[Insert Name of Hospital] **NURSING POLICY AND PROCEDURE**

DATES:	**Original Issue:**	**[Insert Date]**
	Annual Review:	**[Insert Date]**
	Revised:	**[Insert Date]**
Owner:	**[Insert Name]**	
Approved by:	**[Insert Name]**	

TITLE: INFANT SAFE SLEEP POLICY

I. Purpose

A. Establish guidelines and parameters for infant positioning.
B. Establish appropriate and consistent parental education on safe sleep positions and environment.
C. Establish consistent safe sleep practices by healthcare professionals for infants prior to discharge.

II. Definitions

Infant Mortality Rate: Number of deaths in infants aged under 1 year of life per 1,000 live births in a given geographic location.

Neonatal Mortality Rate: Number of deaths in infants aged under 29 days of life per 1,000 live births in a given geographic location.

Post-neonatal Mortality Rate: Number of deaths in infants aged 29 to 364 days of life per 1,000 live births in a given geographic location.

SIDS (Sudden Infant Death Syndrome): The sudden death of an infant younger than one year of age that remains unexplained after a complete investigation.

SUID (Sudden Unexpected Infant Death): The death of an infant less than one year of age that occurs suddenly and unexpectedly, and whose cause of death is not immediately obvious before the investigation. Most SUIDs are reported as one of three types:

- SIDS
- Accidental suffocation or strangulation in bed
- Unknown Cause

SUPC (Sudden Unexpected Postnatal Collapse) Any condition resulting in temporary or permanent cessation of breathing or cardiorespiratory failure in a well-appearing, full-term newborn with Apgar scores of eight or more, occurring during the first week of life. Many, but not all, of these events are related to suffocation or entrapment.

NAS (Neonatal Abstinence Syndrome): Is a constellation of symptoms that occur in a **newborn** who has been exposed to addictive opiate drugs. This is most commonly due to prenatal or maternal use of substances that result in withdrawal symptoms in the newborn. It may also be due to discontinuation of medications such as fentanyl or morphine used for pain therapy in the newborn (postnatal NAS).

III. Policy Statement

The infant mortality rate is a widely-used indicator of the nation's health. In 2010, the United States (U.S.) ranked 26th in infant mortality among industrialized nations, with an overall infant mortality rate of 6.1 deaths per 1,000 live births. [1] The leading causes of infant mortality in the U.S. are a) congenital malformations, b) short gestation/low birth weight, c) sudden infant death syndrome (SIDS), d) maternal complications, and e) unintentional injuries (mostly suffocations)[2]. Although the infant mortality rate in the U.S. decreased to 5.96 deaths per 1,000 live births in 2015, this still represents approximately 24,000 deaths per year, of which, **about 3,500 are sudden unexpected infant deaths (SUID).**

In 1992 the American Academy of Pediatrics (AAP) recommended that infants no longer sleep in the prone position. By 1994, the National Institutes of Health, introduced the Back to Sleep campaign. Over the next 10 years, the sudden infant death syndrome (SIDS) rate in the U.S. fell 53%, correlating with an increase in exclusive supine sleep.

Despite these advances, approximately 1,500 infant deaths occur due to SIDS each year. SIDS is the third-leading cause of infant mortality overall, and it is the leading cause of post-neonatal mortality. And although the incidence of SIDS continues to decline, other deaths (including accidental suffocation and strangulation in bed and undetermined deaths) have increased, suggesting a possible "diagnostic coding shift," resulting in little change in the incidence of SUID in recent years.

The AAP recommends "Health care professionals, staff in newborn nurseries and NICUs, and child care providers should endorse and model the SIDS risk reduction recommendations from birth. All physicians, nurses, and other health care providers should receive education on safe infant sleep. Hospitals should ensure that hospital policies are consistent with updated safe sleep recommendations and that infant sleep spaces (bassinets, cribs) meet safe sleep standards."

However, studies show that many hospitals do not currently provide consistent and accurate information or model appropriate behavior in the hospital. In one study, parents reported receiving instruction on sleep position from either nurses and doctors less than 50% of the time and only 37% of parents reported seeing their infant placed exclusively in the supine position in the nursery. Yet parents who reported both receiving instruction and observing their infant put to sleep in the supine position were most likely to keep their babies in the supine position for sleep at home (70%), while parents who received no instruction and did not see their babies' supine in the nursery were least likely to report using the supine position at home (22%). Parents are less likely to believe that infant

[1] (MacDorman, Matthews, Mohangoo, & Zeitlin, 2014).

[2] (MacDorman, Hoyert, & Matthews, 2013).

safe sleep practices are important when the hospital staff is inconsistent with their message and behavior.

Healthcare professionals play a vital role by showing mothers/caregivers a positive model for safe sleep practices in the hospitals or office settings and educating parents and caregivers on the importance of infant sleep safety**.** The challenge for hospitals is to provide education about reducing the potential for accidental injury or death while still promoting methods for mothers/caregivers to bond with their newborns**.** Healthcare providers should have open, frank, nonjudgmental conversations with families about their sleep practices. Healthcare facilities can make a difference by providing education for staff and families and promoting and monitoring safe sleep behaviors that can reduce the risk of injury or infant death.

IV. Equipment

Open cribs/bassinets, isolettes or infant warmers

V. Procedure

A. [Insert Name of Unit, i.e. Newborn Nursery/Rooming-In]:

1. Place all infants on their backs to sleep and the head of the bed flat. Infants with a medical contraindication to supine sleep position -- i.e. congenital malformations, upper airway compromise, severe symptomatic gastroesophageal reflux -- should have a physician's order along with an explanation documented.

2. A firm sleep surface should be used (firm mattress with a thin covering). Use of soft bedding such as pillows, quilts, blanket rolls, and stuffed animals should not be used.

3. If an infant is found in bed with a sleeping mother/parent, the infant should be placed in their bassinet and can be returned to the newborn nursery at the discretion of the nurse. The mother/parent should then be re-educated on safe sleep practices as soon as practical. If this continues to be a reoccurring problem an "Infant Safe Sleep Non-Compliance" release form should be signed by the parent that he or she has been educated and understands that sleeping with an infant is dangerous with the most serious consequence being death.

4. Infants should be swaddled/bundled no higher than the axillary or shoulder level. A "wearable blanket" may be used. If temperature instability occurs, an additional layer of clothing can be used. Swaddling the baby with an additional blanket or wearable blanket is also acceptable.

The following measures are to be discouraged, since they are not consistent with the AAP Guidelines:

i. Use of extra blankets should be discouraged. If a baby cannot maintain temperature with normal clothing and swaddling materials, it is preferable to place the infant in an incubator or under a radiant warmer. Alternatively, the baby may be covered transiently with an extra blanket tucked in under the mattress. If this is required, please remove prior to discharge and re-educate the mother/caregiver on the importance of "no loose" or "bulky blankets" in

the crib or bassinet.

ii. If a hat is still needed for thermoregulation at discharge, educate the parents/caregivers to monitor baby's temperature, and to attempt to discontinue using the hat after 2-3 days of stable temperatures at home. If the baby maintains a normal temperature without the hat, then it can be permanently discontinued. Generally, a hat should not be needed after a few days in home environment.

5. Environmental temperature should be maintained at 72-78 degrees Fahrenheit.

6. The following recommendations for **skin to skin** bonding, when the mother is awake and fully alert, will decrease the risks of **SUPC** (see page 1 for definition.)

- Infant's face can be seen
- Infant's head is in "sniffing" position
- Infant's nose and mouth is not covered
- Infant's head is turned to one side
- Infant's neck is straight, not bent
- Infant's shoulders and chest face mother's
- Infant's legs are flexed
- Infant's back is covered with blanket
- Mother-infant dyad is monitored continuously by the staff in the delivery environment and regularly on the postpartum unit
- When mother want to sleep, infant is placed in bassinet or with another support person who is awake and alert

B. Infants in the Neonatal Intensive Care Nursery (NICU): [Add this section if you have a NICU]
Please see home safe sleep environment algorithm

1. Infants who are ill and do not meet the criteria for the home safe sleep environment should have the Therapeutic Positioning Card at their bedside stating: "Infant is not ready for the Home Sleep Environment (HSE)"

2. Place all infants on their backs to sleep and the head of the bed flat, using the Home Sleep Environment guidelines (HSE). NICU infants should be placed exclusively on their backs to sleep when stable and in the convalescent stage of their development (see #5 for guidelines). The placement of NICU infants on their back to sleep should be done well before discharge, to model safe sleep practices to their families.

The following exceptions should be noted:

i. Infants with upper airway compromise, life-threatening GE reflux (not mild to moderate apnea/bradycardia), respiratory distress, or a greater degree of prematurity may be placed prone or side lying until resolution of symptoms.

ii. Preterm infants and ill newborns may benefit developmentally and physiologically from prone or side lying positioning and may be positioned in this manner when continuously monitored and observed.

iii. Infants with Neonatal Abstinence Syndrome (NAS) with difficult to control symptoms

may be placed in a prone position for brief periods of time (see addendum for guidelines).

3. The following recommendations for skin to skin when mother is fully awake, and alert will decrease the risks of SUPC (see page 1 for definition):

    - Infant's face can be seen
    - Infant's head is in "sniffing" position
    - Infant's nose and mouth is not covered
    - Infant's head is turned to one side
    - Infant's neck is straight, not bent
    - Infant's shoulders and chest face parent's
    - Infant's legs are flexed
    - Infant's back is covered with blanket
    - Parent-infant dyad is monitored continuously by the staff in the NICU
    - If the parent becomes drowsy, infant is placed back in the incubator, warmer or bassinet, or with another support person who is awake and alert.

    iv. A firm sleep surface should be used (firm mattress with a thin covering). Soft bedding and objects such as pillows, quilts, blanket rolls, bumpers and stuffed animals should not be present. Positioning devices (such as snugglies) may be used for developmentally sensitive care of any infant in the NICU (premature infant, infant with neurologic or orthopedic abnormalities) as determined by the team (including occupational and physical therapy).

    v. Infants should be swaddled/bundled no higher than the axillary or shoulder level. A "wearable blanket" may be used. If temperature instability occurs, an additional layer of clothing can be used. Swaddling the baby with an additional blanket or wearable blanket is also acceptable.

The following measures are to be discouraged, since they are not consistent with the AAP Guidelines:

i. **Use of extra blankets should be discouraged. If a baby cannot maintain temperature with normal clothing and swaddling materials, it is preferable to place the infant in an incubator or under a radiant warmer. Alternatively, the baby may be covered transiently with an extra blanket tucked in under the mattress. If this is required, please remove prior to discharge and re-educate the mother/caregiver on the importance of "no loose" or "bulky blankets" in the crib or bassinet.**

ii. **If a hat is still needed for thermoregulation at discharge, educate the parents/caregivers to monitor baby's temperature, and to attempt to discontinue using the hat after 2-3 days of stable temperatures at home. If the baby maintains a normal temperature without the hat, then it can be permanently discontinued. Generally, a hat should not be needed after a few days in home environment.**

4. Environmental temperature should be maintained at 72-78 degrees Fahrenheit.

5. The following guidelines should be used to transition NICU patients to the Home Sleep

Environment (HSE):

i. Babies with a gestational age of 33 weeks and beyond AND greater than 1500 grams without respiratory distress should be placed in HSE.

ii. Babies with gestational age 34 weeks and beyond with respiratory distress may be positioned prone until respiratory symptoms are resolving.

iii. Babies with gestational age under 34 weeks should be assessed when reaching a post-conceptional age of 33 weeks and weight greater than 1500 grams:

iv. If the baby has respiratory distress, staff may continue with prone positioning until respiratory symptoms are resolving. Safe sleep modeling can be performed with an infant on Low flow nasal cannula or High Flow Nasal Cannula <2. LPM.

v. If the baby has no respiratory symptoms, then the primary nursing team should discuss the infant's neuromuscular status with Occupational Therapy. Once the baby no longer requires positioning devices, begin HSE protocol.

6. Once it is determined that an infant is ready for home sleep environment, the following actions should be completed:

i. Apply the HSE card/safe sleep ticket to the baby's bedside.
ii. Fill out the graduation certificate with the baby's name.
iii. At the parent's next visit, have them watch the safe sleep DVD and then provide modeling and review of the appropriate home sleep environment.
iv. After completion of the training, present the family with the graduation certificate.

Also educate the mother/caregiver on the following:

i. No burp cloth under infant.
ii. No sleeping in swing or car seats. It is acceptable to place a fussy baby in a swing to calm down, then transfer to the bassinet for sleeping.
iii. Prior to discharge the MD/NNP to give the "Sleep Baby Safe and Snug" book to family and review education. **[add if you utilize this book]**

C. Infants in the Pediatric Unit (Infants less than 1 year of age): [Add this section if you have a PICU or Peds]

1. Follow the guidelines for the Newborn Nursery
2. If an infant is found in bed with a sleeping mother/parent, the infant should be placed in their bassinet or crib. The mother/parent should then be re- educated on safe sleep practices as soon as practical. If this continues to be a reoccurring problem an "Infant Safe Sleep Non-Compliance" release form should be signed by the parent that he or she has been educated and understands that sleeping with an infant is dangerous, with the most serious consequence being death.

VI. Documentation

A. Document the infant's position on the Newborn Nursery, NICU, or Pediatric Flow sheets.

B. Family/Parental teaching: All parents will be educated on SIDS and safe sleep environments and positioning. Additionally, other caregivers (daycare workers, grandparents, and babysitters) should be encouraged to participate in this education.

1. All healthy infants should be placed on their backs to sleep.
2. All infants should be placed in a separate but proximate sleeping environment (in a safety approved crib, infant bassinet, or Pack 'n Play/play yard).
3. All infants should be placed on a firm sleep surface. Remove all soft-loose bedding, quilts, comforters, bumper pads, pillows, stuffed animals and soft toys from the sleeping area.
4. Never place a sleeping infant on a couch, sofa, recliner, cushioned chair, waterbed, beanbag, soft mattress, air mattress, pillow, synthetic/natural animal skin, or memory foam mattress.
5. Avoid bed sharing with the infant.
   Note the risk of bed sharing:
   - Adult beds do not meet federal standards for infants. Infants have suffocated by becoming trapped or wedged between the bed and the wall/bed frame, injured by rolling of the bed, and infants have suffocated in bedding.
   - Infants have died from suffocation due to adults rolling over on them.
   - Sleeping with an infant when fatigued, obese, a smoker, or impaired by alcohol or drugs (legal or illegal) is extremely dangerous and may lead to the death of an infant.
6. If a blanket must be used, the preferred method is to swaddle/bundle the infant no higher than the axillary or shoulder level.
   - **Swaddling should be discontinued when the infant shows signs of rolling over.**
7. The use of a "wearable blanket" may be used in place of a blanket.
8. Avoid the use of commercial devices marketed to reduce the risk of SIDS.
9. Avoid overheating. Do not over swaddle/bundle, overdress the infant, or over heat the infant's sleeping environment.
10. Consider the use of a pacifier (after breastfeeding has been well established) at sleep times during the first year of life. Do not force an infant to take a pacifier if he/she refuses.
11. Avoid maternal and environmental smoking.
12. Avoid alcohol and drug use.
13. Breastfeeding is beneficial for infants.
14. Home monitors are not a strategy to reduce the risk of SIDS, this includes both Medical grade and direct to consumer devices/monitors.
15. Encourage tummy time when the infant is awake and supervised, to decrease positional plagiocephaly.

C. Document all parental teaching (note if a contract was signed and whether the Safe Sleep DVD was viewed) related to sleep safe practices on the parental teaching portion of the plan of care.

D. For additional information please refer to the Hospital Certification Toolkit on https://cribsforkids.org/hospital-certification-toolkit/

NAS & Prone Positioning [Add this section if you treat NAS infants]

Infant Irritable
Comfort Measures

- Rocking (including use of swings/Mamaroo)
- Holding (volunteers)
- Swaddling
- White noise
- Appropriate Skin-to-skin care
- Infant massage

Irritability continues > 12 hours that necessitates prone positioning at times
Consult with MD/NNP to review scores and meds

Re-assess need for prone positioning and ALWAYS use comfort measures BEFORE placing an infant prone!

Getting ready for home--

- Discontinue prone positioning if used.
- Discuss with primary nursing team, PT/OT, MD/NNP
-

Begin Home Sleep Environment (if not done earlier) when-

- Morphine dose 0.16mg every 3 hours
- Average abstinence scores of < 6 over 24 hours
- No scores > 10 in the last 24 hours
- No prn doses needed in the previous 24 hours

Implement the "home sleep environment" at least 1 week before discharge if not sooner.

- **KEY POINT -implement when infant is ready for "home sleep" and not earlier in the hospitalization**

- View video
- Post Safe sleep ticket
- Post-Graduation card - make this a "special" day for parents!
- Review information and safe sleep DVD with parents
- Swing time limited to awake/fussy times.
- Safe Sleep baby book given to parents by MD, NNP

Family Education

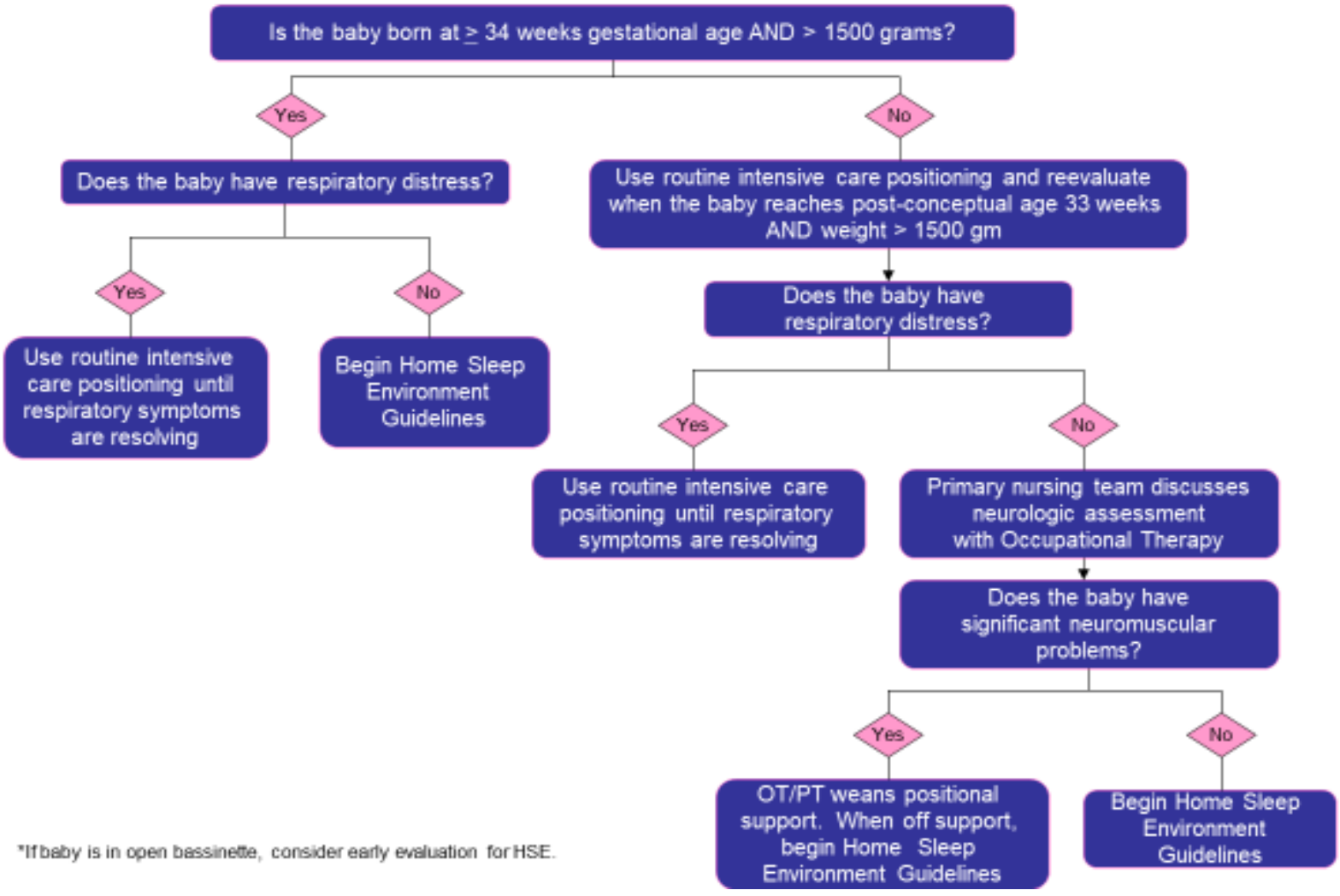
- Need extra education when prone
- **DO NOT say**, "I couldn't get him to sleep so I put him on his belly". "She was very fussy last night and slept better being on her belly", "belly sleeping is okay here in the NICU because our babies are monitored – don't do this at home"
- **DO say**, "to help her calm I put her on her belly for a brief time. This special therapy is sometimes needed to help with withdrawal symptoms".
- **Be consistent** with messages

Considerations

- Staffing – try to avoid clustering NAS babies in 1 area
- Avoid triage assignments if possible
- Consistent care givers are important
- Maintain positivity
- Communicate with charge nurse any concerns with assignments
- Safe Sleep Notes
- May begin in isolette, bassinet, or open crib
- No washcloths under infant

[Add page numbers]

Assessment of SCN Patients for Home Sleep Environment (HSE)



*If baby is in open bassinette, consider early evaluation for HSE.

Safe Sleep Positioning (SSP) Algorithm

PCA 33 weeks AND weight >1500g?

YES

Is there any medical condition precluding SSP?
Ex: Respiratory Distress, Congenital Malformations, Upper Airway Compromise, or sever GERD?

NO

- ☐ Initiate and model SSP per P/P _____(date)
- ☐ Parents watched video_____(date)
- ☐ Graduation Card given to parents_____(date)
- ☐ Safe Sleep ticket on bed _____(date)
- ☐ "Hats off" or educate parents if a hat is needed for temperature stability. Monitor and DC(discontinue)hat 3 days prior to discharge _____(date)
- ☐ Safe Sleep Book given by MD/NNP _____(date)

NO

Infant Therapeutic Position (ITP)
Prone, Supine, Side-lying, HOB raised, Positioning-Aid, etc.

Medical Condition Resolved?

YES

Positioning Notes:

- Low flow NC or HFC <21pm does NOT preclude initiation of SSP
- HOB raised has NOT been shown to be of benefit in respiratory distress, but placing he infant prone has been shown to be of benefit
- Severe GERD need a MD/NNP order to preclude initiation of SSP

VI. Applies to – Persons permitted to perform

- ☐ Nurse Executive
- ☐ RN
- ☐ LPN

VII. Area(s) performed:

- ☐ L&D
- ☐ Maternity
- ☐ NICU
- ☐ Pediatrics

VIII. References/Resources

Resources:

- ☐ Review of literature
- ☐ Expert opinion
- ☐ Guidelines
- ☐ Other _____

References: *"Portions of the following resources may have been consulted as part of the development of this policy. These resources are not authoritative."*

Moon RY and AAP TASK FORCE ON SUDDEN INFANT DEATH SYNDROME. SIDS and Other Sleep-Related Infant Deaths: Evidence Base for 2016 Updated Recommendations for a Safe Infant Sleeping Environment. *Pediatrics.* 2016;138(5): e20162940

AAP TASK FORCE ON SUDDEN INFANT DEATH SYNDROME. SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment. *Pediatrics.* 2016;138(5): e201629

Feldman-Winter L, Goldsmith JP, AAP COMMITTEE ON FETUS AND NEWBORN, AAP TASK FORCE ON SUDDEN INFANT DEATH SYNDROME. Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns. *Pediatrics.*2016;138(3): e20161889

Infant Safe Sleep Policy template adapted from Wellspan Health-York Hospital (revised 2017).

***DIRECTOR OF HOSPITAL AND COMMUNITY INITIATIVE POLICY NOTES:**

1. **Title must include the word "policy".**
2. **You may remove any sections that exclusively address units or procedures that are not applicable to your hospital.**
3. **Policy requires authorized signature(s) and date of approval.**
4. **You may copy and paste from this example policy or use as a guide to create your own.**
5. **All new policies must be implemented for a minimum of 90 days, prior to certification policy.**