

2017 Queensland Infant Care Study Questionnaire



Unique 4-Letter Code: (Providing your unique code will remove you from the Registry of Births, Deaths and Marriages reminder list)

Today's Date: / / (the date you started filling in this questionnaire)

Caregiver completing questionnaire: Mother
 Father/partner
 Other caregiver (e.g. Kinship carer, Grandmother): _____

Was baby a multiple birth? (e.g. a twin) Yes No

If you have had a multiple birth, please answer the questionnaire for the baby who is the eldest.

Baby's Details

1. Baby's date of birth? April 2017

2. Baby's gender? Boy Girl

3. Baby's birth weight? grams
 OR lbs oz

4. Length of pregnancy? weeks of gestation
 - If unsure, was baby premature (born before 37 weeks)?
 Yes No

5. Was baby admitted to a Special Care Nursery or Neonatal Intensive Care Unit? Yes No

6. Place of birth (e.g. Nambour Hospital or home birth)?

7. Indigenous status of baby?

- Aboriginal
 Torres Strait Islander
 Both Aboriginal & Torres Strait Islander
 Neither Aboriginal nor Torres Strait Islander

8. How many people (not including baby) usually live in baby's household?

- children (0-13 years old)
 adults (14+ years old)

9. What is baby's postcode?

10. What is baby's usual suburb of residence?

Feeding

1. How was baby fed when baby arrived home from hospital (or day 3 after home-birth)?

- Breastmilk only Mostly breastmilk with some infant formula
 Infant formula only Mostly infant formula with some breastmilk

2. How was baby fed over the last 2 days?

- Breastmilk only Mostly breastmilk with some infant formula
 Infant formula only Mostly infant formula with some breastmilk

- If baby had infant formula only over the last 2 days, how old was baby when he/she last had any breastmilk?

- never had breastmilk less than 7 days old weeks old

3. Has baby ever had any soft, semi-soft or solid foods (such as mashed food or infant cereal e.g. Farex)?

- Yes No

- If YES, how old was baby when baby first ate these foods? weeks old

4. Has baby ever been given any medication or substances that you thought might help baby settle or sleep?

- No, baby has only been given milk feeds or baby foods
 Panadol Nurofen
 Colic/wind drops Alcohol (e.g. dash of whisky in bottle)
 Other type(s) of substance, drink or medicine(s): _____

Dummy (Pacifier) Use

1. Did baby use a dummy **at any time yesterday**? Yes No

2. Did baby use a dummy **at any time during the last 2 weeks**? Yes No

- If YES, 2a) What age did baby **first** start using a dummy?

less than 7 days old

weeks old

2b) When does baby **usually** use a dummy? (mark all that apply)

while awake between feeds

for daytime sleeps

for night-time sleeps

other: _____

2c) Do you use a clip or chain to secure the dummy to baby's clothes, pram or bedding?

Yes No

- If YES, what type of dummy clip or chain do you use?

fabric/material design bead design chain link design other: _____

Health Advice

1. Do you remember receiving any advice about safe sleeping for baby? Yes No

-If YES, who gave you this advice? (mark all that apply)

Doctor/GP

Nurse/Midwife

Family/Friends

Antenatal classes

Internet

Books/Brochures

Previous experience Baby store/shop/expo

Social Media (Facebook, Twitter)

Media (TV, radio, magazines)

Other: _____

2. Who or what was your **main** source of advice?

3. Would you have liked to receive more information about safe sleeping from your healthcare workers (e.g. Doctor, Midwife)? Yes No

-If YES, what would you have liked to receive more information about? _____

4. Have you ever heard of Sudden Unexpected Death in Infancy (SUDI) which includes Sudden Infant Death Syndrome (SIDS) and fatal sleeping accidents?

Yes No

5. Can you list any key safe sleeping recommendations that reduce the risk of sudden unexpected death in infancy? Yes No

• _____

• _____

• _____

• _____

• _____

• _____

• _____

• _____

• _____

6. Do you find any of the recommendations difficult to do with baby? Yes No

- If YES, **which recommendation(s)** do you find the most difficult and **why** is it difficult?

Sleeping Room

1. Who slept in the same room as baby for most of **last night**? (mark all that apply)

- baby slept in room alone
 mother father/partner
 other children, how many?
 other adults, how many?
 pets

2. Who **usually** slept in the same room as baby during the **last 2 weeks** for night-time sleeps? (mark all that apply)

- baby slept in room alone
 mother father/partner
 other children, how many?
 other adults, how many?
 pets

3. Does baby sleep in the **same** room during the day compared to where baby usually sleeps at night-time?

- Always Most of the time Sometimes Never

4. During the **last 2 weeks** did baby sleep in a room alone for day-time sleeps?

- Always Most of the time Sometimes Never

Sleeping position

Please refer to the below sleep position drawings (A, B, C or D) to answer the following questions:

(A)



Lying on front with face down

(B)



Lying on front with face to side

(C)



Lying on back

(D)



Lying on side

1. Which sleep position best describes how baby was placed to sleep **last night**?

- A B C D

2. Which sleep position best describes how baby was **usually** placed to sleep over the **last 2 weeks**?

- A B C D

3. Which sleep position best describes how baby was **usually** placed to sleep at **4 weeks old**?

- A B C D

4. Which sleep position(s) describe how baby has **ever** been placed to sleep? (tick all that apply)

- A B C D

Bedding environment

1. What items did baby **usually** sleep with in their bed or sleeping place during the **last 2 weeks**?

(mark all that apply)

- pillow beanie/hat/hoodie
 sheepskin cot bumper(s)
 blankets doona/duvet
 dummy soft toys (e.g. teddy)
 rolled towels/blanket
 positioning device/wedges
 infant nest (explain type/brand) _____
 other item(s): _____
 none of these

2. What items has baby **ever** slept with in their bed or sleeping place? (mark all that apply)

- pillow beanie/hat/hoodie
 sheepskin cot bumper(s)
 blankets doona/duvet
 dummy soft toys (e.g. teddy)
 rolled towels/blanket
 positioning device/wedges
 infant nest (explain type/brand) _____
 other item(s): _____
 none of these

3. Did baby sleep on or with a pillow during the **last 2 weeks**? Yes No

-If YES, 3a) What kind of pillow did baby use?

- a baby pillow an adult pillow

3b) How was the pillow used? (mark all that apply)

- for baby's head for baby's whole body to stop baby rolling other _____

4. Has baby **ever** slept on or with a pillow? Yes No

5. Did baby sleep with any soft toys (e.g. teddy) during the **last 2 weeks**? Yes No

Bed type/sleep surface

1. What type of bed or sleeping surface did baby *usually* sleep on during the *last 2 weeks* for *night* time sleeps?

(please mark only **one** answer)

- | | | |
|---|---|---|
| <input type="radio"/> Cot | <input type="radio"/> Bassinet | <input type="radio"/> Portable/Travel cot |
| <input type="radio"/> Double/Queen/King bed | <input type="radio"/> Single bed | <input type="radio"/> Mattress on floor |
| <input type="radio"/> Waterbed | <input type="radio"/> Couch/Sofa/Armchair | <input type="radio"/> Beanbag |
| <input type="radio"/> Pēpi-pod | <input type="radio"/> Infant Hammock | <input type="radio"/> Co-sleeper device/Nest on adult bed |
| <input type="radio"/> Baby capsule/Car seat | <input type="radio"/> Rocker/Swing/Bouncer | <input type="radio"/> Clip on co-sleeper cot/crib |
| <input type="radio"/> Pram or Stroller | <input type="radio"/> Other bed type or sleeping surface: _____ | |

2. What type of bed or sleeping surface did baby *usually* sleep on during the *last 2 weeks* for *day* time sleeps?

(please mark only **one** answer)

- | | | |
|---|---|---|
| <input type="radio"/> Cot | <input type="radio"/> Bassinet | <input type="radio"/> Portable/Travel cot |
| <input type="radio"/> Double/Queen/King bed | <input type="radio"/> Single bed | <input type="radio"/> Mattress on floor |
| <input type="radio"/> Waterbed | <input type="radio"/> Couch/Sofa/Armchair | <input type="radio"/> Beanbag |
| <input type="radio"/> Pēpi-pod | <input type="radio"/> Infant Hammock | <input type="radio"/> Co-sleeper device/Nest on adult bed |
| <input type="radio"/> Baby capsule/Car seat | <input type="radio"/> Rocker/Swing/Bouncer | <input type="radio"/> Clip on co-sleeper cot/crib |
| <input type="radio"/> Pram or Stroller | <input type="radio"/> Infant carrier/Baby sling | <input type="radio"/> Rug/Playmat |
| <input type="radio"/> Other bed type or sleeping surface: _____ | | |

3. During the *last 2 weeks* did baby sleep on the *same* bed or sleeping surface during the day compared to where baby usually sleeps at night-time?

- Always Most of the time Sometimes Never

4. What type of bed or sleeping surface has baby *ever* slept on when at home? (mark all that apply)

- | | | |
|---|---|---|
| <input type="radio"/> Cot | <input type="radio"/> Bassinet | <input type="radio"/> Portable/Travel cot |
| <input type="radio"/> Double/Queen/King bed | <input type="radio"/> Single bed | <input type="radio"/> Mattress on floor |
| <input type="radio"/> Waterbed | <input type="radio"/> Couch/Sofa/Armchair | <input type="radio"/> Beanbag |
| <input type="radio"/> Pēpi-Pod | <input type="radio"/> Infant Hammock | <input type="radio"/> Co-sleeper device/Nest on adult bed |
| <input type="radio"/> Baby capsule/Car seat | <input type="radio"/> Rocker/Swing/Bouncer | <input type="radio"/> Clip on co-sleeper cot/Crib |
| <input type="radio"/> Pram or Stroller | <input type="radio"/> Infant carrier/Baby sling | <input type="radio"/> Rug/Playmat |
| <input type="radio"/> Other bed type or sleeping surface: _____ | | |

5. If not at home (e.g. visiting friends/family) when baby needs a sleep, what type of bed or sleeping surface has baby *ever* slept on? (mark all that apply)

- | | | |
|---|---|---|
| <input type="radio"/> Cot | <input type="radio"/> Bassinet | <input type="radio"/> Portable/Travel cot |
| <input type="radio"/> Double/Queen/King bed | <input type="radio"/> Single bed | <input type="radio"/> Mattress on floor |
| <input type="radio"/> Waterbed | <input type="radio"/> Couch/Sofa/Armchair | <input type="radio"/> Beanbag |
| <input type="radio"/> Pēpi-Pod | <input type="radio"/> Infant Hammock | <input type="radio"/> Co-sleeper device/Nest on adult bed |
| <input type="radio"/> Baby capsule/Car seat | <input type="radio"/> Rocker/Swing/Bouncer | <input type="radio"/> Clip on co-sleeper cot/Crib |
| <input type="radio"/> Pram or Stroller | <input type="radio"/> Infant carrier/Baby sling | <input type="radio"/> Rug/Playmat |
| <input type="radio"/> Other bed type or sleeping surface: _____ | | |

Infant placement in cot for sleep

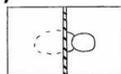
Please refer to the below drawings (A, B, C or D) to answer the following questions:

(A)



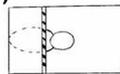
Head to top of cot

(B)



In middle of cot

(C)



Feet to foot of cot

(D)



Baby did not sleep in cot

1. Which drawing best describes baby's position when baby was placed to sleep in a cot or bassinet *last night*?

- A B C D

2. Which drawing best describes baby's *usual* position when placed in a cot or bassinet to sleep over the *last 2 weeks* for day or night-time sleeps?

- A B C D

Bed sharing

1. Has baby **ever** slept on any of the following sleep surfaces with another person who was sleeping at **any time since birth?** (mark all that apply)

- Cot/Bassinet Pēpi-Pod
 Double/Queen/King bed Single bed
 Mattress on floor Waterbed
 Infant bed on adult bed Portable/Travel cot
 Couch/Sofa/Armchair Beanbag
 Other bed type or sleeping surface: _____
 Baby has never shared a sleep surface

2. Was it **usually** planned to share the sleep surface with baby? Yes No

- Baby has never shared a sleep surface

3. Who has **ever** shared a sleep surface with baby?

(mark all that apply)

- Mother Father/partner
 Other children Other adult(s)
 Pets
 Nobody has ever shared a sleep surface with baby

4. How often does baby share a sleep surface?

- every night/normal routine
 most nights (4-6 nights a week)
 some nights (2-3 nights a week)
 occasionally (about once a week or less often)
 other: _____
 Baby has never shared a sleep surface

5. How long does baby **usually** share a sleep surface?

- hours Less than 1 hour
 Baby has never shared a sleep surface

6. Has baby **ever** shared a sofa or couch with another person who was sleeping **at any time?**

- Yes No

7. Has baby slept on a sleep surface with another person who was sleeping **at any time** during the **last 2 weeks?** Yes No

-If **YES, 7a)** which of the following sleep surfaces does baby **usually** share? (mark all that apply)

- Cot/Bassinet Pēpi-Pod
 Double/Queen/King bed Single bed
 Mattress on floor Waterbed
 Infant bed on an adult bed Portable/travel cot
 Couch/Sofa/Armchair Beanbag
 Other bed type or sleeping surface: _____

7b) Who does baby **usually** share a sleep surface with? (mark all that apply)

- Mother Father/partner
 Other adult(s), how many?
 Other children, how many?
 Pets

7c) Where in the shared sleep space does baby **usually** sleep? (please mark only **one** answer)

- between 2 people
 between a person and the edge of the bed
 in an infant bed on the adult bed
 on a person
 other: _____

Smoking

1. Who in baby's household smokes? (mark all that apply)

- Mother Father/partner
 Other household members, how many?
 Nobody

2. Where do household members smoke? (mark all that apply)

- inside the house
 outside the house
 in the car
 other: _____
 household members do not smoke

3. Does anyone **ever** smoke in the room where baby sleeps? Yes No

4. Has baby's mother **ever** smoked cigarettes?

- Yes No

5. Did baby's birth mother smoke during pregnancy?

- Yes No

- If **YES**, how many cigarettes were smoked per day?

cigarettes per day

6. Has baby's mother/primary caregiver smoked **any** cigarettes since having baby? Yes No

Immunisations

1. Was baby immunised at birth (i.e. did baby receive a Hepatitis B vaccination)? Yes No

2. Has baby had their **2 month old** immunisations? Yes No

-If **NO**, do you plan on immunising baby? Yes No

Infant wrapping and infant sleeping bags

1. Has baby **ever** slept in an infant sleeping bag or commercially designed sleeping swaddle? Yes No

Yes No

- If **YES**, did the infant sleeping bag or swaddle have fitted neck and arm holes? Yes No

2. In the **last 2 weeks** did you **ever** wrap baby for sleep time? Yes No

-If **YES, 2a)** How many weeks old was baby when you started wrapping baby?

less than 1 week old

weeks old

2b) What material do you **usually** use to wrap baby?

cotton sheet/muslin cloth or sheet

flannel sheet

blanket/bunny rug

other: _____

2c) When wrapping baby for sleep do you **usually**:

wrap with arms in

wrap with arms out

2d) When wrapping baby for sleep do you **usually**:

wrap below shoulders

wrap above shoulders but below chin

wrap covering back of baby's head

2e) How do you **usually** wrap baby for sleep?

very tight firm loose very loose

2f) How often do you wrap baby?

almost all the time (when both awake and asleep)

for every sleep time

for most sleeps (both night and day)

mostly night-time sleeps

mostly day-time sleeps

other: _____

2g) When do you plan to stop wrapping baby?

around 3 months

around 4 months

around 5 months

around 6 months

when baby is more than 6 months old

as soon as baby shows signs of being able to roll

haven't thought about it/ don't know

Adult worn infant carrier or sling

1. Have you ever received advice or read information about using an infant carrier or baby sling? Yes No

2. Have you ever used a baby sling or infant carrier with baby? Yes No

-If **YES, 2a)** Which picture below **best matches** the style carrier/sling you **usually** use?

(please mark only **one** answer)



Sling (over shoulder) style



Carrier (pack) style



Wrap-around style

Other _____

2b) Has baby ever slept in the carrier or sling? Yes No

2c) Can baby's chin touch his/her chest when in the carrier? Yes No

3. Have you ever heard of the T.I.C.K.S principle when using a baby sling or infant carrier? Yes No

Heating/Cooling

1. Was baby's room heated or cooled at any time **last night**? Yes No

-If **YES**, what type of heating or cooling was used?

thermostatic controlled heating other type of heating _____

thermostatic controlled cooling other type of cooling _____

Baby monitors

1. Do you use a baby monitor while baby is sleeping?

Yes No

- If **YES, 1a) What type of baby monitoring system do you use?** (mark all that apply)

Sound monitor Video monitor

Movement/Breathing mat or sensor

Other: _____

1b) Who recommended using a baby monitor?

Advice from doctor/health professional

Received as a gift

Parental choice

Friend or family member

Other: _____

Other care practices

1. Have you ever covered baby's pram, carrier or sling with a wrap or blanket to block out light/distractions to help baby sleep? Yes No

2. Does baby ever wear a necklace (e.g. an amber teething necklace)? Yes No

-If **YES**, does baby ever wear the necklace during sleep? Yes No

Baby's health

1. How long was baby in hospital after birth before being discharged home?

Baby was not born in/taken to hospital at birth

Less than 1 day old

days old

100 or more days old

Baby is still in hospital – has not yet been home

2. Has baby stayed overnight in hospital (e.g. in a children's ward) for observation or treatment since being discharged home after birth? Yes No

- If **YES, 2a) How old was baby when admitted to hospital?**

less than 1 week old

weeks old

2b) What was the main reason for baby going to hospital?

breathing problems/respiratory illness

feeding problems/weight loss

high temperature pain

vomiting/diarrhoea jaundice

other: _____

2c) Where did baby sleep while in hospital? (mark all that apply)

plastic bassinet hospital cot

baby capsule/car seat pram or stroller

hospital bed with mother/caregiver

sofa chair/pull-out parent bed with mother/caregiver

other: _____

Recommendations

Which sleep position(s) is recommended for healthy babies? (mark all that apply)

Lying on back on flat surface

Lying on side on flat surface

Lying on tummy/front on flat surface

I'm not sure/ don't know

Lying on back with head elevated (i.e. tilted surface)

Lying on side with head elevated

Lying on tummy/front with head elevated

Which sleep position(s) is recommended for babies with reflux? (mark all that apply)

Lying on back on flat surface

Lying on side on flat surface

Lying on tummy/front on flat surface

I'm not sure/ don't know

Lying on back with head elevated (i.e. tilted surface)

Lying on side with head elevated

Lying on tummy/front with head elevated

Select the answer you believe to be the main key messages for safe sleeping: (please mark only **one** answer)

- Immunise baby; Sleep baby on back or side; Keep baby smoke-free; Keep head and face uncovered; Use a dummy; Breastfeed baby; Room-share with baby
- Sleep baby on back; Keep baby smoke-free; Keep head and face uncovered; Bed-share with baby; Safe sleep environment night and day; Immunise baby
- Immunise baby; Sleep baby on back or side; Keep baby smoke-free; Use a dummy; Safe sleep environment night and day; Avoid baby overheating; Breastfeed baby
- Sleep baby on back; Keep head and face uncovered; Keep baby smoke-free; Safe sleep environment night and day; Room-share with baby; Breastfeed baby
- None of the above
- I'm not sure/don't know

Caregiver's Details

1. Mother's date of birth? / /

2. Mother's Indigenous status?

- Aboriginal
- Torres Strait Islander
- Aboriginal & Torres Strait Islander
- Neither Aboriginal or Torres Strait Islander

3. Mother's country of birth?

- Australia
- Other: _____

4. Mother's current marital status:

- Married De facto
- Single (never married)
- Single (separated, divorced)
- Single (widowed)

5. Is this your first baby?

- Yes No

- If **No**, how many other children have you given birth to? children

6. Do you have a healthcare card? Yes No

7. What is your highest level of **completed** education?

- <Year 10 Year 10 Year 11 Year 12
- TAFE University Post Graduate Studies

8. Have you had an alcoholic drink of any kind since the birth of baby? Yes No

- If **YES**, how often since baby's birth have you consumed alcohol?
- every day
 - 5-6 days a week
 - 3-4 days a week
 - 1-2 days a week
 - 2-3 days a month
 - about 1 day a month
 - less than once a month

9. Do you take any medication or drugs (either prescribed, over the counter or illicit) that sometimes makes you drowsy or sleepy? Yes No

- If **YES**, please list types/names of medications/drugs:

Other

Is there anything else you would like to share with us about baby's care and sleeping routines?

*Thank you for participating in the 2017 Queensland Infant Care Study.
Your time and contribution is greatly valued and appreciated.*

If you are interested in receiving information about future research projects exploring the care of infants and children please provide your contact details through our secure link at <https://survey.usc.edu.au/opinio/s?s=6712>.