1.0 Introduction

Health Canada, the Canadian Paediatric Society and American Academy of Pediatrics all have clearly outlined position statements regarding safe sleep practices for infants and children. These guidelines discuss sleep surface, positioning, and other factors aimed at decreasing the incidence of Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Death in Infants (SUDI).

These guidelines have been used to guide practice that ensures a safe sleep environment for infants hospitalized at SickKids. Health care professionals should role model best practices as well as teach caregivers about their role in ensuring their child's safety both in hospital and home. Keeping in mind that there are many social, cultural and emotional influences, as well as customs and traditions surrounding infant sleep, creating a safe sleep environment is a priority for health care professionals and parents/caregivers alike.

2.0 Definitions

**Bed-sharing:** The practice of sharing a sleep space between infant and an adult (either in a bed, cot, chair or on a couch).

**Caregiver:** Parents or responsible adult providing care and supervision.

**Crib:** The sleeping space dedicated to an infant. The most common crib used at SickKids is the Pedigo 500 model pediatric crib. Cribs may have different names labelled on them depending on the manufacturer's name for the crib at the time of purchase. Some Stryker cribs are in use, called Stryker Cub Cribs. Cribs are used for infants and may be used for young children up to 4 or 5 years depending on the child's size, developmental age and risk factors that are suited to a crib environment for sleep.

**Plagiocephaly:** A condition characterized by an asymmetrical distortion (flattening of one side) of the skull. Often this is the result of lying in one position or secondary to a diagnosis of torticollis.

**SIDS:** Sudden Infant Death Syndrome (SIDS) is characterized by the death of a child under one year of age, which remains unexplained after a thorough case investigation. SIDS is a diagnosis of exclusion, providing all other aspects of the death investigation are negative.

**SUDI:** Sudden Unexpected Death in Infants (SUDI) refers to unexpected and sudden death in a child under one year of age when any part of the death investigation is positive (e.g. negative autopsy, but evidence of an unsafe sleep environment). Where there is any significant concern regarding any part of the death investigation that cause of death should be classified as a “Sudden Unexpected Death in Infancy”, and the manner of death will be recorded as "undetermined".
3.0 Policy for Creating a Safe Sleep Environment

3.1 Policy Statements | Rationale
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3.1.1 All infants/toddlers under 2 years of age will be placed in a crib, incubator or isolette overbed as clinically appropriate while in hospital | To reduce SIDS and SUDI as per evidence-based safe sleep practices

   The practice of bed-sharing has been identified as an unsafe sleep environment for infants (particularly with medically fragile infants) and as such, caregivers will be asked to refrain from bed-sharing (including day bed, couch etc.).

3.1.2 Infants are to be placed on their backs to sleep | To reduce SIDS and SUDI as per evidence-based safe sleep practices

3.1.3 Ongoing assessment of the infant's developmental state will be performed to inform safe sleep practices | To ensure the individual infant's need for the safest sleep environment is being met as they grow and develop.

3.1.4 Safe sleep policy statements and guidelines may be adapted to meet the needs of the medically complex patient, while keeping in mind the underlying guiding principles. | A large number of patients have medical conditions or are undergoing treatments requiring positioning other than supine (e.g. NICU, ICU and other locations as medically indicated)

4.0 Guidelines for Creating a Safe Sleep Environment:

4.1 Indications for a crib:
When assessing the need for a crib, the following should be considered:

| Indication | Guideline |
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4.1.1 Age | - Under 2 years of age will be placed in a crib, incubator or isolette overbed as clinically appropriate while in hospital (unless there is a possibility that the child could climb out on their own and/or are taller than 90cm)
- 2 years up to approximately 4 years of age may potentially require a crib environment due to their size, stage of development or other risk factors

4.1.2 Height and/or Developmental Stage | - A crib dome will be used if the child is able to pull themselves to standing to prevent climbing over the rail or if the child is over 90 cm (35 in) tall. Please see Least Restraint ==>

4.1.3 Weight | - The weight maximum for Pedigo 500 is 200 lbs or 90 Kg. should not be exceeded.

4.1.4 Transportation | - An infant/toddler should be transported in their assigned crib with all side rails in the...
4.2 Appropriate sleep surface:

- 4.2.1 All cribs will arrive with a mattress in place. Air mattresses, egg crate mattresses and additional padding in sleep areas are not considered safe for use in young children and should not be routinely used as a sleep surface.
- 4.2.2 For patients at risk of skin breakdown, use preventative measures such as repositioning and skin hygiene practices. Be aware that soft surfaces used to prevent skin breakdown put infants at risk for an unsafe sleep environment and use during hospitalization should be limited to only when deemed medically necessary.
- 4.2.3 If a therapeutic surface (e.g. RIK mattress) is deemed appropriate for patient use, continuous electronic monitoring of the patient must be in place while the infant is sleeping or left unobserved.
- 4.2.4 Infants should not be left to sleep in strollers, car seats, seating devices, playpens or swings. Many of these devices do not allow for a baby to lie flat/supine which may lead to a decrease in air flow and is one of the risk factors contributing to SIDS. Infants occasionally fall asleep while in positioning devices or infant seats. Attempts should be made to move the infant to a more appropriate and safe environment for sleep. If this is not possible, then every effort should be made to ensure the fundamental aspects of the safe sleep guidelines are being met, such as securing safety belts appropriately; ensuring crib side rails are in the uppermost position, observation of the child etc. Refer to Upright Seat Cardiorespiratory Monitoring for Infants and Children for more information.

4.3 Side rails:

- 4.3.1 Side rails of the crib should be secured in the most upward position* when care is not being directly provided to the patient.
- 4.3.2 When providing bedside care, the rail should be lowered on the side where care is being provided and then raised to the full position once care is completed.
- 4.3.3 Reinforce the message of ensuring side rails are up with caregivers.
- 4.3.4 Anticipatory guidance should be provided to caregivers regarding child development and mobility that could increase the infant's risk of falls.

*Note: Clinicians are encouraged to use clinical reasoning and judgment if competing risks are identified with the crib rails in the most upward position. These can include risks associated with the dislodgement of lines/tubes, entanglement, patient acuity and gaining access to the patient. Additionally, rails in the mid-position may be appropriate if the child's age and development do not add additional risk to the patient. To ensure patient safety there should be an ongoing assessment of the environment including the height of crib rails as per guideline 3.6.

4.4 Infant Positioning Considerations:

- 4.4.1 Alternate positioning for infants with complex medical conditions or the need for certain treatments are often required and/or recommended by the health-care team. If the medical decision is to place an infant/child in any position other than supine, there should be documentation in the chart and the plan of care to support the rationale for positioning and the use of any positioning rolls. Clinical observation and/or continuous electronic monitoring are recommended in these situations. Caregivers should be provided with clear explanations regarding any modifications to safe sleep practices.
- 4.4.2 Strategies should be incorporated to reduce the incidence of plagiocephaly (refer to AboutKidsHealth: Flattened Head Syndrome (Positional Plagiocephaly)). If modified positioning is required as a medical treatment for positional...
plagiocephaly, this should be clearly documented in the chart and reviewed as the patient's status changes. Educational materials on the prevention and management of positional plagiocephaly are also available through the Family Resource Centre.

- 4.4.3 Supervised "tummy time" should be encouraged when the infant is awake to prevent positional plagiocephaly and to encourage normal development.

4.5 Crib Environment:
- 4.5.1 The crib should be free of all toys, stuffed animals, extra bedding, diapers, creams, medicines, clothing and seating devices. Bumper pads are not recommended for use as they impair airflow and pose a smothering danger. In situations where bumper pads may be seen as a necessary precaution, consider all reasonable alternatives (e.g. supervision until the child is asleep, constant observation). There may, however, be individual situations and/or medical conditions (e.g. seizure disorders, head injuries) which warrant the use of bumper pads. In such cases:
  a) Provide clear documentation in the patient record as to the rationale for the use of the bumper pads.
  b) Contact transportation to request the bumper pads and they will deliver them to the unit (If using bed bumper pads, see instructions for assembly in section 5.0 Related Documents).

- 4.5.2 Allow only one child per crib.
- 4.5.3 The crib should be assessed for potential strangulation dangers (e.g. call bell device cords, over-bed light cords and cables attached to patient monitors). Ensure that all cords and wires are removed from the child's reach as best as possible. Care must be taken to ensure the appropriate use of patient monitors to ensure the safest sleep environment possible. Please see Electronic Patient Monitoring and Prevention of Entanglement, Strangulation, Entrapment (ESE) and Falls.

- 4.5.4 Pacifiers should be CSA approved and should not be placed around the neck of an infant at any time as this poses a strangulation risk. The use of a pacifier is a personal choice for parents, but it is imperative to advocate the safe use of a pacifier for sleep.

- 4.5.5 Infants should not be overdressed during sleep as evidence suggests a connection between overheating and SIDS. A general clothing guideline is to dress the child in 1-2 light layers and adjust the room temperature to the comfort level of a lightly clothed adult.

4.6 Ongoing assessment of the environment:
- It is imperative to ensure that the sleeping environment is reassessed on a shift by shift basis to ensure that the infant/child’s developmental and medical condition, level of wellness or needs have not changed as changes could create new safety hazards that need to be addressed. For example, infants may learn to roll, sit, or move in new ways while they are in the hospital.

4.7 Communication with Caregivers about safe sleep environments:
- 4.7.1 Caregiver education may include information re: safe sleep and their role in ensuring a safe environment for their child while in hospital. Caregivers can be directed to safe sleep written and electronic resources available through the Family Resource Centre, as well as, About Kids Health, Health Canada and the Public Health Agency of Canada as necessary.

- 4.7.2 Safe sleep recommendations are to be reviewed and documented at the time of a patient's discharge home.
- 4.7.3 Caregivers' and children's sleep quality and preferences may be discussed.

- 4.7.4 Ask caregivers and children what may assist them to get good quality sleep while also ensuring safe environment.
5.0 Failure to comply with safe sleep policy and guidelines:

5.1 Caregiver Consideration:
- 5.1.1 In the event that caregivers decline to follow hospital recommendations outlined in this policy, refer to the Algorithm for Infant Safe Sleep Practice (below) on how to manage and escalate the situation. (See attachment section at end of document)
- 5.1.2 Conversations with caregivers regarding safe sleep recommendations and a decision not to comply should be clearly documented in the chart.
- 5.1.3 A Safety Report should be completed when there is a decision not to comply with safe sleep recommendations.

6.0 Related Documents

- Bumper Pads for Hill Rom Beds
- Intrahospital Transfer of Patients
- Upright Seat Cardiorespiratory Monitoring for Infants and Children for more information
- Electronic Patient Monitoring
- Prevention of Entanglement, Strangulation, Entrapment (ESE) and Falls
- Least Restraint

6.0 References

- About Kids Health - Flattened head syndrome
- American Academy of Pediatrics - Sleep Issues

Canadian Paediatric Society Update: Positional Plagiocephaly and Sleep Positioning

sleep policy CPS.pdf

Coroner's Report 2008, Pediatric Death Review Committee; p.19-22; "Unsafe Sleeping and Bedsharing vs. Co-sleeping"


First Candle/SIDS Alliance

Health Canada Safety Advisory - Safe Sleep Practices for Infants
**Safe Sleep Environment for Infants and Toddlers under 2 years of age**

National Institute of Child Health and Human Development  
[https://www.nichd.nih.gov/health/topics/sids](https://www.nichd.nih.gov/health/topics/sids)

Public Health Agency of Canada  

RNAO Clinical best Practice Guidelines – Working with Families to Promote Safe Sleep for Infants 0-12 Months of Age (2014)

The Association of SIDS and Infant Mortality  

**Attachment:**  
Safe Sleep Practice Algorithm August 21, 2013.pdf

**Attachments:**  
- Bumper Pads for Hill Rom Beds.pdf  
- Safe Sleep Practice Algorithm August 21, 2013.docx  
- Safe Sleep Practice Algorithm August 21, 2013.pdf  
- sleep policy CPS.pdf