastic” (Maddie, personal communication, September 4, 2009). However, as Nikki states, the reality of the situation is “how can we do it with the least amount of people and still have people that are able to fill in when someone calls in” (personal communication, November 6, 2009). Directors are subservient to the daily act of running a child care center with little time and concentration left for theoretical constructs. Operationalizing developmentally appropriate practice, best practice, continuity of care and quality indicators of infant and toddler care becomes inconsequential.

Theme 2: What We Do Works

This section focuses on the theme of program operation that emerged from the following research questions posed at the beginning of this study: do child care center directors perceive there to be a disconnect between best practice policy and implementation of continuity of care; and if so, what are the reasons for this disconnect? Operating costs, classroom arrangement, transition practice, teacher retention, administrative issues, and implementation continuity of care will each be discussed in greater detail as they relate to the theme.

Operating Costs

In this study, 13 (62 percent) of the child care centers are non-profit and 8 child care centers are for-profit (38 percent). Of the for-profit centers, 3 are a locally based sole proprietorship and 5 are supported by a national corporate headquarters. Within the non-profit

programs, only three directors (23 percent) reported receiving financial assistance such as in-kind donation of space, building supplies and utilities, and scholarship funding for families in need of tuition assistance. Financial assistance was provided through the host church or college campus.

Regardless of the center's profit status, all directors work within a tight budget and are conscious of program operating costs. Directors set aside a substantial portion of the operating budget for teacher training. Yet, additional funding is necessary in order to send teachers to training more often and for an early childhood specialist to provide training onsite at the center. Sylvie recalls an instance when there was not enough money to send her staff to the annual professional development training conference. Directors from various sites worked together to conduct training sessions for the collective staff. To supplement training costs, programs utilize scholarship monies through the state-funded Educational Incentive Program, as well as fundraising efforts and grants.

Directors aspire to offer teachers higher wages and more hours, as well as hire additional full-time support staff in the classroom. Having three full-time teachers in each classroom would improve upon adult-child ratios. "Everything always translates back to money, which is such a pain in the neck; because you can combat the energy thing if you could bring in enough money" (Carrie, personal communication, October 15, 2009). Katie argues: "more money would make it even better – the economy doesn't allow it, but we do our best with what we have and that's all that anybody can ever ask for" (personal communication, September 28, 2009).

Centers serving a large proportion of low-income families are particularly hard hit. Tuition is paid through a subsidy from the department of social services, however, "it's tough

because they pay monthly and it doesn't cover the cost of care" (Anna, personal communication, October 1, 2009). In addition, parents struggle to pay their fee for service and revenue coming into the center is unpredictable. Anna explains:

I wanted to get a teacher some clear contact paper to have more things down at the infant eye level in that room. But, it's crazy because money is so tight. I mean, we are barely holding on by a thread. I think people don't understand contact paper is \$20 a roll. You know what? That \$20 goes towards food. I get a lot of stuff donated like diapers and things, because some parents come in and they don't have the diapers. Just getting materials for day-to-day things is hard (personal communication, October 1, 2009).

Classroom Arrangement

Directors determine classroom arrangements for infants and toddlers based upon age, developmental stage, and space availability. Thirty-eight percent of directors established an infant room ranging in age from 6 weeks to 18 months. An infant enrolled in this classroom experiences continuity, provided there is no teacher turnover, for approximately 17 months. Sixty-two percent of directors created infant rooms based upon a child's mobility. Non-mobile infants were placed in a classroom for children ages 6 weeks to approximately 9 to 12 months. Once mobile, infants were moved into a classroom for children ages 12 to 18 months old. Infants in the latter arrangement experience continuity for approximately 8 to 11 months followed by 6 months. Keeping non-mobile infants safe from their mobile peers is one of the concerns influencing director's decision-making.

Classroom arrangements differed for toddlers. According to state regulations, toddlerhood begins at 18 months of age with preschool beginning at 3 years old. Fifty-two

percent of directors established one toddler classroom ranging in age from 18 to 36 months. The remaining 48 percent of directors created two separate toddler classrooms, with one classroom for toddlers ages 18 to 24 months and one classroom for toddlers ages 24 to 36 months. Table 3 displays classroom arrangements as reported by directors. Gina explains: “we feel that setting up the mini-toddler room is more stimulating and challenging for the children and it is a best practice. I think socially, having children together with the same age really supports different learning styles” (personal communication, October 15, 2009). Toddlers enrolled in the latter arrangement experience continuity for approximately 6 months followed by 12 months, whereas toddlers in the previous arrangement experience continuity for 18 months. Directors assert that enrollment and transitions are ultimately based upon space availability. Juggling arrangements within a few months is common practice.

Table3: Infant and Toddler Classroom Arrangements

Infant Classrooms			
	Classroom Age Range	Number of Centers	Months in Classroom
	6 weeks to 9 months	3	8
	6 weeks to 12 months	9	11
	6 weeks to 18 months	8	17
	9 to 12 months	1	3
	9 to 18 months	1	9
	12 to 18 months	9	6
	12 to 24 months	2	12
Toddler Classrooms	Classroom Age Range	Number of Centers	Months in Classroom
	18 to 36 months	11	18
	18 to 24 months	9	6
	24 to 36 months	8	12
	24 to 30 months	1	6
	30 to 36 months	1	6

Transition Practices

In this study, child care center directors based transitions on classroom arrangements, as described previously. Depending upon the center's classroom arrangement, a child may encounter a minimum of two classroom transitions or upwards of four classroom transitions within a three year timeframe. All directors in this study followed a procedure for transitioning children between classrooms. The procedures are intended to make the transition process as smooth as possible for children, parents and teachers. Sue suggests, "the transition is more for the parents" (personal communication, October 20, 2009). Colleen recalls a time when there was not a transition plan at her center, "it was just, the child turns 18 months and here you go; you're going to the toddler room" (personal communication, September 24, 2009). Without a plan and communication, it did not work. At the previous center where Mary worked, "the day they turned three they were moved and kids were scared of their birthday because they were leaving their friends" (personal communication, November 6, 2009).

Scheduled visitation to the next classroom is the most popular method endorsed by directors. For the first visit, one of the current classroom teachers accompanies the child to the new environment and stays with the child for a few minutes. Nikki explains, "we started doing this because some of our infants were having a very difficult time and were crying, crying, crying" (personal communication, November 6, 2009). Visits to the new classroom often coincide with an activity such as story time or snack and build up to spending naptime in the new environment. "After maybe the third visit, the teacher will go out in the hall and look through the window and let the child get used to the room" (Nikki, personal communication, November 6, 2009).

Length of transition time varies due to individual differences among children and programmatic considerations. Some programs allow only one week for a child to transition, while others allow up to one month. Daily classroom visits range from as a little as ten minutes up to two hours at a time. Sofia notes, “not that we ever do any fast transitions, but if there is a child that does have the ability to go up without an issue, then we would look into that” (personal communication, November 13, 2009).

Margaret questions if two weeks are necessary for children to transition between classrooms. “Either we can drag it out and make it worse for the child, or you can condense it” (Margaret, personal communication, November 19, 2009). Children at her center transition in one week according to the following plan:

The first day is one or two hours from nine o’clock in the morning to just before lunch.

The second day, let’s try a little bit more and go from nine through lunch and sit with the group at lunch. The third day is getting from nine through just before nap, having your diaper changed, getting washed up, and then head back to your classroom. The fourth day, let’s try staying for nap. The fifth day is trying to get through nap and staying for snack in the afternoon (Margaret, personal communication, November 19, 2009).

Children and teachers float between classrooms to promote comfort within the new environment. Younger infants and older infants are often combined in the morning and at the end of the day as a cost effective means for scheduling staff. The children “already know those teachers so it’s not like a big shock to their system” (Sofia, personal communication, November 13, 2009). In Nikki’s center:

The toddler teacher goes down to the infant room when they know a transition is coming up, and the infant teacher will go to the toddler room. So, the baby can see his new teacher in his room and get to know her before he goes to her room. We make a conscious effort to make the child feel comfortable in their move so by the time it really happens they know what to expect (personal communication, November 6, 2009).

Directors also use assistant teachers as floaters between rooms so that there is at least one familiar face in the next classroom when the child moves up. Directors believe this allows teachers to get to know all of the children.

Patty views transitions as having a different purpose for toddlers than infants: “infants don’t get it, but for toddlers and the older kids, they see their name, meet the teachers and get a feel for the room” (personal communication, October 9, 2009). Margaret believes “infants are still too young to realize that change just happened” (personal communication, November 19, 2009). Amy observes changes in toddler’s behavior due to transitions: “some bursts go on and regressions can happen because they have to learn what the expectations are of this new person” (personal communication, October 9, 2009). It’s also common for children to address their new caregiver by their previous caregiver’s name.

Thirty-eight percent of directors in this study identified a particular age group where transitions were more difficult for the parents. The infant and toddler classroom environment “is warm and cozy and it’s their own little world” (Nikki, personal communication, November 6, 2009). Fourteen percent of directors believe transitions are particularly difficult for young infants transitioning to an older infant or toddler classroom, while 24 percent of directors believe transitions are particularly difficult for toddlers transitioning to a preschool environment. “It is a

transition for the parent because their baby is growing up and she's not going to be in this little room; she's going to be in this big toddler room and it's much bigger with more children" (Margaret, personal communication, November 19, 2009).

Transitions require intensive communication. "Families really need to be included in the transition in order to be comfortable with where the child is moving to and coming from" (Gina, personal communication, October 15, 2009). Directors prepare parents for the transition process through several means of communication. Colleen's center begins the transition process with a letter to parents stating "congratulations your child is ready" (personal communication, September 24, 2009). Information packets and newsletters geared towards parents are framed positively and answer commonly asked questions regarding changes in the daily schedule, activities and equipment. Some programs ask the parent to complete a profile form about their child. This is an opportunity for the parent to share expectations for the next classroom as well as goals for their child. Directors encourage parent-teacher conferences, however, parents do not often engage in scheduled face-to-face meetings. Carrie explains:

If we are lucky they stop down two or three times and say hello and that's if we are lucky and they have time. We certainly invite them to do that and encourage them to try to make sure that we go down and do a walk-through with them. But, the parents have a brief moment in the morning, they are in a hurry, they're trying to get to work, and the kids don't want to leave. So, it's dealing with all of that and they are needing to create a relationship within that kind of time and that is stressful and hard for them (personal communication, October 15, 2009).

Transitions are associated with a sense of loss for teachers and parents. Teachers at Christina's center become attached to the children. "Some of them get really emotional. We let them know as soon as possible and they all know their birthdays. They ask, 'why does that one have to go'? They try and keep them in their rooms" (Christina, personal communication, November 6, 2009). Parents also request specific caregivers for their child's next classroom. The teachers at Sue's center develop close relationships with families. Sue asserts:

The infant teachers are usually in tears. I'm not sure if it's harder on her or the parents when it's time for the baby to move up. Especially if you get first-time parents that are nervous – the teacher has so much experience and the teacher is so good with them. She helps parents with everything. The parent is usually nervous about who the next teacher is going to be. Are they still going to get all the advice that they were getting before? (personal communication, October 20, 2009).

The infant teacher at Nikki's center experienced a difficult time with the infants transitioning to the toddler room. The teacher "felt that the expectations were a little too great; she feels much better now because she was able to go down there and see things" (Nikki, personal communication, November 6, 2009). It is commonplace for teachers to visit a child in his new classroom to see how the child is adjusting to change. The infant and toddler teachers see the children "as their babies and want to hold onto them" (Sylvie, personal communication, November 24, 2009).

Directors believe that strong bonds are established between a teacher and child, however, "staff understand that the child is ready for a different environment and a new challenge" (Gina, personal communication, October 15, 2009). As Molly explains:

This is the natural progression of the child care center; the child is going to leave you.

It's definitely not an easy thing all the time and they might want to go visit. That is fine as long as it is not disrupting the child's day. If it is disrupting the child's day, then we talk about not going to see him because we don't want to upset him. There is always a new child coming in for us to focus on and love (personal communication, November 12, 2009).

Even with intensive communication and a positive approach on behalf of directors, transitions remain difficult for parents and they make requests for the teacher to move with their child to the next classroom. Sofia explains:

The parents have a habit of coming into the same room and they know what to expect.

They know that their child leaves without an issue and they don't want to go through that separation anxiety again. They just feel at ease with the teachers that they are already with (personal communication, November 13, 2009).

Molly conveyed to parents at her center that "it really wouldn't be fair to all of the other children in the classroom; it's just a natural progression of a child care center" (personal communication, November 12, 2009).

As a director, Carrie personally struggles with transitions at her center. "I think it works, but it's less than ideal" (Carrie, personal communication, October 15, 2009). Ideally, directors need to consider the teacher-child relationship and assess if the "climate where they're moving to is going to allow them to continue that relationship" (Carrie, personal communication, October 15, 2009). Carrie explains:

It's like a gear in one of those big gear toys. If one of them is off a little bit, that's going to stop everything else from working. So, first off, I would like to make sure that the child and caregiver were connected and that was positive and good and moving forward; and then make sure that could continue after they moved. And then personally, if you could definitely see that and knew that, you would be sitting back pretty happy with yourself with what was going on in the center (personal communication, October 15, 2009).

Overall, directors do not perceive any major problems with parents regarding transitions. "More often than not, I feel that parents defer to us because we are with the child a lot during the day. We see how the child is growing, where the milestones are, and we know a lot about the next room and whether we feel the child will be ready or not." (Gina, personal communication, October 15, 2009). Along the way, directors spend time with parents communicating the program philosophy and expectations for each age group. Typically, parents seek out information, but do not have any major resistance. "Most of them just kind of go with it; usually when we say they are ready, the parents are in sync with that" (Sue, personal communication, October, 20, 2009).

Parents know transitions are a part of the growth of their child. Parents get used to the transition process once they have gone through it at least once. "Okay, this is how it works – we are going to be there for a while and then we are going to move on"(Carrie, personal communication, October 15, 2009). "I think our reputation is out there and that we have a good reputation. Parents have learned to trust me; we don't have issues here" (Mary, personal communication, November 6 2009).

Teacher Retention

Directors perceive a connection between continuity of care and teacher retention. Implementing continuity of care is problematic due to a high rate of teacher turnover. Nineteen percent of directors make decisions to change classroom assignments because of the teacher relationship in the classroom and to prevent teacher burnout. “I don’t want my teachers to be burnt out. A couple of them take off for the summer and then they come back” (Kathy, personal communication, September 4, 2009). As mentioned previously, directors fear teacher turnover and seek to make their teachers happy. “If you are happy doing something and you’re doing it well, then I don’t think we should bother with the system” (Margaret, personal communication, November 19, 2009). Interestingly, 14 percent of directors believe teachers would experience greater work satisfaction and staff retention would improve if continuity of care were instituted.

Directors perceive teacher retention is partially due to a good benefits package and pride in their work. Gina explains:

When someone is making a lower wage and they don’t have anything left over to contribute, being able to have a very rich benefit, I think, is the reason why a lot of people stay. They have gotten a degree in early childhood, they are established in their field, are happy and comfortable with their job, and that’s where they want to be (personal communication, October 15, 2009).

Mary relies on a contractual agreement to ensure teacher retention. Teachers sign a contract pledging employment with the child care center for the duration of the school calendar. At the end of the school year or summer program are the only times when resignations are allowed. Mary explains:

When they sign their contract, if they leave prior to when the contract ends, then they have to pay back all their sick days and their vacation days. I have made it a policy and have checked with a lawyer that it's okay to do it that way. So, in the nine years I have been director, I can count on one hand the number of people that have left the program during the school year. It's usually been because the husband is moving or transferred or something (personal communication, November 6, 2009).

Other directors feel that their leadership style influences teacher retention. Providing a flexible, motivating and supportive work environment is important for teachers. "Sometimes they just need to be heard and they just need someone to listen because they have personal problems at home; I try to help them with those kinds of things as far as problem-solving" (Sofia, personal communication, November 13, 2009). Molly maintains,

If you don't have the right director in the right school and teachers aren't happy, then they will leave. I have a great rapport with my staff and parents love it; it makes a big difference. That's how you keep your staffing and that's how you keep your parents. The staff and I have a give-and-take relationship – I am here for you if you are here for me. Every new person that walks in, I tell them what to expect from me and what I expect of them in return. It's just a really great beginning to a support system and then everyone who has already been here just takes on that mentality and it grows one big happy family (personal communication, November 12, 2009).

According to directors, parent retention and recruitment is related to teacher retention. Christina notes, "on every tour the parent asks how long staff have been here and how long they have been in that room" (personal communication, November 6, 2009). At Emma's center:

We have one staff here that has been here for 20 years; since the day the center opened. She is in my infant room. On the one hand, she is my biggest selling point in this center for an infant parent coming in. I had a family come back – she just had another child – and the infant teacher was out on vacation when she toured. The parent said, ‘if she is not here anymore I’m not coming back; she is the reason why we are enrolling’ (personal communication, August 31, 2009).

When teacher turnover occurs families lose confidence and “you start to lose those families when they don’t feel that continuity of care in the classroom” (Emma, personal communication, August 31, 2009).

Teacher turnover is perceived by directors as cyclical. As a teacher, Amy recalls, “I spent four years with the same teaching partner and then my final year in there I had three different co-teachers” (personal communication, October 9, 2009). At the time of this study, 67 percent of directors were not experiencing high teacher turnover rates. Sixty-seven percent of directors report that the teachers employed at their center were in their position between one and four years. Two directors (10 percent) report employing veteran teachers reaching 20 and 30 years of service. Molly asserts:

Every classroom has someone that has been here with us for at least four years, which is very hard to do. I know, because I’ve been to those other centers, just temporarily, where it’s every week you are hiring and interviewing and it just seems like that is all you are doing (personal communication, November 12, 2009).

Directors perceive less teacher turnover for their infant and toddler staff than older age groups. “I have had one teacher with the babies since – I don’t even know when – but, she would never

leave them” (Sue, personal communication, October 20, 2009). Ironically, during the course of this study, 8 directors (38 percent) resigned and 2 child care centers closed due to financial difficulties.

Administrative Issues

Child care center directors encounter an array of administrative challenges on a daily basis. Seven individuals (33 percent) accepted the director’s position at a child care center that was experiencing difficulties. Directors inherited a center where there were unresolved regulatory violations, financial hardship, or no active director on record overseeing the program. Maddie expresses, “when I came into this center it was actually tottering on; it was not doing well at all. The doors were almost closing and we were giving it months to see if we could pull it out” (personal communication, September 4, 2009). This group of directors invested a substantial amount of time to give rise to a minimally operational program. “I haven’t been able to do anything yet except just try to get it back on its feet again; we are almost there” (Maddie, personal communication, September 4, 2009). Christina explains, “I have been here as the director for almost three years and it took a good year and a half to get it to where I really thought that it was a special program” (personal communication, November 6, 2009).

Being a director of a child care center is a substantial obligation. Directors are responsible for staffing, financial operation of the program, correspondence with parents, and policies and procedures. “As a director, I am ultimately responsible for everything that happens in the school; my name is on the license” (Carol, personal communication, October 9, 2009).

Staffing a child care center is complex due to financial compensation, state regulations mandating minimum educational requirements and continuing education hours, and scheduling.

The hiring process is time consuming, tentative, and yields uncertain results. “I have interviewed candidate after candidate and they are just not who I want; there are so many issues” (Anna, personal communication, October 1, 2009).

I do probably an hour and a half interview, check the references, bring them in here, have them do their prints, have them do their physical and TB shot; to sit there and tell them what we are going to pay them. Then, they say they can’t live on that (Carol, personal communication, October 9, 2009).

Finding reliable, trustworthy staff is difficult given the dynamics within child care. “I would not hire a warm body. I would rather just be in the classroom myself” (Anna, personal communication, October 1, 2009). Molly contends, “a lot of times it’s just the feeling that you get from these people during the interview; it’s an instinct about people” (personal communication, November 12, 2009).

Developing a daily schedule that fulfills age-specific teacher-child ratios, fits within the payroll budget, and meets teacher’s needs is a daunting task. With a workforce of 60, Nikki asserts, “I was overwhelmed with the number of staff that are in our building” (personal communication, November 6, 2009). Covering classrooms on a daily basis for lunch breaks, attendance at training, vacations, and illness is challenging. Sue explains:

Sometimes when we have issues, like if someone calls in sick when someone already had the day off, then you have to look at who showed up that day. Who do we have today and can we rearrange them so that they are still in their age group? (personal communication, October 20, 2009).

Directors hope for a larger payroll budget in order to guarantee staff 40 hours a week and hire additional teachers. In reality, directors review the daily attendance of children and often send teachers home to save on payroll when attendance is low for the day.

If I need them to stay, then I have to get them out early the next day. I wish I could guarantee people 40 hours all the time to pay the bills. It's okay when I hire them and people really want a job, but then they settle in. People work hard and then you are asked to get sent home; that is a little discouraging. We are low on staff and you are going to go home (Carol, personal communication, October 9, 2009).

Financial pressures impact director's hiring practices:

When you work at a program that doesn't have a lot of funding, you take the first thing that comes along because you can afford that. We should avoid that because we know that it's not always the best thing to do. I think, unfortunately, that happens in a lot of centers with budget restraints (Sylvie, personal communication, November 24, 2009).

Eighty-one percent of directors report having aspirations for making change towards quality improvement by "raising the bar for staff" (Sylvie, personal communication, November 24, 2009). Finding time to spend observing in classrooms, and teaching and training staff is an important goal for directors. As Sylvie explains,

This job is extremely overwhelming for me. Just finding the time to do that with all the paperwork – I am not used to having to do the budget, attendance, timesheets, and all of that. I am used to having a person do that for me. Having to do all of that just hinders me from getting into the classroom as much as I would like to (personal communication, November 24, 2009).

Aspirations towards improving upon quality are often constrained by finances. “I know I said we could do anything with just little scraps, but you have to put into the program too; and sometimes my hands are tied” (Kathy, personal communication, September 4, 2009). Directors prioritize spending for food and essential materials, while non-essential supplies are put on a wish list. Families at Mary’s center struggle with job loss and affording child care tuition. Mary explains:

Parents are reducing schedules and we are having to fill it with someone else; when they are going to want it, it’s not going to be there. So, I wish I didn’t have to make decisions about families based on financial need to keep me going. I would like to be able to say, ‘it’s okay, I know you are going through a rough time; I will keep it open for you for eight weeks’. But, I can’t pay staff and operate that way. So, I have a conflict between making a morally kind decision and my financial need (personal communication, November 6, 2009).

Correspondence with parents around programmatic policies and procedures is a daily task for directors. Directors regularly inform parents about the illness policy and administration of medication, which is driven by state regulations, as well as maintain required paperwork. Directors are also involved with parents around more sensitive issues requiring confidentiality and extensive documentation such as, separation and divorce; referral for developmental screening, evaluation, and early intervention services; and child preventative services .

Directors discover that managing a child care center is a desk job that involves a great deal of paperwork. “We sit behind a desk and a computer, put this idea into a new policy and procedure, put it in black and white, hand it to them, and expect them to do it” (Carrie, personal

communication, October 15, 2009). All the while, directors are keenly aware of the mass of challenges that await them once they are able to step outside the office. As the sole person responsible for the program, directors cope with each obstacle. “You have to do what works and you have to be flexible to see what works best because each day is different” (Christina, personal communication, November 6, 2009).

Continuity of Care Implementation

As previously explained, directors are not opposed to the concept of continuity of care, rather they struggle with putting continuity of care into practice. The majority of directors (52 percent) do not understand how it could be implemented at their program. “Anytime I have heard it mentioned I just think it must be for somebody else. I can’t imagine how we would even try to do that. I see the benefits of it, but I can’t wrap my head around how to even begin to do it” (Sue, personal communication, October 20, 2009).

Continuity of care is viewed as a practice that works outside of child care centers. Primarily, directors associate continuity of care with the practice of looping in elementary schools. Continuity of care is a practice that also works in family child care settings “where there is not a vast number of educators that all contribute to the growth and development and support of the child” (Gina, personal communication, October 15, 2009).

However, implementing continuity of care in a child care center setting is not impossible. Directors did note of a few child care centers where continuity of care is practiced. At a training seminar, Kristen met a colleague who practices continuity of care at her center. Informally, the director shared her implementation process with the group of directors at the training. Kristen states: “I don’t remember anyone thinking it was a bad idea; there were just a lot of questions.

The questions were about how you get it to work” (personal communication, November 13, 2009). Anna visited a child care center practicing continuity of care and thought it was amazing that the director could implement such a system given the dynamics of child care. “I think about that center that the other director runs and I think that is the dream place. And, this is the reality of it all” (Anna, personal communication, October 1, 2009).

Several directors have talked with teachers about continuity of care, particularly with regards to the infant classrooms. Infant teachers are primarily concerned about the child’s day-to-day progress and daily communication with parents rather than that which occurs over an extended period of time. Teachers prefer to work with a specific age group and “have some instinctive things that are built into them and to their genetic makeup that drive them to be with that age group” (Amy, personal communication, October 9, 2009). Teachers are not comfortable, knowledgeable, or skilled at working with a wider range of ages. Anna explains:

I wouldn’t ask someone who is more comfortable with three and four-year-olds to be an infant teacher. I know I am not comfortable in the infant room and I was there all day yesterday. I like to go in there and play and love all over them, but to constantly be the one in there; that’s a special person. Why take that special person’s gift away from them? (personal communication, October 1, 2009).

Other directors believe teachers would be oppositional and it would take some time to convince staff that this was a good idea. Gina notes: “we talked when we first got the new accreditation standards, but what we do works” (personal communication, October 15, 2009).

Seventy-six percent of directors did not think continuity of care could be successfully implemented at their center due to a number of barriers specific to their program. “I have tried to

visualize this in my center; I don't think it would work here" (Kathy, personal communication, September 4, 2009). Centers serving a large proportion of families receiving subsidies were particularly doubtful that continuity of care would be successful. Sofia explains:

Our families are so transient. The child will just get settled here and feel like this is a place where they will be going every day until the child loses funding to attend the program. It's not like we are out in the suburbs and you have mom and dad that work all year long and there are paychecks coming in so you pretty much know you have the child all year. We don't know if we have more than a week or a year (personal communication, November 13, 2009).

Directors also struggle with other human service systems such as foster care and parental employment training programs. According to Anna, parent employment training programs are not supportive of children. Anna explains:

We go through the process of getting them enrolled and then three days later they are pulled out. We just get children acclimated to their room and the teacher and then they are pulled out. Then, they have to go through a whole other setting. Children are going from center to center and they are not getting used to the teachers. If there was a way parents could fulfill the system's requirements and we could still have their children, I think that would be better for the children in care (personal communication, October 1, 2009).

The majority of families do not return to the same center and directors are unable to hold a slot, especially an infant slot in high demand. Since child care is a tuition-based business, fluctuations in enrollment creates financial hardship on the functioning of the center. "It's the

enrollment piece that always seems to be the hindrance for me being able to move forward” (Sylvie, personal communication, November 24, 2009).

Generally, enrollment occurs at a variety of times throughout the year and is unpredictable. Directors find themselves in a quandary over which pre-determined classroom to place a child and juggle factors such as the child’s age, availability, and anticipated length of time in the classroom before moving up. Once enrolled, children individually transition to the next classroom due to the vast age range, rather than an entire group of children. “If you move that teacher out with two or three children because they have moved up, then who is left with the remaining children in that class?” (Margaret, personal communication, November 19, 2009). On one occasion, the assistant teacher at Kristen’s center moved with a large group of toddlers to the preschool classroom. Kristen asserts, “I think I would try it again as long as we were able to arrange it. I think it would just really depend on the ability of the staff that we have” (personal communication, November 13, 2009).

Meeting minimum educational requirements for lead teachers, required by state regulations, is challenging for directors when teacher turnover occurs; and more so, if teachers were to move between classrooms and age groups. To find teachers with skills and knowledge needed to work with children ages six weeks to three or five years of age would be difficult. “So, now I am looking at having a deep enough staff that I have another person ready and waiting” (Carrie, personal communication, October 15, 2009). Expecting current staff to span this age range would require extensive training, that is costly and time intensive. Furthermore, when a staff member is highly revered as an infant teacher and moves with her group to the toddler classroom, directors lose one of the biggest selling points for their program. In order to

implement continuity of care, Patty states “you have to have the right staff for it” (personal communication, October 9, 2009).

Directors have mixed feelings about implementing continuity of care. Mandy uncertainly expresses, “I guess it would be good” to figure out a way to make the program flow and get teachers and parents on board; however, “I don’t think I know enough about how to implement it to know whether or not it would be our best practice” (personal communication, September 11, 2009). Implementing continuity of care is a long process that involves “a learning curve – you have to know what you are doing and it has to be intentional” (Carrie, personal communication, October 15, 2009).

Conclusions

Administering a child care center has complex challenges that impact the financial stability of a program. Teacher retention, classroom arrangement, and transition practices are connected to operating costs. Hiring teachers that meet the minimum qualifications and provide quality caregiving is challenging when offering substandard wages. Teacher retention is essential for enrollment; therefore, directors seek to keep teachers happy to prevent burnout and turnover. Directors desire well-trained teachers and aspire to invest in their staff; however, costs are prohibitive.

Directors are often pressured to make administrative decisions based upon what they can financially afford, in lieu of personal preferences or best practices. Classroom arrangements and transition practices are based upon enrollment to maximize operating capacity in each classroom. Arrangements may change at any time depending upon a waiting list, child’s birthday, or turnover. Sue explains that she cannot consider transitions from the perspective of whether it fits

with a parent's request, rather "it's going to depend on our enrollment, how many kids we have, age, and where I need to put them; it's going to be based on a lot of different things that all makes sense in the end" (personal communication, October 20, 2009).

Thus, directors are aware that classroom arrangements and transition practices impact the center's financial stability. Carrie contemplates, "how many hours are you using as opposed to how many children are you getting revenue for?" (personal communication, October 15, 2009). The primary focus is on the health of enrollment and not continuity of care for children and families.

Transition plans are established to support children, parents, and teachers through the move; however, all involved encounter a difficult time. Regardless of the emotional aspect of transitions, directors have a child care center to manage. Katie asserts: "unfortunately, we can't give every child that individual, all-day-long attention. You have to meet the needs of the whole center versus one or two kids; we meet the state ratios" (personal communication, September 28, 2009). Transitions are a necessary function of running a child care business. Eventually, teachers become accustomed to the change, parents learn to trust the director's decision and the caregiving of their child's new teachers, and children adapt to the new classroom within a specified period of time.

Directors manage an environment characteristic of change. Since multiple aspects of child care involve change as a constant, directors are satisfied with the notion of 'what we do works'. As Mandy expresses, "If you have something that is working and it's good and you have a full center, then you feel like you're doing what you need to do" (personal communication, September 11, 2009).

Directors spend the majority of their time managing schedules for teachers and children, handling parent correspondence; and reviewing policies, procedures, and paperwork. Little time remains to focus on quality improvements, conducting classroom observations, and reflective supervision. These realities of child care center administration makes implementation of continuity of care unmanageable. When it comes to implementing continuity of care, Anna asserts, “that’s the long-term; I can’t even say it’s a goal; it’s more like a dream” (personal communication, October 1, 2009).

Directors are uncomfortable asking teachers to work with a group of children outside the age range of the teacher’s preference. In order to implement continuity of care, a more skilled workforce is needed to enable directors to hire lead teachers with the educational qualifications and aptitude for a wider age range. Anna wonders:

Do you ever get to the point where you walk in and you feel like everything is the way you want it to be? I don’t. I just feel like there is so much more we want to do, so much more we want to grow. It’s funny, and I think to myself, will I ever get to the point where the center could run itself? Because, we are not there yet. We have a lot of room to grow. There’s definitely much more that we could do; much more effort that could be put in (personal communication, October 1, 2009).

Theme 3: For the Love of the Children

This section focuses on the theme of career development that emerged from the following research questions posed at the beginning of this study: what are child care center directors’ feelings about their staff’s caregiving abilities and how does this relate to ongoing professional

development? Compensation, child care as a profession, and teacher training and education will each be discussed in greater detail as they relate to the theme.

Compensation

Directors repeatedly referenced a limited earnings potential for early educators in child care. Earnings were typically at or slightly above minimum wage, based upon an hourly rate of pay with fluctuations in hours according to child enrollments, and no opportunity for overtime pay. Directors are unable to compensate employees for a lack of earnings potential by offering an extensive benefits package outside of sick and vacation time. Health, dental, and life insurance benefits are offered, but premiums are often too expensive for employees to afford on minimum wage. Carrie's (personal communication, October 15, 2009) concern is "they don't get enough vacation time or they can't pay their electric bill or they are worried about putting snow tires on their car. And that almost makes my stomach sick to think how we can fix this".

Overwhelmingly, directors expressed a strong desire to be able to pay their staff higher wages and offer a better benefits package. Directors did not think staff was adequately compensated for the expectations of the job. There was also a fear that staff would not remain in the position because of the earnings potential as an early educator. Receptionist jobs, teacher assistant positions in a school district and retail employment are viewed as more a lucrative employment opportunity than early care and education. "It's hard with the pay that we can offer in day care; even when they do call in, they are only losing 30 dollars for the whole day. Even myself as a director, is my student loan really worth the schooling that I had to go through for this job" (Christina, personal communication, November 6, 2009).

Hiring and retaining quality staff given the compensation is another challenge that directors face. Nikki (personal communication, November 6, 2009) finds it “frustrating to try to hire; embarrassing with the pay rate”. Offering a higher rate of pay would allow directors to attract staff with credentials to improve upon the quality of the program. “I really think that if there were more money in the field, that we would get more professionalism and higher levels of education” (Kristen, personal communication, November 13, 2009). Investing in training for staff, creating a pleasant work environment, and offering incentives are strategies aimed at staff retention. “I think that they really care and we try to encourage teachers to stay with us even though the pay is hard” (Christina, personal communication, November 6, 2009).

Directors also conveyed a strong belief that early educators are not in this type of work for the money. Child care is not just a job where you earn a living. Carol (personal communication, October 9, 2009) states: “You wanting to be here is more than just getting a paycheck”. Kathy (personal communication, September 4, 2009) conveys to her staff, “if this is just a job, then you can make more money at Burger King and there’s the door”. There exists a viewpoint that early educators are dedicated to the children and families with whom they work and that this is work that comes from the heart. “People don’t come into child care because they want to make a million dollars; because it’s just not going to happen” (Colleen, personal communication, September 24, 2009). With monetary compensation lacking, the real rewards are thought to be gleaned through a love for children.

Child Care as a Profession

The view of child care as a profession depends upon the individual and her role pertaining to the early care and education system. Seventy-six percent of directors view child

care as a profession with a clear purpose. “We are not just here to play with children; it’s a school and we are here to teach them – it’s a school” (Carol, personal communication, October 9, 2009). Molly (personal communication, November 12, 2009) explains, “we are basically preparing them for their life and we say in our mission statement: to provide an environment where they are going to love learning and lifelong learning”.

Directors are keenly aware that early care and education is a people profession requiring professionals with a specific skill set similar to that of a social worker. Kathy (personal communication, September 4, 2009) passionately expresses, “a lot of times you don’t think of that, but you are dealing with people’s lives here”.

According to directors, staff’s view of early care and education as a profession is conflicting. Directors do not see the level of professionalism and investment from staff that they desire. It takes a special person to want to work with young children in an early care and education setting and not everyone is cut out for this career. Carrie asserts:

They have this ingrained sense that they are *just* the day care teacher and nobody else thinks I’m good at it. One of my pet peeves is that you are a *real* teacher if you are a teacher in a public school. These are real teachers right here too. They don’t see themselves as professionals and they also don’t see what a huge impact they can have on these children – or, they *do* have; it’s not can. Just the mere fact of being with them for eight hours a day, they do have an impact (personal communication, October 15, 2009).

As reported by 33 percent of directors, teachers are resistant to encouragement from directors towards higher standards of professionalism and providing more professional care. Some staff with a college degree do not want to work in a child care setting. “I don’t think

anyone can understand daycare unless you actually have been in it” (Christina, personal communication, November 6, 2009). Child care is often viewed as an entry level position by those with a college degree and used as a means towards employment at a higher paying position. Carrie explains,

I get young people that come out of school and you know coming in that they’re just taking this job just because they need a job and eventually they’re going to be leaving for something else. I try to tell them every chance I get that the field is wide open and there are just unlimited opportunities for how you can contribute to something like this. Think about it – if you like the child development piece, then maybe you want to consider working in this, but I don’t think they hear it because of the respect for the field (personal communication, October 15, 2009).

On the other hand, directors also work with staff that recognizes early care and education as a career. Staff convey pride and joy in their work, knowing that what they do is important. “This is why they are here 8, 10, 12 and 14 years” (Gina, personal communication, October 15, 2009). This group of early educators has a strong passion for working with young children, love children, and knows this is the work they were meant to do. Patty asserts,

You have to have a knack for working with children, you have to have patience; you have to have love, compassion, kindness, and caring. If you don’t have that, then don’t work in a day care. You are not here because of your paycheck, you are here because you love kids and you want to take care of them. If that’s not why you are in a day care, then you shouldn’t be (personal communication, October 9, 2009).

Directors maintain that early care and education is misunderstood and underappreciated by individuals outside of the profession, including parents and professionals in supporting roles. Directors adamantly argue that child care is not babysitting. “We are raising up our generation and this is a huge job” (Maddie, personal communication, September 4, 2009). Molly proclaims,

I just get so angry when people think of us as just babysitters because we are not that; we are a learning center. These children are learning – not only are they being loved, but they are learning. I don’t think you get that all the time, especially in your public schools. You don’t get that like you do here. I even heard a therapist come in the other day and she was working with one of the kids. She said, ‘he’s just not successful in a day care setting’. Excuse me? That’s not what we are. We are so much more than that and people don’t see it, unfortunately (personal communication, November 12, 2009).

Directors do find staff who choose to work with young children because it is their passion. However, they would like to have all staff with these qualities and this influences their hiring practices.

I always ask the question, ‘why did you choose childcare as your field’? I only find teachers who say, ‘because I like the children or because I want to make a difference, or because I love working with children and I want to contribute something’. So, you have to find out why they are here (Colleen, personal communication, September 24, 2009).

Teacher Training and Education

OCFS requires all early educators working in a New York State licensed child care center to obtain 30 hours of training within each 2-year licensing period. In addition, New York State regulations require lead infant and toddler teachers to meet specific criteria around education and

experience. The lead teacher for a group of infants and toddlers must have an associate degree in early childhood, child development, or a related field; a CDA credential; or nine college credits in early childhood, child development or a related field, with a professional development plan leading towards a CDA. Lead teachers are also required to have a minimum of one year experience specific to infant or toddler care. According to directors, training and education requirements for early educators present both opportunities and barriers.

Obtaining training is strongly encouraged by directors. Several child care centers close their program during the course of the year and provide a professional development day for all staff. Directors find this to be an efficient means of training staff due to barriers around sending teachers to afternoon training held during naptime. New York State regulations for adult-to-child ratios are required during naptime and it is difficult to maintain a list of substitute caregivers to release staff to attend training. Attending evening trainings after work hours is often difficult due to family obligations. Early educators with young children struggle to financially afford a babysitter, due to issues around compensation described earlier, and many times hold a second job in the evening. Online and distance learning training formats have become an alternative for some.

Directors have differing views regarding teacher's responsibility for professional development. Some directors post various training opportunities and encourage staff to plan and attend those of interest, while other directors take full control and plan all of the training for staff. Mary mandates her staff to attend training, held onsite at the center, the third Wednesday of every month. Staff enters into a contract as part of their employment, which allows Mary to ensure state training requirements are upheld. Similarly, Carrie admits she has a difficult time

requiring her staff to take full responsibility for their professional development. Staff understand they are required to obtain thirty hours of training every licensing period, “but they don’t want to have to put much effort or their own personal resources into getting it, which I think is just misguided” (Carrie, personal communication, October 15, 2009).

Other directors develop a customized onsite training program for their staff in consultation with an early childhood specialist at the local CCR&R. Whether training is obtained through workshops, a professional development day, or a customized onsite training program; early childhood specialists from the CCR& R are frequently cited as the main source of information.

The child care resource and referral agency is a pillar of knowledge and that’s what they do. I think bringing them in was a pretty good thing for us because there are different training styles and different trainers, but the staff knows that they have to have training hours. So, instead of just sitting there and being there, the way they train is really interactive and it gets you pumped up (Carol, personal communication, October 9, 2009).

Qualifications of the trainer are an important consideration for directors. Expertise on specific training topics is sought through the county health department, fire department, early childhood direction center, American Red Cross, and college professors local to the area. Staff are also encouraged to attend local and state conferences through the Association for the Education of Young Children. “Just the fact that you get out and meet other people in your field and you exchange ideas; there’s a certain amount of energy in that” (Sylvie, personal communication, November 24, 2009).

Overall, directors feel staff are well-trained, but there is always room for more training. Repeatedly, directors expressed a need for their staff to obtain additional training in the following topics: challenging behaviors, working with children with special needs, best practices, working with infants and toddlers, professionalism, and curriculum. Intensive onsite training, where an early childhood specialist offers technical assistance directly at the center, was viewed most favorably by 57 percent of directors. Directors noted that this mode of training had the greatest impact on teachers because of the opportunity for dialogue with an early childhood specialist and fellow colleagues in a specific context.

Directors are looking for teachers to apply knowledge, gained through training and formal education, into the classroom. For teachers working on their CDA, “it was real obvious that they would bring things right back and share with the other teachers in their classroom, whether it be ideas or materials” (Nikki, personal communication, November 6, 2009). In other instances, directors wished teachers would attend a workshop and garner new concepts and techniques to bring back and try in the classroom. Instead, “they come back from training and say ‘oh, that was good’; but they don’t seem to want to bring it into the classroom” (Margaret, personal communication, November 19, 2009). In some cases, teachers implement training and education to impact the center positively, while other teachers get comfortable with their style and are resistant to new ideas and methods.

Previous experience in the field of early care and education is highly valued by directors. “Sometimes it’s more important to have that experience in childcare and sometimes that outweighs the education at times. Just having that experience, especially with infants and toddlers, I know it’s very important” (Christina, personal communication, November 6, 2009).

Molly (personal communication, November 12, 2009) states, “I think it’s great that now we are required to have a degree to teach in the field, but I think life experience is sometimes much more important”.

Working knowledge of the state regulations and training specific to a child care setting is preferred. There is an important connection between theory and practice. Molly explains:

I had a couple of teachers with their bachelor’s degree in early childhood education. I loved them. I interviewed them and the interview went well, but in the classroom they were terrible. They had no clue how to take care of the children. So, I don’t always think that a degree is important in childcare. I mean, it’s great to have, but I don’t necessarily think that because you have a degree you are a better teacher than somebody who doesn’t (personal communication, November 12, 2009).

Knowledge and skills gained through hands-on experience is something that cannot be taught through a book. Sue admits:

I would trade experience for any amount of education with someone who is working with babies – especially with babies. You can’t learn any of that stuff from a book or a classroom; pretty much none of it. It just kills me every time that experience is not valued as much. It bothers me because some people’s instincts are that good (personal communication, October, 20, 2009).

Sixty-seven percent of directors reported that teachers were enrolled in a CDA credential program or a college degree program, partially related to the national trend requiring increased educational requirements, as previously explained. Gina explains:

As it turned out, when the new qualifications came out, I had to sit down with them and say ‘you have been in the field, we value you, but you need to go back to school’. We talked a little bit about the CDA program. Ironically, it didn’t faze any of them. Two of them were in their 50’s and were getting a lot of teasing about going back to school. All three of them felt very, very confident that they could prepare their portfolios, take their tests, and get through the program (personal communication, October 15, 2009).

Directors encourage staff without lead teacher credentials to enroll in a CDA program. The CDA program is viewed favorably by directors because it is “more specialized in infant, toddler, or preschool” and teachers “seem to have a better grasp of meeting the children’s needs and lesson plans” (Mandy, personal communication, September 11, 2009). Ultimately, directors prefer staff to have a college degree. Margaret explains:

It’s great that you have your CDA. I’m not knocking it, but your CDA gets renewed. You renew that and it means you go through the process again. If you get your associate’s, then no one can take that from you; that is yours forever. She took that to heart and she is enrolled in a program (personal communication, November 19, 2009).

Teacher enrollment in a CDA credential program is also related to hiring practices. Newly hired staff members without a degree, commit to earning a CDA as an employment contingency to become a lead teacher. Teachers with a four year degree in a related field, such as psychology, are also taking college courses to meet minimum licensing requirements.

On the other hand, directors reported instances where staff were not motivated to further their formal education either due to age, a language barrier, or contentment working in an assistant position. “I have some people here that say, ‘what is another year of school going to do

for me when I have been here for 10 years” (Patty, personal communication, October 9, 2009).

Sylvie explains:

You try to motivate them and get them to go back to school, which I try to plant the seeds. They are grandfathered in so they can be in that position. But, I try to tell them that the world is changing. You say you want to do better and you want to make more money. Well, you need to go back to school because if you don’t, this is where you are going to be 15 or 20 years from now. Do you still want to be here? So, those are the kind of seeds that I’m trying to plant here. Maybe I won’t get to water them, but at least I can plant them (personal communication, November 24, 2009).

“As far as those that have the associate degree, I don’t see a lot of opportunities for them to continue their education. I think a lot of it is a time commitment; it could also be the fact that there are some challenges with funding education” (Gina, personal communication, October 15, 2009).

Ideally, directors seek individuals with a college degree and experience in an early care and education setting. Sylvie explains:

You need to know that there are theories behind why you do the things you do. You need to know the stages of development and what is appropriate and what is not. But, I also think people coming out of school have to understand that everything that you’ve learned in school – now you have to learn how to put that into practice. It’s not some magical world that you step into and children act the way the book says they act; you have to be flexible (personal communication, November 24, 2009).

There is a perception that teachers with education and experience bring a higher level of maturity and ethics to the workplace. As a teacher with education and experience, “you know what children need rather than what you think you want to give them” (Carol, personal communication, October 9, 2009).

Directors are aware that juggling work, family, and school is challenging. “I believe in education, but sometimes I think there needs to be an easier ends to a means; the CDA is a lengthy process” (Anna, personal communication, October 1, 2009). Directors support staff by offering use of the computer during a lunch break and changing the work schedule so they can attend classes on campus. Directors are willing to offer non-financial support “as long as it pertains to trying to better themselves for the children and best practices” (Patty, personal communication, October 9, 2009).

Conclusions

Directors feelings about staff caregiving abilities relates to ongoing professional development through compensation, view of child care as a profession, and teacher training and education. Compensation, including wages and benefits, in early care and education is insufficient. It is challenging for early educators financially to afford professional development programs and to juggle family obligations with limited resources. For many, spending money to earn a college degree is not feasible when there is a struggle to afford living expenses.

Increasing minimum educational requirements for early educators is a national and state trend aimed to encourage professionalization of child care. Directors have difficulty hiring and retaining high quality early educators with minimum qualifications, as well as funding ongoing training and professional development opportunities. While directors and early educators believe

early care and education is a critical profession, those outside the field do not hold similar values. It is difficult to convince others that early care and education is a critical profession when little to no formal education is required for the position. Caring for young children is reduced to a job that anyone is able to perform if they have a love for children.

Directors prefer staff to have practical experience; yet, the importance of formal education to supplement training workshops is also recognized. In order to advance the professionalization of the early care and education field, directors need a larger pool of qualified applicants and the means to offer an acceptable compensation package. However, given the earnings potential in the field, early educators often leave the child care classroom for employment in higher paying positions leaving behind non-degreed caregivers perpetuating the notion of child care as babysitting.

CHAPTER 4

Conclusions and Implications

Conclusions

Three major themes around continuity of care, child care program operation, and career development emerged from this research study. Child care center directors create their own definition of continuity of care, which is inconsistent with that of national guidelines from NAEYC, PITC, CLASP and Early Head Start. Directors define continuity of care according to sameness, focusing more on consistency of routines and the daily schedule. Continuity of care is a phenomenon that occurs within the child care building or individual classroom and not between a child and caregiver. “For me, our continuity is that I have a lot of staff that we have had for a long time” (Sue, personal communication, October 20, 2009).

Despite encountering difficulty in defining continuity of care, directors view the practice positively and regard it as important for the establishment of safety, security and trust for children and parents. Directors’ beliefs are consistent with Ainsworth’s (1979) notion that infants are likely to become distressed when cared for by unfamiliar adults in unfamiliar environments; in addition to Honig’s (2002) proposition that attachment stems from the quality of caregiving experiences that are nurturing and responsive, as well as through an ongoing relationship with a special caregiver.

However, directors are inconsistent with the length of time a child remains with his caregiver. Directors suggest children remain with a caregiver for a minimum of 9 months and maximum of 18 months, yet there is no common practice. Cryer, Hurwitz and Wolery (2000) found the connection between belief and implementation of the practice of continuity of care was

weak. Similar to the findings of this study, decisions that influenced transitioning from one classroom to another revolved around reaching a developmental milestone or age, space availability in the next classroom and if a younger child had been enrolled into the center requiring an older child to move up. As in this study, center accreditation did not influence practice.

Implementing continuity of care is incomprehensible given the array of challenges directors encounter to keep the child care center operating. Administering a child care center is primarily centered on business management. Operating budgets are unyielding regardless of the profit status of the child care center and directors spend the bulk of their time managing complexities around finances. Directors dedicate a large portion of the budget to staff development; however, additional funding is required to improve wages, increase hours, and hire more teachers. Directors seek to enhance the quality of their program but cannot financially afford the means to improve upon ratios or teacher training and education. Career development of the early care and education workforce is challenging since compensation hovers around minimum wage. Directors highly value prior child care experience and working knowledge of the state regulations more so than a college degree; however, in reality, directors seek to hire teachers with a degree because of increased educational requirements. High quality child care is difficult to offer considering “issues that have been plaguing our country’s infant-toddler child care profession since it first started still exist” (Lally, 2009, p.53). Lally (2009) explains, “with low salaries, high turnover, large class sizes, little training, and inadequate time for reflection, it is hard for infant care teachers to implement what they are coming to know is best practice” (p. 53).

Directors feel strongly about child care as a profession and would like to see more professionalism from their staff. Directors believe teachers are well-trained, yet feel they are resistant to being held to a higher standard. Directors reason that higher wages would attract a more professional workforce with higher levels of education, but they report and feel that child care is misunderstood and underappreciated. When turnover occurs, teachers leave the field to earn higher wages in a job unrelated to child care; therefore, individuals who remain represent those who have a love for children. Those who remain and do not meet the minimum educational qualifications for a lead teacher position, are required to earn a degree. Although many teachers are enrolled in a program leading towards a CDA credential or college degree, directors believe it is a difficult and lengthy process that needs to be made easier.

Classroom arrangements and transition practices are driven by enrollment and budgetary considerations. Directors disregard concepts of developmentally appropriate practice, best practice, and quality out of necessity to keep their center operational. Center practices are based upon convenience, teacher satisfaction, and previous experience of what works; rather than research based evidence promoting positive child outcomes. Classroom arrangements and transitions cease to be about the children and families. Directors view transition times as a collaborative process; however, teachers and parents experience a sense of loss. Parents request their child remain with the current teacher, yet directors dictate the transition process based upon current financial need. Ultimately, parents go along with the director's decision.

Despite having difficulty defining continuity of care, directors feel their staff understands the practice. Directors do not provide formal training on continuity of care; rather teachers learn it through experience in the classroom or on an intrinsic level. Teachers often request to stay with

their group of children. Conversely, directors maintain that teachers are not happy or comfortable working with a range of age groups. Directors seek to prevent turnover and burnout and do not believe teachers would buy into continuity of care.

On the other hand, directors believe continuity of care would improve teacher retention and work satisfaction. In the study conducted by Cryer, Hurwitz and Wolery (2000), staff longevity was present in their sample indicating that continuity of care was possible at least into the second year. Aguillard, Pierce, Benedict, and Burts (2005) found only 5 percent of transitions due to teacher turnover, with 65 percent of transitions due to teacher attitudes and abilities. Similarly, teacher turnover was not a factor at the time of this study. Sixty-seven percent of directors were not experiencing teacher turnover; however, turnover among directors was prevalent.

Implications for Practice

As this study has revealed, directing a child care center requires knowledge and skills in business, management and economics. State regulations for director qualifications require a bachelor's degree in early childhood education, child development, or a related field; in addition to one year teaching experience and one year experience supervising staff. Individuals with experience and an earned program administrator's credential also meet the qualifications; however, very few credentials are awarded within the state. Eighty-one percent of directors in this study earned a college degree in elementary education, early childhood education or a related field such as psychology, human services, or social work. Only two directors (9.5 percent) earned a degree in a business related discipline. Of the eight directors that resigned, three had earned a master's degree in education, three had earned a bachelor's degree in education or a related field, and two had earned a bachelor's degree in a discipline outside of

early care and education. Of the two child care centers that closed due to financial difficulties, both directors had earned an associate degree in human services.

Educational and experiential requirements for child care center directors need re-examining. With little to no background in business, are directors adequately educated and experienced to successfully administer a child care center? Is director turnover due to a lack of knowledge and skill in the area of business? Is director turnover further compounded by a lack of knowledge of the concepts of developmentally appropriate practice, best practice and continuity of care? Are directors with a combination of education and experience in child development and business administration better prepared to manage a child care center than directors with an educational background focused on a single discipline? These findings raise several questions about the adequacy and focus of child care center directors' training and education.

Only one child care center in this study was not on record with OCFS as having a serious regulatory violation within the past two years. Fifty-seven percent of the violations encountered by centers were associated with program operation issues on behalf of the director, while 43 percent of violations were associated with teacher performance and career development issues. Appendix I contains the most frequently cited serious regulatory violations encountered by child care centers included in this study. Fourteen percent of the child care centers in this study earned accreditation through NAEYC and all but one received a serious regulatory violation. Fifteen percent of child care centers with citations had unresolved serious violations, all of which experienced turnover of the director. Although it would be interesting to further analyze trends in the data regarding serious regulatory violations, the small sample size prohibits

this due to lack of variability in the data. In addition, one area of deficiency within a program is often the source of several overlapping regulatory violations, making analysis difficult.

This study reveals that child care center directors encounter difficulty achieving quality levels above the minimum requirements of the state regulations. Whitebook, Sakai, Gerber, and Howes (2001) report teacher turnover negatively affected child care center directors' own career goals. Eighty-five percent of directors in the study reported teacher turnover negatively affected their ability to do their job at the center and 78 percent of directors reported staff turnover negatively impacted the overall functioning of the program (Whitebook, Sakai, Gerber, &Howes, 2001). Developmentally appropriate practice, best practice, and continuity of care exceed minimum standards and as such; directors are resistant to policies and standards of care geared towards enhancing quality. Directors are mystified in believing that what they do works. What exactly is working and who is it working for? Is it a realistic expectation for directors to implement quality improvements given the dynamics of child care discussed in this study? Directors assert they would affect quality enhancements and implement continuity of care if they could; however, practical knowledge and skill is lacking.

Directors are fearful of teacher turnover due to burnout; however, this study reveals director turnover is more of a central issue. Whitebook, Sakai, Gerber, and Howes (2001) found a 40 percent turnover rate for directors in their study with two-thirds of centers having two or more directors within a four year period. Fifty percent of directors who sought employment elsewhere remained in the field of early care and education, while the other fifty percent left the field entirely. No significant differences were found between directors who left a program and those that remained (Whitebook, Sakai, Gerber, &Howes, 2001).

Directors are cautious about supporting continuity of care as a policy and deeply resistant to mandating continuity of care as a standard of caregiving. Perhaps, child care center directors are experiencing burnout. Directors are consumed with managing regulatory violations and center finances, leaving little time to devote to programmatic matters and teacher support. Directors hold teachers accountable for professional development and educational advancement, yet lack the resources to invest in their staff. Teachers exhibit resistance to being held to a higher standard and directors lack the knowledge and confidence in implementing developmentally appropriate practices and best practices. Conceivably, teachers may aspire to remain with the same group of children provided the director is available to support them effectively in their role. Perhaps, successful administration of a child care center requires a multidisciplinary team approach rather than a single individual with a narrow educational background.

Just as this study has implications for practice, there are implications for the field of early care and education. One intent of this study was to examine directors' perceptions of continuity of care as a best practice. Repeatedly, directors reported multiple barriers to implementing best practices in their program. Administrative challenges prevented directors from implementing continuity of care, best practices in general, and maintaining regulatory compliance. With greater emphasis on quality improvements in the field, this has implications for the development and implementation of Quality Rating and Improvement Systems (QRIS). Ensuring programs meet minimum state licensing requirements is an essential first step prior to establishing QRIS with an expectation towards best practice.

With continuity of care represented in environmental rating tools and the national guidelines of NAEYC, PITC, CLASP and Early Head Start; the approach is currently perceived as a best practice. Additional research is essential in order to determine the true impact of continuity of care with infants and toddlers specific to a child care center setting. Relying on theoretical constructs and limited research based upon a group care setting is not helpful for informing child care center director's practice and is not enough evidence to designate continuity of care as a field-tested, research based best practice.

Limitations of the Study

As with all research studies, limitations exist. The sample for this study is limited in scope to child care center directors from the northeast region of the United States. Although the sample size is respectable for a qualitative study, only five directors from child care centers serving a large proportion of children receiving subsidies were represented making it difficult to analyze trends across centers serving diverse populations. Similarly, considering 95 percent of the child care centers in this study have a serious regulatory violation on file through OCFS, testing for variability with the remaining 5 percent of the sample that does not have a serious regulatory violation is not possible.

During the course of this study, 48 percent of child care centers experienced director turnover. Although interviews with each of the directors were conducted prior to turnover, it would have been interesting to interview those individuals who left the program to learn more about the dynamics of director turnover and possible connections to any of the areas addressed in this study.

Further Research

For over 40 years practitioners dedicated to the growth and development of young children have contributed to the establishment of an early care and education system. As a profession, the field of early care and education is currently at a crossroads. Does a vocation that relies upon the notion of “what we do works” and “if we could we would” merit recognition as a valued profession? Is it enough to have a love for children and a heart for this work to be regarded as a professional?

Goffin and Washington (2007) note the field of early care and education is experiencing extensive change that will impact children, families, society and the field as a whole. They call for a “networked, field-wide leadership capable of envisioning, advancing, and executing complex systemic change” (Goffin & Washington, 2007, p.10). We need to identify current leaders within early care and education to determine the characteristics, skills, and knowledge they possess to administer a child care center successfully. What types of skills and knowledge are needed by directors in order to evoke systemic change? What types of support systems are required to support directors in acquiring identified skills and knowledge? Do incentives effectively encourage directors to improve upon their own professional development and that of their staff? How do these factors influence the quality of caregiving and the overall professionalism of the field of early care and education? Where does QRIS fit within these systems and are they capable of advancing the field? These are questions worthy of future research.

Future research pertinent to teacher education is equally important for advancing the early care and education profession. Knowledge gained through early childhood education and child

development courses and workshops for caregivers has been shown to promote high quality center-based child care (Honig&Hirallal, 1998). Adult learners, regardless of their chosen profession, juggle work, family, and schooling. Child care center directors expect teachers to engage in professional development, yet feel that the process towards earning a degree is lengthy and difficult. Why does the course of career advancement need to be lessened for individuals who choose a career in early care and education? Do education and training command appreciation, recognition, and respect for the early care and education workforce? Would such a workforce then have an effect on wages and the view of the profession as a whole?

Much like the legitimization of the field of training and human resource development, early care and education needs a national organization of scholars to provide empirical grounding for the work of the national membership organization of NAEYC and to further define itself as a field. The concepts of developmentally appropriate practice, high quality and best practice must be reexamined within the scope of sound empirical evidence. Research that contributes to new knowledge, as well as, documents positive outcomes prior to implementation of practices, policies and regulations is essential to advance the professionalism of the field of early care and education.

Footnote

In the Spring of 2010, I submitted a proposal for a Foundation Research Award through the National Association of Early Childhood Teacher Educators (NAECTE). The goal of the NAECTE Foundation is to recognize and support research, conducted by early childhood teacher educators, relevant to policy and advocacy issues surrounding early childhood teacher education. Research proposals were evaluated according to the following criteria: evidence based, clarity and significance of the research question, soundness of the research methods, contributes to the knowledge base of early childhood teacher education, addresses quality in teacher education, and budget. My proposal outlined a plan for the purchase of software and equipment to aid in the analysis of my dissertation. Proposals were blind reviewed by a committee and I received notification in June that I was selected for the 2010 award.

As part of the research award, I purchased Dragon Naturally Speaking voice recognition software, NVivo 8 qualitative data analysis software package, and NVivo 8 resource manuals. The funding also supported my participation in the QSR NVivo 8 eWorkshop, a one-week intensive, interactive online training. The training occurred synchronously with a live instructor and revolved around the use of sample data to create projects and learn how to work with materials in NVivo.

Appendix A

Dear Center Director:

My name is Desalyn De-Souza and I am a graduate student at Syracuse University working under the direction of Dr. Bruce Carter. I am interested in learning more about continuity of care in child care programs and am conducting a research study for a course requirement. I would like to invite you, as the Director of the child care program, to participate in the study.

Participation in the study would involve answering questions in an interview that should take no more than two hours. A set of children's books for infants and toddlers will be given to those who take the time to participate in the study, as a token of appreciation for time invested in the interview process.

If you have been the Director of the child care center for at least one year, serve infants and toddlers, have at least one classroom for each age group, and are not currently practicing a form of continuity of care, then you are eligible to participate in the study. If you are interested in participating and/or have any questions, please call me at 315-460-3145. Please note that space is limited to the first 20 people. I plan to conduct the interviews by the end of the summer.

Sincerely,

Desalyn De-Souza, MS Ed.
Doctoral Candidate

Appendix B

Child Care Center Directors' Perceptions of Continuity of Care: A Qualitative Investigation

My name is Desalyn De-Souza and I am a graduate student at Syracuse University working under the direction of Dr. Bruce Carter. I would like to invite you to participate in a research study. Your participation in the study is voluntary and you may choose to participate or not. This form will explain the study to you. If you have any questions about the research please feel free to ask and I would be happy to answer your questions.

I am interested in learning more about continuity of care in child care programs. You will be asked a series of questions in an interview about child care caregiving practices. The interview should take no more than two hours of your time. All information will be kept confidential. I will assign a number to your responses and only my faculty advisor and myself will have the key to indicate which number belongs to which participant. In any articles I write or presentations that I make, I will not reveal details that would identify who you are. A second interview, lasting no longer than 30 minutes, may or may not be necessary to ask additional follow-up questions from the previous interview.

An audiotape recorder will be used to record your responses to the questions asked during the interview. The tapes will not be used for any other purpose other than to capture all of the details of the interview, which would otherwise be difficult to capture in handwritten notes. Once the study is concluded, the tapes will be erased.

The benefit of this research is that you will help me to understand continuity of care. This information should help me to have a better understanding of caregiving practices for infants and toddlers, which may ultimately influence policies and practices. There are no direct benefits to you by taking part in this study.

The risks of participation in this study are: you may feel uncomfortable at times during the interview, saddened or upset in remembering earlier caregiving experiences, and/or frustrated over regulations and policies impacting child care. These risks will be minimized by your right to refuse to answer any questions that cause discomfort. You have the right to withdraw from the study at any time without penalty. Also, if you decide to take part and later no longer wish to continue, you have the right to withdraw from the study at any time, without penalty.

A set of children's books for infants and toddlers will be given to participants as a token of appreciation for time invested in the interview process. If you decide to withdraw from the study, the set of children's books will be given to you at the time of withdrawal.

If you have any questions, concerns or complaints about the research, you may contact Dr. Bruce Carter at 315-443-3144 or Desalyn De-Souza at 315-460-3145. If you have any questions about your rights as a research participant, or questions, concerns or complaints that you wish to

address with someone other than the investigator, you may contact the Syracuse University Institutional Review Board at 315-443-3013.

All of my questions have been answered, I am over the age of 18 and I wish to participate in this research study. I have received a copy of this consent form.

_____ I agree to be audio taped.

_____ I do not agree to be audio taped.

Signature of Participant

Date

Printed name of Participant

Signature of Researcher

Date

Printed name of Researcher

Appendix C

Interview Questions

1. Please describe the physical layout of your center, the number of classrooms, and the ages of the children enrolled.
2. Describe the population that you serve at your child care center. Are there issues that arise with the children and families that are challenging? How might continuity of care work in your center?
3. Tell me what continuity of care means? How do you think it could be implemented?
4. The National Association for the Education of Young Children (NAEYC) encourages that infants and toddlers remain with the same caregiver for at least a period of 9 months. This is referred to as continuity of care. What do you think about this policy?
5. What do you think your staff understands about continuity of care?
6. What do you think characterizes a high quality child care center?
7. The 10 Components of Quality Child Care from Florida State University includes continuity of care as the 5th component. What do you think about continuity of care as one of the indicators of a high quality child care program for infants and toddlers?
8. What do you think your staff understands about quality child care?
9. What do you think are best practices?
10. Professionals in the field of early care and education feel that “best practices” relate to a higher level of quality child care. What do you think of continuity of care as a “best practice”?
11. What do you think your staff understands about best practices?

12. Is there anything that you wish were different about the quality of child care offered at your center?

13. Is there anything that keeps you from implementing best practices?

14. What do you think about the training and education that your staff receives?

15. Is there anything else that you have not mentioned that you would like for me to know?

Possible Probes:

- What do you mean?
- Would you explain that?
- Tell me about it.
- Give me an example.
- Take me through the experience.

Appendix D

Demographic Questionnaire

1. How long have you been the director of this child care center?

_____years _____months

2. Have you been the director of any other child care centers prior to your current position? _____yes _____no

If yes, what is the total amount of time that you have been a director at other child care centers? _____years _____months

3. I have earned a: (check the highest one earned)

_____Child Development Associate Credential (CDA)

_____New York State Children's Program Administrator Credential

_____Associate's Degree

_____Bachelor's Degree

_____Master's Degree

_____Doctoral Degree

If you earned an Associate's, Bachelor's, Master's or Doctoral Degree, what was your major?_____

4. How many conferences/workshops have you attended within the last 2 years?

5. Have you completed any college coursework specific to infants and toddlers?

_____yes _____no

If yes, how many credits did you complete? _____

What are the courses that you completed specific to infants and
toddlers? _____

Appendix E

List of Tree Nodes: Parent and Child

Licensing	Capacity Child Age Requirements Staff Education & Training Requirements As Quality Control
Best Practice	Continuity of Care as Best Practice Understanding Of Definition of
Relationships	General Statements Teachers Parents Licensors
Career Development	Salary Child Care as a Profession Teacher Training & Education
Program Operation	Classroom Arrangement Transition Practice Continuity of Care Implementation Cost Administration Issues Curriculum Staff Retention
Continuity of Care	9 Months as Policy Definition of Pros and Cons Continuity of Staff Understanding Of
Diversity of Center Quality	

Appendix F

Memo of Main Ideas

3/2/2011 11:56 AM

"Licensing"

Capacity:

- directors report being at capacity with infants and toddlers or very close to capacity. No one reported having difficulty filling infant/toddler slots. made reference that there is a need for infant/toddler care and that they get a lot of phone calls for this age group.
- noted they would like to increase capacity in infant/toddler rooms but have a barrier with meeting lead teacher staff qualifications

Child Age Requirements:

- directors refer to waivers for various reasons
- references are made to ratios
- references are made about transitions based upon age

3/9/2011 10:11 AM

As Quality Control:

- director's view regulations in positive light and use the regs to support their position/program
- director's see regulations in a negative light: unclear, subjective and open to interpretation; needing improvement (lagging behind); FCC vs. Centers; viewed as "inspectors"
- regulatory violations referenced

Staff Education & Training Requirements (from a licensing standpoint):

- finding lead teachers is difficult because of degree requirements, experience requirements (not and/or, but both)
- teachers learn best by hands-on/on-the-job training
- experience with infants/toddlers that is required by the regulations is a barrier for finding lead teachers, moving teachers around from within the program, for trying continuity of care if there is going to be movement of teachers
- some teachers have the experience with infants and toddlers, but do not have the degree
- some applicants have both the degree and experience, but are not viewed as quality by director during interview process
- director's mention that staff need to know more about the regulations and what they say
- licensing requires training and tells them what to take; they are minimum requirement

"Career Development"

Salary:

- Recruitment (quality of staff) and retention of staff is addressed in many ways.
- connection between quality of staff and rate of salary.
- directors at corporate and accredited centers believe they offer better rate of pay
- director's talk about offering benefits other than salary: health benefits, pay staff to attend inservice training days when center closes down, vacation, free/reduced child care on site for their own children
- references made about low wages - not here for the money
- directors wish they could pay more and invest in staff (monetarily and otherwise - i.e. training)

3/16/2011 4:50 PM

Teacher Training & Education:

- Professional qualifications - mention range of degrees, college coursework, credentials, accreditation standards, experience (as an important criteria/on the job training/hands on)
 - is there a continuum from these responses? how does this meet the Regs and/or relate to the Regs?
- responses around training for purposes of professional development - topics that staff need,
- responses about training institutions - formats or methods that work best or are preferred, quality of the trainers, sources of training (CCRR, employers/corporate, director, community resources)
- challenges with training and education

3/17/2011 12:03 PM

Child Care as a Profession:

- the idea of a job vs. a career vs. a profession - several times the "babysitter" was mentioned
- an understanding of the profession comes from experience in the role of teacher (do mention education, but overwhelmingly mention experience to really know what it's like)
- Recognition of child care as a profession - many referenced a lack of recognition by others; the profession as underappreciated; lack of benefits and money
- numerous references about teachers being in the profession because of passion, love for children, having heart for the work
 - is passion, love for children, heart for the work enough for a career? do these qualities make a professional? how does education and experience play into this?
- connection between compensation (benefits & salary), level of educational attainment, & child care professional/recognition of the profession

"Diversity of Center"

- demographic description of children and families served at center

- ethnicity, race
- SES in reference to subsidy, profession of parents
- family structure - single parents, two parent homes, foster care
- children with special needs
- families that have/learning English as a second language

"Continuity of Care"

Definition of:

- definition is based on caregiver-child relationship
- definition is based on day to day programming for children
- definition is based on day to day center policies
- one director was unsure of the meaning and asked for a definition - did not try to define what she thought it might be
 - many defined it in their own way according to what the word sounded like it meant, by training attended, according to practice of what they see at their center
 - interesting that most can come up with a working definition of what it means for themselves...how does this relate to the other categories of implementation, understanding of continuity of care and continuity of care as a best practice, understanding of best practice?

Understanding of:

- understand continuity of care as exclusivity - it's about the caregiver-child relationship and not about working with colleagues as a team approach to care for the child
- understand continuity of care as "sameness" - same caregivers, same schedule, same routines, same cohort of children, same expectations
- understand continuity of care as "continuous or something that continues" - mention continuing with curriculum in classroom from one classroom to next/from home to school and school to home
- true understanding of continuity of care occurs when you become a parent
- understand continuity of care as something that occurs within a classroom
- teachers understand continuity of care by:
 - through experience over time with children and it's through their behavior that they exhibit (at least one example from Anna's interview)
 - working in a child care program (pointing at simply attendance at work and the flip side is when the teacher is sick/vacation/not there)
 - through supervision and their director's telling them about it
 - through attending training workshops
 - they understand it intrinsically - can't put it into words, but they just know
 - few changes
 - running smoothly
- continuity of care is something the teachers don't understand - don't talk about it with staff and do not attend trainings on the topic

9 months as Policy:

- Length of time as a factor: 9 months is enough time; 9 months should be a minimum amount of time; 9 months is not considered to be continuity of care
- the concept is a good idea and they are in agreement with it, but question this as a policy in terms of a standard practice that should be instituted for programs or something that should be enforced
- distinction between policy vs. actual practice - some state that this is what they already do; mention challenges to the practice of it that influence what they think about the policy (staff turnover, age of enrollment of child and into what age room)
- one program commented, "if we could we would"

Pros and Cons:

- positive influence on parent-teacher relationship
- positive influence on child's development - cognitive, emotional
- positive influence on developing a sense of security and bonding for both parents and children
- cons mentioned have to do with staffing: problem with turnover rates, teacher illness, not clicking with a parent, child becomes too attached to a caregiver and transition is difficult

Continuity of Staff:

- response to continuity/discontinuity of staff - response of parents, teachers, child; also includes concept of staff that specialize in a certain age group (i.e. I am an infant teacher)
- continuity of staff within the classroom (as opposed to concept of looping over several years) - variety of responses that identify continuity of staff as something that is based within a classroom and not a practice that occurs from classroom to classroom through the center
- importance of continuity of staff - for optimal child development

"Best Practice"

Understanding of:

- staff understand best practices based upon the following factors: length of time at the center (experience dependent and not education dependent); training from director/assistant director
- mixed response as to whether staff understand - 3 report that they do; 2 report that they do not; remainder of respondents did not directly answer the question

Continuity of Care as Best Practice:

- 1 director disagrees with it as best practice (not good practice for child to have just 1 relationship), 2 are undecided (more about case by case basis; doesn't know enough about it to make a judgment), 16 agree with it as best practice
 - agreement or disagreement is based upon their own definition of what continuity of care is - and the definitions vary
- words that come up are: theory, ideal, strive for

Best Practice:

- provide examples of various 'practices' of best practice
 - this varies based upon how they define what a best practice is; not a consistent definition
 - examples include: classroom environment, paperwork, teaching practices in classroom/outdoors, routine caregiving (nap, feeding, diapering), ratios, staff communication/asking questions
 - best practice as a means to enforcing practice with parents
 - NAEYC accreditation as the guide for best practice
- implementation of best practices in the center
 - importance of hiring quality staff/knowledgeable staff that can implement
 - references to licensing
 - barriers to implementing best practice: time, money, paperwork, not enough admin staff for support, state mandates, turnover, parents, training time to train staff, energy
 - assets: money

Definition of:

- licensing as a standard for best practice
- licensing as a minimum and best practice is going above and beyond (6 people responded to this effect)
- best practice as DAP
- something that is best for the child
- best practices are individualized - case by case basis
- don't know what it is (3 people responded this way)
- having qualified staff
- best practice is "the" practice
- best practice is an idea/philosophy rather than actions

"Program Operation"

Curriculum:

- focus is on education and preparation for skill development/kindergarten; little mention of relationships as basis for education of infants and toddlers
 - focus on themes and lesson plans
 - curriculum is content focused (literacy, nutrition, colors, numbers, shapes)
 - mention play-based curriculum; no mention of teacher-child play - more of the idea that you provide the toys and time in the schedule to play
- several directors mention using a corporate/predesigned curriculum that they follow; some mention of using Creative Curriculum; 1 states that she wrote the curriculum; 2 mention not using a curriculum at all.
- regardless of curriculum format used; all are focused on skill development and do not mention importance of teacher-child relationship as a means for learning and development.

Cost:

- cost as it's related to the cost of the program for families - mention subsidy, scholarships; parents that do not pay
- cost as it's related to the cost of training for staff (decision to send staff to training vs. have someone come to the program to train all staff at once); paying staff to attend trainings; staff that are responsible for paying for their own training; fundraising so staff can attend state conference
- cost as it's related to making operating decisions: ability to hire full time floaters to assist in infant/toddler rooms; ability to hire a third full time permanent teacher in infant room for better ratios; making decisions about staff schedule based upon budget; subsidy rates not covering full cost of care; making decisions on where to spend money (food, teacher materials, diapers for parents)
- programs range with the funding support for their program: one program has large percentage of support from SUNY system, seek grants when they are non-profit status; one program is proprietary
 - grants used for purchase of program materials (toys), building maintenance
 - use fundraising outside of grants to assist with program materials (piano)

Classroom Arrangement:

- description of the actual age ranges of each of the infant/toddler classrooms
- reasons for age division/ranges in classrooms include: mobility of infants; waiting list for certain age slots; developmental readiness factors (cite language skills & muscle tone); age/birthday; clusters of children the same age that can move up to make room for more enrollment

Transition Practice:

- Factors for transitions:
 - time as a factor for transition: based on school year; allow one week; gradual and based upon reaction to short visits
 - developmental level of child as a factor for transition: motor skills, meets milestones, independence skills
 - child's age/birthday as a factor for transition
 - space availability in next room/waiting list for children entering program
 - children get too comfortable and need to move up
 - don't move up because closed for summer
 - staying within NYS Regs
 - staff float between rooms so children know all staff to prepare for moving up
- visitation as a method for easing transitions: schedule for child to visit next classroom; parents visit room; teachers go on visit with child to promote comfortableness;
- process of transition for the families: explanation provided when child enrolls in program, families meet new teachers; given a packet of information; classroom observation; teachers make parents feel comfortable; topic for newsletter; have an open house at the beginning of the year

- communication between staff members of classrooms
- feelings of loss associated with transitions:
 - loss experienced by teachers - teachers visit children once they move up; great quotes from Christina; viewed as something that happens in child care/move on to the next child
 - loss experienced by parents - parent request for teacher to move with child (director responded "not fair")
 - for children - bursts and regressions in behavior occur due to period of readjustment; clicking with next set of teachers; crying for extended periods of time
- several directors identify a time when one transition is more difficult than another. For example, when a transition involves moving to a different part of the building. A particular age that is more difficult than another age.

Continuity of Care Implementation:

- continuity of care within classroom; with same caregivers in the classroom; within center
- moving helps with preparing children
- directors struggle with actual implementation - cannot picture how it would work; don't think it would work and don't explore it; have many unanswered questions
- Barriers of implementation
 - lose teachers if they were to move up with their children: lose them in their specialty area (infants); teachers would refuse to work with different age group
 - meeting staffing qualifications/skills/individual preferences,
 - scheduling: of staff for shifts, of children at they enroll in program
 - turnover of children going in and out of program; turnover of staff
 - how to group children (what criteria do you use?), moving children as they age
 - regulations
 - changing practice/culture of center when it's always been done another way
 - resistance from parents
 - budget
- education is required to make it work
- several directors commented that they have it - but no one actually has staff move with children as an intentional practice (may have done it on occasion)
- discussion of changing policies in order to consider implementing it

Administration Issues:

- issues for administrators can be further subdivided into categories of:
 - working with Boards
 - building issues and maintenance
 - preparedness of being a director
 - staffing: hiring practices, scheduling practices, managing staff
 - program policies & paperwork
 - enrollment
 - program operation and the structure and set up that is assumed by the director (including violations; staff meetings; training staff in-house)

Staff Retention:

- longevity of staff attracts and retains parents enrolled at center
- connection between turnover rates and continuity of care
 - how teachers get along in the classroom and longevity;
 - research on improved staff retention with continuity of care
 - problems associated with implementing continuity of care because of turnover rates
 - fear of turnover if continuity of care were instituted (i.e. infant teacher is the infant teacher)
- directors concerned about teacher burn-out
- low turnover due to: health/vacation/sick benefits; pride in their work; profession of choice; director's management & support; incentives; flexibility afforded to employees
- turnover rates due to: teachers with degrees move to school district; lack of benefits for teachers (including bringing own children for free/reduced fees)
- center contract around turnover (Mary)
- director's time investment in training new staff

"Relationships"

General Statements:

- children: what they need, things they like,
 - director's ideas about what adults need to offer to children in a relationship
- idea of a family-friendly child care center and the characteristics that director's describe that makes the environment family-friendly
- relationships among staff: we are like family

Licensors:

- continuity of licensor as important for directors
- directors want licensors to see their staff and program for what they think it is; not just according to the impersonal interpretation of the regulations.

Teachers:

- bond formed between teacher and child: children return to visit their infant/toddler teachers; experience in infant/toddler classrooms perceived as being more nurturing relationship for children than preschool; territorial and possessive of their children (gatekeeping and competition)
- teacher-teacher relationships: impact children; conflict resolution
- teacher-parent relationships: teachers serve many supportive roles for parents; build trust with them
- teacher-director relationship: need to highlight positives to teachers more often; teachers need to speak up to tell director what they need

Parents:

- Director-family relationship: open door policy, viewed as customer
- forms of communication with families: notes, daily sheets, tours, 1 written positive about child's day; conferences & meetings, open house
- situations families bring with them to child care: lifestyle (medical residency, lack of family supports to take the children, work hours); social service system; developmental delays/concerns/screening/referral; jobs, money, use of medical system, nutrition, outside relationships with staff
- impression of parents & families: first time parents, single parents,
 - tone is one that child care knows more than parents and parents need their help and knowledge; they need to educate parents
 - tone is child care is home away from home
 - tone is to offer services at child care to improve "quality of life" - sounds like replacing the parent's role

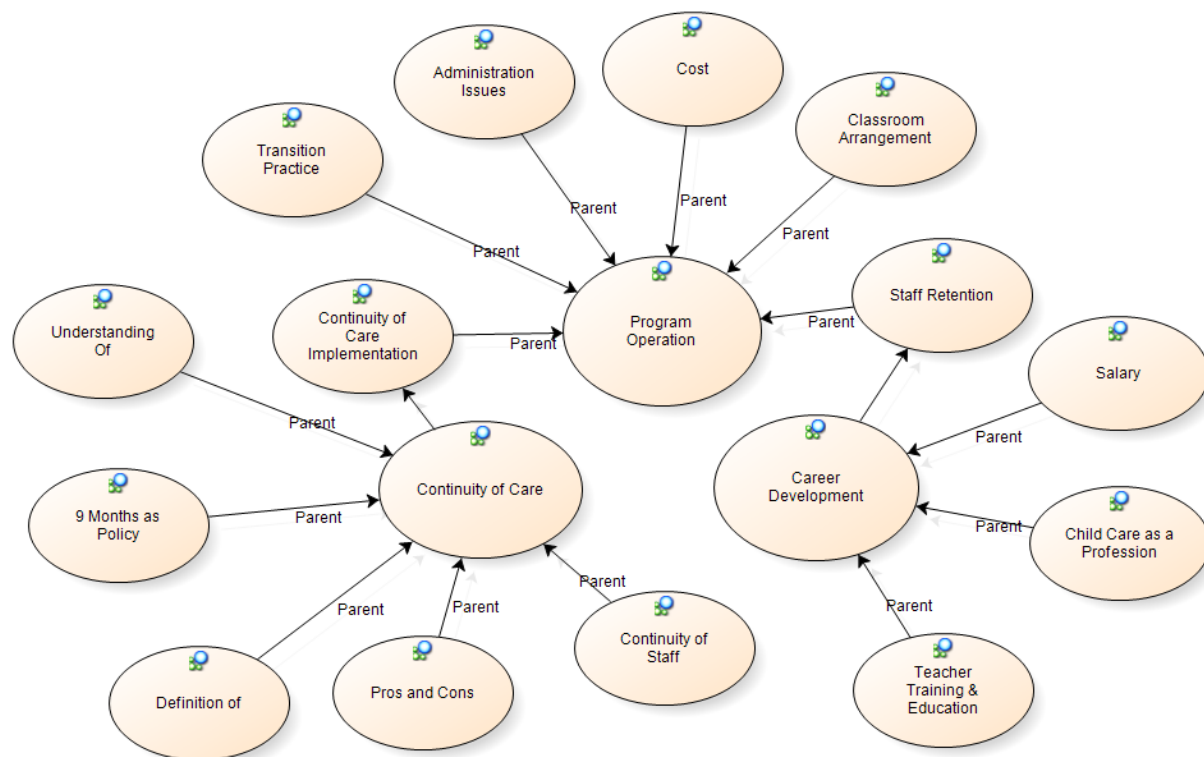
"Quality"

- NAEYC accreditation as a measure of quality
- characteristics of quality:
 - curriculum
 - staff: qualified, education, ongoing training, longevity, experience; intrinsic understanding
 - costs more
 - customer service
 - health & safety; secure building
 - parents satisfaction
 - love & dedication to the children
 - supplies & resources/money
 - evidence of learning
 - communication with parents & staff
 - physical environment of classroom/equipment
 - resources available for working with children with special needs
 - following regulations
 - DAP
 - budget (Sylvie)
 - quantity of love and care vs. quantity of stuff/materials the center has
 - not about rating tools and star systems - can't capture the quality
- continuity of care as quality
 - yes, it's an indicator of quality
 - not sure it's an indicator of quality (Gina)
 - would place it higher than 5
 - it should be #3 on the list after safety & qualified staff

- it should be #1, especially for infants and toddlers
- want to see it in action to determine if it's a quality program
- staff understanding of quality
 - they understand quality
 - they understand more and more as time goes on
 - difficult concept for them to understand
 - depends on each staff member
 - understand from director that they need to provide quality because parents are paying a lot of money
 - quality stars is viewed as licensing inspection
 - would be better if they followed and embraced the curriculum
 - it's important to make the parents happy and that's what they understand about quality
 - understand it more if you are a parent yourself
 - quality is a feeling; cannot describe it
 - too focused on things and materials as quality
- director states they are a quality center: 11
 - wouldn't change a thing
 - what we do works
 - demand for infant care is high because of quality program
 - quality goes through cycles as staff turnover
 - center has a reputation from past years as not quality
 - would like to make improvements: nurse on staff, therapist for special needs, new rugs & materials/supplies for classrooms; a curriculum for the infants and toddlers (like High Scope for preschool); move the program to a new building; social worker on staff
 - feels quality would change (for worse), if did looping with teachers
 - mentor staff through TP training
 - quality would improve if more opportunities for training and resources

Appendix G

NVivo 8 Model of Main Themes



Appendix H

Node Summary Report

Tree Node				
	sources	references	words	paragraphs
9 months as policy	21	43	1728	34
administration issues	21	182	9763	154
as quality control	10	22	660	16
best practice	19	53	2523	48
capacity	15	21	547	20
child age requirements	13	25	842	24
child care as profession	17	57	1926	47
classroom arrangement	21	59	2550	44
continuity of care as best practice	19	34	1083	28
continuity of care implementation	20	132	6690	106
continuity of staff	20	77	4157	67
cost	15	39	1243	37
curriculum	14	50	3395	44
definition of best practice	21	41	2039	35
definition of continuity of care	21	39	1960	36
diversity of center	21	53	2216	41
general statements	10	17	719	14
licensors	3	8	306	6
parents	18	60	3683	53
pros and cons	18	62	3060	58
quality	21	187	7830	145
salary	15	54	1670	39
staff education and training requirements	15	46	1547	41
staff retention	19	55	2875	53
teacher training and education	21	213	11207	165
teachers	11	21	1093	19
transition practices	20	148	10926	119
understanding of continuity of care	20	43	2296	38
understanding of best practice	20	34	1831	29

Appendix I

Serious Regulatory Violation History

Corporal punishment is prohibited. This includes punishment inflicted directly on the body including, but not limited to, spanking, biting, shaking, slapping, twisting or squeezing; demanding excessive physical exercise, prolonged lack of movement or motion, or strenuous or bizarre postures; and compelling a child to eat or have in the child's mouth soap, foods, hot spices or other substances. (7 programs; 35% of sample)

Methods of discipline, interaction or toilet training which frighten, demean or humiliate a child care prohibited. (5 programs; 25% of sample)

Suitable precautions must be taken to eliminate all conditions in areas accessible to children which pose a safety or health hazard. (5 programs; 25% of sample)

Children cannot be left without competent direct supervision at any time. (5 programs; 25% sample)

Adequate means of egress must be provided. Children may be care for only on such floors as are provided with readily accessible alternate means of egress to other floors, in the case of fire-resistant buildings, and to the outside in the case of non-fire-resistant buildings. Such means of egress must be remote from each other. (4 programs; 20% of sample)

In the event of an accident or illness for which a child requires immediate health care, the provider must secure such care and notify the child's parent or guardian. (4 programs; 20% of sample)

All corridors, aisles, and approached to exits must be kept unobstructed at all times (3 programs; 15% of sample)

The minimum education and experience qualifications for the Director, Heads of Group for Preschoolers, Infants/Toddlers and School Age Children, and Assistant to Head of Group (all ages) must comply with the qualifications set forth in this section. (3 programs; 15% of sample)

The health care plan must protect and promote the health of children in a manner consistent with the health care plan guidelines issued by the Office. The health care plan must be on site, available upon demand by a parent or guardian or the Office, and followed by the provider. For programs offering care to infants and toddlers, care to mildly or moderately ill children, or the administration of medications, the health care plan must be approved by the program's health care consultant. This approval can be revoked by the consultant, under which circumstances the health care consultant must immediately notify the provider and the provider must immediately notify the Office. (3 programs; 15% of sample)

The child day care center must employ or have available staff who will promote the physical, intellectual, social, cultural and emotional well-being of the children. (2 programs; 10% of sample)

All buildings used for day care centers must remain in compliance with the applicable provisions of the New York State Uniform Fire Prevention and Building Code. Any part of any building used as a day care center shall meet the requirements applicable under the code as appropriate to the ages of the children in care. (2 programs; 10% of sample)

In accordance with the provisions of the Social Services Law, child day care center staff must report or cause a report to be made of any suspected incidents of child abuse or maltreatment concerning a child in care to the Statewide Central Register of Child Abuse and Maltreatment. (2 programs; 10% of sample)

The provider must immediately notify the Office upon learning of the death, serious injury or infectious illness of an enrolled child which occurred while the child was in care at the center or was being transported by the provider. (2 programs; 10% of sample)

All matches, lighters, medicines, drugs, cleaning materials, detergents, aerosol cans and other poisonous or toxic materials must be stored in their original containers, used in such a way that they will not contaminate play surfaces, food or food preparation areas, or constitute a hazard to children, and kept in a place inaccessible to children. (2 programs; 10% of sample)

References

- Academy of Human Resource Development. (2009). Retrieved April 10, 2009, from <http://www.ahrd.org>
- Aguillard, A., Pierce, S., Benedict, J., & Burts, D. (2005). Barriers to the implementation of continuity-of-care practices in child care centers. *Early Childhood Research Quarterly, 20*, 329-344.
- Ahnert, L., Pinquart, M., & Lamb, M. E. (2006). Security of children's relationships with nonparental care providers: A meta-analysis. *Child Development, 74*(3), 664-679.
- Ainsworth, M. (1989). Attachments beyond infancy. *American Psychologist, 44*, 709-716.
- Ainsworth, M. (1979). Infant-Mother Attachment. *American Psychologist, 34*, 932-937.
- American Society for Training and Development. (2008). Retrieved April 10, 2009, from <http://www.astd.org>
- Bazeley, P. (2010). *Qualitative Data Analysis with NVIVO*. Los Angeles, CA: Sage.
- Belsky, J., & Fearon, R. M. (2002). Early attachment security, subsequent maternal sensitivity, and later child development: Does continuity in development depend upon continuity of caregiving? *Attachment and Human Development, 4*, 361-387.
- Belsky, J., Burchinal, M., McCartney, K., Vandell, D. L., Clarke-Stewart, K. A., & Owen, M. T. (2007). Are there long-term effects of early child care? *Child Development, 78*(2), 681-701.

- Belsky, J., Bakermans-Kranenburg, M., & van IJzendoorn, M. (2007). For better and for worse: Differential susceptibility to environmental influences. *Association for Psychological Science, 16*, 300-304.
- Bogdan, R. C., & Biklen, S. K. (2003). *Qualitative Research for Education: An Introduction to Theories and Methods* (4th ed.). Boston, MA: Allyn and Bacon.
- Bornstein, M., Hahn, C., Gist, N., & Haynes, O. (2006). Long-term cumulative effects of childcare on children's mental development and socioemotional adjustment in a non-risk sample: the moderating effects of gender. *Early Child Development and Care, 176*, 129-156.
- Bornstein, M., & Hahn, C. (2007). Infant childcare settings and the development of gender-specific adaptive behaviors. *Early Child Development and Care, 177*, 15-41.
- Bronfenbrenner, U. (1989). Ecological systems theory. *Annals of Child Development, 6*, 187-249.
- Bronfenbrenner, U. (1993). Ecological models of human development. In *Readings on the Development of Children*, eds. M. Gauvain & M. Cole, 37-43. New York, NY: Freeman.
- Burchinal, M., Robert, J., Nabo, L., & Bryant, D. (1996). Quality of center child care and infant cognitive and language development. *Child Development, 67*, 606-620.
- Bureau of Labor Statistics. (2005). *Employment Characteristics of Families in 2004*. Washington, DC: U.S. Department of Labor.

- Center for Law and Social Policy. (2008). *Continuity of Care: Charting Progress For Babies in Child Care Research-based Rationale*. Retrieved from the Center for Law and Social Policy Web site: http://www.clasp.org/publications/cp_rationale3.pdf
- Clasien de Schipper, J., Van IJzendoorn, M., & Tavecchio, L. (2004). Stability in center day care: Relations with children's well-being and problem behavior in day care. *Social Development, 13*, 531-550.
- Coffey, A., & Atkinson, P. (1996). *Making Sense of Qualitative Data*. Thousand Oaks, CA: Sage.
- Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory Into Practice, 39*, 124-130.
- Cryer, D., Hurwitz, S., & Wolery, M. (2000). Continuity of caregiver for infants and toddlers in center-based child care: Report on a survey of center practices. *Early Childhood Research Quarterly, 15*, 497-514.
- Cryer, D., Wagner-Moore, L., Burchinal, M., Yazejian, N., Hurwitz, S., & Wolery, M. (2005). Effects of transitions to new child care classes on infant/toddler distress and behavior. *Early Childhood Research Quarterly, 20*, 37-56.
- Denzin, N. K., & Lincoln, Y. S. (Eds.). (2005). *The SAGE Handbook of Qualitative Research* (3rd ed.). Thousand Oaks, CA: Sage.

- Elicker, J., Englund, M., & Sroufe, L. (1992). Predicting peer competence and peer relationships in childhood from early parent-child relationships. In *Family-peer relationships: Models of linkage*, eds. R. Parke & G. Ladd, 77-106. Hillsdale, NJ: Erlbaum.
- Essa, E., Favre, K., Thweatt, G., & Waugh, S. (1999). Continuity of care for infants and toddlers. *Early Child Development and Care*, 148, 11-19.
- Field, T., Vega-Lahr, N., & Jagdish, S. (1984). Separation stress of nursery infants and toddlers graduating to new classes. *Infant Behavior and Development*, 7, 277-284.
- Goffin, S., & Washington, V. (2007). *Ready or Not: Leadership Choices in Early Care and Education*. New York: Teachers College Press.
- Goossens, F. A., & van IJzendoorn, M. H. (1990). Quality of infants' attachments to professional caregivers: Relation to infant-parent attachment and day-care characteristics. *Child Development*, 61, 832-837.
- Graham, M., Hogan, A., White, B., & Chiricos, C. (2003). Enhancing the quality of relationships in infant-toddler child care: A developmental process. *Zero To Three*, 24, 14-20.
- Harms, T., Cryer, D., & Clifford, R. (2006). *Infant/Toddler Environment Rating Scale Revised Edition*. New York: Teachers College Press.
- Head Start Information and Publication Center. (2005). *Early Head Start Tip Sheet No. 25*. Retrieved from the US Department of Health & Human Services Administration for Children & Families Web site: http://www.headstartinfo.org/infocenter/ehs_tipsheet/tip25.htm

Hesse-Biber, S. N., & Leavy, P. (2011). Analysis and interpretation of qualitative data.

In S. N. Hesse-Biber & P. Leavy (Eds.), *The Practice of Qualitative Research* (2nd ed.) (pp. 301-331). Thousand Oaks, CA: Sage.

Honig, A. (2002). *Secure Relationships: Nurturing Infant/Toddler Attachment in Early Care Settings*. Washington, DC: National Association for the Education of Young Children.

Honig, A., & Hirallal, A. (1998). Which counts more for excellence in childcare staff – years in service, education level or ECE coursework? *Early Child Development and Care*, 145, 31-46.

Howes, C., & Hamilton, C. (1992). Children's relationships with caregivers: Mothers and child care teachers. *Child Development*, 63, 859-866.

Huston, A. C., & Rosenkrantz Aronson, S. (2005). Mothers' time with infant and time in employment as predictors of mother-child relationships and children's early development. *Child Development*, 76, 467-482.

Kvale, S. (1996). *InterViews: An Introduction to Qualitative Research Interviewing*. Thousand Oaks, CA: Sage.

Lally, J. R., Griffin, A., Fenichel, E., Segal, M. Szanton, E., & Weissbourd, B. (1995). *Caring for infants and toddlers in groups: Developmentally appropriate practice*. Washington, DC: Zero To Three.

Lally, R. (2009). The science and psychology of infant-toddler care: How an understanding of early learning has transformed child care. *Zero To Three*, 29, 47-53.

- Lamb, M. & Lewis, C. (2005). The role of parent-child relationships in child development. In M. H. Bornstein & M. E. Lamb (Eds.), *Developmental Science: An advanced textbook* (5th ed.) (pp. 429-468). Mahwah, New Jersey: Lawrence Erlbaum Associates.
- Legendre, A. (2003). Environmental features influencing toddlers' bioemotional reactions in daycare centers. *Environment and Behavior*, 35, 523-549.
- Lincoln, Y. S., & Guba, E. (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage.
- Loeb, S., Fuller, B., Kagan, S., & Carrol, B. (2004). Child care in poor communities: Early learning effects of type, quality and stability. *Child Development*, 75, 47-65.
- Marshall, C., & Rossman, G. B. (2011). *Designing Qualitative Research* (5th ed.). Thousand Oaks, CA: Sage.
- Maxwell, J. A. (1996). *Qualitative Research Design: An Interactive Approach*. Thousand Oaks, CA: Sage.
- Maxwell, J. A. (2005). *Qualitative Research Design An Interactive Approach* (2nd ed.). Thousand Oaks, CA: Sage.
- Miles, M. B., & Huberman, A. M. (1984). *Qualitative Data Analysis: A Sourcebook of New Methods*. Beverly Hills, CA: Sage.
- National Association for the Education of Young Children. (1997). *Developmentally Appropriate Practice in Early Childhood Programs Serving Children from Birth through Age 8*. Washington, DC: National Association for the Education of Young Children.

National Association for the Education of Young Children. (2007). *Elevating the Field: Using NAEYC Early Childhood Program Accreditation to Support and Reach Higher Quality in Early Childhood Programs*. Washington, DC: National Association for the Education of Young Children.

National Association for the Education of Young Children. (2008). *Guidance on NAEYC Accreditation Criteria*. Retrieved from the National Association for the Education of Young Children Web site: http://www.naeyc.org/selfstudy/pdf/Additional_Guidance_Accreditation.pdf

National Association of Child Care Resource and Referral Agencies. (2008). *Child Care in America: 2008 State Fact Sheets*. Retrieved from the National Association of Child Care Resource and Referral Agencies Web site: <http://www.naccrra.org/policy/docs/childcareinamericafactsheet.pdf>

National Resource Center for Health and Safety in Child Care and Early Education. (2003). *Indiana Rule 4.7 Child Care Centers, Licensing*. Retrieved from the National Resource Center for Health and Safety in Child Care and Early Education Web site: http://nrckids.org/STATES/IN/in_rule4.7.htm#pgfld-416000

National Resource Center for Health and Safety in Child Care and Early Education. (2006). *Part 407 Licensing Standards for Day Care Centers: Section 407.210 Special Requirements for Infants and Toddlers*. Retrieved from the National Resource Center for Health and Safety in Child Care and Early Education Web site: http://nrckids.org/STATES/IL/il_407.htm#0_pgfld-1003768

- NICHD Early Child Care Research Network. (1999). Child outcomes when child-care center classes meet recommended standards for quality. *American Journal of Public Health, 89*, 1072-1077.
- NICHD Early Child Care Research Network. (2006). Infant-mother attachment classification: Risk and protection in relation to changing maternal caregiving quality. *Developmental Psychology, 42*, 38-58.
- Patton, M. Q. (2002). *Qualitative Research and Evaluation Methods* (3rd ed.). Thousand Oaks, CA: Sage.
- Perry, G., & Duru, M. (2000). *Resources for Developmentally Appropriate Practice: Recommendations from the Profession*. Washington, DC: National Association for the Education of Young Children.
- Program for Infant/Toddler Caregivers. (2007). Retrieved from the Program for Infant/Toddler Caregivers Web site: http://www.pitc.org/pub/pitc_docs/ww.html
- Raikes, H. (1993). Relationship duration in infant care: Time with a high-ability teacher and infant-teacher attachment. *Early Childhood Research Quarterly, 8*, 309-325.
- Ritchie, S., & Howes, C. (2003). Program practices, caregiver stability, and child-caregiver relationships. *Applied Developmental Psychology, 24*, 497-516.
- Ritchie, S., & Willer, B. (2005). *Leadership and Management: A Guide to the NAEYC Early Childhood Program Standard and Related Accreditation Criteria*. Washington, DC: National Association for the Education of Young Children.
- Signer, S., & Wright, S. (1993). *The Program for Infant Toddler Caregivers Trainer's Manual: Social-Emotional Growth and Socialization*. California: WestEd.

- Spangler, G., & Grossmann, K. (1993). Biobehavioral organization in securely and insecurely attached infants. *Child Development*, 64, 1439-1450.
- Stayton, D. J., Ainsworth, M., & Main, M. (1973). Development of separation behavior in the first year of life: Protest, following and greeting. *Developmental Psychology*, 9, 213-225.
- Swanson, R., & Holton, E. (2009). *Foundations of Human Resource Development* (2nd ed.). California: Berrett-Koehler Publishers.
- Vandell, D. L., Burchinal, M., Vandergrift, N., Belsky, J., & Steinberg, L. (2010). Do effects of early child care extend to age 15 years? Results from the NICHD Study of Early Child Care and Youth Development. *Child Development*, 81, 737-756.
- Vermeer, H., & van IJzendoorn, M. (2006). Children's elevated cortisol levels at daycare: A review and meta-analysis. *Early Childhood Research Quarterly*, 21, 390-401.
- Watanabe, S., Donzella, B., Alwin, J., & Gunnar, M. (2003). Morning-to-afternoon increases in cortisol concentrations for infants and toddlers at child care: Age differences and behavioral correlates. *Child Development*, 74, 1006-1020.
- Whitebook, M., Sakai, L., Gerber, E., & Howes, C. (2001). *Then & Now: Changes in Child Care Staffing, 1994-2000 Technical Report*. Washington, DC: Center for the Child Care Workforce.
- ZERO TO THREE. (2008). *Including Infants and Toddlers in Quality Rating and Improvement Systems*. Retrieved from the ZERO TO THREE Web site: <http://www.zerotothree.org/policywebinars>

DESALYN R. DE-SOUZA

SUNY Empire State College Offices:

Central New York Center	Onondaga Community College	Watertown Unit
6333 Route 298	Higher Education Center	Higher Education Center East
Syracuse, NY 13057	4926 Onondaga Road	1220 Coffeen Street
315-460-3145	Syracuse, NY 13215	Watertown, NY 13601
	315-498-2726	315-786-6541

EDUCATION

Doctor of Philosophy in Child & Family Studies – May 2012

Syracuse University, Syracuse, NY.

Dissertation (passed with distinction): Child care center directors' perceptions of continuity of care: A qualitative investigation

Master of Science in Education – 2005

LeMoyne College, Syracuse, NY.

Concentration in Adult Education.

Thesis: Child care providers' views of child care as a profession and themselves as professionals.

Bachelor of Arts in Psychology – 1996

Siena College, Loudonville, NY.

Graduated *cum laude*.

CERTIFICATION & SPECIALIZED TRAINING

1. *Program for Infant/Toddler Caregivers Program Assessment Rating Scale*, 2010. Met interrater reliability.
2. *Early Childhood Environment Rating Scale – Revised Edition*, 2010. Met interrater reliability.
3. Syracuse Touchpoints Site, Community Level Training Team Member, Brazelton Touchpoints Center, 2008.
4. Certified Infant Massage Educator (CIMI), Infant Massage USA/International Association of Infant Massage, 2006.
5. *Infant Toddler Environment Rating Scale*, 2001. Met interrater reliability.

HONORS AND AWARDS

40 Under Forty Award, Community involvement and leadership in Central New York, 2011.

Research Award, *National Association of Early Childhood Teacher Educators Foundation*, 2010.

\$2,000 award in support of dissertation research.

ACADEMIC EXPERIENCE

Assistant Professor/Mentor
Part-time Mentor

2009 to present
2008-2009

SUNY Empire State College

- Develop and teach undergraduate courses in Early Childhood Education and Community and Human Services towards an associate or bachelor's degree program.
- Offer courses in a variety of learning modes including independent study, study group, residency-based format, blended model, and online.
- Mentor adult learners and work with individual students to design a customized degree program based upon the student's interests and academic goals.
- Evaluate student's prior learning to recommend college-level credit through a formal assessment process.
- Participate in community outreach and college governance.

Research Assistant
Search Committee Member
Teaching Assistant
Syracuse University

- Conducted literature searches and designed tables and graphs for on-going research projects.
- Worked on National Survey of Families and Households data set using the SPSS statistical package.
- Interviewed potential faculty members for an assistant professor position in the Child and Family Studies Department as part of a search committee.
- Assisted in teaching undergraduate courses in Child and Family Studies for two full-year terms. Courses included: "Prosocial and Moral Development of Children", "The Developing Infant", and "The Developing Child Within the Family".

PUBLICATIONS

1. De-Souza, D. (in press). Educating the early childhood educator: A mentoring model for self-directed adult learners, *Young Children*.
2. De-Souza, D., &Radell, J. (2011). Superheroes: An opportunity for pro-social play, *Young Children*, 66(4), 26-31 .
3. De-Souza, D. (2010). Influencing the development of character, citizenship, mutual respect and social responsibility with preschoolers, *E-Reporter*, New York State Association for the Education of Young Children.
4. De-Souza, D. (2005). Does training for caregivers really make a difference in quality of care? *Focus on Infants & Toddlers*, Association for Childhood Education International, 17(4), 4 & 8.

ACADEMIC & PROFESSIONAL PRESENTATIONS

1. De-Souza, D. (2011). Child care center directors' perceptions of continuity of care: A qualitative investigation. Poster session, 26th Annual Zero To Three National Training Institute. Washington, DC.
2. De-Souza, D., &Radell, J. (2011). Superheroes: An opportunity for Pro-social Play. *Syracuse Association for the Education of Young Children*, Keynote Speakers, Syracuse, NY.
3. Coolhart, D., Gedro, J., De-Souza, D., Sithole, M., & Forbes, K. (2010). Creating A Multidisciplinary Community: Educational Planning as a Group Study. *SUNY Empire State College All Areas of Study Conference*. Saratoga Springs, NY.
4. De-Souza, D. (2010). Educating the early childhood educator: A mentoring model for self-directed adult learners. *National Head Start Association 27th Annual Parent Training Conference*. Virginia Beach, VA.
5. De-Souza, D., &Nightengale, H. (2010). Early childhood education and the residency: A trajectory for student credentialing. *SUNY Empire State College Annual All College Conference*. Saratoga Springs, NY.

6. De-Souza, D. (2010). Seeing development through the eyes of the infant and toddler. *New York State Association for the Education of Young Children Annual Conference*. Verona, NY.
7. De-Souza, D. (2010). Moving towards family-friendly service delivery: An Onondaga County collaboration project. *SUNY Empire State College Human Service Learning Community Residency*. Keynote/lunch speaker, Syracuse, NY.
8. De-Souza, D. (2009). Moving towards family-friendly service delivery: An Onondaga County collaboration project. *National Head Start Association 26th Annual Parent Training Conference*. San Jose, CA.
9. De-Souza, D. (2009). Using the Touchpoints principles to connect with parents and families. *New York State Association for the Education of Young Children Annual Conference*. Brooklyn, NY.
10. De-Souza, D. (2009). Primary caregiving and continuity: Exploring policies that support high quality care. *New York State Association for the Education of Young Children Annual Conference*. Brooklyn, NY.
11. De-Souza, D. (2008). Promoting first relationships: Implications for infant and toddler caregivers. *Jefferson-Lewis Child Care Project Bright Beginnings Annual Conference*. Watertown, NY.
12. De-Souza, D. (2007). Spoiling or building trust? *New York State Region 1 Infant/Toddler Network Annual Conference*. Buffalo, NY.
13. De-Souza, D. (2007). Getting in touch: Infant massage. *New York State Association for the Education of Young Children Annual Conference*. Rye Town, NY.
14. De-Souza, D. (2006). Encouraging early literacy with infants and toddlers. *Syracuse Association for the Education of Young Children Early Childhood Education Conference*. Keynote speaker, Utica, NY.
15. De-Souza, D. (2006). School readiness for infants and toddlers. *New York State Association for the Education of Young Children Annual Conference*. Saratoga Springs, NY.

16. De-Souza, D., &Brouillette, A. (2006). Culture and temperament. *New York State Association for the Education of Young Children Annual Conference*. Saratoga Springs, NY.
17. De-Souza, D. (2006). Promoting positive behavior through room arrangement. *The State University of New York Campus Child Care Annual Conference*. Syracuse, NY.
18. De-Souza, D. (2005). Encouraging early literacy with infants and toddlers. *Syracuse Association for the Education of Young Children Winter Institute*. Syracuse, NY.
19. De-Souza, D. (2005). Culture: How does it shape our caregiving practices with infants and toddlers? *New York State Association for the Education of Young Children Annual Conference*. Rochester, NY.
20. De-Souza, D., &Brouillette, A. (2005). Encouraging early literacy with infants and toddlers. *New York State Association for the Education of Young Children Annual Conference*. Rochester, NY.
21. De-Souza, D. (2005). Brain development for babies: What do we know? *The State University of New York Campus Child Care Annual Conference*. Syracuse, NY.
22. De-Souza, D. (2004). Brain development for babies. *Syracuse Association for the Education of Young Children Winter Institute*. Syracuse, NY.
23. De-Souza, D. (2004). Nuts and bolts of behavior guidance with infants and toddlers. *St. Lawrence County Early Childhood Conference*. Canton, NY.
24. De-Souza, D. (2004). Arranging your infant/toddler caregiving environment. *St. Lawrence County Early Childhood Conference*. Canton, NY.
25. De-Souza, D. (2004). First look forward training and mentoring project. *New York State Infancy Conference*. Binghamton, NY.
26. De-Souza, D. (2003). Learning environments for infants and toddlers. *The State University of New York Campus Child Care Campus Conference*. Syracuse, NY.

27. De-Souza, D. (2003). Toilet training. *Child Care Council of the Finger Lakes Annual Early Childhood Conference*. Auburn, NY.
28. De-Souza, D. (2003). Taking infants and toddlers outside. *Cortland Association for the Education of Young Children Annual Conference*. Cortland, NY.
29. De-Souza, D. (2002). Safe havens: The impact of violence on children. *Syracuse Association for the Education of Young Children Winter Institute*. Syracuse, NY.
30. De-Souza, D. (2001). Safe havens: The impact of violence on children. *Central New York Skills Building Conference – Upstate Medical University Continuing Medical Education*. Syracuse, NY.
31. De-Souza, D. (2001). Creating safe havens for children and families. *Central New York Skills Building Conference – Upstate Medical University Continuing Medical Education*. Syracuse, NY.

PROFESSIONAL EMPLOYMENT

New York State Infant & Toddler Resource Network Coordinator

Early Childhood Specialist (promoted)

Child Care Solutions, Syracuse, NY

- Coordinate a 14-county region and improve the quality of care for infants and toddlers.
- Cultivate and maintain working relationships with 10 partnering Child Care Resource and Referral Agencies, Office of Children and Family Services, Local Departments of Health, Colleges and Universities, and an array of Social Service agencies.
- Conduct annual needs assessment, collect and evaluate data, and submit quarterly reports and a year-end summary report.
- Formulate, launch, and manage professional development programs for adult learners including child care providers, parents, and social service professionals.
- Conduct intensive on-site technical assistance on a one-on-one basis and assist programs in meeting New York State Licensing standards.
- Supervise 2 part-time Infant/Toddler Specialists, housed at satellite sites in Binghamton and Oriskany.
- Seek additional funding sources and coordinate special grant programs as awarded.

Assistant Director

Childtime Children's Center, Cicero, NY.

- Carried out fundraising, fiscal planning, and marketing of the accredited child care center on a daily basis.
- Provided tours of facility to prospective enrollees and maintained full enrollment capacity of 100 children ages 18 months to 12 years old.
- Supervised team of 15 teachers and monitored professional development of all staff to meet state licensing standards.

Residence Counselor

Catholic Charities, Syracuse, NY.

- Provided care for adolescents in a group home setting.
- Maintained household environment and monitored behavior management of residents.
- Implemented therapeutic goals of individual residents.

Residence Counselor

Northeast Parent and Child Society, Schenectady, NY.

- Provided care for adolescents in a group home setting.
- Taught residents independent living skills and social skills within a therapeutic home environment.
- Monitored progress on daily basis.

PROFESSIONAL DEVELOPMENT

Community Level Touchpoints Training. Brazelton Touchpoints Center, Boston, MA.

Touchpoints in Early Care & Education Individual Level Training. Brazelton Touchpoints Center, Boston, MA.

Preventing Child Abuse and Neglect: Parent-Provider Partnerships in Child Care. Zero To Three, Washington, DC.

Promoting First Relationships. University of Washington, Seattle, WA

A Toolkit for Evaluating Initiatives to Improve Child Care Quality. Bank Street College of Education, New York, NY.

Looking Together: Learning To Use the Ounce Scale Early Childhood Assessment. Erikson Institute, Chicago, Illinois.

Relationship-Based Reflective Consultation. Zero To Three Center for Program Excellence, Washington, DC.

New York State School Age Child Care Credential Endorser Training. Cornell University, Ithaca, NY.

PROFESSIONAL AFFILIATIONS

American Associate Degree Early Childhood Educators

Infant Massage USA

National Association for the Education of Young Children

Syracuse Association for the Education of Young Children (local affiliate)

National Association of Early Childhood Teacher Educators

BOARD & COMMITTEE SERVICE

The Newland Center for Adult Learning and Literacy, Board of Directors.

SUNY Empire State College Center for Mentoring and Learning, Advisory Board Member.

New York State Association for the Education of Young Children, Co-Chair of Governance Board. Reelected for second two-year term.

New York State Infant Toddler Network, Higher Education Representative, Advisory Council.

SUNY Jefferson Community College Early Childhood Development Program External Advisory Committee