Clinical Guideline

Burton Hospitals NHS Foundation Trust

SUPPORTING SAFER SLEEPING PRACTICES IN BABIES AND INFANTS

Approved by:	**Trust Executive Committee**
On:	**25 May 2016**
Review Date:	**April 2019**
Corporate / Directorate:	**Corporate**
Clinical / Non Clinical:	**Clinical**
Department Responsible for Review:	**Safeguarding Children**
Distribution: • Essential Reading for: • Information for:	**All Midwives** **All Maternity Support Midwives** **All Neonatal Nurses** **All Paediatric Nurses**
Policy Number:	**316**
Version Number:	**1**
Signature: Date:	**Chief Executive** **25 May 2016**

Burton Hospitals NHS Foundation Trust

Policy Index Sheet

Title:	**Supporting Safer Sleeping Practices in Babies and Infants**
Original Issue Date:	**September 2011**
Date of Last Review:	**May 2016**
Responsibility:	**Matron, Safeguarding Children**
Stored:	**Corporate Policies – Safeguarding Children**
Linked Trust Policies:	**Trust Policy Framework for Safeguarding Children**
E & D Impact assessed	
Consulted	**Matrons and Head Nurses** **Named Professionals for Child Protection** **Clinical Governance Midwife** **Paediatricians** **ED Consultants Midwives Sister Paediatrics** **Paediatric Nurses**

REVIEW AND AMENDMENT LOG

Version	Type of change	Date	Description of Change
1	Previously a Directorate Policy - WC/OG/81	April 2016	Routine review and update

Burton Hospitals NHS Foundation Trust

Supporting Safer Sleeping Practices in Babies and Infants

1.0 INTRODUCTION

It is recognised that the factors, which influence the sleeping arrangements of infants and children, are a combination of parental values, socio-economic factors and cultural diversity.

All relevant practitioners are responsible for the holistic assessment of risk to babies or infants, offer advice on the relative risks of unexpected infant death for babies and infants sleeping alone or with their parents and review of sleeping practices. They should do so with an understanding of parental expectations and goals, while also taking into account the need to provide a secure physical and emotional sleeping environment for their children, taking into account the parenting capacity, family and environmental factors, and the child's health and development.

2.0 AIMS OF THE GUIDANCE

To reduce the death rate of babies and infants

- By identifying where babies and infants sleep and maximising the ability of the carers to implement safer infant sleep practices.

To reduce the numbers of babies and infants who are put down to sleep in unsafe conditions

- By informing families of the risks of bed-sharing/co-sleeping and other unsafe sleeping practices with babies and infants
- By promoting safer sleeping for all babies and infants

To provide staff with evidence based research to increase their confidence to enable them to educate and support parents.

This Guidance reflects

- Every Child Matters [1]

Keeping children safe from injury and death

Article 24, of the Convention on the Rights of the Child [2] parts
2a: to diminish infant and child mortality
2f: to develop preventive health care guidance for parents.

Information must be communicated to staff so they can give appropriate information and advice to parents and carers to enable them to make an informed choice regarding safer sleeping arrangements for their babies and infants.

All parents will be given the opportunity to discuss safer sleeping arrangements on a one-to-one basis with the relevant Practitioners, and encouraged to seek further advice should their circumstances change.

3.0 BACKGROUND

3.1 Co-sleeping and bed-sharing

The term co-sleeping is often used to refer *only* to the sharing of a sleep surface by an infant and a parent. However, co-sleeping in reality refers to the diverse ways in which infants sleep in close social and/or physical contact with a committed caregiver (usually the mother)[3].

Bed-sharing is just one form of co-sleeping. Forms of co-sleeping such as sharing a mat, futon, or the floor are different from bed-sharing because the surfaces are different, and may not have the same risks as that of soft mattresses, quilts, water beds, sofas, couches or car seats etc. **It is important to be aware that adult beds are not designed to assure infants safety.**

3.2 Reducing the risk of SIDS

Since May 2004, the Department of Health advised against bed-sharing, and instead recommended that babies sleep in their own cot in the parents' room for the first six months of life.

The only population-based prospective study of bed-sharing and SIDS published so far was done in England[4]. Blair et al found that:

- Co-sleeping with an infant on a sofa was associated with particularly high risk of sudden infant death syndrome.
- The risk linked with bed-sharing among younger infants seemed to be associated with recent parental consumption of alcohol, overcrowded housing conditions, extreme parental tiredness, and the infant being under a heavy cover such as a quilt.
- Among infants whose parents do not smoke or infants older than 14 weeks there was no association between infants being found in the parental bed and an increased risk of sudden infant death.
- Sharing a room with the parents was associated with a lower risk of sudden infant death syndrome.

The authors of this study conclude that there has been little in the way of direct observation data until recently, but it is becoming clear that sharing a bed both for infants and mothers results in complex interactions that are completely different from isolated sleeping and that need to be understood in detail before application of simplistic labels such as 'safe' or 'unsafe'. They go on to say "... perhaps it is not bed-sharing per se that is hazardous but rather the particular circumstances in which bed-sharing occurs. That some of these circumstances may be modifiable has important implications in terms of social guidelines and health education" [4].

Bed-sharing and co-sleeping have received considerable negative comment in the medical literature in recent years as a cause of infant deaths.[5,6,7,8,9] and directives to "never sleep with your baby" fail to make important distinctions between the different forms of co-sleeping and bed-sharing.

There is no research evidence that shows bed-sharing, even without recognised risk factors, is safe and no study has ever found bed-sharing to be associated with a reduced risk of SIDS [39,40,52]**.** The condition of the sleeping surface i.e. the bed in Western cultures, the condition and frame of mind of the adult bed-sharers/co-sleepers, and the purposes for bed-sharing/co-sleeping - are very important in assessing the dangers of sleeping with a baby or infant. One study, looking at the quality of sleep in infants, found co-sleeping to be stressful for infants [53].

Specific Circumstances

Precautions need to be taken if families elect to bed-share e.g. bed-sharing should be avoided entirely if the mother smokes (either throughout her pregnancy or after) as maternal smoking combined with bed-sharing increases the chances of SIDS. If there is another person sharing the bed who smokes there should be no bed-sharing, so *there should be no bed-sharing if either or both adults smoke*.

Accidental suffocation can and does occur in bed-sharing situations. In the overwhelming number of cases in which overlaying by adult occurred, extremely unsafe sleeping conditions were identified, including situations where adults were:

- not aware that the infant was in the bed,
- sleeping with a partner who was drunk or had consumed alcohol
- desensitised by drugs or medications,
- indifferent to the presence of the baby.

It should never be assumed that the other adult sharing the same bed knows that the baby is present. Parents should discuss with each other and agree the safe sleeping arrangements for their baby.

Cases of suffocation often occur while the parent and infant sleep on a sofa or couch together and there is also the potential for wedging and accidental asphyxia of infants sleeping alone on a sofa.[54]

Promoting breast feeding

Several published studies have found that breast feeding protects against the risk of SIDS.[49,50] and should be recommended as a protective measure against SIDS [51,63] . Mother-child co-sleeping has been found to extend the duration of breastfeeding in the human infant, who, relative to other mammals, develops more slowly, requires frequent feedings, and is born neurologically less mature[10,11,12] and bed-sharing has long been promoted as a method to facilitate breastfeeding. [13,14,15,16.17] . Nevertheless, it is significant that no studies have found bed-sharing/co-sleeping **under any circumstances to be safe** and at least 5 studies have shown a statistically significant risk *even if the parents are non-smokers* [4, 25,32,35,40].

Cigarette smoking

Studies have demonstrated a significantly increased risk of SIDS when infants bed-share with mothers who smoke cigarettes. Exposure to cigarette smoke as a foetus and in infancy appears to contribute to this risk and is independent of other known risk factors including social class.[4,18,19,20,21,22,23,24]. Babies and infants therefore should never bed-share with carers who smoke, no matter how many cigarettes, or where, **even if they never smoke around the baby**. There is evidence that infants bed-sharing with non-smoking mothers are at increased risk of SIDS [40,48] compared with infants of smoking mothers who **do not** bed-share [40]. Thus bed-sharing poses a risk whether parents/carers smoke or not.

Car seats and travel systems

Parents need to be made aware of the risks associated with day time naps and night-time sleeping in inappropriate sleeping environments e.g. car seats and travel systems as babies have been reported to stop breathing when sleeping in these situations[36,37,38]. There have been local incidences of babies dying whilst asleep in car seats.

Bed-sharing risk to young, premature and low birth weight babies

Babies under 11 weeks of age who sleep in an adult bed with parents are at increased risk of sudden infant death, even if their parents are non-smokers and the baby is breastfed [25.26].

Bed-sharing with a baby who is ill or has a high temperature

These babies are at increased risk of Sudden Infant Death and it is not known whether co-sleeping increases this risk further [27].

Cultural/Diversity

Whilst cultural differences need to be considered, research shows that co-sleeping in other cultures is different from the bed-sharing that occurs in this country[4,41,42,43]. It has been reported that there is a 20-fold increase in the risk of suffocation when infants were placed to sleep in adult beds rather than on those surfaces designed for infants [44]. Placing infants to sleep in adult beds should be discouraged [45] and infants should sleep in a cot that conforms to national safety standards [46].

Daytime sleep

Blair et al [47] found that the same risk factors are significant for both night and day time deaths. They found that 75% of babies who died during the daytime were solitary sleepers and a significant number had their heads covered. Sharing a room with a carer during the day was associated with a lower risk of sudden infant death syndrome. Consequently all the safety sleep messages apply to daytime sleep as well as nighttime sleep.

Dummy/pacifier use

Many studies have identified a protective association between dummy (pacifier) use and a reduced risk of SIDS [55, 56, 57,58] . A meta-analysis of research studies demonstrated a significantly reduced risk of SIDS with pacifier use particularly when placed for sleep [59] and a later, more compelling population-based study (which was too late to be included in the meta-analysis) showed an even greater degree of protection with dummy use citing a 90% reduced risk of SIDS in babies who used a dummy, compared to those who did not:. "Pacifiers may prevent accidental hypoxia as a result of the face being buried into soft bedding, or overlain by objects (such as blankets…) by providing an air passage created by the bulky handle" and "sucking on a pacifier may enhance the development of neural pathways that control the potency of the upper airway" [60] .

As a result the Lullaby Trust formally known as (Foundation for the Study of Infant Deaths (FSID) now recommends that if parents chose to use a dummy it should be offered when settling the baby to sleep every time the baby goes to sleep and that it need not be replaced if it falls out. As the protective association appears to occur as the baby falls asleep. Babies who refuse a dummy should not be forced to have one [51].

It has been suggested that dummy use may be negatively associated with breast feeding. When this relationship is analysed statistically it appears that dummy use is more likely to be *a consequence of breast feeding difficulties than a cause of them* [61] and introduction of a dummy to breast feeding infants after the age of 1 month does not increase the risk for cessation of breastfeeding [62]. A more recent study found that the introduction of a dummy from 15 days did not produce any significant decrease in the frequency of breastfeeding at different ages, or in the duration of lactation [64].

UNICEF recommends that dummies should not be introduced until breast feeding is established. The Lullaby Trust recommends that dummies should not be introduced to breast fed babies until 4 weeks of age.

4.0 SCOPE

This guidance applies to all relevant practitioners employed by Burton Hospitals NHS Foundation Trust that provide antenatal and postnatal care, including those staff in the emergency department and paediatric settings irrespective of the place of birth.

5.0 GUIDANCE TO SUPPORT SAFER SLEEPING PRACTICES IN BABIES AND INFANTS

5.1 All relevant Practitioners have a responsibility to ensure parents and carers receive the following information*:*

Parents will be advised that it is **not** safe for babies and infants to sleep in an adult bed.

The safest place for your baby to sleep is always in a cot in your room for the first six months.

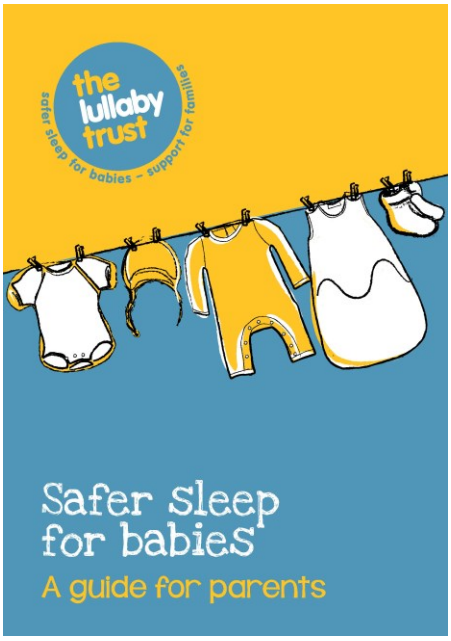
Parents will be advised not to bed-share if their baby was born premature or low birth-weight or has a temperature/fever.

Keep your baby smoke free during pregnancy & after birth

Don't sleep in the same bed as your baby if you smoke, drink or take drugs, including prescribed or over the counter medication that may cause drowsiness

Never sleep on a sofa or in an armchair with your baby

Avoid overheating, use of inappropriate bedding, bumpers and unnecessary soft toys



All relevant practitioners should ensure that all parents and carers have received safer sleep advice leaflet such as the lullaby trust A guide for parents (The Lullaby Trust, 2013) http://www.lullabytrust.org.uk/our-publications-2014)

Best practice is to reinforce safe sleeping guidance at all other contacts during the first year of life. If sleeping arrangements, method of feeding or home circumstances have changed the assessment should be repeated.

5.2 The evidence

- There is no evidence that bed-sharing alone reduces the risk SIDS [39,40]
- Sleeping on the back carries the lowest risk of SIDS [30,31]
- Room sharing lowers the risk of SIDS [4,32]
- The risk of SIDS is significantly increased when infants bed-share with mothers who smoke cigarettes [4,21,32]
- Bed-sharing with an adult who is extremely fatigued or impaired by alcohol or drugs (legal or illegal) that has an impact on arousal can be hazardous to the baby/infant [4,21,34]

- The use of soft bedding, pillows and covers that can cover the head increase the risk of death in all sleeping environments [13,34].

- Sleeping with an infant on a sofa is associated with a particularly high risk of sudden unexpected death in infancy [4,34]

- Bed-sharing with a baby who is premature or low birth-weight increases the risk of infant death [26]

- Bed-sharing with an ill baby or a baby with a high temperature increases the risk of infant death [27].

- Breast-feeding is always best for babies but sharing a bed, even if there are no recognized factors, carries a risk [4,25,32,35, 39, 40.]

Community practitioners should maximize their opportunities to offer supportive yet balanced and **evidence-based** advice about sleeping arrangements as an integral part of anticipatory guidance in well-baby care. The recommended practice of separate sleeping is the preferred sleeping arrangement, but a significant proportion of families will still elect to sleep together. The risk of suffocation and entrapment in adult beds or unsafe cots will need to be addressed for both practices to ensure these types of accidents do not occur.

5.3 Safe sleeping advice for professionals to give parents

Based on the available scientific evidence, it is recommended that the safest place for babies and infants to sleep is in their own cot, and in the parent's room for the first six months of life. However, it is also acknowledged that some parents will, nonetheless, choose to share a bed with their baby. With these caveats in mind, the following recommendations will be made:

The safest place for your baby to sleep is always in a cot in your room for the first six months.

Do not share a bed with your baby if you or your partner:

- are smokers (no matter where or when you smoke)
- have been drinking alcohol
- are unwell
- take medication or drugs
- feel very tired.
- Do not share a bed with your baby if it was born premature or low birth-weight
- Never sleep with a baby on a sofa, armchair or settee
- Never let your baby sleep on a 'make shift bed' such as that made from sofa
- cushions, pillows, duvets or other bedding or soft furnishings
- Do not share a bed if your baby is ill or has a high temperature

If you have none of the above risk factors and have your baby in bed there is still a risk that:

- your baby could die of SIDS

- you might roll over in your sleep and suffocate your baby
- your baby may be smothered
- your baby may become overheated
- your baby could get caught between the wall and the bed
- your baby could roll out of an adult bed

5.4 Safer sleep advice for parents caring for Twins or multiple births

Research conducted by Durham University's Parent-Infant Sleep Lab found no evidence that putting twins in the same cot in the early months increases their risk.

•It is not recommended that you co-bed in a Moses basket due to the limited space and the risk of overheating.
•In the early weeks, when your babies can't roll over onto each other, they can be placed side by side on their backs at the bottom of the cot in 'feet to foot' position (see above for explanation of the 'feet to foot' position)
•Another option is to sleep them at either end of the cot on their backs with their heads in the middle
•Follow all the same advice as for single babies - it applies to multiples, whether they are in a cot together or not
•It is particularly important that all the advice on reducing the risk of cot death is followed for babies who are born at a low birth weight (under 2.5kg or 5.5lbs) or were born before 37 weeks (multiples can often fall within this category)
•For triplets or higher order multiples, co-bedding all babies in the same cot while they are still small enough to fit is an efficient use of space. However, there has been no specific research undertaken on sleeping arrangements for triplets and higher multiples. If three or more babies are sleeping together, parents should be mindful of any size discrepancies and take note of whether the smallest one gets crowded by the others if placed between them
•If you choose to co-bed triplets and higher multiples, it is important to ensure that parents keep a very close eye on them, move them when they get more mobile. [64]

5.5 Supporting Advice for Professionals

Adult beds are not designed for babies and do not conform to safety standards for infant sleep location.

Only fully breastfed babies should ever be fed in bed, and if so, should be positioned on the outside of the bed and returned to the cot after the feed has finished.

Smoking is the biggest factor contributing to SIDS.

Babies should always be placed to sleep on their backs.

The safest place for babies to sleep is in their own crib/cot in their parents' bedroom, and with minimal covers or in a baby sleeping bag including tog rated sleeping bags.

To prevent babies from becoming overheated, suffocated or trapped:

- The cot mattress must be firm and flat.
- The room should be no hotter than 18 degrees C.
- Pets should not be left in a room with a sleeping baby

- Babies should never be left unsupervised on a bed
- Parents should never place babies to sleep on settees, or sleep with them on settees or armchairs, including 'make shift' sleeping arrangements.
- Babies should never sleep with other children
- If swaddling always use a light cotton sheet.

Babies and infants should never be left for long periods in travel systems or car seats. Please refer to manufacturers guidelines regarding the specific length of time recommended. Car seats / travel systems are not designed for babies and infants to sleep in; the safest place for a baby or infant to sleep is in a crib / cot.
The Lullaby Trust recommends that when babies roll onto their tummies that they are gently repositioned onto their backs up to the age of 6 months.

6.0 SAFE SLEEPING ASSESSMENT

An assessment tool to be completed by community professionals has been developed see appendix 1 with guidance on its use as follows:

6.1 Guidance for completion of Safe sleeping assessment

Locally and nationally around 60% of babies and infants who have died suddenly and expectedly over the last 5 years were sharing either a bed or sofa with a parent when they died. Ensuring that babies sleep in their own cot in a room with the parent/carer will reduce the incidence of babies dying in unsafe sleeping conditions.

Practitioners need to make themselves familiar with the contents of the following resources:

- Safer Sleep for babies: a Guide for Parents (The Lullaby Trust, 2013) http://www.lullabytrust.org.uk/document.doc?id=303
- Sudden infant Death Syndrome: a guide for professionals (2013)
- Easy Read Card (2013)

and the appropriate sections in:

- "The Pregnancy Book" (2014 edition Department of Health) pp129, http://www.publichealth.hscni.net/publications/pregnancy-book-0

- "Birth to Five" (2014 edition Department of Health) pp 26 27 http://www.publichealth.hscni.net/publications/birth-five

All parents/ carers should be made aware of how to access copies of these publications.

6.1.2 Acute Antenatal contacts

Practitioners who come into contact with pregnant women must give them anticipatory advice and guidance on safe sleeping for their expected babies. This must be documented in the maternal records.

6.1.3 Community Antenatal contacts

Antenatal contacts in the home could include observation of where the baby will sleep, together with appropriate anticipatory safe sleeping advice. This must then be documented in the maternal records or health visiting record.

6.1.4 Acute Postnatal contacts

Practitioners who come into contact with parents of babies and infants must ensure they are given, the relevant safer sleep information and assess their understanding of this information. . This must be documented in the appropriate records.

6.1.5 Community Postnatal Contacts

It is imperative that practitioners see where the baby is sleeping in order to give appropriate safe sleeping advice. This applies to day-time and night-time sleeping including offering advice regarding temporary sleeping arrangement eg, staying with family or holidays.

6.1.6 Safe sleeping assessment

The midwife will undertake a safer sleep assessment on the first postnatal visit. The midwife will observe where the baby sleeps for both day and night time sleeps, in order to ensure safe sleeping advice is given right from the outset. Also to reinforce advice given in hospital and maintain consistency for families to make safe decisions about where and how their baby sleeps.

The assessment must be completed in the Parent Held Child Health Record (Red Book page 16) Once the assessment has been completed the 2nd carbonated copy should be taken from the red book and filed in the baby's community midwifery hand held notes.

If the Midwife does not see where the baby sleeps then the reason why must be documented on the assessment form.

The Health Visitor will also perform the safer sleep assessment again at the new birth visit. The Health Visitor will also observe where the baby sleeps at the first home visit in order to ensure safe sleeping advice is given.

6.1.7 Safe sleeping assessment form

The form is designed to gather as much information about a baby's sleeping situation in order that appropriate advice is given. The assessment enables professionals to identify any concerns and to develop an action plan with the family to reduce the risk of SIDS. The assessment must be completed in full for every baby living in Staffordshire County irrespective of where they were born. For babies living outside of Staffordshire with a Staffordshire midwife. Community midwifes must complete the original assessment form. See appendix 2.

6.1.8 Completion of the safe sleeping assessment form

Practitioners must document the details of the baby. It would be good practice to document where the assessment took place in your records.
The sleeping place must be seen in order that appropriate advice is given. If the practitioner does not see and assess where the baby sleeps then this must be documented and the reason why; . Every effort must be made to observe where the baby sleeps.

The practitioner must see where the baby sleeps during the day time as well as the night time.

Practitioners must complete the assessment and document any concerns, this should also include the plan to reduce any risk. If any responses indicate an increased risk to the baby then the associations must be discussed as per NICE guidance 37; Routine postnatal care of women and their babies (NICE, 2014)[67.]

If this discussion does not take place the reason why must be documented.

6.1.9 Analysis
Clearly document how the baby's sleeping arrangements will impact on their health and well-being.

6.1.10 Action Plan
The action plan agreed must be clearly documented together with the time scales for completion of the plan which may include a STAFFORDSHIRE EARLY HELP ASSESSMENT (EHA) / CAF (Common Assessment Framework) or referral to Children's social care.

6.1.11 Midwives
When the safer sleep assessment has been completed and appropriate advice has been given, the 2nd carbonated page from the red book should be filed in the baby's community midwifery hand held notes.

6.1.12 Health Visitors
The safer sleep assessment will be repeated by the Health Visitor at the new birth visit. When the completed assessment of where the baby sleeps and appropriate advice has been given, the 3rd carbonated page from the red book will be filed with the Health Visitor Records.

If, following the safer sleep assessment parents/carers choose to have their baby sleep in bed with them or follow unsafe sleeping practices, they must be made aware of all the dangers noted on the assessment form, and It this must be documented in the Parent Held Child Health Record (Red book) and in the Health Visitor records, as per NICE guidance 37: Routine postnatal care of women and their babies(NICE, 2014)[67]

7.0 MONITORING COMPLIANCE

Monitoring of this guidance will be by joint annual audit between Midwifery services and Health Visiting colleagues employed in South Staffordshire and Stoke on Trent Partnership Trust.

There is a recommendation that a random selection of 50 assessments will be made and results monitored by the Directorate Community Liaison group.

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Safer sleep assessment in the red book

The Safe Sleep assessment

* Please place a sticker (if available) otherwise write in space provided.

Health professional assessment (signatures)

Midwife: .....

(Interpreter):.....

Date:...../...../.....

Health Visitor: .....

(Interpreter):.....

Date:...../...../.....

Surname:

First names:

NHS number: Unit no:

Address:.....

Post code:.....

D.O.B:...../...../.....

Sex: M / F

G.P: Code:

H.V: Code:

	(Further information can be entered on notes pages at back of record if needed)	Yes/No (MW)	Yes/No (HV)	MW: Any concerns identified? Plan to reduce any risk	HV: Notes on any concern / plan
1	Where did the baby sleep last night? Is this where baby normally sleeps? Where does baby sleep in the day? - Advice for the first 6 months				
2	Is baby placed on back to sleep?				
3	Is baby placed feet to foot?				
4	Is temperature of room/ clothing of baby as advised?				
5	Are soft toys and pillow avoided in cot with the baby?				
6	Do parent(s) or key carers ever sleep on a sofa or armchair with the baby?				
7	Do parent(s) or any key carers smoke?				
8	Do parent(s) or any key carers drink alcohol?				
9	Do parent(s) or any key carers take any drugs or medication?				
10	Have parent(s) /key carers considered safer sleep when away from home?				
11	Are parent(s) or key carers aware of signs that baby is unwell and know how to seek advice?				
12	**Health Professional:** Have you seen where the baby sleeps?				

Top copy remain in PCHR 2nd copy to Midwife 3rd copy to HV 4th copy to Child Health (if required)

16

The Safe Sleep assessment

Appendix 2

Safer sleep assessment tool for babies that reside outside of Staffordshire

NHS No……Post Code……

Baby's Name ……..DOB ……

Please Complete

1. Where did this assessment take place? ……		
2. Did you see where baby sleeps? (e.g. bedroom)	Y	N
3. Where does baby sleep at night? (e.g. cot) ……..		
4. Where does baby sleep during the day? ……..		
Consider. Are the above in line with FSID recommendations?	Y	N
Routine Questions		
5. Do you ever bring your baby into bed with you?	Y	N
6 Do you share your bed with anyone else?	Y	N
7. Do you smoke?	Y	N
If yes how many per day?.....		
8 Does your partner smoke?	Y	N
If yes how many per day?.....		
9. Do you take any medication/drugs?	Y	N
If yes please list……		
10. Does your partner take medication/drugs?	Y	N
If yes please list……		
11. Do you drink alcohol?	Y	N
If yes how much?……..		
12. Does your partner drink alcohol?	Y	N
If yes how much?……..		
Consider. Have you discussed the above risk factors?	Y	N
If No – give reason……		
Have you discussed the following safe sleeping issues?		
Back to sleep/feet to foot?	Y	N
Room Temperature / Suitable Bedding?	Y	N
Use of Dummies?	Y	N
Sofa/Car Seats?		Y
N		
What to do if baby unwell/has a temperature?	Y	N

Analysis - What risk factors have been identified during this assessment?

Action Plan – What is your Action Plan and what are the time scales?

Date Baby Discharged from Hospital……..

Completed by:…….. Date:……

Midwives file top copy in Parent Held Child Health Record (red book), 2nd copy to Maternal health Held record (" Purple Notes")
Health Visitors top copy in Health Visitor Records.

Appendix 3

Safe Sleeping Advice and Completion of Safe Sleeping Assessment