

10 CARE OF NEONATE

10.2 ROUTINE CARE OF THE NEONATE IN THE WARD

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10.2.5.1 Bed Sharing/Co-sleeping
Section B
Clinical Guidelines
King Edward Memorial Hospital
Perth Western Australia

10.2.5 STRATEGIES TO REDUCE SUDDEN INFANT DEATH SYNDROME (SIDS)

10.2.5.1 BED-SHARING / CO-SLEEPING

AIMS

- To ensure the safest possible sleeping environment for mothers and babies
- To reduce the risk of sudden unexpected infant death associated with bed-sharing in high risk situations
- To ensure that parents are provided with all the information required to make an informed choice, and for those who do choose to share a bed with their baby, to enable them to do so as safely as possible

KEY POINTS

1. Bed sharing / co-sleeping clinical guidelines should be read in conjunction with Clinical Guideline [B 10.2.5 Strategies to Reduce Sudden Infant Death Syndrome](#).
2. Maternity staff play a key role in promoting a safe sleeping environment. Information needs to be consistent between hospital, the home and the community. Please ensure that a written information sheet is given to all.

DEFINITIONS

For the purpose of this document:¹

Co-sleeping refers to a mother or her partner/support person (or any other person) being **asleep** on the same sleep surface as the baby

Although the term **bed-sharing** is sometimes used to include sharing the sleep surface when the adult is awake, in the research literature, **bed-sharing** is used inter-changeably with co-sleeping. To be consistent with the literature, this document will consider co-sleeping and bed-sharing to be the same, i.e. a baby sharing a sleep surface (bed, couch or other surface) with an adult when the adult is asleep.

BACKGROUND INFORMATION

SIDS and SUDI

SIDS is defined as the sudden and unexpected death of an infant under one year of age, where the onset of the lethal episode is apparently during sleep and the death remains **unexplained** after a thorough investigation (complete autopsy, review of the circumstances of death and clinical history). As SIDS rates have declined, there is more attention being paid to **explained** deaths, including infection, cardiac, metabolic, and particularly sleep accidents due to an unsafe sleep environment.

The term **SUDI** (Sudden and Unexpected Death of an Infant) includes both unexplained deaths (SIDS) and explained deaths.

THE CHANGING EPIDEMIOLOGY OF SIDS

It is a remarkable achievement that the number of SIDS deaths in Australia from the late 1980s has decreased by over 85%². Public education campaigns about risk factors for SIDS are thought to have contributed to this reduction, especially the factors of parental/smoking and baby sleeping in the prone position. There is still the potential to reduce the numbers of deaths further. Studies of SIDS show that co-sleeping is also a risk factor.

RISKS AND BENEFITS OF CO-SLEEPING

“There is vehement debate regarding the merits as opposed to the dangers of infant parent bed-sharing”³. The issue of bed-sharing or co-sleeping is an emotive and important area.

Within our culturally diverse community, bed-sharing is an accepted child care practice which is becoming more popular in mainstream Australia. In a small Australian study, up to 80% of babies spent some time sharing a bed with one or two parents⁴. For some parents, sharing a bed with their baby may be the only practical option. In other instances it is seen as necessary to protect the baby.

There are positive aspects of bed-sharing such as enhancing maternal-infant bonding. Parents who share a bed with their baby are able to respond immediately to their baby’s needs. Some research has shown that bed-sharing babies, experienced an increased level of maternal response through touching, looking and breastfeeding than cot sleeping infants⁵. Relationships have been found between parent-infant bed sharing and successful breastfeeding, as well as prolonged duration of breastfeeding⁶. Studies have also suggested long term benefits, with those who shared the parental bed as babies becoming adults with higher self esteem, and better social and emotional outcomes⁷.

There are many advocates for breastfeeding and co-sleeping, however the evidence shows that there is a significantly increased risk of SIDS related to co-sleeping, especially in the presence of other SIDS risk factors⁸⁻¹³. It is important to note there is evidence that room sharing (not co-sleeping) with an infant may reduce the risk of SIDS.

The Perinatal and Infant Mortality Committee of WA has noted that a number of infant deaths occurred in situations of co-sleeping, and has published a guideline about co-sleeping whilst breastfeeding¹⁴. The Coroner in WA has also raised the issue¹⁵.

The risk of SIDS in connection with co-sleeping is significantly increased by the other known risk factors for SIDS, such as:

- Sleeping in the prone position
- Antenatal and postnatal exposure to cigarette smoke^{8-11, 13}
- Preterm/low birth weight babies^{10, 16}
- Parental alcohol and drug use
- Soft sleep surfaces (e.g. beanbag or waterbed)^{12, 17}. There is evidence that co-sleeping on a couch is of particularly high risk^{9, 12}.

EVIDENCE ABOUT CO-SLEEPING AND SIDS

There have been many studies of co-sleeping and SIDS, where cases of SIDS have been compared with live controls and information obtained about the sleeping environment and other factors.

The most recent results are summarised in the table.

Recent Case Control Studies of Co-Sleeping and SIDS

Year	Authors	Location	Design	Sample size	Findings re bed-sharing and SIDS
2007	Ruys et al	Netherlands	Case control	138 cases Population data from infant welfare clinics - 1628	Babies less than 4 months Age gradient: 9 fold risk in first month, 4 fold at 1-2 months and not significant from 3 months on (adjusted for smoking)
2006	Blair et al	UK (five regions) Avon study	Case control	325 cases 1300 controls	No excess risk from bed-sharing with non-smoking parents provided baby not preterm or less than 2500gm
2006	McGarvey et al	Ireland	Case control	287 cases 831 controls	Increased risk for babies less than 10 weeks old, even in non-smoking parents. Risk increased 3 fold if low birth weight.
2005	Tappin et al	Scotland	Case control	123 cases 263 controls	Increased risk for babies less than 11 weeks, even if non-smoking parents.
2004	Carpenter et al	European Union ECAS	Case control	745 cases 2411 controls	If mother non-smoking increased risk only in first 8 weeks
2004	Vennemann et al	Germany	Case control	333 cases 998 controls	Significantly increased risk only if smoking mother

The increased risks in the presence of multiple SIDS risk factors can be very high. For example, some New Zealand data showed that the combined SIDS risk for a preterm baby prone sleeping was 18 times higher than a term baby not sleeping prone^{18, 9, 10}.

A large English case control study^{9, 16} recently examined the effect of various risk factors for SIDS in babies who were born preterm (<37 weeks) or of low birthweight (called “small at birth”), and in babies who were not “small at birth”. The risks were compared with the risks for babies not small at birth, sleeping beside the parents’ bed. The effect of all risk factors for SIDS, including bed-sharing, was greater for babies who were small at birth. For babies of normal birthweight and not preterm there was no significant increased risk of SIDS if co-sleeping with non-smoking parents (OR 1.12, 95% CI 0.30-4.27). In the case of co-sleeping with smoking parents there was nine times the risk of SIDS (OR 9.11 95% CI 4.12 - 20.22). For the babies small at birth (preterm or low birthweight), co-sleeping with smoking parents, there was 37 times the risk of SIDS (OR 37.41 95% CI 5.83 – 239.86) and even for co-sleeping with non-smoking parents there was a significant increase in the risk of SIDS (OR 15.18, 95% CI 1.02 to 225.50).

The authors commented that virtually all of the apparent risks associated with bed-sharing with non-smoking parents applied to preterm and low birthweight babies. This study also found that there was an increased risk of SIDS associated with sleeping in a separate room from the parents, for both groups of babies, with the risk being higher for those small at birth.

However, other research has found that whilst the risk of SIDS for babies of normal birth weight co-sleeping with non-smoking parents is small, it is still statistically significant in babies under the age of 11 weeks^{10, 12, 18}.

Most of the research on co-sleeping has been about SIDS and not about sleep accidents (suffocation or asphyxia). One United States study of co-sleeping and suffocation has shown that while the risk of suffocation death in an adult bed was at least 20 times the risk for babies in their own crib, the absolute risk was low at 12 to 25 deaths per 100,000 infants aged less than 8 months. Data on SUDI in NSW showed that the risk of SIDS was 4.2 per 1000 live births.

SUMMARY OF RESEARCH ON CO-SLEEPING

In summary, the research shows:

- There is an increased risk of SIDS associated with co-sleeping with young babies (<2-3 months) and especially those who are preterm and of low birthweight.
- The risk is increased by smoking in pregnancy and parental smoking after birth.
- There is little evidence of an increased risk of SIDS after 2-3 months if no parental smoking.
- There is an increased risk of suffocation compared with sleeping in a cot, but the absolute risk is low. Co-sleeping on a couch is particularly hazardous.

It is clear from the research that where other risk factors for SIDS are present, co-sleeping should be discouraged. In addition, co-sleeping should be discouraged for babies less than 11 weeks. It should be noted that in the UK, over 90% of co-sleeping deaths occurred in an unsafe co-sleeping environment as defined by the UK guidelines (prone sleeping, parents smoke, have recently consumed alcohol, slept on a sofa, or a combination of these factors)¹⁹.

As there is evidence that room sharing with an adult, (with the baby in a separate cot) is protective^{11, 13}, it would appear prudent for health professionals to encourage this behaviour. It is hoped that this will promote bonding and breastfeeding, in the safest manner. The use of clip-on cots in hospital situations would be an ideal method of encouraging this²⁰.

SITUATIONS WHEN BED-SHARING / CO-SLEEPING IS CONSIDERED HIGH RISK^{10, 11, 19, 21}

Research has identified the following situations in which co-sleeping possesses a significantly higher risk of SIDS and should not be recommended:

- Either the mother or father/partner is a smoker
- The mother smoked in pregnancy
- Either the mother or father/partner have consumed alcohol or taken any medication or illicit drugs which may alter consciousness or cause drowsiness
- Extreme tiredness – to the point where parents would find it difficult to respond to their baby
- Sleeping with a baby on a sofa, couch, waterbed, bean bag or sagging mattress
- Excessive bedding e.g. doonas
- Preterm or small for gestational age babies
- Babies under 11 weeks of age
- Sharing a sleep surface with other children or pets¹⁵

It is recommended to AVOID co-sleeping in the following situations:

- * **parental smoking or impaired conscious state,**
- * **preterm and other small babies**
- * **all babies under 11 weeks of age**

Note that supine sleeping position (back to sleep) is particularly important

BENEFITS OF BED-SHARING

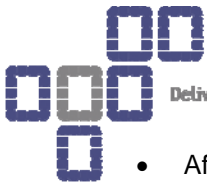
- Promotes breastfeeding
- Allows parents to respond more quickly to the baby's needs
- Helps with settling and comforting babies
- Helps with maternal-infant bonding

SAFER BED-SHARING / CO-SLEEPING INFORMATION FOR PARENTS

It must be recognised that for parents in some situations, bed-sharing is the only possible option. These parents, and those who choose to share a bed with their baby, need advice about how to do so in the safest possible manner. Advice about other risk factors is given above.

The following advice should be given to parents choosing to bed-share or co-sleep with their babies:

- Ensure the mattress is firm and flat
- Make sure the bedding or covers do not overheat the baby
- Ensure that baby is free from pillows and bedding
- Use a safe baby sleeping bag, one fitted with neck and arm holes, as a safe alternative to bedding
- Do not leave the baby alone on the bed



- After breastfeeding make sure the baby is in the supine position and not side lying or prone
- Never let other children or pets sleep near the baby
- Make sure baby can't fall out of bed
- It is safest for the baby to be placed between the mother and the side of the bed, rather than between parents. Cradling the baby with the mother's arm can reduce the chance of the baby falling out of bed.
- Sleeping on a low mattress may be safer than a high bed
- Mothers should sleep facing the baby

BENEFITS OF ROOM SHARING

Research has shown room sharing with an adult is protective against SIDS^{11, 13}. It is advised that the baby share a room with the parents for the first 6 to 12 months of life. Parents should ensure that items such as soft toys, cot bumpers, sleep positioners or sheep skins are removed from the cot.

Room sharing enables the parents to:

- respond to their baby's needs more quickly
- more conveniently and easily settle and comfort their babies than if sleeping in a separate room
- communicate with their baby.

SAFE SLEEPING IN MATERNITY FACILITIES

It is clear from the above research that a number of factors in the maternity hospital (very young babies and tired mothers, often with after effects of medications which cause drowsiness) increase the risks of co-sleeping and therefore precautions need to be taken to reduce the chance of unintended co-sleeping.

On the other hand, close skin to skin contact between mother and baby is vital for the establishment of breastfeeding and the development of maternal infant attachment. For many, if not most women, this includes breastfeeding and settling their baby in their bed. Some women will need closer supervision to ensure that they don't fall asleep with the baby in the bed.

RISK ASSESSMENT FOR MOTHERS AND BABIES IN HOSPITAL

A varying level of supervision will be required depending on the mother's clinical condition for women choosing to breastfeed and/or settle their baby in her bed. Any woman experiencing the following clinical conditions: inability to remain alert, restricted movement and severe difficulty with spatial awareness will require close supervision when feeding and/or settling her baby in her own bed.

SAFETY OF THE PHYSICAL ENVIRONMENT

It is important that babies are protected from falling out of the bed.

Use of clip-on cots, where available, will make it possible for the woman and her baby to be left unsupervised for longer periods²¹. At present clip-on cots are not available at King Edward Memorial Hospital.

In some instances suitable family members can be asked to supervise the woman to ensure the baby's safety. The health professional must use professional judgement to assess the family member's willingness and suitability to supervise the mother and baby, providing appropriate instructions, as needed.

Document in the woman's medical records if she chooses to bed-share against medical advice.

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