Baby Essentials

Peer education to prevent sudden infant death

User's Resource Kit

Stephanie Cowan and Sharon Bennett

October 2009

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www.changeforourchildren.co.nz

change FOR OUR children
respect for every child - hope for every future

Atawhaitia ahau i roto moemoea
(From my earliest beginnings, pursue protection so that I may dream.)

Words given to the project by Whaea Terehia Kipa

Baby Essentials
Peer education to prevent sudden infant death

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Section 1. Presentation

Preparation for presenting 'Baby Essentials' to others

INTRODUCTION

'Baby Essentials' is an education package of essential understandings for protecting a baby's life. It has been designed to align a nation in its efforts to prevent sudden unexpected death in infancy. The presentation offers the bare essentials. It has been designed for all who work in organisations that have a role in supporting families - board members, managers, service and support staff.

Each slide has several layers of value: from just the bottom line for some, the graphics and key points for others or the full content for many. It belongs to a family of 'Essentials' materials we have designed for addressing family smoking. The hope is that every viewer, whatever their role in an organisation will take one thing from this presentation and use it to build a safer start to life for our children. This is why the material is for everyone.

PRESENTING

Principle: Protecting children is everyone's business

Purpose: To build a knowledge base, challenge attitudes that can undermine safety and align a nation with a set of principles for protecting infant life.

Time: Allow 30 minutes all up: 15 minutes for the presentation and 15 minutes for discussion.

Resource: The 24 slide MS power point presentation, 'Baby Essentials', is available at www.changeforourchildren.co.nz. A handout template for copying is provided with this Users' Kit.

Introduce presentation: Open with: 'Baby Essentials' is a national programme of essential education for protecting a baby's life. It has been designed specifically for use in busy work settings and for everyone in the organisation. There are two parts: information update (understanding) and skill practice (doing). This presentation is the "understanding" part. I bring it to you as your peer, not as an expert. We can discuss as we go and / or discuss at the end of the session. I will take responsibility for keeping to time. We have allocated 30 minutes all up."

Presentation: Use the "slide guide" on pages 6 and 7 as a prompt for explaining each slide and to identify key learning points. Avoid simply reading each slide. We suggest a time of silence as each new slide appears to enable people to orientate to the slide and personalise learning. Draw attention to the summary trailer at the bottom of each slide. Present information at a steady pace and as neutral fact. Resist the temptation to understate or overstate the information. Let it speak for itself. Invite comments and reactions. Hear these. Avoid being drawn into defending information or opinions. Recognise the difference between what is opinion and what is fact. Direct any questions that you cannot answer to a trusted expert, or to Change for our Children. We will check it out with the appropriate source on your behalf. Remember, you are a peer educator in this situation. You do not need to know all the answers yourself.

Discussion: Facilitate a discussion that encourages people to respond to the information ("How was that for you?", "What are your first thoughts?"), highlight specific learning ("What did you learn in particular ?"), apply it to their practice ("What does this mean for us as ...?")

Close and Link: "Let's move now from understanding to practice; from why we need to act to what we need to do. Our focus for the next 30 minutes will be 'baby essentials' discussions."

TIPS ON PRESENTING

The CME principle

Remember to make your presentation **C**lear, **M**emorable and **E**mpowering

- build — on strengths, experience, knowledge, what is currently going well
- be clear — talk in bullets not paragraphs, lift out key points and summarise
- personalise — make memorable by sharing a story, using a prop ...
- empower — leave people with more control; with ways to act on what they know

Bring people with you

How people receive information depends on how they see things - on their particular beliefs, expectations, experiences, environments and backgrounds. These can either free people to take on new information and ideas, or block them and cause defensiveness and resistance.

As presenters we need to work gently to influence -

- vulnerability — Does this concern me?
- seriousness — Do I believe this is important?
- degree of control — Can I do anything about this?
- action triggers — Is this a good time to change things?
- costs and benefits — Is it worth the effort?

Tips

Tip	Example
Open	Open strongly to engage people, draw them in
Set-up	Take time to set up expectations. This is about … We expect ...
Package	Consider appropriate context (cultural, professional …) for group
Number	There are 3 points here, 1 …, 2…, 3…
Emphasise	… This is important …
Repeat	60 children … That's 60 children who ...
Talk	In punchy bullet points not waffled paragraphs
Restate	Let's look at that another way …
Focus	See here (point)
Bridge	We've looked at beliefs, now let's look at how to influence ...
Question	So what do you see as positives here?
Invite	Would someone like to comment on that?
Affirm	These are good questions
Summarise	Let's just pull things together here.
Close	Close strongly to share accountability for change

Slide Guide

Guidelines for

"Baby Essentials"

presentation

Slide 1: Baby Essentials

Purpose:

- Title slide to introduce the overall programme and its aims
- Names of featured children to reflect the "through the eyes of a child" perspective of the programme

Key point to make:

Programme name carries the hope of the project - safety principles essential to protecting babies from sudden unexpected death.

Slide 2: My name is Devotion

Purpose:

- To introduce the programme
- To engage participants directly with babies and the theme of protection
- To enable babies to have a voice

Key point to make:

Information is universal (all babies everywhere) and not 'culture dependent' or packaged for specific groups.. Protecting them is a shared and national responsibility.

Slide 3: Babies do die

Purpose:

- To provide context for what is to follow
- To give perspective on the size of the problem
- To clarify terms and extend understanding to all SUDI causes

Key point to make:

Babies do die from preventable causes at rates not acceptable for older children or adults (3 class rooms lie empty each year …).

Slide 4: Which babies die?

Purpose:

- To profile the SUDI baby and show SUDI to be a developmental issue
- To clarify the three groups of risk (triple risk model). To stress they work together to load a baby with risk .

Key point to make:

Unsafe sleep is what tips the balance for many. 'Preventable' means we haven't done enough to protect them.

Slide 5: How do babies die?

Purpose:

- To focus on a breathing
- To present the 2 pathways: weakened baby, sleep hazards, or both
- To promote using protection (not risk) language to create the new reality

Key point to make:

Any action that protects breathing protects life.

Slide 6: Why is arousal important?

Purpose:

- To offer a possible mechanism for death
- To show the links between arousal challenges and SUDI risks
- To inform that arousal 'resets' vital functions, is a babies 'wake-up' call

Key point to make:

Arousal is a critical life-support response for babies and needs to be protected.

Slide 7: Where do babies die?

Purpose:

- To provide facts about location of death.
- To balance the perception that a cot is safe and an adult bed is not. Babies die in both places. Place needs to be made safe.
- The cot is designed as structurally safe for babies but the sleep context matters, too.

Key point to make:

Context is everything. Safety depends on more than the location. Need the triple response.

Slide 8: The co-sleeping debate

Purpose:

- To present the argument for both sides
- To clarify where there is strong agreement

Key point to make:

Debate is good. It is how we get closer to the truth. It means more research is needed to clarify things. We need to share uncertainty with people while we work hard with what we know for sure.

Slide 9: My name is Vaiuli

Purpose:

- To move from knowing facts to believing them
- To stress that more than knowing may be needed

Key point to make:

Information needs to be believed if it is to be acted on. We may need to 'go beyond the leaflet' and 'go beyond telling' in our conversations with families.

Slide 10: Reality check

Purpose:

- To profile an actual SUDI case and make the issue real
- To present the humanity of the situation—caring mother, doing her best
- To influence a sense of responsibility re awareness of risks - unsafe position unsafe swaddling, soft surface, 7 weeks

Key point to make:

The anguish of a preventable death.

Slide 11: Coroner's findings

Purpose:

- To tabulate the build-up of risks
- To strengthen the reality check
- To move the spotlight from bed sharing to highlight positioning, wrapping, pillows, smoking, formula feeding risks

Key point to make:

It is highly likely that these babies need not have died.

Slide 12: Why people don't believe

Purpose:

- To explain the 'but my mother … and we were all fine" phenomenon
- To stress the relationship between developing baby and changing risks
- To provide an understanding for why people do not heed the safety advice (parents and professionals)

Key point to make:

Need to listen for beliefs behind words to influence confidence in safety information.

Slide 13: Some parents say

Purpose:

- To acknowledge the common barriers to believing SUDI information
- To create discomfort in participants who share the perspectives presented

Key point to make:

Prevention needs to extend to helping families with the day to day realities of caring for a baby (e.g. settling, cold houses, crying, winding, head shape, wrapping) yet not undermine essential safety principles.

Slide 14: My name is Chen

Purpose:

- To be representative of NZ society by including Pacific, Maori, Asian and Caucasian babies
- To make a plea for supporting action

Key point to make:

Parents associate addressing issues with a quality service. It is expected. May help to see SUDI is a health issue, not a social one. (This shift has helped re smoking.)

Slide 15: Some professionals say

Purpose:

- To acknowledge the attitudes of professionals that may reduce the confidence of parents in safety advice
- To create discomfort for any participants of this education if they hold the attitudes portrayed

Key point to make:

Attitudes need to align with evidence/best practice. It is a professional integrity issue.

Slide 16: Aligning with protection

Purpose:

- To place opposing paradigms side by side to illustrate two ways to think
- To encourage a shift in attitude towards positive thinking and protective action

Key point to make:

Language carries our attitudes and orientation. Let's orientate towards pursuing protection and make our talk align with that. In this way we create the new reality, help people see it.

Slide 17: Focus on the face

Purpose:

- To share evidence from a large authoritative study re a focus on the face
- To quantify study's risk values (colour matched %s) for professional audiences
- To address common concerns about back sleeping (airway protection reflexes)

Key point to make:

Protection is needed sleep by sleep. Beware 'usually … but …" situations.

Slide 18: Why smokefree matters

Purpose:

- To stress smoking builds a baby's vulnerability, offer a rationale for why and portray 'trapped'
- To present it as '**playing with fire**' especially when combined with bed sharing

Key point to make:

If we only do one thing for children, protect them from smoke. This will improve health development and survival most of all.

Slide 19: Protection beyond sleep ...

Purpose:

- To point out that some SUDI are due to infections, accidents, neglect and abuse
- To identify how care that is **essential for thriving** is also **essential for surviving**.

Key point to make:

Protecting infant life is a package of care. 'Face-up' protects through a critical stage of development, others more generally. Development makes new demands on care.

Slide 20: My name is Katie

Purpose:

- To remind participants of their influence
- To extend the value of SUDI work to the future
- To point out that we influence by what we do or do not do, what we say or do not say - both

Key point to make:

Be strategic about your influence with colleagues and whanau/families. Be conscious about it. Pursue protection.

Slide 21: Safe Sleep Blitz

Purpose:

- To link people to the national effort
- To emphasise that if we do what we have always done, we'll get what we have always had.
- To present a challenge, a call to action

Key point to make:

The vision is for safe sleep for every baby, in every place, at every sleep. This is equity in action. We need to act as one.

Slide 22: What can you do?

Purpose:

- To direct participants towards action that is possible for them.
- To offer options.
- To stress that both systematic and opportunistic action is needed

Key point to make:

Prevention happens through talk. That is how we create change**.**

Slide 23: The partnership

Purpose:

- To present support and change as partners. Professionals support and families change/act

Key point to make:

We need a triple response to the triple risk: face-up + face + clear + smokefree every time a baby sleeps

Slide 24: Summary slide

The 6 principles for protecting infant life

Section 2: Brief intervention

Preparation for shaping discussions with families

INTRODUCTION

This programme is not just about learning. It is also about creating change. We have the knowledge to prevent death and disease for most children of the world. What we also need is a way to turn that knowledge into protection. We have designed this programme to harness the efforts of a lot of people in a short time to pursue protection for babies as they sleep. There needs to be shared leadership, broad participation and the application of clear principles in order to create lasting change. The actions below are about leading change through leading conversations that lead to enhanced protection for babies.

ACTIVITY

Principle: 'A little and often by many over time' creates change.

Purpose: To give practice in using new resources to shape discussions with families about principles for essential care. To allow colleagues to feel "2 minutes" and assess for themselves the value of the "brief intervention".

Time: Allow 30 minutes all up, 10 minutes for each resource. Work in pairs and allow 2 mins practice for each person on each resource and a 5 minute discussion between resources.

Introduce activity: Open with: "We have three resources to help shape and focus a discussion with families. We will take them one at a time. I will demonstrate first. Then we will work in pairs to practice using the resource and see what we can achieve in two minutes. I will set the clock." Introduce, demonstrate, practice and discuss for each resource.

1. Baby Essentials Talk Card*:*

- **Pictures side:** Introduce with "This is to open a discussion about essential infant protection." Demonstrate as if for a parent in pregnancy or with a newborn as appropriate to the group. e.g. Open with "I use this card to have a conversation with every family about essential safety for babies". With the person, identify an appropriate picture and use the format of the ABC discussion guide **Ask, Be clear, Check** to shape your brief discussion. Close with "We will talk more about the other principles another time."
- **Check side:** Introduce with "This is to guide an infant safety check with families." Demonstrate as if for a vulnerable baby (e.g. mother smoking and pregnant or baby born premature) as appropriate to the group. Assess vulnerability/resilience (step 1) and link this to a baby's need for extra protection during sleep. Use the check to plan intentions, assess current practice or guide change. Close with "Face-up, face clear, smokefree, own bed."

2. Safe Sleep Essentials leaflet: Introduce with "This is to provide information about safe infant sleep that extends your discussion and people can take home." Demonstrate as if for someone concerned about babies choking on the back. Open with "We give this leaflet to everyone to be sure everyone knows about safe sleep for babies." Link to fears or uncertainties and emphasise that sleeping babies are not unconscious. They have strong reflexes to guard their airway which work best on the back. Close with "Babies need this protection **every time** they sleep."

3. Safe Sleep Cot Card: For use in hospital cots for newborns to be sure every family knows.

Close and Link: Restate the value of frequent, brief, focused discussions as a way to support families protect their babies from sudden unexpected death.

ABC BABY ESSENTIALS DISCUSSION GUIDE

The table below offers a format for having a brief discussion about each of the six principles for protecting a baby's life. The change principle is: a little and often by many over time. It is the 'by many' that is the power of brief interventions. The table supports a range of 2 minute conversations that can be positive, focussed, supportive and brief.

- **ASK**: to raise the issue.
- **BE CLEAR**: to state what is essential.
- **CHECK**: to support action

Ask	*What are you hearing is the best position for babies to sleep in?*
Be clear	Be clear that sleeping face-up is **essential** care, every place, every sleep. *Face-up is essential protection during a critical stage of a baby's development.*
Check	Check understanding and address concerns. *Is there any occasion when you might not sleep your baby face-up (on the back)?*

Ask	*How much do people talk with you about protecting a baby's face?*
Be clear	Be clear that a clear face and head is **essential** care, in every sleep. *A clear face and head helps a baby breathe freely and protects from suffocation.*
Check	Check confidence with identifying hazard situations *How confident are you about doing a 'hazards check' of where your baby sleeps?*

Ask	*What support have you had to keep your baby smokefree?*
Be clear	Be clear that smokefree is **essential** care, both during pregnancy and after. *A smokefree start builds protection into babies as they develop. It is essential.*
Check	Check expectations and offer referral for smokefree support. *Are/were you smokefree (in pregnancy)? Family smokefree? Home smokefree?* *If you were smokefree, how would things be different? Would you like support?*

Ask	*What are the thoughts of people you know about why breast is best?*
Be clear	Be clear that breastfeeding is **essential** care. *Breastfeeding is much more than food. It strengthens vital systems eg breathing.*
Check	Check understanding and address concerns *Is there any reason you can think of why you might not breastfeed your baby?*

Ask	*How much have you heard about where babies should and shouldn't sleep?*
Be clear	Be clear that 'close to a parent' is **essential** care, day and night, and every sleep. *The safest place for your baby to sleep is in their own safe space near to you.*
Check	Check understanding and address concerns. *When might your baby sleep in another room or a place not designed for babies?*

Ask	*How are you with managing tiredness and your crying baby's crying?*
Be clear	Be clear that gentle handling is **essential** care. *Gentle handling protects your baby's brain from damage at a critical stage.*
Check	Check understanding and address concerns *What support do you have to stay on top of stress / manage crying?*

Section 3: Resource Materials

Sample materials for copying

SAFE SLEEP TALK CARD

This simple Talk Card is for use by professionals to engage families in discussion about protecting a baby's life. It has a deliberate focus on promoting the positive protective behaviours.

Baby Essentials Safe Sleep Check

1. **From the very start**, make babies as strong as possible.

How strong is my baby?

- ☐ Was my baby smokefree in pregnancy?
- ☐ Was my baby born after 36 weeks?
- ☐ Did my baby weigh more than 2500 grams at birth?
- ☐ Is my baby breastfed?

For more vulnerable babies, the extra protection of their very own 'baby bed' (a bed designed for babies) is **essential** every time they sleep.

2. **For every sleep**, make it as easy as possible for babies to breathe freely.

Can my baby breathe freely?

- ☐ Have I put my baby down to sleep face-up? (not side, front or propped on pillows)
- ☐ Is there plenty of space around the face?
- ☐ Is there no chance of getting onto the tummy, near pillows, under covers or into gaps? (i.e. in a safe space)
- ☐ Does my baby breathe only smokefree air?

3. **In every place they sleep**, make the environment as safe as possible.

How safe is the sleeping place?

- ☐ Is my baby close by me (in the same room when I am also asleep)?
- ☐ Is my baby in their own 'baby bed' or in a sleeping space I have made safe for my baby?
- ☐ Have I noticed and removed, or avoided, possible hazards?
- ☐ Does my baby have a sober person with them when there is alcohol, drugs or partying?

Hidden Sleep Hazards

Ordinary things can become sleep hazards for babies as they pass through a critical stage of development. Placing babies in unsafe positions can be why they get into trouble later in their sleep. Hazards may come from: pillows, soft items, loose covers, adult bedding, a soft surface, mattress tipping sideways, being propped, couches, people in the same bed, bulky or tight wrapping, an unusual neck position, pressure on a tiny chest, alcohol, drugs and partying.

SAFE SLEEP ESSENTIALS LEAFLET

This is a general audience information leaflet promoting essential principles for protecting a baby's life. It aims to support professionals shape purposeful discussions that empower families.

Safe Sleep Check

Young babies nap and sleep in many places. This safety check is a way to be confident that every sleep is as safe as possible for your baby.

1. From the very start, make your baby as strong as possible (less vulnerable)

- ☐ Smokefree in pregnancy?
- ☐ Born after 36 weeks?
- ☐ Weighed more than 2500 gm at birth?
- ☐ Breastfed?

Essential: More vulnerable babies need the extra protection of their very own 'baby bed' (a bed designed for babies) every time they sleep.

2. For every sleep, make it as easy as possible for your baby to breathe

- ☐ Placed for sleep face up (on the back)?
- ☐ Plenty of space around your baby's face?
- ☐ In a safe space (no chance of getting onto the tummy, under covers, near pillows or into gaps)?
- ☐ Breathes only smokefree air?

3. In every place your baby sleeps, make it as safe as possible

- ☐ Close by you (same room as you when you sleep)?
- ☐ In own 'baby bed' or own safe space?
- ☐ All possible hazards noticed and removed or avoided?
- ☐ A sober person with your baby if there is alcohol, drugs or partying?

atawhaitia ahau i roto moemoea

from my earliest beginnings, pursue protection so that I may dream

Tummy time

Back for sleep, front for play, upright for cuddles and hugs.

This will help **gravity** protect your baby's head shape.

Summary

Sleeping **face up** (on the back) protects babies through a critical stage of development.

A **clear face** protects babies from suffocation.

A **smokefree** start to life makes babies strong.

The SUDI evidence

Information about SUDI changes as more deaths are explained. Some findings from research are stronger than others. This leaflet is based on major findings agreed by researchers around the world, and is supported by the findings of coroners.

Main Reference:
Carpenter, R.G. et al. Lancet 2004;363:185-91.

October 2009. Code HE1228

Child and Youth Mortality Review Committee

The Office of the Chief Coroner

New Zealand Government

www.changeforourchildren.co.nz

safe sleep ESSENTIALS

Every year, about 60 babies die suddenly in their sleep.

Most deaths are preventable.

Safe sleep means face up, face clear, smokefree every time and place a baby sleeps.

change FOR OUR children

Information on preventing SUDI (sudden unexpected death in infancy)

Message to parents

Precious new baby? Advice from everyone? How do you decide what is essential and what is not? This leaflet offers you essential up-to-date information to help you keep your baby safe every time and every place they sleep.

What is SUDI?

SUDI stands for sudden, unexpected death in infancy. Some SUDI deaths can be explained (e.g. asphyxia or suffocation). Others cannot be (e.g. SIDS or cot death). Most happen in the first six months of life when a baby is asleep.

How does it happen?

Babies have a natural drive to breathe. This fails for SUDI babies. They stop breathing in their sleep. Their breathing may stop because of:

- things in their sleeping environment
- things that weaken a baby's drive to breathe

Who is at risk?

SUDI risk comes from a set of things that act together:

- Some babies have a weaker drive to breathe than others, e.g. due to smoking in pregnancy, a low birth weight, being born prematurely or being bottle fed or unwell.
- Some sleeping situations have more hazards than others, e.g. from pillows, unsafe positioning, people in the bed, loose covers, soft bedding or unsafe swaddling.

All babies, all places, every sleep

All babies need protecting from SUDI, in all the places they may sleep, and every time they sleep.

safe sleep = face up + face clear + smokefree

Sudden unexpected death is extremely rare for babies protected by this safety formula.

Face up

Your baby was designed to sleep face up (on the back). Their drive to breathe works best in this position and their airway is also safer. A built-in alarm reminds them to breathe, and strong gag and swallow reflexes protect their airway if they spill.

Face clear

Your baby was designed to sleep with a clear face. This helps them breathe freely and not get too hot. Your baby may fall asleep with their face clear, but will it stay clear? This will depend on how they lie, where they sleep, and how you make it safe.

Smokefree

Your baby was designed to grow and develop smokefree. All smoking harms babies, especially in pregnancy. Smoking takes oxygen and weakens vital systems as babies develop, e.g. breathing. When born, such babies need extra protection.

Other ways to protect your baby from SUDI

Your baby was also designed to need you **close by** (in the same room as you when you sleep), to be **breastfed** (this strengthens their drive to breathe), and to be **handled gently** (to protect their brain). This is essential care for all babies.

Focus on the face

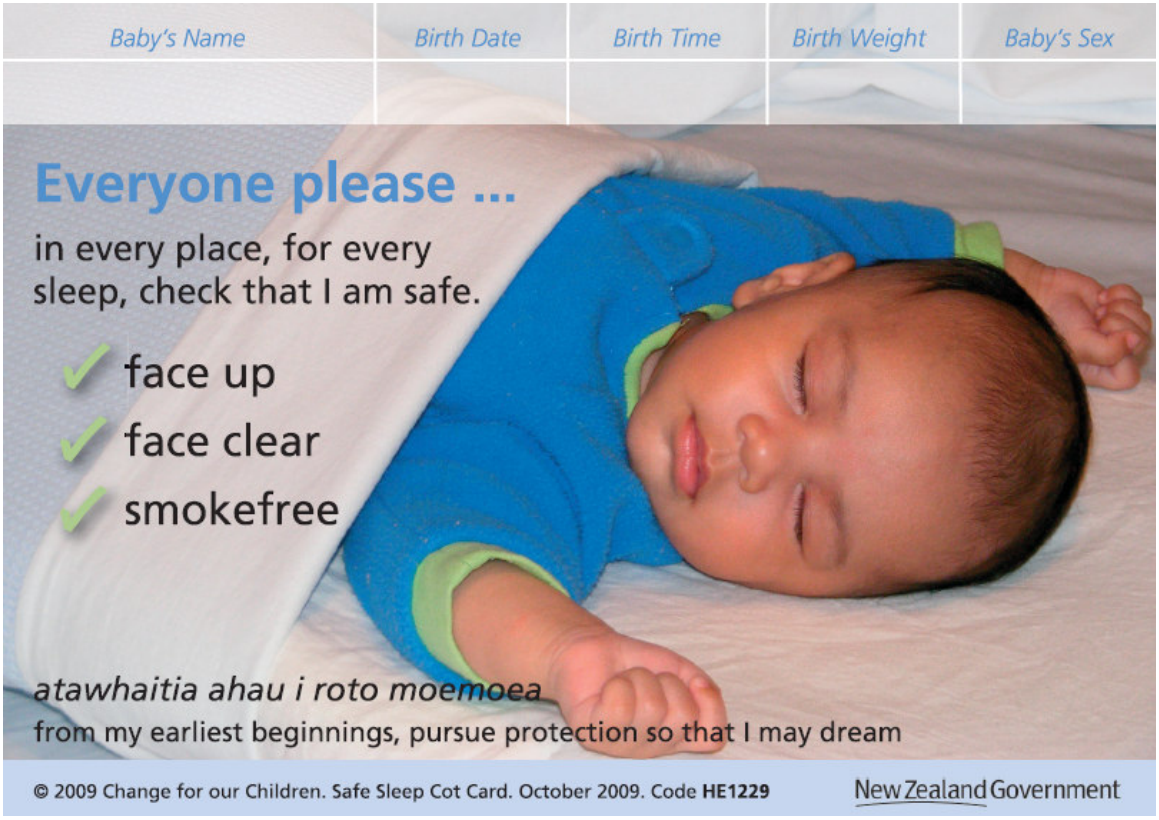
Sleeping babies need to breathe. Placing babies in unsafe sleeping positions, especially if also propped on pillows, swaddled or wrapped, is dangerous. They may suffocate.

What can happen

Too many SUDI babies were placed for sleep on the tummy, or on the side (but rolled forward) or on the back (but propped on pillows). Sadly, many were then found pressed into pillows, underneath bedding, wedged into gaps, with covers over their heads and faces, or under people.

SAFE SLEEP COT CARD

This resource is designed for placement in the infant bed of every newborn baby to encourage a discussion about safe sleep with every family before babies go home. It is a way to be a safety net for all 60000 babies born in New Zealand each year and be sure no baby misses out.



This is why ...

Like all babies, I need to breathe even when I sleep. If air is stopped from reaching my lungs I suffocate. I need whoever cares for me to be sure I am safe **every time I sleep.**

Face up: I am designed to sleep face up (on my back). My wake-up (arousal) response works best in this position. It reminds me to breathe. You may worry I will choke when I sleep on my back, but my gag and swallow reflexes protect my airway if I spill.

Face clear: My face needs to stay clear all through my sleep. Things can change. If you prop me on pillows I may slip off, roll to face-down, or slide down under bedding. If there are others in the bed, they may tip the mattress or even roll onto me. I may get wedged into gaps on couches and chairs. Soft things, like pillows, may smother me. A safe place for me is one where my face stays clear and these things cannot happen.

Smokefree: Smoking, especially in pregnancy, takes oxygen away from me. It weakens my vital systems as they develop. My breathing is not so strong, so I need extra protection when I sleep. Like all babies, I do need to be close to you, day and night, but **if you smoke (or I am premature or low birth weight)** I also need my very own 'baby bed' (such as a cot) every time you put me down to sleep. This is **essential protection** for me.

If people use alcohol, drugs or they party, I need to have a sober person with me.

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POCKET PROMPTS

Baby Essentials

- talking points -

Sleeping 'face-up' is essential protection during a critical stage of a baby's development.

A clear face and head helps a baby breathe freely and protects from suffocation when asleep.

A smokefree start builds protection into babies as they develop. It is essential to protection.

Breastfeeding is much more than food. It strengthens vital systems as they develop.

The safest place for your baby to sleep is in their own safe space near to you.

Gentle handling protects your baby's brain from damage at a critical stage.

ABC Baby Essentials

- to help shape a discussion -

Ask	**To raise the issue**; Ask about: sleep position, the sleeping environment, smokefree exposure in pregnancy and in the household, breastfeeding, location of sleep, closeness to a parent, day and night, and about ways to manage stress
Be clear	To state what is essential
Check	To support action. Check understanding, confidence, expectations and address concerns

Baby Essentials

education for all on protecting babies' lives

Brought to you by Devotion, Vaiuli, Chen, Katie and Change for our Children (2009)

www.changeforourchildren.co.nz

change FOR OUR children

My name is Devotion

Knowing

Please make sure everyone **knows** the information that follows. If we could speak, this is the protection all babies, everywhere would ask for. Fa'afetai.

Protecting babies is everyone's business. 2

Babies do die

Total number (NZ 1994-2005)

- 2072 (all causes, 1-12 months)
- 990 (SIDS/SUDI)

Ref: NZHIS

SUDI deaths include:

- Explained (e.g. suffocation or accidental asphyxia)
- Unexplained (e.g. SIDS or cot death)

SUDI is the term for all sudden unexpected deaths in infancy. 3

Which babies die?

Babies are at risk if:

- Under six months
- More vulnerable due to
  - smoking in pregnancy
  - born before 36 weeks
  - birth weight < 2500 grams
  - influence of alcohol / drugs
- In unsafe sleeping situations

Most SUDI deaths are preventable.

Triple Risk

Ref: Guntheroth et al PEDIATRICS Vol. 110 No. 5 2002

Sleep factors trigger death for most SUDI babies. 4

How do babies die?

Babies have a natural drive to breathe or arousal response. This fails for SUDI babies. They stop breathing in their sleep.

Breathing may stop due to

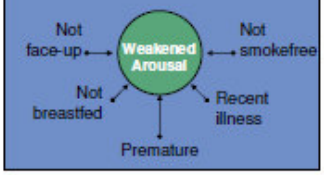
- things that weaken arousal
  - smoking in pregnancy, being premature, low birth weight, bottle fed or unwell.
- hazards in the sleeping environment
  - pillows, unsafe positioning, people in the bed, loose covers, soft bedding, the influence of alcohol and drugs, or partying
- a mix of these

Sleeping babies need to breathe. 5

Why is arousal important?

- It is a baby's defense for life-threatening events
- It 'resets' a baby's vital functions e.g. heart rate, blood pressure, breathing.
- The same factors that weaken arousal, increase SUDI risk.
- Their effect on arousal is greatest at 2-3 months, the peak age for SUDI.

Factors that weaken the arousal response



Ref: Horne R, Paediatr Child Health Vol 11 Suppl A 2006

Arousal is a baby's wake-up call. 6

Where do babies die?

- In any place that babies sleep
- Lower rates in beds designed for babies
  - e.g. cots, bassinettes …
- Higher rates in other places
  - e.g couches, adult beds or mattresses, make shift beds, armchairs …

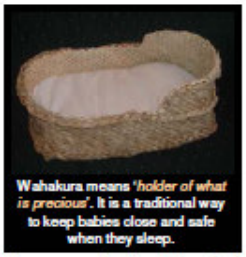
A 'baby bed' is a bed designed for babies.

Ref: Carpenter et al. The Lancet. Vol 363, 2004

Babies need a protected space wherever they sleep. 7

The co-sleeping debate

- Some support a universal ban on babies sleeping in the same bed as parents
- Others support a 'remove hazards and make it safe' approach
- All agree
  - 'in same room as sleeping parent'
  - 'in a bed designed for babies', for high risk situations:
    - Smoking in pregnancy
    - Premature or low birth weight
    - Alcohol, drugs or partying



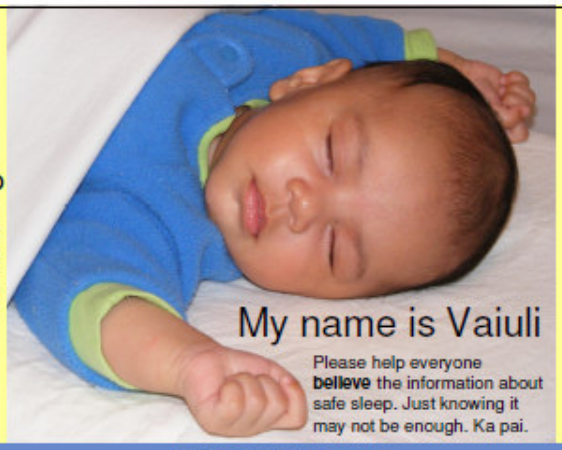
Wahakura means '*holder of what is precious*'. It is a traditional way to keep babies close and safe when they sleep.

No place guarantees safety. It needs to be made safe.

Ref: Paediatr Child Health Vol 11 Suppl A 2006

Disagreement is a sign that more research is needed. 8

Believing



My name is Vaiuli

Please help everyone **believe** the information about safe sleep. Just knowing it may not be enough. Ka pai.

Knowing may not be enough. 9

Reality Check

Circumstances

- healthy baby girl, 7 weeks old, normal birth at 38 weeks weighing 2890 grams, formula fed, smokefree mother
- in portacot in parents' room on three mattresses, top one covered by a sheet, with a top sheet and 3 blankets all tucked in firmly. No pillows.
- baby wrapped tightly in fleecy blanket, her arms tucked in, placed on her tummy, as usual, with head to one side.
- mother knew tummy risky, tried back in first 2 weeks, but baby settled better on tummy
- mother found her baby with her face down into mattress
- **Verdict:** possible suffocation from sleeping on the tummy

Death is a cruel consequence for a parent acting with love. 10

Coroner's findings

Table 1: Accumulation of risks for the seven Wellington SUDI babies

Baby	Unsafe position	Unsafe wrapping	Smoking	Pillows	Formula fed	Smoking & bed sharing	Total risks
A	Yes	Yes	Yes	Yes	Yes	Yes	6
B	Yes	Yes	Yes	Yes	Yes	Yes	6
C	Yes	Yes	Yes	Yes	No	Yes	5
D	Yes	Yes	Yes	Yes	No	Yes	5
E	Yes	Yes	Yes	No	Yes	No	4
F	Yes	Yes	No	No	Yes	No	3
G	Yes	No	?	Yes	Yes	No	3

We have the knowledge to prevent such deaths. 11

Why people don't believe

Healthy adopters
Practices that are high risk in some situations are widely adopted.

Gone away
Compared to 250 SUDI deaths a year 60 seems not many.

Windows of risk
Babies develop their way *into* and then *out of* periods of risk.

Hidden in ordinary
Sleep hazards are not seen in ordinary situations.

Safety advice needs to make sense to people. 12

Some parents say

- I'm scared she will choke on her back.
- He's on his side so he won't get a flat head.
- I prop her on pillows to help her wind, but she is on her back.
- I know back is best, but she settles better on her tummy.
- We all sleep together to keep warm. Our house is freezing.
- When my baby is sick he always sleep in bed with me.
- I thought that was a pakeha thing – sleeping on the back
- We fall asleep together feeding on the couch, never in our bed.
- You can't use patches when you're pregnant. That's why I'm still smoking.
- Can't see what breastfeeding's got to do with cot death. They just say what they like.
- The crying gets to you. I'll do what works. Better than throwing him out the window.

The realities of the moment can compete with what is essential. 13

My name is Chen

Supporting Action

Please help everyone to act on the information in this presentation. Believing it may not be enough. Xie xie ni .

People expect professionals to help them do what is best. 14

Some professionals say

- I don't waste my time on this if they are low risk.
- Too much to cover. You have to pick and choose your topics.
- I did it all wrong with my kids, smoked, on the tummy, in our bed, but they are 'healthy as'.
- I don't agree with babies sleeping in their own beds. No wonder women struggle with breastfeeding.
- It's about whakamā for me.
- Some of these people have very difficult lives. We are there to support them not judge them or tell them what to do.
- Everything keeps changing - cot death, SIDS, SUDI. It just confuses everyone. I've stopped listening.
- I prefer the traditional ways - tightly wrapped, on the side with the bassinette propped.
- Not an issue, now. Used to be.

Attitudes of professionals show in their practice. 15

Aligning with protection

from	to
optional	essential
informing	transforming
messages	principles
usually	always
knowing	understanding
fear	confidence
single issues	in context
avoiding risk	**pursuing protection**

The language of protection helps create the change. 16

Focus on the face

Babies are designed to sleep face-up. Their arousal response reminds them to breathe and strong gag and swallow reflexes protect their airway if they spill.

The Carpenter Study

A large study of 745 SUDI babies and 2411 healthy comparisons found:

62% of deaths were due to:

- Being placed on the tummy (39% vs 11%; risk ↑by 13)
- Turning from side to tummy (12% vs 2%; risk ↑by 45)
- Getting a covered head (25% vs 3%; risk ↑by 12)

Positioning risks change with age.

Ref: Carpenter, et al. The Lancet, Vol 363, 2004

'Face-up, face clear' saves lives. 17

Why smokefree matters

Te Whare Tangata

- a child's first home -

Babies cannot open a window or escape from harm - they are trapped.

- Smoking builds vulnerable babies (more than 1500/year in NZ)
  - takes oxygen, delivers poisons
  - makes placenta struggle and it may 'give up' early (premature birth)
  - weakens vital systems as they develop
  - makes babies weak, sick and die
- Is a highly significant risk for SUDI
  - As is 'smoking + bed sharing' combo (15% vs 2%; risk ↑by 18)
  - smoking is involved in most bed sharing deaths (77%)
- **Is the main cause of preventable death and disease for babies**

Ref: Carpenter, et al. The Lancet, Vol 363, 2004

Smokefree from the start builds resilient babies. 18

Protection beyond sleep

Breastfeeding

Around the world breastfeeding saves lives. It strengthens every aspect of development: breathing, learning, growth, immunity … It helps prepare a child for independent life.

Closeness

Human babies need a parent close by, day and night. The parent must be close enough and able to respond when their baby, or a situation, alerts them to a need.

Gentle handling

Survival depends on gentle handling. Rough handling can tear blood vessels inside the head and cause brain damage or death. A stressed parent needs support.

A baby's care must match the demands of their development. 19

My name is Katie

You have influence. Please use it to protect us.
Thank you.

Influencing

Through children we influence the future. 20

Safe Sleep Blitz

Can we build a culture of **safe sleep for every baby** in New Zealand in the next 12 months?

No, if we

- don't aim to
- keep doing what we do

Yes, if we

- think it matters
- work together
- do things differently

Vision: safe sleep for every baby, in every place, at every sleep. 21

What can you do?

- Do what you can
- The strategy is simple
  - korero
  - talk
  - pecha kucha (chatter)
- Be systematic
  - E.g. build a guided 'baby essentials check' into your practice with every family.
- Seize opportunities

Ideas for conversations		
✓affirm safe sleep practices	✓advise against pillows near a sleeping baby	✓refer for smokefree support
✓be the voice of the baby	✓explain safe swaddling	✓address side sleeping when you see it
✓advise on safe ways to settle babies	✓help balance closeness and safety	✓stress 'every' time, place and sleep
✓stress dangers of falling asleep with babies on sofas	✓guide a 'baby essentials' check	✓be clear about risks for prem and low birth weight babies

Remember the babies. 22

The partnership

Support people to create the change

- From the very start, make babies as strong as possible
  - Smokefree, breastfed …
- For every sleep make breathing as easy as possible
  - Face-up, face clear …
- Make every place a baby sleeps in as safe as possible
  - Designed for babies, checked for hazards …

Development demands a triple response to the triple risk
safe sleep = face-up + face clear + smokefree

A baby essentials 'safe sleep' check is practical support. 23

Six principles for protecting a baby's life

The SUDI story is about to change. Thanks to you. 24

Section 4: System Support

Templates for embedding SUDI prevention practices into service standard

INFORMATION FOR MANAGERS

Thank you

Thank you for participating in the "Safe Sleep" programme. In accepting the invitation to participate, you have declared your commitment to improving the health and survival of children. This is a key step in ensuring success with implementation in your environment.

Coroners

SUDI is the main cause of preventable death of children in the first year of life, after the neonatal period. It takes its place with drowning and suicide as a major concern for protecting our young. New Zealand coroners have taken a particular and high profile interest in SUDI and are asking questions of professionals, services and organisations involved with families when a baby dies. They are asking for what has been discussed with families, what has been recorded, what resources have been shared, what advice given. They are wanting to prevent these deaths, too.

Creating a supportive environment

The nominated Safe Sleep Coordinator from your organisation or service has been prepared to deliver this programme to peers. That person will look to their manager for systems support. This section of the "User's Resource Kit" offers support to managers, in the form of systems templates to guide the change process.

Managers provide the supportive environment within which effective change strategies happen. Like banks on a river, systems direct action from the evidence to the child. They support the flow from knowing to doing to change. Systems to support an effective Safe Sleep intervention may vary with organizations and Change for our Children expects to support where we can. This resource is a start and contains:

- A "Safe Sleep" standard for self-assessment of your service and "Current Issues" and "Work Action Plan" templates to focus planning
- A sample checklist for developing a "Baby Essentials" staff education plan
- Three starter resources (a leaflet, Talk Card and Cot Card) to support implementation
- Sample pocket prompts to support staff to initiate safe sleep discussions with families
- Administrative support for Safe Sleep Champions leading the programme in your setting

Safe Sleep Champions

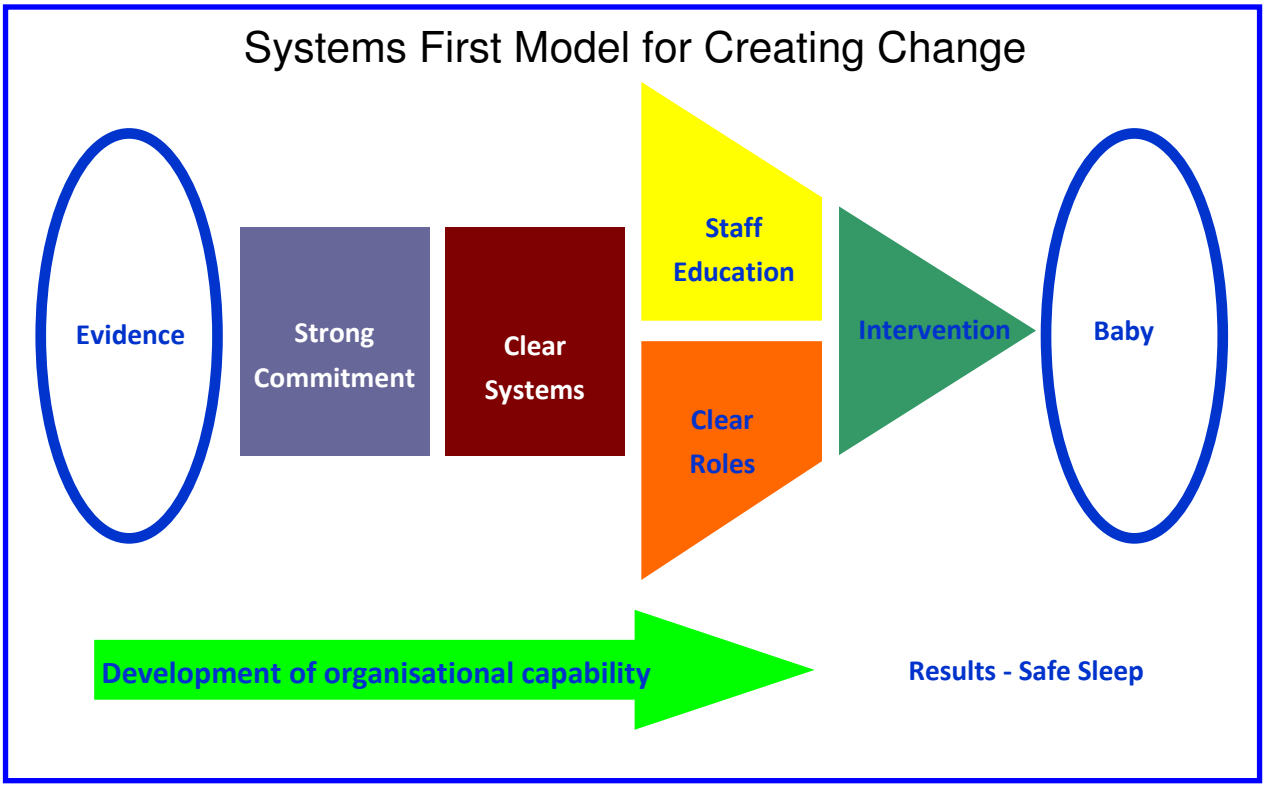
Some district health boards have formalised the Safe Sleep Champion role and we are hoping that all organizations working for the health and wellbeing of children follow this lead. We at Change for our Children will support you and your champion with implementation.

Continuing support

The person you put forward for this role will be part of a national network of peer educators/safe sleep champions working to implement the programme throughout New Zealand. This network will be linked by a regular email communiqué, brief information updates and access to web-based resources. We would ask that this role and resource kit be passed to another senior staffer should there be a change in circumstance for the current person. Thank you for supporting this programme.

MODEL FOR CREATING CHANGE

Our preventive actions need to be highly geared if we are to influence a change in SUDI statistics. They also need to be coordinated, monitored and measured. Sitting firmly behind discussions with families there needs to be a strong commitment from the organization, clear systems to embed education into practice, clear expectations and defined roles. These things build the capability of the organization, education builds the capability of the staff and effective discussions build the capability of families.



INFLUENCE REQUIRES

Strong commitment Statement of organizational commitment to preventing SUDI

Clear Systems
- For providing Baby Essentials Education
- For identifying safe sleep practices of families
- For monitoring change in practice (workers and families)

Staff education 'Baby Essentials' presented to all

Clear roles A nominated Safe Sleep Champion for each region

Safe Sleep Discussions Happening as standard for every family

SERVICE STANDARD

A Safe Sleep service standard is offered as a way to support a coordinated approach to protecting infant life that tracks development and provides accountability to funders and managers for the investment made.

SAFE SLEEP SERVICE STANDARD

Promoting safe sleep for children is an "important but not urgent" activity for most well child services. It is preventive healthcare. It competes for staff attention and time with "urgent and important" activities such as very ill children and families in crisis. There may be individuals in a programme team who have built SUDI prevention activity into their day to day practice. However, reliance on champions such as these means that only some children and families are included in support. When interventions become standard for all, the principle of equity is respected.

For all these reasons, a systematic approach is needed if safe sleep action is to take its place in a baby's total care and enable all families to benefit. Systems support staff to know what is expected. They provide prompts and make intervention simple, brief and more likely. Systems define the standard. The standard below, is a tool for assessing organizational capability to provide an accountable intervention. It is a simple checklist of "essentials" for a systematic approach to promoting safe sleep for babies. It may serve as a self-assessment tool, basis for planning and a way to mark quality improvements.

How well does your service provide a supportive environment for protecting babies from sudden unexpected death in infancy (SUDI)?

Service:

Information provided by: **Date:**

STEP 1 Commitment

This service has a written statement of commitment to preventing SUDI which includes … (attach any relevant documents)

	Y/N	Rating	Comments
► safe sleep assessments expected for **every** baby/family			
► safe sleep education to be provided for **all** staff			
► referral to support services e.g. a smoking cessation service as appropriate			
STEP 1 Total	**/3**	**/15**	

STEP 2 Systems

The service has systems for …

	Y/N	Rating	Comments
► **staff education** – involving and updating all current and new staff			
► **screening** – recording safe infant sleep practices in families			
► **intervening** – discussing safe sleep issues with families			
► **monitoring** these systems and providing feedback to staff			
STEP 2 Total	**/4**	**/20**	

STEP 3 Education

The service has a documented plan that ensures all staff receive ongoing safe sleep education including…

	Y/N	Rating	Comments
► evidence for what is protective and why (six principles)			
► evidence of what increases risk and why			
► attitudes that can support/block the uptake of safety information			
► practice in assessment, planning and discussion skills			
► knowledge of roles, responsibilities, expectations and standards			
STEP 3 Total	**/5**	**/25**	

STEP 4 Roles

	Y/N	Rating	Comments
► champion assigned to champion safe sleep initiatives			
► responsibilities defined for every staff member			
► standard interventions achieved at risk-specific times			
► referral programmes accessed (as relevant)			
STEP 4 Total	**/4**	**/20**	

STEP 5 Intervention

	Y/N	Rating	Comments
► ask about safe sleep related practices to raise the issue			
► be clear about what is essential care (for each of the six principles)			
► check understanding, address concerns, plan for safety			
► guide a safe sleep check with every family of a baby < 6 months			
STEP 5 Total	**/4**	**/20**	

OVERALL TOTALS	**Y/N**	**Rating**
Actual		
Possible	20	100

Guidance Notes

Ratings:
5 Full
4 Substantial
3 Moderate
2 Limited
1 Minimal

Notes:
This assessment is designed to:
provide an overall assessment of *status quo*
highlight achievements
identify current issues and challenges
Y/N rating indicates **fully** present or not
Numerical rating indicates level of achievement as shown at left
Comments exemplify ratings and provide detail of history, achievements, etc

SAFE SLEEP – CURRENT ISSUES

Service:	**As at:** << date >>

This list of key current issues draws on the information gathered during the service's Safe Sleep Service Standard self assessment. It is designed to provide a one-page summary of significant issues that require focused attention and action in order to more fully provide a supportive environment for protecting babies from sudden unexpected death in infancy (SUDI).

ISSUE 1 -

ISSUE 2 -

ISSUE 3 -

ISSUE 4 -

ISSUE 5 -

SAFE SLEEP – WORK ACTION PLAN

Service: **As at:** << date >>

GOAL: To provide a supportive environment for protecting babies from sudden unexpected death in infancy (SUDI)

Targets (Goal statements, top priorities assigned)	**Actions** (Tasks, persons responsible, timelines, tick when complete)

Commitment/Policy

ISSUE -	***Priority***
☐	
☐	

Systems

ISSUE -	***Priority***
☐	
☐	

Education

ISSUE -	***Priority***
☐	
☐	

Role Clarity

ISSUE -	***Priority***
☐	
☐	

Intervention

ISSUE -	***Priority***
☐	
☐	

STAFF EDUCATION PLAN

A guide to support health professionals plan for the systematic use of the "Baby Essentials" education programme. Please compete as appropriate. Thank you.

What is it for? Why are we using this? What do we expect it to achieve?

Describe this programme's place in your overall staff education strategy

- ☐ To support a culture of "promoting a safe start to life" within this service/organisation
- ☐ To establish baseline levels of safe sleep knowledge and intervention skill across the service
- ☐ To prepare a lot of staff in a short time through "on the spot" peer delivery of the programme
- ☐ To integrate into education on other important issues for babies and families
- ☐ Complement other free education and training available to staff
- ☐ Other:

Comment:

When & where will this programme be used?

- ☐ All staff
- ☐ Some staff
  - ☐ Family Start workers
  - ☐ Staff working in allied programmes
  - ☐ non-clinical (board members/management/administration /support staff)

Comment:

Who will participate in this programme?

- ☐ As a stand alone presentation
- ☐ Within a dedicated staff development day
- ☐ At ward/new staff orientation sessions
- ☐ In a time designated by Team Leader
- ☐ Other: ……..

Comment:

How will people participate in the programme?

- ☐ Through a facilitator (with data show or OHP)
  - ☐ Small group (<10 people)
  - ☐ Large group (10 or more people)
- ☐ Scheduled participation
  - ☐ Choose from a schedule of times slots
  - ☐ Other:
- ☐ Duration of session
  - ☐ 30 minute single session
  - ☐ two 15 minute sessions (Information/skills)
  - ☐ 60 minute single session
  - ☐ Other

Comment:

What are our expectations of participants of this programme?

- ☐ Ask families about safe sleep plans and practices for their babies (raise the issue)
- ☐ Be clear about what is best for babies and why
- ☐ Carry out a safe sleep check with every family of a baby (expected or borne)
- ☐ Record safe sleep status of every child at nominated time intervals
- ☐ Discuss safe sleep protection for the child with parents of every child
- ☐ Other:

Comment:

How will we communicate expectations for involving staff in this programme?

☐ At meetings
☐ By memo
☐ Other:

Comment:

How will we know about participation in the programme? What is/are our performance target(s)?

☐ ____ % of staff participated in the programme within ____ weeks
☐ ____ staff participated in the programme by __/__/____
☐ ____ total presentations delivered by __/__/____
☐ Other:
……..

Comment:

How will we know the programme has been useful?

☐ Increased documentation of safe sleep positioning intention/actions at enrolment and/or intervals
☐ Increased documentation of safe sleep discussions
☐ Increased referral to smokefree support
☐ Positive experience in discussing safe sleep issues reported by surveyed staff and families
☐ Other: ……..

Comment:

How will we monitor the implementation process of the programme?

☐ Regular reports against an implementation schedule for each organisation/area
☐ Other: ……..

Comment:

How will we report on the implementation of the "Baby Essentials" programme?

☐ Session reports by facilitators giving names of attendees, appraisal of the session, issues raised
☐ One page collective report to document purpose, participation outcomes, other outcomes, issues
☐ One page Audit report to document periodic audits of caseworker family notes
☐ Other:
☐ Presented to Manager / Family Start service leader by __/__/____
☐ Presented to Change for our Children by __/__/____

Comment:

Required format

☐ Internet file ☐ OHP slides ☐ Other: ……

Comment:

Any other key comments

Comment:

Contact Person(s)

Name: ……..…. Phone: ……

Designation: ……. Email: ……

OPTIONS FOR EDUCATION SESSIONS

Option 1: Fifteen minute session

The 15 minute option involves presenting the two parts of the programme separately and taking 15 minutes for each part. It may suit smaller hospitals or organisations who cannot release several people at once for education.

Individual viewing

The "Baby Essentials" presentation would be viewed by individuals or pairs on a computer

- as a pre-requisite to the skill-based part of the programme
- as a refresher for people who have seen the presentation previously
- as part of a new staff induction process

Individual coaching

The three resources for shaping safe sleep discussions would be introduced to individual colleagues (or groups of 2 or 3) who have previously seen the "Safe Sleep" slide presentation. They would be coached by the Safe Sleep Champion) in how to use resources with families.

New Staff Induction

Once all staff have been through the programme it can be built in to new staff induction.

Option 2: Sixty minute session

Facilitated session

This is the recommended option. It is the one for which the programme has been designed and is likely to have the best outcome. The two part programme, (information update and brief intervention practice), would be presented together by the peer educator (Safe Sleep Champion) who has been prepared for this by Change for our Children. It would involve groups of about 10 participating in the programme. A punchy delivery of the information and focused skill practice are important if the session is to keep to time. Practice with using materials helps with confidence.

Follow-up session

The 60 minute session could be built into a six-monthly or annual rotation and offered more than once. There is educative value in repetition and as people become more confident having safe sleep discussions with families, they may glean more from subsequent sessions.

Option 3: Two hour session

Facilitated session

There is scope for both parts of the programme to be presented in a more comprehensive way with more time for discussion. This would be suitable in workplaces where there was strong support for safe sleep interventions and where staff release was well supported.

Option 4: Integrated session

The programme could be integrated into a study day about an associated issue e.g. NICU/SCBU newborn care, smokefree, breastfeeding, Maori or Pacific health, family violence ...

SCREENING AND AUDIT

Every service will have its own processes for recording and auditing family information. Below is an easily audited checklist of a standard safe sleep intervention **"ask, be clear, check"** that is simple and practical. It records the safety status of the baby, the action taken by the service team and the action planned by the family. It could be included on the admission page or discharge page of notes or in the file information of the service.

For Audit	**Baby's safety status and family action plan**
☐ **Ask**	About smokefree status of baby: Smokefree in pregnancy y / n Smokefree at home y / n
	About sleep intentions/practices: Position: face-up y / n Place: own 'baby bed' y / n
☐ **Be clear**	Status smokefree? (Yes if household, home and pregnancy all smokefree) ☐**yes** ☐no ☐?
☐ **Discuss**	"Safe Sleep" plan: on ___/___/_____ Family action decided: _____
	Follow-up arranged with: ☐GP ☐Quitline ☐Hospital: ___/___/_____

Section 5: Administration

PEER EDUCATOR ROLE DESCRIPTION - Expectations

Your role in this programme is as a peer educator. You are expected to:

☐ Deliver the "Baby Essentials" presentation to as many colleagues and others as possible (minimum 20).

☐ Report on the first 5 sessions to Change for our Children and include the list of participants for each session. (Reporting not required for subsequent sessions.)

These requirements are an expectation of our contract and will be included in our service reports to the Ministry.

We also expect that you:

☐ Prepare a colleague to take over your role and this resource kit should you leave

You may also find it useful to:

☐ Discuss the programme with your manager

☐ With your manager, carry out a Safe Sleep Service Standard assessment

☐ Develop a plan for the "**Baby Essentials**" education sessions, with your manager

☐ Liaise with relevant others in your setting for systems support as needed

☐ Be an advocate for safe sleep in your work setting

☐ Participate in the "Transform" email network

Before a session

☐ Arrange dates, times, venues with sufficient notice to colleagues

☐ Check the availability of a data projector or OHP

☐ Prepare the flier and promote the session to colleagues

☐ Prepare your materials

- ☐ Down-load the "Baby Essentials" presentation file from http:// www.changeforourchildren.co.nz/safe_start_programme/safe_sleep_project
- ☐ Ensure you have enough practice resources (leaflet and Talk Cards)
- ☐ Ensure you have enough Participant Evaluation forms
- ☐ Ensure you keep a record of the session on the Activity Report

☐ The day before the session, go over materials to refresh yourself

At the session

☐ Prepare your setting (seating, lighting, fresh air, safety)

☐ Welcome your colleagues

☐ Deliver your session according to the guidelines in this resource kit

☐ Collect *Participant Attendance* list

Immediately after a session

☐ Collect Participant Evaluation Forms

☐ Complete your Session Report (there and then is best or as soon as possible)

☐ Check that you have your manager's signature as verification

☐ Place in the stamped addressed envelope provided

☐ Send to Change for our Children, PO Box 13 864, Christchurch within 7 days of session

We thank you for your accountability.

Safe Start is a programme of Change for our Children that is funded by the Ministry of Health. It is peer education designed to align a nation in its efforts to prevent sudden unexpected death in infancy.

“Baby Essentials”

Protecting children is everyone’s business

You are invited to join your colleagues
for a 30 minute presentation on

- The Safe Sleep blitz and what it means for you
- Six principles for protecting a baby’s life
- How to guide a safe sleep check with families

Date	
Time	
Venue	
Presenter	
For more information	

Attendance List

For circulating at a session and recording evidence of participation

Presenter: _____ Organisation: _____ Date:

List of Participants Please identify your professional group: (nurse, allied health, doctor, other)	**Professional group**
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
Summary: Nurses: _____ Allied health: _____ Doctors _____ Other: _____	

Participant Evaluation

"Baby Essentials"

We invite your feedback on this peer education session. A summary of feedback from participants across the country will be included in the service report to the Ministry of Health. Thank you.

1. How would you rate the overall value of this session to you? (on a scale of 1 to 9)

(low value) *1* *2* *3* *4* *5* *6* *7* *8* *9* *(high value)*

2. How confident do you now feel to discuss infant safe sleep practices with families and others in your circle of influence?

(no more confident) *1* *2* *3* *4* *5* *6* *7* *8* *9* *(much more confident)*

3. Comments on the session:

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"Baby Essentials" Activity Report

To be completed by Safe Sleep Champions

The *Safe Start* programme is partly funded by the Ministry of Health. For reporting reasons, Change for our Children asks that those participating in passing on *Baby Essentials* education, complete this form and email / send it to:

Change for our Children, PO Box 13 864, Christchurch.

To monitor participation by the various professional groups, please indicate the practice status of participants as: M=midwife, W=whanau worker, N=nurse, A=allied health, D=doctor, O=other. In this way we are all accountable for the resource allocated to this programme.

Thank you

Session details	
Name of Presenter **:**	
Session Date **:**	Session Length :
Organisation :	City/Town **:**
No. Attending (list names below)**:**	No. of evaluation forms attached **:**

Presenter's Evaluation	
Issues raised **:**	
Signed (Presenter):	Signed (Manager):

List of Participants	**Professional Group**
1	
2	
3	
4	
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8	
9	
10	
Summary: Midwife ___ Whanau worker ___ Nurse ___ Allied health ___ Doctor ___ Other ___	

NB: Please attach participants' evaluation forms

Section 6: Research Articles / Abstracts

Selected abstracts are provided in the following pages.

1	Fleming P, Blair P S. **Sudden Infant Death Syndrome and parental smoking**. Early Human Development. 2007;83(11):721-5.
2	Carpenter R G, Irgens L M, Blair P S, Fleming P, Huber J, Jorch G, Schreuder P. **Sudden unexplained infant death in 20 regions in Europe: case control study.** The Lancet, Vol 363, Jan 17 2004
3	Bredemeyer S L. **Implementation of the SIDS guidelines in midwifery practice.** Australian Midwifery Volume 17, Issue 4, November 2004, Pages 17-21
4	*Colson ER, Levenson S, Rybin D, Calianos C, Margolis A, Colton T, Lister G, Corwin MJ.* **Barriers to following the supine sleep recommendation among mothers at four centers for the Women, Infants, and Children Program.** Pediatrics. 2006 Aug;118(2):e243-50.
5	Scheers N J, Rutherford G W, and Kemp J S. **Where Should Infants Sleep? A Comparison of Risk for Suffocation of Infants Sleeping in Cribs, Adult Beds, and Other Sleeping Locations**. *Pediatrics* 2003;112;883-889
6	Aris, C; Stevens T P; Lemura C; Lipke B; McMullen S; Côté Arsenault D, Consenstein L. **NICU Nurses' Knowledge and Discharge Teaching Related To Infant Sleep Position and Risk of SIDS.** Advances in Neonatal Care: October 2006 - Volume 6 - Issue 5 - p 281-294
7	Escott A, Elder D E, Zuccollo J M. **Sudden unexpected infant death and bedsharing: referrals to the Wellington Coroner 1997–2006.** Journal of the New Zealand Medical Association, 03-July-2009, Vol 122 No 1298
8	Vennemann M, Bajanowski T, Butterfass-Bahloul T, Sauerland C, Jorch G, Brinkmann B, Mitchell EA. **Do risk factors differ between explained sudden unexpected death in infancy and sudden infant death syndrome.** Arch Dis Child. 2007 Feb;92(2):133-6. Epub 2006 Aug 25.
9	Hutchison L, Stewart A and Mitchell E. **Infant sleep position, head shape concerns, and sleep positioning devices.** Journal of Paediatrics and Child Health 43 (2007) 252–257
10	Horsley T, Clifford T, Barrowman N, Bennett S, Yazdi F, Sampson M, Moher D; Ding-wall O, Schachter H, Côté A. **Benefits and Harms Associated With the Practice of Bed Sharing. A Systematic Review.** *Archives of Pediatrics & Adolescent Medicine,* March 2007;161(3):237-245.
11	van Sleuwen BE, Engelberts AC, Boere-Boonekamp MM, Kuis W, Schulpen TW, L'Hoir MP. **Swaddling: A Systematic Review.** *Pediatrics 2007 Oct; 120(4):e1097-106.*

Sudden Infant Death Syndrome and parental smoking

Peter Fleming, Peter S. Blair
Institute of Child Life and Health, University of Bristol, UK
Early Human Development. 2007;83(11):721-5.

Abstract

Prenatal exposure to tobacco smoke is a major risk factor associated with Sudden Infant Death Syndrome (SIDS) and the risk has increased despite continued advice against this practice. Evidence from the UK suggests the prevalence of maternal smoking during pregnancy has risen amongst SIDS mothers (from 50% to 80%) when the rate amongst expectant mothers in the general population has fallen (from 30% to 20%) confirming pooled estimates from recent studies of a fourfold risk. An additional risk from postnatal exposure has also been identified; increasing with the number of smokers in the household or the daily hours the infant is subjected to a smoke-filled environment. Exposure may lead to a complex range of effects upon normal physiological and anatomical development in fetal and postnatal life that places infants at greatly increased risk of SIDS. Recent legislation prohibiting smoking in public places needs to emphasise the adverse effects of tobacco smoke exposure to infants and amongst pregnant women.

Sudden unexplained infant death in 20 regions in Europe: case control study

Carpenter R G, Irgens L M, Blair P S, Fleming P, Huber J, Jorch G, Schreuder P.

The Lancet, Vol 363, Jan 17 2004

Background

After striking changes in rates of sudden unexplained infant death (SIDS) around 1990, four large case-control studies were set up to re-examine the epidemiology of this syndrome. The European Concerted Action on SIDS (ECAS) investigation was planned to bring together data from these and new studies to give an overview of risk factors for the syndrome in Europe.

Methods

We undertook case-control studies in 20 regions. Data for more than 60 variables were extracted from anonymised records of 745 SIDS cases and 2411 live controls. Logistic regression was used to calculate odds ratios (ORs) for every factor in isolation, and to construct multivariate models.

Findings

Principal risk factors were largely independent. Multivariately significant ORs showed little evidence of intercentre heterogeneity apart from four outliers, which were eliminated. Highly significant risks were associated with prone sleeping (OR 13·1 [95% CI 8·51—20·2]) and with turning from the side to the prone position (45·4 [23·4—87·9]). About 48% of cases were attributable to sleeping in the side or prone position. If the mother smoked, significant risks were associated with bed-sharing, especially during the first weeks of life (at 2 weeks 27·0 [13·3—54·9]). This OR was partly attributable to mother's consumption of alcohol. Mother's alcohol consumption was significant only when baby bed-shared all night (OR increased by 1·66 [1·16—2·38] per drink). For mothers who did not smoke during pregnancy, OR for bed-sharing was very small (at 2 weeks 2·4 [1·2—4·6]) and only significant during the first 8 weeks of life. About 16% of cases were attributable to bed-sharing and roughly 36% to the baby sleeping in a separate room.

Interpretation

Avoidable risk factors such as those associated with inappropriate infants' sleeping position, type of bedding used, and sleeping arrangements strongly suggest a basis for further substantial reductions in SIDS incidence rates.

Implementation of the SIDS guidelines in midwifery practice

Sandie L Bredemeyer

Australian Midwifery Volume 17, Issue 4, November 2004, Pages 17-21

Abstract

The literature suggests that midwives strongly influence parenting practices immediately after birth and during early postnatal management of the newborn. Midwives must therefore be aware of the current evidence and public health recommendations for reducing the risk of Sudden Infant Death Syndrome (SIDS) and provide consistent information about use of the supine position. Midwives must also include information about environmental factors that are also known to increase the risk of SIDS such as exposure to cigarette smoke, covering the infant's face during sleep and other potential unsafe sleeping practices such as co-sleeping and bed sharing with their infant.

The position midwives use to settle infants and place them for sleep is an important example for parents. The position favoured by midwives when placing a newborn to sleep will have a significant impact on parental practice after discharge home. A standardised evidenced based approach to the SIDS Guidelines immediately after birth will facilitate consistency in practice and uniformity in the message parents are given about safe sleeping practices for their newborn infant.

Barriers to following the supine sleep recommendation among mothers at four centers for the Women, Infants, and Children Program.

Colson ER, Levenson S, Rybin D, Calianos C, Margolis A, Colton T, Lister G, Corwin MJ.

Pediatrics. 2006 Aug;118(2):e243-50.

Objectives

The risk for sudden infant death syndrome in black infants is twice that of white infants, and their parents are less likely to place them in the supine position for sleep. We previously identified barriers for parents to follow recommendations for sleep position. Our objective with this study was to quantify these barriers, particularly among low-income, primarily black mothers.

Design/Methods

We conducted face-to-face interviews with 671 mothers, 64% of whom were black, who attended Women, Infants, and Children Program centers in Boston, Massachusetts, Dallas, Texas, Los Angeles, California, and New Haven, Connecticut. We used univariate analyses to quantify factors that were associated with choice of sleeping position and multivariate logistic regression to calculate adjusted odds ratios for the 2 outcome variables: "ever" (meaning usually, sometimes, or last night) put infant in the prone position for sleep and "usually" put infant in the supine position to sleep.

Results

Fifty-nine percent of mothers reported supine, 25% side, 15% prone, and 1% other as the usual position. Thirty-four percent reported that they ever placed infants in the prone position. Seventy-two percent said that a nurse, 53% a doctor, and 38% a female friend or relative provided source of advice. Only 42% reported that a nurse, only 36% a doctor, and only 15% a female friend or relative recommended the supine position for sleep. When a female friend or relative recommended the prone position, mothers were more likely ever to place their infants in the prone position and less likely usually to choose supine compared with those who received no advice from friends or relatives. When a doctor or a nurse recommended a nonsupine position, the mothers were less likely to choose supine compared with those who received no advice from a doctor or a nurse. Mothers who trusted the opinion of a doctor or a nurse about infant sleeping position were more likely to place their infants in the supine position. Half of the mothers believed that infants were more likely to choke when supine, and they were less likely to place their infants supine. Mothers who believed that infants are more comfortable in the prone position (36%) were more likely to place their infants prone. Twenty-nine percent believed that having their infants sleep with an adult helps prevent sudden infant death syndrome, and only 43% believed that sudden infant death syndrome is related to sleeping position.

Conclusions

We identified specific barriers to placing infants in the supine position for sleep (lack of or wrong advice, lack of trust in providers, knowledge and concerns about safety and comfort) in low-income, primarily black mothers that should be considered when designing interventions to get more infants onto their back for sleep.

Where Should Infants Sleep? A Comparison of Risk for Suffocation of Infants Sleeping in Cribs, Adult Beds, and Other Sleeping Locations

N. J. Scheers, PhD; George W. Rutherford, MS‡; and James S. Kemp, MD§

Pediatrics 2003;112;883-889

Objectives.

To ascertain whether the number of sudden infant deaths as a result of suffocation in cribs, in adult beds, on sofas or chairs, and on other sleep surfaces was increasing whether attributable to increased reporting, diagnostic shift, or an actual increase in suffocation deaths and to compare the risk of reported accidental suffocation for infants on sleep surfaces designed for infants with the risk on adult beds.

Methods.

We reviewed all accidental suffocation deaths among infants <11 months of age reported to the United States Consumer Product Safety Commission from 1980 through 1983 and 1995 through 1998. We compared infants' ages and other demographic data, the sleep location and surface used, and the reported mechanism or pattern of death. For 1995–1998, we used data on sleep location from an annual survey of randomly selected households of living infants younger than 8 months, collected as part of the National Infant Sleep Position Study at the National Institute of Child Health and Human Development, to calculate risk for death as a result of suffocation in cribs, in adult beds, and on sofas or chairs. The number of reported suffocation deaths by location were compared between the 1980s and 1990s using logistic regression modeling to calculate odds ratios (OR), 95% confidence intervals (CI), and *P* values. Comparative risks for suffocation deaths on a given sleep surface for infants in the 1990s were examined by calculating rates of death per 100 000 exposed infants and comparing the 95% CI for overlap.

Results.

From the 1980s, 513 cases of infant suffocation were considered; from the 1990s, 883 cases. The number of reported suffocation deaths in cribs fell from 192 to 107, the number of reported deaths in adult beds increased from 152 to 391, and the number of reported deaths on sofas or chairs increased from 33 to 110. Using cribs as the reference group and adjusting for potential confounders, the multivariate ORs showed that infant deaths in adult beds were 8.1 times more likely to be reported in the 1990s than in the 1980s (95% CI: 3.2–20.3), and infant deaths on sofas and chairs were 17.2 times more likely to be reported in the 1990s than in the 1980s (95% CI: 5.0 –59.3). The sleep location of a subset of cases from the 1990s, 348 infants younger than 8 months at death, was compared with the sleep location of 4220 living infants younger than 8 months. The risk of suffocation was approximately 40 times higher for infants in adult beds compared with those in cribs. The increase in risk remained high even when overlying deaths were discounted (32 times higher) or the estimate of rates of bedsharing among living infants doubled (20 times higher).

Conclusions.

Reported deaths of infants who suffocated on sleep surfaces other than those designed for infants are increasing. The most conservative estimate showed that the risk of suffocation increased by 20-fold when infants were placed to sleep in adult beds rather than in cribs. The public should be clearly informed of the attendant risks.

NICU Nurses' Knowledge and Discharge Teaching Related To Infant Sleep Position and Risk of SIDS

Aris, C; Stevens T, Lemura C; Lipke B; McMullen S; Côté-Arsenault D, Consenstein L.

Advances in Neonatal Care: October 2006 - Volume 6 - Issue 5 - p 281-294

Infants requiring neonatal intensive care are often placed prone during their acute illness. After hospital discharge the American Academy of Pediatrics (AAP) recommends supine sleep position to reduce the risk of Sudden Infant Death Syndrome (SIDS). Little is known about nursing knowledge and practice regarding best sleep positions for infants as they transition from neonatal intensive care to home.

Objective

To explore and describe neonatal intensive care unit (NICU) nurses' knowledge and practice in the NICU, and to determine the content of parent instruction regarding infant sleep position at discharge.

Study Design

This survey was conducted in 2 phases. In Phase I, a questionnaire was designed and completed by 157 neonatal nurses currently practicing in Level III and IV NICUs in the state of New York. After content analysis of responses and item revisions, a panel of experts reviewed questionnaire items. Phase II involved completion of the final questionnaire by 95 NICU nurses in 4 additional hospitals. The combined results of Phase I and II are reported.

Results

Of 514 questionnaires distributed, 252 (49%) were completed and analyzed. During NICU hospitalization, nurse respondents identified prone position as the best general sleep position for preterm infants (65%) followed by either prone or side-lying (12%). The nurses' assessment of the infants' readiness for supine sleep position at the time of NICU discharge varied. Most nurses responded that preterm infants were ready to sleep supine anytime (29%), close to discharge (13%), when maintaining their body temperature in an open crib (25%), between 34 to 36 weeks postmenstrual age (PMA) (15%), after 37 weeks PMA (13%), and when the infant's respiratory status was stable (6%). Typical sleep positions chosen for full-term infants in the NICU were supine (40%), side or supine (30%), all positions (18%), side (8%), prone or side (3%), and prone (1%). Frequently cited reasons to place full-term infants to sleep prone were: reflux (45%), upper airway anomalies (40%), respiratory distress (29%), inconsolability (29%), and to promote development (17%). At NICU discharge, 52% of nurses instructed parents to place their infants in the supine position for sleep. The most common nonsupine sleep positions recommended by nurses at discharge were either supine or side (38%), and exclusive side positioning (9%).

Conclusions

Nearly 95% of respondents identified a nonsupine sleep position as optimal for hospitalized preterm infants. Further, only 52% of neonatal nurses routinely provide discharge instructions that promote supine sleep positions at home. This study suggests that nursing self-reports of discharge teaching practices are inconsistent, and in some cases in direct conflict with the national Back to Sleep recommendations, which emphasize that the supine position is the safest position for healthy full-term and preterm infants after hospital discharge.

Sudden unexpected infant death and bedsharing: referrals to the Wellington Coroner 1997–2006

Alistair Escott, Dawn E Elder, Jane M Zuccollo

Journal of the New Zealand Medical Association, 03-July-2009, Vol 122 No 1298

Aims

To describe the factors associated with sudden unexpected infant deaths, for which there was no clear medical diagnosis, referred to the Wellington-based coronial paediatric pathology service over the decade from 1997 to 2006.

Methods

The postmortem report, Police 47 file, Coroner's findings and deceased infant's medical records were used to create a profile for each sudden and unexpected infant death.

Results

There were 64 deaths in the period: 54 of these occurred during sleep and did not have a clear medical diagnosis. Māori and Pacific infants and infants from low decile areas were over-represented in the group. The majority (88.7%) of infants were < 6 months of age at death. Overall, 50% of infants had been placed to sleep in a non-recommended sleep position and 38% usually slept in a non-recommended location. Bedsharing was associated with 53.7% of deaths. There was a significant association between bedsharing and being found dead on a Sunday morning (p=0.04).

Conclusion

Sudden unexpected death in infancy is associated with unsafe sleep environments and sleep positions. Every effort should be made to ensure that information about safe infant sleep practices reaches the caregivers of those particularly at risk.

Do risk factors differ between explained sudden unexpected death in infancy and sudden infant death syndrome

Vennemann M, Bajanowski T, Butterfass-Bahloul T, Sauerland C, Jorch G, Brinkmann B, Mitchell EA.

Arch Dis Child. 2007 Feb;92(2):133-6. Epub 2006 Aug 25.
Institute for Legal Medicine, University of Münster, Münster, Germany.
mechtild.vennemann@ukmuenster.de

Background
In Germany, 2910 infants died in 2004;for many infants the reason was clear, especially prematurity or congenital abnormalities. However, 394 babies die every year suddenly and unexpectedly. The cause may be immediately clear, but is often not obvious.

Aims
(1) To describe the causes of explained sudden unexpected death in infancy (SUDI) and (2) to compare risk factors for sudden infant death syndrome (SIDS) and explained SUDI.

Methods
A 3-year population-based case-control study in Germany, 1998-2001.

Results
455 deaths, of which 51 (11.2%) were explained. Most of these deaths were due to respiratory or generalised infections. The risk factors for SIDS and explained SUDI were remarkably similar except for sleep position and breast feeding. Prone sleeping position is a major risk factor for SIDS (adjusted odds ratio (OR) 7.16, 95% confidence interval (CI) 3.85 to 13.31) but not for explained SUDI (adjusted OR 1.71, 95% CI 0.25 to 11.57). Not being breast fed in the first 2 weeks of life is a risk factor for SIDS (adjusted OR 2.37, 95% CI 1.46 to 3.84) but not for explained SUDI (adjusted OR 0.39, 95% CI 0.08 to 1.83).

Conclusions
Prone sleeping position is a unique risk factor for SIDS. Socioeconomic disadvantage and maternal smoking are risk factors for both SIDS and explained SUDI, and provide an opportunity for targeted intervention.

Infant sleep position, head shape concerns, and sleep positioning devices

Lynne Hutchison, Alistair Stewart and Edwin Mitchell

Department of Paediatrics and School of Population Health, University of Auckland, Auckland, New Zealand

Journal of Paediatrics and Child Health 43 (2007) 252–257

Aim

The Back To Sleep campaign has successfully promoted the use of the supine sleep position for infants, with a corresponding decrease in sudden infant death syndrome death rates around the world. The aim of this study was to survey current infant sleep position practices, concerns about plagiocephaly, and the use of sleep positioning devices.

Methods

A postal survey of 400 mothers of infants aged 6 weeks to 4 months was carried out in Auckland, New Zealand.

Results

Of the 278 (69.5%) respondents, the supine position was usually used in 64.8%, the prone position in 2.9%, with 32.3% using the side position or a combination of side and back positions. Approximately one-third had a concern about their infant's head shape, and 80% described practices to help prevent head deformation. Thirty per cent reported they had changed their infant's sleep position because of head shape concerns. A third of the mothers used some sort of positioning system to maintain the infant's sleep position.

Conclusions

Anxieties about plagiocephaly, aspiration of vomit, and poor quality sleep are the main concerns that parents have about sleeping their infants on their backs. Further education is needed to inform mothers about these issues and to alleviate their fears.

Benefits and Harms Associated With the Practice of Bed Sharing

A Systematic Review

Horsley T, Clifford T, Barrowman N, Bennett S, Yazdi F, Sampson M, Moher D; Dingwall O, Schachter H, Côté A.

Archives of Pediatrics & Adolescent Medicine,March 2007;161(3):237-245.

Objective

To examine evidence of benefits and harms to children associated with bed sharing, factors (eg, smoking) altering bed sharing risk, and effective strategies for reducing harms associated with bed sharing.

Data Sources

MEDLINE, CINAHL, Healthstar, PsycINFO, the Cochrane Library, Turning Research Into Practice, and Allied and Alternative Medicine databases between January 1993 and January 2005.

Study Selection

Published, English-language records investigating the practice of bed sharing (defined as a child sharing a sleep surface with another individual) and associated benefits and harms in children 0 to 2 years of age.

Data Extraction

Any reported benefits or harms (risk factors) associated with the practice of bed sharing.

Data Synthesis

Forty observational studies met our inclusion criteria. Evidence consistently suggests that there may be an association between bed sharing and sudden infant death syndrome (SIDS) among smokers (however defined), but the evidence is not as consistent among nonsmokers. This does not mean that no association between bed sharing and SIDS exists among nonsmokers, but that existing data do not convincingly establish such an association. Data also suggest that bed sharing may be more strongly associated with SIDS in younger infants. A positive association between bed sharing and breastfeeding was identified. Current data could not establish causality. It is possible that women who are most likely to practice prolonged breastfeeding also prefer to bed share.

Conclusion

Well-designed, hypothesis-driven prospective cohort studies are warranted to improve our understanding of the mechanisms underlying the relationship between bed sharing, its benefits, and its harms.

Swaddling: a systematic review

van Sleuwen BE, Engelberts AC, Boere-Boonekamp MM, Kuis W, Schulpen TW, L'Hoir MP

Pediatrics 2007 Oct; 120(4):e1097-106.

Swaddling was an almost universal child-care practice before the 18th century. It is still tradition in certain parts of the Middle East and is gaining popularity in the United Kingdom, the United States, and The Netherlands to curb excessive crying. We have systematically reviewed all articles on swaddling to evaluate its possible benefits and disadvantages. In general, swaddled infants arouse less and sleep longer. Preterm infants have shown improved neuromuscular development, less physiologic distress, better motor organization, and more self-regulatory ability when they are swaddled. When compared with massage, excessively crying infants cried less when swaddled, and swaddling can soothe pain in infants. It is supportive in cases of neonatal abstinence syndrome and infants with neonatal cerebral lesions. It can be helpful in regulating temperature but can also cause hyperthermia when misapplied. Another possible adverse effect is an increased risk of the development of hip dysplasia, which is related to swaddling with the legs in extension and adduction. Although swaddling promotes the favorable supine position, the combination of swaddling with prone position increases the risk of sudden infant death syndrome, which makes it necessary to warn parents to stop swaddling if infants attempt to turn. There is some evidence that there is a higher risk of respiratory infections related to the tightness of swaddling. Furthermore, swaddling does not influence rickets onset or bone properties. Swaddling immediately after birth can cause delayed postnatal weight gain under certain conditions, but does not seem to influence breastfeeding parameters.