Category:	Nursing
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TITLE: SAFE SLEEP / BED SHARING

PURPOSE:	To promote the safest sleep environment for patients while hospitalized and ensure patient comfort and accessibility for optimal patient care.
SCOPE:	Multidisciplinary

POLICY:

These guidelines will be followed to promote a safe sleep environment in the hospital.

RELEVANT FACTORS:

DEFINITIONS:

Co-sleeping or bed sharing is defined as any person/patient sleeping in the same bed as the patient. This does not include sharing a bed during daytime hours, while breastfeeding or comforting a patient while the patient and caregiver are awake.

SIDS is the sudden death of an infant under one year of age which remains unexplained after the performance of a complete post-mortem investigation including: performance of a complete autopsy, examination of the death scene, and review of the case history.

SUID is sudden unexpected infant death.

Tummy time: during wakefulness and while supervised, it is best to allow babies time on their stomachs to enhance development. This would also have the effect of relieving constant pressure tending to flatten the head on one side. This allows for strengthening the upper body muscles that are not used as much when babies sleep on their backs.

Medically stable: infant is off significant respiratory support (such as HFNC, CPAP, Ventilator, etc.), post operatively recovered, and have no evidence of anatomic or functional airway abnormalities causing aspiration or obstruction.

PROCEDURE:

I. POSITIONING FOR SLEEP

A. Supine sleeping should be utilized for all medically stable infants. All stable infants should have supervised "tummy time" throughout the day when awake.

B. Exceptions for supine positioning may be include but are not limited to:

1. **Infants with significant oxygen requirements (such as HFNC, CPAP, Ventilator) for whom prone positioning improves ventilation and oxygenation (prematurity < 32 weeks corrected age, respiratory distress syndrome, pulmonary hypertension, etc.)**
2. **Infants with congenital anomalies who cannot be placed supine (ex. Neural tube defects, Pierre Robin sequence, etc.)**

C. Transition to supine sleeping for convalescing infants should begin at 32 weeks corrected age and when the infant is clinically stable. By 34 weeks corrected age or when infant has successfully weaned to open crib and is medically stable, infant should sleep supine, without nest or developmental supports.

D. The head of bed should remain flat unless the infant is on VAP protocol or is less than 32 weeks corrected age. A physician order is required for head of bed to remain elevated. Documentation of clinical rationale must be documented in the medical record.

E. Once an infant can roll from supine to prone and from prone to supine, the infant can be allowed to remain in the sleep position that he or she assumes.

II. BOUNDARIES AND POSITIONING AIDS

A. Boundaries and positioning aids may only be used in those infants who are not medically stable or less than 32 weeks corrected age.

B. Transitioning out of boundaries/positioning aids should begin when a premature infant is greater than 32 weeks corrected age and can maintain a flexed posture without assistance of aids and/or is medically stable.

C. Infants with neurological or muscular disorders may benefit from neurodevelopmental care aids and support. However, as part of the transition to home it is necessary to develop a safe sleep environment plan and implement before discharge.

III. BEDDING / CRIB ENVIRONMENT

A. Sheepskins or other very soft material (i.e. water beds, gel mattresses) should only be utilized in those infants who are experiencing skin breakdown or are less than 32 weeks corrected age.

B. Once successfully weaned to a crib, infants should be able to maintain their temperature utilizing an undershirt plus one layer of clothing. Readiness to wean from an isolette should be questioned if patient is unable to maintain temperature without use of additional blankets. Infants should be dressed in a manner to avoid over-bundling or over-heating and to set room temperature at a comfortable level.

C. The bassinet or crib should be set up as follows: one tight fitted sheet or a thin blanket securely tucked underneath the mattress (serving as a sheet). If a thin blanket is used, it must be securely tucked underneath the mattress at the foot end and sides and come no higher than the infant's chest (infant's feet to foot of bed)..

Encourage parents to display toys near, but not in the isolette, open warmer, or crib.

D. No equipment, bottles or other objects should be near the infant's face while in the bassinet or crib.

Pacifiers can be used to get the infant asleep, but should not be reinserted once asleep. Do not secure the pacifier to infant's clothing, blanket, or bedding.

E. For an infant in the surgery or PACU environment, extra blankets may be used for thermoregulation until normal body temperature is achieved. Appropriate observation should be maintained while additional blankets are utilized.

F. When swaddling is indicated, ensure that the blanket comes no higher that the infant's shoulders.

IV. BED SHARING / CO-BEDDING

Age (corrected for prematurity)	Recommended Sleep Surface	Co-Bedding Permitted	Co-Bedding Consent Required
0 – 2 months	Bassinet	No	N/A
2 months – 1 year	Crib	No	N/A
1 year – 3 years	Crib	Yes	Yes
3 years and older	Bed	Yes	N/A

*Considerations being given to bassinet availability and patient size. Should a bassinet be unavailable or infant size contraindicated for bassinet placement, the patient will be placed in a crib.

A. Bed sharing beyond the age of three is not allowed in clinical situations in which there is a potential to compromise patient safety.

B. If a patient less than 1 year old is found with a parent/caregiver who is asleep:

- The RN or PCA is to arouse the parent/caregiver and request the infant be placed in bassinet or crib while the parent is sleeping.
- All other disciplines are to notify the nurse responsible for the patient of an unsafe sleep environment.

C. If patient's age is between 1-3 years and is found in bed with parents:

1. **Notify the shift leader/charge nurse of incident. ETCH will provide the parent/guardian written information on bed sharing and discuss the risk of SIDS and injury.**
2. **If the parent/guardian continues to insist on bed sharing the assigned RN will:**
   - **a. Obtain parent/guardian signature on release of liability form.**
   - **b. Place bed in lowest position.**

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D. On admission to an inpatient floor or PICU or upon discharge from the NICU the nurse will ask if parent/guardian has a safe sleep environment (safety approved crib) for infant at home. Nurse will ask if parent/guardian knows about the Consumer Product Safety Commission standards for a safe crib. For those who have not received this information, the nurse will provide an information sheet with correct information. If parent/guardian does not have safety approved crib at home, the nurse will provide appropriate referral to Social Work.

PRECAUTIONS: N/A

SUPPORTIVE DATA:

A major decrease in the incidence of sudden infant death syndrome (SIDS) followed the 1992 American Academy of Pediatrics (AAP) recommendation that infants be placed for sleep in a non-prone position, however, the decline plateaued in recent years and other causes of sudden unexpected infant death (SUID) that occur during sleep (sleep-related deaths) including suffocation, asphyxia, and entrapment have increased in incidence. It has become increasingly important to address these other causes of sleep-related infant death, therefore the AAP is expanding its recommendations from focusing only on SIDS to focusing on a safe sleep environment that can reduce the risk of all sleep-related infant deaths, including SIDS.

Policy Owner:	Director of Critical Care Services
References:	East Tennessee Children's Hospital (2013). Safe Sleep/Bed Sharing Policy. Retrieved from East Tennessee Children's Hospital. Palmer, M. (2013). Safe sleep hospital. East Tennessee Children's Hospital CME. Schurr, P., Findlater, C.K. (2012). Neonatal myth busters: Evaluating the evidence for and against pharmalogic and non pharmalogic management for gastro esophageal reflux. *Neonatal Network,* 31 (4), 229-241. Task Force on Sudden Infant Death Syndrome. (2012). SIDS and other sleep-related infant deaths: Expansion of recommendations for a safe infant sleeping environment. *Pediatrics*, 28(5), 1030-1039. Retrieved from http://www.pediatrics.aapublications.org Tennessee Department of Health. Safe sleep for your baby: Tennessee statistics. Retrieved March 20, 2013 from http://safesleep.tn.gov/datapage.shtml

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Vandenplas, Y., Rudolph, C.D., DiLorenzo, C., et al. (2009). Pediatric gastroesophageal reflux clinical practice guidelines: joint recommendations of the North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition (NASPGHAN) and the European Society for Pediatric Gastroenterology, Hepatology, and Nutrition (ESPPGHAN).” *Journal of Pediatric Gastroenterology Nutrition*, 49 (4), 498-547.

Vanderbilt Children’s Hospital. (2013). Safe sleep [PowerPoint Slides]. Retrieved from Vanderbilt Children’s Hospital.

Vanderbilt Children’s Hospital (2012). Safe sleep environment for infants. Retrieved from Vanderbilt Children’s Hospital.

Related Policies:	
Related Documents:	
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