

DATES: Effective 8/1995
 Reviewed
 8/2010 Revised
 3/2011

Submitted by: Mike Goodstein, MD

Approved by: W&C SL Council

TITLE: **INFANT POSITIONING / SAFE SLEEPING PRACTICE POLICY**

I PURPOSE:

- A. Establish guidelines and parameters for infant positioning.
- B. Establish appropriate and consistent parental education on safe sleep positions and environment.
- C. Establish consistent safe sleep practices by healthcare professionals for infants prior to discharge.
- D. To comply with AAP recommendations on evidence-based practices for provision of education for parents relating to sudden infant death syndrome and sudden unexpected death of infants.

II POLICY STATEMENT:

SIDS (Sudden Infant Death Syndrome) is considered to be the sudden death of an infant younger than one year of age that remains unexplained after a complete investigation. There has been a significant decrease in the number of infants who have died from SIDS due to healthcare providers and public health campaigns educating parents and caregivers of the risk factors related to SIDS. Healthcare professionals have a vital role in educating parents and families regarding the “Back to Sleep” campaign. The “Back to Sleep” campaign was started in 1994. In 1992 the SIDS rate was 1.2 deaths per 1000 live births. In 2001, the SIDS rate was 0.56 deaths per 1000 live births, which was a decrease of 53% over a ten-year period. The decreasing SIDS rate is occurring due to a reduction in prone positioning. In 1992, prone positioning was seen in 70%, compared to 13% in 2006.

As important role models, healthcare professionals are critical in communicating SIDS risk reduction strategies to parents and families, and by practicing safe sleep practices while infants are still in the hospital.

There are factors that have been identified that place an infant at an increased risk of SIDS. They include: stomach sleeping, sleep surfaces that are soft (loose, fluffy bedding), overheating during sleep, maternal smoking (during pregnancy or in the infant’s environment), and bed sharing.

- III. **EQUIPMENT:** Open cribs/bassinets, isolettes or infant warmers.

IV. PROCEDURE:

A. Infants in the Newborn Nursery:

- 1. Place all infants on their backs to sleep and the head of the bed flat.
*Infants with a medical contraindication to supine sleep position (i.e. congenital malformations, upper airway compromise, severe symptomatic gastroesophageal reflux)

should have a physician's order along with an explanation documented.

1. A firm sleep surface should be used (firm mattress with a thin covering). Use of soft bedding such as pillows, quilts, blanket rolls, and stuffed animals should not be used.
2. If an infant is found in bed with a sleeping mother/parent, the infant should be placed in their bassinet and can be returned to the newborn nursery at the discretion of the nurse. The mother/parent should then be re-educated on safe sleep practices as soon as practical. If this continues to be a reoccurring problem an "Infant Safe Sleep Non-Compliance" release form should be signed by the parent that he or she has been educated and understands that sleeping with an infant is dangerous with the most serious consequence being death.
3. Infants should be swaddled/bundled no higher than the axillary or shoulder level. A "sleep sack" may be used. Sleep sacks may be used on infants < 38 pounds and 1 year of age.
 - *If temperature instability occurs, infants may have an additional blanket used by tucking the blanket around the mattress and covering the infant no higher than the axillary or shoulder level.
1. The infant's feet should touch the bottom of the bed so he/she cannot wiggle down below the blanket.
2. Environmental temperature should be maintained at 72 to 78 degrees F.

B. Infants in the Neonatal Intensive Care Nursery (NICU):

1. Place all infants on their backs to sleep and the head of the bed flat.
 - * Infants with upper airway compromise, life-threatening GE reflux (not mild to moderate apnea/bradycardia), respiratory distress, or a greater degree of prematurity may be placed prone or side lying until resolution of symptoms.
 - * Preterm infants and ill newborns may benefit developmentally and physiologically from prone or side lying positioning and may be positioned in this manner when continuously monitored and observed.
 - * Infants with Neonatal Abstinence Syndrome (NAS) with difficult to control symptoms may be placed in a prone position for brief periods of time (see addendum for guidelines).
 - * NICU infants should be placed exclusively on their backs to sleep when stable and in the convalescent stage of their development. (see number 6 for guidelines)
 - * Placement of NICU infants on their backs to sleep should be done well before discharge in order to model safe-sleep practices to their families.
2. A firm sleep surface should be used (firm mattress with a thin covering). Use of soft bedding such as pillows, quilts, blanket rolls, and stuffed animals should not be used.
 - * Positioning devices (snugglies) may be used for developmentally sensitive care of the extremely premature.
3. Infants should be swaddled/bundled no higher than the axillary or shoulder level. A "sleep sack" may be used.
 - * If temperature instability occurs, infants may have an additional blanket used by tucking the blanket around the mattress and covering the infant no higher than the axillary or shoulder level.
4. The infant's feet should touch the bottom of the bed so he/she cannot wiggle down below the blanket.
5. Environmental temperature should be maintained at 72 to 78 degrees F.
6. The following guidelines should be used to transition NICU patients to the Home Sleep Environment (HSE):
 - a. Babies with a gestational age of 34 weeks and beyond AND greater than 1500 grams

- without respiratory distress should be placed in HSE.
- b. Babies with gestational age 34 weeks and beyond with respiratory distress may be positioned prone until respiratory symptoms are resolving.
 - c. Babies with gestational age under 34 weeks should be assessed when reaching a post-conceptual age of 33 weeks and weight greater than 1500 grams:
 1. If the baby has respiratory distress, staff may continue with prone positioning until respiratory symptoms are resolving.
 2. If the baby has no respiratory symptoms, then the primary nursing team should discuss the infant's neuromuscular status with Occupational Therapy. Once the baby no longer requires positioning devices, begin HSE protocol.
7. Once it is determined that an infant is ready for home sleep environment, the following actions should be completed:
- a. Apply the HSE card/safe sleep ticket to the baby's bedside.
 - b. Fill out the graduation certificate with the baby's name.
 - c. At the parent's next visit, have them watch the safe sleep DVD and then provide modeling and review of the appropriate home sleep environment.
 - d. After completion of the training, present the family with the graduation certificate.

C. Infants in the Pediatric Unit: (Infants less than 1 year of age)

1. Follow the guidelines for the Newborn Nursery.
2. If a blanket is needed for the infant, the infant's feet should touch the bottom of the bed so he/she cannot wiggle down below the blanket. If no blanket is needed, the infant may be positioned in the bed appropriately.
3. If an infant is found in bed with a sleeping mother/parent, the infant should be placed in their bassinet or crib. The mother/parent should then be re-educated on

safe sleep practices as soon as practical. If this continues to be a reoccurring problem an "Infant Safe Sleep Non-Compliance" release form should be signed by the parent that he or she has been educated and understands that sleeping with an infant is dangerous, with the most serious consequence being death.

V. DOCUMENTATION:

- A. Document the infant's position on the Newborn Nursery, NICU, or Pediatric Flow sheets.
- B. Family/Parental teaching: All parents and caregivers (daycare workers, grandparents and babysitters) will be educated on SIDS and safe sleep environments and positioning.
 1. All healthy infants should be placed on their backs to sleep.
 2. All infants should be placed in a separate but proximate sleeping environment (crib, infant bassinet, or Pac 'N' Play).
 3. All infants should be placed on a firm sleep surface. Remove all soft-loose bedding, quilts, comforters, bumper pads, pillows, stuffed animals and soft toys from the sleeping area.
 4. Never place a sleeping infant on a couch, sofa, recliner, cushioned chair, waterbed, beanbag, soft mattress, air mattress, pillow, synthetic/natural animal skin, or memory foam mattress.
 5. Avoid bed sharing with the infant.

Risk of bed sharing:

* Adult beds do not meet federal standards for infants. Infants have suffocated by

becoming trapped or wedged between the bed and the wall/bed frame, injured by rolling off the bed, and infants have suffocated in bedding.

* Infants have died from suffocation due to adults rolling over on them.

* Sleeping with an infant when fatigued, obese, a smoker, or impaired by alcohol or drugs (legal or illegal) is extremely dangerous and may lead to the death of an infant.

1. If a blanket must be used, the preferred method is to swaddle/bundle the infant no higher than the axillary or shoulder level or use an appropriate size blanket that can be tucked in around the crib mattress and position the infant's feet at the bottom of the bed.
2. The use of a "sleep sack" may be used in place of a blanket.
3. Avoid the use of commercial devices marketed to reduce the risk of SIDS.
4. Avoid overheating. Do not over swaddle/bundle, overdress the infant, or over heat the infant's sleeping environment.
5. Consider the use of a pacifier (after breastfeeding has been well established) at sleep times during the first year of life. Do not force an infant to take a pacifier if he/she refuses.

11. Avoid maternal and environmental smoking.
12. Breastfeeding is beneficial for infants.
13. Home monitors are not a strategy to reduce the risk of SIDS.
14. Encourage tummy time when the infant is awake to decrease positional plagiocephaly.

- C. Document all parental teaching (include if the contract was signed and whether the Safe Sleep DVD was viewed) related to sleep safe practices on the parental teaching portion of the plan of care.
- D. For additional information please refer to the York Hospital tool kit on Safe Sleep Practices.

NAS & Prone Positionin

<p>Infant Irritable Comfort Measures</p>
<ul style="list-style-type: none"> • Rocking • Holding (volunteers) • Swaddling • Etc.
<p>IF irritability continues despite efforts to calm</p> <ul style="list-style-type: none"> • May position infant prone • Re-assess symptoms of withdrawal when infant awakens
<p>Irritability continues > 12 hours that necessitates prone positioning at times</p> <ul style="list-style-type: none"> • Consult with MD/NNP to review scores and meds
<p>Re-assess need for prone positioning and ALWAYS use comfort measures BEFORE placing an infant prone!</p>
<p>Getting ready for home--</p> <ul style="list-style-type: none"> • Discontinue prone positioning if used. • Discuss with primary nursing team, PT/OT, MD/NNP <p>Begin Home Sleep Environment (if not done earlier) when-</p> <ul style="list-style-type: none"> • Morphine dose 0.22mg-0.16mg every 3 hours • Average abstinence scores of < 6 over 24 hours • No scores > 10 in the last 24 hours • No prn doses needed in the previous 24 hours
<p>Implement the "home sleep environment" at least 1 week before discharge if not sooner.</p>

<ul style="list-style-type: none"> • KEY POINT -implement when infant is ready for "home sleep" and not earlier in the hospitalization
<ul style="list-style-type: none"> • Post Safe sleep ticket • Post Graduation card - make this a "special" day for parents!
<ul style="list-style-type: none"> • Review information and safe sleep DVD with parents

<p>Family Education</p> <ul style="list-style-type: none"> • Need extra education when prone • DO NOT say "I couldn't get him to sleep so I put him on his belly". "She was very fussy last night and slept better being on her belly", "belly sleeping is okay here in the NICU because our babies are monitored – don't do this at home" • DO say "to help her calm I put her on her belly for a brief time. This special therapy is sometimes needed to help with withdrawal symptoms". • Be consistent with messages
<p>Considerations</p> <ul style="list-style-type: none"> • Staffing – try to avoid clustering NAS babies in 1 area • Avoid triage assignments if at all possible • Consistent care givers are important • Maintain positivity • Communicate with charge nurse any concerns with assignments

E. For information on House Bill 47/ACT 73, please refer to attachment below.

SENATE AMENDED **PRIOR PRINTER'S NOS. 36,**

1795

PRINTER'S NO. 3776

THE GENERAL ASSEMBLY OF PENNSYLVANIA
HOUSE BILL

No. 47

INTRODUCED BY CURRY, BELFANTI, BEYER, BISHOP, BOYD,
 BRENNAN, CALTAGIRONE, CHRISTIANA, COHEN, CONKLIN, DeLUCA,
 DONATUCCI, FLECK, FRANKEL, GEORGE, GOODMAN, HENNESSEY, HESS,
 KOTIK, KULA, MANDERINO, McILVAINE SMITH, MELIO, M. O'BRIEN,
 O'NEILL, PRESTON, RAPP, READSHAW, REICHLEY, ROCK, SCAVELLO,
 SIPTROTH, SOLOBAY, SONNEY, STERN, TRUE, VULAKOVICH, WATSON,
 WHEATLEY, WALKO, BEAR, WANSACZ, PETRARCA, HARPER, PHILLIPS, K.
 SMITH, GINGRICH, MYERS, MURT, EACHUS, FREEMAN AND SHAPIRO, JANUARY
 26, 2009

SENATOR CORMAN, APPROPRIATIONS, IN SENATE, RE-REPORTED
 AS AMENDED, MAY 24, 2010

AN ACT

Providing for education for parents relating to sudden infant death

syndrome and sudden unexpected death of infants; establishing the Sudden Infant Death Syndrome Education and Prevention Program; and providing for duties of the Department of Health.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short title.

This act shall be known and may be cited as the Sudden Infant Death Syndrome Education and Prevention Program Act.

Section 2. Legislative findings.

The General Assembly hereby finds and declares as follows:

1. The sudden, unexpected death of a newborn is the 14 third most common cause of death among newborns and is only 15 exceeded in the first year of life by congenital malformations and prematurity.

1. Most sudden infant deaths occur when a baby is between two and four months old, and 90% of all sudden infant deaths occur before six months of age.

2. Most babies that die of sudden infant death syndrome (SIDS) or sudden unexpected death in infants (SUDI) appear to be healthy prior to death.

3. Sixty percent of SIDS victims are male and 40% are female.

4. While SIDS occurs in all socioeconomic, racial and ethnic groups, African-American and Native-American babies are two to three times more likely to die of SIDS than Caucasian babies.

5. In 1994, the American Academy of Pediatrics, in conjunction with other major health organizations in the United States, launched the national "Back to Sleep" campaign, which endorsed and promoted the placement of infants on their backs both for sleeping and napping.

6. The incidence of sudden infant death in the United States decreased by more than 50% since the inception of this campaign.

7. In 2005, the American Academy of Pediatrics issued a new recommendation to further reduce the risk of SIDS that defined and promoted the use of a safe sleeping environment for infants.

8. At this time there is no known way to prevent SIDS or SUDI, but the risk can be minimized. Parents should learn

risk factors associated with SIDS and SUDI and share with others information on how to create a safe sleeping environment for an infant to reduce the risk of sudden and unexpected death.

Section 3. Definitions.

The following words and phrases when used in this act shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Acknowledgment statement." A form signed by a parent, acknowledging that the parent has received, read and has an understanding of the educational and instructional materials provided on sudden infant death syndrome and sudden unexpected death in infants.

"Birth center." A facility not part of a hospital which provides maternity care to childbearing families not requiring hospitalization. As used in this definition, the term "maternity care" includes prenatal, labor, delivery and postpartum care related to medically uncomplicated pregnancies.

"Department." The Department of Health of the Commonwealth.

"HEALTH CARE PRACTITIONER." AN INDIVIDUAL WHO IS AUTHORIZED TO PRACTICE SOME COMPONENT OF THE HEALING ARTS BY A LICENSE, PERMIT, CERTIFICATE OR REGISTRATION ISSUED BY A COMMONWEALTH LICENSING AGENCY OR BOARD.

"Hospital." A for-profit or nonprofit hospital providing clinically related health services for obstetrical and newborn care, including those operated by the State, local government or an agency. The term shall not include an office used primarily for private or group practice by health care practitioners where no reviewable clinically related health services are offered.

"Infant." A child 30 days of age or older and younger than 24 months of age.

"Newborn." A child 29 days of age or younger.

"Parent." A natural parent, stepparent, adoptive parent, legal guardian or legal custodian of a child.

"Program." The Sudden Infant Death Syndrome Education and Prevention Program.

"Sudden infant death syndrome" or "SIDS." The sudden, unexpected death of an apparently healthy infant that remains unexplained after the performance of a complete postmortem

investigation, including an autopsy, an examination of the scene of death and a review of the medical history.

"Sudden unexpected death in infants" or "SUDI." The sudden, unexpected death of an apparently healthy infant.

Section 4. Establishment of program.

a. Establishment.--The department shall establish a Sudden Infant Death Syndrome Education and Prevention Program to promote awareness and education relating to SIDS and SUDI with the focus on the risk factors of SIDS and SUDI and safe sleeping practices for newborns and infants.

b. Public awareness.--The department shall design and implement strategies for raising public awareness concerning SIDS and SUDI, including, but not limited to, the following:

1. Risk factors for sudden infant death, including infant sleep position, exposure to smoke, overheating, inappropriate infant bedding and bed sharing.

2. Suggestions for reducing the risk of SIDS and SUDI.

Section 5. Materials.

a. Educational and instructional materials.--The program shall include the distribution of readily understandable information and educational and instructional materials regarding SIDS and SUDI. The materials shall explain the risk factors associated with SIDS and SUDI and emphasize safe sleeping practices. The materials shall be provided to parents prior to discharge from a hospital or birth center or by a HEALTH CARE PRACTITIONER for births that take place in settings other than a hospital or birth center.

b. Acknowledgment statement.--The acknowledgment statement shall be signed by a parent prior to discharge from a hospital or birth center or after births performed by a HEALTH CARE PRACTITIONER in settings other than a hospital or birth center. One copy of the acknowledgment statement shall be given to a parent, and one copy shall remain on file in the hospital or birth center. Copies of acknowledgment statements signed by parents in settings other than a hospital or birth center shall be kept on file by the health care practitioner performing the birth. The acknowledgment statement shall be set forth in a form to be prescribed by the department.

c. Distribution of materials.--The information and educational and instructional materials described in subsection(a) shall be provided without cost by each hospital, birth center or

HEALTH CARE PRACTITIONER to a parent of each newborn upon discharge from a hospital or birth center OR AFTER BIRTHS THAT TAKE PLACE IN SETTINGS OTHER THAN A HOSPITAL OR BIRTH CENTER.

d. LIABILITY.--A HOSPITAL, BIRTHING CENTER OR HEALTH CARE PRACTITIONER SHALL NOT BE CIVILLY OR CRIMINALLY LIABLE FOR THE ACTION OR INACTION OF A PARENT WITH REGARD TO A NEWBORN'S OR INFANT'S SLEEPING POSITION PURSUANT TO MATERIALS GIVEN TO THE PARENT RELATING TO SIDS OR SUDI.

Section 6. Scope of act.

The department shall do the following:

1. Work to improve the capacity of community-based services available to parents regarding the risk factors involved with SIDS and SUDI and safe sleeping practices for newborns and infants.

2. Work with other State and local governmental agencies, community and business leaders, community organizations, health care and human service providers and national organizations to coordinate efforts and maximize State and private resources in the areas of education about SIDS and SUDI, including the risk factors and safe sleeping practices.

3. Identify and, when appropriate, replicate or use successful SIDS and SUDI programs and procure related materials and services from organizations with appropriate experience and knowledge of SIDS and SUDI.

Section 7. Regulations.

The department may promulgate regulations necessary to implement the provisions of this act.

Section 20. Effective date.

This act shall take effect in 60 DAYS.

VI. APPLIES TO: PERSON TO WHOM PERFORM:

Nurse Executive	
RN	<u>X</u>
LPN	<u>X</u>
NA	X
Other	—

VII. AREA PERFORMED:

NICU	<u>X</u>
L&D	<u>X</u>
Maternity	<u>X</u>
Pediatrics	X

VII. REFERENCES/RESOURCES:

- U Review of literature
- U Expert opinion
- U Guidelines
- U Other

American Academy of Pediatrics Policy Statement, Task Force on Sudden Infant Death Syndrome. The Changing Concept of Sudden Infant Death Syndrome: Diagnostic Coding Shifts, Controversies Regarding Sleeping Environment, and New Variables to Consider in Reducing Risk. Pediatrics, November 2005; 16(5): 1245-1255.

National Institute of Child Health and Human Development (NICHD), Continuing Education Program on SIDS Risk Reduction.

VII. KEYWORDS:

Positioning