Babies - Safe Sleeping Clinical Practice Guideline

NSW GOVERNMENT Health

CONTENTS

1 BACKGROUND

The rate of Sudden Unexpected Death in Infancy (SUDI) has declined in Australia in recent decades, but has plateaued in more recent years. The overall decline reflects a change in post-neonatal SUDI (infants older than 28 days).[1]

Aboriginal and Torres Strait Islander children and those families known to the child protection system are over represented in SUDI deaths compared with the general population.[1,2]

Most of the risk factors associated with SUDI are modifiable therefore the implementation of safe sleep practices could reduce the incidence of SUDI.[1]

2 UNIVERSAL SAFE SLEEPING MESSAGES AND PRACTICES

To reduce the incidence of SUDI it is essential all families receive consistent, clear and sensitive safe sleeping information and education.[2]

NSW Health staff should model safe sleeping practices and provide written and verbal information to influence the behaviour of expectant parents, parents, extended family members and caregivers.[3] These interventions should occur during the antenatal period and at each opportunity until the baby is 12 months of age, and the actions of health professionals recorded in the clinical notes.

2.1 The six key safe sleeping messages

The six safe sleeping messages are evidence based and are aligned with international best practice:

- sleep baby on their back from birth, **not** on the tummy or side
- sleep baby with head and face uncovered
- keep baby smoke free before and after birth
- provide a safe sleeping environment **night and day**
- sleep baby in their own safe sleeping place in the same room as an adult caregiver for the first six to twelve months
- breastfeed baby.

Staff should strongly encourage parents and caregivers to use safe sleeping practices in any environment where the baby is placed to sleep.

NOTE: There is **NO SAFE** way to make an adult sleeping surface safe for a baby.

2.2 Safe sleeping resources

All parents should receive a culturally appropriate, safe sleeping information pamphlet, containing the six safe sleep messages. Safe sleeping resources can also support and inform the safe sleeping discussion with parents. These resources may include:

- *Red Nose - saving little lives - safe sleeping*
- NSW Health Kids and Families, Maternal, Child and Family Health
    - NSW Health, *Safe Sleep Cot Card*
    - *My personal health record* - (Blue Book).

2.3 Safe sleeping messages and practices to model and discuss

The safe sleeping practices are based on the six safe sleeping messages. Parents and caregivers should receive consistent information in line with Table 1.

Table 1: List of safe sleeping practices for staff to model and discuss with parents and caregivers.

Key messages	Safe sleeping practices to model and discuss
1. Sleep baby on their back from birth, not on the tummy or side	Sleep baby on his/ her back reduces the risk of SUDI. Healthy babies placed on their back to sleep are less likely to choke on vomit than prone (on tummy) sleeping or side sleeping babies. Older babies who are able to move around the cot should be placed on the back and allowed to find their own sleeping position. The risk of SUDI in babies over six months is lower. When an adult is present and baby is awake, tummy play is safe and good for baby's development.
2. Sleep baby with head and face uncovered	**Remove head coverings before baby** is placed to sleep. Head covering such as hats, bonnets, and hooded clothing may cause suffocation and overheating. Bedding should be tucked in securely so it is not loose, or use a safe sleeping bag. The cot **must be flat.** Position the baby's feet at the bottom of the cot to prevent baby moving down the cot and becoming covered by bedding.
3. Keep baby smoke free before and after birth	The risk of SUDI is increased if parents or other household members are smokers, either before or after birth. Smoking leaves harmful chemical residue on the clothes and surfaces around the smoker so it is important that **anywhere the baby spends time should be smoke free**. Parents and caregivers who are smokers should be encouraged to contact *Quitline* (phone: 137848) or *iCanQuit* to discuss smoking cessation with an appropriate health care professional.
4. Provide a safe sleeping environment night and day	Bean bags, bouncinettes, rockers and prams should not be used as an unsupervised sleeping place. Soft bedding, such as soft mattresses, doonas, pillows, cushions, cot bumpers and sheepskins **are unsafe** for the baby's sleeping area. Keep toys out of the baby's sleeping area. Soft objects in the baby's sleeping environment pose a risk of suffocation. If a bassinet is used, it should only be used in the first few months of baby's life. Once the baby can roll he/she should be placed in a safe cot. If a portable cot is used, only use the mattress supplied, with no additional padding. The risk of an injury and SUDI is increased if a baby sleeps, or is left unsupervised, on an adult bed, a lounge, sofa or other unsafe surface.
5. Sleep baby in their own safe sleeping place in the same room as an adult caregiver for the first 6 to 12 months of age	Sleeping in a safe cot in the same room as parents for the first six to twelve months lowers the risk of SUDI. Parents should never sleep on the same sleep surface with their baby. Sharing a sleep surface increases the risk of SUDI, by entrapment and/ or suffocation, in babies up to 12 months of age. The highest risk is associated with: • Adults affected by alcohol or other drugs, medication (prescribed or other) that cause drowsiness, or an adult who is a smoker. • Babies under 3 months of age. • Babies born prematurely and/ or small for gestational age. If a baby is brought into an adult bed for feeding or settling, the baby must be returned to their own safe sleeping place prior to the adult falling asleep. Parents should avoid unintentionally falling asleep with baby on surfaces such as a sofa or couch, water bed, hammock or bean bag
6. Breast-feed baby	There is strong evidence that breastfed babies have a reduced risk of SUDI. If the baby is bottle fed, prop feeding should be discouraged , as it may lead to choking and death.[4]
Parents and caregivers may question the safe sleeping messages, based on their beliefs, cultural practices or experiences with previous children. If this happens clinicians should refer to *Safe Sleep for Newborns- FAQs for Professionals*, to guide and inform discussions.	

3 HIGHER RISK OF SUDI

There is an increased risk of SUDI associated with a number of baby and/ or family characteristics. The peak incidence for SUDI occurs in infants less than two months of age with more male babies represented than female babies.[1]

It is important to note that Aboriginal and Torres Strait Islander children are over represented in SUDI deaths. The proportion in 2015 was the highest in the last 15 years.[1]

SUDI is also significantly more likely in families who are known to the child protection system. These families are disadvantaged, poorly resourced and experience a range of issues that impact on the parent's capacity to make safe sleeping choices for their baby.[2]

3.1 Risk assessment for factors that may cause SUDI

Risk assessment for factors that are associated with SUDI should be conducted with the family by NSW Health staff, and documented in the mother's/baby's clinical notes. The following factors should be considered:

- mother's clinical condition
- baby's clinical condition
- family circumstances
- safety of the physical environment.

3.1.1 Mothers clinical condition

Postnatal maternal risk factors may include women who are:

- recovering from a general anaesthetic (first 24 hours)
- immobile due to spinal or epidural anaesthetic (until fully mobile)
- experiencing a medical condition that may affect consciousness or ability to respond normally to the baby, for example, fever, excessive blood loss, severe hypertension
- under the influence of drugs/ medications that may cause drowsiness, for example: sedatives, analgesia especially narcotics and other opioids such as, methadone, alcohol, illicit drugs
- tired or exhausted so that their ability to respond to the baby is affected for example women who have laboured through the night or awake >24 hours.

3.1.2 Baby's clinical condition

There is an increased risk of SUDI associated with:

- less than 12 weeks of age[1]
- premature birth (at less than 37 weeks)[1,2,5,6]
- low birth weight (less than 2,500g)[1,6]
- a history of upper respiratory tract infections in the two weeks prior to death including: signs of cold/ flu, chesty coughs and/ or wheezing; ear infection; staphylococcus infections; gastrointestinal illness or fever.

3.1.3 Family circumstances

Risk factors within some families and populations may lead to a higher incidence of SUDI. These may include:

- parents with drug and/ or alcohol use[1,2]
- parents using medications which may cause drowsiness[1]
- parents or caregivers who smoke[1,7]
- families of Aboriginal or Torres Strait Islander descent[1]
- families with a child protection history[1,2]
- families living in remote areas of NSW
- families experiencing unstable or violent family relationships[1,2]
- younger maternal age, particularly under 21 years.[1,2,5]

3.1.4 Safety of the physical environment

To ensure a safe sleeping environment families need:

- access to a cot that complies with the Australian Safety Standards
- adequate housing (for some families homelessness or overcrowding may be an issue).

3.2 Risk of significant harm

If health professionals are concerned about the risk of significant harm to an infant they should consult the *NSW Health Child Wellbeing Unit*, on 1300 480 420 (Monday – Friday 8:30am – 5:30pm).

4 STRATEGIES TO SUPPORT FAMILIES

Families who have identified risk factors for SUDI may not receive, understand or adopt the safe sleep messages. It is therefore important that health professionals build relationships with these families and communities to support families to find ways to keep their babies safe. Health professionals must be sensitive, clear and consistent about the safe sleeping messages and non-judgemental when talking with the family.[2] The use of appropriate resources about the six key safe sleeping messages will help families understand the evidence.

4.1 Aboriginal families

'Building trust and sharing respect is central to good work with Aboriginal families. The importance of culturally responsive practice with Aboriginal families cannot be overstated. It involves acknowledging the trauma and impact of the Stolen Generations while genuinely valuing Aboriginal culture and connection to community, and working collaboratively within that context to address any safety and risk issues identified for children'.[2]

Consider referral of Aboriginal and Torres Strait Islander families to maternity and child and family health services such as the Aboriginal Maternal and Infant Health Services (AMIHS) and Building Strong Foundations (BSF) where available. These services can provide additional support to families to help mitigate risks. Further information about these services is available at NSW Health Kids and Families, Maternal Child and Family

Health website. Ensure families are provided with the NSW Health *Safe Sleeping for Your Baby* – strong women strong babies brochure.

4.2 Culturally and linguistically diverse families

The following resources are available to support families where English is not their first language:

- *My personal health record* (The Blue Book) - available in many languages
- parent information brochure *red nose - saving little lives - safe sleeping*
- a health care interpreter for families who are not fluent in English or who are deaf, in line with PD2017_044 *Interpreters - Standard Procedures for Working with Health Care Interpreters*.

4.3 Referral to family support services

A range of factors may act as barriers to a family ensuring a safe sleep environment (see Section 3.1.4). In these circumstances it is important to provide additional support, information and education. Health professionals should:

- Proactively support families to access relevant services, supports or referrals, or if necessary, engage relevant services, supports or referrals on their behalf. This may include social workers and welfare services available in the local health districts (district) and/ or the Department of Family and Community Services.
- Refer the family to Family Referral Services as required, for further support services and community resources.

5 SPECIFIC ADVICE TO PARENTS

In addition to providing all families with the six safe sleeping messages and practices (see Table 1) some parents may need more information about specific issues.

5.1 Exposure to tobacco smoke

The harm of exposure to tobacco smoke is a risk factor for SUDI. Strategies to minimise the risks may include:

- referral to *Quitline* phone: 137 848 or *iCanQuit*
- education on the association between cigarette smoking and risk of SUDI
- smoke after, not before feeding or holding the baby
- prevent nicotine and toxin contact with the baby by changing clothes after smoking
- keep the house and car smoke free
- designated outside smoking areas, away from doors and windows.

5.2 The risk of co-sleeping

It is important that NSW Health professionals provide parents with evidence based information that the safest place for a baby to sleep is in her/his own safe sleeping place in the same room as an adult caregiver for the first six to 12 months of age. This includes baby not sharing any sleep surface with another baby, child, parent or caregiver regardless of their cultural background, social or life circumstances.[8] A guide to

responding to questions about co-sleeping, *Safe Sleep for Newborns- FAQs for Professionals* is available on the NSW Health website.

Parents may request information on how to make an adult bed safe for sharing with a baby. However, there is no evidence that an adult bed can be made safe for a baby. Sharing a sleep surface increases the risk of SUDI, even when there are no other risk factors.[9]

5.2.1 Unintentionally falling asleep with baby

Parents should be advised of the risk of unintentionally falling asleep when feeding or settling baby either in bed, on a sofa or couch, armchair, water bed, hammock or bean bag.[8] In 2015 as many as six infants died in these circumstances.[1] The risk of unintentionally falling asleep on a soft surface may be higher, if the parent is excessively tired or sleepy. If a baby is brought into an adult bed or soft surface (described above) for feeding or settling, the baby must be returned to their own safe sleeping place prior to the adult falling asleep. The partner or other caregiver, can help by returning the baby to the cot after feeding.

5.2.2 Twins and multiple births

Co-bedding of twins and multiples is **NOT** recommended.[8] It is important for postnatal staff to follow the same sleep practices for twins and multiple births as they would with other infants in line with Table 1. There is no compelling evidence of the benefit of co-bedding.[8]

Furthermore, twins and higher-order multiples are often born prematurely and with low birth weight and have a higher risk of SUDI. Co-bedding these babies increases their risk with the potential to cause overheating, rebreathing and the difference in size of the infants may increase the risk of suffocation.

5.3 The risk of baby's head and face being covered

Wrapping baby, without covering the head or face, may be used as a settling and sleeping strategy in babies who have not started rolling. The wrap must be loose enough to allow for hip flexion and chest wall expansion, and the baby should not be overdressed under the wrap.

Wrapping may become a hazard for babies who have started rolling and may be over six months of age. Once the baby moves enough to become tangled in wrapping consider using a safe sleeping bag. If bed linen is used it should be tucked in firmly to prevent baby's head and face becoming covered.

5.4 The risks associated with other sleep environments

Babies should not be left unsupervised when they are asleep in places other than their own safe cot Table 1. Babies who are under three months of age[1]; premature; low birth weight or having breathing difficulties may be at greater risk where their airway may become compromised.[9]

A warning has been issued regarding the use of fabric baby carriers or slings following child deaths and associated coronial findings. For more information, see the Australian Competition and Consumer Commission Product Safety Australia safety alert *Baby Sling Safety*.

5.5 Use of a pacifier (dummy)

Breastfeeding a baby is protective against SUDI.[1] If a baby is breastfeeding, a dummy should not be used until breastfeeding is established, usually at about six weeks of age. The evidence indicates that the use of a dummy may be protective against the risk of SUDI. However, if a baby is not showing a preference, the evidence does not support active encouragement of the use of a dummy.[4,5]

5.6 Immunisation

The evidence shows that immunisation may be protective against SUDI.[9] Parents should be strongly encouraged to vaccinate their children on time, in line with the National Immunisation Program Schedule. Resources are available on the NSW Health Immunisation website.

6 IMMEDIATE POSTNATAL CONSIDERATIONS

The orientation of families to postnatal care environments in Public Health Organisations (PHO) must include the safe sleeping messages and practices outlined in Table 1. This must include a demonstration of safe sleeping positioning of baby in the cot. Care planning will include consideration of previously identified safe sleeping risks and any further risks identified, appropriate advice and documentation.

6.1 Safe sleeping environment in maternity facilities

Staff should be aware that some mothers are at greater risk of unintentionally falling asleep when feeding or settling their baby in their adult bed, which increases the risk of SUDI (see Section 3.1.1). It is therefore important that staff are vigilant in the early postnatal period to support those mothers.

To promote a safe sleeping environment, staff of NSW PHOs must advise all mothers that co-sleeping with their babies increases the risk of SUDI and therefore is not recommended. Babies in NSW PHOs should be returned to their own safe cot prior to the mother falling asleep.

6.2 Baby feeding and settling

When the father/ partner/ support person is assisting with feeding and/ or settling of the baby, it is important to remind them of the need to return the baby to their own safe cot for sleeping.

In the event that a baby requires breastfeeding or settling whilst the mother is receiving medication of a sedative nature, regular monitoring and support by staff is required. In addition, staff should consider the following:

- lowering the bed as far as possible
- place the call bell/ buzzer as close as possible to the mother/ parents
- ensure that if bed rails are used, they do not cause a danger of entrapment to the baby.

There may be instances where a parent chooses to co-sleep with their baby despite advice from health professionals. The advice and subsequent actions should be documented in the health care record.

7 NEONATAL INTENSIVE CARE/ SPECIAL CARE SETTINGS

Districts and Specialty Health Networks should ensure that newborn care settings such as neonatal intensive care, newborn care nurseries and some paediatric units (where newborn care is provided):

- develop strategies to 'normalise' the care of the baby consistent with safe sleep practices at an appropriate time (e.g. when cardio- respiratory monitoring is ceased, prior to discharge)[9]
- ensure that staff discuss with parents or caregivers the rationale of any variation to safe sleep practices in a newborn care environment at appropriate times, and to model the recommended safe sleep practices once care has been normalised prior to discharge
- provide all parents/ caregivers taking their baby home from a newborn care environment with education regarding the six safe sleeping messages and any variation to the messages if medically stipulated for their particular baby.

8 COMMUNITY SETTING CONSIDERATIONS

The safe sleeping messages and practices described in Table 1 should be applied in community settings and discussed with all parents and caregivers. These safe sleeping messages and practices should be applied in all residential or community settings where any baby up to 12 months of age is placed to sleep.

At the first home visit the child and family health nurse should:

- use a partnership approach to discuss the contents of the Table 1 and offer to assist parents in making changes to the sleep environment as required
- ensure all parent and caregivers have the information brochure *red nose - saving little lives - safe sleeping*, (available in multiple languages), and discuss this information with them
- ensure the delivery of services to promote safe sleeping is accurately and comprehensively documented in the baby's health care record in line with this Guideline.

9 BABIES IN OTHER HEALTH CARE SETTINGS

It is recommended that health professionals working in any NSW PHO settings, where babies up to 12 months of age are placed to sleep should,

- undertake a clinical risk assessment to facilitate a safe sleeping environment for the baby, as outlined in Section 3.1
- model the safe sleeping practices in line with Table 1
- discuss the safe sleeping practices in line with Table 1 with parents/ caregivers.

These settings may include, children's hospitals, emergency departments, paediatric wards and any other department where the baby may be a hospital boarder and accommodated with a mother or other caregiver such as day stay and residential settings.

There may be instances where a parent chooses to co-sleep with their baby despite advice from health professionals. The advice and subsequent actions should be documented in the clinical notes.

10 DOCUMENTATION

Comprehensive contemporaneous documentation of the safe sleeping information given, risk assessment, maternal choices and a clear care plan should be attended in line with PD2012_069 *Health Care Records – Documentation and Management*.

11 KEY DEFINITIONS

Bed sharing - Bringing a baby onto a sleep surface where co-sleeping is possible, whether intended or not.

Co-sleeping - A mother, her partner and/ or any other person being asleep on the same sleep surface as the baby.

Must - an action that is to be complied with.

Neonatal period - From birth to 28 days of age.

Partnership approach - Health professionals and family members working together in pursuit of a common goal. This approach is based on shared decision making, shared responsibility, mutual trust and mutual respect in line with PD2010_017 *Maternal Child Health Primary Health Care Policy*

Prop feeding - babies being fed by a bottle propped up by an object rather than held by a parent or caregiver directly.

Recommended - suggest (something) as a course of action.

Room sharing - The baby sleeps in a cot in the same room as the parents or other adult caregiver.

Sharing a sleep surface - Practices of bed sharing and co-sleeping on the same sleep surface.

Should - Indicates actions that ought to be followed unless there are justifiable and documented reasons for taking a different course of action.

Sudden Infant Death Syndrome (SIDS) - The sudden and unexpected death of an infant under 1 year of age, with onset of the lethal episode apparently occurring during sleep, that remains unexplained after thorough investigation including performance of a complete autopsy, a review of the circumstances of death and the clinical history.

Sudden Unexpected Death in Infancy (SUDI) - Is a classification rather than a cause of death. The term defines the death of an infant aged less than 12 months of age that is sudden and unexpected, where the cause was not immediately apparent at the time of death. Included in SUDI are:

- Deaths that were unexpected and unexplained at autopsy (i.e. those meeting the criteria for Sudden Infant Death Syndrome).
- Deaths occurring in the course of an acute illness that was not recognised by carers and/ or health professionals as potentially life threatening.
- Deaths arising from a pre-existing condition that had not been previously recognised by health professionals.
- Deaths resulting from accident, trauma or poisoning where the cause of death was not known at the time of death.[1]

In some cases, a cause of death may be identified by autopsy and examination of the circumstances of the infant's death. For others, no clear cause can be determined and many of these deaths are classified as SIDS.

12 REFERENCES

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