Children's Hospital and Health System
Patient Care Policy and Procedure

This policy applies to the following entity(s):

☒ CHW- Milwaukee ☒ CHW -Fox Valley ☒ CHW - Surgicenter

SUBJECT: Infant Safe Sleep

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DEFINITIONS

Infant: An infant (for this policy and procedure) is defined as a child less than one year of age.

SIDS: The sudden death of an infant younger than one year of age that remains unexplained even after autopsy, a death scene investigation and thorough review of the clinical history are conducted[2]. The leading cause of death for infants 1-12 months of age[5]. Approximately 3500 infant deaths are related to SIDS in the United States annually[5].

Original: 12/04
Revised: 08/25/2015
Effective: 05/16/2018
Infant Safe Sleep/Process Owner: APN NICU

POLICY

1. Uniformly implement and model the American Academy of Pediatrics (AAP) recommendations regarding safe sleep in order to keep infants safe in the hospital setting and model and educate best practices to families within the organization [5].
2. Model safe sleep to caregivers.
3. Promote developmentally appropriate care to all hospitalized infants, including premature and ill term infants.
4. Identify exclusions to supine positioning (See below for exceptions).
5. Caregivers must be awake while holding the infant.

PROCEDURE

I. Sleep Position

All hospitalized infants will be placed alone, in a crib, and supine to sleep, regardless of time of day, per the AAP recommendations, unless an exception is noted[5]. (See Toolkit below for exceptions)

- Premature infants will be transitioned to a safe sleep environment as developmentally appropriate, as soon as possible, prior to discharge. Infants should have recovered from respiratory distress syndrome (RDS) and should be without tachypnea, apnea and bradycardia requiring intervention. (See Toolkit for Developmentally Appropriate Positioning and Transitioning a Previously Ill Infant to Safe Sleep)[5]. This transition should occur by 34 weeks corrected gestational age, unless PT/OT or provider exception is noted.
- All caregivers of hospitalized infants will be screened on admission and prior to discharge for a safe sleep environment for the infant.
    - Staff will ask caregivers “where does/will your baby sleep?” If they do not have a safe sleep environment, a social work consult should be ordered.
- All caregivers will be taught rationale for safe sleep.
- Infants should always be placed supine to sleep; alternative positions are acceptable once an infant can roll themselves or if an exception is noted.

II. Exceptions to a Safe Sleep Environment:

Some infants may benefit from alternative positioning, including prone, during sleep.

These exceptions include but are not limited to:

- Supine position causes medical or neurobehavioral instability.

- Any symptomatic infant with signs of respiratory distress (increased work of breathing, apnea or tachypnea), with or without assisted ventilation, or poor digestion for whom prone positioning is clinically beneficial.
- Asymptomatic, very low birthweight preterm infants (<1250 grams) for whom alternative positioning provides a respiratory and developmental advantage[5].
- Infants that are in a Giraffe bed, isolette or radiant warmer.
    - Exception: a small blanket, with mother's scent, can be placed in a premature infant's sleep environment when in a warmer or incubator, to promote bonding.
    - Infants in specialty warming beds can still be in a safe sleep environment, in a bed free of items, despite their position to model this behavior for families early on.
- Intubated infants who need their head of bed (HOB) elevated for VAE (ventilator associated events). Trach/vent dependent patients who are on the discharge home track will have HOB flat. The bed should be free of all items.
- Infants with severe gastroesophageal reflux who show improvement when placed on their left side or prone.[7]
- Infants with birth defects for whom the supine position would be contraindicated (such as children with neural tube defects or Pierre Robin sequence).
- Infants with risk for skin breakdown (such as neurologically compromised infants).
- Infants that require alternative positions, as determined by a provider or PT/OT. Nursing communication must be in electronic health record (EHR).
- If an infant cannot be placed supine after discharge home, a medically provided monitor is required.

III. Sleep Surface

- Cribs and bassinets will have only a tightly fitted sheet or thin blanket, unless contraindicated for skin integrity[9].
- Crib railings will be raised whenever the child is in the bed, except when care is being delivered. [5]
- Infants may never sleep on a couch, recliner, cushioned chair, soft mattress, pillow, or any other soft object[9].
- Loose bedding and soft objects should not be in the crib[9.]
- Swaddling, with a lightweight, cotton blanket is appropriate and acceptable for infants who cannot roll [5] (See Swaddling Guidelines and Tips addendum). Any additional blankets must be securely tucked under the mattress [5].
- Developmental positioning devices should not be used when infant meets safe sleep environment criteria [9]. (See Toolkit for Swaddling Guidelines and Tips and the Use of Developmental Positioning Devices)
- Hospital staff will model a safe sleep environment to families [9].
- Infants will be placed in alternative positions, such as tummy time, while awake and supervised [5] (See Toolkit for tummy time tips and plagiocephaly prevention).

IV. Overheating and Bundling

Hospital staff will avoid overheating infants[9]. Hats should be removed as soon as thermoregulation has been achieved by the infant[11]. (See Infant Thermoregulation Policy and Procedure, and Toolkit for Swaddling Guidelines and Tips)

V. Other Guidelines

- Hospital staff will educate families about safe sleep, on the rationale, and the importance of tummy time to play. Verbal teaching, demonstration, written National Institute of Health (NIH) brochure and Safe Sleep video should all be used. Families will teach back to staff to show their understanding. Staff will document family teaching in the education record of EHR. (See Toolkit for tummy time tips and family talking/teaching points)
- Swings and infant seats are not to be used for overnight sleeping[11].These devices are to be used for short periods of time, while supervised[11]. If the infant falls asleep in the swing or infant seat, they should be transitioned back to the crib as soon as possible[11].
- Breastfeeding, immunizations, and the use of pacifiers will be encouraged by hospital staff to prevent SIDS, unless exceptions are noted [5]. (See Toolkit for detailed information on SIDS prevention)
- Bed-sharing and co-sleeping are not allowed within the hospital [5] (See Safe Sleep Chain of Command in Toolkit if family refuses to oblige). If a parent is found sleeping with an infant, the infant will be placed in their crib, and family will be re-educated. Room-sharing should be encouraged [11] (See Toolkit for SIDS Prevention and Details).
- Alternative positioning should be used when infant is awake and supervised. Tummy time should be encouraged during this time.

VI. Family Education (See Addendum H for further details)

Safe Sleep education to families should occur with **all** infants on admission, upon transition to safe sleep, and prior to discharge.

1. Model safe sleep to families.
2. Provide family with safe sleep education. Below are suggested references to guide teaching
    - *Safe Sleep for Grandparents and Other Trusted Caregivers* video.
    - *Safe Sleep for Your Baby: Reduce the Risk of SIDS and Other Sleep-Related Causes of Infant Death* (General Outreach) brochure.
    - "I Graduated to Safe Sleep Certificate" to be posted at the bedside, as a visual cue for staff to know teaching has been done. (See Appendix D)

3. Discuss the importance of a safe sleep environment and provide rationale to caregivers.
4. Have family perform teach back on safe sleep principles including on their back, alone, and in a crib.
5. Document family education, what resources were used, and what materials were given to family in the EHR, in patient education.

VI. References

1. DandelLION Medical. (2009). *DandleROO2*. Retrieved from http://www.dandlelionmedical.com/products/dandle-roo2/
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5. Moon, R & AAP Task Force on Sudden Infant Death Syndrome. (2016). SIDS and other sleep-related infant deaths: evidence base for 2016 updated recommendations for a safe infant sleeping environment. *Pediatrics, 138*(5). doi.10.1542/peds.2016-2940
6. Phillips Newborn Solutions. (2017). *Positioning training quick tips*.
7. Schurr, P. & Findlater, C. (2012). Neonatal Mythbusters: Evaluating the Evidence for and Against Pharmacologic and Nonpharmacologic Management of Gastroesophageal Reflux. *Neonatal Network, 31*(4), pp 229-241.
8. Sweeney, J & Gutierrez, T. (2002). Musculoskeletal implications of preterm infant positioning in the NICU. *Journal of Perinatal & Neonatal Nursing*, 16(1), 58-70.
9. Voos, K., Terreros, A., Larimore, P., Leick-Rude, MK., & Park, N. (2015). Implementing safe sleep practices in neonatal intensive care unit. *The Journal of Maternal-Fetal & Neonatal Medicine, 28*(14), 1637-1640. doi: 10.3109/14767058.2014.964679
10. Ward, S. & Balfour, G. (2016). Infant safe sleep interventions, 1990-2015: A review. *Journal of Community Health, 41*(1), 180-196. doi: 10.1007/s10900-015-0060-y
11. Zachritz, W., Fulmer, M., & Chaney, N. (2016). An evidence-based infant safe sleep program to reduce sudden unexplained infant deaths. *American Journal of Nursing, 116*(11).

Approved by the Joint Clinical Practice Council April 16, 2018

TOOLKIT

Addendum A - SIDS Prevention and Details

- The American Academy of Pediatrics (AAP) recommends **supine** sleeping as an intervention to decrease the risk of sudden infant death syndrome (SIDS) in healthy, term infants (≥ 37 weeks)[5]. Supine sleeping is also recommended for Preterm infants (<37weeks) who have recovered from respiratory distress syndrome (RDS) and who are asymptomatic (without tachypnea, apnea, bradycardia requiring intervention)[5].
- Evidence does not support the use of **commercial devices** marketed to decrease the risk of SIDS[5].
- Evidence does not support the use of **home monitors** to decrease the risk of SIDS [5]. Medically fragile infants sent home in the prone position require medically provided home physiologic monitoring.
- The AAP recommends that infants are **immunized** [5]. Immunized infants are half as likely to die from SIDS [5].
- **Breastfeeding** is recommended and is associated with a reduced risk of SIDS[5].
- Placing an infant prone or left side-lying does reduce the incidence of **reflux**; however, the risk of SIDS is significantly greater than that of reflux[5].

Addendum B - Transitioning a Previously Ill Infant to Safe Sleep Environment

Developmentally Supportive Positioning: for infants < 37weeks gestation or physiologically compromised monitored infants

Purpose: Support normal growth and development, provide physiologic flexion, prevent torticollis, and protect the premature infant's musculoskeletal system.

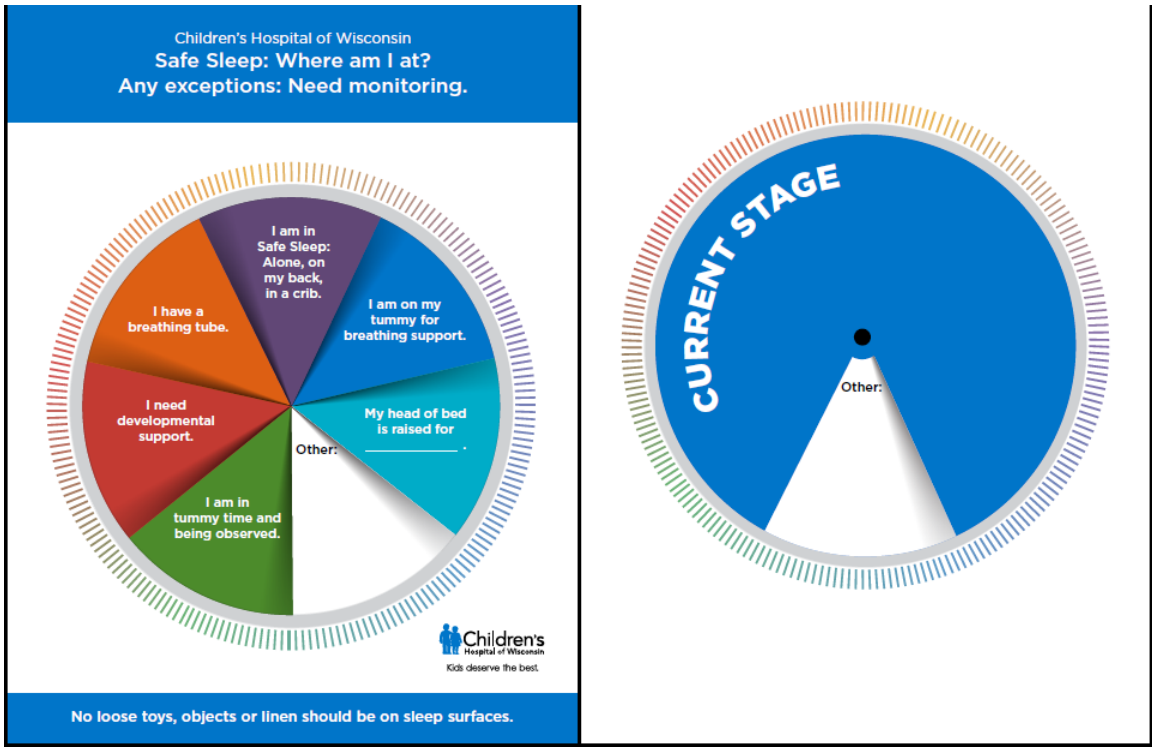
1. Monitored infants requiring intensive care should be positioned with appropriate developmental and positional support in supine, side lying or prone position depending on gestational age, acuity of illness and medical diagnosis.
   a. All immobilized, sedated, or paralyzed, infants need to be repositioned to prevent skin breakdown.
2. Principles of developmental supportive positioning:
   a. Neonatal positioning is used to position high risk, preterm or medically unstable neonates in a manner that promotes physiologic, neuromuscular and neurobehavioral development.
   b. Premature infants have an inability to change static posture which may result in muscle imbalance and positional deformities.
   c. In addition, medically unstable near-term and full-term neonates with hypotonia, caused by illness severity or sedation, are at risk for positioning deformities, muscle shortening, and contractures of the muscles.
   d. Possible complications stemming from developmental immaturity and restricted movement include frog legs, W position of the arms, neck extension, arching postures, head molding and torticollis [3, 4].
   e. All positioning (correct and incorrect) has an ongoing impact on the developing neuromotor, physiologic, and neurological status of the preterm and/or compromised infant[6].
   f. Every positioning option (supine, prone, side lying) has both medical and developmental advantages and disadvantages.
   g. Always turn head and entire body as a unit.
   h. To avoid neck flexion use small neck roll under the shoulders.
   i. Handle infant gently, avoiding sudden changes in posture.
   j. Developmentally supportive positioning:
      i. Promotes physiologic flexion through positioning of infant and provision of supportive equipment and boundaries. Containment touch- boundaries are provided using positional devices and support such as bendy bumper, snuggly, and frogs.
      ii. Maintains head, trunk and pelvic alignment in all positions.
      iii. Promotes midline forward positioning of arms and legs. Arms, legs and feet are flexed and tucked toward midline of trunk in all positions.
      iv. Promotes infant's self-regulatory efforts (to stay calm and steady) such as hands to mouth, flexed and tucked trunk and extremities.
      v. Supports respiratory stability.

When infant no longer requires positions, other than supine, to maintain physiologic stability, they should be transitioned to a safe sleep environment[5]. This environment should be in a flat crib, alone, on their back without anything in the crib with them [5]. This transition should occur well before discharge to model safe sleep practices for families[5].

Transitioning Tips:

- Developmental positioning tools should be discontinued at the time of transition, unless ordered by PT/OT [9].
- No positioning tools should not be used once transitioned to a safe sleep environment [9].
- Transition should occur when the infant no longer displays signs of respiratory distress, symptomatic gastroesophageal reflux, or the need for developmental support [5].
- This transition should occur as soon as possible, at least 2 weeks prior to discharge.
- Dress infants when medically stable.
- While every infant is different, begin assessing for supine readiness at 32 weeks [5]. Ideally, this transition will occur prior to 34 weeks. An exception may be noted by PT/OT or a provider.
- Hats should only be used during the wean from an isolette and should be discontinued as soon as they have proven to be normothermic out of the isolette[10].
- Do not use fleece bedding, fleece sleepsacks, or fleece blankets as they prevent air exchange and can cause overheating. Fleece may be used to cover an incubator.
- Turn Safe Sleep Wheel to “I am in Safe Sleep”.

Addendum C - Safe Sleep Wheels



Addendum D - Safe Sleep Certificate

Please print certificate on next page and hang at patient's bedside when infant transitions to a safe sleep environment.

I Graduated to Safe Sleep Today

I can now sleep on my back, in a crib, by myself!

Patient's Name

Today's Date

Children's Hospital of Wisconsin

Kids deserve the best.

Addendum E - Appropriate Use of Developmental Positioning Devices

Positioning devices should be used in the hospital to support developmental care and prevent muscular skeletal problems. These devices should never be used in the home environment.

Gel pillows and specialty mattresses do not support safe sleep, however, are appropriate for infants with impaired skin integrity (See Skin Integrity Maintenance Policy for details).

The following are the manufacturer recommendations and guidelines for developmental positioning tools. Children's Hospital staff are to follow these guidelines, unless other recommendations are provided by PT/OT[6]**.**

❖ SnuggleUP

❖ "Bum to bottom" – Infant should be tucked deep into the SnuggleUp- not necessarily aligned with straps (once boundary is in place, the straps should be in a proper position)

❖ Ensure proper sizing- if kicking legs over, either they aren't deep enough in SnuggleUp pocket or they need to go up a size.

- ❖ Straps should be snug, but not so tight that they restrict movement. This is designed so infant can extend arms out, touch a boundary, and come back to flexed midline.
- ❖ No t-shirts or blanket rolls to support legs or hips- infant needs to be deeper in the pocket
- ❖ Use Bendy rather than blanket roll to support from shoulder to hip to maintain appropriate alignment.

❖ Bendy Bumper

❖ Bendy Bumpers are designed to mimic the womb by providing a boundary that the infant can extend into and that provides a recoil so the infant can come back to a flexed position.

❖ This is ideal for assisting with development of physiological flexion and muscle tone.

- ❖ Seam goes on the bottom (best trick is to be mindful when putting on the cover so the cover's seam is also on the bottom)
- ❖ Ensure correct size is used with Prone Plus- Height of Bendy Bumper is the deciding factor- it should be taller than infant. Enough so that if the infant does a "pushup", he will not be able to roll on top of the Bendy
- ❖ Bendy can be folded in any position to meet the baby's needs. But must be stored straight to maintain the life of the internal iron rod.

❖ Freddy Frog

❖ Weighs **1 pound**- under no circumstances should the entire weight be placed on the infant.

❖ Should never be used in place of a prone positioner.

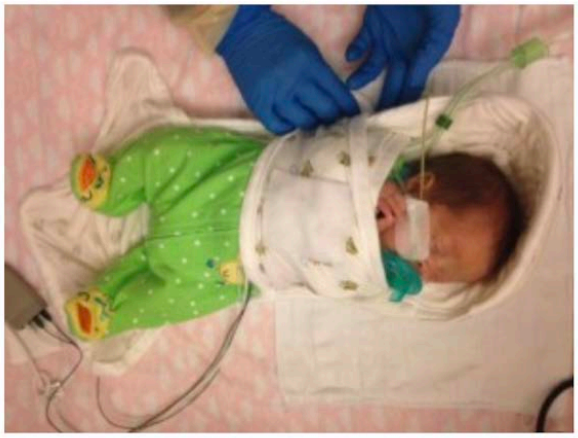
❖ Avoid having a large amount of beads across the chest or back.

- ❖ Use "legs" as comforting hands to calm baby or to assist with procedures.
- ❖ Can act as additional side roll to support infant in side lying position
- ❖ Use "legs" around the head to keep midline.

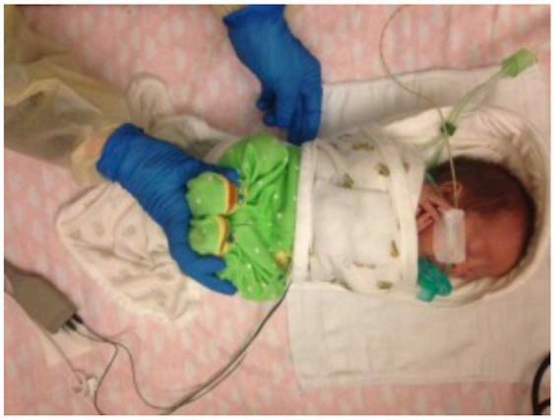
Recommendations for Roo2 positioner devices[1]:

How to use the ROO2

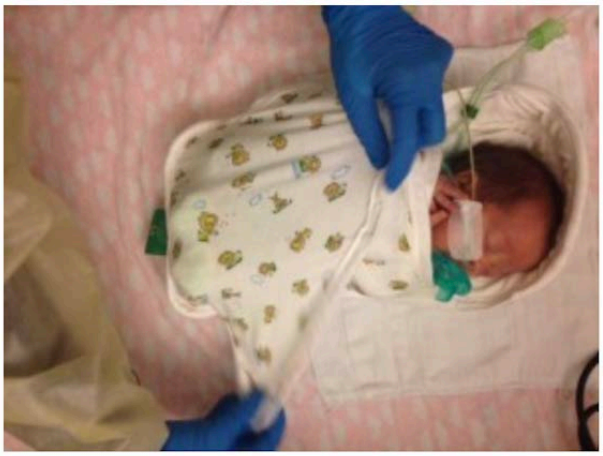
1: Place baby in the ROO2 with the head touching the headroll. Put hands to face and pull first the short wing over the chest, ensuring shoulders are rounded forward, then the longer wing and attach Velcro to the back.



2: Pull hips into a pelvic tilt (approximately a 90° angle) and hold in that position using the multi-purpose roll.



3: Pull up the pouch, keeping legs flexed, attach to the wing and the back.



Addendum F - Swaddling Guidelines and Tips

1. Swaddling should be done with a lightweight cotton blanket. The blanket is not to be above the shoulders and the arms should be free to get hands to mouth to support self-regulation [11].
2. Goal is to have flexed and tucked lower extremities (and infant's shoulders wrapped to support arms forward into flexion) (See photo 1 for example) [11].
3. Swaddling must be discontinued once the infant can roll to prevent any suffocation risk [5].
4. Monitored infants in the NICU, who cannot roll, may need an additional blanket to maintain temperature in the hospital environment (if the room temperature cannot be well controlled[5]. Hyperthermia should be avoided [5].
    a. The blanket should be tucked at the foot of the mattress and not reach beyond the infant's chest so that the infant's face is protected from being covered. Do not use this method if the infant has the ability to move under the blanket (See photo 2 for example of correct blanket placement).
5. A covered face, even in the supine position is considered a risk factor for SIDS. Loose blankets should not be used to cover an infant's face as a comfort modality [5].
6. Infants should be dressed appropriately, with one layer more than an adult.
7. Fleece bedding and blankets should not be used to avoid overheating.
8. Hats should only be used during initial wean from isolette to avoid a potential loose object in the bed[11]. Loose objects in the crib can cause suffocation [5].

Photo 1:

Photo 2:

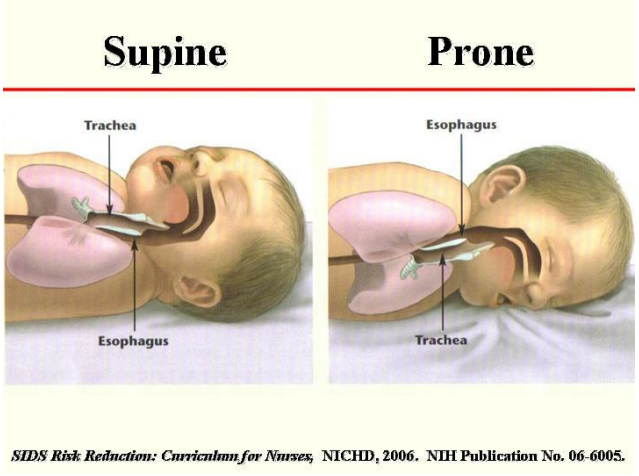
Addendum G - CHW Teaching Sheets

1. **Back to Sleep/ Tummy to Play #1087**
2. **Infant Head Shape #1220**
3. **Safe Use of Infant Play Equipment #1013**

Addendum H - Family Teaching and Talking Points

Sleep Position:

- Side and prone sleeping are no longer recommended by the AAP [5].
- Lying flat, on the infants back does not increase the risk for aspiration [5].
    - When a baby is supine, the trachea lies on top of the esophagus. Anything regurgitated or refluxed from the esophagus must work against gravity to be aspirated into the trachea.
    - Conversely, when baby is in the stomach sleeping position, anything regurgitated or refluxed will pool at the opening of the trachea, making it easier to aspirate. (on teaching sheet #1258)



- Patients will transition to a safe sleep environment as soon and developmentally and physiologically appropriate (See Transitioning a Previously Ill Infant to Safe Sleep in Toolkit) [5].

Teaching Points:

- Demonstrate, model and have parents do teach back of safe sleep positioning at time of transition to safe sleep environment[5].
- Emphasize the need for families to teach other caregivers the importance of a safe sleep environment.
- Use Safe Sleep Wheel as a visual tool.
- The risk of SIDS is significantly higher in infants that sleep in positions other than supine.
- Once an infant can roll, the infant is allowed to remain in whatever position they put themselves in [5].

Sleep Surface:

- Crib or bassinet mattress should be firm[5].
- Tightly fitted sheets should be used[5].

Teaching Points:

- Soft surfaces such as a couch, recliner, cushioned chair, soft mattress, pillow, or any other soft object are not appropriate sleeping surfaces for an infant.
- Infant seats, swings, and other seated devices are not recommended for sleep and are for occasional use while awake.

Bedding:

- Only a fitted sheet should be used [5].
- No soft blankets or loose bedding [5].
- Infants may be swaddled in a light, cotton blanket (See Swaddling Guidelines and Tips in Toolkit for more information) [5].
- Sleep sacks or wearable blankets are acceptable [5].

Teaching Points:

- No bumper pads, stuffed animals or toys should be in the crib
- Additional quilts, blankets, and other soft materials should not be used in a crib at home.

Smoking, Drugs and Alcohol:

- Keep infant away from secondhand smoke [5].
- Avoid alcohol and other drug use when caring for infant [5].

Teaching Points:

- Wash hands after smoking and before touching the infant.
- Change clothing or use a gown if clothing smells of smoke to protect the infant from second-hand smoke.
- Encourage families to have a smoke-free home and smoke outdoors if necessary.
- Sleep deprivation, in combination with alcohol drug use, puts the infant at risk.

Sleep Environment:

- Room sharing is recommended [5].
- Infants should be close, but in a separate sleep area, like a portable crib or basinet [5].

Teaching Points:

- Bed-sharing with anyone, including parents/caregivers, siblings, or multiples is not safe and against the AAP recommendation.
- Infant's crib, bassinet, or portable crib, like a Pack 'N Play, should be placed in the caregiver's room.
- Infants should not be fed or held on a soft couch or recliner, or in a bed, if falling asleep is likely. Feed the baby in a well-lit room to avoid falling asleep.
- Sleeping on a soft surface (mattress, couch, etc.) is not safe.

Pacifier Use:

- Pacifier use is recommended during sleep by the AAP unless contraindicated by medical condition [5].

Teaching Points:

- There is no need to reinsert a pacifier if it falls out while the infant is sleeping.
- Do not force the infant to take a pacifier.
- Do not prop the pacifier in the infant's mouth with any blanket or device.
- Pacifiers should not be attached to infant's clothing while sleeping.

Overheating and Over Bundling:

- Overheating and over bundling should be avoided, as it increases the risk for SIDS [5].
- Infants should be dressed for the environment [5].

Teaching Points:

- Avoid fleece blankets.
- Do not use hats to avoid loose objects in the crib if it falls off.
- Sleepsacks may be used.
- Acknowledge cultural beliefs and help educate and accommodate them within safe sleep guidelines.
- Kangaroo care is a great way to maintain thermoregulation when caregiver is awake.
- There is no recommended room temperature to prevent overheating[5].

Positioning Aids and Commercial Devices:

- Devices marketed to prevent SIDS should be avoided [5].

Teaching Points:

- There is no research to support that these products reduce SIDS, suffocation or that they are safe for infants.

Monitoring Devices:

- Cardiopulmonary monitors may be used while in the hospital [5].
- No monitors can prevent or provide early identification of SIDS [5].

Teaching Points:

- There is no evidence to support the use of home monitors in the prevention of SIDS.

Tummy Time:

- While awake, it is important for the infant to have tummy time daily [5].
- Tummy time supports motor development and strengthens the infant's muscles.
- Spending time prone prevents plagiocephaly or misshapen head shape.

Teaching Points:

- Tummy time should be supervised and only while awake.
- Short periods of tummy time should be encouraged, gradually increasing the time.

Breastfeeding:

- Breastfeeding is recommended for at least 6 months by the AAP [5].
- Breastfeeding is associated with a reduced risk of SIDS [5].

Teaching Points:

- Breastmilk is shown to be protective to infants.
- Exclusivity increases the protective benefits.
- Any amount of breastmilk is shown to be more protective than formula

Immunizations:

- The AAP recommends that infants receive immunizations according the Centers for Disease Control and Prevention [5].

Teaching Points:

- Evidence suggests that immunizations protect infants from SIDS.

Addendum I - Safe Sleep Escalation Decision Tree

1. Per policy, educate family on safe sleep.
2. If a family is found in unsafe sleep
    a. RN speaks with family (refer to Safe Sleep Teaching/Talking Points in Toolkit)
    b. Document discussion in EHR
        i. Electronic health record progress note
            1. What did you tell the family and what was the family response? May use quotes if appropriate.
        ii. It is not recommended that a sticky note be used as this is not part of the EHR after discharge.
    c. Reinforce education using “ABC’s of safe sleep” and/or safe sleep pamphlet.
3. If family refuses to comply at CHW-Milwaukee and Fox Valley (CHW Surgicenter to use onsite resources)
    a. Charge nurse involved and speaks with family
        i. FYI for unit leadership and provider team
        ii. Notify social work as FYI
        iii. Document discussion in EHR
4. If family still refuses to comply CHW-Milwaukee and Fox Valley (CHW Surgicenter to use onsite resources)
    a. PCD/Unit Leadership or PCM on call notified and will meet with family
        i. Involve medical leadership as FYI (may also need medical provider to speak with family)
5. If family still refuses to comply- CHW-Milwaukee and Fox Valley (CHW Surgicenter to use onsite resources)
    a. PCD/unit leadership will call huddle with Attending provider, AOC, Security, Safety team representative, Patient relations and/or Social Work, Risk Management, to come up with plan
    b. If urgent situation occurs off-shift or weekend include PCM on call, security, unit leadership/charge RN
    c. Interventions may include:
        i. Behavioral contract
        ii. Limit Visitation, which may include removing parent/legal guardian from hospital
        iii. Options for holding infant (family members alternate every 4 hours – staying awake and alternating holding).
        iv. Involve Social Work and/or report to Child advocacy and CPS
        v. Transfer to another facility (last resort after all else exhausted)