CHCECE032
Nurture babies and toddlers

Learner Guide

One World for Children Pty Ltd

Updated to include National Quality Framework changes

Aspire Learning Resources

CHCECE032

Nurture babies and toddlers

Release 1

Learner Guide

Aspire Version 2.1

One World for Children Pty Ltd

Aspire Learning Resources

CHCECE032 Nurture babies and toddlers, Release 1

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Aspire Learning Resources
Supporting Vocational Education and Training for 30 years
1991 to 2023

Contents

Before you begin

This Learner Guide is based on the unit of competency *CHCECE032 Nurture babies and toddlers*, Release 1.

Your trainer or training organisation must give you information about this unit of competency as part of your training program. Information regarding how this Learner Guide relates to this unit of competency is detailed in our mapping guide.

How to work through this Learner Guide

This Learner Guide contains a number of features that will assist you in your learning. Your trainer will advise which parts of the Learner Guide you need to read, and which Practice Tasks and Learning Checkpoints you need to complete.

Feature of the Learner Guide	How you can use each feature
Learning content	➢ Read each topic in this Learner Guide. If you come across content that is confusing, make a note and discuss it with your trainer. Your trainer is in the best position to offer assistance. It is very important that you take on some of the responsibility for the learning you will undertake.
Examples	➢ These highlight learning points and provide realistic examples of workplace situations.
Practice Tasks	➢ Practice Tasks give you the opportunity to put your skills and knowledge into action. Your trainer will tell you which Practice Tasks to complete.
Summaries	➢ Key learning points are provided at the end of each topic.
Learning Checkpoints	➢ There are Learning Checkpoints at the end of each topic. Your trainer will tell you which activities to complete. These activities give you an opportunity to check your progress and apply the skills and knowledge you have learnt.

This table maps each topic in this Learner Guide to the National Quality Standard and national learning framework: Early Years Learning Framework (EYLF).

T = Topic

Topics	National Quality Standard (NQS)
T1	Quality Area 1: Educational program and practice
T1–T5	Quality Area 2: Children's health and safety
T1–T5	Quality Area 3: Physical environment
T2	Quality Area 4: Staffing arrangements
T1–T5	Quality Area 5: Relationships with children
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	Early Years Learning Framework
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T1–T5	Respect for diversity
	Aboriginal and Torres Strait Islander perspectives
T1–T5	Equity, inclusion and high expectations
	Sustainability
T1, T2	Critical reflection and ongoing professional learning
	Collaborative leadership and teamwork
	Practice
T1–T5	Holistic, integrated and interconnected approaches
T1–T5	Responsiveness to children
T1, T4, T5	Play-based learning and intentionality
T1, T2, T4, T5	Learning environments
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T1, T2, T4, T5	Continuity of learning and transitions
	Assessment and evaluation for learning, development and wellbeing
	Learning Outcomes
T1–T5	1. Children have a strong sense of identity
T1–T5	2. Children are connected to and contribute to their world
T1–T5	3. Children have a strong sense of wellbeing
T1–T5	4. Children are confident and involved learners
T1	5. Children are effective communicators

Topic 1

In this topic you will learn about:

- **1A** Building relationships and providing learning
- **1B** Recognising and responding to cues

Understanding babies and toddlers

Communicating and using language enables babies and toddlers to develop their own sense of identity.

The terms 'baby' and 'infant' are used to define a child who is less than one year old. In particular, a baby or infant is a child who is not yet able to walk. Once a child can walk, they are termed a toddler. You will need to cater for children's needs differently depending on their age and individual abilities.

From infancy and through childhood, children begin to develop a sense of self-awareness. It is a time in their lives where they are developing and learning about themselves and how to express themselves. The physical environment also provides messages to children and their families, influencing their feelings of belonging.

1A Building relationships and providing learning

Development occurs through play as babies and toddlers examine everything around them, and learn by using their senses.

Babies and toddlers explore and experiment to discover new information. They master new skills through practice and repetition.

Element 1.1.3 of the National Quality Standard (NQS) expects that 'All aspects of the program, including routines, are organised in ways that maximise opportunities for each child's learning'. This includes the way you engage children in learning through play and routine times, as well as how you develop a responsive relationship.

Encourage children to learn through play.

Influences on development

Different factors influence and impact babies' and toddlers' development, and therefore development varies for each child.

Babies gradually adapt their reflexes and learn to think in deliberate ways. Skills will be achieved slightly earlier or later than expected based on the experiences and abilities of each child.

Some of the factors that influence development are outlined in the following table.

Factor	Influence on development
Age	➤ Children progress through stages sequentially. Their understanding increases as they develop and they are able to understand more complex concepts.
Gender	➤ Traditionally, boys and girls have been known to show more interest in particular and different types of play and exploration from each other. ➤ Babies may not demonstrate these differences as they simply interact with basic sensory and manipulative objects. ➤ Toddlers will start to demonstrate their preferences. Commonly, boys will be involved in more active, constructive and experimental play, whereas girls will be involved in nurturing, communicative activities. This usually occurs based on the types of activities they are presented with and drawn to.

Factor	Influence on development
Family background, beliefs and cultural practices	➤ Family interest or accessibility to a diverse range of concepts and interests can influence the child's understanding of the world and what it has to offer. This may influence their opportunities for learning. ➤ In some families, children are expected to behave within strict guidelines, while other families have fewer boundaries. ➤ This leads to different expectations about play and enjoyment, attitudes to learning and teaching methods.
Attachment relationships	➤ If a child develops attachment relationships with people who provide consistent, responsive care, their brains will be wired to expect this. ➤ If their care is inconsistent and their needs are not met, their brain wiring will be different, less responsive to and expectant of positive relationships and care. A securely attached child will be more likely to explore and experiment.
Ability	➤ Each child's genetic level of intelligence influences their ability. The environment adds to these capabilities; however, some limitations may occur due to developmental challenges, such as how well a child understands concepts or whether a material or resource is accessible to them. ➤ Some children may be naturally higher in intelligence and be able to ask questions and calculate information in a way that builds their understanding and interest.
Temperament	➤ Children with easy-going temperaments may be more likely to participate in activities that are social rather than cognitive-based. Other temperaments may find experiences challenging or frustrating.
Interests	➤ Children are drawn to activities they find stimulating and enjoyable. They learn from these experiences and build on many areas of their development through these interests.
Peer groups	➤ Peers learn from each other in play as information is shared. For babies and toddlers, this might come from watching and copying other children.

Brain development

Research has proven that the quality of the experiences and interactions babies receive links to how well their brain develops.

Children's brains are constantly developing new connections (synapses), which reflect their life experiences. These synapses develop early in life and, along with genetics, determine a child's possible brain capabilities later in life. When the brain is provided with learning opportunities and experiences, the circuit of synapses is strengthened. However, when skills are not encouraged or experienced, the synapses are lost.

Times when the brain is at its optimum learning potential are called 'windows of opportunity', 'critical learning periods' or 'prime times'. You will notice a window of opportunity when a child initially starts to explore and attempt to learn or master a new skill. These skills are called emerging skills because they are just starting to show.

When children show emerging skills, scaffolding experiences are most valuable. Scaffolding experiences are actions that occur in order to build skills as they emerge. You can notice these windows of opportunity almost constantly for babies and toddlers. They are open to all the quality positive, stimulating interactions provided to them. When exploratory behaviour is encouraged the child will develop to a higher level.

Stress and brain development

Stress causes a number of changes in the body.

One of the changes stress causes is the release of a hormone called cortisol. When stress is constant and long-lasting, it is called 'toxic stress', and during these times, cortisol is highest and most damaging to the brain.

Examples of toxic stress include:

- ongoing abuse
- neglect
- family violence
- poverty
- lack of housing
- lack of secure relationships or attachments.

Cortisol increases during these distressing times and reduces the ability of the synapses to connect and strengthen.

Caring and positive relationships can reduce stress levels and increase the resilience of the baby or toddler.

Example

Windows of opportunity

Jade usually sits quietly while being fed. Today she has reached for the spoon. Her educator, Lily, identifies that Jade has an emerging skill; wanting to explore the activity of feeding herself. Lily sees this window of opportunity as a time to provide scaffolding experiences for Jade. At the next meal Lily feeds Jade; however, she also offers Jade her own spoon and encourages her to try to scoop some food onto the spoon.

Sensorimotor cognitive development

The sensorimotor stage is the first part of cognitive development within the constructivist theory (developed by Jean Piaget).

This stage spans from birth to approximately two years old and is determined by a child's use of physical actions to explore with their senses. Children in this stage are only able to think about people or events in the current situations they are in.

A baby can't predict what is going to happen and so constantly experiments through trial and error. Many of these experiments are repetitive so the baby can see whether the same thing happens each time it occurs.

Repetitive play includes:

- copying games
- dropping and picking up games
- repeated action games
- reactions following cues; for example, the baby says 'ah' and you make a surprised face.

There are six sub-stages to the sensorimotor stage; each of these has clear characteristics and relates to the concept of object permanence. This is the process of learning that leads to recognising that an object exists even if it can no longer be seen. By the age of one, infants usually have fully developed object permanence. This development helps explain why infants are fascinated with toys and games that involve hiding and finding.

Object permanence play includes:

- peek-a-boo
- pop-up games
- hiding and finding games.

The following table outlines the sub-stages of the sensorimotor stage through the characteristics that indicate each one, as well as object permanence development.

Sensorimotor sub-stage	Characteristics	Examples	Object permanence
Sub-stage 1: Reflexive (Birth to approximately one month)	• Reflexes are used. • There is little or no imitation.	• The child is occupied by inborn reflexes: looking about, grasping and sucking.	• None. Unable to find an object even when watching it being hidden.
Sub-stage 2: Primary circular reactions (Approximately one to four months)	• Simple motor actions are centred on the child's own body. • The child copies another person's behaviour.	• Opening and closing fingers. • If the child blows bubbles and this is repeated by an adult, the child will do it a second time.	• None. Unable to find an object even when watching it being hidden.

Sensorimotor sub-stage	Characteristics	Examples	Object permanence
Sub-stage 3: Secondary circular reactions (Approximately four to eight months)	➤ Actions are oriented towards recapturing interesting effects. ➤ The child imitates the behaviour of a model, but only if the action is one the child has already learnt.	➤ The child may shake a rattle to repeat the effect gained or kick their feet to make a mobile move. ➤ If the child is able to gurgle and an adult gurgles to the child, the child may repeat the action.	➤ Able to retrieve a partially hidden object. ➤ Unable to find a completely hidden object even when watching it being hidden.
Sub-stage 4: Coordination of secondary circular reactions (Approximately eight to 12 months)	➤ Actions are goal-directed and serve as a means to an end. ➤ The child can imitate actions that are slightly different from the ones they have already learnt.	➤ The child may reach out (the means) to grab a toy (the end). ➤ If the child can gurgle and an adult gurgles with a start/stop action, the child may imitate. ➤ The child is excited by pop-up toys and hide-and-find games as they challenge their development of object permanence.	➤ Able to retrieve a partially hidden object from the first location it is hidden in, but will not look in a second hiding place. ➤ The child is beginning to understand that objects exist when out of sight – this links with the onset of separation anxiety.
Sub-stage 5: Tertiary circular reactions (Approximately 12 to 18 months)	➤ The child explores the properties of objects by acting on them. ➤ The child imitates unfamiliar actions.	➤ The child explores objects through sucking, biting, throwing, etc. ➤ If the child cannot clap but an adult claps in play, the child can imitate the action.	➤ The child is able to search in successive locations for a hidden toy.
Sub-stage 6: Mental representation (Approximately 18 months to two years)	➤ There is now some symbolic representation. ➤ The child has a good memory of objects and events.	➤ The child may cradle a doll or make a 'brrroomm' noise as they push a car around on the floor.	➤ Able to find hidden objects without first seeing the hiding action.

Emotional and social development

Babies quickly develop social skills for engaging with adults and learning about the world.

When babies/toddlers are settled in their environment they will feel emotionally safe. This security allows them to explore and investigate. The relationship the child has with you and other educators grows as they develop trust in you. Standard 5.1 of the NQS: Respectful and equitable relationships are maintained with each child, focuses on supporting educators to develop the concept 'Relationships with children'.

The following table provides some expected social developmental milestones at different ages.

Age	Developmental milestones
The first signs of social activity	➢ Touching and holding your fingers during feeding ➢ Showing recognition of their primary caregivers ➢ Paying attention to what is happening around them
By four months	➢ Reaching for familiar people ➢ Playing with toys
By six months	➢ Exchanging interactions with a caregiver ➢ Able to smile and play peek-a-boo games
By nine months	➢ Initiating activities ➢ Developing strategies for gaining attention ➢ Clinging to familiar people ➢ Cooperating in games
By 12 months	➢ Looking to their caregivers to check self-need ➢ Wanting someone familiar when they are hungry or hurt ➢ Beginning to be independent

Through routines and play, educators can engage in one-to-one interactions with babies and toddlers. This will help them to develop a nurturing and securely attached relationship. Some things educators can do to enhance this relationship, include:

- Learn about the child's individual routines, preferences, cues and planned or spontaneous play needs.
- Observe the child to learn about how they express themselves, how you can develop a stronger relationship with them and what their abilities and needs are. Discuss the child's needs with their family, colleagues, others significant in their life and/or specialists. This might also include discussion of simple topics with the child; for example, by asking questions such as 'Are you hungry?', 'Would you like a cuddle?' or 'Where do you want to sit?' You can talk about what the child is interested in and what they enjoy. Babies may not be able to converse in detail, but they can respond with words, actions or facial expressions.

- Be aware of the comfort items each child brings from home, such as a blanket or dummy. These can provide a connection that helps the child feel secure. This allows you to be responsive to their needs and reduce any distress.

As you get to know each baby or toddler, you become familiar with the activities they enjoy. When you take time to enjoy any one-to-one time with a child, you provide a relaxed, calm, physical time and lots of contact appropriate to the baby or toddler's preferences; for example, by:

- cuddling them
- sitting them on your knee
- rubbing their back
- holding their hand.

Attachment theory

Babies can form attachments, or bonds, with a number of people.

The attachment is strongest with their primary caregiver, but any number of other attachments may follow. A primary caregiver is the person who most often cares for the child, providing for their physical and emotional needs consistently and responsively. This person is usually a parent or guardian.

Other attachments are important to a baby's social and emotional development, and it is expected that each child will develop an attachment relationship with their educators.

Attachment relationships in babies and toddlers may be demonstrated in a number of ways, some of which are outlined below.

Social referencing

This is when a child watches the emotional response of someone they are attached to and responds in a similar way.

For example, if a spider or bug is crawling on the wall, the baby or toddler may copy the response of the educator. If the educator screams, the baby or toddler may scream; if the educator says, 'Hey, look how many legs it has! How interesting!' the baby or toddler may show interest.

Anchoring

This is when a child moves off to explore, but doesn't move too far from the person they are attached to. The baby or toddler ensures this person is within close proximity, and may be confused and concerned if they move away unexpectedly.

Refuelling or checking in

This is when a child periodically returns to the person they are attached to with a toy or activity, or just to make sure they are still there. The baby or toddler may also return to this person when they are frightened, hurt or upset.

When you observe these attachment behaviours, you can see how well you have developed relationships with a baby or toddler. This helps you understand what a child requires from you. Attachment relationships also help you see why it is important for primary carers to respond to the emotional needs of a baby or toddler. Providing strong, genuine relationships helps children and families feel a sense of belonging.

Attachment relationships support a child to develop confidently and capably. The child will feel able to venture into and explore their environment knowing they are supported and safe. A child without this feeling of attachment may have a reduced ability to learn about and feel confident in the world. This may reduce their development in all areas, as self-confidence and an interest in finding out motivates children to learn.

Reflecting on relationships

You should document information about the relationships you have with the babies and toddlers in your service, and critically reflect on these.

Writing down details of your interactions and relationships will enable you to take the time to think about your understanding of each child. You will also be able to:

- identify how you can be more responsive to each child
- develop strategies for improvement
- increase your understanding of why they do what they do.

Document your relationships using a diary, log or communication book. This will also allow other educators to contribute to your notes, so building a wide view of the child's relationships within the service as a whole. This can demonstrate the depth of bond between you and the child, or indicate where and in what ways the relationship needs to be strengthened.

Example

Reflecting critically

Susan, an educator, has critically reflected on her relationships in the interaction log. She notices that Julian has been upset and this has taken her attention away from Chloe. Chloe has quietly settled into the service within the last two weeks; however, Susan's interaction log highlights that she must build a relationship with Chloe so that she feels safe, secure and comfortable in her new environment.

Susan uses every part of the day as an opportunity to bond with Chloe and to extend her learning. She provides experiences that are appropriate to Chloe's developmental level, such as soft blocks to play with and objects to pull herself up on, and uses this time to build her language development. Susan incorporates learning and enjoyment into routine activities, such as settling to sleep and nappy changing, by singing songs and playing peek-a-boo, whilst keeping these routines unhurried and respectful.

Susan knows that through these routines and engagement she can develop a nurturing relationship with Chloe and maximise her time for learning, while still providing for the needs of all the children in her care.

Language development

The first signs of formed language are through a child's experimentation with different sounds.

Babies often begin by making 'raspberries' with their mouths and experimenting with different volumes and tones, such as squeals and moans. These simple sounds then begin to form 'baby babble' and, eventually, simple words that form part of the child's social interactions.

Even at this early stage, you will notice that the baby communicates with you by watching your face and responding with smiles and noises. The communication that takes place is in a conversation style, with you and the baby taking turns to interact.

Children's listening skills also begin to develop from birth. Babies from three or four weeks of age begin to demonstrate their listening skills by using simple gestures, such as turning their head towards the direction of different sounds. These simple signs of listening develop further as they are exposed to a variety of experiences that support and enrich this development.

The following table illustrates the language milestones for each age group.

0–6 months

- Coos back and forth with caregiver
- Responds to own name (4–5 months)
- Pays attention to human voices more than any other sound
- Gives and receives communication
- Imitates and responds to speech

6–12 months

- Communicates by crying, cooing, babbling, imitating, facial expressions, body language and gestures
- Responds to simple verbal requests
- Understands that words relate to objects
- Begins to imitate spoken words
- First words may be spoken

12–23 months

- Uses combinations of words in meaningful ways
- Knows names of people and familiar objects
- Has a vocabulary of up to 200 words

A baby or toddler will interact with you throughout the day and practise their language skills spontaneously. This is a time when they are developing knowledge of themselves and also becoming aware of the impact they have on you and their environment. To support them in this, value the time you spend interacting and talking with them, and respond to them as individuals.

Communication that supports learning, development and wellbeing should include:

- face-to-face interactions
- one-to-one relationships
- having realistic expectations and using developmentally appropriate language
- encouraging all babies/toddlers
- never forcing communication
- giving simple feedback
- making sure your facial expressions and body language match your words.

Actions you can include to support language learning are:

- repeating or imitating words, sounds and gestures
- singing
- reciting rhymes
- introducing finger games
- waiting for babies/toddlers to return your interactions
- modelling positive interactions appropriate to age groups and cultural differences
- using non-verbal communication, such as smiling, clapping and waving
- moving down to their eye level and making eye contact
- allowing babies/toddlers to participate at their own skill level
- encouraging babies to explore
- talking about the toys and activities used
- discussing the actions that are occurring as part of events or routines; for example, while changing a nappy
- reading books.

Physical development

Babies gradually learn to gain control over their physical movements and use their senses to understand the world around them.

At birth, a baby only has reflexes, movement and instincts aimed at meeting their basic needs. Some physical milestones include:

- Gross motor skills:
  - 3 months – rolls over
  - 4 months – lifts head up
  - 5 months – sits without support
  - 6 months – stands up while holding on
  - 9 months – walks with assistance
  - 12 months – walks unassisted, throws and kicks a ball
  - 12 to 18 months – pushes and pulls
  - 12 to 23 months – climbs
  - 18 to 23 months – runs.

- Fine motor skills:
  - 3 months – grasps objects and is able to follow movements with eyes
  - 6 months – grasps using palm and fingers
  - 9 months – grasps using fingers and thumb
  - 12 to 18 months – hits pegs on a peg board, claps, feeds self
  - 18 to 23 months – stacks, pours, dresses and undresses.

Some exploratory experiences you can provide to help stimulate babies' physical development are shown in the table below.

0–3 months	➤ Rattles ➤ Mobiles
3–6 months	➤ Tummy time (lying on tummy during play times) ➤ Low mirror at child's eye level ➤ Textured items to manipulate
6–12 months	➤ Large soft blocks ➤ Stacking cups ➤ Safe open spaces to roll and crawl around ➤ Low sturdy furniture to pull self up
12–23 months	➤ Thick crayons and large paper ➤ Push and pull-along toys ➤ Balls ➤ Dress ups ➤ Basic puzzles ➤ Low climbing equipment ➤ Sandpit and sand toys

Movement guidelines, developed by the Department of Health, have determined what is recommended for each early childhood age group. While these guidelines remind us that sleep and rest are important, they also encourage educators to use indoor and outdoor environments throughout the year and to have fun, while moving and playing every day.

Babies	➤ Support babies to be active several times a day in a variety of ways. ➤ Include at least 30 minutes of tummy time a day for those children who are not yet mobile. ➤ Encourage reaching, grasping, pushing and pulling. ➤ Use floor-based play such as crawling for older babies. ➤ Screen time is not recommended.
Toddlers	➤ Include at least 180 minutes (3 hours) of physical activity per day, including energetic play spread throughout the day. ➤ Screen time should be no more than 1 hour per day, less is better.
All children under 2 years	➤ Restrict restraint in a stroller, highchair or car seat to a maximum of 1 hour. ➤ When children are not involved in active play, encourage reading, singing, puzzles, storytelling and educator engagement. ➤ Support good-quality sleep.

You can access the *Australian 24-hour movement guidelines for the early years (birth to 5 years)* at: aspirelr.link/24hour-movement-guidelines-0-to-5

Personal care routines

Routines help to make sure that tasks are done on time, and that the environment is predictable, consistent and supportive.

Routines help you structure the day and allow everyone to feel ready for what is coming next. They should be relaxed and calm times when individual needs are met, and where interaction and play occur. They provide opportunities for you to focus on the personal needs of each child and allow you to spend quality moments with them. They are times that should be rich and enjoyable for children.

Personal care routines must be flexible and created around each child's needs. They should:

- reflect the family's culture and preferences
- meet the child's individual hygiene needs
- make the most of any one-to-one interaction that may occur
- be valuable, relaxed physical contact opportunities
- allow the baby or toddler to learn about their own needs
- be enjoyable.

Babies and toddlers need to move through personal care routines at their own pace or in small groups with others who have similar needs. This helps ensure their routines are implemented in a way that provides choice and flexible timing. It also makes the day more spontaneous and enjoyable.

Make the most of spontaneous one-to-one times in the routine as an opportunity to interact. Consider the examples in the following table.

Routine	Possible activities
Settling the child to sleep and welcoming them after sleep	Do this slowly and make this a calming and relaxing one-to-one time by: - stroking - patting - talking or whispering - singing.
Changing nappies	Do this slowly and make this a happy one-to-one time by: - singing - touching and talking about body parts such as toes and fingers - looking at a mobile or poster - talking about what you are doing - repeating baby/toddler sounds.
Feeding the child	Do this slowly and make this a fun one-to-one time by: - watching the baby's face - reacting to sounds and movements - talking about the food or drink - talking quietly about the physical experience; for example, hot, cold, tastes and textures.

Respectful routines

During routines, it is important to treat babies and toddlers with respect.

You can demonstrate that they are important by:

- returning the interactions they initiate with you
- greeting and fare-welling every child
- using children's names often
- respecting a child's name by using it correctly
- never giving children nicknames unless these are provided by family members as the name the child is known by
- being affectionate, but avoiding terms like 'darling' or 'sweetie'.

Show respect by using an approach that assists you to gain the baby's trust. Whether you need to wipe a nose, change a nappy, move the child to another area or put them in a high chair, always approach them, move to their level and tell them what you are going to do. Just because the child is not able to communicate with words does not mean they are unable to understand or that they shouldn't be prepared for a change.

Guidelines

A number of guidelines and standards exist outlining how you should interact with children and provide routines.

You can find much of this information in the *Guide to the National Quality Framework* at: aspirelr.link/nqf-guide-pdf.

Some information about child development and early childhood education and care standards are outlined in the following table.

Guideline	Statement	Link
Education and Care Services National Regulations	Regulation 73 – Educational program: (2) An educational program is to contribute to the following outcomes for each child – a. the child will have a strong sense of identity b. the child will be connected with and contribute to his or her world c. the child will have a strong sense of wellbeing d. the child will be a confident and involved learner e. the child will be an effective communicator.	aspirelr.link/acecqa-national-regulations
National Quality Standard (NQS)	Quality area 5 – Relationships with children	aspirelr.link/national-quality-standard

Guideline	Statement	Link
Brain development	Finding 2: Brain development is contingent on a complex interplay between genes and the environment. Finding 3: Experience wires the brain. Repetition strengthens the wiring.	aspirelr.link/brain-development-article
EYLF	Principle – Equity, inclusion and high expectations: educators view all children as competent and hold high expectations for their learning. They strive to provide all children with equitable and participatory environments and experiences to promote their learning, development and wellbeing.	aspirelr.link/eylf
	Principle – Aboriginal and Torres Strait Islander perspectives: educators welcome and take responsibility for creating connections with First Nations' families and their wider community, being sure to recognise any kinship systems and cultural connections.	
United Nations Convention on the Rights of the Child	Article 31: Children have the right to relax, play and join in a wide range of leisure activities.	aspirelr.link/unicef-child-rights

Example

Planning for learning and relationships

Jenna, the team leader, knows that every part of her planning needs to be an opportunity to maximise Priya's learning. Jenna has made a connection with Priya to help her feel safe and secure. Priya is starting to stand up and experiment with holding objects, so Jenna provides experiences to enhance her learning, such as objects for Priya to pull herself up on, holding on to her hands as she walks and soft blocks and toys to promote upper body gross motor development. She also knows that impromptu and one-to-one activities are just as important for her development, so she utilises any chance she gets to bond with Priya by talking with her as she plays, participating in her play and having conversations during feeding and nappy-change routines.

Jenna has a routine in her room that ensures all of Priya's needs are met in an unhurried, respectful and enjoyable way. She knows these routines are a perfect opportunity for spontaneous one-to-one interactions, such as singing a song or playing peek-a-boo.

Priya's development is constantly changing, so Jenna understands that her planning and opportunities for learning also need to grow and change with her.

Practice Task 1

1. Number each stage from 1 to 5 in the order a child develops.

   ☐ Reaching for familiar people

   ☐ Pulling self up on furniture

   ☐ Coos back and forth with caregiver

   ☐ Using push and pull-along toys

   ☐ Exchanging interactions with the caregiver

2. Which of the following statements are correct about care that is predictable, consistent and positive, and stimulates skill development? Select all that apply.

   ☐ Identify an individual child's patterns, routine needs and cultural context and take time to meet these while providing activities that meet physical abilities.

   ☐ Getting through routines on time and keeping toys and equipment stored correctly is more important than having a relaxed and calm environment.

   ☐ Provide opportunities for relaxed physical contact, interactions and one-to-one time that lets a child know they belong, that they are important and supports their learning, development and wellbeing.

   ☐ Prepare children for routines by explaining what will happen and letting them know before a routine starts.

   ☐ Children enjoy being held in different ways. Sometimes you will need to sit down while holding a child.

   ☐ Children should only use comfort items like dummies and blankets during sleep times.

   ☐ *The Australian 24-hour movement guidelines for the early years (birth to 5 years)* reminds us that sleep and rest are important, and that children should have fun while moving and playing every day.

3. Draw a line to match the example of practice on the left to the action on the right.

* One-to-one interaction with a toddler	* 'Bub, bub, bub.'
* Talking about objects and encouraging exploratory behaviour with a toddler	* 'Let's go and change your nappy. Can you collect your nappy?'
* Repeating words, sounds or gestures with a baby	* 'Sing with me while you get dressed: This little piggy went to market, this little piggy stayed at home...'
* One-to-one interaction with a baby	* 'Yum, squishy peas. Can you pick up your carrots with the fork?'
* Describing events and routine activities with a toddler	* 'Let me pick you up to have a cuddle and tickle your tummy.'

4. Which of the following statements about brain development and attachment are correct? Select all that apply.

- ☐ Educators can enhance their relationships with children though documenting observations, discussing practice with others and reflecting critically.
- ☐ Brain development can be influenced by the attachment relationships children have with educators.
- ☐ It is detrimental to children if they have strong, secure attachments or bonds to more than one educator.
- ☐ Physical, cognitive, language, emotional and social development are connected to brain development, however attachment links to emotional development only.
- ☐ Synapses within the brain are damaged when children experience toxic stress.

5. Draw a line to match the National Quality Framework (NQF) component on the left to the guidance they provide on the right.

* Quality area 5 of the NQS	* Includes regulations, laws, standards and frameworks that guide your relationships with children.
* EYLF Principle	* Relationships with children
* The National Quality Framework	* Equity, inclusion and high expectations

1B Recognising and responding to cues

The way you respond to babies' or toddlers' cues and needs influences their ability to form trusting relationships for the rest of their lives.

A baby develops trust when you respond to their cues quickly and appropriately. They learn mistrust when you misunderstand their cues or fail to respond appropriately. Trust and mistrust link with social and emotional wellbeing.

Pay attention to cues and respond appropriately.

High-quality care for babies and toddlers includes having a priority towards providing happy, healthy environments where all children's needs are met. This means achieving the EYLF goals of belonging, being and becoming. You can find a copy of the EYLF at your service or at: aspirelr.link/eylf.

Children experience a whole range of feelings and needs. While toddlers are able to provide some verbal feedback to help you identify their feelings and needs more readily, babies use their own communication methods – a range of non-verbal signals and sounds called cues. Sometimes these cues are difficult to interpret and understand; other times they are simple and clear.

A non-verbal cue is a behaviour or action; for example, crying, which may mean different things depending on the type of cry and the physical actions that accompany it.

The following table lists some common cues that babies display and their common meanings.

Cue	Common meaning
Gurgling	Content
Laughing	Happy
Pointing	Needing or wanting something
Fidgeting	Restless, bored
Grizzling	Unhappy, uncomfortable, tired
Smiling	Happy, content
Sobbing	Distressed, hurt
Crying	Hungry, uncomfortable, hurt, lonely
Singing	Happy, content
Yawning	Tired

Wriggling	Uncomfortable, frustrated
Screaming	Angry, in pain, hungry, fearful
Turning head away	Distaste, full
Throwing themselves on the floor	Angry, distressed
Throwing items across the room	Angry
Screwing up face	Distaste, angry
Staring hard at someone or something	Unsure, anxious

Responding to cues

Although there are similarities in the ways babies and toddlers use non-verbal cues and sounds, each child develops their own specific way of communicating.

As you work with individual children, you will learn each of their individual cues. Ask each child's family members about their cues to help you gain an understanding of them. This will guide you on how to relate to individual cultural practices, rituals and routines.

The following outlines a variety of cues and different ways to respond to them.

Hunger cues

Babies require frequent feeding. They have small stomachs and their bodies are growing quickly, they have stronger hunger pains than older children and are lighter sleepers. These features mean that they are more likely to wake when they feel hungry, and, in some circumstances, feelings of hunger might occur regularly or frequently.

Babies often stir when they feel their first faint hunger pains and may begin to whimper. At this point, many babies will put themselves back to sleep without any assistance, but some babies may need to be comforted.

Other signs and cues that a baby is ready for a bottle or breastfeed include:

- snuggling and looking for a breast or bottle
- crying inconsolably
- sucking their fist.

A quick, calm and reassuring response teaches the baby to trust you.

When responding to a baby's hunger cues:

- anticipate when a baby is likely to feel hungry – you can anticipate that the baby may experience strong hunger pains between half an hour to an hour before they are usually due for a bottle
- prepare the bottle and have it ready and waiting for the baby – do not wait for the baby to experience strong hunger pains before you begin to prepare this
- respond to the hungry cry immediately – pick up the baby and feed them in a calm, reassuring manner
- stop what you are doing and no matter how busy or anxious you may be, try to relax and be calm during bottle feeding as a baby can sense your non-verbal cues as well.

As children start to eat solid food, their signs and cues of hunger may change. Some of the cues you might notice include:

- clinging to an educator
- grizzling or crying
- attempting to gain constant attention
- showing a temper
- asking for food
- pointing to food
- pointing to the place where food arrives from
- sitting at the table or trying to get into a chair or high chair.

Fear or distress cues

Babies and toddlers are often frightened by things in their immediate environment, such as strange noises, objects, unfamiliar people, pain, falling, not knowing what to expect and sudden movements. As they become older, they begin to replace these fears with other fears, such as a fear of the dark or of 'monsters'.

Young children might demonstrate fear or distress through crying, screaming, moving away from the fear or hiding their face.

To overcome these fears, babies/toddlers need educators who understand them and take these fears seriously. Strategies that can be used to reassure children who demonstrate fear or distress include:

- gently stroking them
- talking or singing to them in a gentle voice
- rocking them in a cot/pram
- recognising the child's needs and responding to them
- offering physical comfort, support and reassurance, including using a security item, such as a toy, blanket or dummy
- trying to prevent frightening situations from occurring
- preparing for new and unfamiliar events by explaining what to expect; even if the child doesn't understand, they will learn to apply your words to the situation.

Anger and frustration cues

Once babies begin to understand that they can make some things happen, they may feel anger or frustration when they cannot control them.

Babies may express anger or frustration when:

- a toy is taken away from them
- they are being held and want to get down
- they are stopped from doing something they want to do
- their primary educator leaves the room for a period of time
- they are put down for a sleep, but would rather stay awake.

A baby or toddler may show anger and frustration by:

- screaming loudly
- arching their back
- grunting
- turning red in the face
- throwing their arms and legs around and crying, often without tears.

Babies and toddlers, just like adults, are more likely to learn if they are given support and guidance when they are frustrated. A certain amount of frustration is positive as it encourages children to try to solve a problem or task they are finding difficult.

When frustration becomes overwhelming it may be labelled as a tantrum; however, anger and frustration should not be viewed as bad emotions. Just as learning occurs in other areas, the way children deal with their frustration or anger is also a learning experience.

To support the child to develop self-knowledge and awareness you can respond to their anger or frustration cues in positive ways and accept them as a justified response to things that are out of the child's control.

When a baby is expressing frustration or anger, you might:

- act promptly to avoid frustration turning into anger
- acknowledge the baby's right to be angry
- prevent the cause of anger, if possible
- provide comfort while allowing the baby to express themselves
- ensure they don't hurt themselves.

When responding to a toddler's anger and frustration, be realistic about your expectations and remember that toddlers need to:

- assert their autonomy and independence
- gain power and control over their lives
- learn to regulate their emotions and calm down after experiencing strong emotions
- assert some control over their environment by saying 'no'
- have space, support and guidance
- make simple choices and decisions about what they want to do.

Toddlers are generally unable to understand another person's point of view and are unable to wait for long periods of time. They become frustrated with the limitations of their abilities. When they express themselves in a tantrum, try some of the following techniques, but remember that each child will react differently to your strategies.

Ways to help a frustrated toddler:

- Meet individual needs – tired and hungry children are more likely to become emotional.
- Distract a toddler when you see they are starting to become emotional – acting at the correct time can avoid extreme emotions. This doesn't mean ignoring the child's feelings, but is about catching the emotions before they become overwhelming.
- Stay calm – adding your emotions to the toddler's will only create a larger issue.
- Think about what the toddler wants or needs – when they are calm you may be able to support them to gain what they want in another way.
- Be consistent.
- Think laterally – sometimes you need to be creative to move the toddler from one overwhelming or emotional situation to a calmer and more controlled state.
- Reward success – use hugs, thanks, and words of support and encouragement.

Tiredness cues

Babies and toddlers need much more sleep than older children and adults. Many babies and toddlers give straightforward cues when they are tired.

A baby may look sleepy, yawn or lie around waiting to fall asleep. Some babies express tiredness by rubbing their eyes or becoming grizzly and easily upset; others tend to search for a bottle, breast or dummy.

When responding to tiredness cues:

- respond quickly
- provide comfort by picking the baby up, talking gently to them and providing their comfort item
- follow the baby's individual routines and rituals; for example; some babies need to be rocked, patted or rubbed gently on their backs
- respond in a calm and relaxed way to settle the baby to sleep, having everything ready beforehand
- adjust the environment to the baby's needs; this may involve changing the level of noise, light, temperature and ventilation.

Recognise that each baby or toddler will have their own sleep routine. Communicate with family members to clarify this. Some babies have a bottle before a sleep, some babies prefer to be placed in their cots and fall asleep on their own, some need quiet, settling time before bed.

Example

Understanding individual rest needs

At rest time, Asante shows no signs of tiredness although he is often restless and noisy. At first the educators think that he does not always need to rest or sleep, so instead they let him get up and play quietly.

Asante is nearly 18 months old and has recently started to bite other children. The educators realise that Asante only bites the other children in the afternoons when he has not had a sleep. It seems that on these days he becomes overtired and can't tolerate the other children being near him, so he bites them.

When educators realise this, they spend more time helping Asante to fall asleep, providing him with a more suitable sleep routine. As soon as they do this, the biting stops.

Pain cues

Babies have different thresholds for pain. Some react severely to pain, whereas others will hardly react at all. When a baby is experiencing pain, you may find that their cries are high-pitched and that they cry vigorously.

When identifying that a child is in pain, try to determine the cause and remove this. Respond to a baby in pain by trying to comfort them by holding or rocking them, as long as this does not worsen their pain.

If an incident has occurred and a baby continues to scream or cry strongly for some time, they should be referred to a medical practitioner for examination. Some babies who are seriously hurt or experiencing great pain may go into shock and not cry at all. In this case you need to be quick to observe all signs of possible shock. Signs of shock to be aware of include:

- coldness
- blue hands and feet
- a grey mottled appearance
- moist and clammy skin.

Anxiety cues

Anxiety is common for babies and toddlers. Young children are not able to make sense of what they are seeing or experiencing when they are confronted with something new, meet new people or are put in a new situation. This can make them feel anxious or fearful.

Stranger anxiety is particularly common for babies between eight and 12 months old.

Children express this anxiety or fear of strangers by:

- staring intently at the new person
- bursting into tears
- holding tightly to their caregiver.

When you notice stranger anxiety, respond calmly and offer reassurance to the child. They will watch how you respond to the situation and then reflect your action in their own.

Example

Reacting to stranger anxiety

The plumber, Leroy, arrives to unblock the service's sink. He is a big man with a loud voice and he is carrying a large bag of tools.

As Leroy comes into the room, Jace (10 months) and Amy (12 months) look up at the educator, Michael, and their faces begin to crumple. Michael has anticipated their nervousness and is already walking towards them. He smiles at them and says, 'It's okay, Leroy is going to fix the sink.' Michael picks up Jace, takes Amy's hand and starts to chat to Leroy, being cheerful and relaxed.

All the time Michael is talking to Leroy, Jace and Amy keep looking between Michael's face and Leroy's face.

After Michael has spoken to Leroy for a while, he takes Jace and Amy to the meal area where they have their morning tea. Both children only nibble at their food.

All the time Leroy is in the room, they keep looking between him and Michael. Although they do not totally relax, Jace and Amy do not cry. When Leroy leaves, they both begin to eat their morning tea with a hearty appetite.

Michael recognised each of the babies' cues. He responded in a calm and reassuring manner to assist the children to cope.

Separation anxiety

It is common for babies and toddlers to be distressed by separation.

Together, object permanence and attachment relationships contribute to understanding why a baby reacts differently to a family member leaving, depending on the age or stage of the child.

Babies and toddlers often move between home and care without stress. When you have a strong, trusting relationship with the child's family, the child will pick up on this feeling. This will help them make a positive move into the environment.

Some things you can try to help babies and toddlers settle and feel safe include:

- physically comforting with a cuddle, hug or a rub on the back, arm or shoulder
- rocking them
- providing comforters to relax them, usually a favourite toy or object
- talking to them

- listening to them
- redirecting or distracting them with another activity
- taking time with separation.

Supporting transitions

Routines include constant transitions as you move from meeting one need to another.

Strong relationships lead to healthy transitions, but these can only develop if you put basic child-focused practices into place. These practices include:

- having educators consistently caring for the same baby or toddler
- meeting or exceeding the ratio of children to adults so that needs can be supported promptly
- creating a sense of belonging for each child
- understanding the age and stage of the baby or toddler, and having realistic expectations
- highly prioritising relationships with children and families
- providing predictable yet flexible routines
- responding to the individual patterns and routines of the baby or toddler.

One of the most challenging transition times is separation. This is when family members drop off their child.

You can support positive separation transitions by:

- welcoming children and families at arrival
- developing a rapport with the child's family
- encouraging family members to stay until the baby or toddler is settled
- supporting the baby or toddler to take an interest in activities, or involving them in an activity
- being positive
- providing an attractive environment
- ensuring health and safety issues are managed
- using comfort items from home such as a blanket, toy or dummy.

If you are the person a baby or toddler is showing some fear or anxiety towards, avoid overwhelming them with a direct approach. It is usually better to stay back from the baby or toddler, or sit on the floor at their level and wait until they are ready to approach you. Try to be cheerful and friendly to the baby's educator or family member.

Playing with a toy that is interesting or exciting often encourages a child to come over to you to see what is happening. Allow the child to watch you and to join in the play at their own pace. This approach is called using a transition action.

Example

Using a transition action

It is Cathy's first day as an educator and she feels a bit anxious about how the babies may react to her. After speaking with the other educator, Francesco, Cathy decides to sit on the mat a short distance from where most of the babies are playing. She finds a pop-up toy and begins to play with it. As she plays with the toy she can sense some of the babies stopping their play and looking at her. After about 10 minutes of playing by herself, Georgia, aged 11 months, crawls over and sits next to Cathy, who doesn't stop playing with the pop-up toy, but turns and smiles at Georgia.

After a minute, Cathy asks Georgia if she would like a turn. She shows Georgia how to push the balls down tightly before pressing the trigger to release them. As the balls spring into the air, both Georgia and Cathy laugh. Georgia turns to Cathy and says, 'More!' and Cathy repeats the game.

After another five minutes, two more children come and join in. Cathy begins to relax as she realises that, with the right techniques, a baby's anxiety is not so difficult to overcome after all.

Practice Task 2

1. Which of the following statements about cues are correct? Select yes or no for each one.

a.	Babies' and toddlers' cues are the same so you don't need to respond differently.	* Yes	* No
b.	Cues should be closely monitored and responded to in a calm way.	* Yes	* No
c.	Anger and frustration may be expressed by babies when they can't control something; however, a certain amount of frustration is actually beneficial.	* Yes	* No
d.	You should wait until the baby has strong hunger pains before you get ready to feed them.	* Yes	* No
e.	Families can assist you to understand each child's own specific cues for hunger, distress, pain and tiredness. Understanding these will help you meet their rituals and routines.	* Yes	* No

2. Number each step from 1 to 6 in the order you would follow to meet a child's hunger needs and develop a bond.

☐	Prepare the bottle and any favourite toy or comfort item, so it is ready for the child.
☐	Once the child has finished the bottle, take notice of their cues and follow their routine to cater for their individual needs.
☐	Promptly deal with the hunger cue by picking the baby up, comforting them with a cuddle and reassuring them by talking about what you are going to do.
☐	Speak to a family member to know when the child is due for a bottle, what their cues are and so that you understand the family's practices and beliefs.
☐	Sit together while the child has their bottle. Use this time to develop your one-to-one relationship with them and to maximise learning opportunities.
☐	Watch/monitor the child for cues that they are getting hungry (starting to cry/grizzle) around the time they are due for their next feed.

3. Draw a line to match the non-verbal cues on the left to the correct common meaning and action on the right.

* Yawning, rubbing eyes and becoming increasingly upset	* Hungry – provide food or drink
* Screaming/crying for no apparent reason shortly after a feed and sleep	* Tired – prepare the child to settle for sleep
* Grunting while throwing his/her body around without any tears	* Pain – remove the cause and/or comfort the child
* Clinging to a familiar caregiver	* Anger – comfort the child and support them to resolve the issue
* Restless sleep with whimper increasing to crying and screaming	* Anxiety – provide physical contact and a comfort item

Summary

- Babies and toddlers prefer predictable routines that are flexible to their needs.
- Routines should be predictable, consistent and positive times when one-to-one interaction can occur.
- During routines, there are many opportunities to discuss objects and events with babies and toddlers.
- You can use comfort items or favourite toys to assist you to develop relationships with babies and toddlers.
- Your physical contact with babies and toddlers should be relaxed.
- The language of babies and toddlers is promoted with repetition of words, sounds and gestures.
- Babies and toddlers use individual cues to send you messages about what they want or need.
- Babies and toddlers will initiate interactions with you.
- Babies and toddlers need your support to explore their world.

Learning Checkpoint 1
Understanding babies and toddlers

Part A

Read the case study and then answer the questions that follow.

Case study

Harrison is nine months old. His parents inform you that he loves to eat with his hands and get messy, and that he has a dummy and special blanket for when he is upset or tired. He loves to explore and pull himself up on items.

His daily routine is usually as follows:

- 6.30am bottle
- 8am breakfast
- 9am bottle and sleep
- 12pm lunch
- 1.30pm bottle and a sleep
- 5pm dinner
- 6pm bath
- 7pm bottle and sleep

1. It is 1.15pm. Harrison has started to get a little unsettled and is rubbing his eyes and yawning. When you walk past he puts his hands up and cries.

   Harrison is showing cues that indicate he is ready for which of the following routines? Select all that apply.

   - [ ] Breakfast
   - [ ] Lunch
   - [ ] Bottle and sleep
   - [ ] Dinner
   - [ ] Bath

2. During his bottle-feeding routine, you interact and respond to Harrison and provide for his needs as guided by the NQS Quality area 5. Draw a line to match your actions on the left to the examples on the right.

* Providing a relaxed, calm, responsive environment with physical comfort	* 'Harrison, look at your new socks, they are very fluffy.'
* Repeating words and sounds	* 'Harrison, let's get your bottle and then we'll put you down for a rest.'
* Describing objects	* As Harrison drinks his bottle you smile at him and let him hold your finger. When he is lying in his cot you sing his favourite lullaby.
* Interacting one to one	* As Harrison drinks his bottle, he holds his special blanket. When in his cot, you provide his dummy.
* Talking about routine activities and events	* You cradle Harrison so he can see your face while he is drinking.
* Providing a favourite toy or comfort item	* Harrison stops drinking and blows a 'raspberry'. You laugh and blow a 'raspberry' back.

3. Which of the following statements about Harrison's care and development are correct? Select yes or no for each one.

a. Harrison will develop a securely attached relationship with you if you observe him and help him to fit into the routine of your service.	* Yes	* No
b. Harrison may change his routine over time. This occurs as he develops physically and emotionally. It may also alter based on his family culture and personal practices that change.	* Yes	* No
c. As part of Harrison's language and physical development, he might show he is attached to you by the way he checks where you are now and again while he is playing.	* Yes	* No

d. As Harrison grows, his brain will grow and synapses will be seen in the window of opportunity. * Yes * No

e. If Harrison develops secure attachments he will have more confidence in exploring the world and learning. His brain wiring will strengthen. * Yes * No

f. By documenting observations you make, and critically reflecting on the relationship you have built with Harrison, you will be able to increase your understanding of his needs and share this information with other educators so they can also form attachment relationships with Harrison. * Yes * No

4. When you understand stages of development and key milestones, you are able to provide valuable learning experiences. Draw a line to match each learning experience on the left to the value it will have for Harrison's development on the right.

* Clearing spaces	* Cognitive development – with encouragement Harrison will experiment with object permanence.
* Providing one-to-one relaxed physical contact and responding to cues	* Language development – Harrison will listen and familiarise with sounds and words.
* Hiding a ball under a pillow for Harrison to find	* Physical development – Harrison will be able to crawl safely.
* Reading books, repeating sounds and singing	* Emotional development – building a safe and trusting attachment that contributes to Harrison's wellbeing.
* Blowing bubbles into the sky	* Social development – interacting with Harrison and having fun.

Part B

Read the case study and then answer the questions that follow.

Case study

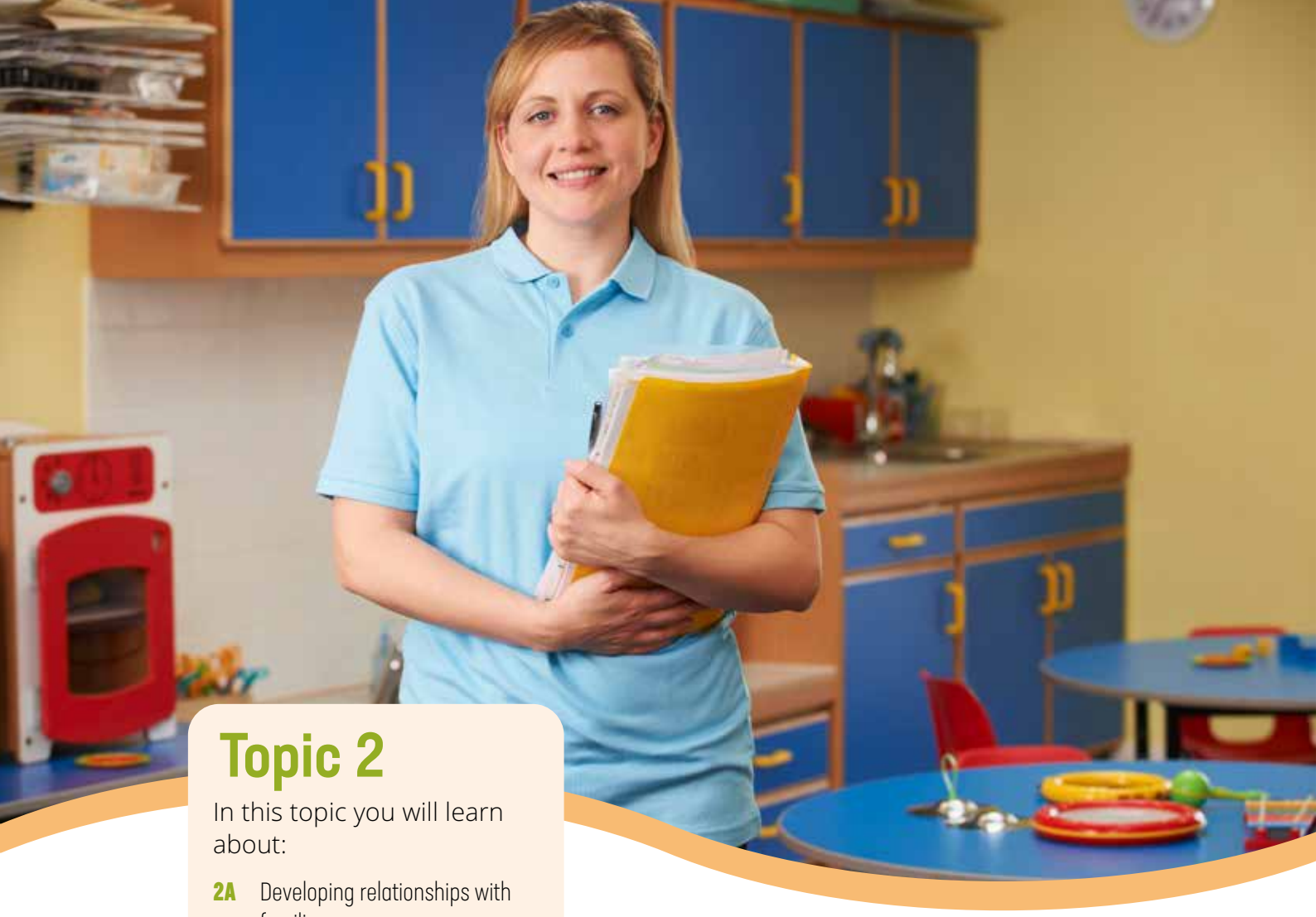
Nora is an educator, and is present when Ethan (18 months) arrives in the morning. Ethan is comfortable with Nora but can become upset around other educators and always looks for Nora. Nora knows about Ethan's routines, cues and interests. For example:

- In the morning he sleeps around 10am. He sucks his thumb when he is hungry and likes to cuddle a blanket from home while he is sleeping.
- Ethan points to the kitchen when he is hungry. He loves lunchtime.
- In the afternoon Ethan has a nap.
- Ethan loves playing with cars, blocks and dress-ups.
- If Ethan hears a loud noise he runs away and hides.

1. Draw a line to match Ethan's cues on the left, to the most suitable action Nora should give from the choices on the right.

* Ethan is stacking blocks. He sees an educator, Reanne, approaching and runs to Nora.	* Nora approaches Ethan. 'Let's see if a snack is ready, I am getting hungry. Are you?'
* Two older children begin to roar like lions. Ethan puts his hands over his ears and hides under a table.	* Nora gives Ethan a cuddle. 'Hi Ethan. This is Reanne and she loves to play blocks. Let's build together.'
* Ethan is lying on the floor and sucking his thumb.	* Nora gets Ethan's blanket. She asks, 'Ethan are you getting tired? Let's get ready for bed.'
* Ethan is pointing to the kitchen door.	* Nora moves to Ethan. 'Are those lions a bit loud? I don't like loud noises either. Let's go and find somewhere quiet.'

2. How much physical activity and screen time does the *Australian 24-hour movement guidelines for the early years (birth to 5 years)* recommend for Ethan?



Topic 2

In this topic you will learn about:

2A Developing relationships with families

2B Providing safe environments

Creating healthy, safe environments

Assess the environment to determine how it should operate and ensure safety and security.

Family members can provide the information you need to understand their child's individual needs. They expect that you will respect their values and support them in achieving what they want for their baby or toddler. They will identify whether you respect their values by considering:

- how you interact with them
- the questions you ask
- how confident you are in leading the relationship
- how you relate to their child and others
- the policies and procedures of your service
- how you involve them in the care environment
- whether you interact spontaneously with their baby or toddler
- the types of planned activities you organise for their baby or toddler.

2A Developing relationships with families

Family members expect you to be interested in investigating their values, and their baby's or toddler's individual needs.

The communication of information begins from the moment a family decides to use your service. This may begin with the interest you show for their needs and by them asking for enrolment form details, but should grow into a partnership where you show enthusiasm while working with them and support them in caring for their child.

Communicate regularly with families about their child's needs.

The opportunity for a child to settle into your service positively can be dramatically influenced by this ability to communicate openly, whether that is on the first day you meet them, or the first time you see them each day.

Communication guidelines

A number of guidelines, standards and regulations support the meaningful communication you have with families.

Some of these guidelines are outlined in the following table.

Guideline	How it applies to communication	Link
National Quality Standard (NQS)	Element 6.1.2: 'The expertise, culture, values and beliefs of families are respected and families share in the decision-making about their child's learning and wellbeing.' By sharing and respecting this information, educators are able to develop strong relationships with children.	aspirelr.link/national-quality-standard
EYLF	Principle 2: 'Partnerships, talks about how educators can develop strong relationships with children if they maintain clear partnerships with families.	aspirelr.link/eylf

Guideline	How it applies to communication	Link
Education and Care Services National Regulations	Regulation 76: 'Information about educational program to be given to parents: The approved provider of an education and care service must ensure that a parent of a child being educated and cared for by the service is provided with the following information on request: › information about the content and operation of the educational program so far as it relates to that child › information about the child's participation in the program › a copy of the documents kept under Regulation 74 in respect of the child'.	aspirelr.link/acecqa-national-regulations
United Nations Convention on the Rights of the Child	Various articles refer to families' rights and responsibilities, including Article 5: 'Governments should respect the rights and responsibilities of families to guide their children so that, as they grow up, they learn to use their rights properly.'	aspirelr.link/unicef-child-rights

Methods for sharing information

To meet a child's needs and develop a nurturing relationship with them, you will need a process for gathering information and advice.

Gathering information represents a large proportion of the communication in your relationship with family members, and the success of each interaction builds to develop a partnership. The information you gather will help you discover the different practices and routines of a family and their child, including any cultural expectations or any personal requests. A strong partnership will support the child's emotional and social development, including supporting their attachment needs.

A successful partnership results in communication that assists children to transition smoothly between home and care. This is vital when a child first starts, but must continue throughout their relationship with you. Be sure to follow organisational standards, philosophies, policies and procedures because they support you to remain professional and give you guidelines that you can use to explain or share information.

The methods for collecting information about children's needs and routines may be either formal or informal. The most common informal method is through daily conversations. This can happen through discussion at arrival and departure times, or through digital apps, social media and emails.

Formal methods include the following.

Enrolment forms

A standard form that collects the same information from each family.

Enrolment interviews

Occurring as part of an orientation process, where families are shown around the service, introduced to the environment, and they are asked questions about their needs, values and expectations.

Referral agents
Shared information from other services used by the family, given with the family's consent.
Meetings
Uninterrupted time where information about children's interests, routines and preferences can be exchanged, discussed and negotiated. These may be scheduled throughout the year.
Surveys
Questionnaires asking about particular information; this may be done regularly or just on certain occasions.
Curriculum strategies
Involving family members at curriculum planning times and requesting their knowledge of certain areas and information about their needs, goals or hopes for their child.

To ensure this partnership is successful, you need to implement the skills that are common to all your professional relationships. This means you must:

- be non-judgmental
- be open to different perspectives
- apply empathy
- demonstrate active listening
- check understanding.

Communicating with families

Common communication methods collect information about a baby or toddler's individual needs, patterns and preferences.

Sharing this information allows family members and educators to provide for each child's individual routines and preferences, taking into consideration knowledge of what has happened while they were not present.

This shared information is important for a baby or toddler as they are unable to communicate their own needs. Details include:

- cultural requirements
- expectations of the family
- developmental abilities
- additional support needs
- play needs and interests
- preferred toys and activities
- preferred levels of social interaction
- food and drink preferences, experiences and needs
- sleeping and rest patterns
- health status
- daily physical care routines.

Some things you may need to communicate with families include:

- Bottle needs – times and quantities
- Solid food – when it was eaten, what was eaten and how much was eaten
- Nappy changes – times, whether there were bowel or bladder movements and sometimes a description of stools, if there are any nappy-related issues or if creams need to be used
- Sleep or rest – times, comfort items, settling issues and length of sleep
- Medication – if required, plus documentation, management, signs of illness
- Emotions – how the child has presented during the time and if they were upset, grizzly, playful or quiet.

Information should be documented as a confidential record. This might occur through:

- a diary or communication book
- a portfolio
- a take-home sheet
- a digital communication app
- an email
- a text message.

A common method for communicating day-to-day health information is by using an individual chart. The chart you use should be set out with all the things you need to communicate and have spaces for comments and additions. It should be clear, so everyone can read it easily, but comprehensive enough to record the things that are required. If possible, the chart should be one the family can take home so they have access to the information and have time to take in all the details. Digital communication apps make this possible.

Example

Communicating using text

Jody usually sleeps for half an hour in the afternoon, but today she doesn't want to sleep.

Jody's educator, Matilda, feels that Jody will manage without the sleep, but wants to make sure Jody's mum agrees. Matilda texts Jody's mum and explains the situation. Jody's mum texts back that she is happy for Jody to do some quiet activities and see how she manages today.

Example

Communicating using a chart

Nico's educator has filled out the following chart about Nico's personal care routines.

Child's name	Nico
Date	Monday 22nd August
Routine notes	
Sleep notes	
Time	**Details**
10:15 AM	Slept for one hour and settled well with dummy and blanket.
1:45 PM	Slept for one and a half hours and settled well with dummy and blanket.
Nappy/toileting notes	
Time	**Details**
8:30 AM	Wet
10 AM	Soiled (solid)
12:20 PM	Wet
2:30 PM	Wet
Bottle notes	
Time	**Details**
10 AM	¾ bottle taken (formula)
1:30 PM	Full bottle taken (formula)
Food notes	
Time	**Details**
12:30 PM	Cereal and formula (2 teaspoons)
Interest/play notes	
Nico enjoyed listening to the book 'Look at me' and laughed at the funny noises. Nico enjoyed looking at himself in the mirror.	
Reminder notes	
We need more of Nico's nappy cream please.	

Conducting an orientation

Starting care for the first time or moving to a new service is a significant transition for a child and their family.

Although each child and family will adapt and accommodate changes at a different rate and in a different manner, it will always take time and trust to reach a stage where a new routine is understood, becomes predictable and is looked forward to.

Orientation is a time for family members, the child and educator to get to know each other, share information and begin to develop a relationship. An orientation process may span a number of days or weeks and can include time where a family member stays and an educator observes. The age and stage of the child, the child's experiences and temperament, and the needs and abilities of the family member influence the process.

Educators provide information to families about the service. To help families feel welcome and encourage them to participate in the service community, families new to the service need to be aware of:

- the service's values and philosophy
- how an education and care program is developed
- the type of activities provided
- the role of the educators
- the role of family members
- communication strategies and decision-making.

To assist in the transition from home to service, educators need to know basic information about the child. There are informal and formal ways you can collect family information. The most common informal method of collecting information is through daily conversation. This may happen through discussion at arrival and departure times, or through digital apps, social media and emails.

Communicating daily

Regular sharing of information and continued relationship building occurs during arrival and departure routines.

This is a time for welcoming and taking time to gather information about the child's needs. It is also an opportunity to allow families to actively participate with their child. Responsive, child-centred arrival times support the emotional and social development of the child through minimising stress, creating attachments and building relationships. The following is a guide to ensuring responsive daily communication during arrival times. The order might alter depending on the needs of those involved.

Responsive action	How this occurs
Welcome on arrival	Educators welcome families and children. They show their interest in the family and child.
Individual acknowledgment	Educators acknowledge families in an individual way. They might talk about: - individual needs, interests and plans - things that have been brought into the environment - events - activities.
Proactive engagement	When educators interact in a welcoming way towards children, families feel more at ease. Contact that is initiated early in the arrival, while the family member is still present, ensures that separation is gradual and that both family member and child feel ready to part. This helps the whole family feel that they belong.
Information exchange	An exchange of information about the child ensures their needs are met during the day and that educators are aware of what has been happening in the home. This might mean gathering routine information and details of emotional reactions. The older the child, the more interest-focused the exchange will be. The child might also participate in the exchange of information.
Settling into activity	Educators should settle children into activities and show their interest in the child. For babies and toddlers this might mean involving them in a routine or supporting them to play. Family members will expect that their child is given your attention and support; this helps them build trust.
Establish plans	Exchange of information establishes requirements for the day and lets family members know their child and their own needs are important. If a family member chooses to stay to settle the child or enjoy participation, this should be seen as a positive. Be aware that sometimes a family member may stay if they feel uncomfortable or anxious.
Establish a goodbye routine	Families may be in the process of establishing goodbye routines. Some families may already have a strategy, others may not be sure of what to do, and at times a child may need a different approach or reaction. Culture may have an influence as some families may be physical with their children, giving hugs and kisses, while others may be more verbal, simply saying goodbye. Family members may seek educator guidance, and may do this by asking for help; however, at times their anxiety or difficulty in leaving is the indicator that they need support. Despite the situation or child, every family member must farewell their child. This is a developmental must as it helps the child to develop feelings of security, attachment and trust. When family members disappear unexpectedly, a child will feel anxious in the environment.

Responsive action	How this occurs
Reassure the child	If a child is stressed, you may need to comfort them and help them farewell their family member. Always acknowledge the child's feelings and reassure them that their family member will return. When family members see educators supporting their child, they feel trust in them.
Reassure the family member	If a family member is stressed, you may need to offer suggestions for support, such as having a coffee in the staff lounge before leaving, going with a staff member to have a chat or a cry, calling the service later to find out how their child is doing or using a support service if the situation relates to family stress. Some family members will tell you they are stressed, while others won't. Signs of stress include: › obvious emotions like crying or tearing up › checking over and over that you understand what their child needs › watching for a long time after they've said goodbye › calling or contacting you frequently to check on the child.
Farewell the family	Educators should always farewell family members. This acknowledges them, shows you prioritise the relationship you have with them and lets them know that they are important.

Gathering health information

Discussing routines and other activities allows you to share information with family members about a child.

These discussions also give you the opportunity to share information about healthy choices. Use communication opportunities to gather health information and to share your knowledge.

Some health information you share might link to:

- dietary needs and daily food/bottle intake
- safety
- incidents, injuries, traumas, illnesses or medical conditions
- infectious diseases
- sleep and rest durations
- development
- current research
- individual needs
- immunisation.

In an effort to improve childhood immunisation rates, the Commonwealth Government has imposed immunisation requirements that are linked to tax rebates, childcare subsidies and early childhood education and care service guidelines. Identified as 'No Jab, No Pay', the program expects that children meet the immunisation requirements of the National Immunisation Program Schedule, unless the child has a medical reason not to be immunised, as defined by national guidelines.

Laws in states and territories differ as to whether or not all children are required to be immunised to attend early childhood education and care. Check your local guidelines at: aspirelr.link/no-jab-no-play.

Assist families to keep their child's immunisation up to date and help them remember to provide you with current records. There are a few strategies you can use to support families in remembering to immunise their baby/toddler at the appropriate times, as outlined below.

Strategies to help families stay up to date with immunisations
➤ Diarise the dates that immunisations are due for each baby/toddler and then ask families about their status. If applicable, you can refer them to the 'No Jab, No Pay' information available from the service.
➤ Add reminders about immunisation to invoices or other notices.
➤ Use noticeboards or newsletters to remind families about the importance of immunisation.
➤ Use electronic media such as SMS, email or social media.
➤ Provide an online form that can be completed and submitted when the child's immunisation is updated.

You can find out more information about childhood immunisation at: aspirelr.link/immunise-australia.

Practice Task 3

1. Draw a line to match the beginning of each sentence about communication with families on the left to the correct ending on the right.

* Communication with families on arrival	* provides families with information about a child's activities, such as what they were interested in, how long they slept, what they have eaten and had to drink.
* Orientation processes	* helps you to build ongoing, trusting relationships where you can make decisions together.
* Communication with families at departure	* helps you understand what the child's needs are for that day, which will assist in providing a smoother home-to-care transition.
* Daily communication with families	* are an opportunity for you to develop one-to-one relationships that help you find out about the individual child's routines, needs and cues, as led by family values.

2. Which of the following statements relate to meeting a family's and child's needs? Select all that apply.

- [ ] In order to develop a nurturing relationship, you need to build a partnership with family members as well as the child.
- [ ] Orientations are different for every family. Use this time get to know each other, gather information and assist in the transition to care.
- [ ] If you notice a child or family member is stressed at separation, you should ask the family member to leave as soon as possible.
- [ ] When families arrive, educators must support the transition to care by greeting them immediately and proactively engaging with children while a family member is still present.
- [ ] Communicate with family members to gain an understanding of the individual patterns and routines of a baby or toddler.
- [ ] Initial enrolment information provides all you need to understand a child's requirements.

2B Providing safe environments

Because of their age, babies and toddlers may unintentionally put themselves into dangerous situations.

While many incidents are unavoidable, some preventable injuries occur, including:

- falls (the most common cause of injury)
- grazes
- hits
- bites.

These injuries occur due to the developmental stage of the baby/toddler, their lack of understanding of the world and its dangers, needing to keep themselves safe and their need for independence.

Minor incidents and injuries are often unavoidable.

The activities that babies/toddlers regularly take part in may pose a high risk of harm. Gross motor activities, such as rolling, sitting, crawling and walking, are safe enough on their own, but can become dangerous depending on the space provided.

Due to their age and stage of development, babies and toddlers are:

- curious
- spontaneous in their behaviour
- unable to follow limits and guidelines consistently
- prone to forgetting what the limits and guidelines are
- frequently testing limits and guidelines to see if they alter and what happens
- interested in adult-modelled behaviour
- seeking independence and making attempts at greater independence
- at different stages of mobility and stability.

Babies explore with their hands, mouths and bodies. As they grow and begin to move around, the danger of accidents increases because they can:

- get into small spaces
- pick up small objects and put them into their mouths with the risk of swallowing, inhaling or choking
- fall into a wading pool, water trough or unfenced swimming pool
- fall down stairs
- pull heavy objects from shelves and tables onto themselves as they start to stand and walk around furniture.

The environment must be made safe by limiting the potential risks. The National Quality Standard (NQS) Quality Area 2: Children's health and safety can help guide this.

Some risks to be aware of are described in the following table.

Risk	Safety actions
Babies are at risk of falling from a bed, sofa or change table.	➤ Collect all the equipment and materials required for nappy changing or bathing prior to collecting the baby. ➤ Always take the baby with you if you need to move away from the table, bench or bed. ➤ A useful rule is to always have one hand on the baby.
Unrestrained babies can easily slide out of strollers and highchairs, and be injured from a fall or catch their neck as they slide.	➤ Use suitable, age-appropriate restraints. ➤ Keep children in your sight at all times.
Babies can injure themselves on poorly designed furniture; for example, catching their leg in the bars of a cot.	➤ Check equipment meets standards and guidelines. ➤ Remove furniture or equipment if it poses a risk.
As babies begin to eat solid food, choking becomes a high risk.	➤ Food must be prepared to meet the eating abilities of the baby or toddler. ➤ Meal, snack and bottle-feeding times must be carefully supervised.

A useful way to avoid dangers is to complete a physical check for hazards. A hazard check may be different depending on the age and stage of the babies/toddlers using the space; however, all babies and toddlers explore their environment with their hands, mouths and bodies, need safe areas to practise new skills and have a higher risk of injury due to their lack of understanding of danger. Every educator should be aware of the hazards to look out for and report them where necessary.

Checklist for an indoor playroom:

- ☐ Room is free from small objects that may be choking hazards.
- ☐ Pathways are free from clutter.
- ☐ There are no tripping hazards.
- ☐ Accessible electrical plugs are covered.
- ☐ Chemical and cleaning products are stored safely or eliminated.
- ☐ There are gates on stairs.

Checklist for an outdoor area:

- ☐ Area is free from needles, sharp implements and other dangerous materials (especially around the fence line).
- ☐ There is adequate soft fall around falling hazards.
- ☐ Water features or water troughs are emptied when not being supervised.
- ☐ Paths are swept and accessible.
- ☐ Animal droppings are removed.
- ☐ Fences and gates are closed using a locking mechanism.
- ☐ Out-of-bounds areas are clearly identified.

To find out what services and each educator needs to do to meet the NQS, go to the Guide to the National Quality Framework: aspirelr.link/guide-to-the-nqf

Supervising children

Babies and toddlers need to take calculated risks so they can develop, but this must be balanced with their safety.

This balance will change depending on how closely a baby or toddler needs to be supervised and their:

- age
- level of independence
- previous risk-taking history
- activity
- ability.

Your service's health and safety policies, procedures, regulations and standards are all designed to help reduce the incidence of injury. Should injury occur, staff may face legal implications if they have not supervised adequately. Service guidelines provide clear expectations and stipulate responsibilities in relation to:

- supervision tasks
- ratios of educators to children
- hazards and risks
- hygiene and infection control.

Check the regulations for the correct educator-to-child ratios, and meet these at all times.

You can access the Education and Care Services National Regulations at any regulated service or at: aspirelr.link/acecqa-national-regulations.

Direct and indirect contact

At least one educator must remain in direct contact with children at all times.

This educator needs to be a member of staff and not a student or volunteer. Supervision using direct contact occurs when you can see what is happening, and direct physical contact occurs when changing a nappy or bathing a baby and you are holding the child.

Most direct contact happens during routine or play times when you are encouraging children, interacting to support them, helping them develop skills and checking to create safe spaces.

When using indirect contact, you will be relying on what you hear and need to be aware of noises of concern. Listening is most effective when combined with regular visual checks. Noises of concern include:

- cries
- bangs and falls
- silence
- unusual or unrecognisable sounds.

There are often viewing windows in bathrooms and sleeping rooms. Be aware that regular visual checks must be used to gain a full picture of the child's safety in these areas. Viewing windows may be supported by an audio monitor, and charts may need to be completed to show visual checks have been made.

Direct contact

Direct contact means being able to see all the babies/toddlers you are responsible for and immediately interacting with them if necessary.

Direct physical contact

Direct physical contact means that you are touching the child in some way, whether having a hand on the child's body, holding their hand, carrying them or sitting with them in your lap.

Indirect contact

Indirect contact occurs when you are able to hear the babies/toddlers or see them through a glass viewing window. Indirect contact can be used for monitoring, but it should not be used as the primary method of supervision for any length of time.

Example

Direct supervision

Wendy is changing a nappy. She places her hand on the baby's stomach as she reaches for the wash cloth sitting on the edge of the sink. This allows her to feel if the baby is wriggling or attempting to sit up, and she can also hold the baby in place so he does not fall.

When a baby is learning to roll, sit, crawl or walk, Wendy provides direct supervision and uses smiles, claps, supportive comments or physical support to provide learning moments. She finds that often she needs to move furniture or toys out of a child's way to ensure that the child doesn't injure themselves or trip.

Hand hygiene

Hand-washing is the single most important thing you can do to reduce the spread of infection.

This is why hand-washing is always included in advice from food and health authorities, and in your service's hygiene and infection control policies and procedures.

Micro-organisms, or 'germs', are naturally present on the hands at all times and live in the oil and moisture that is produced on your skin. Although many germs are harmless, you can pick up potentially harmful organisms when handling uncooked food, using the toilet or coming into contact with bodily fluids such as saliva.

Soap or detergent and water removes most of these organisms and greatly decreases the risk of infection.

Hand-washing is most effective when the guidelines outlined in the following table are adhered to.

Area	Guidelines
Sink	Use a sink that is solely for washing hands. Hand-washing must not be carried out in sinks that are used for food preparation, as this could allow cross-contamination.
Water	Use warm running water if possible, but cold running water is also acceptable.
Soap dispenser	Dispense soap or detergent from a liquid dispenser. A cake of soap harbours micro-organisms that grow and can then spread to the next person who uses it.
Hands	Clean hands with soap or detergent, including the sides and backs of hands and between the fingers. Rub your hands together for at least 20 seconds.
Scrubbing brush	Use a scrubbing brush to clean dirty fingernails.
Taps	Turn off the tap using a paper towel or your arm. If possible, use a tap with an automatic sensor. Remember that if you touch the tap after washing, your hands will pick up germs again.
Drying	Use paper towels or a hand dryer to dry hands because cloth towels retain bacteria. Leaving hands damp also increases the growth of micro-organisms because wet hands become warm to a temperature that micro-organisms thrive in.

When you wash your hands you are removing dirt and germs. Most educators have access to an antibacterial hand treatment to use instead of hand-washing. This can be used when water and soap is inconvenient or if someone's hands have become cracked and dry from excessive washing.

Be aware that these antibacterial treatments are only effective if there is no residue on the hands. This is because they only act to kill bacteria, not to remove residue. For example, if you wipe a child's nose and mucus is transferred to your hands, you must wash your hands with soap and water. If you wipe a child's nose and mucus does not transfer to your hands, the antibacterial solution is suitable.

Information about good hand hygiene should be placed in positions that remind staff, families and others in the service to be vigilant about washing and drying their hands. There are many posters available for communicating this information.

Source: Reproduced with permission of NSW Health.

Wearing gloves

If you wear disposable gloves, remember to change them regularly.

Gloves become contaminated and grow bacteria just as hands do. Wash and dry your hands prior to putting on gloves and then consider your use of gloves, just as you would your hands. Wearing gloves does not automatically mean you are being hygienic.

It is necessary to change gloves:

- if they become contaminated
- if they tear or get a hole
- when switching between raw and ready-to-eat food
- when changing tasks
- after cleaning
- if you handle rubbish
- if you touch any other surface, object or person, including your own body.

Remove gloves by peeling them back from your wrists inside-out, and dispose of them in the appropriate bin. With practice you can remove both gloves without touching the outer soiled area. You may even be able to fold the gloves over each other for greater hygiene.

National Health and Medical Research Council guidelines within *Staying Healthy: Preventing infectious diseases in early childhood education and care services* provide support for understanding appropriate practices with hand hygiene. You can access a copy of *Staying healthy* at: aspirelr.link/nhmrc-staying-healthy-pdf.

Holding and carrying children

One of the most common injuries faced by an educator relates to holding and carrying children.

Work health and safety procedures, regulations and laws call holding and carrying 'manual handling'. You will find information on safe procedures for manual handling, including a code of practice, on the Safe Work Australia website at: aspirelr.link/safework-australia-manual-handling.

Your service may have a policy regarding lifting and holding children. The way you hold and carry a child can have a long-term impact on your body, and, over time, can cause debilitating damage and resulting pain. In addition to these hazards, holding and carrying can be dangerous to the child. A newborn child is especially vulnerable to harm. They are unable to support their own bodies and can easily gain head and neck injuries.

Follow these tips to help prevent injuries:

- Only carry children when necessary. The correct way to carry a child is to:
  - hold the child facing you as close to your body as possible
  - place one arm under the child's buttocks and the other arm behind the child's back.
- Avoid carrying children on your hip; this may strain your back.

- Young babies can be carried in your arms in a lying position. Keep the child close to your body.
- When steps are provided for nappy-change benches, use these for all children who are developmentally able to climb.
- When lifting children out of cots:
  - lean close against the cot
  - raise the child as close to your body as possible.
- To avoid neck and back injuries, kneel or crouch down rather than bending from the waist.
- Always lift from a crouched position rather than bending from the waist.
- Never twist while lifting.
- Ensure you can see where you are going when carrying a child.
- Ensure the workplace is tidy and that floors are uncluttered, even and non-slippery.

Follow these steps to prevent injuries while lifting.

Lifting	1. Place your feet in a stride position. 2. Keep your breastbone as elevated as possible. 3. Bend your knees. 4. Brace your stomach muscles. 5. Lift using your legs.
Carrying	1. Lift using your legs. 2. Hold the child close to your centre of gravity, around your navel. 3. Move your feet, not your spine. 4. Move in a forward-facing direction so you can see where you are going.
Lowering	1. Place your feet in a stride position. 2. Brace your stomach muscles and bend your legs to lower using your legs. 3. Keep your breastbone as elevated as possible.

Holding children

There are a number of ways you can hold a child.

Children may feel most comfortable in a particular position, but mostly they will be content if they are secure and your actions are caring and gentle.

The following are some suggestions for holding children. If you are not skilled using these holds, try them while sitting down first.

Cradling

Cradle the child in your arms by supporting their neck and body.

Always support the head of a newborn baby.

This hold is best for a baby. An older child may enjoy this hold; however, you may need to sit down as the child grows or becomes heavier.

	**Football hold** Similar to cradling; however, the child is facing your body and curled towards you with their legs extended behind. Support the baby's head with your arm. This hold is best for a small baby. An older baby may enjoy this hold; however, you may need to sit down as they grow or become heavier.
	**Shoulder hold** Rest the child on your chest and shoulder. Support the baby's head. Place your hand on their bottom. This hold is best for a baby. An older child may enjoy this hold; however, you may need to sit down as the child grows or becomes heavier.
	**Belly hold** Lay the baby with their stomach facing down on your forearm. Their head should be at your elbow. Lay your hand across the baby's back to help them feel secure. This hold is most suited to a newborn baby.
	**Chair hold** Let the baby rest the back of their head on your chest to support it. Place one hand across their chest to prevent them leaning forwards. Place the other hand under the baby's bottom. This hold is suited to babies.
	**Lap hold** Place your feet firmly on the ground while sitting. The baby's head is on your legs with their face upward. Place both hands under the baby's head for support. Let the baby's feet tuck into your waist. This hold is most suited to babies.
	**Toddler hold** Hold the child facing you at the front of your body. Allow their weight to rest on your arms and chest. Keep your arms about the child's back and bottom. For extra support, ask them to hold on with their legs or hold you around your neck. This hold is suited to children able to stabilise their necks and hold onto you.

Practice Task 4

1. Chloe is 10 months old. While unsteady on her feet, she is starting to walk while holding onto furniture. Chloe explores materials by putting them into her mouth. Which of the following statements about Chloe's safety are correct? Select yes or no for each one.

a.	Chloe is learning to walk, so she needs a safe environment to allow her to practise her new skills.	* Yes	* No
b.	Chloe needs to be closely supervised when walking and exploring materials, as she is at higher risk of injury.	* Yes	* No
c.	Despite Chloe's age or stage of development, educators will monitor and encourage her physical exploration and learning.	* Yes	* No
d.	Small toys are okay for Chloe; she needs to learn about dangers.	* Yes	* No
e.	As long as you are supervising Chloe she is safe. Hazard checklists and hazard reports are only needed if you are unable to supervise closely.	* Yes	* No

2. Draw a line to match the beginning of each sentence about providing a safe environment on the left to the correct ending on the right.

* Service guidelines, policies, procedures and standards	* provide educator-to-child ratios that must be followed at all times to ensure health and safety.
* Guidelines for infection control	* describe how the service will keep children safe and manage accident/injury, hazards and risks, supervision and hygiene and infection control.
* Education and Care Services National Regulations	* are in place to limit the spread of infection in education and care environments.

3. Which of the following images shows the best example of how Nora should carry Ethan?

☐ 

☐ 

☐ 

Summary

- Development involves activities that can be unsafe. You must ensure the environment is prepared for children's physical exploration and learning.
- Supervise babies and toddlers closely to reduce the risk of injury.
- The transition from home to care is made simpler if information relating to the baby's or toddler's needs is gathered from family members.
- Positive relationships with family members allow you to share information successfully and provide modelling for babies and toddlers that says, 'this place is safe'.
- The information you gather from family members about their baby or toddler allows you to support the child's feeling of belonging.

Learning Checkpoint 2
Creating healthy, safe environments

Part A

1. Use the following images to show that you understand how to create a safe environment for babies/toddlers, where they can use their hands, mouths and bodies to explore.

i.

ii.

iii.

iv.

v.

vi.

a. Identify three images that show activities that might be unsafe for babies/toddlers and explain why.

b. Identify two images that show activities that are most appropriate for a baby and explain why.

c. Identify one image that shows an activity that is most appropriate for a toddler and explain why.

Part B

Read the case study and then answer the questions that follow.

Case study

Alison, a parent, arrives with Cade (22 months). Beatrix, an educator, asks Alison how she went with her course enrolment yesterday. They move to the block mat and Beatrix sits with Cade while he begins to stack the blocks. Beatrix and Alison discuss how Cade is moving from two sleeps to one during the day, but may need two today. Cade had his travel vaccination yesterday and has been a little grumpy and has not been eating. Cade had some paracetamol at home and has been fine since. Alison asks Beatrix to give her a call if Cade does not seem well.

Alison seems more hesitant than usual about leaving Cade and peeks in the window, watching him for 10 minutes.

1. **Which of the following questions could Beatrix ask Alison that would help her to meet Cade's needs today and ease his transition from home to care? Select all that apply.**

- ☐ 'Did Cade have any breakfast this morning?'
- ☐ 'When would you like Cade to sleep today?'
- ☐ 'How did you go with your job interview?'
- ☐ 'Cade seems to be enjoying those blocks. Does he play with them at home too?'
- ☐ 'Where are you off to on your holiday?'

2. What did Beatrix do to assist in Cade's transition to care while Alison was still present?

3. What is one sign of stress that Alison showed when leaving Cade, and what is one thing Beatrix could do to assist?

4. From the discussion between Alison and Beatrix, which two of Cade's routines may need to change today?

5. Which of the following actions should Beatrix take to provide a safe environment for Cade? Select all that apply.

- ☐ Cade will explore using his hands, mouth and body, so Beatrix should make sure the environment is clear from risk, removing small items that may be mouthed and objects that may fall.
- ☐ Beatrix must be aware of hazards, such as how to safely lift and how to carry Cade.
- ☐ Beatrix must supervise Cade. He is more likely to participate in activities that pose harm due to his age, stage of development and the type of exploration he enjoys.
- ☐ Beatrix must provide indirect contact at all times, as it is the most effective supervision for Cade.
- ☐ Beatrix must prevent the spread of infection by hand-washing and sanitising toys and surfaces regularly.

6. Draw a line to match the topic on the left with the location of the most detailed information on the right.

* Hazards and manual handling	* Education and Care Services National Regulations
* Communication with families	* Safe Work Australia website
* Educator-to-child ratios	* Staying healthy
* Children's health and safety	* NQS Element 6.1.2
* Hand-washing	* NQS Quality Area 2

Topic 3

In this topic you will learn about:

3A Catering for sleep needs

3B Creating safe sleep environments

Promoting safe sleep

Rest includes sleep and time spent quietly relaxing.

Finding out children's needs and providing safe and hygienic sleep and rest options helps the baby or toddler to feel safe, secure and supported, which in turn helps them feel a sense of belonging. This links to Outcome 1 of *Belonging, being and becoming: The early years learning framework for Australia* (EYLF)*:* Children have a strong sense of identity.

3A Catering for sleep needs

Parents and other carers can help you find out about the sleep preferences of each child.

When you seek information about the children's sleep and rest needs, you are gaining information about how to develop an appropriate environment and how to assist children to feel safe.

Talk to parents to understand babies' individual sleep needs.

You may care for babies and toddlers who:

- sleep in their own cot
- sleep in a shared bed or room
- sleep with their parents
- are rocked to sleep every time
- sleep on their backs
- sleep in a hammock, sling, cradle or shawl
- sleep with many or no blankets
- sleep many times a day or have no sleep in the day
- are swaddled or wrapped tightly.

Some questions you can ask, and the types of details you will need to know, are found in the following table.

Question	Details needed
What times does the baby or toddler usually sleep or rest?	Is it one or more times a day, in the morning or the afternoon, or only at night?
What does the baby or toddler do before they sleep or rest?	Do they eat, drink, play, read a book or want a cuddle?
How is the baby or toddler usually settled?	Are they cuddled, rocked, left alone or left with music playing?
Does the baby or toddler have a special toy or comfort item they use to settle?	Do they have a dummy, blanket, toy, book or person nearby?
Where does the baby or toddler sleep or rest?	Do they use a cushion, cot, bed, mattress, hammock, sling or pram?
What specific physical or emotional needs does the baby or toddler have during sleep or rest?	Do they use a blanket to keep warm, only use a sheet, rest in their underwear, remain fully dressed, lie on a pillow, have someone in the same room, have a night light or prefer a silent environment?

Sleep requirements

The sleep needs of babies and toddlers change constantly, so flexibility is essential.

For example, a baby requiring a morning and afternoon sleep may move to a stage of requiring only an afternoon sleep.

You may have a document that initially collects information from a family about their child's needs, but your daily communication with families must include asking questions to ensure you continue to stay up to date about the baby's ongoing needs and family preferences. The baby or toddler may have needs that change from week to week, or even day to day, depending on their home routines and health.

The *Australian 24-hour movement guidelines for the early years (birth to 5 years)* provides the following estimation of sleep duration. You can find the guidelines at: aspirelr.link/24hour-movement-guidelines-0-to-5.

Age	Sleep duration
0 to 3 months	14 to 17 hours per day
4 to 11 months	12 to 16 hours per day
12 months to 23 months	11 to 14 hours per day

Every child is different, but, generally, as they get older they move from daily sleeps to only having a rest period or time of quiet play. You will notice that as these changes take place, the baby or toddler will develop an understanding of their own needs. However, sometimes they will need your help to understand their own needs.

You can help children develop the ability to assess their own sleep needs by:

- encouraging them to lie down and see if they fall asleep
- suggesting some rest that may turn into sleep
- asking the child questions about how they feel and then assisting them to recognise these feelings as tiredness, if this is the case
- talking to the child about how sleep is good for their body and will give them energy to play later
- making sleep and rest times pleasant
- never forcing children to sleep or stay in a resting position for long periods of time.

Settling interactions

Sleep times are excellent opportunities to interact one to one with babies and toddlers.

Each child will have their own routine for sleep preparation, some going down to bed with minimal expectation, others having a regular process.

Whatever the requirement from you, remember that this is important to the child and that they are learning about human interaction, caring and how the world works. This might mean taking a breath and slowing down, or rearranging the timetable or routine so that educators are given the greatest opportunity to develop a gentle, caring relationship.

Sometimes it can be difficult to provide individual routines and one-to-one attention for multiple children. To help you do this, you should:

- plan in advance
- have enough resources prepared
- avoid babies being over-tired by knowing their routines and preparing for sleep; for example, if you know two babies will be tired around 11 am, you may prepare for one to go to bed at 10.50 am so you are free for the other at 11.10 am
- request another educator at times when you need an extra pair of hands.

Children need time to wind down to allow for a balanced day. Look out for the signs that a baby or toddler is tired so that you can respond to their needs.

Signs of tiredness include:

- a loss of interest in play
- crying
- clinginess
- irritability
- throwing tantrums
- asking for a security item
- cuddling up
- reduced coordination
- rubbing eyes or ears
- sucking their thumb.

Preparing for rest

If you accept that a baby or toddler may need to rest rather than sleep, you are respecting their needs and rights.

The United Nations Convention on the Rights of the Child says that children have the right to relax, play and join in a wide range of leisure activities. Therefore, rest and wind-down periods should include a variety of activities, each occurring in a relaxed and calm way.

Some ideas for rest are:

- lying quietly on a mattress or cushion
- simple stretching or breathing exercises – try the ones at: aspirelr.link/calm-for-kids
- helping to leisurely set up the room for the next routine
- reading books
- listening to audio books or music
- looking through photo albums or their individual portfolio
- drawing
- playing with or cuddling soft toys
- undertaking single-child activities, such as playing with a doll's house.

Be realistic about the length of time you expect children to relax for. The timing must meet children's relaxation needs rather than your routine timetable.

Example

Adapting sleep needs

Destiny, an educator, noticed that Toby was getting grizzly and yawning. Toby has recently started staying a few hours later each day and wouldn't normally be here at this time. Destiny sits with Toby and reads him a quiet book and they do a puzzle together. Not long after, Toby's mum Laura comes to collect him. Destiny asks Laura if Toby normally has a sleep after he leaves. Laura informs Destiny that Toby usually has a sleep on the way home in the car, but when he is staying longer he can have an extra sleep in the afternoon.

Practice Task 5

1. Draw a line to match the child's age and needs on the left to the appropriate sleep preparation and settling interaction on the right.

* A 23-month-old toddler having a rest	* The educator picks the child up and gives them a cuddle. 'Come on, let's get your dummy and have a sleep.' The educator sings a lullaby as she puts the child in the cot.
* A nine-month-old baby going to sleep	* The educator approaches the child, who is rubbing his eyes. The educator gets to the child's level and asks, 'Are you feeling tired and ready for a sleep?'
* A 13-month-old toddler having a rest	* The child is getting restless and gets up every time he is put on his bed. The educator says, 'That's okay if you don't want to sleep. Let's read a book together on your bed.'
* An 18-month-old toddler going to sleep	* It is time for the child's sleep but they don't want to go to bed. The educator says, 'That's okay if you don't want to sleep. Maybe we could do a puzzle together instead?' While they are doing the puzzle, they talk about why we need sleep.

2. Johan (10 months) usually sleeps once in the morning and once in the afternoon. This week he is teething, and is clingy and upset.

   Which of the following statements relate to Johan's needs? Select all that apply.

   - [ ] Johan's sleep routine may change due to his discomfort.
   - [ ] I could ask Johan's parents if Johan is sleeping well at home and if he is still using his comfort items.
   - [ ] Johan will sleep normally; he is only 10 months old.
   - [ ] I could ask Johan's parents if they think he needs additional comfort to sleep. While we usually provide a relaxed and calm environment, he may need extra physical contact and one-to-one attention.
   - [ ] Johan's parents won't be able to help me; he reacts differently at our service.
   - [ ] Mary is 10 months old and is also teething. She is clingy and upset. Her sleep routine and her sleep needs should be the same as Johan's.

3B Creating safe sleep environments

Appropriate sleep environments include making sure the environment is hygienic and safe.


Ensure bedding is clean and hygienic.

This should form part of the daily housekeeping practices that are recorded in the service's health and safety policy. Following these policies will reduce the risks of infection, cross-contamination and accidents.

Hygienic sleep practices rely on these daily housekeeping tasks. To reduce the risks of infection and cross-contamination, the environments where children sleep should be clean, organised and well ventilated. Each child should be provided with a bed and bedding that is suited to their age, stage and their individual needs. This includes the provision of sheets and blankets adequate to the child, taking into consideration their preference for warmth and comfort. Check your service's policy about bedding because some services require parents to provide and wash bedding, whereas other services will provide and wash their own linen.

Some practices that support good sleep hygiene include:

- washing bed linen regularly and more often when soiled
- disinfecting mattresses and beds after each child's use
- providing each child with their own specific bedding
- storing individual bedding separately where they do not touch the bedding of other children; for example, in named pillow cases or baskets
- clearly labelling each child's bedding.

National Health and Medical Research Council guidelines, *Staying healthy: Preventing infectious diseases in early childhood education and care services,* provide support for understanding appropriate practices for cleaning cots and linen. You can access a copy of *Staying healthy* at: aspirelr.link/nhmrc-staying-healthy-pdf

Supervising sleep

One of the greatest preventions of harm comes from educators supervising sleeping children at all times.

Hazard-prevention skills are key to providing safe sleep environments.

Tasks and actions for a safe sleep environment:
➤ Place beds in positions where equipment or furniture cannot fall on them.
➤ Position beds and cots away from heaters, power points and cords.
➤ Remove any restrictive clothing, strings or ties.
➤ Keep cots uncluttered.
➤ Check that the design and construction of the bedding and furniture meet Australian Standards (for example, AS/NZS 2172:2003), which states that: – the bars or panels must be between 50 mm and 95 mm apart – there must be a minimum depth of 600 mm from the base of the mattress to the top of the cot – the gap between the mattress base and the sides and ends should be no more than 20 mm – there must be no spaces or holes where arms, legs or fingers could be trapped – wheels must lock.

The health and safety policies, regulation requirements for staff employment and rostering, along with the design and access of your service, will dictate how supervising sleeping children should occur. It may mean one or some of the following:

- An educator is present in the same room as any sleeping child at all times. They make consistent and ongoing direct observation.
- Regular checks, by entering the sleep space or using viewing windows, should be made at designated intervals; for example, every 10 minutes. This system works best if the person making the check documents this by noting the time and their initials on a checklist for reference. This record provides a demonstration that duty of care has been provided and also allows educators to remember how long it has been since the last check.
- Sound monitors, video monitors and other technology rely on the educator checking regularly and remaining in contact with the device. Methods that allow you to see what is happening are most effective as a child who is needing attention may not be able to cry out or may only cry out quietly or momentarily. These methods should be supplemented by one of the other options described.

It can be challenging caring for multiple young children. The routines and needs of each individual child will be different, from their play times to eating and sleeping times. Plan out your strategies, including monitoring, so that each educator is aware of their responsibilities.

Sudden infant death syndrome (SIDS)

Sudden infant death syndrome (SIDS), also known as cot death, is the name given to the sudden death of a baby or child where it is not possible to demonstrate an adequate cause of death.

Although SIDS is most common between the ages of two and four months, it can occur in younger and older babies, including children over 12 months of age, although this is rare.

SIDS can occur in both breastfed and bottle-fed babies, at any time of the day or night, and may occur in cots, prams, car seats and bassinets.

Other than SIDS, sleeping babies may get into dangerous situations that can also cause harm or death; for example, they may:

- suffocate under bedding
- choke by sucking on toys or other objects
- get caught between the side of the cot and the mattress
- be strangled by cords and ribbons.

The reasons for this are that babies:

- are not able to control their own sleeping situations
- cannot understand danger
- may not be able to move out of a dangerous situation
- may place things in their mouths or around their necks.

Guidelines that took effect in October 2017 within the Education and Care Services National Law and Regulations state that service health and safety policies and procedures must include reference to safe sleeping as a prevention of SIDS.

Safe sleeping can be achieved by following some simple rules.

Safe sleeping rules:
Place the baby on their back to sleep.
When putting a baby to sleep, place their feet at the end of the cot, and make up the cot so that the baby's head is not able to slide under the bedding.
Tuck in bedding securely so that it is not loose.
Ensure quilts, doonas, duvets, pillows and cot bumpers are not in the cot.
Always keep the baby's head uncovered; never dress them in hats, hoods or rugs when sleeping.
Remove any clothing that has long drawstrings, ribbons or cords to avoid the baby being strangled.

To find out more about SIDS, access the Red Nose website at: aspirelr.link/red-nose. The safe sleeping information can be translated over the phone or downloaded in various languages.

Example

Safe sleeping environments

Alwyn, a new baby, has started in Camille's room. Camille already has all cots in use, so she will need to prepare another one for him to use. Camille checks the new cot to make sure it meets all Australian Standards and is not faulty. She then positions it in a location where she can see all cots easily, and makes sure that it is away from cords, power points and loose furniture. Camille makes up a sleep sack for Alwyn's individual bedding and labels it.

When Alwyn is placed in his cot Camille follows the SIDS safe-sleeping guidelines and monitors him regularly. Later, Alwyn's individual bedding is packed up and his cot disinfected, as outlined in the service's procedures.

Practice Task 6

1. Which of the following statements are correct about safe sleeping environments? Select yes or no for each one.

   a. Service hygiene and safety procedures and the NHMRC publication, *Staying healthy: Preventing infectious diseases in early childhood education and care services*, provide information on how to prepare cots, bedding and equipment. * Yes * No

   b. The guidelines for sudden infant death syndrome require that babies are placed on their back to sleep. Education and Care Services National Regulations state that services must follow SIDS guidelines and they must be demonstrated in policies and procedures. * Yes * No

   c. Services should wash sheets weekly. During the week the sheets are stored separately for each child. * Yes * No

   d. Cot bumpers, doonas and cuddly toys should be placed in beds to help the babies sleep. * Yes * No

   e. When an educator is supervising a child while sleeping, they may need to document each time they check on the child. * Yes * No

2. Which of the following statements help provide safe sleep practices? Select all that apply.

- [ ] Red Nose safe sleeping guidelines must be followed to reduce the risk of SIDS.
- [ ] Bedding and furniture must meet Australian Standards and be placed in a safe position.
- [ ] Educators must remove any child's clothing that is restricting or has ties. Cots must be free from clutter.
- [ ] Educators must complete a safety checklist every time a child is placed in their bed or cot.
- [ ] Educators must put routines and strategies in place to regularly monitor all children that are asleep and to cater for individual sleep routines.
- [ ] National Quality Standard 2 Children's health and safety requires all educators to sit with each child until they go to sleep.

Summary

- Discussion with the families must inform your knowledge of the sleep needs of their children.
- Most families are interested to know how their child's sleep or rest routine went during the day.
- Cots, bedding and equipment must meet approved standards.
- Hygiene and safe-sleeping procedures assist in the provision of quality sleeping environments and the safety of children.
- Education and care services must include SIDS guidelines in their policies and procedures, and put these into practice.

Learning Checkpoint 3
Promoting safe sleep

Read the case study and then answer the questions that follow.

Case study

Maud is setting up a new sleep room. She has calculated the number of cots and beds needed based on the ages of the children. She is designing a room layout and routines for sleep to make sure children are safe when they are asleep and that their individual needs are met. Two children who will sleep in the room are Lilly and Cassandra.

1. Which of the following are age-appropriate actions and interactions that Maud might use to prepare and settle Lilly to sleep? Select all that apply.

- ☐ Speak to Lilly in a calm and relaxed manner. 'Lilly, time for sleep. Here is your special sleep blanket.'
- ☐ Give Lilly a cuddle and sing a lullaby.
- ☐ Help Lilly do some gentle breathing exercises. 'Let's breathe slowly and take a big, deep breath in.'
- ☐ Give Lilly a five-minute warning, then play a chasing game to wear her out.
- ☐ Talk to Lilly and let her know what is happening. 'You look tired, Lilly. I know it's nearly lunchtime, but I think we will go find your cot.'

2. Which of the following statements should Maud take into consideration to make sure the sleep room is safe? Select all that apply.

- ☐ Cots, beds and mattresses must be checked to ensure they meet hygiene and safety procedures and the Education and Care Services National Regulations.
- ☐ Sleeping children don't need to be directly supervised; they are safe when they are sleeping if they wear clothing that does not have cords or ribbons.
- ☐ Cots, beds and mattresses must be disinfected and bedding washed at least weekly to reduce risk of infection and cross-contamination. These guidelines are outlined in the publication *Staying healthy: Preventing infectious diseases in early childhood education and care services*.
- ☐ Cots, beds and mattresses must be set up in a safe environment away from power points, loose furniture and ties or cords.
- ☐ Cots, beds and mattresses look lovely when set with bumpers, soft toys and blankets. As long as there are no small items to choke on, this will meet safe sleeping guidelines to reduce the risk of SIDS.

3. Which of the following statements describe the positive sleep routines Maud should arrange? Select yes or no for each one.

a.	A sleep routine that is organised with families to meet their child's individual needs and provides a predictable routine that assists in the transition from home. This includes using comfort items that are brought from home.	* Yes	* No
b.	A sleep routine that is flexible and adjusts to a child's needs and cues of tiredness.	* Yes	* No
c.	A sleep routine that follows the needs of the service. How the child sleeps at home will be different to how they sleep when they are with Maud.	* Yes	* No
d.	A sleep routine that is completed quickly to make sure Maud's routine is on time. Young children must sleep during the day; they are unable to make sensible choices.	* Yes	* No
e.	A sleep routine that is a relaxed, calm, enjoyable time that allows for personal interactions, physical contact and time to build relationships and trust. This would meet NQS Quality Area 2 Children's health and safety.	* Yes	* No
f.	A positive sleep routine that involves all children sleeping for the same amount of time so that educators can monitor them and so that they don't disturb other children.	* Yes	* No

4. What is one way Maud might arrange to monitor the sleep of multiple children with varying sleep patterns?

Topic 4

In this topic you will learn about:

- **4A** Following hygienic nappy-change routines
- **4B** Supporting toilet learning

Providing positive nappy-change and toileting experiences

Babies and toddlers will be at various stages in their toilet use and will have individual needs.

Children and their families will have different habits, routines and preferences. Each choice a family makes is usually backed up by beliefs, cultural values and their own life experiences. By understanding each child's toileting needs, you can incorporate these into your daily routine.

4A Following hygienic nappy-change routines

A hygienic nappy-changing procedure, as dictated by your service's health and safety policies and procedures, assists you to minimise the spread of infection.

This is supported by the National Health and Medical Research Council guidelines, *Staying healthy: Preventing infectious diseases in early childhood education and care services*. You can access a copy of *Staying healthy* at: aspirelr.link/nhmrc-staying-healthy-pdf.

The environment and equipment you use for nappy changing and toileting should be easy to clean, safe and comfortable. Babies and toddlers need constant support, modelling and guidance while they develop their toileting skills.

A nappy-changing process includes:

- preparing for nappy change
- interacting with the child
- changing the nappy
- cleaning and sanitising.

Preparing for nappy change

Prior to bringing the child to the nappy-change area, collect all materials needed and have these within reach.

Babies and toddlers will have different toileting needs and nappy preferences. For example, you may care for children who:

- use cloth nappies
- use disposable nappies
- must not be in the nappy change or toilet area if there is a child of the opposite sex present
- are used to having their nappies changed only when heavily soiled
- wear no nappy or bottom covering at home
- have their nappy changed often.

Make sure you always wear gloves when changing nappies.

Nappies must be checked regularly and changed immediately whenever you notice they are wet or soiled. It is recommended that nappies be checked at least every two hours to reduce the time a child may be damp; however, soiled nappies should be changed as soon as noticed. Some services schedule nappy changing, while others check children regularly during their continuous contact, only changing nappies when required.

First collect all materials and have these within reach, so you never need to leave the baby/toddler unattended. Some items you will need include:

- a clean nappy
- pins or fasteners
- wipes or cloths
- gloves
- a nappy-change area
- nappy creams or lotions
- disinfectant
- clean clothes if the child has soiled their clothing.

Make sure that the change surface is safe for the child's sensitive skin and that the surface is protected from soiling. If a cleaning/disinfecting agent has been sprayed onto the change area, wipe this down.

Interacting with the child

Interaction during a nappy change starts before the change.

When preparing a baby/toddler, always approach them at their level and let them know what is going to happen. It is most effective to use a comment to let them know about this event, rather than a question. This is respectful, yet also gives a clear message. For example, rather than saying, 'Can I change your nappy?', say, 'I am going to change your nappy now, let's go to the change room.' Then take the child.

To continue your respectful interaction and support language skills, allow the child to help as much as possible. You might ask them to collect a new nappy, climb the steps, help undress or dress, lift and move their bodies or tell you how they feel. Continue to talk with them about what you are doing as you complete the nappy change. Encourage the child to play and keep them interested with discussion, toys or visual stimulation from hanging mobiles, photographs or posters.

When you encourage children to help with routines, by collecting items or climbing nappy bench steps, you are:

- encouraging them to gain new skills
- providing opportunities for them to develop self-knowledge and self-awareness
- helping them learn about safe practices
- supporting their social, emotional, physical and language development.

Nappy-change times provide opportunities for relaxed and calm one-to-one interactions that are aimed at enhancing relationships and supporting learning.

Enhance the interaction by:	
➤ hanging mobiles from the ceiling	➤ having photos or pictures on the wall
➤ singing simple songs to catch the child's attention	➤ pulling funny faces
➤ talking about the child's body parts; for example, their toes, fingers, bellybutton, nose, legs or arms	➤ chatting about what you are doing; for example, 'Now I am putting on my gloves.'; 'Let's take off your shorts.'
➤ allowing the baby/toddler to bring a toy into the change area or have a selection of toys ready, you will need to disinfect the toy before it is taken from the change area or used by another child.	➤ describing what the child can see, smell or hear; for example, 'Look at that squiggly toy on the shelf.'; 'Can you see your nappy?'; 'Yes, that cream is a little bit smelly, it's making your nose wriggle.'

If you talk about the smell of the child or their nappy content, it is preferred that you label the smell rather than labelling the child. For example: 'That is a big smell,' rather than, 'You are a smelly baby.'

As you get to know each baby and toddler, you become familiar with the things they enjoy the most, and you can include these in the routine. Babies/toddlers who dislike nappy-change time and wriggle around or become upset will benefit from your preparation as you can involve them in an interaction that reduces or limits these issues.

If your current routine causes you to race through the process, it is not a child-centred practice and should be reviewed. A rushed or unresponsive nappy-change routine is detrimental to the emotional wellbeing of the child.

Changing the nappy

Being prepared and organised will ensure a relaxed and child-centred nappy change occurs.

Place the baby/toddler on the nappy-change bench, or, if they can walk, assist them to use the steps provided. Remember to use proper lifting techniques and have babies/toddlers use the steps whenever possible to avoid hurting your back.

When a child is ready for a nappy change, remove their clothes as required to change the nappy. If the clothes are soiled, put gloves on before commencing this stage. Wear gloves for every change if you are pregnant because some diseases can be dangerous to the unborn child.

Remove any waterproof cover and nappy, placing the items safely away from the child's reach. Make sure nappy pins are closed once removed and placed well away from the child's reach. Take precautions to ensure you don't come into contact with body fluid.

Clean the child's bottom – wipe away excess faeces with the soiled nappy, then thoroughly clean the child's bottom with a wipe or cloth. Bottoms that are only wet still need to be wiped so that the skin is cared for.

Put on a clean nappy and waterproof cover. Ensure any pins are placed in a horizontal position with the pin head facing outwards or use a nappy fastener. Remove gloves, if worn, and dress the child.

Wash your hands and the child's hands. You might use a wipe or support the child to use a child-sized sink.

Cleaning and sanitising

- Between each nappy change, the bench or change mat must be cleaned with soap or detergent and water. Vinegar is an environmentally sound disinfectant; this should be applied to the change mat and left for at least two minutes before being wiped prior to the next use. Bleach might be used to disinfect the area; however, bleach can be dangerous to a child's skin and often has a strong smell that may cause breathing reactions. Your service's health and safety policy and procedures will highlight the methods, timing and materials to be used.
- If an area is directly soiled, a cleaning process should occur and disinfection should immediately follow. In addition to cleaning after use, the whole nappy-change area should be disinfected at least once during the day.
- Soiled nappies, wipes, paper and washers must be kept out of reach of children and placed in lidded containers as soon as possible after use.
- Toilet areas require the same level of care as nappy-change benches. Potties must be emptied into the toilet, and cleaned and disinfected immediately after use. They should never be cleaned in a hand-washing sink as this will spread germs.

Example

Positive nappy-change routine

Melita walks past Jevin and notices he needs his nappy changed. Melita makes sure the change mat is clean and she has everything she needs before she walks back to Jevin. As she kneels to his level, she says, 'Hi Jevin, it's time to change your nappy. Let's go and find a nappy.' Melita takes Jevin over to the nappy lockers and Jevin finds a nappy in the storage cubes and hands it to Melita.

Melita carefully lifts Jevin onto the changing mat and then puts on her gloves. 'Okay, Jevin, let's take your clothes off,' she says. Melita sings a song about clothes as she starts to undress him. Melita talks to Jevin as she wipes his bottom and disposes of the soiled materials.

While changing Jevin's nappy she notices his bottom is quite red, so she gets the nappy cream his mum has provided. 'This might be a little cold,' she says as she applies the cream.

After taking her gloves off, Melita puts on Jevin's clean nappy and gets him dressed again as she plays with him and jokes about which body part his shoes go on.

Once Jevin is dressed, Melita helps him to wash his hands. She lifts Jevin from the bench, then cleans the change mat.

Practice Task 7

1. Which of the following statements demonstrate a responsive and enjoyable nappy-change and toileting routine? Select all that apply.

- [ ] Communicate with families regularly about toileting so that their needs are being met and to ensure you understand their current routines.
- [ ] Service policies and procedures for nappy changing and toileting must be followed at all times. If you have a certain amount of time and need to rush through the routine, it is acceptable as long as you are meeting the guidelines.
- [ ] An individual child's nappy-changing or toileting routine will change. Be flexible and adjust your practice to their current requirements and routines, and make them relevant to their developmental level and interests.
- [ ] Nappy-changing and toileting routines should be relaxed and calm and used as a time to develop a one-to-one bond with the child, create learning opportunities and help them gain self-knowledge and new skills.
- [ ] Knowledge of a child's development as well as their routines and interests will allow you to know how they might respond when changing their nappy and what you can do to make this an enjoyable and positive experience for them.
- [ ] *Staying healthy*, a publication provided by the NHMRC, provides guidelines for safe and hygienic nappy-change and toileting routines.

2. Number each step from 1 to 6 in the order you would follow to change a soiled nappy and provide a relaxed, calm and enjoyable experience.

- [ ] Prepare for the nappy change. Ensure the nappy-changing area is clean and collect all materials you need.
- [ ] Put gloves on, if required, and talk to the child while you remove their clothes and soiled nappy. Make sure items are placed out of reach of the child and keep a hand on the child at all times.
- [ ] Wash your hands and the child's hands. The nappy-changing area needs to be cleaned to limit the spread of infection.
- [ ] Change the nappy. Wipe away excess faeces with the existing nappy and then clean the child's bottom with a clean cloth or wipe. Talk about what you are doing with the child and use the time to interact with them to help them learn about feeling safe as well as supporting their language development.
- [ ] Approach the child at their level and explain what you are going to do. Take them to the changing area and provide them with warm physical contact that creates a relaxed, calm and enjoyable environment.
- [ ] Dispose of soiled materials and gloves in the appropriate bin and put on a clean nappy and cover.

4B Supporting toilet learning

As with many skills, toilet learning can be supported through understanding, encouragement, interest and acknowledgment.

Toilet learning is commonly known as toilet training. The term 'toilet training', however, gives the impression that the child is being trained or taught to do something that is out of their control. If you use the term 'toilet learning', you are giving the message that this is a period of learning that is based on the child's readiness. The term helps families and educators remember that this is a child-focused process.

Support toilet learning by encouraging children and acknowledging their progress.

National Health and Medical Research Council guidelines, *Staying healthy: Preventing infectious diseases in early childhood education and care services,* provide some guidance for managing toilet learning. You can access a copy of *Staying healthy* at: aspirelr.link/nhmrc-staying-healthy-pdf.

Toilet learning readiness

Toilet learning is more successful when the toddler has developed physical sensations and abilities that demonstrate readiness.

A toddler who displays these signs or abilities is demonstrating to you that they are ready for the toilet-learning process.

Signs of readiness for toilet learning include:

- an understanding of what wet and dry mean
- being able to identify wet and dry feelings on the skin
- an interest in toilets, toileting, urine and faeces
- having a dry nappy for extended periods of time
- being able to hold on for the period of time between identifying the need to use the toilet and getting there
- the ability to remove pants or clothes and place themselves on the toilet
- an awareness of their own physical needs and how to meet these.

Commencing learning before they are ready may cause some toddlers to become anxious, afraid or confused. This may even cause the learning period to take much longer than if you had waited for the signs of readiness.

It would be appropriate to speak to the toddler's family when you notice signs of readiness. The family may have their own toilet-learning routines, opinions about the toddler's readiness and style of learning, or they may be keen to follow your lead. Some families are keen and eager to commence toilet learning, while others are anxious and prefer to delay. Some families have cultural practices that include starting toilet learning very early. If your discussion with the family and your observation of the baby/toddler shows that this is doing no harm, then there is no concern in you following their request.

Once children begin to use the toilet they will show cues that they may need to use the toilet. Look for times when the child is wriggling, crossing their legs or using their hand to try to stop the process.

During toilet learning, the child and their family will need your support. They may need gentle reminders, materials, equipment and encouragement.

Discussion with family members is a good way to start the toilet-learning process and create a positive start for the child. Discussion should then continue each day as you share progress and make decisions together.

You can find out the family's routines and preferences by asking questions such as the following.

Question	Information you may need to know
What words would the family like to use?	Consider the family's words for: › the toilet › urination and faeces › the genitals.
What facilities do the family prefer and what facilities will their child feel comfortable with?	The family may want the child to use: › a potty or potty chair › a small toilet › an adult toilet with a child's seat and foot stool.
How independent will the child be?	Consider whether the family wants you to: › allow the child to dress and undress themselves › steady the child on the toilet › wipe the child's bottom › allow the child to complete the task themselves › talk the child through what to do next.
What approach will the family want you to take?	The family may want you to: › encourage the child to use the toilet at specific times, such as before and after sleep, before and after meals, before and after going out, or during outings › allow the child to choose when to use the toilet › remind the child to use the toilet, but not insist.
What specific family expectations should be applied?	Determine any cultural or personal values or beliefs, such as: › privacy expectations › observation of children of other genders › supervision requirements.

The information you gain from asking these questions allows you to interact with the child and describe objects and events in ways they understand. It will also help you understand their cues and needs.

Encouraging toilet learning

When adults are responsive to the needs of children, provide consistent expectations and work at the child's pace, learning is most likely to be successful.

Some actions you may take to be encouraging include:

- providing positive reinforcement, such as giving a high-five, offering encouragement, giving a hug or a pat on the back, giving a thumbs-up, clapping, cheering or sharing successes with others
- telling the child how you feel about their success and discussing what they have achieved
- letting the child know that trying is valuable, and if they make a mistake or don't succeed, they can try next time, so it's okay
- valuing the little steps and seeing these as learning moments. A child may not succeed at toileting independently; however, they may have noticed the need to toilet, undressed, asked for help or used the toilet too early or too late.

At times, families or educators may suggest a controversial strategy. A controversial strategy is one that challenges beliefs or understandings of the National Quality Standard (NQS) and the Education and Care Services National Regulations related to your relationships with children. Two controversial strategies that are commonly used during toilet learning include:

- tangible rewards
- incentive charts.

Tangible rewards	A tangible reward is something that is given to the child as a reward for a specific behavioural action, in this case, using the toilet. Common tangible rewards include stickers, lollies and toys. While tangible rewards appeal to a child and have immediate results, they do not always have a positive effect on the child's self-esteem. This is because there is always the threat that if they do not succeed they will not receive the reward. Because of this, when a child has a toileting accident and does not receive a reward, they are, in effect, feeling punished. The possible effect of not receiving a reward can be stressful, cause anxiety and decrease success for the child.
Incentive charts	Incentive charts are sometimes used to encourage a child to achieve something or to demonstrate consistent behaviour consistently. Unfortunately, if the child is not in control of their abilities, then the incentive chart is just another way to demonstrate their failures. If the child is learning, making mistakes and still trying to establish the skill of toilet use, then an incentive chart is just a reminder of their inability. However, incentive charts may be useful when children are in control of their toilet learning and need some support to become consistent.

It is preferred that instead of tangible rewards and incentive charts, encouragement through words and actions are used to support children. This will help children to feel success, motivation, increased skill and self-esteem. Encouragement through rewards and charts can increase the child's need to receive material possessions for their actions, and is something that can be demotivating if they are not provided.

Toilet learning and other skills

During toilet learning, an enormous amount of development takes place.

Because the child sees new things and tries new tasks, they are developing physically, socially and emotionally, and you can provide various scaffolding experiences to aid them in this.

Opportunities exist to develop a wider range of knowledge and skills than simply knowing how to use a toilet. For example, providing support and enough time enables you to boost the toddler's self-esteem.

Learning opportunities can include the areas outlined in the following table.

Physical development, hygiene and self-help:

- Washing hands
- Drying hands
- Flushing toilets
- Dressing and undressing
- Using nappies, underpants or pull-ups
- Cleaning bathroom floors and sinks

Science, biology and anatomy:

- Gender differences
- Ways the toilet is used
- Why we go to the toilet
- Where urine and faeces come from
- What germs and infections are
- Why we use toilet paper
- Where the flush takes waste
- The different ways water is used

Toddlers who are toilet learning enjoy exploring the properties of water and the ways it can be used. Water play in the bathroom is not always hygienic and may cause hazards, but you can capitalise on their interest and provide water play in an appropriate place rather than discouraging them.

Each child will raise different questions as they learn according to their age, abilities, level of interest and depth of understanding. These questions and investigations are valid and should be answered honestly, in an age-appropriate manner and as guided by family decisions.

Toileting accidents

Despite a child's age or developmental level, toileting accidents do occur.

To support toddlers at these times, you can:

- accept that accidents will happen
- react calmly and sensitively to accidents
- keep spare clothes on hand
- be flexible and allow toddlers to use the toilet when they ask to
- support toddlers without overshadowing them
- understand that toddlers often identify a need to use the toilet shortly before they do, rather than when you ask them or when it is convenient
- provide information for families if necessary
- know how your service expects you to manage soiled clothing.

Reasons a toddler may have a toileting accident include:

- not being ready to start toilet learning or having physical difficulties
- a lack of self-esteem and feeling that they have little privacy; for example, insecure toilet doors
- not feeling comfortable in the environment
- feeling a lack of support, encouragement and supervision
- fear of punishment
- having drunk more fluids than usual
- cold weather
- excitement
- health issues
- a change in diet
- distractions
- having difficulty removing clothing
- fear or anxiety.

As the causes of toileting accidents are either out of the toddler's control or part of a larger issue, it is unreasonable to punish them for toileting accidents.

Be aware that an ongoing problem may indicate an infection or emotional issue, or it may just be that the toddler has difficulty focusing on bodily functions while engrossed in an activity.

Whatever the cause, your role is to support the toddler in returning to a clean and dry state, while following infection-control procedures that include hygiene protocols. You should:

- wear protective gloves
- rinse or wash wet or soiled clothing, following the service's procedure for dealing with infectious materials
- wash and dry the clothing or place in a sealed bag if returning to the family.

Example

Toilet learning

Sandra, an educator, is talking to Jacklyn, Bret's mum, when she drops him off in the morning. Jacklyn tells Sandra that they have started toilet training at home and asks if Sandra can do this too.

Sandra asks Jacklyn a series of questions to establish how they are going at home and what she would like her to do with Bret. Jacklyn explains that they can tell when Bret needs to use the toilet as he usually crosses his legs. She is aware that Bret sometimes gets distracted, especially when he is doing something he loves. She says that they are doing hourly toilet reminders and that he uses their adult toilet. Bret has started wearing jocks and is very proud.

Sandra explains that they will follow the same routine as at home and assures Jacklyn she will let her know how Bret is getting on. She also reminds Jacklyn to put extra changes of clothes in Bret's bag in case of accidents.

Several times during the day, Sandra reminds Bret about going to the toilet and he successfully does wee in the toilet. They both giggle in excitement as she shows him how to flush and wash his hands. They give each other a big high-five.

Later, when Bret is outside, Sandra observes that Bret is crossing his legs, so she walks over to remind him to come to the toilet. On approaching, she notices that Bret has had a toileting accident. Sandra quietly talks to Bret and takes him to the toilets to get changed. She reassures him that it is okay and reminds him how he went earlier and did an amazing job.

When Jacklyn arrives Bret runs over excitedly as Sandra tells her that he went to the toilet that day.

Practice Task 8

Tom has independently used the toilet for the first time. He has left the toilet without flushing and is washing his hands. He squirts soap over the bench and starts to draw in the soap, splashing water on the floor. Tick all statements that demonstrate a positive experience that is designed to enhance learning and relationships.

- ☐ Educators should provide encouragement for Tom's first attempt at going to the toilet by himself and support his self-awareness and actions taken.
- ☐ Tom's toileting achievement should be communicated with his family. Information can be gathered from *Staying healthy* if additional details would be useful.
- ☐ Tom's home-toileting routine may not include the things educators expect, so it is wise to set boundaries and expect these to be met during toilet learning, despite any cultural or personal family expectations.
- ☐ Educators should use this as a learning opportunity to show Tom how to flush the toilet and discuss why. This sensitive and positive interaction may lead to further discussions about what the different buttons are for, where the flush takes the waste, etc.
- ☐ Tom is exploring the soap, its texture and his motor skills by playing in the soap. Educators should capitalise on this interest and provide a similar substance in the room to extend his learning opportunities and support skill development.
- ☐ Tom needs to learn about the entire routine. Today he was able to toilet independently, so the educator needs to focus on correcting his flushing and hand-washing properly so he learns about health and safety.

Summary

- Nappy-change procedures and areas must be hygienic to prevent cross-infection.
- Babies/toddlers will be at various stages in their toileting routines and have various needs, which may be influenced by family practices.
- Babies/toddlers learning to use the toilet need sensitive and positive support.
- Use positive comments and behaviour to help the baby/toddler learn about toileting.
- Toilet learning will be more successful if you consult with families.

Learning Checkpoint 4
Providing positive nappy-change and toileting experiences

Part A

Read the first case study and then answer the questions that follow.

Case study 1

Ned notices Della, five months, has soiled her nappy. Ned says to Della, 'I think we need to change your nappy,' then picks Della up and takes her to the change room. On the way Ned talks to Della about changing her nappy.

While the service uses disposable nappies, Della's parents have requested that the educators always use the cloth nappies they provide. Ned prepares all items needed before placing Della on the bench. He washes his hands, then removes Della's nappy and wipes her bottom. He then replaces it with a disposable nappy. As he changes Della's nappy, he plays 'peek-a-boo'. Afterwards he washes his hands before helping Della to wash her hands.

1. What must Ned be aware of prior to changing Della's nappy? Select all that apply.

- ☐ Service nappy-changing routines, policies and procedures
- ☐ Element 7.1.3 of the National Quality Standard (NQS)
- ☐ *Staying healthy* infection-control guidelines
- ☐ How high the change bench should be
- ☐ Della's individual routine, needs and requirements as relayed by her parents

2. Which of the following statements are correct about this nappy-changing case study? Select yes or no for each one.

a.	Ned is creating a positive experience that builds a relationship with Della.	* Yes	* No
b.	Ned is respecting the parents' requests.	* Yes	* No
c.	Ned is following hygiene practices.	* Yes	* No
d.	Ned is changing Della's nappy safely.	* Yes	* No
e.	Ned is supporting Della's learning and wellbeing while changing her nappy.	* Yes	* No

3. Which of the following are appropriate interactions Ned could have with Della? Select all that apply.

- ☐ 'Phew, you are smelly!' Holding his nose.
- ☐ 'Come on, Della, let's change your nappy.'
- ☐ 'Socks off! I'll give them a pull! Off they go.'
- ☐ 'Where is your foot? There it is!'
- ☐ 'Would you like me to change your nappy now or wait until I change the other babies?'

Part B

Read the second case study and then answer the questions that follow.

Case study

Penny mentions to Evelyn, the educator, that her daughter Clarissa (22 months) has recently shown interest in using the toilet. Penny has purchased some pull-ups for Clarissa and given toilet learning a try, but they haven't had much success.

Evelyn asks Penny what they have been doing, but Penny says that they try taking Clarissa to the toilet during the day and just see what happens. Penny doesn't want to push Clarissa.

Evelyn shows Clarissa where the toilets are and tells her she can go whenever she wants. Clarissa sees other children go to the toilet and decides to go, but gets there too late and has an accident, wetting her pants. Later that day, Clarissa wees in the toilet and is excited to use the flush.

When Penny arrives that evening, Clarissa runs to tell her mum.

1. Draw lines to match the questions Evelyn could ask Penny on the left with the type of information she might gather on the right.

* 'What are you doing at home to help Clarissa learn about toileting?'	* Establishes Clarissa's stage of readiness and gains an understanding of Clarissa's signs and cues.
* 'How can you tell Clarissa is interested in going to the toilet?'	* Establishes whether a toilet, potty seat, potty or potty chair have been used and how the family is implementing toilet learning.
* 'What would you like us to do here?'	* Establishes the terminology Clarissa will understand and feel comfortable using; for example, what urination means, and what her body parts are called.
* 'What toileting terms are you using?'	* Establishes how toilet learning will be implemented while Clarissa is in the service.

2. Which of the following should Evelyn have done to encourage Clarissa when she used the toilet successfully? Select all that apply.

- ☐ Get her a stamp and a special gift to celebrate.
- ☐ Take her to find a special treat; there are lollipops hidden in the kitchen.
- ☐ Cheer and give her a high-five.
- ☐ Tell her how excited she is.
- ☐ Say, 'Look how happy you are, you are really clever!'
- ☐ Create an incentive chart and give it to Penny for home.

3. Which of the following should Evelyn have done when Clarissa had a toileting accident? Select all that apply.

- ☐ Evelyn should encourage Clarissa's effort; for example, by saying, 'Great job for trying!'
- ☐ Evelyn should remind Clarissa that toilet accidents happen sometimes when you are learning.
- ☐ Evelyn should not mention it as doesn't want to upset Clarissa.
- ☐ Evelyn should tell Clarissa that it's okay and she can try again next time.
- ☐ Evelyn should put Clarissa back in a nappy for the rest of the day.

Topic 5

In this topic you will learn about:

5A Positive mealtimes

5B Food hygiene

Promoting quality mealtime environments

Mealtimes are valuable opportunities for educators to interact with children.

When working with babies and toddlers, mealtimes often give you the opportunity to spend one-to-one time interacting. Children learn from what they see, so by providing positive and healthy mealtimes you are introducing long-term skills.

Bacteria are micro-organisms that can cause disease. Bacteria is commonly found on skin and in the environment, and can cause food poisoning in a young child. During food preparation, cooking or cleaning processes might spread bacteria. With babies and toddlers who use their hands and mouths to explore, bacteria can spread through the eating process.

5A Positive mealtimes

You can provide a positive mealtime environment by ensuring it is happy, relaxed and fun.

Babies and toddlers learn to eat by watching other people, so you are modelling healthy eating attitudes and demonstrating skills with your actions. The food you offer and the habits developed at mealtimes can influence the food habits developed by the baby or toddler.

Smiling and interacting with children help to make mealtimes a positive experience.

Mealtimes are excellent opportunities to interact with the baby/toddler. Interactions need to be calm to eliminate the chance of choking, but they are an excellent time for using language and social interaction. For example, by:

- smiling
- holding hands or fingers during bottle feeding
- using simple language; for example, naming foods or labelling textures
- singing rhymes
- describing actions and feelings
- providing a spare spoon for the baby to use.

Mealtime routines

The routines of the day are determined by the needs of each baby or toddler.

You may care for babies and toddlers who:

- eat with their hands
- are fed by an adult
- eat a simple meal or eat a large cooked meal at lunchtime
- have food allergies, dislikes, intolerances, preferences and cultural requirements
- have commenced eating solid foods early or have not commenced eating solid foods even though they are older
- sit at a table, on a knee, at a highchair or walk around while eating
- are breastfed or bottle fed
- have additives in their bottles; for example, cereal, cordial, lemonade or flavoured milk.

Some practices will be acceptable, some you may need to adapt to and some may be considered inappropriate. Your communication with families will guide you to understand the child's needs and history so you can make informed decisions. At times, this will include providing education to family members, while at other times you may be learning. Daily discussions help to maintain consistency between home and care.

Adapting to individual routines means you need to be extremely flexible and organised, and that no two days are the same. There will usually be more than one routine occurring at the same time; for example, some children may sleep while others eat, or one child may be playing while another is sleeping and another is eating lunch. In addition, you will be monitoring each child to identify their individual signs of hunger and adapting to meet these.

Sometimes it can be difficult to provide individual routines and one-to-one attention for multiple children.

Provide individual routines by:

- planning in advance
- having enough resources prepared
- avoiding babies being over-hungry by knowing their routines and preparing for feeds; for example, if you know two babies will be hungry around 11 am, you may prepare for one to have a bottle at 10.50 am so you are free for the other at 11.10 am
- requesting another educator at times when you need an extra pair of hands.

When you provide a bottle, try to make this a warm and individual one-to-one experience, just as if the baby were being breastfed. This is a special time for the baby and for developing a bond of attachment.

Babies being bottle-fed or being given solid foods should be observed closely by an adult. This routine is one of the most important times for them to develop confidence in you and to be emotionally soothed by physical holding or close one-to-one attention. The EYLF encourages this physical contact as it supports the child's sense of belonging.

Example

Adapting routines at mealtimes

Daniella, an educator, has started to organise the table for lunch when she notices that Harry is starting to get grizzly. He will be due to have a bottle at the same time lunch is starting. She asks Mary, another educator, if she can get Harry's bottle and then sit down with him to read a book. By doing this, Daniella will be able to sit with the children who are ready for lunch and interact with them while they eat.

Daniella chose Mary to care for Harry as she has a stronger relationship with Harry. Daniella knows what foods have been organised for the children with allergies and cultural requirements, and by sitting with them she is able to ensure the children get the right meals.

Beginning feeding

As babies and toddlers are introduced to new foods, they show likes and dislikes and develop new skills.

Babies and toddlers move from being fed to controlling their own eating, welcoming foods and making choices based on experience.

Solid foods are usually introduced at about six months of age, and this process is called 'weaning'. If a baby is often hungry, this may be an indication that their body requires more nutrition than milk and they are ready to start weaning. Other reasons for introducing food include:

- providing enough nutrition for physical growth
- replenishing iron to avoid iron-deficiency anaemia
- scaffolding physical skills required for eating; particularly important before nine months
- decreasing the risk of allergy.

At around six months of age, social skills have increased and babies usually start to show an interest in food. They are watching and learning from others who are interacting with food.

Physical skills also develop at this age. For example:

- the digestive system has matured
- oral coordination is improving and babies can move food towards the back of their mouths to swallow
- hand–eye coordination has improved to support the child picking up food or utensils
- teeth are emerging
- babies can put their fingers in their mouth
- they have the ability to move their tongue up and down
- they are able to sit upright and support their head independently
- they can reach out to grab food or cutlery
- they can indicate they have had enough by closing their mouth when food is offered.

Babies and toddlers love to explore new foods by seeing, touching, smelling and tasting them as well as listening to you use new words to describe them. From about seven months of age, mealtimes can become a fabulous time to promote exploration, discovery and confidence.

Although babies are messy when they first begin to self-feed, this improves with practice and encouragement. The benefits of self-feeding are that the baby is learning a new self-help skill, which is motivated by their hunger. They are also learning to identify when they are full and which foods they like best.

Introducing foods

The introduction of new foods must be led by families.

Your daily communication with families will allow you to understand their home routines and to follow these to create consistent home-to-care routines. At times, families may request your support and ask you to guide the introduction of new foods. Keep in mind the cultural and personal backgrounds of the family when this occurs, including food choices as well as allergies. Follow the home routine by offering similar or the same foods at the same times. For example, some babies may refuse foods given at lunchtime if they usually eat these for dinner.

When introducing new foods, introduce one food at a time. By doing this, you can see whether there are any reactions or allergies to each food. It is recommended that the child tries each food two or three times before another new solid food is introduced, as this will help you identify any reaction. You must have permission before introducing a new food.

Babies require close observation while they try new foods as they begin to learn to swallow and, later, to chew. These motor skills are constantly developing, and the control babies have over their mouths and throats may vary.

After 12 months, most babies/toddlers are eating the same foods as older children and can share the family meal.

The National Health and Medical Research Council's *Eat for health: Infant feeding guidelines* provide recommendations for nutritional needs. you can access these guidelines at: aspirelr.link/infant-feeding-guidelines.

The following is an overview of the guidelines.

Infant feeding guidelines:
Introduce solids around six months of age.
Start with iron-rich foods, such as iron-fortified cereal, pureed meat and poultry, tofu, legumes and beans.
Introduce foods in any order as long as iron-rich foods are first.
Begin with pureed foods then move to lumpy and normal textures, as suited to the child's development.
Avoid whole nuts and other hard foods as they are a choking risk.
Avoid adding sugar, honey, juice or sweetened foods as these increase dental concerns.
Salt is difficult for infants to digest and can damage their kidneys.
Avoid high levels of fat, particularly in nutrient-poor foods such as cakes, biscuits and potato chips.
Toddlers older than twelve months:
Pasteurised full-cream milk may be introduced. Low-fat milks are not recommended.
Toddlers should be eating foods at normal consistencies.
Offer drinks in a cup.
Unless fortified or recommended by a medical practitioner, soy, rice and oat milk should not be offered as alternatives to pasteurised full-cream milk, breastmilk or formula milk until the child is over two years.

Choking can be a hazard to all babies and toddlers, so supervise closely and be aware of foods that are hard. In addition, cut slippery or round foods so that the child's teeth can group them to chew, and remember that dried foods swell so they should be cut small and quantities should be minimal. While whole nuts are a choking hazard, nut products may be included as new foods after the child is six months old. There is evidence that if children are introduced to these products early, their risk of developing an allergy may be reduced. Nut products that may be suitable include butters or oils. If a child has a condition, such as eczema, asthma, hay fever or a diagnosed food allergy, there is a higher risk of them developing further allergies.

Food allergies

Food allergies can cause serious, life-threatening reactions, so special care is needed when providing meals.

Families of children who have an allergy must provide a medical plan. This will need to be displayed where you can see it, and all staff should be advised of the dangers to that child.

The most common types of foods that children may be allergic to are:

- eggs
- cow's milk and dairy products
- nuts
- fish and seafood.

The symptoms of a food allergy include:

- anaphylactic shock
- itching, burning and swelling around the mouth
- a runny nose
- a skin rash (eczema)
- hives
- diarrhoea and/or abdominal cramps
- breathing difficulties, including wheezing and asthma
- nausea and vomiting.

Be alert to these symptoms and know what to do if you see a child displaying any of them.

Anaphylaxis

Anaphylaxis is a severe allergic reaction that needs urgent medical attention. Nuts, insect stings and some medicines are the most common allergens that cause anaphylaxis. Within minutes of exposure to the allergen, a child may experience potentially life-threatening symptoms such as:

- difficult or noisy breathing
- swelling of the tongue
- swelling or tightness in the throat
- difficulty talking or a hoarse voice
- wheezing or a persistent cough

- loss of consciousness or collapse
- becoming pale and floppy (in young children).

Several factors influence the severity of anaphylaxis, such as exercise, heat, the amount of food eaten and how food is prepared and eaten.

To prevent severe injury or death, a person experiencing anaphylaxis requires an injection of adrenalin. For babies and toddlers, these injections can be given by an educator or other adult. They are available by prescription or directly from a pharmacy. If you suspect anaphylaxis, follow your service's first-aid policy.

Due to the severe reaction of anaphylaxis and allergy, it is advised that any food that may cause such a reaction be removed. For example, many services are nut-free. In some cases, the child may only need to smell or touch the food to develop an allergic response. This possibility means you must acknowledge the issue of contamination and separate all foods of danger during preparation, handling and service. Cross-contamination can occur on:

- cutting boards and knives
- baking and cooking utensils
- serving utensils and crockery.

Cross-contamination can also occur when foods are served close together on a platter.

Food intolerances

Intolerances are less severe and much more common than allergies.

A food intolerance differs to a food allergy in that an allergy is usually a fast response by the body's immune system, whereas an intolerance is the body's inability to process a particular food.

Symptoms of food intolerance can include:

- stomach ache
- nervousness
- tremors
- sweating
- palpitations
- rapid breathing
- headache, migraine
- diarrhoea
- burning on the skin
- tightness across the face and chest
- breathing problems – asthma-like symptoms
- skin rashes including eczema and hives
- allergy-like reactions.

Reading food labels

Food labels allow you to choose healthy foods suited to children's needs.

All packaged products include on their label:

- a list of ingredients
- any relevant advisory statement that a food may or does contain a common food allergen
- a nutritional information panel (NIP).

Food ingredients are always listed in order from the greatest amount to the least by how much they weigh. If an ingredient shows a percentage (%), this highlights the amount of this ingredient that makes up the whole food. If the food label mentions an ingredient as 'flavoured', it means the ingredient is not present, but the food is flavoured so that it tastes as though the ingredient has been used.

Advisory statements are provided to ensure that people with allergies and intolerances can avoid foods they react to. An advisory statement must be provided on the label if a food contains any of the following, or their products:

- sesame seeds
- eggs
- fish
- milk
- peanuts
- soybeans
- tree nuts
- bee pollen
- crustaceans (crab, lobster, crayfish, prawn, etc.)
- aspartame and phenylalanine
- caffeine
- guarana (contains caffeine)
- quinine (contains caffeine)
- unpasteurised egg and milk products
- plant sterols.

The following is an example of an advisory statement.

Allergy advice:

Contains gluten. May contain: egg, milk, tree nuts, sesame seeds & soy.

Oral health

Babies' bottles have been identified as a common cause of tooth decay.

If a baby or toddler falls asleep with a bottle in their mouth, there is not only a high risk of choking, but also that the contents of the bottle sit in the child's mouth, coating their teeth and gums for long periods of time. This can cause tooth decay, which can occur even before a child's teeth erupt, as well as once they are visible.

Bottles should only contain fluids low in sugar. Generally, just water, milk or formula.

To prevent babies and toddlers from developing dental decay, it is recommended that you:

- encourage breastfeeding
- remove a bottle from a child's mouth unless they are feeding
- only use a bottle for water, milk or formula
- introduce a cup as soon as possible

- clean the baby's or toddler's teeth after feeding using a face washer or soft cloth
- never dip a dummy in food or liquid, as the coating will sit on the teeth.

Tooth decay and general oral health can affect a child's:

- health and general wellbeing
- ability to eat
- ability to speak.

Example

A baby refuses food

Montana is 11 months old. At home she chews on a rusk and is fed mashed fruit for lunch. Educators follow the lunch menu and provide Montana with vegetables, as they do the other children. Montana is used to a rusk and fruit for lunch, so she becomes annoyed and wriggly, and refuses to eat the vegetables. The educators are not sure why she won't eat, so they call her mum to find out what she usually eats.

Once the educators are aware of her meal preferences, they provide these foods at the mealtimes suited to Montana.

Practice Task 9

1. Theo is nine months old and is just starting to explore finger foods. Which of the following statements relate to promoting a positive mealtime? Select all that apply.

- [ ] Mealtimes should be a positive and enjoyable experience for Theo that follow his individual routines. It is important one-to-one time to assist him, interact and to use language to describe new foods, textures and colours.
- [ ] Educators can prepare and serve foods in a safe and hygienic way if they read their service's policies and procedures on relationships with children.
- [ ] Theo should be encouraged to explore new self-help skills. Providing him with a spoon so he can experiment with feeding himself would build his confidence.
- [ ] Theo explores foods using all of his senses. If he is allowed to self-feed, he will make a mess. This is too much work in a busy service and the mess would limit the amount of relaxed physical contact that could occur.
- [ ] New foods should be introduced for Theo to explore at the service, as identified in the NHMRC *Infant feeding guidelines*. Educators are trained to deal with allergies that may arise, so if he hasn't tried these foods at home his family will understand.
- [ ] Theo should be closely supervised as he eats as choking is a risk for babies.

2. Provide two ways that you can prevent babies and toddlers from developing dental decay.

5B Food hygiene

Of all age groups, babies have the most complex nutritional needs due to their transition from a milk-only diet to a variety of solid foods by the end of their first year.

Introducing this diet requires an observation of the baby's intake and their developmental aspects, including their physical skills.

Ensure you always follow food hygiene procedures when preparing food.

This development requires the use of safe hygiene practices when preparing milk and food. The areas and equipment used for food preparation, handling, storage and serving are vulnerable to micro-organism growth and may harbour bacteria, which can be dangerous, especially to babies and toddlers. Food-associated infection and disease can be extreme and even fatal, so any service with food, including breastmilk and formula feeds, must follow health and safety policies and procedures for cleaning and disinfection.

National Health and Medical Research Council guidelines within *Staying healthy: Preventing infectious diseases in early childhood education and care services* outline food safety, including:

- the basics for meals and snacks
- preparing food
- preparing, heating and storing bottles
- children's cooking classes.

This information extends on the details provided in this topic. You can access a copy of *Staying healthy* at: aspirelr.link/nhmrc-staying-healthy-pdf.

Food handling

Good hygiene when handling food assists in reducing cross-contamination.

Effective hygiene involves:

- washing your hands before preparing or handling food
- washing your hands again if you are interrupted while preparing food or feeding a child
- washing and drying the child's hands before eating
- checking that children do not share food, plates or utensils
- using a separate spoon for each baby or toddler you feed
- using a dishwasher, if available
- using sterilisers.

If you are involved in handling, preparing or serving food, remember these basic food safety standards:

- Keep raw and cooked foods separate to prevent cross-contamination.
- Use separate utensils for raw and cooked food.
- Clean and sterilise equipment and utensils regularly.
- Keep food hot (over 60°C) or cold (under 4°C).
- Keep a thermometer in your fridge so you can check that the temperature is below 4°C.
- Heat meals that have come from home thoroughly (above 60°C) and then let them cool down.
- Throw out leftovers – tell families what their baby/toddler left uneaten, but do not return the leftover food as it may not be safe to reheat.
- Only heat food once.
- Only heat milk for bottles once.
- Check that food has cooled before giving it to the baby/toddler; remove a small piece of food with a spoon to another plate and test the temperature of the food with your hand, rather than blowing onto the child's food to cool it.
- Ensure the service has a hand basin, soap and disposable towels in the kitchen so educators who prepare food can easily wash their hands.
- Wear clean clothes when working in the kitchen.

Studies have shown that in services where the same educators change nappies and prepare or serve food on the same day, there is over three times the number of incidents of diarrhoea as compared to services where educators do not do both of these jobs. If possible, a staff member who prepares and serves food should not also change nappies on that day.

Services are not responsible for foods that are provided by families; however, services must comply with food-handling expectations.

Where meals are pre-prepared and delivered to the service, food handling, storage and safety should be observed, as is required with any foods.

Bottle hygiene

Your hygiene routine will include sterilising and making up bottles, storing and preparing breastmilk or formula, and bottle-feeding babies or toddlers.

For most of these tasks you will be required to follow your service's procedures; however, hygiene is entirely your responsibility and cleanliness should be taken seriously.

Sterilising should occur using one of the following methods:

- electric steam sterilising
- microwave sterilising
- dishwasher sterilising
- boiling
- chemical sterilising.

The method you use will either be based on instructions that come with the steriliser or based on your service's procedures. Following sterilisation, you must store the equipment in a clean, covered container in the fridge.

The following checklist can help remind you of bottle hygiene practices.

Checklist for sterilising equipment:

- ☐ Gather and prepare the required equipment.
- ☐ Wash hands and all work areas before sterilising.
- ☐ Wear gloves.
- ☐ Wash or scrub bottles, teats and other items adequately.
- ☐ Place items in the steriliser as directed by the manufacturer.
- ☐ Operate the sterilising equipment correctly.
- ☐ Sterilise equipment for adequate length of time.
- ☐ Wash hands after sterilising.

Checklist for preparing bottles:

- ☐ Gather and prepare the required equipment.
- ☐ Make sure all equipment has been sterilised.
- ☐ Wash hands.
- ☐ Wear gloves.
- ☐ Check you understand the chosen formula ratio, e.g. how many millilitres of water and how many scoops of formula.
- ☐ Identify how to prepare boiled water. Families may only provide the formula powder. You may need to boil water or access a store of boiled water.
- ☐ Add the right amount of water required per scoop.
- ☐ Ensure the scoop measurement is level. A useful method is to scoop the formula, tap the scoop to remove air bubbles, then level with the back of a knife.
- ☐ Shake the bottle well.

Checklist for hygiene during bottle times:

- ☐ Wash hands.
- ☐ Gather and prepare the required equipment.
- ☐ Heat the formula or breastmilk correctly. Avoid microwaves as they create hot spots.
- ☐ Have a strategy for testing milk temperature. The most common practice is to shake the bottle then sprinkle a few drops of milk onto the inner side of your wrist. The milk should feel neither hot nor cold. Avoid contact with the teat.
- ☐ Identify a suitable environment for feeding; somewhere safe with minimal distraction.
- ☐ Feed each baby individually. Hold the baby in a comforting way close to your body.
- ☐ Burp the baby. Some babies may need burping intermittently during the feed, others may only need a burp at the end.
- ☐ Milk or formula must be discarded after an hour if not refrigerated. This includes any period of time that the content is not chilled.
- ☐ Know what to do with leftover formula or breastmilk that has been heated. Does the family wish to have this returned or can you discard this?
- ☐ Record details on a chart so communication with families is clear.
- ☐ Reduce the risk of dental damage by only providing bottles at mealtimes. Children who sleep with a bottle are at higher risk.
- ☐ Only provide milk or water in bottles.

Bottle contents

For babies up to the age of six months, breastmilk or formula is their main source of nutrition.

Some mothers may provide breastmilk for their baby by expressing milk, either by hand or by using a mechanised or electric pump. This can be extremely time-consuming and demanding for the mother, so you must take good care of this milk and waste as little as possible.

Breastmilk can be stored in the refrigerator for up to 48 hours or in a freezer for up to three months. Frozen breastmilk must be thawed quickly, but never put in boiling water or it may curdle. Never microwave breastmilk as hot spots damage the milk. Instead, place the container under cold running water and gradually allow the water to get warmer until the milk becomes liquid. Test the temperature by dropping a little milk onto your inner wrist.

It is preferred that formula or cow's milk be heated in the same way as breastmilk; however, it will not be damaged in a microwave. Be sure to shake the bottle thoroughly to distribute heat evenly because milk can turn to steam and collect at the top of the bottle, causing a danger of scalding the baby.

Babies should not be provided with milk that is leftover or has been stored at room temperature for over an hour. Never refreeze or reheat leftover milk.

Some tips for keeping bottle contents safe include:

- asking mothers to supply breastmilk in multiple small quantities to prevent waste
- asking for an additional formula bottle or formula
- marking a bottle to show the time it was made up or brought to room temperature
- investing in a bottle warmer.

Breastfeeding support

Encourage mothers to come into the service and breastfeed during the day if this fits into their schedule.

Remind mothers during enrolment that this is possible and also throughout the time their child is breastfeeding.

You may need to provide a private area; however, many mothers like to sit in the play space. Mothers will need a comfortable place to sit and some basic things that they may provide herself or request from you; for example, a blanket or a pillow. Ask the mother what she needs. For mothers who ask for privacy, a sign on the door can help to let others know she is feeding. This can be useful for babies who are easily distracted, and can make for a pleasant time they enjoy together.

If mothers need support while breastfeeding, you can offer them contacts through the Breastfeeding Helpline or the local Australian Breastfeeding Association branch. If a mother is not sure whether she is allowed to feed in public, you can assure her that the *Sex Discrimination Act 1984* (Cth) states that it is a legal right, as does all state and territory legislation.

Example

Breastfeeding and using breastmilk

Talitha is a parent who usually comes in several times a day to breastfeed her daughter Mae. She usually sits on a couch in the meeting room to feed Mae as it is quiet and comfortable for them both.

Today, Talitha has a meeting in the afternoon, so she has provided some frozen breastmilk to use for Mae's afternoon feed. Virginia, the educator, collects this from Talitha along with the bottle. Virginia follows the checklist for sterilising and preparing the bottle, as well as guidelines regarding giving a bottle. She knows that it is not easy for Talitha to express breastmilk, so she takes good care of it and wastes as little as possible.

When feeding Mae her bottle, Virginia holds her close. She knows Mae is used to this position while she breastfeeds, and holding her this way creates a close bond that helps Mae feel secure.

Practice Task 10

Read the case study and then answer the questions that follow.

Case study

Jess (an educator) is playing with Tory on the floor. He starts to get unsettled and Jess knows that Tory is soon due for a bottle. Jess has saved some formula from Tory's last bottle, so she grabs this from the fridge. Jess uses boiling water in a jug to heat the leftover formula. Jess leaves the formula to heat up while she goes to the other side of the room to get Tory's dummy and sleep toy, as she knows he has a sleep after his bottle. Once the bottle is heated, Jess sits down with Tory to give him his bottle. She doesn't need to test the temperature of the formula as she left it for the same time as the last bottle. Jess holds Tory and sings to him as he has his bottle. He is holding his dummy and toy. When he is finished with his bottle, Jess gives it a quick rinse in the sink with the other bottles and pops it on the bench.

1. Which of the following statements about the case study are correct? Select yes or no for each one.

   a. Jess knows Tory's individual routines and preferences. * Yes * No

   b. Jess prepares the bottle according to the basic food safety standards. * Yes * No

   c. Jess did not need to wash her hands as she was already playing with Tory. * Yes * No

   d. Jess did not follow health and safety practices when she left the jug of boiling water. * Yes * No

   e. Jess cleans the bottle in a safe way and stores it in a hygienic and safe way, as guided by the NHMRC publication *Staying healthy*. * Yes * No

   f. Jess provides an enjoyable, predictable one-to-one routine when she sits with Tory and sings to him. This strengthens their relationship. * Yes * No

2. What are three things Tory's mum might need if she came in to breastfeed?

. .....

. .....

. .....

Summary

- Mothers should be encouraged to breastfeed their baby/toddler while attending your service.
- Breastfeeding may be encouraged by providing spaces and support for mothers in your service, or by demonstrating that you value the breastmilk that is provided.
- Safety and hygiene must be observed when bottle-feeding and providing food.
- Heat bottles and food carefully to ensure babies and toddlers are not scalded.
- Provide positive mealtime environments.
- Organise mealtimes around the individual child's routine.
- Communicate with families to gather information about their needs.

Learning Checkpoint 5
Promoting quality mealtime environments

Part A

Read the case study and then answer the questions that follow.

Case study

Tilly is an educator who supports Merita, a five-month-old baby. Merita's mother, Hazel, works nearby and sometimes comes in to breastfeed Merita. Hazel rings beforehand so that the educators are ready. If Hazel expects to be busy at work, she will bring in a bottle of expressed breastmilk for Merita instead. At other times, if she hasn't had the opportunity to express any milk, Merita will drink formula prepared by Tilly using the following guidelines.

Infant milk formula feeding guide

Approximate age	Weight of baby (kg)	Single feed preparation – no. of level scoops	Cooled boiled water (mL)	Feeds in 24 hours
2 months	5	5	150	5
5 months	7	6	180	5
8 months	9	7	210	3

1. Which of the following might Hazel need if she comes in during the day to breastfeed Merita? Select all that apply.

- ☐ She may need to lie on a bed in a quiet and private room.
- ☐ She may need to feed in a comfortable area within the playroom.
- ☐ She may need a comfortable and supportive place to sit, such as an armchair or a couch.
- ☐ She may need a pillow, cushion or blanket.
- ☐ It is illegal to breastfeed in public, so she will need a private place where there are no interruptions from men.

2. On the days when Hazel brings in expressed breastmilk, Tilly would need to store and prepare the bottle. Which of the following statements are correct about storing and preparing breastmilk? Select yes or no for each one.

a.	Tilly can heat the breastmilk in the microwave.	* Yes	* No
b.	Tilly can store the breastmilk in the refrigerator for up to 48 hours or in the freezer for up to three months.	* Yes	* No
c.	Tilly must thaw the breastmilk quickly. She should place the bottle straight into boiling water.	* Yes	* No
d.	To thaw breastmilk, Tilly should run the bottle under cold water and gradually increase the temperature of the water until the breastmilk becomes a liquid.	* Yes	* No
e.	To test the temperature of the breastmilk, Tilly could drop a little bit onto her inner wrist.	* Yes	* No
f.	Merita should not be left with a bottle sitting in her mouth. The milk can coat her teeth and cause tooth decay, even if the teeth have not erupted yet.	* Yes	* No
g.	If Hazel provides the breastmilk in a cool pack, Tilly can leave it in there until needed.	* Yes	* No

3. When Tilly prepares a formula bottle, which of the following ratios of water and formula must be used for Merita? Tick the one that is correct.

- ☐ 150 mL water with 5 scoops of formula
- ☐ 180 mL water with 5 scoops of formula
- ☐ 180 mL water with 6 scoops of formula
- ☐ 200 mL water with 6 scoops of formula
- ☐ 210 mL water with 7 scoops of formula

4. Look at the image of Tilly feeding Merita and identify two ways this shows that Tilly is meeting Merita's needs for comfort.

5. Once Tilly has finished feeding Merita, she will need to sterilise the equipment and utensils used. Number each step from 1 to 8 in the order Tilly would follow.

- ☐ Sterilise the equipment for the adequate length of time.
- ☐ Use the sterilising equipment correctly.
- ☐ Wash hands after sterilising.
- ☐ Remove and store the sterilised equipment in a clean, covered container in the fridge.
- ☐ Wash or scrub bottles, teats and other items adequately.
- ☐ Place items in the steriliser as directed by the manufacturer.
- ☐ Wash hands and all work areas before sterilising.
- ☐ Gather and prepare the required equipment.

Part B

1. Which of the following statements are correct? Select yes or no for each one.

   a. Educators might cut up food or give a toddler a fork to make it easier for them to manage. * Yes * No

   b. Toddlers may become discouraged and frustrated if they are given foods they are unable to manage. Educators should feed children when difficult foods are provided. * Yes * No

   c. Toddlers like to explore foods. Educators should allow this. It is part of the toddler's learning. * Yes * No

   d. Educators could use this mealtime to describe foods and utensils. This helps the toddler learn and explore. * Yes * No

2. The children have been served a salad. Ruby, 22 months, is allergic to tomato and dislikes cucumber. Which of the following statements correctly describes what an educator should do?

   - [ ] Serve Ruby the salad then remove the cucumber and tomato.
   - [ ] Prepare a salad for Ruby that does not include cucumber or tomato.
   - [ ] Be sure to keep all tomato separate from other foods Ruby will eat.
   - [ ] Wash the preparation areas and be sure not to let cucumber touch the other foods.
   - [ ] Ask Ruby if she would like cucumber today.
   - [ ] Ask Ruby if she would like tomato today.