Infants and Children: Acute Management of the Unsettled and Crying Infant

Summary This guideline presents the current best evidence for acute management of the unsettled and crying infant. The guideline is primarily targeted to clinicians caring for infants and managing any task related to the unsettled and crying infant.

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INFANTS AND CHILDREN: ACUTE MANAGEMENT
OF THE UNSETTLED AND CRYING INFANT

PURPOSE
The Infants and Children: Acute Management of the Unsettled and Crying Infant 1st Edition Clinical Practice Guideline provides direction to clinicians and is aimed at achieving the best possible paediatric care in all parts of the state. The Clinical Practice Guideline was prepared for the NSW Ministry of Health by an expert clinical reference group under the auspice of The Office of Kids and Families.

KEY PRINCIPLES
This guideline is primarily targeted to clinicians caring for infants and managing any task related to the unsettled and crying infant. It requires the Chief Executives of all Local Health Districts and Specialty Health Networks to determine where local adaptations are required or whether it can be adopted in its current Clinical Practice Guideline format in all hospitals and facilities required to manage unsettled and crying infants.

The clinical practice guideline reflects what is currently regarded as a safe and appropriate approach to the management of unsettled and crying infants. However, as in any clinical situation there may be factors which cannot be covered by a single set of guidelines. This document should be used as a guide, rather than as a complete authoritative statement of procedures to be followed in respect of each individual presentation. It does not replace the need for the application of clinical judgement to each individual presentation.

USE OF THE GUIDELINE
Chief Executives must ensure:

- This guideline is adopted or local protocols are developed based on the Infants and Children: Acute Management of the Unsettled and Crying Infant 1st Edition Clinical Practice Guideline
- Local protocols are in place in all hospitals and facilities likely to be required to manage unsettled and crying infants
- Ensure that all staff treating infants and children are educated in the use of locally developed protocols for infants and children.

Directors of Clinical Governance are required to inform relevant clinical staff treating paediatric patients of this new guideline.

REVISION HISTORY

<table>
<thead>
<tr>
<th>Version</th>
<th>Approved by</th>
<th>Amendment notes</th>
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<tr>
<td>March 2016</td>
<td>Deputy Secretary, Strategy and Resources</td>
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ATTACHMENT

Infants and Children: Acute Management of the Unsettled and Crying Infant 1st Edition

Issue date: March-2016
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1 PURPOSE

This guideline is aimed at achieving the best possible care in NSW. This guideline presents the current best evidence for acute management of the unsettled and crying infant. Its purpose is to inform practice for Australian health care providers.

The document should not be seen as a stringent set of rules to be applied without the clinical input and discretion of the managing professionals. Each patient should be individually evaluated and a decision made as to appropriate management in order to achieve the best clinical outcome.

This guideline is primarily targeted to clinicians caring for infants and managing any task related to the unsettled and crying infant.

The systematic review underpinning this guideline was completed in 2012. The guideline was developed between June 2012 and November 2015. State wide consultation occurred during October and November 2013. It is recommended that the literature is revisited and this document is reviewed in 2020.

This guideline was developed by a representative group of NSW clinicians with expertise in acute and community paediatric care.

No conflict of interest was identified.

In the interests of patient care it is critical that contemporaneous, accurate and complete documentation is maintained during the course of patient management from arrival to discharge.

Respecting the difference – be aware of cultural differences of Aboriginal people. Refer to your local Aboriginal liaison officer or for further information see NSW Health Communicating positively – A guide to appropriate Aboriginal terminology.

Parental anxiety should not be discounted: it is often of significance even if the child does not appear especially unwell.

2 SUMMARY

Young infants in their first few months of life frequently present with crying and unsettled behaviour as their primary problem.¹

In the majority of these cases, parents present with their infants to their GP or community health centres and are successfully managed in an outpatient setting. However some parents have difficulties accessing the help they need to manage problem crying in their infants and resort to the use of multiple services, including emergency departments.²

While excessive and problematic crying can occur in otherwise healthy young infants, a crying and unsettled baby may also have a more serious underlying organic problem. Distinguishing between the two, however, may not be straightforward as symptoms and signs of organic disease in young infants can be non-specific.

Despite the frequency of these presentations, there are currently no guidelines to assist clinicians working in emergency departments (ED) in management of infants presenting with excessive crying. Great variation exists in practice across clinical sites and between
clinicians. Overly aggressive pharmacological treatment may cause harm as can failing to investigate and manage organic disease that is causing crying behaviours in an infant. Advice provided to parents on how to manage excessive crying in otherwise healthy infants tends to vary and parents report feeling frustrated when given conflicting advice.\(^2\)

Many psychosocial factors can impact on infant crying and it is important in the assessment of the infant to include assessment of the parent-infant relationship and factors such as parental disharmony, fatigue, anxiety, depression, financial stressors, lack of intergenerational support and isolation.

Additionally, managing parental anxiety, assessing parents’ ability to cope with the unsettled infant, and excluding child protection concerns in the at risk infant can be challenging for clinicians working in a busy ED. While the importance of community follow-up is well recognised, arranging appropriate discharge plans for families can be a challenge for clinicians not familiar with resources in the community. Efforts must be made to ensure that follow up occurs with primary care or ambulatory care practitioners within 48 hours of discharge from the emergency department.

This clinical practice guideline (CPG) will offer a structured approach for the assessment of infants who present with excessive crying and unsettled behaviours and provide a framework for the management of common causes of excessive crying in this age group. Advice on discharge planning and follow up plans for well infants with crying and settling problems will be discussed.

2.1 Family centred care

When a child is sick or their wellbeing is compromised the whole family is affected. Similarly, the family context, structure, culture and circumstances will affect the sick child. Best practice recommends that all staff working with a child presenting to hospital for care use a family centred care approach.

Key aspects of family centred care are\(^3\)

- Recognising the family as a constant in the child’s life
- Facilitating parent-professional collaboration at all levels of health care
- Honouring the racial, ethnic, cultural, and socio-economic diversity of families
- Recognising family strengths and individuality and respecting different methods of coping
- Sharing complete and unbiased information with families on a continuous basis
- Encouraging and facilitating family-to-family support and networking
- Responding to child and family developmental needs as part of healthcare practices
- Adopting policies and practices that provide families with emotional and financial support
- Designing health care that is flexible, culturally competent and responsive to family needs
2.2 Cultural considerations

- Cultural identity may be significant for many different cultures therefore best practice is to ask both general and specific questions in relation to identity and cultural beliefs and values.

- Family structures are varied due to the changes in society and cultural norms. Many families from different cultural backgrounds see the role of extended family as a critical component of their cultures. It is not uncommon for multiple family members to be living in the same household (e.g. grandparents, aunts, uncles, cousins etc.) playing a key part in the care of infants or children. Even where extended family members do not reside in the same household the important role they play in supporting and nurturing the development of children cannot be underestimated.

- If an Aboriginal Liaison Officer, Aboriginal Health Worker, Cultural Liaison Officer or Aboriginal Health Education Officer is available to assist the family the family should be made aware of this option.

- If a parent/carer does not speak English, staff are required to engage the Healthcare Interpreter service and should not rely on family members or other support staff as interpreters.

3 OVERVIEW

3.1 What is normal crying in an infant?

Infants cry for a variety of reasons, such as hunger, thirst, tiredness, and discomfort. Their crying signals their need for a response from their care giver.

The first three months of life is the period of ‘peak’ crying, infants cry more during this time than at any other time. It affects most babies regardless of gender, ethnic background, cultural origin or parenting practices. It is more apparent in those in 'westernised' cultures where there is less infant carrying and breastfeeding on demand.

This period of increased crying typically starts at around 2 weeks of age, peaks at 4-6 weeks, and resolves around 4-6 months. Crying tends to be concentrated in the late afternoon or early evening, occurs in prolonged bouts, and often with no apparent trigger. Many parents report that while crying, their infants go red in the face, pull up their legs, or pass wind. This may not necessarily represent abdominal pain.

3.2 What is ‘new’ crying?

It is important to look at the pattern of crying behaviour:

- Is there a history of the infant having had problematic crying for some time, or is this a presentation of ‘new’ crying behaviour which is not characteristic for this particular infant?

- Is the tone or pitch of the crying different to usual crying?

- If it is ‘new’ crying, is the infant unwell? Has anything changed in the caregiving for this infant, which has resulted in this uncharacteristic “new” crying? e.g. spacing of
feeds, introduction of formula (even once), and changes in stool colour or odour suggesting infection?

3.3 What is ‘problematic crying’ in infants?

While most young infants have bouts of inconsolable crying, up to 20% of parents report ‘excessive and problematic’ crying in their otherwise healthy infant at two months’ of age.\(^1\) This pattern of behaviour has been termed ‘infantile colic’, although this does not necessarily suggest a gastrointestinal cause.

There are no defined criteria for what constitutes problematic crying in infancy. However, a commonly used definition is Wessel’s ‘rule of three’:

- Crying that lasts for more than three hours per day, occurs on more than three days per week, and persists for more than three weeks.\(^6\)

However, not all infants with problematic crying may fit this definition.

The aetiology of problematic crying is poorly understood, but may be a result of an altered balance between parental expectation, infant temperament and physiological or pathological causes. What we know is that:

- Less than 5% of infants with excessive crying have an underlying organic problem found.\(^7\) Most infants have no underlying medical cause.\(^8\)
- It is possible that colic is the upper end of a continuum of increased crying reflective of normal infant development and gut maturation including establishment of intestinal flora.\(^9\)
- Cultures where cue-based parenting practices are used (including more carrying of babies and breastfeeding on demand) are associated with decreased duration (although not frequency) of the crying bouts.\(^1,10\)
- Maternal and paternal depression and family stress have been shown to be associated with increased infant crying behaviours,\(^11-13\) as is a history of complications during the pregnancy or delivery.\(^14\)
- Parental perception of what is normal crying behaviour varies.\(^14\) Differences in culture of upbringing among parents can promote stress and discord.

3.4 Effects of excessive crying in infancy

Excessive crying in an otherwise healthy baby is not a trivial problem. While not a medical emergency, it causes considerable stress on families and has a direct effect on parenting patterns and family functioning over time.\(^10\) Excessive crying may be associated with:

- Parental anxiety and depression
- Parental sleep deprivation
- Attachment difficulties between parent and infant
- Physically abusive behaviour towards the infant, in particular, inflicted traumatic brain injury.\(^15\) See sections (5.7) Head Injury & (6) Evaluating safety and wellbeing concerns for infant and sibling
When parents present to the ED with a crying infant they are generally seeking three things:

1. Reassurance about their actions to date in managing their crying infant at home
2. Exclusion of serious disease or problem
3. Coping strategies for the rest of the night and into the future including social supports.
4 ASSESSMENT ALGORITHM

Infant less than 6 months of age presenting with crying and unsettled behaviour

Does this infant appear sick?

YES
Resuscitate and manage as per Recognition of a Sick Baby or Child Clinical Practice Guideline or Paediatric Sepsis Pathway

NO
Stop and consider:
Is this baby at risk of harm?
Assess child protection concerns and consult mandatory reporting guide PD2013-007
See section 5.

Structured history, physical examination, urinalysis, heel prick for blood glucose level
(See Table 1, p8 and Table 2, p9 as a guide)

Organic disease not suspected

Consider sleep, settling and feeding problems, maternal factors and family issues.

Undertake further history and assessment (See Table 6, p16) and consider need for consultation with paediatrician, midwife/lactation consultant and/or social worker.

Organic disease suspected.
(See Table 3, p10) for a list of differential diagnoses

Undertake further investigations.
(See Table 5, p11)

Manage condition as appropriate.
Discuss with senior clinicians.
5 ASSESSMENT AND INITIAL MANAGEMENT

It is important that infants presenting to ED with crying who are sick or unwell are recognised early and assessed promptly. Clinicians should refer to Recognition of a Sick Baby or Child in the Emergency Department Clinical Practice Guideline or the Paediatric Sepsis Pathway which outlines key points of what to look for in neonates and children during the initial assessment. In particular, the section on Recognition of the Sick Neonate gives additional helpful information relevant to infants less than one month of age. Neonates and premature infants are particularly high risk groups that can deteriorate quickly and a heightened level of concern should be applied in the assessment of these children, including undertaking repeated observations over time.

5.1 Identify serious and life-threatening illness

The first step in the assessment of infants presenting with crying and unsettled behaviour is to exclude serious and life-threatening illness (see Assessment algorithm). An assessment of the infant's Airway, Breathing, Circulation, Disability (neurologic state), Exposure (temperature and rash), Fluids status (fluids in/fluids out) and Glucose should be performed.

5.2 Structured history and examination: identify organic disease

If an infant is assessed as not being acutely unwell or needing resuscitation, then the next step is to complete a structured history and physical examination to identify whether there is an organic cause for the problem. History-taking at this stage should be focused on obtaining from carers possible clinical features indicative of organic disease, such as fever or poor weight gain. Table 1 (p8) gives a list of clinical features to help clinicians in their history-taking. While not exhaustive, this list of symptoms and signs may alert the clinician to the possibility of organic disease.

Signs to look for in the physical examination of the infant are listed in Table 2 (p9). Abnormal vital signs such as increased respiratory rate, tachycardia or low oxygen saturation indicate possible organic disease. A head to toe physical examination done with proper exposure of the infant is essential to avoid missing important physical findings. This may mean in some cases, waking an infant who is settled and asleep after many hours of crying at home or in the ED waiting room. Neurological assessment including tone, eye movements and pupillary reflexes should also be performed as part of the physical examination. Skin should be thoroughly examined to check for any rash or bruising. Limbs and joints should be examined to exclude tenderness, swelling or deformities.

While the majority of infants who present with excessive crying do not have an organic underlying cause, a minority (about 5%) of infants do have an organic illness, with urinary tract infection being the most common cause. A urinalysis should be done as part of the initial assessment, with consideration for urine culture in infants in the first few months of life, even if afebrile. The urine, if available, should be sent for microscopy and culture. A heel prick for blood glucose level should be done if clinically appropriate (e.g. in infants with poor feeding).

Apart from urinary tract infections, other organic causes of excessive crying in infants are listed in Table 3 (p10).
# Table 1 - Clinical features indicative of possible organic disease: history taking

<table>
<thead>
<tr>
<th>History</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Apnoea</strong></td>
<td>Apnoea is the absence of respiratory effort</td>
<td>Is frequently followed by bradycardia</td>
</tr>
<tr>
<td><strong>Seizures</strong></td>
<td>Signs of a seizure can include stiffening or jerking of limbs and/or body</td>
<td></td>
</tr>
<tr>
<td><strong>Fever</strong></td>
<td>Normal temperature in infants is 36°C to 37°C</td>
<td>Temperature above 38°C is considered a fever</td>
</tr>
<tr>
<td><strong>Rash</strong></td>
<td>Can indicate infection or allergy</td>
<td></td>
</tr>
<tr>
<td><strong>Reduced oral intake/feed refusal</strong></td>
<td>Normal oral intake is 120-140ml/kg/day (for infants 0-6 months of age)</td>
<td>Can be difficult to estimate in breast-fed infants (review the assessment of breastfeeding in Appendix 10.3.1 at this point if infant is stable).</td>
</tr>
<tr>
<td><strong>Reduced urine output</strong></td>
<td>Normal urine output is around 6 wet nappies per day</td>
<td>Parents can often tell if nappies are not as wet or needed less frequent changing than usual</td>
</tr>
<tr>
<td><strong>Vomiting</strong></td>
<td>Should be distinguished from physiological regurgitation</td>
<td>Vomiting implies forceful expulsion of stomach contents</td>
</tr>
<tr>
<td><strong>Diarrhoea</strong></td>
<td>Consider both frequency and consistency of stools</td>
<td>Normal stools in infants can be any colour (except for when there is red blood or melaena in stools), and should be soft in consistency</td>
</tr>
<tr>
<td><strong>Poor weight gain or failure to thrive</strong></td>
<td>Average weight gain for infants is 150g/week – check recent weight</td>
<td>Weight loss of greater than 10% of birth weight during the neonatal period is abnormal</td>
</tr>
<tr>
<td><strong>Injuries</strong></td>
<td>Injury can be unintentional/accidental or inflicted/non-accidental</td>
<td>There may be no history of trauma in an infant who is crying due to injury</td>
</tr>
</tbody>
</table>
Table 2 - Clinical features indicative of possible organic disease: physical examination

<table>
<thead>
<tr>
<th>Physical Examination</th>
<th>What to look for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal vital signs as per Blue, Yellow and Red Zones on the NSW Health Standard Paediatric Observation Chart (SPOC), Paediatric Emergency Department Observation Chart (PEDOC)</td>
<td>• A patent  &lt;br&gt; • B respiratory rate, oxygen saturation, effort, air entry  &lt;br&gt; • C heart rate, capillary refill, pulse volume, blood pressure  &lt;br&gt; • D alertness, posture  &lt;br&gt; • E temperature, rash  &lt;br&gt; • F fluids in/fluids out, fontanelle  &lt;br&gt; • G glucose</td>
</tr>
<tr>
<td>Head and neck</td>
<td>• Bulging or sunken fontanelle  &lt;br&gt; • Increased head circumference  &lt;br&gt; • Abnormal neck posture or movement  &lt;br&gt; • Oral ulcers, pharyngeal inflammation  &lt;br&gt; • Gum laceration, torn frenulum of upper lip  &lt;br&gt; • Localised scalp swelling</td>
</tr>
<tr>
<td>Ears</td>
<td>• Red or bulging tympanic membrane</td>
</tr>
<tr>
<td>Eyes</td>
<td>• Foreign body  &lt;br&gt; • Corneal abrasion  &lt;br&gt; • Abnormal eye movements or pupillary reactions to light</td>
</tr>
<tr>
<td>Neurological</td>
<td>• Hypotonia  &lt;br&gt; • Irritability  &lt;br&gt; • Poor responsiveness</td>
</tr>
<tr>
<td>Chest findings</td>
<td>• Cardiac murmur  &lt;br&gt; • Abnormal heart sounds, palpable thrill, displaced apex beat  &lt;br&gt; • Decreased air entry, crackles/crepitation, wheeze  &lt;br&gt; • Increased respiratory effort</td>
</tr>
<tr>
<td>Abdominal findings (including hernia &amp; genitalia)</td>
<td>• Distension  &lt;br&gt; • Tenderness  &lt;br&gt; • Masses  &lt;br&gt; • Liver or splenic enlargement  &lt;br&gt; • Reduced bowel sounds  &lt;br&gt; • Check for hernias  &lt;br&gt; • Check genitalia (bruising, bleeding, infection, tourniquet)  &lt;br&gt; • Check femoral pulse</td>
</tr>
<tr>
<td>Limbs and joints</td>
<td>• Tender, swollen or deformed joints or limbs, consider dislocated hip and its complications  &lt;br&gt; • Decreased movement of a limb  &lt;br&gt; • Limb stiffness or unusual movements or posturing  &lt;br&gt; • Hair tourniquet on fingers or toes</td>
</tr>
<tr>
<td>Skin</td>
<td>• Rash  &lt;br&gt; • Bruising anywhere  &lt;br&gt; • Cellulitis  &lt;br&gt; • Skin Abscess</td>
</tr>
</tbody>
</table>
### Table 3: Organic causes of excessive crying in infants: list of differential diagnoses

<table>
<thead>
<tr>
<th>Type/System</th>
<th>Diagnosis</th>
</tr>
</thead>
</table>
| Infection   | • Urinary tract infection (most common organic cause)  
             | • Sepsis  |
| Ear, Nose, Throat (ENT) | • Otitis media  
                            | • Nasal congestion  
                            | • Oral thrush  
                            | • Oral ulceration  |
| Cardiovascular (rare) | • Heart failure  
                          | • Supraventricular tachycardia  
                          | • Anomalous origin of left coronary artery  |
| Neurologic | • Head injury **  
            | • Meningitis  
            | • Raised intracranial pressure  
            | • Subdural haematoma or other intracranial bleed†  |
| Eyes | • Foreign body  
      | • Corneal abrasion  
      | • Glaucoma  |
| Gastrointestinal | • Intussusception  
                       | • Constipation  
                       | • Hernia (inguinal/femoral/umbilical)  
                       | • Volvulus  
                       | • Anal fissure  
                       | • Cow’s milk protein allergy*  
                       | • Gastro-oesophageal reflux disease*  |
| Genitourinary | • Urinary tract infection  
                       | • Urinary tract obstruction  
                       | • Meatal ulcer  
                       | • Torsion of testis or ovary  |
| Skin | • Eczema  
      | • Hair tourniquet (of digit or penis)  |
| Skeletal | • Fracture  
          | • Osteomyelitis  
          | • Septic arthritis  |
| Metabolic (rare) | • Hypoglycaemia  
                  | • Acidosis  
                  | • Hyperammonemia  |

* see section 5.4 for gastro-oesophageal reflux disease and section 5.5 cow’s milk protein allergy  
** see section 5.7 for head injury, including subdural haematoma and other intracranial bleeding
Table 4 - Normal ranges for vital signs in infants (as per white zones in NSW Health Paediatric Emergency Department Observation Chart)

<table>
<thead>
<tr>
<th></th>
<th>0-3 months (Neonates)</th>
<th>3-12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Rate</td>
<td>30 - 55 breaths per minute</td>
<td>30 - 45 breaths per minute</td>
</tr>
<tr>
<td>Oxygen Saturation (in room air)</td>
<td>greater than 95%</td>
<td>greater than 95%</td>
</tr>
<tr>
<td>Heart Rate</td>
<td>110 - 160 beats per minute</td>
<td>100 - 160 beats per minute</td>
</tr>
<tr>
<td>Capillary Refill</td>
<td>less than 3 seconds</td>
<td>less than 3 seconds</td>
</tr>
<tr>
<td>Blood Pressure (Systolic)</td>
<td>60-100 mmHg</td>
<td>70-110 mmHg</td>
</tr>
<tr>
<td>Temperature (axillary)</td>
<td>35.5 - 38.5°C</td>
<td>35.5 - 38.5°C</td>
</tr>
</tbody>
</table>

5.3 Organic disease suspected: perform appropriate investigations

If an organic disease is suspected then appropriate investigations should be performed. A list of investigations to consider is outlined in Table 5. Second-line investigations such as lumbar puncture or neurological or abdominal imaging should be performed only after discussion with a senior clinician.

Table 5 - Further investigations to consider when organic disease suspected

<table>
<thead>
<tr>
<th>Type</th>
<th>Investigation</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood tests</td>
<td>• Full blood count</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Electrolytes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Venous blood gas</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Blood culture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Blood glucose level</td>
<td></td>
</tr>
<tr>
<td>Urine</td>
<td>• Urine microscopy &amp; culture</td>
<td>Should be considered even in afebrile infants</td>
</tr>
<tr>
<td></td>
<td>• Urine metabolic screen</td>
<td></td>
</tr>
<tr>
<td>Imaging</td>
<td>• Abdominal x-ray (supine &amp; decubitus)</td>
<td>If suspect surgical abdomen, or signs including abdominal distension, tensity, mass, decreased bowel sounds, or bile-stained vomiting</td>
</tr>
<tr>
<td></td>
<td>• Chest x-ray</td>
<td>If increased respiratory rate, decreased saturation, or chest findings on examination</td>
</tr>
<tr>
<td></td>
<td>• X-ray limb(s)/joint(s)</td>
<td>If tenderness, swelling, deformity of limbs, or joint redness or swelling</td>
</tr>
<tr>
<td></td>
<td>• Abdominal ultrasound</td>
<td>If abdominal mass or suspected pyloric stenosis</td>
</tr>
<tr>
<td></td>
<td>• Ultrasound of joint</td>
<td>If septic arthritis suspected</td>
</tr>
<tr>
<td>Other</td>
<td>• Fundoscopy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Fluorescein exam of eyes</td>
<td>If concerns for foreign body in eye or corneal abrasion</td>
</tr>
<tr>
<td>Second-line investigations</td>
<td>• Lumbar puncture</td>
<td>Second line investigations should only occur after discussion with specialist</td>
</tr>
<tr>
<td></td>
<td>• CT head</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• CT abdomen</td>
<td></td>
</tr>
<tr>
<td>Second-line investigations</td>
<td>• Head ultrasound</td>
<td>Not recommended if concern is for non-accidental head injury (CT head is first-line investigation in such cases)</td>
</tr>
</tbody>
</table>
Infants and Children: Acute Management of the Unsettled and Crying Infant 1st Edition

5.4 Gastro-oesophageal reflux (GOR) and gastro-oesophageal reflux disease (GORD)

Gastro-oesophageal reflux (GOR) refers to the physiological passage of stomach contents back into the oesophagus due to the transient relaxation of the lower oesophageal sphincter. This results in possetting after feeds. It is a normal self-limiting phenomenon occurring in all infants, with peak incidence at 1-4 months of age and generally improving by 6-8 months with sitting and resolving by walking age. It is not a cause of crying or unsettled behaviour in most infants.

In a small proportion of infants, GOR is associated with frequent large volume regurgitation, feeding difficulties, poor weight gain, and haematemesis. This is termed gastro-oesophageal reflux disease (GORD) and can cause problematic crying in a small number of infants.

Simple regurgitation in the absence of other associated symptoms (e.g. feeding difficulties or feed refusal, poor weight gain, haematemesis or respiratory complications) should not be considered GORD.

Treatment of GORD should start with conservative management (e.g. positioning; smaller more frequent feeds; or thickening feeds). Medication, initially including antacids (e.g. Mylanta), H2-receptor antagonists (e.g. ranitidine) and proton-pump inhibitors (e.g. omeprazole) could be considered for infants where there is definite clinically significant GORD, particularly as these medications are not without side-effects. The use of medication should be done in conjunction with advice from a paediatrician. Vomiting due to cow’s milk protein allergy (CMPA) may respond to treatment for CMPA (see section 5.5).

Studies evaluating treatment effect on symptoms attributed to GORD including crying and irritability have demonstrated no significant difference between treatment (H2-receptor antagonists and proton pump inhibitors) and placebo groups, despite reduction in gastric acid and oesophageal acid exposure.\textsuperscript{17-19} Thus, in the majority of cases, oesophageal acid exposure is not the cause of crying and irritability.

Infants with severe or refractory symptoms should be referred to a paediatric gastroenterologist. Infants commenced on treatment require follow-up by a paediatrician to monitor progress and ensure that ongoing treatment is appropriate.

It is important to remember that even when an organic cause has been identified, clinicians should keep in mind the question ‘is this infant at any risk of harm?’ (see section 6: Evaluating safety and wellbeing concerns for infants and siblings).

Clinicians should ensure that any psychosocial concerns for parents/carers are explored and addressed.
5.5 Cow’s Milk Protein Allergy (CMPA)

The majority of infants who present with persistent crying do not have cow’s milk protein allergy (CMPA) as a cause of their crying. Most infants who have CMPA present with specific symptoms, depending on the clinical subtype of CMPA:

- CMPA which is IgE mediated (very rare) tends to be rapid-onset (within minutes to hours of ingestion), with symptoms such as vomiting, rash, lip and tongue swelling, and wheezing.
- Non-IgE mediated CMPA can cause proctocolitis (causing loose stools with fresh blood, which can occur up to 7-10 days after ingestion) and enterocolitis (resulting in vomiting, diarrhoea, dehydration and/or failure to thrive). Presence of white and red cells in stool examination supports the presence of colitis.

The diagnosis of CMPA relies on a limited trial (2-4 weeks) of cow’s milk elimination and subsequent challenge, or gastrointestinal endoscopic biopsy and histologic examination. This should be done in consultation with a paediatrician.

CMPA in infancy

1. Majority of infants with persistent crying do not have CMPA
2. Most infants with CMPA present with specific symptoms rather than persistent crying
3. If concerned about CMPA then refer to a paediatrician, paediatric allergy specialist or paediatric gastroenterologist for further advice
4. There is no evidence to support stopping breastfeeding and changing to formula in breastfed infants unless the diagnosis of CMPA has been made by your paediatrician, paediatric allergy specialist or paediatric gastroenterologist
5. The decision to put mothers on a dairy-free diet in breastfed infants where CMPA is suspected should only be done in conjunction with input and follow up from a paediatrician
6. Any elimination diet should be assessed for nutritional adequacy.
5.6 Diagnosis and management of infants with suspected GORD/CMPA

In an unsettled and crying infant:
If you are worried about Gastro-oesophageal Reflux Disease (GORD) or Cow’s Milk Protein Allergy (CMPA)

<table>
<thead>
<tr>
<th>GORD: Frequent and symptomatic large volume regurgitation</th>
<th>CMPA: Frequent loose stools with blood/mucous</th>
<th>Unlikely to be GORD/CMPA: Absence of frequent large volume regurgitation or bloody diarrhoea</th>
</tr>
</thead>
<tbody>
<tr>
<td>+/- Feeding difficulties/refusal</td>
<td>+/- Feeding difficulties/refusal</td>
<td></td>
</tr>
<tr>
<td>+/- Poor weight gain</td>
<td>+/- Poor weight gain</td>
<td></td>
</tr>
<tr>
<td>+/- Haematemesis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Discuss with paediatrician
2. Start with conservative management
3. PPI’s should only be used in infants with definite documented Oesophagitis

1. Send stool sample for microscopy (white and red cells) and culture
2. Refer to paediatrician for further assessment, may need to consider hypoallergenic formula

Consider other organic or non-organic causes.

5.7 Head Injury, including subdural haematoma and other intracranial bleeding

Excessive crying in an infant may be a presenting sign of an occult head injury (e.g. a subdural haematoma or some other intracranial bleeding) from a shaking and/or impact injury to the head. There may be other accompanying signs (e.g. boggy head swelling, bruising and irritability) however in the case where an infant had been shaken, the resultant subdural haematoma may not be accompanied by any visible signs of external injury.

All infants who present with excessive crying need a thorough neurological examination as part of their overall assessment. Where concerns exist about a possible underlying head injury as the cause of the crying then head imaging (e.g. a CT scan of the head) should be undertaken after consultation with senior medical advice.

On the other hand, infants who cry excessively are at an increased risk of having inflicted injuries (including shaking and abusive head trauma). Thus even if the infant is otherwise well and has no underlying organic cause for their injuries, an assessment needs to be undertaken in the ED as to how the parents are coping with the stress of managing their infant, what support services are available to the family, and how these supports may be maximised.
5.8 Organic disease not suspected: further history and assessment

In this guideline, a two-step approach is recommended: first, a history and examination targeted at excluding organic disease, followed by a history and assessment targeted at addressing sleep, settling, feeding and psychosocial aspects of the presenting problem. While this is presented as a linear approach, in practice these two steps may in fact occur in parallel with one another, depending on the clinical circumstances.

The secondary history should include (see Table 6, p16):

- Details of the crying behaviour, including what methods have been tried so far to manage the problem crying and whether any of these methods have made any difference
- Questions about feeding, sleep and settling
- Psychosocial assessment on how the parents/carers are coping, and what support mechanisms are in place.
Table 6 - Further history and assessment if suspect non-organic cause for crying

<table>
<thead>
<tr>
<th>History</th>
<th>Questions to ask</th>
</tr>
</thead>
</table>
| Crying history (Appendix 2)   | • How often? How long?  
• Since when has it been a problem?  
• What has been tried so far? |
| Feeding history (Appendix 3)  | • If breast feeding, ask about:  
  o How often baby feeds, how long  
  o Attachment, cracked nipples, audible suck and swallow  
  o Mother’s supply  
• If bottle feeding, ask about:  
  o What formula, how much, any changes in formula  
  o What type of teat/bottle  
• For both breast and bottle feeds:  
  o Vomit/possets  
  o Burping  
  o Stools  
  o Wet nappies  
• Any changes in feeding and reasons why |
| Sleep and settling (Appendix 5)| • What is the sleep pattern?  
• How is the baby put to sleep?  
• Ensure safe sleep practices (SIDS guidelines) |
| Psychosocial (Appendix 6)     | • How are parents coping?  
• What supports are available to the family?  
• What strategies worked for parents with older siblings? What is different this time? |

Where possible it is preferable for the clinician to obtain an overview from the clinical notes of previously explored areas. This can then be clarified with the parents to ensure accuracy and therefore minimise the need for them to retell the whole story.

The aim of the assessment is to work with families to identify any contributing factors and possible solutions on how parents can proceed with caring for the crying infant safely.

A good starting point can be to say something like; “Let’s look at what else might be happening to make it difficult for your baby to be more settled?” or “What do you think might be happening for your baby?”

Parents may offer what they think may be a significant contributing factor, however, if not, there are some prompts below. The family assessment questions in Appendix 2 - 6 provide questions and strategies that can be used during conversation with the parent/family and specific information on how to deal with crying, feeding, sleep and settling, and psychosocial concerns once they are identified.
Identify the biggest concern then start with questions from the relevant section.

If at all possible, the infant should be observed during a feed to assess attachment (if breastfeeding), any sucking/swallowing difficulties and vomiting/possetting post-feeds (for both breastfed and bottle-fed babies).

**Note:** It is best practice when providing a breastfeeding assessment and support to use a ‘hands off’ approach and consent must always be sought from the mother prior to any ‘hands on’ assistance.

Open, honest, empathic and respectful interactions with parents are essential in building rapport and trust. This will assist when it is necessary to explore potentially challenging and sensitive issues. All staff should ensure they introduce themselves when meeting the family for the first time.

**Once again, it is important for clinicians to stop and consider the question: “is this infant at any risk of harm?”** The following section, evaluating risk of harm to the infant, gives further information and suggestions as to how to proceed.

### 6 EVALUATING SAFETY AND WELLBEING CONCERNS FOR INFANT AND SIBLINGS

While assessments for organic or non-organic causes are taking place, clinicians need to remember that it is important to pause and consider if the infant is at any risk of harm.

#### 6.1 Are there concerns for the safety and wellbeing of the infant?

Things to consider:

- Are the parents coping with the care of the infant?
- Are there supports available to the family if they need a break?
- Are there any concerns regarding parental mental health e.g. post-natal depression?
- Are there any concerns regarding domestic violence?
6.2 **Are there concerns for the safety and wellbeing of siblings?**

- If there are siblings, how are they responding to a new baby in the household? Is there a source of tension in the home?
- Are there any specific concerns regarding the safety and wellbeing of siblings?

6.3 **Where safety and wellbeing concerns have been identified**

If an infant presents with indicators of physical abuse or neglect, or in the event that Family and Community Service or Police requires an infant to be medically examined under section 173 of the Children and Young Persons (Care and Protection) Act 1998, medical staff should refer to and follow GL2014_012 Suspected Child Abuse and Neglect (SCAN) Medical Protocol (see below), in conjunction with PD2013_007 Child Wellbeing and Child Protection Policies and Procedures for NSW Health; and where appropriate, seek consultation with a tertiary child protection service.

- Document any concerns or injuries
- Injury documentation should be done using the SCAN medical protocol (GL2014_012 Suspected Child Abuse and Neglect (SCAN) Medical Protocol)
- Use Mandatory Reporter Guide (MRG) and respond as advised
- Seek advice from paediatrician/child protection specialist
- Consult the NSW Health Child Wellbeing Units 1300 480 420 for advice if still unsure about whether a suspected risk of harm report should be made
- Plan (in consultation with relevant services e.g. social worker, mental health) what actions Health can take to address lower level risk issues
- Consult with other services currently or recently involved with the family

Admission of the infant should be considered while advice is sought from Child Protection specialists, the NSW Health Child Wellbeing Unit or, (if reported as suspected risk of significant harm) with Family and Community Services.
6.4 Support to help you work with the family

- Support the engagement of a social worker (if available)
- Discuss concerns with a senior clinician, e.g. ED consultant, paediatrician or child protection specialist
- KEEP THEM SAFE
- Your NSW Health Child Wellbeing Unit is available for advice and support about service options or your reporting responsibilities 1300 480 420.

6.5 If postnatal depression or domestic violence concerns are identified

Table 7 provides additional information to support you to work with the family where concerns regarding postnatal depression or domestic violence have been identified. The information outlines which further assessments should take place, in conjunction to relevant services.

Table 7: What to do when the following concerns are identified

<table>
<thead>
<tr>
<th>Concerns</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postnatal depression</td>
<td>• Consider Edinburgh Post Natal Depression Scale (EPDS) (Appendix 8)</td>
</tr>
<tr>
<td></td>
<td>• Discuss with social worker/mental health clinician</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>• Document concerns/any injuries</td>
</tr>
<tr>
<td></td>
<td>• Provide non-judgemental support and validation of the women’s account</td>
</tr>
<tr>
<td></td>
<td>• Ask about the history of violence, listen without pressure to talk and ask about child safety</td>
</tr>
<tr>
<td></td>
<td>• Provide practical care that responds to the women’s concerns</td>
</tr>
<tr>
<td></td>
<td>• Provide information and resources (such as to legal and other crisis services). If no local services are available/known contact the NSW Domestic Violence Line on 1800 656 463. This is a state-wide free-call number and is available 24 hours, seven days a week</td>
</tr>
<tr>
<td></td>
<td>• Discuss or refer to a social worker to support and inform safety planning</td>
</tr>
<tr>
<td></td>
<td><strong>NSW Health PD2006_084 Domestic Violence, Identifying and Responding:</strong></td>
</tr>
</tbody>
</table>

6.6 If unsure, admit

If there is any doubt about parents’ ability to safely care for the infant at home or if supports are not available for the family upon discharge, then admission and a period of observation of the infant should be considered as an option to ensure safety of the infant.

7 TALKING TO PARENTS AND CARERS

In the case where an infant has been assessed as being well (no underlying organic disease) and safe (not at risk of harm, and parents have appropriate supports in place), then discharge from the hospital is appropriate.
Provide parents or carers with a copy of the Crying Baby Fact Sheet and talk through the factsheet with the family and address any question or concerns.

The following provide ideas that may help in your discussion with parents and carers, and what to say to parents about their infant’s crying:

- At the moment, their baby has been assessed as medically well
- This period of crying may be part of what is normal crying. Crying in infancy occurs across all cultures, with the same peak time
- In most cases, the crying will improve over time
- In a difficult time such as this, it is important for the parents to look after and care for themselves and each other.

If they feel that they want further help or reassurance, their options are:

- Call their local Child and Family Health Nurse
- See their GP or Paediatrician
- Contact Tresillian or Karitane
- Return to ED for another assessment.

Remember, no matter how frustrated the parents may feel with their baby’s crying shaking the baby is never acceptable. *Suggest that the parents consider putting their baby safely in the cot or on the floor, then shutting the door and walking away for a few minutes.*

8 MANAGEMENT OF SLEEP AND SETTLING ISSUES IN INFANCY

Many strategies have been proposed in the management of infants with problematic crying. While some methods work for some infants some of the time, no single treatment works for all infants all the time.

Some general principles however apply:

- Help parents cope with the infant’s crying
- Help maintain a strong attachment in the parent-child relationship
- Address any feeding difficulties (for more information on feeding see Appendix 3)
- Offer practical advice regarding settling techniques
- Reassure parents that it is appropriate to cuddle and carry their infant
- Address any psychosocial factors that may impact on infant crying.

8.1 Settling techniques

For babies whose primary problem is a settling issue, the following techniques may be useful for parents/carers in helping to settle their babies:

**Preparing for Sleep**

Make sure the baby is not hungry, has a clean nappy, is not overdressed or underdressed and is comfortable.
Have a ‘quiet time’ during the day and at night before sleep. A pre-sleep routine can help your baby develop positive sleep patterns. An example of a pre-sleep routine is found below and can be adapted for children of all ages.

- Gentle ‘ssshhh’ sounds
- Talk quietly, using comforting tones
- Pat gently and rhythmically
- Apply gentle contact on your baby’s body, leg or arm
- Gently and slowly rock your baby’s body side to side
- Stroke gently and rhythmically, e.g. forehead or head, arm, leg
- Gently rock the cot/bassinette after making sure your baby is securely tucked in and it is safe to do so.

### 8.2 Medication and complementary medicines

Various medications are marketed as treatments for “infantile colic”, e.g. Simethicone ("Infacol"), which is widely available as an over-the-counter medication. Studies have shown that Simethicone is not effective in the treatment of problematic crying in infants. Complementary medicines, including homeopathic preparations, herbal teas and “gripe water” have not been proven to be of benefit and should be avoided.

### 8.3 Nutritional therapies

There is some evidence to suggest that use of a casein hydrosylate formula may assist symptoms in formula-fed infants, however this evidence is not conclusive. There is no evidence to support use of lactose-free formulas or addition of lactase or additional fibre to formulas.

### 8.4 Manipulative therapy

Evidence for the efficacy of spinal manipulation in treating problematic crying in infants is inconclusive. Clinicians should NOT recommend spinal manipulations in infants. Other alternative therapies, such as acupuncture, have not been proven to be of benefit.

### 8.5 Probiotics

There is emerging evidence that probiotics may have a role in reducing problematic crying in infancy. The benefit of supplementation with *Lactobacillus reuteri* has been recently reported. Further research is currently underway to explore its efficacy.

### 9 DISCHARGE PLANNING

#### 9.1 Discharging from ED and Resource Information

When deciding which resources to provide for families, it is important to ensure that they are able to access them, e.g. that there are no literacy issues, that they have
phone/internet access. If specific services exist for the client’s identified cultural/language group, they should be given the choice of where they would prefer to seek support.

Where possible, provide the family with a specific follow up appointment within 1 week of discharge.

Routinely on discharge everyone should be given appropriate information including the Crying Baby Fact Sheet as well as contact phone numbers for:

- Local GP after hours service
- Child and Family Health Team local to parent’s address (if available)
- Tresillian 1300 272 736
- Karitane 1300 CARING (1300 227 464)
- Health Direct 1800 022 222

Families should also be provided with contact details for culturally specific services:

- Aboriginal Health Workers
- Aboriginal Medical Services
- Transcultural Mental Health
- Local bilingual counsellors

9.2 Resources

It is important that the clinician discusses the information with parents, rather than just handing it to them.

Parents should be given ‘permission’ (once they ensure their infant is fed, clean and dry) to leave the crying infant in a cot for a short time and take a short break e.g. 1-2 minutes.

Strategies on how to use that time to calm themselves or make decisions regarding the need to get additional help should be discussed, e.g. ask a friend to come over.

See Appendix 7 for further resources available for you to discuss with parents.

9.3 Communication with other health professionals

It is important to ensure that with parental/carer consent a detailed discharge summary is provided to other health professionals (e.g. patient’s GP or Child & Family Health Nurse) and agencies (where appropriate), to ensure continuity of care. There should be a specific appointment within 1 week.

Where concerns exist for the safety, welfare or wellbeing of an infant, health professionals can exchange information without consent under Chapter 16a of the Children and Young Persons (Care and Protection) Act 1998. Further information regarding information sharing provisions can be found in PD2013_007 Child Wellbeing and Child Protection Policies and Procedures for NSW Health.
10 APPENDICES

10.1 Appendix 1: References


### 10.2 Appendix 2: Crying history

<table>
<thead>
<tr>
<th>Explore with the family</th>
<th>Rationale for question</th>
<th>Response to parent/carer</th>
</tr>
</thead>
</table>
| 1 | What in particular about the crying caused you to seek help today? | • Identify the trigger  
• Helps locate main contributing factor/s for the infant and maternal distress | • Acknowledge the appropriateness of their choice to come to the Emergency Department  
• Demonstrate empathy for parent/carer e.g. “I can only imagine how difficult this must be for you”  
• Acknowledge parent/carer concerns for their infant |
| 2 | Can you describe the pattern of your baby’s crying?  
e.g. How long does he/she cry, and at what times of the day/night, before/after or unrelated to feeds? | • Determine whether crying is within typical parameters | • Explore the typical crying behaviours  
• Newborns may be unsettled, with crying and fussing  
• Some may be inconsolable for up to 3 hours/day without obvious cause. Usually settles around 4 - 6 months of age  
• Child and Family Health Nurses (CFHN) may assist parent/carer to understand child development/sleep and settling  
• Offer Crying Baby card and Fact Sheet (see Appendix 7 Resources) |
| 3 | When did the crying start to become a problem for you?  
Were there any significant changes at that time? e.g. feeding, family changes? | • Adds perspective (for parent/staff) on stress and coping of the parent  
• Can inform you of recent changes that may need further exploration | • Acknowledge the effect of the environment on baby, parents and family members |
<table>
<thead>
<tr>
<th>Explore with the family</th>
<th>Rationale for question</th>
<th>Response to parent/carer</th>
</tr>
</thead>
</table>
| **4** Have you found anything which helps to calm your baby? | • Determine what calming techniques/strategies have been tried and/or found helpful | • Acknowledge what has been tried  
• Encourage repeated use of successful techniques and offer alternate strategies  
• A sleep/crying diary may be helpful  
• Confirm referrals to and provide contact details for GP, Child and Family Health Nurse or other agencies as agreed with the family  
• Provide contact details for 24 hour phone lines (see resource list) |
| **5** How are you feeling/coping, particularly when your baby is very upset/hard to comfort? | • Establishing parent/carer feeling when the baby cries helps determine any possibility that the baby may be harmed by parents/carers actions/reaction | • Acknowledge that hearing your own baby cry can be very distressing  
• Offer strategies/suggestions to assist parent/carer to settle baby  
• Refer to resource list for parent handout. |
| **6** Do you have anyone at home who can help you or take your baby to give you a break? | • Acknowledge if the parent /carer can have a break it may assist them in this situation | • Parents/carers might wish to look for ways to get a break to take the stress out of the situation. e.g. “Can you think of something or someone that might help?” |
| **7** How is your baby feeding and sleeping? | • Establish the baby’s feeding and sleeping from the parent/carer viewpoint | • Explore the specific issues identified using the appropriate section of this guideline |
| **8** Does the crying remain the same regardless of who is caring for your baby, or where your baby is? | • Establish if the crying is/has been perceived as a problem more for one parent/carer than the other | • Acknowledge that each parent/carer may react/cope differently to crying  
• Discuss referral to Tresillian or Karitane Residential Unit |
10.3 Appendix 3: Feeding

When exploring the area of feeding, clarify with parent/carer if they are;

- Breast feeding
- Bottle feeding expressed breast milk
- Formula feeding
- Giving both breast and bottle feeds
- Giving the infant anything else than milk (e.g. solids, herbal remedies, chamomile tea).

Associated problems may also include input and output issues e.g. parents perception that the child is constipated.

Proceed with questions/discussions in appendix 10.3.1 – 10.3.3.
10.3.1 Breastfeeding

<table>
<thead>
<tr>
<th>Explore with the family</th>
<th>Rationale for question</th>
<th>Response to parent/carer</th>
</tr>
</thead>
</table>
| 1 How often does your baby feed in 24 hours? | - Establish adequate feeds are given to infant each 24 hours | - Discuss issues of overfeeding, underfeeding or if the feeding is unrelated to screaming episodes as appropriate  
- Discuss Australian Breastfeeding Association (ABA) information  
- Child Family Health Nurse referral  
- Lactation Consultant referral  
- Speech Pathologist referral |
| 2 How long does your infant feed each time? Does infant feed from one breast per feed or from both breasts? Does infant settle after feeds? | - Establish adequate length of time for breast feeds  
- Determine if infant has an established feeding pattern and is draining one breast or both breasts  
- Determine if feeding is infant led or mother led | - Acknowledge breast fed infants can feed for varying lengths of time  
- Stress the importance of draining the first breast before attaching to second breast to ensure adequate nutrition  
- In hot weather or during growth spurts infants may demand feeds more often. 2 hourly feeding can be normal in the first 6 weeks around the clock, changing to 3 – 4 hourly in the next few months  
- The infant, not the clock, should determine when the feed is finished |
| 3 What do you think your supply is like i.e. adequate, increasing or decreasing? | - Gain insight to mother’s perception about breast milk supply | - Establish if parents can identify if discomfort is related to low supply, or to infant gulping from plentiful, fast flowing supply |
| 4 Has your baby gained weight? | - Establish infants weight has increased and consistent with WHO and CDC Growth Charts | - Explain to parent that poor weight gain or static weight may indicate low supply or poor milk transfer  
- Check Personal Health Record and growth charts |
<table>
<thead>
<tr>
<th>Explore with the family</th>
<th>Rationale for question</th>
<th>Response to parent/carer</th>
</tr>
</thead>
</table>
| **5** Determine who mother has sought help from  
Have you been using nipple shields and have they helped? | Determine who mother has sought help from  
Establish if mothers nipples are flat or inverted and latching has been difficult leading to under stimulated milk flow | Acknowledge mother’s efforts to seek lactation support and advice  
Discuss how a referral to a lactation consultant can assist  
Advise parent/carer about Child Family Health Nurses or ABA counsellor’s expertise and availability to provide this service |
| **6** How well does your baby latch (or attach) to the breast for feeds? | Determine if baby latching is adequate for nutrition | A poor latch may lead to low supply, cracked nipples  
Ask permission to observe a feed and observe infant’s ability to latch especially if mother complains of pain  
Discuss referral to a lactation consultant – Child Family Health Nurses or ABA counsellors provide this service |
| **7** Does your baby vomit with feeding? Do you think I could observe a feed? It may help to assess what the problem is | Specific description of vomits may help with diagnosis i.e. a spoonful, cup full, dribble out, or spurt out forcefully  
When do vomits occur – with burping, during, after or in between feeds?  
What does vomit look like i.e. curdled milk, watery, blood stained, yellow or green?  
Any signs of pain, having a poor suck and swallow needs priority referral to a speech pathologist | Acknowledge parents description of vomits  
Reinforce that some positing is normal  
Acknowledge forceful vomiting can be frightening particularly if the vomit comes out of nasal passage and infant seems short of breath |
## 10.3.2 Breast milk and bottle feeding

<table>
<thead>
<tr>
<th>Explore with the family</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Does your baby have expressed breast milk by bottle? How much do you give and how often?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>2</strong> Are you using baby formula? Is this given before, after or instead of breast feeds? Has the formula been changed? When were changes made and why? How long did you give each formula? Did you notice any differences with these changes?</td>
</tr>
<tr>
<td><strong>3</strong> Who usually feeds your baby the bottle?</td>
</tr>
<tr>
<td><strong>4</strong> How is your baby usually positioned for feeds (on his/her back in bed, cuddled for feeds)?</td>
</tr>
<tr>
<td><strong>5</strong> What type of bottle and teat are you using?</td>
</tr>
<tr>
<td>Explore with the family</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
</tbody>
</table>
| Does your baby vomit with feeding? Do you think I could observe a feed? It may help assess what the problem is | • Specific description of vomits may help with diagnosis i.e. a spoonful, cup full, dribble out, spurts out forcefully  
• When do vomits occur – with burping, during, after or in between feeds?  
• What does vomit look like i.e. curdled milk, watery, blood stained, yellow or green?  
• Any signs of pain, having a poor suck and swallow needs priority referral to a speech pathologist | • Acknowledge parents’ description of vomits  
• Reinforce that some positing is normal  
• Acknowledge forceful vomiting can be frightening particularly if the vomit comes out of nasal passage and baby was short of breath |
### 10.3.3 Formula Feeding

<table>
<thead>
<tr>
<th>Explore with the family</th>
<th>Rationale for question</th>
<th>Response to parent/carer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 What formula are you using?</td>
<td>Establish if appropriate formula is being used</td>
<td>Acknowledge if formula type is appropriate for their baby</td>
</tr>
<tr>
<td>2 How do you make up the formula? Can you talk me through this?</td>
<td>Is recipe being followed, water being boiled and cooled, correct powder to water ratio</td>
<td>Advise families to follow the recipe unless there is a valid reason not to do so (e.g. baby with Congenital Heart Disease may need extra calories)</td>
</tr>
<tr>
<td>3 How much does he/she usually drink? How long does a feed take?</td>
<td>Provides more information regarding the infant’s feeding pattern, history</td>
<td>Identify if infant is crying because he/she is hungry or is being overfed</td>
</tr>
<tr>
<td>4 Has the formula been changed? What formulas have you given? Who suggested the change of formula? How long did you give each formula? Did you notice any differences with these changes?</td>
<td>An accurate feeding history is essential to determine links between feeding, crying and unsettled behaviour</td>
<td>If family have been advised by Child and Family Health Nurse, GP or paediatrician then a referral back to them may be appropriate</td>
</tr>
<tr>
<td>5 What type of bottle and teat are you using?</td>
<td>Some teats may make feeding more difficult for the infant, or may have a faster/slower flow rate than needed</td>
<td>Some teat shapes, flow rates are easier for babies to manage</td>
</tr>
</tbody>
</table>

Observing a feed may provide further answers Determine if feeding system is appropriate
<table>
<thead>
<tr>
<th>Explore with the family</th>
<th>Rationale for question</th>
<th>Response to parent/carer</th>
</tr>
</thead>
</table>
| 7  | Does your baby vomit with feeding? May I observe a feed? It may help to assess what the problem is | • Specific description of vomits may help with diagnosis i.e. a spoonful, cup full, dribble out, or spurt out forcefully  
• When do vomits occur – with burping, during, after or in between feeds?  
• What does vomit look like i.e. curdled milk, watery, blood stained, yellow or green?  
• Any signs of pain, having a poor suck and swallow needs priority referral to a speech pathologist | • Acknowledge parents description of vomits  
• Reinforce that some positing is normal  
• Acknowledge forceful vomiting can be frightening particularly if the vomit comes out of nasal passage and infant was short of breath  
• Observe parent child interaction during the feeding process |
| 8  | Has your infant gained weight? | • Establish baby’s weight has increased and consistent with WHO and CDC Growth Charts | • Check Personal Health Record and growth charts |
## 10.4 Appendix 4: Output

<table>
<thead>
<tr>
<th></th>
<th>Explore with the family</th>
<th>Rationale for the question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>How often does your infant have a dirty nappy? What does it look like? Is it very smelly?</td>
<td>• Identify constipation, diarrhoea, gastroenteritis</td>
<td>• Breast fed babies may pass a loose mustard coloured stool every nappy change or not pass stools for several days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identify possible milk intolerance/sensitivity</td>
<td>• Artificially fed infants usually pass stools every 1 – 2 days, some a little more frequently</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• If indication of underlying medical problem this requires further medical evaluation</td>
</tr>
<tr>
<td>2</td>
<td>How many wet nappies does your infant have each day? Is the urine smelly?</td>
<td>• Identify possible dehydration or urinary infection</td>
<td>• 4-6 wet nappies</td>
</tr>
<tr>
<td>3</td>
<td>Do you change the nappy every feed, more often than that or only when it is very wet?</td>
<td>• Determine if the information provided in response to the above question is accurate</td>
<td>• Some parents change the infant’s nappy so frequently the nappy may only ever be damp not wet</td>
</tr>
</tbody>
</table>
### 10.5 Appendix 5: Sleeping and settling

<table>
<thead>
<tr>
<th>Explore with the family</th>
<th>Rationale for question</th>
<th>Response to parent/carer</th>
</tr>
</thead>
</table>
| 1.                      | What is the problem with your baby’s sleeping?                                          | Identify parent’s perception of problem:  
  - Difficulty getting off to sleep  
  - Difficulty staying asleep for more than 30 minutes  
  - No pattern to their sleep habits  

  - Babies may take up to 30 minutes to go to sleep  
  - Overtired babies may need extra holding/cuddles/gentle rocking until almost asleep  
  - A dummy may help some babies. If breastfeeding, using a dummy before 6 weeks is not recommended  
  - Irregular sleep patterns/insufficient sleep may cause the infant to be restless and to have difficulty sleeping soundly for long periods of time  
  - Encourage parents to resettle the infant if the sleep is less than 1 hour. Walking with baby in pouch if under 3 months or pram may assist  
  - The wake, feed, play, sleep pattern may help develop a more predictable sleep pattern  
  - Baby playtime varies, dependent on age – on average 30 minutes at 6 weeks of age to 1.5 - 2 hours at 6 months of age |
### Explore with the family

### Rationale for question

#### 2 How do you know when your baby is tired?

- Identify parents’ ability to appropriately recognise early tired signs

#### 3 Where does baby sleep?

- Ensure carers to have a suitable place for baby to sleep

### Response to parent/carer

- The end of playtime is indicated by tired signs as demonstrated by the infant
- Tired signs include: glazed eyes, ‘staring into space’, clenched fists, jerky movements, yawns, sighs, being easily distracted for infants over 3 months
- Late tired signs include: prolonged grizzling and crying, difficulty getting to sleep, restless sleep
- Babies adapt to different locations for sleep, if parent responds to early tired signs in a similar way each time

- See SIDS guidelines
### 10.6 Appendix 6: Psychosocial

In order to better support you and your infant, we would like to ask some more questions about how your family works.

<table>
<thead>
<tr>
<th>Explore with the family</th>
<th>Rationale for question</th>
<th>Response to parent/carer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Who lives in the house with you and your baby?</td>
<td>To identify the level of social supports for parents/carers</td>
<td>Acknowledge parent/carer response and identify if parent/carer is living alone. Parent/carer may not have support in the home</td>
</tr>
<tr>
<td>2. Who mostly cares for your baby?</td>
<td>Acknowledges the range of cultural norms regarding primary responsibility for caring tasks</td>
<td>Many members in the family does not mean that caring is shared</td>
</tr>
<tr>
<td>3. Apart from those who live with you, who are your support people? Are they available and helpful to you?</td>
<td>Do the parents/carers consider these people to be supportive e.g. grandparents may live with the parents but not provide any assistance</td>
<td>Encourage acceptance of help offered from supports identified. If none available consider referral to relevant services, Child Family Health Nurse is a good starting place if not already linked</td>
</tr>
<tr>
<td>4. Do you have any agencies or other people that assist you?</td>
<td>Support services may be in place for any family member, knowledge of this assists in discharge planning</td>
<td>Request contact details and consent to contact any agencies involved and phone them</td>
</tr>
<tr>
<td>5. Do you follow any cultural or religious practices that help you with your parenting?</td>
<td>Cultural practices may support but may impact on the ability to access additional supports e.g. a lying in period after delivery may mean mother is unable to attend appointments</td>
<td>Are there cultural specific services that you can consult with/refer to for additional supports? Are there alternative ways services can be delivered e.g. requesting a home visit from the Child Family Health Nurse?</td>
</tr>
<tr>
<td>Explore with the family</td>
<td>Rationale for question</td>
<td>Response to parent/carer</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **6** Is your family experiencing any additional challenges at present e.g. financial, housing, recent losses? | • Additional stressors increase the vulnerability of the family e.g. casual work may mean partner is unable to take time off to help. Understanding these stressors can ensure appropriate supports are put in place | • If urgent e.g. currently homeless or no income to cover the needs of infant, immediate action may be needed. Consider admission  
• Referrals may be required to specific agencies for additional supports. Consider referral to Social Work (if available) |
| **7** Do you have any health issues that impact on your ability to care for your baby at present e.g. depression, anxiety? | • Needs to be considered for all adults who have caring responsibilities for the infant, not just the mother  
• Could include mental health, intellectual disabilities, substance use  
• Consider whether risk of significant harm exists for infant | • Obtain family’s consent to contact any services already involved  
• Referral to appropriate agencies e.g. Mental Health Team may be required  
• Consider whether report to Community Services is required |
| **8** What impact has becoming a parent had on you as an individual/as a couple? What do you find most challenging about being a parent? What do you enjoy the most about being a parent? | • Provides the opportunity to explore parent’s expectations  
• Provides the opportunity to explore the impact of parenthood on the individual and on the couple level  
• Provides the opportunity to build on the positives and proactively addresses challenges they are experiencing | • Consider how well parents/carers are coping  
• Consider attachment to infant, grief and loss in relation to birth and parenting experience  
• Consider what early intervention parenting supports may be of assistance/interest to the family |
<table>
<thead>
<tr>
<th>Explore with the family</th>
<th>Rationale for question</th>
<th>Response to parent/carer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>9</strong> Have you felt anxious, miserable, worried or depressed over the last few weeks? Have you felt overwhelmed with caring for the infant and all the other things in your life?</td>
<td>To identify any parental mental health issues, in particular Postnatal Depression which can have a significant impact on the parent’s capacity to meet their infant’s needs</td>
<td>If yes to either question consider whether further mental health assessment, including the Edinburgh Postnatal Depression Scale, is required</td>
</tr>
</tbody>
</table>
| **10** Do you or your partner have any history of mental illness? If yes then need to clarify:  
- Is the parent receiving treatment?  
- Is treatment current, e.g. medication/therapy?  
- Who provides this treatment?  
- Does parent find it helpful? If previous MH issue, what helped then?  
- Do they have a plan in case symptoms occur again? | Unidentified/untreated parental mental health issues may have a significant impact on the developing infant  
Ensuring that the parent/carer is linked with adequate mental health support is essential  
Urgent intervention may be required to ensure the safety of the parent and/or infant | Determine whether mental health assessment is needed now  
Seek consent from parent to contact their treating clinician(s) and inform them of relevant information from this presentation  
If not currently linked with relevant mental health services, make appropriate referrals after seeking consent |
| **11** Are there any other issues you would like to mention or talk about? | Allows parent/carer to raise any additional issues | Identified areas will need further exploration at this visit or may require referral for follow up in the community |
10.7 Appendix 7: Resources

A Crying baby Fact Sheet has been jointly developed by The Sydney Children’s Hospitals Network (Westmead and Randwick) and Kaleidoscope Hunter Children’s Health Network. 

Disclaimer: This fact sheet is for educational purposes only. Please consult with your doctor or other health professional to make sure this information is right for your child.

10.7.1 Crying Baby
- Parent Fact Sheet – Crying Baby
- Karitane Information – Your Crying Baby
- Raising Children Website
- Period of Purple Crying
- Research – The Relation of Crying and Shaken Baby Syndrome

10.7.2 Sleep and Settling
- SIDS and KIDS safe sleeping guidelines
- Karitane information – Settling Strategies
- Tresillian information - Settling
- Raising Children website – Newborns sleep what to expect

10.7.3 Breast Feeding
- Australian Breastfeeding Association information
- Raising Children website - Sore nipples, mastitis and blocked milk ducts

10.7.4 Formula Feeding
- How to make up formula
- Raising Children website – bottle feeding articles

10.7.5 Parental self-care
The following websites contain information which may be helpful to families
- Parents - Looking after yourself
- PANDA - Practical Strategies for feeling better
- Adjusting to Parenthood
- Tresillian - Advice and tips for new parents
10.8 Appendix 8: Edinburgh Postnatal Depression Scale

The Edinburgh Postnatal Depression Scale (EPDS) is a set of 10 screening questions that can indicate depression and anxiety during pregnancy and in the year following the birth of a child. It reflects the woman’s experience in the 7 days prior to completing the questionnaire. The EPDS is not a diagnostic tool and must always be used in conjunction with clinical assessment. Administration of the EPDS should only be carried out by a clinician trained in its use.

EDINBURGH POSTNATAL DEPRESSION SCALE

Please select one response for each question that is the closest to how you have felt in the PAST SEVEN DAYS.

1. I have been able to laugh and see the funny side of things:
   - As much as I always could [0]
   - Not quite as much now [1]
   - Definitely not so much now [2]
   - Not at all [3]

2. I have looked forward with enjoyment to things:
   - As much as I ever did [0]
   - Rather less than I used to [1]
   - Definitely less than I used to [2]
   - Hardly at all [3]

3. I have blamed myself unnecessarily when things went wrong:
   - Yes, most of the time [3]
   - Yes, some of the time [2]
   - Not very often [1]
   - No, never [0]

4. I have been anxious or worried for no good reason:
   - No, not at all [0]
   - Hardly ever [1]
   - Yes, sometimes [2]
   - Yes, very often [3]
5. I have felt scared or panicky for no very good reason:
   - Yes, quite often [3]
   - Sometimes [2]
   - Hardly ever [1]
   - Never [0]

6. Things have been getting on top of me:
   - Yes, most of the time I haven’t been able to cope at all [3]
   - Yes, sometimes I haven’t been coping as well as usual [2]
   - No, most of the time I have coped quite well [1]
   - No, I have been coping as well as ever [0]

7. I have been so unhappy that I have had difficulty sleeping:
   - Yes, most of the time [3]
   - Yes, sometimes [2]
   - Not very often [1]
   - No, not at all [0]

8. I have felt sad or miserable:
   - Yes, most of the time [3]
   - Yes, quite often [2]
   - Not very often [1]
   - No, not at all [0]

9. I have been so unhappy that I have been crying:
   - Yes, most of the time [3]
   - Yes, quite often [2]
   - Only occasionally [1]
   - No, never [0]

10. The thought of harming myself has occurred to me*:
    - Yes, quite a lot [3]
    - Yes, sometimes [2]
    - No, not much [1]
    - No, not at all [0]
SCORING THE EPDS
Add up individual scores from the 10 questions to obtain the total score

Range of EPDS Scores:

0 - 9: Scores in this range may indicate the presence of some symptoms of distress that may be short-lived and are less likely to interfere with day to day ability to function at home or at work. However, if these symptoms have persisted more than a week or two further enquiry is warranted.

10 - 12: Scores within this range indicate presence of symptoms of distress that may be discomforting. Repeat the EDS in 2 weeks’ time, and continue monitoring progress regularly. If the scores increase to above 12 assess further and consider referral as needed.

13 +: Scores above 12 require further assessment and appropriate management as the likelihood of depression is high. Referral to a psychiatrist/psychologist may be necessary.

*Item 10: Any woman who scores 1, 2 or 3 on item 10 requires further evaluation before leaving the office to ensure her own safety and that of her baby.

10.9 Appendix 9: Working Party Members

Prof John Eastwood (Chair) Director, Community Paediatrics, Liverpool Hospital, South Western Sydney Local Health District

Dr Grace Wong (Chair) Community Paediatric Fellow, Liverpool Community Health Centre, South Western Sydney Local Health District

Ms Margaret Kelly (til June 2013) Greater Eastern and Southern Child Health Network Coordinator

Ms Clare Godfrey Coordinator Children’s Healthcare Network, Southern Region

Ms Sarah Patterson Project Officer, Paediatrics, Clinical Excellence Commission

Ms Gill Patterson Clinical Nurse Consultant, Child and Family Health, Sydney Children’s Hospitals Network, Westmead

Ms Jenni Jones Clinical Nurse Consultant Child & Family Health Sydney Local Health District

Ms Jenny Rose Senior Social Worker Emergency Dept./Student Educator, Sydney Children’s Hospitals Network, Westmead

Ms Karen Willcocks Clinical Nurse Consultant Child & Family Health, Karitane

Dr Matthew O’Meara Director Emergency Department, Sydney Children’s Hospitals Network, Randwick

Dr Sanj Fernando Emergency Physician, Liverpool and Campbelltown Hospitals, Conjoint Lecturer, UNSW; Retrieval Specialist, NSW Ambulance Service

Dr Susan Marks Department Head, Child Protection Unit, Sydney Children’s Hospitals Network, Westmead

Ms Mary Dowswell Children’s Healthcare Network, Paediatric Clinical Nurse Consultant, Illawarra Shoalhaven Local Health District

Ms Julie Friendship Children’s Healthcare Network, Paediatric Clinical Nurse Consultant, South Eastern Sydney Local Health District
### Consultants on the CPG

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Dr Keith Howard</td>
<td>Paediatrician, Maitland Hospital</td>
</tr>
<tr>
<td>Dr Jacinta M Tobin</td>
<td>Senior Lecturer Medical Education in Indigenous Health, Sub Dean Western Clinical School, University of Melbourne, Nutritional Gastroenterology Paediatric and Adolescent</td>
</tr>
</tbody>
</table>

Dr Jodi Culbert
- General Practitioner, Wagga Wagga, Rural Doctors Association of NSW

Ms Joanne Goulding
- Aboriginal Child & Family Program Co-ordinator, Narellan Community Health Centre

Dr Keith CY Ooi
- Paediatric Gastroenterologist, Sydney Children’s Hospitals Network, Randwick

Laura Kelly/Jane Cichero (from October 2014)
- Senior Analyst, Office of Kids and Families