HSC Public Health Agency

Promoting Safe Sleeping for Infants

Brief guidance for practitioners.

April 2018

Improving your health and wellbeing

Promoting Safe Sleeping for Infants

Background: The Northern Ireland Infant Death Thematic Review (2015) was undertaken to develop a better understanding of how and why young babies die, to learn more about sudden and unexpected infant death and to use the findings to prevent other deaths and improve the health, safety and wellbeing of all children in Northern Ireland. The review was undertaken by a partnership between Queen's University Belfast; the Public Health Agency in Northern Ireland; the Safeguarding Board for Northern Ireland; and the Northern Ireland Coroner's Service

The review aimed to address some important gaps in our knowledge about infant death and co-sleeping in Northern Ireland by undertaking a review of international and national evidenced-based material to understand the relationship between infant death and co-sleeping; an analysis of a retrospective review of all paediatric deaths (0-2 years) referred to the Coroner's Office for Northern Ireland from 2007 – December 2013; experiential learning from health professionals; an awareness and development of educational strategies to decrease SIDS; and guidance for future public health policy development that promotes clear, balanced and standardized evidence-based practice guidelines to support parents through the development of safe sleep guidelines in Northern Ireland.

Introduction: The risk of an infant dying suddenly is low, but it does happen. As such it is important that factors which are modifiable are understood by parents, carers and health professionals. The research evidence is clear in respect of some simple measures which can increase parents' understanding

about risks to their child, and how they can mitigate these. Safe sleep messages need to be tailored to the particular needs and circumstances of both an individual infant and their parents/carers, and that while consistency in the message given is important, the manner in which it is delivered needs personalised. In doing so it is hoped that further decreases in the numbers of SIDS deaths can be achieved.

It is acknowledged that consistent messages about safe sleeping should be provided regularly both in the antenatal period and postnatally in ways which reduce parents feeling judged less they conceal aspects of sleep practices. It is important to consider when and how to give the message in the midst of all the important messages being given to parents, and "having the conversation as opposed to just delivering the message."

Midwives, health visitors, paediatricians, GPs and other healthcare staff who have consultations with pregnant women and their partners in the antenatal and postnatal period and parents of new or very young babies at home or in the community should use the opportunity to:

- Talk more openly about SIDS and ask about sleeping arrangements for the infant and promote the safe sleeping messages.
- Provide information to parents and carers on a case-by-case basis, taking individual and family circumstances into account.
- Identify risk factors, and put measures in place to minimize the impact of these.
- Assist fathers, grandparents and older siblings to understand and apply the advice.
- Model and discuss safe sleeping practices.

- Promote and support breastfeeding, and the right of parents to make informed choices about their infant's care. Understand that bed sharing is an important tool in keeping babies' breastfeeding and that in the absence of any risk factors breastfed babies who bed share with their mothers are at low risk of sudden infant death.
- Talk sensitively around cultural differences for infant's sleep environments.

The Public Health Agency in consultation with practitioners from the key disciplines across all 5 HSCT's have developed 2 new resources to assist practitioners.

1. A Parent Information Card
2. A risk Assessment Tool for professionals

Parent Information Card

1. The parent information card and risks of co-sleeping should be introduced and discussed by the midwife in the early antenatal period and reinforced following delivery and again in the early postnatal period. Midwives prior to discharge from hospital, at initial home visit and prior to discharge to health visiting services should discuss and reinforce safe sleeping messages.

2. The health visitor/ family nurse during the Healthy Child Healthy Futures antenatal home visit and/ or the subsequent new birth visit should also discuss safe sleeping messages

3. The health visitor/ family nurse should revisit safe sleep advice at both the 6 week and 14-16 week review.

Health professionals should signpost parents/ carers to the Pregnancy and Birth to Five Books for further information.

Risk Assessment Tool for Professionals

The risk assessment tool has been developed using the NI research data. It is intended that professionals use the risk assessment tool in cases where they have identified some degree of concern regarding risks or sleeping practices. We have not been prescriptive regarding how to use the tool as this will be up to professional judgement. This is more about having a conversation and opening opportunities to discuss individual circumstances and how to reduce risks. Each health visitor, family nurse and midwife will be issued with a risk assessment tool for their own use.

We wish to acknowledge the expert advice, guidance and support from the PHA communications teams in the development, design and printing of the resources.

Both resources are also available electronically on the PHA website at http://www.publichealth.hscni.net/directorate-nursing-and-allied-health-professions/nursing/safeguarding-children-and-young-people .

If you require any additional information please contact Emily.roberts@hscni.net

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