Document Title:	**MANAGEMENT OF BED SHARING FOR MOTHERS AND BABIES**		
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Related Trust Policies (to be read in conjunction with)	04071 Standard Infection Prevention 04072 Hand Hygiene 06036 Guideline for Maternity Record Keeping including Documentation in Handheld Records 08094 Feeding Guidelines for Preterm Babies on the Postnatal Ward 08013 Care of the Preterm and Small for Gestational Age Infants on the Postnatal Ward 09111 Guideline for the Management of Breast Feeding in the Postnatal Period 09062 Mandatory training policy for maternity services incorporating training needs analysis

Document Review History:			
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1.0	Denise Gray		October 2009
2.0	Denise Gray		23 August 2012
3.0	Dora Bergman		6th October 2015
4.0	Cher Smith	Full Review	12th December 2018

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1.0 Purpose

1.1 To allow mothers and healthy babies to derive the benefits of bed sharing in hospital, while protecting both mother and infant safety.

2.0 Definition

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

2.2 The term bed sharing is used when a mother is sharing a bed with her baby to feed, comfort or provide skin to skin contact while awake.

3.0 Equality Impact Assessment

3.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals
(Refer to Appendix A)

4.0 Background

4.1 This guideline is designed to support safe co sleeping primarily primarily while in a hospital setting however the guidance is also applicable for parents once at home. It is recognised that mothers often take their baby into bed in hospital to feed, provide comfort and closeness without any intention of sleeping with their baby. 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 feeding or holding her baby elsewhere.

4.2 Co-sleeping is associated with longer and more restful infant and maternal sleep.

4.3 Babies who co-sleep with their mother tend to feed more frequently and are more likely to be breastfeeding at three months of age.

4.4 Planned and unplanned co-sleeping is common among parents with new babies after discharge from there is an increased risk of accidents if co-sleeping is not managed appropriately. All parents should be provided with evidence based information regarding co-sleeping to enable informed decisions

5.0 Recommendations

5.1 The safest place for a baby to sleep is in a cot in the same room as the mother for the first 6 months. Co-sleeping should not be recommended or initiated in hospital where there are any concerns for the mother or baby’s health and wellbeing.

5.2 Staff should discuss the benefits of and contraindications to co-sleeping with all mothers in the antenatal period and again in the early postnatal period to allow parents to make a fully informed choice.

5.3 All parents should be informed of the following information:

- The dangers of bed-sharing if either the mother or father is a smoker
- The dangers of bed-sharing if either the mother or father have consumed alcohol or taken drugs which alter consciousness or cause drowsiness
- The dangers of bed-sharing when unusually tired (i.e. to a point where parents would find it difficult to respond to their baby)
- The dangers of sleeping with a baby on a sofa, waterbed, beanbag or a sagging mattress
- The dangers of letting a baby sleep alone in an adult bed
- The dangers of letting a baby sleep with other children or pets and the ways to reduce the risk of accidents
- The importance of ensuring the baby does not overheat whilst bed-sharing
- The benefits of co-sleeping to successful breastfeeding in the absence of contraindications
- The benefits of bed-sharing and co-sleeping for settling and comforting babies

5.3 The patient information leaflet entitled “sharing a bed with your baby” may be useful to assist parents in making an informed choice.

5.4 Mothers who choose to co-sleep while in hospital will need to have an individual risk assessment completed (See appendix A).The mother should then be advised accordingly. It should be noted that mothers and babies circumstances often change quickly therefore, risk assessments will need to be reviewed as required.

5.5 Discussion of the benefits and contraindications to co-sleeping and details of the risk assessment should be documented with the maternal notes including any risks noted and details of the advice given to mothers.

5.6 All staff with responsibility of caring for mother infant dyads should discuss with the mother any risk factors which would indicate strongly advising against co-sleeping.

5.7 If mothers wish to co sleep then the following points should be considered:

- Babies should be either supine or breastfeeding; preferably in skin to skin they should always be placed on the mattress, not on a pillow and never covered by a quilt.
- The baby’s head should be free from all coverings including hats and bed clothes
- no part of the mother’s body should cover the head or face of the baby
- The call bell should be in easy reach of the mother
- Care should be taken that the baby cannot fall out or become trapped between the bed and other furniture. Pillows should not be used to prevent baby from falling out as they can be dangerous for new-borns
- The bed should be on its lowest possible setting
- If the partner or another visitor isn’t present then the curtains should be pulled back or door left open to allow staff to monitor frequently without disturbing.
- When handing over care staff must ensure that it is highlighted that this mother and baby are co-sleeping
- Hospital staff should check and document every 30 minutes that the baby is in an appropriate position and nothing is covering the face or head.

5.8 Contraindications to co sleeping within the hospital

- Mother smokes
- Mother has recently drunk alcohol
- Mother has taken legal or illegal drugs recently, consider prescription medication e.g. oramorph may cause some women to sleep deeply
- Mother has a condition which may alter her state of consciousness e.g. epilepsy or recovering from a general anaesthetic.
- Mother is very obese as this may mean that there is not sufficient space for the baby to sleep safely
- Mother has restricted mobility e.g. recovering from spinal analgesia
- Mother or infant has pyrexia or any other signs of illness
- Infant is preterm or small for dates
- Mother is too tired to respond to the baby's needs, consider very long difficult labours or an extended induction process.
- Infant is not breastfed, mothers who breastfeed respond differently and have been found to sleep facing the baby. Infants who are formula feed sleep more deeply for longer periods and are more prone to respiratory tract infections

5.9 Every mother should be provided with the leaflet "sharing a bed with your baby' when discharged from the unit

6.0 Staff Training

6.1 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training.

6.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

7.0 Infection Prevention

7.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

8.0 Audit and Monitoring

8.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

8.2 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

8.3 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

8.4 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

8.5 Key findings and learning points will be disseminated to relevant staff.

9.0 Guideline Management

9.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

9.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

9.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

9.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for future training needs will be met using methods such as 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

10.0 Communication

10.1 A quarterly 'maternity newsletter' is issued to all staff to highlight key changes in clinical practice to include a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly. Midwives that are on maternity leave or 'bank' staff have letters sent to their home address to update them on current clinical changes.

10.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.

10.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

10.4 Regular memos are posted on the guideline and audit notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

11.0 References

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Unicef UK Baby Friendly Initiation (2013). Caring for your baby at night (online). Unicef UK Baby Friendly Initiative. Available: https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/sleep-and-night-time-resources/caring-for-your-baby-at-night/ accessed on 21/08/18

Useful resources:

https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2016/07/Co-sleeping-and-SIDS-A-Guide-for-Health-Professionals.pdf

https://www.lullabytrust.org.uk/safer-sleep-advice/

https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2017/08/UNICEF_UK_statement_bed_sharing_research_210513.pdf

http://www.nhshighland.scot.nhs.uk/YourHealth/Documents/Breastfeeding/UNICEF%20Sample%20Policy%20-%20Babies%20Sharing%20their%20Mothers%20Bed%20while%20in%20Hospital.pdf

Appendix A: Preliminary Equality Analysis

This assessment relates to: Management of bed sharing for mothers and babies (09091)

A change in a service to patients		A change to an existing policy	**X**	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	Answers
1. What are you proposing to change?	Full Review
2. Why are you making this change? (What will the change achieve?)	3 year review
3. Who benefits from this change and how?	Patients and clinicians
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Refer to pages 1 and 2

Preliminary analysis completed by:

Name	Cher Smith	**Job Title**	Senior Midwife	**Date**	November 2018

Appendix B

Guidelines for Assessing the Level of Risk when Mothers and Babies are Sharing a Bed in Hospital

1. The level of risk depends on the following factors at the time that bed-sharing will occur:
   - Clinical condition of the mother
   - Other contra-indications to co-sleeping
   - Feeding method
   - The safety of the physical environment

Clinical Condition of the Mother

2. 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 supervision when sharing a bed with her baby. It is not advisable for these mothers to co-sleep unless constantly supervised

3. Examples of such mothers would include those who are:

   - Under the effects of the 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 it would affect 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 such as multiple sclerosis or paralysis, or conditions affecting spatial awareness such as blindness
   - Very obese (individual assessment will be required, preferably with the mother, based on the mother's mobility, spatial awareness and the space available in the bed)
   - Likely to have temporary losses of consciousness e.g insulin dependant diabetic, epileptic

4. The level of supervision required will depend on the severity of the mother's condition. This will need to be assessed by a suitably trained health professional. When possible, this assessment should be carried out in consultation with the mother. It is **not** advisable for these mothers to sleep with their babies unless **constantly** supervised

Other contraindications to breastfeeding

5. Any mother or baby to whom any of the following applies will require some level of supervision when bed-sharing as there is evidence to suggest that **co-sleeping for these mothers may cause an increased risk of sudden infant death or accident:**

   - Mothers who smoke
   - Baby is premature or ill*

6. These mothers should be informed that it is advisable to avoid sleeping with their baby. Mothers should be asked to inform staff when taking their baby into bed if there is a

possibility that they may fall asleep. Some level of supervision will then be required until the baby is put back in the cot to ensure that mother and baby are well and the mother has not fallen asleep

7. An ill or premature baby may require professional supervision over and above that outlined in this policy. These babies are at increased risk of sudden infant death and it is not known whether co-sleeping increases this risk further. Therefore a cautionary approach is recommended.

Feeding method

8. There is evidence to suggest that breastfeeding mothers sleep facing their babies and adopt a protective sleeping position. However, mothers who are artificially feeding can sometimes turn their backs on their babies once they have fallen asleep. Therefore, whilst bottle feeding mothers may take their baby into bed for comforting and settling, it is probably safest to advise that the baby be put back in the cot before going to sleep, as at present it is unknown whether teaching safe sleeping positions to bottle feeding mothers is feasible and effective.

9. These mothers should be asked to inform staff when taking their baby into bed if there is a possibility that they may fall asleep. Some level of supervision will then be required until the baby is put back into the cot to ensure that the mother and baby are well and the mother has not fallen asleep.

10. A breastfeeding mother with none of the contraindications listed in A or B whose baby is healthy and term may find it helpful to bed share in order to allow her to rest or sleep while the baby feeds. She should be asked ton inform staff when taking her baby into bed if there is a possibility that she may fall asleep. If the mother wishes to co-sleep with her baby then appropriate sleeping positions should be discussed using the leaflet ’Sharing a bed with your baby’.

11. An assessment should be carried out by a suitably qualified health professional in conjunction with the mother, and in light of availability of suitable safety equipment to determine the level of supervision required during bed-sharing. When the mother is asleep, checks will be required to ensure the baby’s head remains uncovered and when not feeding, the baby is in the supine position and that no other risk factors are present.

The Safety of the Physical Environment

12. It is important that babies are protected from falling out of bed. In Hospital the bed should always be lowered as far as possible and the bed clothes tucked around mother and baby. Some units use cot sides/bed-guards to prevent the baby falling out of bed. These have proved successful and popular with mothers. However, some cot-sides/bed-guards leave a gap between the side and the bed which presents a danger of entrapment. Therefore care should be taken when choosing and using cot-sides. The use of three-sided clip-on cots may also be used if available. These allow the mother easy access to her baby and can prevent the baby falling out of bed.

13. For some mothers, depending on clinical condition, the use of such equipment as a clip-on cot or cot side will make it possible for the mother and baby to be left unsupervised for longer periods. Additionally, 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 asses the family’s willingness and suitability and give basic

instruction. The presence of a family member or suitable equipment does not negate the professional responsibility and accountability for safety.

Level of Supervision Required

14. 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
- Frequent supervision, e.g. every 5-10 minutes for mothers who can be left for short periods only.
- Intermittent checks to ensure that the mother has not fallen asleep if she is bed-sharing when co-sleeping is contra-indicated, e.g. mothers who smoke.
- Intermittent checks for breastfeeding mothers with none of the contra-indications listed in A and B who are sleeping to ensure that no dangers are present for the baby

15. The level of supervision and frequency of checks required must be decided by a suitably qualified health professional based on the factors listed from A to D above.
It is important to ensure that the bed-sharing guideline is fully implemented for all mothers and babies who are bed-sharing. Ensuring that mothers and babies can easily be seen when bed-sharing will assist staff to make the necessary checks easily and quickly without disturbing the mothers and babies. Keeping curtains slightly open and low level lighting can help with this.