

Guidance to Support Safe Sleeping Practices in Babies and Infants

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Version Control

<i>This document is a multi-agency guidance document and it replaces all other previously published documents, including those within health.</i>				
Version	Author/s	Signed off by	Date	Review Date
1.	Liz Richardson	DSCB Policy and Procedures Group	February 2014	February 2016

1. Introduction

In response to new research evidence and the apparent rise in infant deaths in Derby City, Derbyshire County and nationally, Trusts are working together to implement appropriate and timely advice and information for all parents to promote safe sleeping practices for their babies and infants.

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.

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.

Community practitioners should offer advice on the relative risks of unexpected infant death for babies and infants sleeping alone or with their parents. 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.

2. Aims

- 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 safe 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 safe sleeping for all babies and infants
- To provide staff with evidence based research to support their discussions with parents.

This Guidance reflects Healthy Child Programme¹ Keeping children safe from injury and death and Article 24, of the Convention on the Rights of the Child² parts 2a: to diminish infant and child mortality and 2f: to develop preventive health care guidance for parents.

As best practice this information must be communicated to staff so they can give appropriate information and advice to parents to enable them to make an informed choice regarding safe sleeping arrangements for their babies and infants. All parents will be given the opportunity to discuss safe sleeping arrangements on a one-to-one basis with Community Health Practitioners, and encouraged to seek further advice should their circumstances change.

3. Background

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.*

Reducing the risk of Sudden Infant Death Syndrome (SIDS)

The only population-based prospective study of bed-sharing and SIDS published so far was done in England⁴. 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 65}. 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 infants⁵³.

4. 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 an 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; and
- 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 sofa⁵⁴.

4.1 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, 65}.

4.2 Cigarette smoking

Studies have demonstrated a significantly increased risk of SIDS⁶⁵ 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, 65}. Babies and infants therefore should never bed-share with carers who smoke, no matter how many cigarettes, or where they smoke, *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, 65} compared with infants of smoking mothers who do not bed-share⁴⁰. Thus bed-sharing poses a risk whether parents / carers smoke or not.

4.3 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.

4.4 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, 65}.

4.5 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 further²⁷.

4.6 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 infants⁴⁴. Placing infants to sleep in adult beds should be discouraged⁴⁵ and infants should sleep in a cot that conforms to national safety standards⁴⁶.

4.7 Daytime sleep

Blair et al⁴⁷ 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 safe sleep messages apply to daytime sleep as well as night-time sleep.

4.8 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 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 one⁵¹.

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 breastfeeding⁶². 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 lactation⁶⁴.

UNICEF recommend 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.

5. Guidelines for health Staff to support safe sleeping practices in babies and infants

Midwifery and Health Visiting Team members have a responsibility to ensure parents receive the following information:

1. Parents will be advised that it is **not** safe for babies and infants to sleep in an adult bed.
2. ***The safest place for a baby to sleep is always in a Moses basket or cot in the parents' room for the first six months.***
3. Parents will be advised not to bed-share if their baby was born premature or low birth-weight or has a temperature / fever.
4. The Midwife should complete the initial safe sleeping assessment (see Appendices 1- 3) following the birth and give the form to the Health Visitor at the formal handover or inform the Health Visitor if this has not been completed. If not completed by the Midwife, the Health Visitor will complete the assessment at the first visit. The completed assessment form should be placed in the child health record.
5. Following completion of the assessment, any identified needs should be addressed and the action plan completed.
6. If there is any doubt as to either parent's understanding then a Review of Parental Awareness (Appendix 4) must be carried out and safe sleeping messages reinforced.
7. Midwifery and Health Visiting Team members will regularly review the baby's feeding and give advice on safe sleeping practices. This will be documented in the Parent Held Record.

8. The completed assessment form is part of the clinical record and will be included in routine record keeping audits.
9. **At all contacts** parents should be asked if there is any change in their baby's sleep circumstances and if they are having any difficulty following the Lullaby Trust safe sleeping advice. This must be followed by appropriate advice and guidance.
10. Midwifery and Health Visiting Team members should ensure that parents are aware of useful resources including "[Safer Sleep for Babies](#)"²⁹, "[Reduce the risk of Cot death](#)"⁶⁶ and "[Caring for your baby at Night](#)"²⁸ (image on page 7). Parents may also wish to view the Department of Health video "[Where should my baby sleep](#)".



The evidence:

- There is **no evidence that bed-sharing reduces** the risk of SIDS^{39, 40}.
- Sleeping on the back in a cot in the same room as carers carries the lowest risk of SIDS^{30, 31}.
- Room sharing lowers the risk of SIDS^{4, 32, 65}.
- The risk of SIDS is increased by 5 times in breast feeding babies when sleeping in bed with a carer/s **who do not smoke or have any other risk factors**⁶⁵.
- The risk of SIDS is significantly increased when infants bed-share with mothers who smoke cigarettes^{4, 21, 32, 68}.
- Risks associated with bed sharing are greatly increased when combined with parental smoking, maternal alcohol consumption and / or drug use⁶⁵.
- Bed-sharing with an adult who is extremely fatigued or impaired by alcohol or drugs (legal or illegal) that impair 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 death²⁶.

- Bed sharing with an ill baby or a baby with a high temperature increases the risk of infant death²⁷.
- Breast-feeding is always best for babies but sharing a bed, even if there are no recognised factors, carries a risk^{4, 25, 32, 35, 39, 40}.
- There is no increased risk for breast-fed babies who are taken into the parents' bed to feed or comfort provided the infant is returned to his or her own cot^{4, 35}.

Midwifery and Health Visiting Team members 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.

If breast feeding parents indicate that they intend to bed share, then a copy of the joint “Caring for your baby at night” leaflet²⁸ must be given to the parents. 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 / pods / nests or other marketed sleep equipment will need to be addressed for both practices to ensure these types of accidents do not occur.



6. Multi-agency guidelines to support safe sleeping practices in babies and infants

Check that a safe sleep assessment completed by health has taken place at the address where the baby is sleeping. If a safe sleep assessment has not taken place and the baby is not yet six months of age then a referral to the relevant Midwife or Health Visitor should be made.

Safe sleeping advice for all staff 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:

- It is recommended that the safest place for your baby to sleep is in a moses basket or cot in your room for the first six months.
- **NEVER** share a bed with your baby if you or your partner;
 - are smokers (no matter where or when you smoke)
 - have been drinking alcohol
 - used any illicit substances
 - are unwell
 - take medication or drugs that make you drowsy
 - 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.
- 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 small risk that;
 - your baby could die of SIDS
 - you might roll over in your sleep and suffocate your baby
 - your baby could get caught between the wall and the bed
 - your baby could roll out of an adult bed.

7. Baby and infant sleeping equipment

Midwifery and Health Visiting Team members, as well as multi-agency partners, need to be aware that there are many items of baby and infant sleeping equipment sold via the internet e.g. “sleep nests”, “sleep pods”, cocoons and sleeping bags that may be dangerous for babies. It is good practice to promote the use of equipment carrying recognised symbols of quality and safety e.g. The BSI Kitemark™ and CE mark indicating a product’s compliance with EU legislation.

Supporting advice

- 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 Sudden Infant Death Syndrome (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 sleep bag.
- 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.
- Babies should never sleep with other children.
- If swaddling always use a light cotton sheet.
- Babies and infants should never be left to sleep for long periods in travel systems or car seats.
- The Lullaby Trust recommends that babies are gently put back onto their backs up to the age of 6 months.

Appendix 1: Sleeping Assessment Safe Sleeping Practice
(To be used by Midwives and Health Visitors only)

Baby's Name:

DOB:

NHS No:

Postcode:

Please complete

1. Where did this assessment take place?		
2. Did you see where the baby sleeps e.g. bedroom?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
3. Where does the baby sleep at night?		
4. Where does the baby sleep during the day?		
5. Consider: are the above in line with FSID recommendations?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Routine questions		
6. Do you ever bring your baby to bed with you?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Do you share your bed with anyone else?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. Do you smoke? If yes, how many per day?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
9. Does your partner smoke? If yes, how many per day?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
10. Do you take medication / drugs? If yes, please list:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
11. Do you drink alcohol? If yes, how much?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
12. Does your partner drink alcohol? If yes, how much?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13. Consider: have you discussed the above risk factors? If no, give reason:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Have you discussed the following safe sleeping issues?		
14. Back to sleep / feet to foot?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
15. Room temperature / suitable bedding?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
16. Use of dummies?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
17. Sofa / car seats?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
18. What to do if baby unwell / has temperature?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Analysis What risk factors have been identified with this assessment?
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Action Plan What is your action plan and what are the timescales?
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Date baby discharged from hospital:		
Completed by:	Designation:	Date:

Appendix 2: Reducing the risk of babies dying in unsafe sleeping conditions Guidelines for Midwives and Health Visitors to aid the completion of a safe sleep 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. In Derby and Derbyshire at least 4 - 5 babies a year are dying in unsafe sleeping situations and therefore probably preventable deaths. 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.

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

- “Guidance to support safe sleeping practices in babies and infants” (2014), Derby and Derbyshire Safeguarding Children Boards’
- “Reduce the risk of cot death” (March 2009), Department of Health
- Safer sleep for babies; A guide for parents (2013) Lullaby Trust
- Safer sleep for babies; easy read card (2013) Lullaby Trust
- Sharing a bed with your baby (2011) UNICEF UK/FSID

1. Antenatal Contacts

Midwifery and Health Visiting Team members 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 and health visiting record.

In the community: 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. Multi agency partners to promote safe sleeping for all babies and document in appropriate records.

2. Postnatal Contacts

Midwifery and Health Visiting Team members who come into contact with parents of babies and infants must ensure they are given, and understand, information on how to ensure the safe sleeping of their babies and infants⁶⁷. This must be documented in the appropriate records. Where there are doubts about parents’ understanding then a Review of Parental Awareness must be carried out and the results documented in the Parent Held Child Health Record (Red book) and appropriate health record.

In the community: It is imperative that all Midwifery and Health Visiting team members and multi agency partners see where the baby is sleeping in order to promote safe sleeping of babies and infants. This applies to day-time and night-time sleeping.

3. Safe sleeping assessment

The Midwife will undertake a safe sleeping assessment by observing where the baby sleeps at the first post-natal home visit, in order to ensure safe sleeping advice is given right from the outset and reinforces advice given in hospital. The assessment form must be completed and the top copy sent to the Health Visiting team and a copy for the maternal records. If the Midwife does not see where the baby sleeps then the reason why must be documented on the assessment form and the Health Visitor informed promptly. Where there are doubts about either parent’s understanding then a Review of Parental Awareness must be carried out and the results documented in the Parent Held Child Health Record (Red book) and appropriate health record.

If the Midwife has not assessed where the baby sleeps then the Health Visitor must carry out the assessment at the primary birth visit. The Health Visitor will undertake a sleeping assessment by

observing where the baby sleeps at the first home visit in order to ensure safe sleeping advice is given.

4. 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 format requires Midwifery and Health Visiting Team members to indicate yes / no answers and also add free text. This must be completed in full for every baby living in Derby City and Derbyshire County irrespective of where they were born. It is imperative that anyone who completes a safe sleeping assessment sees where the baby is sleeping in order to promote safe sleeping of babies and infants and give appropriate advice.

5. Completion of the safe sleeping assessment form

Midwifery and Health Visiting Team members must document the name of the baby, the baby's age and where in the home the assessment took place.

The sleeping place must be seen in order that appropriate advice is given. If the Midwifery or Health Visiting Team member does not see and assess the where the baby sleeps then they must document the reason why, and document what action is to be taken to ensure this happens as soon as possible.

Every effort must be made to observe where the baby sleeps. The Midwifery and Health Visiting Team members must see where the baby sleeps during the day time as well as the night time.

Midwifery and Health Visiting Team members must complete the assessment and document the responses including whether or not these are in line with the Lullaby Trust's recommendations. If any responses indicate an increased risk to the baby then the risk factors must be discussed. If the risk factors are not discussed the reason why must be document on the form.

6. Analysis

All risk factors identified in the assessment must be clearly documented.

7. Action Plan

The action plan agreed must be clearly documented together with the time scales for completion of the plan. Where there are emerging needs the plan may include an early help assessment. If there are serious / complex needs or child protection concerns a referral must be made to Children's Social Care.

8. Midwives

When the sleeping assessment has been completed and appropriate advice has been given, the form must be sent to the Health Visitor. It must also be documented in the Parent Held Child Health Record (Red book) that the assessment has been completed together with the advice given.

9. Health Visitors

When the completed assessment of where the baby sleeps and appropriate advice is given, the form must be filed in the electronic child health records. It must also be documented in the Parent Held Child Health Record (Red book) that the assessment has been completed together with advice given.

10. Parents who chose to have their baby sleep in bed with them

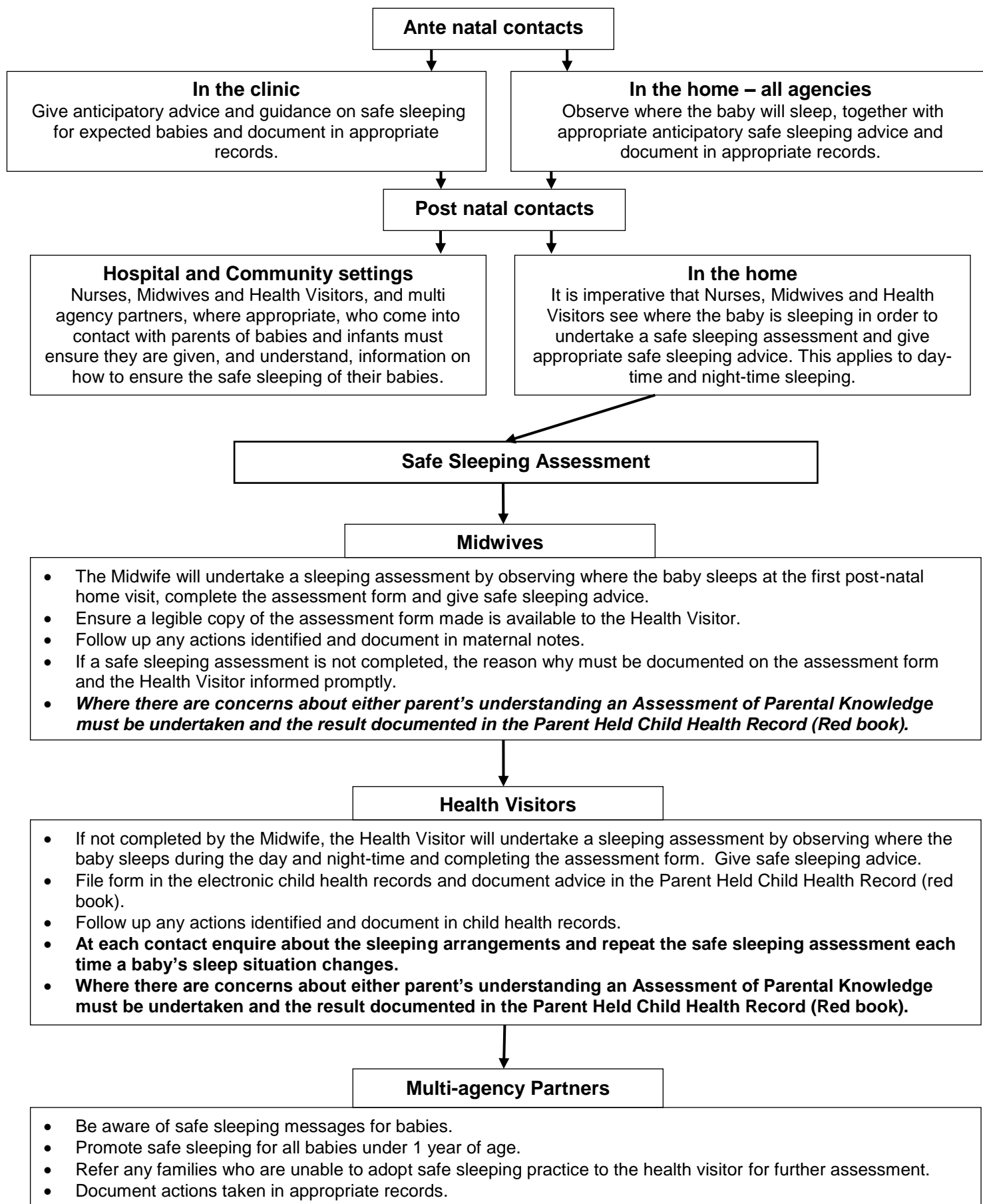
If, following the safe sleeping assessment parents / carers choose to have their baby sleep in bed with them, they must be made aware of all the dangers noted on the assessment form, together with the possibility of them rolling over and suffocating the baby, the baby becoming caught in or under bedding and pillows, and of the baby falling out of the bed or getting trapped between the bed and the wall. It must be documented that this advice has been given in the Parent Held Child Health Record (Red book) and in maternity or electronic child health records.

Where any risks have been identified they must be documented in the Parent Held Child Health Record, together with advice given, and supported with the UNICEF leaflet²⁸.

11. Multi-agency partners

Multi agency partners must be aware of safe sleeping messages and promote safe sleeping for all babies. They must refer those families who are unable to follow safe sleeping guidelines to the Health Visitor for further assessment and advice.

Appendix 3: Safe Sleeping Advice and completion of safe sleeping assessment



Appendix 4: Keeping Infants and Babies Safe; Review of Parental Awareness
(For use by Health Visitors only, when working with parents with learning disabilities)

1. Safe Sleeping Awareness

Advice	Aware without prompting	Awareness only when prompted	Not aware	Record verbatim parent's understanding of reason for this advice
Sleeping position (on back, NOT front or side)				
Co-sleeping				
Risks of smoking				
Sleeping feet to foot				
Not overheating				
Use of dummy				
Cot and mattress				

2. What are parents' plans for controlling cigarette smoke exposure?

Mother

Father

Other carers

Other visitor's to the house?

3. What plans do parents have for overcoming any problems they have with following the safe sleeping advice?

4. What will parents do if baby doesn't settle at night when they are implementing the safe sleeping advice?

5. Recognising illness

	Response from parents using their words / language	Checklist
How would parents know if their baby was unwell?		<ul style="list-style-type: none"> • Off feeds • Sleepy • Persistent vomiting • Change in bowel habits • Crying more than usual • Screaming • Fewer wet nappies
What would parents do if their baby became unwell?		<ul style="list-style-type: none"> • Seek advice from more experienced parents • Speak to health visitor • Call doctor • Take to emergency department

Analysis What risk factors have been identified with this review?

Action Plan What is your action plan and what are the timescales?

Completed by:	Designation:	Date:
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Appendix 5: References

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