WOMEN'S HEALTH AND PAEDIATRICS

MATERNITY UNIT & ALL PAEDIATRIC INPATIENT AREAS

Safe Sleeping Guidance for Babies

Amendments			
Date	Page(s)	Comments	Approved by
July 2021	17	New Guideline	Women's Health Guidelines Group

Compiled by: Jo Wilding-Hillcoat and Enrica Boscarato

In Consultation with: Head of Midwifery
Ratified by: Women's Health Guidelines Group

Date Ratified: July 2021
Date Issued:
Next Review Date: 2024
Target Audience: All staff working within the maternity department
Impact Assessment Carried Out By: Women's Health Guidelines Group

Comments on this document: Enrica Boscarato

Executive summary

This guideline is intended to support and educate mothers to enjoy the benefits of bed-sharing in hospital, whilst also protecting their safety. This encourages successful breastfeeding and the implementation of the UNICEF Baby Friendly Standards (2017).

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1.0 INTRODUCTION

It is recognised that mothers take their baby into bed in hospital to provide skin to skin, comfort and closeness without any intention of sleeping with their baby. This guideline is intended to support and educate mothers to enjoy the benefits of bed-sharing in hospital, whilst also protecting their safety. This encourages successful breastfeeding and the implementation of the UNICEF Baby Friendly Standards (2017).

Although there is an association between bed-sharing and Sudden Infant Death Syndrome (SIDS), increasingly the evidence suggests that it is not bed sharing per se that is a risk factor, but the circumstances within which it occurs (UNICEF, 2017). SIDS is not a cause from which babies die, but a category to which they are assigned if no cause can be found for their deaths. It is still not known why babies die unexpectedly in their sleep, but certain circumstances have been linked to SIDS such as prone sleep position, exposure to smoking including prenatal smoke exposure, lack of breastfeeding, prematurity, low birthweight, overheating and head-covering and some bed sharing practices (Middlemiss and Kendall- Tackett, 2014).

The ability for a health professional to be able to have an informed discussion irrespective of any personal beliefs or taking the simplistic position of regarding bed-sharing as either safe or unsafe without considering the circumstances in which bed-sharing occurs is unhelpful, may undermine parents, and could put babies at risk (Ball, 2009; Viara R.Mileva -Seiztz et *al*. 2017).

Breastfeeding provides significant health benefits to babies and has been shown to reduce the chance of SIDS; however, it is important to help mothers breastfeed in the safest way possible. There are studies which suggest that babies who share a bed with their mother are more likely to successfully breastfeed and to be continuing to breastfeed at 12 months (Blair et *al*.,2010).

It is easy to fall asleep whilst breastfeeding as lactation hormones induce sleepiness, but the key message to parents must be that the safest place for a baby to sleep is in the same room as their parents, in a cot, crib or moses basket lying on their back for the first six months. It is not recommended that babies co-sleep with their mothers whether intended or not (Department of Health (DH), 2009, Public Health England, (PHE) 2015).

2.0 PURPOSE

The purpose of this guideline is to enable staff to provide consistent, evidenced-based advice on safe sleeping for babies, including bed sharing or co-sleeping at home or in the maternity unit, as well as to ensure that staff feel equipped to promote safe sleeping advice to parents and carers throughout both the antenatal and postnatal periods.

3.0 DEFINITIONS

Bed-sharing is defined as babies sharing a bed with their awake mother to provide skin to skin contact, breastfeed or receive comfort. This may be on a regular basis or happen occasionally and may be intentional or unintentional.

4.0 DUTIES AND RESPONSIBILITIES

All clinical staff have a duty to be familiar with this guidance and to use it to inform their practice and to be able to pass this information onto parents. This guidance should comply with the current base of evidence and best practice guidance and be current and in date.

5.0 GUIDANCE FOR PARENTS ON SAFE SLEEP, INCLUDING 'BED SHARING'

5.1 Information in the Antenatal period.

In the antenatal period a discussion should be had with a woman by the 32nd week of pregnancy. The woman should also be advised to look at the ASPH maternity website and Badger Notes App for further information.

5.2 Advise and care immediately following birth.

Following birth, the midwife should recommend that the mother performs skin to skin with her baby. The baby should be placed on the mother's chest, with the chin in a neutral position. The mother and partner/relative should be given enough information to be able to monitor the baby's well-being i.e., colour, tone, chest movement. This conversation should be recorded in the digital notes.

Women and their partner should be advised to read the safe sleep for baby's guide. Women should be advised that the safest place for their baby to sleep is in their cot and given the 'Safe Sleep for Baby' guide with the Child Health Record (Red Book).

Women should be advised that because single hospital beds reduce the amount of space available and women and their babies cannot be constantly observed, co-sleeping is not supported or advised by the maternity department.

5.3 Bed Sharing Risk Assessment for women on the labour ward.

Following delivery, a risk assessment should be undertaken to determine the level of supervision required for bed-sharing on labour ward (see Appendix A). This risk assessment can only be utilised immediately after delivery and should not be used for patients on the postnatal ward, where constant supervision is not possible.

Any mothers who may be unable to remain awake/sustain consciousness, or who may have restricted movement or severe difficulty with spatial awareness, will require constant supervision when sharing a bed with her baby.

Examples of such mothers would include those who are:

- Under the effects of a general anaesthetic.
- Immobile due to spinal anaesthetic.
- Under the influence of drugs which cause drowsiness e.g., morphine, high doses of codeine.

- Ill to the point that it may affect consciousness or ability to respond normally e.g., high temperature, following large blood loss, severe hypertension.
- Excessively tired to the point that would affect ability to respond to the baby suffering any condition that would affect spatial awareness e.g., conditions that would severely affect mobility and sensory awareness such as multiple sclerosis or paralysis, or conditions affecting spatial awareness such as visual impairment.
- A raised BMI (an individual assessment will be required, based on the mother's mobility, spatial awareness and the space available in the bed). Likely to have temporary losses of consciousness e.g., poorly controlled insulin dependent diabetic or epileptic.

This list is not exhaustive and where the midwife, mother or partner considers the mother to be at higher risk of falling asleep, constant supervision should be given. Constant supervision can be undertaken by either a member of staff or the mother's birth partner, but the midwife should make sure the birth partner understands that they have been asked to monitor the baby's condition as in appendix A.

Professional judgment must be used by the health professional to assess the family members' willingness and suitability to observe the mother and baby and be clear that it is their role to observe and to ensure that the safety of the baby is maintained. The midwife should ensure that the birth partner knows how to call a member of staff immediately if they have any concerns. Basic instructions should be given by the health professional to prevent overlaying, overheating and airway obstruction of the baby.

5.4 Advise during the postnatal period.

Staff should take every opportunity to discuss safer sleeping arrangements for babies. This should be explained daily in the teaching sessions on the postnatal ward.

During bedside handover on admission to the postnatal ward the receiving midwife should refer the woman to the Safe sleep for baby guide and remind that although skin-to-skin contact is supported, woman co-sleeping is not supported or advised by the maternity department.

During the postnatal inpatient period, the safe sleeping assessment and action plan in the Child Health Record (Red Book) should be completed. If the woman has had a homebirth, this should be completed before the midwife leaves the house after the delivery.

5.5 Bed-Sharing

It is recognised that mothers take their baby into bed in hospital to provide skin to skin, comfort and closeness without any intention of sleeping with their baby. This guideline is intended to support and educate mothers to enjoy the benefits of bed-sharing in hospital, whilst also protecting their safety. This encourages successful breastfeeding and the implementation of the UNICEF Baby Friendly Standards (2017).

5.6 Advice regarding bed sharing

The following should be discussed with a mother:

- Pillows should be kept clear of the baby.
- Bed clothes should be tucked around both the mother and the baby.
- Women using the Private Room on the postnatal ward should be advised that if they plan to bed share, the duvet should be changed to a sheet and blanket.
- Babies should never be swaddled in blankets whilst bed-sharing.
- To lower the bed as far as possible.
- Curtains should be pulled back from bed to enable good visibility of baby.
- Ensure the physical environment is safe and that the cot-side adjacent to baby is up.
- Low level lighting at night supports good visibility.
- Ensure mother has access to call bell and that it is working.

5.7 General Advice:

5.7.1 Sleeping Advice.

New mothers should be advised that there is substantial research evidence that, always, the safest place for a baby to sleep, regardless of feeding method, is on their back next to their mother's bed for the first six months of life (UNICEF, 2017). This will enable the mother to respond to the baby's feeding cues. This also includes babies discharged from the neonatal unit where an alternative sleeping position was used whilst they were continually monitored in hospital.

Babies must always be placed in the 'feet to foot' position on a firm flat mattress which is clean and in good condition with the bedclothes securely tucked in, so they reach no higher than the shoulders or a baby sleeping bag. After the first twenty-four hours of life, babies do not need to wear hats indoors (The Lullaby Trust, 2019).

Adult beds and bedding are not designed for babies and they are at risk of overheating, suffocating, becoming trapped and falling out of bed. It is recommended that babies are returned to their cot to sleep and are never left unsupervised in or on an adult bed.

Durham University's infant sleep information source website (www.BasisOnline.org.uk) suggests it is important to explain that around half of all parents will sleep with their baby at some point, be this planned or unplanned and, although SIDS is rare, it is much more likely to occur in circumstances such as:

- Sleeping with their baby on a sofa or armchair (The National Institute for Health and Care Excellence (NICE), 2021)
- If parents co-sleep after drinking alcohol or having taken drugs (prescription analgesics/social drugs). Drink and drugs also affect decision making ability.
- Parents that smoke or have smoked antenatally or are in frequent contact with other smokers smoking.
- Parents with a raised BMI may cause their baby to be squashed suffocated or overheat.
- Low birth weight or premature babies
- Recently discharged from a neonatal unit
- Unwell babies

- Other factors include:
    - Not to use duvets and pillows, bumpers or any type of wedge as this could lead to overheating or suffocation.
    - Sleeping between parents or siblings.
    - Pets access to the baby's sleeping area
    - SIDS is also associated with overheating, sleeping prone and the baby's head becoming covered (Confidential Enquiry into Stillbirth and Death in Infancy (CESDI), 2000).

The ideal room temperature for a baby is between 16-20 degrees Celsius. Overheating can increase the risk of SIDS. It is recommended that babies wear no more than 12 TOG units.

Baby Clothing	**TOG**	**Bedding**	**TOG**
Vest	0.2	Sheet	0.2
Babygro	1.0	Old blanket	1.5
Jumper	2.0	New Blanket	2.0
Trousers	2.0	Quilt	9.0
Sleepsuit	4.0	Wrapped in single sheet	0.8
Disposable Nappy	2.0	Wrapped in a single blanket	8.0

5.7.2 Cots.

Avoid putting the cot/moses basket next to a window, heater, fire, radiator, or in direct sunlight, as it could make the baby too hot.

Avoid curtains and blinds with cords and keep baby monitors at a safe distance. Any cord carries a risk of strangulation.

Mattresses should be firm, fit the cot well without any gaps and a well- fitting sheet used.

5.7.3 Formula fed babies.

Bed sharing can enable longer periods of rest for the mother and her baby and can aid breastfeeding (NICE, 2015). However, NICE (2015) advises that there is an association between Sudden Infant Death Syndrome (SIDS) and co-sleeping if the mother/partner is over tired. It is advised that parents that formula feed should not bed share.

Ball (2006) provides evidence to suggest that breastfeeding mothers sleep facing their babies and adopt a protective sleeping position. However, mothers who are artificially feeding can sometimes turn their backs on their babies once they have fallen asleep. Formula fed babies should be offered a dummy. Regular use of a dummy has been found in several studies to be associated with a lower risk of SIDS, although it is not clear exactly why this is (The Lullaby Trust, 2019).

5.7.4 Armchairs and sofas.

Parents/carers should be advised they should never sleep with their babies on a sofa or armchair with their baby either next to them or on their chest as they can become trapped down the side of sofas or between cushions and this is one of the most significant contribution factors in SIDS.

5.7.5 Slings.

If slings are the choice for a parent for carrying their infant the following principles are advised:

- It is firm and upright.
- The adult can always see their baby's face by glancing down.
- The adult can kiss their baby's head by tipping their head forward.
- The baby should never be curled up so their chin is forced into their chest as this can restrict their breathing.

5.7.6 Car Seats

Concerns have been raised around the length of time it is safe for a new-born baby in a car seat. Further studies are needed to consider the safety of new-borns travelling in car seats. But for now, car safety remains paramount, parents and carers should continue to use car seats according to their instructions. Parents should not stop using car safety seats to transport their infants. Infants must be protected in moving vehicles, and UK law requires car seats be used whenever infants travel in cars.

But it may be a good idea to rethink leaving a baby in a car seat for prolonged periods when they are not travelling. It has been recommended by the Royal Society for the Prevention of accidents that whilst travelling, a 15-minute break is taken every 2 hours and to remove the baby from the car seat. It is suggested that a baby should not be left for prolonged periods of time to sleep in a car seat as there have been reported links with babies having breathing difficulties (Tonkin SL et *al.,* 2006). It is also recommended that a baby should wear simple clothing without coats/snowsuits whilst in the car and the use of a single blanket which can be removed according to the temperature in the car.

5.7.7 Twins

Twins should only be placed side by side in a cot in the early weeks when they cannot roll together and should not be too close. Twins can be put at opposite ends of their cot where they will both be 'feet to foot' position with their own bedding (The Lullaby Trust, 2019).

6.0 TRAINING.

All staff working in the maternity unit will receive safe sleep training on an annual basis.

7.0 APPROVAL AND RATIFICATION.

Ratification of this policy will be sourced from the Women's Health Guideline Group.

8.0 REVIEW AND REVISION ARRANGEMENTS.

The guideline will be reviewed every 3 years or sooner if the local service changes or there are changes to the evidence supporting the guideline.

9.0 DOCUMENT CONTROL AND ARCHIVING

Where minor amendments are required e.g., change of names, job titles, these can be made then approved and ratified by the relevant Chair of the Committee through Chairman's action. The amendments must be recorded in the history brief (page 2) of the document. Where this occurs, this should be minutes at the next committee meeting. Previous guidelines must be archived and kept.

10.0 DISSEMINATION AND IMPLEMENTATION.

The policy will be disseminated through global email to clinical staff working within the maternity department. This policy will be published on the trust intranet and internet sites.

11.0 MONITORING COMPLIANCE WITH THIS POLICY.

Measurable Policy Objective	Monitoring/ Audit method	Frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to which groups/ committees, inc responsibility for reviewing action plans
RCA of any incidents reported related to bed sharing	Datix	Following each reported incident.	Clinical Midwifery Manager Joan Booker Ward.	Women's Health Governance Meeting

12.0 References

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UNICEF UK (2017). The Baby Friendly Initiative and Foundation for the Study of Infant Deaths Sharing a bed with your baby – A guide for breast feeding mothers.[Online]. Available at: http://unicef.org.uk/babyfriendly. (Accessed 08 April 2021).

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APPENDIX A
RISK ASSESSMENT TOOL FOR A MOTHER BED SHARING WHILST HAVING SKIN TO SKIN (LABOUR WARD)

This assessment should be carried out in consultation with the mother. For some mothers, suitable family members can be asked to supervise the mother to ensure baby's safety is maintained. Professional judgement must be used by the health professional to assess the family members willingness and suitability to observe the mother and baby and be clear that it is their role to observe and to ensure that the safety of the baby is maintained, if they have any concerns they must know how to call a member of staff immediately. Basic instructions should be given by the health professional to prevent overlaying, overheating and airway obstruction of the baby. This would not negate the professional responsibility.

Factors requiring constant supervision when bed – sharing	YES	N0
The mother is still experiencing the effects of a general anaesthetic		
The mother is immobile following spinal anaesthesia		
The mother has been given drugs which cause drowsiness		
The mother is too ill to the point of affecting her level of consciousness or ability to respond normally to the baby, e.g. pyrexia, pre-eclampsia, or following severe haemorrhage		
The mother is excessively tired, affecting her ability to respond to the baby		
The mother suffers from a condition that would affect her spatial awareness, such as sight impairment, or that would severely affect mobility and sensory awareness e.g. multiple sclerosis or paralysis		
The mother is likely to have temporarily loss of consciousness e.g. unstable insulin-dependent diabetes or epilepsy		
Raised BMI (an individual assessment will be required, preferably with the mother, based on the mother's mobility, spatial awareness and the space available in the bed).		
Completed by: Signature Date and Time:		

APPENDIX B: EQUALITY IMPACT ASSESSMENT

Equality Impact Assessment Summary

Name and title: Safe Sleeping Guidance for Babies

Background • Who was involved in the Equality Impact Assessment
Clinical midwifery managers Consultant obstetrician Infant Feeding Lead Midwife
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
This guideline will be applied to all women who using the maternity services. The guideline was informed by UNICEF and BFI. The guideline was reviewed by the multidisciplinary team.
Key Findings • Describe the results of the assessment. • Identify if there is adverse or a potentially adverse impacts for any equalities groups.
This guidance ensures all women using the maternity service receives appropriate evidence based advice on safe sleeping for their baby.
Conclusion • Provide a summary of the overall conclusions
This guideline will ensure that all women using the maternity service receives appropriate evidence based advise on safe sleeping for their baby.
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment. • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified. • Describe the plans for reviewing the assessment.
The guidance should be updated three yearly or as when new evidence is discovered.

Policy/Service:

Background • Description of the aims of the policy. • Context in which the policy operates. • Who was involved in the Equality Impact Assessment.
• To ensure consistent and evidence based care to safe sleeping for babies. • Maternity Services. • Maternity Guideline group.
Methodology • A brief account of how the likely effects of the policy were assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age). • The data sources and any other information used. • The consultation that was carried out (who, why and how?)
• Impact assessment revealed no obvious impact identified. • N/A • The multidisciplinary team delivering maternity care had the opportunity to contribute to development of the policy.
Key Findings • Describe the results of the assessment. • Identify if there is adverse or a potentially adverse impacts for any equalities groups.
• No impact identified.
Conclusion • Provide a summary of the overall conclusions.
• No impact.
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment. • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified. • Describe the plans for reviewing the assessment.
• Impact assessment will be reviewed at next policy review.

Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to	**Religion or belief** (include dress, individual care needs, family relationships, dietary

information on services and employment, and ease of access to services and employment).	requirements and spiritual needs for consideration).
Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people).	**Sexual orientation including lesbian, gay and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs.
Genders (consider care needs and employment issues, identify and remove or justify terms which are gender specific).	**Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior).
Cultures (consider dietary requirements, family relationships and individual care needs).	**Social class** (consider ability to access services and information, for example, is information provided in plain English?)

APPENDIX C: CHECKLIST FOR THE REVIEW AND APPROVAL OF DOCUMENTS

To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.

Title of the document: Safe Sleep Guidance for Babies
Policy (document) Author: Jo Hillcoat-Wilding
Executive Director:

		Yes/No/ Unsure/ NA	Comments
1.	**Title**		
	Is the title clear and unambiguous?	**Yes**	
	Is it clear whether the document is a guideline, policy, protocol or standard?	**Yes**	
2.	**Scope/Purpose**		
	Is the target population clear and unambiguous?	**Yes**	
	Is the purpose of the document clear?	**Yes**	
	Are the intended outcomes described?	**Yes**	
	Are the statements clear and unambiguous?	**Yes**	
3.	**Development Process**		
	Is there evidence of engagement with stakeholders and users?	**Yes**	
	Who was engaged in a review of the document (list committees/ individuals)?	**Yes**	
	Has the policy template been followed (i.e. is the format correct)?	**Yes**	
4.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	**Yes**	
	Are local/organisational supporting documents referenced?	**Yes**	
5.	**Approval**		
	Does the document identify which committee/group will approve/ratify it?	**Yes**	

		Yes/No/ Unsure/ NA	Comments
	If appropriate, have the joint human resources/staff side committee (or equivalent) approved the document?		
6.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	**Yes**	
	Does the plan include the necessary training/support to ensure compliance?	**Yes**	
7.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	**Yes**	
8.	**Review Date**		
	Is the review date identified and is this acceptable?	**Yes**	
9.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	**Yes**	
10.	**Equality Impact Assessment (EIA)**		
	Has a suitable EIA been completed?	Yes	

Committee Approval (insert name of Committee) Women's Health Guidelines Group			
If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner			
Name of Chair		**Date**	
Ratification by Management Executive (if appropriate)			
If the Management Executive is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner			
Date: n/a			