



Postnatal Guidelines

No 2 Bed sharing between mother and infant

1. Definition of bed-sharing

For the purpose of this policy 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. It is recognised that whilst in hospital mothers take their baby into bed with them for many reasons (e.g. to feed and to provide comfort and closeness) without any intention of sleeping with their baby. In the absence of maternal sleep, there is no evidence to suggest that this incurs greater risk than the mother holding her baby elsewhere.

Mothers who bed share may fall asleep whether they intend to or not. There is evidence to suggest that co-sleeping is associated with an increased incidence of Sudden Infant Death.

It is the aim of this policy to allow mothers and their babies to derive the many benefits of close contact, whilst ensuring safety.

2. Care for women who wish to bed share whilst in hospital

An individual risk assessment must be carried out for every mother and baby prior to bed-sharing. The level of risk depends upon the following factors:

- Clinical condition of the mother.
- Other contra-indications.
- Feeding method.
- The safety of the physical environment.
- Prematurity of baby (<37 weeks).
- Low Birth Weight (<2.5kg or 5.5lb).
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(See appendix 1 for full risk assessment and details of the above)

Mothers' and babies circumstances can change quickly; therefore risk assessment will need to be reviewed as required. Once a risk assessment has been carried out:

- Ensure the mother is using sheets and a blanket (not duvet) and pillows are out of the way.
- Protect the baby from falling out of bed (see appendix 1, section D -safety of the physical environment).
- Discuss the benefits of and facilitate skin-to-skin contact.
- If breastfeeding, ensure the baby is attaching well to the breast.
- Ensure that the mother has easy access to the call bell.
- Avoid over/under heating baby.

- Covers should be no higher than shoulders.
- Baby in a smoke free environment.
- Assess the level of supervision. This will vary depending on a number of factors. (See appendix, factors A-D).

Categories of supervision will include:

- Constant supervision for mothers whose clinical condition means they cannot take any responsibility for their baby.
- Frequent supervision (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 in the case of bed-sharing when co-sleeping is contra-indicated (e.g. mothers who smoke).
- Intermittent checks for breastfeeding mothers with no contra-indications who are sleeping.
- When handing over care, make it clear that the mother and baby are sharing a bed and the level of supervision required.

3. Parent information.

Parents should be given information in line with the Department of Health guidance about sudden infant death syndrome (SIDS) and co-sleeping, which states that 'The safest place for your baby to sleep is in a cot in your room for the first six months. While it's lovely to have your baby with you for a cuddle or a feed, it's safest to put your baby back in their cot before you go to sleep. There is also a risk that you might roll over in your sleep and suffocate your baby, or that your baby could get caught between the wall and the bed, or could roll out of an adult bed and be injured.'

Parents should be advised never to sleep on a sofa or armchair with their babies. If parents choose to share a bed with their baby, they should be advised that there is an increased risk of SIDS, especially when the baby is less than 11 weeks old, if either parent:

- is a smoker
- has recently drunk any alcohol
- has taken medication or drugs that make them sleep more heavily
- is very tired.
- If a baby has become accustomed to using a pacifier (dummy) while sleeping, it should not be stopped suddenly during the first 26 weeks.

4. Record keeping and documentation

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.

All entries must have the **date and time** together with **signature and printed name**.

Appendix 1

Assessing the level of risk when mothers and babies are bed-sharing in hospital.

A. Clinical condition of the mother

Any mother who would be unable to remain awake, have restricted movement or difficulty with spatial awareness will require constant supervision when bed-sharing. These mothers should not co-sleep unless constant supervision can be provided.

To include the following mothers:

- Under the effects of a GA.
- Immobile due to spinal/epidural anaesthetic.
- Under the influence of any drug which causes drowsiness.
- Ill to the point which may affect consciousness or her ability to respond normally.
- Excessive tiredness which would affect her ability to respond to her baby.
- Very obese (make an individual assessment based on mobility and space in the bed).
- Likely to have temporary losses of consciousness e.g. insulin dependent diabetic/epileptic.

A suitably trained health professional should assess the severity of the mother's condition and the level of supervision required.

B. Other contra-indications to co-sleeping.

There is evidence to suggest that for mothers or babies to whom the following apply, co-sleeping may cause an increased risk of Sudden Infant death or accident.

- Mothers who smoke
- Baby is premature or ill (These babies are at an increased risk of Sudden Infant death and it is not known whether co-sleeping increases this risk further).

Therefore a cautionary approach is appropriate. These mothers and babies will require some level of supervision when bed-sharing. Mothers in this group should be informed that it is advisable to avoid sleeping with their baby.

C. Feeding method

Evidence shows that breastfeeding mothers adopt certain protective positions when co-sleeping with their babies. However, mothers who are artificially feeding do not display the same behaviour and sometimes turn their backs on their babies once they are asleep. Therefore, it is safest to advise a bottle feeding mother, who takes her baby into bed to feed or comfort, to return the baby to the cot prior to going to sleep. Staff should advise these mothers to inform them when taking their baby into bed if there is a possibility that they may fall asleep. Some level of supervision will then be required to ensure that the mother has not fallen asleep.

If the mother wishes to co-sleep with her baby, she should be advised to inform staff. Then appropriate sleeping positions can be discussed and suitable checks carried out to ensure baby's safety when mother is sleeping. Checks will be required to ensure that the baby's head is not covered and, when not feeding, that the baby is in the supine position.

D. The safety of the physical environment

It is paramount that babies are protected from falling out of bed. The bed should always be lowered as far as possible and the bedding securely tucked around mother and baby. If cot sides are present then they should be raised. However, care should

be taken with different types of cot sides, as some leave a gap between the sides of the bed which presents a danger of entrapment.

Monitoring and Audit

Auditable standards:

Please refer to audit tool, location: 'Maternity on cl2-file11', Guidelines

Reports to:

Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit

Frequency of audit:

Bi Annual

Responsible person:

Senior midwife

Cross references

PN 1. New-born Feeding Guideline and Management of Weight Loss

References

Department of Health (2009) Reduce the risk of cot death. London: Department of Health.
Available from: www.dh.gov.uk

National Institute for Health and Clinical Excellence 2006 Routine postnatal care of women and their babies. London, UK

<http://www.nhs.uk/conditions/Sudden-infant-death-syndrome/Pages/Introduction.aspx>

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