Sleep – Safe Sleeping for Babies

Document Type	Policy
Function	Clinical Service Delivery
Healthcare Service Group (HSG)	National Women's Health
Department(s) affected	Maternity
Patients affected (if applicable)	All postnatal women in Maternity (and their babies)
Staff members affected	All clinicians in Maternity including access holder Lead Maternity Carers (LMCs)
Key words (not part of title)	cot death, SUDI
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1. Purpose of policy

The purpose of this policy is to provide clear information for all National Women's Health staff members within Auckland District Health Board (ADHB) around safe sleeping practices to ensure a safe sleep at every sleep for all babies.

The main principals being that every baby should be placed to sleep so that they remain face up, with face clear and in a smoke free environment at all times. Every contact with health professionals is an opportunity to impart knowledge about safe sleep practices and inform care givers of the hazards present for infants sleeping in some situations

Research has shown that the safest position for babies to sleep is on their backs. The NZ cot death study (1987 – 1990) actually showed babies to be at increased risk of cot death or sudden unexpected deaths in infancy (SUDI) if placed prone on their stomach while sleeping. Lying on their backs is twice as safe as lying on their side, and six times safer than lying on their front. Face up position protects arousal in babies during a critical stage of development and a clear face protects the baby from asphyxia.

Sudden unexpected death in infancy continues to be the major cause of death in the postneonatal age group (28 days through to the first birthday). For most countries the SUDI rate is around 1/1000 live births. In New Zealand approximately 60 babies a year die from SUDI.

This policy is in relation to well infants born at term. This policy does not apply to infants admitted to NICU or the late pre-term infant (34 – 36 weeks).

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2. Policy statements

All babies should have a safe sleep in a safe place at every sleep.

ADHB supports and promotes skin to skin contact for the baby and rooming in at all times.

ADHB does not recommend bed sharing for the mother and baby while in hospital or at home. It is recommended that the mother places her baby back into the cot, with their face up, face free and in a smoke free environment when the mother needs to sleep.

If a mother makes an informed decision to bed share in hospital then this must be documented. This does not negate professional responsibility to educate women and provide evidence based information so women are fully informed on safe sleeping.

All staff members have a responsibility to educate women and their families on safe sleeping practices for babies, whilst also being sensitive to the emotional and physical needs of the mother and baby.

Staff members must ensure an interpreter is utilised if necessary, to ensure an understanding of this policy.

Bed sharing and the associated risk should be discussed during the antenatal and postnatal period, with all women and their family/whānau.

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3. Definitions

For the purpose of this policy the following definitions apply:

- **SUDI** is sudden unexpected death of an infant
- **Bed sharing** is defined as the parent sleeping with the infant on the same sleeping surface (usually a mattress). A key feature is that the parent is asleep
- **Co-sleeping** and **bed sharing** were synonymous, however the advocates of co-sleeping have broadened the term to include parents and infants sleeping in close proximity (e.g. room sharing but not bed sharing). To avoid confusion, the term co-sleeping is not used in this policy and should not be used verbally
- **Skin to skin** means the placing of the naked newborn baby prone on the mother’s bare chest, whilst protecting the baby’s airway and this should start immediately after birth.

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4. SUDI risk factors and statistics

Risks

- Bed sharing
- Smoking during and after pregnancy
- Babies sleeping on their tummy
- Babies not breastfeeding

High risk profile

- Māori and Pacific (62% of SUDI cases are Māori babies and 13% Pacific) The rate for Maori is 2.3 deaths per 1000 births
- High deprivation
- Mother under 25 years of age (mothers under the age of 20 are most at risk 250:100,000 births compared to women 30 - 34 years 50:100,000 births)
- Babies under 6 months of age (babies 1 - 3 months of age are most at risk)
- Premature infants, the late pre term infant (34 - 36 weeks) and SGA baby. 250:100,000 compared to term infants of normal weight that have a rate of 60:100,000

Bed sharing combined with other high risk activities or combined with factors from the high risk profile significantly increase the risk of SUDI occurring. It is important that health professionals are aware of these interactions so that they can provide women with evidence based information that is relevant to the individual.

One small group have been identified as having no increased risk of SUDI when bed sharing. They are breast fed infants over 3 months of age whose parents do not smoke and whose mother does not take 2 or more units of alcohol or drugs and does not bed share on a sofa (Carpenter et al, 2013, see supporting evidence section).

The following table provides an overview of the absolute risks and increases in risk associated with bed sharing for 6 combinations of risk factors (BMJ May 2013).

Risk factors present			**Room Sharing**	**Bed Sharing**	
Feeding	**Smoking**	**Alcohol**	**Rate/1000**	**Rate/1000**	**Ratio**
Br	No	No	0.08	0.23	2.7
Bot	No	No	0.13	0.34	2.7
Br	Partner	No	0.09	0.52	5.6
Br	Mother	No	0.13	1.27	9.7
Br	Both	No	0.24	1.88	7.7
Bot	Both	Yes	1.77	27.5	15.6

(Predicting SUDI mortality rates for cohabitating white mother aged 26 to 30, having her second normal weight baby with birth weight between 2.5kg and 3.5kg and having no other risk factors, that is the mother is not a drug user, has a partner and room shares).

This table shows that for room sharing breastfeeding infants placed supine and whose parents do not smoke and have no other risk factors the SUDI rate is predicted to be 0.08/1000 live births. This rate is predicted to increase by 2.7 times to 0.23/1000 when bed sharing. For all combinations of risk factors the predicted increases in risk associated with bed sharing are statistically significant.

With the combination of young parents who both smoke, bed sharing, bottle feed their infant and consumes alcohol; the incidence of SUDI is 100:1000 births (10%).

SUDI is also more common in the first 3 months of life. In a 10 year review of SUDI cases in Auckland 64% of cases occurred when bed sharing and in infants less than one month of age 92% were bed sharing.

Consumption of alcohol also increases the risk of SUDI. In a review of all infant deaths referred to the coroner in the Auckland region between 2000 and 2009, 188 were classified as SUDI. Of those 121 (64%) occurred while bed sharing and alcohol was implicated in 17 (14%).

A high BMI combined with bed sharing also increases the rate of SUDI especially when combined with a sagging mattress.

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5. Principles of postnatal care

a) Midwives/nurse responsibility in the immediate postnatal period

All mothers and their babies must receive active and ongoing assessment in the immediate postnatal period (for a minimum of 1 hour), regardless of the context around the birth. During this time the mother and baby should not be left alone, even for a short time. This time period should be extended if there are any concerns for the wellbeing of the mother or baby. The facilitation and supervision of skin to skin contact should occur during this time, ensuring the baby's nose and mouth are not occluded and that parents understand the importance of this.

It is recognised that the mother with her family/whānau may need a time of privacy after the birth. Observation of the baby may be transferred to the family/whānau if this is deemed clinically appropriate. But the baby must be well, the mother alert and well and the family/whānau must understand that they are ensuring the baby's nose and mouth are clear and they are there to observe the baby's colour and respirations.

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b) Midwives/nurses responsibility during the ongoing postnatal period

Constant supervision needs to be provided to mothers who are breastfeeding and are:

- Still experiencing the effects of general anaesthesia
- Unwell to the level that it is affecting her level of consciousness
- Suffering any condition that affects their spatial awareness e.g. sight impairment, multiple sclerosis

Frequent supervision (i.e. the mother can be left alone for short periods) needs to be provided to mothers who are breastfeeding and are:

- Excessively tired, to the extent that it may affect her ability to respond to her baby
- Immobile due to a regional anaesthetic
- Obese BMI >35

The supervision needs to include assessment of the baby ensuring colour and respirations are with in normal limits and the baby's nose is clear

This supervision can be delegated to a member of the family or another health care professional as long as they understand what is expected of them. Women should have easy access to the call bell when left alone with their infant and be advised when to use it.

Babies are more at risk of respiratory difficulties from a compromised airway where their mother or family/whānau have been or are exposed to medications, drugs, alcohol and/or smoking.

The principles of safe sleep should be discussed and demonstrated antenatally and then repeated and reinforced during the immediate and ongoing postnatal period and then at home.

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6. Important information that should be provided to parents

Midwife/nurse responsibility

Health professionals have a duty of care to ensure women and their families are educated on the risks of bed sharing. When this information is provided the staff member needs to sign and date the SUDI education sticker and place in the clinical record to demonstrate the information has been given. The information provided should include the following:

- Always day and night place the baby on his/her back when its time to sleep. The practice of always placing baby on his/her back with face clear to sleep should begin at birth. Incorrect sleep position is the most significant proven risk factor for SUDI
- Always keep the baby's environment smoke free. The more a baby is exposed to smoke the greater the risk of SUDI. Provision of smoking cessation advice, referrals and support is a vital component of care for all families where smoking occurs
- Parents should never share a bed with a baby when they have had alcohol or drugs, especially any time they may fall asleep
- Babies need to sleep on a firm surface (not a sofa, water bed, bean bag or a sagging mattress) and pillows must not be used to prop them up or to lie on
- Head position should be varied between night and day time sleeping ("night towards the right, in the day, the other way"), if the baby already has asymmetry, the baby's head should be turned regularly to avoid pressure on the problem spot. NB. This principle excludes pre-term babies or babies with respiratory distress on neo-natal monitors and also some specific medical condition e.g. Pierre-Robin Syndrome, gastro-oesophageal reflux
- Bed sharing is not recommended in hospital or at home and babies should not sleep alone in an adult bed
- Babies need to sleep in their own space, not with other children or pets and preferably in a cot or bassinet (or other safe sleeping place such as a pepe pod)
- Babies room sharing with their parents for the first 6 months of life is proven to offer some protection against SUDI
- Cots and mattresses are to be kept flat and not propped up. Propping up can result in obstruction of the airway
- Suffocation and over heating can occur with excessive bedding
- If parents can monitor and control the temperature of their house they can be advised that an ideal temperature is 18 – 22 degrees
- Babies are not to be firmly wrapped for sleep. Babies need to be able to move their hands and arms as this provides stimulation
- The baby's head should never be covered with bedding/blankets
- Breastfeeding can help protect against SUDI
- When breastfeeding, women should be advised how to do so safely to avoid increasing the risk of SUDI. Where possible women should be sat up either in bed or in a chair as opposed to lying down while breastfeeding
- Safe strategies for night feeds and how to settle infants, especially at night
- If a woman decides to bed share after being given all the relevant evidenced based information, she also needs to be provided with information to bed share as safely

possibly i.e. reducing other interactions that will increase the risk of SUDI (e.g. smoking and alcohol consumption)

The midwife/nurse should provide women and their whānau with written information to support the verbal education given; this should include giving them the following pamphlets (see other documents section below):

- Protecting your baby’s head shape, Ministry of Health 2009
- Safe Sleep Essentials, Change for our Children

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7. Supporting evidence

- Carpenter R, et al. Bed sharing when parents do not smoke: is there a risk of SIDS? An individual level analysis of five major case control studies. *BMJ Open 2013;3*
- Inch S. (2003) Bed sharing and co-sleeping in the UK – implications for midwives. RCM Midwives. Vol 6. No 10. October 2003. 425-427
- McKenna JJ, Mosko SS, Richard CA (1997) Bed sharing promotes breastfeeding Paediatrics 100:214-9
- Mitchell E, Blair P (2012) SIDS prevention: 3000 lives saved but can we do better The New Zealand Medical Journal. Vol 125. No 1359. August 2012
- MOH Consensus statement Observation of Mother and Baby in the Immediate Postnatal Period: consensus statements guiding practice July 2012
- NZCOM Consensus statement *Safe Sleeping for Baby*
- Preventing sudden unexpected death in infancy Information for health practitioner, Ministry of Health, NZ (includes further references)
- RCM (2004) Bed sharing and co-sleeping Position Statement
- UNICEF UK Baby Friendly Hospital Initiative with the foundation for the study of infant deaths. (2005-2006)
- UNICEF UK Baby Friendly Initiative. (2004)

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8. Associated ADHB documents

- Infant Feeding - Breastfeeding

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9. Other documents

Patient information

- Protecting your baby's head shape Ministry of Health 2009
- Safe Sleep Essentials Change for our Children

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10. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or the Clinical Policy Advisor without delay.

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