Co-sleeping and Bed-sharing for Mothers and Babies Guideline

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Departments/Group this Document applies to:	Maternity

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Guideline to be followed by (target staff): Midwives, Nursery Nurses and Maternity Care Assistants

To be read in conjunction with the following documents:
Caring For Your Baby at Night Patient Information Leaflet - UNICEF UK 2019

Are there any eCARE implications? No

CQC Fundamental standards:
Regulation 9 – person centred care
Regulation 12 – Safe care and treatment
Regulation 19 – Fit and proper

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.
The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

The reason for the guideline is to provide guidance to staff on co-sleeping and bed-sharing and reduce the known risks to babies.

Executive Summary

Guideline Statement and Aim

The aim of the guideline is to ensure a standardised approach to safe practice and co-sleeping.

Objectives

- To reduce the risk of inappropriate co-sleeping in hospital and at home.
- To provide parents with accurate information about the benefits, risk and alternatives to co-sleeping.
- To increase the likelihood of appropriate bed-sharing and reduce the risk of co-sleeping once mothers and babies return home.

Definitions

It is recognised that mothers take their baby into bed to feed and provide skin-to-skin comfort so co-sleeping can be intentional or unintentional. While it is acknowledged that no activity is entirely without risk, in the absence of maternal sleep there is no evidence that this incurs any greater risk than the mother holding or feeding her baby elsewhere. There is, however, evidence to indicate that co-sleeping is associated with a greater incidence of accident or Sudden Infant Death Syndrome (SIDS) where certain risk factors are present.

- For the purpose of this guideline the term **bed-sharing** will be used to cover bed sharing when **co-sleeping is possible whether intended or not**.

- The term **co-sleeping** is used to cover when a mother is **asleep** in bed with her baby.

Abbreviations

SIDS Sudden Infant Death Syndrome

1.0 Roles and Responsibilities:

It is the role of all clinical staff caring for parents and their babies to be familiar with the guideline and to ensure that appropriate advice is given and documented in the woman's notes in the relevant section.

It is the overall responsibility of the Senior Midwives/Governance to ensure that the guideline is reviewed regularly and uses the latest national guidance.

2.0 Implementation and dissemination of document

This document will be accessible electronically on the hospital intranet. The mandatory Infant Feeding training sessions will discuss the Co-sleeping and bed sharing recommendations.

3.0 Processes and procedures

3.1 Risk Factors

Inform the parents or carers that:

- the association between co-sleeping and SIDS is likely to be greater if they or their partner smoke
- the association between co-sleeping and SIDS may be greater with:
  - parental or carer recent alcohol consumption
  - parent or carer drug use
  - babies less than 2500g or premature infants (less than 37 weeks gestation)
  - a fever or signs of illness in the baby

(NICE, 2006 updated 2015, CG37, Sections 1.4.47-49)

Parents/carers must be informed of:

- the dangers of bed sharing when the parent or carer is unusually tired (i.e. to a point where they would find it difficult to respond to their baby)
- the dangers of sleeping with a baby on a sofa, chair, waterbed, bean bag or a sagging mattress
- the danger of letting a baby sleep alone in an adult bed
- the dangers of letting a baby sleep with other children or pets
- the dangers of babies being placed prone or on their side to sleep or in a room alone
- the dangers of overheating and the use of duvets and pillows

(Lullaby Trust, undated, *Safer sleep: saving babies lives. A guide for professionals.*)

3.2 Reducing the risks of SIDS

Early antenatal education of parents and carers is essential. This should include a discussion of both the benefits and contra-indications of bed-sharing with all parents and carers. This should be repeated in the early postnatal period to enable a fully informed choice.

Ensure all parents have access to the Unicef UK leaflet '*Caring for your baby at night: a guide for parents'.*

- The safest place for a baby to sleep is a cot by the parental bed. This allows close observation and the mother is able to respond early to feeding cues (restlessness, murmuring sounds and finger sucking) before baby wakes fully and begins to cry.
- Encourage exclusive breastfeeding for at least 6 months.
- Discuss the benefits of the baby rooming in with the parents for at least the first 6 months regardless of how the baby is fed
- Ensure the room is smoke free
- Skin-to-skin contact provided by either parent can be helpful in settling a restless baby. This should be provided in circumstances in which there is no danger of falling asleep with the baby, if the parent is on the sofa or chair.
- Carrying the baby around or lying on the parental bed is safer than sitting or lying with the baby on a chair or on a sofa.
- If a baby has become accustomed to using a dummy whilst sleeping it should not be stopped suddenly during the first 6 months (Lullaby Trust, 2016).

3.3 Clinical condition of the mother

Any mother who may be unable to remain awake or sustain consciousness or who may have restricted movement or severe difficulty with spatial awareness will require constant supervision when sharing a bed with her baby. Examples of such mothers would include those who are:

- Under the effects of a general anaesthetic.
- Immobile due to spinal anaesthetic.
- Under the influence of drugs, which cause drowsiness.
- ill to the point that it may affect consciousness or ability to respond normally e.g. high temperature, following large blood loss, severe hypertension.
- Excessively tired to the point that would affect her ability to respond to the baby.
- Suffering any condition that would affect spatial awareness e.g. conditions that would severely affect mobility and sensory awareness.
- Bariatric women.
- Likely to have temporary losses of consciousness e.g. insulin dependent diabetic or epileptic.
- All women will be assessed on an individual basis for the above risk factors.

3.4 Safety of the physical environment

It is important that babies are protected from falling out of the bed. The presence of a family member or suitable equipment does not negate professional responsibility and accountability for safety. Babies must not be laid to sleep on the adult hospital mattress.

In hospital:

The bed should always be lowered as far as possible and the bed clothes tucked around mother and baby.

- Ensure pillows are kept well clear of the baby.
- Babies should never be swaddled in wraps or blankets. This includes when sharing a bed with their mother.
- For some mothers, suitable family members can be asked to supervise the mother to ensure the baby's safety. The health professional must use professional judgement to assess the family member's willingness and suitability and give basic instruction.
- The presence of a family member or suitable equipment does not negate professional responsibility and accountability for safety.
- Assess the level of supervision required and implement appropriately.
- Where possible, bedside curtains should be pulled back to allow staff to see women and their babies.
- Ensure the mother has easy access to the call bell system in case of difficulty.
- Current recommendations are that a baby should be placed by the bed in a cot to sleep
- Baby should be placed in the cot with their feet touching the end so they don't slip under the covers.

At home, if the baby is in the parent's bed, as above and:

- Parents/carers should be advised to make sure that the baby cannot fall out of bed or get stuck between the mattress and the wall
- The baby is kept cool, ensuring bedding does not cover the baby
- The baby is placed to sleep on their back rather than on their front or side.
- Parents/carers should be advised not to risk falling asleep with baby on the sofa or armchair

3.5 Level of supervision required

The level of supervision required for mothers when bed-sharing will vary depending on the above factors. Categories of supervision would include:

- Constant supervision for mothers whose clinical condition means that they cannot take any responsibility for their baby.
- Intermittent checks to ensure that the mother has not fallen asleep to avoid co-sleeping.

It is important to ensure that the bed-sharing guideline is fully implemented for all mothers and babies who are bed-sharing. Ensure that mothers and babies can be easily seen when bed-sharing. This will assist staff to make the necessary checks easily and quickly without disturbing them. Keeping curtains open and low-level lighting at night can help with this.

The Midwife should discuss the Unicef UK leaflet '*Caring for your baby at night: a guide for parents'* with parents on discharge and on transfer of care to the Health Visitor.

4.0 Statement of evidence/references

References:

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Vennemann, M.M., et al. (2009) Does breastfeeding reduce the risk of sudden infant death syndrome? *Pediatrics* [Online] **123**(3), pp.e406-10.
Abstract: https://pubmed.ncbi.nlm.nih.gov/19254976/

5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made
6.1	07/2020	Laura Jewell/Natalie Lucas	Audit criteria amended
6	10/2017	Janice Styles/Ros Mcfadden	Review and updated
7	03/2021	Michelle Hancock	Complete review

5.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Women's Health Digital document review group	Women and Children	20/02/2021	31/03/2021	Yes	Yes
Clinical Improvement Group (CIG)	Women and Children	07/04/2021		None	

5.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
Co-sleeping/bed sharing has been discussed before discharge home and evidence of this. Parents have been given 'Caring for your baby at night' patient information leaflet - UNICEF UK 2019.	Monitor via Perfect Ward	Postnatal Ward Senior Sister	Perfect Ward completed weekly	Quarterly Maternity Quality Meetings Any concerns are reviewed by the Postnatal Ward Senior Sister and Matron as required.

5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Women and children's Health	Department	Maternity
Person completing the EqIA	Michelle Hancock	Contact No.	86402
Others involved:	No	Date of assessment:	04/2021
Existing policy/service	Yes	New policy/service	No

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be affected?	*Midwives, Nursery Nurses and Maternity Care Assistants*

Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	YES	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?
Emails, teams meetings
How are the changes/amendments to the policies/services communicated?
emails
What future actions need to be taken to overcome any barriers or discrimination?

What?	Who will lead this?	Date of completion	Resources needed
Review date of EqIA	04/2024		