Supporting Quality Child Care and Learning for all Children and Youth

Quality First

Progress Report 2010
The Quality First initiative was launched in 2005 in recognition of the need to support a high level of quality child care in Halton. The program is currently operated by The Halton Resource Connection (THRC). Parents and caregivers should expect the best for their children. A key indicator of program success is when parents ask the centres before registering their child “are you involved in Quality First?” Centres that are a part of the Quality First initiative in Halton are committed to providing quality care for their children and families.

In A Vision for Children in Halton Report Card (2008), the Our Kids Network identified key results and indicators for children and youth in Halton. The Halton 7 population results are: Children are Healthy, Children are Learning, Children are Positively Connected, Children are Safe, Families are Strong and Stable, Schools are Connected to the Community, and Neighbourhoods are where we Live, Work and Play. Although child care and Quality First are appropriate indicators for many of these results, it is reported as a contribution to strong and stable families.

At Halton Region, we are excited to see the growth of the Quality First initiative and the inherent supports and enhancements it brings to our child care community. When our early learning practitioners take the time to self-reflect, set goals, participate in professional development, implement their knowledge, skills and abilities while working closely with the families they support, the children of Halton will benefit. I would like to thank the Quality First Report Committee for bringing forth this report and its findings. Quality First is making a difference!

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For more information on the A Vision for Children in Halton Report Card visit www.ourkidsnetwork.ca
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PURPOSE OF THIS REPORT

"Our best future is one in which all children are healthy and secure; emotionally and socially competent; eager, confident, and successful learners; and respectful of the diversity of their peers."

(Charles E. Pascal, Special Advisor on Early Learning in Ontario)

Quality First is a program of The Halton Resource Connection (THRC). THRC is operated through a collaborative partnership between Milton Community Resource Centre and Halton Region, Children’s Services. Since 2005, Quality First has provided licensed child care and early learning programs in Halton with an opportunity to participate in quality improvement. This report is intended to provide brief, high level information to people who make decisions about child care and management in Halton, and to those who work in early learning child care environments.

The Purpose of this Report is to:

- Provide information that will enable child care operators, educators and professionals to identify areas of vulnerability and strength in the overall quality of their centres and centre program practices;
- Reveal gaps and indicate the changes needed;
- Present a clearer picture of the early learning child care environment in which our children (infant to school-age) are growing;
- Provide a baseline of information so that improvement in the well-being of early childhood educators (ECEs), child care staff and caregivers over time can be tracked;
- Provide measurement tools and supports to track improvement in the delivery and impact of Quality First over time and help prompt and guide further research or changes to the model;
- Stimulate community action to help children get the best possible start in life.
Organization of the Report

This report consists of performance results and measures to improve outcomes for children. Results describe a condition of well-being for early childhood educators, child care centres and the child care system (see page 24). Throughout this report you will find data on 17 performance measures, selected by members of The Halton Resource Connection as the most important ways to measure how well Quality First supports the development of young children and individuals working with children, and their families.

Data in the report come from several sources. These include environment rating scale scores from the Infant Toddler, Early Childhood, and School-Age Care Environment Rating Scales, as well as scores from the Caregiver Interaction Scale, Inclusion Quality Scale, Checklist for Quality Inclusive Education, and participant self-report surveys.

How to Use this Report

There are a number of things to consider when interpreting the results found in this report. While every effort has been made to ensure the most accurate data are available there are still some limitations to consider. For instance, some of the data were collected through self-report surveys which are prone to response bias.

Data presented in this report are meant to provide a snapshot of information. Use this document to inform child care operators, educators and other professionals on how well Quality First is working. While each of the performance measures in this report is important, using multiple measures to form evidence of respective strengths and needs is a much stronger approach. This report may be helpful as a reference when discussing:

- How well children’s developmental needs are being met in the classroom
- How well ECEs professional needs are being met in the centre
- How to examine any impact of Quality First on the child care system
LITERATURE REVIEW: QUALITY MATTERS

What Do We Know About Child Care in Canada?

Over the past eight years, the proportion of Canadian children in some form of child care has increased significantly. This trend may be explained by a substantial rise in the labour force among Canadian women who have children under the age of 18, over the past 25 years. The most recent figures on working mothers show that women with children under the age of three participating in the paid labour force rose from 28% in 1976 to 68% in 2007. Similarly, the number of women with children between the ages of three and five increased dramatically, from 37% in 1976 to 79% in 2007 (Statistics Canada, 2006; Beach, Friendly, Ferns, Prabhu & Forer, 2009).

In 2007, 83% of total regulated child care spaces for children aged 0-12 were centre-based.
(CRRU, University of Toronto, 2007)

The rapid increase in the workforce participation since 2000 has produced high levels of demand for all types of child care (Cleveland, 2008). An increase in the child care rate occurred for children from almost all backgrounds, regardless of geographic location, household income, family structure, parental employment status or parental place of birth. Statistics Canada’s National Longitudinal Study of Children and Youth reported the most common type of care for children with two working parents was care outside of the home by a non-relative, accounting for nearly 30% in 2004 to 2005. The rate was higher in Ontario, close to 34%. In the case of children with single working parents, centre-based programs were the most common form of child care (Bushnik, 2006). This has sparked an explosion of interest in non-parental child care.

Communities across Canada continue to show a growing need for child care, a result of the increasing number of women joining or returning to the workforce. Research about the effects of quality in early learning and child care on young children calls attention to the need for more availability of child care that is regulated and of high quality (Doherty, 1996 & 2001; Lowe, 2000; Friendly, 2006; CCAAC, 2006; Cleveland, 2008).
What is Quality Child Care?

The term “high quality” indicates something that does not just meet minimum standards, but provides added value. When parents use a licensed child care program in Ontario, which is regulated under the Day Nurseries Act, they can be assured the program is monitored annually. Licensed child care programs have to meet provincial health and safety standards. However, licensing alone is not an adequate indicator of high quality child care.

High quality child care goes beyond being a safe and secure place for children; it provides nurturing relationships and stimulating environments that support children’s growth and development, and fosters learning. For example, a quality child care program will have warm and responsive caregiver interactions with children. In addition, research shows that high quality child care has the following characteristics: low child to adult ratios and small group sizes, staff/caregivers well-trained in early childhood education, decent wages and working conditions (including support and resources), and adequate health, safety and physical environment policies and practices in place.

Why is Quality Child Care Important?

The established view among child care researchers is that child care quality contributes to children’s developmental outcomes and a higher quality of care associated with better developmental outcomes for children. Research consistently demonstrates that high quality early learning and child care can play a crucial role in promoting social, emotional, physical and cognitive development of young children (Harms, 1998; Doherty, 1991 & 2000; Shonkoff, 2000; Friendly, 2006).

Parents and caregivers also benefit from quality child care environments. The encouragement of learning and development in early childhood supports the participation of parents in employment and education and ultimately improves early learning and child care for families with young children. More specifically, parents of children who are involved in high quality early learning and child care programs experience improved parenting skills, improved parent engagement, and overall improved family interactions (CCAAC, 2006).

The case for quality child care is well documented. The Quality by Design project at the University of Toronto, Childcare Resource and Research Unit (CRRU) insists that poorer adult to child ratios influence caregiving styles. These ratios are associated with staff harshness and detachment, less sensitive, less responsive and less appropriate caregiving, and less social, less verbal and cognitive stimulation with the children in a classroom. Children in programs with poor ratios have less secure relationships with caregivers and adults, are less compliant, less able to regulate their own behaviour, and have more exposure to potential danger. These children will also have poorer verbal and social interaction scores (Doherty, 2000; Friendly, Doherty & Beach, 2006). Similarly, larger group sizes are associated with less responsive care, less individualizing, and less cooperative children. Small group sizes are associated with less hostile and less antisocial children. The children in small groups also talk and play more with other children and score higher on tests of social ability (Canadian Council on Learning, 2006).

Staff/caregivers are identified as the most critical factor that determine the quality of child care. According to the CRRU, child care staff with specific training in early childhood education are less likely to be harsh, are more responsive, and provide more developmentally appropriate care. Children in the care of qualified and trained staff exhibit more cooperative behaviour, higher levels of language and cognitive skills, and possess better general knowledge. Analysis of the You Bet I Care! data, a major Canadian study, found that higher levels of ECE training predict higher quality ratings (Doherty & Forer, 2004).
Good working conditions and wages of child care workers and providers are associated with higher job satisfaction and morale, lower staff turnover, and a less stressful child care environment. These factors are also related to more developmentally appropriate, more sensitive, less harsh caregiving, as well as better language development and higher levels of appropriate play in children (Doherty, 1991; Doherty, 2000).

Substandard health practices like poor diaper changing, lack of hand washing and improper food handling procedures are associated with higher rates of infectious illness. In addition, elements of early learning child care environments such as amount of space, access to the outdoors, arrangement of rooms, availability of a variety of materials, air quality, equipment, and lighting play a role in children’s happiness, creativity, and their learning to live in and with the natural environment (THRC, 2009). Children in crowded child care spaces are often aggressive or uncooperative. Sufficient well-designed indoor and outdoor spaces are associated with better cognitive development, behavioural and social skills (Canadian Council on Learning, 2006).

It has also been shown that the physical environment - how easy or difficult it is to carry out a program in, or whether there are physical amenities that support staff such as a private staff room and adequate program resources - have an impact on staff morale. This in effect has an impact on the quality of the centre program (Friendly & Beach, 2005; Canadian Council on Learning, 2006).

In summary, certain caregiver behaviours and environmental characteristics have been found to be consistently associated with higher levels of child well-being and functioning. These include caregiver support and encouragement of children’s exploration, caregiver responsibility for only a few children rather than a larger group, and the availability of a variety of age-appropriate toys and activities. The presence or absence of certain adult behaviours or environmental characteristics is used to define a particular care situation as high or low quality.

“Child care should support a child’s emotional, social, intellectual and physical well-being.”

(The Canadian Child Care Federation)
Halton’s Vision for Early Learning

Clearly, the quality of early childhood child care experiences can have a huge impact on children’s later success. Quality First was developed to make lasting changes in program quality and to provide increased support to child care professionals working with young children in Halton. The program supports the current research and knowledge base in Canada and internationally on early learning and child care and early childhood development. It addresses the need for quality care and positive environments for children. The program facilitates positive, meaningful and sustained change in the design and delivery of quality child care and early learning in Halton. Quality First provides early learning and child care programs in Halton with the opportunity to make improvements to the quality of individual centres.

The Halton Resource Connection

Supporting Quality Care and Learning for All Children and Youth

THRC is a place where early childhood educators, teachers, parents and other related professionals can call or visit to access equipment and resources to enhance early learning programs for children and youth. It is a place where you can contact related community agencies and exchange supports. They provide curriculum resources, services, equipment and professional development which enhance the quality of care and learning environments for children and families.

The members of THRC are committed to working together to address the following vision and mission:

Vision:
A community that values quality care

Mission:
THRC works in partnership with individuals, organizations and families promoting the best interest of all children and youth within Halton and the broader community.

www.thrc.ca
In 2005, the Ontario Minister of Children and Youth Services commissioned a report to look at the principles behind early learning in the province. A panel of professionals from the early childhood education and the formal education sectors in Ontario were invited to participate and share their expertise. This report has since been used to support decisions made about children’s learning, using child development as a foundation for curriculum and program planning. The following statement of principles is taken from the report Early Learning for Every Child Today, the work of the Best Start Expert Panel on Early learning.

**Statement of Principles**

Six principles set the basis for quality programs for children in Ontario. In Halton, the early learning community is working together to build on this framework in support of growth in quality ELCC programs.

1. Early child development sets the foundation for lifelong learning, behaviour and health.

2. Partnerships with families and communities strengthen the ability of early childhood settings to meet the needs of young children.

3. Demonstration of respect for diversity, equity and inclusion are prerequisites for optimal development and learning.


5. Play is a means to early learning that capitalizes on children’s natural curiosity and exuberance.

6. Knowledgeable and responsive early childhood professionals are essential to early childhood settings.

A high-quality child care centre responds sensitively and appropriately to children’s individual needs, stimulates their curiosity and recognizes their particular interests. It should also promote the development of language skills and other skills needed to ensure the best start in school.

(centre of Excellence for Early Childhood Development, 2009)
The Brain: An Overview

The primary building block of the brain is the neuron. Neurons must connect with other neurons in order to work. Neurons work by sending messages through the body in the form of electrical signals. These messages come from the experiences a baby gets from their world. At birth, a baby’s brain has already begun to make the necessary connections with the brain cells responsible for newborn reflexes such as breathing, hearing and sucking. Caregivers play an important role in creating healthy, stimulating and nurturing environments for babies and young children. Neurons that are repeatedly stimulated form a pathway that allows impulses and messages to travel faster (Wilson, 2010). This means that when a child repeats the same action over and over, the smoother the action becomes because of the stronger, faster nerve and brain connection.

Why is a Child’s Early Experience so Important to the Development of Brain Architecture?

The early period of development is one of both opportunity and vulnerability. During this time, the brain is receptive and impressionable, and has the capacity to shape itself dramatically. This is the time when a child’s brain responds to experiences with their environment (Mustard, 2006; Shonkoff, 2009; NSCDC, 2007). Early experiences have a powerful and lasting influence on how the brain develops. Specifically, early childhood provides an opportunity that allows multifaceted sets of experiences to shape a child’s brain architecture.

The physical and chemical conditions that encourage the building of a strong, adaptive brain architecture are enabled by experience to adapt to the challenges an individual faces throughout one’s life. When those experiences are healthy, the brain develops in a way that anticipates living in a healthy environment, and consequently the child is able to meet life’s challenges with success. Conversely, undesirable early experiences can weaken the developing brain architecture causing dysfunctional adaptations, and can result in a brain that is not suited for operating in a healthy, complex environment. As the brain ages, experiences lock in the way information is processed, making it more difficult for the brain to change to other ways of processing information and dealing with challenges (Mustard, 2006; Shonkoff, 2009; NSCDC, 2007).

What We’ve Learned

1. Some aspects of the brain are genetically determined, and most neurons are present at birth.
2. Structures supporting social, emotional and mental development are developed in early childhood; capacity to build these foundations is greatest in early childhood and decreases over time.
3. Early stimulation (positive interaction with parents, caregivers and the environment) is required for healthy brain development.
THE HISTORY OF QUALITY FIRST

In April of 2004, the Speaking of Quality forum was held in Halton. The forum was hosted by the Halton branch of the Association of Early Childhood Educators Ontario (AECEO) and organized by various representatives from the child care community including Sheridan College, Halton Region Children’s Services, community based child care programs, front line educators and the Ministry of Children and Youth Services. The forum centred on answering the question, “how is Halton doing with regards to the delivery of quality child care programs?” Eighty community members attended the discussion, to share and provide their feedback. Results from the forum highlighted three priority areas needed to develop and sustain quality child care programs throughout Halton. These key areas to improve the level of quality in child care programs, develop the level of professionalism of individuals working with children, and support the success of early childhood education students.

Regular meetings were held to continue discussion around quality care and to develop the key areas brought to light by the forum. The Quality First initiative evolved in response to the community’s recognition of the need to develop and support a high level of quality care and education for young children and their families. In 2005, the program received funding from the Halton Healthy Community Fund to provide licensed preschool programs with the opportunity to participate in a model for quality improvement. By September, four licensed child care centres in Halton were selected as pilot sites for the new preschool model of Quality First. Evaluations from these sites provided valuable feedback and generated new ideas on how to enhance the Quality First model. In 2006, three-year funding from the Trillium Foundation, as well as some support from the Ontario Best Start Plan, helped to secure additional staffing and resources. In 2008, the infant/toddler model was launched, followed by the school-age model in 2009.

Since the launch of the full program in 2006, staff in the Halton child care community continue to show an interest in Quality First. Enrolment continues to rise each year with more staff and centres participating. As part of a continuous improvement framework, enhancements to the model continue to be made and the question “how is Halton doing with regards to the delivery of quality child care programs?” continues to be discussed.

Knowledge, collaboration, Excellence, Empowerment
Mission: to facilitate positive, meaningful and sustained change in the design and delivery of quality care and learning in the Halton child care community by developing the professionalism of individuals involved in the care and education of young children, improving the level of quality indicators in children’s programs, and collaborating with local colleges to promote the professional readiness of early childhood educators.

The Quality First model is based on current research, validated tools and best practices in the field of child care and early learning. The initiative focuses on improving quality child care programs, increasing professionalism and supporting early childhood education students.

The implementation process consists of three phases leading up to a Progressive phase, which helps to sustain quality over the long term. Each phase takes one year to complete and explores the use of various tools. Training, consultation and support to participants are also provided throughout each phase. Additional training opportunities exist for learning about Environment/Curriculum, Professionalism, Adult-Child Interactions, Inclusive Practices, Administration and Supervision. Support for ECE college students is also provided as part of the program. To facilitate success, centres are assigned a consultant who assists with goal setting and reaching objectives.

The program provides training and support using seven tools that provide centres with regular feedback on how they are doing:

1. Early Childhood Environment Rating Scale-Revised (ECERS-R)
2. Infant/Toddler Environment Rating Scale-Revised (ITERS-R)
3. School-Aged Environment Rating Scale (SACERS)
4. Caregiver Interaction Scale (CIS)
5. Partners in Quality (PIQ)
6. SpeciaLink’s Inclusion Quality Scales (IQS) formerly the Inclusive Practices Profile & Principles Scale
7. Checklist for Quality Inclusive Education (C-QIE)

The initiative was originally managed by the AECEO but is currently operated as a program of The Halton Resource Connection (THRC), with ongoing support from the ECE community through its Advisory Group. The committee meets regularly and has volunteer representation from various sectors of the child care community, including non-profit child care, commercial child care, nursery school programs, programs supporting children with special needs, and family resource centres.

Quality First Objectives:

1. To develop the professionalism of individuals involved in creating and implementing programs for children.
2. To improve the level of quality child care indicators in children's programs in Halton.
3. To collaborate with local college programs in promoting the professional growth of the developing early childhood educator.
4. To support supervisors of child care programs, early childhood educators and people who work with children in licensed child care programs to support the positive development of children.
5. To support parents to effectively select and evaluate child care programs to meet their child’s needs.
6. To build on existing structures in the community to implement these actions in conjunction with the Our Kids Network and the Best Start Network.
Since the launch of Quality First in Halton, much progress has been made in establishing a Quality First community, delivering training and tools, and collecting data. Quality First continues to grow in strength and numbers around the Region. As of September 2010, there were 120 participating sites, run by 67 operators. A total of 1,127 early childhood educators have been trained by Quality First since it’s inception.

In May, 2010 the provincial pairs mentoring program, Mentoring Pairs for Child Care (MPCC) recognized the work of Quality First in maintaining best practices and quality environments in child care centres. To reduce duplication for supervisors who participate in both programs, Quality First and MPCC have aligned their activities and now provide exemptions and credits for completion of specific professional development workshops.

The figure shown provides an overview of the overall program milestones and key milestones achieved to date.

“Quality First is not about the end product. It’s about the journey you take to get there - the evolution of quality. It’s about focusing on the positives, enhancing your program, and getting involved in making a difference!”

(As quoted by a supervisor of a licensed child care centre participating in Quality First)
THRC takes lead role for QF (April)

Halton Region begins funding QF (April)

Launch of infant/toddler pilot sites (May)

6 preschool sites participate in longitudinal study

2 QF consultants hired (November)

Launch of infant/toddler model (May)

QF model at SpecialLink national symposium in Winnipeg (August)

Launch of school-age pilot sites (September)

3 additional QF consultants hired (November)

69 sites participating (May)

Launch of school-age model (September)

120 sites participating (67 Operators)

7,642 total children have participated in QF

1,127 total ECEs have participated in QF

Launch new centre-based model

QF partnership with MPCC program

6 additional QF consultants hired (May)

2007 2008 2009 2010 2011

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2010
2011

Together We Make Quality Happen
VALIDATED TOOLS

"The Quality First tools are simple, easy to use and effective in identifying strengths to celebrate and areas needing improvement. The major tools and training workshops help to provide a clear vision of what quality child care is."

(As quoted by a supervisor of a licensed child care centre participating in Quality First)

The use of standardized rating scales allows quality comparisons to be made between classrooms. It also allows centres and classrooms to monitor changes in quality. There are five scales that are used in the Quality First initiative: the Infant/Toddler Environment Rating Scale – Revised (ITERS-R; Harms, Cryer, & Clifford, 1998), the Early Childhood Environment Rating Scale – Revised (ECERS-R; Harms, Cryer, & Clifford, 1980), the School-Aged Care Environment Rating Scale (SACERS; Harms, Jacobs, & White, 1996), the Caregiver Interaction Scale (CIS; Arnett, 1989), and SpecialLink’s Child Care Inclusion Practices Profile and Principles Scale, now called the Inclusion Quality Scale (IQS). Two additional tools, Partners in Quality (PIQ) and the Checklist for Quality Inclusive Education (C-QIE) supplement the use of the scales. Quality First participants learn about these tools and how they are used through training and professional development workshops. The training is meant to promote reflective thinking about environments, interactions, personal growth and inclusive practices.

Centre quality is assessed using one of three observational instruments, the revised version of the ITERS, ECERS, and SACERS. Which tool is utilized is dependent on the setting and age range of the children in a particular program. The Environment Rating Scales (ERS) have been internationally tested for reliability and validity in providing information about the quality of childhood programs, based on research regarding positive child outcomes. Findings strongly suggest significant relationships between ERS scores and child outcome measures, teacher characteristics, and teacher behaviours. In particular, these tools are considered to be significant predictors of a child’s cognitive and linguistic progress. The CIS, PIQ, IQS, and C-QIE are used in conjunction with the ERS to assess the educational aspects of quality and professional development. Additionally, Quality First incorporates various techniques borrowed from Reflective Practice and mentoring programs.

**Infant/Toddler Environment Rating Scale - Revised (ITERS-R)**

The ITERS-R provides a scale with which to review the quality of infant and toddler environments, including child care centres, family resource and parenting programs. It is designed to assess center-based child care programs for infants and toddlers up to 30 months of age. The scale focuses on the physical environment and looks at the use of space, play materials, and learning experiences, as well as at adult-child interactions. There are thirty-nine items on the scale organized into seven subscales. New items have been added to make the scale more inclusive and culturally sensitive, to address professional needs of staff, and to reflect the latest health and safety information. Each item is ranked from one to seven. A ranking of one describes inadequate conditions...
while a ranking of seven describes excellent conditions. The subscales include:

- Space and Furnishings
- Personal Care Routines
- Language-Reasoning
- Activities
- Interactions
- Program Structure
- Parents and Staff

### Early Childhood Environment Rating Scale - Revised (ECERS-R)

The ECERS-R provides a scale with which to review the quality of early childhood environments, including child care centres, family resource centres, parenting programs and kindergarten classrooms. It is designed to assess centre-based child care programs for children of preschool through kindergarten age (2½ - 5 years). The scale focuses on the physical environment and looks at the use of space, play materials, learning experiences, daily schedule and supervision, as well as adult-child interactions. There are 43 items on the scale organized into seven subscales. The revised ECERS contains inclusive and culturally sensitive indicators for many items. Each item is ranked from one to seven. A ranking of one describes inadequate conditions while a ranking of seven describes excellent conditions. The subscales are the same as those used in the ITERS-R.

The ECERS-R covers the basic aspects of all early childhood facilities and thus can be used in a number of ways and in a variety of settings by child care facilities and children’s programs. Program staff may use the tool to complete a self-assessment of the quality of their classrooms and to determine areas of high quality and areas that may need additional attention. Staff may also use the tool as a self improvement guide where minimal scores can help specify areas for emphasis in training and learning. Decision-makers can use the tool to determine strategy and action plans and researchers may use the tools to measure the impact of quality of programs, training and continuing education over time. In addition to the ECERS-R, there are comparable tools for infant and toddler settings and school-age settings.

### School-Age Care Environment Rating Scale (SACERS)

The SACERS provides a scale with which to review the quality of school-age environments, including child care centres, family resource centres, parenting programs and after-school programs. It is designed to assess child care programs for children of school age (5 - 12 years). The scale focuses on the physical environment and looks at the use of space, play materials, learning experiences, as well as adult-child interactions. There are 49 items on the scale including six supplementary items for programs enrolling children with disabilities. The items cover seven categories. Each item is ranked from one to seven. A ranking of one describes inadequate conditions while a ranking of seven describes excellent conditions. The subscales include:

- Space and Furnishings
- Health and Safety
- Activities
- Interactions
- Program Structure
- Staff Development
- Special Needs

### Caregiver Interaction Scale (CIS)

Positive interactions and relationships between children and caregivers are essential for the growth and well-being of each child. The CIS is used as a means to observe and understand staff interactions with children in three subscale dimensions: **Sensitivity** – the extent to which the adult is warm, attentive and engaged with the children; **Harshness** – the extent to which the adult is critical, sounds irritated or hostile when speaking to children, is punitive, or uses threats to address children’s inappropriate behaviour; and **Detachment** – low levels of interaction, low levels of expression of interest in the children’s activities, behaviour such as simply standing and looking at children rather than being engaged with them. During a two-hour observation, behavioural examples are recorded for each subscale item by the observer and centre supervisor. After the tool is scored, goals are identified that will enhance positive interactions with children using the strengths and challenges that were highlighted as part of the observation.
Partners in Quality (PIQ)

Partners in Quality is a research and development project sponsored by the Canadian Child Care Federation to explore how child care providers, parents, and other partners can work together to support and improve quality in child care. In 2000, Gillian Doherty published a document to support child care providers and to enhance the dialogue within communities on the importance of quality child care environments. This reference is widely used amongst the early childhood community. The document explores the issues in providing quality child care and addresses a number of topics including: adult-child relationships, infrastructure, partnerships with families, and partnerships with the community. It introduces the Standards of Practice and Code of Ethics for both administrators and practitioners. Also included is a guide to self-reflection; a tool for practitioners that is meant to help caregivers think about their current practice and reflect upon possible changes.

SpeciaLink’s Child Care Inclusion Quality Scale (IQS)

SpeciaLink’s Child Care Inclusion Practices Profile and Principles Scales, now known as the Inclusion Quality Scale (IQS) has become a key tool for measuring the quality of inclusion of children with special needs in Canadian early learning and child care programs. The inclusion tool is meant to be used along with the ECERS-R/ITERS-R/SACERS for a picture of both inclusion quality and overall program quality. SpeciaLink’s Child Care Inclusion Practices Profile consists of 11 items and 158 indicators, and the Principles Scale includes 6 items and 92 indicators. The Principles Scale is completed after both the ECERS-R/ITERS-R/SACERS and Practices Profile. Unlike ECERS-R, many of the indicators cannot be observed, thus must be scored through a combination of questioning and document review. Scoring procedures are similar to those in the Environment Rating Scales.

Checklist for Quality Inclusive Education (C-QIE)

In 1994, the Early Childhood Resource Teacher Network of Ontario developed the Checklist of Quality Inclusive Education (1997) to assist ECEs in identifying diversity and inclusion within early childhood settings. ECEs can use the tool to assess how inclusive their centre practices are or it can be used individually by an educator wishing to improve personal inclusive practices. The C-QIE measures observable practices that define the optimal level of inclusion in early childhood education programs.
Since the beginning, Quality First has been committed to a continuous improvement process of its service delivery. Part of this process involved gathering information through surveys, focus groups, and interviews from members of the Quality First community. Feedback was received from parents, participating Quality First centre staff, Halton Region Children’s Services staff and organizations and agencies in the community who work with Quality First sites. These included the Ontario Ministry of Children and Youth Services, Reach Out Centre for Kids (ROCK), Community Living North Halton and Community Living Burlington. Participants were asked to provide feedback about the original model, their involvement and experiences in the program, and feelings about working with other centres as an effect of their involvement in Quality First. Suggestions to improve the model were also discussed. Findings from the focus groups pointed to a need to make improvements to the original model to enhance program delivery and effectiveness. Suggestions were considered by the Quality First Advisory Group, who responded to four key areas of concern: time, staff, administration, and training.

1. **Time**: Feedback on program activities and goals revealed that the original models six-month time period allotted to achieve goals was insufficient. Classrooms were sometimes at various phases of Quality First, making management complicated for supervisors at each centre.

   **Improvements Made**: Each six-month phase was extended to one year with a centre-based approach as opposed to classroom-based to ensure the whole centre operates at the same level. Additionally, the requirement commitment from participating centres increased from 18 months plus annual maintenance to 30 months plus annual maintenance. See pages 19-20 for details.

2. **Staff**: Feedback from staff working in community agencies spoke to inconsistencies in quality between classrooms within a Quality First centre, as not all rooms were participating. Staff mentioned that while some rooms were high-quality, others within the same centre were of lesser quality, raising the concern that knowledge transfer within the centre was not taking place throughout the centre. There was also some concern over how staff turnover impeded training and progress.

   **Improvements Made**: Shifted to a centre-based model to improve differences in quality between classrooms within a centre. High-quality performance and environments are now associated to all classrooms within a centre and are no longer attached to individual staff. A centre-based approach ensures that staff turnover does not affect participation and progress in the Quality First program.

3. **Administration**: Staff complained that completing sections of paperwork was repetitive and completing administrative forms felt like extra work and was tedious. This resulted in many staff feeling that paperwork was not important and was often pushed aside for other priorities.

   **Improvements Made**: Shortened and condensed sections of reporting and applied them centre-wide in order to alleviate repetition and reduce paperwork.

4. **Training**: Focus group participants stated that training workshops were often held at inconvenient times. Not only was it challenging for staff to schedule time to attend, many expressed additional frustration that workshops occurred within such a short period of time.

   **Improvements Made**: Provided more training opportunities with the added option of holding workshops within the centre in order to support the ability of staff to attend. Also considered ideas about shared attendance and self-study where training does not require sitting in the same room together.

In addition to these modifications, the new Quality First model suggests identifying a Centre Mentor, an individual chosen by each centre to actively support the Quality First work. This staff person acts as the go-to person for Quality First information and ultimately maintains momentum at the centre in order to aid success in the Quality First process.
Child care centres who have entered into Quality First realize the importance of quality. They actively strive to better their understanding of what constitutes quality in early childhood practice and to deliver this quality to their children and families in a consistent, cohesive and meaningful way. Developmentally appropriate practice is central to achieving this goal and is a principal component of our professional early childhood work. It requires that individuals working with young children and their families have an understanding of and adhere to some fundamental beliefs. These are that teachers play a critical role in supporting children’s development and learning, that classrooms or groups of children are regarded as communities of learners where the relationship between adult and child is important, that culture and families play a significant role in education, that children with special learning needs are included, and the importance of meaningful and contextually relevant curriculum is recognized.

The Quality First model reflects both the fundamental beliefs of developmentally appropriate practice and the statement of principles as recommended by the Best Start Expert Panel on Early Learning (see page 7). This table provides a brief description of the activities and expectations associated with each level of the program.

<table>
<thead>
<tr>
<th>Level</th>
<th>All Components of Quality</th>
<th>Environment and Curriculum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foundational Level I 1 year</td>
<td>Introduction to Quality First  • Owner, Operator, all staff, Board members, parents</td>
<td>Introduction to Environment Rating Scales (ITERS-R, ECERS-R, SACERS)  Professional Development Self-Study  • Supervisor and Centre Mentor</td>
</tr>
<tr>
<td>Developmental Level II 1.5 years</td>
<td>Introduction to Reflective Practice  Professional Development  • Supervisor, Centre Mentor, and one staff per room</td>
<td>Scoring Practice:  • Supervisor, Centre Mentor and Quality First consultant or volunteer in a Quality First site or their site</td>
</tr>
<tr>
<td>Progressive Level III Annual</td>
<td>Partners in Quality  Professional Development  • Supervisor, Centre Mentor, and one staff per room</td>
<td>Partners in Quality  Professional Development  • Supervisor, Centre Mentor and all staff  • Submit “results” section of the self-reflection Action Plans</td>
</tr>
</tbody>
</table>

Environment Rating Scales (ITERS-R, ECERS-R, SACERS)  Professional Development  • Supervisor and Centre Mentor  • Self-study package for all staff  • Supervisor and Centre Mentor self score all rooms

Environment Rating Scales  • Update and submit “results” section of initial Action Plans

Environment Rating Scales (ITERS-R, ECERS-R, SACERS)  • 3rd party observation will be done in one of the Infant, Toddler, Preschool or School-age rooms  • Year end expectation “5”
<table>
<thead>
<tr>
<th>Supervision/ Administration</th>
<th>Professionalism</th>
<th>Inclusion</th>
<th>Adult/Child Interactions</th>
<th>Support for ECE students</th>
</tr>
</thead>
</table>
| Supervisor and Centre Mentor Supports: Supervisors Guidebook | Professional Organization Memberships  
- Centre or one staff per room | Introduction to The Inclusion Quality Scale  
Professional Development Self-Study  
- Supervisor and Centre Mentor | No Activity at this Level | College Series Professional Development  
- 1/3 of staff |
| Supervisor and Centre Mentor Supports: Coaching Network | Professional Organization Memberships  
- Centre or one staff per room  
Participation in Professional Development  
- Supervisor and all staff complete two 2 hour P.D. | The Inclusion Quality Scale in Depth  
Professional Development  
- Supervisor and Centre Mentor  
Self-study package for all staff  
Scoring Practice:  
- Supervisor and Quality First consultant or volunteer  
#1,2,4,6,7,9 in all rooms | Caregiver Interaction Scale  
Professional Development  
- Supervisor, Centre Mentor, and one staff per room  
- Self-study package for all staff  
- Supervisor, Centre Mentor, and Quality First consultant or volunteer to complete all staff Caregiver Interaction Scale observations | Student Placement Site Form  
- Complete and submit |
| Supervisor and Centre Mentor Supports: Coaching Network | Professional Organization Memberships  
- Centre or one staff per room  
Participation in Professional Development  
- Supervisor and all staff complete two 2 hour P.D.  
Supervisor to develop a P.D. for all staff | The Inclusion Quality Scale  
- Supervisor and Centre Mentor self score all rooms  
Year end expectation “5”  
Quality Inclusive Education  
- Complete checklist  
- Submit summary | Caregiver Interaction Scale  
- Supervisor and Centre Mentor to complete a minimum of 25% staff observations  
Year end expectation: each staff to achieve 70% | Maintain Placement Site Status |
"You can rest assured that any child care centre who exhibits involvement with the Quality First program is striving for their best!"

(As quoted by a supervisor of a licensed child care centre in Halton participating in Quality First)

In May 2010, a new model of Quality First was launched. Based on the original concepts, tools and feedback the new model restructured the activities of the old program and condensed them into three progressive levels. This section of the report describes the activities and expectations associated with each level of the program.

**Foundational: Level I**

At Level 1, child care centres are introduced to Quality First, including the program levels, model components and tools. An assigned Quality First consultant works closely with each program to define goals and to build knowledge and relationships between the staff, supervisors and the operator. A plan is developed collaboratively and then implemented into the program to support the centre in meeting their goals.

The knowledge and relationship building components of this level include an introduction to Reflective Practice, coaching skills and mentoring. Reflective Practice is a concept and formal process which focuses on helping staff build and maintain competence in their work. Staff review aspects of their practice and determine what worked and what could have been done differently. Supervisors and Centre Mentors then learn about the way relationships are built through coaching exercises meant to facilitate positive interaction. Skill building practices ensure supervisors and staff work together to support each other and the program.

Additionally, supervisors are expected to attend periodic Supervisors Connection meetings, a network for those in managerial positions. In support of the work being completed during Level 1, the THRC’s Supervisors Guidebook is used as a resource for supervisors of licensed child care programs. The guide contains information on operating a child care program, including best practices and support strategies.
care centre, human resources, professional development and training opportunities, as well as information on inclusionary practice. This stage also includes selecting a ‘centre mentor’. This person is elected by staff to help keep momentum going in the program. They also participate in training with the supervisors during the implementation process.

Quality First participants are also introduced to the tools used in the program. Specifically, supervisors and Centre Mentors learn about the Environment Rating Scales and SpecialLinks’ Inclusion Quality Scale. A description of how to use the tools and proper scoring is practiced to encourage and increase familiarity with the various subscales. Comfort and knowledge in utilizing the tools is important during all three levels of the model.

The last component of this level focuses on supporting ECE students who play an important role in the Quality First process. Quality First aims to foster ECEs who understand the core elements of high quality child care environments by including them in the training process. Student placement at Quality First sites offers both short and long-term benefits to both the student ECE and the centre. These benefits include increased knowledge, experience and potential employment.

Developmental: Level II

At this level, program staff, the centre mentor and supervisors attend various professional development events to enhance knowledge and proper use of the tools. In addition to a review of the Level 1 tools, Level 2 introduces materials and tools to support the development of relationships with both the child and family. These include the Partners in Quality resources and the Caregiver Interaction Scale. Staff who attend training are expected to bring back information learned during the workshops and share the knowledge with their team. Taking part in knowledge transfer activities benefits both attendee and the team, as the process helps to solidify new knowledge and increase uptake. Centre staff also continue focusing on using Reflective Practice in their everyday work.

The role of the Quality First consultant during this phase is to support the supervisor and staff in their learning. Consultants work closely with program supervisors to develop a professional development plan for each individual staff in the centre. This plan is adopted by the centre and integrated directly into their program and work. By the end of this level, the entire centre should be knowledgeable and experienced in setting program goals, using tools to assist in the development of those goals, and be working with ECE students from a local community college.

Progressive: Level III

The Progressive stage is to be repeated annually by participating Quality First programs. Centres who reach this level participate in an annual process that strives to sustain levels of centre quality and continue to accurately use the tools. In order to advance to this level, participants must first submit documentation to their Quality First consultant who considers it for criteria completion. Centres must demonstrate an ability to maintain the level of quality which has been achieved as participants of the program.

Centres must also maintain College Placement Site status and demonstrate an ability to meet the expectations of participating post-secondary early childhood education programs. Centre staff continue to attend Quality First professional development workshops that focuses on working with student placements, in order to maximize the work placement and experience.

A support network for staff is built by attending professional development events on a continuous basis and by liaising with staff from other centres. Centres who actively operate at the Progressive level achieve the status of a supporting site. They become fully operating centres that are recognized as demonstration sites for others to visit and observe examples of Quality First levels.
Map: Child Care Centres Participating in Quality First (2010)
For easier understanding of the performance of the Quality First Initiative, the evaluation focuses on three performance results which represent the main goals of Quality First. The results are:

1. Early childhood educators and centre staff are engaged quality practitioners
2. Quality First centres promote healthy child development through quality environments
3. Quality First positively impacts Halton’s child care system

In order to evaluate the performance of Quality First, three questions are asked for each of three performance results:

1. How much did we do?
2. How well did we do it?
3. Is anyone better off?
## PERFORMANCE RESULTS & MEASURES

### Early Childhood Educators (ECEs) and Centre Staff are Engaged Quality Practitioners

**Perfromance Measures**

<table>
<thead>
<tr>
<th>Performance Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Child Interactions</td>
</tr>
<tr>
<td>Knowledge Building</td>
</tr>
<tr>
<td>Commitment to Quality First</td>
</tr>
</tbody>
</table>

ECEs and centre staff that are actively involved in planning, practicing, and gaining deeper understanding about early childhood practices support young children’s early development and readiness to learn.

### Quality First Centres Promote Healthy Child Development through Quality Environments

**Performance Measures**

<table>
<thead>
<tr>
<th>Performance Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Quality of the Child Care Environment</td>
</tr>
<tr>
<td>Quality of the Physical Environment</td>
</tr>
<tr>
<td>Quality of Personal Care of Children</td>
</tr>
<tr>
<td>Quality of Communications with Children</td>
</tr>
<tr>
<td>Quality of Activities for Children</td>
</tr>
<tr>
<td>Quality of Opportunities to Build Relationships</td>
</tr>
<tr>
<td>Quality of the Program Structure</td>
</tr>
<tr>
<td>Quality of Support for Parents and Staff</td>
</tr>
<tr>
<td>Quality of Inclusion for Children with Special Needs</td>
</tr>
</tbody>
</table>

High quality child care programs have the capacity to provide opportunities for learning and social interaction in a safe, engaging and stimulating environment through which all children can thrive.

### Quality First Positively Impacts Halton’s Child Care System

**Performance Measures**

<table>
<thead>
<tr>
<th>Performance Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Positive Impact on the Child Care System</td>
</tr>
<tr>
<td>Common Language for Quality Child Care</td>
</tr>
<tr>
<td>Common Understanding of Quality Child Care</td>
</tr>
<tr>
<td>Positive Interactions Between Child Service Agencies and</td>
</tr>
<tr>
<td>Child Care Centres</td>
</tr>
<tr>
<td>Ease of Service Delivery</td>
</tr>
</tbody>
</table>

Quality child care centres enrich experiences that foster the development of abilities and skills. They provide training and facilitate networking between providers to boost centre quality levels.
Result: Early Childhood Educators and Centre Staff are Engaged Quality Practitioners.

Early childhood is a period of significant milestones in mental, physical, emotional and social development. A growing body of research tells us that what children learn and experience in the first five years of life can make an impact that lasts a lifetime. The World Health Organization (WHO) believes that ongoing warm relationships between adult/caregiver and a young child are as crucial to the child’s survival and healthy development as food, stimulation and discipline.

About this Performance Result

In child care environments, early childhood educators work with infants, toddlers, preschool, and school-aged children in a variety of settings. Responding to children’s physical, emotional and social health needs is an integral part of the early childhood educator’s everyday responsibilities. They help to design high quality care and learning environments that promote healthy growth for young children and encourage developmental progress. Ultimately, educators become more alert and responsive to the needs of young children when they are active and engaged in their care and learning. In addition, many researchers support the suggestion that education focused specifically on child development and early childhood education improves the performance of child care providers (Friendly & Beach, 2005; Canadian Council on Learning, 2006).
How Do We Know We Are Making a Difference?

In order to evaluate Quality First’s effectiveness at engaging and improving the quality of ECEs, three measures were used.

1. **Positive Child Interactions:** The ability of ECEs to positively interact with children is one of the most important indicators of quality child care. To measure the ECEs interaction skills the Caregiver Interaction Scale was completed by trained Quality First staff at the start of their participation in Quality First and then repeated up to three more times.

2. **Knowledge Building:** Two of the most important things ECEs do as professionals is maintain their AECEO Certification and participate in ongoing professional development opportunities. Knowledgeable ECEs are more able to make appropriate judgements and adaptations. They are better equipped to recognize a child’s aptitudes, teach them new skills, and monitor as well as respond to a child’s cues, movements and expressions. In order to evaluate the extent to which the ECEs participating in Quality First are actively building knowledge, participation in training and self-report of improvements in knowledge were tracked throughout the various phases of Quality First.

3. **Commitment to Quality First:** By participating in Quality First, educators and caregivers become committed to achieving a gold standard for high quality care in Halton’s child care system. In order to achieve the maximum commitment to quality child care, it is important that ECEs are fully and actively participating in the training provided by Quality First. Based on this, Quality First evaluated ECEs engagement in improving the standards of quality child care in Halton by tracking how many of the ECE participants completed 100% of the Quality First training.

### Table 1:

<table>
<thead>
<tr>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How Much Did We Do?</strong></td>
<td></td>
</tr>
<tr>
<td>1,127 ECEs and centre staff are participating in Quality First (QF)</td>
<td></td>
</tr>
<tr>
<td>446 Hours of training provided to ECEs/staff</td>
<td></td>
</tr>
<tr>
<td>21 Unique training programs have been developed by QF staff</td>
<td></td>
</tr>
<tr>
<td>223 Professional development events have been offered to ECEs and centre staff</td>
<td></td>
</tr>
<tr>
<td>3,255 ECE/staff attendance at QF professional development training events</td>
<td></td>
</tr>
<tr>
<td>3,255 Training manuals and resources provided to workshop participants</td>
<td></td>
</tr>
</tbody>
</table>

### Table 2:

<table>
<thead>
<tr>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How Well Did We Do It?</strong></td>
<td></td>
</tr>
<tr>
<td>100% ECEs/staff strongly agree or agree that they felt comfortable accessing supports from QF staff (100% strongly agree)</td>
<td></td>
</tr>
<tr>
<td>87% ECEs/staff rated the QF workshop a 5 out of 5</td>
<td></td>
</tr>
<tr>
<td>97% ECEs/staff strongly agree or agree that the activities provided in the QF workshops helped in understanding the content more thoroughly (47% strongly agree)</td>
<td></td>
</tr>
<tr>
<td>100% ECEs/staff strongly agree or agree that they felt supported by QF staff (72% strongly agree)</td>
<td></td>
</tr>
</tbody>
</table>

### Table 3:

<table>
<thead>
<tr>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Is Anyone Better off?</strong></td>
<td></td>
</tr>
<tr>
<td>97% ECEs/staff strongly agree or agree that QF workshops increased their knowledge and awareness (47% strongly agree)</td>
<td></td>
</tr>
<tr>
<td>100% ECEs/staff meeting the minimum standard score for quality interactions by final assessment</td>
<td></td>
</tr>
<tr>
<td>100% ECEs/staff completed 100% of QF training</td>
<td></td>
</tr>
</tbody>
</table>
A program quality manager of a licensed child care and school-age program in Georgetown wrote to us to say, “What is quality child care? It is the reason we (ECEs) got into this profession. We want to make a positive impact on young children’s lives. Sometimes leading the busy life of an ECE teacher or supervisor this focus can be placed on the back-burner or completely lost. The Quality First Program helped our centre get back on track and back to those ideals. Although basic in theory, Quality First is a powerful program that encourages and empowers the whole child care centre to come together and strive for quality in every interaction, choice and attitude we adopt.

Quality First is about focusing on the positives, making enhancements and setting realistic and practical goals for the program. Every little thing we do adds to our centre’s quality. We are passionate about quality child care and know we are making a difference in the families we serve.”

A program supervisor of a licensed child care centre in Oakville, Ontario said, “Since starting the program back in May 2007, my staff and I have benefited a lot from the workshops and tools implemented. It showed us the bigger picture, all the strengths and weaknesses in the centre. I know that my staff have benefited greatly by learning the ECERS/ITERS, IPPS and CIS tools and have gained confidence by realizing their strengths and skills. I have gained so much knowledge about inclusion! We all strive to be inclusive centres and this is a wonderful program to help you to do so.

Quality First is fantastic and I strongly recommend it to other centres. Both the program staff and volunteers are very helpful and consistent! We look forward to implementing this program into the rest of the classrooms in the centre.”
THE VALUE OF EARLY CHILDHOOD EDUCATORS

A letter from a supervisor at a child care centre participating in Quality First and member of the Association for Early Childhood Educators of Ontario (AECEO), Halton Branch

“This past year has brought some great changes to our early childhood profession as well as recognition to our practices. On a provincial level, the College of Early Childhood Educators has been created and although separate, the AECEO will continue on in their role as an advocate for early childhood educators.

In Halton, we have received huge interest and participation in the Quality First initiative. A wonderful program that enables child care centres and empowers ECEs and centre staff to achieve their full potential. That being said, I believe that it is important that we as ECEs continue to voice how important we are in our community.

I would like to send congratulations to the centres that have chosen to take part in Quality First. You are not only supporting the children in these programs but you are also supporting and providing opportunity to ECEs in Halton.”
The program supervisor of a licensed child care centre in one of our Halton neighbourhoods took the time to write to us and say, “The centre-based model is a fantastic way of getting all the rooms on board at the same time, so that Quality First is happening throughout the entire school. The supervisors and staff at the centre see a difference in the Quality First rooms versus the non-participating rooms in the previous model. The new model is very hands on, requires a lot less paper work, and provides more time to focus on goals. As a result, we have more time to achieve our goals.”

An ECE in a Quality First Centre says, “The self-study components of Quality First have been positively received by both supervisors and staff involved. It is viewed as a valuable resource for new staff and a refresher for all staff. It is well written, easy to use, and helps reduce the time spent attending training sessions or commitment to attending evening workshops after a long day of work. Staff believe that they will retain the information better by reviewing material at their own convenience and pace.”

A director of a licensed child care centre in Halton Hills, Ontario wrote to us to say, “Volunteering with Quality First has been both an informative and valuable learning experience. It has also provided me with excellent networking opportunities. Being able to spend time in other programs has helped me to develop ideas and plan goals for my own program. Being a part of Quality First has been very rewarding, so much that I have encouraged other staff at my centre to become involved as a volunteer as well!”

IS ANYONE BETTER OFF?

“Quality First has trained us to apply a variety of current helpful tools and has allowed us to participate in supportive educational workshops. Since we started, I have seen major improvements in the care and programs our centre provides daily.”

(As quoted by a supervisor of a licensed child care centre participating in Quality First)
“Knowledge and concepts of best practice constantly change. Staff need to be enabled and encouraged to engage in professional development in order to keep current.”
(The Halton Resource Connection)

Detailed Findings

Positive Interaction: The maximum score an ECE can receive on the Caregiver Interaction Scale is 53 and the minimum acceptable score is 37 or 70% of the maximum score of 53. The results show that ECEs score very high on this scale and all ECEs participating in the Quality First Initiative were meeting the minimum standards for positive interactions at the onset of their participation. There is little to no improvement in interaction scores as ECEs move through the phases of Quality First. This lack of improvement in scores can be explained by the already very high scores at the beginning of their enrolment – meaning there is very little room for improvement using this scale.

Figure 1.

Average Caregiver Interaction Scores
(Maximum score = 53)

About this Performance Result

High quality child care programs have the capacity to provide all children with excellent learning environments to optimize physical, cognitive, social, and emotional development. This is supported by both longitudinal research findings on the effects of early education on children, and by emerging research on the influence of the environment on brain development (architecture) in young children (Best Start Expert Panel, 2006; Shonkoff, 2009). This performance result focuses on aspects of the child care environment that are known to be related to quality child care.

How Do We Know We are Making a Difference?

In order to measure improvements in the quality of the child care environment, a number of validated measures were used. (See detailed description of measures on pages 13-15). Each centre was assessed with these measures at the start of their participation and then repeated up to three more times. In addition to these centres, seven classrooms that were not participating in Quality First were included in the assessments. The non-participating centres were used as “control” centres to allow us to measure progress and make comparisons between Quality First classrooms and classrooms not actively engaged in a quality improvement process. It was expected that these control centres would show little to no improvement in their assessment scores.

Table 4 shows the number of assessments completed at each phase of Quality First and the average number of days between assessments.
Assessments were completed by specially trained Quality First staff during the first two phases of Quality First training. Centres were then responsible for completing self-assessments during Phase 3 and Maintenance. The four measures used include:

1. **Infant/Toddler Environment Rating Scale – revised (ITERS-R):** Measures the quality of infant and toddler child care environments

2. **Early Childhood Environment Rating Scale – revised (ECERS-R):** Measures the quality of early childhood environments for preschool through to kindergarten programs (2½ - 5 years)

3. **School-Age Care Environment Rating Scale (SACERS):** Measures the quality of school-age child care environments

4. **Inclusion Quality Scale (IQS):** IQS is an effective, reliable and user-friendly tool which assesses inclusion quality in early childhood centres. It examines the extent to which physical and human resources are in place and parents, staff and external professionals work together to ensure that each child’s individual needs are met within an early learning program.

### Table 4.

<table>
<thead>
<tr>
<th>Number of Assessments and Time Between Assessments</th>
<th>Quality First Phase</th>
<th>Number of Assessments</th>
<th>Average Number of Days Between Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Phase 1 to Phase 2</td>
<td>82</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>Phase 2 to Phase 3</td>
<td>55</td>
<td>315</td>
</tr>
<tr>
<td></td>
<td>Phase 3 to Maintenance</td>
<td>20</td>
<td>342</td>
</tr>
</tbody>
</table>

### Table 5.

<table>
<thead>
<tr>
<th>How Much Did we Do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>120 Centres enrolled in Quality First (September 2010)</td>
</tr>
<tr>
<td>67 Unique operators enrolled in Quality First</td>
</tr>
<tr>
<td>7,642 Total child care spaces participating in Quality First</td>
</tr>
</tbody>
</table>

### Table 6.

<table>
<thead>
<tr>
<th>How well did we do it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% ECEs/staff strongly agree or agree that the consultants/volunteers were knowledgeable about the assessment tools (72% strongly agree)</td>
</tr>
<tr>
<td>100% ECEs/staff strongly agree or agree that the consultants/volunteers provide feedback in a supportive way (67% strongly agree)</td>
</tr>
<tr>
<td>100% ECEs/staff strongly agree or agree that the consultants/volunteers provide follow-up in a timely manner (72% strongly agree)</td>
</tr>
</tbody>
</table>

### Table 7.

<table>
<thead>
<tr>
<th>Is anyone better off?</th>
</tr>
</thead>
<tbody>
<tr>
<td>22% Increase in the overall quality of the child care environment</td>
</tr>
<tr>
<td>19% Increase in the quality of space and furnishings</td>
</tr>
<tr>
<td>30% Increase in the quality of personal care routines</td>
</tr>
<tr>
<td>36% Increase in the quality of language-reasoning communication</td>
</tr>
<tr>
<td>42% Increase in the quality of activities for children</td>
</tr>
<tr>
<td>17% Increase in the quality of staff-child and child-child interactions</td>
</tr>
<tr>
<td>16% Increase in the quality of the centre’s program structure</td>
</tr>
<tr>
<td>8% Increase in the quality of support to parents and staff</td>
</tr>
<tr>
<td>49% Increase in the principles of inclusion of parents and staff</td>
</tr>
<tr>
<td>29% Increase in practices related to inclusion of children with special needs</td>
</tr>
<tr>
<td>100% ECEs/staff strongly agree or agree that the ECERS tool helped them identify areas for improvement (72% strongly agree)</td>
</tr>
<tr>
<td>100% ECEs/staff strongly agree or agree that their ECERS action plan resulted in changes in at least one of the identified areas (67% strongly agree)</td>
</tr>
</tbody>
</table>
A centre was reluctant to participate in the Quality First program. The supervisor and staff were all hesitant to join because they worried that the work involved would be too time consuming. They were also not convinced that the older ‘room-based’ model in Quality First could have an impact on their large centre. Reluctantly, they signed up one of their preschool classrooms.

By Phase Two, the supervisor started to see differences in that classroom in every aspect of their preschool program. Teachers were making appropriate modifications to their program using the tools taught to them in Quality First. Examples of these changes ranged from effectively using their planning time, to ordering materials and equipment that would enhance and better all their children’s learning experiences.

When the school learned that the new Quality First model would now be centre based, they were thrilled. They had such success with their Preschool room that they now look forward to the impact Quality First will have on their entire school!"
Dear Quality First,

“Our centre has completed Quality First in our preschool program and is now undergoing the maintenance phase of the program. Quality First is an excellent way to motivate your staff to achieve quality child care within your centre. It helped us open our eyes to the important practices that make us more resourceful and involved in the community.

Quality First not only improves your classroom environment but also staff training and awareness. It educates you to improve in all areas of the program such as inclusion, coaching and training for supervisors, programming, positive caregiver interactions, the environment and customer service. The Quality First team is very supportive and made it very easy and stress free for us to go the distance and become successful.

Quality First has educated us to become more supportive within the centre of the needs of the children, as well as their parents. It has enhanced many of our policies, practices and procedures for the best. Quality First is certainly a beneficial tool for child care centres.”

(As quoted by a supervisor of a licensed child care centre participating in Quality First)

The director and owner of a licensed child care centre in Milton, Ontario took the time to write to us and say, “We have noticed a great change in our center since we have started the Quality First. We have a better understanding regarding classroom set-up through the use of tools like ECERS-R. The teachers and staff are able to analyze and scan the room for different areas that need enhancement. Overall it has been a great experience in guiding the staff to further extend their classroom.”

A supervisor of a licensed child care centre in Burlington, Ontario wrote to us to say, “The Infant Program in our child care has just completed the first phase of Quality First and our experiences have been absolutely wonderful. The training that has been provided to our staff has been helpful, informative and inspiring. Staff and parents have noticed a difference in our program, not just in the physical environment but have seen a positive difference in the children's behaviour. The Quality First consultants and volunteers are very knowledgeable and friendly. They have answered my questions in a timely way and have offered great support throughout the process. Our toddler and preschool teachers can’t wait to start their process in Quality First. We are so happy that we joined and are excited to continue the process.”

A supervisor of a licensed child care centre in Georgetown, Ontario wrote to us to say, “Quality First training is motivating, great for networking and coming together as a powerful profession. The Quality First tools and professional development workshops provide a clear vision of what quality child care is. The program has made a positive impact on our centre, parents, community, other professionals and most importantly the children. We are a Quality First child care centre!”
"Results from a number of studies demonstrate that child care quality matters. In fact, the importance of child care quality is one of the most robust findings in developmental psychology."

(McKartney, 2004; Centre of Excellence for Early Childhood Development)

**Detailed Findings**

**Overall Quality of the Child Care Environment:** The ECERS-R/ITERS-R/SACERS were used to assess overall centre quality. Quality First assists participating centres to obtain at least a score of five by the end of Phase 3 (seven is the maximum score). Figure 2 shows the average score at entry into Quality First was 5.1, meaning centres were already performing at the minimum standards prior to beginning. While centres showed high scores at entry, there was still significant growth in the centres throughout their training. This improvement was not found in the control centres suggesting Quality First did impact on the quality conditions of the centres.

Figure 2.

![Average ECERS-R Total Scores](image)

Further analyses of the ECERS-R scores show that 36% of the centres were assessed with a score below five at entry into Quality First – see Figure 3. However, by the time the centres reach the final maintenance phases of Quality First, mostly all centres are scoring at least at the minimum standards for quality (five).

Figure 3.

![Percentage of Centres not Meeting the Minimum Quality Standards (ECERS-R=5 or Higher)](image)
Quality of the Physical Environment (Space and Furnishings): The eight items under this subscale include indoor space, furniture and routine care, play and learning, furnishings for relaxation and comfort, room arrangement for play, space for privacy, child-related displays, space for gross motor play and gross motor equipment. Some examples of what is evaluated under this subscale include having sufficient/ample space to function adequately and the presence of sound-absorbing materials in the classroom being observed. The classroom should also be “reasonably clean” and show signs of daily maintenance. Furnishing for play and not just routine care furnishings are scored in this section. As well, in assessing space for gross motor play, both outdoor and indoor play areas are included. In order for the indoor space to be considered minimally acceptable, it must be accessible to children and adults with disabilities who are currently a part of the program (Harms, Clifford & Cryer, 2005).

Figure 4 shows significant improvement in the space and furnishing scores for Quality First centres. At the start of the program, 33% of centres were not reaching the minimum standard score of five, but by the final assessment only 5% of those centres were not reaching the minimum score.

Quality of Personal Care of Children: The six items under this subscale include greeting/departing, meals/snacks, nap/rest, toileting/diapering, and health and safety practices. Examples of evaluated practices under this subscale include children being acknowledged by staff upon entering the classroom and being greeted warmly. Additionally, that nutritionally adequate meals and snacks are served within an acceptable timeframe and sanitary conditions are complied with and maintained following diapering/toileting use, blood handling or bodily fluid spills. Also in this subscale, all observable major indoor and outdoor hazards are recorded as safety problems.

Figure 5 shows large improvements in this scale score. Centres go from an average of 4.6 at the start of Quality First and improve their scores to an average of 6.4. This represents a 39% improvement in scores over 12 months of participation in Quality First. In terms of reaching the minimum standard score for this scale, about 56% of the Quality First centres start below the minimum score of five. By the final assessment this number drops to 15% for centres still scoring below five.

Figure 4.

Figure 5.
"The preschool program at this school has been through three phases of training with Quality First and it has been one of the best decisions I made on this job."

(As quoted by a director of a school providing preschool programming in Halton and participating in Quality First)

**Quality of Communications with Children (Language & Reasoning):**
The four items under this subscale include books and pictures, encouraging children to communicate, using language to develop reasoning skills, and informal use of language. Examples of evaluated practices under this subscale include having a wide selection of books accessible to children as well as examples of additional language materials such as posters and picture card games. The program should include suitable activities for children speaking a different primary language or for those requiring alternative communication methods, such as signing. Also, activities by staff should encourage children to communicate and include concepts of matching, classifying, sequencing, and spatial or cause and effect relationships.

Figure 6 shows significant improvement in language-reasoning scores for Quality First centres. On average, centres begin the program at a score of 4.7 but increase their scores substantially to 6.4. This represents a 36% improvement in average scores. Further analysis shows 51% of centres entered into the Quality First initiative with an average score of less than five on this scale. By the final assessment, only 10% were still scoring under the minimum standard score of five.

**Figure 6.**

*Average ECERS-R Scores Over Time*

**Language-Reasoning (Maximum Score = 7)**
**Quality of Activities for Children:** The ten items under this subscale include fine motor, art, music/movement, blocks, sand/water, dramatic play, nature/science, math/number, use of TV, video, and/or computers, and promoting acceptance of diversity. Some examples of what is evaluated under this subscale include the availability of various types of fine motor and artist materials (crayons, puzzles, etc.) and the condition of those materials (missing or broken pieces). Examples of music materials that are accessible to the children in the classroom are also scored. Additionally, incorporating dramatic play or make-believe as well as having open-ended nature/science activities that children can explore in their own way are considered in this category. Diversity in materials, specifically obvious examples of racial and cultural differences is also assessed in the classroom.

Figure 7 shows that significant gains were made in the quality of activities provided by Quality First centres. Seventy-eight percent of participating centres were not meeting the minimum standard score on this scale at the start of training which compares to only 5% by the final assessment.

**Quality of Opportunities to Build Relationships (Interaction):** The two items under this subscale include staff-child interactions and interactions among children. Examples of evaluated behaviours under this subscale include nature of reaction, response to a child’s feelings and appropriateness of actions. Programs are evaluated for the use of any activities that encourage children to work together.

Figure 8 shows that participating centres already have high scores on this scale on entry into the program but still show significant improvement throughout their involvement in Quality First.
"Quality First has broadened my understanding of quality and inclusion. It has also provided greater learning opportunities for myself, my staff and the children at our centre."

(As quoted by a supervisor of a licensed child care centre in Halton participating in Quality First)

**Quality of the Program Structure:** The four items under this subscale include schedule, free play, group time, and provisions for children with disabilities. An example of evaluated practices includes the existence of a basic daily schedule that is familiar to children (routines and activities occur in relatively the same sequence most days) and which is posted in the classroom (Friendly, Doherty & Beach, 2006). Other examples assessed under this subscale include indoor and outdoor play periods, opportunities to engage in free play under supervision, and time allotted for large or whole group activities. If applicable, attempts to meet children’s special needs including minor modifications to the program or classroom are scored.

Figure 9 shows that although Quality First centres were scoring high on this scale at entry, they were still able to show improvements throughout their training.

**Figure 9.**

![Average ECERS-R Scores Over Time](image-url)

*Program Structure (Maximum Score = 7)*

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Phase 3</th>
<th>Maintenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality First Centres</td>
<td>4.7</td>
<td>6.0</td>
<td>6.3</td>
</tr>
<tr>
<td>Control Centres</td>
<td>4.6</td>
<td>4.7</td>
<td>4.3</td>
</tr>
</tbody>
</table>
Quality of Support for Parents and Staff: The six items under this subscale include provisions for parents, personal needs of staff, and professional needs of staff. Additionally, staff interaction and cooperation, supervision and evaluation of staff, and opportunities for professional growth are included. This subscale looks at practices concerning written communication between the program and parents, parent engagement, meeting staff needs, adequate office space, fair treatment, interpersonal interactions among staff, and any in-service training courses provided to staff or the availability of current learning materials and classic books. In addition, whether or not the program organizes regular meetings and events that encourage other staff and/or parents to participate in together is considered.

Figure 10 shows that Quality First centres were able to improve their scores significantly throughout their participation. Twenty-two percent of the centres were not meeting the minimum standard score of five at entry which drops significantly to 5% at the final assessment.

Quality of Inclusion for Children with Special Needs: The scale produces two sub-scales, one which reflects the positive philosophy of inclusion and the other which reflects practices that promote inclusion. The scale is scored so that the maximum score is seven and the minimum standard score is five.

Figure 11 shows that centres score higher on the Principles of inclusion as compared to their Practices related to inclusion. This is true throughout their involvement in Quality First. For both the Principles and Practices scale, there is significant improvement in scores. The Practices score rises from 3.8 to 4.9 which is a 29% improvement in scores. Meanwhile, the Principles score rises from 4.3 to 6.4 which is a 49% improvement in scores.

Figure 11.
Result: Quality First positively impacts Halton’s child care system. Child care is undoubtedly a major influence in the way many Canadian children live, grow and learn. That is why it is essential for children to experience high-quality child care in any type of child care setting.

About this Performance Result

One of the key outcomes of the Quality First initiative was to have a positive impact on Halton’s child care system. Ideally, the child care system in Halton should be better off because there is a quality initiative in place.

How Do We Know We are Making a Difference?

In order to measure the positive impacts of Quality First on Halton’s child care system, five performance measures were developed. These performance measures include:

1. **Overall Positive Impact on the Child Care System:** This measure is an attempt to provide an overall impression of the positive impact of Quality First on the child care system.

2. **Common Language for Quality Child Care:** The use of a common language combined with other good communication practices can increase understanding between individuals and influence interactions overall. One of the barriers in improving the quality of the child care system in Halton was that the system was void of a common language in which to communicate effectively to and between service providers. One of the main outcomes of Quality First was to create a common language to help overcome this barrier.
3. **Common Understanding of Quality Child Care**: A key outcome of the Quality First initiative was to create a common understanding on what is meant by quality child care. Quality First has engaged in numerous activities to create a common understanding so this measure will attempt to evaluate the success of those activities.

4. **Positive Interactions between Child Service Agencies and Child Care Centres**: Creating a common language and understanding for quality child care allows for enriched interactions between service agencies and child care centres. These interactions are not always as good as they can be. With a common language and understanding, the quality of these interactions can be improved. This measure is an attempt to evaluate if the quality of these interactions has improved since the implementation of Quality First.

5. **Ease of Service Delivery**: Another great advantage of having both a common language and common understanding is the noticeable improvement of service delivery by other service providers within the child care centres. This measure is an attempt to evaluate if Quality First has made it easier to deliver services within child care centres that are actively involved in the Quality First initiative.

In order to gather information on these five performance measures, the Quality First advisory group was surveyed. The advisory group consists of key Halton service providers representative of services supporting our child care system. The survey asked respondents to self-report their perceptions of how well Quality First has done in achieving these five key improvements to the child care system. All twenty members of the advisory group completed the survey for a response rate of 100 percent.

<table>
<thead>
<tr>
<th>Table 8. How much Did we Do?</th>
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<tbody>
<tr>
<td>298,593 Quality First newspaper inserts distributed to homes in Halton</td>
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<tr>
<td>34 Quality First community displays</td>
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<tr>
<td>128 Quality First presentations made in the community</td>
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<tr>
<td>16 Partnerships between Quality First and other organizations</td>
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<tr>
<th>Table 9. How Well Did we Do It?</th>
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<tbody>
<tr>
<td>80% Report newspaper inserts were easy to understand</td>
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<td>100% Report newspaper inserts were informative</td>
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<tr>
<th>Table 10. Is Anyone Better off?</th>
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<tbody>
<tr>
<td>100% Key stakeholders report that Quality First has had a positive impact on the child care system (35% strongly agree)</td>
</tr>
<tr>
<td>85% Key stakeholders report that Quality First has created a common language for quality child care (30% strongly agree)</td>
</tr>
<tr>
<td>95% Key stakeholders agree that Quality First has created a common understanding of quality child care (30% strongly agree)</td>
</tr>
<tr>
<td>63% Key stakeholders agree that Quality First has helped to develop more positive interactions between service agencies and child care centres (12% strongly agree)</td>
</tr>
<tr>
<td>79% Key stakeholders agree that Quality First has made it easier to deliver external services in child care centres and to child care centres (16% strongly agree)</td>
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</table>
"Some of the recommendations by Quality First are similar to mine as a resource consultant. This similarity reinforces and increases the likelihood that certain strategies I provide will be implemented by the child care centre."

(As quoted by a Halton Region resource consultant)
“In 2004 I had the opportunity to volunteer with Quality First as a Resource Consultant with Community Living Burlington. They were looking for consultants to support SpeciaLink’s Inclusive Quality Scales as part of their pilot project (formerly Inclusive Principles and Practices Scales) and for consultants to provide feedback. The pilot was a success and once the full project launched in 2005, I continued to volunteer with the program.

I assisted with the training of new volunteers, facilitated workshops and helped to conduct IQS observations in participating Quality First rooms. The change that I witnessed in the community was amazing. Centres that were once struggling with inclusive practices or afraid to enrol children with special needs, embraced the children in their program and were open to try new things. I was so inspired by this change and by being able to reach out to so many centres that I applied to be a full time consultant with Quality First.

I am very passionate about inclusion and believe that all children, regardless of their ability, should be able to access quality child care. I continue to work with centres, increasing their knowledge of inclusion and continue to be amazed by what I see. Quality First has made such a huge impact on our community. I am thrilled and privileged to be a part of such an amazing program.”

IS ANYONE BETTER OFF?

A story from a resource consultant and Quality First volunteer

Together We Make Quality Happen
The purpose of this evaluation is to show the impact of Quality First on ECEs, child care environments and the child care system in Halton. There is strong evidence to show that Quality First has had significant impacts in all of these areas. ECEs are reporting significant improvements in knowledge and practices through their participation in Quality First. Child care centres have demonstrated significant improvements in key measures of quality. Key stakeholders of the child care system are reporting positive gains for the child care system since the implementation of Quality First. The next step will be to review the findings presented in this report with partners and key stakeholders to develop recommendations and strategies for improvement.
REFERENCES


